Normal font = comments, bold = questions, highlighted = unanswered questions

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| CDM TABLE | CDM FIELD | NOTES / QUESTIONS |
| Location | ALL | Beneficiary\_summary contains three years of data per patient – use first year of data   * + Location does not change over three years |
| sp\_state\_code  bene\_county\_cd | Can be reported exactly as the source values are reported – “All fields in the Location tables contain the verbatim data in the source, no mapping or normalization takes place.” |
| location\_source\_value | Separate sp\_state\_code and bene\_county\_cd by dash |
| Person | gender\_source\_concept\_id | **Should this be 0?** |
| gender\_source\_value  race\_source\_value  ethnicity\_source\_value | **Put a readable label or leave as source value?** |
| Visit\_occurrence | provider\_id | LOGIC: Use the LIN\_ALOWD\_CHRG\_AMT\_# to find the column that has the MAX() amount. That column identifies the PRF\_PHYSN\_NPI\_# that you need to choose. Alternate proposal (Optimal) - sum up by PRF\_PHYSN\_NPI the LIN\_ALOWD\_CHRG\_AMT, the NPI with the larges charge amount wins the PROVIDER\_ID  **^ which is preferred?**   * + Mark: *Second (optimal)* |
| Provider | care\_site\_id | **Null or look up?**   * + Could potentially use tax ids to map to care\_site\_id for carrier claims |
| Death |  | **Only if deceased? Always write for beneficiary\_summary?**   * + Mark: *One record per person, only write record if person is deceased – use beneficiary\_summary (preferred)* |
| Drug\_exposure | drug\_exposure\_end\_date | “Prescription” is misspelled |
| Procedure\_occurrence | procedure\_source\_concept\_id | COMMENTS: In CARRIER\_CLAIMS & OUTPATIENT\_CLAIMS map to HCPC CONCEPT\_IDs. Only write rows for HCPCs that have a drug associated domain. IN INPATIENT\_CLAIMS map to ICD9 Procedures CONCEPT\_IDs  **^ is this correct?** |
| procedure\_type\_concept\_id | **Outpatient codes not sequential – is position 1 code correct?**   * + Ryan: *yes* |
| Fact\_relationship |  | **What if ICD9 diag is not in condition domain?**  **3 rows not included because diagnosis codes were in observation domain** |
| Visit\_cost | paid\_toward\_deductible | Comment section typos |
| Payer\_plan\_period |  | **Start date & end date?**   * + Mark: *Jan 1 & Dec 31 unless turned 65 that year (change start date) or died (change end date)* |

* “Look up” ids inconsistent formatting – examples:
  + Person table from beneficiary\_summary → location\_id
  + Visit\_occurrence table from carrier\_claims, outpatient\_claims & inpatient\_claims → provider\_id
* HCPCS 90775 not in database – cannot find domain to place it
  + Mark: *make it a procedure occurrence with concept\_id = 0*
* HCPCS vs. CPT4 – first character is letter in HCPCS, others classified as CPT4
* **Is condition\_occurrence table part of domain distinction? Procedure\_occurrence 10 comes from condition\_occurrence table (icd 9 diag) → makes procedure\_concept\_id hold value of condition\_concept\_id (snomed), etc.**
  + Ryan: *okay*
* **Other tables? E.g. cohort, cohort\_definition, era tables, etc. (“**[**Standardized Derived Elements**](http://www.ohdsi.org/web/wiki/doku.php?id=documentation:cdm:standardized_derived_elements)**”)**
  + Ryan: *no*