

EXHIBIT B SUBMITTED INFORMATION

1. Submitted Information. The Data Supplier shall provide detailed line item Medical and Pharmacy claims and encounter data for the Data Supplier’s Commercial, Individual and Medicare lines of business within the State of Oregon, excluding Medicare Supplement, consistent with Data Supplier’s contractual obligations with purchasers and self-insured plans. The Data Supplier shall make good faith efforts to provide optional fields as indicated below and shall provide such other data elements or information as reasonably requested by the Quality Corp to accomplish the purposes of this Agreement. Data Supplier does/ does not specify the included lines of business for submitted claims in optional “Supplement 1-Product Lines and ASO Customers” that accompanies this Exhibit B.

Without limiting the foregoing, the Submitted Information shall:

- 1.1 Exclude information on sensitive conditions or treatment regimens that would require the express permission of the patient.
- 1.2 Include all applicable physician-specific identifiers and all practice-specific identifiers, including Tax Identification Number, DEA Number and National Provider Identifier.
- 1.3 Include all applicable facility indicators, including the name and address of the facility where services were rendered (and not the central billing location) if available.
- 1.4 Include a record count for each data file and control totals for each numeric field.
- 1.5 The initial time period requested shall cover services paid and incurred from January 2007 through March 31, 2013 with updates to occur on an ongoing quarterly basis thereafter or as otherwise mutually agreed by the Parties.
- 1.6 Be submitted to Data Services Vendor in a file format to be agreed upon between Data Services Vendor and the Data Supplier, including but not limited to one of the following: Secure FTP transfer or other electronic media that is mutually agreeable to the Parties.
- 1.7 Have no more than ten percent of certain key fields blank or hold invalid values. These key fields are labeled as “required” in Section 2 of this Exhibit B, excluding fields prohibited by HIPAA and/or other Federal or state law privacy protections.
- 1.8 Be submitted along with contact information for the individual designated by the Data Supplier as responsible for data management activities.

2. Key Fields.

The table below contains the list of required and optional data elements that will be required of all data suppliers for this project.

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Facility, Physician and Rx claims have the same file layout. All claim types may be sent in the same file or may be sent in separate files, but the layout is the same for all. All columns must be represented on the file. If a column is optional, not applicable, or unavailable, you may leave it empty. Only tab or pipe-delimited files are acceptable. Each file should have a column header row reflecting the column names listed below. No quoted strings should be sent.

“Required” field means that if you have this element, you must send it to ensure the most accurate results. If you do not have basic required elements like service codes or member identifiers or dates of service on certain claims, those claims should be excluded from the file.

Additional fields such as charges and paid amounts are now included (see chart). These fields are required for new work approved by the Oregon Health Care Quality Board of Directors and include new programming for national RWJ grant, expanded work products related to utilization and efficiency analysis and all relevant fields anticipated for the Oregon Health Authority All Payer All Claims (OHA APAC) database submission. The new fields are highlighted in the table.

The data format and fields required for the OHA APAC submission may be submitted in lieu of the optional and required fields listed below. The data layout and specifications for the OHA APAC can be found at: http://www.oregon.gov/OHA/OHPR/RSCH/Pages/APAC.aspx#Informational_Documents

ALL CLAIM TYPES							
Field	Data Field	Applies to			Type/Format	Req/Opt	Comments
#		UB	Phys	Rx			
1	Row Type	X	X	X	Char(1)	Required	1=UB, 2=Phys, 3=Rx, 4=Lab Include lab only if including actual lab values
2	Claim Status	X	X	X	Char(1)	Required	P=Paid, D=Denied, E=Encounter Denied Claims and Encounters are highly desirable for accurate HEDIS Reporting
3	Recipient ID	X	X	X	Varchar(50)	Required	Any internal identifier for the member. Native or encrypted. Must be consistent over time, must exist on the eligibility file, and be unique to one individual.
4	Claim Number	X	X	X	Varchar(80)	Required	Required if source is not sending final-only versions of claims ¹
5	Prior Version Claim Number	X	X	X	Varchar(80)	Required	Required if source is not sending final-only versions of claims ¹
6	Claim Received Date	X	X	X	yyyymmdd	Required	Required if source is not sending final-only versions of claims ¹
7	Claim Paid Date	X	X	X	yyyymmdd	Required	Required if source is not sending final-only versions of claims ¹

¹ If client intends to send data incrementally, even if each transmission is “final version” only claims, this must be supplied.

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ALL CLAIM TYPES							
Field	Data Field	Applies to			Type/Format	Req/Opt	Comments
#		UB	Phys	Rx			
8	Billing Provider ID	X	X	X	Varchar(30)	Required	Any internal identifier for the billing provider. Must be unique to one clinician or entity . Must exist on the provider file. If supplying for Rx, use pharmacy provider ID.
9	Principal Diagnosis	X	X		Varchar(5)	Required	No periods, left justified
10	Diagnosis 2	X	X		Varchar(5)	Required	No periods, left justified
11	Diagnosis 3	X	X		Varchar(5)	Required	No periods, left justified
12	Diagnosis 4	X	X		Varchar(5)	Required	No periods, left justified
13	Diagnosis 5	X	X		Varchar(5)	Required	No periods, left justified
14	Diagnosis 6	X	X		Varchar(5)	Required	No periods, left justified
15	Diagnosis 7	X	X		Varchar(5)	Required	No periods, left justified
16	Diagnosis 8	X	X		Varchar(5)	Required	No periods, left justified
17	Diagnosis 9	X	X		Varchar(5)	Required	No periods, left justified
18	Diagnosis 10	X	X		Varchar(5)	Required	No periods, left justified
19	Diagnosis 11	X	X		Varchar(5)	Required	No periods, left justified
20	Diagnosis 12	X	X		Varchar(5)	Required	No periods, left justified
21	Diagnosis 13	X	X		Varchar(5)	Required	No periods, left justified
22	Admit Date	X			yyyymmdd	Required	For <u>inpatient</u> claims only. Must be <= Discharge Date.
23	Discharge Date	X			yyyymmdd	Required	For <u>inpatient</u> claims only. Must be >= Admit Date.
24	Service Date	X	X	X	yyyymmdd	Required	For Rx, use Dispensed date. If unavailable, use Fill date, or least desirable, Rx written date.
25	Covered Days	X			Int	Optional	For future compatibility
26	DRG	X			Char(3)	Optional	For inpatient claims only. If available, improves compatibility, must be CMS V25+ (MS) or V24 (CMS)
27	DRG Type	X			Char(1)	Optional	For inpatient claims only. Must be populated if DRG populated. Valid values are 'C' (CMS) or 'M' (MS)
28	Attending Provider ID	X	X	X	Varchar(30)	Required	Any internal identifier for the Attending/Rendering/Service provider. Must be unique to one clinician . Must exist on the provider file. <i>For Rx, supply prescriber id if available and the prescriber id exists on your provider file..</i>
29	UB Type of Bill	X			Char(4)	Required	For all facility claims. <u>Industry standard numeric values only.</u>
30	UB Discharge Status	X			Char(2)	Required	For inpatient claims only. Form locator 22 <u>Industry standard discharge status codes only.</u>
31	ICD9 Surgical Procedure 1	X			Varchar(4)	Required	ICD-9 Surgical Procedure Code1 (Principal Surgery). No periods.

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ALL CLAIM TYPES							
Field	Data Field	Applies to			Type/Format	Req/Opt	Comments
#		UB	Phys	Rx			
32	ICD9 Surgical Procedure 2	X			Varchar(4)	Required	ICD-9 Surgical Procedure Code2. No periods.
33	ICD9 Surgical Procedure 3	X			Varchar(4)	Required	ICD-9 Surgical Procedure Code3. No periods.
34	ICD9 Surgical Procedure 4	X			Varchar(4)	Required	ICD-9 Surgical Procedure Code4. No periods.
35	ICD9 Surgical Procedure 5	X			Varchar(4)	Required	ICD-9 Surgical Procedure Code5. No periods.
36	ICD9 Surgical Procedure 6	X			Varchar(4)	Required	ICD-9 Surgical Procedure Code6. No periods.
37	CPT or HCPCS Code	X	X		Varchar(5)	Required	Industry standard codes only.
38	CPT Modifier 1	X	X		Char(2)	Required	Industry standard modifiers only.
39	CPT Modifier 2	X	X		Char(2)	Required	Industry standard modifiers only.
40	CPT Modifier 3	X	X		Char(2)	Required	Industry standard modifiers only.
41	CPT Modifier 4	X	X		Char(2)	Required	Industry standard modifiers only.
42	CPT II Code	X	X		Varchar(5)	Required	If available, improves accuracy of certain numerators.
43	LOINC Code	X	X		Varchar(8)	Required	If available, enables output of certain lab result based numerators / Improves accuracy of others.
44	Lab Result	X	X		Varchar(8) Format nnn.nn	Optional	Enables output of certain lab result based numerators.
45	Micro/Macro Albumin Result	X	X		Char(1)	Optional	P=Positive, N=Negative
46	Unit of Service (Quantity)	X	X	X	Int	Required	Positive for original or replacement claims Negative for reversal/voids Zero for denied.
47	Revenue Code	X			Varchar(4)	Required	Zero pad to 4 digits
48	NDC Code			X	Varchar(11)	Required	11 Digit standard NDC codes only.
49	Drug Days Supply			X	int	Required	Only provide actual days supply, not quantity dispensed or other value.
50	Drug Dispensed as Written Indicator			X	Char(1)	Optional	Useful for measure expansion. Y=Dispense as written; N=Substitution permitted
51	Drug Metric Quantity Dispensed			X	Numeric(10,2)	Optional	Useful for measure expansion.
52	Rx Retail / Mail Indicator			X	Char(1)	Optional	R=Retail, M=Mail Blank for unknown
53	Place of Service		X		Char(2)	Required	Industry standard place of service.
54	Detailed Claim Status	X	X	X	Char(2)	Required	See lookup table
55	Total Billed Amount	X	X	X	Numeric(10,2)	Required	
56	Allowed Amount	X	X	X	Numeric(10,2)	Required	

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ALL CLAIM TYPES							
Field	Data Field	Applies to			Type/Format	Req/Opt	Comments
#		UB	Phys	Rx			
57	Paid Amount	X	X	X	Numeric(10,2)	Required	
58	COB Allowed Amount	X	X	X	Numeric(10,2)	Required	
59	Risk Withhold Amount	X	X	X	Numeric(10,2)	Required	
60	Co-payment	X	X	X	Numeric(10,2)	Required	
61	Co-Insurance	X	X	X	Numeric(10,2)	Required	
62	Deductible	X	X	X	Numeric(10,2)	Required	

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PROVIDER				
Field #	Data Field	Type/Format	Req/Opt	Comments
1	Provider ID	Varchar(30)	Required	Any internal identifier for the provider. Must be unique to one clinician or other provider entity .
2	Provider TIN	Char(9)	Required	Provider Tax ID
3	Provider State License Number	Varchar(15)	Required	State license number. Prefix with standard two character State abbreviation.
4	Provider Medicaid Number	Varchar(12)	Required	If available.
5	Provider NPI	Varchar(12)	Required	If available.
6	Provider CMS UPIN	Varchar(12)	Required	If available.
7	Provider DEA Number	Varchar(12)	Required	If available.
8	Provider Last Name	Varchar(20)	Required	Facility name or clinician last name.
9	Provider First Name	Varchar(20)	Required	For clinician only.
10	Provider Middle Initial	Char(1)	Required	For clinician only. Initial Only.
11	Provider Suffix	Char(10)	Required	For clinician only
12	Provider DOB	yyyymmdd	Required	If available
13	Provider Office Address Street	Varchar(50)	Required	
14	Provider Office Address City	Varchar(20)	Required	
15	Provider Office Address State	Char(2)	Required	
16	Provider Office Address ZIP	Char(5)	Required	
17	Provider Mailing Address Street	Varchar(50)	Required	If available
18	Provider Mailing Address City	Varchar(20)	Required	If available
19	Provider Mailing Address State	Char(2)	Required	If available
20	Provider Mailing Address ZIP	Char(5)	Required	If available, 5 digit zip
21	Internal Provider Specialty Description	Varchar(50)	Required	No codes, must be a description like "Family Practice"
22	Provider is PCP	Char(1)	Required	For clinician records only, Y=Yes, N=No
23	Provider is OBGYN	Char(1)	Required	For clinician records only, Y=Yes, N=No
24	Provider is Mental Health	Char(1)	Required	For clinician records only, Y=Yes, N=No
25	Provider is Eye Care Provider	Char(1)	Required	For clinician records only, Y=Yes, N=No
26	Provider is Dentist	Char(1)	Required	For clinician records only, Y=Yes, N=No
27	Provider is Nephrologist	Char(1)	Required	For clinician records only, Y=Yes, N=No
28	Provider is Chem. Dep	Char(1)	Required	For clinician records only, Y=Yes, N=No
29	Provider is Nurse Practitioner	Char(1)	Required	For clinician records only, Y=Yes, N=No
30	Provider is Phys Assist	Char(1)	Required	For clinician records only, Y=Yes, N=No
31	Provider can Prescribe Rx	Char(1)	Required	If Known, For clinician records only, Y=Yes, N=No

ELIGIBILITY

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Field #	Data Field	Type/Format	Req/Opt	Comments
1	Recipient ID	Varchar(50)	Required	Any internal identifier for the member. Native or encrypted. Must be consistent over time, and be unique to one individual.
2	Recipient SSN	Char(9)	Optional	If agreed to send, may provide valuable crosswalking capability and actionable reporting for providers.
3	Recipient Last Name	Varchar(20)	Required	
4	Recipient First Name	Varchar(20)	Required	
5	Recipient Middle Name	Varchar(20)	Required	
6	Recipient DOB	Yyyymmdd	Required	Actual DOB, no proxies. Must be provided for accurate HEDIS reporting.
7	Recipient Gender	Char(1)	Required	M, F, blank if unknown
8	Recipient Street Address	Char(75)	Required	As of eligibility
9	Recipient City	Char(20)	Required	As of eligibility
10	Recipient State	Char(20)	Required	As of eligibility
11	Recipient ZIP	Char(5)	Required	As of eligibility segment start. 5 digit only.
12	Eligibility Segment Effective Date	Yyyymmdd	Required	The effective date of this eligibility information. ² Cannot be a “default” or unknown date.
13	Eligibility Segment Term Date	Yyyymmdd	Required	The termination date of this eligibility information. If segment is open-ended at this time, leave column blank. A member id should not have more than 1 open-ended segment.
14	PCP ID	Varchar(20)	Required	Any internal identifier for the PCP provider, if known or plan assigned. Must be unique to one clinician or entity . Must exist on the provider file.
15	Subscriber ID	Varchar(50)	Required	Could be used for enhanced reporting. Must be a known Recipient ID
16	Relationship to Subscriber	Char(1)	Optional	M=Self, D=Dependant, S=Spouse
17	Subscriber Last Name	Varchar(20)	Required	
18	Subscriber First Name	Varchar(20)	Required	
19	Subscriber Middle Name	Varchar(20)	Required	
20	Medical Benefit	Char(1)	Required	For current enrollment segment, Y=Yes, N=No
21	ChemDep Benefit - Inpatient	Char(1)	Required	For current enrollment segment, Y=Yes, N=No
22	ChemDep Benefit - Day/Night	Char(1)	Required	For current enrollment segment, Y=Yes, N=No
23	ChemDep Benefit - Ambulatory	Char(1)	Required	For current enrollment segment, Y=Yes, N=No
24	Dental Benefit	Char(1)	Required	For current enrollment segment, Y=Yes, N=No
25	Drug Benefit	Char(1)	Required	For current enrollment segment, Y=Yes, N=No
26	Mental Health Benefit – Inpatient	Char(1)	Required	For current enrollment segment, Y=Yes, N=No
27	Mental Health Benefit - Day/Night	Char(1)	Required	For current enrollment segment, Y=Yes, N=No
28	Mental Health Benefit - Ambulatory	Char(1)	Required	For current enrollment segment, Y=Yes, N=No

² For accurate HEDIS® processing, these dates should reflect the actual effective and termination dates of individual coverage segments, with each row reflecting accurate information as of that time window. For example, If a member moves from a POS product to a PPO product, a new enrollment segment would begin and the Payer Type field would reflect the change. The same would apply to a benefit change. If a member moved from a plan with a drug benefit to a plan without a drug benefit, or vice-versa, a new enrollment segment would begin.

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ELIGIBILITY				
Field	Data Field	Type/Format	Req/Opt	Comments
#				
29	Plan Specific Contract Number	Char(128)		
30	PEBB flag	Char(1)	Required	For current enrollment segment, Y=Yes, N=No
31	OEBB Flag	Char(1)	Required	For current enrollment segment, Y=Yes, N=No
32	State Medical Home Flag	Char(1)	Required	For current enrollment segment, Y=Yes, N=No
33	Payer Type	Char(3)	Required	For current enrollment segment, provide the three character Payer Type: 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 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 Child Health Insurance Program
34	Payer	Char(1)	Required	For current enrollment segment provide the single character Payer: C Carrier D Medicaid G Other government agency P Pharmacy benefits manager T Third-party administrator U Unlicensed entity
35	Payer Sequence Code	Char(1)	Required	Indicates payer responsibility. Use P (primary), S (secondary), or T (tertiary)
36	Race	Char(2)	Required	1 White 2 Black or African American 3 American Indian and Alaska Native 4 Asian 5 Native Hawaiian and Other Pacific Islander 6 Some Other Race 7 Two or More Races 9 Unknown Race
37	Ethnicity	Char(2)	Required	1 Hispanic or Latino 2 Not Hispanic or Latino 3 Unknown Ethnicity
38	Language	Char(2)	Required	1 English 2 Spanish 3 Other Indo-European Language 4 Asian and Pacific Island Languages 8 Other Languages 9 Spoken Language Unknown

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Field	Data Field	Type/Format	Req/Opt	Comments
#				
39	Oregon HVMH Flag	Char(1)	Optional	For current enrollment segment, Y=Yes, N=No This field is required for data suppliers participating in the OHLC high value medical home
40	OHVMH Clinic	Char(2)	Optional	This field is required for data suppliers participating in the OHLC high value medical home Look up table
41	OHVMH Eligibility Segment Effective Date	yyyymmdd	Optional	This field is required for data suppliers participating in the OHLC high value medical home The effective date of this eligibility information. ³ Cannot be a “default” or unknown date.
42	OHVMH Eligibility Segment Term Date	yyyymmdd	Optional	This field is required for data suppliers participating in the OHLC high value medical home The termination date of this eligibility information. If segment is open-ended at this time, leave column blank. A member id should not have more than 1 open-ended segment.
43	Prepaid Amount/PMPM	Numeric(10,2)	Required	

**Lookup Table: Detailed Claim status
Code Value**

- 1 Processed as primary
- 2 Processed as secondary
- 3 Processed as tertiary
- 4 Denied
- 19 Processed as primary, forwarded to additional payer(s)
- 20 Processed as secondary, forwarded to additional payer(s)
- 21 Processed as tertiary, forwarded to additional payer(s)
- 22 Reversal of previous payment
- 25 Predetermination pricing only – no payment

3. General Requirements for the Preparation of the Submitted Information. The Data Supplier shall:

3.1 Apply all adjustments, reversals, rejections, and any other changes to the Submitted Information before it is sent to Data Services Vendor.

3.2 Provide the most granular service lines for each claim or encounter and not “roll-up” or aggregate individual services lines to a single visit, claim, or encounter.

³ For accurate HEDIS® processing, these dates should reflect the actual effective and termination dates of individual coverage segments, with each row reflecting accurate information as of that time window. For example, If a member moves from a POS product to a PPO product, a new enrollment segment would begin and the Payer Type field would reflect the change. The same would apply to a benefit change. If a member moved from a plan with a drug benefit to a plan without a drug benefit, or vice-versa, a new enrollment segment would begin.

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3.3 Provide capitated claims (encounter data) if they contain the minimum required data elements.

3.4 Provide the effective dates and termination dates for each eligible period for that member if multiple eligibility records exist for a given member in a given year.

3.5 Ensure that all data should have longitudinal and referential integrity – medical events and services must be relatable to a patient and provider over time.