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DELAWARE COMPENSATION RATING BUREAU, INC.

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MEDICAL DATA CALL MANUAL

A. Overview

The information contained in this Medical Data Call Manual represents the final phase in the two-phase roll out of the reporting guidelines for the Call. This Medical Data Call Manual replaces all previously released Medical Data Call Implementation Guides and transitions to a web-based manual located on the Bureau's website at www.dcrb.com.

B. Medical Data Call Background

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 represent over 55 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 on NCCI states and is being 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 Contacts

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

Mail:
Medical Data Reporting Department
Delaware Compensation Rating Bureau, Inc.
United Plaza Building – Suite 1500
30 South 17th Street
Philadelphia, PA 19103-4007

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

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SECTION I – GENERAL RULES

A. Scope and Effective Date

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., United Plaza Building, Suite 1500, 30 S. 17th Street, Philadelphia, PA 19103.

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

B. General

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C. Participation / Eligibility

Participation will be 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.)

1. Carrier Group Participation

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

2. Reporting Responsibility

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

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

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

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

D. Reporting Frequency

The Medical Data Call will begin on a mandatory basis with medical transactions occurring in 3rd quarter 2010. Data will be due by the close of the following quarter. The Bureau will also accept monthly submissions with partial quarter's data beginning in 3rd quarter 2010. Below are examples of monthly and quarterly submission schedules:

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

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

1. Duration of Reporting

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

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

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

E. Data Submission Procedures

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

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

Before data submitters can send Medical Data Call production files using **CDX,** a completed Insurance Group Administrator (IGA) Application for each submitter must be on file, and each submitter's electronic data submissions must pass Certification Testing. Refer to the **Insurance Group Administrator (IGA) Application** section of this manual for details and the **Appendix** of this manual for a copy of the form.

If a carrier group has already established an IGA and currently submits policy data or statistical reporting data to Bureau via CDX, a carrier does not need to submit an additional IGA application to submit Medical Data Call transactions.

F. Insurance Group Administrator (IGA) Application

Each applicant is required to designate an Insurance Group Administrator (IGA) for the entire Group. The IGA 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.

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1. IGA Application Instructions

The IGA Application form must be filled out in its entirety and signed both by the IGA and an Authorizing Officer of the Applicant who shall be fully authorized to bind the Applicant to the Terms and Conditions of Use of the CDX site.

2. Submission of Application

The application can be mailed, faxed or scanned and e-mailed to the CDX Central Administrator at CDX Central Support, c/o Axispoint, 350 Madison Ave., 4th floor, New York, NY 10017; Fax: 212-944-5489; E-mail: cdxcentralsupport@axispoint.com. If a method other than mailing is used, a signed original must also be mailed to the CDX Central Administrator.

Once the account has been created, the Applicant's IGA will receive an e-mail notifying the IGA that an account has been established and informing the Applicant's IGA of its temporary password. A copy of this e-mail, without the password, will be sent to the Applicant's Authorized 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 Bureau requires the CDX permission(s) to be handled through the standard TPA user setup within CDX. This means if you have vendors that report, you must have them set-up by your Carrier Administrator (CA) on your CDX account.

4. User Request Changes

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

G. Business Exclusions Options

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 Bureau does recognize that in certain limited circumstances this 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 Bureau 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, etc.)

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

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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 Bureau's Medical Data Reporting Department to submit documentation describing these circumstances. The Bureau 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 Bureau for review. The requests can be submitted to the Bureau 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 Method 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.

2. Method 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 Bureau.

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.

Here are the 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, 2008 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%**

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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 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 2007 Calendar Year Direct Premiums Written in Delaware—the participant finds this information on Schedule T of its 2007 NAIC Annual Statement (due on April 1, 2008). 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.

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. 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	
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%

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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 20% 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

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.

Gross Premium Estimation Worksheet			
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)	

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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 Estimation Worksheet

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 Estimation Worksheet
3. Calculate Items E through I of the Premium Estimation 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

Method 4—Use the gross (of deductible) premium in Unit Statistical Plan 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 the state of Delaware.

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3. Other Premium Determination Methods

Contact the Bureau 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; the participant writes a significant number of large deductible policies).

4. Business Exclusion Request Form

For your convenience, a Business Exclusion Request Form is provided in the **Appendix** of this manual.

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SECTION II – MEDICAL DATA CALL STRUCTURE

A. General

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

B. Bill Header Data Elements

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

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

Bill Header data elements include:

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

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

C. Bill Detail Data Elements

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

Bill Detail data elements include:

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

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- Primary ICD-9 Diagnostic Code
- Secondary ICD-9 Diagnostic Code
- Quantity/Number of Units per Procedure Code
- Secondary Procedure Code

Note: Some detail data elements, such as ICD-9 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
- Claim Number Identifier
- Bill Identification Number
- Line Identification Number

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

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SECTION III – RECORD LAYOUTS

A. Overview

In order for the Bureau 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 quick 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	
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-9 Diagnostic Code**	AN	208–221	14	H/D	CMS 21-1 (D) UB 67 (H)

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21	**Secondary ICD-9 Diagnostic Code**	AN	222–235	14	H/D	CMS 21-2 (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
28	**Secondary Procedure Code**	AN	290–314	25	D	UB 42
29	**Reserved for Future Use**		315–350	36		

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

Source Notes:

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

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

Provider: Data is not on a form; it is provided by the healthcare provider.

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

C. Submission Control Record

One, and only one, Submission Control Record is required for each file submitted. The Submission Control Record does not need to be placed at the beginning or at the end of the file.

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

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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 Submission Control Record. **Note:** Blank rows will be removed during processing and not counted. If blank rows are included in the Record Total, the file will appear out of balance and reject. Format: N 11, this field must be right justified and left zero-filled	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.

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

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SECTION IV – DATA DICTIONARY

A. Overview

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

B. Data Dictionary

Accident Date

Field No.:	9
Position(s):	53-60
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD
Definition:	The date the claimant was injured.
Reporting 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

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Format:	A/N 30, exclude non-ASCII characters. This field must be left justified and contain blanks in all spaces to the right of the last character if the Bill Identification Number is less than 30 bytes.
Definition:	A unique number assigned to each bill by the payer.
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. For older claims where the claim number has changed since reporting the unit statistical data, report the Claim Number Identifier that identifies the claim in your system today. This number must be used consistently for all future reporting of the claim transactions.

Claimant Gender Code

Field No.:	7
Position(s):	48
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	1
Format:	A/N
Definition:	A code that corresponds to the claimant’s gender.

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Reporting Requirement: Report the code that corresponds to the claimant's gender. Leave blank or zero-fill 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
Definition: A code that corresponds to the state under whose Workers Compensation Act the claimant's benefits are being paid.
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.

Jurisdiction	State Code
Delaware	07

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 State Act. However, reimbursement for the medical service was determined under California medical billing requirements. Medical transactions for this claimant would be reportable under the Medical Data Call.

Line Identification Number

Field No.: 12
Position(s): 99-128
Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes: 30
Format: A/N 30, exclude non-ASCII characters. This field must be left justified and contain blanks in all spaces to the right of the last character if the Line Identification Number is less than 30 bytes.
Definition: A unique number that the administering entity assigns to each line associated with the Bill Identification Number (Positions 69-98)
Reporting 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 provider belongs to a provider network.
Reporting Requirement: Report the code that indicates whether the service provider belongs to a provider network regardless of whether a network discount was applied.

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Code	Description
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).

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If the bill reflects a procedure code other than the procedure code associated with the reimbursement, report the Paid Procedure code associated with the reimbursement in this field and the billed procedure code in the Secondary Procedure Code (Positions 290–314). Report an APC or DRG code as the Paid Procedure Code if it is the basis of the reimbursement; otherwise, report the CPT®, CDT, HCPCS, or NDC code.

For example, an ambulatory surgery center bills for a facility fee using a CPT® code. However, the reimbursement is determined by assigning an APC code. The APC code is reported as the Paid Procedure Code and the CPT® code is reported as the Secondary Procedure Code (Positions 290–314).

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, APC, or DRG).

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**

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APC-Ambulatory Payment Classification	4	• Numeric codes classify procedures into related groups for outpatient services • Left justify and blank-fill all spaces to the right of the last number • 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** • DRG Versions 25 and higher will be accepted
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 an APC or 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 Bureau.

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 or zero-fill.
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.

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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 Bureau.
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.

Place of Service*			
Code	**Description**	**Code**	**Description**
01	Pharmacy	34	Hospice
02	Unassigned – Not valid for DE	35-40	Unassigned – Not valid for DE
03	School	41	Ambulance-Land
04	Homeless Shelter	42	Ambulance-Air or Water
05	Indian Health Service-Free Standing Facility	43-48	Unassigned – Not valid for DE
06	Indian Health Service Provider-Based Facility	49	Independent Clinic
07	Tribal 638 Free-Standing Facility	50	Federally Qualified Health Center
08	Tribal 638 Provider-Based Facility	51	Inpatient Psychiatric Facility
09	Prison-Correctional Facility	52	Psychiatric Facility-Partial Hospitalization
10	Unassigned – Not valid for DE	53	Community Mental Health Center
11	Office	54	Intermediate Care Facility/Mentally Retarded
12	Home	55	Residential Substance Abuse Treatment Facility
13	Assisted Living Facility	56	Psychiatric Residential Treatment Center
14	Group Home	57	Non-Residential Substance Abuse Treatment Facility
15	Mobile Unit	58-59	Unassigned – Not valid for DE
16	Temporary Lodging	60	Mass Immunization Center
17-19	Unassigned – Not valid for DE	61	Comprehensive Inpatient Rehabilitation Facility
20	Urgent Care Facility	62	Comprehensive Outpatient Rehabilitation Facility
21	Inpatient Hospital	63-64	Unassigned – Not valid for DE
22	Outpatient Hospital	65	End-Stage Renal Disease Treatment Facility
23	Emergency Room-Hospital	66-70	Unassigned – Not valid for DE
24	Ambulatory Surgical Center	71	Public Health Clinic
25	Birthing Center	72	Rural Health Clinic
26	Military Treatment Facility	73-80	Unassigned – Not valid for DE
27-30	Unassigned – Not valid for DE	81	Independent Laboratory
31	Skilled Nursing Facility	82-98	Unassigned – Not valid for DE
32	Nursing Facility	99	Other Place of Service
33	Custodial Care Facility		

* Source: Centers for Medicare & Medicaid Services (www.cms.hhs.gov)

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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).

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, exclude punctuation marks, symbols, and special characters. This field must be left justified and contain blanks in all spaces to the right of the last character if the Policy Number Identifier is less than 18 bytes.
Definition: 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).
Reporting Requirement: 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).

Primary ICD-9 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-9 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_ _ _ _ _ _ _ _ _ _

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.
• 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.

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Reporting Requirement: Report the NCHS (National Center for Health Statistics) or CMS (Centers for Medicare & Medicaid Services) ICD-9 code that identifies the primary diagnosis associated with the medical service rendered. Refer to NCHS (www.cdc.gov/nchs/about/otheract/icd9/ abticd9.htm) or CMS (www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/) for the ICD-9 Diagnostic Code listing.

Note: The Bureau does ***not*** recognize 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., state-required number, unique carrier coding scheme, Federal Employer Identification Number, or National Provider Identification) that billed for the service. For example, if a line item of a hospital bill indicates that a Registered Physical Therapist provided therapy to a claimant as an employee of the hospital, report the hospital's Provider Identification Number.

Note: In cases where a billing house bills the payer, report the Provider Identification Number of the medical service provider for whom the billing house is submitting the bill.

A unique carrier coding scheme may be used in lieu of a state-required number when reporting to the Bureau. 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. If unavailable, report only the first three digits of the postal (ZIP) code of the provider's billing address.

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.

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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.

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.

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 [www.wpcedi.com/taxonomy])

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 is reported in minutes. For example, if 220 minutes of anesthesia was provided, report 0000220 in this field.

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Secondary ICD-9 Diagnostic Code

Field No.: 21
Position(s): 225-235
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-9 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_ _ _ _ _ _ _ _ _ _

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.
- 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-9 code that identifies the secondary diagnosis associated with the medical service rendered. Refer to NCHS (www.cdc.gov/nchs/about/otheract/icd9/abticd9.htm) or CMS (www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/) for the ICD-9 Diagnostic Code listing.

Note: The Bureau does not recognize code 999.9 (complication of medical care not elsewhere classified) as a valid code.

Leave blank or zero-fill 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).

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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.

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

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

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**
APC- Ambulatory Payment Classification	4	• Numeric codes classify procedures into related groups for outpatient services • Left justify and blank-fill all spaces to the right of the last number • 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** • DRG Versions 25 and higher will be accepted

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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 an APC or 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 Bureau.

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	0422	20080108	0000002
1001	2	0422	20080110	0000002
1001	3	0422	20080115	0000002
1001	4	0422	20080117	0000002

*For Paid Procedure Codes which specify each 15-minute segment as 1 unit, then 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.

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Reporting Requirement: Use this field for the starting date of service if an - in-patient hospital payment spanning multiple days was made and the specific service date (line item) detail is unavailable. In all other cases, zero-fill this field and report the date of service in Service Date (Positions 129–136).

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

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

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

This field is the 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).

Transaction Code

Field No.: 5
Position(s): 44-45
Class: Numeric (N) – Field contains only numeric characters
Bytes: 2
Format: N 2
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 Bureau. 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 Bureau's database before a Cancellation (02) or a Replacement (03) can be submitted.

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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 Bureau 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 Bureau with its 2nd Quarter submission on 07/01/2008. The Transaction Date for this replacement record is 05/01/2008 (reported as 20080501).

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SECTION V – REPORTING RULES

A. Original Reports

Medical Call data is the detailed line information of a bill, also referred to as a medical transaction, reported to the Bureau 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 Bureau 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 Bureau 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 Bureau'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 Bureau'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, 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, 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.

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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, 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.

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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, 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.

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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, 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. 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, submitters are responsible for filtering out duplicates before sending data to the Bureau.

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The Bureau 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 Bureau will keep the record with the latest Transaction Date. If the Transaction Date is also the same, the Bureau 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 Bureau. 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 Bureau. 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 received durable medical equipment. 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 durable medical equipment, 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 durable medical equipment bills 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	E1399	00000007500	0000001
12345	01	201	1	E1399	00000007500	0000001

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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	E1399	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 Bureau's database):

Claim Number	Transaction Code	Bill ID	Line ID	Paid Procedure Code	Amount Charged	Quantity/ Number of Units
12345	01	201	1	E1399	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	E1399	00000007500	0000001
12345	02	101	1	E1399	00000007500	0000001
12345	01	201	1	E1399	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 Bureau. 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.

D. 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 Bureau, include these fees 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, unless state regulations require the fees to be itemized as a separate record. 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.

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1. Reporting Dispensing Fees Separately

Dispensing fees should only be reported as separate records if state regulations require it. In these cases, the dispensing fee record should follow these guidelines:

(a) Report a Paid Procedure Code that differs from the drug's code.
(b) If the state has a state-specific dispensing fee code, use that code.
(c) If there is no state-specific code but there is an applicable HCPCs code (such as codes for inhalants), use the HCPCs code.
(d) If there is no applicable code, leave the Paid Procedure Code field blank.
(e) Report zero (0) in the Quantity/Units field.

Example: Reporting Dispensing Fees separately
A pharmacy charges $100 for a 30-day supply of Nebupent inhalant, with an additional $33 dispensing fee in a state in which requires dispensing fees are reported separately. Report the Nebupent on one record with a Procedure Code of 54868252800 (its NDC Code), an Amount Charged of $100, and a Quantity/Units of 30. The dispensing fee is reported as a separate record, with Procedure Code G0333 (Pharmacy dispensing fee for inhalation drugs; per 30 days), an Amount Charged of $33, and a Quantity/Units of 0.

E. File Replacements

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

Note: A Replacement (R) file received by the Bureau more than nine months after the first day of the reporting quarter will be rejected.

Example: A data submitter wants to replace a file reported in 1st quarter 2011. The first day of the quarter is 01/01/2011. The Bureau will not accept a replacement file submitted on or after 10/01/2011.

1. Deleting Files

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

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

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2. Replacing Files

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

Example: Replacing a file submitted in error
A file is submitted on February 21, 2011 and contains 5,000 records for 4th quarter 2010. On February 23, 2011, the data provider realizes that 500 of the transactions for which records were submitted were reported with Transaction Date 20101209 (12/09/2010) but actually occurred on 01/09/2011 (1st quarter). To replace the entire file, the data provider submits a new file with the 4,500 records for 4th quarter 2010. The Submission Control Record for the replacement file is completed as follows:

Field No.	Field Title/Description	Reported as
1	Record Type	SUBCTRLREC
2	Submission File Type Code	R (Replacement)
3	Carrier Group Code	Same as file being replaced
4	Reporting Quarter Code	4
5	Reporting Year	2010
6	Submission File Identifier	Same as file being replaced
7	Submission Date	20110223
8	Submission Time	Time this file was generated
9	Record Total	4,500
10	Reserved for Future Use	

The 500 records reported in error must be submitted with 1st quarter 2011 data with the corrected Transaction Date.

Note: A Replacement (R) file received by the Bureau more than nine months after the first day of the reporting quarter will be rejected.

Example: A data submitter wants to replace a file reported in 1st quarter 2011. The first day of the quarter is 01/01/2011. The Bureau will not accept a replacement file submitted on or after 10/01/2011.

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SECTION VI – EDITING AND OTHER VALIDATION PROCEDURES

A. Editing Process

The Bureau'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.

The result of the tests will determine the reporting group's status for the Medical Data Call Quality Incentive Program.

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) Conditional (O) – Indicates that the data element must be provided but is conditional on state-mandated criteria or dependent on a condition or conditions. For example, Service To Date and Service From Date are required only if a - payment spanning multiple days was made and the specific service date detail is unavailable. This element must be valid if populated.

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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	**C**
3	Policy Effective Date	**P**
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	**C/O**—Must be populated if Service From Date and Service To Date are missing. Must be valid if populated.
14	Service From Date	**C/O**—Must be populated if Service Date is missing. Must be valid if populated.
15	Service To Date	**C/O**—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-9 Diagnostic Code	**P**—Codes validated against valid ICD9 Diagnostic codes
21	Secondary ICD-9 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	**O**—Must be valid if populated.

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

1. Edit Types

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

- Submission edits ensure that the file record length is correct, data provider information is valid, a Submission Control Record exists, and the record count balances
- Field edits ensure that the data contained in each data field is acceptable

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- 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 Bureau's database

2. File Acceptance

Every Medical Data Call file received by the Bureau 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 Bureau can process the file. Refer to Edit Types in this section for edit type descriptions.

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

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

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

To ensure the completeness and validity of the required fields, field and relational level edits are also performed during this stage on any field that is identified as "Required for File Acceptance." Refer to Validating a Submission in this section for data element tolerance descriptions. The required fields include the four key fields (Carrier Code, 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 Bureau Carrier Code.
- Relational edits check for acceptable relationships between elements on different records, either within the submission or on the Bureau'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 Bureau'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 Bureau will return those records that failed to the data submitter.

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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 Bureau 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 Bureau's database. For example, if an Original record (Transaction Code 01) already resides on the Bureau's database, a new Original with the same key fields (Carrier Code, 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, or Low). Refer to Validating a Submission in this Part for data element tolerance descriptions.

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

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

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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 when all expected data for the entire reporting quarter has been received. The entire quarter's data is considered to be all of the reporting carrier's or carrier group's data that has been submitted for the quarter, whether submitted by the carrier or by multiple reporters (e.g., service providers).

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 logical and relational edits are performed in this stage:

- Logical edits check the relationship between elements within the same record. For example, Paid Amount is greater than Amount Charged by Provider. Although there are some instances where the paid amount will be greater than the amount charged, the frequency across all submissions should be low.
- Relational edits check the entire submission for completeness and reasonability. For example, an office visit is the most common Place of Service; therefore, the Bureau 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 logical edit failures are aggregated, and the results are provided at the Group level. For each data element, if any edit fails, the transaction is counted and the number of transactions that fail are evaluated against a tolerance level (Critical, Priority, or Low). Refer to Validating a Submission in this section for data element tolerance descriptions.

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

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

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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
Logical	Determines if the relationship between fields in the same record is acceptable	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 Bureau's database. This online edit matrix is the most comprehensive resource for information on the Bureau'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.

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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.

Ambulatory Payment Classification (APC) A grouping used in the determination of facility fee payments. Ambulatory payment classifications categorize outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

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.

APC See *Ambulatory Payment Classification*.

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 Bureau's database.

Carrier See *Insurance Carrier*

Carrier Group Insurance companies under a common ownership

Claim A demand to recover from a loss or damage covered by a policy of insurance. A Medical Data Call claim (identified by claim number) includes one or more *bills* for medical services.

Claimant The person who makes a *claim*. The claimant receives the medical services listed on the *bill*(s) for the associated claim.

CMS-1500 Form The standard claim form of the Centers for Medicare and Medicaid Services used by non-institutional providers or suppliers to bill Medicare carriers and durable medical equipment regional carriers (DMERCs) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. It is also used for billing of some Medicaid State Agencies.

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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 Bureau. 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 Bureau. This includes, but may not be limited to, *insurance carriers*, *Third Party Administrators (TPAs)*, bill review vendors, and pharmacy vendors. See also *Reporting Group*.

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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 Bureau.

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 Bureau 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.

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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 Bureau 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.

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SECTION VIII – APPENDIX

A. Overview

The following examples are included in the Appendix:

- **Business Exclusion Request Form** (preformatted)
- **Premium Verification Worksheet** (including instructions and examples) - For use with Premium Determination Method 1
- **Gross Premium Estimation Worksheet** (including instructions and examples) - For use with Premium Determination Method 3
- **CDX Insurance Group Administrator (IGA) Application**

Participants in the Call are required to submit their basis for exclusion to the Bureau 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, refer to Business Exclusion Option in the **General Rules** section of this manual.

B. Business Exclusion Request Form

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, etc.)
2. Document the carriers (by carrier code) and states that are handled by each excluded business segment.
3. If using Premium Determination Method 1, complete the Premium Verification Worksheet. If using Premium Determination Method 3, complete the Gross Premium Estimation Worksheet.

   Note: If the methods described are not appropriate for determining the exclusion percentage, contact the Bureau 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) the participant writes a significant number of large deductible policies).
4. 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 medicaldata@dcrb.com.

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C. Premium Verification Worksheet and Instructions

1. Worksheet

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. 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

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%.

Example:
A carrier group named Alphabet Insurance wishes to exclude medical data for two subsidiaries, A Insurance Company and B Insurance Company, in Delaware. The verification table is filled as shown below. Numbers in parentheses, such as (1), refer to the step of the Instructions.

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)
(1) A Insurance Co	(2) $1,500,000		
(1) B Insurance Co	(2) $2,000,000		
TOTAL	**(3) $3,500,000**	**(4) $357,500,000**	**(5) 1.0%**

D. Gross Premium Estimation Worksheet Example

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

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Gross Premium Estimation Worksheet			
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.

For the example in Premium Verification Worksheet Instructions above, the Total percentage in Column D is less than 15%, so the exclusions are permissible.

E. Compensation Data Exchange (CDX) Information

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

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

CDX Insurance Group Administrator (IGA) Application (see subsequent page)

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Compensation Data Exchange (CDX)

A service of Compensation Data Exchange, LLC.

Insurance Group Administrator (IGA) Application

Applicant Information

Carrier Group Name ______________________________

Group Number (This is the carrier group number, not the NAIC number) ______________________________

Insurance Group Administrator (IGA) Information

User ID (Please provide a desired User ID) ______________________________

First Name ______________________ Last Name ______________________

Address ______________________________

Address 2 ______________________________

City ______________________State ______________________ Zip ______________

Phone Number ______________________ Fax Number ______________________

Email Address ______________________________

Authorizing Officer for Applicant

Last Name ______________________ First Name ______________________

Title ______________________ E-mail Address ______________________

Please attach a business card, or copy of a business card, of the authorizing officer for verification.

The undersigned is duly authorized to execute this application on behalf of the above named Applicant and each of its individual carriers within the Carrier Group. By executing this application, the Applicant and each of the individual carriers agree to be bound by the Terms and Conditions of Use set forth on the reverse of this Application and on the ACCCT Web site at www.accct.org, together with all future modifications thereof.

______________________________ ______________________________

Applicant Signature Authorizing Officer Signature

INTERNAL USE ONLY

Date Received Date Confirmation Sent

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