# Business Requirements

The Model B ACOs currently receive an SUD Summary of SUD excluded of Suppressed claims that only provides a summary of dollars and count of claims either excluded or suppressed. The new Model B SUD Extract is a necessary addition to the suite of monthly reports Model B ACOs receive from Aeach month. This new SUD Extract will allow Model B ACOs to better assess provider and program performance, and will enhance Model B ACOs’ cost management (i.e. managing TCOC) and program evaluation efforts. With this extract, Model B ACOs will gain valuable claim-level (diagnosis codes, injury diagnosis codes, procedure codes, revenue codes etc.) insight into the experience of their members with an SUD.

* 1. In order to give Model B ACOs this enhanced ability, the Model B SUD Extract will need to include all claims that have been completely excluded from the standard monthly claims extract due to SUD and all SUD-related claims that have a diagnosis or injury code suppressed in their standard monthly claims extract (with the diagnosis or injury code “un-masked” for the Model B SUD Extract). It is essential to include the full claim, with SUD-related diagnosis or injury codes “un-masked”, so that the ACOs can more effectively analyze the cost of services provided on these claims. Without seeing the full list of diagnoses or injury codes associated with these claims, ACOs may be over-estimating the cost associated with services the provided. For additional details regarding the business requirement, please refer to the Project Charter in Appendix
  2. Data/reports specification details for Member, Claims and SUD data extracts/reports that the ACOs currently receive are explained in relevant BRDs attached in the Appendix. The Member, Claims, and SUD BRDs will be referenced throughout this BRD so as not to duplicate the requirements in this BRD. Readers are advised to refer to those documents if additional information is needed about core SUD requirements or existing Member/Claims data extracts/reports that are delivered to ACO/MCOs every month.
  3. The Model B SUD Extract should in no way impact production of the standard ACO/MCO monthly reports/extracts explained in the Member and Claims BRDs (See Appendix)

# In-Scope Requirements

This Business Requirements document will explain the data requirements, reports delivery requirements, data scenarios where applicable, and recommended test cases for the new SUD extracts as explained in scope below.

* 1. The new SUD extracts are only applicable for Model B ACOs.

Table 1 - Model B ACOs

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CDE\_ENTITY** | **DSC\_ENTITY** | **CDE\_ENTITY\_ID\_TYPE** | **ID\_ENTITY** | **CDE\_ENTITY\_MODEL** |
| CCC | COMMUNITY CARE COOPERATIVE (C3) | PIDSL | 110117145B | ACOB |
| PHACO | PARTNERS HEALTHCARE CHOICE | PIDSL | 110117149B | ACOB |
| STEWARD | STEWARD HEALTH CHOICE | PIDSL | 110117869B | ACOB |

* 1. Each one of the ACOBs listed above will receive the following SUD extracts as a pipe-delimited text file
     1. Medical SUD Claims Pipe delimited extract – The data elements and file structure are same as the Medical Claims extract (See Claims BRD) except for one new field. The data elements will be listed again in this BRD as the source for this Medical SUD Claims extract will be different than the standard Medical Claims extract.
     2. Pharmacy SUD Claims Pipe delimited extract – The data elements and file structure are same as the Pharmacy Claims extract (See Claims BRD). The data elements will be listed again in this BRD as the source for this Pharmacy SUD Claims extract will be different than the standard Pharmacy Claims extract.
     3. Control totals file – The control totals file is an excel file listing the name of each pipe-delimited file in the Model B SUD Extract report (medical claims, pharmacy claims) and its corresponding row count
  2. The SFTP folder names and names of DW, DI, ACO Reporting team, ACO staff who need access to the new folders will be listed in this BRD.

# Out Of Scope Requirements

* 1. Virtual Members should not be included in these new SUD extracts as these were members prior to the ACO program start date of 3/1/2018.
  2. Quality Control (QC) checks have not been included in this BRD. A separate Test Case document will be created by the DW QA group which should be based on the data and quality assurance (QA) requirements explained in this BRD.
  3. SFTP folder/account creation details will not be included in this BRD because that process is handled by DW Operations.

# Data generation and filter Requirements

The overall data filter requirements that are in place for Member and Claims apply to these new Model B SUD extracts as well. (Refer to Section 4 of Claims and Member BRD). The following requirements are specific to the Model B Claims SUD extracts -

* 1. The tables/views created to generate these SUD extracts must be refreshed at the same time as the ACO monthly medical and pharmacy claims views are refreshed.
  2. These SUD extracts will only be delivered to Model B ACOs [where CDE\_ENTITY\_RECIP in (‘CCC’,’STEWARD’,’PHACO’)]
  3. Claims data price masking requirements as explained in Req 7.3 of the Claims BRD wherever applicable for ACOBs should also apply to the Model B SUD extracts.
  4. Claims for virtual Members should not be included in these reports as first SUD extract will be delivered in August 2020 or later and 24 months prior to that date is greater than 03/01/2018 (Virtual members are only applicable prior to 03/01/2018 – see Member BRD if you need more details)

# File Name and Type Requirements

* 1. Each Model B ACO will receive 1 Medical Claims SUD Extract, 1 Pharmacy Claims SUD Extract, and 1 Control Totals (metadata) file. High level contents and file naming convention is given in the table below. Data requirements for the Medical Pharmacy files will be explained in detail in subsequent sections.
  2. Double quotes should be used as qualifiers in the pipe delimited files.

Table 2 - Model B ACO Claims SUD Extract File Names

| **#** | **aco\_pidsl** | **aco\_name** | **File Naming Convention** | **File Contents** | **File Type** |
| --- | --- | --- | --- | --- | --- |
|  | 110117145B | COMMUNITY CARE COOPERATIVE (CCC) | ACO-CCC\_Jun\_2020\_Medical\_SUD\_Claims.txt | All SUD flagged and SUD suppressed medical claims where the report recipient is CCC | Pipe-delimited .txt |
|  | 110117145B | COMMUNITY CARE COOPERATIVE (CCC) | ACO-CCC\_Jun\_2020\_Rx\_SUD\_Claims.txt | All SUD flagged Pharmacy claims where the report recipient is CCC | Pipe-delimited .txt |
|  | 110117145B | COMMUNITY CARE COOPERATIVE (CCC) | ACO-CCC\_Jun\_2020\_SUD\_metadata.csv | The control totals file (explained in section 2) for CCC | Excel |
|  | 110117149B | PARTNERS HEALTHCARE CHOICE (PHACO) | ACO-PHACO\_Jun\_2020\_Medical\_SUD\_Claims.txt | All SUD flagged and SUD suppressed medical claims where the report recipient is PHACO | Pipe-delimited .txt |
|  | 110117149B | PARTNERS HEALTHCARE CHOICE (PHACO) | ACO-PHACO\_Jun\_2020\_Rx\_SUD\_Claims.txt | All SUD flagged Pharmacy claims where the report recipient is PHACO | Pipe-delimited .txt |
|  | 110117149B | PARTNERS HEALTHCARE CHOICE (PHACO) | ACO-PHACO\_Jun\_2020\_SUD\_metadata.csv | The control totals file (explained in section 2) for PHACO | Excel |
|  | 110117869B | STEWARD HEALTH CHOICE (STEWARD) | ACO-StewardB\_Jun\_2020\_Medical\_SUD\_Claims.txt | All SUD flagged and SUD suppressed medical claims where the report recipient is Steward | Pipe-delimited .txt |
|  | 110117869B | STEWARD HEALTH CHOICE (STEWARD) | ACO-StewardB\_Jun\_2020\_Rx\_SUD\_Claims.txt | All SUD flagged Pharmacy claims where the report recipient is Steward | Pipe-delimited .txt |
|  | 110117869B | STEWARD HEALTH CHOICE (STEWARD) | ACO- StewardB\_Jun\_2020\_SUD\_metadata.csv | The control totals file (explained in section 2) for Steward | Excel |

# Medical SUD Claims Extract Requirements

## Data Requirements

* + 1. The Medical SUD Claims extract should include SUD Claims data (SUD excluded or SUD suppressed claims) from EA\_ACOMCO\_MEDI\_CLAIM only when any one of the 2 conditions in the table 3 below are met –

SUD indicators given in the table below is how Claims are flagged as Y or N in DW view EA\_ACOMCO\_MEDI\_CLAIM. The definitions of these indicators are given below. Please refer to the SUD BRD in Appendix if you need details about SUD criteria.

IND\_CLAIM\_SU 🡪 Y = SUD CLAIM; N = Non-SUD claim

IND\_DIAG\_SUPRESSION 🡪  Y = Diagnosis code suppressed due to an SUD code; N = Diagnosis code not suppressed

IND\_INJURY\_SUPRESSION 🡪 Y = Injury diagnosis code suppressed due to an SUD code; N = Injury diagnosis code not suppressed

Table 3 - Model B ACO Claims SUD Extract Logic

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **#** | **IND\_CLAIM\_SU** | **Condition** |  | **IND\_DIAG\_SUPPRESSION** | **Condition** | **IND\_INJURY\_SUPPRESSION** |  |
|  | Y | n/a |  | n/a | n/a | n/a |  |
|  | N | AND | ( | Y | or | Y | ) |

* + 1. The conditions in table 3 above equate to the following data scenarios (data from DW as of 5/21/2020) in table 4 below:

SELECT IND\_CLAIM\_SU,

IND\_DIAG\_SUPRESSION,

IND\_INJURY\_SUPRESSION,

COUNT (CLAIM\_NUMBER)

FROM EA\_ACOMCO\_MEDI\_CLAIM

WHERE CDE\_ENTITY\_RECIP IN ('CCC', 'PHACO', 'STEWARD')

AND ( IND\_CLAIM\_SU = 'Y'

OR ( IND\_CLAIM\_SU = 'N'

AND (IND\_DIAG\_SUPRESSION = 'Y' OR IND\_INJURY\_SUPRESSION = 'Y')))

GROUP BY IND\_CLAIM\_SU, IND\_DIAG\_SUPRESSION, IND\_INJURY\_SUPRESSION

ORDER BY IND\_CLAIM\_SU DESC

Table 4 - SUD and Suppressed Claims Data Scenarios

|  |  |  |  |
| --- | --- | --- | --- |
| **IND\_CLAIM\_SU** | **IND\_DIAG\_SUPRESSION** | **IND\_INJURY\_SUPRESSION** | **COUNT(CLAIM\_NUMBER)** |
| Y | N | N | 5,641,680 |
| Y | N | Y | 105 |
| Y | Y | N | 549,561 |
| N | N | Y | 13 |
| N | Y | N | 1,555,842 |

* + 1. Non-SUD claims data that meets the following condition should not be included in the Medical SUD claims extract –

IND\_CLAIM\_SUD = N and IND\_DIAG\_SUPPRESSION = N and IND\_INJURY\_SUPPRESSION = N

* + 1. A new flag called IND\_EXCLUDED should be added (Field ID 154) to the Medical SUD Claims extract . This new field should populate with ‘Y’ on claims that have been **excluded** due to an SUD from the standard monthly medical claims extract and ‘N’ on claims that have a diagnosis or injury code suppressed but are still included in the standard monthly medical claims extract.

The above requirement translates to the logic as below, also given in a table format –

CASE

when IND\_CLAIM\_SU = 'Y' AND (IND\_DIAG\_SUPPRESSION = 'Y' or IND\_INJURY\_SUPPRESSION = 'N') then 'Y'

when IND\_CLAIM\_SU = 'Y' AND (IND\_DIAG\_SUPPRESSION = 'N' or IND\_INJURY\_SUPPRESSION = 'Y') then 'Y'

when IND\_CLAIM\_SU = 'Y' AND (IND\_DIAG\_SUPPRESSION = 'N' or IND\_INJURY\_SUPPRESSION = 'N') then 'Y'

when IND\_CLAIM\_SU = 'N' AND (IND\_DIAG\_SUPPRESSION = 'Y' or IND\_INJURY\_SUPPRESSION = 'Y') then 'N'

END IND\_EXCLUDED

Table 5 - Ind\_Excluded Logic

| **#** | **IND\_EXCLUDED** | **IND\_CLAIM\_SU** | **Condition** |  | **IND\_DIAG\_SUPPRESSION** | **Condition** | **IND\_INJURY\_SUPPRESSION** |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Y 🡪 | Y | AND | ( | Y | or | N | ) |
|  | Y 🡪 | Y | AND | ( | N | or | Y | ) |
|  | Y 🡪 | Y | AND | ( | N | or | N | ) |
|  | N🡪 | N | AND | ( | Y | or | Y | ) |

* + 1. For SUD excluded claims (where Ind\_Claim\_SU = ‘Y’) the following original diagnosis codes, injury diagnosis codes, and associated present on admission fields should be populated in the Medical SUD claims extract (table 6). Please see Business Requirement 1.1 for justification for this data requirement.

1. Original Diagnosis codes on the claim in Field IDs 28 through 53 in table 6 Medical Claims SUD Extract
2. Original Injury Diagnosis codes on the claim in Field IDs 54 through 65 in table 6 Medical Claims SUD Extract
3. Original Present on Admission codes associated with Diagnosis codes on the claim in Field IDs 108 through 132 in table 6 Medical Claims SUD Extract
4. Original Present on Admission codes associated with injury Diagnosis codes on the claim in Field IDs 133 through 144 in table 6 Medical Claims SUD Extract
   * 1. The SUD suppressed claims due to diagnosis codes or injury diagnosis codes must be un-masked in the SUD Medical Claims extract. Un-masked means the shift-replace logic should not be applied on the SUD suppressed claims, the original diagnosis or injury diagnosis codes should be retained on the claim line. Detailed data requirements are given below. Please see Business Requirement 1.1 for justification for this data requirement.
5. For SUD Suppressed claims due to SUD Diagnosis codes (where IND\_DIAG\_SUPPRESSION = ‘Y) the original diagnosis codes (not suppressed codes as a result of shift-replace logic as per SUD BRD, see Appendix) should be populated in Diagnosis 2 through 25 fields of Medical SUD Claims Extract (dx\_2 through dx\_25; Field IDs 30 through 53 in table Medical Claims SUD Extract Layout below.
6. For SUD Suppressed claims due to SUD Diagnosis codes (where IND\_DIAG\_SUPPRESSION = ‘Y) the original Present on Admission codes (not suppressed codes as a result of shift-replace logic as per SUD BRD, see Appendix) associated with the original diagnosis codes should be populated in Present on Admission 2 through 25 fields of Medical SUD Claims Extract (present\_on\_admission\_2 through present\_on\_admission\_25; Field IDs 109 through 132 in table Medical Claims SUD Extract Layout below)
7. For SUD Suppressed claims due to SUD Injury Diagnosis codes (where IND\_INJURY\_SUPPRESSION = ‘Y) the original Injury diagnosis codes (not suppressed codes as a result of shift-replace logic as per SUD BRD, see Appendix) should be populated in Injury diagnosis 2 through 12 of Medical SUD Claims Extract (e\_dx\_2 through e\_dx\_12; Field IDs 55 through 65 in table Medical Claims SUD Extract Layout below)
8. For SUD Suppressed claims due to SUD Injury Diagnosis codes (where IND\_ INJURY\_SUPPRESSION = ‘Y) the original Present on Admission codes (not suppressed codes as a result of shift-replace logic as per SUD BRD, see Appendix) associated with the original injury diagnosis codes should be populated in Present on Admission 2 through 12 fields of Medical SUD Claims Extract (e\_dx\_present\_on\_admission\_2 through e-dx\_present\_on\_admission\_25; Field IDs 133 through 144 in table Medical Claims SUD Extract Layout below)

## File Layout

The columns in the file layout table mean the following --

* + 1. The field names in the table below will be the column headers in the pipe delimited file
    2. The Field Description gives additional information about the data this field contains
    3. Table/View Name lists the table/view name from where the data is sourced
    4. Column Name lists the column name in the ‘Table/View Name from where the data should be sourced.
    5. Logic/Comments explains any join conditions/pseudo code logic to derive the fields or can contain any additional comments
    6. The pipe delimited file output should meet the data type and length requirements as listed in the Medical Claims tab of the Monthly SUD Report Data Dictionary v1 (see Appendix 10.5)

Table 6 - Medical Claims SUD Extract Layout

| **ID** | **Field Name** | **Field Description** | **Table/View Name** | **Column Name** | **Logic/Comments** |
| --- | --- | --- | --- | --- | --- |
|  | member\_id | Unique identifier of the member receiving services | EA\_ACOMCO\_MEDI\_CLAIM | MEMBER\_ID |  |
|  | claim\_number | Unique claim identifier | EA\_ACOMCO\_MEDI\_CLAIM | CLAIM\_NUMBER |  |
|  | line\_number | Line detail, unique identifier for each line on a claim | EA\_ACOMCO\_MEDI\_CLAIM | LINE\_NUMBER |  |
|  | aco\_pidsl | ACO PIDSL | EA\_ACOMCO\_MEDI\_CLAIM | ACO\_PIDSL |  |
|  | aco\_name | ACO name | EA\_ACOMCO\_MEDI\_CLAIM | ACO\_NAME |  |
|  | pcc\_pidsl | PCC PIDSL | EA\_ACOMCO\_MEDI\_CLAIM | PCC\_PIDSL |  |
|  | pcc\_name | PCC name | EA\_ACOMCO\_MEDI\_CLAIM | PCC\_NAME |  |
|  | pcc\_npi | PCC NPI | EA\_ACOMCO\_MEDI\_CLAIM | PCC\_NPI |  |
|  | pcc\_taxid | PCC TIN | EA\_ACOMCO\_MEDI\_CLAIM | PCC\_TAXID |  |
|  | mco\_pidsl | MCO PIDSL | EA\_ACOMCO\_MEDI\_CLAIM | MCO\_PIDSL |  |
|  | mco\_name | MCO name | EA\_ACOMCO\_MEDI\_CLAIM | MCO\_NAME |  |
|  | source | Source of the claim – MMIS or Encounter | EA\_ACOMCO\_MEDI\_CLAIM | CDE\_SOURCE |  |
|  | claim\_type | Type of Claim – Physician, Inpatient, Dental, Outpatient, etc. | EA\_ACOMCO\_MEDI\_CLAIM | CLAIM\_TYPE |  |
|  | member\_dob | Member Date of Birth | EA\_ACOMCO\_MEDI\_CLAIM | MEMBER\_DOB |  |
|  | patient\_status | Patient status is discharge status and helps indicate deceased patients as well as those still a patient - critical for quality measure development (Add leading zero to the single digit numbers for Ex: 1, 2, 3 should be like 01,01,03) | EA\_ACOMCO\_MEDI\_CLAIM | PATIENT\_STATUS |  |
|  | service\_start\_date | First date of service on the claim line | EA\_ACOMCO\_MEDI\_CLAIM | SERVICE\_START\_DATE |  |
|  | service\_end\_date | Last date of service on the claim line | EA\_ACOMCO\_MEDI\_CLAIM | SERVICE\_END\_DATE |  |
|  | admit\_date | Admit date on inpatient claims | EA\_ACOMCO\_MEDI\_CLAIM | ADMIT\_DATE |  |
|  | discharge\_date | Discharge date on inpatient claims | EA\_ACOMCO\_MEDI\_CLAIM | DISCHARGE\_DATE |  |
|  | type\_of\_bill | Standard Type of Bill code (two digits - necessary for capturing differences in type of service between inpatient and outpatient  For encounter data the new source will contain new data and historical data as following – Industry standard Type of Bill from Encounter data including CDE\_BILL\_FREQ as the last digit. The historical Type of bill data will be converted to be in the same format as new industry standard. | EA\_ACOMCO\_MEDI\_CLAIM | TYPE\_OF\_BILL |  |
|  | admit\_source | Source of admission is to understand transfers between facilities and other services | EA\_ACOMCO\_MEDI\_CLAIM | ADMIT\_SOURCE |  |
|  | admit\_type | Admit type - such as urgent/elective, helps categorize the services and can be useful in quality metrics as well as categorizing certain costs. | EA\_ACOMCO\_MEDI\_CLAIM | ADMIT\_TYPE |  |
|  | frequency\_code | The bill frequency is the third digit of the type of bill code and necessary to understand if the claim is a new, append, replacement or void claim. | EA\_ACOMCO\_MEDI\_CLAIM | FREQUENCY\_CODE |  |
|  | paid\_date | Paid date. Remit date helps establish the length of time between submission of a claim and payment, for complementary analysis | EA\_ACOMCO\_MEDI\_CLAIM | PAID\_DATE |  |
|  | billed\_amount | Dollar amount billed to payer, total, by provider. Necessary for total cost of care analysis - reflects established fee schedule. | EA\_ACOMCO\_MEDI\_CLAIM | BILLED\_AMOUNT |  |
|  | allowed\_amount | Dollar amount for claim allowed by payer - necessary for total cost of care analysis. | EA\_ACOMCO\_MEDI\_CLAIM | ALLOWED\_AMOUNT |  |
|  | paid\_amount | Amount paid for claim net of any other adjustments. Necessary for total cost of care and other analyses. This is the FFS amount not the actual capitation amt. | EA\_ACOMCO\_MEDI\_CLAIM | PAID\_AMOUNT |  |
|  | admit\_diagnosis | Admit diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_ADMIT | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_1 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_1 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_2 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_2 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_3 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_3 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_4 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_4 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_5 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_5 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_6 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_6 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_7 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_7 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_8 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_8 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_9 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_9 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_10 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_10 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_11 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_11 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_12 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_12 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_13 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_13 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_14 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_14 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_15 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_15 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_16 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_16 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_17 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_17 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_18 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_18 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_19 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_19 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_20 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_20 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_21 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_21 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_22 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_22 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_23 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_23 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_24 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_24 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | dx\_25 | Diagnosis code identified by provider. Necessary to categorize services for all subsequent analysis. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_25 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_1 | E Diagnosis code identified by provider. Necessary for service and member categorization and quality measures. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_I1 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_2 | E Diagnosis code identified by provider. Necessary for service and member categorization and quality measures. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_I2 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_3 | E Diagnosis code identified by provider. Necessary for service and member categorization and quality measures. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_I3 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_4 | E Diagnosis code identified by provider. Necessary for service and member categorization and quality measures. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_I4 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_5 | E Diagnosis code identified by provider. Necessary for service and member categorization and quality measures. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_I5 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_6 | E Diagnosis code identified by provider. Necessary for service and member categorization and quality measures. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_I6 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_7 | E Diagnosis code identified by provider. Necessary for service and member categorization and quality measures. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_I7 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_8 | E Diagnosis code identified by provider. Necessary for service and member categorization and quality measures. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_I8 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_9 | E Diagnosis code identified by provider. Necessary for service and member categorization and quality measures. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_I9 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_10 | E Diagnosis code identified by provider. Necessary for service and member categorization and quality measures. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_I10 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_11 | E Diagnosis code identified by provider. Necessary for service and member categorization and quality measures. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_I11 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_12 | E Diagnosis code identified by provider. Necessary for service and member categorization and quality measures. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_DIAG\_I12 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | icd\_version | ICD version for Surgical Procedures | EA\_ACOMCO\_MEDI\_CLAIM | ICD\_VERSION |  |
|  | surgical\_procedure\_code\_1 | Surgical procedure code 1 | EA\_ACOMCO\_MEDI\_CLAIM | SURGICAL\_PROCEDURE\_CODE\_1 |  |
|  | surgical\_procedure\_code\_2 | Surgical procedure code 2 | EA\_ACOMCO\_MEDI\_CLAIM | SURGICAL\_PROCEDURE\_CODE\_2 |  |
|  | surgical\_procedure\_code\_3 | Surgical procedure code 3 | EA\_ACOMCO\_MEDI\_CLAIM | SURGICAL\_PROCEDURE\_CODE\_3 |  |
|  | surgical\_procedure\_code\_4 | Surgical procedure code 4 | EA\_ACOMCO\_MEDI\_CLAIM | SURGICAL\_PROCEDURE\_CODE\_4 |  |
|  | surgical\_procedure\_code\_5 | Surgical procedure code 5 | EA\_ACOMCO\_MEDI\_CLAIM | SURGICAL\_PROCEDURE\_CODE\_5 |  |
|  | surgical\_procedure\_code\_6 | Surgical procedure code 6 | EA\_ACOMCO\_MEDI\_CLAIM | SURGICAL\_PROCEDURE\_CODE\_6 |  |
|  | revenue\_code | Revenue code at the line level, defines type of services delivered, critical for identification of emergency services, rooms, etc. | EA\_ACOMCO\_MEDI\_CLAIM | REVENUE\_CODE |  |
|  | place\_of\_service\_code | Similar to type of service, helps categorize where and what type of service delivered for analysis. | EA\_ACOMCO\_MEDI\_CLAIM | PLACE\_OF\_SERVICE\_CODE |  |
|  | procedure\_code | Procedure code at the line level, defines type of services delivered, used in all subsequent analysis | EA\_ACOMCO\_MEDI\_CLAIM | PROCEDURE\_CODE |  |
|  | procedure\_modifier\_1 | Procedure code modifiers provide additional information about the procedure code | EA\_ACOMCO\_MEDI\_CLAIM | PROCEDURE\_MODIFIER\_1 |  |
|  | procedure\_modifier\_2 | Procedure code modifiers provide additional information about the procedure code | EA\_ACOMCO\_MEDI\_CLAIM | ORIG\_PROCEDURE\_MODIFIER\_2 |  |
|  | procedure\_modifier\_3 | Procedure code modifiers provide additional information about the procedure code | EA\_ACOMCO\_MEDI\_CLAIM | ORIG\_PROCEDURE\_MODIFIER\_3 |  |
|  | procedure\_modifier\_4 | Procedure code modifiers provide additional information about the procedure code | EA\_ACOMCO\_MEDI\_CLAIM | ORIG\_PROCEDURE\_MODIFIER\_4 |  |
|  | drg\_code | DRG classify the discharge based on diagnoses, procedures and patient characteristics | EA\_ACOMCO\_MEDI\_CLAIM | DRG\_CODE |  |
|  | drg\_version\_code | DRG version of the DRG used in payment, critical for benchmarking | EA\_ACOMCO\_MEDI\_CLAIM | DRG\_VERSION\_CODE |  |
|  | severity\_of\_illness | Severity of illness - when receiving certain DRG types, this field indicates the severity of the episode. Currently used in re-pricing | EA\_ACOMCO\_MEDI\_CLAIM | SEVERITY\_OF\_ILLNESS |  |
|  | service\_provider\_npi | NPI of the provider actually rendering the services, necessary for utilization analysis | EA\_ACOMCO\_MEDI\_CLAIM | SERVICE\_PROVIDER\_NPI |  |
|  | id\_provider\_servicing | Unique identifier of the provider actually rendering the services, necessary for utilization analysis | EA\_ACOMCO\_MEDI\_CLAIM | ID\_PROVIDER\_SERVICING |  |
|  | servicing\_taxid | Tax ID of the provider actually rendering the services, necessary for utilization analysis | EA\_ACOMCO\_MEDI\_CLAIM | SERVICING\_TAXID |  |
|  | servicing\_provider\_name | Name of the provider actually rendering the services, necessary for utilization analysis | EA\_ACOMCO\_MEDI\_CLAIM | SERVICING\_PROVIDER\_NAME |  |
|  | servicing\_provider\_type | Type of the provider actually rendering the services, necessary for utilization analysis | EA\_ACOMCO\_MEDI\_CLAIM | SERVICING\_PROVIDER\_TYPE |  |
|  | servicing\_provider\_taxonomy | Taxonomy of the provider actually rendering the services, necessary for utilization analysis | EA\_ACOMCO\_MEDI\_CLAIM | SERVICING\_PROVIDER\_TAXONOMY |  |
|  | servicing\_address | Line 1 of the Mailing Address of the provider actually rendering the services, necessary for utilization analysis | EA\_ACOMCO\_MEDI\_CLAIM | SERVICING\_ADDRESS |  |
|  | servicing\_city | Mailing City of the provider actually rendering the services, necessary for utilization analysis | EA\_ACOMCO\_MEDI\_CLAIM | SERVICING\_CITY |  |
|  | servicing\_state | Mailing State of the provider actually rendering the services, necessary for utilization analysis | EA\_ACOMCO\_MEDI\_CLAIM | SERVICING\_STATE |  |
|  | servicing\_zip | Mailing Zip of the provider actually rendering the services, necessary for utilization analysis | EA\_ACOMCO\_MEDI\_CLAIM | SERVICING\_ZIP |  |
|  | billing\_npi | NPI of the provider billing for the services, required for payment modeling and network analysis | EA\_ACOMCO\_MEDI\_CLAIM | BILLING\_NPI |  |
|  | id\_provider\_billing | Unique identifier of the provider billing for the services, required for payment modeling and network analysis | EA\_ACOMCO\_MEDI\_CLAIM | ID\_PROVIDER\_BILLING |  |
|  | billing\_taxid | Tax ID of the provider billing for the services, required for payment modeling and network analysis | EA\_ACOMCO\_MEDI\_CLAIM | BILLING\_TAXID |  |
|  | billing\_provider\_name | Billing provider name | EA\_ACOMCO\_MEDI\_CLAIM | BILLING\_PROVIDER\_NAME |  |
|  | billing\_provider\_type | Billing provider type | EA\_ACOMCO\_MEDI\_CLAIM | BILLING\_PROVIDER\_TYPE |  |
|  | billing\_provider\_taxonomy | Billing provider taxonomy | EA\_ACOMCO\_MEDI\_CLAIM | BILLING\_PROVIDER\_TAXONOMY |  |
|  | billing\_address | Billing address 1 | EA\_ACOMCO\_MEDI\_CLAIM | BILLING\_ADDRESS |  |
|  | billing\_city | Billing city | EA\_ACOMCO\_MEDI\_CLAIM | BILLING\_CITY |  |
|  | billing\_state | Billing state | EA\_ACOMCO\_MEDI\_CLAIM | BILLING\_STATE |  |
|  | billing\_zip | Billing zip | EA\_ACOMCO\_MEDI\_CLAIM | BILLING\_ZIP |  |
|  | claim\_status | The status of the claim indicates whether the claim was paid or not, and is necessary for many types of analysis. | EA\_ACOMCO\_MEDI\_CLAIM | CLAIM\_STATUS |  |
|  | disbursement\_code | Indicates what source paid the claim. | EA\_ACOMCO\_MEDI\_CLAIM | DISBURSEMENT\_CODE |  |
|  | enrolled\_flag | Enrollment flag | EA\_ACOMCO\_MEDI\_CLAIM | ENROLLED\_FLAG |  |
|  | referral\_circle\_ind | Flag (Y or N) used to indicate whether a claim was paid or denied by a service provider who is part of the referral circle | EA\_ACOMCO\_MEDI\_CLAIM | REFERRAL\_CIRCLE\_IND |  |
|  | mbhp\_flag | MBHP flag | EA\_ACOMCO\_MEDI\_CLAIM | MBHP\_FLAG |  |
|  | present\_on\_admission\_1 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_1 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_2 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_2 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_3 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_3 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_4 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_4 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_5 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_5 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_6 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_6 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_7 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_7 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_8 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_8 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_9 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_9 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_10 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_10 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_11 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_11 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_12 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_12 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_13 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_13 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_14 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_14 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_15 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_15 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_16 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_16 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_17 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_17 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_18 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_18 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_19 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_19 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_20 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_20 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_21 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_21 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_22 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_22 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_23 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_23 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_24 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_24 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | present\_on\_admission\_25 | Diagnosis code indicates present on admission. Each relates to diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_25 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_present\_on\_admission\_1 | Diagnosis code indicates present on admission. Each relates to E diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_I1 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_present\_on\_admission\_2 | Diagnosis code indicates present on admission. Each relates to E diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_I2 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_present\_on\_admission\_3 | Diagnosis code indicates present on admission. Each relates to E diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_I3 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_present\_on\_admission\_4 | Diagnosis code indicates present on admission. Each relates to E diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_I4 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_present\_on\_admission\_5 | Diagnosis code indicates present on admission. Each relates to E diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_I5 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_present\_on\_admission\_6 | Diagnosis code indicates present on admission. Each relates to E diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_I6 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_present\_on\_admission\_7 | Diagnosis code indicates present on admission. Each relates to E diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_I7 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_present\_on\_admission\_8 | Diagnosis code indicates present on admission. Each relates to E diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_I8 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_present\_on\_admission\_9 | Diagnosis code indicates present on admission. Each relates to E diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_I9 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_present\_on\_admission\_10 | Diagnosis code indicates present on admission. Each relates to E diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_I10 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_present\_on\_admission\_11 | Diagnosis code indicates present on admission. Each relates to E diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_I11 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | e\_dx\_present\_on\_admission\_12 | Diagnosis code indicates present on admission. Each relates to E diagnosis code of same number. Necessary for some quality metrics. | NW\_B\_DIAGNOSIS\_GROUP | CDE\_POA\_I12 | Join with NW\_B\_DIAGNOSIS\_GROUP on DIAGRP\_SEQ |
|  | quantity | Identifies the volume of services billed by provider. Used in modeling, analysis, metrics, total cost of care. | EA\_ACOMCO\_MEDI\_CLAIM | QUANTITY |  |
|  | price\_method | Pricing method used for payment of the claim, needed for payment analysis. | EA\_ACOMCO\_MEDI\_CLAIM | PRICE\_METHOD |  |
|  | cde\_cos\_rollup | This classification level is the lowest level of COS granularity and is a larger roll-up of the detailed categories described below. The COS roll-up will be used as high level rollup for reporting and rate setting purposes | EA\_ACOMCO\_MEDI\_CLAIM | CDE\_COS\_ROLLUP |  |
|  | cde\_cos\_category | This classification is the mid-level categorization of COS. The COS category is prefixed by a letter - ‘P’ for Professional, ‘I’ for Institutional, ‘R’ for Pharmacy - and suffixed by two digits; for example, a COS category can be ‘P-23’, ‘I-14’, ‘R-04’.  **Note**: If there is no further detail on the category, the COS category can be the highest level of granularity and there will be no differentiation between the Category and Subcategory (the COS Category and COS Subcategory will be identical). | EA\_ACOMCO\_MEDI\_CLAIM | CDE\_COS\_CATEGORY |  |
|  | cde\_cos\_subcategory | This classification level is the highest level of COS granularity and contains the most detailed description of the service performed on the claim. The COS Subcategory is prefixed by a letter - ‘P’ for Professional, ‘I’ for Institutional, ‘R’ for Pharmacy - and suffixed by 4 digits containing two decimals; for example, a COS subcategory can be ‘P-06.04’ or ‘I-08.03’. | EA\_ACOMCO\_MEDI\_CLAIM | CDE\_COS\_SUBCATEGORY |  |
|  | ind\_mco\_aco\_cvd\_svc | Flag to identify covered vs non-covered services. The ‘Y’ value will populate only on claims for services which are covered by the ACO/MCO per contract with MH and is included in TCOC. The ‘N’ value will populate on claims for services which are not covered by the ACO per contract with MH, therefore is not included in TCOC. | EA\_ACOMCO\_MEDI\_CLAIM | IND\_MCO\_ACO\_CVD\_SVC |  |
|  | cde\_eapg | The EAPG code Identifies an Enhanced Ambulatory Patient Group  (EAPG). EAPGs are designed to explain the amount and type of  resources used in an ambulatory visit. | EA\_ACOMCO\_MEDI\_CLAIM | CDE\_EAPG |  |
|  | num\_weight\_full | The number weight full specifies the unadjusted Enhanced Ambulatory  Patient Group (EAPG) weight | EA\_ACOMCO\_MEDI\_CLAIM | NUM\_WEIGHT\_FULL |  |
|  | num\_weight\_adj | The number weight adjustment specifies the adjusted Enhanced  Ambulatory Patient Group (EAPG) weight after discounting and  consolidation. | EA\_ACOMCO\_MEDI\_CLAIM | NUM\_WEIGHT\_ADJ |  |
|  | ind\_excluded | Populate with ‘Y’ on claims that have been excluded due to an SUD from the standard monthly medical claims extract and ‘N’ on claims that have a diagnosis or injury code suppressed |  | IND\_EXCLUDED | See Logic in Req 6.1.4 |

# Pharmacy SUD Claims Extract Requirements

## Data Requirements

* + 1. The Pharmacy SUD Claims extract should include SUD Claims data from EA\_ACOMCO\_PHRM\_CLAIM only when IND\_CLAIM\_SU = ‘Y’

IND\_CLAIM\_SU is defined as 🡪 Y = SUD CLAIM; N = Non-SUD claim

* + 1. Non-SUD claims data that meets the following condition should not be included in the Medical SUD claims extract

IND\_CLAIM\_SU = ‘N’

## File Layout

The columns in the file layout table mean the following --

* + 1. The field names in the table below will be the column headers in the pipe delimited file
    2. The Field Description gives additional information about the data this field contains
    3. Table/View Name lists the table/view name from where the data is sourced.
    4. Column Name lists the column name in the ‘Table/View Name from where the data should be sourced.
    5. Logic/Comments explains any join conditions/pseudo code logic to derive the fields or can contain any additional comments.
    6. The pipe delimited file output should meet the data type and length requirements as listed in the Pharmacy Claims tab of the Monthly SUD Report Data Dictionary v1 (see Appendix 10.5)

Table 7 - Pharmacy Claims SUD Extract Layout

| **ID** | **Field Name** | **Field Description** | **Table/View Name** | **Column Name** | **Logic/Comments** |
| --- | --- | --- | --- | --- | --- |
|  | member\_id | Member ID | EA\_ACOMCO\_PHRM\_CLAIM | MEMBER\_ID |  |
|  | claim\_number | Claim number | EA\_ACOMCO\_PHRM\_CLAIM | CLAIM\_NUMBER |  |
|  | line\_number | Line number | EA\_ACOMCO\_PHRM\_CLAIM | LINE\_NUMBER |  |
|  | aco\_pidsl | ACO PIDSL | EA\_ACOMCO\_PHRM\_CLAIM | ACO\_PIDSL |  |
|  | aco\_name | ACO name | EA\_ACOMCO\_PHRM\_CLAIM | ACO\_NAME |  |
|  | pcc\_pidsl | PCC PIDSL | EA\_ACOMCO\_PHRM\_CLAIM | PCC\_PIDSL |  |
|  | pcc\_name | PCC name | EA\_ACOMCO\_PHRM\_CLAIM | PCC\_NAME |  |
|  | pcc\_npi | PCC NPI | EA\_ACOMCO\_PHRM\_CLAIM | PCC\_NPI |  |
|  | pcc\_taxid | PCC TIN | EA\_ACOMCO\_PHRM\_CLAIM | PCC\_TAXID |  |
|  | mco\_pidsl | MCO PIDSL | EA\_ACOMCO\_PHRM\_CLAIM | MCO\_PIDSL |  |
|  | mco\_name | MCO name | EA\_ACOMCO\_PHRM\_CLAIM | MCO\_NAME |  |
|  | source | Source | EA\_ACOMCO\_PHRM\_CLAIM | CDE\_SOURCE |  |
|  | claim\_type | Type of Claim – Pharmacy, Compound Drug Claims | EA\_ACOMCO\_PHRM\_CLAIM | CLAIM\_TYPE |  |
|  | member\_dob | Member Date of Birth | EA\_ACOMCO\_PHRM\_CLAIM | MEMBER\_DOB |  |
|  | refill\_quantity | Refill information provides additional information on an individual’s condition  *allowed refills set by NDC* | EA\_ACOMCO\_PHRM\_CLAIM | REFILL\_QUANTITY |  |
|  | service\_start\_date | First date of service on the claim | EA\_ACOMCO\_PHRM\_CLAIM | SERVICE\_START\_DATE |  |
|  | service\_end\_date | Last date of service on the claim | EA\_ACOMCO\_PHRM\_CLAIM | SERVICE\_END\_DATE |  |
|  | paid\_date | Paid date also known as Remit Date. Remit date helps establish the length of time between submission of a claim and payment, for complementary analysis. | EA\_ACOMCO\_PHRM\_CLAIM | PAID\_DATE |  |
|  | days\_supply | Number of days a prescribed drug should last a recipient; provides condition information and allows for possible analysis into drug abuse | EA\_ACOMCO\_PHRM\_CLAIM | DAYS\_SUPPLY |  |
|  | billed\_amount | Dollar amount billed to payer, total, by provider. Necessary for total cost of care analysis – reflects established fee schedule. | EA\_ACOMCO\_PHRM\_CLAIM | BILLED\_AMOUNT |  |
|  | allowed\_amount | Dollar amount for claim allowed by payer – necessary for total cost of care analysis. | EA\_ACOMCO\_PHRM\_CLAIM | ALLOWED\_AMOUNT |  |
|  | paid\_amount | Amount paid for claim net of any other adjustments. Necessary for total cost of care and other analyses. This is the FFS amount not the actual capitation amt. | EA\_ACOMCO\_PHRM\_CLAIM | PAID\_AMOUNT |  |
|  | prescriber\_npi | Prescribing NPI | EA\_ACOMCO\_PHRM\_CLAIM | PRESCRIBER\_PROVIDER\_NPI |  |
|  | id\_prescriber\_servicing | Prescribing ID | EA\_ACOMCO\_PHRM\_CLAIM | ID\_PROVIDER\_PRESCRIBER |  |
|  | prescriber\_taxid | Prescriber TIN | EA\_ACOMCO\_PHRM\_CLAIM | PRESCRIBER\_TAXID |  |
|  | prescriber\_name | Prescriber name | EA\_ACOMCO\_PHRM\_CLAIM | PRESCRIBER\_PROVIDER\_NAME |  |
|  | prescriber\_type | Prescriber prov. Type | EA\_ACOMCO\_PHRM\_CLAIM | PRESCRIBER\_PROVIDER\_TYPE |  |
|  | prescriber\_taxonomy | Prescriber taxonomy | EA\_ACOMCO\_PHRM\_CLAIM | PRESCRIBER\_PROVIDER\_TAXONOMY |  |
|  | prescriber\_address | Prescriber address | EA\_ACOMCO\_PHRM\_CLAIM | PRESCRIBER\_ADDRESS |  |
|  | prescriber\_city | Prescribing city | EA\_ACOMCO\_PHRM\_CLAIM | PRESCRIBER\_CITY |  |
|  | prescriber\_state | Prescribing state | EA\_ACOMCO\_PHRM\_CLAIM | PRESCRIBER\_STATE |  |
|  | prescriber\_zip | Prescribing zip | EA\_ACOMCO\_PHRM\_CLAIM | PRESCRIBER\_ZIP |  |
|  | billing\_npi | Billing provider NPI | EA\_ACOMCO\_PHRM\_CLAIM | BILLING\_NPI |  |
|  | id\_provider\_billing | Unique identifier of the provider billing for the services, required for payment modeling and network analysis | EA\_ACOMCO\_PHRM\_CLAIM | ID\_PROVIDER\_BILLING |  |
|  | billing\_taxid | Billing provider TIN | EA\_ACOMCO\_PHRM\_CLAIM | BILLING\_TAXID |  |
|  | billing\_provider\_name | Billing provider name | EA\_ACOMCO\_PHRM\_CLAIM | BILLING\_PROVIDER\_NAME |  |
|  | billing\_provider\_type | Billing provider type | EA\_ACOMCO\_PHRM\_CLAIM | BILLING\_PROVIDER\_TYPE |  |
|  | billing\_provider\_taxonomy | Billing provider taxonomy | EA\_ACOMCO\_PHRM\_CLAIM | BILLING\_PROVIDER\_TAXONOMY |  |
|  | billing\_address | Billing address 1 | EA\_ACOMCO\_PHRM\_CLAIM | BILLING\_ADDRESS |  |
|  | billing\_city | Billing city | EA\_ACOMCO\_PHRM\_CLAIM | BILLING\_CITY |  |
|  | billing\_state | Billing state | EA\_ACOMCO\_PHRM\_CLAIM | BILLING\_STATE |  |
|  | billing\_zip | Billing zip | EA\_ACOMCO\_PHRM\_CLAIM | BILLING\_ZIP |  |
|  | ndc\_code | National Drug Codes, like diagnosis codes and procedure codes, provide details on conditions and their treatments. | EA\_ACOMCO\_PHRM\_CLAIM | NDC\_CODE |  |
|  | dosage\_form\_code | indicates the dosage of the drug such as grams, milligrams, etc. While also may be coded in the NDC, this is necessary as a validation and helps establish how much of a drug a patient has on hand. | EA\_ACOMCO\_PHRM\_CLAIM | DOSAGE\_FORM\_CODE |  |
|  | therapeutic\_class | Specialty class for the drug in its most preferred usage. Supplements NDC code information | EA\_ACOMCO\_PHRM\_CLAIM | THERAPEUTIC\_CLASS |  |
|  | daw\_ind | Dispense as written indicator. Indicator that the brand drug (not a generic substitute) was used due to Professional Claim necessity reasons. Used to profile the delivery patterns of pharmacies and physicians | EA\_ACOMCO\_PHRM\_CLAIM | DAW\_IND |  |
|  | gcn | Generic code number. Used to identify generic formulation of a drug | EA\_ACOMCO\_PHRM\_CLAIM | GCN |  |
|  | claim\_status | The status of the claim indicates whether the claim was paid or not, and is necessary for many types of analysis. | EA\_ACOMCO\_PHRM\_CLAIM | CLAIM\_STATUS |  |
|  | disbursement\_code | Disbursement code | EA\_ACOMCO\_PHRM\_CLAIM | DISBURSEMENT\_CODE |  |
|  | enrolled\_flag | Entity enrolled flag | EA\_ACOMCO\_PHRM\_CLAIM | ENROLLED\_FLAG |  |
|  | drug\_name | Description field, name of the label of a drug, used in reporting. | EA\_ACOMCO\_PHRM\_CLAIM | DRUG\_NAME |  |
|  | brand\_vs\_generic\_indicator | Brand vs generic indicator. Brand vs. generic provides insight on medication prescribed to individuals by their providers | EA\_ACOMCO\_PHRM\_CLAIM | BRAND\_VS\_GENERIC\_INDICATOR |  |
|  | price\_method | Price method | EA\_ACOMCO\_PHRM\_CLAIM | PRICE\_METHOD |  |
|  | quantity | Quantity billed. Identifies the volume of services billed by provider. Used in modeling, analysis, metrics, total cost of care | EA\_ACOMCO\_PHRM\_CLAIM | QUANTITY |  |
|  | route\_of\_administration | Route of administration. Code for how the drug is administered to the patient (oral, subcutaneous, intravenous, etc.). Necessary to help separate out drugs that may require practitioner delivery. | EA\_ACOMCO\_PHRM\_CLAIM | ROUTE\_OF\_ADMINISTRATION |  |
|  | cde\_cos\_rollup | This classification level is the lowest level of COS granularity and is a larger roll-up of the detailed categories described below. The COS roll-up will be used as high level rollup for reporting and rate setting purposes | EA\_ACOMCO\_PHRM\_CLAIM | CDE\_COS\_ROLLUP |  |
|  | cde\_cos\_category | This classification is the mid-level categorization of COS. The COS category is prefixed by a letter - ‘P’ for Professional, ‘I’ for Institutional, ‘R’ for Pharmacy - and suffixed by two digits; for example, a COS category can be ‘P-23’, ‘I-14’, ‘R-04’.  **Note**: If there is no further detail on the category, the COS category can be the highest level of granularity and there will be no differentiation between the Category and Subcategory (the COS Category and COS Subcategory will be identical). | EA\_ACOMCO\_PHRM\_CLAIM | CDE\_COS\_CATEGORY |  |
|  | cde\_cos\_subcategory | This classification level is the highest level of COS granularity and contains the most detailed description of the service performed on the claim. The COS Subcategory is prefixed by a letter - ‘P’ for Professional, ‘I’ for Institutional, ‘R’ for Pharmacy - and suffixed by 4 digits containing two decimals; for example, a COS subcategory can be ‘P-06.04’ or ‘I-08.03’. | EA\_ACOMCO\_PHRM\_CLAIM | CDE\_COS\_SUBCATEGORY |  |
|  | ind\_mco\_aco\_cvd\_svc | Flag to identify covered vs non-covered services. For Pharmacy claims this columns will always populate as Y because there are no specific Covered vs Non covered rules for Pharmacy claims (As per COS BRD v2.5) | EA\_ACOMCO\_PHRM\_CLAIM | IND\_MCO\_ACO\_CVD\_SVC |  |

# Data Delivery/Access (SFTP), and Archival Requirements

* 1. The SUD extracts will be provided to the 3 Model B ACOs via pipe delimited files written to a secure AFTP site. Each Model B ACO has their own folder on the MH SFTP site to access these reports.

|  |  |  |
| --- | --- | --- |
| **#** | **ACO Name** | **SFTP Directory/Folder Path** |
|  | COMMUNITY CARE COOPERATIVE (CCC) |  |
|  | PARTNERS HEALTHCARE CHOICE (PHACO) |  |
|  | STEWARD HEALTH CHOICE (Steward) |  |

* 1. Read/Write access to the folders in Req ID 8.1 should be restricted only to the ACO staff members and DW staff members listed in the table below.

|  |  |  |  |
| --- | --- | --- | --- |
| **#** | **Staff Member’s Name** | **Group/Department** | **Access Type** |
|  | DW Operations | Data Warehouse | Read/Write/Delete |
|  | Jamie Lannon | ACO Reporting Team | Read/Write/Delete |
|  | Danielle Masone | Data Integrity | Read/Write/Delete |
|  | Sravan Andela | Data Warehouse | Read/Write/Delete |
|  | Siddharth Sulladmath | Data Warehouse | Read/Write/Delete |
|  |  | ACO-CCC | Read |
|  |  | ACO-PHACO | Read |
|  |  | ACO-Steward | Read |

* 1. The monthly SUD extracts package will be delivered to ACOs in one zipped file. This zipped file will contain all 3 files (as listed in Section 5). This zipped file name will follow the naming convention as below -

“ACO-<ACOName>\_<Month>\_<Year>\_SUD”

For zipped file naming conventions, “ACOName” will reflect the short name of the ACO, and “Month\_Year” will reflect the last month of service dates included in the report. For example, a Monthly Report package delivered to Steward containing dates of service through June 30, 2020, the zipped file containing all monthly reports will be named, “ACO-StewardB\_June\_2020\_SUD

* 1. The SUD report packages will be delivered the week following the delivery of the standard monthly report packages. For example, if the Standard monthly reports are delivered to ACOs on a Friday, the SUD monthly report packages will be delivered to the ACOs the following Monday.
  2. Three rolling months of data should be maintained in DW tables for answering/troubleshooting any questions from the ACOs. – Cognos is not saving on portal.

# Quality Assurance (QA) Requirements

The requirements below is not a complete list of all QA requirements, they are the minimum recommended QA requirements. The QA team should also create their own test cases to ensure that the SUD extracts meet the Data/Business/QA requirements explained in this BRD.

## Medical SUD Claims Extract

* + 1. SUD Claims Excluded due to SUD

1. Claim\_numbers for SUD excluded claims (ind\_excluded = ‘Y’; see table 5 in Req 6.1.4 ) in the Medical SUD Claims extract for each ACOB should match the claim\_numbers for SUD excluded claims (ind\_claim\_su = ‘Y’; see table 3 in Req 6.1.1) in the Medical claims view 🡪 EA\_ACOMCO\_MEDI\_CLAIM.
2. SUD Claims in SUD Claims extract should not be present in the standard medical claims extract.
   * 1. SUD Claims Suppressed due to SUD
3. Claim\_numbers for SUD suppressed claims (ind\_excluded = ‘N’; see table 5 in Req 6.1.4) in the Medical SUD Claims extract for each ACOB should match the claims\_numbers for SUD suppressed claims (ind\_claim\_su = ‘N’; see table 3 in Req 6.1.1) in the Medical claims view 🡪 EA\_ACOMCO\_MEDI\_CLAIM.

## Pharmacy SUD Claims Extract

* + 1. SUD Claims excluded due to SUD

1. Claim\_numbers for SUD excluded claims in the Pharmacy SUD Claims extract for each ACOB should match the claim\_numbers for SUD excluded claims (ind\_claim\_su = ‘Y’; see Req 7.1.1) in the Pharmacy claims view 🡪 EA\_ACOMCO\_PHRM\_CLAIM