Table of Contents

Introduction

Welcome to the QSI Implementation Guide. This document will help you properly format and structure the input data files for HEDIS 2012.

Implementation Guide Changes V15

The following changes were made to the 2012 Implementation Guide that could impact your HEDIS reporting.

Data Type	Change	Description
Claim	MajorSurgery Flag added	This works like the RoomBoardFlag variable. If you wish to force the software to flag a claim record as major surgery set value to 'Y'. Otherwise, QSI will build the major surgery indicator when applicable based on an internal cross reference. This field is used for RRU measures.
Member	Added additional optional fields	The fields added allow plans to store additional data elements on each member record (MedicareID, MedicaidID, marital status, etc.)
Member	Race Source and Ethnicity Source	Prior QSI versions stored this as RaceEthnicitySource. Beginning with version 15, These values are stored in separate fields. Member data should be extracted with these values separated.
ProviderSpecialty	Additional Provider Type Cross Reference	Added two new ProviderTypes (AMB, DME) to the ProviderSpecialty/ProviderType Cross Reference.
MemberEnrollment	DMEligibleFlag	Added flag to enrollment for those plans that wish to identify members in a disease management program. (This field is used for NCQA's Disease Management measures).

General Input File Properties

All input data files for QSI must be tab delimited text files with header rows. Header names must exactly match the template field names. All fields must be present for each record. No additional fields are allowed when using QSI's default layout in this guide. However, QSI contains a template building tool that allows for customization to the default layout. Indicate null fields with two consecutive delimiters with no intervening blanks. Use Carriage Return to indicate the end of a record. The final record on the file must end with a Carriage Return.

All character fields must be left justified with no leading spaces. Character fields must not contain the delimiter. All dates must be in the format MM/DD/YYYY (include the slash marks). Appropriate values for single-character flag fields are 'Y' and 'N'.

QSI does not allow single quote (') or double quote (") characters within the data. If your data contains these characters, they will be removed as part of the load process.

Historical Data Sources

For HEDIS reporting it is recommended that customer load the following historical data to meet reporting obligations.

Data Type	Minimum history to load
Claims and Encounter sources	3.5 years
Pharmacy data	3.5 years
Lab	2 years
Vision	2 years
Mental Health	2 years
Dental	1 year
Member	Members that have at least one day of enrollment during the MY or PY. For all those members load at least 3.5 years of enrollment data.

File Names

There are no specific requirements as to file names, although we recommend using filenames that generally conform to the data types specified in this implementation guide.

Empty Files

Only create input data files when data is actually present. QSI does not require sources to be loaded when no data is present.

The first section of this guide documents the production data sources. Production sources are those that materially affect HEDIS® measure results. Reference data sources, which have no material impact, are documented in the next section.

The nine production data sources are:

- ✓ Claim
- ✓ HomegrownMod
- ✓ HomegrownPx
- ✓ LabClaim
- ✓ Member
- ✓ MemberEnrollment
- ✓ Provider
- ✓ ProviderSpecialty
- ✓ RxClaim

Claim

The Claim file contains claims for medical services. It may also contain lab services that do not have an associated result, pharmaceuticals administered in the practitioners office (usually documented by J codes in the CPT field), and medical encounter data. The Claim file should contain one record per unique claim. There is no harm done by duplicate claims for the same service.

If your source data contains multiple values where this guide only allows one, your conversion process must generate additional like QSI claim records (lines) or you may use QSI's template editor to build a custom template for your source data.

Data elements for the Claim file (highlighted fields are not required but exist in the database for additional/alternate reporting. These fields are not part of the standard file layout. If you wish to add these additional fields to QSI, you will need to use QSI's Template Editor)

Field Name	Type	Length	Order in File	Notes
MemberKey	character	30	1	
ProviderKey	character	25	2	
ClaimNumber	character	25	3	
ClaimStatus	character	1	4	A
DOS	date	mm/dd/yyyy	5	B
DOSThru	date	mm/dd/yyyy	6	B
ICDDxPri	character	5	7	C
ICDDxSec1	character	5	8	C
ICDDxSec2	character	5	9	C
ICDDxSec3	character	5	10	C
ICDDxSec4	character	5	11	C
ICDDxSec5	character	5	12	C
ICDDxSec6	character	5	13	C
ICDDxSec7	character	5	14	C
ICDDxSec8	character	5	15	C
ICDDxSec9	character	5	16	C
ICDDxSec10	character	5	17	C
PCPFlag	character	1	18	D
HCFAPOS	character	2	19	
DRG	character	3	20	E, O, R
DRG2	character	3	21	E, O, R
MSDRG	character	3	22	O

Field Name	Type	Length	Order in File	Notes
MSDRG2	character	3	23	O
TOB	character	3	24	Q
UBRevenueCode	character	4	25	L
UBOccurCode1	character	3	26	
UBOccurCode2	character	3	27	
UBOccurCode3	character	3	28	
UBOccurCode4	character	3	29	
HCPCSPx	character	5	30	I
HCPCSMod	character	2	31	I
CPTPx	character	5	32	I, M
CPTMod1	character	2	33	I
CPTMod2	character	2	34	
ICDPx1	character	4	35	F,I
ICDPx2	character	4	36	F
ICDPx3	character	4	37	F
ICDPx4	character	4	38	F
ICDPx5	character	4	39	F
ICDPx6	character	4	40	F
ICDPx7	character	4	41	F
ICDPx8	character	4	42	F
ICDPx9	character	4	43	F
ICDPx10	character	4	44	F
DischargeStatus	character	2	45	
DaysDenied	numeric	integer	46	G
RoomBoardFlag	character	1	47	H
HomegrownPx	character	25	48	I
HomegrownMod1	character	5	49	I
ProviderSpecialty	character	15	50	J
ExcludeFromDischarge	character	1	51	H
RxProviderFlag	character	1	52	K
ClaimAltID1	character	30	53	N
ClaimAltID2	character	30	54	N
RRUUnitsofService	numeric	Integer	55	P

Field Name	Type	Length	Order in File	Notes
MajorSurgery	character	1	56	W
Allowed	numeric	money	57	V
Billed	numeric	money	58	V
Copay	numeric	money	59	V
Cost	numeric	money	60	V
Paid	numeric	money	61	V
APDRG	character	3	62	R
APRDRG	character	3	63	R
POA	character	1	64	S
POS	character	2	65	T
ProviderType	character	4	66	U

Notes for the Claim file

A. The following *ClaimStatus* values are acceptable:

Value	Description
A	Adjustment to original claim
D	Denied claims
I	Initial Paid Claim
P	Pended for adjudication
R	Reversal to original claim

B. Use DOS for the beginning date of service and DOSThru for the ending date of service. Do not use paid date, submitted date, process date or receipt date, etc. For claims that only have a single date of service, set DOSThru equal to DOS. For inpatient room and board claims, use DOS for the admission date and DOSThru for the discharge date.

C. ICD-9 diagnosis codes should contain all available digits. Do not include the period that follows the third digit. If no fourth or fifth digit was coded, do not pad the missing spaces (e.g., V42.0 should be loaded as V420).

Use ICDDxPri for the primary diagnosis. Use ICDDxSec1 through ICDDxSec10 for secondary diagnoses. The secondary diagnoses need not be listed in any particular order. Do not repeat the primary diagnosis as one of the secondary diagnoses, since some HEDIS measures look specifically for claims with no secondary diagnoses.

D. PCPFlag indicates whether or not the claim provider serves as a PCP for the health plan. It refers to the provider's contractual relationship to the MCO, rather than his or her medical specialty. Acceptable values are 'Y' and 'N'.

E. HEDIS specifications do not include APDRG or APRDRG values. APDRGs or APRDRGs can be loaded into QSI; however; a custom template must be created using the Data Template Editor. (Do not load either of these codes into the DRG field in the standard template). You should consult with your auditor for approval of this mapping. DRG codes should be converted to the standard 3-digit length prior to loading into QSI. It is acceptable to convert a DRG code to 3-digits by adding leading zeros.

F. ICD-9 procedure codes should contain all available digits. Do not include the period that follows the second digit.

G. For wholly or partially denied inpatient claims, indicate the number of denied days as a whole integer.

H. The Discharge Builder algorithm within QSI uses RoomBoardFlag as the basis of determining discharges. Only claims with a RoomBoardFlag value of 'Y' can create discharge records. Normally, RoomBoardFlag is derived from UBRevenueCode during the Discharge Build process. Use a value of 'Y' in the RoomBoardFlag field on the Claim record if you wish to supplement the data derived from UB Revenue code.

   By setting RoomBoardFlag to 'Y' on a Claim record, you make it possible for the record to create a discharge. Setting RoomBoardFlag to 'N' does not have the effect of preventing a discharge from being built. The Discharge Builder will still use the record to build a discharge if the UBRevenueCode indicates room and board care. If you wish to specifically exclude a claim record from the discharge building process (regardless of its UBRevenueCode), set ExcludeFromDischarge to 'Y'.

I. Use HomegrownPx and HomegrownMod1 to capture nonstandard procedure codes and modifiers. For these codes to have an effect on measure results, it will be necessary to map them to standard codes within QSI's homegrown code mapping tables or to define your own event definitions based on the codes.

   When you load HomegrownPx codes, QSI will try to automatically map them to the appropriate fields (CPT procedure, HCPC procedure, and ICD-9 procedure codes) by looking for valid codes. If it finds a match, then the code will be moved to the appropriate field. If it does not find a match, then the code will remain in the HomegrownPx field. The user will be able to load a file to map HomegrownPx to CPT procedure, HCPC procedure, and ICD-9 procedure codes that will be applied during the event build. The user will be able to modify this mapping without having to reload the claim files. They will also be able to create event definitions that look directly at HomegrownPx.

   HomegrownMod functionality will parallel HomegrownPx but is completely independent, and requires separate mapping.

J. Use the ProviderSpecialty field for the MCO's native provider specialty values. These values should correspond to the ProviderSpecialty values used for the ProviderSpecialty reference table.

K. Use a value of 'Y' in RxProviderFlag to indicate that the claim provider has prescribing privileges for the MCO members.

L. 4-digit revenue codes must be used. QSI doesn't recognize 3-digit codes. If claim data contains 3-digit UB Revenue codes, they should be converted to standard 4-digit UB Revenue codes prior to loading into QSI. It is acceptable to convert a 3-digit code to a 4-digit code by adding a leading zero.

M. Level II CPT codes are supported by HEDIS. These codes should be placed in the same field as other CPT procedure codes.

N. Alternate IDs are purely for reference purposes, and may be used at your discretion. The default QSI layout includes two AlternateIDs, but customers may use QSI's Template Editor if they wish to add subsequent AlternateIDs.

O. MSDRG is a data type introduced in late 2007. MSDRGS are an entirely distinct set of codes from Federal DRGs. It is the Plan's responsibility to separate and appropriately classify these codes from each other.

P. RRUUnitsofService is used for the cost calculation for the Cost of Care measures.

Q. QSI only supports 3-character Type of Bill codes. Customers must convert 4-character codes to meet this requirement.

R. APDGR and APRDRG codes are specific to our NY State Customers. You will need to use the QSI Template Editor to build custom claim templates that include either of these two data types. Once loaded, you will need to create you custom mapping (event definitions) so that they are used for you measure results.

S. Present on Admission (POA). This data type is used for non-HEDIS reporting and therefore is not required. If you wish to load data in support of this data type for other reporting, you should build a custom template using QSI's Template Editor. Your template must have exactly the same number of POA and ICD Dx columns. The value in each POA column must correspond to value of the ICD Dx column as shown below.

	Primary	**Secondary 1**	**Secondary 2**	**Secondary 3**	
ICD Dx	ICDDxPri	ICDDxSec1	ICDDxSec2	ICDDxSec3	…
POA	POAPri	POASec1	POASec2	POASec3	…

The following POA values are acceptable:

Value	Description
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1.

T. QSI builds these values using internal xref processing. However, if you wish to load claim lines The following POS values are acceptable.

Value	Description
BC	Birthing Center
DN	Day/Night (Partial Hospitalization)
ER	Emergency Room
IA	Inpatient Acute
IN	Inpatient Non-Acute
LA	Laboratory
OA	Outpatient/Ambulatory
OC	Office/Clinic
OT	Other
RM	Mail Order Prescription Drugs
RR	Retail Pharmacy

U. Refer to the ProviderSpecialty section of this Implementation Guide for the list of acceptable values. If you choose to load your Xref'd provider type values on each claim line, store the values here. Otherwise QSI will use the PRoviderSpecialty XREF to build the appropriate ProviderType value.

V. Do not include the '$' symbol in these fields.

W. This works like the RoomBoardFlag variable. If you wish to force the software to flag a claim record as major surgery set value to 'Y'. Otherwise, QSI will build the major surgery indicator when applicable based on an internal cross reference. This field is used for RRU measures.

Homegrown Codes

The HomegrownCode file should contain one record per unique value contained within the HomegrownPx field for claims that you wish to map to another value. If you do not wish to build the HomegrownCode file externally to QSI, you may use QSI's AutoScan function to find all distinct values within the HomegrownPx field and populate this table. Homegrown codes can only be mapped to the procedure codes listed below.

Data elements for the HomegrownCode file

Field Name	Type	Length	Order in File	Notes
HomegrownPx	character	25	1	
HCPCSPx	character	5	2	
CPTPx	character	5	3	
ICDPx	character	4	4	A

Notes for the HomegrownCode file

A. ICD-9 procedure codes should contain all available digits. Do not include the period that follows the second digit.

Homegrown Modifier

The Homegrown Modifiers should contain one record per unique value contained within the HomegrownMod field for claims that you wish to map to another value. Homegrown Modifier codes can only be mapped to the procedure modifiers listed below.

Data elements for the HomegrownMod file

Field Name	Type	Length	Order in File	Notes
HomegrownMod	character	5	1	
HCPCSMod	character	2	2	
CPTMod	character	2	3	

LabClaim

The LabClaim file contains claims for laboratory services and allows lab results to be stored. Claims for lab services that do not have an associated result may also be stored on the claims file. The LabClaim file should contain one record per unique lab service claim.

Data elements for the LabClaim file

Field Name	Type	Length	Order in File	Notes
MemberKey	character	30	1	
ProviderKey	character	25	2	
ClaimNumber	character	25	3	
ClaimStatus	character	1	4	A
DOS	date	mm/dd/yyyy	5	
CPTPx	character	5	6	
LOINC	character	7	7	B
Result	numeric	decimal	8	C
PosNegResult	character	1	9	D
ClaimAltID1	character	30	10	E
ClaimAltID2	character	30	11	E

Notes for the LabClaim file

A. The following ClaimStatus values are acceptable:

Value	Description
A	Adjustment
D	Denied
I	Initial Paid Claim
P	Pended
R	Reversal

B. LOINC codes must contain the dash character that precedes the final digit. Do not pad any missing characters for codes with fewer than seven characters.

C. Use Result to document numeric lab results. This field accepts values with or without the decimal point. It accepts 10 positions to the right of the decimal.

D. Use PosNegResult to document lab results that are positive or negative, and do not have an associated numeric result. Use '1' to indicate a positive result and '0' to indicate a negative result.

E. Alternate IDs are purely for reference purposes, and may be used at your discretion. The default QSI layout includes two AlternateIDs, but customers may use QSI's Template Editor if they wish to add additional data elements in subsequent AlternateIDs.

Member

The Member file should contain exactly one record per person enrolled in the plan during the time period covered by the data extract. No claim or enrollment record will be loaded by QSI unless there is a corresponding record (same value in the *Memberkey* field) on the Member file. The Member file, therefore, must be the first file loaded, and it must be as complete as possible.

Data elements for the Member file (highlighted fields are not required but exist in the database for additional/alternate reporting. These fields are not part of the standard file layout. If you wish to add these additional fields to QSI, you will need to use QSI's Template Editor)

Field Name	Type	Length	Order in File	Notes
MemberKey	character	30	1	A
SubscriberKey	character	30	2	B
MemberName	character	50	3	C
DOB	Date	mm/dd/yyyy	4	
Sex	character	1	5	D
MemberAddress1	character	50	6	E
MemberAddress2	character	50	7	E
MemberCity	character	50	8	E
MemberState	character	2	9	E
MemberZip	character	9	10	E
MemberPhone1	character	15	11	E
SSN	character	11	12	
MemberCounty	character	50	13	
MemberAltID1	character	30	14	F
MemberAltID2	character	30	15	F
MemberAltID3	character	30	16	F
MemberAltID4	character	30	17	F
MemberAltID5	character	30	18	F
MemberAltID6	character	30	19	F
RaceType	character	2	20	H
EthnicityType	character	2	21	I
RaceSource	character	1	22	J
EthnicitySource	character	1	23	J
LanguageSpoken	character	1	24	K
LanguageWritten	character	1	25	K
LanguageOther	character	1	26	K

Field Name	Type	Length	Order in File	Notes
LanguageSpokenSource	character	1	27	L
LanguageWrittenSource	character	1	28	L
LanguageOtherSource	character	1	29	L
Email	character	50	30	
MaritalStatus	character	2	31	M
MedicaidID	character	15	32	N
MedicareID	character	15	33	O
MemberPhone2	character	15	34	
Relationship	Character	2	35	P

Notes for the Member file

A. MemberKey should be the unique person identifier that serves as a valid referential key between the Member file, the MemberEnrollment file, and all Claims, LabClaims, and RxClaims files.

B. SubscriberKey should be the MemberKey of the primary subscriber who forms the basis of the member's eligibility. It is used to link children to guardians for the CAHPS child survey.

C. The MemberName should follow the format 'LastName, FirstName M'.

D. Appropriate values are 'M' for male and 'F' for female.

E. Member address data is used to mail the CAHPS survey. It may also be used as a means to define Reporting Populations.

F. Alternate IDs may be populated for internal health plan reference purposes at your discretion. However; if you are a plan that produces any of the extracts using QSI you will need to store the specified member identifiers in AlternateID fields, MemberKey, or SubscriberKey, MedicareID, or MedicaidID fields.

- CMS Patient Level Detail requires HIC Number.
- For SNP population the SNP Enrollee and SNP Plan ID may be required.
- PA EQRO requires the Enrollee CIS
- CA MRMIB requires the Medicaid ID
- CA CCHRI requires the Medicaid ID
- NY QARR requires the Medicaid CIN

H. The following RaceType values are acceptable:

Value	Description
01	White
02	Black or African American
03	American Indian and Alaska Native
04	Asian
05	Native Hawaiian and Other Pacific Islander
06	Some Other Race
07	Two or more Races
08	Declined
09	Unknown Race

I. The following EthnicityType values are acceptable:

Value	Description
11	Hispanic or Latino
12	Not Hispanic or Latino
18	Declined Ethnicity
19	Unknown Ethnicity

J. The following RaceSource and EthnicitySource values are acceptable:

Value	Description
C	CMS Databases
S	State Databases
N	Surname Analysis
G	Geo-coding Analysis
D	Health Plan Direct
U	Unknown Data Collection Method
O	Other

K. The following Language values are acceptable:

Value	Description
E	English
N	Non-English
D	Declined
U	Unknown

L. The following LanguageSource values are acceptable:

Value	Description
D	Health Plan Direct
C	CMS Databases
S	State Databases
O	Other

M. The following Marital Status values are acceptable:

Value	Description
01	Married
02	Single
03	Unknown

N. MedicaidID should be the member identifier assigned by the State Medicaid Agency. It is only applicable to Medicaid plan members.

O. MedicareID should be the Medicare Health Insurance Claim Number assigned by CMS. It is also known as the HIC number and is only applicable to Medicare Advantage members. It serves as referential key between all associated Medicare data such as MOR, MMR and RAPS files.

P. Relationship should indicate what relationship exists between the Subscriber and the Member. Acceptable values for Relationship are:

Value	Description
01	Self
02	Spouse
03	Father
04	Mother
05	Guardian
06	Child
07	Domestic Partner

MemberEnrollment

The MemberEnrollment file may contain many records for each member. Each record represents a distinct period of time enrolled in the plan, with *EffectiveDate* and *TerminationDate* marking the beginning and end of the period. Each member should have at least one enrollment record, and the MemberEnrollment file should contain exactly as many records for each member as are needed to document changes to the values within the fields of the file. For example, if a member changes his or her benefit package or assigned PCP, a new record should begin. For purposes of the continuous enrollment calculation, a member is deemed to be continuously enrolled if the *EffectiveDate* of a record is one or two days later than the *TerminationDate* of an earlier record. Enrollment breaks of exactly one day (e.g., one record terminates on the 15th of the month and the next is effective on the 17th of the month) are considered to be continuous enrollment. The termination date must not be left blank. For members that do not have a termination date (i.e, they are still enrolled with the plan) populate the termination date with a date value into the future such as 12/31/2099.

Do not overlap enrollment records, and do not break enrollment records into smaller time periods than are necessary to track changes to the field values. These data scenarios may degrade the performance of QSI and could affect the accuracy of the measure results.

For each benefit flag, use the value 'Y' to indicate a covered benefit and the value 'N' to indicate that the member does not have the benefit. If a member begins with a benefit but exhausts it, use one record with a value of 'Y' for the period leading up to the last qualifying service and another record with a value of 'N' for the period thereafter.

Data elements for the MemberEnrollment file (highlighted fields are not required but exist in the database for additional/alternate reporting. These fields are not part of the standard file layout. If you wish to add these additional fields to QSI, you will need to use QSI's Template Editor)

Field Name	Type	Length	Order in File	Notes
MemberKey	character	30	1	A
EffectiveDate	date	mm/dd/yyyy	2	
TerminationDate	date	mm/dd/yyyy	3	
ProductCode	character	1	4	B
PayerCode	character	2	5	C
PCP_ProviderKey	character	25	6	D
MentalHealthAmbulFlag	character	1	7	E
MentalHealthInpatientFlag	character	1	8	E
MentalHealthDayNightFlag	character	1	9	E
ChemDependAmbulFlag	character	1	10	E
ChemDependInpatientFlag	character	1	11	E
ChemDependDayNightFlag	character	1	12	E
RxFlag	character	1	13	F
VisionFlag	character	1	14	G
DentalFlag	character	1	15	H

Field Name	Type	Length	Order in File	Notes
PlanCode	character	25	16	I, K
MemberGroupCode	character	25	17	I, K
PlanEmployeeFlag	character	1	18	J
EmployerCode	character	25	19	I
MemberEnrollmentCustomCode1	character	25	20	I, K
MemberEnrollmentCustomCode2	character	25	21	I, K
MemberEnrollmentCustomCode3	character	25	22	I, K
MemberEnrollmentCustomCode4	character	25	23	I, K
MemberEnrollmentCustomCode5	character	25	24	I, K
MemberEnrollmentCustomCode6	character	25	25	I, K
MedicareContractCode	character	25	26	I, K
DMEligibleFlag	character	1	27	L
SeverityFactor	numeric	decimal	28	M

Notes for the MemberEnrollment file

A. MemberKey should be the unique person identifier that serves as a valid referential key between the Member file, the MemberEnrollment file, and all Claims, LabClaims, and RxClaims files.

B. ProductCode differentiates product lines. It is a required field that is used as part of the continuous enrollment calculation. Acceptable values are as follows:

Value	Description
F	PFFS
H	HMO
S	POS
P	PPO
O	Other

C. PayerCode differentiates lines of business. It is a required field that is used as part of the continuous enrollment calculation. Acceptable values are as follows:

Value	Description
C	Commercial
RR	Medicare Risk Contract
RC	Medicare Cost Contract
D	Medicare/Medicaid Dual Eligible
M	Medicaid
ML	Medicaid (Other Low Income)
MD	Medicaid (Disabled)
MR	Medicaid (Restricted Benefit Package)
NC	Special Needs Plan – Chronic Condition
ND	Special Needs Plan – Dual Eligible
NI	Special Needs Plan – Institutionalized
S	Self Insured
H	CHIP
F	Family Care
O	Other

D. Populate PCP_ProviderKey with the ProviderKey value for the member's assigned PCP.

E. These fields track whether or not the member has mental health and chemical dependency benefits. If your plan tracks benefits at only the general level, set each of the three settings for that benefit type to the same value, Y or N.

F. RxFlag indicates whether or not the member has a pharmacy benefit.

G. VisionFlag indicates whether or not the member has a vision benefit.

H. DentalFlag indicates whether or not the member has a dental benefit.

I. These variables are helpful for defining Reporting Populations but are not required by QSI. Use them at your own discretion.

J. Use a value of 'Y' to indicate that the member is an employee (or dependant of an employee) of the health plan, and therefore WILL be excluded from any hybrid sample that might require the member's medical records to be reviewed. Otherwise, set to 'N'.

K. This is not an appropriate location for alternate member identifiers (Medicare SNP enrollee type, Medicare Plan ID, Medicaid CIN, Medicare HIC, etc.). Use the

MemberAltID or other custom member demographic fields on the member file to store these types of values.

L. Use a value of 'Y' on the coverage segment(s) to indicate that the member is in a disease management program.

M. Use Result to document severity factor. This field accepts values with or without the decimal point. It accepts 10 positions to the right of the decimal.

Provider

The Provider file should contain exactly one record per provider contracting with the plan during the time period covered by the data extract. If a claim, Lab claim, Rx claim or enrollment record is loaded by QSI and there is no corresponding record (same value in the ProviderKey field) on the Provider file, QSI will automatically add an "unknown" record for that ProviderKey value to the Provider table. As an updated provider file containing these providerkeys is loaded, QSI will update any record from "unknown" with the demographic data loaded on the file.

Data elements for the Provider file

Field Name	Type	Length	Order in File	Notes
ProviderKey	character	25	1	A
ProviderName	character	61	2	B
ProviderAddress1	character	50	3	C
ProviderAddress2	character	50	4	C
ProviderCity	character	50	5	C
ProviderState	character	2	6	C
ProviderZip	character	9	7	C
ProviderFax	character	15	8	C
ProviderPhone1	character	15	9	C
ProviderPhone2	character	15	10	C
ProviderDEACode	character	25	11	D
FacilityCode	character	25	12	E
ManagementGroupCode	character	25	13	E
Languages	character	50	14	G
LocationKey	character	25	15	E
ProviderAltID1	character	30	16	F
ProviderAltID2	character	30	17	F
ProviderAltID3	character	30	18	F
ProviderAltID4	character	30	19	F
ExcludeFromMRChase*	character	1	20	H
ExcludeFromPRRelationship*	character	1	21	H

*These additional fields are optional. However; if you desire to use either, you must include both or create a custom template using QSI's Template Editor.

Notes for the Provider file

A. ProviderKey should be the unique identifier that serves as a valid referential key between the Provider file, the ProviderEnrollment file, the MemberEnrollment file, and all Claims, LabClaims, and RxClaims files. For this reason, we suggest that you store the NPI (National Provider Identifier) in a ProviderAltID field, unless the NPI is being used consistently across all data sources mentioned above. NPI is not a required value in QSI.

B. ProviderName should be formatted as you wish it to appear in reports sent to the provider office. Institutional names should be used for facilities. Individual practitioners' names should be formatted as 'LastName, FirstName M'.

C. Provider address data will be used to determine the locations of medical records pursued for hybrid reporting. You should take care to use the physical address of the provider office where patient medical records are most likely to be stored. Do not use billing addresses or PO Boxes. Format address data uniformly and consistently for providers at the same locations, as this will effect processing using the location build roll-up process.

D. ProviderDEACode is not required for HEDIS reporting. However, it can be useful when trying to analyze which provider wrote a member's prescription.

E. FacilityCode, ManagementGroupCode, and LocationKey are not required for HEDIS reporting. However, they can be useful when trying to identify medical record pursuits or report measure results by provider group.

F. Alternate IDs are for reference purposes, and may be used at your discretion. This is the suggested location for alternate provider identifiers (Hospital PFI, Provider MMIS, Provider License, Collector Identification Number, etc.). Customers that report non-HEDIS results (state specific reporting) may be required to store specific identifiers required by your reporting entity. Customers may also store native specialist information that may be useful for the medical record data collection process. The default template contains four AlternateIDs, QSI allows up to eight AlternateIDs. You should use QSI's Template Editor to create a custom mapping to add any additional AlternateIDs to your project.

G. Provider language data is purely for reference purposes, and may be used at your discretion.

H. ExcludeFromMRChase is an optional field that may be used to flag providers for whom you do not wish QSI to build medical record chases. Acceptable values are 'Y' and 'N'. ExcludeFromPRRelationship is an optional field that may be used to flag providers for whom you do not wish QSI to build provider reporting relationships (only relevant for the QSI Provider Reporting module). Acceptable values are 'Y' and 'N'.

ProviderSpecialty

The ProviderSpecialty is a cross-reference that maps the MCO's native provider specialty codes to the standardized ProviderType values needed by QSI. The ProviderSpecialty file should contain one record per unique ProviderSpecialty value within the MCO data.

Data elements for the ProviderSpecialty file

Field Name	Type	Length	Order in File	Notes
ProviderSpecialty	character	15	1	A
ProviderSpecialtyDescription	character	50	2	
ProviderType1	character	4	3	B
ProviderType2	character	4	4	B
ProviderType3	character	4	5	B

Notes for the ProviderSpecialty file

A. Include each unique MCO native provider specialty value. These values should correspond to the ProviderSpecialty values used in the Claim file.

B. The following ProviderType values are acceptable:

Value	Description
AMB	Ambulance
ANE	Anesthesiologist
CARD	Cardiologist
CD	Chemical Dependency Provider
DME	Durable Medical Equipment
DN	Dental Provider
ENDO	Endocrinologist
FAC	Facility
GAST	Gastroenterologist
GYN	Gynecologist (use OB for OB/GYNs)
INFD	Infectious Disease Specialist
MHN	Mental Health Provider without Prescribing Privileges
MHP	Mental Health Provider with Prescribing Privileges
NEPH	Nephrology
NPCP	Non-Physician Primary Care (e.g., Nurse Practitioner or PA in PCP Office)
OB	Obstetrician (also OB/GYNs)
OTHR	Other
PCP	Primary Care Provider
PNC	Prenatal Care Provider (e.g., Nurse Midwife or NP/PA in OB/GYN Office)
RN	Registered Nurse
RPH	Clinical Pharmacist
UC	Urgent Care Center
VC	Vision Care Provider

RxClaim

The RxClaim file contains pharmacy claims. The RxClaim file should contain one record per unique pharmacy claim. Duplicate claims for the same service are not allowed.

Data elements for the RxClaim file

Field Name	Type	Length	Order in File	Notes
MemberKey	character	30	1	
ProviderKey	character	25	2	
ClaimNumber	character	25	3	
ClaimStatus	character	1	4	A
FillDate	date	mm/dd/yyyy	5	
NDC	character	11	6	
DaysSupply	numeric	integer	7	G
QuantityDispensed	numeric	float	8	F, G
Cost	numeric	money	9	B
SupplyFlag	character	1	10	C
ProviderDEACode	character	25	11	D
ClaimAltID1	character	30	12	E
ClaimAltID2	character	30	13	E

Notes for the RxClaim file

A. The following ClaimStatus values are acceptable:

Value	Description
A	Adjustment
D	Denied
I	Initial Paid Claim
P	Pended
R	Reversal

B. Cost should be calculated as MCO costs plus member costs. Typically, this is the discounted ingredient cost plus the dispensing or professional fee, plus the administrative fee, less formulary or other rebates.

One should be able to sum the Cost column for all initial paid, reversed, and adjustment RxClaim records and determine the total cost of prescriptions. For initial paid claims, therefore, Cost should be represented as a positive dollar amount. For reversals, Cost should be a negative dollar amount equal to the cost of the corresponding initial paid

claim. Adjustments may be positive or negative. The cost should be expressed as a number without the $ symbol. Negative numbers should be expressed with a – symbol, not with ( ) symbols.

C. Set SupplyFlag to 'Y' to indicate a claim for supplies (e.g., syringes) rather than medications.

D. ProviderDEACode is not required for HEDIS reporting. However, it can be useful when trying to analyze which provider wrote a member's prescription.

E. Alternate IDs are purely for reference purposes, and may be used at your discretion. The default QSI layout includes two AlternateIDs, but customers may use QSI's Template Editor if they wish to add additional data elements in subsequent AlternateIDs.

F. For the Cost of Care measures, NCQA advises that metric quantity must be used when available. This field is typically populated in grams.

G. When QuantityDispensed is not supplied the RRU cost will be calculated by multiplying DaysSupply by a standard cost provided by NCQA. The QSI Cost Builder will only recognize positive numbers for both QuantityDispensed and DaysSupply. For QuantityDispensed, anything that is less than "0" will be converted to a "0" value. For DaysSupply, any value less than "1" will be converted to "1".

Reference Data Sources

The next section of this guide documents the reference data sources. These are the sources that provide ancillary data and document values used on the production data sources. All reference data sources are considered optional by QSI.

The fourteen reference data sources are:

- ✓ Employer
- ✓ Facility
- ✓ Location
- ✓ ManagementGroup
- ✓ MedicareContract
- ✓ MemberEnrollmentCustomCode1
- ✓ MemberEnrollmentCustomCode2
- ✓ MemberEnrollmentCustomCode3
- ✓ MemberEnrollmentCustomCode4
- ✓ MemberEnrollmentCustomCode5
- ✓ MemberEnrollmentCustomCode6
- ✓ MemberGroup
- ✓ Plan
- ✓ ProviderEnrollment
- ✓ ProviderPanel

Employer

The Employer file is a reference table that documents the MCO's native employer codes. The Employer file should contain one record per unique EmployerCode value within the MCO data.

Data elements for the Employer file

Field Name	Type	Length	Order in File	Notes
EmployerCode	character	25	1	A
EmployerDescription	character	50	2	

Notes for the Employer file

A. Include each unique MCO native EmployerCode value. These values should correspond to the EmployerCode values used in the MemberEnrollment file.

Facility

The Facility file is a reference table that documents the MCO's native facility codes. The Facility file should contain one record per unique FacilityCode value within the MCO data.

Data elements for the Facility file

Field Name	Type	Length	Order in File	Notes
FacilityCode	character	25	1	A
FacilityDescription	character	50	2	

Notes for the Ethnicity file

A. Include each unique MCO native FacilityCode value. These values should correspond to the FacilityCode values used in the Provider file.

Location

The Location file should contain exactly one record per unique provider location.

Data elements for the Location file

Field Name	Type	Length	Order in File	Notes
LocationKey	character	25	1	A
LocationName	character	61	2	B
LocationAddress1	character	50	3	C
LocationAddress2	character	50	4	C
LocationCity	character	50	5	C
LocationState	character	2	6	C
LocationZip	character	9	7	C
LocationFax	character	15	8	C
LocationPhone1	character	15	9	C
LocationPhone2	character	15	10	C

Notes for the Location file

A. LocationKey should be the unique identifier that serves as a valid referential key to the Provider file.

B. LocationName should be formatted as you wish it to appear in reports sent to the location. Institutional names should be used for facilities. Individual practitioners' names should be formatted as 'LastName, FirstName M'.

C. Location address data can be used to determine the locations of medical records pursued for hybrid reporting. You should take care to use the physical address of the location where patient medical records are most likely to be stored. Do not use billing addresses or PO Boxes.

D. LocationAltID1-8 are for reference purposes, and may be used at your discretion. This is the suggested location for alternate location identifiers. Customers that report non-HEDIS results (state specific reporting) may be required to store specific identifiers required by your reporting entity. Customers may also store native information that may be useful for the medical record data collection process.

ManagementGroup

The ManagementGroup file is a reference table that documents the MCO's native management group codes. The ManagementGroup file should contain one record per unique ManagementGroup value within the MCO data.

Data elements for the ManagementGroup file

Field Name	Type	Length	Order in File	Notes
ManagementGroupCode	character	25	1	A
ManagementGroupDescription	character	50	2	
ManagementGroupAddress1	character	50	3	
ManagementGroupAddress2	character	50	4	
ManagementGroupCity	character	50	5	
ManagementGroupState	character	2	6	
ManagementGroupZip	character	9	7	
ManagementGroupFAX	character	15	8	
ManagementGroupPhone1	character	15	9	
ManagementGroupPhone2	character	15	10	
ManagementGroupAltID1	character	25	11	
ManagementGroupAltID2	character	25	12	
ManagementGroupAltID3	character	25	13	

Notes for the ManagementGroup file

A. Include each unique MCO native ManagementGroupCode value. These values should correspond to the ManagementGroupCode values used in the Provider file.

MedicareContract

The MedicareContract file is a reference table that documents the MCO's native Medicare contract codes. The MedicareContract file should contain one record per unique MedicareContract value within the MCO data.

Data elements for the MedicareContract file

Field Name	Type	Length	Order in File	Notes
MedicareContractCode	character	25	1	A
MedicareContractDescription	character	50	2	

Notes for the MedicareContract file

A. Include each unique MCO native MedicareContractCode value. These values should correspond to the MedicareContractCode values used in the MemberEnrollment file.

Member Enrollment Custom Codes

MemberEnrollmentCustomCode1

The MemberEnrollmentCustomCode1 file is a reference table that documents the MCO's native codes. The MemberEnrollmentCustomCode1 file should contain one record per unique MemberEnrollmentCustomCode1 value within the MCO data.

Data elements for the MemberEnrollmentCustomCode1 file

Field Name	Type	Length	Order in File	Notes
MemberEnrollmentCustomCode1	character	25	1	A
MemberEnrollmentCustomCode1Description	character	50	2	

Notes for the MemberEnrollmentCustomCode1 file

A. Include each unique MCO native MemberEnrollmentCustomCode1Code value. These values should correspond to the MemberEnrollmentCustomCode1Code values used in the MemberEnrollment file.

MemberEnrollmentCustomCode2

The MemberEnrollmentCustomCode2 file is a reference table that documents the MCO's native codes. The MemberEnrollmentCustomCode2 file should contain one record per unique MemberEnrollmentCustomCode1 value within the MCO data.

Data elements for the MemberEnrollmentCustomCode2 file

Field Name	Type	Length	Order in File	Notes
MemberEnrollmentCustomCode2	character	25	1	A
MemberEnrollmentCustomCode2Description	character	50	2	

Notes for the MemberEnrollmentCustomCode2 file

A. Include each unique MCO native MemberEnrollmentCustomCode2Code value. These values should correspond to the MemberEnrollmentCustomCode2Code values used in the MemberEnrollment file.

MemberEnrollmentCustomCode3

The MemberEnrollmentCustomCode3 file is a reference table that documents the MCO's native codes. The MemberEnrollmentCustomCode3 file should contain one record per unique MemberEnrollmentCustomCode3 value within the MCO data.

Data elements for the MemberEnrollmentCustomCode3 file

Field Name	Type	Length	Order in File	Notes
MemberEnrollmentCustomCode3	character	25	1	A
MemberEnrollmentCustomCode3Description	character	50	2	

Notes for the MemberEnrollmentCustomCode3 file

A. Include each unique MCO native MemberEnrollmentCustomCode3Code value. These values should correspond to the MemberEnrollmentCustomCode3Code values used in the MemberEnrollment file.

MemberEnrollmentCustomCode4

The MemberEnrollmentCustomCode4 file is a reference table that documents the MCO's native codes. The MemberEnrollmentCustomCode4 file should contain one record per unique MemberEnrollmentCustomCode4 value within the MCO data.

Data elements for the MemberEnrollmentCustomCode4 file

Field Name	Type	Length	Order in File	Notes
MemberEnrollmentCustomCode4	character	25	1	A
MemberEnrollmentCustomCode4Description	character	50	2	

Notes for the MemberEnrollmentCustomCode4 file

A. Include each unique MCO native MemberEnrollmentCustomCode4Code value. These values should correspond to the MemberEnrollmentCustomCode4Code values used in the MemberEnrollment file.

MemberEnrollmentCustomCode5

The MemberEnrollmentCustomCode5 file is a reference table that documents the MCO's native codes. The MemberEnrollmentCustomCode5 file should contain one record per unique MemberEnrollmentCustomCode5 value within the MCO data.

Data elements for the MemberEnrollmentCustomCode5 file

Field Name	Type	Length	Order in File	Notes
MemberEnrollmentCustomCode5	character	25	1	A
MemberEnrollmentCustomCode5Description	character	50	2	

Notes for the MemberEnrollmentCustomCode5 file

A. Include each unique MCO native MemberEnrollmentCustomCode5Code value. These values should correspond to the MemberEnrollmentCustomCode5Code values used in the MemberEnrollment file.

MemberEnrollmentCustomCode6

The MemberEnrollmentCustomCode6 file is a reference table that documents the MCO's native codes. The MemberEnrollmentCustomCode6 file should contain one record per unique MemberEnrollmentCustomCode6 value within the MCO data.

Data elements for the MemberEnrollmentCustomCode6 file

Field Name	Type	Length	Order in File	Notes
MemberEnrollmentCustomCode6	character	25	1	A
MemberEnrollmentCustomCode6Description	character	50	2	

Notes for the MemberEnrollmentCustomCode6 file

A. Include each unique MCO native MemberEnrollmentCustomCode6Code value. These values should correspond to the MemberEnrollmentCustomCode6Code values used in the MemberEnrollment file.

MemberGroup

The MemberGroup file is a reference table that documents the MCO's native codes. The MemberGroup file should contain one record per unique MemberGroup value within the MCO data.

Data elements for the MemberGroup file

Field Name	Type	Length	Order in File	Notes
MemberGroupCode	character	25	1	A
MemberGroupDescription	character	50	2	

Notes for the MemberGroup file

A. Include each unique MCO native MemberGroupCode value. These values should correspond to the MemberGroupCode values used in the MemberEnrollment file.

Plan

The Plan file is a reference table that documents the MCO's native codes. The Plan file should contain one record per unique Plan value within the MCO data.

Data elements for the Plan file

Field Name	Type	Length	Order in File	Notes
PlanCode	character	25	1	A
PlanDescription	character	50	2	

Notes for the Plan file

A. Include each unique MCO native PlanCode value. These values should correspond to the PlanCode values used in the MemberEnrollment file.

ProviderEnrollment

The ProviderEnrollment file may contain many records for each provider. Each record represents a distinct period of time that the provider contracted with the plan, with ProviderEffectiveDate and ProviderTerminationDate marking the beginning and end of the period. Each provider should have at least one enrollment record, and the ProviderEnrollment file should contain exactly as many records for each provider as are needed to document changes to the values within the fields of the file. Do not overlap enrollment records, and do not break enrollment records into smaller time periods than are necessary to track changes to the field values. If your data does not support historical data for these provider data elements, create a single record for each provider and use a default ProviderEffectiveDate of 01/01/1900 and a default ProviderTerminationDate of 12/31/2099.

Data elements for the ProviderEnrollment file

Field Name	Type	Length	Order in File	Notes
ProviderKey	character	25	1	A
ProviderEffectiveDate	date	mm/dd/yyyy	2	
ProviderTerminationDate	date	mm/dd/yyyy	3	
PayerCode	character	2	4	C
ProductCode	character	1	5	B
PlanCode	character	25	6	
BoardCertification	character	1	7	
NetworkFlag	character	1	8	
ProviderPanelCode	character	25	9	

Notes for the ProviderEnrollment file

A. ProviderKey should be the unique identifier that serves as a valid referential key between the Provider file, the ProviderEnrollment file, the MemberEnrollment file, and all Claims, LabClaims, and RxClaims files.

B. ProductCode differentiates product lines. Acceptable values are as follows:

Value	Description
F	PFFS
H	HMO
S	POS
P	PPO
O	Other

C. PayerCode differentiates lines of business. Acceptable values are as follows:

Value	Description
C	Commercial
RR	Medicare Risk Contract
RC	Medicare Cost Contract
D	Medicare/Medicaid Dual Eligible
M	Medicaid
ML	Medicaid (Other Low Income)
MD	Medicaid (Disabled)
MR	Medicaid (Restricted Benefit Package)
NC	Special Needs Plan (Chronic Condition)
ND	Special Needs Plan (Dual Eligible)
NI	Special Needs Plan (Institutionalized)
S	Self Insured
H	CHIP
F	Family Care
O	Other

ProviderPanel

The ProviderPanel file is a reference table that documents the MCO's native codes. The ProviderPanel file should contain one record per unique ProviderPanel value within the MCO data.

Data elements for the ProviderPanel file

Field Name	Type	Length	Order in File	Notes
ProviderPanelCode	character	25	1	A
PanelDescription	character	50	2	

Notes for the ProviderPanel file

A. Include each unique MCO native ProviderPanelCode value. These values should correspond to the ProviderPanelCode values used in the ProviderEnrollment file.