Appendix A: Medical claims data file layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC001	Payer type	Text	1	Yes	See lookup table MC001	0%
MC003	Product code	Text	3	Yes	See lookup table MC003	0%
MC004	Claim ID	Text	80	Yes	Payer's unique claim identifier	0%
MC005	Service line counter	Numeric	4	Yes	Increments of 1 for each claim line	0%
MC010	Member ID	Text	30	Yes	Plan-specific unique member identifier	0%
MC017	Payment date	Date	8	Yes	CCYYMMDD (example: 20090624). Blanks allowed for denied claims only.	0%
MC018	Admission date	Date	8	Yes	CCYYMMDD (example: 20090603). Required only for institutional claims.	1.2%
MC023	Discharge status	Text	2	Yes	See lookup table MC023. Required only for institutional claims.	1.2%
MC024	Rendering provider ID	Text	30	Yes	Identifier for the rendering provider as assigned by the reporting entity	1.2%
MC036	Type of bill	Numeric	3	Situational	See lookup table MC 036. Required only for institutional claims.	1.2%
MC037	Place of service	Text	2	Situational	See lookup table MC 037. Required only for professional claims.	1.2%
MC038	Claim status	Text	1	Yes	Was claim paid, denied, CCO encounter, or MCO encounter only? Valid values: P (paid), D (denied), C (CCO encounter), E (other managed care encounter)	0%
MC038A	COB status	Text	1	Yes	Was claim a COB claim? Valid values: Y (yes), N (no)	1.2%
MC041	Principal diagnosis	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC041P	POA flag 1	Text	1	Yes	Present on admission flag for principal diagnosis. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC042	Diagnosis 2	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC042P	POA flag 2	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC043	Diagnosis 3	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC043P	POA flag 3	Text	1	Situational	Present on admission flag for diagnosis 3. Required if MC043 is populated. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC044	Diagnosis 4	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC044P	POA flag 4	Text	1	Situational	Present on admission flag for diagnosis 4. Required if MC044 is populated. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC045	Diagnosis 5	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC045P	POA flag 5	Text	1	Situational	Present on admission flag for diagnosis 5. Required if MC045 is populated. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC046	Diagnosis 6	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC046P	POA flag 6	Text	1	Situational	Present on admission flag for diagnosis 6. Required if MC046 is populated. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC047	Diagnosis 7	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC047P	POA flag 7	Text	1	Situational	Present on admission flag for diagnosis 7. Required if MC047 is populated. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC048	Diagnosis 8	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC048P	POA flag 8	Text	1	Situational	Present on admission flag for diagnosis 8. Required if MC048 is populated. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC049	Diagnosis 9	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC049P	POA flag 9	Text	1	Situational	Present on admission flag for diagnosis 9. Required if MC049 is populated. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC050	Diagnosis 10	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC050P	POA flag 10	Text	1	Situational	Present on admission flag for diagnosis 10. Required if MC050 is populated. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC051	Diagnosis 11	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC051P	POA flag 11	Text	1	Situational	Present on admission flag for diagnosis 11 Required if MC051 is populated. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC052	Diagnosis 12	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC052P	POA flag 12	Text	1	Situational	Present on admission flag for diagnosis 12 Required if MC052 is populated. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC053	Diagnosis 13	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC053P	POA flag 13	Text	1	Situational	Present on admission flag for diagnosis 13 Required if MC053 is populated. See look-up table MC041P. Required only for inpatient claims.	1.2%
MC054	Revenue code	Text	4	Yes	Include all digits (example: 0320). Required only for institutional claims.	1.2%
MC055	CPT/CPT II/HCPCS procedure code	Text	5	Yes	CPT, CPT II or HCPCS code. Include all digits (examples: 29870 or G0289)	1.2%
MC056	Procedure modifier 1	Text	2	Yes	CPT or HCPCS modifier. Include all digits (examples: 50 or AA)	1.2%
MC057	Procedure modifier 2	Text	2	Yes	CPT or HCPCS modifier. Include all digits (examples: 50 or AA)	1.2%
MC057A	Procedure modifier 3	Text	2	Yes	CPT or HCPCS modifier. Include all digits (examples: 50 or AA)	1.2%
MC057B	Procedure modifier 4	Text	2	Yes	CPT or HCPCS modifier. Include all digits (examples: 50 or AA)	1.2%
MC058	Principal inpatient procedure code	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058A	Inpatient procedure code 2	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC058B	Inpatient procedure code 3	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058C	Inpatient procedure code 4	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058D	Inpatient procedure code 5	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058E	Inpatient procedure code 6	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058F	Inpatient procedure code 7	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058G	Inpatient procedure code 8	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058H	Inpatient procedure code 9	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058J	Inpatient procedure code 10	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058K	Inpatient procedure code 11	Text	8	Situational	ICD-10 procedure code for dates of service after 10/01/2015. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058L	Inpatient procedure code 12	Text	8	Situational	ICD-10 procedure code for dates of service after 10/01/2015. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058M	Inpatient procedure code 13	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC059	Date of service – From	Date	8	Yes	CCYYMMDD (example: 20090603)	0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC060	Date of service – Thru	Date	8	Yes	CCYYMMDD (example: 20090603)	0%
MC061	Quantity	Numeric	11	Yes	Count of units sent on claim line.	0%
MC062	Charges	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
MC062A	Allowed amount	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
MC063	Payment	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
MC064	Prepaid amount	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
MC065	Co-payment	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
MC066	Co-insurance	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
MC067	Deductible	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
MC067A	Patient pay amount	Numeric	12	Situational	Required if any of MC065, MC066, or MC067 are missing. Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
MC070	Discharge date	Date	8	Situational	Required only for institutional claims. Use 99991231 if patient has not discharged. CCYYMMDD (example: 20090605). Required only for institutional claims.	1.2%
MC076	Billing provider ID	Text	30	Yes	Identifier for the billing provider as assigned by the reporting entity	1.2%
QC05					Do not populate as of 01/01/2018.	N/A
QC06					Do not populate as of 01/01/2018.	N/A
QC22					Do not populate as of 01/01/2018.	N/A
QC23					Do not populate as of 01/01/2018.	N/A
QC37					Do not populate as of 01/01/2017.	N/A
QC38					Do not populate as of 01/01/2017.	N/A
QC39					Do not populate as of 01/01/2017.	N/A
OHLC1					Do not populate as of 01/01/2017.	N/A

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
OHLC2					Do not populate as of 01/01/2017.	N/A
MC008	Plan specific contract number	Text	30	Yes	Plan specific contract number (aka group number)	0%
MC201	ICD version code	Text	2	Yes	Specifies the claim's ICD version. Valid values: 9 (ICD-9) or 10 (ICD-10)	0%
MC202	Network	Text	1	Yes	See lookup table MC202	0%
MC203	Admission Type	Text	1	Situational	Required for inpatient claims. Populate this field only if claim is inpatient. Valid values: 1 (Emergency), 2 (Urgent), 3 (Elective), 4 (Newborn), 5 (Trauma Center), 9 (Information Not Available)	1.2%
MC204	Admission Source	Text	1	Situational	Required for inpatient claims. Populate this field only if claim is inpatient. See lookup table MC204	1.2%
MC205	Admitting Diagnosis	Text	8	Situational	Required for inpatient claims. ICD-10 diagnosis code for dates of service beginning 10/01/2015. Include all characters (example: E10.359). ICD-9 diagnosis code for dates of service before 10/01/2015. If ICD-9 include all digits and exclude decimal point (example: 01220). Required only for inpatient claims.	1.2%
MC206	Pay to Patient Flag	Text	1	Yes	Valid values: Y (patient was directly reimbursed), N (patient was not directly reimbursed). If unknown, default to N.	0%
MC207	Empty field				For future implementation	N/A
MC208	Empty field				For future implementation	N/A
MC209	Empty field				For future implementation	N/A
MC210	Empty field				For future implementation	N/A

Lookup Table MC001: Payer type
This field contains a single letter identifying the payer type.

Code	Value
C	Carrier
D	Medicaid
G	Other government agency
P	Pharmacy benefits manager
T	Third-party administrator
U	Unlicensed entity

Lookup Table MC003: Product code
This field contains the insurance type or product code that indicates the type of insurance coverage the individual has.

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

* Please note that codes "PH" and "MPD" must be used in conjunction with the appropriate lines of business. "PH" should be used for Commercial lines of business only, while MPD should be used for Medicare membership only.

Lookup Table MC023: Discharge status
This field contains the status for the patient discharged from the hospital.

Code	Value
01	Discharged to home or self care
02	Discharged/transferred to another short term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to nursing facility (NF)
05	Discharged/transferred to a designated cancer center or children's hospital
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a Home IV provider
09	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

Lookup Table MC036: Type of bill

This field is required for institutional claims and must not be populated for professional claims. The values of the second digit are situational depending on the value of the first digit.

First digit: type of facility

Code	Value
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

Code	Value
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

Code	Value
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

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

Third digit: claim frequency

Code	Value
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

Lookup Table MC037: Site of service

For professional claims, this field records the type of facility where the service was performed. This field should not be populated for institutional claims.

Code	Value
00	Not supplied
01	Pharmacy
03	School
04	Homeless Shelter
05	Indian Health Service Freestanding Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Freestanding Facility
08	Tribal 638 Provider-Based Facility
09	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
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

Code	Value
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

Lookup Table MC041P: POA flag

This field contains the inpatient present on admission (POA) flag as reported by the provider. Do not populate if not reported by the provider.

Code	Value
Y	Yes
N	No
W	Clinically undetermined
U	Information not in record
1	Diagnosis exempt from POA reporting

Lookup Table MC202: Network

This field contains a single digit indicating whether the provider was paid under a network contract.

Code	Value
1	In-network: The plan has a direct contract with the provider that made the claim.
2	National network: The plan does not have a direct contract with the provider that made the claim, but paid a contracted rate through participation in a national network or reciprocal agreement with a plan operating in another state.
3	Out-of-network: The plan did not pay the provider a contracted rate.

Lookup Table MC204: Admission Source

This field contains a single character indicating source of referral for an inpatient admission. Populate this field only for institutional inpatient claims. Do not populate this field for professional claims. Use codes on the next page if MC203 = 4.

Code	Value if MC203 <> 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

Code	Value if MC203 = 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 - 8	Reserved for national assignment.
9	Information not available.

Appendix B: Eligibility data file layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
ME001	Payer type	Text	1	Yes	See lookup table MC001 (Appendix A)	0%
ME003	Product code	Text	3	Yes	See lookup table MC003 (Appendix A)	0%
ME004A	Eligibility date	Date	8	Yes	CCYYMMDD (example: 20100402). Dates before the submission date range are not valid. See Schedule A for submission data range.	0%
ME005A	Termination date	Date	8	Yes	CCYYMMDD (example: 20100702). Use 99991231 if termination date is open-ended.	0%
ME007	Subscriber ID	Text	30	Yes	Plan-specific unique identifier for subscriber	1.2%
ME009	Plan specific contract number	Text	30	Yes	Plan-specific contract number (aka group number)	1.2%
ME009A	PEBB flag	Numeric	1	Yes	Valid values: 1 (PEBB group), 0 (otherwise)	0%
ME009B	OEBB flag	Numeric	1	Yes	Valid values: 1 (OEBB group), 0 (otherwise)	0%
ME009C	Medical home flag	Numeric	1	Yes	Valid values: 1 (medical home plan), 0 (otherwise)	0%
ME010	Member ID	Text	30	Yes	Plan-specific unique identifier for member	0%
ME012	Relationship code	Numeric	2	Yes	See lookup table ME012	1.2%
ME013	Member gender	Text	1	Yes	Valid values: M (male), F (female), and U (unknown)	1.2%
ME014	Member date of birth	Date	8	Yes	CCYYMMDD (example: 19570402). Do not populate if unavailable.	1.2%
ME015A	Member's street address	Text	50	Yes	Member's primary street address. If member's address is missing then default to subscriber's address. Example: 123 Main Street	1.2%
ME015	Member city	Text	30	Yes	Example: Grants Pass	1.2%
ME016	Member state	Text	4	Yes	Example: OR	1.2%
ME017	Member ZIP	Text	10	Yes	Example: 97209-1234 or 97209	1.2%
ME018	Medical coverage flag	Text	1	Yes	Y or N	0%
ME019	Prescription drug coverage flag	Text	1	Yes	Y or N	0%
ME101	Subscriber last name	Text	35	Yes		1.2%
ME102	Subscriber first name	Text	25	Yes		1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
ME103	Subscriber middle name	Text	25	Situational	Populate if available.	N/A
ME104	Member last name	Text	35	Yes		1.2%
ME105	Member first name	Text	25	Yes		1.2%
ME106	Member middle name	Text	25	Situational	Populate if available.	N/A
QC013					Do not populate as of 01/01/2018.	N/A
QC014					Do not populate as of 01/01/2018.	N/A
QC015					Do not populate as of 01/01/2018.	N/A
QC016					Do not populate as of 01/01/2018.	N/A
QC018					Do not populate as of 01/01/2018.	N/A
QC019					Do not populate as of 01/01/2018.	N/A
QC020					Do not populate as of 01/01/2018.	N/A
RE1	Member race	Text	1	Yes*	See lookup table RE1	TBD
RE2	Member ethnicity	Text	1	Yes*	See lookup table RE2	TBD
RE3	Primary spoken language	Text	3	Yes*	See lookup table RE3	TBD
OHLC3					Do not populate as of 01/01/2017.	N/A
OHLC4					Do not populate as of 01/01/2017.	N/A
OHLC5					Do not populate as of 01/01/2017.	N/A
OHLC6					Do not populate as of 01/01/2017.	N/A
OHLC7					Do not populate as of 01/01/2017.	N/A
ME009D	OMIP flag	Numeric	1	Yes	Valid values: 1 (OMIP member), 0 (otherwise)	1.2%
ME009E	HKC flag	Numeric	1	Yes	Valid values: 1 (Healthy Kids Connect plan), 0 (otherwise)	1.2%
ME201	Medicare coverage flag	Text	2	Yes	Type of Medicare coverage. Valid values: A (Part A), B (Part B), AB (Parts A and B), C (Part C only), D (Part D only), CD (Part C and Part D), X (other), Z (none)	1.2%
ME202	Market Segment	Text	2	Yes	See lookup table ME202	0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
ME203	Metal Tier	Text	1	Yes	Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the Patient Protection and Affordable Care Act, Public Law 111-148, Section 1302: Essential Health Benefits Requirements. Valid values: 0 (Not a QHP or catastrophic plan), 1 (Catastrophic), 2 (Bronze), 3 (Silver), 4 (Gold), 5 (Platinum)	0%
ME204	HIOS Plan ID	Text	14	Yes	Health Insurance Oversight System ID. Required for qualified health plans (QHPs) as defined in the Patient Protection and Affordable Care Act (ACA). If plan is not a QHP under the ACA, enter 99999999999999.	0%
ME205	High Deductible Health Plan Flag	Text	1	Yes	Valid values: Y (policy meets IRS definition of HDHP), N (policy does not meet IRS definition of HDHP)	1.2%
ME206	Primary Insurance Indicator	Text	1	Yes	Valid Values: Y (primary insurance), N (secondary or tertiary insurance). If unknown, default to Y.	0%
ME207					For future implementation	N/A
ME208					For future implementation	N/A
ME209					For future implementation	N/A
ME210					For future implementation	N/A

*** - Implementation date TBD**

Lookup Table ME012: Relationship code
This field contains the member's relationship to the subscriber or the insured.

Code	Value
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

Lookup Table RE1
This field contains a single letter identifying the member's race.

Code	Value
A	Asian
B	Black or African American
I	American Indian or Alaska Native
P	Native Hawaiian or Pacific Islander
W	White
O	Other (or multiple races)
R	Refused
U	Unknown

Lookup Table RE2
This field contains a single letter identifying the member's ethnicity.

Code	Value
H	Hispanic
O	Not Hispanic
R	Refused
U	Unknown

Lookup Table RE3
This field contains the ANSI/NISO three-character string identifying the member's primary spoken language. Please refer to most recent version of ANSI/NISO Z39.53 (Codes for the Representation of Languages for Information Interchange); the 2017 version is freely available here:
https://www.loc.gov/standards/iso639-2/php/code_list.php

Lookup Table ME202
This field contains an integer indicating the 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

Appendix C: Medical provider data file layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
MP003	Provider ID	Text	30	Yes	Identifier for the provider as assigned by the reporting entity	1.2%
MP004	Provider Tax ID	Text	9	Yes	Tax ID of the provider (example: 1234567890)	1.2%
MP006	Provider first name	Text	25	Yes	First name of the provider (example: John); null if provider is an organization entity	1.2%
MP007	Provider middle initial	Text	1	Yes	Middle initial of the provider (example: M); null if provider is an organization entity	1.2%
MP008	Provider last name	Text	100	Yes	Last name of the provider or organization entity name	1.2%
MP010	Provider specialty	Text	10	Yes	See lookup table MP010	1.2%
MP010A	Provider second specialty	Text	10	Situational	Required if available. See lookup table MP010	1.2%
MP010B	Provider third specialty	Text	10	Situational	Required if available. See lookup table MP010	1.2%
MP011A	Provider street address1	Text	50	Yes	First line of physical address of practice. Example: 123 Main Street	1.2%
MP011B	Provider street address2	Text	50	Situational	Required if available. Second line of physical address of practice. Example: Bldg. A, Suite 100	1.2%
MP011	Provider city	Text	30	Yes	Physical address of practice. Example: Grants Pass	1.2%
MP012	Provider state	Text	2	Yes	Physical address of practice. Example: OR	1.2%
MP013	Provider ZIP	Text	10	Yes	Physical address of practice. Examples: 97209-1234 or 97209	1.2%
MP017					Do not populate as of 01/01/2018.	N/A
MP018	Provider NPI	Text	10	Yes	NPI of the provider (example: 1234567890)	1.2%
MP201					For future implementation	N/A
MP202					For future implementation	N/A
MP203					For future implementation	N/A
MP204					For future implementation	N/A
MP205					For future implementation	N/A
MP206					For future implementation	N/A
MP207					For future implementation	N/A

Data element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
MP208					For future implementation	N/A
MP209					For future implementation	N/A
MP210					For future implementation	N/A

Lookup Table MP010: Provider specialty
Report the HIPAA-compliant health care provider taxonomy code. The reference code set is extensive, published semi-annually, and freely available at the National Uniform Claims Committee's web site: http://www.nucc.org/. To access the taxonomy files, point to the Code Sets menu, then point to the Taxonomy menu, and then click on either PDF (if you want a PDF file) or CSV (if you want a comma-delimited text file).

Appendix D: Pharmacy claims data file layout and dictionary

Note: this layout intends to maintain consistency with Version 1.0 of the NCPDP Uniform Healthcare Payer Data Implementation Guide.

Data element	Name	Max. Length	Type	Required?	NCPDP Field	NCPDP Source	Description	Error threshold
PC001	Payer type	1	Text	Yes	N/A	N/A	See lookup table MC001 (Appendix A)	0%
PC008	Plan-specific contract number	30	Text	Yes	246	P	Plan-specific contract number (aka group number)	1.2%
PC010	Patient ID	30	Text	Yes	332-CY	P	Unique identifier for member	0%
PC003	Insurance type/ product code	3	Text	Yes	New	P	See lookup table MC003	1.2%
PC021	Pharmacy NPI	15	Text	Yes	201-B1	C/P	The pharmacy's National Provider Identifier (NPI)	1.2%
PC021A	Pharmacy alternate identifier	15	Text	Situational	201-B1	P	The pharmacy's alternate identifier as assigned by the payer; required if NPI is not available	N/A
PC020	Pharmacy Name	35	Text	Yes	833-5P	P		1.2%
PC022	Pharmacy city	30	Text	Yes	728	P		1.2%
PC023	Pharmacy state	2	Text	Yes	729	P		1.2%
PC024	Pharmacy ZIP	15	Text	Yes	730	P		1.2%
PC048	Prescribing provider NPI	15	Text	Yes	411-DB	C	Identifier for the provider who prescribed the medication as assigned by the reporting entity	1.2%
PC047							Do not populate as of 01/01/2018.	N/A
PC025	Claim status	3	Text	Yes	399	P	Was claim paid, denied, CCO, or encounter only? Valid values: P (paid), D (denied), C (CCO encounter), E (other managed care encounter)	0%
PC026	NDC	11	Text	Yes	407-D7	C	National Drug Code (NDC)	1.2%

Data element	Name	Max. Length	Type	Required?	NCPDP Field	NCPDP Source	Description	Error threshold
PC032	Date filled	8	Date	Yes	401-D1	C	Date the prescription was filled. CCYYMMDD (example: 20090624)	0%
PC017	Payment date	8	Date	No	216	P	CCYYMMDD (example: 20090624). Blanks allowed for denied claims only.	0%
PC033	Quantity dispensed	10	Numeric	Yes	442-E7	C		1.2%
PC028A	Alternate refill number	2	Numeric	Situational	403-D3	C	Required if PC028 (calculated refill number) is not available	N/A
PC034	Days supply	4	Numeric	Yes	405-D5	C	Days supply of the prescription	1.2%
PC030	Dispense as written code	1	Text	Yes	408-D8	C	See look-up table PC030	1.2%
PC028	Calculated refill number	2	Numeric	Yes	254	P	Processor's calculated refill number. If the processor is not able to calculate, the alternate refill number (PC028A) is to be used.	1.2%
PC031	Compound drug indicator	1	Numeric	Yes	406-D6	C	Indicates if this is a compound drug. Valid values: 1 (no), 2 (yes)	1.2%
PC004	Claim ID	30	Text	Yes	993-A7	P	Payer's unique claim control number	0%
PC036	Payment	12	Numeric	Yes	281	P	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
PC035	Charges	12	Numeric	Yes	430-DU	P	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
PC037	Ingredient cost/list price	12	Numeric	Yes	506-F6	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
PC039	Dispensing fee paid	12	Numeric	Yes	507-F7	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%

Data element	Name	Max. Length	Type	Required?	NCPDP Field	NCPDP Source	Description	Error threshold
PC040	Co-pay	12	Numeric	Yes	518-FI	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
PC041	Coinsurance	12	Numeric	Yes	572-4U	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
PC042	Deductible	12	Numeric	Yes	517-FH	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
PC043	Patient pay amount	12	Numeric	Situational	505-F5	C	Required if any of PC040, PC041, or PC042 are missing. Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0%
PC201							For future implementation	N/A
PC202							For future implementation	N/A
PC203							For future implementation	N/A
PC204							For future implementation	N/A
PC205							For future implementation	N/A
PC206							For future implementation	N/A
PC207							For future implementation	N/A
PC208							For future implementation	N/A
PC209							For future implementation	N/A
PC210							For future implementation	N/A

Look-up Table PC-030: Dispense as Written Code
This field contains the NCPDP Dispense as Written Code.

Code	Value
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

Appendix E: Control totals

Note: the control totals are two separate tab-delimited data files.

1. Claims file control totals layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
CFCT1	Payer	Text	7	Yes	Payer abbreviation. See lookup table CFCT1	0%
CFCT2	File	Text	10	Yes	Valid values: medical, pharmacy, enrollment, provider, and premium	0%
CFCT3	Data_Rows	Numeric	8	Yes	Count of data rows in the submitted file	0%
CFCT4	Amt_Billed	Numeric	12	Yes	Sum of MC062 (medical) or PC035 (pharmacy) or PB010 (premium). Two explicit decimal places. Do not populate if File is enrollment or provider	0%
CFCT5	Amt_Paid	Numeric	12	Yes	Sum of MC063 (medical) or PC036 (pharmacy). Two explicit decimal places. Do not populate if File is enrollment or provider	0%

2. Claims file control totals example

Payer	File	Data_Rows	Amt_Billed	Amt_Paid
OMIP	Medical	12345678	123456789.12	123456789.12
OMIP	Pharmacy	12345678	123456789.12	123456789.12
OMIP	Enrollment	12345678		
OMIP	Provider	123456		
OMIP	Premium	12345	123456789.12	

3. File naming convention is <payer abbreviation>_<submitter abbreviation>_totals_<quarter>_<file created date>.dat

Example: OMIP_OMIP_totals_2015Q2_20150521_010101.dat

4. Member months control totals layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MMCT1	Payer	Text	7	Yes	Payer abbreviation. See lookup table CFCT1	0%
MMCT2	Method	Text	1	No	Placeholder for future compatibility	N/A
MMCT3	Month	Date	6	Yes	CCYYMM	0%
MMCT4	Medical_Members	Numeric	8	Yes	Count of members with medical coverage as of first of month. Do not populate if no medical members.	0%
MMCT5	Pharmacy_Members	Numeric	8	Yes	Count of members with pharmacy coverage as of first of month. Do not populate if no pharmacy members.	0%

5. Member months control totals example

Payer	Method	Month	Medical_Members	Pharmacy_Members
OMIP		201001	12345678	12345678
OMIP		201002	12345678	12345678
OMIP		201003	12345678	12345678
OMIP		201004	12345678	12345678
OMIP		201005	12345678	12345678
OMIP		201006	12345678	12345678
OMIP		201007	12345678	12345678
OMIP		201008	12345678	12345678
OMIP		201009	12345678	12345678
OMIP		201010	12345678	12345678
OMIP		201011	12345678	12345678
OMIP		201012	12345678	12345678

6. **File naming convention is <payer abbreviation>_<submitter abbreviation>_membership_<quarter>_<file created date>.dat**
   Example: OMIP_OMIP_membership_2015Q2_20150521_010101.dat

7. **If a mandatory reporter contracts with another entity, the mandatory reporter remains responsible for reporting all required lines of business. If the mandatory reporter elects to have the data reported by the contracted entity, the mandatory reporter is required to notify the Authority and to provide contact information for the contracted entity.**

Lookup Table CFCT1: Payer abbreviation

This field contains up to seven characters which abbreviate the payer name. The list below is as inclusive as possible of mandatory reporters.

Payer Name	Abbreviation
A & A DRUG CO. / SAV-RX PRESCRIPTION SERVICES	SAVRX
AETNA LIFE INSURANCE COMPANY /	AETNA
AETNA HEALTH MANAGEMENT, LLC	AETNA
AETNA MEDICARE RX SAVER 064	AETNA
AETNA PHARMACY MANAGEMENT (APM)	APM
ALLCARE HEALTH PLAN, INC.	ALLCARE
ANTHEM INSURANCE COMPANIES, INC.	ANTHEM
ARGUS HEALTH SYSTEMS, INC.	ARGUS
ASCELLAHEALTH, LLC	ASCEL
ASURIS MEDICARE SCRIPT (BASIC AND ENHANCED)	ASUR
ATRIO HEALTH PLANS, INC.	ATRIO
BENECARD PBF	BENE
BENESYS INC.	AI
BRIDGESPAN HEALTH COMPANY	BRDGSPN
CAREMARK, LLC	CVS
CAREMARKPCS HEALTH LLC	CVS
CAREOREGON ADVANTAGE	CAREOR
CAREOREGON ADVANTAGE PLUS	CAREOR
CIGNA HEALTH AND LIFE INSURANCE COMPANY	CIGNAHL
CIGNA PHARMACY MANAGEMENT, A DIVISION OF CONNECTICUT GENERAL LIFE INSURANCE COMPANY	CIGNA
CIGNA – HEALTHSPRING RX SECURE – EXTRA 275	CIGNAX
CIGNA – HEALTHSPRING RX SECURE – 148	CIGNAS
COSTCO HEALTH SOLUTIONS, INC.	COSTCO
COVENTRY HEALTH CARE WORKERS COMPENSATION, INC.	COV
EMPIRX HEALTH, LLC	EMPIRX
EMPLOYEE BENEFIT MANAGEMENT SERVICES, INC.	EBMS
EMPLOYEE HEALTH INSURANCE MANAGEMENT, INC.	EHIM
ENVISION PHARMACEUTICAL SERVICES, INC.	EPS
ENVISIONRX PLUS 030	EPS
ENVOLVE PHARMACY SOLUTIONS, INC	USSCR
EXPRESS SCRIPTS ADMINISTRATORS LLC	EXPR
EXPRESS SCRIPTS MEDICARE – CHOICE 215	EXPRC
EXPRESS SCRIPTS MEDICARE – SAVER 246	EXPRS
EXPRESS SCRIPTS MEDICARE – VALUE 132	EXPRM
FAIRVIEW PHARMACY SERVICES LLC DBA CLEARSCRIPT	FAIRVW
FAMILYCARE COMMUNITY	FCARE

Payer Name	Abbreviation
FAMILYCARE HEALTH	FCARE
FAMILYCARE HEALTH PLANS, INC.	FCARE
FIRST HEALTH PART D PREMIER PLUS 192	
FIRST HEALTH PART D VALUE PLUS 153	
GUIDANTRX, INC.	PBMP
HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY	HCSC
HEALTH E SYSTEMS, LLC	HLTHSYS
HEALTH NET	HNOR
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR
HEALTH NET LIFE INSURANCE COMPANY	HNOR
HEALTH NET PHARMACEUTICAL SERVICES	HNOR
HEALTH PLAN OF CAREOREGON INC.	CAREOR
HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.	HMA
HEALTHCARE SOLUTIONS, INC.	HLTHCRE
HEALTHPLAN SERVICES, INC	HARR
HUMANA INSURANCE COMPANY	HUMANA
HUMANA ENHANCED 028	HUMANA
HUMANA HEALTH PLAN INC	HUMANA
HUMANA MEDICAL PLAN INC	HUMANA
HUMANA PHARMACY SOLUTIONS, INC.	HPS
HUMANA PREFERRED RX PLAN 113	HPS
HUMANA WALMART RX PLAN 176	HPS
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFHPNW
KAISER PERMANENTE	KP
KAISER PERMANENTE INSURANCE COMPANY	KP
KROGER PRESCRIPTION PLANS INC	OPTUMRX
LEEHAR DISTRIBUTORS, INC. DBA LDI INTEGRATED PHARMACY SERVICES	LDI
MAGELLAN RX MANAGEMENT, INC.	MAGRX
MARQUIS ADVANTAGE, INC.	MARQUIS
MAXCARE, LLC	MAXCARE
MAXORPLUS, LTD.	MAXORP
MED ONE, LC	MEDONE
MEDIMPACT HEALTHCARE SYSTEMS, INC.	MEDIMP
MEDTRAK SERVICES, L.L.C.	MEDTRAK
MERITAIN HEALTH INC.	MERITAIN
MITCHELL INTERNATIONAL, INC.	MITCH
MODA HEALTH PLAN, INC.	ODS
NAVITUS HEALTH SOLUTIONS, LLC	NAV
NWPS, INC.	NWPS

Payer Name	Abbreviation
OMEDARX, INC.	CATRX
OPTUMRX, INC.	OPTUMRX
OPRUMRX PBM OF MARYLAND, LLC.	OPTUMRX
OPTUM HOSPICE PHARMACY SERVICES, LLC	OPTUMRX
OPTUMRX ADMINISTRATIVE SERVICES, LLC	OPTUMRX
OPTUMRX PBM OF ILLINOIS, INC	OPTUMRX
/OPTUMRX PBM OF WISCONSIN, LLC	OPTUMRX
OREGON HEALTH & SCIENCE UNIVERSITY	OHSU
PACIFIC SOURCE COMMUNITY HEALTH PLANS, INC.	PSCHP
PACIFICSOURCE HEALTH PLANS	PSHP
PACIFICSOURCE MEDICARE	PSCHP
PHARMACEUTICAL TECHNOLOGIES INC	PTI
PHARMACY DATA MANAGEMENT, INC.	PDM
PRIME THERAPEUTICS LLC	PRIME
PROCARE PHARMACY BENEFIT MANAGER, INC.	PRORX
PROGRESSIVE MEDICAL LLC	PROGMED
PROGYNY, INC.	PROGYNY
PROVIDENCE HEALTH PLAN	PROV
PROVIDENCE HEALTH ASSURANCE	PROV
REGENCE BLUECROSS BLUESHIELD OF OREGON	REG
RXEDO, INC.	RXEDO
RXSENSE PRESCRIPTION MANAGEMENT, LLC	RXSENSE
SAMARITAN ADVANTAGE HEALTH PLAN	SAM
SAMARITAN HEALTH ADVANTAGE HEALTH PLAN	SAM
SAMARITAN HEALTH PLANS, INC.	SAM
SERVE YOU CUSTOM PRESCRIPTION MANAGEMENT, INC.	SRVYOU
SHASTA ADMINISTRATIVE SVCS INC	SHASTA
SILVERSCRIPT CHOICE 60	CVS
SILVERSCRIPT PLUS 061	CVS
TMESYS	TMESYS
TRILLIUM ADVANTAGE	TCHP
TRILLIUM COMMUNITY HEALTH PLAN, INC.	TCHP
UMR INC	UMR
UNITED HEALTHCARE SERVICES, INC.	UHS
UNITEDHEALTHCARE	UHCOR
UNITEDHEALTHCARE AARP MEDICARERX PREFERRED 029	UHCM
UNITEDHEALTHCARE AARP MEDICARERX SAVER PLUS 374	UHCM

Payer Name	Abbreviation
UNITEDHEALTHCARE AARP MEDICARERX WALGREENS 411	UHCM
UNITEDHEALTHCARE INSURANCE COMPANY	UHC
UNITEDHEALTHCARE LIFE INSURANCE COMPANY	UHC
UNITEDHEALTHCARE OF OREGON INC.	UHCOR
WELLCARE CLASSIC 020	WCARE
WELLCARE EXTRA 126	WCARE
WELLDYNE RX, INC.	WELLD
ZENITH AMERICAN SOLUTIONS, INC.	ZENITH
ZOOM HEALTH PLAN INC	ZOOM

Appendix F: Subscriber billed premium data file layout and dictionary

Note: Mandatory reporters are only required to file this report for subscribers in fully-insured commercial and Medicare Advantage plans. PBM's that offer stand-alone prescription drug plans are also required to submit this report. Mandatory reporters do not have to file a Form APAC-1 (waiver or exception of reporting requirements), for subscribers in plans which are not required to file this report.

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
PB001	Payer type	Text	1	Yes	See lookup table MC001 (Appendix A)	0%
PB003	Product code	Text	3	Yes	See lookup table MC003 (Appendix A)	0%
PB202	Market segment	Text	2	Yes	See lookup table ME202 (Appendix B)	0%
PB007	Subscriber ID	Text	30	Yes	Plan-specific unique identifier for subscriber	0%
PB008	Premium billed month	Date	6	Yes	Month in which subscriber and related members had coverage for which subscriber was billed. CCYYMM	0%
PB009	Covered members in premium billed month	Numeric	3	Yes	Number of members with coverage for which subscriber was billed in the premium billed month.	0%
PB010	Total Premium Billed for Premium Billed Month	Numeric	12	Yes	Total premium amount the group or individual that was billed for coverage in premium billed month. Report premium billed, not premium paid or another amount. Enter 0 if amount equals zero. Example: 15102.00	0%

Appendix G: Annual Supplemental Provider Level APM Summary

Note: Mandatory reporters are not required to file this report, nor do they have to file a Form APAC-1 (waiver or exception of reporting requirements) for the following lines of business: prescription drugs only and dental benefits only.

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
PRAPM003	Billing Provider or Organization Plan ID	Text	30	Yes	Internal ID of billing provider or organization. Same as MP003 (see Appendix C) If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1%
PRAPM018	Billing Provider or Organization NPI	Text	10	Yes	NPI for the billing provider or organization which holds the contract with the mandatory reporter If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1%
PRAPM004	Billing Provider or Organization Tax ID	Text	9	Yes	Federal taxpayer's ID of the billing provider or organization/facility which holds the contract with the mandatory reporter. Include leading zeros and do not include dashes. Example: 012345678 If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1%
PRAPM008	Billing Provider Last Name or Organization	Text	100	Yes	Last name of the billing provider or the full name of the organization which holds the contract with the mandatory reporter If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1%
PRAPM006	Billing Provider First Name	Text	25	Situational	First name of the billing provider which holds the contract with the mandatory reporter. Leave blank if the provider is an organization or facility. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1%
PRAPM101	Billing Provider or Organization Entity Type	Numeric	2	Yes	Valid Values:1 – Person, 2 – Facility, 3 – Professional Group, 4 – Retail Site, 5 – E-Site, 6 – Financial Parent, 7 – Transportation, 8 – Other	1%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
					See Lookup Table PRAPM101 (Appendix G) If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	
PRAPM102	Line of Business	Text	4	Yes	Indicates insurance line of business. Only report the following lines of business using the codes below: COMM = Commercial MADV = Medicare Advantage CCO = Medicaid CCOs PEBB = Public Employees' Benefit Board OEBB = Oregon Educators' Benefit Board	2%
PRAPM103	Payment Arrangement Category	Text	1	Yes	Indicates the payment arrangement type that is being reported. See Lookup Table PRAPM103 (Appendix G) If there is more than one payment arrangement type with a billing provider/organization, then separately report each payment arrangement type. NOTE: ALL PAYMENT ARRANGEMENT CATEGORIES ARE MUTUALLY EXCLUSIVE WITH RESPECT TO PAYMENTS. Valid value "A" and "V" must be reported once for every distinct line of business (PRAPM102)	1%
PRAPM104	Performance Period Start Date	Date	8	Yes	Effective date of performance period for reported Insurance Line of Business and Payment Arrangement Type. CCYYMMDD If varying performance periods apply to a billing provider or organization (for a particular line of business and payment arrangement type), report results on separate lines. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	2%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
PRAPM105	Performance Period End Date	Date	8	Yes	End date of performance period for reported Insurance Line of Business and Payment Arrangement Type. CCYYMMDD If varying performance periods apply to a billing provider or organization (for a particular line of business and payment arrangement type), report results on separate lines. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	2%
PRAPM106	Member Months	Numeric	7	Situational	Total number of members in reported stratification that participate in the reported payment arrangement, expressed in months of membership Membership should align with inclusion criteria of annual NAIC/SERFF filings and should only be reported for those members for whom the mandatory reporter is the primary payer. No decimal places; round to nearest integer. Example: 12345 If PRAPM103 = P, then leave this field null If PRAPM103 = S, then leave this field null If PRAPM103 = B, then leave this field null If PRAPM103 = F, then leave this field null If PRAPM103 = O, then leave this field null	2%
PRAPM107	Total Primary Care Claims Payments	Numeric	12	Yes	Sum of all associated primary care claims payments (paid claims only), including patient cost-sharing amounts, that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings. Reference the way OHA operationalizes OAR 836-053-1500 through 836-053-1510 and any supplemental documents referenced in those OARs for the definition of primary care.	1%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
					Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care claims payments made. This value should never exceed the amount of Total Claims Payments (PRAPM109). If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	
PRAPM108	Total Primary Care Non-Claims Payments	Numeric	12	Yes	Sum of all associated non-claims payments that pertain to primary care, that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings. Reference the way OHA operationalizes OAR 836-053-1500 through 836-053-1510 and any supplemental documents referenced in those OARs for the definition of primary care. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care non-claims payments made. This value should never exceed the amount of Total Non-Claims Payments (PRAPM110). If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1%
PRAPM109	Total Claims Payments	Numeric	12	Yes	Sum of all associated claims payments (paid claims only), including patient cost-sharing amounts, that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization	1%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
					has to pay the mandatory reporter. Enter 0 if no claims payments made. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	
PRAPM110	Total Non-Claims Payments	Numeric	12	Yes	Sum of all associated non-claims payments that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no non-claims payments made If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1%
PRAPM201					For future implementation.	N/A
PRAPM202					For future implementation.	N/A
PRAPM203					For future implementation.	N/A
PRAPM204					For future implementation.	N/A
PRAPM205					For future implementation.	N/A
PRAPM206					For future implementation.	N/A
PRAPM207					For future implementation.	N/A
PRAPM208					For future implementation.	N/A
PRAPM209					For future implementation.	N/A
PRAPM210					For future implementation.	N/A

Lookup Table PRAPM101: Billing Provider or Organization Entity Type

This field contains all valid values for types of billing provider or organization entity types

Code	Value	Definition/Example
1	Person	Physician, clinician, orthodontist, and any individual that is licensed/certified to perform healthcare services
2	Facility	Hospital, health center, long-term care, rehabilitation, and any building that is licensed to transact healthcare services
3	Professional Group	Collection of licensed/certified healthcare professionals that are practicing healthcare services under the same entity name and Federal Tax ID Number
4	Retail Site	Brick-and-mortar licensed/certified place of transaction that is not solely a healthcare entity (i.e., pharmacies, independent laboratories, vision services)
5	E-Site	Internet-based order/logistic system of healthcare services, typically in the form of durable medical equipment, pharmacy, or vision services.
6	Financial Parent	Financial governing body that does not perform healthcare services itself but directs and finances healthcare service entities, usually through a board of directors
7	Transportation	Any form of transport that conveys a patient to/from a healthcare provider
8	Other	Any type of entity not otherwise defined that performs health care services

Lookup Table PRAPM103: Payment Arrangement Categories

This field contains all valid values for types of payment arrangement categories

Code	Value	Definition/Example
P	Pay for Performance/Payment Penalty	Payments or penalties made to a billing provider for performance against non-financial goals (quality and utilization metrics) during reporting year.
S	Shared Savings/Shared Risk	Payments or penalties made to the billing provider for performance against spending targets during reporting year.
G	Global Budget	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for either a: • Comprehensive set of services for a broadly defined population • Defined set of services, where certain benefits such as BH or Rx are carved out and not part of the budget Must, at a minimum, include physician services and IP/OP hospital services.
L	Limited Budget	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for a non-comprehensive set of services to be delivered by a single provider organization (e.g. capitated primary care or oncology services)
C	Capitation – Unspecified	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for a set of services for a defined population, for which it cannot be determined if the arrangement is a global budget or limited budget arrangement.
B	Bundled/Episode-Based	Payments made to a billing provider where a set budget was set for a defined episode of care for a specific condition (e.g. knee replacement) delivered by providers across multiple provider types
I	Integrated Delivery System	One or more legal entities encompassing financing and delivery of a full-spectrum of healthcare services under a mutually exclusive contract agreement. Resources and decision making rights are shared across entities, and reimbursement is not dependent on services provided.

Code	Value	Definition/Example
H	Patient-Centered Primary Care Home/ Patient-Centered Medical Home	Payment for recognition as a Patient-Centered Primary Care Home (PCPCH) or other type of patient-centered medical home (PCMH), including recognition under a proprietary PCMH initiative. Only reported for payments exclusively for PCPCH or other PCMH recognition. FFS, pay-for-performance, shared savings, and capitation payments made for members in a PCPCH or other PCMH should be reported under those payment arrangement categories.
O	Other, Non-FFS	All other payments made to a billing provider which are not based on a FFS model, including payments for health information technology structural changes; payments or expenses for supplemental staff or supplemental activities integrated into the practice, such as practice coaches, patient educators, or patient navigators; and other infrastructure payments.
F	FFS	Payments made to a billing provider under a traditional fee-for-service model, where each service rendered to a patient is separately reimbursed. FFS includes: Diagnosis Related Groups (DRGs), per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs), claims-based payments adjusted by performance measures, and discounted charges-based payments.
A	All Member Months	Total enrollment during the previous calendar year. Enrollment should be reported (in de-duplicated member months) for insurance policies that align with the inclusion criteria of annual NAIC/SERFF filings, and should only be reported for those members for whom the mandatory reporter was the primary payer. This value must be reported only once for every distinct line of business (PRAPM102)
V	Alternative Arrangement Member Months	Total enrollment in alternative payment arrangements during the previous calendar year.

Code	Value	Definition/Example
		Enrollment should only be reported for members in payment arrangement categories G, L, C, I and H. Enrollment should be reported (in de-duplicated member months) for insurance policies that align with the inclusion criteria of annual NAIC/SERFF filings, and should only be reported for those members for whom the mandatory reporter was the primary payer. This value must be reported only once for every distinct line of business (PRAPM102). Note: In many cases, the value reported for code "V" will be a subset of the value reported for code "A".

***Note: Although they are valid values for PRAPM103, codes "A" and "V" are not payment arrangement categories. Instead, these values capture total enrollment, as specified, in policies that align with the inclusion criteria of annual NAIC/SERFF filings.

Appendix H: Control Totals for Annual Supplemental Provider Level APM Summary

Note: Mandatory reporters are not required to file this report, nor do they have to file a Form APAC-1 (waiver or exception of reporting requirements) for the following lines of business: prescription drugs only and dental benefits only.

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
PRAPMCT101	Submitted File	Text	60	Yes	Data File Name Example: *ABCD_ABCD_SupplAPM_Provider_201609_20160918.dat.*	0%
PRAPMCT102	Data Rows	Numeric	10	Yes	Number of data rows in the submitted file	0%
PRAPMCT103	Member Months	Numeric	10	Yes	Sum of member months. No decimal places; round to nearest integer. Example: 12345	0%
PRAPMCT104	Total Primary Care Claims Payments	Numeric	12	Yes	Sum of Total Primary Care Claims Payments, as reported in Appendix G (PRAPM107)	0%
PRAPMCT105	Total Primary Care Non-Claims Payments	Numeric	12	Yes	Sum of Total Primary Care Non-Claims Payments, as reported in Appendix G (PRAPM108)	0%
PRAPMCT106	Total Claims Payments	Numeric	12	Yes	Sum of Total Claims Payments	0%
PRAPMCT107	Total Non-Claims Payments	Numeric	12	Yes	Sum of Total Non-Claims Payments	0%