**20 December 2018**

TRICARE Dental Program (TDP)

for the

MHS Data Repository (MDR)

United Concordia Companies, Inc. (UCCI)

(Version 2.00.00)

Current Specification

**Revision History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version** | **Date**  | **Para/Tbl/Fig** | **Originator** | **Description of Change** |
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 | A. Hong |  |

**TRICARE Dental Program (TDP) Processing for the MDR**

1. Sources

The source data files used to create the MDR TRICARE Dental Program files are provided according to the TDP contracts, via Secure FTP. These data represent claims for care provided to beneficiaries enrolled in the TRICARE Dental Program. A separate TDP Provider file is also sent to the MDR, containing detail information for TDP providers, and is maintained separately from the main TDP claims file.

1. Transmission (Format and Frequency)

Source files are provided on a monthly basis. Data are to be provided no later than the 15th calendar day of each month reflecting the previous month’s claims activity. If data have not been provided within 7 business days of the expected date of delivery, DHSS shall contact the TDP Program Manager or designee. The format of the data is described in the Interface Control Document (ICD).

1. Organization and batching

The MDR TDP files are stored as fiscal year files, in SAS format. Each month’s process incorporates new (and updated) records received from the TDP contractor that month. Each MDR TDP file that has been made available to users shall be archived and made available to authorized users per special request of the functional proponent. Raw files will also be archived and made available as needed.

Source Data: The first step in MDR processing is to store the raw files in

**/mdr/raw/dental/tdp/claims/** **dyymmdd.txt.Z** and

**/mdr/raw/dental/tdp/provider/d*yy*mmdd.txt.Z**

where “yymmdd” represents the date of the file. Raw batches must be made available (and remain available) to the staff at TMA that will process the raw data.

Output Products: The MDR TDP processor produces the files described in table 1. The preparation of them is described in subsequent sections of this document.

**Table 1: MDR TDP Processor Output Products**

|  |  |  |
| --- | --- | --- |
| **MDR ADDP File** | **File Naming Convention** | **Member Name** |
| TDP Claims File  | /mdr/pub/dental/tdp3/claims/fy\*\* | fy\*\*.sas7bdat |
| TDP Provider File | /mdr/pub/dental/tdp3/provider | Providers.sas7bdat |

Archival of files is also required, so that corresponding “apub” and other files (i.e., log, aprod, etc) are also loaded into the MDR according to routine operating procedures.

1. Receiving Filters

By the 15th calendar day of each month, the TDP contractor shall provide the MDR with a file containing all records altered or newly created during the previous month. In other words, the feed files will include new records, as well as adjustments to records previously sent.

1. Update Procedures

Within a file of records, there will be updated claims to those received in the previous month’s file. Therefore, updating the TDP data consists of two parts, once to the records within the raw monthly file and once to the appended master dataset:

* Within the raw monthly file, the adjustments within the monthly file must be handled first.
	+ Adjustments are identified by “CLAIMID LINENUM CLMPDDT”
	+ Adjustments must be collapsed into one record and the billed, allowed, paid and OHI amounts should be summed.
	+ Header information should be taken from the last record “if last.linenum” after being sorted by “CLAIMID LINENUM ENDDATE CLMPDDT”
* Separate the records by fiscal year and then append all of the records from the current file to the corresponding fiscal year master database and then the master database needs to be updated:
	+ identify adjustments by “CLAIMID LINENUM ENDDATE CLMPDDT”
	+ Adjustments must be collapsed into one record and the billed, allowed, paid, OHI and patpay amounts should be summed.
	+ Header information should be taken from the last record “if last.linenum” after being sorted by “CLAIMID LINENUM ENDDATE CLMPDDT”
	+ Only retain records where the record where the “Claim Line Rejection Reason Code” (LINEREJ = ‘’) is blank/null.
1. Field Transformations, Deletions, and File Types for MDR Core Databases

There are three different types of data elements available in the TDP files. There are data elements that are:

* Read in and retained from the TDP data feeds, or
* Derived from data provided in the TDP feeds, or
* Derived as a result of merges to external files.

The external merges should be applied to the entire database each processing cycle. These merges and associated merge keys are described in Table 2.

**Table 2: TDP Data Merges**

| **Merge** | **Date Matching** | **Additional Matching** |
| --- | --- | --- |
| NPPES | N/A | NPI |
| Master Person Index | N/A | See VM-6 Specifications |
| Longitudinal VM6 File | End Date of Care on record | EDI\_PN if available |
| Omni-CAD | FY/FM of end date of care, FY/FM of MDR Omni CAD | Subscriber ZIP code & sponsor Service; Also based on provider ZIP code |
| DMIS ID Index | FY | Enrollment Site |
| Dental Weighed Value Unit Table | FY (before 1/1/2016) or CY (starting 1/1/2016) of end date of service with DWV Tables | CDT / Modifier & Procedure Code / Modifier |
| Relative Value Unit Table | Calendar year of begin date of care with calendar year of RVU Table | CDT / Modifier & Procedure Code / Modifier |

1. Record Layout and Content

**MDR TDP Claims**: The MDR TDP Claims files are stored as SAS data sets, in separate fiscal year files. Table 3 below describes the format, file layout, and field derivation rules for the master TDP file.

**Table 3: TDP Claims Data File Layout**

| **Variable Name** | **SAS Name** | **Format** | **Input Position in Source Feed** | **Business Rule** |
| --- | --- | --- | --- | --- |
| Sponsor SSN | RSPONSSN | $9. | 1 | No transformation |
| EDI\_PN | REDI\_PN | $10. | 10 | No transformation |
| Raw Relationship Code | RELCODE\_R | $1. | 20 | No transformation |
| Type of Contract | CONTTYPE | $1. | 21 | No transformation |
| Patient Date of Birth  | PATDOB | $8. | 22 | No transformation |
| Raw Branch of Service | SVC | $1. | 30 | No transformation |
| Components | COMPONT | $1. | 31 | No transformation |
| Performing Provider ID | PROVID | $9. | 55 | No transformation |
| Provider Tax ID | TAXID | $9. | 64 | No transformation |
| National Provider ID | NPI | $10. | 73 | No transformation |
| Performing Provider Zip Code | PROVZIP | $5. | 83 | No transformation |
| Performing Provider Specialty | PROVSPEC | $3. | 88 | No transformation |
| Provider Network Status | NETWORK | $1. | 91 | No transformation |
| Provider Degree | PROVSUFF | $4. | 92 | No transformation |
| Billing Provider ZIP | BILLZIP | $5. | 96 | No transformation |
| Claim Number | CLAIMID | $13. | 101 | No transformation |
| Claim Line-Item Number | LINENUM | $4. | 114 | No transformation |
| Line-Item Final Status | FINSTAT | $1. | 118 | No transformation |
| Line-Item Rejection Reason | LINEREJ | $1. | 119 | No transformation |
| Special Processing Code | SPC | $2. | 120 | No transformation |
| Alternate Treatment Code | ALTTREAT | $2. | 122 | No transformation |
| Benefit Category | BENEFIT | $35. | 124 | No transformation |
| End Date of Service | ENDDATE | $8. | 159 | No transformation |
| Claim Receipt Date | CLMRECDT | $8. | 167 | No transformation |
| Claim Paid Date | CLMPDDT | $8. | 175 | No transformation |
| Claim Finalized date | CLMFINDT | $8. | 183 | No transformation |
| Date of Last Exam | LASTEXAM | $8. | 191 | No transformation |
| Accident Indicatory | ACCIDENTIND | $1. | 199 | No transformation |
| CDT Procedure Code 1 | CDT | $5. | 200 | No transformation |
| CDT Version | CDTVERS | $2. | 205 | No transformation |
| Adjustment Reason Code | ADJREAS | $2. | 207 | No transformation |
| Adjustment Code | ADJCODE | $1. | 209 | No transformation |
| Original Line-Item Number | ORIGLINENUM | $4. | 210 | No transformation |
| Tooth Code 1 | TOOTH1 | $2. | 214 | No transformation |
| Tooth Code 2 | TOOTH2 | $2. | 216 | No transformation |
| Tooth Code 3 | TOOTH3 | $2. | 218 | No transformation |
| Tooth Code 4 | TOOTH4 | $2. | 220 | No transformation |
| Anterior / Posterior Indicator 1 | AP\_ID1 | $1. | 222 | No transformation |
| Anterior / Posterior Indicator 2 | AP\_ID2 | $1. | 223 | No transformation |
| Anterior / Posterior Indicator 3 | AP\_ID3 | $1. | 224 | No transformation |
| Anterior / Posterior Indicator 4 | AP\_ID4 | $1. | 225 | No transformation |
| First Treated Tooth Surface | SURFACE1 | $5. | 226 | No transformation |
| Second Treated Tooth Surface | SURFACE2 | $5. | 231 | No transformation |
| Third Treated Tooth Surface | SURFACE3 | $5. | 236 | No transformation |
| Fourth Treated Tooth Surface | SURFACE4 | $5. | 241 | No transformation |
| Quadrant | QUADRANT | $2. | 246 | No transformation |
| Provider Charge | BILL | 8. | 248 | See Update Procedures (V.) |
| Allowed Amount | ALLOW | 8. | 257 | See Update Procedures (V.) |
| Approved Amount | PAID | 8. | 266 | See Update Procedures (V.) |
| Other Carrier Payment | OHI | 8. | 275 | See Update Procedures (V.) |
| Prior Placement Date | PRIORPLACE | $8. | 284 | No transformation |
| Ortho Indicator | ORTHO | $1. | 292 | No transformation |
| Treatment Type | TRMTTYPE | $1. | 293 | No transformation |
| Dental Readiness Classification | DRC | $1. | 294 | No transformation |
| Pay Grade | PAYGRD | $3. | 295 | No transformation |
| **Internally Derived Fields** |
| ACV GROUP | ACVGROUP | $2. | N/A | If begin date is >=1/1/2018 then:f enr\_grp is “P” then set to “PR” elseif enr\_grp is “L” then set to “PL” elseif enr\_group=”U” then set to “DP” elseif (bencat common=4 and pcm\_type=N) then “R” elseif pcm\_type=”O” then “R” elseif elg\_grp in (“R” “S”) then “O” else “O”For logic prior to Jan 2018, see appendix A |
| Age Group | AGEGRP | $1. | N/A | If 0 le patage <= 4 then set to “A”, else if patage<=14 then set to “B”, else if patage<=17 then set to “C”, else if patage<=24 then set to “D”, else if patage<=34 then set to “E”, else if patage<=44 then set to “F”, else if patage<=64 then set to “G”, else if patage not blank or negative set to “H”, else set to “Z” |
| Change Date (MDR) | CHGDATE | $8. | N/A | Set to the most recent date that any data element on the MDR record was changed. For records that never change, this will be equal to the initial processing date. |
| Calendar Month | CM | $2. | N/A | Characters 5 and 6 of the end date of care. |
| Beneficary Category Common | COMBEN | $1. | N/A | Derived from BENCAT:4 = ACT, GRD1 = DA, DGR2 = RET3 = All others |
| Calendar Year | CY | $4. | N/A | Characters 1-4 of the end date of care.  |
| Extract Date | EXTR\_DT | $7. | N/A | Set to date the raw data is extracted: dyymmdd |
| Fiscal Month | FM | $2. | N/A | Fiscal month equivalent of calendar month of end date of care |
| Fiscal Year | FY | $4. | N/A | Fiscal year equivalent of calendar year of end date of care |
| New Record Flag | NEW\_REC | $1. | N/A | Set to 1 if this version of the record was received in most recent processing cycle. Otherwise, set to 0. |
| Paid Calendar Month | PAIDCM | $2. | N/A | From CLMPDDT |
| Paid Calendar Year | PAIDCY | $4. | N/A | From CLMPDDT |
| Paid Fiscal Month  | PAIDFM | $2. | N/A | Derive from CLMPDDT |
| Paid Fiscal Year | PAIDFY | $4. | N/A | Derive from CLMPDDT |
| Patient Age | PATAGE | 8. | N/A | Calculated as age in completed years from variables PATDOB and ENDDATE. |
| Patient Paid Amount - Derived | PATPAY | 8. | N/A | Calculate as follows:if network = 1 then patpay = (allow)-(paid)-(ohi)if network = 1 or if network is blank/null then patpay = (bill)-(paid)-(ohi) |
| Initial Processing Date (MDR) | PROCDATE | $8. | N/A | Set to initial date that this record was prepared for the MDR. |
| Number of Services | SVCS | 8. | N/A | et number of services to the number of teeth populated in tooth1-tooth4 for each record |
| **NPPES Merge** |
| Provider Specialty, HIPAA | HIPAASPEC | $10. | N/A | Match by NPI |
| **MDR Dental Weighted Value Table Merge** |
| Dental Weighted Value | DWV | 8. | N/A | Match to DWV tables based on CDT and either FY or CY to retrieve DWV. For date matching, use FY tables before 1/1/2016 and CY table DWVs starting 1/1/2016. Use FY15 DWV table for the 10/2015-12/2015 period.  |
| **MDR Relative Value Unit Table Merge** |
| Facility Practice Expense RVU | FACPERVU | 8. | N/A | Match to RVU table based on CDT and CY and retrieve practice expense RVU (Facility)  |
| Non-facility Practice Expense RVU | NFPERVU | 8. | N/A | Match to RVU table based on CDT and CY and retrieve practice expense RVU (Non-facility)  |
| Work RVU | RVU | 8. | N/A | Match to RVU table based on CDT and CY and retrieve purchased care work RVU |
| **Master Person Index Merge** |
| DEERS Person ID - Derived | EDIPN | $10. | N/A | See MPI specification |
| Person Association Reason Code | PARC | $2. | N/A | See MPI specification |
| Patient Gender - Derived | PATSEX | $1. | N/A | See MPI specification |
| Sponsor SSN - Derived | SPONSSN | $9. | N/A | See MPI specification |
| **Longitudinal DEERS File Merge** |
| DEERS Alternate Care Value | ACV | $1. | N/A | Fill with ACV from LVM, if the begin date of care on the claim is between the begin and end date associated with the ACV. See VM-6 Specification, Sections G18 and 19 for segment and field positions. BLANK FILL JAN1, 2018 and later |
| DEERS Beneficiary Category | BENCAT | $3. | N/A | Fill with DEERS beneficiary category from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS beneficiary category. If no match for the person, set to “UNK” See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| DEERS Zip Code | DEERSZIP | $5. | N/A | Fill with DEERS ZIP code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS ZIP code. See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| DEERS Enrollment DMIS ID | DENRSITE | $4. | N/A | Fill with enrollment DMISID from LVM, if the begin date of care on the claim is between the begin and end date associated with the enrollment site. See VM-6 Specification, Sections G18 and 19 for segment and field positions  |
| Dental HCDP Flag | DHCDP\_FL | $1. | N/A | IF the HCDP code from LVM is dental and the encounter date is within the Dental HCDP begin and end date, the patient is eligible (Y) if not the patient is not eligible (N). See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| DEERS Sponsor Service | DSPONSVC | $1. | N/A | Fill with DEERS sponsor service from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS sponsor service. See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| DEERS Sponsor Service Aggregate | DSVCAGG | $1. | N/A | Fill with DEERS sponsor service (aggregate) from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS sponsor service (aggregate). See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| DEERS Ethnicity Code | ETHNIC | $1. | N/A | Fill with DEERS ethnicity code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS ethnicity code. See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| DEERS Health Care Delivery Program Code - Enrolled | HCDP | $3. | N/A | Fill with DEERS HCDP code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS HCDP code. See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| DEERS Medicare Flag | MEDFLAG | $1. | N/A | Fill with DEERS medicare flag from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS medicare flag. See VM-6 Specification, Sections G18 and 19 for segment and field positions  |
| PCM ID | PCMID | $32. | N/A | Fill with PCM ID from LVM, if the begin date of care one the claim is between the begin and end date associated with the PCM ID. See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| DEERS Medical Privilege Code | PRIVCODE | $1. | N/A | Fill with DEERS privilege code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS privilege code. See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| DEERS Race Code | RACE | $1. | N/A | Fill with DEERS race code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS race code. See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| DEERS Relationship to Sponsor | RELCODE | $1. | N/A | Fill with DEERS relationship to sponsor code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS relationship to sponsor code. See VM-6 Specification, Sections G18 and 19 for segment and field positions  |
| DEERS HCDP - ASSIGNED | HCDP\_ASSGN | $3. | N/A | Fill with asgn\_hcdp\_plan\_cvg\_cd from LVM, if the begin date of care on the claim is between the begin and end date associated with the segment. See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| ENROLLMENT GROUP | ENR\_GRP | $1. | N/A | Fill with d\_enr\_grp\_cd code from LVM, if the begin date of care on the claim is between the begin and end date associated with the segment. See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| ELIGIBILITY GROUP | ELG\_GRP | $1. | N/A | Fill with d\_elg\_grp\_cd code from LVM, if the begin date of care on the claim is between the begin and end date associated with the segment. See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| PCM TYPE | PCM\_TYPE | $1. | N/A | Fill with d\_pcm\_type\_cd code from LVM, if the begin date of care on the claim is between the begin and end date associated with the segment. See VM-6 Specification, Sections G18 and 19 for segment and field positions |
| **MDR Omni-CAD Format File Merge Based On Subscriber ZIP Code** |
| Residence Catchment Area | CATCH | $4. | N/A | Based on matching FY, FM and ZIP Code; if dsvcagg=A then set equal to ACATCH, if dsvcagg = F then set equal to FCATCH; if dsvcagg in (M, N) then set equal to NCATCH, otherwise set equal to OCATCH. If ZIP code not found in MDR Omni-CAD, set equal to ‘0999’ |
| Residence Prism Area | PRISM | $4. | N/A | Based on matching FY, FM and ZIP code; if dsvcagg=A then set equal to APRISM, if dsvcagg = F then set equal to FPRISM; if dsvcagg in (M, N) then set equal to NPRISM, otherwise set equal to OPRISM. If ZIP code not found in MDR Omni-CAD, set equal to ‘0999’ |
| Residence Region | RESREG | $2. | N/A | MOD\_REG, based on matching FY, FM and ZIP code |
| Residence TNEX Region | RESTNEX | $1. | N/A | HSSCREG, based on matching FY, FM and ZIP code |
| Patient MTF Service Area | MTFSVCAREA | $4. | N/A | Based on matching FY, FM, zip and sponsor service; returns Service related MTF service area |
| Beneficiary T3 Region | BEN\_T3\_REG | $2. | N/A | T3\_REG, based on matching FY, FM and ZIP code |
| Beneficiary T2017 Region | BEN\_T17\_REG | $2. | N/A | T17\_REG, based on matching FY, FM and ZIP code |
| **MDR Omni-CAD Format File Merge Based On Provider ZIP Code** |
| Provider Catchment Area | PVCATCH | $4 | N/A | Based on matching FY, FM and PROVZIP; set to OCATCH. If PROVZIP not found in MDR Omni-CAD, set equal to ‘0999’ |
| Provider PRISM Area | PVPRISM | $4. | N/A | Based on matching FY, FM and PROVZIP; set to OPRISM. If PROVZIP not found in MDR Omni-CAD, set equal to ‘0999’ |
| Provider TNEX Region | PVTNEX | $1. | N/A | HSSCREG, based on matching FY, FM and PROVZIP |
| Provider MTF Service Area | PMTFSVCAREA | $4. | N/A | Based on matching FY, FM, PROVZIP; returns Other MTF Service Area |
| Provider T3 Region | PROV\_T3\_REG | $2. | N/A | T3\_REG, based on matching FY, FM and PROVZIP |
| Provider T2017 Region | PROV\_T17\_REG | $2. | N/A | T17\_REG, based on matching FY, FM and PROVZIP |
| **From DMIS ID Index Table** |
| Enrollment Site T3 Region | ENR\_T3\_REG | $2. | N/A | T3\_REG, based on matching FY and Enrollment Site |
| Enrollment Site T2017 Region | ENR\_T17\_REG | $2. | N/A | T3\_REG, based on matching FY and Enrollment Site |

**MDR TDP Provider**: The provider feed data is compared with the existing MDR TDP claims dataset each processing cycle, using the provider ID and most recent month of MDR claims data as the basis of comparison. If the provider ID is in the most recent month of the MDR claims data, the delete month and termination flag are set to blank. If the provider ID is in the existing MDR claims data in any month other than the most recent, the provider termination flag is set to ‘T’ and the delete month is set to the date of the last month of MDR claims data that the provider ID was present in. If the provider ID is not found in the MDR claims data, then the delete month is set to blank and the termination flag is set to ‘T’.

Table 3 describes the format and file layout for the TDP Provider file.

**Table 3: TDP Provider Data File Layout**

| **Variable Name** | **SAS Name** | **Format** | **Source Position** | **Business Rule** |
| --- | --- | --- | --- | --- |
| Provider Tax ID | TAXID | $9. | 1 | No transformation |
| Provider Identifier | PROVID | $18. | 10 | No transformation |
| Provider/Group Name | PROVGROUP | $53. | 28 | No transformation |
| Provider Specialty | PROVSPEC | $3. | 81 | No transformation |
| Provider Network Status | NETSTAT | $1 | 84 | No transformation |
| Provider Telephone Number | PROVTELNO | $23. | 85 | No transformation |
| Provider Street Address Line 1 | PROVADD1 | $50. | 108 | No transformation |
| Provider Street Address Line 2 | PROVADD2 | $50. | 158 | No transformation |
| Provider State | PROVST | $2. | 208 | No transformation |
| Provider ZIP Code | PROVZIP | $9. | 210 | No transformation |
| Provider Country | PROVCTRY | $3. | 219 | No transformation |
| National Provider Identifier | NPI | $10. | 221 | No transformation |
| **Internally Derived Fields** |
| Delete Month | DEL\_MNTH | YYYYMM | N/A | Last month of MDR claim data that the provider ID was present in; if not present set to blank |
| Last Claim Date | LAST\_CLM\_DT | YYYYMMDD | N/A | Last end date of MDR claim data that the provider ID was present in. |
| Provider Termination Flag | TERM\_FLG | $1 | N/A | Set to “T” if provider is terminated during file update process or not present in MDR claims data, else leave blank. |
| Processing Date | PROCDATE | YYYYMMDD | N/A | Set to initial date that this record was prepared for the MDR. |

1. Refresh Frequency

Frequency of updates, based on end date of care:

* Current and Prior FY: monthly
* All other FYs: twice a year in October and April.
* After 5 years old, stop processing back FYs
1. Data Quality

It is expected that when the TDP processor is run each month, that basic quality checks are performed. It is recommended that the DHSS vendor develop a spreadsheet which tracks key characteristics of the data across processing cycles; making it relatively easy to understand how the data should generally look. DHSS vendors need to review these statistics each month prior to releasing the data. DHCAPE (the functional proponent and the specification author) should be contacted immediately should any quality issues arise. These checks, at a minimum, should include:

* Total record counts in the claims and provider data feeds should be relatively stable across processing cycles. Any anomalies should immediately be investigated.
* The distribution of all categorical fields (ex. NETWORK, CDT) should be consistent. The results of proc freq analyses will verify this.
* The number of null values for important fields such as SPONSSN, EDIPN, PROVID should be tracked across monthly updates.
* When reading in the TDP claim and provider data feeds, a small number of records should be manually inspected to ensure they have been read in properly.
* Cross tabulations should be reviewed on derived elements to ensure the derivation logic works.
* A data flow tracker should be built to ensure that all records that are intended to make it into the final TDP datasets do. In other words, all inserts, updates, and deletions should be tracked and explained in the data flow worksheet.

**Appendix A:**  ACV Group

For time periods before Jan 1, 2018, ACV is derived as follows:

For FY03 and before:

If ACV = A, D, or E then “PR”

Else if ACV = G or L then “PL”

Else if ACV = U then “DP”

Else if Ben Cat Common = 4 then “R”

Else “O”

For FY04 and after:

If ACV = A, E, H, or J then “PR”

Else if ACV = B or F then “OP”

Else if ACV = G or L then “PL”

Else if ACV = U then “DP”

Else if ACV = R or V then “O”

Else if ACV = M or Q then “R”

Else if Ben Cat Common = 4 then “R”

Else “O”