CHAPTER 911. DATA SUBMISSION AND COLLECTION

Authority

The provisions of this Chapter 911 issued under sections 5 and 6 of the Health Care Cost Containment Act (35 P. S. §§ 449.5 and 449.6), unless otherwise noted.

Source

The provisions of this Chapter 911 adopted August 14, 1987, effective August 15, 1987, 17 Pa.B. 3409, unless otherwise noted.

Subchapter A. STATEMENT OF POLICY

§ 911.1. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Act—The Health Care Cost Containment Act (35 P. S. §§ 449.1—449.19).

Ambulatory service facility—A facility licensed in this Commonwealth, not part of a hospital, which provides medical, diagnostic or surgical treatment to patients not requiring hospitalization. The term includes, but is not limited to, ambulatory surgical facilities, ambulatory imaging or diagnostic centers, birthing centers, freestanding emergency rooms and other facilities providing ambulatory care which charge a separate facility charge. The term does not include the offices of private physicians or dentists, whether for individual or group practice.

Council—The Health Care Cost Containment Council.

Covered services—Health care services or procedures connected with episodes of illness that require either inpatient hospital care or major ambulatory service such as surgical, medical or major radiological procedures, including initial and follow-up outpatient services associated with the episode of illness before, during or after inpatient hospital care or major ambulatory service. The term does not include routine outpatient services connected with episodes of illness that do not require hospitalization or major ambulatory service.

Data source—The term includes, but is not limited to, the following:

(i) A hospital.

(ii) An ambulatory service facility.

(iii) A physician.

(iv) A health maintenance organization as the term is defined in the Health Maintenance Organization Act (40 P. S. §§ 1551—1567).

(v) A hospital, medical or health service plan with a certificate of authority issued by the Insurance Department, including, but not limited to, hospital plan corporations as defined in 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations) and professional health services plan corporations as defined in 40 Pa.C.S. Chapter 63 (relating to professional health services plan corporations).

(vi) A commercial insurer with a certificate of authority issued by the Insurance Department providing health or accident insurance.

(vii) A self-insured employer providing health or accident coverage or benefits for employes employed in this Commonwealth.

(viii) An administrator of a self-insured or partially self-insured health or accident plan providing covered services in this Commonwealth.

(ix) A health and welfare fund that provides health or accident benefits or insurance pertaining to covered service in this Commonwealth.

(x) The Department of Public Welfare for those covered services it purchases or provides through the Medical Assistance program under the Public Welfare Code (62 P. S. §§ 101—1411).

(xi) Other payors for covered services in this Commonwealth other than an individual.

External cause code (E code)—The classification of environmental events, circumstances and conditions as the cause of injury, poisoning and other adverse effects. An external cause of injury is an injury which can be assigned an E code. The E code classification should be used as an additional code for more detailed analysis.

Health care facility—The term includes, but is not limited to, the following:

(i) A general or special hospital, including tuberculosis and psychiatric hospitals.

(ii) Kidney disease treatment centers, including freestanding hemodialysis units.

(iii) Ambulatory service facilities as defined in this section.

(iv) Hospices, both profit and nonprofit, and including those operated by an agency of State or local government.

Hispanic/Latino origin or descent—Hispanic/Latino refers to people whose origins are from Spain, Mexico or the Spanish-speaking countries of Central or South America. Origin can be viewed as the ancestry, nationality, lineage or country in which the person or the person's ancestors were born before arrival in the United States.

Hospital—An institution, licensed in this Commonwealth, which is a general, tuberculosis, mental, chronic disease or other type of hospital, or kidney disease treatment center, whether profit or nonprofit, and including those operated by an agency of State or local government.

Major ambulatory service—Surgical or medical procedures. The term includes, but is not limited to, diagnostic and therapeutic radiological procedures, commonly performed in hospitals or ambulatory service facilities, which are not of a type commonly performed or which cannot be safely performed in a physician's office and which require special facilities such as operating rooms or suites or special equipment such as fluoroscopic equipment or computed tomographic scanners, or a postprocedure recovery room or short-term convalescent room.

Patient severity—A measure of severity of illness as defined by the Council using appropriate clinical findings, such as physician examinations, radiology findings, laboratory findings and pathology findings or any other relevant clinical factors.

Pennsylvania Uniform Claims and Billing Form format—The Uniform Hospital Billing Form UB-82/HCFA 1450, and the HCFA 1500, or their successors, as developed by the National Uniform Billing Committee, with additional fields as necessary to provide the data in section 6(c) and (d) of the act (35 P. S. § 449.6(c) and (d)).

Physician—An individual licensed under the statutes of the Commonwealth to practice medicine and surgery within the scope of the Osteopathic Medical Practice Act (63 P. S. §§ 271.1—271.18) or the Medical Practice Act (63 P. S. §§ 422.1—422.45).

Provider—A hospital, or an ambulatory service facility or a physician.

Authority

The provisions of this § 911.1 amended under the Health Care Cost Containment Act (35 P. S. §§ 449.1—449.19).

Source

The provisions of this § 911.1 adopted August 14, 1987, effective August 15, 1987, 17 Pa.B. 3409; amended October 30, 1987, effective October 31, 1987, 17 Pa.B. 4447; amended February 26, 1993, effective upon submittal of data elements to the Council beginning with data from the second quarter of 1993, which begins April 1, 1993, 23 Pa.B. 971; amended October 1, 1999, effective October 2, 1999, 29 Pa.B. 5109. Immediately preceding text appears at serial pages (242545) to (242547).

§ 911.2. Pennsylvania Uniform Claims and Billing Form format—Statement of Policy.

(a) *General requirements.* The Pennsylvania Uniform Claims and Billing Form format consists of the UB-92/HCFA 1450 and HCFA 1500, or their successors, and additional elements adopted by the Council. The billing form shall be

utilized and maintained by data sources and for services covered by the act for the purposes of maintaining common data and common billing formats.

(b) *Uniform definitions for the Pennsylvania Uniform Claims and Billing Form format.* Definitions for use of the Uniform Claims and Billing Form shall be in accordance with the manual developed by the National Uniform Billing Committee and definitions contained in the Council manual number HC-87-101. Definitions in the Council manual HC-87-101 take precedence over National Uniform Billing Committee definitions.

(c) *Patient bill requirements.* Beginning November 13, 1987, a provider shall present to a patient a copy of a bill for covered services upon discharge from a health care facility or provision of physician services or within a reasonable time thereafter. When providing a patient with copies of a bill for inpatient or outpatient covered services, a provider may use revenue descriptions and charges contained in the Pennsylvania Uniform Claims and Billing Form format or may itemize the charges for services, equipment, supplies and medicine.

Authority

The provisions of this § 911.2 amended under the Health Care Cost Containment Act (35 P. S. §§ 449.1—449.19).

Source

The provisions of this § 911.2 adopted August 14, 1987, effective August 15, 1987, 17 Pa.B. 3409; amended October 30, 1987, effective October 31, 1987, 17 Pa.B. 4447; amended July 23, 1993, effective July 24, 1993, 23 Pa.B. 3477. Immediately preceding text appears at serial pages (177650) to (177651).

§ 911.3. Council adoption of methodology.

Under section 6(d) of the act (35 P. S. § 449.6(d)), the Council will adopt a methodology required to collect and report provider quality and provider service effectiveness. Periodically, the Council will review the methodology and, if a change is necessary, it will be made by majority vote of the Council at a public meeting. Notice of the change will be given to all appropriate data sources within 30 days and at least 180 days before the change is to be implemented.

Source

The provisions of this § 911.3 amended October 1, 1999, effective October 2, 1999, 29 Pa.B. 5109. Immediately preceding text appears at serial pages (242548) to (242549).

§ 911.4. Adoption of data elements to be reported to the Council.

(a) The Council adopted the data elements in Table A and identified fields on the Pennsylvania Uniform Claims and Billing Form format (see Table A).

(b) As required by section 6 of the act (35 P. S. § 449.6), the Council will promulgate rules and regulations establishing technical specifications and schedules, and the identification of data sources required to submit specific data elements to the Council.

(c) The Council will promulgate in the rules and regulations the following data elements:

(1) Field 21c, Unusual Occurrences—Nosocomial infections.

(2) Field 21d, Unusual Occurrences—Readmissions.

(3) Field 35, Patient Race.

TABLE A
PENNSYLVANIA UNIFORM CLAIMS AND BILLING FORM DATA ELEMENTS

Field	*Data Element*	*Definition*
1	Uniform Patient Identifier	Patient's Social Security Number.
2	Patient Date of Birth	The date of birth of the patient.
3	Patient Sex	The sex of the patient as recorded at the date of admission, outpatient service, or start of care.
4	Patient Zip Code	Zip code of patient taken from the patient name and address field.
5	Date of Admission	The date that the patient was admitted to the provider for inpatient care, outpatient services or start of care.
6	Date of Discharge	The ending service date of patient care. The date that the patient was discharged from the provider's care.

Field	*Data Element*	*Definition*
7a	Principal Diagnosis	The code that identifies the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization) that exists at the time of admission or develops subsequently that has an effect on the length of stay.
7b, c, d, e	Secondary Diagnosis	The diagnosis code corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.
8a, b	Principal Procedure Code and Date	The code that identifies the principal procedure performed during the period between admission and discharge and the date on which the principal procedure described was performed.
9a1 through 9c2	Secondary Procedure	The code identifying the procedures other than the principal procedure, performed during the patient's stay and the dates on which the procedures (identified by the codes) were performed.
10	Uniform Identifier of Health Care Facility	Number identifying the provider facility as developed and used by Medicaid.

Field	*Data Element*	*Definition*
11	Attending Physician Identifier	The PA state license number of the physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.
12	Operating Physician Identifier	The PA state license number of the physician other than the attending physician who performed the principal procedure.
13a1 through 13w1	Revenue Description	A narrative description of the related revenue categories included for a patient.
13a2 through 13w2	Revenue Code	A code which identifies a specific accommodation, ancillary service or billing calculation.
13a3 through 13w3	Units of Service	A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, pints of blood, or renal dialysis treatments, etc.
13a4 through 13w4	Total Charges	Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
13a5 through 13w5	Noncovered Charges	Those charges that are not covered by a payor for this patient.
14a	Actual Payments to the Health Care Facility	Payments for services performed by the provider from the payor segregated according to Revenue Code.

Field	*Data Element*	*Definition*
14b	Payor Identification	Name and Pennsylvania Insurance Department number identifying each payor organization from which the provider might expect some payment for the bill.
14c	Deductible Amount	The amount assumed by the hospital to be applied to the patient's deductible amount involving the indicated payor.
14d	Co-Insurance Amount	The amount assumed by the hospital to be applied toward the patient's co-insurance amount involving the indicated payor.
14e	Estimated Responsibility	The amount estimated by the hospital to be paid by the indicated payor.
14f	Prior Payments—Payor and Patient	The amount the hospital has received toward payment of this bill prior to the billing date by the indicated payor.
14g	Estimated Amount Due	The amount estimated by the hospital to be due from the indicated payor (estimated responsibility less prior payments).
15a	Physician Identification	License number of the physician who charged the patient for a service related to an episode of illness for the period indicated in Fields 5 and 6.
15b	Type of Physician/ Professional Service	The type of service performed for which payment is expected.

Field	*Data Element*	*Definition*
15a3	Physician/ Professional Services Charge	Amount charged for services rendered to the patient for the procedure indicated in HCFA 1500, item 24d.
16	Physician/ Professional Services Payment	Payments received for services performed for the procedures indicated in Field 8a.
17	Uniform Identifier of Primary Payor	Pennsylvania Department of Insurance number. If the number is not available, the Health Care Cost Containment Council will assign a number based on the name in Field 14b.
18	Zip Code of Facility	XXXXXYYYY. Five character zip code with a four character extension. If the four character extension is unknown, fill with blanks.
19	Payor Group Number	The identification number, control number, or code assigned by the carrier or plan administrator to identify the group under which the individual is covered.
20	Patient Discharge Status	The status of the patient at discharge.

Field	*Data Element*	*Definition*
21c	Unusual Occurrence	Infections acquired while in the hospital. Nosocomial infections are defined as those infections that are clinically manifested after 72 hours in the hospital, unless: 1. They are evident within 72 hours after admission and are related to a previous hospitalization; 2. They are related to a hospital procedure performed within the first 72 hours.
21d	Unusual Occurrence	Patient readmission to the hospital within 30 days.
22	Type of Bill	A code indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.)
23	Patient Control Number	Patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual case records and posting of the payment.
24	Diagnosis Related Group (DRG)	The condition established after study as being chiefly responsible for the admission of a patient to the hospital for care that exists at the time of admission or develops subsequently that has an effect on the length of stay.
25	Procedure Coding Method Used	An indicator that identifies the coding method used for procedure coding on this bill.
26	Type of Admission	A code indicating the priority of this admission.
27	Source of Admission	A code indicating the source of this admission.

Field	*Data Element*	*Definition*
28	Patient's Relationship to Insured	A code indicating the relationship of the patient to the identified insured.
29	Certificate/Social Security Number/Health Insurance Claim/ Identification Number	Insured's unique identification number assigned by the payor organization.
30	Principal and Other Diagnoses Descriptions	Narrative description of the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing the hospitalization or use of hospital services) and other diagnoses.
31	Principal and Other Procedure Descriptions	A narrative description of the principal procedure (i.e., the procedure that was performed for definitive treatment rather than the one performed for diagnostic or exploratory purposes or the procedure most related to the principal diagnosis) and other procedures. The principal procedure is to be shown first.
32	Employer Name	The name of the employer that might or does provide health care coverage for the individual identified in Field 33.
33	Employment Information	A code that indicates whether the employment information given in the related areas applies to an insured, the patient or the patient's spouse.

Field	*Data Element*	*Definition*
34	Employment Status Code	A code used to define the employment status of the individual identified in Field 33.
35	Patient Race	This code indicates the patient's racial/ethnic background.
36	Reserve Field	To be reserved for future use by the Council.

Source

The provisions of this § 911.4 amended October 1, 1999, effective October 2, 1999, 29 Pa.B. 5109. Immediately preceding text appears at serial pages (242549) to (242556).

§ 911.5. Interpretation of Hispanic/Latino origin or descent and patient race.

(a) *Field 35a: Hispanic/Latino origin or descent*. This should be reflected as follows:

Hispanic/Latino origin

1 = Yes

2 = No

(b) *Field 35b: Patient race.*

W = White

B = Black

A = Asian or Pacific Islander

I = Native American or Eskimo

N = Other

U = Unknown

Source

The provisions of this § 911.5 adopted February 26, 1993, effective upon submittal of data elements to the Council beginning with data from the second quarter of 1993, which begins April 1, 1993, 23 Pa.B. 971.

§ 911.6. Interpretation of Secondary Diagnosis Code.

Anytime information about an external cause of injury appears on a patient record, the appropriate E code should be placed in field 7e. If an E code is not indicated, another secondary diagnosis code is acceptable.

Source

The provisions of this § 911.6 adopted February 26, 1993, effective upon submittal of data elements to the Council beginning with data from the second quarter of 1993, which begins April 1, 1993, 23 Pa.B. 971.

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