DELAWARE MEDICAL DATA CALL MANUAL

Issued November 1, 2019

DELAWARE COMPENSATION RATING BUREAU, INC.

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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 is located on the DCRB's website at www.dcrb.com.

The Medical Data Call Manual applies to data submitted to DCRB. Data providers are required to comply with the instructions and guidelines contained in this manual in conjunction with DCRB'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 DCRB's criteria.

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

B. Purpose of Medical Data Call

During its July 30, 2008 meeting, the Delaware Compensation Rating Bureau's Governing Board voted unanimously to authorize the DCRB 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 represented over 62 percent of loss costs in Delaware
- Medical detail could enhance DCRB's ability to explain filings
- Medical cost containment issues are potentially important public policy matters
  - Fee Schedule – Relationships to Medicare, overall richness of reimbursements
  - Charge Master System
  - Treatment Protocols
- Medical detail would be imperative for DCRB to be able to opine with authority on a variety of possible proposals to change the payment system for workers compensation in Delaware
- 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 DCRB 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 Contact Information

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

Mail: Medical Data Reporting Department
Delaware Compensation Rating Bureau, Inc.

30 South 17th Street – Suite 1500
Philadelphia, PA 19103-4007

Phone: (302) 654-1435
Website: www.dcrb.com
E-mail: medicalcall@dcrb.com

SECTION I – GENERAL RULES

A. Scope and Effective Date

Medical Data Call is the bill detail that comes from medical services rendered. All medical transactions with a Jurisdiction State of Delaware 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 Delaware Compensation Rating Bureau, Inc., 30 S. 17th Street, Suite 1500, Philadelphia, PA 19103.

The Call began with mandatory medical transactions occurring in 3rd Quarter 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 Delaware over the most recent three years (overall average equals 1% or more.) Participation is re-evaluated every three years. Questions regarding participation/eligibility of a carrier should be addressed to the DCRB.

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. The carrier group is identified based on NAIC group code.

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 DCRB
(b) Authorizing their vendor business partners (TPAs, Medical Bill Review Vendors, etc.) to report the data directly to DCRB

Regardless of who submits the Call to the DCRB, 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, timeliness and quality 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 required to report the Call as part of that carrier/group. DCRB will provide lead time for the acquired carrier/group to begin reporting the Call.

Example:

Mergers and Acquisition Scenarios

If. . .	And. . .	Then. . .
Carrier A currently reports the Call	Merges with Carrier B, that does not report the Call	Carrier A will continue to report the Call; Carrier B will be provided lead time to report the Call
Carrier A does not currently report the Call	Merges with Carrier B, that currently reports the Call	Carrier B will continue to report the Call; Carrier A will be provided lead time to report the Call
Carrier A currently reports the Call	Merges with Carrier B, that currently reports the Call	Both Carrier A and Carrier B will 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 will 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

All medical transactions that occur within a specific quarter, based on the Transaction Date, must be reported by the end of the following quarter. DCRB accepts monthly or quarterly submissions. -- 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 December 31).

Quarterly: One submission is reported by the end of the following quarter (example: 3rd quarter is due by December 31) but can be reported as early as October.

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 2010
A medical transaction occurs in July 2010 for a claim whose accident date is August 1980. The medical transaction would have been reported with the 3rd quarter 2010 submission. No further reporting of medical transactions for this claim is expected. Medical transactions greater than 30 years may be reported but are not required.

Example: Reporting duration for claim with an accident date on or after 3rd quarter 2010
A medical transaction occurs in August 2010 for a claim whose accident date is July 2010. The medical transaction is initially reported with the 3rd quarter 2010 submission. All subsequent transactions for this

claim are reported through July 1, 2040. 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 DCRB through Compensation Data Exchange (CDX).

CDX provides a common platform for insurance carriers and data collection organizations (CDX Members) to exchange data that conforms to the industry approved WCIO format. 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 CDX or individual DCOs. These guidelines may be accessed through the CDX web site at www.cdxworkcomp.org. CDX 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 a UMG primary administrator and currently submits policy data or statistical reporting data to DCRB 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.cdxworkcomp.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 Farragut Systems
2775 Meridian Pkwy
Durham, NC 27713

E-mail: CDXCentralSupport@farragut.com
Fax: 919-572-0783

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 DCRB requires the CDX permission(s) to be handled through the TPA Request function within CDX. It will take 2 to 3 business days for CDX 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 of the data submitter to notify the carriers' UMG Primary Administrator immediately in order to restrict a user from having access to CDX.

G. Business Exclusion Option

It is expected that 100% of medical transactions from workers compensation claims in the state of Delaware will be reported in the Medical Data Call. The DCRB 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 Delaware 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 DCRB 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.)

DCRB annually reviews previously filed exclusion requests to determine if a re-examination 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 DCRB's Medical Data Reporting Department to submit documentation describing these circumstances. The DCRB 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 DCRB for review. The requests can be submitted to the DCRB 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.
(c) 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 an example of premium determination.
(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 DCRB.

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 Entities for Proposed Exclusion	Column B Entities' Calendar Year Written Premium	Column C Carrier Group Calendar Year Written Premium	Column D 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 Delaware 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 Delaware premium proposed to be excluded.
3. Determine the 2012 Calendar Year Direct Premiums Written in Delaware—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—Affiliate 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 Delaware. 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%
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 Delaware is $1,000,000
- Large Deductible Direct Premium to be excluded for Delaware is $20,000
- Non-Large Deductible Direct Premium to be excluded for Delaware is $40,000

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

1. 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 affiliate 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 Delaware.

Premium Verification Worksheet – Method 3			
Item	**Description**	**Formula**	**Amount**
	NAIC Direct Written Premium:		
A	Total including Large Deductible		
B	Large Deductible		
C	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 (D + E)	
G	Add-on for Large Deductible business	4 times B (4 x B)	
H	Estimated Total	Sum of A and G (A + G)	
I	Ratio	F divided by H (F / H)	

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 Delaware is $1,000,000
- Large Deductible Direct Premium for Delaware is $300,000
- Large Deductible Direct Premium to be excluded for Delaware is $20,000
- Non-Large Deductible Direct Premium to be excluded for Delaware is $40,000

Premium Verification Worksheet – Method 3			
Item	**Description**	**Formula**	**Amount**
	NAIC Direct Written Premium:		
A	Total including Large Deductible		1,000,000
B	Large Deductible		300,000
C	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 (D + E)	140,000
G	Add-on for Large Deductible business	4 times B (4 x B)	1,200,000
H	Estimated Total	Sum of A and G (A + G)	2,200,000
I	Ratio	F divided by H (F / H)	6.4%

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 Unit Statistical premium data, gross of deductible, as reported in the Premium Amount field of the Exposure Record for the most recent 12 months of reported data. 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 Delaware or Federal Act.

Example: Premium determination (Method 4)
A participant needs to exclude business for two subsidiaries that represent 1% of total gross premium. The participant determines the exclusion on July 1, 2018, utilizing gross premium to determine the percentage of excluded premium.

Column A Entities for Proposed Exclusion	Column B Entities' Gross Premium	Column C Affiliate Group Gross Premium	Column D Entities' Gross Premium as % of Affiliate 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 affiliate group determines the gross premiums for Delaware 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 premium proposed to be excluded.
3. Determine the 2017 workers compensation gross premiums for the entire affiliate group for Delaware or Federal Act. This information is entered on the Total line in Column C.
4. Calculate the percentage 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 4 and submission instructions.

3. Other Premium Determination Methods

Contact the DCRB 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

- 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

Key fields that are reported in other data types (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier) must be reported consistently within the Medical Data Call as well as across data types (i.e. Unit Statistical data). Correctly reporting the key fields ensures the accurate linking and unique identification of claims. Accurate linking of claims across data types enables DCRB to use data elements for the same claim, across data types, thereby reducing the number of elements that would be duplicated.

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.

SECTION III – RECORD LAYOUTS

A. Overview

In order for the DCRB 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	H	Payer
2	**Policy Number Identifier***	AN	6-23	18	H	CMS 11
3	**Policy Effective Date***	N	24–31	8	H	Payer
4	**Claim Number Identifier ***	AN	32–43	12	H	Payer
5	**Transaction Code**	N	44–45	2	D	Payer
6	**Jurisdiction State Code**	N	46–47	2	H	Payer
7	**Claimant Gender Code**	AN	48	1	H	CMS 3 UB 11
8	**Birth Year**	N	49–52	4	H	CMS 3 UB 10
9	**Accident Date**	N	53–60	8	H	CMS 14
10	**Transaction Date**	N	61–68	8	D	Payer
11	**Bill Identification Number ***	AN	69–98	30	H	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	H	CMS 18 UB 6
15	**Service To Date**	N	145–152	8	H	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**	AN	178–185	8	D	CMS 24D UB 44 or Payer
	First Paid Procedure Code Modifier		(178-181)	(4)		
	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 21A (D) UB 67 (H)

21	**Secondary ICD -- Diagnostic Code**	AN	222–235	14	H/D	CMS 21B (D) UB 67 A (H)
22	**Provider Taxonomy Code**	AN	236-255	20	H	Provider or Payer
23	**Provider Identification Number**	AN	256–270	15	H	CMS 33A UB 56
24	**Provider Postal (ZIP) Code**	AN	271–273	3	H	CMS 32 UB 1
25	**Network Service Code**	A	274	1	H	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	H	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.
****** Refer to Place of Service Crosswalk in the **Appendix**.

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. File Control Record

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

File Control Record Layout				
Field No.	**Field Title/ Description**	**Class**	**Position**	**Bytes**
1	**Record Type** Report "SUBCTRLREC" One File 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

4	**Reporting Quarter Code *** 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	N	17	1
5	**Reporting Year *** Report the year that corresponds to the year when the medical transactions being reported occurred. Format: YYYY	N	18-21	4
6	**Submission File Identifier *†** Report the unique identifier created by the data provider to 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.	AN	22-51	30
7	**Submission Date **** Report the date the file was generated. Format: YYYYMMDD	N	52-59	8
8	**Submission Time **** Report the time the file was generated in military time. Format: HHMMSS (HH = Hours, MM = Minutes, SS = Seconds)	N	60-65	6
9	**Record Total** Report the total number of records in the file, **excluding** the File 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	N	66-76	11
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.

† Valid characters in the file name include 0 through 9, A through Z, dash '-', underscore '_', or period '.'.

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

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 Requirement:	Report the date the claimant was injured. The Accident Date must be the same as or after 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 Requirement:	Report the total amount per line that was billed by the service provider for the applicable line. 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

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 bytes.
Definition:	A unique number assigned to each bill by the administering entity.
Reporting Requirement:	Report the unique number assigned to the bill that corresponds to this transaction.

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 Requirement:	Report the year the claimant was born. The Birth Year must be before Accident Date (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 Requirement:	Report the 5-digit NCCI assigned Carrier Code. Do not report the NCCI Group ID or NAIC 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 Requirement:	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 reported for this claim**. 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. The Claim Number Identifier can neither be all zeros nor all blanks nor a combination of zeros and blanks.

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.
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, Data field is to be right justified and left zero-filled.
Definition: The code that corresponds to the governing jurisdiction that would administer the claim and whose statutes will apply to the claim adjustment process.
Reporting Requirement: Report the code that corresponds to the state under whose Workers Compensation Act or Employers Liability Act the claimant's benefits are being paid or Federal Act (Jurisdiction State Code 59.) Report the code the corresponds to the state workers compensation law, the employers liability law, or the federal law under which the claimant's benefits are being paid.

Jurisdiction	State Code
Delaware	07
Federal Act (USL&HW)	59

Note: When the jurisdiction state is Delaware, 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 Delaware Workers Compensation system established by law in Title 19 of the Delaware Code. 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 Requirement: Report the unique number assigned to the line associated with the Bill Identification Number (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 Requirement: Report the code that indicates whether the service is provided through a provider network regardless of whether a network discount was applied.

Code	Description
B	Pharmacy Benefit Manager
H	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
P	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

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 Requirement: Report the Paid Procedure Code from the jurisdiction-approved code table (refer to the 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.

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 field (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, DRG, or NDC, --, or DRG.)

The Delaware Workers' Compensation Health Care Payment System guidelines state that:

> "…if a prescription drug or medicine has been repackaged, the Average Wholesale Price used to determine the maximum reimbursement in controverted and uncontroverted cases shall be the Average Wholesale Price for the underlying drug product, as identified by its national drug code, from the original labeler.

Based on this guideline, 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

		• 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**
Drug Dispensing Fees	n/a	• No separate transactional reporting of drug dispensing fees is required in Delaware. Refer to the Reporting Rules section for further information.
Compound Drugs	11	• In Delaware, compound drugs shall be billed by listing each drug included in the compound and separately calculating the charge for each drug, using national drug codes (NDC). When compounding, a single compounding fee of ten dollars ($10.00) per prescription shall be added to the calculated total. **OR** • Report as HCPCS code J7999 (Compounded drug, not otherwise classified) in the Paid Procedure Code field with all the ingredients rolled up • Left justify and blank-fill Positions 164-177
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 Delaware, the DRG code version is the CMS (Medicare) MS-DRG code.
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 – 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 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 DCRB.

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 blank-filled to the right of the last number or character when the Second Paid Procedure Code 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 Requirement: Report the Paid Procedure Code Modifier(s) related to the Paid Procedure Code (Positions 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: 8
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 DCRB.

Definition: A code that indicates where the medical service was performed.
Reporting Requirement: Report the Place of Service Code from the Place of Service list that indicates where the medical service was performed. **Do not report Place of Service Code 99 (Other Place of 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	Telehealth	34	Hospice
03	School	35-40	Unassigned – Not valid for DE
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 DE
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 DE	52	Psychiatric Facility-Partial Hospitalization
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 DE
17	Walk-In Retail Health Clinic	60	Mass Immunization Center
18	Place of Employment - Worksite	61	Comprehensive Inpatient Rehabilitation Facility
19	Off-Campus Outpatient Hospital	62	Comprehensive Outpatient Rehabilitation Facility
20	Urgent Care Facility	63-64	Unassigned – Not valid for DE
21	Inpatient Hospital	65	End-Stage Renal Disease Treatment Facility
22	On-Campus Outpatient Hospital	66-70	Unassigned – Not valid for DE
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 DE
26	Military Treatment Facility	81	Independent Laboratory
27-30	Unassigned – Not valid for DE	82-98	Unassigned – Not valid for DE
31	Skilled Nursing Facility	99	Other Place of Service
32	Nursing Facility	DS	Dispensary**

* 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.

**This is an NCCI-assigned value. CMS does not currently have a code for dispensary.

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 Requirement: Report the effective date that corresponds to the date shown on the policy Information Page or 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 Requirement: Report the unique set of numbers and/or letters that identify the policy under which the claim occurred.

Policy Number Identifier must match the Unit Statistical data Policy Number Identifier, reported for this claim, including any prefixes or suffixes. The Policy Number Identifier can neither be all zeros nor all blanks nor a combination or zeros and blanks.

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

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: A code that identifies the primary diagnosis associated with the medical service rendered.
Reporting Requirement: 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: DCRB accepts both ICD-9 and ICD-10 codes in this field as of January 1, 2014.

Note: DCRB 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
Bytes: 15
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.
Reporting Requirement: Report the number that uniquely identifies the medical/service provider (i.e., National Provider Identification Number, state-required number, Federal Employer Identification Number, or unique carrier coding scheme) that billed for the service. The National Provider Identification Number is the preferred code to be reported, when applicable. 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: 3
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: DCRB 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: 20
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 Requirement: Report the taxonomy code that identifies the type of provider that billed for and is being paid for 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. DCRB 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: 7
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.
Definition: The number of units of service performed or the quantity of drugs dispensed.
Reporting Requirement: Report the number of units of service performed or the quantity of drugs dispensed that are related to the Paid Procedure Code. (Positions 153-177). Use the base quantity specified by 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 are 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
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 Secondary 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: A code that identifies the secondary diagnosis associated with the medical service rendered.
Reporting Requirement: 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: DCRB will accept both ICD-9 and ICD-10 codes in this field as of January 1, 2014.

Note: DCRB 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 a secondary procedure related to the Paid Amount (Positions 197-207).

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

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 Delaware Workers' Compensation Health Care Payment System guidelines state that:

> "…if a prescription drug or medicine has been repackaged, the Average Wholesale Price used to determine the maximum reimbursement in controverted and uncontroverted cases shall be the Average Wholesale Price for the underlying drug product, as identified by its national drug code, from the original labeler.

Based on this guideline, 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 • 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 Delaware, the DRG code version is the CMS (Medicare) MS-DRG code.
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**

* 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 DCRB.

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 Requirement: Report the date the service related to Line Identification Number (Positions 99-129) was 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 Requirement: Use this field for the starting date of service if an inpatient 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.

Service To Date

Field No.: 15
Position(s): 145-152
Class: Numeric (N) – Field contains only numeric characters
Bytes: 8
Format: YYYYMMDD
Definition: The date when services were terminated.
Reporting Requirement: Use this field for the ending date of service if an inpatient 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 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
Position(s): 44-45
Class: Numeric (N) – Field contains only numeric characters
Bytes: 2
Format: N 2, Data field is to be right justified and left zero-filled.
Definition: A code that identifies the type of transaction that the record represents.
Reporting Requirement: Report the code that identifies the type of transaction of the record being submitted.

Code	Description
01	Original – the initial report of the record to the DCRB. 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 DCRB'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: 8
Format: YYYYMMDD
Definition: The date the information in the transaction was processed as established by the original

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 Requirement: Report the date corresponding to the Transaction Code (Positions 44-45) of the record being 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 DCRB 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 DCRB with its 2nd Quarter submission on 07/01/2008. The Transaction Date for this replacement record is 05/01/2008 (reported as 20080501).

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 DCRB 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 DCRB 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 DCRB 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 DCRB'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 DCRB'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
A	99990	0006	01	20071210	1001	1	20071203	00000010000	00000010000	0000001
B	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
A	99990	1000	01	20071210	1001	1	20071203	00000010000	00000010000	0000001
B	99990	1000	02	20071217	1001	1	20071203	00000010000	00000010000	0000001
C	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
A	99990	0001	01	20071210	1001	1	20071203	00000009999	00000008999	0000001
B	99990	0001	03	20071217	1001	1	20071203	00000009999	00000009999	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
A	99990	0001	01	20071210	1001	1	20071203	00000010000	00000010000	0000001
B	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.

4. 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.
(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 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.

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
A	99990	0001	01	20071210	1001	1	20071203	00000010000	00000000000	0000001
B	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 File Control Record (Record Type - SUBCTRLREC). For record layout and data element details, refer to File Control Record in the **Record Layouts** section of this manual.

Note: A Replacement (R) file received by the DCRB 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. DCRB will not accept a replacement file submitted on or after 01/01/2015.

1. Deleting Files

To delete an entire file from the DCRB's database, submit a File Control Record with no other records in the file. The File 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 File Control Record in the count*)
10	Reserved for Future Use	

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

2. Replacing Files

To replace an entire file that was previously submitted in error, submit a new file with a File 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 20121209 (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 File 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 DCRB 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. The DCRB 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, **data submitters are responsible for filtering out duplicates before sending data to the DCRB.**

The DCRB will review submissions for records with the same key fields (Carrier Code, 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 DCRB will keep the record with the latest Transaction Date. If the Transaction Date is also the same, the DCRB 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 DCRB. 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 DCRB. 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 DCRB'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	00000007500	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 DCRB's database):

Claim Number	Transaction Code	Bill ID	Line ID	Paid Procedure Code	Amount Charged	Quantity/ Number of Units
12345	01	201	1	99201	00000007500	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	00000007500	0000001
12345	02	101	1	99201	00000007500	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 DCRB. 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. When reporting to the DCRB, include

these fees combined along with the cost of the medication or supply.

Add the dispensing fee to the Amount Charged and Paid Amount in the record for the item dispensed --. For example, if a pharmacy charges $50 for a medication, with an additional $1 dispensing fee, one record with an Amount Charged of $51 would be reported.

There is no separate reporting of dispensing fees in Delaware.

Prescribed drugs are capped at the lesser of the provider's usual charge; a negotiated contract amount; or the Average Wholesale Price (AWP) for the National Drug Code (NDC) for the prescription drug or medicine on the day it was dispensed minus a percentage reduction set by the Workers' Compensation Oversight Panel plus a dispensing fee set by the Workers' Compensation Oversight Panel for brand-name drugs or medicines and generic drugs or medicines.

The Workers' Compensation Oversight Panel shall be authorized to set different percent reductions and dispensing fees for brand drugs or medicines and generic drugs or medicines. Absent a contract, which is governed by 19 Del.C. §2322B(4), the actual charge is the maximum allowed, if it is less than the amount specified in the regulation.

Physicians dispensing drugs from their office do not receive the dispensing fee referenced above.

F. Per Diem Hospital Charges

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

The Delaware Workers' Compensation Health Care Payment System 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 NCCI's proprietary code "PER-DIEM" in the Paid Procedure Code field. Data submitters may report supporting codes, if any, in the Secondary Procedure Code field. Refer to Part IV – Data Dictionary for reporting specifications.

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 Delaware 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

Line Identification Number	Service From Date	Service To Date	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	00000000000
3	20130604	20130606	508	0270	00000147265	00000000000
4	20130604	20130606	508	0360	00000551900	00000000000
5	20130604	20130606	508	0370	00000345900	00000000000
6	20130604	20130606	508	0710	00000133800	00000000000

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

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	00000000000
3	20130604	20130606	0270		00000147265	00000000000
4	20130604	20130606	0360		00000551900	00000000000
5	20130604	20130606	0370		00000345900	00000000000
6	20130604	20130606	0710		00000133800	00000000000

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

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	00000000000
3	20130604	508	0270	00000147265	00000000000
4	20130604	508	0360	00000551900	00000000000
5	20130604	508	0370	00000345900	00000000000
6	20130604	508	0710	00000133800	00000000000
7	20130605	508	0111	00000043046	00000156124
8	20130605	508	0250	00000051027	00000000000
9	20130606	508	0111	00000043046	00000156124
10	20130606	508	0250	00000027475	00000000000

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 Number	Service Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130604	0111		00000043046	00000156124
2	20130604	0250		00000117753	00000000000
3	20130604	0270		00000147265	00000000000
4	20130604	0360		00000551900	00000000000
5	20130604	0370		00000345900	00000000000
6	20130604	0710		00000133800	00000000000
7	20130605	0111		00000043046	00000156124
8	20130605	0250		00000051027	00000000000
9	20130606	0111		00000043046	00000156124
10	20130606	0250		00000027475	00000000000

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 Number	Service From Date	Service To Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130118	20120120	460	0110	00000130000	00001541298
2	20130118	20120120	460	0250	00000427703	00000000000
3	20130118	20120120	460	0270	00000025700	00000000000
4	20130118	20120120	460	0271	00000042500	00000000000
5	20130118	20120120	460	0272	00000151900	00000000000
6[1]	20130118	20120120	0278		00004415600	00001388978
7	20130118	20120120	460	0300	00000002000	00000000000
8	20130118	20120120	460	0305	00000003000	00000000000
9	20130118	20120120	460	0360	00001580000	00000000000
10	20130118	20120120	460	0370	00000069200	00000000000
11	20130118	20120120	460	0710	00000050000	00000000000

[1]Line 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
2	20130118	20120120	0250		00000427703	00000000000
3	20130118	20120120	0270		00000025700	00000000000
4	20130118	20120120	0271		00000042500	00000000000
5	20130118	20120120	0272		00000151900	00000000000
6[2]	20130118	20120120	0278		00004415600	00001388978
7	20130118	20120120	0300		00000002000	00000000000
8	20130118	20120120	0305		00000003000	00000000000
9	20130118	20120120	0360		00001580000	00000000000
10	20130118	20120120	0370		00000069200	00000000000

11	20130118	20120120	0710		00000050000	00000000000

[2]Line 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 DS—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.

Medical Marijuana – Reimbursement to Claimant

When an injured worker is provided with a prescription for medical marijuana that is reimbursed to the injured worker, it is reported with Paid Procedure Code MM001, Naturopath as the Taxonomy Code, and Dispensary as the Place of Service Code; and the Date of Service should be reported as a single Service Date. The Quantity Number of Units field should be populated with the number of grams dispensed.

Example: Correct Reporting – Medical Marijuana – Reimbursement to Claimant

Bill Identification Number	Line Identification Number	Paid Procedure Code	Taxonomy Code	Place of Service Code
1001	1	MM001	175F00000X	DS

Medical Marijuana – Reimbursement to Dispensary

When an injured worker is provided with a prescription for medical marijuana that is reimbursed to a dispensary, it is reported with Paid Procedure Code MM002, Naturopath as the Taxonomy Code, and Dispensary as the Place of Service Code; and the Date of Service should be reported as a single Service Date. The Quantity Number of Units field should be populated with the number of grams dispensed.

Example: Correct Reporting – Medical Marijuana – Reimbursement to Dispensary

Bill Identification Number	Line Identification Number	Paid Procedure Code	Taxonomy Code	Place of Service Code
2001	1	MM002	175F00000X	DS

SECTION VI – EDITING AND OTHER VALIDATION PROCEDURES

A. Editing Process

The DCRB'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:

The editing process will evaluate each data element within a file for completeness, validity, and reasonableness. Once all the files have been received, the total number of records that fail per data element will be compared to predetermined error tolerance levels for the complete quarterly data. Error 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 – File Control Record – Indicates that the File 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:

Field No.	Data Element	Tolerance/Edit
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 File 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 DCRB's database

2. File Acceptance

Every Medical Data Call file received by the DCRB 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 DCRB 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 File Control Record, there is only one File Control Record per file, and the File 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 DCRB Carrier Code.
- Relational edits check for acceptable relationships between elements on different records, either within the submission or on the DCRB'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 DCRB'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 DCRB 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 DCRB to process the file	Reject file
Field (required fields)	Ensures complete and valid entry	Greater than tolerance = Reject file Below tolerance = Return record
Relational (required fields)	Determines if the relationship between fields in different records is acceptable	Return record

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 DCRB's database. For example, if an Original record (Transaction Code 01) already resides on the DCRB'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 section 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, and aggregate 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.

In addition, Quality Validation results for certain edits are communicated at the file level and aggregate level. Validation results show occurrences and thresholds for the applicable edits.

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

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

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 DCRB 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 expected values (including the corresponding data elements) and as distribution graphs.

The DCRB 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 DCRB's database. This online edit matrix is the most comprehensive resource for information on the DCRB'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 DCRB's website, *www.dcrb.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

A. Definitions of Terms

Adjustment A change to the paid amount on a previously reported *record*. Adjustments do not include changes due to data reporting errors.

Administering Entity The *insurance carrier*, *Third Party Administrator*, bill review vendor, or other entity that receives the *bill* from a medical *service provider* and that pays for the medical transaction.

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Ambulatory Surgical Center (ASC) A state-licensed facility that is used mainly to perform outpatient surgery, has a staff of 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*.

ASCII (American Standard Code for Information Interchange) standard code for representing 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 DCRB'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.

Count Occurrences	A mechanism for tracking record level edits that pass or fail. During File Acceptance 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*.
Data Element	The smallest unit of physical data for which attributes are defined.
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 DCRB. 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 paying 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 Provider	Any unique data reporting entity that is certified to send Medical Call data to the DCRB. 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.*
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 DCRB.
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.
Special Characters	Refers to the additional characters other than letters A–Z and numbers 0–9.
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 DCRB 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.

Third Party Administrator (TPA)	An organization hired to perform one or more of the business functions of another company, which may include reporting insurance data to the *statistical agent*.
TPA	See *Third Party Administrator*.
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 DCRB 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 ***Delaware 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 state-specific 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 1 - 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 DCRB 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:

1. 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.

   Note: If the methods described are not appropriate for determining the exclusion percentage, contact the DCRB 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 Delaware Compensation Rating Bureau, Inc., United Plaza

Building, Suite 1500, 30 S. 17th Street, Philadelphia, PA 19103 or emailed to medicalcall@dcrb.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 Delaware 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 Entities for Proposed Exclusion	Column B Entities' Calendar Year Written Premium	Column C Carrier Group Calendar Year Written Premium	Column D 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 Delaware.
2. In Column B, enter the Calendar Year Written Premium for Delaware 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 Delaware (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. 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 Delaware 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:		
A	Total		
B	Large Deductible to be excluded		
C	Non-Large Deductible to be excluded		
	Estimated Gross Premium:		
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.
2. 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 Delaware 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:		
A	Total including Large Deductible		
B	Large Deductible		
C	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 (D + E)	
G	Add-on for Large Deductible business	4 times B (4 x B)	
H	Estimated Total	Sum of A and G (A + G)	
I	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.

7. Worksheet – Method 4

Use this worksheet to determine if proposed exclusions are less than or equal to 15% of the group's total gross premium when using Premium Determination Method 4. This method uses the gross (of deductible) premium in Unit Statistical data (reported in the Premium 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 Delaware or Federal Act.

Column A Entities for Proposed Exclusion	Column B Entities' Gross Premium	Column C Affiliate Group Gross Premium	Column D Entities' Gross Premium as % of Affiliate Group (Col. B / Col. C)
TOTAL			

8. Worksheet Instructions – Method 4

1. In Column A, list the entities excluded from the Affiliate Group.
2. In Column B, enter the gross (of deductible) premium for Delaware or Federal Act 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 Affiliate Group's gross premium for Delaware or Federal Act as applicable.
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%.

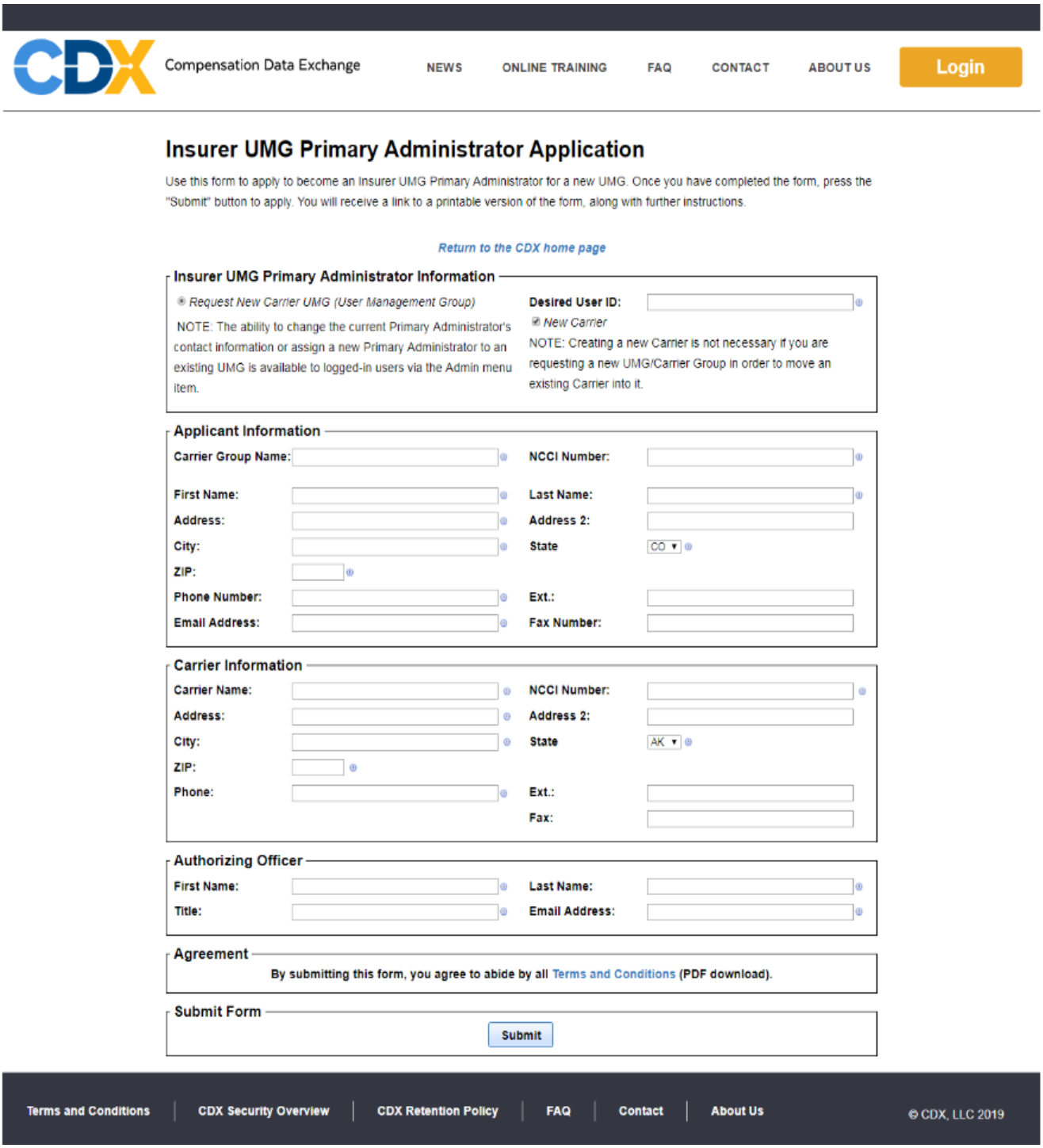
D. Compensation Data Exchange (CDX) Information

CDX is a service of Compensation Data Exchange, LLC which is owned by the following data collection organization members. --

- 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.cdxworkcomp.org to complete this application.



Compensation Data Exchange

NEWS ONLINE TRAINING FAQ CONTACT ABOUT US Login

Insurer UMG Primary Administrator Application

Use this form to apply to become an Insurer UMG Primary Administrator for a new UMG. 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.

Return to the CDX home page

Insurer UMG Primary Administrator Information

Request New Carrier UMG (User Management Group)

NOTE: The ability to change the current Primary Administrator's contact information or assign a new Primary Administrator to an existing UMG is available to logged-in users via the Admin menu item.

Desired User ID:

New Carrier

NOTE: Creating a new Carrier is not necessary if you are requesting a new UMG/Carrier Group in order to move an existing Carrier into it.

Applicant Information

Carrier Group Name: **NCCI Number:**
First Name: **Last Name:**
Address: **Address 2:**
City: **State** CO
ZIP:
Phone Number: **Ext.:**
Email Address: **Fax Number:**

Carrier Information

Carrier Name: **NCCI Number:**
Address: **Address 2:**
City: **State** AK
ZIP:
Phone: **Ext.:**
Fax:

Authorizing Officer

First Name: **Last Name:**
Title: **Email Address:**

Agreement

By submitting this form, you agree to abide by all Terms and Conditions (PDF download).

Submit Form

Submit

Terms and Conditions | CDX Security Overview | CDX Retention Policy | FAQ | Contact | About Us © CDX, LLC 2019

NCCI Medical Data Call
Place of Service Crosswalk

The Place of Service Crosswalk is intended for reporting facility and hospital services that are using Form CMS-1450, which does not contain a Place of Service Code field. With the crosswalk, the Type of Bill on Form CMS-1450 can be mapped to the Place of Service Code on the Medical Data Call, as shown in the following chart.

The Type of Bill, located in Field 4 of the National Uniform Billing Committee (NUBC)-approved UB-04 Claim Form CMS-1450, is a three-digit code (without a leading zero). Each digit defines a different aspect of the medical bill: Type of Facility, Bill Classification, and Frequency of the Bill.

Some providers report the Type of Bill 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.

For more details, refer to the Chart Key directly beneath 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 Code[1]	Place of Service Description
11X	Hospital	Inpatient	21	Inpatient Hospital
12X	Hospital	Inpatient	21	Inpatient Hospital
13X	Hospital	Outpatient	22/19[2]	On-Campus/Off-Campus Outpatient Hospital
14X	Hospital	Other	22/19[2]	On-Campus/Off-Campus 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	22/19[2]	On-Campus/Off-Campus 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/Mental 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 August 2016

NCCI Medical Data Call
Place of Service Crosswalk

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 Code[1]**	**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	22/19[2]	On-Campus/Off-Campus Outpatient Hospital

[1] Source: Centers for Medicare and Medicaid Services (www.cms.hhs.gov)

[2] Place of Service Code 22 should be reported only when the type of outpatient hospital facility is not known or not available

Note: Place of Service Code 23—Emergency Room should be reported when the Paid Procedure Code reported in Field 42 (on Form CMS-1450) is equal to Revenue Codes 0450 through 0459, or 0981.

Chart Key for Place of Service Crosswalk	
Type of Bill	Located in Field 4 of the NUBC-approved UB-04 claim form, also known as Form CMS-1450.
Type of Bill Code (1st Position)	Identifies the Type of Facility that provided the medical services. The following are two examples: • For Type of Bill 11X, the 1 in position 1 represents services provided at a Hospital • For Type of Bill 21X, the 2 in position 1 represents services provided at a Skilled Nursing facility
Type of Bill Code (2nd Position)	Identifies the Bill Classification. The following are two examples: • For Type of Bill 11X, the 1 in position 2 represents Inpatient Services • For Type of Bill 13X, the 3 in position 2 represents Outpatient Services
Type of Bill Code (3rd 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.

NCCI Place of Service Crosswalk
Revised August 2016