Diamond State Hospital Cost Review Board

Utilization Summary

DRAFT 2026.08.11

Instructions

Complete cells shaded in yellow. Total column and total rows sum from the completed inputs.

Each encounter is attributed to one primary payer. Emergency department visits include visits that result in an inpatient admission; the memo line reports that subset and is not additive, as the encounters also appear as an inpatient discharge. Surgical cases, deliveries, and newborn encounters are supplemental and are not additive to discharge, day, or visit counts.

Definitions provides additional detail and Reporting Basis summarizes service classifications.

Reporting Entity

Hospital	
Medicare CCN	
Reporting Period	
Preparer / Title	
Date	

Case Mix

All-Patient Case Mix Index	
Grouper used (e.g., MS-DRG, APR-DRG)	
Grouper / weight version	

Utilization

Utilization Measure	Medicare (Original / FFS)	Medicare Advantage	Medicaid (FFS)	Medicaid Managed Care	Commercial	Self-Pay	Other	Total
Inpatient Discharges								
Acute (Medical / Surgical)								0
Psychiatric Distinct-Part Unit								0
Rehabilitation Distinct-Part Unit								0
Skilled Nursing Subprovider								0
Total Inpatient Discharges	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Inpatient Days								

Acute (Medical / Surgical)								0
Psychiatric Distinct-Part Unit								0
Rehabilitation Distinct-Part Unit								0
Skilled Nursing Subprovider								0
Total Inpatient Days	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Outpatient and Emergency								
Outpatient Visits (excluding ED)								0
Emergency Department Visits								0
of which: resulting in inpatient admission (memo, not additive)								0
Observation Cases								0
Surgical Cases (supplemental, not additive)								
Inpatient Surgical Cases								0
Outpatient Surgical Cases								0
Obstetric (supplemental, not additive)								
Deliveries								0
Newborn (supplemental, not additive)								
Newborn / Nursery Discharges								0

Reporting Basis

All measures are derived from the Hospital's institutional (UB-04) claims as recorded in its patient-accounting system, applying the claim identifiers below.

Utilization Line	Claim-Level (UB-04) Basis
Inpatient Discharges: Acute (Med / Surg)	Institutional inpatient claims, type of bill 11X, under the acute care CCN; newborns excluded.
Inpatient Discharges: Psychiatric DPU	Inpatient claims, type of bill 11X, under the IPF distinct-part subunit CCN.
Inpatient Discharges: Rehabilitation DPU	Inpatient claims, type of bill 11X, under the IRF distinct-part subunit CCN.
Inpatient Discharges: SNF Subprovider	Skilled nursing inpatient claims, type of bill 21X.
Inpatient Days (all components)	Accommodation (routine and special care) revenue codes 010X to 021X on the corresponding inpatient claims; day of admission counted, day of discharge not.
Outpatient Visits (excluding ED)	Institutional outpatient claims, type of bill 13X, excluding claim lines bearing emergency room revenue codes.
Emergency Department Visits	Emergency room revenue codes 045X, including visits that result in an inpatient admission.
ED Visits resulting in admission (memo)	Encounters with emergency room revenue codes 045X that convert to an inpatient admission (linked to the same-stay type of bill 11X claim); subset of ED Visits, not additive.
Observation Cases	Observation revenue code 0762, counted once per episode.
Surgical Cases (IP and OP)	Operating room / procedure revenue codes 036X, counted once per episode; inpatient versus outpatient by type of bill.
Deliveries	Delivery episodes identified by delivery MS-DRG / APR-DRG or delivery procedure code.
Newborn / Nursery	Nursery accommodation revenue codes 017X; well-baby reported here, neonatal intensive care counted as inpatient discharge.
Case Mix Index	Grouper summary (MS-DRG or APR-DRG) from the hospital's case-mix system.

Definitions

All-Patient Case Mix Index (CMI)	The Hospital's average case mix index across all inpatient discharges during the Reporting Period, calculated using the grouper and weight set used by the Hospital for internal case-mix reporting. The Hospital shall identify the grouper (e.g., MS-DRG, APR-DRG) and the grouper or weight version applied.
Commercial	Health insurance coverage provided by a private insurer, including employer-sponsored plans, individual market plans, and self-insured employer plans.
Delivery	An obstetric delivery event resulting in one or more births, counted once per delivery event and not per neonate.
Emergency Department (ED) Visit	A registered visit to the hospital's emergency department, identified from emergency room revenue codes (045X), whether or not the visit results in an inpatient admission.
ED Visit Resulting in Inpatient Admission	The subset of Emergency Department Visits in which the emergency encounter converts to an inpatient admission during the same stay. Reported as a memo line; it is a subset of Emergency Department Visits and is also counted as an Inpatient Discharge. Not additive.
Inpatient Discharge	The formal release of an admitted patient from inpatient status, identified from institutional inpatient claims (type of bill 11X; type of bill 21X for the skilled nursing subprovider), including discharge to home, transfer to another facility, and death, and excluding newborns. Counted once per inpatient stay.
Inpatient Day (Patient Day)	A day of inpatient care, identified from accommodation revenue codes on the inpatient claim and counted using the standard census convention (the day of admission is counted; the day of discharge is not).
Medicaid (Fee-For-Service or FFS)	Payments made directly by the State on a fee-for-service basis and excluding payments made through managed care organizations.
Medicaid Managed Care	Payments received from managed care organizations that contract with the State to provide or arrange for Medicaid-covered services.
Medicare (Original / FFS)	Payments received from traditional Medicare Part A and Part B and excluding Medicare Advantage.
Medicare Advantage	Health insurance plans approved by CMS to provide Medicare Part A and Part B benefits, reported separately from Medicare original.
Newborn / Nursery	An inpatient episode for a newborn identified from nursery accommodation revenue codes (017X). Well-baby and normal newborn encounters are reported on the supplemental newborn line and are excluded from inpatient discharges and days. Neonatal intensive care encounters are reported acute inpatient discharges.
Observation Case	An episode of outpatient observation services (revenue code 0762), counted once per episode.
Other [Payment Source]	Other payers, comprising workers' compensation programs, TRICARE, CHAMPVA, Indian Health Services, and payments not otherwise classified.
Outpatient Visit	A single encounter for outpatient services on a given date, identified from institutional outpatient claims (type of bill 13X), excluding emergency department visits and services incidental to an inpatient stay.
Primary Payer	The payer financially responsible as the first source of payment for an encounter, determined as of the date of discharge for inpatient encounters and the date of service for outpatient encounters. Each encounter is assigned to one and only one Primary Payer among the following categories: Medicare (Original / FFS), Medicare Advantage, Medicaid (FFS), Medicaid Managed Care, Commercial, Self-Pay, or Other.

Self-Pay	Amounts billed to patients who do not have coverage for the service, who elect to pay outside of other available payment mechanisms, or who are responsible for a balance not covered by a third-party payer, including deductibles, copayments, and coinsurance not subject to a charity care write-off.
Surgical Case	A surgical procedure episode identified from operating room or procedure revenue codes (036X), counted once per episode and reported separately for inpatient and outpatient settings by type of bill.
Utilization	The volume of patient encounters furnished by the Hospital during the Reporting Period, measured in claim-based units derived from the hospital's institutional (UB-04) claims. Each unit is attributed to a single Primary Payer.