Oregon All Payer All Claims Database (APAC)

Data Dictionary
2011-2016 Dates of Service
Release APAC 2018.2

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Version Log

Version	Description	Author	Date
2018.2	Update of all sections	Mary Ann Evans	11-27-2018

Table of Contents

The APAC data dictionary is organized by the data structure: claims, member static demographics, monthly eligibility, provider data and billed premiums. Data elements available for both medical and pharmacy claims are listed first and followed by data elements available only for medical claims, only for pharmacy claims, monthly eligibility, demographics provider data and billed premiums. Description and values are listed for each data element.

A check mark in the payer reported column indicates that the data element was reported directly by payers. The payer reported threshold column indicates the amount of missing or data error allowed in the quarterly data submission.

A check mark in the public use data column indicates that the data element is in public use data sets. A check mark in the limited column indicates the data element is available for a limited data request.

Data elements with no check mark in the limited column are only available by custom data request. Data elements with restricted or limited access are listed last and require more detailed information about the purpose and data security and may be subject to review by the Oregon Department of Justice.

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Both Medical and Pharmacy Claims:							
Year or incurred_year	Year of service or eligibility occurred	YYYY			x	x	x
YearMonth or incurred_year_and_month	Year and month service or eligibility occurred	YYYYMM			x		x
incurred_month_start_date	First day of the month the service or eligibility occurred	YYYY-MM-DD			x		x
Incurred_cal_quarter	Quarter the service or eligibility occurred	Numeric			x		
Fromdate or fill date or from_date	Service begin date or pharmacy fill date	YYYY-MM-DD	x	0.0%			x
Todate or to_date	Service end date	YYYY-MM-DD	x	0.0%			x
Paydate or paid_date	Payment date	YYYY-MM-DD	x	0.0%			x
Paid_Month_Start_Date	First day of the month the service was paid	YYYY-MM-DD			x		x
Paid_Year_and_Month	claim paid year and month	YYMM			x		
Paid_Year	claim paid year	YYYY			x		
paid_cal_quarter	claim paid calendar quarter	Numeric			x		
paid_fiscal_year	claim paid fiscal year	YYYY			x		
paid_fiscal_quarter	claim paid fiscal quarter	Numeric			x		
MI_Post_date	End date of the vendor posting period	YYYY			x		
Claim_Entry_Date	Date claim entered into APAC	YYYY-MM-DD			x		
Claim_rec_Date	Date claim received by payer	YYYY-MM-DD	x	N/A	x		
Patid or member ID or member_key	Unique person identifier created from payer reported identifier for each plan. Not unique across payers and years	Numeric	x	0.0%			x
Personkey or MI_Person_key	Unique identifier created for a person across payers and years	Numeric			x		x
Member_ID_Encrypted	Encrypted unique person identifier created from payer reported identifier for each plan. Not unique across payers and years	Text			x		x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Both Medical and Pharmacy Claims:							
Relation	Member's relationship to the subscriber i.e., child and/or spouse	See Relationship Table	x	1.2%			
Services_key	Primary key for claims	Numeric			x		
Clmid or Claim_ID_Key	Payer specific claim identifier created from the payer reported claim identifier. Not unique across payers and years. Claims can have one or more service lines per identifier. There are some claims without an identier 2011-2013 (null identifier). The ID is Zero (0) when the claim row is incurred but not reported	Numeric			x		x
Claim line or SV_lin	Claim service line numbe	Numeric	x	0.0%			x
CS_Claim_ID_key	Vendor proprietary Health care grouper (HCG) determined continous stay claim identifier in an inpatient facility	Numeric			x		x
Form_type	Type of claim. If revenue code (MC054) is not null and does not contain values like ('','0','00','000','0000') then ‘U’ is assigned otherwise ‘H’ is assigned. Rx claims are defaulted to ‘D	U=UB, H=CMS1500, D=Prescription drug			x		
clmstatus or sv_stat	Claim status	P, D, E, F	x	0.0%			x
SV_Stat_and_Desc	Claim status description	paid, denied, encounter, reversed			x		x
Member_month_defaulted	Flag indicates if the member month key connected to monthly eligibility was derived by the gap fill methodolog	1 (defaulted), 0 (not defaulted)					x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Both Medical and Pharmacy Claims:							
Member_month_defaulted_Product_Level	IFlag indicates if the member month key connected to monthly eligibility was derived by the gap fill methodology at the product level	1 (defaulted at product level), 0 (default did not occur at the product level)					x
hcg or HCG_MR_line	HCG is the lowest level of the vendor health care grouping system	See HCG table			x	x	x
hcg_Version	Version 2010 V 3.0.12	Text			x		
hcg_Year	Year associated with HCG version	YYYY			x		
HCG_MR_Line_Des	Description of HCG MR_LIN	Text			x		
HCG_Setting	Highest level of the HCG system. One of five categories	1 (inpatient), 2 (outpatient), 3 (professional), 4 (prescription drug), 5 (ancillary) See HCG table			x		
HCG_MR_Line_Group	Second level of the HCG system	HIP (hospital inpatient), HOP (hospital outpatient), PHY (professional), RX			x		
HCG_MR_Line_Code_and_Des	Over 100 HCG line group categories	Text			x		
HCG_MR_Line_Rollu	Third level of the HCG system	Text			x		
HCG_MR_Line_Rollup_Des	61 HCG line group categories	Text			x		
MR_Line_Case_Key	Represents and HCG MR line cas	Text			x		
Cases	HCG measure of unique services; number of inpatient admits	Numeric			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Both Medical and Pharmacy Claims:							
Case_source	HCG Source of case counts	Text			x		
Case_basis	HCG Type if case	Admit or case			x		
Util_Source	HCG Source of utlization counts	Text			x		
Util_Basis	HCG description of utilization type	Text			x		
MR_Admit_cases_raw	HCG source admit or cases	Text			x		
MR_Units_Days_Raw	HCG source units or days	Text			x		
PBP_Admits_cases_raw	HCG source Medicare Plan Benefit Package admits or cases	Text			x		
PBP_line_code_and_desc	Desciption HCG source Medicare Plan Benefit Package categories	See HCG PBP table			x		
qtydisp or quantity or qty or SV_Units	Quantity or count of services delivered; Revenue code count for inpatient hospitalization and CPT count for outpatient services; Quantity of pharmaceutical dispensed	Numeric	x	0.0%	x	x	x
Medicareflag	Medicare coverage flag derived from HCG based on plan benefit package line (PBP). PBP is based on CPT/HCPCS, revenue and diagnosis codes.	Y (yes), N (no). See HCG PBP Table for more information		1.2%	x		
Payer_LOB	Payer line of business from derived from payer reported product code from eligibility data only and not claims data. Orphan claims assigned null.	Commercial, Medicaid, Medicare or null. See product code table for crosswalk			x		
Paytype or payer_type	Payer reported payer type codes from eligibility data only and not from claims data	C, D, G, P, T, U	x				x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Both Medical and Pharmacy Claims:							
MC001_APAC _Payer_type	Payer reported payer type codes from claims data	C, D, G, P, T, U	x				
MC001_APAC _Payer_type_desc and claims payer type	Payer type description	(C) Carrier, (D) Medicaid, (G) Other government agency, (P) Pharmacy benefits manager, (T) Third-party administrator, (U) Unlicensed			x		x
Prod	Payer reported product code from eligibility data only and not claims dat	See product code table	x	0.0%		x	x
APAC_Product_code	Payer reported product code from claims data	See product code table	x	0.0%		x	
APAC_Product_code_code_and_desc	Product code description	See product code table			x		
Claim_specific_LOB	Derived from payer reported product code from eligibility data only and defaulted to a specific LOB for some identifed payers	See claim specific LOB payer table			x		
medflag	Indicates medical coverage for the month when claim occurred	Numeric: 1 (yes), 0 (no)	x	0.0%			
rxflag	Indicates pharmacy coverage for the month when claim occurred	Numeric: 1 (yes), 0 (no)	x	0.0%			
HVMHflag	Required for members in OHLC high valu medical home initiativ	Y (yes), N (no)	x	N/A			x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Both Medical and Pharmacy Claims:							
PEBB_OEBB	Public Employees Benefit Board or Oregon Educators Benefit Board covered members. Includes Oregonians and out-of-state residents	PEBB, OEBB, Null		0.0%	x		
PEBB_OEBB_Desc	Public Employees Benefit Board or Oregon Educators Benefit Board covered members. Includes Oregonians and out-of-state residents	PEBB, OEBB, Null			x		
PEBB Flag	Public Employees Benefit Board covered members. Includes Oregonians and out-of-state residents	0 (no), 1(yes)					x
OEBB Flag	Oregon Educators Benefit Board covered members. Includes Oregonians and out-of-state residents	0 (no), 1(yes)					x
Contract	Payer provided claim line specific contract data	Text	x				
Age_on_DOS	age on date of service	Numeric			x		
Age_Band_Name	child, adult, over 65 age bands calculated based on month of date of service	00-18, 19-64, 65+			x		
agegrp	Five year age groups calculated based on month of date of service	0-4,5-9,10-14 etc			x	x	
Attid or att_prov_key	Vendor created unique identifier for attending, rendering or pharmacy provider based on payer reported unique identifier. Identifier is payer specific and not unique across payers or years	Numeric		1.2%	x		x
Attid_encrypt or Att_Prov_ID_encrypted	encrypted ProviderID	Text			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Both Medical and Pharmacy Claims:							
ATT_PROV_CW_KEY	Vendor created unique attending provider identifier across payers and years				x		
Billic	APAC assigned billing provider II	Text	x	1.2%			x
Billid or Bill_Prov_Key	Vendor created unique identifier for billing provider based on payer reported unique identifier. Identifier is payer specific and not unique across payers or years	Numeric	x	101.2%	x		x
BILL_PROV_CW_KEY	Vendor created unique billing provider identifier across payers and years				x		
Billid_taxonomy	National uniform claim committee (NUCC) provider taxonomy for the billing provider; NPI if not reporte	Text			x		
Entity or bill_prov_name	Name of the entity that generated the bill for the service. Medical billing provider or pharmacy name. Name is payer specific and not unique across payers or years	Text	x				x
COB or COB_stat	Coordination of benefit claim	Y (yes), N (no)	x	1.2%			x
Network_indicator	Indicator of whether service received in or out of network	1 (in network), 2 (National network), 3 (out-of-network)	x	0.0%			

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Both Medical and Pharmacy Claims:							
Paid or amt_paid	Payment made by payer. Does not include expected copayment, coinsurance and deductible that patient is responsible to pay to the provider	Two decimal places. 0 if amount equals zero. Blank if missing	x	0.0%		x	x
Copay or amt_copay	Expected Co-payment by the member	Two decimal places. 0 if amount equals zero. Blank if missing	x	0.0%			x
Coins or amt_coins	Expected Co-insurance by the member	Two decimal places. 0 if amount equals zero. Blank if missing	x	0.0%			x
Deduct or amt_deduct	Expected Deductible by the member	Two decimal places. 0 if amount equals zero. Blank if missing	x	0.0%			x
OOP or amt_pat_paid	Expected Patient paid amount. Amount patient paid. Required if co-payment, co-insurance or deductible are missing	Two decimal places. 0 if amount equals zero. Blank if missing	x	0.0%		x	x
Billed or amt_billed	Payer reported charges or billed amount for the service	Two decimal places. 0 if amount equals zero. Blank if missing	x	0.0%			

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Both Medical and Pharmacy Claims:							
amt_COB	Coordination of benefit claim amount paid	Two decimal places. 0 if amount equals zero. Blank if missing	x	1.2%			x
Pay_to_Patient	Pay to patient	y (directly reimbursed), N (not directly reimbursed), N (if unknown)	x	0.0%			
Amt_Prepaid	Prepaid amount	Two decimal places. 0 if amount equals zero. Blank if missing	x	0.0%			
sensitive_condition_Flag	Identifies if a claim is a sensitive condition. See logic in sensitive condition tab	Y , N			x		
sensitive_condition_Flag_desc	Sensitive condition description	Y (yes), N (no)			x		
Orphan_claim_Line_flag	Identifies if a claim is an orphan claim with no link to any monthly eligibility segment +/- 12 months from the date of service	Y (yes), N (no)			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
TOB or UB_bill_type	Type of bill on the uniform billing form (UB)	See type of bill table	x	1.2%			x
UB_bill_factype_desc	Type of bill description	See type of bill table			x		
POS	Industry standard place of service code	See place of service table	x	1.2%		x	x
Adm_date	Admission date required for inpatient hospitalizations	YYYY-MM-DD	x	1.2%			
Dis_date	Discharge date required for inpatient hospitalization	YYYY-MM-DD	x	1.2%			
admtype	Admission type is required for inpatient claims	1 (Emergency), 2 (Urgent), 3 (Elective), 4 (Newborn), 5 (Trauma Center), 9 (Information Not Available)	x	1.2%			
admsrc	Admission source is required for inpatient claims	See admission source table	x	1.2%			
admdiag	Admitting diagnosis required for inpatient claims. ICD-9 for dates of service before 10/01/2014 and ICD-10 on or after	Alphanumeric	x	1.2%			
ptstatus or dis_stat	Status for member discharged from the hospital	See discharge status table	x	1.2%		x	x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
los	length of inpatient hospital stay. Length of stay equals discharge date minus admission date	Equals 1 or more for inpatient hospitalizations			x	x	x
ICD version or ICD_10_OR_HIGHER	Specifies the claim ICD version ICD9 or ICD1(	9 or 10	x	0.0%		x	x
dx1 or ICD_DIAG_01_Primary	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%		x	x
dx1 description or ICD_DIAG_DESC_PRIMAI	Primary diagnosis description	Text			x		
dx2 or ICD_DIAG_02	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x
dx3 or ICD_DIAG_03	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x
dx4 or ICD_DIAG_04	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x
dx5 or ICD_DIAG_05	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x
dx6 or ICD_DIAG_06	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x
dx7 or ICD_DIAG_07	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
dx8 or ICD_DIAG_08	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x
dx9 or ICD_DIAG_09	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x
dx10 or ICD_DIAG_10	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x
dx11 or ICD_DIAG_11	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x
dx12 or ICD_DIAG_12	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x
dx13 or ICD_DIAG_13	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x
ICD_DX_AHRQ_CSS_L1	AHRQ highest level grouping for primary diagnosis	Text			x		
ICD_DX_AHRQ_CSS_L2	AHRQ second highest level grouping for primary diagnosis	Text			x		
ICD9_DX_AHRQ_CSS_L3	AHRQ third highest level grouping for primary diagnosis ICD9	Text			x		
ICD10_DX_AHRQ_CSS_L3	AHRQ third highest level grouping for primary diagnosis ICD1(	Text			x		
px1 or ICD_Proc_01_Principle	The main or principal inpatient surgery ICD code	Alphanumeric	x	1.2%		x	x
px2 or ICD_Proc_0	Inpatient surgery ICD code 2	Alphanumeric	x	1.2%			x
px3 or ICD_Proc_0	Inpatient surgery ICD code 3	Alphanumeric	x	1.2%			x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
px4 or ICD_Proc_0	Inpatient surgery ICD code	Alphanumeric	x	1.2%			x
px5 or ICD_Proc_0	Inpatient surgery ICD code	Alphanumeric	x	1.2%			x
px6 or ICD_Proc_0	Inpatient surgery ICD code	Alphanumeric	x	1.2%			x
px7 or ICD_Proc_0	Inpatient surgery ICD code	Alphanumeric	x	1.2%			x
px8 or ICD_Proc_0	Inpatient surgery ICD code	Alphanumeric	x	1.2%			x
px9 or ICD_Proc_0	Inpatient surgery ICD code	Alphanumeric	x	1.2%			x
px10 or ICD_Proc_1	Inpatient surgery ICD code 1	Alphanumeric	x	1.2%			x
px11 or ICD_Proc_1	Inpatient surgery ICD code 1	Alphanumeric	x	1.2%			x
px12 or ICD_Proc_1	Inpatient surgery ICD code 1	Alphanumeric	x	1.2%			x
px13 or ICD_Proc_1	Inpatient surgery ICD code 1	Alphanumeric	x	1.2%			x
poa1	Inpatient present on admission flag for diagnosis 1. Required if diagnosis 1 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
poa2	Present on admission flag for diagnosis 2. Required if diagnosis 2 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x
poa3	Present on admission flag for diagnosis 3. Required if diagnosis 3 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
poa4	Present on admission flag for diagnosis 4. Required if diagnosis 4 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x
poa5	Present on admission flag for diagnosis 5. Required if diagnosis 5 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
poa6	Present on admission flag for diagnosis 6. Required if diagnosis 6 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x
poa7	Present on admission flag for diagnosis 7. Required if diagnosis 7 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
poa8	Present on admission flag for diagnosis 8. Required if diagnosis 8 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x
poa9	Present on admission flag for diagnosis 9. Required if diagnosis 9 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
poa10	Present on admission flag for diagnosis 10. Required if diagnosis 10 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x
poa11	Present on admission flag for diagnosis 11. Required if diagnosis 11 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
poa12	Present on admission flag for diagnosis 12. Required if diagnosis 12 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x
poa13	Present on admission flag for diagnosis 13. Required if diagnosis 13 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x
proccode or Proc_code	The Current Procedural Terminology (CPT) code or the Healthcare Common Procedure Coding System (HCPCS) code	Alphanumeric	x	1.2%		x	x
proc_desc	CPT and HCPCS code descriptior	Text			x		x
proc_code_ and_ desc	CPT and HCPCS code and descriptic	Text			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
proc_code_ family_ID	High level grouping procedure codes from HRT HCPCS code referenc	Text			x		
proc_code_ family_level_1	Highest level procedure code groups from HRT HCPC	Text			x		
proc_code_ family_level_2	Second Highest level procedure code groups from HRT HCPC	Text			x		
proc_code_ family_level_3	Lowest level procedure code groups from HRT HCPC	Text			x		
proc_code_ ahrq_ccs	Agency for Healthcare Research and Quality (AHRQ) clinical classification grouping of procedure codes (CPT or HCPCS	Text			x		
mod1	CPT or HCPCS modifier with all digits and numeric codes https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.htm	See modifiers table	x	1.2%			x
mod2	CPT or HCPCS modifier with all digits and numeric codes https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.htm	See modifiers table	x	1.2%			x
mod3	CPT or HCPCS modifier with all digits and numeric codes https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.htm	See modifiers table	x	1.2%			x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
mod4	CPT or HCPCS modifier with all digits and numeric codes https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.htg	See modifiers table	x	1.2%			x
revcode or rev_code	Revenue code	Numeric	x	1.2%			x
rev_code_desc	Revenue code description	Text			x		
rev_code_and_desc	Revenue code and description	Text			x		
MI_MS_DRG_Cod	Vendor derived DRG code version 25+	Text			x		
MI_MS_DRG_desc	Vendor derived DRG code description version 25+	Text			x		
MI_MS_DRG_Code_and_desc	Vendor derived DRG code and description version	Text			x		
msdrg	MS DRG is a Medicare grouping system that classifies inpatient hospital services into one of approximately 750 groups.	Text			x	x	x
ms_drg_desc	MS DRG code description	Text			x		
ms_drg_code_and_desc	MS DRG code and description	Text			x		
MR_procs_raw	HCG source number of procedures	Text			x		
PPACA_Preven	HCG source indicates service is preventable	Text			x		
MR_exclusion_code	Indicates service may be excluded because it is zero allowed or not covered under typical benefits	Text			x		
PBP_line_code_and_desc	Medicare Plan Benefit Package defined benefit service category	Text			x		
MA_line_Det_code_and_desc	Medicare Advantage codes and descriptions	Text			x		
MA_line_code_and_desc	Medicare Advantage code descriptions	Text			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
cchg	Chronic condition hierarchical group (CCHG) is a proprietary grouping algorith.	Alphanumeric			x		
cchg_desc	CCHG description	Text			x		
cchg_cat_code_and_desc	CCHG and CCHG_de	Text			x		
megcode	Medical episode group (MEG) is a vendor proprietary grouping algorithm that creates episodes of care that describe a patient's complete course of care for a single illness or conditior	Alphanumeric			x	x	x
megdesc	MEG episode description	Alphanumeric			x	x	x
megbodysys	MEG body system uses a proprietary grouping algorithm and groups episodes of care into body systems	Alphanumeric			x	x	x
MEG_rollu	MEG rollu	Text			x		
megstage	MEG stage of the given episode	Alphanumeric			x	x	x
MEG_high_stage	MEG disease stage within episode	Text					
megtype	MEG Type of care episode	Alphanumeric			x	x	x
megcomplete	MEG indicator that episode is complete.	1 (yes), 0 (no)			x	x	x
megnum	MEG unique identifier for a single episode	Numeric			x	x	x
megdays	MEG duration of episode in days	Numeric			x	x	x
MEG_Episode_Months_duratio	Total number of months	Numeric					

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
megprorate	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.	Numeric			x	x	x
MEG_EPISODE_count_paid_prorate	Prorated episode paid amount allocation for service line	Numeric			x		x
megoutlier	MEG indicator for an outlier episode	1 (yes), 0 (no)			x	x	x
meglow	MEG indicator for low outlier episode	1 (yes), 0 (no)			x	x	x
meghigh	MEG indicator for high outlier episode	1 (yes), 0 (no)			x	x	x
MEG_Min_Incurred_Month_start_date	MEG start month for episode	Text			x		
MEG_Max_Incurred_Month_start_date	MEG end month for episode	Text			x		
MEG_Episode_primary_prov_I	MEG vendor defined primary provide	Text			x		
MEG_Episode_managing_prov_ID	MEG vendor defined managing provider	Text			x		
MEG_Episode_Top_facility_Prov_ID	MEG vendor defined facility	Text			x		
MEG_Episode_Top_facility_prov_name	MEG vendor defined name	Text			x		
mm_credible	Indicates if enrollment associated with claim credible based on month compared to previous and future month enrollment	Text			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Avaliable Only for Medical Claims:							
incur_credible	Indicates if incurred amount associated with claim credible based on month compared to previous and future month claims	Text			x		
paid_credible	Indicates if paid amount associated with claim credible based on month compared to previous and future month paid	Text			x		
month_credible	Indicates if claim credible based on member month credible flag, incurred credible flag, and the paid credible flag	Text			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available Only for Pharmacy Claims:							
NDC	National Drug Code	Text	x	1.2%		x	x
NDC_Prod_Nam	Name of the drug associated with NDC	Text			x		
NDC_Code_and_Prod_Nam	NDC code and NDC_Prod_Nam	Text			x		
rxclass or Ther_class	NDC therapeutic class. Medi-Span defined grouping of drugs with the same therapeutic properties	The first 10 characters of Medi-Span's Generic Product Identifier (GPI			x	x	x
Main	NDC therapeutic class. Medi-Span defined grouping of drugs with the same therapeutic properties. Name of class	Text			x		
Manufacturer_Name	Name of the company that manufactured the drug	Text			x		
Product_description	Drug name, dose, strength	Text			x		
GPIgenericNam	Medi-Span generic product indicato	Text			x		
brand	Indicates if the drug is available as a generic, brand or over the counter	Multiple source brand (MSB), single source brand (SSB), over the counter (OTC)	x			x	x
brand_status_rollup	Roll up indicates if brand or generic	Text			x		
Dosage_form	Medium of drug delivery i.e., foam, gel, tablet	Text	x				
Strength	Amount or potency of the drug	Text	x				
qtydisp	Quantity dispensed	Numeric	x	1.2%		x	x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available Only for Pharmacy Claims:							
rxdays	Number of days that the drug will last if taken at the prescribed dose	Numeric	x	1.2%		x	x
RX_Refills	Count of times prescription refillec	Numeric	x	1.2%			
rxcompound	Indicates if it is a compound drug	1 (no), 2 (yes) , Null, [0 and 9 are not valid values]	x	1.2%			x
subcat1	Medi-Span second level rollup of therapeutic drugs	Text			x		
subcat2	Medi-Span third level rollup of therapeutic drugs	Text			x		
daw	Dispense as written. Indicates if the provider authorized a drug substitution	See dispense as written table	x	1.2%		x	x
Alternate_refil_num	alternate refill numbe	Text	x				

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available Only for Pharmacy Claims:							
Substitution_type	One of seven substitution methods used	Generic bioequivalence, drug bioequivalence, Generic no bioequivalence, drug no bioequivalence, TCS no bioequivalence, Therapeutic no bioequivalence, and drug class no bioequivalence			x		
NDC_sub	Unique idenfier for for substituted drug	Text			x		
NDC_product_name_sub	Name of substituted drug	Text			x		
NDC_code_and_prod_name_sub	NDC_sub and NCD_Product_name_sub	Text			x		
Brand-status_sub	Indicates if substituted drug is available	generic, multiple source, single source or over the counter			x		
Dosage_form_sub	Medium substituted drug delivered	foam, gel, tablet			x		
Strength_sub	Amount or potency of the substituted drug	Text			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available Only for Pharmacy Claims:							
Brands_status_rollup_sub	Indicates if drug substitutes is brand or generic	Text			x		
Manufacturer_Name_sub	Name of the substituted drug company	Text			x		
Product_descrption_sub	Substituted drug name, dose, strength	Text			x		
GPIgenericName_sub	Medi-Span substituted generic product indicator	Text			x		
Pharmacy name	Pharmacy name	Text	x	1.2%			
Pharmacy city	Pharmacy city	Text	x	1.2%			
Pharmacy state	Pharmacy state	Text	x	1.2%			
Pharmacy zip	Pharmacy zip	Text	x	1.2%			
ingredient cost/list price	ingredient cost/list price	Numeric	x	0.0%			
dispensing fee paid	dispensing fee paid	Numeric	x	0.0%			

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Member Demographic Data (static except for age related data elements):							
patid or member ID or member_key	Payer specific unique person identifier created from payer reported identifier. Not unique across payers and plans	Numeric	x	0.0%			x
personkey or MI_Person_key	Unique identifier created for a person across payers and data years	Numeric			x		x
MEMBER_ID_ENCRYPTED	Encrypted unique person ID created from payer reported identifier for each plan. Not unique across payers and plans	Text			x		x
gender or Mem_gender	Member Gender	M (male), F (female), and U (unknown)	x	1.2%		x	x
YOB	Member year of birth	YYYY			x		x
YOD	Member year of death. Data only reported by the Centers for Medicaid and Medicare Services	YYYY			x		
MOD	Member month of death. Data only reported by the Centers for Medicaid and Medicare Services.	MM			x		
Age	Age of the member calculated based on month of eligibility	Numeric			x		
agegrp	Five year age groups calculated based on month of eligibility	0-4,5-9,10-14 etc			x	x	
Age_Band_Name	child, adult, over 65 age bands calculated based on month of eligibility	00-18, 19-64, 65+			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Member Demographic Data (static except for age related data elements):							
race or mem_race	Member race reported by payer. Static from latest quarterly data submitted. Race data for 59% of unique people is missing or unknown.	4 (Asian), 2 (Black or African American), 3 (American Indian or Alaskan Native), 5 (Native Hawaiian or Pacific Islander), 1 (White), 6 (other or multiple races), 9 (unknown) and 0 (not	x			x	x
ethn or mem_ethnicity	Member ethnicity reported by payer. Static from latest quarterly data submitted. Ethnicity data for 72% of unique people is missing or unknown.	1 (Hispanic), 2 (Not Hispanic), 3 (unknown), Null	x			x	x
lang or Mem_language	Primary spoken language; Static from latest quarterly data submitted. Payers report three-character string from ANSI/NISO https://www.loc.gov/standards/iso639-2/php/code_list.php Vendor recodes ANSI/NISO to numeric codes. Language	Numeric. See language table	x			x	x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Member Demographic Data (static except for age related data elements):							
MSA or Mem_MSA	Member metropolitan statistical area defined by US Census. Static from latest quarterly data submitted	Text			x	x	x
Member_MSA_Name	Name of metropolitan statistical area. Static from latest quarterly data submitted	Text			x		
STATE or Mem_state	Member State. Static from latest quarterly data submitted	Two letter abreviation	x	1.2%			x
urban	Zip codes grouped into urban and rural identified by OHA. Static from latest quarterly data submitted	1 (Urban), 2 (not Urban)			x	x	

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Monthly Member Eligibility Data:							
YEAR and incurred_year	Year of service or eligibility occurred	YYYY			x		
YEARMONTH and incurred_year_and_month	Year and month service or eligibility occurred	YYYYMM			x		
incurred_month_start_date	First day of the month the service or membership occurred	YYYY-MM-DD			x		
incurred_cal_quarter	Quarter month the service or eligibility occurred	Numeric			x		
patid and member ID and member_key	Payer specific unique person identifier created from payer reported identifier. Not unique across payers and years	Numeric	x	0.0%			
personkey or MI_Person_key	Vendor created unique identifier for a person across payers and years	Numeric			x		
MEMBER_ID_ENCRYPTED	Encrypted unique person identifier created from payer reported identifier. Not unique across payers and plans	Text			x		
SUBSCRIBER_KEY	Payer specific unique identifier for the person with employer paid insurance, Medicaid coverage or the person who purchased insurance	Numeric	x	1.2%			
Relation	Member's relationship to the subscriber i.e., spouse, child, dependent	See relationship table	x	1.2%			
Medicare_coverage_ flag	Medicare coverage reported by payer. X (other), C (Medicare part C only), D (Medicare part D only), CD (Medicare parts C and D), B (Medicare Part B), AB (Medicare parts A and B), Z (none), Null and blank	X , C , D , CD , B , AB , Z , Null and blank	x	1.2%			

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Monthly Member Eligibility Data:							
PAYER_LOB	Payer line of business derived from payer reported product code from eligibility data only and not claims data. Orphan claims assigned null.	Commercial, Medicaid, Medicare or null. See product code table for crosswalk			x		
paytype or MC001_APAC _Payer_type	Payer type codes reported by payer for eligibility data only and not from claims data	C, D, G, P, T, U	x				
MC001_APAC _Payer_type_desc	Payer type description	(C) Carrier, (D) Medicaid, (G) Other government agency, (P) Pharmacy benefits manager, (T) Third-party administrator, (U) Unlicensed			x		
prod or APAC_Product_code	Payer reported product code from eligibility data only and not claims data. N null values	See product code table	x	0.0%			
APAC_Product_code_code_and_de sc	Product code description	See product code table			x		
Enrollment_contract_number	Payer provided plan specific contract number from monthly eligibility fil	Text	x	0.0%			
EFF_DATI	First day of the month member enrolle	YYYY-MM-DD	x	0.0%			

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Monthly Member Eligibility Data:							
TERM_DAT	Last day of the month member enrolle	YYYY-MM-DD	x	0.0%			
MI_Post_date	End of the posting period for membership load	YYYY-MM-DD			x		
primary or primary_insurance	Primary Insurance Indicator	Y (primary insurance), N (secondary or tertiary insurance). If unknown, default to Y	x	0.0%			

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Monthly Member Eligibility Data:							
Prod_type	Derived type of membership. If member eligible for medical and payer is not behavioral health and is not pharmacy plan and is not Medicare part D then equals medical. If member eligible for pharmacy and payer is not behavioral health then equals pharmacy. Behavioral health if payer is behavioral health. The behavioral health type was created to mark duplicate medical member months. Medical Coverage is assigned if Medical_coverage_flag (ME018) =1 and payer is not behavioral health and payer type (ME001) is not pharmacy and product_code (ME003) is not pharmacy or Medicare part D. Rx Coverage is assigned if Prescription Drug Coverage Flag (ME019) =1 and payer is not behavioral health and submitter_abbr column does not equal 'OMIP'. Behavioral Health is assigned if Medical_coverage_flag (ME018) =1 and payer is behavioral health. Prod_type or prod_type_Key necessary for analysis	Text: medical, rx, dental, behavioral, vision [No dental or vision in APAC]			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Monthly Member Eligibility Data:							
Prod_type_key	Generated number that represents the type of membership Prod_type. This key is used to join claims with monthly member data for efficiency. Necessary for analysis of member months	Integer: 0 (combined), 1(medical member month), 2 (pharmacy member month), 4 (vision member month), 6 (behavioral health member month)			x		
MM_UNITS	Flag that indicates medical coverage for the month for the membe	Numeric: 1 (yes), 0 (no)			x		
RX_UNITS	Flag that indicates prescription drug coverage for the month for the membe	Numeric: 1 (yes), 0 (no)			x		
Sub_MM_UNITS	Flag that indicates medical coverage for the month for the subscriber	Numeric: 1 (yes), 0 (no)			x		
Sub_RX_UNITS	Flag that indicates prescription drug coverage for the month for the subscriber	Numeric: 1 (yes), 0 (no)			x		
TPA_OR_PBM_DUPLICATE_MM	Identifies duplicate member months reported by third party administrator or pharmacy benefit manager for the month	1 , 2 , 0			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Monthly Member Eligibility Data:							
TPA_OR_PBM_DUPLICATE_MM_Desc	Description of duplicate member months reported by third party administrator or pharmacy benefit manager	1 (medical member month duplication), 2 (pharmacy member month duplication, 0 (no duplication)			x		
PEBB_OEBB	Public Employees Benefit Board or Oregon Educators Benefit Board covered members Oregon and out-of-state residents	PEBB, OEBB, Null		0.0%	x		
PEBB_OEBB_Desc	Public Employees Benefit Board or Oregon Educators Benefit Board covered members Oregon and out-of-state residents descrption	PEBB, OEBB, Null			x		
market	Market Segment	See market table	x	0.0%			
metal	Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the ACA	0 (Not a QHP or catastrophic plan), 1 (catastrophic0, 2 (bronze), 3 (silver), 4 (gold), 5 (platinum)	x	0.0%			
HDHF	High Deductible Health Plan Fla	Y (Yes), N	x	1.2%			

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Monthly Member Eligibility Data:							
OMIPflag	Oregon Medical Insurance High risk Pool flag	Y (yes), N (no)	x	1.2%			
HKCflag	Oregon Healthy Kids flag	Y (yes), N (no)	x	1.2%			
Medicareflag	Medicare coverage flag derived from HCG. Not reported by payer	Y (yes), N (no)		1.2%	x		
HVMHflag	Required for members in OHLC high valu medical home initiativ	Y (yes), N (no)	x				
Med_home_flag	Flag indicates medical hom	1 , 0	x	0.0%			
Enrollment_key	Vendor generated number that represents an enrollment record. Key can be used to join claims and enrollment				x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Provider Data:							
Prov_CW_Key	Vendor created unique provider identifier across payers	Integer			x		
ATT_PROV_CW_KEY	Vendor created unique attending provider identifier across payers	Integer			x		
prov_key or ATTID or att_prov_key	Payer specific identifier number for the attending, servicing, or rendering medical or pharmacy provider. Identifier is not unique across payers	Integer		1.2%	x		x
attid_encrypt or Att_Prov_ID_encrypted	Encrypted payer specific identifier number for the attending, servicing, or rendering medical or pharmacy provider. Identifier is not unique across payers	Text			x		
Prov_DEA	Provide Drug Enforcement Agency (DEA) registry number	Text	x	1.2%			
Prov_NPI	Provider National Provider Identification (NPI) registry numbe	Text	x	1.2%			
Prov_Tin or Bill_Prov_TIN	Attending or billing provider Tax identifier	Text	x	1.2%			
Prov_taxonomy or billid_taxonomy	NUCC provider taxonomy for the billing provider; NPI if not reported	See Health care provider taxonomy codes www.nucc.or	x				
spec or Attending_MI_Specialty	Vendor derived provider specialty for attending, servicing or rendering provider	See Health care provider taxonomy codes www.nucc.or			x		x

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Provider Data:							
Prov_SPEC_CODE or ATT_Prov_source_spec	Vendor derived provider specialty	See Health care provider taxonomy codes www.nucc.or	x				
ATT_HCG_Primary_Car	HCG derived primary care provide	Text			x		
Prov_Lname or ATT_PROV_LNAME	Provider last name or organization name	Text	x	1.2%			
Prov_Fname or ATT_PROV_FNAME	Provider first name; null if provider is an organization entity	Text	x	1.2%			
Prov_Mname or Attending provider middle initia	Provider middle initial	Text	x	1.2%			
Provider_DOE	Provider date of birth	YYYY-MM-DD	x				
Provider street address	Provider street address	Text	x	1.2%			
Provider street address2	Provider street address	Text	x	1.2%			
Provider city	Provider city	Text	x	1.2%			
ATT_PROV_ZII	Provider location zip	Numeric	x	1.2%			
ATT_PROV_State	Provider location state	Text	x	1.2%			
ID_Provider_MCAID	Medicaid provider identifier provided by Medicaic	Text	x				
billic	APAC assigned billing provider II	Text	x	1.2%			
Bill_Prov_ID_encrypted	Encrypted unique identifier for billing provider	Text			x		
Bill_Prov_Key	Unique identifier generated for billing provider	Numeric			x		
Bill_Prov_ID_FAC_CW	Billing provider unique identifier across payers	Numeric			x		
Bill_Prov_Name	Name of billing provide	Text	x				x
BILL_PROV_ZIP	Billing provider zip	Five or nine digit zip code	x				

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Provider Data:							
BILL_PROV_COUNTY	County location of billing provider derived from zip code	Text			x		
BILL_PROV_state	Location of pharmacy or provider	Text	x				
BILL_PROV_MSA_Code	Billing provider Metropolitan statistical area name derived from zip code	Text			x		
BILL_PROV_MSA_Nam	Metropolitan statistical area name	Text			x		
BILL_PROV_LNAME_FAC_CW	Oregon Hospital and Oregon Ambulatory Surgical Center Names. All other null	Text			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Data Elements Available for Billied Premium Data:							
Patid or member ID or member_key	Unique person ID created from payer reported identifier for each plan. Not unique across payers and years	Numeric			x		x
Personkey or MI_Person_key	Unique identifier created for a person across payers and years	Numeric			x		x
Subscriber_Key	Payer specific unique identifier for the person with employer paid insurance, Medicaid coverage or the person who purchased insurance. Not unique across payers and plans	Numeric	x	1.2%			x
MC001_APAC _Payer_type_key	Payer reported payer type codes from eligibility data only and not from claims data	C, D, G, P, T, U	x				
APAC_Product_code_key	Payer reported product code from eligibility data only and not claims data. N null values	See product code table	x			x	
PEBB_OEBB	Public Employees Benefit Board or Oregon Educators Benefit Board covered members Oregon and out-of-state residents	PEBB, OEBB, Null		0.0%	x		
Premium_employer_paid	Monthly premium paid by employer or subscriber	Numeric	x	0.0%			
Premium_bill_dat	Date premium bille	YYYY-MM-DD	x	0.0%			
Premium_Exp_dat	Date premium expire	YYYY-MM-DD	x	0.0%			
PREM_DEP_Cou	Number of dependents	Numeric	x	0.0%			

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Restricted Access Data Elements that Require Strong Justification and Detailed Data Security and Release Plan:							
member month of birtl	Member month of Birtl	MM			x		
MEMBER_COUNTY	Member county of residency derived from zip code. Static from latest quarterly data submittec	Text			x		
ZIP or member_zip	Static from latest quarterly data submitted	Numeric	x	1.2%			
Zip3	First three characters of member's zip code	Numeric					
cco_id	Unique identifier for Medicaid coordinated care organizations from the Medicaid supplemental monthly recipient eligibility file	Numeric	x				
cco_id_desc	Name of Medicaid coordinated care organizations	Text	x				
CDE_PERC	Medicaid program eligibility codes	See PERC table	x				
OHA_Medicaid_cde_pgm_health	Medicaid health plan type for Medicaid recipients only	See cde pgm health table	x				
OHA_Medicaid_cde_enroll_recip_status	Medicaid enrollment status for Medicaid recipients only	See cde enroll status table	x				
OHA_Medicaid_cde_del_type	Medicaid healthcare delivery system type for Medicaid recipients only: Physical Health, Mental, or Denta	See cde delivery type table	x				
OHA_Medicaid_cde_mc_region or CDE_MC_Region	Medicaid member managed care region location: different geographical zip codes, counties, or the entire state for Medicaid recipients only	Region values available by request	x				

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Restricted Access Data Elements that Require Strong Justification and Detailed Data Security and Release Plan:							
OHA_Medicaid_cde_medicare_status	Medicare Third Party Resource (TPR) health insurance coverage for Medicaid recipients only: MA, MB, or MAB. Blank if the Mediciad recipient does not have Medicare coverage	See cde Medicare status table	x				
OHA_Medicaid_dosbeg	Begin date of service for Medicaid recipients only	date	x				
OHA_Medicaid_dosend	End date of service for Medicaid recipients only	date	x				
OHA_Medicaid_ind_tp	Third party payer for Medicaid members only	Y(yes), N (no)	x				
BR_Payer_Lob	Combines Payer_LOB and OEBB_PEBB from payer reported member eligibility. PEBB and OEBB members are removed from commercial and assigned PEBB or OEBB	Commercial, Medicaid, Medicare, PEBB, OEBB, Null	x				
BR_YEARMONTH	Minimum from date for the entire claim (MC059). This may be different than the from date on each service line	YYYYMM	x				
BR_YEAR	Year of the minimum from date of service for the entire claim (MC059). This may be different than the from date on each service line	YYYY	x				
Product_code	OHA medicaid supplemental eligibility data file	C or M for Medicaid. All else null	x				

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Restricted Access Data Elements that Require Strong Justification and Detailed Data Security and Release Plan:							
AMT_withhold	Amount withheld for risk pool. Stopped collecting in 2017	Two decimal places. 0 if amount equals zero. Blank if missing	x				
Oregon_HVMH_Flag_Desc	high value medical home flag description. Stopped data collection 2017	1 (medical home), 0 (otherwise)	x				
Oregon_HVMH_clinic_Desc	high value medical home clinic description. Stopped data collection 2017	Text	x				
HVMH_eff_date	high value medical home begin date. Stopped data collection 2017	yyyy-mm-dd	x				
HVMH_Term_date	high value medical homeTermination date. Stopped data collection 2017	yyyy-mm-dd	x				
Provider is PCP	HEDIS processing in Q-Corp Initiative. Payer defined.Stopped collecting from payers in 2016	Y or N	x				
Provider is OB/GYN	HEDIS processing in Q-Corp Initiative. Payer defined.Stopped collecting from payers in 2016	Y or N	x				
Provider is mental health	HEDIS processing in Q-Corp Initiative. Payer defined.Stopped collecting from payers in 2016	Y or N	x				
Provider is eye care	HEDIS processing in Q-Corp Initiative. Payer defined.Stopped collecting from payers in 2016	Y or N	x				
Provider is dentist	HEDIS processing in Q-Corp Initiative. Payer defined.Stopped collecting from payers in 2016	Y or N	x				

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Restricted Access Data Elements that Require Strong Justification and Detailed Data Security and Release Plan:							
Provider is nephrologist	HEDIS processing in Q-Corp Initiative. Payer defined.Stopped collecting from payers in 2016	Y or N	x				
Provider is chem depen	HEDIS processing in Q-Corp Initiative. Payer defined.Stopped collecting from payers in 2016	Y or N	x				
Provider is nurse practitioner	HEDIS processing in Q-Corp Initiative. Payer defined.Stopped collecting from payers in 2016	Y or N	x				
Provider is physician assistant	HEDIS processing in Q-Corp Initiative. Payer defined.Stopped collecting from payers in 2016	Y or N	x				
Provider is prescribe rx	HEDIS processing in Q-Corp Initiative. Payer defined.Stopped collecting from payers in 2016	Y or N	x				
Lab_result	Stopped collecting from payers in 2017	Text	x				
Albumin_result	Stopped collecting from payers in 2018	Text	x				

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Restricted Access Data Elements that Are Never Shared or Rarely Shared, require Strong Justification, Detailed Data Security and Release Plan, and Subject to DOJ review:							
payer reported member ID	Reported payer specific member identifier used by vendor to create patient ID and member ID		x				
Medicaid_delivery_system	From the Medicaid supplemental claims file and only populated for Medicaid members						
OHA_Medicaid_ID	Unique person Medicaid recipient identifier. Medicaid ID does not indicate Medicaid enrollment by itself. Enrollment dates by APAC product code Medicaid types indicate Medicaid enrollment	Text	x				
prov_ID or att_prov_id	Only for Medicaid payer and includes payer ID. All others nul	Text	x				
Bill_prov_ID	Only for Medicaid payer and includes payer ID. All others nul	Text	x				
payer_id	Unique identifier for each payer	Text			x		
Payer_ID_Description	Payer reported name	Text			x		
HIOS_ID	Identifier required for qualified health plans (QHPs) defined in the ACA	Numeric. If plan is not a QHP (99999999999999)	x	0.0%			
substance_abuse_flag	Identifies if a claim is a substance abuse claim. See logic in substance abuse tab. These claims are not available for request	Null, 1			x		

Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data
Restricted Access Data Elements that Are Never Shared or Rarely Shared, require Strong Justification, Detailed Data Security and Release Plan, and Subject to DOJ review:							
allowed or amt_allowed	Allowed amount	Two decimal places. 0 if amount equals zero. Blank if missing	x	0.0%			
AMT_allowed_Disc	Description amount allowec	Text			x		
Mem_DOE	member date of birth	YYYYMM	x	1.2%			
Mem_DOD	member date of death-only reported by the Centers for Medicaid and Medicare	YYYYMM	x				
Subscriber last name	Subscriber last name	Text	x	1.2%			
subscriber first name	Subscriber first name	Text	x	1.2%			
Subscirber middle name	Subscirber middle name	Text	x				
Member last name	Member last name	Text	x	1.2%			
Member first name	Member first name	Text	x	1.2%			
Member middle nam	Member middle nam	Text	x				
street address	street address	Text	x	1.2%			
city	city	Text	x	1.2%			

Relationship Codes

Value	Description
1	Spouse
4	Grandfather or Grandmother
5	Grandson or Granddaughter
7	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
18	Self
19	Child
20	Employee
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner

Health Care Group (HCG)

Value	Description	Setting
I11a	HIP Medical - General	1. Facility Inpatient
I11b	HIP Medical - Rehabilitation	1. Facility Inpatient
I12	HIP Surgical	1. Facility Inpatient
I13a	HIP Psychiatric - Hospital	1. Facility Inpatient
I13b	HIP Psychiatric - Residential	1. Facility Inpatient
I14a	HIP Alcohol and Drug Abuse - Hospital	1. Facility Inpatient
I14b	HIP Alcohol and Drug Abuse - Residential	1. Facility Inpatient
I21a	HIP Mat Norm Delivery	1. Facility Inpatient
I21b	HIP Mat Norm Delivery - Mom\Baby Cmbnd	1. Facility Inpatient
I22a	HIP Mat Csect Delivery	1. Facility Inpatient
I22b	HIP Mat Csect Delivery - Mom\Baby Cmbnd	1. Facility Inpatient
I23a	HIP Well Newborn - Normal Delivery	1. Facility Inpatient
I23b	HIP Well Newborn - Csect Delivery	1. Facility Inpatient
I23c	HIP Well Newborn - Unknown Delivery	1. Facility Inpatient
I24	HIP Other Newborn	1. Facility Inpatient
I25	HIP Maternity Non-Delivery	1. Facility Inpatient
I31	HIP SNF	1. Facility Inpatient
O10	HOP Observation	2. Facility Outpatient
O11	HOP Emergency Room	2. Facility Outpatient
O12a	HOP Surgery - Hospital Outpatient	2. Facility Outpatient
O12b	HOP Surgery - Ambulatory Surgery Center	2. Facility Outpatient
O13a	HOP Radiology General - Therapeutic	2. Facility Outpatient
O13b	HOP Radiology General - Diagnostic	2. Facility Outpatient
O14a	HOP Radiology - CT/MRI/PET - CT Scan	2. Facility Outpatient
O14b	HOP Radiology - CT/MRI/PET - MRI	2. Facility Outpatient
O14c	HOP Radiology - CT/MRI/PET - PET	2. Facility Outpatient
O15	HOP Pathology/Lab	2. Facility Outpatient
O16a	HOP Pharmacy - General	2. Facility Outpatient
O16b	HOP Pharmacy - Chemotherapy	2. Facility Outpatient
O17	HOP Cardiovascular	2. Facility Outpatient
O18	HOP PT/OT/ST	2. Facility Outpatient
O31a	HOP Psychiatric - Partial Hospitalization	2. Facility Outpatient
O31b	HOP Psychiatric - Intensive Outpatient	2. Facility Outpatient
O32a	HOP Alcohol & Drug Abuse - Partial Hospitalization	2. Facility Outpatient
O32b	HOP Alcohol & Drug Abuse - Intensive Outpatient	2. Facility Outpatient
O41a	HOP Other - General	2. Facility Outpatient
O41b	HOP Other - Blood	2. Facility Outpatient
O41d	HOP Other - Clinic	2. Facility Outpatient
O41e	HOP Other - Diagnostic	2. Facility Outpatient
O41f	HOP Other - Dialysis	2. Facility Outpatient
O41g	HOP Other - DME/Supplies	2. Facility Outpatient
O41h	HOP Other - Trtmt/SpcltySvcs	2. Facility Outpatient
O41j	HOP Other - Pulmonary	2. Facility Outpatient
O41l	HOP Other - Urgent Care	2. Facility Outpatient

Health Care Group (HCG)

Value	Description	Setting
O51a	HOP Preventive - General	2. Facility Outpatient
O51b	HOP Preventive - Colonoscopy	2. Facility Outpatient
O51c	HOP Preventive - Mammography	2. Facility Outpatient
O51d	HOP Preventive - Lab	2. Facility Outpatient
P11	PHY Inpatient Surgery	3. Professional
P13	PHY Inpatient Anesthesia	3. Professional
P14	PHY Outpatient Surgery	3. Professional
P15	PHY Office Surgery	3. Professional
P16	PHY Outpatient Anesthesia	3. Professional
P21a	PHY Maternity - Normal Deliveries	3. Professional
P21b	PHY Maternity - Cesarean Deliveries	3. Professional
P21c	PHY Maternity - Non-Deliveries	3. Professional
P21d	PHY Maternity - Ancillary	3. Professional
P21e	PHY Maternity - Anesthesia	3. Professional
P31d	PHY Inpatient Visits - Medical	3. Professional
P31e	PHY Inpatient Visits - Psychiatric	3. Professional
P31f	PHY Inpatient Visits - Alcohol and Drug Abuse	3. Professional
P32c	PHY Office/Home Visits - PCP	3. Professional
P32d	PHY Office/Home Visits - Specialist	3. Professional
P33	PHY Urgent Care Visits	3. Professional
P34a	PHY Office Administered Drugs - General	3. Professional
P34b	PHY Office Administered Drugs - Chemotherapy	3. Professional
P35	PHY Allergy Testing	3. Professional
P36	PHY Allergy Immunotherapy	3. Professional
P37a	PHY Miscellaneous Medical - General	3. Professional
P37b	PHY Miscellaneous Medical - Gastroenterology	3. Professional
P37c	PHY Miscellaneous Medical - Ophthalmology	3. Professional
P37d	PHY Miscellaneous Medical - Otorhinolaryngology	3. Professional
P37e	PHY Miscellaneous Medical - Vestibular Function Tests	3. Professional
P37f	PHY Miscellaneous Medical - Non-Invas. Vasc. Diag. Studies	3. Professional
P37g	PHY Miscellaneous Medical - Pulmonology	3. Professional
P37h	PHY Miscellaneous Medical - Neurology	3. Professional
P37i	PHY Miscellaneous Medical - Central Nervous System Tests	3. Professional
P37j	PHY Miscellaneous Medical - Dermatology	3. Professional
P37k	PHY Miscellaneous Medical - Dialysis	3. Professional
P40a	PHY Preventive Other - General	3. Professional
P40b	PHY Preventive Other - Colonoscopy	3. Professional
P40c	PHY Preventive Other - Mammography	3. Professional
P40d	PHY Preventive Other - Lab	3. Professional
P41	PHY Preventive Immunizations	3. Professional
P42	PHY Preventive Well Baby Exams	3. Professional
P43	PHY Preventive Physical Exams	3. Professional
P44	PHY Vision Exams	3. Professional
P45	PHY Hearing and Speech Exams	3. Professional

Health Care Group (HCG)

Value	Description	Setting
P51a	PHY ER Visits and Observation Care - Observation Care	3. Professional
P51b	PHY ER Visits and Observation Care - ER Visits	3. Professional
P53	PHY Physical Therapy	3. Professional
P54	PHY Cardiovascular	3. Professional
P55b	PHY Radiology IP - CT Scan	3. Professional
P55c	PHY Radiology IP - MRI	3. Professional
P55d	PHY Radiology IP - PET	3. Professional
P55e	PHY Radiology IP - General - Therapeutic	3. Professional
P55f	PHY Radiology IP - General - Diagnostic	3. Professional
P56a	PHY Radiology OP - General - Therapeutic	3. Professional
P56b	PHY Radiology OP - General - Diagnostic	3. Professional
P57a	PHY Radiology OP- CT/MRI/PET - CT Scan	3. Professional
P57b	PHY Radiology OP- CT/MRI/PET - MRI	3. Professional
P57c	PHY Radiology OP- CT/MRI/PET - PET	3. Professional
P58c	PHY Radiology Office - General - Therapeutic	3. Professional
P58d	PHY Radiology Office - General - Diagnostic	3. Professional
P58e	PHY Radiology Office - General - Radiology Center - Therapeutic	3. Professional
P58f	PHY Radiology Office - General - Radiology Center - Diagnostic	3. Professional
P59a	PHY Radiology Office - CT/MRI/PET - CT Scan	3. Professional
P59b	PHY Radiology Office - CT/MRI/PET - MRI	3. Professional
P59c	PHY Radiology Office - CT/MRI/PET - PET	3. Professional
P59d	PHY Radiology Office - CT/MRI/PET - CT Scan - Radiology Center	3. Professional
P59e	PHY Radiology Office - CT/MRI/PET - MRI - Radiology Center	3. Professional
P59f	PHY Radiology Office - CT/MRI/PET - PET - Radiology Center	3. Professional
P61a	PHY Pathology/Lab - Inpatient & Outpatient - Inpatient	3. Professional
P61b	PHY Pathology/Lab - Inpatient & Outpatient - Outpatient	3. Professional
P63a	PHY Pathology/Lab - Office - General	3. Professional
P63b	PHY Pathology/Lab - Office - Venipuncture	3. Professional
P63c	PHY Pathology/Lab - Office - Independent Lab	3. Professional
P65	PHY Chiropractor	3. Professional
P66	PHY Outpatient Psychiatric	3. Professional
P67	PHY Outpatient Alcohol & Drug Abuse	3. Professional
P81a	OTH Prescription Drugs - Non-Specialty Generic	4. Prescription Drug
P81b	OTH Prescription Drugs - Non-Specialty Multi Source Brand	4. Prescription Drug
P81c	OTH Prescription Drugs - Non-Specialty Single Source Brand	4. Prescription Drug
P81e	OTH Prescription Drugs - OTC	4. Prescription Drug
P81g	OTH Prescription Drugs - Specialty	4. Prescription Drug
P82a	OTH Private Duty Nursing/Home Health - HH	5. Ancillary
P82b	OTH Private Duty Nursing/Home Health - Hospice	5. Ancillary
P83	OTH Ambulance	5. Ancillary
P84	OTH DME and Supplies	5. Ancillary
P85	OTH Prosthetics	5. Ancillary
P89	OTH Benefits Glasses/Contacts	5. Ancillary
P99a	OTH Benefits Other - General	5. Ancillary

Health Care Group (HCG)

Value	Description	Setting
P99b	OTH Benefits Other - Hearing Aids	5. Ancillary
P99c	OTH Benefits Other - Dental	5. Ancillary
P99d	OTH Benefits Other - Acupuncture	5. Ancillary
P99e	OTH Benefits Other - Reproductive Medicine	5. Ancillary
P99f	OTH Benefits Other - Temporary Codes	5. Ancillary
P99g	OTH Benefits Other - Documentation/Unclassified	5. Ancillary
P99h	OTH Benefits Other - Non-Emergency Transportation	5. Ancillary

Health Care grouper (HCG) and Plan Benefit Package (PBP) Description

Value	Description	Medicare Covered
A01	Inpatient Hospital - Acute	1
A02	Inpatient Hospital - MH/SA	1
A03	Inpatient Psychiatric	1
A06	Skilled Nursing Services	1
A08	Home Health Services	1
B10	Emergency Care / Post Stabilization Care	1
B11	Urgently Needed Care / Urgent Care Centers	1
B15	Partial Hospitalization	1
B16a	Mental Hlth Spec - Non-Physician (Group and Individual)	1
B16b	Psychiatric Services (Group and Individual)	1
B16c	Outpatient Substance Abuse Svcs	1
B20a	Cardiac Rehabilitation Services	1
B20b	Pulmonary Rehabilitation Services	1
B21a	Occupational Therapy Services	1
B21b	Physical and Speech Therapy	1
B25	Primary Care - Consults/Office Visits/Home Visits	1
B26	Physician Specialist Services - Consults/Office Visits/Home Visits	1
B27	Chiropractic Services	1
B28a	Podiatry Services	1
B28b	Diabetic Footcare	1
B29	Vision Exams	1
B31	Hearing Exams	1
B40a	Physical Exams (Initial Exam and Annual Wellness Visit)	1
B40b	Routine Exams (Covered and Non-Covered)	0
B41	Immunizations	1
B42a	Professional - Other Preventive Services	1
B42b	Pap Smears and Pelvic Exams Screening	1
B42c	Prostate Cancer Screening	1
B42d	Colorectal Screening	1
B42e	Bone Mass Measurement	1
B42f	Mammography Screening	1
B42g	Nutrition Training for Diabetes & Renal Dialysis	1
B42h	Kidney Disease Education Services	1
B42i	Diabetes Self-Management Training	1
B45	Outpatient Diagnostic Procedures/Tests/Lab	1
B47a	Outpatient Radiological Services - X-Rays	1
B47b	Outpatient Radiological Services - General Diagnostic	1
B47c	Outpatient Radiological Services - Complex Diagnostic	1
B47d	Outpatient Radiological Services - Therapeutic	1
B50	Physician Services - Pathology/Lab	1
B52a	Physician Services - X-Rays	1
B52b	Physician Services - General Diagnostic Radiology	1
B52c	Physician Services - Complex Diagnostic Radiology	1
B52d	Physician Services - Therapeutic Radiology	1
B55	Outpatient Hospital Services - Surgery	1

Health Care grouper (HCG) and Plan Benefit Package (PBP) Description

Value	Description	Medicare Covered
B56	Ambulatory Surgical Center Services	1
B60	Outpatient Hospital Services - Preventive	1
B61	Blood	1
B62a	Outpatient Hospital Services - Observation Care	1
B62b	Outpatient Hospital Services - Other	1
B62c	Rehab Services (CORF)	1
B65	Physician Services - Inpatient and Outpatient Surgery	1
B66	Physician Services - Office Surgery	1
B67a	Primary Care - Facility Visits	1
B67b	Physician Specialist Services - Facility Visits	1
B68	Physician Services - Other	1
B70	Medicare Part B Drugs - General - Hospital	1
B71	Medicare Part B Drugs - Chemotherapy - Hospital	1
B72	Medicare Part B Drugs - General - Office	1
B73	Medicare Part B Drugs - Chemotherapy - Office	1
B75	Ambulance	1
B76	Durable Medical Equipment	1
B77	Medical Supplies	1
B78	Diabetes Supplies	1
B79	Prosthetics Devices	1
B80	Renal Dialysis	1
D95	Prescription Drugs	0
X27	Chiropractic Services - Routine (Non-Covered)	0
X28	Routine Footcare (Non-Covered)	0
X29	Routine Eye Exams (Non-Covered)	0
X30	Glasses/Contacts (Non-Covered)	0
X31	Routine Hearing Test (Non-Covered)	0
X32	Hearing Aids (Non-Covered)	0
X41	Immunizations (Non-Covered)	0
X42b	Additional Pap Smears and Pelvic Exams Screening (Non-Covered)	0
X42c	Additional Prostate Cancer Screening (Non-Covered)	0
X42d	Additional Colorectal Screening (Non-Covered)	0
X42f	Additional Mammography Screening (Non-Covered)	0
X90	Services not Provided within the United States	0
X91	Transportation (Non-Covered)	0
X92a	Preventive Dental (Non-Covered)	0
X92b	Comprehensive Dental (Non-Covered)	0
X93	Acupuncture (Non-Covered)	0
X94	Hospice	1
X95	Medicare Part B Drugs - Pharmacy	1

Product Code

Value	Description	Line of Business (LOB)
MDE	Medicaid dual eligible HMO	Medicaid
MD	Medicaid disabled HMO	Medicaid
MLI	Medicaid low income HMO	Medicaid
MRB	Medicaid restricted benefit HMO	Medicaid
MR	Medicare Advantage HMO	Medicare
MP	Medicare Advantage PPO	Medicare
MPD	Medicare Part D only*	Medicare
MC	Medicare Cost	Medicare
PPO	Commercial PPO	Commercial
POS	Commercial POS	Commercial
HMO	Commercial HMO	Commercial
SN1	Special needs plan – chronic condition	Medicare
SN2	Special needs plan – institutionalized	Medicare
SN3	Special needs plan – dual eligible	Medicare
CHP	Children's Health Insurance Program (SCHIP)	Medicaid
MDF	Medicaid fee-for-service	Medicaid
SIP	Self-insured PPO	Commercial
SIF	Self-insured POS	Commercial
SIH	Self-insured HMO	Commercial
PH	Pharmacy benefits only*	Commercial
IN	Commercial indemnity	Commercial
EPO	Commercial EPO	Commercial
SL	Commercial stop loss	Commercial
ZZ	Unknown	Commercial
Null	Null	Commercial

Claim Specific Line of Business

1.The Payer LOB value from the member month record linked to the claim is used for the claims specific LOB unless that value is not consistent with the payer's known line of business in the table below

2. If the Payer LOB from the member month record is not consistent with the payer's known LOB in the table below, the value is overwritten with the payer default LOB listed

3.Claims with null LOB Payer LOB from the member month record linked to the claim are assigned commercial for the claim specific LOB

Payer Abbreviation	Payer Name	Payer Default LOB
PTI	PTI - National Pharmaceutical Services	Commercial
UHC	UNITEDHEALTHCARE INSURANCE COMPANY	Commercial
AI	A & I BENEFIT PLAN ADMINISTRATORS INC	Commercial
UMR	UMR INC	Commercial
HARR	HARRINGTON HEALTH SERVICES INC	Commercial
LWH	LIFEWISE HEALTH PLAN OF OREGON INC.	Commercial
CAREOR	HEALTH PLAN OF CAREOREGON INC.	Medicare
MRIPA	MID ROGUE HEALTH PLAN, INC.	Medicare
OHA	OHA	Medicaid
UHCM	UHCM	Medicare
UHCOR	UHCOR	Commercial
UHCORM	UHCORM	Medicare
UHS	UHS	Commercial
CMS	MEDICARE FFS	Medicare
TIME	TIME INSURANCE COMPANY	Commercial
HMA	HEALTHCARE MANAGEMENT ADMIN	Commercial
SHASTA	SHASTA ADMINSTRATIVE SVCS INC	Commercial
BOON	BOON	Commercial
SRC	SRC	Commercial

* List provided by Milliman November 2017

Type of Bill

First digit: type of facility

Value	Description
1	Hospital
2	Skilled Nursing
3	Home Health
4	Christian Science Hospital
5	Christian Science Extended Care
6	Intermediate Care
7	Clinic
8	Special Facility

Second Digit if First Digit = 1-6

Value	Description
1	Inpatient (Including Medicare Part A)
2	Inpatient (Medicare Part B Only)
3	Outpatient
4	Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
5	Nursing Facility Level I
6	Nursing Facility Level II
7	Intermediate Care -Level III Nursing Facility
8	Swing Beds

Second Digit if First Digit =7

Value	Description
1	Rural Health
2	Hospital Based or Independent Renal Dialysis Center
3	Free Standing Outpatient Rehabilitation Facility (ORF)
5	Comprehensive Outpatient Rehabilitation Facilities (CORFs)
6	Nursing Facility Level II
7	Community Mental Health Center
9	Other

Second Digit if First Digit = 8

Value	Description
1	Hospice (Non Hospital Based)
2	Hospice (Hospital-Based)
3	Ambulatory Surgery Center
4	Free Standing Birthing Center
9	Other

Type of Bill

Third digit: claim frequency

Value	Description
1	Admit Through Discharge
2	Interim-First Claim
3	Interim-Continuing Claims
4	Interim-Last Claim
5	Late Charge Only
7	Replacement of Prior Claim
8	Void/Cancel of a Prior Claim
9	Final Claim for a Home Health Encounter

Place of Service

Value	Description
0	Not supplied
1	Pharmacy
2	Telehealth
3	School
4	Homeless Shelter
5	Indian Health Service Freestanding Facility
6	Indian Health Service Provider-Based Facility
7	Tribal 638 Freestanding Facility
8	Tribal 638 Provider-Based Facility
9	Prison/Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Off campus-Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance-Land
42	Ambulance-Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility-Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility

Place of Service

Value	Description
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

Admission Source

Value	Description: Value if Admission Type <> 4
0	ANOMALY: invalid value, if present, translate to '9'
1	Non-Health Care Facility Point of Origin (Physician Referral): The patient was admitted to this facility upon an order of a physician.
2	Clinic referral: The patient was admitted upon the recommendation of this facility's clinic physician.
3	HMO referral: Reserved for National Assignment. Prior to 3/08, HMO referral: The patient was admitted upon the recommendation of a health maintenance organization (HMO) physician.
4	Transfer from a hospital (different facility): The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient.
5	Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF): The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.
6	Transfer from another health care facility: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient.
7	Emergency room: The patient was admitted to this facility after receiving services in this facility's emergency room.
8	Court/law enforcement: The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.
9	Information not available: The means by which the patient was admitted is not known.
A	Reserved for National Assignment. (eff. 3/08) Prior to 3/08 defined as: Transfer from a Critical Access Hospital: patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.
B	Transfer from Another Home Health Agency: The patient was admitted to this home health agency as a transfer from another home health agency.(Discontinued July 1,2010- See Condition Code 47)
C	Readmission to Same Home Health Agency: The patient was readmitted to this home health agency within the same home health episode period. (Discontinued July 1, 2010)
D	Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer: The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.
E	Transfer from Ambulatory Surgical Center
F	Transfer from hospice and is under a hospice plan of care or enrolled in hospice program
Value	**Value if Admission type = 4**
1	Normal delivery - A baby delivered without complications. ***Invalid for discharges after 12/31/2011.***
2	Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status. ***Invalid for discharges after 12/31/2011.***
3	Sick baby - A baby delivered with medical complications, other than those relating to premature status. ***Invalid for discharges after 12/31/2011.***
4	Extramural birth - A baby delivered in a non-sterile environment. ***Invalid for discharges after 12/31/2011.***
5	Born inside this hospital.
6	Born outside this hospital.
7 to 8	Reserved for national assignment.
9	Information not available.

Discharge Status

Value	Description
1	Discharged to home or self care
2	Discharged/transferred to another short term general hospital for inpatient care
3	Discharged/transferred to skilled nursing facility (SNF)
4	Discharged/transferred to nursing facility (NF)
5	Discharged/transferred to a designated cancer center or children's hospital
6	Discharged/transferred to home under care of organized home health service organization
7	Left against medical advice or discontinued care
8	Discharged/transferred to home under care of a Home IV provider
9	Admitted as an inpatient to this hospital
20	Expired
21	Discharged/transferred to court/law enforcement
30	Still patient or expected to return for outpatient services
40	Expired at home
41	Expired in a medical facility
42	Expired, place unknown
43	Discharged/transferred to a Federal hospital
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to a hospital based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital
63	Discharge/transferred to a long-term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a critical access hospital (CAH)
70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list

Modifiers

CPT or HCPCS modifier with all digits and numeric codes. For a complete up to date list see: https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html

Modifier - as the name implies a modifier will modify a service / procedure or an item under certain circumstances for appropriate reimbursement. Modifiers may add information or change the description according to the physician documentation to give more specificity for the service or procedure rendered. Appending of an appropriate modifier will effectively respond to

Modifier are two digit codes and are categorized into two levels
1. Level I Modifiers: Normally known as CPT Modifiers and consists of two numeric digits and are updated annually by AMA - American Medical Association.
2. Level II Modifiers: Normally known as HCPCS Modifiers and consists of two digits (Alpha / Alphanumeric characters) in the sequence AA through VP. These modifiers are annually updated by CMS - Centres for Medicare and Medicaid Services.

Both the above levels of Modifiers are recognized nationally.

List of Level I Modifiers:
Modifier -21 Prolonged Evaluation and Management Services (Deleted, please use CPT 99354-
Modifier -22 Unusual Procedural Services
Modifier -23 Unusual Anesthesia
Modifier -24 Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period
Modifier -25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
Modifier -26 Professional Component
Modifier -27 Multiple Outpatient Hospital E/M Encounters on the Same Date.
Modifier -29 Global procedures, those procedures where one provider is responsible for both the professional and technical component. This modifier has been deleted. If a provider is billing for a global service, no modifier is necessary.
Modifier -32 Mandated Services
Modifier -33 Preventive Service
Modifier -47 Anesthesia by Surgeon
Modifier -50 Bilateral Procedure
Modifier -51 Multiple Procedures
Modifier -52 Reduced Services
Modifier -53 Discontinued Procedure
Modifier -54 Surgical Care Only
Modifier -55 Postoperative Management Only
Modifier -56 Preoperative Management Only
Modifier -57 Decision for Surgery
Modifier -58 Staged or Related Procedure or Service by the Same Physician During the
Modifier -59 Distinct Procedural Service
Modifier -62 Two Surgeons
Modifier -63 Procedure Performed on Infants less than 4kg

Modifiers

Modifier -66 Surgical Team
Modifier -73 Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure prior to the Administration of Anesthesia
Modifier -74 Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure after Administration of Anesthesia
Modifier -76 Repeat Procedure by Same Physician
Modifier -77 Repeat Procedure by Another Physician
Modifier -78 Return to the Operating Room for a Related Procedure During the Postoperative
Modifier -79 Unrelated Procedure or Service by the Same Physician During the Postoperative
Modifier -80 Assistant Surgeon
Modifier -81 Minimum Assistant Surgeon
Modifier -82 Assistant Surgeon (when qualified resident surgeon not available)
Modifier -90 Reference (Outside) Laboratory
Modifier -91 Repeat Clinical Diagnostic Laboratory Test
Modifier -92 Alternative Laboratory Platform Testing
Modifier -96 Habilitative Services
Modifier -97 Rehabilitative Services
Modifier -99 Multiple Modifiers

Dispense as Written

Value	Description
0	No product selection indicated
1	Substitution not allowed by provider
2	Substitution allowed- patient requested product dispensed
3	Substitution allowed- pharmacist selected product dispensed
4	Substitution allowed- generic drug not in stock
5	Substitution allowed- brand drug dispensed as generic
6	Override
7	Substitution not allowed- brand drug mandated by law
8	Substitution allowed- generic drug not available in marketplace
9	Other

Language

Value	Description	MI7CODE
ang	English, Old (ca. 450-1100)	1
eng	English	1
enm	English, Middle (ca. 1100-1500)	1
spa	Spanish	2
ine	Indo-European (Other)	3
lat	Latin	3
swe	Swedish	3
ind	Indonesian	4
jpn	Japanese	4
tha	Thai	4
vie	Vietnamese	4
aar	Afar	8
abk	Abkhaz	8
ace	Achinese	8
ach	Acoli	8
ada	Adangme	8
afa	Afroasiatic (Other)	8
afh	Afrihili (Artificial language)	8
afr	Afrikaans	8
aka	Akan	8
akk	Akkadian	8
alb	Albanian	8
ale	Aleut	8
alg	Algonquian (Other)	8
amh	Amharic	8
apa	Apache languages	8
ara	Arabic	8
arc	Aramaic	8
arm	Armenian	8
arn	Mapuche	8
arp	Arapaho	8
art	Artificial (Other)	8
arw	Arawak	8
asm	Assamese	8
ath	Athapascan (Other)	8
aus	Australian languages	8
ava	Avaric	8
ave	Avestan	8
awa	Awadhi	8
aym	Aymara	8
aze	Azerbaijani	8
bad	Banda	8
bai	Bamileke languages	8
bak	Bashkir	8
bal	Baluchi	8

Language

Value	Description	MI7CODE
bam	Bambara	8
ban	Balinese	8
baq	Basque	8
bas	Basa	8
bat	Baltic (Other)	8
bej	Beja	8
bel	Belarusian	8
bem	Bemba	8
ben	Bengali	8
ber	Berber (Other)	8
bho	Bhojpuri	8
bih	Bihari	8
bik	Bikol	8
bin	Bini	8
bis	Bislama	8
bla	Siksika	8
bnt	Bantu (Other)	8
bos	Bosnian	8
bra	Braj	8
bre	Breton	8
btk	Batak	8
bua	Buriat	8
bug	Bugis	8
bul	Bulgarian	8
bur	Burmese	8
cad	Caddo	8
cai	Central American Indian (Other)	8
car	Carib	8
cat	Catalan	8
cau	Caucasian (Other)	8
ceb	Cebuano	8
cel	Celtic (Other)	8
cha	Chamorro	8
chb	Chibcha	8
che	Chechen	8
chg	Chagatai	8
chi	Chinese	8
chk	Truk	8
chm	Mari	8
chn	Chinook jargon	8
cho	Choctaw	8
chp	Chipewyan	8
chr	Cherokee	8
chu	Church Slavic	8
chv	Chuvash	8

Language

Value	Description	MI7CODE
chy	Cheyenne	8
cmc	Chamic languages	8
cop	Coptic	8
cor	Cornish	8
cos	Corsican	8
cpe	Creoles and Pidgins, English-based	8
cpf	Creoles and Pidgins, French-based (	8
cpp	Creoles and Pidgins, Portuguese-ba	8
cre	Cree	8
crp	Creoles and Pidgins (Other)	8
cus	Cushitic (Other)	8
cze	Czech	8
dak	Dakota	8
dan	Danish	8
day	Dayak	8
del	Delaware	8
den	Slave	8
dgr	Dogrib	8
din	Dinka	8
div	Divehi	8
doi	Dogri	8
dra	Dravidian (Other)	8
dua	Duala	8
dum	Dutch, Middle (ca. 1050-1350)	8
dut	Dutch	8
dyu	Dyula	8
dzo	Dzongkha	8
efi	Efik	8
egy	Egyptian	8
eka	Ekajuk	8
elx	Elamite	8
epo	Esperanto	8
est	Estonian	8
ewe	Ewe	8
ewo	Ewondo	8
fan	Fang	8
fao	Faroese	8
fat	Fanti	8
fij	Fijian	8
fin	Finnish	8
fiu	Finno-Ugrian (Other)	8
fon	Fon	8
fre	French	8
frm	French, Middle (ca. 1400-1600)	8
fro	French, Old (842-ca. 1400)	8

Language

Value	Description	MI7CODE
fry	Frisian	8
ful	Fula	8
fur	Friulian	8
gaa	Gã	8
gay	Gayo	8
gba	Gbaya	8
gem	Germanic (Other)	8
geo	Georgian	8
ger	German	8
gez	Ethiopic	8
gil	Gilbertese	8
gla	Scottish Gaelic	8
gle	Irish	8
glg	Galician	8
glv	Manx	8
gmh	German, Middle High (ca. 1050-150(	8
goh	German, Old High (ca.750-1050)	8
gon	Gondi	8
gor	Gorontalo	8
got	Gothic	8
grb	Grebo	8
grc	Greek, Ancient (to 1453)	8
gre	Greek, Modern (1453-)	8
grn	Guarani	8
guj	Gujarati	8
gwi	Gwich’in	8
hai	Haida	8
hau	Hausa	8
haw	Hawaiian	8
heb	Hebrew	8
her	Herero	8
hil	Hiligaynon	8
him	Himachali	8
hin	Hindi	8
hit	Hittite	8
hmn	Hmong	8
hmo	Hiri Motu	8
hun	Hungarian	8
hup	Hupa	8
iba	Iban	8
ibo	Igbo	8
ice	Icelandic	8
ijo	Ijo	8
iku	Inuktitut	8
ile	Interlingue	8

Language

Value	Description	MI7CODE
ilo	Iloko	8
ina	Interlingua (International Auxiliary La	8
inc	Indic (Other)	8
ipk	Inupiaq	8
ira	Iranian (Other)	8
iro	Iroquoian (Other)	8
ita	Italian	8
jav	Javanese	8
jpr	Judeo-Persian	8
jrb	Judeo-Arabic	8
kaa	Kara-Kalpak	8
kab	Kabyle	8
kac	Kachin	8
kal	Kalâtdlisut	8
kam	Kamba	8
kan	Kannada	8
kar	Karen	8
kas	Kashmiri	8
kau	Kanuri	8
kaw	Kawi	8
kaz	Kazakh	8
kha	Khasi	8
khi	Khoisan (Other)	8
khm	Khmer	8
kho	Khotanese	8
kik	Kikuyu	8
kin	Kinyarwanda	8
kir	Kyrgyz	8
kmb	Kimbundu	8
kok	Konkani	8
kom	Komi	8
kon	Kongo	8
kor	Korean	8
kos	Kusaie	8
kpe	Kpelle	8
kro	Kru (Other)	8
kru	Kurukh	8
kua	Kuanyama	8
kum	Kumyk	8
kur	Kurdish	8
kut	Kutenai	8
lad	Ladino	8
lah	Lahnda	8
lam	Lamba	8
lao	Lao	8

Language

Value	Description	MI7CODE
lav	Latvian	8
lez	Lezgian	8
lin	Lingala	8
lit	Lithuanian	8
lol	Mongo-Nkundu	8
loz	Lozi	8
ltz	Letzeburgesch	8
lua	Luba-Lulua	8
lub	Luba-Katanga	8
lug	Ganda	8
lui	Luiseño	8
lun	Lunda	8
luo	Luo (Kenya and Tanzania)	8
lus	Lushai	8
mac	Macedonian	8
mad	Madurese	8
mag	Magahi	8
mah	Marshall	8
mai	Maithili	8
mak	Makasar	8
mal	Malayalam	8
man	Mandingo	8
mao	Maori	8
map	Austronesian (Other)	8
mar	Marathi	8
mas	Masai	8
may	Malay	8
mdr	Mandar	8
men	Mende	8
mga	Irish, Middle (ca. 1100-1550)	8
mic	Micmac	8
min	Minangkabau	8
mis	Miscellaneous languages	8
mkh	Mon-Khmer (Other)	8
mlg	Malagasy	8
mlt	Maltese	8
mnc	Manchu	8
mni	Manipuri	8
mno	Manobo languages	8
moh	Mohawk	8
mol	Moldavian	8
mon	Mongolian	8
mos	Mooré	8
mul	Multiple languages	8
mun	Munda (Other)	8

Language

Value	Description	MI7CODE
mus	Creek	8
mwr	Marwari	8
myn	Mayan languages	8
nah	Nahuatl	8
nai	North American Indian (Other)	8
nau	Nauru	8
nav	Navajo	8
nbl	Ndebele (South Africa)	8
nde	Ndebele (Zimbabwe)	8
ndo	Ndonga	8
nds	Low German	8
nep	Nepali	8
new	Newari	8
nia	Nias	8
nic	Niger-Kordofanian (Other)	8
niu	Niuean	8
nno	Nynorsk	8
nob	Bokmål	8
non	Old Norse	8
nor	Norwegian	8
nso	Northern Sotho	8
nub	Nubian languages	8
nya	Nyanja	8
nym	Nyamwezi	8
nyn	Nyankole	8
nyo	Nyoro	8
nzi	Nzima	8
oci	Occitan (post-1500)	8
oji	Ojibwa	8
ori	Oriya	8
orm	Oromo	8
osa	Osage	8
oss	Ossetic	8
ota	Turkish, Ottoman	8
oto	Otomian languages	8
paa	Papuan (Other)	8
pag	Pangasinan	8
pal	Pahlavi	8
pam	Pampanga	8
pan	Panjabi	8
pap	Papiamento	8
pau	Palauan	8
peo	Old Persian (ca. 600-400 B.C.)	8
per	Persian	8
phi	Philippine (Other)	8

Language

Value	Description	MI7CODE
phn	Phoenician	8
pli	Pali	8
pol	Polish	8
pon	Ponape	8
por	Portuguese	8
pra	Prakrit languages	8
pro	Provençal (to 1500)	8
pus	Pushto	8
que	Quechua	8
raj	Rajasthani	8
rap	Rapanui	8
rar	Rarotongan	8
roa	Romance (Other)	8
roh	Raeto-Romance	8
rom	Romany	8
rum	Romanian	8
run	Rundi	8
rus	Russian	8
sad	Sandawe	8
sag	Sango	8
sah	Yakut	8
sai	South American Indian (Other)	8
sal	Salishan languages	8
sam	Samaritan Aramaic	8
san	Sanskrit	8
sas	Sasak	8
sat	Santali	8
scc	Serbian	8
sco	Scots	8
scr	Croatian	8
sel	Selkup	8
sem	Semitic (Other)	8
sga	Irish, Old (to 1100)	8
sgn	Sign languages	8
shn	Shan	8
sid	Sidamo	8
sin	Sinhalese	8
sio	Siouan (Other)	8
sit	Sino-Tibetan (Other)	8
sla	Slavic (Other)	8
slo	Slovak	8
slv	Slovenian	8
sme	Northern Sami	8
smi	Sami	8
smo	Samoan	8

Language

Value	Description	MI7CODE
sna	Shona	8
snd	Sindhi	8
snk	Soninke	8
sog	Sogdian	8
som	Somali	8
son	Songhai	8
sot	Sotho	8
srd	Sardinian	8
srr	Serer	8
ssa	Nilo-Saharan (Other)	8
ssw	Swazi	8
suk	Sukuma	8
sun	Sundanese	8
sus	Susu	8
sux	Sumerian	8
swa	Swahili	8
syr	Syriac	8
tah	Tahitian	8
tai	Tai (Other)	8
tam	Tamil	8
tat	Tatar	8
tel	Telugu	8
tem	Temne	8
ter	Terena	8
tet	Tetum	8
tgk	Tajik	8
tgl	Tagalog	8
tib	Tibetan	8
tig	Tigré	8
tir	Tigrinya	8
tiv	Tiv	8
tkl	Tokelauan	8
tli	Tlingit	8
tmh	Tamashek	8
tog	Tonga (Nyasa)	8
ton	Tongan	8
tpi	Tok Pisin	8
tsi	Tsimshian	8
tsn	Tswana	8
tso	Tsonga	8
tuk	Turkmen	8
tum	Tumbuka	8
tur	Turkish	8
tut	Altaic (Other)	8
tvl	Tuvaluan	8

Language

Value	Description	MI7CODE
twi	Twi	8
tyv	Tuvinian	8
uga	Ugaritic	8
uig	Uighur	8
ukr	Ukrainian	8
umb	Umbundu	8
urd	Urdu	8
uzb	Uzbek	8
vai	Vai	8
ven	Venda	8
vol	Volapük	8
vot	Votic	8
wak	Wakashan languages	8
wal	Walamo	8
war	Waray	8
was	Washo	8
wel	Welsh	8
wen	Sorbian languages	8
wol	Wolof	8
xho	Xhosa	8
yao	Yao	8
yap	Yapese	8
yid	Yiddish	8
yor	Yoruba	8
ypk	Yupik languages	8
zap	Zapotec	8
zen	Zenaga	8
zha	Zhuang	8
znd	Zande	8
zul	Zulu	8
zun	Zuni	8
und	Undetermined	9

Market Segment

Code	Value
1	Policies sold and issued directly to individuals (non-group) inside exchange
2	Policies sold and issued directly to individuals (non-group) outside exchange
3	Policies sold and issued directly to employers having 50 or fewer employees inside exchange
4	Policies sold and issued directly to employers having 50 or fewer employees outside exchange
5	Policies sold and issued directly to employers having 51 to 100 employees inside exchange
6	Policies sold and issued directly to employers having 51 to 100 employees outside exchange
7	Policies sold and issued directly to employers having 101 or more employees
8	Self-funded plans administered by a TPA, or a carrier acting as a TPA, where the employer has purchased stop-loss or group excess insurance coverage
9	Self-funded plans administered by a TPA, or a carrier acting as a TPA, where the employer has not purchased stop-loss, or group excess insurance coverage
10	Associations/Trusts and Multiple Employer Welfare Arrangements (MEWAs)
11	Other

Medicaid PERCs Reported to APAC

Value	Description
Null	PERC is null for Medicaid payer
1	Old Age Assistance
2	Aid to Dependent Children
3	Aid to the Blind
4	Aid to the Disabled
5	GA Maintenance, Med, Money
19	Foster Children - CAF-CW
1W	Native American/Alaska Native age 19 or older, not pregnant, child less than 19 or unborn on case, income less 100% FPL
1Y	Native American/Alaska Native age 19 or older, no child or unborn on case, income less 100% FPL
82	Unemployed-Aid to Dependent Children
A1	OAA Medical only
B3	Aid to the Blind - Medical
BC	Oregon Health Plan (OHP) plus benefits, FFS only
C2	C2
C5	Medical only, under age 21
CS	Adult 19-64 with children or unborn on the case who live in Oregon and are Medicaid eligible except they are not in the country legally. Only emergency, labor and delivery care covered.MAGI FPL <= 133
CT	Adult 19-64 with no children or unborn on the case who live in Oregon and are Medicaid eligible except they are not in the country legally. MAGI FPL <= 133
CU	Adult 19-64 with children or unborn on the case who live in Oregon and are Medicaid eligible except they are not in the country legally. 12 month continuous Medicaid eligibility
CW	Citizens/Alien waived Emergent medical (CAWEM); people who live in Oregon and are Medicaid eligible except they are not in the country legally. Only emergency, labor and delivery care covered
CX	CX - Pregnant CAWEM women. Care during pregnancy, labor and delivery covered. FPL <=185
D4	D4 - AD Medical only
EX	EX - Default perc
GA	GA - General Assistance, CAF-CW
H1	H1 - OHP age <1, <100% FPL
H2	H2 - OHP child age 1 to 5 under FPL
H3	H3 - OHP child age 6-12 under FPL
H4	H4 - OHP child age 13-18, DOB >=10/1/83 under FPL
H5	H5 - OHP-SCHIP to Medicaid
HA	HA - OHP age <1, <100% to 170% FPL
HB	HB - OHP child age 1-5 over FPL
HC	HC - OHP age <1, >170% FPL (AEN)
HD	HD - Healthy Kids eligible < age 1
HE	HE - Healthy Kids eligible age 1-5
HF	HF - Healthy Kids eligible age 6-12
HG	HG - Healthy Kids eligible age 13-18

Medicaid PERCs Reported to APAC

Value	Description
KA	KA - Parent/Other Caretaker Relative (PCR), <=50%FPL
L2	L2 - OHP pregnant, under FPL
L3	L3 - OHP child, with DOB before 10/01/83, under FPL (Obsolete after 7/1/1998)
L6	L6 - OHP pregnant, over FPL
L8	L8 - OHP person w/due, >170% FPL
LA	LA - New Pregnant Women, <133%FPL
LB	LB - New Pregnant Women, >=133%FPL
LC	LC - New Pregnant Women,12 month continuous eligibility
LD	LD - New Pregnant Women,Protected Pregnant Women Eligibility
M1	M1 - Age 19 or older, not pregnant, child <19 or unborn on case income <=133% FPL
M2	M2 - Age 19 or older, not pregnant, child <19 or unborn on case income <75% FPL
M3	M3 - Age 19 or older, not pregnant, no child <19 or unborn on case income <=133% FPL
M4	M4 - Age 19 or older, not pregnant, no child <19 or unborn on case income <75% FPL
M5	M5 - Age 19 or older, not pregnant, child <19 or unborn on case
M6	M6 - Age 19 or older, not pregnant, no child <19 or unborn on case
MC	MC - CW MAGI Child
MD	MD - MAGI Child Age < 1, <=185%FPL
ME	ME - MAGI Child Age 1 - 5, 0-<=133% FPL
MF	MF - MAGI Child Age 6 -18, 0-<=133% FPL
MG	MG - MAGI Child (AEN)
NP	NP - Reinstated Transplant Clients (Prescription Drugs ONLY)
P2	P2 - P2 dump code (Obsolete after 2/1/94)
QB	QB - Qualified Beneficiary
QI	QI - Qualifying Individuals
SL	SL - Specified Low-Income Medicare Beneficiaries
U1	U1 - CHP-MAGI eligible < age 1; FPL 185-200
U2	U2 - CHP-MAGI eligible age 1 - 5; FPL 133-200
U3	U3 - CHP-MAGI eligible age 6-18; FPL 133-200
U4	U4 - CHP-MAGI eligible < age 1; FPL 201-250
U5	U5 - CHP-MAGI eligible age 1 - 5; FPL 201-250
U6	U6 - CHP-MAGI eligible age 6-18; FPL 201-250
U7	U7 - CHP-MAGI eligible < age 1; FPL 251-300
U8	U8 - CHP-MAGI eligible age 1 - 5; FPL 251-300
U9	U9 - CHP-MAGI eligible age 6-18; FPL 251-300
V2	V2 - All Other Refugees
W0	W0 - Age 19 or older, not pregnant, child <19 or unborn on case income 0<10% FPL
W1	W1 - Age 19 or older, not pregnant, child <19 or unborn on case, income 10<50% FPL
W2	W2 - Age 19 or older, not pregnant, child <19 or unborn on case, income 50<65% FPL
W3	W3 - Age 19 or older, not pregnant, child <19 or unborn on case,income 65<85% FPL

Medicaid PERCs Reported to APAC

Value	Description
W4	W4 - Age 19 or older, not pregnant, child <19 or unborn on case, income 85<100% FPL
W5	W5 - Age 19 or older; not pregnant; = child or unborn on case; income = 100<110% FPL
XE	XE - ADC Extended Medical
Y0	Y0 - OHP age 19 or older, no child or unborn on case, income 0<10% FPL
Y1	Y1 - OHP age 19 or older, no child or unborn on case, income 10<50% FPL
Y2	Y2 - OHP age 19 or older, no child or unborn on case, income 50<65% FPL
Y3	Y3 - OHP age 19 or older, no child or unborn on case, income 65<85% FPL
Y4	Y4 - OHP age 19 or older, no child or unborn on case, income 85<100% FPL
Z1	Z1 - CHIP eligible < age 1, 133% to 170% FPL
Z2	Z2 - CHIP eligible age 1-5
Z3	Z3 - CHIP eligible age 6-12, 100% to 170% FPL
Z4	Z4 - CHIP eligible age 13-18, 100% to 170% FPL
Z5	Z5 - CHIP eligible < age 1, 170% to 185% FPL
Z6	Z6 - CHIP eligible age 1-5, 170% to 185% FPL
Z7	Z7 - CHIP eligible age 6-12, 170% to 185% FPL
Z8	Z8 - CHIP eligible age 13-18, 170% to 185% FPL
ZA	ZA - Healthy Kids eligible < age 1
ZB	ZB - Healthy Kids eligible age 1-5
ZC	ZC - Healthy Kids eligible age 6-12
ZD	ZD - Healthy Kids eligible age 13-18
ZH	ZH - Healthy Kids eligible age 13-18
ZK	ZK - CHP eligible < age 1; FPL 201-300
ZL	ZL - CHP eligible age 1 - 5; FPL 201-300
ZM	ZM - CHP eligible age 6-18; FPL 201-300

Medicaid Health Program Codes submitted to APAC

Value	Description
CCOA	Mental, physical and dental health
CCOB	Mental and physical health
CCOE	Mental Health Organization
CCOG	Mental and dental health
FCHP	Fully capitated health plan
FCHPD	Fully capitated health plan
FFS	Fee-for-service
MHO	Mental Health Organization
PACE	Program for all-inclusive care for the elderly
PCM	Primary care managers
PCO	Physician care organization
NULL	Not one of the above listed programs or not a Medicaid recipient

Medicaid enrollment status submitted to APAC

Value	Description
1	01 - Medicaid Eligible, MCO Enrolled, Cap Payment
3	03 - Medicaid Eligible, MCO Enrolled, no Cap Payment
5	05 - Medicaid Eligible, not MCO Enrolled, Cap Payment
6	06 - Fee-for-service
NULL	Not any status listed above or not a Medicaid recipient

Medicaid delivery type submitted to APAC

Value	Description
H	Health
M	Mental Health
NULL	Not H programs or not a Medicaid recipient

Medicare delivery type submitted to APAC

Value	Description
NULL	No Medicare Coverage
MA	MA – Part A only
MAB	MAB – both Part A and Part B
MABD	MABD – Part A, Part B, and Part D
MAD	MAD – Part A and Part D
MB	MB - Part B only
MBD	MBD – Part B and Part D
MD	MD – Part D only

Substance Abuse Chemical Dependency claims exclusion algorithm

Step	Criteria	Rationale	APAC fields	Values	If Yes	If No
1	Site of service is a substance abuse treatment facility; OR	These are clearly claims from patients in substance abuse treatment	MC037	55, 57	Flag claims	Step 2
	Substance abuse treatment revenue code; OR	These are substance abuse treatment claims.	MC054	See Rev codes		
	Substance abuse treatment CPT or HCPCS code; OR	These are substance abuse treatment claims.	MC055	See CPT codes		
	Substance abuse treatment CPT or HCPCS modifiers; OR	These are substance abuse treatment claims.	MC056, MC057,	See CPT modifiers		
	Substance abuse treatment ICD-9 procedure code; OR	These are substance abuse treatment claims.	MC058, MC058A-	See ICD-9 px codes		
	Principal or secondary diagnosis for substance abuse; OR	A primary or secondary diagnosis of substance abuse may identify patients	MC041, MC042	See ICD-9 dx codes		
	Pharmacy claim for a substance abuse treatment medication.	Medications for substance abuse treatment may identify a patient in a	PC026	See NDC		
2	Tertiary or higher diagnosis for substance abuse	These claims typically have 2 or more mental health diagnoses followed by a	MC043-MC053	See ICD-9 dx codes	Flag claims	Step 3
3	Provider is licensed and business is substance abuse treament only	These are clearly claims from patients in substance abuse treatment	MP003, MP004,	See NPI	Flag claims	Do not flag
	Provider's primary taxonomy is substance abuse treatment	Providers who primarily treat substance abuse may identify a treatment program	MP010	See Taxonomy	Flag claims	Do not flag
	Provider is licensed and self-identifes as a substance abuse treatment	Providers who self-identify as a program are clearly a substance abuse	MP003, MP004,	See NPI	Flag claims	Do not flag