

HUSKY A MCO EMERGENCY DEPARTMENT UTILIZATION REPORT

TITLE: EMERGENCY DEPARTMENT

SOURCE: RFA

FREQUENCY: SEMI-ANNUALLY

PERIOD COVERED:

APRIL 1ST – SEPTEMBER 30TH

OCTOBER 1ST – MARCH 31ST

DATE DUE: 3 MOS. AFTER REPORT PERIOD

DUE: JANUARY 1ST

DUE: JULY 1ST

EMERGENCY DEPARTMENT UTILIZATION

As the mockup indicates, list the hospitals by name in alphabetical order. For each hospital, show the number of visits to the emergency department. Show visits coded as "Emergencies" and "Non-emergencies" as one total per hospital. Please show a total all visits for all hospitals at the bottom, as indicated in the mock-up.

If a plan uses revenue center codes (RCCs), it should use them. If a plan does not use revenue center codes, it may use CPT's. *The two methods should not be used together, since that would result in double-counting.*

No service should be omitted from this report on the basis of diagnosis. Emergency department services should also be counted regardless of whether or not they lead to an inpatient admission.

REVENUE CENTER CODES

Revenue Center Codes for visits to the emergency department are described in the UB-92 Form Locator, pages 124 and 124A.

The following codes and combinations of codes should be included:

“Emergencies”

1. 450 alone
2. Combination of 451 and 452

“Non-emergencies”:

3. 451 alone
4. 456 alone
5. 459 alone
6. 451 plus 456
7. 451 plus 459
8. 456 plus 459

Stand-alone use of 452 is not permitted. Combinations other than those shown above are also not permitted. The distinctions between emergency and non-emergency are presented here are information only, since we are no longer requiring separate reporting.

CPT CODES

If a plan does not use Revenue Center Codes as outlined above, then the following CPT codes should be included:

"Emergencies"

1. 99283
2. 99284
3. 99285

"Non-emergencies"

4. 99281
5. 99282

The attached spreadsheet headed "Emergency Department Visits" presents this information in an alternative form, together with definitions of the Revenue Center Codes.

HUSKY A MCO HOSPITAL INPATIENT SERVICES UTILIZATION REPORT

TITLE: HOSPITAL INPATIENT UTILIZATION

SOURCE: RFA

FREQUENCY: SEMI-ANNUALLY

PERIOD COVERED:

APRIL 1ST – SEPTEMBER 30TH

OCTOBER 1ST – MARCH 31ST

DATE DUE: 3 MOS. AFTER REPORT PERIOD

DUE: JANUARY 1ST

DUE: JULY 1ST

SPECIFICATIONS FOR INPATIENT UTILIZATION OVERVIEW

DEFINITIONS OF COLUMN HEADINGS DEFINITIONS OF COLUMN HEADINGS

Days:

For Inpatient Days, include the day of admission but not the day of discharge. If the date of admission and the date of discharge are the same day, it should be counted. Count days which were part of the discharges occurring within the reporting period, even if some of the days occurred prior to the reporting period. Do not count days for which the discharge did not occur within the reporting period, even if some of the days did. Do not count days for which the primary diagnosis is one of mental health or substance abuse. For detailed instructions on this see under "Discharges" below.

Discharges:

Count all discharges which occurred during the reporting period, with the following exceptions:

Those with a mental health or substance abuse primary diagnosis. The discharges to be excluded are those with diagnoses in the ranges 290 through 316, 965.0x, 965.8x 967.xx, 968.5x, and 969.xx

Average Length of Stay - ALOS:

Total days (column 1) divided by total discharges (column 2).

Days/1,000 member months (total days incurred/(member months/1000)):

Unless otherwise specified, should include all members. A member month is one month's enrollment by one person. The count of member months should include months for which a person was retroactively enrolled.

Discharges/1,000 member months (total discharges/(member months/1000)):

Unless otherwise specified, should include all members. A member month is one month's enrollment by one person. The count of member months should include months for which a person was retroactively enrolled.

LINE INSTRUCTIONS

Total (no line number):

Columns 1-2 should be unduplicated counts of days and discharges, respectively. Column 3 Total should be calculated in the same way as in Lines 1-9. Columns 4 and 5 should be calculated with all members in the denominator. None of the columns in this line should be derived by calculating the sum of Lines 1-9, since that would lead to double-counting. This line, like the other lines, should exclude discharges with a mental health or substance abuse primary diagnosis.

Total excluding newborns (no line number):

This line should be computed in the same way as the "total" line, *except* that it should exclude all discharges with a primary or secondary diagnosis of V30.xx through V39.xx.

Line 1. Maternity, Mother (live births):

Include all inpatient stays that resulted in a live birth. It should include only stays by a mother who is a member of the plan during the stay. A stay that resulted in a multiple birth should be counted as one discharge. For a description of ICD-9 codes to use to identify live births, see pages 71-72 of HEDIS 2000, tables E6-A and E6-B. In counting days/1,000 member months and discharges/1,000 member months, count in the denominators only members who are i) female and ii) between the ages of 15 and 44.

Line 2. Maternity-Mother Linked to Baby:

This includes all inpatient stays included in Line 1 for which the MCO was able to link the mother and the baby. The data given on this line is still the information for the mother, not the baby. In counting days/1,000 member months and discharges/1,000 member months, count in the denominators only members who are i) female and ii) between the ages of 15 and 44.

Line 3.

Well newborns - Newborns who are not defined as complex and have a LOS of less than five days. In multiple births, each baby should be counted separately. In counting days/1,000 member months and discharges/1,000 member months, count in the denominators only members who are i) female and ii) between the ages of 15 and 44.

Line 4. Baby Discharged (Complex): Newborns are reported as complex if:

- their LOS is greater than or equal to five days, ***or***
- their LOS is less than five days and the newborn expired, ***or***
- the newborn is transferred to another facility and the MCO is unable to track total LOS between the two facilities.

In multiple births, each baby should be counted separately.

.In counting days/1,000 member months and discharges/1,000 member months, count in the denominators only members who are i) female and ii) between the ages of 15 and 44.

Line 5. Baby Deceased:

This should count cases included in Line 4 in which the baby died prior to discharge. Identification of such cases may be based on discharge code, or on other methods chosen by each plan. Days should include all days of the baby's stay. In counting days/1,000 member months and discharges/1,000 member months, count in the denominators only members who are i) female and ii) between the ages of 15 and 44.

Note:

In Lines 3-5 please count the baby's discharges and days, but use women age 15-44 as the denominator. In multiple births, each baby should be counted wherever he/she falls.

Line 6. Asthma:

This should include all hospital discharges with a principal diagnosis of asthma (ICD-9 code 493.xx).

Line 7. Hypertension-Principle Diagnosis:

This should include all hospital discharges with a hypertension-related principle diagnosis. The list of ICD-9 codes which should be used is drawn from pages 154-155 of the ICD-9 manual, fourth edition, ~~fifth~~ seventh printing.

Line 8. Hypertension - Second or Third Diagnosis:

This should include all hospital discharges with a hypertension-related second or third diagnosis. The list of ICD-9 codes that should be used is the same as for Line 7.

Line 9. Other:

Should include all discharges not included in Lines 1-8, *except* for those with a mental health or substance abuse primary diagnosis. *The discharges to be excluded are the same as those identified in the instructions for column 2: Discharges with diagnoses in the ranges 290 through 316, 965.0x, 965.8x 967.xx, 968.5x, and 969.xx*

HUSKY A MCO MATERNAL/PRENATAL SERVICES UTILIZATION REPORT

TITLE: MATERNAL\PRENATAL REPORT

SOURCE: RFA

FREQUENCY: SEMI-ANNUALLY

PERIOD COVERED:

JANUARY 1ST – JUNE 30TH

JULY 1ST – DECEMBER 31ST

DATE DUE: 6 MOS. AFTER REPORT PERIOD

DUE: JANUARY 1ST

DUE: JULY 1ST

SPECIFICATIONS FOR MATERNAL/PRENATAL REPORT

Line 1. Number of Deliveries:

Report the number of deliveries that occurred to plan members during the reporting period. Please follow HEDIS of the previous year for this specification for the January report and of the current year for the July report.

Line 2. Live Births:

Report the number of children born to plan members during the reporting period who showed any sign of life after birth, no matter how brief. Please follow HEDIS of the previous year for this specification for the January report and of the current year for the July report.

Line 3. Fetal Deaths:

Report the number of deaths to fetuses after twenty or more weeks of gestation. If a member has multiple fetal deaths (for example, stillborn twins) each fetus should be counted separately.

Line 4a. Moderately Low Birthweights:

Report the number of children included in #2 whose birthweight is greater than or equal to 1500 grams but less than 2500 grams.

Line 4b. Very Low Birthweights:

Report the number of children included in Line 2 whose birthweight is less than 1500 grams.

Line 4c. Birthweight unknown:

Report the number of children included in Line 2 whose birthweight is unknown to the plan.

Line 5. Women delivering with no prenatal care:

Report the number of women included in Line 1 who had no prenatal care visits. Please follow HEDIS of the previous year for this specification for the January report and of the current year for the July report.

Lines 6a through 6e. Number of women with various levels of prenatal care:

For each woman included in #1, this measure involves calculating the number of expected visits, counting the number of actual visits, computing the number of actual visits as a percentage of the number of expected visits, and reporting the member on the correct line.

Line 6a	# with 20% or Less of Expected Visits
Line 6b	# with 21-40% of Expected Visits
Line 6c	# with 41-60% of Expected Visits
Line 6d	# with 61-80% of Expected Visits
Line 6e	# over 80% of Expected Visits

Please follow HEDIS of the previous year for this specification for the January report and of the current year for the July report.

None of the Lines in 6a through 6e should include women with no prenatal visits. Those women should be counted in Line 5. The sum of Lines 5 through 6e should equal Line 1.

Line 7a. Continuously Enrolled Postpartum:

Please follow HEDIS of the previous year for this specification for the January report and of the current year for the July report.

Line 7b. Postpartum Visit 21 days to 56 days after delivery:

Please follow HEDIS of the previous year for this specification for the January report and of the current year for the July report.

A postpartum visit that took place within 21-56 days of delivery should be counted even if it took place outside the reporting period.

Line 8a, 8b, 8c. Number Enrolled in First Trimester:

Number of women counted in Line 1 whose effective date of enrollment in the plan was earlier than or equal to twelve weeks of gestational age. This should include both those who became pregnant after enrollment in the plan and those who joined the plan within twelve weeks of gestation.

Line 9a, b and c. Number with First Trimester Care:

Please follow HEDIS of the previous year for this specification for the January report and of the current year for the July report.

For 9a, prenatal visits should be identified by the same criteria as in Line 5.

Women with no prenatal visits should not be counted in Lines 9a.

Please follow HEDIS of the previous year for this specification for the January report and of the current year for the July report.

General Note regarding use of HEDIS specifications regarding this report:

The reporting committee will not routinely review **any** changes to HEDIS specifications for these two reports. Changes made to HEDIS specifications annually are to be incorporated into HUSKY reports unless DSS and the MCOs explicitly decide otherwise.

MCOs or DSS can bring up for discussion any changes about which they have concerns. The Reporting Committee/DSS and the HUSKY MCOs will discuss changes made to HEDIS that are brought forward for discussion and *may* decide not to accept some of these changes. However, any such changes to revised HEDIS will be considered by DSS only after the committee discusses and recommends them.

HUSKY A MCO OTHER SERVICES UTILIZATION REPORT

TITLE: OTHER SERVICES REPORT

SOURCE: RFA

FREQUENCY: SEMI-ANNUALLY

PERIOD COVERED:

JANUARY 1ST – JUNE 30TH

JULY 1ST – DECEMBER 31ST

DATE DUE: 3 MOS. AFTER REPORT PERIOD

DUE: OCTOBER 1ST

DUE: APRIL 1ST

COLUMN DEFINITIONS

Row # of services:

Varies by line. See below.

Services per 1,000 member months (total services/(member months/1000)):

Unless otherwise specified, should include all members.

LINE DEFINITIONS

Emergency Transports:

Count the number of services under the following codes:

- i. A0427 Ambulance Service, Advanced Life Support, level 1, (ALS 1 -emergency)
- ii. A0429 Ambulance Service, basic life support, emergency transport (BLS – emergency)

A0225, A0430, A0431, A0433, A0434

(A0430 and A0434 can be NEMT instead of emergency, but this is rare.)

Non-Emergency Transports:

Count all trips that are not included in Emergency Transport above or bus passes, below, which are one-way and are identifiable as single trips. A round trip should be counted as two trips.

Include the codes on table 1, attached, or their equivalent. Codes in Table 2 should be counted as NEMT *only if appropriate*.

Bus/Train Passes:

Count the number of bus or train passes purchased.

Vision Exams:

Count services under procedure codes 92002, 92004, 92012, and 92014.

Eyeglasses/Contact Lenses:

Count days on which clients received vision equipment. If several V codes were used on the same day for the same client count this as one pair of eyeglasses/contacts/piece of vision equipment. If a client received vision equipment on more than one day per reporting period count each day that they received vision equipment as a separate service.

V2020-V2599

V2600-V2615 (Low Vision Aids)

V2623-V2629 (Prosthetic Eye)

V2630-V2632 (Intraocular Lenses)

Table 1

(Preferred) DSS Transportation Codes effective 8/2006		X = Counted when counting trips	
A0021	Ambulance service, outside state, per mile, transport		
A0080	Non-emergency transportation, per mile-vehicle provided by volunteer with no vested interest		<u>Either A0080 or A0090 can be used</u>
A0090	Non-emergency transportation, per mile-vehicle provided by volunteer with vested interest		
A0100	Non-emergency transportation, taxi	X	
A0110	Non-emergency transportation and bus, intra or interstate carrier	X	For bus or train
A0120	Non-emergency transportation: minibus, mountain area transports or other transportation systems	X	Minibus/minivan for shared trips
A0130	Non-emergency transportation, wheelchair van	X	
A0140	Non-emergency transportation, and air travel (private or commercial) intra- or interstate	X	
A0160	Non-emergency transportation, per mile- caseworker or social worker		
A0170	Transportation ancillary: parking fees, tolls, other		
A0380	BLS Mileage (per mile)		
A0382	BLS routine disposable supplies		
A0390	ALS Mileage (per mile)		
A0394	ALS Specialized service, disposable supplies; IV drug therapy		
A0398	ALS routine disposable supplies		
A0420	Ambulance waiting time (ALS or BLS), one half hour increments		
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation		
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged)		
A0425	Ground mileage, per statute		

	mile		
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)	X	
A0428	Ambulance service, basic life support, non-emergency transport (BLS)	X	
A0433	Advanced life support, level 2 (ALS 2)		
A0800	Ambulance transport provided between the hours of 7pm and 7am		
A0999	Unlisted ambulance service		
S0215	Non-emergency transportation, mileage, per mile		NEMT Mileage
T2003	Non-emergency transportation encounter/trip	X	Trip not described elsewhere, should be rarely used
3500A	Livery Base Rate, One Recipient, One Way	X	
3502A	Livery No Show, Base Rate Charge		
3507A	Livery, Passenger Assistance		
3540A	Livery Base Rate, Additional Passenger, One Way	X	Note change in text
3912A	Invalid Coach, Additional Passenger, One Way	X	Note change in text

Table 2 These codes can be either emergency or nonemergency but are most frequently emergency			
A0430	<i>Ambulance service, conventional air services, transport, one way (fixed wing)</i>	X (if NEMT)	
A0434	<i>Specialty care transport (SCT)</i>	X (if NEMT)	

Note: You do not have to use these codes. However you must use clearly defined codes that let us count one-way trips and total paid, by type of transportation provided. The only exception is bus or train passes where we understand that it may be difficult to determine number of trips taken.

Case No	Member ID	Date of Birth	Referral Source	Ref. Source Descript (Opt.)	Reason for Ref.1	Reason for Ref.2	Reason for Ref.3	Reason for Ref.4	Type of Case or Diag	CM Start Date	Case Mgr ID	DesOut come-1	DesOut come-2	DesOut come-3	DesOut come-4	DesOut come-5	Status	Rsn for Closure
1	002145033	07/04/01	6	INPATIENT CENSUS	2	3			1	07/07/01	524G	4	5				ACTIVE	6
2	001999990	05/05/93	1	HEALTH- HELP	4				2	01/04/01	524U	1	2	3			ACTIVE	6
3	002666966	09/24/89	2	CONCUR- RENT REVIEW	4				2	01/05/01	A50	1	2	3	5		ACTIVE	6
4	002690325	04/28/01	6	INPATIENT CENSUS	1	5			5	05/02/01	A52	3	5				ACTIVE	6
5	002492222	04/11/00	6	INPATIENT CENSUS	2				3	04/12/00	A52	2	3	4			CLOSED	1
6	002000006	03/03/00	4	PCP/Provider	2				8	03/05/00	A54	1	2	5			ACTIVE	6
7	001654329	11/27/01	6	INPATIENT CENSUS	2	4			2	01/01/10	A66	1	2	3			CLOSED	3

(Leave blank, but do not omit)

Medicaid ID
text format
2 leading zeroes

See List 1

See List 2

See List 2

See List 2

See List 2

See List 3

See List 4

See List 5

MCO CLINICAL CASE MANAGEMENT REPORT

**MCO Name
Q1 200X**

Submitted 9/30/03

HUSKY A
EPSDT SIX-MONTH UTILIZATION REPORT

	MCO/HEALTH PLAN NAME:								
	SIX MONTH REPORTING PERIOD:								
	DATE REPORT COMPILED:								
			Age Groups						
Line	DESCRIPTION	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
1	Total Eligible for HealthTrack								
2a	State Periodicity Schedule		6	4	3	2.5	4.5	4	2
2b	Number of Years in Age Group		1	2	3	4	5	4	2
2c	Average Expected Screens in Six Months		3	1	0.5	0.3125	0.45	0.5	0.5
3a	Total Months of Enrollment								
3b	Average Period of Eligibility		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
4	Expected Number of Screenings per Member		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
5	Expected Number of Screenings		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
6	Total Screens Received								
7	Screening Ratio		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
8	Total Eligibles Who Should Receive at Least One Initial or Periodic Screen		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
9	Total Eligibles Receiving at Least one Initial or Periodic Screen								
10	Participant Ratio		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
11	Total Members Referred for Corrective Treatment								
12a	Total Members Receiving Any Dental Services								
12b	Total Members Receiving Preventive Dental Services								
12c	Total Members Receiving Dental Treatment Services								
12d	Percent of full-time equivalent member months receiving any dental services		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
12e	Percent of full-time equivalent member months receiving preventative dental services		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

HUSKY A
MATERNAL / PRENATAL REPORT

MCO/HEALTH PLAN NAME and Contact Name:
REPORTING PERIOD:
DATE REPORT COMPILED:

LINE	DESCRIPTION	TOTAL
1	NUMBER OF DELIVERIES*	
2	LIVE BIRTHS	
3	FETAL DEATHS	
4a	MODERATELY LOW BIRTHWEIGHT	
4b	VERY LOW BIRTHWEIGHT	
4c	BIRTHWEIGHT UNKNOWN	
5	WOMEN WITH NO PRENATAL CARE	
6a	# WITH 20% OR LESS OF EXPECTED VISITS	
6b	# WITH 21-40% OF EXPECTED VISITS	
6c	# WITH 41-60% OF EXPECTED VISITS	
6d	# WITH 61-80% OF EXPECTED VISITS	
6e	# OVER 80% OF EXPECTED VISITS	
7a	# CONTINUOUSLY ENROLLED POSTPARTUM	
7b	# OF WOMEN IN LINE 7a WITH POSTPARTUM VISIT 21 TO 56 Days after Delivery	
8a	NUMBER ENROLLED IN FIRST TRIMESTER	
8b	NUMBER ENROLLED IN SECOND TRIMESTER	
8c	NUMBER ENROLLED IN THIRD TRIMESTER	
9a	NUMBER WITH FIRST TRIMESTER CARE	
9b	NUMBER WITH SECOND TRIMESTER CARE	
9c	NUMBER WITH THIRD TRIMESTER CARE	
10	<i>Number of Caesarean Deliveries</i>	

* to women enrolled at least 42 days before delivery.

Addendum:

Women delivering less than 42 days after delivery:

Total Deliveries:
 Total Births:
 Births very low birthweight
 Births moderately low birthweight
 Women who remained enrolled in MCO for 8 weeks postpartum with postpartum visit 6-8 weeks after delivery
 Number of these who received a timely postpartum visit.

HUSKY A
OTHER SERVICES REPORT

	MCO/HEALTH PLAN NAME: REPORTING PERIOD: DATE REPORT COMPILED:		
LINE	NAME	RAW # OF SERVICES	SERVICES PER 1,000 MEMBER MONTHS
1	EMERGENCY TRANSPORTS		
2	NON-EMERGENCY TRANSPORTS		
3	BUS PASSES / BUS TOKENS		
4	VISION EXAMS		
5	EYEGASSES / CONTACT LENSES		

EMERGENCY DEPARTMENT VISITS

Health Plan Reporting:

Period Covered:

Date Report Compiled:

Hospital	Emergency Dept. Visits
Name of Hospital 1	
Name of Hospital 2	
etc.	
TOTAL	

MOCKUP, HOSPITAL INPATIENT REPORT, HUSKY A

INPATIENT UTILIZATION OVERVIEW						
Health Plan:					Member Months, Total: XX,XXX	
Period Covered:					Member Months Females aged 15-44: YYYY	
Date Report Compiled:						
		1	2	3	4	5
		DAYS	DISCHARGES	ALOS	DAYS/1000 MEMB MONTHS	DISCHARGES/ 1000 MEMB MONTHS
1a	Total, all inpatient					
1b	Total, excluding newborns					
2	Maternity, mother, (live births)					
3	Newborn (well) discharged after less than 5 days					
4	Newborn (complex) discharged after 5 or more days*					
5	-Newborn deceased (also included above)					
For columns 4-5, rows 2-5, rates are based on female members age 15-44.						
* or transferred to another hospital and LOS unknown.						

Report on **Prior Authorization Request Outcomes**, to be Prepared Quarterly

Member Months, Clients under age 21 at middle month of Quarter
Member Months, Clients age 21 and up at middle month of Quarter

74651
26915

Inpatient Services or Outpatient				0	0
Top Reason for Denial					
2nd most common reason for Denial					
3rd most common reason for denial					
Inpatient Services or Outpatient Surgery¹ Clients age 21 or above				0	0
Top Reason for Denial					
2nd most common reason for Denial					
3rd most common reason for denial					

¹We agreed that Ambulatory Services other than surgery are so varied and so rarely denied that it is not appropriate to report on them.
 Age listed is that as of date of the request.

* Partial Denials were partially approved and partially denied.

Note: This report does not include prior authorised pharmacy or transportation services.

Report on Denials of Prior Authorization Requests for Selected Service Types

Member Months, Clients under age 21 at middle month of Quarter

Member Months, Clients age 21 and up at middle month of Quarter

Part 2- DME, Home Health and Therapies

	Approvals	Denials	Approvals per 1,000 Member Months	Denials per 1,000 Member Months
Durable Medical Equipment Clients under age 21			#DIV/0!	#DIV/0!
Top Reason for Denial				
2nd most common reason for Denial				
3rd most common reason for denial				
Durable Medical Equipment Clients age 21 or above		0	#DIV/0!	#DIV/0!
Top Reason for Denial				
2nd most common reason for Denial				
3rd most common reason for denial				
Home Health Clients under age 21		0	#DIV/0!	#DIV/0!
Top Reason for Denial				
2nd most common reason for Denial				
3rd most common reason for denial				
Home Health Clients age 21 or above		0	#DIV/0!	#DIV/0!
Top Reason for Denial				
2nd most common reason for Denial				
3rd most common reason for denial				
Therapies (OT, PT, Speech, Chiropractor) Clients under age 21		0	#DIV/0!	#DIV/0!
Top Reason for Denial				
2nd most common reason for Denial				
3rd most common reason for denial				
Therapies (OT, PT, Speech, Chiropractor) Clients age 21 or above		0	#DIV/0!	#DIV/0!
Top Reason for Denial				
2nd most common reason for Denial				
3rd most common reason for denial				

Note: This report does not include prior authorised pharmacy or transportation services.
Age listed is that as of date of the request.

* Partial Denials were partially approved and partially denied.

Appendix IX - G
XYZ PCP Panel, Q3 '00

MCO	NPI	Medicaid Provider ID No.	PCP Last Name	First Name	Panel Size at Beginning of Quarter	Panel Size at End of Quarter	Group or Clinic Name	Group or Clinic FEIN	Hospital Affiliation	HUSKY B ?	Other
XYZ	0003615487	001316388	ADAM	Todd	23	24	Hartford Physicians	486873650	Hartford Hospital	Y	
XYZ	6198052458	001603288	ALAINO	George	182	220	Pediatrics of Old Lyme	302661240		Y	
XYZ		004122636	ALEXANDER	Ginger	5	7	Southeast Med Grp	061213115		Y	
XYZ	2504056406	001719492	ALLEN	Seth	17	17	Allen and Yu, MDs	556320106	Hosp. Of St. Raphael	N	
XYZ	0655456542	001918377	SMITH	Morris	4	4	Wood St. Physicians	011206344	Bridgeport Hosp.	Y	St. Vincent's Hosp.
XYZ		004106037	SMITH	Vicky	11	11	Brightside Obstetrics	635463452		N	
XYZ	1561646343	001778322	WALKER	Ellen	9	9	Hartford Physicians	486873650	Hartford Hospital	Y	
XYZ	0518654835	001026034	YU	Peter	29	34	Allen and Yu, MDs	556320106	Hosp. Of St. Raphael	Y	635463452-Orange HealthCare Grp
XYZ		001903104	ZACK	Hilda	348	373			Danbury Hospital	N	
		Note - Text format- two leading zeroes			General format	General format		Note - Text format			

Preventative Care-I

Children Receiving Well Child Care Visits Through 15 Months

No. of Children age 1-15 Months Who: <i>Percent of all Continuously Enrolled Children Through Age 15 Months</i>	Received No WCC Visits	Received One WCC Visit	Received Two WCC Visits	Received Three WCC Visits	Received Four WCC Visits	Received Five WCC Visits	Received Six or More WCC Visits

Children in Sample Population through age 15 months, Continuously*
Enrolled

Children and Adolescents Receiving Well Child Care Visits at Age 3-6 and 12-21

Children Receiving at least One WCC Visit in the Year Children in Sample Population, Continuously* Enrolled <i>Percent of all Continuously Enrolled Children</i>	Age 3-6	Age 12-21

Adults Receiving a Preventative Care Service

Adults Receiving a Preventative Care Service during the Year Adults in Population, Continuously* Enrolled <i>Percent of all Continuously Enrolled Members</i>	Age 22-29	Age 30 or older

* - 11 of 12 months. Please see specs.

Supplemental Schedule

REVENUES:

Premiums earned, *net of reinsurance*

Retain/add: *Net Investment Income*

Total revenues:

EXPENSES:

Health care expenses, *net of prior year adjustments*

Total prior year restatement of medical expenses, by year, not due to errors*

Change of errors from prior periods

General and Administrative expenses, *net of prior year adjustments*

*Prior year restatement of general and administrative expenses **, not included above*

*Significant additional nonrecurring adjustments** (please describe below)*

Total expenses

Net Profit/Loss (before Federal Income Taxes, if relevant)

* Must be listed if equals 5% of total report on this line.

** Must be listed if equals 10% of total reported administrative expenses.

HUSKY A MCO						
QUARTERLY REPORT OF NON-HYDE AMENDMENT ABORTIONS						
Quarter Ended: June 30, 2006						
DOS	PROC CODE	DIAG	PROVIDER ID	PROVIDER NAME	PAID DATE	PAID
3/14/2006	00940	63592	1133910011	SMITH MD, SHARON	5/27/2006	\$97.00
4/26/2006	59840	63592	004137332	HARTFORD GYN PROVIDER	5/27/2006	\$453.24
5/20/2006	00940	63592	004137332	HARTFORD GYN PROVIDER	6/24/2006	\$58.05
5/20/2006	00940	63592	004137332	HARTFORD GYN PROVIDER	6/24/2006	\$58.05