PENNSYLVANIA MEDICAL DATA CALL MANUAL

Issued July 1, 2016

PENNSYLVANIA COMPENSATION RATING BUREAU

MEDICAL DATA CALL MANUAL

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MEDICAL DATA CALL MANUAL

A. Overview

The information contained in this Medical Data Call Manual contains the -- reporting guidelines for the Call. This Medical Data Call Manual replaces all previously released Medical Data Call Implementation Guides and Manuals. The current web-based manual located on the PCRB's website at www.pcrb.com.

The Medical Data Call Manual applies to data submitted to PCRB. Data providers are required to comply with the instructions and guidelines contained in this manual in conjunction with PCRB's **Statistical Plan**. Each data provider should develop its own internal methods for how to apply the information contained in these manuals. However, the end result must meet PCRB's criteria.

This manual is your source for PCRB's Medical Data Call reporting rules and requirements, as well as additional information and examples to assist you in meeting your reporting requirements.

B. Medical Data Call Background

During its July 30, 2008 meeting, the Pennsylvania Compensation Rating Bureau's Governing Board voted unanimously to authorize the PCRB to begin collecting detailed medical data. That vote was taken after careful consideration of the potential importance and utility of detailed medical data, as well as available methods for accomplishing the collection of such information. Factors addressed in the Board's discussion included the following points:

- Medical losses represent over 55 percent of loss costs in Pennsylvania
- Medical detail could enhance PCRB's ability to explain filings
- Medical cost containment issues are potentially important public policy matters
 - o Fee Schedule Relationships to Medicare, overall richness of reimbursements
 - Charge Master System
 - o Treatment Protocols
- Medical detail would be imperative for PCRB to be able to opine with authority on a variety of possible proposals to change the payment system for workers compensation in Pennsylvania
- The ability to compare data with other jurisdictions will emerge with the common collection of this data elsewhere

The National Council on Compensation Insurance, Inc. (NCCI) has, through an extended and rigorous process, established a construct for the reporting and collection of medical detail information. That process has been accepted by carriers for use by NCCI states and has been implemented in those states. The NCCI refers to the collection of this medical detail as the Medical Data Call. The NCCI has shared the formats, timelines and related collateral for the Medical Data Call with all independent bureaus and has advised those bureaus that they are at liberty to adopt and use any portion(s) of that intellectual property as they may see fit. The PCRB believes, and the Governing Board has specifically concurred, that using and conforming as much as possible to the NCCI standards for the collection of medical detail information will be the most beneficial and effective means of expanding our information base to include medical detail information.

C. Medical Data Call Contacts

If you have any questions about the Medical Data Call, please contact the PCRB via one of the following:

Mail: Medical Data Reporting Department

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Pennsylvania Compensation Rating Bureau United Plaza Building – Suite 1500 30 South 17th Street Philadelphia, PA 19103-4007

Phone: (215) 568-2371 Website: www.pcrb.com

E-mail: medicalcall@pcrb.com

SECTION I – GENERAL RULES

A. Scope and Effective Date

All medical transactions with a Jurisdiction State of Pennsylvania are reportable. This includes all workers compensation claims, including medical-only claims. The Jurisdiction State corresponds to the state under whose Workers Compensation Act the claimant's benefits are being paid.

All transactions must be submitted electronically to the Pennsylvania Compensation Rating Bureau, United Plaza Building, Suite 1500, 30 S. 17th Street, Philadelphia, PA 19103.

The Call began with mandatory medical transactions occurring in 3rd Quarter 2010, due to be reported to the PCRB by December 31, 2010. --

B. General

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C. Participation / Eligibility

Participation is limited to carrier groups with at least 1% market share in the state of Pennsylvania over the most recent three years (overall average equals 1% or more.) Participation is re-evaluated every three years.

1. Carrier Group Participation

When a carrier group is included in the Call, all companies that are aligned within that group are required to report under the Call.

2. Reporting Responsibility

Participants in the Call will have the flexibility of meeting their reporting obligation in several ways, including:

- (a) Submitting all of their Call data directly to the PCRB
- (b) Authorizing their vendor business partners (TPAs, Medical Bill Review Vendors, etc.) to report the data directly to PCRB

Regardless of who submits the Call to the PCRB, the data submitter must report the standard record layout in its entirety with all data elements populated. Refer to the **Record Layouts** section of this manual.

Note: Although data may be provided by an authorized vendor on behalf of a carrier or carrier group, quality and timeliness of the data is the responsibility of the carrier.

3. Mergers and Acquisitions

If a carrier/group is required to report the Call prior to a merger or acquisition, the obligation to continue to report the Call remains. If a carrier/group that was not previously required to report the call merges with or becomes acquired by a reporting carrier/group, the acquired carrier/group is not required to report as part of that carrier/group until a future participation evaluation deems it eligible.

Example:

Mergers and Acquisition Scenarios

lf	And	Then
Carrier A currently reports the Call	Merges with Carrier B, that does not report the Call	Only Carrier A reports the Call unless a future participation evaluation deems AB eligible
Carrier A does not currently report the Call	Merges with Carrier B, that currently reports the Call	Only Carrier B reports the Call unless a future participation evaluation deems AB eligible
Carrier A currently reports the Call	Merges with Carrier B, that currently reports the Call	Both Carrier A and Carrier B continue to report the Call
Carrier A currently reports the Call as part of reporting Group B	Leaves Group B	Both Carrier A and Group B continue to report the Call
Carrier A does not currently report the Call	Merges with Carrier B, that does not currently report the Call	Neither Carrier A nor B reports the Call unless a future participation evaluation deems AB eligible

D. Reporting Frequency

The Medical Data Call transactions are required to be reported on a quarterly basis. Transactions for any given quarter are required to be reported by the close of the following quarter. Monthly transactions are also accepted. Below are examples of monthly and quarterly submission schedules:

Monthly: Three monthly data submissions are submitted, with the entire quarter's data due at the end of the following quarter (example: for 3rd quarter, the monthly reporting of July data can be reported in August, August data in September, September data in October—with the entire quarter's data due by 12/31)

Quarterly: One submission is reported by the end of the following quarter (example: 3rd quarter is due by 12/31)

1. Duration of Reporting

Medical Data Call transactions are required to be reported until transactions no longer occur for the claim or 30 years from the claim Accident Date, whichever comes first.

Example: Reporting duration for claim with an accident date prior to 3rd quarter 2010A medical transaction occurs in July 2010 for a claim whose accident date is August 1980. The medical transaction would be reported with the 3rd quarter 2010 submission. No further reporting of medical transactions for this claim is expected.

Example: Reporting duration for claim with an accident date on or after 3rd quarter 2010A medical transaction occurs in August 2010 for a claim whose accident date is July 2010. The medical transaction would be reported with the 3rd quarter 2010 submission. Medical transactions reported after July 1, 2040 will be accepted but are not required.

E. Data Submission Procedures

Medical Data Call transactions are to be submitted electronically to the PCRB through Compensation Data Exchange (CDX).

CDX is a self-administered service offered to carriers who are members of one or more of the ACCCT members. (Please refer to the appendix for a list of ACCCT members.) The use of CDX for the submission or retrieval of data and to provide access to other services or products is subject to availability and the terms and conditions of use established by ACCCT, Compensation Data Exchange, LLC., or individual DCOs. These guidelines may be accessed through the ACCCT website at www.accct.org. ACCCT disclaims all liability, direct or implied, and all damages, whether direct, incidental, or punitive, arising from the use or misuse of the CDX site or services by any person or entity.

Before data submitters can send Medical Data Call production files using CDX, a completed Insurer User

Management Group (UMG) Primary Administrator Application for each carrier/group must be on file, and each submitter's electronic data submissions must pass Certification Testing. Refer to the Insurer User

Management Group (UMG) Primary Administrator Application section of this manual for details and the Appendix of this manual for a copy of the digital (online) form.

If a carrier group has already established an UMG primary administrator and currently submits policy data or unit statistical data to the PCRB via CDX, a carrier does not need to submit an additional -- application to submit Medical Data Call transactions.

F. Insurer User Management Group (UMG) Primary Administrator Application

Each applicant is required to designate an Insurer User Management Group (UMG) Primary Administrator for the entire Group. The UMG primary administrator shall be solely responsible for the following activities: (a) establishing, controlling, and maintaining Applicant's access to CDX and its products and services; (b) creating and maintaining accounts for the Applicant; (c) establishing and maintaining all Carrier User account levels; and (d) assessing and responding to all security issues and breaches.

1. - Application Instructions

The digital (online) application form must be filled out in its entirety and submitted online. --

2. Submission of Application

Once you have successfully submitted the application, click the hyperlink labeled 'Click here to print this application for submission' to launch a printable version. You will receive an e-mail titled "Insurer UMG Primary Administrator Application Received", which also includes a link to print the application. The printable copy will include instructions on how to complete the application process.

This printed application must be signed by the Primary Administrator and an Authorizing Officer of the Applicant who shall be fully authorized to bind the Applicant to the Terms and Conditions of Use at www.accct.org. The completed application with the signatures, along with a copy of the authorizing officer's business card or letter head, must be mailed, faxed, or e-mailed to:

CDX Central Support c/o Axispoint 1180 Ave. of the Americas, Suite 400A New York, NY 10036 E-mail: cdxcentralsupport@axispoint.com Fax: 212-944-5489 Page 6

If a method other than mailing is used, a signed original must also be mailed to CDX® Central Support.

Once your account has been created, the Applicant's Primary Administrator will receive an e-mail notifying an account has been established and informing them of the temporary password. A copy of this e-mail, without the password, will be sent to the Applicant's Authorizing Officer.

3. Third Party Administrator Requirement

For carriers or carriers groups that use a Third Party Administrator (TPA), bill review vendor, or pharmacy vendor, the PCRB requires the CDX permission(s) to be handled through the TPA Request function within CDX. It will take 2 to 3 business days for ACCCT to review and approve the request. Once you are notified that the request has been approved, then the Primary Administrators for the carrier/group and the TPA will complete the set-up and data transfer permissions in CDX.

4. User Request Changes

In the event there is a need to modify TPA access to CDX, it is the responsibility to notify the carriers' UMG Primary Administrator immediately in order to restrict a user from having access to CDX.

G. Business Exclusion Options

It is expected that 100% of medical transactions from workers compensation claims in the state of Pennsylvania will be reported in the Medical Data Call. The PCRB does recognize that in certain limited circumstances this can be very difficult, if not impossible, for participants (carrier groups) to comply with reporting 100% of the expected medical transactions.

Accordingly, a carrier group participating in the Call may exclude data for claims that represent up to 15% of gross premium (direct premium gross of deductibles) for the state of Pennsylvania from its reporting requirement. This option may be utilized for small subsidiaries and/or business segments (e.g., coverage providers, branches, TPAs) where it may be more difficult for these entities to establish the required reporting infrastructure. The exclusion option must be based on a business segment, not claim type or characteristics. All requests for such exclusions must be presented to the PCRB for acceptance. Refer to Requests for Business Exclusion in this section.

The 15% exclusion does **not** apply to selection by:

- Medical services provided (pharmacy, hospital fees, negotiated fees, etc.)
- Claim characteristics such as claim status (e.g., open, closed)
- Claim types such as specific injury types (medical only, death, permanent total disability, catastrophic, etc.)

PCRB annually reviews previously filed exclusion requests to determine if a reexamination is warranted based upon changes in market share. Additionally, business exclusions are reviewed when participation/eligibility is re-evaluated.

Once a claim has been reported under the Call, all related medical transactions must be reported according to the reporting requirements for the Call.

Example: Need to Exercise Business Exclusion Option:

A carrier group has a TPA that does not process medical bills electronically. The premium associated with this TPA represents less than 15% of the participant's gross premium. The carrier group may exclude the

TPA's transactions from Call reporting.

Note: If a participant has unique circumstances that cannot be accounted for within the exclusion option, contact the PCRB's Medical Data Reporting Department to submit documentation describing these circumstances. The PCRB will address these situations on a case-by-case basis.

1. Requests for Business Exclusion

Participants in the Call are required to submit their basis for exclusion to the PCRB for review. The requests can be submitted to the PCRB starting in March of 2009.

All exclusion requests must include the following documentation:

- (a) The nature of what data is to be excluded (e.g., any vendors or entities).
- (b) An explanation as to why you are using the exclusion option.
- Output used to demonstrate that the excluded segment(s) will be less than 15% of premium. Refer to Methods of Determining Gross Premium for Business Exclusion in this section of the manual for premium determination methods (including examples).
- (d) Contact information for the individual responsible for the review documentation.

Refer to Appendix of this manual for a Business Exclusion Request Form, worksheets, and submission instructions.

2. Methods of Determining Gross Premium for Business Exclusions

The measurement of the 15% business exclusion is based on direct workers compensation premiums, gross of deductibles. Below are four methods for estimating the proportion of business excluded; any of these four are acceptable to the PCRB.

Some methods use the NAIC Direct Premium, which is reported in the "Exhibit of Premiums and Losses (Statutory Page 14)" in the NAIC Annual Statement. This premium can be either written or earned premium, whichever is more convenient. This premium is net of deductibles.

There are four methods carriers may use to estimate the exclusion percentage:

Method 1—Carriers with Large Deductible Direct Premium less than 0.3% of their total premium (NAIC Direct Premiums) may determine their estimated exclusion using Direct Premium, without adjustment.

Example: Premium determination (Method 1)

A participant with Large Deductible Direct Premium less than 0.3% of its total needs to exclude business for two small subsidiaries. The participant determines the exclusion on July 1, 2013 utilizing Direct Written Premium to determine the percentage of excluded premium.

Column A	Column B	Column C	Column D
Entities for Proposed Exclusion	Entities' Calendar Year Written Premium	Carrier Group Calendar Year Written Premium	Entities' Written Premium as % of Carrier Group (Col. B / Col. C)
Subsidiary #1	\$1,500,000		
Subsidiary #2	\$2,000,000		
TOTAL	\$3,500,000	\$357,500,000	1.0%

The following steps are performed to determine whether the proposed exclusions are less than 15% of the total gross written premium.

1. Based on premium data that it maintains, the carrier group determines the Calendar Year

- Direct Premiums Written in Pennsylvania or Federal Act for each subsidiary to be excluded. It enters the information in Column B.
- 2. Add up the data in Column B to get the Pennsylvania premium proposed to be excluded.
- 3. Determine the 2012 Calendar Year Direct Premiums Written in Pennsylvania—the participant finds this information on Schedule T of its 2012 NAIC Annual Statement (due on April 1, 2013). This information is entered on the Total line in Column C.
- 4. Calculate percentages for Column D (equals Column B divided by Column C).
- 5. Compare the Total line percentage to the 15% requirement. In this case the proposed exclusion is less than 15%, so it is allowable.

Refer to Appendix of this manual for Premium Verification Worksheet and Instructions – Method 1 and submission instructions.

Method 2—Carrier groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums) may use the table **Large Deductible Net to Gross Ratio**, included in this section, to determine their estimated exclusion using Direct Premium.

Determine the Large Deductible Net Ratio by calculating the ratio of excluded Large Deductible Direct Premium to total Direct Premium for Pennsylvania. Use this net ratio to look up the gross ratio using the **Large Deductible Net to Gross Ratio** table **below**. Calculate the ratio of excluded non-Large Deductible Direct Premium to total Direct Premium. Add the corresponding Gross Ratio found in the table to the ratio of excluded non-Large Deductible Direct Premium (if any) to determine the percentage of excluded Direct Premium.

Large Deductible Net to Gross Ratio			
Net Ratio	Gross Ratio		
0.0%	0.0%		
0.1%	0.5%		
0.2%	1.0%		
0.3%	1.5%		
0.4%	2.0%		
0.5%	2.5%		
0.6%	2.9%		
0.7%	3.4%		
0.8%	3.9%		
0.9%	4.3%		
1.0%	4.8%		
1.1%	5.3%		
1.2%	5.7%		
1.3%	6.2%		
1.4%	6.6%		
1.5%	7.1%		
1.6%	7.5%		
1.7%	8.0%		
1.8%	8.4%		
1.9%	8.8%		
2.0%	9.3%		
2.1%	9.7%		
2.2%	10.1%		
2.3%	10.5%		
2.4%	10.9%		
2.5%	11.4%		
2.6%	11.8%		

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2.7%	12.2%
2.8%	12.6%
2.9%	13.0%
3.0%	13.4%
3.1%	13.8%
3.2%	14.2%
3.3%	14.6%
3.4%	15.0%
3.5%	15.4%

Example: Premium determination (Method 2)

A participant with Large Deductible Direct Premium greater than 0.3% of its total must exclude one of its medical data providers. The participant has the following premium values:

- Total Direct Premium in Pennsylvania is \$1,000,000
- Large Deductible Direct Premium to be excluded for Pennsylvania is \$20,000
- Non-Large Deductible Direct Premium to be excluded for Pennsylvania is \$40,000

The following steps are performed to determine whether the proposed exclusion is less than 20% of the total gross written premium:

- Calculate the Large Deductible Net Ratio—\$20,000 (Large Deductible Direct Premium to be excluded) divided by \$1,000,000 (Total Direct Premium), multiplied by 100 equals a Large Deductible Net Ratio of 2.0% (\$20,000 / \$1,000,000 x 100 = 2.0%)
- 2. Use the Large Deductible Net Ratio of 2.0% and the table to determine the corresponding gross ratio of 9.3%
- 3. Calculate the excluded non-Large Deductible ratio—\$40,000 (non-Large Deductible Direct Premium to be excluded) divided by \$1,000,000 (Total Direct Premium), multiplied by 100 equals an excluded non-Large Deductible ratio of 4.0% (\$40,000 / \$1,000,000 x 100 = 4.0%)
- 4. Determine the percentage of excluded premium—4.0% (excluded non-Large Deductible ratio) added to 9.3% (Large Deductible gross ratio) equals excluded premium of 13.3% (4.0% + 9.3% = 13.3%)
- 5. Compare the excluded premium percentage to the 15% requirement; in this case, the proposed exclusion is less than 15%, so it is allowable

Refer to Appendix of this manual for Premium Verification Worksheet and Instructions – Method 2 and submission instructions.

Method 3—Another option for carrier groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums) is to use the following Gross Premium Estimation Worksheet.

Fill in Items A, B, C, and D, and use the formulas to complete the worksheet. Only include premium from Pennsylvania.

	Premium Verification Worksheet – Method 3				
Item	Description	Formula	Amount		
	NAIC Direct Written Premium:				
Α	Total including Large Deductible				
В	Large Deductible				
С	Large Deductible to be excluded				
D	Non-Large Deductible to be excluded				
	Estimated Gross Premium:				
E	Large Deductible to be excluded	5 times C (5 x C)			
F	Total Excluded	Sum of D and E			

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		(D + E)	
G	Add-on for Large Deductible business	4 times B (4 x B)	
Н	Estimated Total	Sum of A and G (A + G)	
I	Ratio	F divided by H (F / H)	

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If the ratio (I) is 15% or less, the exclusion is acceptable.

Example: Premium determination (Method 3)

A participant with Large Deductible Direct Premium greater than 0.3% of its total must exclude one of its medical data providers. The participant has the following premium values:

- Total Direct Premium including Large Deductible for Pennsylvania is \$1,000,000
- Large Deductible Direct Premium for Pennsylvania is \$300,000
- Large Deductible Direct Premium to be excluded for Pennsylvania is \$20,000
- Non-Large Deductible Direct Premium to be excluded for Pennsylvania is \$40,000

Item	Description	Formula	Amount
	NAIC Direct Written Premium:		
Α	Total including Large Deductible		1,000,000
В	Large Deductible		300,000
С	Large Deductible to be excluded		20,000
D	Non-Large Deductible to be excluded		40,000
	Estimated Gross Premium:		
E	Large Deductible to be excluded	5 times C (5 x C)	100,000
F	Total Excluded	Sum of D and E	140,000
		(D + E)	
G	Add-on for Large Deductible business	4 times B (4 x B)	1,200,000
Н	Estimated Total	Sum of A and G	2,200,000
		(A + G)	
I	Ratio	F divided by H	6.4%
		(F / H)	

The following steps are performed to determine whether the proposed exclusions are less than 15% of the total gross written premium:

- 1. From its records, the carrier group determines its Direct Written Premium for all Large Deductible policies, excluded Large Deductible policies, excluded non-Large Deductible policies, and the total for all policies including Large Deductibles
- 2. Input these values into the Amount column of the applicable row (Items A through D) of the Premium Verification Worksheet
- 3. Calculate Items E through I of the Premium Verification Worksheet
- 4. Compare the excluded premium percentage (Item I) to the 15% requirement; in this case, the proposed exclusion is less than 15%, so it is allowable

Refer to Appendix of this manual for Premium Verification Worksheet and Instructions – Method 3 and submission instructions.

Method 4—Use the gross (of deductible) premium in Unit Statistical Plan data (reported in the Premium

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Amount field of the Exposure Record). Calculate the ratio of total gross premium on business to be excluded to total gross premium on all business and compare the excluded premium percentage to the 15% requirement. Only include premium from the state of Pennsylvania or Federal Act.

3. Other Premium Determination Methods

Contact the PCRB for guidance if the methods described in this section are not appropriate for determining the exclusion percentage. The methods are not appropriate if they do not closely approximate prospective premium distribution in the current calendar year (e.g., a significant shift has occurred in a participant's book(s) of business since the last NAIC reporting; or the participant writes a significant number of large deductible policies).

4. Business Exclusion Request Form

An example of the Business Exclusion Request Form is provided in the Appendix of this manual.

SECTION II - MEDICAL DATA CALL STRUCTURE

A. General

Medical Call data is not aggregated at the bill level. Instead, each line of a bill is reported as a separate record. While certain data elements will be repeated on each line, others are distinct per line. These two classifications of data elements are called Bill Header and Bill Detail.

B. Bill Header Data Elements

Bill Header data elements identify the information that is common to all lines of a bill. Therefore, the data in these elements is the same for all records from the same bill.

Note: A bill is identified by the combination of Claim Number and Bill Identification Number.

Bill Header data elements include:

- Carrier Code
- Policy Number Identifier
- Policy Effective Date
- Claim Number Identifier
- Jurisdiction State Code
- Claimant Gender Code
- Birth Year
- Accident Date
- Bill Identification Number
- Service From Date
- Service To Date
- Provider Taxonomy Code
- Provider Identification Number
- Provider Postal (ZIP) Code
- Network Service Code
- Place of Service Code

These elements are typically located on the header (top) section of standard bill forms such as CMS-1500 or UB-04. For specific locations of the data information on these standard forms (if applicable), refer to the Source column of the Medical Data Call Record Layout table in the **Record Layouts** section of this manual.

C. Bill Detail Data Elements

Bill Detail data elements provide the line level information and, therefore, can differ among the individual records of a bill.

Bill Detail data elements include:

- Transaction Code
- Transaction Date
- Line Identification Number
- Service Date
- Paid Procedure Code
- Paid Procedure Code Modifier
- Amount Charged by Provider
- Paid Amount

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- Primary ICD Diagnostic Code
- Secondary ICD -- Diagnostic Code
- Quantity/Number of Units per Procedure Code
- Secondary Procedure Code

Note: Some detail data elements, such as ICD - Diagnostic Codes, can act like Bill Header data elements because they may be the same for all lines. However, it is possible for these codes to vary per line.

These elements are typically located on the detail (lower) section of standard bill forms, such as CMS-1500 or UB-04. For specific locations of the data information on these standard forms (if applicable), refer to the Source column of the Medical Data Call Record Layout table in the Record Layouts section of this manual.

D. **Key Fields**

The following data elements are considered key fields. They must be reported the same as on the original record for any replacement or cancellation record related to a medical transaction (line):

- **Carrier Code**
- Policy Number Identifier
- Policy Effective Date
- Claim Number Identifier
- Bill Identification Number
- Line Identification Number

Correctly reporting the key fields ensures the accurate linking and unique identification of the cancellation or replacement record to the original record. To change a key field, refer to Record Replacements and Cancellations in the Reporting Rules section of this manual.

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SECTION III - RECORD LAYOUTS

A. Overview

In order for the PCRB to properly receive data submissions, data providers are required to comply with specific requirements regarding record layouts, data elements, and link data when reporting Medical Call data. Data files are transmitted in specific record layouts to allow for efficient processing. This allows the data contained within the record layouts to be formatted, sorted, and customized according to the user's specifications.

The record layouts that comprise the Medical Data Call are provided in this section of the manual.

B. Medical Data Call Record

Report one Medical Data Call Record for each medical transaction (line) of a bill. For specific data element reporting instructions, refer to the **Data Dictionary** section of this manual.

	Medical Data Call Record Layout						
Field No.	Field Title/ Description	Class	Position	Bytes	Header/ Detail	Source	
1	Carrier Code *	N	1-5	5	Н	Payer	
2	Policy Number Identifier*	AN	6-23	18	Н	CMS 11	
3	Policy Effective Date*	N	24–31	8	Н		
4	Claim Number Identifier *	AN	32-43	12	Н	Payer	
5	Transaction Code	N	44–45	2	D	Payer	
6	Jurisdiction State Code	N	46–47	2	Н	Payer	
7	Claimant Gender Code	AN	48	1	Н	CMS 3 UB 11	
8	Birth Year	N	49–52	4	Н	CMS 3 UB 10	
9	Accident Date	N	53–60	8	Н	CMS 14	
10	Transaction Date	N	61–68	8	D	Payer	
11	Bill Identification Number *	AN	69–98	30	Н	Payer	
12	Line Identification Number *	AN	99–128	30	D	Payer	
13	Service Date	N	129–136	8	D	CMS 24A UB 45	
14	Service From Date	N	137–144	8	Н	CMS 18 UB 6	
15	Service To Date	N	145–152	8	Н	CMS 18 UB 6	
16	Paid Procedure Code	AN	153–177	25	D	CMS 24D UB 42 UB 44 or Payer	
17	Paid Procedure Code Modifier		178–185	8		CMS 24D UB 44 or Payer	
	First Paid Procedure Code Modifier	AN	(178-181)	(4)	D		
	Second Paid Procedure Code Modifier		(182-185)	(4)			
18	Amount Charged by Provider	N	186–196	11	D	CMS 24F UB 47	
19	Paid Amount	N	197–207	11	D	Payer	
20	Primary ICD - Diagnostic Code	AN	208–221	14	H/D	CMS 21 A (D) UB 67 (H)	

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21	Secondary ICD - Diagnostic Code	AN	222–235	14	H/D	CMS 21 B (D) UB 67 A (H)
22	Provider Taxonomy Code	AN	236-255	20	Н	Provider or Payer
23	Provider Identification Number	AN	256–270	15	Н Н	CMS 33A UB 56
24	Provider Postal (ZIP) Code	AN	271–273	3	Н	CMS 32 UB 1
25	Network Service Code	Α	274	1	Н	Provider or Payer
26	Quantity/Number of Units per Procedure Code	N	275–281	7	D	CMS 24G UB 46
27	Place of Service Code	AN	282–289	8	Н	CMS 24B UB4**
28	Secondary Procedure Code	AN	290–314	25	D	UB 42
29	Reserved for Future Use		315–350	36		

^{*} This data element is considered a key field and must be reported the same as on the original record for all records related to a medical transaction (line). Refer to Key Fields in the **Medical Data Call Structure** section of this manual.

Source Notes:

CMS: Data is located on form CMS-1500. The field number on the form where the data is located is

also provided.

Payer: Data is not on a form; it is provided by the entity that pays the bill. Provider: Data is not on a form; it is provided by the healthcare provider.

UB: Data is located on form UB-04. The field number on the form where the data is located is also

provided.

C. Submission Control Record

One, and only one, Submission Control Record is required for each file submitted. The Submission Control Record should be placed at the end of the file.

	Submission Control Record Layout			
Field No.	Field Title/ Description	Class	Position	Bytes
1	Record Type Report "SUBCTRLREC" One Submission Control Record is required for each submission. Format: A 10	A	1-10	10
2	Submission File Type Code Report the code that identifies the type of file being submitted. O=Original R=Replacement Format: A, this field cannot be blank.	A	11	1
3	Carrier Group Code * Report the NCCI Carrier Group Code that corresponds to the Reporting Group for which the data provider has been certified to report on its behalf. Format: N 5	N	12-16	5

^{**} Refer to Place of Service Crosswalk in the **Appendix**.

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4	Departing Quarter Code *	N	17	1
4	Reporting Quarter Code *	IN IN	17	'
	Report the code that corresponds to the quarter when the medical transactions being reported occurred.			
	1 = First Quarter			
	2 = Second Quarter			
	3 = Third Quarter			
	4 = Fourth Quarter			
	Format: N			
5	Reporting Year *	N	18-21	4
5	, · ·	IN	10-21	4
	Report the year that corresponds to the year when the medical transactions being reported occurred.			
	Format: YYYY			
6	Submission File Identifier *	AN	22-51	30
	Report the unique identifier created by the data provider to	AIN	22-31	30
	distinguish the file being submitted from previously submitted files.			
	Format: A/N 30, this field must be left justified and contain blanks in			
	all spaces to the right of the last character if the Submission File			
	Identifier is less than 30 bytes.			
7	Submission Date **	N	52-59	8
	Report the date the file was generated.			
	Format: YYYYMMDD			
8	Submission Time **			
	Report the time the file was generated in military time.	N	60-65	6
	Format: HHMMSS (HH = Hours, MM = Minutes, SS = Seconds)			
9	Record Total	N	66-76	11
	Report the total number of records in the file, excluding the			
	Submission Control Record.			
	Note: Blank rows will be removed during processing and not			
	counted. If blank rows are included in the Record Total, the file will			
	appear out of balance and reject.			
	Format: N 11, this field must be right justified and left zero-filled			
10	Reserved for Future Use		77-350	274

If this is a replacement submission (Submission File Type Code, Position 11 is R-Replacement), then this field must be reported the same as the submission being replaced. For details, refer to File Replacements in the Reporting Rules section of this manual.

For replacements (Submission File Type Code R), the combination of Submission Date and Submission Time must be after that of the file being replaced.

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SECTION IV – DATA DICTIONARY

A. Overview

To assist medical data providers in automating their Medical Data Call reporting systems, the alphabetized Data Dictionary in this section provides metadata such as data element descriptions and reporting format associated with the data elements in the Medical Data Call Record Layout. Refer to the **Record Layouts** section of this manual.

B. Data Dictionary

Accident Date

Field No.: 9 Position(s): 53-60

Class: Numeric (N) – Field contains only numeric characters

Bytes: 8

Format: YYYYMMDD

Definition: The date the claimant was injured.

Reporting Report the date the claimant was injured. The Accident Date must be the same as or after Requirement: Policy Effective Date (Positions 24-31), and before or the same as Service Date (Positions

129-136) or Service From Date (Positions 137-144) and Service to Date (145-152).

In the case of occupational disease or cumulative injury, use the last day that the claimant

worked without the disability or the last day of coverage, whichever is earlier.

Amount Charged by Provider

Field No.: 18 Position(s): 186-196

Class: Numeric (N) – Field contains only numeric characters

Bytes: 11

Format: N 11, this field must be right justified and left zero-filled. There is an implied decimal between

positions 194 and 195. If the reported amount does not include digits after the decimal, add

00 to the right of the reported amount. For example:

\$123.45 is reported as 00000012345\$123 is reported as 00000012300

Definition: The total amount per line billed for the medical service by the service provider.

Reporting Report the total amount per line that was billed by the service provider for the applicable line.

Requirement: This amount is reported prior to any adjustments but includes corrections. If a change to the

Amount Charged by Provider occurs to a previously reported record, submit a replacement transaction, Transaction Code 03 (Positions 44-45), and report the current cumulative amount

(original amount plus or minus changes) for the applicable line.

Note: This field should never be a negative value since the total amount charged rather than

the change in charged dollars is to be reported.

For information on changes to an amount field, refer to Record Replacements and

Cancellations in the Reporting Rules section of this manual.

Bill Identification Number

Field No.: 11 Position(s): 69-98

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes: 30

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Format: A/N 30, exclude non-ASCII characters. This field must be left justified and contain blanks in

all spaces to the right of the last character if the Bill Identification Number is less than 30

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bytes.

Definition: A unique number assigned to each bill by the administering entity.

Reporting Report the unique number assigned to the bill that corresponds to this transaction.

Requirement:

Birth Year

Field No.: 8 Position(s): 49-52

Class: Numeric (N) – Field contains only numeric characters

Bytes: 4
Format: YYYY

Definition: The actual or estimated (accident year minus claimant age) year the claimant was born. Reporting Report the year the claimant was born. The Birth Year must be before Accident Date

Requirement: (Positions 53-60).

Carrier Code

Field No.: 1 Position(s): 1-5

Class: Numeric (N) – Field contains only numeric characters

Bytes: 5 Format: N 5

Definition: The carrier code assigned to the carrier by NCCI.

Reporting Report the 5-digit NCCI assigned Carrier Code. Do not report the NCCI Group ID or NAIC

Requirement: Carrier Code.

Claim Number Identifier

Field No.: 4 Position(s): 32-43

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes: 12

Format: A/N 12, letters A–Z and numbers 0–9 only (if the Claim Number Identifier is less

than 12 bytes, this field must be left justified, and blanks in all spaces to the right of

the last character).

Definition: A set of alphanumeric characters that uniquely identify the claim (letters A–Z and numbers 0–

9 only).

Reporting Report the unique set of numbers and/or letters that identify the specific claim that the bill applies to. For the purpose of this requirement, unique means that each time a medical

service is provided and billed for a specific claim, the same claim number is reflected on each

bill.

The Claim Number Identifier must match the Unit Statistical data claim number. For older claims where the claim number has changed since reporting the unit statistical data, report the Claim Number Identifier that identifies the claim in your system today. This number

must be used consistently for all future reporting of the claim transactions.

Claimant Gender Code

Field No.: 7
Position(s): 48

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes: 1 Format: A/N

Definition: A code that corresponds to the claimant's gender.

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Reporting Requirement:

Report the code that corresponds to the claimant's gender. Leave blank - if unknown.

Code	Description
1	Male
2	Female
3	Other

Jurisdiction State Code

Field No.: 6 Position(s): 46-47

Class: Numeric (N) – Field contains only numeric characters

Bytes: 2

Format: N 2, Date field is to be right justified and left zero-filled.

Definition: A code that corresponds to the state under whose Workers Compensation Act the claimant's

benefits are being paid.

Reporting Report the code that corresponds to the state under whose Workers Compensation Act or

Requirement: Employers Liability Act the claimant's benefits are being paid or Federal Act (Jurisdiction

State Code 59.)

Jurisdiction	State Code
Pennsylvania	37
Federal Act	<mark>59</mark>
(USL&HW)	

Note: When the jurisdiction state is Pennsylvania, all qualifying medical transactions for that state must be reported even when the compliance state (IAIABC State Compliance Code) is not an applicable state. For example, a medical service is provided to a claimant whose benefits are being paid under the Pennsylvania Workers Compensation - Act. However, reimbursement for the medical service was determined under California medical billing requirements. Medical transactions for this claimant would be reportable under the Medical Data Call.

Line Identification Number

Field No.: 12 Position(s): 99-128

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes: 30

Format: A/N 30, exclude non-ASCII characters. This field must be left justified and contain blanks in

all spaces to the right of the last character if the Line Identification Number is less than 30

bytes.

Definition: A unique number that the administering entity assigns to each line associated with the Bill

Identification Number (Positions 69-98).

Reporting Report the unique number assigned to the line associated with the Bill Identification Number

Requirement: (Positions 69-98) and for which this record applies.

Network Service Code

Field No.: 25 Position(s): 274

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes: 1 Format: A

Definition: A code that indicates whether the medical service is provided through a provider network. Reporting Report the code that indicates whether the service is provided through a provider network

Requirement: regardless of whether a network discount was applied.

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Code	Description
Н	HMO – the medical service provider belongs to a Health Maintenance Organization agreement
N	No Agreement – the medical service provider does not belong to a provider network
Р	Participation Agreement – the medical service provider is part of an agreement that is not an HMO or PPO
Y	PPO Agreement – the medical service provider belongs to a Preferred Provider Organization agreement
В	Pharmacy Benefit Manager

Paid Amount

Field No.: 19 Position(s): 197-207

Class: Numeric (N) – Field contains only numeric characters

Bytes: 11

Format: N 11, this field must be right justified and left zero-filled. There is an implied decimal between

positions 205 and 206. If the reported amount does not include digits after the decimal, add

00 to the right of the reported amount. For example:

\$123.45 is reported as 00000012345\$123 is reported as 00000012300

Definition: The amount on the bill (line) paid by the coverage provider for the medical service.

For information on changes to an amount field, refer to Record Replacements and

Cancellations in the **Reporting Rules** section of this manual.

Reporting Requirement:

Report the total amount that was paid by the coverage provider for the applicable line. If a change to the Paid Amount occurs to a previously reported record, submit a replacement transaction, Transaction Code 03 (Positions 44-45), and report the current cumulative amount

(original amount plus or minus changes) for the applicable line.

Note: This field should never be a negative value since the total amount paid rather than the change in paid dollars is to be reported.

Paid Procedure Code

Field No.: 16 Position(s): 153-177

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes: 25

Format: A/N Varies, format according to the requirements for the code list used. Refer to the

Procedure Code List Type table in the Reporting Requirement for this field.

Definition: A code from the jurisdiction-approved code table that identifies the procedure associated with

the reimbursement.

Reporting Report the Paid Procedure Code from the jurisdiction-approved code table (refer to the Requirement: Procedure Code List Type table within this description) that corresponds to the Line

Identification Number (Positions 99–128) as it relates to the reimbursement reported in Paid

Amount (Positions 197-207).

The Paid Procedure Code must be populated with correct code values, including leading zeros. When a procedure code is reported without leading zeros, that code may be edited as invalid or may match values from other codes sets.

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For example, if the leading zero is not reported on Hospital Revenue Code 0116 - Room & Board - Private (One Bed), the resulting value appears to be DRG Code 116 - Intraocular Procedures with CC/MCC. Incorrect reporting impacts the pricing of legislative reform.

If the bill reflects a procedure code other than the procedure code associated with the reimbursement, report the Paid Procedure code associated with the reimbursement in this field and the billed procedure code in the Secondary Procedure Code (Positions 290-314). Refer to Paid Procedure Code Reporting section of this manual.

Revenue codes provide only broad classifications; therefore, they should only be reported as a Paid Procedure Code when no other code was used to determine the reimbursement (i.e., CPT, CDT, HCPCS, NDC, --, or DRG.)

The Pennsylvania Workers' Compensation Act was amended by House Bill 1846 (passed during calendar year 2014) and the amended regulations state that:

"A physician seeking reimbursement for drugs dispensed by a physician shall include the original manufacturer's National Drug Code (NDC) number, as assigned by the Food and Drug Administration, on the bills and reports required under this section.

In no event may a physician seek reimbursement in excess of [110] percent of the AWP [Average Wholesale Price] of the drugs dispensed by a physician as determined by reference to the original manufacturer's NDC number.

A repackaged NDC number may not be used and will not be considered the original manufacturer's NDC number..."

Based on this regulation, data submitters should report the original (underlying) NDC code as the Paid Procedure Code and the repackaged NDC code as the Secondary Procedure Code (Positions 290-314).

Procedure Code List Type		
Code List Type*	Code Length (Bytes)	Description/Formatting
CPT-Current Procedural Terminology	5	 Codes are either 5 numbers or 4 numbers followed by a single alpha character Left justify and blank-fill all spaces to the right of the last number Must include leading zeros when part of the code**
CDT-Current Dental Terminology	5	 Codes are either 5 numbers or a single alpha character followed by 4 numbers Left justify and blank-fill all spaces to the right of the last number Must include leading zeros when part of the code**
HCPCS-Healthcare Common Procedure Coding System	5	 Codes are either 5 numbers or a single alpha character followed by 4 numbers Level 1 uses the CPT codes while level 2 adds alphanumeric codes for other services such as ambulance or prosthetics Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes

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		Must include leading zeros when part of the code**
NDC-National Drug Codes	10 or 11	11-byte HIPAA (Health Insurance Portability and Accountability Act) standard codes or 10-byte FDA (Food and Drug Administration) codes Left justify and blank-fill all spaces to the right of the last number Do not include dashes Must include leading zeros when part of the code**
DRG-Diagnostic Related Group	3	 Numeric codes classify procedures into related groups for inpatient services Left justify and blank-fill all spaces to the right of the last number Must include leading zeros when part of the code** Report the DRG code version as authorized in the state workers' compensation fee schedule regulations. For Pennsylvania, as indicated in the regulations, the DRG Grouper was frozen for purposes of workers' compensation inpatient claims. Medicare Grouper 12 was the version in effect on December 31, 1994 and will remain the authorized grouper for all inpatient workers' compendical claims. All DRG-charged admissions must be cross walked by the provider to a Grouper 12 DRG.
Revenue Codes	4	 Left justify and blank-fill all spaces to the right of the last number Must include leading zeros when part of the code**
State-Specific	Varied	 Byte length dependent on state rules Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes Must include leading zeros when part of the code**
NCCI Proprietary – Compound Drugs	11	Report as 99999999999Left justify and blank-fill Positions 164–177
NCCI Proprietary – Per Diem	8	 Report as PER-DIEM Capitalize and include dash Left justify and blank-fill Positions 161–177 Refer to Section V – Reporting Rules Part F – Per Diem Hospital Charges for instructions on using this code
NCCI Proprietary – Medical Marijuana – Reimbursement to injured worker (claimant)	5	 Report as MM001 Left justify and blank-fill Positions 158-177 Refer to Section V – Reporting Rules, Part H-Medical Marijuana Data Reporting for instructions on using this code.
NCCI Proprietary – Medical Marijuana – Reimbursement directly to dispensary	5	 Report as MM002 Left justify and blank-fill Positions 158-177 Refer to Section V – Reporting Rules, Part H-Medical Marijuana Data Reporting for instructions on using this code.

^{*} Report a - DRG code as the Paid Procedure Code if it is the basis of reimbursement; otherwise, report the CPT, CDT, HCPCS, or NDC code.

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** If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if the system stores 5.9 for a code that is listed as 005.9 on the code list, then insert two zeros to the left of the 5 when reporting to the PCRB.

Paid Procedure Code Modifier(s)

Field No.: 17 Position(s): 178-185

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes: 8 – First Paid Procedure Code Modifier (4), Second Paid Procedure Code Modifier (4) Format: First Paid Procedure Code Modifier – A/N 4 (Positions 178-181), left justified and blank-filled

to the right of the last number or character when the First Paid Procedure Code Modifier(s) is

less than 4 bytes.

Second Paid Procedure Code Modifier – A/N 4 (Positions 182-185), left justified and blankfilled to the right of the last number or character when the Second Paid Procedure Code

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Modifier(s) is less than 4 bytes.

If only one Paid Procedure Code Modifier applies, report in Positions 178-181 and leave

Positions 182-185 blank -.

Definition: A code from the jurisdiction-approved code table that identifies the unique circumstances

related to the Paid Procedure Code (Positions 153-177) when the circumstance alters a procedure or service but does not change the Paid Procedure Code or its definition.

Reporting Report the Paid Procedure Code Modifier(s) related to the Paid Procedure Code (Positions Requirement: 153-177). If there are more than two modifiers, report only the modifier(s) that impacts the

reimbursement.

Place of Service Code

Field No.: 27 Position(s): 282-289

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes:

Format: A/N 8, this field must be left justified and blank-filled to right of the last number or character

when the Place of Service Code is less than 8 bytes. Include leading zeros when part of the code. If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if the system stores 9 for a code that is listed

as 09 on the code list, insert a zero to the left of the 9 when reporting to the PCRB.

Definition: A code that indicates where the medical service was performed.

Reporting Report the Place of Service Code from the Place of Service list that indicates where the Requirement: medical service was performed. **Do not report Place of Service Code 99 (Other Place Other Place Ot**

Service) when the place of service is unavailable. Instead, leave this field blank.

For facility and hospital services, the Place of Service Crosswalk was developed to provide a mapping of the Type of Bill code to the Place of Service code. Refer to the Place of Service

Crosswalk in the Appendix.

	Place of Service*		
Code	Description	Code	Description
01	Pharmacy	33	Custodial Care Facility
02	Dispensary	34	Hospice
03	School	35-40	Unassigned – Not valid for PA
04	Homeless Shelter	41	Ambulance-Land
05	Indian Health Service-Free Standing Facility	42	Ambulance-Air or Water
06	Indian Health Service Provider-Based Facility	43-48	Unassigned – Not valid for PA
07	Tribal 638 Free-Standing Facility	49	Independent Clinic
08	Tribal 638 Provider-Based Facility	50	Federally Qualified Health Center
09	Prison-Correctional Facility	51	Inpatient Psychiatric Facility
10	Unassigned – Not valid for PA	52	Psychiatric Facility-Partial Hospitalization

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11	Office	53	Community Mental Health Center
12	Home	54	Intermediate Care Facility/Mentally Retarded
13	Assisted Living Facility	55	Residential Substance Abuse Treatment Facility
14	Group Home	56	Psychiatric Residential Treatment Center
15	Mobile Unit	57	Non-Residential Substance Abuse Treatment
			Facility
16	Temporary Lodging	58-59	Unassigned – Not valid for PA
17	Walk-In Retail Health Clinic	60	Mass Immunization Center
18	Place of Employment - Worksite	61	Comprehensive Inpatient Rehabilitation Facility
19	Unassigned – Not valid for PA	62	Comprehensive Outpatient Rehabilitation Facility
20	Urgent Care Facility	63-64	Unassigned – Not valid for PA
21	Inpatient Hospital	65	End-Stage Renal Disease Treatment Facility
22	Outpatient Hospital	66-70	Unassigned – Not valid for PA
23	Emergency Room-Hospital	71	Public Health Clinic
24	Ambulatory Surgical Center	72	Rural Health Clinic
25	Birthing Center	73-80	Unassigned – Not valid for PA
26	Military Treatment Facility	81	Independent Laboratory
27-30	Unassigned – Not valid for PA	82-98	Unassigned – Not valid for PA
31	Skilled Nursing Facility	99	Other Place of Service
32	Nursing Facility		

^{*} Source: Centers for Medicare & Medicaid Services (www.cms.hhs.gov). The codes listed are valid as of the guidebook issue date. New codes approved by CMS are valid by definition.

Policy Effective Date

Field No.: 3 Position(s): 24-31

Class: Numeric (N) – Field contains only numeric characters

Bytes: 8

Format: YYYYMMDD

Definition: The date the policy under which the claim occurred became effective.

Reporting Report the effective date that corresponds to the date shown on the policy Information Page or Requirement: to endorsements attached. The Policy Effective Date reported must be before or the same as

Accident Date (Positions 53-60).

Report the policy effective date applicable at the time of the claim. Do not report the policy inception date.

Policy Number Identifier

Field No.: 2 Position(s): 6-23

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes: 18

Format: A/N 18, letters A–Z and numbers 0–9 only (if the Policy Number Identifier is less than 18 bytes,

this field must be left justified, and blanks in all spaces to the right of the last character).

Definition: The unique set of numbers and/or letters that identify the policy under which the claim occurred

(letters A–Z and numbers 0–9 only).

Reporting Report the unique set of numbers and/or letters that identify the policy under which the claim

Requirement: occurred.

<u>Policy Number Identifier must match the Unit Statistical data policy number including</u> any prefixes or suffixes.

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Primary ICD -- Diagnostic Code

Field No.: 20 Position(s): 208-221

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes: 14

Format: A/N 14, this field must be left justified and contain blanks in all spaces to the right of the last

character if the Primary ICD -- Diagnostic Code is less than 14 bytes. Additional formatting

rules include (see example):

• Report zeros only when part of the code

Capitalize alphabetic characters

• Report the decimal only if the code contains characters (including zero) to the right of the

decimal

If ICD Diagnostic Code is	Then valid format is ("_" indicates a space)
942	942
942.	942
942.0	942.0
372.61	372.61
043.9	043.9
005.9	005.9
E111	E111
S42	S42
S42.	S42
S42.0	S42.0
S42.001D	S42.001D

Note:

- If converting codes from a system that does not store a decimal, ensure that the decimal is inserted correctly (not always in the 4th position). For example, 7999 may be 079.99 or 799.9.
- For ICD-9 codes, if the code starts with an E, then the decimal is reported in the fifth position; if it starts with a V, then the decimal is reported in the fourth position. If there is no leading alpha character, then report the decimal at the fourth position, if the length of the code is four characters or more.
- For ICD-10 codes, the decimal point is reported in the 4th position (regardless of the leading alpha character.) If the ICD-10 code is only 3 characters, do not report a decimal.
- If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if 5.9 is listed as 005.9 on the code list, insert two zeros to the left of the 5.

Definition:

Reporting

Requirement:

A code that identifies the primary diagnosis associated with the medical service rendered.

Report the NCHS (National Center for Health Statistics) or CMS (Centers for Medicare & Medicaid Services) ICD - code that identifies the primary diagnosis associated with the medical service rendered.

Note: PCRB will accept both ICD-9 and ICD-10 codes in this field as of January 1, 2014.

Note: PCRB does *not* recognize ICD-9 code 999.9 (complication of medical care not elsewhere classified) as a valid code.

Provider Identification Number

Field No.: 23 Position(s): 256-270

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

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Bytes:

Format: A/N 15, this field must be left justified and contain blanks in all spaces to the right of the last

character if the Provider Identification Number is less than 15 bytes.

Definition: A number that uniquely identifies the billing medical provider.

Report the number that uniquely identifies the medical/service provider (i.e., Reporting

state-required number, unique carrier coding scheme, Federal Employer Identification Number, Requirement:

or National Provider Identification) that billed for the service. For example, if a line item of a hospital bill indicates that a Registered Physical Therapist provided therapy to a claimant as an employee of the hospital, report the hospital's Provider Identification Number.

Note: In cases where a billing house bills the payer, report the Provider Identification Number of the medical service provider for whom the billing house is submitting the bill. PCRB considers a PBM (Pharmacy Benefit Management) company to be a billing house.

A unique carrier coding scheme may be used in lieu of a state-required number when reporting to the PCRB. However, the unique carrier coding scheme must be used consistently.

Provider Postal (ZIP) Code

Field No.: 24 Position(s): 271-273

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes: Format: A/N 3

Definition: The code assigned by the postal service (USPS or other) to the medical/service provider

address where the service was performed.

Reporting Requirement:

Report only the first three digits/characters of the postal (ZIP) code for the medical/service provider address where the service was performed. In states where the postal (ZIP) code impacts the reimbursement, report the postal (ZIP) code associated with the reimbursement.

If unavailable, report only the first three digits of the postal (ZIP) code of the provider's billing address unless it is a billing house. When the billing address is a billing house and the postal (ZIP) code for the medical/service provider address where the service was performed is not available, leave this field blank.

Note: PCRB considers a PBM (Pharmacy Benefit Management) company to be a billing

house.

Provider Taxonomy Code

Field No.: 22 Position(s): 236-255

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes:

Format: A/N 20, this field must be left justified and contain blanks in all spaces to the right of the last

character if the Provider Type Code is less than 20 bytes.

Definition: A taxonomy code that identifies the type of provider that billed for and is being paid for the

medical service.

Reporting Report the taxonomy code that identifies the type of provider that billed for and is being paid for Requirement: the medical service. For example, if a line item of a hospital bill indicates that a Registered

Physical Therapist provided therapy to a claimant as an employee of the hospital, report the Provider Taxonomy Code associated with the hospital. Or, if an Orthopedic Surgeon provides surgical services to a claimant through a surgical center, but the surgeon receives the

payment, report the Provider Taxonomy Code associated with the surgeon.

Note: When determining the Provider Taxonomy Code based on the Provider Identification Number, use the source for the Provider Identification Number as indicated in Section III Record Layouts of this manual.

Note: In cases where a billing house bills the payer, report the Provider Taxonomy Code associated with the medical service provider that initially submitted the bill. PCRB considers a PBM (Pharmacy Benefit Management) company to be a billing house.

Use the Provider Taxonomy list of standard codes maintained by the National Uniform Claim Committee—Code Subcommittee (available at www.nucc.org or The Washington Publishing Company --).

Quantity/Number of Units Per Procedure Code

Field No.: 26 Position(s): 275-281

Class: Numeric (N) - Field contains only numeric characters

Bytes:

Format: N 7, rounded up to the nearest whole number. Do not report a decimal.

This field must be right justified and left zero-filled.

The number of units of service performed or the quantity of drugs dispensed. Definition:

Report the number of units of service performed or the quantity of drugs dispensed that are Reporting related to the Paid Procedure Code. (Positions 153-177). Use the base quantity specified by Requirement:

the applicable procedure code to determine the quantity or number to report.

Example: Base size/amount as specified by applicable procedure code

 Supplies – The Paid Procedure Code reported is for surgical gloves. The code specifies that the base quantity is a pair of gloves. For this example, if one pair was used, 0000001 would be reported in this field.

• Physical or Occupational Therapy - The Paid Procedure Code specifies that one unit is equal to a base amount of time and that a base amount of time is equal to 15 minutes. For this example, if the therapy was for 15 minutes, the time would be reported as 0000001.

Note: Additional time spent in therapy is often designated with a distinct procedure code.

For Paid Procedure Codes related to medications, the quantity/units depend on the type of drug.

- For tablets, capsules, suppositories, non-filled syringes, etc., report the actual number of the drug provided. For example, a bottle of 30 pills would be reported as 0000030.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., dispensed in standard packages, report the units as specified by the Procedure Code. For example, a cream is dispensed in a standard tube, which is defined as a unit by the Procedure Code. Report 00000001 (one tube).
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., that are not dispensed in standard packages, report the amount provided in its standard unit of measurement (e.g., milliliters, grams, ounces). For example, codeine cough syrup dispensed by a pharmacist into a four-ounce bottle would be reported as 00000004.

For Paid Procedure Codes related to anesthesia, the quantity/units is reported in minutes. For example, if 220 minutes of anesthesia was provided, report 0000220 in this field.

Secondary ICD -- Diagnostic Code

Field No.: 21 Position(s): 222-235

Alphanumeric (AN) – Field contains alphabetic and numeric characters Class:

Bytes:

Format: A/N 14, this field must be left justified and contain blanks in all spaces to the right of the last

character if the Secondary ICD -- Diagnostic Code is less than 14 bytes. Additional formatting

rules include (see example):

• Report zeros only when part of the code

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- Capitalize alphabetic characters
- Report the decimal only if the code contains characters (including zero) to the right of the decimal

If ICD Diagnostic Code is	Then valid format is ("_" indicates a space)
942	942
942.	942
942.0	942.0
372.61	372.61
043.9	043.9
005.9	005.9
E111	E111
S42	S42
S42.	S42
S42.0	S42.0
S42.001D	S42.001D

Note:

- If converting codes from a system that does not store a decimal, ensure that the decimal is inserted correctly (not always in the 4th position). For example, 7999 may be 079.99 or 799.9.
- For ICD-9 codes, if the code starts with an E, then the decimal is reported in the fifth position; if it starts with a V, then the decimal is reported in the fourth position. If there is no leading alpha character, then report the decimal at the fourth position, if the length of the code is four characters or more.
- For ICD-10 codes, the decimal point is reported in the 4th position (regardless of the leading alpha character.) If the ICD-10 code is only 3 characters, do not report a decimal.
- If converting codes from a system that does not store leading zeros ensure that the leading zero(s) is inserted correctly. For example, if 5.9 is listed as 005.9 on the code list, insert two zeros to the left of the 5.

Definition:

Reporting
Requirement:

A code that identifies the secondary diagnosis associated with the medical service rendered.

Report the NCHS (National Center for Health Statistics) or CMS (Centers for Medicare & Medicaid Services) ICD - code that identifies the secondary diagnosis associated with the medical service rendered.

Note: PCRB will accept both ICD-9 and ICD-10 codes in this field as of January 1, 2014.

Note: The PCRB does **not** recognize ICD-9 code 999.9 (complication of medical care not elsewhere classified) as a valid code.

Leave blank - if a secondary diagnosis has not been identified.

Secondary Procedure Code

Field No.: 28 Position(s): 290-314

Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters

Bytes: 25

Format: A/N 25, format according to the requirements for the code list used. Refer to the Procedure

Code List Type table in the Reporting Requirement for this field.

Definition: A code from the jurisdiction-approved code table that identifies the billed procedure.

Reporting Report the Secondary Procedure Code from the jurisdiction-approved code table (refer to the Requirement: Procedure Code List Type table within this description) if the bill reflects a procedure code

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other than the procedure code associated with the reimbursement.

For example, an ambulatory surgery center bills for a facility fee using a CPT code. However, the reimbursement is determined by assigning an APC code. The CPT code is reported in this field, and the APC code, which is associated with the reimbursement, is reported as the Paid Procedure Code (Positions 153–177).

Leave blank - if the secondary procedure code is the same as the Paid Procedure Code (Positions 153–177).

Refer to Paid Procedure Code Reporting section of this manual for additional instructions and examples.

The Secondary Procedure Code must be populated with correct code values, including leading zeros. When a procedure code is reported without leading zeros, that code may be edited as invalid or may match values from other code sets.

For example, if the leading zero is not reported on Hospital Revenue Code 0116 – Room & Board – Private (One Bed), the resulting value appears to be DRG Code 116 – Intraocular Procedures with CC/MCC. Incorrect reporting impacts the pricing of legislative reform.

Revenue codes provide only broad classifications; therefore, they should only be reported as a Paid Procedure Code when no other code was used to determine the reimbursement (i.e., CPT, CDT, HCPCS, NDC, —, or DRG.)

The Pennsylvania Workers' Compensation Act was amended by House Bill 1846 (passed during calendar year 2014) and the amended regulations state that:

"A physician seeking reimbursement for drugs dispensed by a physician shall include the original manufacturer's National Drug Code (NDC) number, as assigned by the Food and Drug Administration, on the bills and reports required under this section.

In no event may a physician seek reimbursement in excess of [110] percent of the AWP [Average Wholesale Price] of the drugs dispensed by a physician as determined by reference to the original manufacturer's NDC number.

A repackaged NDC number may not be used and will not be considered the original manufacturer's NDC number..."

Based on this regulation, data submitters should report the original (underlying) NDC code as the Paid Procedure Code and the repackaged NDC code as the Secondary Procedure Code (Positions 290–314).

Procedure Code List Type		
Code List Type* Code Length (Bytes) Description/Formatting		Description/Formatting
CPT-Current Procedural Terminology	5	 Codes are either 5 numbers or 4 numbers followed by a single alpha character Left justify and blank-fill all spaces to the right of the last number Must include leading zeros when part of the code**
CDT-Current Dental	5	Codes are either 5 numbers or a single alpha

Terminology		character followed by 4 numbers • Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code**
HCPCS-Healthcare Common Procedure Coding System	5	Codes are either 5 numbers or a single alpha character followed by 4 numbers Level 1 uses the CPT codes while level 2 adds alphanumeric codes for other services such as ambulance or prosthetics Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes Must include leading zeros when part of the code**
NDC-National Drug Codes	10 or 11	 11-byte HIPAA (Health Insurance Portability and Accountability Act) standard codes or 10-byte FDA (Food and Drug Administration) codes Left justify and blank-fill all spaces to the right of the last number Do not include dashes Must include leading zeros when part of the code**
DRG-Diagnostic Related Group	3	 Numeric codes classify procedures into related groups for inpatient services Left justify and blank-fill all spaces to the right of the last number Must include leading zeros when part of the code** Report the DRG code version as authorized in the state workers' compensation fee schedule regulations. For Pennsylvania, as indicated in the regulations, the DRG Grouper was frozen for purposes of workers' compensation inpatient claims. Medicare Grouper 12 was the version in effect on December 31, 1994 and will remain the authorized grouper for all inpatient workers' comp medical claims. All DRG-charged admissions must be cross walked by the provider to a Grouper 12 DRG.
Revenue Codes	4	 Left justify and blank-fill all spaces to the right of the last number Must include leading zeros when part of the code**
State-Specific	Varied	 Byte length dependent on state rules Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes Must include leading zeros when part of the code**

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Service Date

Field No.: 13 Position(s): 129-136

Class: Numeric (N) – Field contains only numeric characters

Bytes: 8

Format: YYYYMMDD

Definition: The date when the medical provider performed the service.

Reporting Report the date the service related to Line Identification Number (Positions 99-129) was Requirement: performed. If an in-patient hospital payment spanning multiple days was made and the specific

service date (line item) detail is unavailable, zero-fill this field and report in Service From Date

(Positions 137–144) and Service To Date (Positions 145–152).

Service Date must be the same as or after Accident Date (Positions 53-60).

Example: Bill spans multiple days—line item detail is available

A claimant receives 30 minutes* of physical therapy on January 8, 10, 15, and 17, 2008. The four services are listed as separate lines (Line Identification Number 1 through 4). Report four records, one for each line. For each record, report the individual date the service was performed in the Service Date field (Positions 129-136). There will only be one date reported for each record. In this example, the Service From Date and Service To Date fields will be zero-filled.

Bill ID (69-98)	Line ID (99-128)	Paid Procedure Code (153-177)	Service Date (129-136)	Quantity/#Units (275-281)
1001	1	97110	20080108	0000002
1001	2	97110	20080110	0000002
1001	3	97110	20080115	0000002
1001	4	97110	20080117	0000002

^{*}For this example, Paid Procedure Code 97110-Therapeutic Procedure specifies each 15 minute segment as 1 unit. Therefore, each 30 minutes of physical therapy is reported as 2 units.

Service From Date

Field No.: 14 Position(s): 137-144

Class: Numeric (N) – Field contains only numeric characters

Bytes: 8

Format: YYYYMMDD

Definition: The date when services were initiated.

Reporting Use this field for the starting date of service if an in-patient hospital payment spanning multiple days was made and the specific service date (line item) detail is unavailable. In all

other cases, zero-fill this field and report the date of service in Service Date (Positions 129-

136).

This field is the first date of a date range and must be accompanied by a Service To Date (Positions 145-152).

Service From Date must be the same as or after Accident Date (Positions 53-60).

Service From Date must not equal Service To Date.

^{*} Report a -DRG code as the Paid Procedure Code if it is the basis of the reimbursement; otherwise, report the CPT, CDT, HCPCS, or NDC code.

^{**} If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if the system stores 5.9 for a code that is listed as 005.9 on the code list, then insert two zeros to the left of the 5 when reporting to the PCRB.

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Service To Date

Field No.: 15 Position(s): 145-152

Class: Numeric (N) – Field contains only numeric characters

Bytes:

Format: YYYYMMDD

The date when services were terminated. Definition:

Use this field for the ending date of service if an in-patient hospital payment spanning multiple Reporting

Requirement: days was made and the specific service date (line item) detail is unavailable. In all other cases, zero-fill this field and report the date of service in Service Date (Positions 129-136).

This field is the last date of a date range and must be accompanied by a Service From Date

(Positions 137-144).

Service To Date must be after Service From Date (Positions 137–144).

Service To Date must not equal Service From Date.

Transaction Code

Field No.: 5 44-45 Position(s):

Class: Numeric (N) – Field contains only numeric characters

Bytes:

N 2, Data field is to be right justified and left zero-filled. Format:

A code that identifies the type of transaction that the record represents. Definition:

Reporting Report the code that identifies the type of transaction of the record being submitted.

Requirement:

Code	Description
01	Original – the initial report of the record to the PCRB. Only one original (Transaction Code 01) may be submitted for a given transaction.
02	Cancellation – cancels (deletes) a previously submitted (Transaction Code 01 or 03) record.
03	Replacement – replaces (changes) a previously submitted (Transaction Code 01 or 03) record.

Note: An Original (01) must be in the same submission or on the PCRB's database before a Cancellation (02) or a Replacement (03) can be submitted.

Transaction Date

Field No.: 10 Position(s): 61-68

Class: Numeric (N) - Field contains only numeric characters

Bytes:

Format: YYYYMMDD

The date the information in the transaction was processed as established by the original Definition:

source of the data. Original source of the data is defined as the entity initially responsible for administering the medical bill(s). This may be an insurer, TPA Bill Review vendor, Pharmacy

Benefit Manager, or other entity that is responsible for medical claim management.

Reporting Report the date corresponding to the Transaction Code (Positions 44-45) of the record being

Requirement: submitted.

If Transaction Code is	Then report
01- Original	The date the information was originally processed by the administering entity. For example: A medical service was performed on 01/15/2008. The medical service provider submitted the bill to a third party administrator, which processed and paid the bill on 01/21/2008. The medical data provider reports the original transaction to the PCRB with its 1st quarter submission on 04/01/2008. The Transaction Date for this original record is 01/21/2008 (reported as 20080121).
02- Cancellation	The date the cancellation was performed in the system of the administering entity.
03- Replacement	The date that the information was changed or corrected in the system of the administering entity. For example: Using the same scenario as described in the example for 01-Original, the administering entity discovers an error on the bill and corrects it in its system on 05/1/2008. The medical data provider reports the replacement transaction to the PCRB with its 2nd Quarter submission on 07/01/2008. The Transaction Date for this replacement record is 05/01/2008 (reported as 20080501).

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SECTION V - REPORTING RULES

A. Original Reports

Medical Call data is the detailed line information of a bill, also referred to as a medical transaction, reported to the PCRB as an individual record. The Original report is the first reporting of the medical transaction, identified by Transaction Code 01-Original in the record layout (Positions 44-45). For record reporting details, refer to the **Medical Data Call Record** section and the **Data Dictionary** section of this manual.

All medical transactions (existing claims and new claims) that occur within a specific quarter, based on Transaction Date (Positions 61-68), must be reported in that quarter's submission. Historical data for existing claims is not to be reported.

Quarterly submissions are due to the PCRB at the end of the following quarter. For example, medical transactions that occur in September are reported in the 3rd quarter submission due to the PCRB by December 31 of the reporting year. For details on quarterly and monthly reporting options, refer to Reporting Frequency in the **General Rules** section of this manual.

B. Record Replacements And Cancellations

Medical data providers may delete or change previously reported records (whether the records were reported in earlier submissions or as a prior record in the current submission). Since Medical Data Call reporting is done at the individual line level of a bill, it is not necessary to resubmit every line of a bill if only one line must be deleted or changed.

Transaction Code (Positions 44-45) is used to identify these changes as follows:

Transaction Code 02 – Cancellation – Deletes a record Transaction Code 03 – Replacement – Changes a record

Note: An Original (01) must be in the same submission or on the PCRB's database before a Cancellation (02) or a Replacement (03) can be submitted.

For additional information, refer to Transaction Code in the **Data Dictionary** section of this manual.

1. Record Deletions

A record or multiple records that have been previously reported can be deleted from the PCRB's database via a cancellation record. The Cancellation transaction (Transaction Code 02) deletes **all** records, whether one or multiple, for a given key field combination (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number).

To delete a previously submitted record, submit a cancellation record with the following:

- (a) All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) populated. The key fields must match those reported on the previous record to which the cancellation applies.
- (b) Transaction Code 02-Cancellation (Positions 44-45).
- (c) Transaction Date (Positions 61-68) reported as the date the cancellation is performed. This date must be after the transaction date on the previous record to which the cancellation applies.

Example: Deleting a single record

Carrier 99990 submits an erroneous record (A). To remove it from the database, the carrier submits a cancellation record (B) with the same key fields and Transaction Code 02. The Transaction Date of the cancellation record is the date when the cancellation is performed.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/ # of Units
Α	99990	0006	01	20071210	1001	1	20071203	00000010000	00000010000	0000001
В	99990	0006	02	20071217	1001	1	20071203	00000010000	00000010000	0000001

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

2. Key Field Changes

To change a key field on a previously submitted record, a cancellation record must first be submitted to remove the record from the database. Refer to Deleting a Record in this section of the manual for details.

After deleting the previously reported record, submit a new record with the following:

- (a) All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) populated with the corrected information and the previously reported information for any key fields that are not being changed.
- (b) Transaction Code 01-Original (Positions 44-45).
- (c) Transaction Date (Positions 61-68) reported as the date the key field change was made.

Example: Key field change

Carrier 99990 submits an original record (A) with an erroneous Claim Number Identifier of 1000. To change the claim number identifier, the carrier first submits a cancellation record (B) with all the key fields as previously reported (including Claim Number Identifier 1000), Transaction Code 02, and Transaction Date as the date the cancellation was performed. After submitting the cancellation, the carrier submits a new record (C) with the corrected Claim Number Identifier and all the other key fields as previously reported, Transaction Code 01, and Transaction Date as the date the change was performed.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/ # of Units
Α	99990	1000	01	20071210	1001	1	20071203	00000010000	00000010000	0000001
В	99990	1000	02	20071217	1001	1	20071203	00000010000	00000010000	0000001
С	99990	0001	01	20071217	1001	1	20071203	00000010000	00000010000	0000001

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

3. Record Changes

A record or multiple records that have been previously reported can be changed via a replacement record. The replacement record shows the current cumulative values for all data elements rather than the change in value.

Changes via a replacement record can only be made to non-key fields. To change key fields, refer to Key Field Changes via Cancellation in this section.

To change a non-key field for a previously reported record (original or replacement), submit a replacement record with the following:

- (a) All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) populated. The key fields must match those reported on the previous record to which the change applies.
- (b) Transaction Code 03-Replacement (Positions 44-45).
- (c) Transaction Date (Positions 61-68) reported as the date the information was changed in the system of the administering entity.
- (d) The current cumulative values for all non-key fields (not the change in value).

Note: The replacement record must include all data elements even if they do not change.

Example: Changing an amount field due to an additional reimbursement

Carrier 99990 submits a record (A) for a medical transaction. One week later, the carrier makes an additional reimbursement of \$1,000. To change the transaction, the carrier submits a replacement record (B) with the same key fields as the record being changed, Transaction Code 03, and the current cumulative value (not the change in value) for all non-key fields including the Paid Amount, which reflects the total after reimbursement. The Transaction Date of the replacement record is the date the additional reimbursement was made in the system of the administering entity.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/ # of Units
Α	99990	0001	01	20071210	1001	1	20071203	00000009999	00000008999	0000001
В	99990	0001	03	20071217	1001	1	20071203	0000009999	0000009999	0000001

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

Example: Changing a quantity field due to a previously reported error

Carrier 99990 submits a record with an error in the Quantity/Number of Units field (A). To correct the error, the carrier submits a replacement record (B) with the same key fields as the record being corrected, Transaction Code 03, and the current cumulative value (not the change in value) for all non-key fields including Quantity/# of Units, which reflects the corrected value. The Transaction Date of the replacement record is the date the change was made in the system of the administering entity.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/ # of Units
Α	99990	0001	01	20071210	1001	1	20071203	00000010000	00000010000	0000001
В	99990	0001	03	20071217	1001	1	20071203	00000010000	00000010000	0000002

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

Multiple Field Changes

Changes may be made to multiple fields in a record by submitting a single replacement record that includes the following:

- (a) All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) populated. The key fields must match those reported on the previously reported original or replacement record to which the changes apply.
- Transaction Code 03-Replacement (Positions 44-45).

- Transaction Date (Positions 61-68) reported as the date the information was changed in the system of the administering entity.
- The current cumulative values for all non-key fields (not the change in value).

Note: The replacement record must include all data elements even if they do not change.

Example: Changing multiple fields

Carrier 99990 must change the Service Date, Amount Charged by Provider, and Paid Amount (A). The carrier submits a replacement record (B) with the same key fields as the record being changed. Transaction Code 03, and the current cumulative value (not the change in values) for all non-key fields including Service Date, Amount Charged by Provider, Paid Amount, and Quantity/#of Units. The Transaction Date of the replacement record is the date the change was made in the system of the administering entity.

	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/ # of Units
1	99990	0001	01	20071210	1001	1	20071203	00000010000	00000000000	0000001
Ι	99990	0001	03	20080115	1001	1	20071215	00000020000	00000020000	0000002

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

C. **File Replacements**

Medical data providers may delete or replace an entire file that was previously submitted by using Submission File Type Code "R" (Replacement) on the Submission Control Record (Record Type - SUBCTRLREC). For record layout and data element details, refer to Submission Control Record in the Record Layouts section of this manual.

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Note: A Replacement (R) file received by the PCRB more than 24 months or more from the first day of the reporting quarter will be rejected.

Example: A data submitter wants to replace a file reported in 1st quarter 2013. The first day of the quarter is 01/01/2013. PCRB will not accept a replacement file submitted on or after 01/01/2015.

Deleting Files

To delete an entire file from the PCRB's database, submit a Submission Control Record with no other records in the file. The Submission Control Record for the file is completed as follows:

Field No.	Field Title/Description	Reported as
1	Record Type	SUBCTRLREC
2	Submission File Type Code	R (Replacement)
3	Carrier Group Code	Same as file being deleted
4	Reporting Quarter Code	Same as file being deleted
5	Reporting Year	Same as file being deleted
6	Submission File Identifier	Same as file being deleted
7	Submission Date	Date this file was generated
8	Submission Time	Time this file was generated
9	Record Total	0 (Do not include the Submission Control
		Record in the count*)
10	Reserved for Future Use	

^{*}Record Total = 1 will be accepted for carriers counting the Electronic Transmittal Record --.

Replacing Files 2.

To replace an entire file that was previously submitted in error, submit a new file with a Submission Control Record and all the records to be replaced.

Example: Replacing a file submitted in error

A file is submitted on February 21, 2013 and contains 5,000 records for 4th quarter 2012. On February 23, 2013, the data provider realizes that 500 of the transactions for which records were submitted were reported with Transaction Date 2012 1209 (12/09/2012) but actually occurred on 01/09/2013 (1st quarter). To replace the entire file, the data provider submits a new file with the 4,500 records for 4th quarter 2012. The Submission Control Record for the replacement file is completed as follows:

Field No.	Field Title/Description	Reported as
1	Record Type	SUBCTRLREC
2	Submission File Type Code	R (Replacement)
3	Carrier Group Code	Same as file being replaced
4	Reporting Quarter Code	Same as file being replaced
5	Reporting Year	Same as file being replaced
6	Submission File Identifier	Same as file being replaced
7	Submission Date	Date this file was generated
8	Submission Time	Time this file was generated
9	Record Total	Record count for this file
10	Reserved for Future Use	

The 500 records reported in error must be submitted with 1st quarter 2013 data with the corrected Transaction Date.

Note: A Replacement (R) file received by the PCRB 24 months or more from the first day of the reporting quarter will be rejected.

Example: A data submitter wants to replace a file reported in 1st quarter 2013. The first day of the quarter is 01/01/2013. PCRB will not accept a replacement file submitted on or after 01/01/2015.

D. Duplicate Records

Duplicate records are two or more records that refer to a single service that was performed by a medical provider. Duplicates can affect medical analysis by overstating utilization. Therefore, <u>submitters are</u> responsible for filtering out duplicates before sending data to the PCRB.

The PCRB will review submissions for records with the same key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) and the same Transaction Code. If the key fields and Transaction Code are the same, the PCRB will keep the record with the latest Transaction Date. If the Transaction Date is also the same, the PCRB will keep the latest record submitted.

1. True Duplicates (Repeating a Single Bill or Line)

It is possible to have records that are truly duplicates but do not share all key fields. This can occur if a service provider sends a second bill (notice) for a service that was not paid. The payer's system might create two records with different Bill Identification Numbers although they are for a single service. In this situation, the data submitter must filter out the duplicate records. **Do not submit both records since it will overstate utilization.**

There are three options to accomplish this:

- Option # 1 Do not submit the second record to the PCRB. The original record will be considered the current record on the database.
- Option # 2 If both records are created in the same quarter and the first has not yet been reported, do not submit the first record to the PCRB. The second record, once submitted, will be considered the current record on the database.
- Option # 3 Cancel the original record and submit a new original record. The second record will be considered the current record on the database. For details, refer to Record Replacements and Cancellations above.

Note: It is possible that the duplicate bill includes additional lines (e.g., follow-up visits, prescriptions). Report the additional lines in accordance with standard reporting procedures.

Example: Reporting options for true duplicates

A claimant visits a doctor's office. The service provider bills payer (Bill ID 101) but does not get paid immediately. The following month, the service provider sends another bill to the payer with the charge for the original office visit, and the payer's system assigns Bill ID 201 to the second notice.

Incorrect reporting:

If both records are submitted, the PCRB's database will show two office visits for a total charge of \$150, double the amount of what actually occurred:

Claim Number	Transaction Code	Bill ID	Line ID	Paid Procedure Code	Amount Charged	Quantity/ Number of Units
12345	01	101	1	99201	00000007500	0000001
12345	01	201	1	99201	0000007500	0000001

Correct reporting (3 options):

Option #1-Submitting only the first record provides an accurate picture of what occurred and minimizes the number of records stored on the database:

Claim Number	Transaction Code	Bill ID	Line ID	Paid Procedure Code	Amount Charged	Quantity/ Number of Units
12345	01	101	1	99201	00000007500	0000001

Option #2 – Submitting only the second record provides an accurate picture of what occurred and minimizes the number of records stored on the database (this option may not be used if the first record is already on the PCRB's database):

Claim Number	Transaction Code	Bill ID	Line ID	Paid Procedure Code	Amount Charged	Quantity/ Number of Units
12345	01	201	1	99201	0000007500	0000001

Option #3 – Submitting a cancellation record (Transaction Code 02) cancels the first record. Submitting a new record (Transaction Code 01) then provides an accurate picture of what occurred.

Claim Number	Transaction Code	Bill ID	Line ID	Paid Procedure Code	Amount Charged	Quantity/ Number of Units
12345	01	101	1	99201	0000007500	0000001
12345	02	101	1	99201	0000007500	0000001
12345	01	201	1	99201	00000007500	0000001

Note: If Bill 201 includes additional lines (e.g., follow-up visits, prescriptions), report the additional lines in accordance with standard reporting procedures.

2. Multiples of a Procedure Code

It is possible to have a situation where a service provider performs the same service multiple times. These instances are not considered true duplicates (single service billed multiple times) and must be reported to the PCRB. For example, a claimant receives an X-ray, and the service provider requests a second X-ray that repeats the first. Both procedures would be reported.

E. Dispensing Fees

Dispensing fees are charges assessed when providers issue drugs or supplies to claimants. These dispensing fees include overhead, supplies, and labor, etc., to fill a prescription. Dispensing fees are not reimbursed by

the Pennsylvania Workers' Compensation Fee Schedule.





F. Per Diem Hospital Charges

Inpatient hospital bills contain many services over multiple days. When reporting inpatient hospital bills to the PCRB, only one transaction is required.

The Pennsylvania Workers' Compensation Fee Schedule uses Diagnostic Related Group (DRG) codes to determine reimbursement of inpatient hospital bills. Report the DRG code for the Paid Procedure Code. Do not report NCCl's proprietary code "PER-DIEM" in the Paid Procedure Code field, but data submitters may report supporting codes, if any, in the Secondary Procedure Code field. Refer to Part IV – Data Dictionary for reporting specifications. "PER-DIEM" may be reported on bills from acute care provided in a trauma center or a burn facility.

G. Paid Procedure Code Reporting

Medical billings can contain procedure codes billed by the medical provider that are not directly involved in the reimbursement calculation for the services rendered. For the Medical Data Call, the Paid Procedure Code (Positions 153–177) identifies the procedure associated with the reimbursement paid on a line item or bill. The Secondary Procedure Code (Positions 290–314) field identifies the related procedures billed by the medical provider.

For example, for an inpatient hospital bill, the billed services are often coded using Hospital Revenue Codes, and yet, according to the state fee schedule, the reimbursement is based on a Diagnosis-Related Group (DRG). In these cases, the DRG should be reported as the Paid Procedure Code for every line to which the DRG reimbursement applies. The Secondary Procedure Code field should reflect the underlying CPT/HCPCS or Revenue Code billed by the hospital.

The examples in this section illustrate the reporting of Paid Procedure Codes and Secondary Procedure Codes.

1. DRG Reimbursement (Multiple Dates of Service) Example

A billing for inpatient shoulder surgery shows charges at the Revenue Code level. For this example, assume that applicable state regulations indicate that the appropriate reimbursement is based on a DRG code. The DRG may have been supplied in the PPS code field (FL 71) on the UB-04 form or it is derived by the billing review software.

When reporting the bill transactions on the Medical Data Call, every record should report the DRG as the Paid Procedure Code when applicable. Each record reports a single Revenue Code as the Secondary Procedure Code along with the associated billed charges as the Amount Charged by Provider (Positions 186-196). The DRG reimbursement applies to the entire bill. The Paid Amount (Positions 197-207) may be reported on one transaction (reflecting a bill level reimbursement), and all other transactions for the bill are reported as \$0.

The following is an example of correct reporting when multiple dates of services are audited separately:

Example: Correct Reporting – Services Audited Separately

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Line Identification Number	Service From Date	Service To	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130604	20130606	508	0111	00000129138	00000468372
2	20130604	20130606	508	0250	00000196255	0000000000
3	20130604	20130606	508	0270	00000147265	0000000000
<mark>4</mark>	20130604	20130606	508	0360	00000551900	0000000000
5	20130604	20130606	<mark>508</mark>	0370	00000345900	0000000000
6	20130604	20130606	508	0710	00000133800	0000000000

Alternatively, when one cannot proportion this reimbursement among the entire billed lines, one can report the total DRG reimbursement as the Paid Amount on a single transaction.

The following is an example of correct reporting when multiple dates of services are bundled together:

Example: Correct Reporting – Bundled Billing

Line Identification	Service From	Service To	Paid Procedure	Secondary Procedure	Amount Charged by		
Number	Date	Date	Code	Code	Provider	Paid Amount	
1	20130604	20130606	508	0111	00000129138	00000468372	Ī

The following is an example of incorrect reporting when multiple services are audited separately – in this case, Hospital Revenue Codes were used as the Paid Procedure Codes instead of the correct DRG codes:

Example: Incorrect Reporting – Services Audited Separately

Line Identification Number	Service From Date	Service To Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130604	20130606	0111		00000129138	00000468372
2	20130604	20130606	0250		00000196255	0000000000
3	20130604	20130606	0270		00000147265	0000000000
4	20130604	20130606	0360		00000551900	0000000000
<mark>5</mark>	20130604	20130606	0370		00000345900	0000000000
6	20130604	20130606	0710		00000133800	0000000000

2. DRG Reimbursement (Single Service Date) Example

Alternatively, inpatient hospital transactions reimbursed under a DRG can be reported on a per-day basis. Because the DRG determined the reimbursement, report the DRG as the Paid Procedure Code. When submitting transactions for individual service dates of an inpatient stay, report the daily reimbursement amount on one of the bill lines for the day as the Paid Amount. The Paid Amount on all other transactions with the same Service Date (Positions 129-136) is reported as \$0 because the daily reimbursement amount was already included on another bill line. Note that the sum of the Paid Amounts will equal the total reimbursement for the entire bill.

The following is an example of correct reporting for a single service date when services are audited separately:

Example: Correct Reporting – Single Service Date

 ILLI OILLING HOLLO	
Issued July 1, 2016	

Line Identification Number	Service Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130604	508	0111	00000043046	00000156124
2	20130604	508	0250	00000117753	0000000000
3	20130604	508	0270	00000147265	0000000000
<mark>4</mark>	20130604	508	0360	00000551900	0000000000
5	20130604	508	0370	00000345900	0000000000
6	20130604	5 08	0710	00000133800	0000000000
<mark>7</mark>	20130605	508	0111	00000043046	00000156124
8	20130605	508	0250	00000051027	0000000000
9	20130606	5 08	0111	00000043046	00000156124
10	20130606	508	0250	00000027475	0000000000

The following is an example of incorrect reporting for a single service date when services are audited separately:

Example: Incorrect Reporting – Single Service Date

Line Identification		Paid Procedure	Secondary	Amount Charged	
Number	Service Date	Code	Procedure Code	by Provider	Paid Amount
1	20130604	0111		00000043046	00000156124
2	20130604	0250		00000117753	0000000000
3	20130604	0270		00000147265	0000000000
1	20130604	0360		00000551900	0000000000
5	20130604	0370		00000345900	0000000000
6	20130604	0710		00000133800	0000000000
7	20130605	0111		00000043046	00000156124
3	20130605	0250		00000051027	0000000000
)	20130606	0111		00000043046	00000156124
10	20130606	0250		00000027475	0000000000

3. DRG Reimbursement With Implant Example

The standard DRG reimbursement does not always cover the entire bill, especially bills charging for services or equipment that are expected to vary greatly in cost. Implants and prosthetics are one category of devices that often are not subject to the DRG calculation and, instead, are reimbursed separately.

When reporting the bill line transactions reimbursed according to the DRG, report the applicable DRG in the Paid Procedure Code. For bill line transactions that are not reimbursed under the DRG, report the procedure code (typically a Hospital Revenue Code) used to determine the reimbursement for that bill line in the Paid Procedure Code field and the associated reimbursement in the Paid Amount field.

The following is an example of correct reporting when an implant was billed and reimbursed separately:

Example: Correct Reporting – DRG Reimbursement With Implant

Line Identification	_	Service To	Paid Procedure	Secondary Procedure	Amount Charged by	Paid Amount
Number	From Date	Date	Code	Code	Provider	

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SECTION V - REPORTING RULES

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1	20130118	20120120	<mark>460</mark>	0110	00000130000	00001541298
2	20130118	20120120	460	0250	00000427703	0000000000
3	20130118	20120120	460	0270	00000025700	0000000000
<mark>4</mark>	20130118	20120120	<mark>460</mark>	0271	00000042500	0000000000
<mark>5</mark>	20130118	20120120	<mark>460</mark>	0272	00000151900	0000000000
6 ¹	20130118	20120120	0278		00004415600	00001388978
<mark>7</mark>	20130118	20120120	<mark>460</mark>	0300	0000002000	0000000000
8	20130118	20120120	<mark>460</mark>	0305	00000003000	0000000000
9	20130118	20120120	<mark>460</mark>	0360	00001580000	0000000000
<mark>10</mark>	20130118	20120120	<mark>460</mark>	0370	00000069200	0000000000
<mark>11</mark>	20130118	20120120	<mark>460</mark>	0710	00000050000	0000000000

¹Line ID Number 6 with Paid Procedure Code 0278 in the Implant Revenue code.

The following is an example of incorrect reporting when an implant was billed and reimbursed separately:

Example: Incorrect Reporting – DRG Reimbursement With Implant

Line Identification Number	Service From Date	Service To Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130118	20120120	0110		00000130000	00001541298
<mark>2</mark>	20130118	20120120	0250		00000427703	0000000000
<mark>3</mark>	20130118	20120120	0270		00000025700	0000000000
<mark>4</mark>	20130118	20120120	0271		00000042500	0000000000
<mark>5</mark>	20130118	20120120	0272		00000151900	0000000000
6 ²	20130118	20120120	0278		00004415600	00001388978
7	20130118	20120120	0300		0000002000	0000000000
8	20130118	20120120	0305		0000003000	0000000000
9	20130118	20120120	0360		00001580000	0000000000
<mark>10</mark>	20130118	20120120	0370		00000069200	0000000000
<mark>11</mark>	20130118	20120120	0710		0000050000	0000000000

²Line ID Number 6 with Paid Procedure Code 0278 in the Implant Revenue code.

H. Medical Marijuana Data Reporting

For reporting medical marijuana payments, report the following Paid Procedure Codes:

- MM001 Medical Marijuana—Reimbursement to injured worker (claimant)
- MM002 Medical Marijuana—Reimbursement directly to dispensary

When reporting reimbursement for medical marijuana, this existing Taxonomy Code 175F00000X—Naturopath value is recommended as the closest Taxonomy Code for a dispensary.

In order to specify a dispensary as a new Place of Service Code, the following code is to be reported.

• Place of Service 02—Dispensary (Centers for Medicare & Medicaid Services (CMS) does not currently have a code for dispensary)

If applicable state or nationally recognized code values are created for medical marijuana reporting, those code values should be reported in lieu of MM001 and MM002.

SECTION VI - EDITING AND OTHER VALIDATION PROCEDURES

A. Editing Process

The PCRB's editing process is performed to ensure that the medical data provider's data is consistent with reporting requirements and that it meets quality standards. The edit process for the Medical Data Call is based on three quality components:

- (a) Completeness test (e.g., are the data elements appropriately populated?)
- (b) Validation test (e.g., are the data elements populated with valid values?)
- (c) Reasonableness test (e.g., is the distribution of data elements reasonable?)

These tests will be performed within each data element and across Call elements where needed. Editing for the Call is performed within this data type and does not include cross-data type editing.



B. Validating a Submission

Using data element tolerance levels, the editing process determines the overall quality of the Medical Data Call. Data element tolerance levels are defined as follows:

- (a) Critical (C) Indicates that the data element is of critical importance. Elements in this category have a very low tolerance for missing or invalid data. For example, a tolerance of .1% would indicate that the data element can only be missing or invalid for 100 out of 100,000 records. Records with missing or invalid critical elements above this tolerance level are not viable for Call use.
- (b) Priority (P) Indicates that the data element is very important but the record can still be of some value even with this data element missing. An example of a Priority tolerance level is in the range of 1%-5%.
- (c) Low (L) Indicates that the record is still useful when this data element is missing. An example of a Low tolerance level is in the range of 10% 20%.
- (d) Relational (R) Indicates the relationship of one data element in relation to another data element as a reasonability test.
- (e) Required Indicates that the data element must be provided for file acceptance and data processing.
- (f) Required ETR Indicates that the Electronic Transmittal Record (ETR) contains all the data elements required for file acceptance and data processing.
- (g) Required Submission Control Record Indicates that the Submission Control Record contains all the data elements required for file acceptance and data processing.

Below are the edits and their associated tolerance levels that will be performed on each data element:

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Field	Data Element	Tolerance/Edit
No.		
1	Carrier Code*	Required for file acceptance
2	Policy Number Identifier*	Required for file acceptance
3	Policy Effective Date*	Required for file acceptance
4	Claim Number Identifier*	Required for file acceptance
5	Transaction Code	Required for file acceptance
6	Jurisdiction State Code	C
7	Claimant Gender Code	L
8	Birth Year	L
9	Accident Date	C
10	Transaction Date	Required for file acceptance
11	Bill Identification Number*	Required for file acceptance—Must be unique
12	Line Identification Number*	Required for file acceptance—Must be unique
13	Service Date	R—Must be populated if Service From Date and Service To Date are missing. Must be valid if populated.
14	Service From Date	R—Must be populated if Service Date is missing. Must be valid if populated.
15	Service To Date	R—Must be populated if Service Date is missing and Service From Date is populated. Must be valid if populated.
16	Paid Procedure Code	P—Must be formatted correctly. Codes validated against procedure codes
17	Paid Procedure Code Modifier	P—Validated against a table of valid values. Cannot be missing for every record
18	Amount Charged by Provider	C—Must be greater than zero
19	Paid Amount	C—Must be greater than or equal to zero
20	Primary ICD Diagnostic Code	P—Codes validated against valid ICD Diagnostic codes
21	Secondary ICD Diagnostic Code	L—Cannot be missing for every record
22	Provider Taxonomy Code	P—Must be a valid code
23	Provider Identification Number	P—Priority tolerance where required by
		state mandate
24	Provider Zip Code	P
25	Network Service Code	P
26	Quantity/Number of Units per Procedure Code	P—Must be numeric
27	Place of Service Code	P—Must be a valid code
28	Secondary Procedure Code	R—Must be valid if populated

This data element is considered a key field and must be reported the same as on the original record for all records related to a medical transaction (line). Refer to Key Fields in the **Medical Data Call Structure** section of this manual.

1. Edit Types

Each Medical Data Call edit is classified into one of the edit types—submission, field, logical, or relational edits:

- Submission edits ensure that the file record length is correct, data provider information is valid, a Submission Control Record exists, and the record count balances
- Field edits ensure that the data contained in each data field is acceptable
- Logical edits verify that the data makes sense in relation to one or more other fields on the same report
- Relational edits compare the data in a specific field on the report with another data field contained in the same report submission and/or with a corresponding medical report that was previously submitted and already stored on the PCRB's database

2. File Acceptance

Every Medical Data Call file received by the PCRB goes through three stages of editing. File Acceptance, the first stage of the editing process, includes submission, field, and relational level edits to determine whether the PCRB can process the file. Refer to Edit Types in this section for edit type descriptions.

In the File Acceptance stage, the entire field is either accepted or rejected.

File Acceptance submission level edits determine whether the:

- File name is valid per file naming conventions
- Data reporter is authorized to report Medical Call data and to submit for the Carrier Group Code
- Record length is correct and contains only valid characters
- File contains a Submission Control Record, there is only one Submission Control Record per file, and the Submission Control Record is not a duplicate
- Submission File Type is valid
- Reporting Quarter is valid
- Reporting Year is valid
- Submission Date is valid
- Record Total is valid and matches the number of records in the file
- Replacement file matches a previously submitted file
- Submission Date and Submission Time on a replacement file are later than the file it is intended to replace

Files that fail submission level edits are rejected and not processed. The medical data provider is notified that the file rejected.

To ensure the completeness and validity of the required fields, field and relational level edits are also performed during this stage on any field that is identified as "Required for File Acceptance." Refer to Validating a Submission in this section for data element tolerance descriptions. The required fields include the - key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) plus Transaction Code and Transaction Date.

- Field edits ensure the completeness and validity of each data element. For example, Carrier Code cannot be missing and must be a valid PCRB Carrier Code.
- Relational edits check for acceptable relationships between elements on different records, either within the submission or on the PCRB's database. For example, a Cancellation record (Transaction Code 02) must have an associated Original record (Transaction Code 01) or Replacement record (Transaction Code 03) in the submission or on the PCRB's database.

When a required field fails an edit, the percentage of edit failure occurrences are counted and compared to tolerance levels. If the percentage of edit failure occurrences is greater than the tolerance, the file will be rejected, and the medical data provider is notified that the file was rejected. If the number of edit failure occurrences is below tolerance, the PCRB will return those records that failed to the data submitter. If more than 1,000 records are rejected (but the file is still accepted) only the first 1,000 records will be returned to the data submitter. The records will be returned via a data download option in the Submission Tracking section of the Medical Data Call Manager online application.

Data providers should review all rejected files and all returned records to identify and correct issues in their source systems.

Once a file passes the File Acceptance stage, all records, except those returned, will be processed.

	File Acceptance						
Edit Types	Description	Edit Failure Results					
Submission	Enables the PCRB to process the file	Reject file					
Field (required	Ensures complete and valid	Greater than tolerance = Reject file					
fields)	entry	Below tolerance = Return record					
Relational (required	Determines if the relationship	Return record					
fields)	between fields in different						
	records is acceptable						

For details on all Medical Call edits, refer to the Edit Matrix section of the manual.

3. Quality Tracking

Quality Tracking is the second stage of the editing process. It is at this stage that a data provider can gauge the quality of the data they are reporting.

In this stage, the data elements of each submission are checked for completeness and validity using field, logical, and relational edits:

- Field edits ensure the completeness and validity of each data element. For example, Birth Year cannot be missing, and the year must be a valid year.
- Logical edits check the relationship between elements within the same record. For example, Birth Year must be before Accident Date.
- Relational edits check for acceptable relationships between elements on different records, either within the submission or on the PCRB's database. For example, if an Original record (Transaction Code 01) already resides on the PCRB's database, a new Original with the same key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) and the same Transaction Code and Transaction Date will invoke an edit.

Refer to Edit Types in this section for edit type descriptions.

Each data element is evaluated against one or more edits and either passes or fails each edit. For each data element, if any edit fails, the transaction is counted and the number of transactions that fail are evaluated against a tolerance level (Critical, Priority, Low, or Relational). Refer to Validating a Submission in this Part for data element tolerance descriptions.

In the Quality Tracking stage, the results of the edits are communicated to the medical data provider, at the file level, by the number of data elements that passed Critical, Priority, Low or Relational tolerance levels. The percentage by data element that are available for use, as well as the specific edit or edits that failed for each data element, are also provided.

The PCRB will not reject or return records during this editing stage.

Quality Tracking							
Edit Types Description		Edit Failure Results					
Field (required	Ensures complete and valid	Count occurrences					
fields)	entry						
Logical	Determines if the relationship	Count occurrences					
	between fields in the same						
	record is acceptable						
Relational (required	Determines if the relationship	Count occurrences					
fields)	between fields in different						
	records is acceptable						

For details on all Medical Call edits, refer to the Edit Matrix section of the manual.

4. Quarter End Validation

Quarter End Validation is the third and final stage of the editing process. This stage begins in the due quarter.

During the Quarter End Validation stage, Quality Tracking edits for all the medical data providers reporting for the carrier group are summarized for the entire quarter's data, developing quality statistics across all submissions. Refer to Quality Tracking in this section for details. Additional - relational edits are performed in this stage:

- .
- Relational edits check the entire submission for completeness and reasonability. For example, an office visit is the most common Place of Service; therefore, the PCRB would expect to see the Place of Service code reported, and reported more frequently than other Place of Service codes.

The Quality Tracking and additional - edit failures are aggregated, and the results are provided at the Group level. For each data element, if any edit fails, the transaction is counted and the number of transactions that fail are evaluated against a tolerance level (Critical, Priority, or Low). Refer to Validating a Submission in this section for data element tolerance descriptions.

Aggregate validation distributions based on the additional relational edits are provided as anticipated values (including the corresponding data elements) and as distribution graphs.

The PCRB will not reject or return records during this editing stage.

	Quarter End Validation						
Edit Types	Description	Edit Failure Results					
Quality Tracking (Field, Logical, Relational)	Refer to Quality Tracking in this section for details	Count occurrences					
-	-	-					
Relational (required fields)	Determines if submission meets anticipated values	Display anticipated values and distribution graph					

For details on all Medical Call edits, refer to the Edit Matrix section of the manual.

C. Medical Data Call Edit Matrix

1. Medical Data Call Edit Matrix—All Edits in Production

The Medical Data Call Edit Matrix—All Edits in Production contains details on the enhanced editing process that currently takes place in the PCRB's database. This online edit matrix is the most comprehensive resource for information on the PCRB's Medical Data Call editing and can be used when monitoring quality tracking and quarter end validation to obtain the details on each edit. It is updated frequently to ensure the most current editing information.

The Medical Data Call Edit Matrix—All Edits in Production can be found in the Medical Data Reporting section of the PCRB's website, www.pcrb.com.

2. Medical Data Call Edit Matrix—Future Edit Enhancements

The Medical Data Call Edit Matrix—Future Edit Enhancements contains edits scheduled for future implementation. This edit matrix provides you with lead time and projected implementation dates for planned changes to Medical Data Call editing. This advanced information can be used for planning purposes.

The Medical Data Call Edit Matrix—Future Edit Enhancements has not been established since all the edits are currently contained in the Medical Data Call Edit Matrix.

3. Online Edit Matrix Updates

When changes are made to the Medical Data Call Edit Matrix, carriers will be notified.

SECTION VII - GLOSSARY

Definitions of Terms A.

Adjustment A change to the paid amount on a previously reported record. Adjustments do not include

changes due to data reporting errors.

The insurance carrier, Third Party Administrator, bill review vendor, or other entity that **Administering Entity**

receives the bill from a medical service provider and that pays for the medical transaction.

Ambulatory Surgical

A state-licensed facility that is used mainly to perform outpatient surgery, has a staff of Center (ASC) physicians, has continuous physician and nursing care, and does not provide for overnight stays. An ambulatory surgical center can bill for facility fees much like a hospital, but

generally has a separate fee schedule.

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ASC See Ambulatory Surgical Center.

(American Standard Code for Information Interchange) standard code for representing **ASCII**

characters as binary numbers. In addition to printable characters, the ASCII code includes

control characters to indicate carriage return, backspace, and the like.

Bill A listing (lines) of charges for medical services. A bill may consist of multiple lines.

Calendar Year Premium

Associated with premium within a given calendar year period. Calendar year premium is

final at the end of the period and does not change from valuation to valuation.

Cancellation A Medical Data Call transaction that allows the medical data provider to completely remove

a previously submitted record or multiple records from the PCRB's database.

Carrier See Insurance Carrier

Carrier Group Insurance companies under a common ownership

Claim A demand to recover from a loss or damage covered by a policy of insurance. A Medical

Data Call claim (identified by claim number) includes one or more bills for medical services.

Claimant The person who makes a claim. The claimant receives the medical services listed on the

bill(s) for the associated claim.

CMS-1500 Form The standard claim form of the Centers for Medicare and Medicaid Services used by

> non-institutional providers or suppliers to bill Medicare carriers and durable medical equipment regional carriers (DMERCs) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission

of claims. It is also used for billing of some Medicaid State Agencies.

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A mechanism for tracking record level edits that pass or fail. During File Acceptance **Count Occurrences**

processing, all edits with an outcome of "Count Occurrences" that fail will cause the record to be rejected and returned to the data submitter. Quality Tracking edits with an outcome of "Count Occurrences" that fail will always be displayed as a percentage of the total records. Quarter End Validation edits with an outcome of "Count Occurrences" that fail will be displayed as a percentage of total records when the result exceeds the tolerance level.

Coverage Provider (or Coverage **Provider Group)**

See Insurance Carrier.

The smallest unit of physical data for which attributes are defined. **Data Element**

Deductible A clause in an insurance policy that relieves the *insurer* of responsibility in dollars,

percentage of the total, or percentage of the loss before paying the loss.

Field An area designated for a particular category of data.

File An organized, named collection of related records packaged collectively and reported

> electronically to the PCRB. For Medical Call data, a file may only include the data from one reporting group, but data for multiple carrier codes within the reporting group is acceptable.

Gross Premium In company language, the premium before deducting any premium paid for reinsurance

and, in some cases, before paving any return premium.

Health Maintenance Organization (HMO) An organization of medical care providers that offers a specified range of medical care in

return for a set fee. See also Preferred Provider Organization.

HMO See Health Maintenance Organization.

Individual Reporter A medical data provider that reports data only for its own carrier code. Data will not be

included in a file for other carrier codes.

Insurance Carrier The company that issues the insurance policy. Also referred to as the coverage provider,

insurance carriers include private carriers, state funds, and self-insured groups.

Insured The policyholder. In workers compensation insurance, the insured is the person or

> organization (employer) that is protected (covered) by the insurance policy and is entitled to recover benefits under its terms. The insured is designated in Item 1 of the policy

Information Page.

Insurer The insurance carrier or other organization, such as a syndicate, pool, or association,

providing insurance coverage and services.

Line A single charge for a medical service or services listed on a bill. Also referred to as line

item detail.

Medical Data

Any unique data reporting entity that is certified to send Medical Call data to the PCRB. Provider This includes, but may not be limited to, insurance carriers, Third Party Administrators

(TPAs), bill review vendors, and pharmacy vendors. See also Reporting Group.

Medical/Service

Provider

See Service Provider.

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Patient The person receiving medical services. For a workers compensation claim, the patient is

also the claimant.

Payer The entity that ultimately pays for medical services.

Policy The formal written contract of insurance between the employer (insured) and the *insurance*

carrier (insurer).

PPO See Preferred Provider Organization.

Preferred Provider Organization (PPO) A network of medical care providers contracted by the insurer to provide various medical care services to covered employees for specified fees. The covered employees have the option to go to the network of medical care providers or to go outside of the network for medical care services for reasonable and customary fees after a set deductible is met. See

also Health Maintenance Organization.

Provider See Service Provider.

Quarterly Submission The data file, or files that represent the reporting groups' aggregate submission for a given

three-month (quarter) period.

Record A collection of related data elements that are treated as one unit.

Record Layout Defines the parameters for each data field contained in the record that is submitted

> electronically, including the data field's starting and ending positions on the record and the field's specific type/class (i.e., alpha, numeric, or alpha/numeric). The consistent parameters allow for efficient processing, so the data contained within can be sorted,

formatted, and customized.

Reporting Group An affiliated insurance company or an assembly of affiliated insurance companies (Affiliate

Group) and their designated medical data providers that report Medical Call data to the

PCRB.

Service Provider Service provider, or medical service provider, refers to the individual or group that

furnishes a patient with various medical services (e.g., physician, clinic, hospital,

pharmacy). Refer to Data Dictionary—Provider Taxonomy Code for the source link to the

accepted Provider Taxonomy Code list.

Refers to the additional characters other than letters A–Z and numbers 0–9. **Special Characters**

Statistical Agent Company associations that collect workers compensation data and prepare it according to

rating regulation requirements on behalf of their members. Most state workers

compensation laws permit companies to join together for this purpose.

Submission A file transmitted to the PCRB for a given reporting group. Also referred to as a

transmission.

Subsidiary A corporation that is either wholly owned by another corporation or controlled by a

corporation or business entity that owns a majority of its voting shares.

An organization hired to perform one or more of the business functions of another **Third Party** Administrator (TPA)

company, which may include reporting insurance data to the statistical agent.

TPA See Third Party Administrator.

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Transaction

Refers to either of the following:

- The line item of a medical bill. Referred to as a medical transaction in this manual. Use this definition for Transaction Date.
- The general term given to data transmitted from one computer system to another for the purpose of accessing, querying, or updating a record, file, or database. Use this definition for Transaction Code.

Transmission

See Submission.

UB-04 Form

The basic form that Centers for Medicare and Medicaid Services prescribes for the Medicare program. It is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act (ASCA), Public Law 107105, and the implementing regulation at 42 CFR 424.32.

Unit Statistical Data

The statistical documentation that insurance carriers submit to the PCRB for the purpose of reporting workers compensation insurance data. It includes premium and losses by state at a classification code level.

Utilization

The frequency that a particular medical procedure is performed.

Workers Compensation Insurance

Statutory coverage for employers subject to the workers compensation law of a state. It provides benefits to employees who are injured during the course of their employment. The Pennsylvania Workers Compensation Manual of Rules, Classifications and Rating Values for Workers Compensation and for Employers Liability Insurance contains rules, classifications with descriptions, rates/loss costs for each classification, and statespecific exceptions for writing workers compensation insurance.

SECTION VIII – APPENDIX

A. Overview

The following examples are included in the Appendix:

- Business Exclusion Request Form Example --
- Premium Verification Worksheets and Instructions
 For use with Premium Determination Methods
 3
- . .
- Compensation Data Exchange (CDX) Information
- CDX Insurer User Management Group (UMG) Primary Administrator Application
- NCCI Medical Data Call Place of Service Crosswalk

B. Business Exclusion Request Form Example

Participants in the Call are required to submit their basis for exclusion to the PCRB for review. All requests for review must include the output used to demonstrate that the excluded segment(s) will be less than 15% of gross premium. For details on the methods for premium determination and examples, refer to Business Exclusion Option in the **General Rules** section of this manual.

Date Prepared:

Carrier Group Name:

Carrier Group Number:

Preparer's Contact Information

Name: Address: Phone: Email:

Exclusions – Complete the following steps:

 Document the nature and reason for all proposed exclusions. If more space is needed, please attach a separate page with the explanation(s) to this form.

Note: The exclusion option must be based on business segment, not on claim type or characteristics.

The 15% exclusion does not apply to selection by:

- Medical services provided (pharmacy, hospital fees, negotiated fees, etc.)
- Claim characteristics such as claim status (e.g., open, closed) or deductible programs (e.g., large deductibles)
- Claim types such as specific injury types (medical only, death, permanent total disability, catastrophic, etc.)
- 2. Document the carriers (by carrier code) and states that are handled by each excluded business segment.
- 3. For each applicable carrier, provide an estimate of the percentage of paid losses handled by each excluded business segment.
- 4. If using Premium Determination Methods 1, 2 or 3, complete the corresponding Premium Verification Worksheet. If using Premium Determination Method 3, complete the Gross Premium Estimation Worksheet.

Note: If the methods described are not appropriate for determining the exclusion percentage, contact the PCRB for guidance. The methods are not appropriate if they would not closely approximate prospective premium distribution in the current calendar year (e.g., a significant shift has occurred in

a participant's book(s) of business since the last NAIC reporting or the participant writes a significant number of large deductible policies).

5. Completed requests should be sent to the Pennsylvania Compensation Rating Bureau, United Plaza Building, Suite 1500, 30 S. 17th Street, Philadelphia, PA 19103 or emailed to medicaldata@pcrb.com.

C. Premium Verification Worksheet and Instructions

1. Worksheet - Method 1

Use this worksheet to determine if proposed exclusions are less than or equal to 15% of the group's total written premium when using Premium Determination Method 1. Only include premium from Pennsylvania or Federal Act.

For details on Premium Determination Method 1 and all other premium determination methods, refer to Business Exclusion Option in the **General Rules** section of this manual.

Column A	Column B	Column C	Column D
Entities for Proposed Exclusion	Entities' Calendar Year Written Premium	Carrier Group Calendar Year Written Premium	Entities' Written Premium as % of Carrier Group (Col. B / Col. C)
TOTAL			

2. Worksheet Instructions – Method 1

- 1. In Column A, list the entities excluded from Pennsylvania.
- 2. In Column B, enter the Calendar Year Written Premium for Pennsylvania for each excluded entity.
- 3. In Column B of the Total row, enter the sum of the premium for the excluded entities.
- 4. In Column C of the Total row, enter the Carrier Group's Calendar Year Written Premium for Pennsylvania (as reported in the NAIC Annual Statement—Statutory Page 14).
- 5. In Column D of the Total row, divide Column B by Column C, and enter the result as a percentage. Round to one decimal. This value must be equal to or less than 15%.

3.

3. Worksheet – Method 2

Use this worksheet to determine whether proposed exclusions are less than or equal to 15% of the group's total written premium when using Premium Determination Method 2. This method is an option for affiliate groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums.) Only include premium from Pennsylvania or Federal Act.

For details on Premium Determination Method 2 and all other premium determination methods, refer to Business Exclusion Option in the **General Rules** section of this manual.

Premium Verification Worksheet – Method 2				
Item	Description	Formula	Amount	
	NAIC Direct Written Premium:			
Α	Total			
В	Large Deductible to be excluded			
С	Non-Large Deductible to be excluded			
	Estimated Gross Premium:			

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D	Net Ratio	B divided by A (B / A)
E	Gross Ratio	From table (Refer to Business Exclusion Option in the General Rules section of this manual
F	Non-Large Deductible Ratio	C divided by A (C / A)
G	Ratio	Sum of E and F (E+F)

4. Worksheet Instructions - Method 2

- 1. Fill in Items A, B and C.
- Determine the Net Ratio (D).
- 3. Use the Net Ratio to determine the Gross Ratio (E) from the table. Refer to Business Exclusion Option in the **General Rules** section of this manual.
- 4. Use the formulas to complete the worksheet.
- 5. If the ratio (G) is 15% or less, the exclusion is acceptable.

5. Worksheet - Method 3

Use this worksheet to determine if proposed exclusions are less than or equal to 15% of the group's total written premium when using Premium Determination Method 3. This method is an option for affiliate groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums.) Only include premium from Pennsylvania or Federal Act.

For details on Premium Determination Method 3 and all other premium determination methods, refer to Business Exclusion Option in the **General Rules** section of this manual.

	Premium Verification Worksheet – Method 3				
Item	Description	Formula	Amount		
	NAIC Direct Written Premium:				
Α	Total including Large Deductible				
В	Large Deductible				
С	Large Deductible to be excluded				
D	Non-Large Deductible to be excluded				
	Estimated Gross Premium:				
Е	Large Deductible to be excluded	5 times C (5 x C)			
F	Total Excluded	Sum of D and E			
		(D + E)			
G	Add-on for Large Deductible business	4 times B (4 x B)			
Н	Estimated Total	Sum of A and G			
		(A + G)			
Ī	Ratio	F divided by H			
		(F / H)			

6. Worksheet Instructions – Method 3

- 1. Fill in Items A, B, C. D.
- 2. Use the formulas to complete the worksheet.
- 3. If the ratio (I) is 15% or less, the exclusion is acceptable.

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D. -

E. Compensation Data Exchange (CDX) Information

CDX is a service of Compensation Data Exchange, LLC which is owned by the following data collection organization members of the American Cooperative Council on Compensation Technology (ACCCT):

- Workers' Compensation Insurance Rating Bureau of California
- Delaware Compensation Rating Bureau, Inc.
- Insurance Services Office, Inc.
- Workers' Compensation Rating and Inspection Bureau of Massachusetts
- Compensation Advisory Organization of Michigan
- Minnesota Workers' Compensation Insurers Association, Inc.
- New York Compensation Insurance Rating Board
- North Carolina Rate Bureau
- Pennsylvania Compensation Rating Bureau
- Wisconsin Compensation Rating Bureau

CDX Insurer User Management Group (UMG) Primary Administrator Application (see subsequent page)

The *Insurer User Management Group (UMG) Primary Administrator Application* form is a digital (online) form. The following page contains a screen shot of the form, which is available on the CDX website. Please visit www.accct.org to complete this application.



Insurer UMG Primary Administrator Application

Use this form to apply to become an Insurer UMG Primary Administrator. Once you have completed the form, press the "Submit" button to apply. You will receive a link to a printable version of the form, along with further instructions.

Click here to return to the ACCCT home page.

Request New UMG/Ca	equest New UMG/Carrier Group.		ID:	0
Request New UMG Pri	mary Admin User for Existing UMG.			
O Update Contact Info for	Existing UMG Primary Admin User.			
\				
Applicant Information	1	- C	Nt.	
Carrier Group Name:		Carrier Group (not NAIC Nu		0
		(not naic nu	inder).	
irst Name:		① Last Name:		0
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City:		① State	AK 🗸 🛈	
IP:	0			
Phone Number:		① Ext.:		0
mail Address:		① Fax Number:		
				<u> </u>
Authorizing Officer -				
irst Name:		① Last Name:		0
Title:		① Email Addres	s:	0
Agreement ———	By submitting this form, you	agree to abide by all <u>Terms an</u>	d Conditions (PDF download).	
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		Submit		



NCCI Medical Data Call Place of Service Crosswalk

The Place of Service Crosswalk was developed to provide a mapping of the Type of Bill code on Form CMS-1450 to the Place of Service code, for reporting the Place of Service code on the Medical Data Call. This Place of Service Crosswalk is intended for reporting facility and hospital services that are using Form CMS-1450, because that form **does not** contain a Place of Service code field. Therefore, the Type of Bill code (positions 1 and 2 without leading 0) can be mapped to the Place of Service code as displayed in the following chart.

The Type of Bill code is a three-digit code with each digit defining a different aspect of the medical bill—Type of Facility, Bill Classification, and Frequency of the Bill. This three-digit code is located in field 4 of the National Uniform Billing Committee (NUBC) approved UB-04 Claim Form CMS-1450.

While the Type of Bill is a three-digit code, some providers report it as a four-digit code, with the first digit being a leading zero. Take that into consideration for accurate mapping to the Place of Service code.

Refer to the Key that is located after the Place of Service Crosswalk chart.

	Place of Service Crosswalk				
Type of Bill	Type of Bill Position 1 (Type of Facility)	Type of Bill Position 2 (Bill Classification)	Place of Service*	Place of Service Description	
11X	Hospital	Inpatient	21	Inpatient Hospital	
12X	Hospital	Inpatient	21	Inpatient Hospital	
13X	Hospital	Outpatient	22	Outpatient Hospital	
14X	Hospital	Other	22	Outpatient Hospital	
18X	Hospital	Swing Bed	21	Inpatient Hospital	
21X	Skilled Nursing	Inpatient	31	Skilled Nursing Facility	
22X	Skilled Nursing	Inpatient	31	Skilled Nursing Facility	
23X	Skilled Nursing	Outpatient	32	Nursing Facility	
28X	Skilled Nursing	Swing Bed	32	Nursing Facility	
32X	Home Health	Inpatient	12	Home	
33X	Home Health	Outpatient	12	Home	
34X	Home Health	Other	12	Home	
41X	Religious Nonmedical	Inpatient	21	Inpatient Hospital	
42X	Religious Nonmedical	Inpatient	21	Inpatient Hospital	
43X	Religious Nonmedical	Outpatient	22	Outpatient Hospital	
65X	Intermediate Care	Intermediate Care—Level I	54	Intermediate Care Facility/Mentally Retarded	
66X	Intermediate Care	Intermediate Care—Level II	54	Intermediate Care Facility/Mentally Retarded	
71X	Clinic or Hospital Based Renal Dialysis Facility	Rural Health Clinic (RHC)	72	Rural Health Clinic	
72X	Clinic or Hospital Based Renal Dialysis Facility	Hospital Based or Independent Renal Dialysis Facility	65	End-Stage Renal Disease Treatment Facility	
73X	Clinic or Hospital Based Renal Dialysis Facility	Free Standing Provider- Based Federally Qualified Health Center (FQHC)	49	Independent Clinic	

NCCI Place of Service Crosswalk - Revised November 6, 2009



NCCI Medical Data Call Place of Service Crosswalk

	Toma of Bill	Tomo of Dill		T .
Type of Bill	Type of Bill Position 1 (Type of Facility)	Type of Bill Position 2 (Bill Classification)	Place of Service*	Place of Service Description
74X	Clinic or Hospital Based Renal Dialysis Facility	Outpatient Rehabilitation Facility (ORF)	49	Independent Clinic
75X	Clinic or Hospital Based Renal Dialysis Facility	Comprehensive Outpatient Rehabilitation Facility (CORF)	62	Comprehensive Outpatient Rehabilitation Facility
76X	Clinic or Hospital Based Renal Dialysis Facility	Community Mental Health Center (CMHC)	53	Community Mental Health Center
79X	Clinic or Hospital Based Renal Dialysis Facility	OTHER	49	Independent Clinic
81X	Special facility or hospital ASC surgery	Hospice (Nonhospital Based)	34	Hospice
82X	Special facility or hospital ASC surgery	Hospice (Hospital Based)	34	Hospice
83X	Special facility or hospital ASC surgery	Ambulatory Surgical Center Services to Hospital Outpatients	24	Ambulatory Surgical Center
84X	Special facility or hospital ASC surgery	Free Standing Birthing Center	25	Birthing Center
85X	Special facility or hospital ASC surgery	Critical Access Hospital	22	Outpatient Hospital

	Chart Key
	Place of Service Crosswalk
Type of Bill	Located on the National Uniform Billing Committee (NUBC) approved UB-04 Claim Form, also known as CMS-1450, in field 4.
Towns of Bill Code (4e4	Identifies the Type of Facility that provided the medical services. The following are two examples:
Type of Bill Code (1st position)	Type of Bill 11X, the 1 in position 1 represents services provided at a Hospital
promony	Type of Bill 21X, the 2 in position 1 represents services provided at a Skilled Nursing facility
Type of Bill Code (2 nd position)	Identifies the Bill Classification . Two examples are as follows: Type of Bill 11X, the 1 in position 2 represents Inpatient Services
position)	Type of Bill 13X, the 3 in position 2 represents Outpatient Services
Type of Bill Code (3 rd position)	Identifies the Frequency of the Bill. This position is not needed for the crosswalk mapping.
Place of Service Code	The two-digit code that identifies where the medical service was performed. The Place of Service code is reported in field 27 on the NCCI Medical Data Call.
Place of Service Description	Provides a description of where the medical service was performed.