TN Division of Health Care Finance & Administration

Health Care Innovation Initiative

Detailed Business Requirements

Skin and Soft Tissue Infections Episode

V1.3

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1 Introduction

1.1 VERSIONS AND REVISIONS

To keep track of the version of an episode used at any given time, a versioning system is employed:

- The versioning system is designed to discern between major and minor changes made to the DBR. Changes are reflected by the V0.0 design format.
- Major changes to the DBR will be reflected by an increase of 1.0. For example, V1.0 is the first version of the DBR. If a major change is made, version V2.0 will be released. Major changes include revisions to the algorithm, configuration file or significant content updates to the DBR.
- Minor changes to the DBR will be reflected by an increase of 0.1. For example, V1.0 is the first version of the DBR. If a minor change is made, version V1.1 will be released. Minor changes include revisions that do not impact the design or intent of the DBR (e.g., grammatical, formatting, etc).

Version	Date	Changes
V1.0	2017-06-01	■ First version
V1.1	2017-06-14	■ Configuration File: Added code “L73.9 Follicular disorder, unspecified” to Design Dimension “04 - Identify Claims Included In Episode Spend.”
V1.2	2017-08-16	■ DBR: Updated section 2.3.6 to include DCS custody as a clinical exclusion.
V1.3	2017-10-12	■ Configuration File: Contingent triggers codes for diabetes, dermatitis, and neuropathy have been removed from the subdimension “01- Identify Episode Triggers.” ■ Configuration File: Risk factor codes for dermatitis trigger has been removed from the subdimension “07- Perform Risk Adjustment.”

1.2 SCOPE OF THIS DOCUMENT

The Detailed Business Requirement (DBR) document serves as a guide to understand the definition of an episode.

Section 2 addresses the following questions:

- **Typical patient journey**: Which patient cases are addressed by the episode?
- **Sources of value**: At which points in the typical patient journey do providers have most potential to improve quality of care, outcomes, and cost-effectiveness?
- **Design dimensions**: What decisions underlie the design of the episode?
  - Identify episode triggers: What events trigger an episode?
  - Attribute episodes to providers: Which provider is primarily held accountable for the outcomes of an episode, i.e., Quarterback (QB) or Principal Accountable Provider (PAP)?
  - Determine the episode duration: What is the duration of the episode?
  - Identify claims included in episode spend: Which claims are included in or excluded from the episode spend?
  - Calculate non-risk-adjusted episode spend: How is the spend for an episode calculated?
  - Perform risk adjustment: What approach is taken to adjust episodes for risk factors that cannot be influenced by the Quarterback?
  - Identify excluded episodes: Which episodes are excluded from a Quarterback's average episode spend for the purposes of calculating any gain/risk sharing?
  - Determine quality metrics performance: Which quality metrics are employed to inform Quarterbacks about their quality of care?
  - Calculating gain and risk sharing: How are the gain and risk sharing amounts for Quarterbacks determined?

Section 3 of the DBR explains the data flow of an episode. It addresses the following questions:

- **Input data**: What inputs does the episode algorithm require to build the episode?
- **Episode algorithm and detailed description**: What is the intent of the episode design that needs to be reflected in the code to produce the episode outputs?

- **Configuration file**: What parameters (e.g., number of days) and medical codes (e.g., diagnosis codes) need to be specified to define the episode?
- **Output tables**: What are the recommended outputs of an episode algorithm?

Section 4 contains general elements of the episode algorithm that must be used in conjunction with section 5, as section 5 contains the specific details for the episode described in this DBR. These address the following questions:

- What are the logical steps the episode algorithm needs to complete in order to produce the required outputs?
- What cases does the algorithm need to address?
- Are there exceptions to the overall logic and how are they handled?
- Which algorithm logic is the same across episodes, and which is specific to an episode?

The DBR document does not cover the following topics:

- Background on how episodes compare to the current payment system
- Clinical rationale for inclusions and exclusions
- Intermediate analyses used during design of the episode
- Meeting materials used during design of the episode
- Guidance on data collection/transformation/storage
- Guidance on the episode algorithm coding approach

2 Skin and soft tissue infections episode description

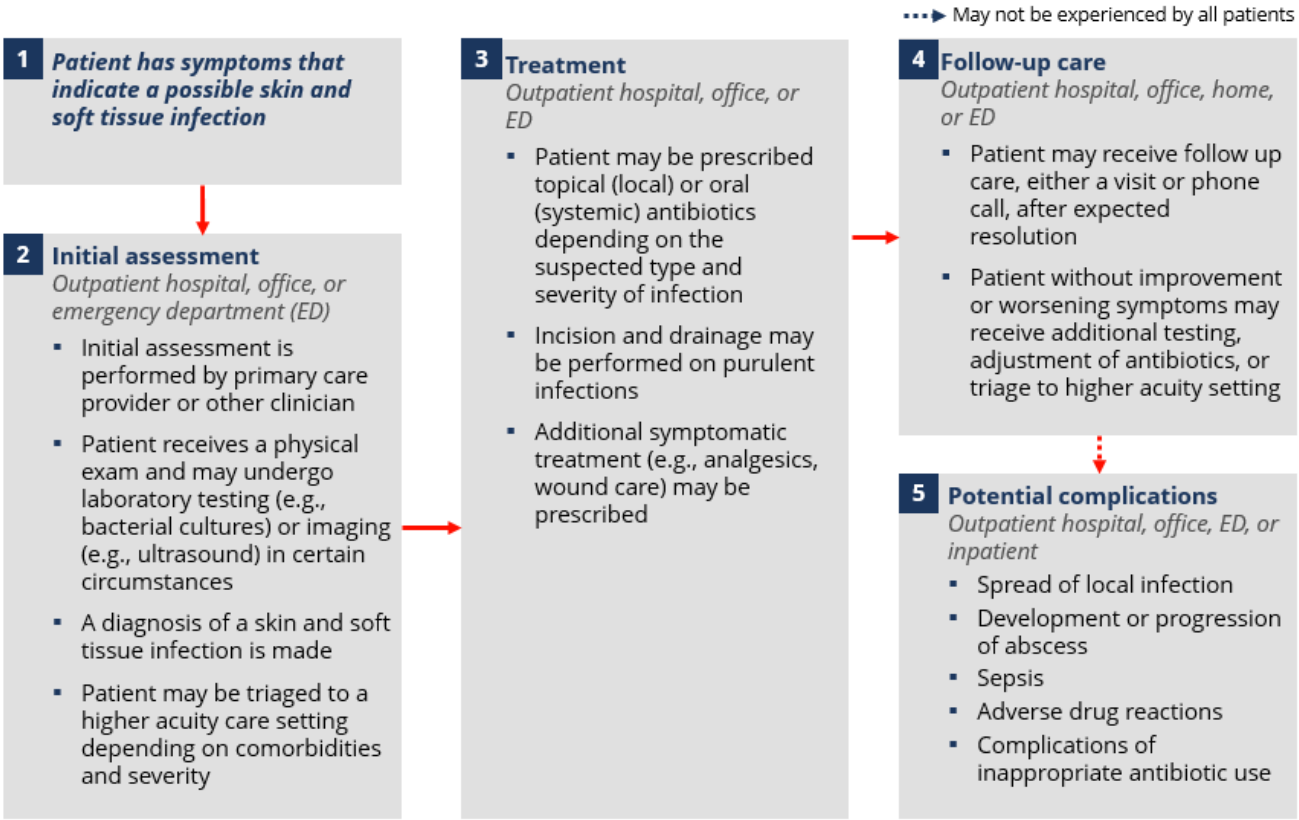
2.1 TYPICAL PATIENT JOURNEY

The episode described in this document pertains to patients who are diagnosed with a skin and soft tissue infection (SSTI). As depicted in Exhibit 1, the patient journey begins when a patient presents to an office, urgent care center, or emergency department (ED) setting with signs and symptoms indicating a skin and soft tissue infection. These are typically localized to the site of infection and include redness, tenderness, warmth, and swelling. While diagnosis is predominantly based on clinical assessment, laboratory testing and imaging may be used in certain circumstances, for example, to evaluate whether an underlying blood clot is causing leg swelling or to delineate the extent of an abscess. Depending on comorbidities and severity, the patient may be triaged to a higher acuity care setting. Patients are typically prescribed oral antibiotics for a course of 5-14 days, depending on the suspected type of infection. If the infection is purulent, an incision and drainage (I&D) procedure may be performed. The clinician may also prescribe additional symptomatic treatment and supportive care, such as wound care or analgesia.

For most patients, the SSTI improves within a few days of antibiotic therapy. Approximately one week after the initial visit, the patient may receive follow-up care, by phone or by in-person visit, to assess the patient's progress. Patients without improvement or with worsening symptoms may receive additional testing, adjustment of antibiotics, and/or triage to a higher acuity care setting.

Some patients may develop complications, resulting in additional office, urgent care center, or ED visits with the possibility of an inpatient stay. Complications from the SSTI include the spread of infection locally, development or progression of abscess, end organ infection, and sepsis. Complications from medications include adverse drug reactions, as well as sequelae from inappropriate antibiotic use, such as the development of drug resistant infections and *Clostridium difficile* colitis.

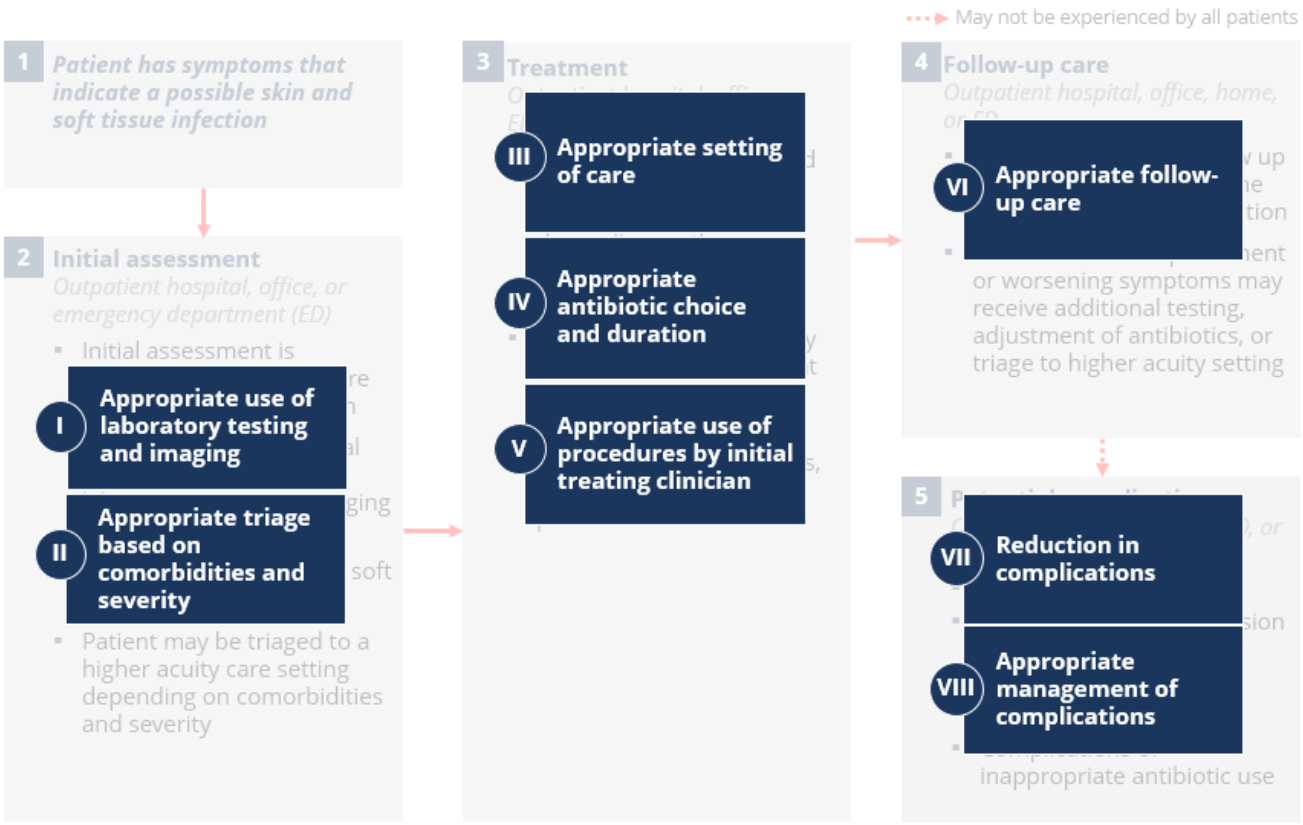
EXHIBIT 1 – TYPICAL PATIENT JOURNEY



2.2 SOURCES OF VALUE

In treating patients diagnosed with a skin and soft tissue infection, providers have several opportunities to improve the quality and cost of care, as depicted in Exhibit 2. Important sources of value include appropriate use of laboratory testing and imaging, following evidence-based guidelines for antibiotic treatment choice and duration, and utilizing a coordinated antimicrobial stewardship program. Other sources of value include appropriate decision-making in patient triage, including performing indicated procedures in the office setting whenever possible. Additionally, providers may increase efficiency and clinical outcomes through timely follow-up care, which in certain circumstances, may be a phone call or other telemedicine follow-up. Taken together, these improvements may help to reduce potentially avoidable complications and decrease costs.

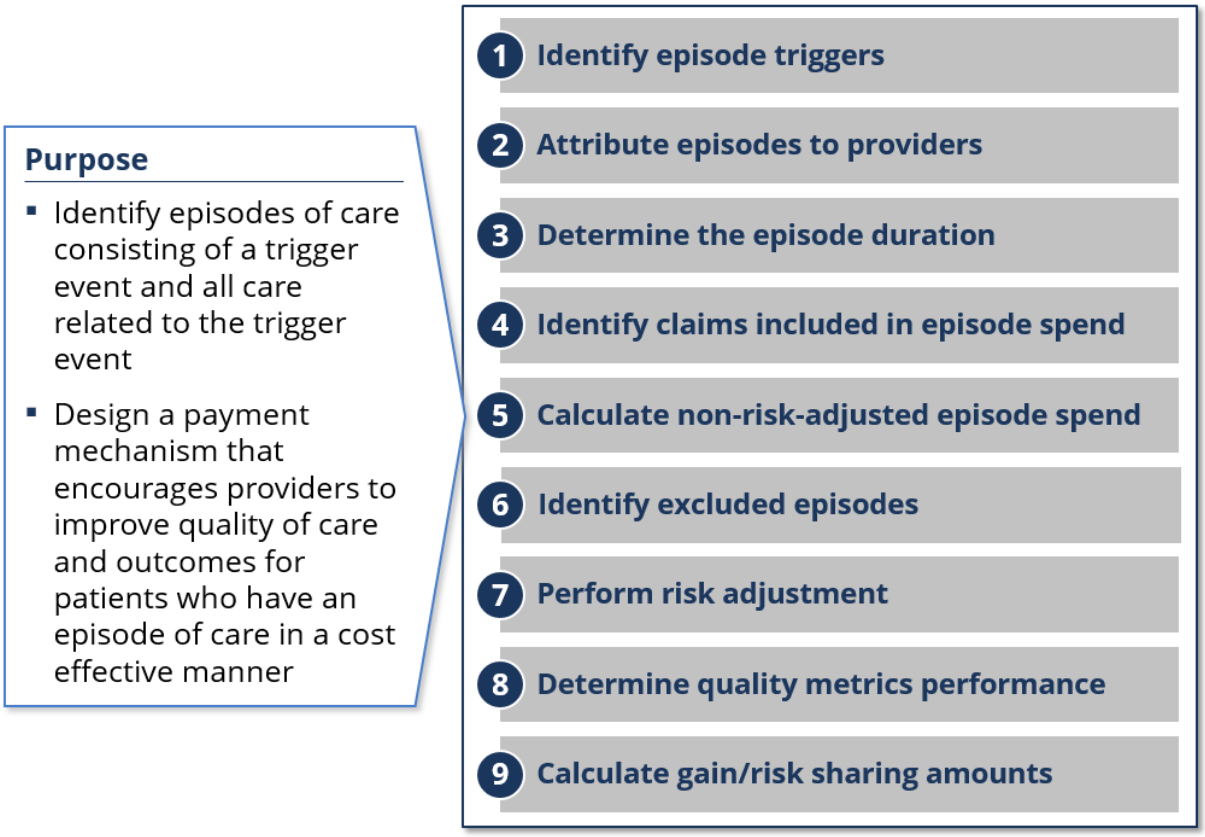
EXHIBIT 2 – SOURCES OF VALUE



2.3 DESIGN DIMENSIONS

Designing and building an SSTI episode comprises nine dimensions, as shown in Exhibit 3. Section 3 provides additional details on the episode data flow.

EXHIBIT 3 – DESIGN DIMENSIONS



2.3.1 Identify episode triggers

A potential trigger for an SSTI episode is a professional claim where the primary diagnosis is an SSTI diagnosis code. In addition, a professional claim with a primary diagnosis of an SSTI specific sign, symptom, or predisposing comorbidity and a secondary diagnosis code from among the SSTI diagnosis codes is also a potential trigger. The encounter can take place in an office, urgent care, ED, or inpatient setting. Of note, episodes that trigger in an inpatient setting are excluded (see section 2.3.6).

To avoid an overlap of SSTI episodes, no potential trigger can become an episode trigger during another episode for a given patient, i.e., a potential trigger is excluded for falling within another episode window. A chronological approach is taken, and the first potential

trigger of a given patient is identified as the earliest (i.e., the furthest in the past) episode trigger.

2.3.2 Attribute episodes to providers

The Quarterback (also referred to as the Principal Accountable Provider, or PAP) is the provider deemed to be in the best position to influence the quality and cost of care for a patient during an SSTI episode – here, the provider who diagnosed the SSTI. The contracting entity or tax identification number of the professional trigger claim will be used to identify the Quarterback.

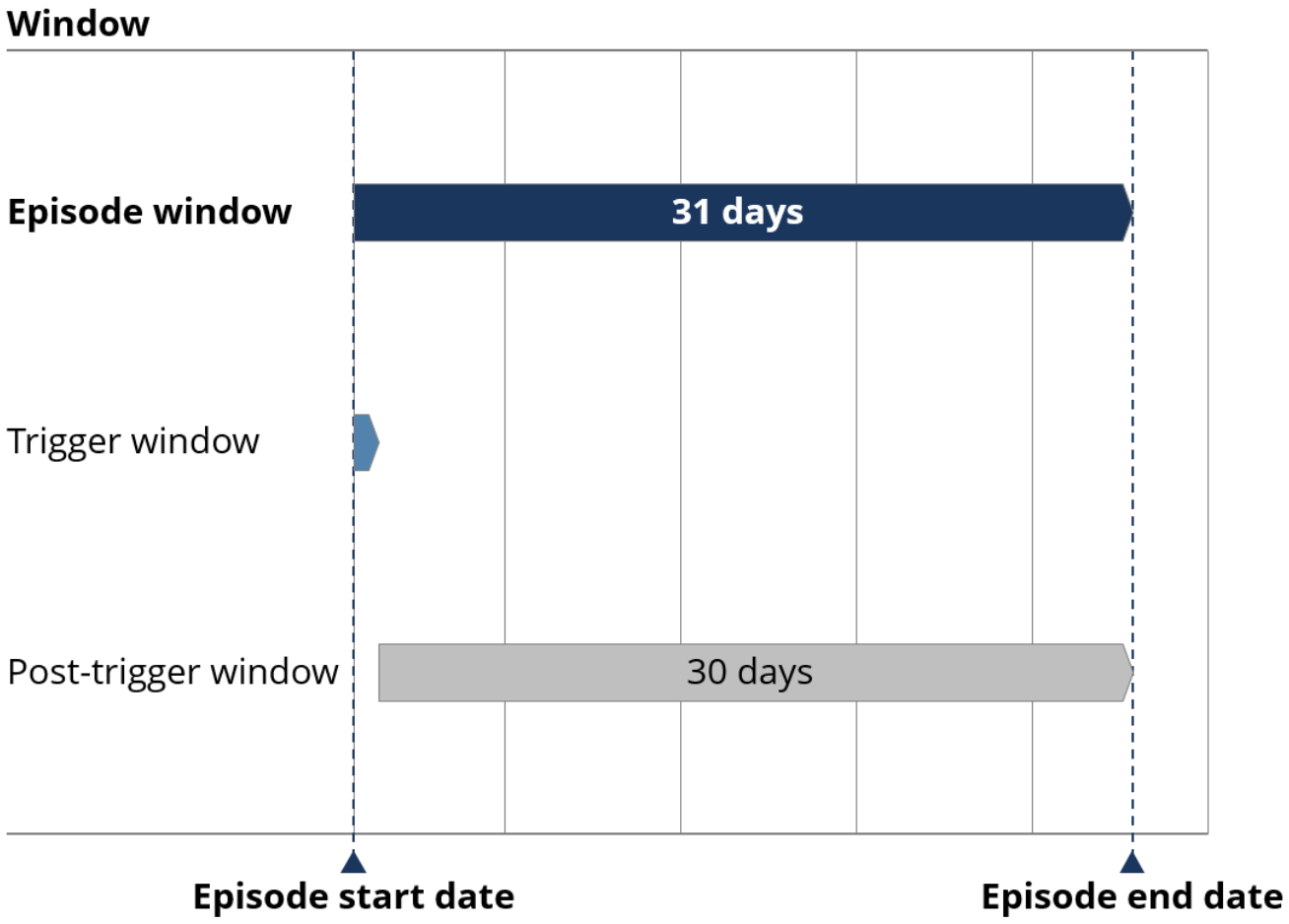
2.3.3 Determine the episode duration

The duration of the SSTI episode comprises the trigger window and the post-trigger window, as shown in Exhibit 4. Overall, the duration of the episode is referred to as the episode window.

- **Pre-trigger window:** This episode has no pre-trigger window.
- **Trigger window:** The trigger window spans the duration of the triggering encounter or stay.
- **Post-trigger window:** The post-trigger window begins the day after the trigger window and extends for 30 days.

If a hospitalization begins on or before the 30th day of the post-trigger window and extends beyond the 30th day (i.e., is ongoing on the 31st day of the post-trigger window), then the post-trigger window is extended until discharge from the hospitalization. Extending the episode in this way may only occur once per episode window and does not lead to further extensions. See section 6 for the definition of hospitalization.

EXHIBIT 4 – EXAMPLE OF DETERMINING THE EPISODE DURATION



2.3.4 Identify claims included in episode spend

Episode spend is calculated on the basis of claims directly related to the SSTI. Claims or claim detail lines that are included in the calculation of the episode spend are referred to as included claims or included claim detail lines. The criteria to identify included claims and included claim detail lines depend on the type of service they belong to, as well as the time window during which a claim occurs. The following types of services are included in the episode:

Pre-trigger window

This episode has no pre-trigger window.

Trigger window

For this episode, claims and claim detail lines assigned to the trigger window are included if they are also assigned to one of the following types of services:

- **Care for specific diagnoses:** Outpatient, professional, and inpatient claims with ICD-9 or ICD-10 diagnosis codes for specific care directly related to the SSTI, a sign, or symptom, are included in the trigger window.
- **Specific imaging and testing:** Outpatient and professional claim detail lines with CPT/HCPCS procedure codes for specific imaging and testing related to the SSTI (e.g., ultrasound, blood counts, fluid cultures) are included in the trigger window.
- **Specific medications:** Pharmacy claims with medication codes for specific medications related to the SSTI (e.g., Clindamycin) and treatment for complications related to the SSTI are included in the trigger window.
- **Specific surgical and medical procedures:** Outpatient and professional claim detail lines with CPT/HCPCS procedure codes, and inpatient claims with ICD-9 or ICD-10 procedure codes, for specific procedures related to the SSTI (e.g., incision and drainage) are included in the trigger window.

Post-trigger window

For this episode, claims and claim detail lines assigned to the post-trigger windows are included if they are also assigned to one of the following types of services:

- **Care for specific diagnoses:** Outpatient, professional, and inpatient claims with ICD-9 or ICD-10 diagnosis codes for specific care directly related to the SSTI, a sign, symptom, or complication are included in the post-trigger window.
- **Care for specific complications:** Outpatient, professional, and inpatient claims with ICD-9 or ICD-10 diagnosis codes for specific care directly related to a complication of the SSTI or complication from medical care are included in the post-trigger window.
- **Specific imaging and testing:** Outpatient and professional claim detail lines with CPT/HCPCS procedure codes for specific imaging and testing related to the SSTI (e.g., ultrasound, blood counts, fluid cultures) are included in the post-trigger window.
- **Specific medications:** Pharmacy claims with medication codes for specific medications related to the SSTI (e.g., Clindamycin) and treatment for complications related to the SSTI are included in the post-trigger window.

- **Specific surgical and medical procedures:** Outpatient and professional claim detail lines with CPT/HCPCS procedure codes, and inpatient claims with ICD-9 or ICD-10 procedure codes, for specific procedures related to the SSTI (e.g., incision and drainage) are included in the post-trigger window.

For this episode, there are no claims and claim detail lines assigned to the trigger and post-trigger windows that are excluded by any specific type of service.

2.3.5 Calculate non-risk-adjusted episode spend

The episode spend is the amount that reflects the totality of all costs included in the episode. The episode spend reflects the paid amount plus patient cost share for included claims. Since the totality of spend for included claims is not risk-adjusted, it is referred to as non-risk-adjusted episode spend.

2.3.6 Identify excluded episodes

Episode exclusions ensure that episodes are comparable to each other and allow fair comparisons between patient panels. After all exclusions that identify invalid episodes have been applied, a set of valid episodes remains. The valid episodes form the basis to assess the performance of Quarterbacks.

- **Business exclusions**
  - **Inconsistent enrollment:** An episode is excluded if there are gaps in the plan coverage of the patient during the episode window.
  - **Third-party liability:** An episode is excluded if an inpatient, outpatient, professional, pharmacy, or long term care claim that is assigned to the episode window (included or not included) is associated with a third-party liability amount.
  - **Dual eligibility:** An episode is excluded if a patient has dual coverage by Medicaid and Medicare at any time during the episode window.
  - **FQHC/RHC:** An episode is excluded if the trigger diagnosis occurs in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC).
  - **No PAP ID:** An episode is excluded if it cannot be associated with a corresponding PAP ID.
  - **Incomplete episodes:** An episode is excluded if either:
    - The triggering professional claim spend is less than or equal to 0, OR

    - It is within the bottom 2.5% of all episodes with the lowest non-risk-adjusted episode spend (not the risk-adjusted episode spend), without taking into account episodes where the triggering professional claim spend is less than or equal to (≤) 0.

- **Clinical exclusions**
  - **Different care pathway:** An episode is excluded if the patient has one or more conditions that would lead to a different care pathway. Codes that indicate a different care pathway are searched for on inpatient, outpatient, and professional claims (included or not included) during a specified length of time, as detailed in the configuration file. Conditions that would lead to a different care pathway are:
    - Department of Children's Services (DCS) custody
    - Patients receiving care in an inpatient setting at initial diagnosis or within one day of initial diagnosis
    - Complicated skin and soft tissue infections at initial diagnosis or prior to the episode (e.g., necrotizing fasciitis)
    - Sepsis or shock at initial diagnosis
    - Diabetic and pressure ulcers at initial diagnosis or prior to the episode
    - Gangrene at initial diagnosis or prior to the episode
    - Post-surgical wound infections at initial diagnosis or prior to the episode
    - Second and third degree burns at initial diagnosis or prior to the episode
    - Multiple myeloma during the episode or prior to the episode

    The detailed list of codes and time window is given in the configuration file under "Clinical – (*condition for exclusion*)".

- **Patient exclusions**
  - **Age:** An episode is excluded if the patient is older than 64 (>64) years of age on the day of the triggering event, or younger than 1 (<1) months of age on the day of the triggering event. See section 6 for the definition of member age.
  - **Death:** An episode is excluded if the patient has a patient discharge status of "expired" on any inpatient or outpatient claim assigned to the episode window. The claim may be an included claim or not.

- **Left Against Medical Advice:** An episode is excluded if a patient has a discharge status of "left against medical advice or discontinued care" on any inpatient or outpatient claim during the episode window. The claim may be an included claim or not.

- **High-cost outlier**
  - An episode is excluded if the risk-adjusted episode spend (not the non-risk-adjusted episode spend) is greater than the high outlier threshold. The high outlier threshold is set at three standard deviations above the average risk-adjusted episode spend for valid episodes. Because this exclusion uses the risk-adjusted episode spend, it is the only exclusion that takes place after the risk adjustment process.

2.3.7 Perform risk adjustment

Quarterbacks are compared based on their performance on quality metrics and based on the average spend for their episodes. Risk adjustment is one of the mechanisms used to achieve a fair comparison in episode spend across Quarterbacks.

Risk factors and risk coefficients are identified using a statistical model that tests for correlation between factors and episode cost. The estimated risk coefficients are used to calculate a risk score for each episode given the risk factors that are present for the episode. The non-risk-adjusted episode spend is adjusted by the risk score to arrive at the risk-adjusted episode spend.

The final risk adjustment methodology decisions will be made at the discretion of the payer after analyzing the data. Because each payer runs its own risk adjustment model based on cost and there are variations in the population covered by each payer, the significant risk factors may vary across payers.

2.3.8 Determine quality metrics performance

A Quarterback must pass all quality metrics tied to gain sharing to be eligible for gain sharing. Quarterbacks receive information on additional quality metrics that allow them to assess their performance but that do not affect their eligibility to participate in gain sharing. The quality metrics are based on information contained in the claims filed for each patient, and some might be based on other information sources. Risk sharing is not dependent on the Quarterback meeting any quality metrics. Setting thresholds for the quality metrics is beyond the scope of this DBR; hence thresholds will be set and provided separately.

- **Quality metrics tied to gain sharing** (also referred to as threshold quality metrics):
  - Bacterial cultures when I&D performed: Of the valid episodes that had an incision and drainage, the percentage of which bacterial cultures were obtained (higher rate indicative of better performance)
  - SSTI episodes with a first line antibiotic: Of the valid episodes with an antibiotic prescription filled within the seven days after initial diagnosis, the percentage of which a first-line antibiotic was filled (higher rate indicative of better performance)
- **Quality metrics not tied to gain sharing** (i.e., included for information only):
  - Infection recurrence: Of the valid episodes with an antibiotic prescription filled within the first 15 days after initial diagnosis, the percentage of which filled a second antibiotic during days 15-30 of the episode window (lower rate indicative of better performance)
  - Hospitalizations after initial diagnosis: Percentage of valid episodes with an inpatient admission during the post-trigger window (lower rate indicative of better performance)
  - ED visits after initial diagnosis: Percentage of valid episodes with an ED visit during the post-trigger window (lower rate indicative of better performance)
  - Ultrasound imaging: Percentage of valid episodes where ultrasound imaging was obtained during the episode window (rate provided for comparison only)
  - Non-ultrasound imaging: Percentage of valid episodes where non-ultrasound imaging was obtained during the episode window (lower rate indicative of better performance)
  - Incision and drainage: Percentage of valid episodes where an incision and drainage was performed during the episode window (rate provided for comparison only)

2.3.9 Calculate gain/risk sharing amounts

During the initial implementation phase the payer will send provider reports to Quarterbacks to inform them about their performance in the episode-based payment model. At a future date, the performance period timing will be established.

The performance of Quarterbacks in the episode-based payment model will be linked to payments at the end of the annual performance period. The description below outlines the approach of linking Quarterbacks' performances to payments. Gain/risk sharing is determined based on the comparison of the average risk-adjusted episode spend of each Quarterback over the course of the performance period in three pre-determined thresholds. The thresholds and their meaning for gain or risk sharing are:

- **Acceptable threshold:** Quarterbacks with average risk-adjusted episode spend above the acceptable threshold owe a risk sharing payment.
- **Commendable threshold:** Quarterbacks with average risk-adjusted episode spend below the commendable threshold that meet the quality metrics tied to gain sharing receive a gain sharing payment.
- **Gain sharing limit threshold:** Quarterbacks with average risk-adjusted episode spend below the gain sharing limit threshold and that pass the quality metrics tied to gain sharing receive a gain sharing payment up to a specified limit.

Quarterbacks with average risk-adjusted episode spend between the acceptable and commendable thresholds neither owe a risk sharing payment nor receive a gain sharing payment.

The gain or risk sharing payment of each Quarterback is calculated based on episodes that ended during the performance period. Quarterbacks receive reports about their performance in the episode-based payment model every quarter. Payments are made once a year. All Quarterbacks (not only those with valid episodes) receive a provider report.

The payers and providers share a portion of the losses/gains in the episode-based payment model. The calculation of the gain or risk sharing payment is as follows:

- **Risk sharing**: Quarterbacks who owe a risk sharing payment pay 50% of the difference between the acceptable threshold and the average risk-adjusted episode spend of the

Quarterback, multiplied by the number of valid episodes of the Quarterback in the reporting period.

- **Gain sharing:**
  - **Quarterbacks below the commendable threshold and above the gain sharing limit**: Quarterbacks receive 50% of the difference between the commendable threshold and the average risk-adjusted episode spend of the Quarterback, multiplied by the number of valid episodes of the Quarterback in the reporting period.
  - **Quarterbacks below the gain sharing limit**: Quarterbacks receive 50% of the difference between the commendable threshold and the gain sharing limit threshold, multiplied by the number of valid episodes of the Quarterback in the reporting period.

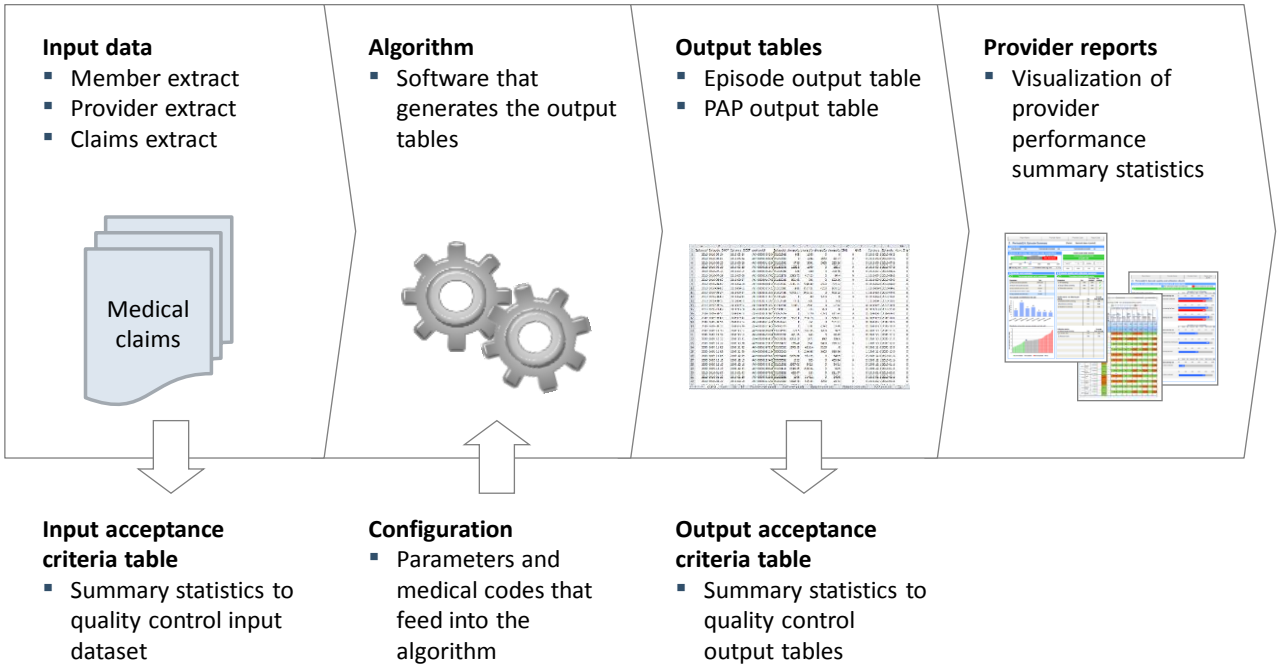
3 Episode data flow

The analytics underlying an episode-based payment model are performed by an episode algorithm. The algorithm takes an input dataset, transforms the data in accordance with the intent of the episode design, and produces a set of output tables (Exhibit 5). The output tables are used to create provider reports.

Several of the episode design dimensions require input parameters such as age ranges, and medical codes such as diagnosis, procedure, and medication codes to specify the intent of the episode. The parameters and medical codes are provided in the configuration file.

It is recommended that the episode data flow includes two elements for quality assurance: (1) An input summary table to assess the content and quality of the input dataset (2) An output summary table to assess the content and quality of the output tables.

EXHIBIT 5 – EPISODE DATA FLOW



3.1 INPUT DATA

To build an episode, the following input data are needed:

- **Member Extract**: List of patients and their health insurance enrollment information.
- **Provider Extract**: List of participating providers and their addresses.
- **Claims Extract**: Institutional claims (UB-04 claim form), professional claims (CMS1500 claim form), and pharmacy claims (NCPDP claim form) at the patient level.

The table below lists the required input fields using the input data field names and a description of these. Sections 4 and 5 describe the use of each input field. In these sections, input fields are referred to by the "Source field name in DBR" and written in italics.

Table – Input data fields

Source field name in DBR	Description
Member Extract	
Member ID	Unique member identifier
Member Name	Member name
Eligibility Start Date	First date member is eligible for coverage by payer
Eligibility End Date	Last date member is eligible for coverage by payer
Date Of Birth	Member date of birth
Provider Extract	
Contracting Entity Name	Contracting entity name
Contracting Entity	Unique identifier of provider by contracting entity
Provider Name	Provider name
Provider ID	Unique identifier of provider
Claims Extract	
Internal Control Number	Unique claim identifier
Type Of Bill	Type of bill
Member ID	Unique member identifier
Billing Provider ID	Unique billing provider identifier
Detail Rendering Provider ID	Unique detail rendering provider identifier
Attending Provider NPI	Attending provider National Provider Identifier
Header From Date Of Service	Date on which service begins on claim header
Header To Date Of Service	Date on which service ends on claim header
Detail From Date Of Service	Date on which service begins on claim detail line
Detail To Date Of Service	Date on which service ends on claim detail line
Admission Date	Admission date
Patient Discharge Status	Patient discharge status
Header Diagnosis Code	All diagnosis codes on claim header
Header Surgical Procedure Code	All surgical procedure codes on claim header
Detail Procedure Code	Procedure code on claim detail line
All Modifiers	All procedure code modifiers on claim detail line
Place Of Service	Place of service
National Drug Code	National drug code

Source field name in DBR	Description
Header Paid Amount	Header paid amount
Detail Paid Amount	Detail paid amount
Header TPL Amount	Header third party liability amount
Detail TPL Amount	Detail third party liability amount
Revenue Code	Revenue code
Patient Cost Share	Patient cost share amount

The date range for the episode input data has to include claims which were submitted for services provided during the defined episode reporting period as well as for a predetermined period of time preceding the reporting period. The duration of this predetermined period is the length of the episode window (see section 5.3 for guidance) plus an additional 12 months. Claims from this additional period preceding the reporting period are needed to allow for identification of risk factors and comorbidities as well as to provide sufficient input data to identify the episode start date for the first episodes that end during the reporting period.

The input data has to contain only unique and paid claims. It is the responsibility of each payer to apply appropriate methods to ensure that all claims in the input data are valid, de-duplicated, and paid. Payers should use denied claims for the purpose of determining quality metrics performance.

If the value of an input field from the Claims Extract that is required to build an episode is missing or invalid, then the corresponding claim is ignored when building the episode. For example, a claim that would be a potential trigger, but is missing the *Header From Date Of Service*, cannot be a potential trigger.

3.2 EPISODE ALGORITHM AND DETAILED DESCRIPTION

The intent of the episode algorithm is detailed in the Episode agnostic algorithm logic (section 4) and the skin and soft tissue infections episode detailed description (section 5) of the DBR. Section 4 contains general elements of the episode algorithm that must be used in conjunction with section 5, as section 5 contains the specific details for the episode described in this DBR.

3.3 CONFIGURATION FILE

The parameters and medical codes needed to define the episode are listed in the configuration file, which is provided as an attachment to the DBR. The file includes:

- **Parameters sheet:** Values for parameters used in the episode, for example the duration of the post-trigger window.
  - Episode: Name of episode, i.e., Skin and soft tissue infections
  - Design Dimension: Episode design dimension, e.g., Determine the episode duration
  - Parameter Description: Description of the parameter, e.g., Duration Of Post-trigger Window
  - Parameter Value: Value of the parameter, e.g., 30
  - Parameter Unit of Measure: Unit of measure of the parameter, e.g., Days
- **Code sheet:** Medical codes used in the episode, such as trigger diagnosis or procedure codes, and codes to identify included claims. The columns contained in the code sheet are:
  - Episode: Name of episode, i.e., Skin and soft tissue infections
  - Design Dimension: Episode design dimension, e.g., Perform Risk Adjustment
  - Subdimension: Grouping of codes used for a specific purpose within the design dimension, e.g., History of sensorineural hearing loss
  - Time Period: Time for which the code is relevant, e.g., With 365 days before trigger start date
  - Code Type: Code system to which the code belongs to, e.g., ICD-9 Dx
  - Code Group: Code group level classification, e.g., Diabetes Mellitus
  - Code Description: Code detailed description, e.g., Diabetes Mellitus Without Mention of Complication Type II or Unspecified Type Not Stated As Uncontrolled
  - Code: Code number, e.g., 25000

Sections 4 and 5 of the DBR explain the intended use of the parameters and medical codes by the episode algorithm. References to medical codes in the configuration file are made using the name for the relevant design dimension subcategory (subdimension) in the code sheet of the configuration file. References to parameters in the configuration file are made using the name for the relevant design dimension in the parameters sheet of the configuration file.

The code sheet may contain CPT codes. CPT is a registered trademark of the American Medical Association (AMA). Vendor purchases one single CPT distribution license for the configuration file of each episode that is delivered to a recipient. If its recipient wishes to further distribute a configuration file, it is the recipient's responsibility to comply with AMA CPT license requirement.

3.4 OUTPUT TABLES

Using the input data tables and the configuration file, an episode algorithm creates two output tables: the episode output table and the Principal Accountable Provider (also referred to as PAP or Quarterback) output table. The episode agnostic algorithm logic (section 4) and skin and soft tissue infections episode detailed description (section 5) describe the definition of each output field. In these sections output fields are referred to by the output field names provided in the tables below and are written in italics.

3.4.1 Episode output table

The episode output table contains the set of episodes identified by the algorithm and the characteristics of each episode. The table “Episode Output Table” below lists the required output fields.

Table – Episode Output Table

Design dimension	Output field name	Report template name
	Episode identification	
1 – Identify episode triggers	Facility Trigger Claim ID	N/A
1 – Identify episode triggers	Facility Trigger Claim Type	N/A
1 – Identify episode triggers	Professional Trigger Claim ID	N/A
1 – Identify episode triggers	Member ID	N/A

Design dimension	Output field name	Report template name
1 – Identify episode triggers	Member Name	Patient Name
1 – Identify episode triggers	Member Age	N/A
1 – Identify episode triggers	Associated Facility Claim ID	N/A
1 – Identify episode triggers	Associated Facility Claim Type	N/A
2 – Attribute episodes to providers	PAP ID	Provider Code
2 – Attribute episodes to providers	Rendering Provider ID	N/A
2 – Attribute episodes to providers	Rendering Provider Name	N/A
3 – Determine the episode duration	Episode Start Date	Episode Start Date
3 – Determine the episode duration	Episode End Date	Episode End Date
3 – Determine the episode duration	Pre-Trigger Window Start Date	N/A
3 – Determine the episode duration	Pre-Trigger Window End Date	N/A
3 – Determine the episode duration	Trigger Window Start Date	N/A
3 – Determine the episode duration	Trigger Window End Date	N/A

Design dimension	Output field name	Report template name
3 – Determine the episode duration	Post-trigger Window Start Date	N/A
3 – Determine the episode duration	Post-trigger Window End Date	N/A
4 – Identify claims included in episode spend	Count of Included Claims	# Claims
	Episode spend	
5 – Calculate non-risk-adjusted spend	Non-risk-adjusted Episode Spend	Non-adjusted cost
5 – Calculate non-risk-adjusted spend	By Pre-trigger Window	N/A
5 – Calculate non-risk-adjusted spend	By Trigger Window	N/A
5 – Calculate non-risk-adjusted spend	By Post-trigger Window	N/A
5 – Calculate non-risk-adjusted spend	By Inpatient facility	Inpatient facility
5 – Calculate non-risk-adjusted spend	By Emergency department or observation	Emergency department or observation
5 – Calculate non-risk-adjusted spend	By Outpatient facility	Outpatient facility
5 – Calculate non-risk-adjusted spend	By Inpatient professional	Inpatient professional
5 – Calculate non-risk-adjusted spend	By Outpatient laboratory	Outpatient laboratory

Design dimension	Output field name	Report template name
5 – Calculate non-risk-adjusted spend	By Outpatient radiology	Outpatient radiology
5 – Calculate non-risk-adjusted spend	By Outpatient professional	Outpatient professional
5 – Calculate non-risk-adjusted spend	By Other	Other
5 – Calculate non-risk-adjusted spend	By Pharmacy	Pharmacy
	Exclusions	
6 – Identify excluded episodes	Any Exclusion	N/A
6 – Identify excluded episodes	Exclusion Inconsistent Enrollment	Patient was not continuously enrolled during episode window
6 – Identify excluded episodes	Exclusion Third-party Liability	Patient has third-party liability charges
6 – Identify excluded episodes	Exclusion Dual Eligibility	Patient has dual coverage of primary medical services
6 – Identify excluded episodes	Exclusion FQHC/RHC	Episode trigger occurred in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC)
6 – Identify excluded episodes	Exclusion No PAP ID	N/A
6 – Identify excluded episodes	Exclusion Incomplete Episode	Episode data was incomplete

Design dimension	Output field name	Report template name
6 – Identify excluded episodes	Exclusion Left Against Medical Advice	Patient has a discharge status of “left against medical advice”
6 – Identify excluded episodes	Exclusion Age	Patients >/< [XX]
6 – Identify excluded episodes	Exclusion Death	Patient died in the hospital during the episode
6 – Identify excluded episodes	Exclusion Different Care Pathway	Risk factor / co-morbidity reference found
6 – Identify excluded episodes	Exclusion High Outlier	Episode exceed the high cost outlier threshold
	Risk adjustment	
7 – Perform risk adjustment	Risk-adjusted Episode Spend	N/A
7 – Perform risk adjustment	Same breakdown as for Non-risk-adjusted Episode Spend	
7 – Perform risk adjustment	Risk Factor <risk factor number>	Episode risk factor
7 – Perform risk adjustment	Episode Risk Score	N/A
	Quality metrics	
8 – Determine quality metrics performance	Quality Metric 1 Indicator	Bacterial cultures when I&D performed
8 – Determine quality metrics performance	Quality Metric 1 Denominator	Bacterial cultures when I&D performed (denominator)

Design dimension	Output field name	Report template name
8 – Determine quality metrics performance	Quality Metric 2 Indicator	SSTI episodes with a first line antibiotic
8 – Determine quality metrics performance	Quality Metric 2 Denominator	SSTI episodes with a first line antibiotic (denominator)
8 – Determine quality metrics performance	Quality Metric 3 Indicator	Infection recurrence
8 – Determine quality metrics performance	Quality Metric 3 Indicator	Infection recurrence (denominator)
8 – Determine quality metrics performance	Quality Metric 4 Indicator	Hospitalizations after initial diagnosis
8 – Determine quality metrics performance	Quality Metric 5 Indicator	ED visits after initial diagnosis
8 – Determine quality metrics performance	Quality Metric 6 Indicator	Ultrasound imaging
8 – Determine quality metrics performance	Quality Metric 7 Indicator	Non-ultrasound imaging
8 – Determine quality metrics performance	Quality Metric 8 Indicator	Incision and drainage

3.4.2 PAP output table

The PAP output table contains information about each PAP and their episodes. The table below lists the required output fields.

Table – PAP Output Table

Design dimension	Output field name	Report Template Name
	PAP identification	

Design dimension	Output field name	Report Template Name
2 – Attribute episodes to providers	PAP ID	Provider Code
2 – Attribute episodes to providers	PAP Name	
2 – Attribute episodes to providers	National Provider Identifier	National Provider Identifier
2 – Attribute episodes to providers	Specialty	
2 – Attribute episodes to providers	Provider Billing ZIP Code	
	PAP spend	
5 – Calculate non-risk-adjusted spend	Average Non-risk-adjusted PAP Spend	Average episode cost (non-adjusted)
5 – Calculate non-risk-adjusted spend	By Inpatient facility	Inpatient facility
5 – Calculate non-risk-adjusted spend	By Emergency department or observation	Emergency department or observation
5 – Calculate non-risk-adjusted spend	By Outpatient facility	Outpatient facility
5 – Calculate non-risk-adjusted spend	By Inpatient professional	Inpatient professional

Design dimension	Output field name	Report Template Name
5 – Calculate non-risk-adjusted spend	By Outpatient laboratory	Outpatient laboratory
5 – Calculate non-risk-adjusted spend	By Outpatient radiology	Outpatient radiology
5 – Calculate non-risk-adjusted spend	By Outpatient professional	Outpatient professional
5 – Calculate non-risk-adjusted spend	By Other	Other
5 – Calculate non-risk-adjusted spend	By Pharmacy	Pharmacy
5 – Calculate non-risk-adjusted spend	By Pre-trigger window	
5 – Calculate non-risk-adjusted spend	By Trigger window	
5 – Calculate non-risk-adjusted spend	By Post-trigger window	
5 – Calculate non-risk-adjusted spend	Total Non-risk-adjusted PAP Spend	Total cost across episodes
	Risk adjustment	
7 – Perform risk adjustment	Average Risk-adjusted PAP Spend	Average episode cost (risk-adjusted)
7 – Perform risk adjustment	By Inpatient facility	Inpatient facility
7 – Perform risk adjustment	By Emergency department or observation	Emergency department or observation

Design dimension	Output field name	Report Template Name
7 – Perform risk adjustment	By Outpatient facility	Outpatient facility
7 – Perform risk adjustment	By Inpatient professional	Inpatient professional
7 – Perform risk adjustment	By Outpatient laboratory	Outpatient laboratory
7 – Perform risk adjustment	By Outpatient radiology	Outpatient radiology
7 – Perform risk adjustment	By Outpatient professional	Outpatient professional
7 – Perform risk adjustment	By Other	Other
7 – Perform risk adjustment	By Pharmacy	Pharmacy
7 – Perform risk adjustment	Total Risk-adjusted PAP Spend	N/A
	Quality metrics performance	
8 – Determine quality metrics performance	PAP Quality Metric 1	Bacterial cultures when I&D performed
8 – Determine quality metrics performance	PAP Quality Metric 2	SSTI episodes with a first line antibiotic
8 – Determine quality metrics performance	PAP Quality Metric 3	Infection recurrence
8 – Determine quality metrics performance	PAP Quality Metric 4	Hospitalizations after initial diagnosis

Design dimension	Output field name	Report Template Name
8 – Determine quality metrics performance	PAP Quality Metric 5	ED visits after initial diagnosis
8 – Determine quality metrics performance	PAP Quality Metric 6	Ultrasound imaging
8 – Determine quality metrics performance	PAP Quality Metric 7	Non-ultrasound imaging
8 – Determine quality metrics performance	PAP Quality Metric 8	Incision and drainage
	PAP performance	
8 – Determine quality metrics performance	Gain Sharing Quality Metric Pass	N/A
9 – Calculate gain/risk sharing amounts	Gain/Risk Sharing Amount	Total gain / risk share
9 – Calculate gain/risk sharing amounts	PAP Sharing Level	Share factor
	Episode counts	
9 – Calculate gain/risk sharing amounts	Count Of Total Episodes Per PAP	Total episodes
9 – Calculate gain/risk sharing amounts	Count Of Valid Episodes Per PAP	Total episodes included
9 – Calculate gain/risk sharing amounts	Same breakdown as for Average Non-risk-adjusted PAP Spend	

4 Episode agnostic algorithm logic

The algorithm logic forms the basis to code an episode algorithm. Section 4 contains general elements of the episode algorithm that must be used in conjunction with section 5, as section 5 contains the specific details for the episode. Sections 4 and 5 used in conjunction explain the intent of the episode design at a level of granularity that will allow an IT implementation team to create an algorithm that matches the episode design.

4.1 IDENTIFY EPISODE TRIGGERS

The first design dimension of building an episode is to identify triggers.

Episode output fields created: *Facility Trigger Claim ID, Facility Trigger Claim Type, Professional Trigger Claim ID, Member ID, Member Age, Member Name, Associated Facility Claim ID, Associated Facility Claim Type*

The episode may be triggered by a professional claim and an associated facility claim, a facility claim alone, or through custom logic. The triggering logic to be used for this episode will be laid out in section 5.1. The first step in identifying episode triggers is to identify potential triggers, then identifying which of the potential triggers become episode triggers based on clean period logic, and lastly to set the output fields.

4.1.1 Identify potential triggers

- **For episodes triggered by a professional claim and an associated facility claim:**

  A potential trigger is defined as a professional trigger claim and an associated facility (inpatient and/or outpatient dependent on the episode) claim for the same patient as identified by the same *Member ID*. Professional, inpatient, and outpatient claims are identified based on the input field *Claim Type* as defined in section 6.

  The professional trigger claim for the potential trigger must have all of the following conditions:

  – The claim has a procedure code for an episode-specific procedure in the input field *Detail Procedure Code* on one or more of its claim detail lines. The configuration file lists the episode-specific procedure codes under “Trigger Procedure”.

– At least one of the claim detail lines with an episode-specific procedure code does not contain a modifier for assistant surgeon, nurse, or discontinued procedure in one of the input fields *All Modifiers*. The configuration file lists the modifiers under "Assistant Surgeon", "Nurse", and "Discontinued".

An associated inpatient claim must meet all of the following conditions:

– The claim has a *Header From Date Of Service* on or before the *Detail From Date Of Service* of the professional trigger claim detail line. It also has a *Header To Date Of Service* on or after the *Detail From Date of Service* of the professional trigger claim detail line.

– The claim has a confirmatory episode-specific diagnosis in the input field *Header Diagnosis Code*. The configuration file lists these diagnosis codes under "Associated Facility".

An associated outpatient claim must meet all of the following conditions:

– The claim's *Header From Date of Service* is within two days (i.e., as early as two days before or as late as two days after, inclusive) of the *Detail From Date of Service* of the professional trigger claim detail line.

– The claim has a confirmatory episode-specific diagnosis in the input field *Header Diagnosis Code*. The configuration file lists these diagnosis codes under "Associated Facility".

To address cases where a professional trigger claim detail line is associated with two or more inpatient or outpatient claims, the following hierarchy is used such that each professional trigger claim detail line is unambiguously associated with one inpatient or outpatient claim. Only the inpatient or outpatient claim that has the highest priority is associated with the potential trigger. The inpatient or outpatient claims that are lower in the hierarchy are treated like any other claims during a potential trigger, not like an associated inpatient or outpatient claim.

– An associated inpatient claim and one of the episode-specific ICD-9 or ICD-10 procedure codes that are listed in the configuration file under "Trigger Procedure" in the input field *Header Surgical Procedure Code* has highest priority.

– An associated inpatient claim without an episode-specific procedure code has second priority.

- An associated outpatient claim and one of the episode-specific CPT procedure codes that are listed in the configuration file under "Trigger Procedure" in the input field *Detail Procedure Code* of one of its claim detail lines has third priority.
- An associated outpatient claim without an episode-specific procedure code has fourth priority.

Throughout the hierarchy the following rules apply:

- At each step of the hierarchy, if two or more associated inpatient claims meet the required criteria, the inpatient claim with the earliest *Header From Date Of Service* is chosen. If two or more associated inpatient claims meet the required criteria and have the same *Header From Date Of Service*, the inpatient claim belonging to the hospitalization with the latest *Header To Date Of Service* is chosen. If the *Header To Date Of Service* is the same, the inpatient claim with the lower *Internal Control Number* is chosen.

- At each step of the hierarchy, if two or more associated outpatient claims meet the required criteria, the outpatient claim with the earliest minimum *Header From Date Of Service* is chosen. If two or more associated outpatient claims meet the required criteria and have the same minimum *Header From Date Of Service*, the claim with the greater duration is chosen. See section 6 for the definition of duration. If the duration is the same, the outpatient claim with the lower *Internal Control Number* is chosen.

The start date of a potential trigger is the earlier of the *Detail From Date Of Service* of the professional trigger claim detail line or the *Header From Date Of Service/Detail From Date Of Service* of the associated inpatient/outpatient claim. If the professional trigger claim detail line is associated with an inpatient claim, use the *Header From Date of Service*. If the professional trigger claim detail line is associated with an outpatient claim, use the *Detail From Date of Service*. The end date of a potential trigger is the later of the *Detail To Date Of Service* of the professional trigger claim detail line or the *Header To Date Of Service/Detail To Date of Service* of the associated inpatient/outpatient claim. If the professional trigger claim detail line is associated with an inpatient claim, use the *Header To Date of Service.* If the professional trigger claim detail line is associated with an outpatient claim, use the *Detail To Date of Service*.

A specific rule applies for potential triggers where the associated inpatient claim is part of a hospitalization consisting of two or more inpatient claims. See section 6 for the definition of hospitalization. If an associated inpatient claim is part of a

hospitalization consisting of two or more inpatient claims, the potential trigger starts on the earlier of the *Detail From Date Of Service* of the professional trigger claim detail line or the *Header From Date Of Service* of the hospitalization that the associated inpatient claim is a part of. The potential trigger ends on the later of the *Detail To Date Of Service* of the professional trigger claim detail line or the *Header To Date Of Service* of the hospitalization of which the associated inpatient claim is a part.

- **For episodes triggered by a facility claim:**

  A potential trigger is defined as a facility trigger claim. A facility trigger claim can be either an inpatient claim or an outpatient claim that meets the conditions below. Inpatient and outpatient claims are identified based on the input field *Claim Type* as defined in section 6.

  The facility trigger claim must meet one of the following conditions:

  – The claim has, in the primary diagnosis field, an episode-specific trigger diagnosis code in the input field *Header Diagnosis Code* and does not have an interim billing, reserved/missing, or transfer discharge status in the input field *Patient Discharge Status*. The configuration file lists the episode-specific trigger diagnosis codes under "Trigger Diagnosis", the interim billing discharge status codes under "Hospitalization – Interim Billing", the reserved/missing discharge status codes under "Hospitalization – Reserved", and the transfer discharge status codes under "Hospitalization – Transfer".

  – The claim has an episode-specific contingent trigger diagnosis code in the primary diagnosis field, as well as an episode-specific trigger diagnosis code in any of the secondary diagnosis fields and does not have an interim billing, reserved/missing, or transfer discharge status in the input field *Patient Discharge Status*. The configuration file lists the contingent trigger diagnosis codes under "Contingent Trigger Diagnosis", the trigger diagnosis codes under "Trigger Diagnosis", the interim billing discharge status codes under "Hospitalization – Interim Billing", the reserved/missing discharge status codes under "Hospitalization – Reserved", and the transfer discharge status codes under "Hospitalization – Transfer".

  In addition, an outpatient claim must also meet the following condition to be a facility trigger claim:

  – The claim has an episode-specific trigger revenue code in the input field *Revenue Code* and does not have an interim billing, reserved/missing, or transfer discharge status in the input field *Patient Discharge Status*. The configuration file lists the

trigger revenue codes under "Trigger Revenue", the interim billing discharge status codes under "Hospitalization – Interim Billing", the reserved/missing discharge status codes under "Hospitalization – Reserved", and the transfer discharge status codes under "Hospitalization – Transfer".

The start date of a potential trigger is the *Header From Date Of Service* of the facility trigger claim (if the trigger claim is an inpatient claim) or the earliest *Detail From Date Of Service* of the facility trigger detail lines (if the trigger claim is an outpatient claim). The end date of a potential trigger is the *Header To Date Of Service* of the facility trigger claim (if the trigger claim is an inpatient claim) or the latest *Detail To Date Of Service* of the facility trigger detail lines (if the trigger claim is an outpatient claim).

A specific rule applies for potential triggers where the inpatient claim is part of a hospitalization consisting of two or more inpatient claims. See section 6 for the definition of hospitalization. If an inpatient claim is part of a hospitalization consisting of two or more inpatient claims, the potential trigger starts on the *Header From Date Of Service* of the hospitalization of which the trigger inpatient claim is a part. The potential trigger ends on the *Header To Date Of Service* of the hospitalization of which the inpatient trigger claim is a part.

4.1.2 Identify episode triggers based on clean period

For a potential trigger (potential professional trigger claim or potential facility trigger claim) to become an episode trigger, its start date cannot fall into the clean period of another potential trigger for the same patient. A chronological approach is taken, and the first potential trigger of a given patient is identified as the earliest (i.e., the furthest in the past) episode trigger. The clean period starts the day after the potential trigger end date and extends for the entirety of the post trigger window plus the number of days equal to the maximum time window allowed for the pre-trigger window (i.e., if fixed, the fixed length, if flexible, the maximum possible number of days). For example:

- If an episode has a flexible pre-trigger window that may be as long as 90 days, and a post-trigger window of 30 days, the clean period for this episode will be 120 days.
- However, if an episode has a fixed pre-trigger window of 30 days, and a post-trigger window of 30 days, the clean period for this episode will be 60 days.

The chronological process continues, and the next potential trigger for that patient that falls after the clean period (i.e., the furthest in the past but after the clean period) constitutes the second trigger.

This process of setting episode windows continues for each patient until the last episode window that ends during the input data date range is defined. The lengths of the pre-trigger and post-trigger windows are listed as parameters in the configuration file under "03 – Determine The Episode Duration".

If two or more potential triggers of the same patient overlap, i.e., the start date of one potential trigger falls between the start date and the end date (inclusive) of one or more other potential triggers of the same patient, then only one of the overlapping potential triggers is chosen as an episode trigger. The following hierarchy is applied to identify the one potential trigger out of two or more overlapping potential triggers that is assigned as episode trigger:

- **For episodes triggered by a professional claim and an associated facility claim:**
  - The potential trigger with the earliest start date has highest priority.
  - If there is a tie, the potential trigger with the latest end date is selected.
  - If there is still a tie, the potential trigger with the earliest *Detail From Date Of Service* for the professional trigger claim detail line with the episode-specific procedure is selected.
  - If there is still a tie, the potential trigger with the lowest *Internal Control Number* on the professional trigger claim with the episode-specific procedure is selected.
- **For episodes triggered by a facility claim:**
  - A potential trigger with an inpatient facility trigger claim has highest priority and takes precedence over an outpatient facility trigger claim.
  - If two or more potential triggers with inpatient facility trigger claims overlap, the potential trigger with the earliest start date has highest priority. If there is a tie, the potential trigger with the latest end date is selected. If there is still a tie, the potential trigger with the lowest *Internal Control Number* on the inpatient trigger claim is chosen.
  - If two or more potential triggers with outpatient facility trigger claims overlap, the potential trigger with the earliest start date has highest priority. If there is a tie, the potential trigger with the latest end date is selected. If there is still a tie, the potential trigger with the lowest *Internal Control Number* on the outpatient trigger claim is chosen.

Apply clean period logic after the associated facility is assigned but before any episode-specific logic regarding the associated facility. For example, for the percutaneous coronary intervention (PCI) episodes, apply clean period logic before identifying an

episode as acute or non-acute. This means that acute and non-acute potential triggers can disqualify each other as part of the clean period logic. See section 2.3.1 for guidance on the clean period.

4.1.3 Setting output fields

- **For episodes triggered by a professional claim and an associated facility claim:**

  The output field *Professional Trigger Claim ID* is set to the input field *Internal Control Number* of the professional claim that identifies the episode trigger. The output field *Associated Facility Claim ID* is the input field *Internal Control Number* of the associated facility claim that identifies the episode trigger. The output field *Associated Facility Claim Type* is the input field *Claim Type*, as defined in section 6, of that associated facility claim.

- **For episodes triggered by a facility claim:**

  The output field *Facility Trigger Claim ID* is set to the input field *Internal Control Number* of the episode trigger. The output field *Facility Trigger Claim Type* is the input field *Claim Type*, as defined in section 6, of the episode trigger.

For both episodes triggered by either a professional claim and an associated facility claim or a facility claim, the output field *Member ID* is set to the input field *Member ID* of the episode trigger. The output field *Member Name* is set to the input field *Member Name* from the Member Extract. The output field *Member Age* is set using the definition for Member Age provided in section 6.

Not all output fields are created for all episodes, e.g., the output field *Associated Facility Claim* is not set for episodes triggered by a facility claim.

4.2 ATTRIBUTE EPISODES TO PROVIDERS

The second design dimension in building an episode is to attribute each episode to a Principal Accountable Provider (also referred to as PAP or Quarterback).

Episode output field created: *PAP ID, PAP Name, Rendering Provider ID, Rendering Provider Name*

PAP output fields created: *PAP ID, PAP Name*

- **For episodes attributed to providers based on the triggering claim:**

The PAP may be a clinician or a facility:

- **Clinician PAP:** If the PAP is the clinician who performed the procedure or made the triggering diagnosis, the output field *PAP ID* is set using the input field *Contracting Entity* of the Provider Extract associated to the *Billing Provider ID* on the *Trigger Professional Claim ID*.
- **Facility PAP:** If the PAP is the facility where the procedure was performed or where the triggering diagnosis was made, the output field *PAP ID* is set using the input field *Contracting Entity* of the Provider Extract associated to the *Billing Provider ID* on the *Trigger Facility Claim ID*.

The output field *Rendering Provider ID* is set differently depending on whether there is a clinician or facility PAP. If the PAP is a facility, it also differs based on being outpatient or inpatient.

- **Clinician PAP:** If the PAP is a clinician, the output field *Rendering Provider ID* is set using the input field *Detail Rendering Provider ID* of the professional trigger claim detail line that is used to set the *Trigger Professional Claim ID*. The output field *Rendering Provider Name* is added from the Provider Extract using the input field *Provider Name.* The output field *PAP Name* is added from the Provider Extract using the input field *Contracting Entity Name.*
- **Outpatient Facility PAP:** If the PAP is an outpatient facility, the output field *Rendering Provider ID* is set using the input field *Detail Rendering Provider ID* of the facility trigger claim that is used to set the *Trigger Facility Claim ID*. The output field *Rendering Provider Name* is added from the Provider Extract using the input field *Provider Name*. The output field *PAP Name* is added from the Provider Extract using the input field *Contracting Entity Name*.
- **Inpatient Facility PAP:** If the PAP is an inpatient facility, the output field *Rending Provider ID* is set using the input field *Attending Provider NPI* of the facility trigger claim that is used to set the *Trigger Facility Claim ID*. The output field *Rendering Provider Name* is added from the Provider Extract using the input field *Provider Name*. The output field *PAP Name* is added from the Provider Extract using the input field *Contracting Entity Name.*

- **For episodes attributed based on plurality of visits:**

The PAP may be a clinician or a facility with the highest number of visits included in episode spend. The definition of visit is provided in section 6:

- **Clinician PAP:** If the PAP is the clinician with the highest number of visits, the output field *PAP ID* is set using the input field *Contracting Entity* of the Provider Extract associated to the *Billing Provider ID* with the highest number of visits included in the episode spend.
- **Facility PAP:** If the PAP is the facility with the highest number of visits, the output field *PAP ID* is set using the input field *Contracting Entity* of the Provider Extract associated to the *Billing Provider ID* with the highest number of visits included in the episode spend.

The output field *Rendering Provider ID* is set differently depending on whether there is a clinician or facility PAP. If the PAP is a facility, it also differs based on being outpatient or inpatient.

- **Clinician PAP:** If the PAP is a clinician, the output field *Rendering Provider ID* is set using the input field *Detail Rendering Provider ID* with the highest number of visits included in episode spend. The output field *Rendering Provider Name* is added from the Provider Extract using the input field *Provider Name.* The output field *PAP Name* is added from the Provider Extract using the input field *Contracting Entity Name.*

- **Outpatient Facility PAP:** If the PAP is an outpatient facility, the output field *Rendering Provider ID* is set using the input field *Detail Rendering Provider ID* with the highest number of visits included in episode spend. The output field *Rendering Provider Name* is added from the Provider Extract using the input field *Provider Name*. The output field *PAP Name* is added from the Provider Extract using the input field *Contracting Entity Name*.
- **Inpatient Facility PAP:** If the PAP is an inpatient facility, the output field *Rending Provider ID* is set using the input field *Attending Provider NPI* with the highest number of visits included in episode spend. The output field *Rendering Provider Name* is added from the Provider Extract using the input field *Provider Name*. The output field *PAP Name* is added from the Provider Extract using the input field *Contracting Entity Name.*

If two or more contracting entities are tied based on the number of visits, the following hierarchy is applied:

- Among contracting entities that are tied, the *Contracting Entity* with the highest amount of spend across included claims is the PAP.
- Among contracting entities that are still tied, the *Contracting Entity* with the visit that starts closest to the *Episode End Date* is the PAP. The visit must be included in episode spend.

- Among contracting entities that are still tied, the PAP is the provider with the lowest *Contracting Entity*.

4.3 DETERMINE THE EPISODE DURATION

The third design dimension of building an episode is to define the duration of the episode.

Episode output fields created: *Pre-Trigger Window Start Date, Pre-Trigger Window End Date, Trigger Window Start Date*, *Trigger Window End Date, Post-Trigger Window Start Date, Post-Trigger Window End Date, Episode Start Date, Episode End Date*

The following time windows are of relevance in determining the episode duration:

- **Pre-trigger window:** As specified in section 5.3, the pre-trigger window may be flexible or fixed:
  - **Flexible pre-trigger window:** For episodes with a flexible pre-trigger window, the duration of the pre-trigger window is dependent on when the patient had his/her first interaction with the PAP within a specified number of days (x days) prior to the trigger.

If there are no professional claims with a *Header From Date of Service* between the xth day prior (inclusive) and one (1) day before the *Trigger Window Start Date,* where the input field *Contracting Entity* of the associated *Billing Provider ID* on the claim is the same as the episode output field *PAP ID*, then the *Pre-Trigger Window Start Date* is left blank and the *Pre-Trigger Window End Date* is left blank, hence there is no pre-trigger window. See sections 4.2 and 5.2 for determining the output field *PAP ID*.

If there is only one professional claim with a *Header From Date of Service* between the xth day prior (inclusive) and one (1) day before the *Trigger Window Start Date,* where the input field *Contracting Entity* associated to the *Billing Provider ID* on the claim is the same as the episode output field *PAP ID,* then the *Pre-Trigger Window Start Date* is set to the *Header From Date of Service* of that claim.

If there are two or more professional claims with a *Header From Date of Service* between the xth day prior (inclusive) and one (1) day before the *Trigger Window Start Date,* where the input field *Contracting Entity* associated to the *Billing Provider ID* on the claim is the

same as the episode output field *PAP ID,* then the *Pre-Trigger Window Start Date* is set to the earliest *Header From Date of Service* of those claims.

The maximum length of the flexible pre-trigger window (x days) is given as a parameter in the configuration file under "03 – Determine The Episode Duration"

- **Fixed pre-trigger window:** For episodes with a fixed pre-trigger window, the duration of the pre-trigger window is fixed at a specified number of days prior (inclusive) to one (1) day before the *Trigger Window Start Date.* The specific number of days is given as a parameter in the configuration file under "03 – Determine The Episode Duration". The output field *Pre-Trigger Window End Date* is set to one (1) day before the *Trigger Window Start Date*. The *Pre-Trigger Window Start Date* is also the *Episode Start Date.*

- **Trigger window**: The output fields *Trigger Window Start Date* and *Trigger Window End Date* are set using the episode trigger start and end dates, which are defined in section 4.1.

- **Post-trigger window:** The output field *Post-Trigger Window Start Date* is set to the day after the *Trigger Window End Date*. The output field *Post-trigger Window End Date* is set to the xth day after the *Trigger Window End Date* (for a post-trigger window of x days duration). The value for the post-trigger window duration (x days) is provided as a parameter in the configuration file under "03 – Determine The Episode Duration". The duration for the post-trigger window is provided relative to the *Trigger Window End Date*. The *Post-trigger Window End Date* is also the *Episode End Date.*

  If a hospitalization is ongoing on the xth day of the post-trigger window, the *Post-Trigger Window End Date* is set to the *Header End Date* of the hospitalization. A hospitalization is ongoing on the xth day of the post-trigger window if the hospitalization has a *Header Start Date* during the first x days of the post-trigger window and a *Header End Date* beyond the first x days of the post-trigger window. If more than one hospitalization is ongoing on the xth day of the post-trigger window, the latest *Header End Date* present on one of the hospitalizations sets the *Post-trigger Window End Date*. The extension of the post-trigger window due to a hospitalization may not lead to further extensions, i.e., if the post-trigger window is set based on the *Header To Date Of Service* of a hospitalization and a different hospitalization starts during the extension of the post-trigger window and ends beyond it, the episode is not extended a second time. See section 6 for the definition of hospitalization.

The combined duration of the pre-trigger window, trigger window, and post-trigger window is the episode window. All time windows are inclusive of their first and last date. See section 6 for the definition of duration.

To determine which claims and claim detail lines occur during an episode the following assignment rules are used. In addition, specific rules apply to assign claims and claim detail lines to windows during the episode (the pre-trigger window, trigger window, post-trigger window, and hospitalizations):

- **Assignment to a window before the episode:**
  - Hospitalizations, all inpatient claims within them, and all claim detail lines of the inpatient claims are assigned to a window before the episode (e.g., 365 days to one day before the *Episode Start Date*, 90 days to one day before the *Episode Start Date*) if the *Header From Date Of Service* of the hospitalization occurs during the specified time window before the *Episode Start Date.*
  - Pharmacy claims and all their claim detail lines are assigned to a window before the episode if the *Header From Date Of Service* occurs during the specified time window before the *Episode Start Date*.
  - For the purpose of counting unique claims, outpatient and professional claims are assigned to the window before the episode if all their claim detail lines are assigned to the window before the episode. For the purpose of calculating spend, outpatient and professional claim detail lines are assigned to the window before the episode if the *Detail From Date Of Service* occurs during the specified time window before the *Episode Start Date*.
- **Assignment to the episode window:**
  - Hospitalizations and all inpatient claims within them are assigned to the episode window if the *Header From Date Of Service* occurs during the episode window.
  - Pharmacy claims are assigned to the episode window if both the *Header From Date Of Service* and the *Header To Date Of Service* occur during the episode window.
  - For the purpose of counting unique claims, outpatient, professional, and long-term care claims are assigned to the episode window if at least one of their claim detail lines is assigned to the episode window. For the purpose of calculating spend, outpatient, professional, and long-term care claim detail lines are assigned to the

episode window if both the *Detail From Date Of Service* and the *Detail To Date Of Service* occur during the episode window.

- **Assignment to the pre-trigger window**:
  - Hospitalizations and all inpatient claims within them are assigned to the pre-trigger window if the hospitalization is assigned to the episode window and also has a *Header From Date Of Service* during the pre-trigger window.
  - Pharmacy claims are assigned to the pre-trigger window if they are assigned to the episode window and also have a *Header From Date Of Servic*e during the pre-trigger window.
  - For the purpose of counting unique claims, outpatient, professional, and long-term care claims are assigned to the pre-trigger window if at least one of their claim detail lines is assigned to the pre-trigger window. For the purpose of calculating spend, outpatient, professional, and long-term claim detail lines are assigned to the pre-trigger window if they are assigned to the episode window and also have a *Detail From Date Of Service* during the pre-trigger window.
- **Assignment to the trigger window**:
  - Hospitalizations and all inpatient claims within them are assigned to the trigger window if the *Header From Date Of Service* of the hospitalization occurs during the trigger window.
  - Pharmacy claims are assigned to the trigger window if both the *Header From Date Of Service* and the *Header To Date Of Service* occur during the trigger window.
  - For the purpose of counting unique claims, outpatient and professional, and long-term care claims are assigned to the trigger window if all their claim detail lines are assigned to the trigger window. For the purpose of calculating spend, outpatient, professional, and long-term care claim detail lines are assigned to the trigger window if both the *Detail From Date Of Service* and the *Detail To Date Of Service* occur during the trigger window.
- **Assignment to the post-trigger window**:
  - Hospitalizations and all inpatient claims are assigned to the post-trigger window if the hospitalization is assigned to the episode window and also has a *Header From Date Of Service* during the post-trigger window.

- Pharmacy claims are assigned to the post-trigger window if they are assigned to the episode window and also have a *Header To Date of Service* during the post-trigger window.
- For the purpose of counting unique claims, outpatient, professional, and long-term care claims are assigned to the post-trigger window if at least one of their claim detail lines is assigned to the post-trigger window. For the purpose of calculating spend, outpatient, professional, and long-term care claim detail lines are assigned to the post-trigger window if they are assigned to the episode window and also have a *Detail To Date of Service* during the post-trigger window.

- **Assignment to hospitalizations**:
  - Outpatient and professional claims are assigned to a hospitalization if they are not assigned to the trigger window and all their claim detail lines are assigned to the hospitalization. Outpatient and professional claim detail lines are assigned to a hospitalization if the *Detail From Date Of Service* and the *Detail To Date Of Service* occur during the hospitalization.

4.4 IDENTIFY CLAIMS INCLUDED IN EPISODE SPEND

The fourth design dimension of building an episode is to identify which claims and claim detail lines are included in the calculation of episode spend. For short, such claims or claim detail lines are referred to as included claims or included claim detail lines.

Episode output fields created: *Count of Included Claims*

Different rules for the inclusion of claims and claim detail lines apply to claims and claim detail lines assigned to different types of services and windows. The breakdown for how to count included claims and claim detail lines by care category is defined in section 6. How different types of services are defined is detailed below. Which type of services are included in the episode, and in which window, are episode specific and detailed in section 5.4. See section 4.3 for how claim and claim detail lines are assigned to different windows during the episode.

The following rules for types of service apply:

- **Specific care after discharge**: Hospitalizations, outpatient, professional, and long-term care claims with ICD-9 or ICD-10 diagnosis codes for specific care after discharge in the input field *Header Diagnosis Code*. See the configuration file under "Care After

Discharge" for the list of codes. The code needs to be in the primary diagnosis code field. A special rule applies whenever a hospitalization is included. All professional and outpatient claims assigned to an included hospitalization are included. See section 4.3 for how professional and outpatient claims are assigned to hospitalizations.

- **Specific anesthesia:** Outpatient and professional claim detail lines with CPT/HCPCS procedure codes for specific anesthesia in the input field *Detail Procedure Code*. See the configuration file under "Anesthesia" for the list of codes.
- **Specific evaluation and management encounters:** Outpatient and professional claim detail lines with CPT/HCPCS procedure codes for specific E&M encounters in the input field *Detail Procedure Code*. See the configuration file under "E&M Visits" for the list of codes. If only office encounters with the PAP are included, the input field *Contracting Entity* associated to the *Billing Provider ID* of the claim for the office encounter must match the *PAP ID* for the episode. To determine if this is the case see section 5.4. If only office encounters with a related diagnosis code are included, there must be an episode-specific relevant ICD-9 or ICD-10 diagnosis code in the primary diagnosis code field. See the configuration file under "Relevant Diagnosis" for the list of codes. To determine if this is the case see section 5.4.
- **Specific imaging and testing:** Inpatient claims, and outpatient and professional claim detail lines with ICD-9/ICD-10/CPT/HCPCS procedure codes for specific imaging and testing in the input field *Header Surgical Procedure Code* or *Detail Procedure Code*. See the configuration file under "Imaging and Testing" for the list of codes. The ICD-9 or ICD-10 procedure codes can be in any field.
- **Specific medications:** Pharmacy claims with HIC3 codes for specific medications. Pharmacy claims with HIC3 codes (Hierarchical Ingredient Code Level 3 identifiers provided by First Databank) for specific medications are identified by the presence of a National Drug Code (NDC) in the input field *National Drug Code*. See the configuration file under "Medications" for the list of codes. To identify specific medications, the HIC3 codes must be cross-walked to NDCs. Since NDCs change over time, an updated crosswalk including current and historical NDCs must be used for each reporting period.
- **Specific pathology:** Outpatient and professional claim detail lines with CPT/HCPCS procedure codes for specific pathology in the input field *Detail Procedure Code*. See the configuration file under "Pathology" for the list of codes.
- **Specific surgical and medical procedures:** Inpatient claims, and outpatient and professional claim detail lines with ICD-9/ICD-10/CPT/HCPCS procedure codes for

specific procedures in the input field *Header Surgical Procedure* Code or *Detail Procedure Code*. See the configuration file under "Surgical and Medical Procedures" for the list of codes. The ICD-9 or ICD-10 procedure codes can be in any field.

- **Specific excluded surgical and medical procedures:** Inpatient claims, and outpatient and professional claim detail lines with ICD-9/ICD-10/CPT/HCPCS procedure codes for specific excluded procedures in the input field *Header Surgical Procedure Code* or *Detail Procedure Code*. See the configuration file under "Excluded Surgical and Medical Procedures" for the list of codes. This exclusion of claims or claim detail lines takes precedence over any other inclusion logic.

The output field *Count of Included Claims* is the total number of claims included in the episode. See section 6 for details on counts of claims by care category.

4.5 CALCULATE NON-RISK-ADJUSTED EPISODE SPEND

The fifth design dimension of building an episode is to calculate the non-risk-adjusted spend for each episode.

Episode output fields created: *Non-risk-adjusted Episode Spend*

PAP output fields created: *Average Non-risk-adjusted PAP Spend*, *Average Non-risk-adjusted PAP Spend by <Care Category X>, Average Non-risk-adjusted PAP Spend by <Window X>, Total Non-risk-adjusted PAP Spend*

The *Non-risk-adjusted Episode Spend* is defined as the sum of:

- The *Detail Paid Amount* for included claim detail lines for detail-paid claim types (e.g., outpatient and professional). If a claim detail line is included for two or more reasons (e.g., due to an included procedure), its *Detail Paid Amount* counts only once towards the *Non-risk-adjusted Episode Spend*.
- The *Header Paid Amount* for included claims for header-paid claim types (e.g., inpatient and pharmacy).
- The *Patient Cost Share* for included claims.

The output field *Non-risk-adjusted Episode Spend* is calculated overall, by window during the episode, and by reporting care category. See section 6 for the definition of the reporting care categories.

The fields *Average Non-risk-adjusted PAP Spend* and *Total Non-risk-adjusted PAP Spend* are added to the PAP output table. *Average Non-risk-adjusted PAP Spend* is calculated as the average of the *Non-risk-adjusted Episode Spend* across valid episodes for a given *PAP ID*. *Total Non-risk-adjusted PAP Spend* is calculated as the sum of the *Non-risk-adjusted Episode Spend* across valid episodes for a given PAP. The output field *Average Non-risk-adjusted PAP Spend* is calculated overall and by reporting care category. See sections 4.2 and 5.2 for the identification of *PAP ID*s and section 4.6 and 5.6 for the definition of valid episodes. See section 6 for the definition of the reporting care categories.

4.6 IDENTIFY EXCLUDED EPISODES

The sixth design dimension of building an episode is to identify episodes that are excluded from the episode-based payment model.

Episode output fields created: *Any Exclusion, Exclusion Inconsistent Enrollment, Exclusion Third-party Liability, Exclusion Dual Eligibility, Exclusion FQHC/RHC, Exclusion No PAP ID, Exclusion Incomplete Episode, Exclusion Different Care Pathway, Exclusion Age, Exclusion Death, Exclusion Left Against Medical Advice, Exclusion High Outlier*

Each *Exclusion <name of exclusion>* output field indicates whether an episode is excluded for a given reason and therefore invalid for the purpose of the episode-based payment model. If an episode is excluded for more than one reason each exclusion is indicated. The output field *Any Exclusion* indicates whether an episode contains any exclusion. Episodes may be excluded for business reasons, clinical reasons, non-clinical patient-specific reasons, or because they are high outliers.

After all exclusions have been applied, a set of valid episodes remains.

Business exclusions

- **Inconsistent enrollment**: An episode is excluded if the patient was not continuously enrolled in the plan during the episode window. Enrollment is verified using the *Eligibility Start Date* and *Eligibility End Date* from the Member Extract.

  A patient is considered continuously enrolled if the patient's *Eligibility Start Date* for the plan falls before or on (≤) the *Episode Start Date* and the *Eligibility End Date* for the plan falls on or after (≥) the *Episode End Date*. The output field *Member ID* of the episode table is linked to the input field *Member ID* of the Member Extract to identify the enrollment information for each patient.

A patient may have multiple entries for *Eligibility Start Date* and *Eligibility End Date* for full enrollment in the plan and some of the dates may be overlapping. In such cases, continuous, non-overlapping records of a patient's enrollment are created before confirming whether the patient was continuously enrolled during an episode. If a patient has an *Eligibility Start Date* without a corresponding *Eligibility End Date* for the plan, enrollment is considered to be ongoing through the last date of the input data.

If a patient was not continuously enrolled in the plan before or after the episode window, but was continuously enrolled during the episode window, the episode is not excluded.

- **Third-party liability**: An episode is excluded if an inpatient, outpatient, professional, pharmacy, or long-term care claim that is assigned to the episode window is associated with a third-party liability amount. A claim is considered to be associated with a third-party liability amount if either the input field *Header TPL Amount* or any of the input fields *Detail TPL Amount* have a value greater than (>) zero. The claim with a positive TPL amount may or may not be included in the calculation of episode spend.

  If a patient has a claim associated with a third-party liability amount before or after the episode window, but not during the episode window, the episode is not excluded.

- **Dual eligibility**: An episode is excluded if the patient had dual coverage by Medicare and Medicaid during the episode window. See the configuration file under "Business – Dual Eligibility".

  If a patient had dual coverage before or after the episode window, but not during the episode window, the episode is not excluded.

- **Federally Qualified Health Center/Rural Health Clinic:**
  - **For episodes triggered by a professional claim and an associated facility claim:** An episode is excluded if either of the *Professional Trigger Claim ID* or the *Associated Facility Claim ID* is a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). For *Professional Trigger Claim ID*, an episode is excluded if the *Place of Service* has a code listed in the configuration file under "Business – FQHC/RHC". For *Associated Facility Claim ID*, an episode is excluded if the *Type of Bill* has a code listed in the configuration file under "Business – FQHC/RHC".
  - **For episodes triggered by a facility claim:** An episode is excluded if the *Facility Trigger Claim ID* is a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). For *Facility Trigger Claim ID*, an episode is excluded if the *Type of Bill* has a code listed in the configuration file under "Business – FQHC/RHC".

- **No PAP ID:** An episode is excluded if the *PAP ID* cannot be identified.
- **Incomplete episodes**: An episode is excluded if either:
  - The triggering professional claim spend is less than or equal to 0.
  - It is within the bottom 2.5% of all episodes with the lowest *Non-risk-adjusted Episode Spend* (not the *Risk-adjusted Episode Spend*), without taking into account episodes where the triggering professional claim spend is less than or equal to (≤) 0.

Clinical exclusions

- **Different care pathway**: An episode is excluded if the patient has a medical code that indicates a different care pathway during a specified time window on any inpatient, outpatient, or professional claim in the input field *Header Diagnosis Code* (any field), *Header Surgical Procedure Code*, or *Detail Procedure Code*. The detailed list of codes and time windows is given in the configuration file under "Clinical – (*condition for exclusion*)".

  The claims and claim detail lines that are searched for different care pathways do not have to be included claims or included claim detail lines. In addition, if a patient lacked continuous eligibility during the year before the episode or during the episode window, codes for different care pathways are checked in the data available.

Patient exclusions

- **Age**: An episode is excluded if the member age does not fall into the valid age range or if it is invalid. The valid age range is listed as parameters in the configuration file under "06 – Identify Excluded Episodes". See section 6 for how member age is defined.
- **Death**: An episode is excluded if the patient has a *Patient Discharge Status* of "Expired" on any inpatient or outpatient claim assigned to the episode window. The claim may be an included claim or not. The values of the *Patient Discharge Status* used to identify whether the patient expired are listed in the configuration file under "Patient – Death".
- **Left against medical advice**: An episode is excluded if the patient has a *Patient Discharge Status* of "Left Against Medical Advice or Discontinued Care" on any inpatient or outpatient claim during the episode window. The claim may be an included claim or not. The value of the *Patient Discharge Status* used to identify whether the patient left against medical advice is listed in the configuration file under "Patient – LAMA".

High-cost outliers

An episode is excluded if the *Risk-adjusted Episode Spend* (not the *Non-risk-adjusted Episode Spend*) is 3 standard deviations above (>) the mean *Risk-adjusted Episode Spend* of all episodes not otherwise excluded. Because this exclusion uses the risk-adjusted episode spend, it is the only exclusion that takes place after the risk adjustment process.

A hierarchy is used to present the exclusions in the provider report. See section 6 for the hierarchy of exclusions.

4.7 PERFORM RISK ADJUSTMENT

The seventh design dimension of building an episode is to risk-adjust the *Non-risk-adjusted Episode Spend* for risk factors that may contribute to higher episode spend given the characteristics of a patient and are outside of the PAP's control.

Episode output fields created: *Risk Factor (risk factor number), Episode Risk Score, Risk-adjusted Episode Spend*

PAP output fields created: *Average Risk-adjusted PAP Spend*, *Average Risk-adjusted PAP Spend by <Care Category X>, Total Risk-adjusted PAP Spend*

Risk adjustment first requires identification of the risk factors that affect each episode. Once risk factors have been determined, each payer calculates the *Episode Risk Score* and the *Risk-adjusted Episode Spend*. Each *Risk Factor (risk factor number)* output field indicates whether an episode's spend is risk-adjusted for a given risk factor. The relevant codes are identified only on claims with *Header From Date of Service* (for header-paid claims) *or Detail From Date of Service* (for detail-paid claims) falling during the time period specified for the given risk factor in the configuration file. When a risk factor is based on the presence of a diagnosis, the output field *Risk Factor (risk factor number)* indicates if a claim exists with a diagnosis in any diagnosis field for the referenced risk factor in the input field *Header Diagnosis Code.*

The PAP output field *Average Risk-adjusted PAP Spend* is calculated as the average of the Risk-adjusted Episode Spend across valid episodes for each *PAP ID*. The *Total Risk-adjusted PAP Spend* is calculated as the sum of the *Risk-adjusted Episode Spend* across valid episodes for each *PAP ID*.

4.8 DETERMINE QUALITY METRICS PERFORMANCE

The eighth design dimension of building an episode is the calculation of the quality metrics and the identification of *PAP ID*s who pass the quality metrics performance requirement. Quality metrics are calculated by each payer on an aggregated basis across all episodes with the same *PAP ID*. Denied claims should be used in the calculation of quality metrics.

Episode output fields created: *Quality Metric (quality metric number) Indicator*

PAP output fields created: *PAP Quality Metric (quality metric number), Gain Sharing Quality Metric Pass*

The number of *Quality Metric Indicator* episode output fields and *PAP Quality Metric* output fields will match the total number of quality metrics for each episode.

For most quality metrics the following logic applies. If there are any exceptions these will be detailed in section 5.8. The *Quality Metric (n) Indicator* marks episodes that complied with quality metric (n). The *PAP Quality Metric (n)* is expressed as a percentage for each PAP based on the following ratio:

- Numerator: Number of valid episodes of the *PAP ID* with *Quality Metric (n) Indicator*
- Denominator: Number of valid episodes of the *PAP ID*

Section 5.8 will provide detail on what the *Quality Metric (n) Indicators* are for this episode.

There are two types of quality metrics: those tied to gain sharing and those that are informational (i.e., not tied to gain sharing). These may be calculated including valid or total episodes of the *PAP ID*. These details are specified in section 5.8.

The output field *Gain Sharing Quality Metric Pass* is set based on the performance of the *PAP ID* on the quality metrics that are tied to gain sharing. The output field *Gain Sharing Quality Metric Pass* indicates if the percentage of valid episodes of the *PAP ID* that comply with quality metrics tied to gain sharing met the required thresholds for gain sharing. Setting thresholds for the quality metrics is beyond the scope of this DBR, hence thresholds will be set and provided separately.

4.9 CALCULATE GAIN/RISK SHARING AMOUNTS

The ninth and final design dimension of building an episode is to calculate the gain or risk sharing amount for each *PAP ID*. Gain and risk sharing are calculated by each payer on an aggregated basis across all of *PAP ID's* episodes covered by that payer.

PAP output fields created: *Count Of Total Episodes Per PAP, Count Of Valid Episodes Per PAP, Gain/Risk Sharing Amount*, *PAP Sharing Level*

Gain and risk sharing amounts are calculated based on the episodes of each *PAP ID* that ended during the reporting period. To calculate the gain or risk sharing amount paid to/by each *PAP ID* the following pieces of information are used:

- Commendable threshold, acceptable threshold, and gain sharing limit threshold. Setting these thresholds is beyond the scope of this DBR.
- Number of episodes of each *PAP ID*: The output field *Count Of Total Episodes Per PAP ID* is defined as the number of total episodes of each *PAP ID* during the reporting period. The output field *Count Of Valid Episodes Per PAP ID* is defined as the number of valid episodes of each *PAP ID* during the reporting period. *Count Of Valid Episodes Per PAP ID* is calculated overall and by reporting care category. Episodes are counted separately by each payer.
- Performance of each *PAP ID* on quality metrics tied to gain sharing: Only *PAP ID*s that pass the quality metrics tied to gain sharing are eligible for gain sharing. Setting thresholds for the quality metrics is beyond the scope of this DBR. See section 4.8 for the calculation of the output field *Gain Sharing Quality Metric Pass,* which indicates whether a *PAP ID* passes the quality metrics tied to gain sharing.
- Gain share proportion and risk share proportion*:* The gain share proportion is set at 50% and the risk share proportion is set at 50%.

Gain sharing payment: A PAP identified by *PAP ID* receives a gain sharing payment if two criteria are met: (1) it passes the quality metrics tied to gain sharing, and (2) the *Average Risk-adjusted PAP ID Spend* is below (<) the *Commendable Threshold*. Two cases exist:

- If the *Average Risk-adjusted PAP ID Spend* is below (<) the *Commendable Threshold* and at or above (≥) the *Gain Sharing Limit Threshold*, the *Gain/Risk Sharing Amount* is:

  Gain Sharing Amount =

((*Commendable Threshold – Average Risk-adjusted PAP ID Spend*) * *Count of Valid Episodes Per PAP ID* * *50%*)

- If the *Average Risk-adjusted PAP ID Spend* is below (<) the *Commendable Threshold* and below (<) the *Gain Sharing Limit Threshold*, the *Gain/Risk Sharing Amount* is:

  Gain Sharing Amount =

  ((*Commendable Threshold – Gain Sharing Limit Threshold*) * *Count of Valid Episodes Per PAP ID* * *50%*)

Risk sharing payment: A PAP identified by *PAP ID* owes a risk sharing payment if its *Average Risk-adjusted PAP ID Spend* is at or above (≥) the *Acceptable Threshold*. The risk sharing payment applies irrespective of the performance of the *PAP ID* on the quality metrics. The *Risk Sharing Amount* is calculated as:

Risk Sharing Amount =

((*Average Risk-adjusted PAP ID Spend – Acceptable Threshold*) * *Count of Valid Episodes Per PAP ID* * *50%*)

To summarize the cost performance of each *PAP ID* in the episode-based payment model, the output field *PAP Sharing Level* is set to

- "1" if *Average Risk-adjusted PAP ID Spend* < *Gain Sharing Limit Threshold*
- "2" if *Average Risk-adjusted PAP ID Spend* < *Commendable Threshold* and also ≥ *Gain Sharing Limit Threshold*
- "3" if *Average Risk-adjusted PAP ID Spend* < *Acceptable Threshold* and also ≥ *Commendable Threshold*
- "4" if *Average Risk-adjusted PAP ID Spend* ≥ *Acceptable Threshold*

5 Skin and soft tissue infections episode detailed description

This section provides skin and soft tissue infections episode-specific details for building the skin and soft tissue infections episode, and must be used in conjunction with section 4, as section 4 contains general elements of the episode algorithm. Sections 4 and 5 used in conjunction explain the intent of the episode design at a level of granularity that will allow an IT implementation team to create an algorithm that matches the episode design.

5.1 IDENTIFY EPISODE TRIGGERS

The skin and soft tissue infections episode is triggered by a professional claim and an associated facility claim as described in section 4.1, with the following three exceptions to section 4.1.1:

- The professional trigger claim for the potential trigger of a skin and soft tissue infections episode, must also meet one of the following conditions:
  - The claim has an ICD-9 or ICD-10 trigger diagnosis code for a skin and soft tissue infection in the input field *Header Diagnosis Code* as listed in the configuration file under "Trigger Diagnosis" in the primary diagnosis field, as well as a CPT/HCPCS procedure code for an evaluation and management encounter in the input field *Detail Procedure Code* as listed in the configuration file under "E&M Visits", OR
  - The claim has an ICD-9 or ICD-10 trigger diagnosis code for a skin and soft tissue infection in the input field *Header Diagnosis Code* as listed in the configuration file under "Trigger Diagnosis" in one of the secondary diagnosis fields, a contingent diagnosis code in the input field *Header Diagnosis Code* as listed in the configuration file under "Contingent Trigger Diagnosis" in the primary diagnosis field, as well as a CPT/HCPCS procedure code for an evaluation and management encounter in the input field *Detail Procedure Code* as listed in the configuration file under "E&M Visits".
- The skin and soft tissue infections episode may or may not have an associated facility claim. Episodes with professional claims that do not have an associated facility claim are assumed to have had the triggering diagnosis taking place in the provider's office. For skin and soft tissue infection episodes that took place in the provider's office, the output field *Associated Facility Claim ID* is left blank, and the output field *Associated Facility Claim Type* is also left blank.

- If two or more potential triggers of the same patient overlap, i.e., the start date of one potential triggers starts on or after the start date of the another potential trigger and also ends before or on the end date of the other potential trigger, then only one of the overlapping potential triggers is chosen as an episode trigger. The following hierarchy is applied to identify the one potential trigger out of two or more overlapping potential triggers that is assigned as episode trigger:
  - The potential trigger with the earliest *Detail From Date Of Service* has the highest priority.
  - If there is a tie, the professional claim trigger with the skin and soft tissue infections diagnosis in the primary diagnosis field is selected over the professional claim trigger with skin and soft tissue infections diagnosis in one of the secondary diagnosis fields.
  - If there is a tie, the potential trigger with the latest *Detail To Date Of Service* is selected.
  - If there is still a tie, the potential trigger with the lower *Internal Control Number* and lower claim detail line number is selected.

5.2 ATTRIBUTE EPISODES TO PROVIDERS

This episode has a clinician PAP and follows the process described in section 4.2.

5.3 DETERMINE THE EPISODE DURATION

For this episode there are two windows:

- **Pre-trigger window:** This episode has no pre-trigger window. For this episode, the output field *Pre-Trigger Window Start Date* is left blank; and the output field *Pre-Trigger Window End Date* is left blank.
- **Trigger window**: Refer to section 4.3 for guidance.
- **Post-trigger window**: Refer to section 4.3 for guidance.

5.4 IDENTIFY CLAIMS INCLUDED IN EPISODE SPEND

For this episode services are included as defined in section 4.4, with the following specifications:

Pre-trigger window

This episode has no pre-trigger window.

Trigger window

For this episode, claims and claim detail lines assigned to the trigger window are included if they are also assigned to one of the following types of services:

- **Care for specific diagnoses:** Hospitalizations, outpatient, professional, and long-term care claims with ICD-9 or ICD-10 diagnosis codes for care for specific diagnoses in the input field *Header Diagnosis Code*. See the configuration file under "Diagnoses" for the list of codes. The code needs to be in the primary diagnosis code field. A special rule applies whenever a hospitalization is included. All professional and outpatient claims assigned to an included hospitalization are included. See section 4.3 for how professional and outpatient claims are assigned to hospitalizations.
- **Specific imaging and testing:** Refer to section 4.4 for guidance.
- **Specific medications:** Refer to section 4.4 for guidance.
- **Specific surgical and medical procedures:** Refer to section 4.4 for guidance.

Post-trigger window

For this episode, claims and claim detail lines assigned to the post-trigger window are included if they are also assigned to one of the following types of services:

- **Care for specific diagnoses:** Hospitalizations, outpatient, professional, and long-term care claims with ICD-9 or ICD-10 diagnosis codes for care for specific diagnoses in the input field *Header Diagnosis Code*. See the configuration file under "Diagnoses" for the list of codes. The code needs to be in the primary diagnosis code field. A special rule applies whenever a hospitalization is included. All professional and outpatient claims assigned to an included hospitalization are included. See section 4.3 for how professional and outpatient claims are assigned to hospitalizations.
- **Care for specific complications:** Hospitalizations, outpatient, professional, and long-term care claims with ICD-9 or ICD-10 diagnosis codes for care for specific diagnoses in the input field *Header Diagnosis Code*. See the configuration file under "Complications" for the list of codes. The code needs to be in the primary diagnosis code field. A special rule applies whenever a hospitalization is included. All professional and outpatient

claims assigned to an included hospitalization are included. See section 4.3 for how professional and outpatient claims are assigned to hospitalizations.

- **Specific imaging and testing:** Refer to section 4.4 for guidance.
- **Specific medications:** Refer to section 4.4 for guidance.
- **Specific surgical and medical procedures:** Refer to section 4.4 for guidance.

5.5 CALCULATE NON-RISK-ADJUSTED SPEND

This episode follows the process described in section 4.5.

5.6 IDENTIFY EXCLUDED EPISODES

This episode follows the process described in section 4.6, with one additional specification:

Clinical exclusions

- **Patients receiving treatment in the inpatient or observation room settings during the trigger window or the first day of the post-trigger window:** An episode is excluded if:
  - The output field *Associated Facility Claim Type* is 'inpatient' OR
  - The output field *Associated Facility Claim Type* is 'outpatient', and the associated facility claim has on any claim detail line a revenue code in the input field *Revenue Code* as listed in the configuration file under "Observation Indicator".
  - An admission included in spend with the *Header From Date of Service* equal to the *Post-trigger Window Start Date*.
  - Observation care included in spend with the *Detail From Date Of Service* equal to the *Post-trigger Window Start Date*.

5.7 PERFORM RISK ADJUSTMENT

This episode follows the process described in section 4.7.

5.8 DETERMINE QUALITY METRICS PERFORMANCE

This episode has two quality metric that are tied to gain sharing and five informational (i.e., not tied to gain sharing) quality metrics. An overview of how to determine quality metric performance is provided in section 4.8. Additionally, the output field *Gain Sharing Quality Metric Pass* is set based on the logic described in section 4.8.

Episode output fields created: *Quality Metric 1 Indicator*, *Quality Metric 1 Denominator*, *Quality Metric 2 Indicator*, *Quality Metric 2 Denominator, Quality Metric 3 Indicator, Quality Metric 3 Denominator, Quality Metric 4 Indicator, Quality Metric 5 Indicator, Quality Metric 6 Indicator, Quality Metric 7 Indicator, Quality Metric 8 Indicator*

PAP output fields created: *PAP Quality Metric 1, PAP Quality Metric 2, PAP Quality Metric 3, PAP Quality Metric 4, PAP Quality Metric 5, PAP Quality Metric 6, PAP Quality Metric 7, PAP Quality Metric 8, Gain Sharing Quality Metric Pass*

Quality metrics tied to gain sharing

- **Bacterial cultures when I&D performed (Quality Metric 1 – higher rate indicative of better performance):**
  - *Quality Metric 1 Indicator* marks episodes that have both of the following conditions:
    - A professional or outpatient claim with a CPT/HCPCS code for a bacterial culture in the input field *Detail Procedure Code*, as listed in the configuration file under "Bacterial Cultures" during the episode window AND
    - An inpatient claim, an outpatient claim detail line, or a professional claim detail line with an ICD-9/ICD-10/CPT/HCPCS procedure code for incision and drainage in the input field *Header Surgical Procedure* Code or *Detail Procedure Code* during the episode window. See the configuration file under "Incision and Drainage" for the list of codes. The ICD-9 or ICD-10 procedure code can be in any field.
  - *Quality Metric 1 Denominator* marks episodes that have an inpatient claim, an outpatient claim detail line, or a professional claim detail line with an ICD-9/ICD-10/CPT/HCPCS procedure code for incision and drainage in the input field *Header Surgical Procedure* Code or *Detail Procedure Code* during the episode window. See the configuration file under "Incision and Drainage" for the list of codes. The ICD-9 or ICD-10 procedure code can be in any field.
  - *PAP Quality Metric 1* is expressed as a percentage for each Quarterback based on the following ratio:

    - Numerator: Number of valid episodes of the *PAP ID* with *Quality Metric 1 Indicator*
    - Denominator: Number of valid episodes of the *PAP ID* with *Quality Metric 1 Denominator*

- **SSTI episodes with a first-line antibiotic (Quality Metric 2 – higher rate indicative of better performance):**
  - *Quality Metric 2 Indicator* marks episodes that have a pharmacy claim with a HIC3 code for a first-line antibiotic. The claim must also have a *Header From Date Of Service* falling on the day of the output field *Episode Start Date* or up to six days after. Pharmacy claims with HIC3 codes (Hierarchical Ingredient Code Level 3 identifiers provided by First Databank) for specific medications are identified by the presence of a National Drug Code (NDC) in the input field *National Drug Code.* To identify specific medications, the HIC3 codes must be cross-walked to NDCs. Since NDCs change over time, an updated crosswalk including current and historical NDCs must be used for each reporting period. The configuration file lists the first-line antibiotic codes under "First-Line Antibiotic".
  - *Quality Metric 2 Denominator* marks episodes that have a pharmacy claim with a HIC3 code for any antibiotic. The claim must also have a *Header From Date Of Service* falling on the day of the output field *Episode Start Date* or up to six days after. The configuration file lists the antibiotic codes under "Antibiotics".
  - *PAP Quality Metric 2* is expressed as a percentage for each Quarterback based on the following ratio:
    - Numerator: Number of valid episodes of the *PAP ID* with *Quality Metric 2 Indicator*
    - Denominator: Number of valid episodes of the *PAP ID* with *Quality Metric 2 Denominator*

Informational quality metrics (i.e., included for information only):

- **Infection recurrence (Quality Metric 3 – lower rate indicative of better performance):**
  - *Quality Metric 3 Indicator* marks episodes that have both of the following conditions:
    - A pharmacy claim with a HIC3 code for an antibiotic on days 16 through 30. The claim must have a *Header From Date Of Service* 16 to 30 days from the *Episode Start Date*. Pharmacy claims with HIC3 codes for specific medications are identified by the presence of an NDC in the input field *National Drug Code.* To identify specific medications, the HIC3 codes must be cross-walked to NDCs. Since NDCs change over time, an updated crosswalk including current and

historical NDCs must be used for each reporting period. The configuration file lists the antibiotic codes under "Antibiotics". AND

    - A pharmacy claim with a HIC3 for an antibiotic from day zero through day 15. The claim must have a *Header From Date Of Service* zero to 15 days from the *Episode Start Date*. The configuration file lists the antibiotic codes under "Antibiotics".

  - *Quality Metric 3 Denominator* marks episodes that have a pharmacy claim with a HIC3 code for an antibiotic from day zero through day 15. The claim must have a *Header From Date Of Service* zero to 15 days from the *Episode Start Date*. The configuration file lists the antibiotic codes under "Antibiotics".
  - *PAP Quality Metric 3* is expressed as a percentage for each Quarterback based on the following ratio:
    - Numerator: Number of valid episodes of the *PAP ID* with *Quality Metric 3 Indicator*
    - Denominator: Number of valid episodes of the *PAP ID* with *Quality Metric 3 Denominator*

- **Hospitalizations after initial diagnosis (Quality Metric 4 – lower rate indicative of better performance):**
  - *Quality Metric 4 Indicator* marks episodes that have at least one hospitalization or observation care assigned to the post-trigger window which is included in episode spend according to section 4.4. The definition of a hospitalization is provided in section 6. Observation care is identified based on an outpatient claim detail line with an observation care revenue code in the input field *Revenue Code*. The configuration file lists the observation care revenue codes under "Observation Indicator".
  - *PAP Quality Metric 4* is expressed as a percentage for each Quarterback based on the following ratio:
    - Numerator: Number of valid episodes of the *PAP ID* with *Quality Metric 4 Indicator*
    - Denominator: Number of valid episodes of the *PAP ID*

- **ED visits after initial diagnosis (*Quality Metric 5* – lower rate indicative of better performance):**
  - *Quality Metric 5 Indicator* marks episodes that have at least one ED visit assigned to the post-trigger window which is included in episode spend according to section 4.4. ED visits are identified based on an outpatient claim detail line with an ED

revenue code in the input field *Revenue Code*. The configuration file lists the ED revenue codes under "ED Indicator".

  - *PAP Quality Metric 5* is expressed as a percentage for each Quarterback based on the following ratio:
    - Numerator: Number of valid episodes of the *PAP ID* with *Quality Metric 5 Indicator*
    - Denominator: Number of valid episodes of the *PAP ID*

- **Ultrasound imaging (Quality Metric 6 – rate provided for comparison only):**
  - *Quality Metric 6 Indicator* marks episodes that have a professional or outpatient claim detail line with a CPT/HCPCS code for ultrasound imaging in the input field *Detail Procedure Code*, as listed in the configuration file under "Ultrasound Imaging" and is assigned to the episode window and included in episode spend according to section 4.4.
  - *PAP Quality Metric 6* is expressed as a percentage for each Quarterback based on the following ratio:
    - Numerator: Number of valid episodes of the *PAP ID* with *Quality Metric 6 Indicator*
    - Denominator: Number of valid episodes of the *PAP ID*
- **Non-Ultrasound imaging (Quality Metric 7 – lower rate indicative of better performance):**
  - *Quality Metric 7 Indicator* marks episodes that have a professional or outpatient claim detail line with a CPT/HCPCS code for non-ultrasound imaging in the input field *Detail Procedure Code*, as listed in the configuration file under "Non-Ultrasound Imaging" and is assigned to the episode window and included in episode spend according to section 4.4.
  - *PAP Quality Metric 7* is expressed as a percentage for each Quarterback based on the following ratio:
    - Numerator: Number of valid episodes of the *PAP ID* with *Quality Metric 7 Indicator*
    - Denominator: Number of valid episodes of the *PAP ID*
- **Incision and drainage (Quality Metric 8 – rate provided for comparison only):**
  - *Quality Metric 8 Indicator* marks episodes that have an inpatient claim, an outpatient claim detail line, or a professional claim detail line with an ICD-9/ICD-10/CPT/HCPCS procedure code for incision and drainage in the input field *Header Surgical Procedure* Code or *Detail Procedure Code* during the episode window. See

the configuration file under “Incision and Drainage” for the list of codes. The ICD-9 or ICD-10 procedure code can be in any field.

- *PAP Quality Metric 8* is expressed as a percentage for each Quarterback based on the following ratio:
  - Numerator: Number of valid episodes of the *PAP ID* with *Quality Metric 8 Indicator*
  - Denominator: Number of valid episodes of the *PAP ID*

5.9 CALCULATE GAIN/RISK SHARING AMOUNTS

This episode follows the process described in section 4.9.

6 Glossary

- **Claim types:** Claim type is defined as follows:

Claim type	Claim form	Type of Bill	HCPCS
Long-term care	UB-04	21x, 66x, 89x	
Home Health	UB-04	32x, 33x, 34x	
Inpatient	UB-04	11x, 12x, 18x, 41x, 86x	
Outpatient	UB-04	13x, 14x, 22x, 23x, 71x-77x, 79x, 83x-85x	
Transportation[1]	CMS-1500		A0000 - A0999, G0240, G0241, P9603, P9604, Q0186, Q3017, Q3020, R0070, R0075, R0076, S0209, S0215, S9381, S9975, S9992, T2001 - T2007, T2049
DME[2]	CMS-1500		A4206 - B9999, C1000 - C9899, E0100 - E8002, G0025, J7341 - J7344, K0001 - K0899, P9044, Q0132, Q0160, Q0161, Q0182 - Q0188, Q0480 - Q0506, Q2004, Q3000 - Q3012, Q4001 - Q4051, Q4080, Q4100 - Q4116, Q9945 - Q9954, Q9958 - Q9968, S0155, S0196, S1001 - S1040, S3600, S4989, S5002, S5010 - S5025, S5160 - S5165, S5560 - S5571, S8002, S8003, S8060, S8095 - S8490, S8999, S9001, S9007, S9035, S9055, S9434, S9435, T1500, T1999, T2028, T2029, T2039, T2101, T4521 - T5999, V5336
Professional[3]	CMS-1500		
Pharmacy	NCPDP		

1. The entire claim is defined as transportation if one or more of the detail lines has one of these HCPCS codes.

2. The entire claim is defined as DME if one or more of the detail lines has one of these HCPCS codes.

3. Professional claims are defined as CMS-1500 claims not defined as transportation or DME.

- **Count of claims and claim detail lines by care category:** Based on the claim's care category, the claim count will either be at the claim level or at the claim detail level. Please note that total claim counts for an episode and summation of claim counts for all care categories will differ (summation of claim counts for all care categories is always going to be same or higher than claim counts for an episode) with this method. The breakdown is below.
  - Claim-specific care categories

Inpatient facility

Pharmacy

  - Claim detail line-specific care categories

Emergency department or observation

Outpatient facility

Inpatient professional

Outpatient laboratory

Outpatient radiology

Outpatient professional

Other

- **CPT:** Current Procedural Terminology
- **DBR:** Detailed Business Requirements
- **Duration of time windows:** The duration of a time window (e.g., the episode window, the trigger window), the duration of a claim or claim detail line, and the length of stay for inpatient stays is calculated as the last date minus the first date plus one (1). For example:
  - A trigger window with a *Trigger Window Start Date* of January 1, 2014 and a *Trigger Window End Date* of January 1, 2014 has a duration of one (1) day.

- A trigger window with a *Trigger Window Start Date* of January 1, 2014 and a *Trigger Window End Date* of January 3, 2014 has a duration of three (3) days.
- A claim with a *Header From Date Of Service* of January 1, 2014 and a *Header To Date of Service* of January 2, 2014 has a duration of two (2) days.

- **Episode window:** See sections 4.3 and 5.3.
- **Exclusion hierarchy**

Hierarchy	Exclusion name	Exclusion used in report
1	Age	Patient below or above age thresholds
2	Inconsistent enrollment	Patient was not continuously enrolled during episode window
3	Third-party liability	Patient has third-party liability charges
4	Dual eligibility	Patient has dual coverage of primary medical services
5	Left against medical advice	Patient has a discharge status of “left against medical status”
6	Death	Patient died in the hospital during episode
7	Incomplete episodes	Episode data was incomplete
8	FQHC/RHC	Episode trigger occurred in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)
9	High outlier	Episode exceeds the high outlier threshold

10	Risk factor / comorbidity	Risk factor / comorbidity reference found

- **HIC3:** Hierarchical Ingredient Code at the third level based on the classification system by First Databank
- **Hospitalization:** A hospitalization is defined as all the inpatient claims a patient incurs while being continuously hospitalized in one or more inpatient facilities. A hospitalization may include more than one inpatient claim because the inpatient facility may file interim inpatient claims and/or because the patient may be transferred between two or more inpatient facilities. A hospitalization consisting of just one inpatient claim starts on the *Header From Date Of Service* and ends on the *Header To Date Of Service* of the inpatient claim. A hospitalization where two or more inpatient claims are linked together starts on the *Header From Date Of Service* of the first inpatient claim and ends on the *Header To Date Of Service* of the last inpatient claim in the hospitalization. Inpatient claims are linked together into one hospitalization consisting of two or more inpatient claims if any of the following conditions apply:
  - Interim billing or reserved/missing discharge status: An inpatient claim with a *Patient Discharge Status* that indicates interim billing (see the configuration file under "Hospitalization – Interim Billing" for the codes used), that is reserved (see the configuration file under "Hospitalization – Reserved" for the codes used), or that is missing is linked with a second inpatient claim into one hospitalization if either of the following conditions apply:
    - There is a second inpatient claim with a *Header From Date Of Service* on the same day as or the day after the *Header To Date Of Service* of the first inpatient claim
    - There is a second inpatient claim with an *Admission Date* on the same day as the *Admission Date* of the first inpatient claim and also a *Header From Date Of Service* on the same day as or within thirty (≤ 30) days after the *Header To Date Of Service* of the first inpatient claim
  - Transfer: An inpatient claim with a *Patient Discharge Status* indicating a transfer (see the configuration file under "Hospitalization – Transfer" for the codes used) is linked with a second inpatient claim into one hospitalization if there is a second inpatient claim with a *Header From Date Of Service* on the same day as or the day after the *Header To Date Of Service* of the first inpatient claim.

- If the second inpatient claim (and potentially third, fourth, etc.) also has a *Patient Discharge Status* indicating interim billing, reserved, missing, or transfer the hospitalization is extended further until an inpatient claim with a discharge status other than interim billing, reserved, missing, or transfer occurs, or until the inpatient claim that follows does not satisfy the required conditions. If any claim has a *Patient Discharge Status* indicating discharge to home (see the configuration file under "Discharge To Home" for the codes used), the hospitalization is terminated.

- **ICD-9:** International Classification of Diseases, Ninth Revision
- **ICD-10:** International Classification of Diseases, Tenth Revision
- **Member Age:** The output field *Member Age* reflects the patient's age in years at the episode trigger. *Member Age* is calculated as the difference in years between the start of the claim that is used to set the *Professional Trigger Claim ID* or *Facility Trigger Claim ID* and the date of birth of the patient. The start of the claim is determined using the input field *Header From Date Of Service* for inpatient claims and the earliest *Detail From Date Of Service* across all claim detail lines for outpatient and professional claims. The date of birth of the patient is identified by linking the *Member ID* of the patient in the episode output table to the *Member ID* of the patient in the Member Extract and looking up the date in the input field *Date of Birth*. *Member Age* is always rounded down to the full year. For example, if a patient is 20 years and 11-months old at the start of the episode, the *Member Age* is set to 20 years. If the *Date of Birth* is missing, greater than (>) 100 years, or less than (<) 0 years, then the output field *Member Age* is treated as invalid.
- **PAP:** Principal Accountable Provider
- **Post-trigger window:** See sections See sections 4.3 and 5.3
- **Pre-trigger window**: See sections See sections 4.3 and 5.3
- **Reporting care categories:** The reporting care categories used, in hierarchical order, are:

Bill Form	Reporting Care Category	Definition	Additional Comments
UB-04	Inpatient facility	Bill Types: 11X, 12X, 18X, 41X, 86X	To include all services provided during an inpatient

			facility stay including room and board, recovery room, operating room, and other services.
UB-04	Emergency Department or Observation	Bill Types: 13X, 14X, 22X, 23X, 73X-77X, 79X, 83X-85X AND (Revenue code 045x, 0760, 0761, 0762, 0769 OR CPT 99281-99285, 99291-99293 OR Place of service = 23)	To include all services delivered in an Emergency Department or Observation Room setting including facility and professional services.
UB-04	Outpatient facility	Bill Types: 13X, 14X, 22X, 23X, 73X-77X, 79X, 83X-85X and NOT Emergency Department	To include all services delivered by a facility during an outpatient surgical encounter, including operating and recovery room and other services.
CMS-1500	Inpatient professional	Place of service = 21	To include services delivered by a professional provider during an inpatient hospital stay, including patient visits and consultations, surgery, and diagnostic tests.
UB-04/CMS-1500	Outpatient laboratory	Place of service = 81 OR Revenue codes 030x	To include all laboratory services in an inpatient,

		OR CPT/HCPCS 80048-88399, G0306,G0307, G0431-G0434, G9143, P codes	outpatient, or professional setting.
UB-04/CMS-1500	Outpatient radiology	Revenue code 035x, 061x, 040x, 032x OR CPT 70010-79999 or HCPCS C8906, C8903, C8907, C8904, C8908, C8905, S8042	To include all radiology services such as MRI, X-Ray, CT, and PET scan performed in an inpatient, outpatient, or professional setting.
CMS-1500	Outpatient professional	Any remaining, non-categorized CMS 1500 claims (excluding DME and transportation)	To include uncategorized professional claims such as evaluation and management, health screenings, and specialists visits.
UB-04/CMS-1500	Other	Any remaining, non-categorized claims	To include DME, transportation, home health, and any remaining uncategorized claims.
NCPDP post adjudication 2.0	Pharmacy		To include any pharmacy claims billed under the pharmacy or medical benefit with a valid National Drug Code.

- **Total episodes:** All episodes, valid plus invalid
- **Trigger window:** See sections See sections 4.3 and 5.3

- **Valid episodes:** See sections 4.6 and 5.6
- **Visit:** A visit is defined as all claim detail lines of professional claims for which the following conditions are met:
  - Same detail line start date
  - Same claim type
  - Same billing provider
  - Same rendering provider

  Claim detail lines that have the same detail line start date, same claim type, a missing billing provider, and a missing rendering provider, are treated as part of the same visit.

  The duration of a visit is defined as the minimum detail line start date to the maximum detail line end date of detail lines that are part of the visit.