**Episodes of Care File (Limited)**

The following data elements are available in the limited data set Episodes of Care file. Requesters must choose which data elements from this data set they are requesting, and justify the request for each individual element. Elements shaded in grey are recommended for all requests, as they are necessary to properly interpret duplicate claims lines. Requesters should request these elements by completing columns A-C; column D is pre-populated for these elements. If for any reason you do not wish to receive these recommended elements, delete the pre-populated justification in column D.

See Instructions tab for further instructions and information about recommended elements.

***Please Note:*** The Episodes of Care file contains All Medical Claims, All Pharmacy Claims and fields from the Medical Episode Grouper (MEG). MEG is a proprietary grouping algorithm that creates episodes that describe a patient's complete course of care for a single illness or condition. If you request the Episodes of Care file, you do NOT need to request any other data set.

If requesting a limited data set, you must also complete the Payers tab.

| Mark each element you are requesting with "X", including shaded elements. Shaded elements are recommended for all requests. | Indicate year(s) for each element requested. | Specify filters for each element requested, if applicable. See Filters tab for sample filters. | Justify why each element requested is necessary. If you do not wish to receive recommended (shaded) elements, delete the pre-populated justification. | Column name that will appear as the column header in the extract file | Name | Description of data |
|---|---|---|---|---|---|---|
| **Element Requested** | **Years Requested** | **Filters Applied** | **Justification** | **Extract Column Name** | **Long Name** | **Description** |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | clmid | Claim ID | Key that represents a unique Claim ID. |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | line | Claim line | Unique number within a claim identifying it as a unique service line item. |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | clmstatus | Claim status | Indicates the state of the claim, e.g. paid, denied, etc. |
| | | | | cob | COB status | Indicates whether claim is a Coordination of Benefits claim. |
| X | 2011-2016 | | Needed to deduplicate people with multiple types of insurance | paytype | Payer type | Type of payer that paid the claim, e.g. carrier, third party administrator, etc. |
| X | 2011-2016 | | Needed to deduplicate people with multiple types of insurance | prod | Product code | Insurance type or product code that indicates the type of insurance coverage the individual has. |
| | | | | payer | APAC Payer | Line of business category of the payer that paid the claim, e.g. Medicaid fee-for-service, Medicare Advantage, etc. |
| | | | | medflag | Medical coverage flag | Flag indicating if the claim has a valid Medical Member Month record in eligibility for the month associated with the incurred date of the claim. |
| | | | | rxflag | Pharmacy coverage flag | Flag indicating if the claim has a valid Pharmacy Member Month record in eligibility for the month associated with the incurred date of the claim. |
| | | | | ohvmhflag | High value medical home flag | Indicates if individual is in high value medical home. Field is only populated for participants in OHLC high value medical home initiative. Values are Y or N. |
| | | | | pebb | PEBB flag | Indicates if member of the claim was associated with Public Employee Benefits Board group during the date of service. |
| | | | | oebb | OEBB flag | Indicates if member of the claim was associated with Oregon Educators Benefits Board group during the date of service. |
| X | 2011-2016 | | Needed to deduplicate the claims in the database | patid | Encrypted patient ID | Unique member key for a person who is or was enrolled in a health insurance plan. The member is the person who has received the service. The same individual has a unique patid for each insurance plan. |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | personkey | Unique person identifier | Unique person key to identify the same individual who is reported by multiple payers or with different member IDs from the same payer. The same individual has one unique personkey across all payers. |
| X | 2011-2016 | Filter based off gender, only giving us women | Needed to chisel our data down to our population of interest | gender | Gender | Member's gender. |
| X | 2011-2016 | Need only those ages 15-44 at the time of visit | Needed to define ages in terms risk groups | yob | Birth year | Year associated with the member's date of birth. |
| X | 2011-2016 | | Needed to identify groups of women at highter risk | race | Race | Member race. |
| X | 2011-2016 | | Needed to identify groups of women at highter risk | ethn | Ethnicity | Member ethnicity. |
| X | 2011-2016 | | Needed to identify groups of women at highter risk | lang | Primary spoken language | Member language. |
| X | 2011-2016 | | Needed to identify groups of women at highter risk | msa | Member MSA code | 5 character code that the member resides in as defined by the Office of Management and Budget. |

| Element Requested | Years Requested | Filters Applied | Justification | Extract Column Name | Long Name | Description |
|---|---|---|---|---|---|---|
| X | 2011-2016 | Only need OR residents | Needed to calculate incicence rates of PID in Oregon | state | Member state | Two digit abbreviation representing the state of the member's address. |
| X | 2011-2016 | | Needed to calculate number of cases by zipcode | zip | Member zip code | 5 digit ZIP code of the member's address. |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | fromdate | From date | For services that span more than one day, such as inpatient hospital stays, this is the first date of a service. For services that do not span more than one day, it is the date of service. This date is from the date of service as supplied on detail claims lines. For pharmacy claims, this is the filled date. |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | todate | To date | For services that span more than one day, such as inpatient hospital stays, this is the last date of service. For services that do not span more than one day it is the date of service. It is from the detail date of service as supplied on detail claims lines. |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | paydate | Payment date | Date that the claim line is considered paid by the plan for general ledger purposes. The presence of the paid date does not necessarily indicate that the claim has been paid, but rather that the claim has been processed and may have been denied. |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | paid | Total payment | Amount in dollars that was paid by the payer to the service provider for the service. |
| | | | | copay | Co-payment | Amount in dollars that is the portion of allowed amount applied to the member's copay. |
| | | | | coins | Co-insurance | Amount in dollars that is the portion of allowed amount applied to the member's coinsurance. |
| | | | | deduct | Deductible | Amount in dollars that is the portion of the allowed amount that was applied to the member's deductible. |
| | | | | oop | Patient pay amount | Amount patient paid. |
| | | | | tob | Type of bill | Code for the type of bill on the UB form. The first digit of bill type encodes facility type (Hospital, Home Health, etc.), the second digit encodes bill classification (Inpatient, outpatient, etc.) and the third encodes claim frequency. |
| X | 2011-2015 | | Needed to calculate number of cases by zipcode | pos | Place of service code | Industry standard place of service code. i.e. 20 = Urgent Care Facility, 21 = Inpatient Hospital, 34 = Hospice, etc. |
| X | 2011-2015 | | Necessary to properly interpret duplicate claim lines | revcode | Revenue code | The revenue code from facility bills. It is a rollup of hospital services, e.g. 0201= INTENSIVE CARE-SURGICAL, 0280 = ONCOLOGY-GENERAL CLASSIFICATION, 0512 = CLINIC-DENTAL CENTER, etc. |
| | | | | qty | Quantity | For hospital inpatient services qty is the number of days spent in the facility. For hospital outpatient qty represents the number of unique events at the outpatient facility. For professional and ancillary services qty represents either the number of visits (for office visits, exams, chiro etc) or a number of procedures performed for non-visit professional services. Rx qty represents the number of prescriptions. |
| | | | | hcg | HCG code | Heath Cost Guideline® MR Line code is the lowest level of the Milliman Health Cost Guideline service grouping system. The MR line groups all services into one of 107 categories, e.g. O12 = HOP Surgery, P14 = PHY Outpatient Surgery, etc. |
| | | | | filldate | Fill date | Date prescription was filled. This date is from the date of service as supplied on detail claims lines. If this date is NULL the row represents an Incurred But Not Reported (IBNR) complete trends row and not an actual claim line item. |
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx1 | Principal diagnosis | The main or principal diagnosis ICD code associated with the service. ICD is the International Statistical Classification of Diseases and Related Health Problems that classifies diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease, e.g. 95909 = FACE & NECK INJURY, 78652 = PAINFUL RESPIRATION, etc. |

| Element Requested | Years Requested | Filters Applied | Justification | Extract Column Name | Long Name | Description |
|---|---|---|---|---|---|---|
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx2 | Diagnosis 2 | Secondary ICD diagnosis code associated with the service. |
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx3 | Diagnosis 3 | Secondary ICD diagnosis code associated with the service. |
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx4 | Diagnosis 4 | Secondary ICD diagnosis code associated with the service. |
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx5 | Diagnosis 5 | Secondary ICD diagnosis code associated with the service. |
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx6 | Diagnosis 6 | Secondary ICD diagnosis code associated with the service. |
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx7 | Diagnosis 7 | Secondary ICD diagnosis code associated with the service. |
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx8 | Diagnosis 8 | Secondary ICD diagnosis code associated with the service. |
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx9 | Diagnosis 9 | Secondary ICD diagnosis code associated with the service. |
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx10 | Diagnosis 10 | Secondary ICD diagnosis code associated with the service. |
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx11 | Diagnosis 11 | Secondary ICD diagnosis code associated with the service. |
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx12 | Diagnosis 12 | Secondary ICD diagnosis code associated with the service. |
| X | 2011-2016 | | Needed to create databases for inpatient and outpatient claims | dx13 | Diagnosis 13 | Secondary ICD diagnosis code associated with the service. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa1 | POA code 1 | Present on admission flag for Primary diagnosis. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa2 | POA code 2 | Present on admission flag for diagnosis 2. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa3 | POA code 3 | Present on admission flag for diagnosis 3. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa4 | POA code 4 | Present on admission flag for diagnosis 4. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa5 | POA code 5 | Present on admission flag for diagnosis 5. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa6 | POA code 6 | Present on admission flag for diagnosis 6. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa7 | POA code 7 | Present on admission flag for diagnosis 7. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa8 | POA code 8 | Present on admission flag for diagnosis 8. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa9 | POA code 9 | Present on admission flag for diagnosis 9. |

| Element Requested | Years Requested | Filters Applied | Justification | Extract Column Name | Long Name | Description |
|---|---|---|---|---|---|---|
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa10 | POA code 10 | Present on admission flag for diagnosis 10. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa11 | POA code 11 | Present on admission flag for diagnosis 11. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa12 | POA code 12 | Present on admission flag for diagnosis 12. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | poa13 | POA code 13 | Present on admission flag for diagnosis 13. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px1 | Principal inpt procedure | The main or principal surgery ICD code associated with the service. ICD is the International Statistical Classification of Diseases and Related Health Problems that classifies diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease, e.g. 0331 = SPINAL TAP, 9921 = INJECT ANTIBIOTIC, etc. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px2 | Procedure 2 | Secondary ICD procedure code associated with the service. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px3 | Procedure 3 | Secondary ICD procedure code associated with the service. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px4 | Procedure 4 | Secondary ICD procedure code associated with the service. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px5 | Procedure 5 | Secondary ICD procedure code associated with the service. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px6 | Procedure 6 | Secondary ICD procedure code associated with the service. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px7 | Procedure 7 | Secondary ICD procedure code associated with the service. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px8 | Procedure 8 | Secondary ICD procedure code associated with the service. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px9 | Procedure 9 | Secondary ICD procedure code associated with the service. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px10 | Procedure 10 | Secondary ICD procedure code associated with the service. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px11 | Procedure 11 | Secondary ICD procedure code associated with the service. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px12 | Procedure 12 | Secondary ICD procedure code associated with the service. |

| Element Requested | Years Requested | Filters Applied | Justification | Extract Column Name | Long Name | Description |
|---|---|---|---|---|---|---|
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | px13 | Procedure 13 | Secondary ICD procedure code associated with the service. |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | proccode | CPT or HCPCS procedure code | The American Medical Association's Current Procedural Terminology (CPT) code or the Healthcare Common Procedure Coding System (HCPCS) code; i.e. 90471 = IMMUNIZATION ADMIN, 80061 = LIPID PANEL, or 74170 = CT ABDOMEN W /O & W /DYE. |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | mod1 | Procedure code modifier 1 | The American Medical Association's CPT modifier that provides a means to indicate that a service or procedure was altered by specific circumstances, e.g. 2E = MLL (ACUTE LEUKEMIA), 7D = HFE (HEMOCHROMATOSIS), etc. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | mod2 | Procedure code modifier 2 | 2nd modifier associated CPT code on claim. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | mod3 | Procedure code modifier 3 | 3rd modifier associated CPT code on claim. |
| X | 2011-2016 | | Needed to validate whether or not the procedures performed are relevant to the diagnoses on the claim | mod4 | Procedure code modifier 4 | 4th modifier associated CPT code on claim. |
| X | 2011-2016 | | Needed to assess what MEG PID falls under, which might help us idenitfy cases that would have been missed | megcode | MEG code | Medical Episode Grouper (MEG) episode code. MEG is a proprietary grouping algorithm that creates episodes that describe a patient's complete course of care for a single illness or condition. |
| X | 2011-2016 | | Needed to assess what MEG PID falls under, which might help us idenitfy cases that would have been missed | megdesc | MEG description | Medical Episode Grouper (MEG) episode description. |
| X | 2011-2016 | | Needed to assess what MEG PID falls under, which might help us idenitfy cases that would have been missed | megbodysys | MEG body system | Medical Episode Grouper (MEG) system in the body. |
| X | 2011-2016 | | Needed to assess what MEG PID falls under, which might help us idenitfy cases that would have been missed | megstage | MEG stage | Medical Episode Grouper (MEG) stage of the given episode. |
| X | 2011-2016 | | Needed to assess what MEG PID falls under, which might help us idenitfy cases that would have been missed | megtype | MEG type of care description | Medical Episode Grouper (MEG) type of episode, e.g. Acute, Chronic and Well Care |
| X | 2011-2016 | | Needed to assess what MEG PID falls under, which might help us idenitfy cases that would have been missed | megcomplete | MEG episode completion | Medical Episode Grouper (MEG) indicator that episode is complete. |
| X | 2011-2016 | | Needed to assess what MEG PID falls under, which might help us idenitfy cases that would have been missed | megnum | MEG episode number | Medical Episode Grouper (MEG) unique identifier for a single episode. |
| X | 2011-2016 | | Needed to assess what MEG PID falls under, which might help us idenitfy cases that would have been missed | megdays | MEG episode duration in days | Medical Episode Grouper (MEG) duration of episode in days. |
| X | 2011-2016 | | Needed to assess what MEG PID falls under, which might help us idenitfy cases that would have been missed | megprorate | MEG prorated episode count | Medical Episode Grouper (MEG) prorated episode allowed amount allocation for the given service line. This field allows a user to sum detail lines for an overall episode count. Summing this field over all related service lines for a given episode will yield a result of 1. |
| X | 2011-2016 | | Needed to assess what MEG PID falls under, which might help us idenitfy cases that would have been missed | megoutlier | MEG outlier indicator | Medical Episode Grouper (MEG) indicator for an outlier episode. |

| Element Requested | Years Requested | Filters Applied | Justification | Extract Column Name | Long Name | Description |
|---|---|---|---|---|---|---|
| X | 2011-2016 | | Needed to assess what MEG PID falls under, which might help us idenitfy cases that would have been missed | meglow | MEG low outlier indicator | Medical Episode Grouper (MEG) indicator for low outlier episode. |
| X | 2011-2016 | | Needed to assess what MEG PID falls under, which might help us idenitfy cases that would have been missed | meghigh | MEG high outlier indicator | Medical Episode Grouper (MEG) indicator for high outlier episode. |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | ndc | NDC | National Drug Code is a unique product identifier for drugs, e.g. i.e. 00006011731 = SINGULAIR, 00025152531 = CELEBREX, etc. NDCs are assigned by the US Food and Drug Administration. |
| X | 2011-2016 | | Needed to help verify PID cases by matching them with PID pharmacuetical treatments | rxclass | NDC therapeutic class | A grouping of drugs with the same therapeutic properties as defined by Medi-Span. It is the first 10 characters of Medi-Span's Generic Product Identifier (GPI), e.g. 4927002510 = *ULCER DRUGS* , 0120001010 = *PENICILLINS*, or 2810001010 = *THYROID AGENTS*. |
| | | | | brand | Brand status | Indicates if the drug is available as a generic, multiple source brand (MSB), single source brand (SSB), or over the counter (OTC). |
| | | | | rxcompound | Compound drug indicator | Indicates if this is a compound drug. |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | qtydisp | Quantity dispensed | Quantity of the prescription that was dispensed. |
| X | 2011-2016 | | Needed to help verify PID cases by matching them with PID pharmacuetical treatments | rxdays | Days supply | Number of days that the drug will last if taken at the prescribed dose. |
| | | | | daw | Dispense as written code | Indicates if the physician has or has not authorized a substitution for the prescribed drug. 'Y' indicates the drug is to be dispensed as written; 'N' indicates a substitution is permissible. |
| | | | | ptstatus | Discharge status | A two-character code that represents the disposition of the patient upon leaving the facility. If the patient died this event may be indicated here. |
| | | | | los | Length of stay | Length of stay as reported by data submitter |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | msdrg | MS-DRG | MedInsight Medicare Severity Diagnostic Related Group Code is the MedInsight derived MS-DRG code. The MS DRG is a Medicare grouping system that classifies inpatient hospital services into one of approximately 750 groups. The codes in this column are for MS DRG version 25 and above. i.e. 864 = FEVER. |
| X | 2011-2016 | | Necessary to validate claims believed to be for a specific condition and to analyze episodes by provider. | attid | Attending provider ID | ID number that represents the attending, servicing, or rendering provider. This is an internal ID to each payer and therefore cannot be used to track a provider across multiple payers. |
| X | 2011-2016 | | Necessary to validate claims believed to be for a specific condition and to analyze episodes by provider. | spec | Provider specialty | Taxonomy code associated with attending provider. |
| X | 2011-2016 | | Necessary to properly interpret duplicate claim lines | billid | Billing provider ID | ID number that represents the billing entity. For medical claims, this is the billing provider ID. For pharmacy claims, this is the billing pharmacy ID. This is an internal ID to each payer and therefore cannot be used to track a provider across multiple payers. |
| X | 2011-2016 | | Necessary to validate claims believed to be for a specific condition and to analyze episodes by provider. | entity | Provider entity name | Name of the entity that generated the bill for the service. For medical claims, this is the billing provider entity name. For pharmacy claims, this is the pharmacy name. |
| X | 2011-2016 | | Needed to identify ICD9 and ICD10 codes | icdver | ICD version | Indicates whether or not the claimline has ICD 10 (or higher) codes. |