



Quality Reporting
Numerator
Data Specifications and Requirements

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Supported Data Formats

Data Type	Description	Numerator
Quality Data Codes (QDC)	QDC codes may be added to medical claims to indicate quality measure performance. If your 837 Claims or PM Data File include QDC codes, MIPS Solutions can use them to calculate measure performance for Registry quality reporting.	✓
QRDA III – EHR Measure Summary	Quality Reporting Document Architecture (QRDA) III files are generated from your Certified EHR Technology (CEHRT). QRDA Category III files provide aggregated data for electronic Clinical Quality Measures (eCQMs, AKA “EHR measures”). CEHRTs calculate quality measure data using annually updated eCQM measures specifications.	✓
QRDA I – CDA Clinical Patient-level Files	Quality Reporting Document Architecture (QRDA) I files are generated from your Certified EHR Technology (CEHRT) for Electronic Clinical Quality Measures (eCQMs). QRDA-I files contain specific patient-level data that may be used to determine performance for a limited set of Registry quality measures.	✓
CCD – CDA Clinical Patient-level Files	Continuity of Care Documents (CCD) are files that are used in Health Information Exchange. They are a “snapshot” of patient chart information and may contain data that could be used to calculate a limited set of quality measures.	✓
Clinical Data Extract	Clinical reports are generated from the clinical system, usually an EHR, using reporting modules or queries to extract data. Mingle Health will then translate the raw clinical data into quality measure performance.	✓
Performance Spreadsheet	Performance Spreadsheets (AKA “Performance Files”) are Excel spreadsheets listing eligible patient visits for selected measures. Spreadsheets can be download from MIPS Solutions. Using the CMS Specifications and Mingle Health Performance Guides, you determine performance for the given eligible instance. Completed Performance Spreadsheets are uploaded and used to calculate measure performance and quality scores.	✓

Clinical File Specification

Summary

Mingle Health can use clinical data exported from Electronic Health Record (EHR) systems to automatically calculate quality measure performance. This specification defines the file structure and content required for the best results. Not all the required data may be available from your EHR. Your Quality Program Consultant will help identify the specific required data (Clinical Concepts) needed for your selected measures.

File Requirements

Clinical data files should be exported as comma-separated (.csv) and Text (.txt) and is the **preferred** file format. Excel (.xlsx) files are also accepted with the caveat the data is formatted correctly.

- Be aware the amount of data may exceed Excel row limits resulting in data loss.
- Column headers should be unfrozen.
- All columns should be unhidden.
- All extra, blank, or formatted rows should be removed.
- Avoid dragging numeric values that autofill cells
- Report formats (e.g. .rpt or .pdf) cannot be processed.
- Cannot use word wrapping
- Should not use the 1904 date system (File/Options/Advanced/When calculating this workbook: unchecked)

Extra fees may apply if files require modification by Mingle Healthcare Solutions. You will be notified before any modifications are performed.

Patient Identifiers

Patient clinical data must be matched to denominator (X12 837 claims or Practice Management file) data using a patient unique identifier. Medical Record Number (MRN) or some other identifier, unique by patient, must be provided to match the patient's clinical and denominator data.

If a matching identifier cannot be provided between the denominator and clinical data, Mingle Health can create one for each patient. The patient's first name, patient's last name, and patient's date of birth (DOB) are required in both the denominator and clinical data to create unique identifiers. Names and birthdates must match between the denominator and clinical data.

Table 1 - Clinical File Data Elements

Field	Date Type (length)	Description
Patient Identifier MRN/XID	alphanumeric (50)	Unique identifier for matching clinical data to denominator data • XID: other unique identifier • See Patient Identifier details above
Patient First Name	alphanumeric (50)	Patient's given first name
Patient Last Name	alphanumeric (50)	Patient's last name
Patient DOB	date (10)	Patient date of birth (mm/dd/yyyy) • Alternate acceptable formats for date of birth: yyyy/mm/dd and yyyymmdd. • Two-digit years cannot be processed.
Name	alphanumeric (200)	Primary medical information (i.e. medication name, procedure name, problem name) Example: Fracture of upper end of tibia
Description	alphanumeric (250)	Free-text details or description Example: Pt sts fell off the stairs
Code	alphanumeric (100)	Code related the Name field Example: S82.1
Codesys	alphanumeric (100)	Coding system for the Code field (ICD-10, SNOMED-CT, RXNORM, LOINC, etc.) • NDC codes cannot be processed Example: ICD-10
Category	alphanumeric (100)	Clinical category; Medication, Problem, Vitals, Lab Result, Social History, Medical History, Surgical History, Family Medical History*, Order, Procedure, Immunization, Referral • Family Medical History should be omitted if possible Example: "Fracture of upper end of tibia" is Problem
Status	alphanumeric (200)	Medical status (active, completed, transitioned, etc.) Example: If the problem is current and medically relevant, it is Active
Textresult	alphanumeric (250)	Text results Examples; positive, clear, yes
Numresult	numeric (32)	Numeric result

Field	Date Type (length)	Description
Units	alphanumeric (75)	Unit type for Numresult Examples; %, mg/dl, lb
Clinical Date	datetime (75)	Start or onset date
Complete Date	datetime (75)	Date Completed Examples; end of a medication course date, end of a problem episode date
Entry Date	datetime (75)	Date the record was documented in the EHR
Order Date	datetime (75)	Date the order was written (i.e. The date that an evaluation is prescribed).
Medication Strength	numeric (50)	Strength of a medication (i.e. 200 for Acetaminophen 200mg • Medication records only
Medication Strength Units	alphanumeric (50)	Units of the medication. For Acetaminophen 200mg, the value in this field is mg. • Medication records only
Dispense Number	numeric (200)	Number of units dispensed Example: 30 {tabs} • Medication records only
Sig	alphanumeric (250)	Directions for medication administration Example: Take 1 pill by mouth daily • Medication records only
Sig Number	alphanumeric (50)	Number of units per dose Example: 1 {pill} • Medication records only
Sig Freq	numeric (50)	Frequency to take this medication Example: daily • Medication records only
Ordering Provider NPI	numeric (10)	NPI number of the provider ordering medication • Medication records only
Refill Times	numeric (200)	Number of refills for a medication • Medication records only

Table 2 - Example: Medication

Patient Identifier MRN/XID	Patient First Name	Patient Last Name	Patient DOB	Name	Description	Code	Codesys	Category	Status	Textresult	Numresult	Units	Clinical Date	Complete Date	Entry Date	Order Date	Medication Strength	Medication Strength Units	Dispense Number	Sig	Sig Number	Sig Freq	Ordering Provider NPI	Refill Times
1234567	Jane	Doe	06/01/1955	Metoprolol Succinate ER 100 MG Oral Tablet XR	For elevated BP	866412	RXNORM	Medication	Active	-	-	-	08/08/2018	-	08/05/2018	08/05/2018	100	-	30	TAKE 1 TABLET DAILY BY MOUTH	1	q	1230000000	MG

Table 3 - Example: Vitals

Patient Identifier MRN/XID	Patient First Name	Patient Last Name	Patient DOB	Name	Description	Code	Codesys	Category	Status	Textresult	Numresult	Units	Clinical Date	Complete Date	Entry Date	Order Date	Medication Strength	Medication Strength Units	Dispense Number	Sig	Sig Number	Sig Freq	Ordering Provider NPI	Refill Times
1234567	Jane	Doe	06/01/1955	BMI	Body Mass Index	39156-5	LOINC	Vitals	Active	-	28	kg/m²	08/05/2020	-	08/05/2020	-	-	-	-	-	-	-	-	-

Table 4 - Example: Orders

Patient Identifier MRN/XID	Patient First Name	Patient Last Name	Patient DOB	Name	Description	Code	Codesys	Category	Status	Textresult	Numresult	Units	Clinical Date	Complete Date	Entry Date	Order Date	Medication Strength	Medication Strength Units	Dispense Number	Sig	Sig Number	Sig Freq	Ordering Provider NPI	Refill Times
1234567	Jane	Doe	06/01/1955	HbA1c (Bld) [Mass fraction]	Hemoglobin A1c/ Hemoglobin.total in Blood	4548-4	LOINC	Laboratory Orders	Active	-	5.3	%	08/08/2020	-	08/05/2020	08/05/2020	-	-	-	-	-	-	1230000000	-

Table 5 - Example: Clinical Concept

Measure# / Description	Concept	Concept Description	Element Priority	Specification	EHR Source	Code System	Clinical File Specification	Begin-End Date	Specification Note
001 / Diabetes, HbA1c Poor Control	Hemoglobin a1c	Hemoglobin a1c, including numeric results	Required	Numerator	Results or Findings	LOINC	Clinical Observations	1/1/2020-12/31/2020	Include problems that were active anytime between the Begin Date and the End Date, even if they were first noted before the Begin Date or are discontinued at the time of reporting. Include text or numeric results and result units, as applicable.
001 / Diabetes, HbA1c Poor Control	Hospice or Palliative Care	Hospice or palliative care	Recommended	Exclusion	Problems or Medical History	SNOMED or ICD-10	Clinical Observations	1/1/2020-12/31/2020	Include problems that were active anytime between the Begin Date and the End Date, even if they were first noted before the Begin Date or are discontinued at the time of reporting. Include text or numeric results and result units, as applicable.

Data Validation Process for Numerator Data

