A. 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 (Part 5) of this guidebook.

### Medical Data Call Record Layout

<table>
<thead>
<tr>
<th>Field No.</th>
<th>Field Title/Description</th>
<th>Class</th>
<th>Position</th>
<th>Bytes</th>
<th>Header/Detail</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Carrier Code^[1]</td>
<td>N</td>
<td>1–5</td>
<td>5</td>
<td>H</td>
<td>Payer</td>
</tr>
<tr>
<td>2</td>
<td>Policy Number Identifier</td>
<td>AN</td>
<td>6–23</td>
<td>18</td>
<td>H</td>
<td>CMS 11</td>
</tr>
<tr>
<td>3</td>
<td>Policy Effective Date</td>
<td>N</td>
<td>24–31</td>
<td>8</td>
<td>H</td>
<td>Payer</td>
</tr>
<tr>
<td>4</td>
<td>Claim Number Identifier^[1]</td>
<td>AN</td>
<td>32–43</td>
<td>12</td>
<td>H</td>
<td>Payer</td>
</tr>
<tr>
<td>5</td>
<td>Transaction Code</td>
<td>N</td>
<td>44–45</td>
<td>2</td>
<td>D</td>
<td>Payer</td>
</tr>
<tr>
<td>6</td>
<td>Jurisdiction State Code</td>
<td>N</td>
<td>46–47</td>
<td>2</td>
<td>H</td>
<td>Payer</td>
</tr>
<tr>
<td>7</td>
<td>Claimant Gender Code</td>
<td>AN</td>
<td>48</td>
<td>1</td>
<td>H</td>
<td>CMS 3 UB 11</td>
</tr>
<tr>
<td>8</td>
<td>Birth Year</td>
<td>N</td>
<td>49–52</td>
<td>4</td>
<td>H</td>
<td>CMS 3 UB 10</td>
</tr>
<tr>
<td>9</td>
<td>Accident[__] Date</td>
<td>N</td>
<td>53–60</td>
<td>8</td>
<td>H</td>
<td>CMS 14</td>
</tr>
<tr>
<td>10</td>
<td>Transaction Date</td>
<td>N</td>
<td>61–68</td>
<td>8</td>
<td>D</td>
<td>Payer</td>
</tr>
<tr>
<td>11</td>
<td>Bill Identification Number^[1]</td>
<td>AN</td>
<td>69–98</td>
<td>30</td>
<td>H</td>
<td>Payer</td>
</tr>
<tr>
<td>13</td>
<td>Service Date</td>
<td>N</td>
<td>129–136</td>
<td>8</td>
<td>D</td>
<td>CMS 24A UB 45</td>
</tr>
<tr>
<td>14</td>
<td>Service From Date</td>
<td>N</td>
<td>137–144</td>
<td>8</td>
<td>H</td>
<td>CMS 18 UB 6</td>
</tr>
<tr>
<td>15</td>
<td>Service To Date</td>
<td>N</td>
<td>145–152</td>
<td>8</td>
<td>H</td>
<td>CMS 18 UB 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>UB 44 or Payer</td>
</tr>
<tr>
<td>17</td>
<td>Paid Procedure Code Modifier</td>
<td>AN</td>
<td>178–185</td>
<td>8</td>
<td>D</td>
<td>CMS 24D UB 44 or Payer</td>
</tr>
<tr>
<td></td>
<td>First Paid Procedure Code Modifier</td>
<td></td>
<td>(178–181)</td>
<td>(4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Second Paid Procedure Code Modifier</td>
<td></td>
<td>(182–185)</td>
<td>(4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amount Charged by Provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>18</td>
<td>N</td>
<td>186–196</td>
<td>11</td>
<td>D</td>
<td>CMS 24F UB 47</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Paid Amount</td>
<td>N</td>
<td>197–207</td>
<td>11</td>
<td>D</td>
<td>Payer</td>
</tr>
<tr>
<td>20</td>
<td>Primary ICD-9 Diagnostic Code</td>
<td>AN</td>
<td>206–221</td>
<td>14</td>
<td>H/D</td>
<td>CMS 21-1 (D) UB [___]67 (H)</td>
</tr>
<tr>
<td>21</td>
<td>Secondary ICD-9 Diagnostic Code</td>
<td>AN</td>
<td>222–235</td>
<td>14</td>
<td>H/D</td>
<td>CMS 21-2 (D) UB [___]67A (H)</td>
</tr>
<tr>
<td>22</td>
<td>Provider [_____] Taxonomy Code</td>
<td>AN</td>
<td>236–255</td>
<td>20</td>
<td>H</td>
<td>Provider or Payer</td>
</tr>
<tr>
<td>23</td>
<td>Provider Identification Number</td>
<td>AN</td>
<td>256–270</td>
<td>15</td>
<td>H</td>
<td>[___]CMS 33A UB 56</td>
</tr>
<tr>
<td>24</td>
<td>Provider Postal (ZIP) Code [_____]</td>
<td>AN</td>
<td>271–273</td>
<td>3</td>
<td>H</td>
<td>CMS 32 UB 1</td>
</tr>
<tr>
<td>25</td>
<td>Network Service Code</td>
<td>A</td>
<td>274</td>
<td>1</td>
<td>H</td>
<td>Provider or Payer</td>
</tr>
<tr>
<td>26</td>
<td>Quantity/Number of Units per Procedure Code</td>
<td>N</td>
<td>275–281</td>
<td>7</td>
<td>D</td>
<td>CMS 24G UB 46</td>
</tr>
<tr>
<td>27</td>
<td>Place of Service Code</td>
<td>AN</td>
<td>282–289</td>
<td>8</td>
<td>H</td>
<td>CMS 24B</td>
</tr>
<tr>
<td>28</td>
<td>Secondary Procedure Code</td>
<td>AN</td>
<td>290–314</td>
<td>25</td>
<td>D</td>
<td>UB 42</td>
</tr>
<tr>
<td>29</td>
<td>Reserved for Future Use</td>
<td></td>
<td>315–350</td>
<td>36</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 (Part 3) of this guidebook.

Source Notes:

CMS: Data is located on the CMS-1500 Form. 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 the UB-04 Form. The field number on the form where the data is located is also provided.


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PART 5—DATA DICTIONARY

A. DATA DICTIONARY

1. Accident [___] Date

   Field(s): 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.

2. Amount Charged by Provider

   Field(s): 18
   Position(s): 186–196
   Class: Numeric (N)—Field contains only numeric characters
   Bytes: 11
   Format: 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 (Part 6) of this guidebook.

3. Bill Identification Number

| Field(s): | 11 |
| Position(s): | 99–98 |
| Class: | Alphanumeric (AN)—Field contains alphabetic and numeric characters |
| Bytes: | 30 |
| Format: | A/N 30, exclude [ ____ ]non-ASCII characters. This field must be left justified and contain blanks in all spaces to the right of the last character if the Bill Identification Number is less than 30 bytes. |

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

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

4. Birth Year

| Field(s): | 8 |
| Position(s): | 40–62 |
| 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/Injury Date (Positions 53–60).

5. Carrier Code

| Field(s): | 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 Carrier Group Code unless it is the same as the Carrier Code. Do not report the NAIC Carrier Code.

6. Claim Number Identifier

| Field(s): | 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 contain 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.

7. Claimant Gender Code

| Field(s): 7 |
| Position(s): 48 |
| Class: Alphanumeric (AN) — Field contains alphabetic and numeric characters |
| Bytes: 1 |
| Format: A/N |

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

Reporting Requirement: Report the code that corresponds to the claimant’s gender. Leave blank or zero-fill if unknown.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
</tr>
<tr>
<td>3</td>
<td>Other</td>
</tr>
</tbody>
</table>

8. Jurisdiction State Code

| Field(s): 8 |
| 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. The Jurisdiction State [ ___ ] must be one of the states included in the list of applicable Medical Data Call states.

Note: When the jurisdiction state is an applicable state, all qualifying medical transactions for that state must be reported even when the compliance state (AIABC 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 Arizona 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.

<table>
<thead>
<tr>
<th>State</th>
<th>Code</th>
<th>State</th>
<th>Code</th>
<th>State</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>01</td>
<td>Kentucky</td>
<td>16</td>
<td>[ ___ ]</td>
<td>[ ___ ]</td>
</tr>
<tr>
<td>Alaska</td>
<td>54</td>
<td>Louisiana</td>
<td>17</td>
<td>[ ___ ]</td>
<td>[ ___ ]</td>
</tr>
<tr>
<td>Arizona</td>
<td>02</td>
<td>Maine</td>
<td>18</td>
<td>Oklahoma</td>
<td>35</td>
</tr>
<tr>
<td>Arkansas</td>
<td>03</td>
<td>Maryland</td>
<td>19</td>
<td>Oregon</td>
<td>36</td>
</tr>
<tr>
<td>[ ___ ]</td>
<td></td>
<td>Massachusetts</td>
<td>20</td>
<td>[ ___ ]</td>
<td>[ ___ ]</td>
</tr>
<tr>
<td>Colorado</td>
<td>05</td>
<td>[ ___ ]</td>
<td>[ ___ ]</td>
<td>Rhode Island</td>
<td>38</td>
</tr>
<tr>
<td>Connecticut</td>
<td>06</td>
<td>[ ___ ]</td>
<td>[ ___ ]</td>
<td>South Carolina</td>
<td>39</td>
</tr>
<tr>
<td>State</td>
<td>[__]</td>
<td>Mississippi</td>
<td>23</td>
<td>South Dakota</td>
<td>40</td>
</tr>
<tr>
<td>--------------</td>
<td>------</td>
<td>-------------</td>
<td>----</td>
<td>--------------</td>
<td>----</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>08</td>
<td>Missouri</td>
<td>24</td>
<td>Tennessee</td>
<td>41</td>
</tr>
<tr>
<td>Florida</td>
<td>09</td>
<td>Montana</td>
<td>25</td>
<td>[___]</td>
<td>[___]</td>
</tr>
<tr>
<td>Georgia</td>
<td>10</td>
<td>Nebraska</td>
<td>26</td>
<td>Utah</td>
<td>43</td>
</tr>
<tr>
<td>Hawaii</td>
<td>52</td>
<td>Nevada</td>
<td>27</td>
<td>Vermont</td>
<td>44</td>
</tr>
<tr>
<td>Idaho</td>
<td>11</td>
<td>New Hampshire</td>
<td>28</td>
<td>Virginia</td>
<td>45</td>
</tr>
<tr>
<td>Illinois</td>
<td>12</td>
<td>New Jersey</td>
<td>29</td>
<td>[___]</td>
<td>[___]</td>
</tr>
<tr>
<td>Indiana</td>
<td>13</td>
<td>New Mexico</td>
<td>30</td>
<td>West Virginia</td>
<td>47</td>
</tr>
<tr>
<td>Iowa</td>
<td>14</td>
<td>New York</td>
<td>31</td>
<td>Wisconsin</td>
<td>48</td>
</tr>
<tr>
<td>Kansas</td>
<td>15</td>
<td>[___]</td>
<td>[___]</td>
<td>[___]</td>
<td>[___]</td>
</tr>
</tbody>
</table>

### 9. Line Identification Number

**Field(s):** 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.

### 10. Network Service Code

**Field(s):** 25  
**Position(s):** 274  
**Class:** Alpha (A) — Field contains only alphabetic 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 [___].

#### Code Description

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>HMO—the medical service provider belongs to[<em><strong>] a Health Maintenance Organization [</strong></em>]</td>
</tr>
<tr>
<td>N</td>
<td>No Agreement—the medical service provider does not belong to a provider network[___]</td>
</tr>
<tr>
<td>P</td>
<td>Participation Agreement—the medical service provider[___] is part of an agreement that is not an HMO or PPO</td>
</tr>
<tr>
<td>Y</td>
<td>PPO Agreement—the medical service [___] provider belongs to a Preferred Provider Organization agreement</td>
</tr>
</tbody>
</table>

### 11. Paid Amount

**Field(s):** 19  
**Position(s):** 197–207  
**Class:** Numeric (N) — Field contains only numeric characters  
**Bytes:** 11
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 (Part 6) of this guidebook.

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.

12. Paid Procedure Code

| Field(s): | 16 |
| Position(s): | 153-177 |
| Class: | Alphanumeric (AN)—Field contains alphabetic and numeric characters |
| Bytes: | 25 |
| Format: | AN 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).

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) [_____ ].

<table>
<thead>
<tr>
<th>Procedure Code List Type</th>
<th>Code Length (Bytes)</th>
<th>Description/Formatting</th>
</tr>
</thead>
</table>
| CPT—Current Procedural Terminology                       | 5                   | - Codes are either 5 numbers or [_____ ] 4 numbers followed by a single alpha character  
<p>|                                                           |                     | - Left justify and blank-fill all spaces to the right of the |</p>
<table>
<thead>
<tr>
<th>Code System</th>
<th>Length</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDT—Current Dental Terminology</td>
<td>5</td>
<td>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.</td>
</tr>
<tr>
<td>HCPCS—Healthcare Common Procedure Coding System</td>
<td>5</td>
<td>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 right of the last number or character when less than 25 bytes. Must include leading zeros when part of the code.</td>
</tr>
<tr>
<td>NDC—National Drug Codes</td>
<td>10 or 11</td>
<td>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 right of the last number. Do not include dashes. Must include leading zeros when part of the code.</td>
</tr>
<tr>
<td>APC—Ambulatory Payment Classification</td>
<td>4</td>
<td>Numeric codes classify procedures into related groups for outpatient services. Left justify and blank-fill all spaces to right of the last number. Must include leading zeros when part of the code.</td>
</tr>
<tr>
<td>DRG—Diagnostic Related Group</td>
<td>3</td>
<td>Numeric codes classify procedures into related groups for inpatient hospital services. Left justify and blank-fill all spaces to right of the last number. Must include leading zeros when part of the code.</td>
</tr>
<tr>
<td>Revenue Codes</td>
<td>4[____]</td>
<td>Left justify and blank-fill all spaces to right of the last number. Must include leading zeros when part of the code.</td>
</tr>
<tr>
<td>State-Specific</td>
<td>Varied</td>
<td>Byte length dependent on state rules. Left justify and blank-fill all spaces to right of the last number or character when less than 25 bytes. Must include leading zeros when part of the code.</td>
</tr>
</tbody>
</table>

[1] 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.

[2] If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is/are inserted correctly. For example, if the system stores 59 for a code that is listed as 0059 on the code list, insert two zeros to the left of the 5 when reporting to NCCI.

13. Paid Procedure Code Modifier(s)

<table>
<thead>
<tr>
<th>Field(s)</th>
<th>Position(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>178-185</td>
</tr>
</tbody>
</table>
14. Place of Service Code

**Field(s):** 27

**Position(s):** 282–289

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

**Bytes:** 6

**Format:** A/N 8, this field must be left justified and blank-filled to the 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 NCCI.

**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

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

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

15. Policy Effective Date

Field(s): 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).

16. Policy Number Identifier

Field(s): 2
Position(s): 6-23
Class: Alphanumeric (AN)—Field contains alphabetic and numeric characters
Bytes: 18
Format: A/N 18, [ ___ ] letters A–Z and numbers 0–9 only (if the Policy Number Identifier is less than 18 bytes, this field must be left justified, and blanks in all spaces to the right of the last character).

Definition: The unique set of numbers and/or letters that identify the policy under which the claim occurred (letters A–Z and numbers 0–9 only).

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

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

17. Primary ICD-9 Diagnostic Code

Field(s): 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 contains 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 of the decimal

<table>
<thead>
<tr>
<th>If ICD Diagnostic Code is . . .</th>
<th>Then valid format is (&quot;_&quot; indicates a space) . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>942</td>
<td>942_</td>
</tr>
<tr>
<td>942.</td>
<td>942_</td>
</tr>
<tr>
<td>942.0</td>
<td>942.0_</td>
</tr>
<tr>
<td>372.61</td>
<td>372.61_</td>
</tr>
<tr>
<td>043.9</td>
<td>043.9_</td>
</tr>
<tr>
<td>005.9</td>
<td>005.9_</td>
</tr>
<tr>
<td>E111</td>
<td>E111_</td>
</tr>
</tbody>
</table>

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 7999.9.
- If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if 59 is listed as 0059 on the code list, insert two zeros to the left of the 5.

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

Reporting Requirement: Report the NCHS (National Center for Health Statistics) or CMS (Centers for Medicare & Medicaid Services) ICD-9 code that identifies the primary diagnosis associated with the medical service rendered. Refer to NCHS (www.cdc.gov/nchs/about/otheract/icd9/abouticd9.htm) or CMS (www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/) for the ICD-9 Diagnostic Code listing.

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

18. Provider Identification Number

| Field(s): | 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 medical/service 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 Number) 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 NCCI. However, the unique carrier coding scheme must be used consistently.

19. Provider Postal (Zip) Code [___]
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.

20. Provider [___] Taxonomy Code

| Field(s):  | 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 [___] Taxonomy Code is less than 20 bytes. |

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

Reporting Requirement: Report the taxonomy code that identifies the type of provider that billed for and is being paid for the medical service. For example, if a line item of a hospital bill indicates that a Registered Physical Therapist provided therapy to a claimant as an employee of the hospital, report the Provider Taxonomy Code associated with the hospital.

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.wpc-edi.com/taxonomy])

21. Quantity/Number of Units Per Procedure Code

| Field(s): | 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.

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[ blank].

For Paid Procedure Codes related to anesthesia, the quantity/units is reported in minutes. For example, if 220 minutes of anesthesia was provided, report 000220 in this field.

22. Secondary ICD-9 Diagnostic Code

| Field(s): | 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 examples):
- 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 |

<table>
<thead>
<tr>
<th>If ICD Diagnostic Code is ...</th>
<th>Then valid format is (&quot;_&quot; indicates a space) ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>942</td>
<td>942__</td>
</tr>
<tr>
<td>942.0</td>
<td>942.0</td>
</tr>
<tr>
<td>372.61</td>
<td>372.61</td>
</tr>
<tr>
<td>043.9</td>
<td>043.9</td>
</tr>
<tr>
<td>005.9</td>
<td>005.9</td>
</tr>
<tr>
<td>E111</td>
<td>E111</td>
</tr>
</tbody>
</table>

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 59 is listed as 0059 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: NCCI 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.
23. **Secondary Procedure Code**

| Field(s): | 28 |
| Position(s): | 290–314 |
| Class: | Alphanumerical (AN)—Field contains alphabetic and numeric characters |
| Bytes: | 25 |
| Format: | A/N 25, format according to the requirements for the code list used. Refer to the Procedure Code List Type table in the Reporting Requirement for this field. |

**Definition:** A code from the jurisdiction-approved code table that identifies [___] the billed procedure[___].

**Reporting 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

<table>
<thead>
<tr>
<th>Code List Type</th>
<th>Bytes</th>
<th>Description/Formatting</th>
</tr>
</thead>
</table>
| 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 alphanumerical 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 | |

[1] Notes: **[*]**
**24. Service Date**

| Field(s): | 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 a negotiated 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/Injury Date (Positions 53–60).

**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.
<table>
<thead>
<tr>
<th>Bill ID (69-98)</th>
<th>Line ID (99-128)</th>
<th>(153-177)</th>
<th>Service Date (129-136)</th>
<th>281</th>
</tr>
</thead>
<tbody>
<tr>
<td>1001</td>
<td>1</td>
<td>97110</td>
<td>20080108</td>
<td>0000002</td>
</tr>
<tr>
<td>1001</td>
<td>2</td>
<td>97110</td>
<td>20080110</td>
<td>0000002</td>
</tr>
<tr>
<td>1001</td>
<td>3</td>
<td>97110</td>
<td>20080115</td>
<td>0000002</td>
</tr>
<tr>
<td>1001</td>
<td>4</td>
<td>97110</td>
<td>20080117</td>
<td>0000002</td>
</tr>
</tbody>
</table>

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

25. Service From Date

| Field(s): | 14 |
| Position(s): | 137-144 |
| Class: | Numeric (N)—Field contains only numeric characters |
| Bytes: | 8 |
| Format: | YYYYMMDD |

Definition: The date when services were initiated.

Reporting Requirement: Use this field for the starting date of service if a negotiated 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/Injury Date (Positions 53-60).

26. Service To Date

| Field(s): | 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 a negotiated 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).

27. Transaction Code

| Field(s): | 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 being submitted to NCCI.
Reporting Requirement: Report the code that identifies the type of transaction of the record being submitted.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Original—the initial report of the record to NCCI. Only one original (Transaction Code 01) may be submitted for a given transaction.</td>
</tr>
<tr>
<td>02</td>
<td>Cancellation—cancels (deletes) a previously submitted (Transaction Code 01 or 03) record.</td>
</tr>
<tr>
<td>03</td>
<td>Replacement—replaces (changes) a previously submitted (Transaction Code 01 or 03) record.</td>
</tr>
</tbody>
</table>

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

28. Transaction Date

| Field(s): | 10 |
| Position(s): | 61–68 |
| Class: | Numeric (N)—Field contains only numeric characters |
| Bytes: | 8 |
| Format: | YYYYMMDD |

Definition: The date the information in the medical 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.

<table>
<thead>
<tr>
<th>If Transaction Code is . . .</th>
<th>Then report . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>01—Original</td>
<td>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, who processed the bill on 01/21/2008. The medical data provider reports the original transaction to NCCI with its 1st quarter submission on 04/01/2008. The Transaction Date for this original record is 01/21/2008 (reported as 20080121).</td>
</tr>
<tr>
<td>02—Cancellation</td>
<td>The date the cancellation was performed in the system of the administering entity.</td>
</tr>
<tr>
<td>03—Replacement</td>
<td>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 on 05/01/2008. The medical data provider reports the replacement transaction to NCCI with its 2nd quarter submission on 07/01/2008. The Transaction Date for this replacement record is 05/01/2008 (reported as 20080501).</td>
</tr>
</tbody>
</table>


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