CHAPTER 912. DATA REPORTING REQUIREMENTS

Authority

The provisions of this Chapter 912 issued under section 6 of the Health Care Cost Containment Act (35 P. S. § 449.6), unless otherwise noted.

Source

The provisions of this Chapter 912 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459, unless otherwise noted.

Cross References

This chapter cited in 28 Pa. Code § 915.51 (relating to procedures for access to Council data by data sources).

Subchapter A. GENERAL PROVISIONS

§ 912.1. Legal base and purpose.

(a) This chapter is promulgated by the Council under section 6 of the act (35 P. S. § 449.6).

(b) This chapter establishes submission schedules and formats for the collection of data from health care facilities specified in section 6 of the act.

Authority

The provisions of this § 912.1 amended under section 5(b) of the Health Care Cost Containment Act (35 P. S. § 449.5(b)).

Source

The provisions of this § 912.1 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459; amended April 8, 1988, effective March 1, 1988, 18 Pa.B. 1607; amended October 1, 1999, effective October 2, 1999, 29 Pa.B. 5093. Immediately preceding text appears at serial page (242559).

§ 912.2. Affected institutions.

This chapter applies to health care facilities in this Commonwealth.

Source

The provisions of this § 912.2 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459.

§ 912.3. 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).

Additional data elements—Data, redefinitions of data or methodologies to calculate data to be added to the Pennsylvania Uniform Claims and Billing Form format.

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, free-standing 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 practices.

Charge—The amount billed by a provider for specific goods or services provided to a patient, prior to adjustment for contractual allowances.

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 elements—Data identified by the Council to be submitted to the Council as part of the Pennsylvania Uniform Claims and Billing Form format.

Executive Director—The Executive Director of the Council.

General hospital—A hospital equipped and staffed for the treatment of medical or surgical conditions, or both, in the acute or chronic stages, on an inpatient basis of 24 or more hours. The term includes hospitals that treat children as their specialty.

Health care facility—The term includes the following:

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

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

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, including those operated by an agency of State or local government.

Major ambulatory service—Surgical or medical procedures, including 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 physicians' offices 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.

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 laws 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 of 1985 (63 P. S. §§ 422.1—422.45).

Provider—A hospital, ambulatory service facility or physician.

Provider quality—The extent to which a provider renders care that, within the capabilities of modern medicine, obtains for patients medically acceptable health outcomes and prognoses, adjusted for patient severity, and treats patients compassionately and responsively.

Provider service effectiveness—The effectiveness of services rendered by a provider, determined by measurement of the medical outcome of patients grouped by severity receiving those services.

Raw data or *data*—Data collected by the Council under section 6 of the act in the form initially received.

Region—A geographical area of contiguous counties formed to provide a basis for implementing data collection activities and reporting according to the following:

(i) Region 1 (Western Southwest)—Allegheny, Armstrong, Beaver, Fayette, Green, Washington and Westmoreland Counties.

(ii) Region 2 (Northwest)—Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, Lawrence, McKean, Mercer, Potter, Venango and Warren Counties.

(iii) Region 3 (Eastern Southwest)—Bedford, Blair, Cambria, Indiana and Somerset Counties.

(iv) Region 4 (North Central)—Centre, Clinton, Columbia, Lycoming, Mifflin, Montour, Northumberland, Snyder, Tioga and Union Counties.

(v) Region 5 (South Central)—Adams, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lancaster, Lebanon, Perry and York Counties.

(vi) Region 6 (Northeast)—Bradford, Lackawanna, Luzerne, Monroe, Pike, Sullivan, Susquehanna, Wayne and Wyoming Counties.

(vii) Region 7 (Eastern)—Berks, Carbon, Lehigh, Northampton and Schuylkill Counties.

(viii) Region 8 (Suburban Southeast)—Bucks, Chester, Delaware and Montgomery Counties.

(ix) Region 9 (Southeast—Philadelphia)—Philadelphia County.

Short term procedure unit—A unit organized for the delivery of nonemergency surgical services to patients who do not remain in the hospital overnight.

Special hospital—A hospital equipped and staffed for the treatment of disorders within the scope of specific medical specialties or for the treatment of limited classifications of diseases in their acute or chronic stages on an inpatient basis of 24 or more hours. The term includes psychiatric and rehabilitation hospitals.

Specialty unit—A functional unit of a hospital that provides drug and alcohol rehabilitation, rehabilitative and psychiatric services.

Authority

The provisions of this § 912.3 amended under section 5(b) of the Health Care Cost Containment Act (35 P. S. § 449.5(b)).

Source

The provisions of this § 912.3 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459; amended April 8, 1988, effective March 1, 1988, 18 Pa.B. 1607; amended October 1, 1999, effective October 2, 1999, 29 Pa.B. 5093. Immediately preceding text appears at serial pages (242560) to (242562).

Subchapter B. PENNSYLVANIA UNIFORM CLAIMS AND BILLING FORM SUBMISSION SCHEDULES

GENERAL PROVISIONS

Sec.
912.21. Required data elements.
912.22. Data element submission schedules.
912.23. Form of data submissions and release by Council.
912.24. Frequency of data submissions.

EXCEPTIONS

INTERPRETATIONS

GENERAL PROVISIONS

§ 912.21. Required data elements.

(a) A health care facility is required to submit the following data elements:

(1) Data elements specified in the act contained in Council Manual HC-87-101, Volume A. (See Appendix A.) A health care facility shall refer to Appendix A to determine specific data elements definitions and formats.

(2) Additional data elements, as defined in Appendix A:

(i) Unusual occurrences.

(A) Nosocomial infections.

(B) Readmissions.

(ii) Patient race.

(b) A hospital is required to submit the following additional data elements:

(1) *Patient morbidity.* A hospital shall refer to Council Manual HC-87-101, Volume A, Field 21b (See Appendix A) to determine formats.

(2) *Patient severity.* A hospital shall refer to Council Manual HC-87-101, Volume A, Field 21a (See Appendix A) to determine formats.

Source

The provisions of the 912.21 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459; amended April 8, 1988, effective March 1, 1988, 18 Pa.B. 1607. Immediately preceding text appears at serial page (124980).

§ 912.22. Data element submission schedules.

A health care facility shall submit data under the following schedules:

(1) General hospitals with more than 100 licensed beds.

(i) *Inpatient data elements.* A general hospital is required to submit data elements for inpatient discharges in the first quarter of 1988 by June 30, 1988, and thereafter, under § 912.24 (relating to frequency of data submissions).

(ii) *Outpatient data elements.* A general hospital is required to submit data elements for outpatient covered services by March 31, 1989, for discharges in the fourth quarter of 1988 and thereafter, under § 912.24.

(iii) *Patient morbidity and patient severity data elements.* A general hospital is required to submit data elements for patient morbidity and patient severity for inpatients admitted on or following the implementation date, excluding those in specialty units, in accordance with the following schedule:

(A) *Region 5.* Discharges in the second quarter of 1988 are due on or before September 30, 1988, and thereafter, under § 912.24.

(B) *Region 7.* Discharges in the third quarter of 1988 are due on or before December 31, 1988, and thereafter, under § 912.24.

(C) *Region 1.* Discharges in the fourth quarter of 1988 are due on or before March 31, 1989, and thereafter, under § 912.24.

(D) *Regions 6 and 8.* Discharges in the first quarter of 1989 are due on or before June 30, 1989, and thereafter, under § 912.24.

(E) *Regions 2, 3 and 4.* Discharges in the second quarter of 1989 are due on or before September 30, 1989, and thereafter, under § 912.24.

(F) *Region 9.* Discharges in the third quarter of 1989 are due on or before December 31, 1989, and thereafter, under § 912.24.

(2) General hospitals with 100 beds or less and other health care facilities. A general hospital with 100 beds or less or health care facility, excluding a health care facility identified in paragraph (1), are required to submit data elements for inpatient discharges and data elements for outpatient covered services rendered in the fourth quarter of 1988 by March 31, 1989, and thereafter, under § 912.24. The following schedule shall be used for patient morbidity and patient severity:

(i) For inpatient admissions beginning July 1, 1989, a general hospital in Regions 1, 2, 3, 4 and 5 shall submit data for discharges in the third quarter of 1989 on or before December 31, 1989, and thereafter, under § 912.24.

(ii) For inpatient admissions beginning October 1, 1989, a general hospital in Regions 6, 7, 8 and 9 shall submit data for discharges in the fourth quarter of 1989 on or before March 31, 1990, and thereafter, under § 912.24.

(iii) For inpatient admissions beginning January 1, 1990, special hospitals and specialty units shall submit data for discharges in the first quarter of 1990 on or before June 30, 1990, and thereafter, under § 912.24.

Source

The provisions of this § 912.22 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459; amended April 8, 1988, effective March 1, 1988, 18 Pa.B. 1607; amended December 2, 1988, effective upon publication and applies retroactively to January 30, 1988, 18 Pa.B. 5351. Immediately preceding text appears at serial pages (127084) to (127085).

§ 912.23. Form of data submissions and release by Council.

Data elements required to be submitted under this subchapter shall be submitted on nine-track labeled 1600 or 6250 BPI (density) tape or computer diskette approved by the Council, according to computer tape format specification contained in Appendix A.

Source

The provisions of this § 912.23 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459.

§ 912.24. Frequency of data submissions.

Data elements required to be submitted under this subchapter shall be submitted on a quarterly basis by the last day of the third month following the close of the quarter. Data elements for inpatient discharges and outpatient services rendered in calendar quarters ending March 31, June 30, September 30 and December 31, shall be submitted by June 30, September 30, December 31 and March 31.

Source

The provisions of this § 912.24 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459.

Cross References

This section cited in 28 Pa. Code § 912.22 (relating to data element submission schedules).

EXCEPTIONS

§ 912.31. Principle.

The Council may, within its discretion and for good reason, grant exceptions to sections within this chapterwhen the policy and objectives of this chapter and the act are otherwise met.

Authority

The provisions of this § 912.31 amended under section 5(b) of the Health Care Cost Containment Act (35 P. S. § 449.5(b)).

Source

The provisions of this § 912.31 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459; amended April 8, 1988, effective March 1, 1988, 18 Pa.B. 1607; amended October 1, 1999, effective October 2, 1999, 29 Pa.B. 5094. Immediately preceding text appears at serial page (242565).

§ 912.32. Requests for exceptions.

Requests for exceptions shall be made in writing addressed to the Executive Director. A request shall be specific to the section in this chapter to which the request applies and shall state in detail the reasons for the request. A request for

an exception shall be received and deemed as complete 90 days prior to the appropriate submission date for which the request applies. The Council will act within 60 days of receipt of a complete request. A majority vote by the Council is necessary to grant an exception. Disapproval of the exception request at the Council level shall be deemed to represent disapproval of the request. Applicants will be notified in writing of the action taken by the Council.

Source

The provisions of this § 912.32 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459.

§ 912.33. Revocation of exceptions.

(a) An exception granted under this chapter may be revoked by the Council. Notice of revocation will be in writing and will include the reason for the action of the Council and a specific date upon which the exception will be terminated.

(b) In revoking an exception, the Council will provide for a reasonable time between the date of written notice of revocation and the date of termination of an exception for the health care facility to come into compliance with this chapter. Failure by the facility to comply after the specified date may result in enforcement proceedings.

(c) If a facility wishes to request a reconsideration of a denial or revocation of an exception, it shall do so in writing within 30 days of receipt of the adverse notification.

Source

The provisions of this § 912.33 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459.

INTERPRETATIONS

§ 912.41. Definition for major ambulatory service.

(a) The Council may issue interpretations of this subchapter which apply to the question of which major ambulatory services are considered to be covered services and submission and modifications to schedules of data pertaining to them.

(b) Interpretations issued under this section will be subject to modification by the Council in an adjudicative proceeding based on the particular facts and circumstances relevant to a service.

Source

The provisions of this § 912.41 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459.

Subchapter C. FINANCIAL REPORTING REQUIREMENTS

Sec.

§ 912.61. Annual audited financial statements.

(a) For fiscal years beginning January 1, 1988, and thereafter, a hospital and ambulatory service facility providing covered services shall file annual audited financial statements within 120 days after the close of the fiscal year.

(b) The financial statements shall be certified by an independent certified public accountant who shall render an opinion that the statements have been prepared in accordance with generally accepted accounting principles, and on the financial position, results of operations and changes in financial positions of the hospital as of and for the period then ended.

(c) The certified annual statements shall contain the following:

(1) A balance sheet detailing the assets, liabilities and net worth of the hospital or ambulatory service facility.

(2) A statement of revenue and expenses that fully discloses deductions from revenue according to contractual adjustments and other deductions.

(3) A statement of changes in financial position.

(4) Footnotes to financial statements.

(d) If more than one health care facility is operated by the reporting organization, the information required by this section shall be reported for each health care facility separately.

Source

The provisions of this § 912.61 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459.

§ 912.62. Quarterly summary utilization and financial reports.

(a) A hospital and ambulatory care facility providing covered services shall compile data following instructions on report format HC-87-Q1 beginning May 1, 1988.

(b) Quarterly summary utilization and financial reports, due 45 days following each quarter, shall be sent to the Council beginning with the first quarter of 1988. Report formats shall follow the instructions and Form HC-87-Q1.

Source

The provisions of this § 912.62 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459.

§ 912.63. Medicare cost reports and Medical Assistance Form 336.

(a) A provider is required to submit to the Council a copy of its Medicare cost report and Medical Assistance Form 336 at the time they are due to the Department of Welfare or the Health Care Financing Administration or within 120 days of the close of its fiscal year reporting period.

(b) A provider is required to submit the settled Medicare cost report and certified MA 336 Form within 30 days of the final settlement.

Source

The provisions of this § 912.63 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459.

Subchapter D. OTHER REQUIREMENTS

Sec.
912.81. Provider information.

§ 912.81. Provider information.

A provider shall submit the following information annually on a form designed by the Council and in accordance with a submission schedule developed by the Council.

(1) *Physicians on staff.* A health care facility shall submit a listing of hospital-based and nonhospital-based physicians on the active, associate, courtesy and consulting medical staff. The listing shall include physician name, Pennsylvania license number and clinical specialty. The listing shall indicate whether the physician is Board-certified in the listed specialties.

(2) *Medicare assignment.* A physician shall indicate whether the physician accepts Medicare assignment as full payment for services.

(3) *Medical Assistance participation.* A physician shall indicate whether the physician is registered as a provider with the Commonwealth's Medical Assistance Program. If the physician is registered, the number assigned by the Medical Assistance Program shall be listed.

(4) *Accreditation, certification and licensure.* A provider shall submit information concerning accreditation, certification and licensure of the facility by the Commonwealth; the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or certified for Medicare Conditions of Participation; and the Commission on the Accreditation of Rehabilitation Facilities. The information shall include the accrediting/certifying/licensing agency, the type of accreditation/certification/licensure and the term, including the expiration date.

(242568) No. 282 May 98

Source

The provisions of this § 912.81 adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459.

APPENDIX A

Pennsylvania
Uniform Claims

and

Billing Form
Reporting Manual

HC-87-101 Volume A—Inpatient Data Reporting

Pennsylvania Health Care Cost
Containment Council
Harrisburg Transportation Center
Suite 208
4th and Chestnut Streets
Harrisburg, Pennsylvania 17101
(717) 232-6787

Purpose

The purpose of this manual is to provide data sources with the technical specifications necessary for data collection and data submissions to the Council. According to Act 89, the collection of health data by the Council will be used to facilitate the continuing provision of quality, cost-effective health services throughout the Commonwealth by providing data and information to the purchasers and consumers of health care on both cost and quality of health care services.

Volume A pertains to data submission formats for hospitals and ambulatory service facilities. The Council will collect the raw data from the various data sources, using some key matching data elements, merge the data to provide records per hospitalization or major ambulatory service visit.

Table of Contents

Index by Data Element Name

Data Element Name	*Field #*	*UB-92 Form Locater*
Admission Date	5	6
Admission Hour	40	18
Admission—Type of	26	19

Data Element Name	*Field #*	*UB-92 Form Locater*
Admission—Source of	27	20
Admitting Diagnosis	36	76
Certification/SSN/ Health Insurance Claim Number	29a—c	60
Discharge Date	6	6
Discharge Hour	41	21
Diagnosis Related Group (DRG)	24	2h
E-Code	37	77
Employer Name	32a—c	65
Employment Status	34a—c	64
Estimated Amount Due	14g	55
Federal Tax ID	39	5
HCPCS/Rates	13a—w6	44
Hispanic/Latino Origin or Descent	35a	2i
Non-Covered Charges	13a—w5	48
Patient Discharge Status	20	22
Patient Date of Birth	2	14
Patient Control Number	23	3
Patient—Uniform Identification	1	2a
Patient Race	35b	2j
Patient Relationship to Insured	28a—c	59
Patient Sex	3	15
Patient Zip Code	4	13
Payor Group Number	19	62
Payor Identification	14b	50
Physician Identification—Attending	11	82
Physician Identification—Operating	12	83
Physician Identification—Referring	38	82
Principal Diagnosis	7a	67
Principal Procedure Code and Date	8a, 8b	80
Prior Payments—Payor and Patient	14f	54
Procedure Coding Method Used	25	79
Provider Quality	21a	2d
Provider Service Effectiveness	21b	2e
Revenue Code	13a—w2	42
Reserve Field	21e	HC4
Secondary Diagnosis	7b—i	68—75
Secondary Procedure Code and Date	9	81
Service Date	13a—w7	45
Total Charges	13a—w4	47
Type of Bill	22	4
Uniform Identifier of Health Care Facility	10	2b
Uniform Identifier of Primary Payor	17	2c

Data Element Name	*Field #*	*UB-92 Form Locater*
Units of Service	13a—w3	46
Unusual Occurrence—Nosocomial Infection	21c	2f
Unusual Occurrence—Readmission	21d	29

Index by Field Number

Data Element Name	*Field #*	*UB-92 Form Locater*
Patient—Uniform Identification	1	2a
Patient Date of Birth	2	14
Patient Sex	3	15
Patient Zip Code	4	13
Admission Date	5	6
Discharge Date	6	6
Principal Diagnosis	7a	67
Secondary Diagnosis	7b—i	68—75
Principal Procedure Code and Date	8a, 8b	80
Secondary Procedure Code and Date	9	81
Uniform Identifier of Health Care Facility	10	2b
Physician Identification—Attending	11	82
Physician Identification—Operating	12	83
Revenue Code	13a—w2	42
Units of Service	13a—w3	46
Total Charges	13a—w4	47
Non-Covered Charges	13a—w5	48
HCPCS/Rates	13a—w6	44
Service Date	13a—w7	45
Payor Identification	14b	50
Prior Payments—Payor and Patient	14f	54
Estimated Amount Due	14g	55
Uniform Identifier of Primary Payor	17	2c
Payor Group Number	19	62
Patient Discharge Status	20	22
Provider Quality	21a	2d
Provider Service Effectiveness	21b	2e
Unusual Occurrence—Nosocomial Infection	21c	2f
Unusual Occurrence—Readmission	21d	29
Reserve Field	21e	
Type of Bill	22	4
Patient Control Number	23	3
Diagnosis Related Group (DRG)	24	2h

Data Element Name	*Field #*	*UB-92 Form Locater*
Procedure Coding Method Used	25	79
Admission—Type of	26	19
Admission—Source of	27	20
Patient Relationship to Insured	28a—c	59
Certification/SSN/Health Insurance Claim Number	29a—c	60
Employer Name	32a—c	65
Employment Status	34a—c	64
Hispanic/Latino Origin or Descent	35a	2i
Patient Race	35b	2j
Admitting Diagnosis	36	76
E-Code	37	77
Physician Identification—Referring	38	82
Federal Tax ID	39	5
Admission Hour	40	18
Discharge Hour	41	21

Hospital and Ambulatory Service Facility Reporting Manual

	Field 1	Revised 3/25/88, 1/1/94
Data Element:	Uniform Patient ID	
Definition:	Patient's Social Security Number	
Procedures:	Right justify, no dashes. If the patient's Social Security Number is unknown, fill this field with blanks after contacting the Department of Social Security in your area.	
Field Size:	1 field, 9 characters	
Record Position:	1—9	
Format:	Alphanumeric	
Reference:	UB-92, Item 2a (Pos 1—9 of 29 character field, upper line)	

	Field 2	Revised 4/1/90
Data Element:	Patient Birthdate	
Definition:	Date of birth of the patient	
Procedure:	MMDDYYYY, No dashes Example: 01011992	
Field Size:	1 field, 8 characters	
Record Position:	10—17	
Format:	Numeric	

Reference:	UB-92, Item 14

Field 3

Data Element:	Patient Sex
Definition:	The sex of the patient as recorded at the date of admission, outpatient service, or start of care.
Procedure:	M = Male F = Female U = Unknown
Field Size:	1 field, 1 character
Record Position:	18
Format:	Alphanumeric
Reference:	UB-92, Item 15

Field 4 Revised 1/1/94

Data Element:	Patient Zip Code
Definition:	Zip code of patient taken from the patient name and address field.
Procedure:	XXXXXYYYY Five character zip code with a four character extension. Facility should attempt to obtain the 4 character zip code extension, however, if the four character extension is unknown, fill with blanks. Left justify.
Field Size:	1 field, 9 characters
Record Position:	19—27
Format:	Alphanumeric
Reference:	UB-92, Item 13

Field 5 Revised 4/1/90

Data Element:	Date of Admission
Definition:	The date that the patient was admitted to the provider for inpatient care or start of care.
Procedure:	MMDDYYYY Example: 01011992
Field Size:	1 field, 8 characters
Record Position:	28—35
Format:	Numeric
Reference:	UB-92, Item 6 (taken from the "FROM" Date field)

Field 6 Revised 4/1/90

Data Element:	Date of Discharge

Definition:	Inpatient: The ending service date of patient care. The date that the patient was discharged from the provider's care.
Procedure:	MMDDYYYY Example: 01011992
Field Size:	1 field, 8 characters
Record Position:	36—43
Format:	Numeric
Reference:	UB-92, Item 6, (taken from "Through" Date field)

Field 7a Revised 7/1/88, 4/1/90, 1/1/94

Data Element:	Principal Diagnosis Code
Definition:	The code describing 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 discovered subsequently that has an effect on the length of stay.
Procedure:	Use ICD-9-CM codes. "V" codes are permitted. The reporting of the decimal between the third and fourth digits is unnecessary because it is implied. Left justify. Fill with blanks right. The code structure must be consistent with the information provided in Fields 7b—i and 25.
Field Size:	1 field, 6 characters
Record Position:	48—53
Format:	Alphanumeric
Reference:	UB-92, Item 67

Field 7b, c, d, e, f, g, h, i Revised 4/1/93, 1/1/94

Data Element:	Secondary Diagnosis Codes
Definition:	The diagnoses codes corresponding to additional conditions that co-exist at the time of admission, or discovered subsequently, and which have an effect on the treatment received or the length of stay.
Procedure:	The code structure must be consistent with the coding used in Fields 7a, 25 and 30. The reporting of the decimal between the third and fourth digits is unnecessary because it is implied. Use ICD-9-CM codes. Other diagnoses codes will permit the use of ICD-9-CM "V"—codes where appropriate. (See Field 37—E-Code to determine other E-Code placement.) Left justify. Blank fill.
Field Size:	8 fields, 6 characters

Record Position:	7b 54—59	7f 78—83
	7c 60—65	7g 84—89
	7d 66—71	7h 90—95
	7e 72—77	7i 96—101
Format:	Alphanumeric	
Reference:	UB-92, Items 68—75	

Field 8a, 8b — Revised 1/1/94

Data Element:	Principal Procedure Code and Date
Definition:	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.
Procedure:	The code structure must be consistent with the information provided in Fields 9 and 25. Use ICD-9-CM codes unless the payor requires HCPCS or CPT-4. The reporting of the decimal between the second and third digits is unnecessary because it is implied. Left justify. Blank fill right. The date must be equal to or greater than admission date (Field 5) and equal to or less than discharge date (Field 6). Record date as MMDD
Field Size:	2 fields, 5 character Procedure Code 4 character date
Record Position:	8a 114—120 (Procedure Code) 8b 121—124 (Date)
Format:	Procedure Code = alphanumeric Date = numeric
Reference:	UB-92, Item 80

Field 9a1, 9a2, 9b2, 9c1, 9c2, 9d1, 9d2, 9e1, 9e2 — Revised 3/25/88, 1/1/94

Data Element:	Secondary Procedure Codes and Dates
Definitions:	The codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis.

Procedure:	The code structure must be consistent with the information provided in Fields 8 and 25. Use ICD-9-CM codes unless the payor requires HCPCS or CPT-4. Enter codes in descending order of importance. The reporting of the decimal between the second and third digits is unnecessary because it is implied. Left justify. Blank fill right. Record date as MMDD. Date must be equal to or greater than admission date (Field 5) and equal to or less than the discharge date (Field 6).
Field Size:	5 fields, 7 character Procedure Code 4 character date
Record Position:	9a1 125—131 (Procedure Code) 9a2 132—135 (Date) 9b1 136—142 (Procedure Code) 9b2 143—146 (Date) 9c1 147—153 (Procedure Code) 9c2 154—157 (Date) 9d1 158—164 9d2 165—168 9e1 169—175 9e2 176—179
Format:	Procedure Code = alphanumeric Date = numeric
Reference:	UB-92, Item 81a—e

Field 10 Revised 4/1/90, 7/1/88

Data Element:	Uniform Identifier for Health Care Facility.
Definition:	Number identifying the provider facility as developed and used by Medicaid. (See Appendix A.) If your unit is not listed in Appendix A, please contact the Council in writing and we will provide you with a Council assigned number for the unit.
Procedure:	Left justify. Blank fill right.
Field Size:	1 field, 8 characters
Record Position:	1751—1758
Format:	Alphanumeric
Reference:	UB-92, Item 2b (Pos 10—17 of 29 character field, upper line)

Field 11 Revised 3/25/88, 4/1/90

Data Element:	Attending Physician ID
Definition:	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.

Procedure:	Character 1—9 = PA State License Number Character 10—21 = Last Name Character 22—23 = First & Middle Initials Do not place the "PA" in the PA State License number in this field. Format as follows: MD123456L. Left justify. Blank fill right, if name unknown.
Field Size:	1 field, 23 characters
Record Position:	203—225
Format:	Alphanumeric
Reference:	UB-92, Item 82 (lower line)

Field 12 Revised 3/25/88, 4/1/90

Data Element:	Operating Physician ID
Definition:	The PA state license number of the physician other than the attending physician who performed the principal procedure.
Procedure:	Character 1—9 = PA State License Number Character 10—21 = Last Name Character 22—23 = First & Middle Initials Do not place the "PA" in the PA State License Number in this field. Format as follows: MD123456L. If no procedure performed, leave blank. Left justify. Blank fill right, if name unknown.
Field Size:	1 field, 23 characters
Record Position:	226—248
Format:	Alphanumeric
Reference:	UB-92, Item 83 (lower line)

Field 13a2—13w2

Data Element:	Revenue Code
Definition:	A code which identifies a specific accommodation, ancillary service or billing calculation.
Procedure:	See the table that indicates payers' specific needs for detailed revenue code information. (See Appendix C.) (See Appendix G for instructions when there are more than 23 lines which would create the need for a second page.) Left justify. Line 23 will be 001
Field Size:	23 fields, 4 characters each
Format:	Alphanumeric
Reference:	UB-92, Item 42

Record Position:	13a2 249—252	13i2 633—636	13q2 1017—1020
	13b2 297—300	13j2 681—684	13r2 1065—1068
	13c2 345—348	13k2 730—732	13s2 1113—1116
	13d2 393—396	13l2 777—780	13t2 1161—1164
	13e2 441—444	13m2 825—828	13u2 1209—1212
	13f2 489—492	13n2 873—876	13v2 1257—1260
	13g2 537—540	13o2 921—924	13w2 1305—1308
	13h2 585—588	13p2 969—972	

Field 13a3—13w3 Revised 3/25/88

Data Element:	Units of Service
Definition:	A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, or renal dialysis treatments, etc., according to Medicare definitions.
Procedure:	Right justify. Zero fill left. Last line fill with zeroes. (See Appendix C.) (See Appendix G for instructions when there are more than 23 lines which would create the need for a second page.)
Field Size:	23 fields, 7 characters
Format:	Numeric
Reference:	UB-92, Item 46

Record Position:	13a3 270—276	13i3 654—660	13q3 1038—1044
	13b3 318—324	13j3 702—708	13r3 1086—1092
	13c3 366—372	13k3 750—756	13s3 1134—1140
	13d3 414—420	13l3 798—804	13t3 1182—1188
	13e3 462—468	13m3 846—852	13u3 1230—1236
	13f3 510—516	13n3 894—900	13v3 1278—1284
	13g3 558—564	13o3 942—948	13w3 1326—1332
	13h3 606—612	13p3 990—996	

Field 13a4—13w4 Revised 3/25/88, 1/1/94

Data Element:	Total Charges (by Revenue Code Category)
Definition:	Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
Procedures:	Right justify. No decimal. Line 23 is the total of all charges in this column. (See Appendix G for instructions when there are more than 23 lines which would create the need for a second page.)

Field Size:	23 fields, 10 characters each: Character 1 = credit {plus(+), minus(−), blank ( )} (If a blank is found, a + is assumed.) Character 2—8 = dollars fill with zeroes from credit character when applicable Character 9—10 = cents
Format:	Alphanumeric
Reference:	UB-92, Item 47

Record Position:			
13a4 277—286	13i4 661—670	13q4 1045—1054
13b4 325—334	13j4 709—718	13r4 1093—1102
13c4 373—382	13k4 757—766	13s4 1141—1150
13d4 421—430	13l4 805—814	13t4 1189—1198
13e4 469—478	13m4 853—862	13u4 1237—1246
13f4 517—526	13n4 901—910	13v4 1285—1294
13g4 565—574	13o4 949—958	13w4 1333—1342
13h4 613—622	13p4 997—1006	

Field 13a5—13w5 Revised 3/25/88, 1/1/94

Data Element:	Non-Covered Charges (by Revenue Category)
Definition:	Those charges that are not covered by a payor for this patient pertaining to the related revenue code.
Procedure:	Right justify. No decimal. Line 23 will be the total of all Non-Covered Charges. (See Appendix G for instructions when there are more than 23 lines which would create the need for a second page.)
Field Size:	23 fields, 10 characters each: Character 1 = credit {plus, (+), minus (−), blank ( )} (If a blank is found, a + is assumed.) Character 2—8 = dollars fill with zeroes from credit character when applicable Character 9—10 = cents
Format:	Alphanumeric
Reference:	UB-92, Item 48

Record Position:			
13a5 287—296	13i5 671—680	13q5 1055—1064
13b5 335—344	13j5 719—728	13r5 1103—1112
13c5 383—392	13k5 767—776	13s5 1151—1160
13d5 431—440	13l5 815—824	13t5 1199—1208
13e5 479—488	13m5 863—872	13u5 1247—1256
13f5 527—536	13n5 911—920	13v5 1295—1304
13g5 575—584	13o5 959—968	13w5 1343—1352
13h5 623—632	13p5 1007—1016	

(242580) No. 282 May 98

Field 13a6—13w6 Revised 1/1/94

Data Element:	HCPCS/Rates
Definition:	The accommodation rate for inpatient bills and the HCFA Common Procedure Coding System (HCPCS) applicable to ancillary services and outpatient bills.
Procedure:	Inpatient Bills: Accommodations must be entered in revenue code sequence. Dollar values reported in this field must include whole dollars and cents (NNNNNNNNN). When multiple rates exist for the same accommodation revenue code (e.g., semi-private room at $300 and $310), a separate revenue line should be used to report each rate, and the same revenue code should be reported on each line. Left justified for HCPCS. Right justified for rates. Field to be further developed. Until such time, fill this field with blanks.
Field Size:	1 field, 23 lines, 9 positions
Format:	Alphanumeric
Reference:	UB-92, Item FL 44

Record Position:			
13a6 253—261	13i6 637—645	13q6 1021—1029
13b6 301—309	13j6 685—693	13r6 1069—1077
13c6 349—357	13k6 733—741	13s6 1117—1125
13d6 397—405	13l6 781—789	13t6 1165—1173
13e6 445—453	13m6 829—837	13u6 1213—1221
13f6 493—501	13n6 877—885	13v6 1261—1269
13g6 541—549	13o6 925—933	13w6 1309—1317
13h6 589—597	13p6 973—981	

Field 13a7—13w7 Revised 1/1/94

Data Element:	Service Date
Definition:	Date that the indicated service was provided.
Procedure:	MMDDYYYY Field to be further developed. Until such time, fill this field with blanks.
Field Size:	1 field, 23 lines, 8 positions
Format:	Alphanumeric
Reference:	UB-92, Item FL 45

Record Position:	13a7 262—269	13i7 646—653	13q7 1030—1037
	13b7 310—317	13j7 694—701	13r7 1078—1085
	13c7 358—365	13k7 742—749	13s7 1126—1133
	13d7 406—413	13l7 790—797	13t7 1174—1181
	13e7 454—461	13m7 838—845	13u7 1222—1229
	13f7 493—501	13n7 886—893	13v7 1270—1277
	13g7 541—549	13o7 934—941	13w7 1318—1325
	13h7 598—605	13p7 982—989	

Field 14b1, 14b2, 14b3 Revised 3/25/88, 7/1/88, 4/1/90, 1/1/94

Data Element: Payor Type and Identification

Definition: Code identifying the type of payor organization and the name identifying the payor organization from which the provider might expect some payment for the bill.

Procedure: Place primary payor in 14b1. {If this is a bill that will be paid by the patient (self-pay), place the word ''self'' in this line.} (Where the guarantor is different than the patient, the guarantor should be listed in 14b1. If the patient and the guarantor are the same, the word ''self'' should be used in 14b1) Place secondary payor in 14b2. Place tertiary payor in 14b3. The first two digits of this field indicate the payor type. The following coding scheme is to be used to determine the appropriate code. The first digit of the two digit code indicates the type of claims paying organization that will make payment. The second digit indicates the types of product offerings of those organizations.

First Digit		Second Digit	
Medicare	1	Unknown/Other	0
Medicaid	2	HMO/PPO	5
Blue Cross	3	Health & Welfare Fund	6
Commercial	4	Workers' Compensation	7
Patient Direct Bill	0	Auto	8
Employer Direct Bill	5	Association	9
Other Government	8	Unknown/Other	9

Facility should utilize best judgement when determining appropriate code. Codes for Champus, Black Lung, and U.S. Postal Service should be coded as 80 = other government. The following are the valid combinations of this two digit code. Any other codes will generate an error for invalid payor code.

(242582) No. 282 May 98

Patient Direct Bill	00
HMO/PPO	05
Medicare	10
HMO/PPO	15
Medicaid	20
HMO/PPO	25
Blue Cross	30
HMO/PPO	35
Union Health & Welfare Fund	36
Association	39
Commercial	40
HMO/PPO	45
Union Health & Welfare Fund	46
Workers' Compensation	47
Auto	48
Association	49
Employer Direct Bill	50
HMO/PPO	55
Union Health & Welfare Fund	56
Workers' Compensation	57
Association	59
Other Government	80
Cat Fund	88
State Workers Insurance Fund	87
Other Unknown	90

If the payor is unknown, place the word ''unknown'' in this field.
If Medicare is entered in line 14b1, this indicates that the provider has developed for other insurance and has determined that Medicare is the primary payor.
Left justify Payor Name.
If Field 17, Uniform Identifier of Primary Payor is blank, this field must be filled. The Council will develop uniform numbers for these payers.

Field Size: 3 fields, 25 characters each

Record Position:				
14b1	1353—1354 Payor code	1355—1377	Payor Name
14b2	1378—1379 Payor code	1380—1402	Payor Name
14b3	1403—1404 Payor code	1405—1427	Payor Name

Format: Alphanumeric

Reference: UB-92, Item 50a, b, c

Field 14f1, 14f2, 14f3, 14f4 Revised 3/25/88, 1/1/94

Data Element: Prior payments—Payor and Patient

Definition:	The amount the hospital has received toward payment of this bill prior to the billing date, by the indicated payor.
Procedure:	Right justify. No decimal. Place the amount paid by the patient in 14f4. 1 = A = Primary 2 = B = Secondary 3 = C = Tertiary 4 = P = Due from patient
Field Size:	1 field, 4 lines, 10 characters each Character 1 = credit {plus (+), minus (−), blank ( )} (If a blank is found, a + is assumed.) Character 2—8 = dollars fill with zeroes from credit character when applicable Character 9—10 = cents
Record Position:	14f1 1428—1437 14f2 1438—1447 14f3 1448—1457 14f4 1458—1467
Format:	Alphanumeric
Reference:	UB-92, Item 54a, b, c, p

Field 14g1, 14g2, 14g3, 14g4 Revised 3/25/88, 1/1/94

Data Element:	Estimated Amount Due
Definition:	The amount estimated by the hospital to be due from the indicated payor (estimated responsibility less prior payments).
Procedure:	The Council will develop a methodology to apply to all hospitals. At the present time, fill with zeroes.
Field Size:	1 field, 4 lines, 10 characters each. Character 1 = credit {plus (+), minus (−), blank ( )} (If a blank is found, a + is assumed.) Character 2—8 = dollars fill with zeroes from credit character when applicable Character 9—10 = cents
Record Position:	14g1 1468—1477 14g2 1478—1487 14g3 1488—1497 14g4 1498—1507
Format:	Alphanumeric
Reference:	UB-92, Item 55a, b, c, p

(242584) No. 282 May 98

	Field 17	Revised 3/25/88, 7/1/88, 1/1/94
Data Element:	Uniform Identifier of Primary Payers.	
Definition:	NAIC Number. If number is not on the attached listing, the Health Care Cost Containment Council will assign a number based on the name in field 14b. (See Appendix D.)	
Procedure:	If the NAIC number is unknown, this field may be blank. If this field is blank, Field 14b, Payor Identification, must be filled. The Council will develop numbers for those Payor numbers that are unknown. Left justify. Fill with blanks right.	
Field Size:	1 field, 7 characters	
Record Position:	1508—1514	
Format:	Alphanumeric	
Reference:	UB-92, Item 2c (Pos 18—24 of 29 character field, upper line)	

	Field 19a, b, c	Revised 7/1/88, 1/1/94
Data Element:	Payor Group Number	
Definition:	The identification number, control number, or code assigned by the carrier or plan administrator to identify the group under which the individual is covered. Group number or policy number derived from Insurance Card as presented by the party responsible for the payment of this bill.	
Procedure:	Left justify. A = Primary Payer B = Secondary Payer C = Tertiary Payer If the claim is a self-pay claim, place the word ''self'' in this field.	
Field Size:	3 lines, 17 characters	
Record Position:	19a 1524—1540 19b 1541—1557 19c 1558—1574	
Format:	Alphanumeric	
Reference:	UB-92, Item 62	

	Field 20	Revised 1/1/94
Data Element:	Patient Discharge Status	
Definition:	A code indicating patient status as of the statement covers through date.	

Procedure:	Right justify Outpatient—zero fill		
	01	=	Discharged to home or self care (routine discharge)
	02	=	Discharged/transferred to another short term general hospital for inpatient care
	03	=	Discharged/transferred to skilled nursing facility (SNF)
	04	=	Discharged/transferred to an intermediate care facility (ICF)
	05	=	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
	06	=	Discharged/transferred to home under care of organized home health service organization
	07	=	Left against medical advice or discontinued care
	08	=	Discharged/transferred to home under care of a Home IV provider
	09**	=	Admitted as an inpatient to this hospital
	10—19	=	Discharge to be defined at state level, if necessary
	20	=	Expired
	21—29	=	Expired to be defined at state level, if necessary
	30	=	Still patient or expected to return for outpatient services
	31—39	=	Still patient to be defined at state level, if necessary
	40*	=	Expired at home
	41*	=	Expired in a medical facility, e.g. hospital, SNF, ICF, or freestanding hospice
	42*	=	Expired—place unknown
	43—99	=	Reserved for national assignment
	* For use *only* on Medicare claims for hospice care. ** For use *only* on Medicare outpatient claims.		
Field Size:	1 field, 2 characters		
Record Position:	1575—1576		
Format:	Numeric		
Reference:	UB-92, Item 22		

Field 21a Revised 7/1/88, 6/21/03

Data Element: Provider Quality

Definition: Provider quality consistent with section 6(d) of the act (35 P. S. § 449.6(d)) and with § 911.3 (relating to council adoption of methodology). Periodically, the Council will review the methodology, and if 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.

Field Size: 1 field, 1 character

Record Position: 1577

Format: Alphanumeric

Reference: UB-92, Item 2d (Pos 1 of 30 character field, lower line)

Field 21b Revised 7/1/88, 4/1/90, 6/21/03

Data Element: Provider Service Effectiveness

Definition: Provider service effectiveness consistent with section 6(d) of the act (35 P. S. § 449.6(d)) and with § 911.3. Periodically, the Council will review the methodology, and if 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.

Field Size: 1 field, 1 character

Record Position: 1578

Format: Alphanumeric

Reference: UB-92, Item 2e (Pos 2 of 30 character field, lower line)

Field 21c Revised 4/1/90

Data Element: Unusual Occurrence

Definition:	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; or 2. are related to a hospital procedure performed within the first 72 hours. The Council will develop a methodology to apply to all hospitals. Until that time, fill with blanks.
Procedures:	One digit code as follows: 1 = Urinary Tract 2 = Surgical Wound 3 = Respiratory Tract 4 = Intravenous 5 = Multiple Types 6 = Undetermined 7 = Other 8 = No nosocomial infection present 9 = Unknown Outpatient—Blank fill
Field Size:	1 field, 1 character
Record Position:	1579
Format:	Alphanumeric
Reference:	UB-92, Item 2f (Pos 3 of 30 character field, lower line)

Field 21d Revised 3/25/88

Data Element:	Unusual Occurrence
Definition:	Patient readmission to the hospital, from a previous discharge, within 30 days. The Council will develop a methodology to apply to all hospitals. Until that time, fill with zeroes.
Procedure:	Right justify. Fill with the number of days since the previous admission.
Field Size:	1 field, 2 characters
Record Position:	1580—1581
Format:	Numeric
Reference:	UB-92, Item 2g (Pos 4—5 of 30 character field, lower line)

Field 21e Revised 4/1/90

Data Element:	Reserve Field
Definition:	To be reserved for future use by the Council.
Field Size:	1 field filler, 532 characters

Record Position:	1769—2300
Format:	Alphanumeric

Field 22 Revised 4/1/90

Data Element:	Type of bill
Definition:	A code indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.)

Procedure: This three digit code requires 1 digit each, in the following sequence:

1. Type of facility
2. Bill classification
   When an outpatient bill is coded, the first and second digits must appear on the Council's tape in the following possible combinations:

1st Digit:	*2nd Digit*:
1	3
1	9
7	3
7	9
7	1
8	3
8	9

3. Frequency
   All positions must be fully coded

See Appendix E

Field Size: 1 field, 3 characters

Record Position: 1582—1584

Format: Alphanumeric

Reference: UB-92, Item 4

Field 23 Revised 4/1/90, 1/1/94

Data Element: Patient Control Number

Definition: Patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.
Use your Patient Billing Account Number.

Procedure: Right justify

Field Size: 1 field, 20 characters

Record Position: 1585—1604

Format: Alphanumeric

Reference: UB-92, Item 3

Field 24 Revised 3/25/88, 4/1/90

Data Element: Diagnosis Related Group (DRG)

Definition: The condition established after study as being chiefly responsible for this hospitalization. Classification of payment group based on diagnosis, age, treatment procedure, and discharge status.

Procedure:	Right justify with leading zeroes. Use the Medicare grouper in effect for each reporting period for DRG classification. If unknown, the Council will assign the DRG code.
Field Size:	3 characters
Record Position:	1605—1607
Format:	Numeric
Reference:	UB-92, Item 2h (Pos 6—8 of 30 character field, lower line)

Field 25

Data Element:	Procedure Coding Method Used
Definition:	An indicator that identifies the coding method used for procedure coding on this bill.
Procedure:	1—3 = Reserved for state assignment 4 = CPT=4 5 = HCPCS (HCFA Common Procedure Coding System) 6—8 = Reserved for National assignment 9 = ICD-9-CM
Field Size:	1 field, 1 character
Record Position:	1608
Format:	Numeric
Reference:	UB-92, Item 79

Field 26 Revised 1/1/94

Data Element:	Type of Admission	
Definition:	A code indicating the priority of this admission	
Procedure:	Code structure:	
	1 = Emergency	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.
	2 = Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.
	3 = Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
	4 = Newborn	Use of this code necessitates the use of special Source of Admission Codes—see Field 27.

	5—8 = Reserved for National assignment.
Field Size:	1 field, 1 character
Record Position:	1609
Format:	Alphanumeric
Reference:	UB-92, Item 19

Field 27 Revised 1/1/94

Data Element:	Source of Admission
Definition:	A code indicating the source of this admission.
Procedure:	*Code structure (for Emergency, Elective or Other Type of Admission)*:

1 = Physician Referral	*Inpatient*: The patient was admitted to this facility upon the recommendation of his or her personal physician.
2 = Clinic Referral	*Inpatient*: The patient was admitted to this facility upon the recommendation of this facility's clinic physician.
3 = HMO Referral	*Inpatient*: The patient was admitted to this facility upon the recommendation of a health maintenance organization physician.
4 = Transfer from a Hospital	*Inpatient*: The patient was admitted to this facility as a transfer from a Hospital from an acute care facility where he or she was an inpatient.
5 = Transfer from a Skilled Nursing Facility	*Inpatient*: The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient.
6 = Transfer from another Health Care Facility	*Inpatient*: The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a non-skilled level of care.

	7 = Emergency Room	*Inpatient*: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.
	8 = Court/Law Enforcement	*Inpatient*: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.
	A—Z	Reserved for national assignment
	Code Structure (for Newborn):	
	1 = Normal Delivery	A baby delivered without complications.
	2 = Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status.
	3 = Sick Baby	A baby delivered with medical complications, other than those relating to premature status.
	4 = Extramural Birth	A newborn born in a non-sterile environment.
	5—8 =	Reserved for National assignment.
	Newborn coding structure must be used when the Type of Admissions (Field 26) code 4	
Field Size:	1 Field, 1 character	
Record Position:	1610	
Format:	Alphanumeric	
Reference:	UB-92, Item 20	

Field 28a, b, c

Data Element:	Patient's Relationship to Insured
Definition:	A code indicating the relationship of the patient to the identified insured.
Procedure:	A = Primary Payer B = Secondary Payer C = Tertiary Payer Right justify. (See Appendix F for code definitions)
Field Size:	3 fields, 2 characters each

Record Position:	28a 1611—1612 28b 1613—1614 28c 1615—1616
Format:	Numeric
Reference:	UB-92, Item 59a, b, c

Field 29a, b, c Revised 7/1/88, 4/1/90

Data Element:	Certification/SSN/Health Insurance Claim Number
Definition:	Insured's unique identification number assigned by the payer organization.
Procedures:	A = Primary Payer B = Secondary Payer C = Tertiary Payer Left justify. If the claim is a self-pay claim, place the word ''self'' in this field.
Field Size:	3 fields, 19 characters each
Record Position:	29a 1617—1635 29b 1636—1654 29c 1655—1673
Format:	Alphanumeric
Reference:	UB-92, Item 60a b, c

Field 32a, b, c Revised 3/25/88, 4/1/90

Data Element:	Employer Name
Definition:	The name of the employer that might or does provide health care coverage for the individual who is responsible for the payment of this bill.
Procedure:	A = Primary Payer B = Secondary Payer C = Tertiary Payer Left justify. If the name of the employer is unknown, place the word ''unknown'' in this field.
Field Size:	3 fields, 24 characters
Record Position:	32a 1674—1697 32b 1698—1721 32c 1722—1745
Format:	Alphanumeric
Reference:	UB-92, Item 65a, b, c

Field 34a, b, c Revised 7/1/88, 4/1/90

Data Element:	Employment Status Code	
Definition:	A code used to define the employment status of the individual who is responsible for the payment of this bill.	
Procedure:	A = Primary Payer B = Secondary Payer C = Tertiary Payer	
	Code Structure:	
	1 Employed full time	Individual states that he/she is employed full time.
	2 Employed part time	Individual states that he/she is employed part time.
	3 Not Employed	Individual states that he/she is not employed full time or part time.
	4 Self Employed 5 Retired 6 On active Military Duty 7—8 Reserved for National Assignment	
	9 Unknown	Individual's employment status is unknown.
Field Size:	3 fields, 1 character each	
Record Position:	34a 1746 34b 1747 34c 1748	
Format:	Numeric	
Reference:	UB-92, Item 64a, b, c	

Field 35a Revised 4/1/93

Data Element:	Hispanic/Latino Origin or Descent
Definition:	Hispanic/Latino Origin 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 his/her ancestors were born before their arrival in the United States
Procedure:	1 = Yes, Patient is of Hispanic Origin or Descent 2 = No, Patient is not of Hispanic Origin or Descent
Field Size:	1 field, 1 character
Record Position:	1749
Format:	Alphanumeric

Reference:	UB-92, Item 2i (Pos 9 of 30 character field, lower line)

Field 35b Revised 3/25/88, 4/1/93

Data Element:	Patient Race
Definition:	This code indicates the patient's racial background.
Procedure:	Coding as follows: W = White B = Black A = Asian or Pacific Island I = Native American or Eskimo N = Other U = Unknown
Field Size:	1 field, 1 character
Record Position:	1750
Format:	Alphanumeric
Reference:	UB-92, Item 2j (Pos 10 of 30 character field, lower line)

Field 36 Revised 1/1/94

Data Element:	Admitting Diagnosis
Definition:	The ICD-9-CM diagnosis code provided at the time of admission by the Attending Physician.
Procedure:	The ICD-9-CM diagnosis code describing the admitting diagnosis as a significant finding representing patient distress, an abnormal finding on examination, a possible diagnosis based on significant findings, a diagnosis established from a previous encounter or admission, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report only one admitting diagnosis. This condition shall be determined based on the ICD-9-CM coding directives in Volumes I and II of the ICD-9-CM coding manuals and the official coding guidelines. The reporting of the decimal between the third and fourth digits is unnecessary because it is implied. Left justify. Blank fill right.
Field Size:	1 field, 6 characters
Record Position:	102—107
Format:	Alphanumeric
Reference:	UB-92, FL 76

Field 37 Revised 1/1/94

Data Element:	E-Code—External Cause of Injury Code

Definition:	The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.
Procedure:	Whenever there is a diagnosis of an injury, poisoning, or adverse effect, this field should be filled using the following priorities: 1. Principal diagnosis of an injury or poisoning; 2. Other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis; 3. Other diagnosis with an external cause. The reporting of the decimal between the third and fourth digits is unnecessary because it is implied. The data contained in this field will also appear in the Diagnosis fields (7a—7i).
Field Size:	1 field, 6 characters
Record Position:	108—113
Format:	Alphanumeric
Reference:	UB-92, FL 77

Field 38 Revised 1/1/94

Data Element:	Referring Physician
Definition:	The PA State License Number of the physician who referred the patient to the Admitting Physician for care and/or treatment.
Procedure:	Character 1—9 = PA State License Number Character 10—21 = Last Name Character 22—23 = First & Middle Initial Do not place the ''PA'' in the PA State License Number in this field. Format as follows: MD123456L. Left justify. Blank fill right if name unknown.
Field Size:	1 field, 23 character
Record Position:	180—202
Format:	Alphanumeric
Reference:	UB-92, Item 82 (upper line)

Field 39 Revised 1/1/94

Data Element:	Federal Tax ID
Definition:	The number assigned to the provider by the Federal Government for tax reports purposes. Also known as a tax identification number (TIN) or employer identification number (EIN)
Procedure:	Format: NN-NNNNNNN Left justify. Include hyphen.
Field Size:	1 field, 10 character
Record Position:	1759—1768

Format: Alphanumeric
Reference: UB-92, Item 5 (lower line)

Field 40 Revised 1/1/94

Data Element: Admission Hour
Definition: The hour during which the patient was admitted for inpatient care.
Procedure: Code Structure:

Code	Time	Code	Time
	AM		PM
00	12:00—12:59	12	12:00—12:59
	Midnight		Noon
01	01:00—01:59	13	01:00—01:59
02	02:00—02:59	14	02:00—02:59
03	03:00—03:59	15	03:00—03:59
04	04:00—04:59	16	04:00—04:59
05	05:00—05:59	17	05:00—05:59
06	06:00—06:59	18	06:00—06:59
07	07:00—07:59	19	07:00—07:59
08	08:00—08:59	20	08:00—08:59
09	09:00—09:59	21	09:00—09:59
10	10:00—10:59	22	10:00—10:59
11	11:00—11:59	23	11:00—11:59
		99	Hour Unknown

Right justify. (All positions fully coded)
Field Size: 1 field, 2 positions
Record Position: 44—45
Format: Numeric
Reference: UB-92, Item 18

Field 41

Data Element: Discharge Hour
Definition: Hour that the patient was discharged from inpatient care.

Procedure: Code Structure:

Code	Time	Code	Time
	AM		PM
00	12:00—12:59	12	12:00—12:59
	Midnight		Noon
01	01:00—1:59	13	01:00—01:59
02	02:00—2:59	14	02:00—02:59
03	03:00—03:59	15	03:00—03:59
04	04:00—04:59	16	04:00—04:59
05	05:00—05:59	17	05:00—05:59
06	06:00—06:59	18	06:00—06:59
07	07:00—07:59	19	07:00—07:59
08	08:00—08:59	20	08:00—08:59
09	09:00—09:59	21	09:00—09:59
10	10:00—10:59	22	10:00—10:59
11	11:00—11:59	23	11:00—11:59
		99	Hour Unknown

Right justify. (All positions fully coded)

Field Size: 1 field, 2 positions

Record Position: 46—47

Format: Numeric

Reference: UB-92, Item 21

Header Record Manual

Field 1

Data Element: Data Source Identifier

Definition: Number identifying the data source Hospitals—use your Medicaid ID Number (See Appendix A)

Procedures: Left justify. Blank fill right.

Field Size: 1 field, 25 characters

Record Position: 1—25

Format: Alphanumeric

Field 2

Data Element: Data Source Name/Address

Definition: Name and address of the data source

Procedure:	Left justify. Fill with blanks right.
	Name = Position 26—50
	Address 1 = Position 51—75
	Address 2 = Position 76—100
	City = Position 101—114
	State = Position 115—116
	Zip Code = Position 117—125
Field Size:	1 field, 100 characters
Record Position:	26—125
Format:	Alphanumeric

Field 3

Data Element:	Period Covered First Day
Definition:	The first day of the quarter from which the data provided on this tape was contained.
Procedure:	MMDDYY
Field Size:	1 field, 6 characters
Record Position:	126—131
Format:	Numeric

Field 4

Data Element:	Period Covered Last Day
Definition:	The last day of the quarter from which the data provided on this tape was contained.
Procedure:	MMDDYY
Field Size:	1 field, 6 characters
Record Position:	132—137
Format:	Numeric

Field 5

Data Element:	Run Date
Definition:	The date that the data source produced this tape.
Procedure:	MMDDYY
Field Size:	1 field, 6 characters
Field Position:	138—143
Format:	Numeric

Field 6 Revised 4/1/90

Data Element:	Filler

Field Size:	1 field filler, 2129 characters
Record Position:	170—2298
Format:	Alphanumeric

Field 7

Data Element:	Inpatient/Outpatient Indicator
Definition:	Letter indicating whether the claims contained in this file are inpatient claims or outpatient claims.
Procedure:	I = Inpatient O = Outpatient
Field Size:	1 field, 1 character
Field Position:	144
Format:	Alphanumeric

Field 8

Data Element:	Batch/Job/Run Number
Definition:	Number for the hospital's use in identifying the tape.
Procedure:	Fill with the number that will identify this tape.
Field Size:	1 field, 25 characters
Field Position:	145—169
Format:	Alphanumeric

Field 9 Created 4/1/90

Data Element:	Submission Type
Definition:	Code indicating whether this submission is an original submission, a resubmission of original data or a submission of correction data.
Procedure:	Place code as follows: O = Original Submission R = Resubmission of original data C = Correction data
Field Size:	1 field, 1 character
Record Position:	2299
Format:	Alphanumeric

Field 10 Revised 4/1/90

Data Element:	Record Type
Definitions:	Code indicating this record to be a header record
Procedure:	H = Header
Field Size:	1 field, 1 character

Record Position:	2300
Format:	Alphanumeric

Trailer Record Manual

	Field 1	Revised 4/1/90
Data Element:	Number of records on this tape	
Definition:	Total number of records contained on this tape, not including the Header and Trailer Records.	
Procedure:	Right justify.	
Field Size:	1 field, 10 characters	
Record Position:	1—10	
Format:	Numeric	

	Field 2	Revised 4/1/90
Data Element:	Number of Claims on this tape	
Definition:	Total number of claims contained on this tape	
Procedure:	Each record of a multi-page claim must be counted as one claim. Right justify.	
Field Size:	1 field, 10 characters	
Record Position:	11—20	
Format:	Numeric	

	Field 3	Revised 4/1/90
Data Element:	Filler	
Field Size:	1 field filler, 2268 characters	
Record Position:	32—2299	
Format:	Alphanumeric	

	Field 4	Created 4/1/90, 1/1/94
Data Element:	Total Dollars	
Definition:	Total Dollars submitted on this tape	
Procedure:	Characters 1—10 = dollars Characters 11—12 = cents Right justify. Zero fill left. No decimal	
Field Size:	1 field, 12 characters	
Record Position:	21—32	
Format:	Numeric	

Field 5 Created 4/1/90

Data Element:	Record type
Definition:	Code indicating that this record is a trailer record
Procedure:	T = Trailer
Field Size:	1 field, 1 character
Record Position:	2300
Format:	Alphanumeric

Hospital and Ambulatory Service Facility Tape Format

Data Element	Data Element Description	Position From	To	Picture	Format
		HEADER RECORD			
1	Data Source Identifier	1	25	X(25)	Left justify. Blank fill right.
2	Data Source Name/Address	26	125	X(100)	Name = Position 26—50 Address 1 = Position 51—75 Address 2 = Position 76—100 City = Position 101—114 State = Position 115—116 Zip Code = Position 117—125
3	Period Covered First Day	126	131	9(6)	MMDDYY
4	Period Covered Last Day	132	137	9(6)	MMDDYY
5	Run Date	138	143	9(6)	MMDDYY. Date that this tape was created.
7	Inpatient/Outpatient Indicator		144	X(1)	I = Inpatient claims. O = Outpatient claims.
8	Batch/Job/Run Number	145	169	X(25)	For hospitals use in identifying the tape.
6	Filler	170	2298	X(2129)	

(242602) No. 282 May 98

Data Element	Data Element Description	Position From	To	Picture	Format
9	Submission Type		2299	X(1)	O = Original Submission R = Resubmission of original data C = Correction data
10	Record Type		2300	X(1)	H = Header Record

Data Element	Data Element Description	Position From	To	Picture	Format*
1	Uniform Patient Identifier	1	9	X(9)	If unknown, fill with blanks. Right justify.
2	Patient Date of Birth	10	17	9(8)	MMDDYYYY
3	Patient Sex		18	X(1)	M = Male, F = Female, U = Unknown
4	Patient Zip Code	19	27	X(9)	XXXXXYYYY. The 9 or 5 character zip code of patient residence. Left justify.
5	Date of Admission	28	35	9(8)	MMDDYYYY. Taken from Locator 15.
6	Date of Discharge	36	43	9(8)	MMDDYYYY. Taken from the last 6 characters of Field 6 plus century.

*All numeric fields should be initialized to 0, and alpha numeric fields initialized to blank, before writing data to tape. Therefore, these characters (or blanks) will remain in fields where data is missing.

Data Element	Data Element Description	Position From	To	Picture	Format
40	Admission Hour	44	45	9(2)	See manual for instructions.
41	Discharge Hour	46	47	9(2)	See manual for instructions.

Data Element	Data Element Description	Position From	To	Picture	Format
7a	Principal Diagnosis Code	48	53	X(6)	Diagnosis code. Left justify. See manual for instructions.
7b	Secondary Diagnosis Code	54	59	X(6)	Diagnosis code. Left justify. See manual for instructions.
7c	Secondary Diagnosis Code	60	65	X(6)	Diagnosis code. Left justify. See manual for instructions.
7d	Secondary Diagnosis Code	66	71	X(6)	Diagnosis code. Left justify. See manual for instructions.
7e	Secondary Diagnosis Code	72	77	X(6)	Diagnosis code. Left justify. See manual for instructions.
7f	Secondary Diagnosis Code	78	83	X(6)	Diagnosis code. Left justify. See manual for instructions.
7g	Secondary Diagnosis Code	84	89	X(6)	Diagnosis code. Left justify. See manual for instructions.
7h	Secondary Diagnosis Code	90	95	X(6)	Diagnosis code. Left justify. See manual for instructions.
7i	Secondary Diagnosis Code	96	101	X(6)	Diagnosis code. Left justify. See manual for instructions.
36	Admitting Diagnosis Code	102	107	X(6)	Diagnosis code. Left justify. See manual for instructions.
37	E-Code	108	113	X(6)	Diagnosis code. Left justify. See manual for instructions.
8a	Principal Procedure Code	114	120	X(7)	Procedure code. Left justify. See manual for instructions.
8b	Date	121	124	9(4)	MMDD

Data Element	Data Element Description	Position From	To	Picture	Format
9a1	Secondary Procedure Code	125	131	X(7)	Procedure code. Left justify. See manual for instructions.
9a2	Date	132	135	9(4)	MMDD
9b1	Secondary Procedure Code	136	142	X(7)	Procedure code. Left justify. See manual for instructions.
9b2	Date	143	146	9(4)	MMDD
9c1	Secondary Procedure Code	147	153	X(7)	Procedure code. Left justify. See manual for instructions.
9c2	Date	154	157	9(4)	MMDD
9d1	Secondary Procedure Code	158	164	X(7)	Procedure code. Left justify. See manual for instructions.
9d2	Date	165	168	9(4)	MMDD
9e1	Secondary Procedure Code	169	175	X(7)	Procedure code. Left justify. See manual for instructions.
9e2	Date	176	179	9(4)	MMDD
38	Referring Physician	180	202	X(23)	Only PA State License Number should be used here. Character 1—9 = PA State License Number. Left justify. Blank fill right if name unknown.
11	Attending Physician ID	203	225	X(23)	Only PA State License Number should be used here. Character 1—9 = PA State License Number. Left justify. Blank fill right if name unknown.

Data Element	Data Element Description	Position From	To	Picture	Format
12	Operating Physician ID	226	248	X(23)	Only PA State License Number should be used here. Character 1—9 = PA State License Number. Left justify. Blank fill right if name unknown.
13a2	Revenue Code	249	252	X(4)	Left justify. See manual for code definitions.
13a6	HCPCS/Rate	253	261	9(9)	Left justify for HCPCS. Right justify rate.
13a7	Service Date	262	269	9(8)	MMDDYYYY
13a3	Units of Service	270	276	9(7)	Right justify. Fill with zeroes left.
13a4	Total Charges	277	286	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit using a leading minus sign (−). Right justify. No decimal.
13a5	Non-Covered Charges	287	296	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit using a leading minus sign (−). Right justify. No decimal.
13b2	Revenue Code	297	300	X(4)	Left justify. See manual for code definitions.
13b6	HCPCS/Rate	301	309	9(9)	Left justify. See manual for code definitions.
13b7	Service Date	310	317	9(8)	Left justify. See manual for code definitions.
13b3	Units of Service	318	324	9(7)	Right justify. Fill with zeroes left.

Data Element	Data Element Description	Position From	Position To	Picture	Format
13b4	Total Charges	325	334	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13b5	Non-Covered Charges	335	344	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13c2	Revenue Code	345	348	X(4)	Left justify. See manual for code definitions.
13c6	HCPCS/Rate	349	357	9(9)	Left justify. See manual for code definitions.
13c7	Service Date	358	365	9(8)	Left justify. See manual for code definitions.
13c3	Units of Service	366	372	9(7)	Right justify. Fill with zeroes left.
13c4	Total Charges	373	382	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13c5	Non-Covered Charges	383	392	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13d2	Revenue Code	393	396	X(4)	Left justify. See manual for code definitions.

Data Element	Data Element Description	Position From	To	Picture	Format
13d6	HCPCS/Rates	397	405	9(9)	Left justify. See manual for code definitions.
13d7	Service Date	406	413	9(8)	Left justify. See manual for code definitions.
13d3	Units of Service	414	420	9(7)	Right justify. Fill with zeroes left.
13d4	Total Charges	421	430	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13d5	Non-Covered Charges	431	440	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13e2	Revenue Code	441	444	X(4)	Left justify. See manual for code definitions.
13e6	HCPCS/Rates	445	453	9(9)	Left justify. See manual for code definitions.
13e7	Service Date	454	461	9(8)	Left justify. See manual for code definitions.
13e3	Units of Service	462	468	9(7)	Right justify. Fill with zeroes left.
13e4	Total Charges	469	478	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.

Data Element	Data Element Description	Position From	To	Picture	Format
13e5	Non-Covered Charges	479	488	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13f2	Revenue Code	489	492	X(4)	Left justify. See manual for code definitions.
13f6	HCPCS/Rates	493	501	9(9)	Left justify. See manual for code definitions.
13f7	Service Date	502	509	9(8)	Left justify. See manual for code definitions.
13f3	Units of Service	510	516	9(7)	Right justify. Fill with zeroes left.
13f4	Total Charges	517	526	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13f5	Non-Covered Charges	527	536	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13g2	Revenue Code	537	540	X(4)	Left justify. See manual for code definitions.
13g6	HCPCS/Rates	541	549	9(9)	Left justify. See manual for code definitions.
13g7	Service Date	550	557	9(8)	Left justify. See manual for code definitions.
13g3	Units of Service	558	564	9(7)	Right justify. Fill with zeroes left.

Data Element	Data Element Description	Position From	To	Picture	Format
13g4	Total Charges	565	574	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13g5	Non-Covered Charges	575	584	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13h2	Revenue Code	585	588	X(4)	Left justify. See manual for code definitions.
13h6	HCPCS/Rates	589	597	9(9)	Left justify. See manual for code definitions.
13h7	Service Date	598	605	9(8)	Left justify. See manual for code definitions.
13h3	Units of Service	606	612	9(7)	Right justify. Fill with zeroes left.
13h4	Total Charges	613	622	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13h5	Non-Covered Charges	623	632	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13i2	Revenue Code	633	636	X(4)	Left justify. See manual for code definitions.

Data Element	Data Element Description	Position From	To	Picture	Format
13i6	HCPCS/Rates	637	645	9(9)	Left justify. See manual for code definitions.
13i7	Service Date	646	653	9(8)	Left justify. See manual for code definitions.
13i3	Units of Service	654	660	9(7)	Right justify. Fill with zeroes left.
13i4	Total Charges	661	670	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13i5	Non-Covered Charges	671	680	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13j2	Revenue Code	681	684	X(4)	Left justify. See manual for code definitions.
13j6	HCPCS/Rates	685	693	9(9)	Left justify. See manual for code definitions.
13j7	Service Date	694	701	9(8)	Left justify. See manual for code definitions.
13j3	Units of Service	702	708	9(7)	Right justify. Fill with zeroes left.
13j4	Total Charges	709	718	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.

Data Element	Data Element Description	Position From	To	Picture	Format
13j5	Non-Covered Charges	719	728	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13k2	Revenue Code	730	732	X(4)	Left justify. See manual for code definitions.
13k6	HCPCS/Rates	733	741	9(9)	Left justify. See manual for code definitions.
13k7	Service Date	742	749	9(8)	Left justify. See manual for code definitions.
13k3	Units of Service	750	756	9(7)	Right justify. Fill with zeroes left.
13k4	Total Charges	757	766	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13k5	Non-Covered Charges	767	776	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13l2	Revenue Code	777	780	X(4)	Left justify. See manual for code definitions.
13l6	HCPCS/Rates	781	789	9(9)	Left justify. See manual for code definitions.
13l7	Service Date	790	797	9(8)	Left justify. See manual for code definitions.
13l3	Units of Service	798	804	9(7)	Right justify. Fill with zeroes left.

Data Element	Data Element Description	Position From	Position To	Picture	Format
13l4	Total Charges	805	814	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13l5	Non-Covered Charges	815	824	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13m2	Revenue Code	825	828	X(4)	Left justify. See manual for code definitions.
13m6	HCPCS/Rates	829	837	9(9)	Left justify. See manual for code definitions.
13m7	Service Date	838	845	9(8)	Left justify. See manual for code definitions.
13m3	Units of Service	846	852	9(7)	Right justify. Fill with zeroes left.
13m4	Total Charges	853	862	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13m5	Non-Covered Charges	863	872	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13n2	Revenue Code	873	876	X(4)	Left justify. See manual for code definitions.

Data Element	Data Element Description	Position From	To	Picture	Format
13n6	HCPCS/Rates	877	885	9(9)	Left justify. See manual for code definitions.
13n7	Service Date	886	893	9(8)	Left justify. See manual for code definitions.
13n3	Units of Service	894	900	9(7)	Right justify. Fill with zeroes left.
13n4	Total Charges	901	910	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13n5	Non-Covered Charges	911	920	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13o2	Revenue Code	921	924	X(4)	Left justify. See manual for code definitions.
13o6	HCPCS/Rates	925	933	9(9)	Left justify. See manual for code definitions.
13o7	Service Date	934	941	9(8)	Left justify. See manual for code definitions.
13o3	Units of Service	942	948	9(7)	Right justify. Fill with zeroes left.
13o4	Total Charges	949	958	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.

Data Element	Data Element Description	Position From	To	Picture	Format
13o5	Non-Covered Charges	959	968	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13p2	Revenue Code	969	972	X(4)	Left justify. See manual for code definitions.
13p6	HCPCS/Rates	973	981	9(9)	Left justify. See manual for code definitions.
13p7	Service Date	982	989	9(8)	Left justify. See manual for code definitions.
13p3	Units of Service	990	996	9(7)	Right justify. Fill with zeroes left.
13p4	Total Charges	997	1006	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13p5	Non-Covered Charges	1007	1016	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13q2	Revenue Code	1017	1020	X(4)	Left justify. See manual for code definitions.
13q6	HCPCS/Rates	1021	1029	9(9)	Left justify. See manual for code definitions.
13q7	Service Date	1030	1037	9(8)	Left justify. See manual for code definitions.
13q3	Units of Service	1038	1044	9(7)	Right justify. Fill with zeroes left.

Data Element	Data Element Description	Position From	To	Picture	Format
13q4	Total Charges	1045	1054	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13q5	Non-Covered Charges	1055	1064	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13r2	Revenue Code	1065	1068	X(4)	Left justify. See manual for code definitions.
13r6	HCPCS/Rates	1069	1077	9(9)	Left justify. See manual for code definitions.
13r7	Service Date	1078	1085	9(8)	Left justify. See manual for code definitions.
13r3	Units of Service	1086	1092	9(7)	Right justify. Fill with zeroes left.
13r4	Total Charges	1093	1102	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13r5	Non-Covered Charges	1103	1112	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13s2	Revenue Code	1113	1116	X(4)	Left justify. See manual for code definitions.

Data Element	Data Element Description	Position From	To	Picture	Format
13s6	HCPCS/Rates	1117	1125	9(9)	Left justify. See manual for code definitions.
13s7	Service Date	1126	1133	9(8)	Left justify. See manual for code definitions.
13s3	Units of Service	1134	1140	9(7)	Right justify. Fill with zeroes left.
13s4	Total Charges	1141	1150	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13s5	Non-Covered Charges	1151	1160	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13t2	Revenue Code	1161	1164	X(4)	Left justify. See manual for code definitions.
13t6	HCPCS/Rates	1165	1173	9(9)	Left justify. See manual for code definitions.
13t7	Service Date	1174	1181	9(8)	Left justify. See manual for code definitions.
13t3	Units of Service	1182	1188	9(7)	Right justify. Fill with zeroes left.
13t4	Total Charges	1189	1198	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.

Data Element	Data Element Description	Position From	To	Picture	Format
13t5	Non-Covered Charges	1199	1208	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13u2	Revenue Code	1209	1212	X(4)	Left justify. See manual for code definitions.
13u6	HCPCS/Rates	1213	1221	9(9)	Left justify. See manual for code definitions.
13u7	Service Date	1222	1229	9(8)	Left justify. See manual for code definitions.
13u3	Units of Service	1230	1236	9(7)	Right justify. Fill with zeroes left.
13u4	Total Charges	1237	1246	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13u5	Non-Covered Charges	1247	1256	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13v2	Revenue Code	1257	1260	X(4)	Left justify. See manual for code definitions.
13v6	HCPCS/Rates	1261	1269	9(9)	Left justify. See manual for code definitions.
13v7	Service Date	1270	1277	9(8)	Left justify. See manual for code definitions.
13v3	Units of Service	1278	1284	9(7)	Right justify. Fill with zeroes left.

Data Element	Data Element Description	Position From	To	Picture	Format
13v4	Total Charges	1285	1294	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13v5	Non-Covered Charges	1295	1304	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13w2	Revenue Code	1305	1308	X(4)	001. Unless it is a continuing record.
13w6	HCPCS/Rates	1309	1317	9(9)	001. Unless it is a continuing record.
13w7	Service Date	1318	1325	9(8)	001. Unless it is a continuing record.
13w3	Units of Service	1326	1332	9(7)	Fill with blanks.
13w4	Total Charges	1333	1342	X(10)	Total of all charges. 7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
13w5	Non-Covered Charges	1343	1352	X(10)	Total of all non-covered charges. 7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
14b1	Payor Identification	1353	1377	X(25)	Left justify. Blank fill right. See manual for code definitions.
14b2	Payor Identification	1378	1402	X(25)	Left justify. Blank fill right. See manual for code definitions.

Data Element	Data Element Description	Position From	To	Picture	Format
14b3	Payor Identification	1403	1427	X(25)	Left justify. Blank fill right. See manual for code definitions.
14f1	Prior Payments—Payor and Patient	1428	1437	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
14f2	Prior Payments—Payor and Patient	1438	1447	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
14f3	Prior Payments—Payor and Patient	1448	1457	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
14f4	Prior Payments—Payor and Patient	1458	1467	X(10)	7 dollar characters, 2 cent characters, and 1 character for credit with a leading minus sign (−). Right justify. No decimal.
14g1	Estimated Amount Due	1468	1477	X(10)	Council will develop a methodology to apply to all hospitals. At the present time, fill with blanks.
14g2	Estimated Amount Due	1478	1487	X(10)	Council will develop a methodology to apply to all hospitals. At the present time, fill with blanks.

Data Element	Data Element Description	Position From	To	Picture	Format
14g3	Estimated Amount Due	1488	1497	X(10)	Council will develop a methodology to apply to all hospitals. At the present time, fill with blanks.
14g4	Estimated Amount Due	1498	1507	X(10)	Council will develop a methodology to apply to all hospitals. At the present time, fill with blanks.
17	Uniform Identifier of Primary Payor	1508	1514	X(7)	Left justify. Fill with blanks right.
18	Zip Code of Facility	1515	1523	X(9)	XXXXXYYYY. Left justify.
19a	Payor Group Number	1524	1540	X(17)	Left justify.
19b	Payor Group Number	1541	1557	X(17)	Left justify.
19c	Payor Group Number	1558	1574	X(17)	Left justify.
20	Patient Discharge Status	1575	1576	9(2)	Right justify. See manual for definitions.

Data Element	Data Element Description	Position From	Position To	Picture	Format
21a	Provider Quality		1577	X(1)	Provider quality consistent with section 6(d) of the act and with § 911.3. Periodically, the Council will review the methodology, and if 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.
21b	Provider Service Effectiveness		1578	X(1)	Provider service effectiveness consistent with section 6(d) of the act and with § 911.3. Periodically, the Council will review the methodology, and if 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.

Data Element	Data Element Description	Position From	Position To	Picture	Format
21c	Unusual Occurrence		1579	X(1)	The Council will develop a methodology to apply to all hospitals. Until that time, fill with blanks.
21d	Unusual Occurrence	1580	1581	9(2)	The Council will develop a methodology to apply to all hospitals. Until that time, fill with zeroes.
22	Type of Bill	1582	1584	9(3)	Right justify. See manual for code definitions.
23	Patient Control Number	1585	1604	X(20)	Left justify.
24	Diagnosis Related Group (DRG)	1605	1607	9(3)	See manual for instructions.
25	Procedure Coding Method Used		1608	9(1)	1—3 = Reserved for state assignment. 4 = CPT-4 5 = HCPCS 6—8 = Reserved for national assignment. 9 = ICD-9-CM
26	Type of Admission		1609	X(1)	1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5—8 = Reserved for National assignment. 9 = Information not available See manual for definitions.

Data Element	Data Element Description	Position From	Position To	Picture	Format
27	Source of Admission		1610	X(1)	1 = Physician referral 2 = Clinic referral 3 = HMO referral 4 = Transfer from hospital 5 = Transfer from SNF 6 = Transfer from another health care facility 7 = Emergency Room 8 = Court/Law Enforcement 9 = Information not available A—Z = Reserved for National Assignment. For Newborn admissions: 1 = Normal delivery 2 = Premature delivery 3 = Sick baby 4 = Extramural birth 5—8 = Reserved for National assignment. 9 = Information not available See manual for definitions.
28a	Patient's Relationship to Insured	1611	1612	9(2)	Right justify. See manual for code definitions.

Data Element	Data Element Description	Position From	Position To	Picture	Format
28b	Patient's Relationship to Insured	1613	1614	9(2)	Right justify. See manual for code definitions.
28c	Patient's Relationship to Insured	1615	1616	9(2)	Right justify. See manual for code definitions.
29a	Certification/Social Security Number/ Health Insurance Claim Number	1617	1635	X(19)	Left justify.
29b	Certification/Social Security Number/ Health Insurance Claim Number	1636	1654	X(19)	Left justify.
29c	Certification/Social Security Number/ Health Insurance Claim Number	1655	1673	X(19)	Left justify.
32a	Employer Name	1674	1697	X(24)	Left justify.
32b	Employer Name	1698	1721	X(24)	See manual for instructions.
32c	Employer Name	1722	1745	X(24)	See manual for instructions.
34a	Employment Status		1746	9(1)	1 = Employed Full time 2 = Employed Part time 3 = Not employed 4 = Self employed 5 = Retired 6 = On active military duty 7—8 = Reserved for National assignment. 9 = Unknown See manual for definitions.

Data Element	Data Element Description	Position From	To	Picture	Format
34b	Employment Status		1747	9(1)	See manual for instructions.
34c	Employment Status		1748	9(1)	See manual for instructions.
35a	Hispanic/Spanish Origin or Descent		1749	X(1)	See manual for instructions.
35b	Patient Race		1750	X(1)	W = White B = Black A = Asian I = Native American or Eskimo N = Other O = Unknown
10	Uniform Identifier for Health Care Facility	1751	1758	X(8)	Left justify. Blank fill right.
39	Federal Tax ID	1759	1768	X(10)	See manual for instructions.
21e	Reserve Field	1769	2300	X(532)	To be reserved for future use by the Council.
	TRAILER RECORD				
1	Number of Records on This Tape	1	10	9(10)	Total number of patient discharge records on this tape.
2	Number of Patients on This Tape	11	20	9(10)	Total number of patients on this tape.
4	Total Dollars	21	32	9(12)	Total dollars on tape. 9 dollar characters and 2 cent characters. Right justify. No decimal.
3	Filler	33	2299	X(2267)	
5	Record Type		2300	X(1)	T = Trailer

(297434) No. 346 Sep. 03

Source

The provisions of this Appendix A adopted January 29, 1988, effective January 30, 1988, 18 Pa.B. 459; amended April 8, 1988, effective March 1, 1988, 18 Pa.B. 1607; amended May 11, 1990, effective May 12, 1990, and apply to second quarter 1990 submissions; amended February 11, 1994, effective January 1, 1994, 24 Pa.B. 840; amended June 20, 2003, effective June 21, 2003, 33 Pa.B. 2865. Immediately preceding text appears at serial pages (242570) to (242626).

[Next page is 913-1.]