CHAPTER 913. PAYOR DATA REPORTING REQUIREMENTS

Subchap.		Sec.
A.	GENERAL PROVISIONS	913.1
B.	DATA SUBMISSION SCHEDULES	913.21
C.	EXCEPTIONS	913.31
D.	INTERPRETATIONS	913.41

Authority

The provisions of this Chapter 913 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 913 adopted July 29, 1988, effective July 30, 1988, 18 Pa.B. 3334, 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

Sec.
913.1. Legal base and purpose.
913.2. Affected parties.
913.3. Definitions.

§ 913.1. Legal base and purpose.

(a) This chapter is promulgated by the Council under section 6 of the Health Care Cost Containment Act (35 P. S. § 449.6).

(b) This chapter establishes data elements, submission schedules and data element formats for the collection of the data elements from payors as specified in section 6 of the act.

§ 913.2. Affected parties.

This chapter applies to payors for covered services rendered in health care facilities licensed by the Commonwealth.

§ 913.3. 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).

Ambulatory service facility—A facility licensed in this Commonwealth, not part of a hospital, which provides medical, diagnostic or surgical treatment to

patients not requiring hospitalization. The term includes, but is not limited to, ambulatory surgical facilities, ambulatory imaging or diagnostic centers, birthing centers, freestanding emergency rooms and other facilities providing ambulatory care which charge a separate facility charge.

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

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.

Health care facility or *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.

Health care insurer—A person, corporation or other entity that offers administrative, indemnity or payment services for health care in exchange for a premium or service charge under a program of health care services, including:

(i) An insurance company, association or exchange with a certificate of authority to issue health insurance policies in this Commonwealth under sections 616—630 of The Insurance Company Law of 1921 (40 P. S. §§ 751—764(a)) but the policies may not include those providing supplemental or indemnity coverage, or both.

(ii) A hospital plan corporation as defined in 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations).

(iii) A professional health services plan corporation as defined in 40 Pa.C.S. Chapter 63 (relating to professional health services plan corporations).

(iv) A health maintenance organization.

(v) A preferred provider organization.

(vi) A fraternal benefit society.

(vii) A beneficial society.

(viii) A third-party administrator.

Health maintenance organization—An organized system which combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled subscribers for a fixed prepaid fee, as defined in the Health Maintenance Organization Act (40 P. S. §§ 1551—1567).

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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. The term includes institutions 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 post-procedure recovery room or short-term convalescent room.

Payor—A person or entity, including health care insurers, purchasers, the Medical Assistance Program in the Department of Public Welfare, and the Federal Medicare Program, that makes direct payments to providers for covered services. With respect to an insurance company, association or exchange, the term includes only those insurers issuing health insurance policies in this Commonwealth under sections 616—630 of The Insurance Company Law of 1921. The health insurance policies may not include those providing supplemental or indemnity coverage, or both.

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 this Commonwealth to practice medicine and surgery within the scope of the Osteopathic Medical Practice Act (63 P. S. §§ 271.1—271.18) or the Medical Practice Act (63 P. S. §§ 422.1—422.45).

Preferred provider organization—An arrangement between a health care insurer and providers of health care services which specifies rates of payment to the providers which differ from their usual and customary charges to the general public and which encourage enrollees to receive health services from the providers.

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

Purchaser—Corporations, labor organizations and other entities that purchase benefits which provide covered services for their employes or members either through a health care insurer or by means of a self-funded program of benefits, and a certified bargaining representative that represents a group of employes for whom employers purchase a program of benefits which provide covered services. The term does not include health care insurers.

Subchapter B. DATA SUBMISSION SCHEDULES

Sec.
913.21. Required data elements.
913.22. Data element submission formats.
913.23. Data element submission schedules.
913.24. Frequency of data submissions.

§ 913.21. Required data elements.

A payor is required to submit data elements specified in the act contained in Council Manual HC-87-101, Volume B. See Appendix A. Payors shall refer to Appendix A to determine specific data element definitions.

§ 913.22. Data element submission formats.

A payor shall submit data elements to the Council according to computer tape format specifications contained in Council Manual HC-87-101, Volume B (Appendix A) on nine track labeled 1600 or 6250 BPI (density) tape or computer diskette approved by the Council.

§ 913.23. Data element submission schedules.

A payor shall submit data according to the following schedules:

(1) *Inpatient data.* A payor shall submit data elements for inpatient discharges beginning with discharges which occurred during the first quarter of 1988. This data shall be submitted on or before September 30, 1988 and thereafter, under § 913.24 (relating to frequency of data submissions).

(2) *Outpatient data.* A payor shall submit data elements for outpatient services rendered beginning with the fourth quarter of 1988. This data shall be submitted on or before June 30, 1989 and thereafter, under § 913.24.

§ 913.24. Frequency of data submissions.

Data elements required to be submitted under this subchapter shall be submitted on a quarterly basis. The data elements will be due to the Council by the last day of the 6th month following the close of the quarter.

Cross References

This section cited in 28 Pa. Code § 913.23 (relating to data element submission formats).

Subchapter C. EXCEPTIONS

Sec.
913.31. Principle.
913.32. Requests for exceptions.
913.33. Revocation of exceptions.

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§ 913.31. Principle.

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

§ 913.32. Requests for exceptions.

(a) A request for an exception shall be made in writing 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. Except as provided for in subsection (b), 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 the 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.

(b) A request for an exception for the first reporting period, that is, data due to the Council by September 30, 1988, shall be received and deemed as complete by the Council by 5 p.m. on August 15, 1988. The Council will act within 30 days of the completed request.

§ 913.33. 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 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 payor to come into compliance with this chapter. Failure by the payor to comply after the specified date may result in enforcement proceedings.

(c) If a payor 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.

Subchapter D. INTERPRETATIONS

Sec.
913.41. Definition for major ambulatory service.

§ 913.41. 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.

APPENDIX A

PENNSYLVANIA UNIFORM CLAIMS AND BILLING FORM HOSPITAL/AMBULATORY SERVICE FACILITY PAYMENTS AND PHYSICIAN PAYMENTS REPORTING MANUAL HC—87—101 VOLUME B TABLE OF CONTENTS

I. Facility and Physician Payments Reporting Manual.
II. Header Record Manual.
III. Trailer Record Manual.
IV. Tape Format for Facility and Physician Payments Reporting.

INDEX

DATA ELEMENT NAME	FIELD #
Certification/SSN/Health Insurance Claim Number	20
Date of Admission/Start of Care/Date of Service	6
Date of Discharge/End of Care/Last Date of Service	7
Identifier of Physician	10
Other Payments	15
Patient Control Number	17
Patient's Birthdate	4
Patient - Uniform Identification	3
Patient Relationship to Insured	19
Patient's Sex	5
Payor Group Number	16

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DATA ELEMENT NAME	**FIELD #**
Place of Service	2
Primary Payor Payments	14
Procedure Code	8
Procedure Coding Method Used	18
Record Type	1
Reserve Field	21
Total Charges	13
Type of Professional Service	11
Uniform Identifier of Health Care Facility	9
Units of Service	12

I. REPORTING MANUAL

FIELD: 1

REQUIRED: Facility and Physician Payments Reporting

DATA ELEMENT: Record Type

DEFINITION: Indicator distinguishing between the different types of records.

PROCEDURE:
1 = Facility payment record.
2 = Physician payment record.
3 = Continuing physician payment record. (When individual patient records contain more than one procedure/service, this field indicates that this record is a continuation of the previous record.)
4 = Continuing facility payment record. (When individual patient records contain more than one procedure/service, this field indicates that this record is a continuation of the previous record.)
5 = This record is a delivery which includes newborn payments.

FIELD SIZE: 1 field, 1 character

RECORD POSITION: 1

FORMAT: Numeric

FIELD: 2

REQUIRED: Facility and Physician Payments Reporting

DATA ELEMENT: Place of Service

DEFINITION: Type of setting.

PROCEDURE: 1 = Hospital Inpatient

	2 = Hospital Outpatient
	3 = Other Ambulatory Service Facility
	4 = Unknown
FIELD SIZE:	1 field, 1 character
RECORD POSITION:	2
FORMAT:	Numeric

FIELD: 3

REQUIRED:	Facility and Physician Payments Reporting
DATA ELEMENT:	Uniform Patient I.D.
DEFINITION:	Patient's Social Security Number.
PROCEDURES:	Left justify. No dashes. If the patient's Social Security Number is unknown, fill this field with zeroes.
FIELD SIZE:	1 field, 9 characters.
RECORD POSITION:	3—11
FORMAT:	Numeric
REFERENCE:	UB-82, Item 2a.

FIELD: 4

REQUIRED:	Facility and Physician Payments Reporting
DATA ELEMENT:	Patient's Birthdate.
DEFINITION:	The date of birth of the patient.
PROCEDURE:	MMDDYYYY. If full birthdate is unknown, place the patient's year of birth in this field. Right justify. No dashes.
FIELD SIZE:	1 field, 8 characters.
RECORD POSITION:	12—19
FORMAT:	Numeric
REFERENCE:	UB-82, Item 12 or HCFA 1500, Item 2

FIELD: 5

REQUIRED:	Facility and Physician Payments Reporting
DATA ELEMENT:	Patient's Sex.
DEFINITION:	The sex of the patient as recorded at the date of admission, outpatient service, or start of care.
PROCEDURE:	M = Male or 1 = Male
	F = Female 2 = Female
	U = Unknown 3 = Unknown

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	M, F, U is the preferred method. Data submitted in the format of a 1, 2, or 3 will be converted to M, F, or U by the Council. Edit reports to data sources will contain M, F, U.
FIELD SIZE:	1 field, 1 character.
RECORD POSITION:	20
FORMAT:	Alphanumeric
REFERENCE:	UB-82, item 13 or HCFA 1500, item 5

FIELD: 6

REQUIRED:	Facility and Physician Payments Reporting
DATA ELEMENT:	Date of Admission/Start of Care/First Date of Service
DEFINITION:	The date that the patient was admitted to the provider for inpatient care, outpatient services, start of care or the beginning date of the period covered by this bill.
PROCEDURE:	MMDDYY.
FIELD SIZE:	1 field, 6 characters.
RECORD POSITION:	21—26
FORMAT:	Numeric
REFERENCE:	UB-82, item 15 or HCFA 1500, item 20 (the first 6 characters of this field.)

FIELD: 7

REQUIRED:	Facility and Physician Payments Reporting
DATA ELEMENT:	Date of Discharge/End of Care/Last Date of Service
DEFINITION:	The ending service date of the period covered by this bill or the date that the patient was discharged from the provider's care.
PROCEDURE:	MMDDYY.
FIELD SIZE:	1 field, 6 characters.
RECORD POSITION:	27—32
FORMAT:	Numeric
REFERENCE:	UB-82, item 22 (the last 6 characters in this field.) or HCFA 1500, item 20 (the last 6 characters of this field.)

FIELD: 8

REQUIRED:	Physician Payments Reporting Only (Blank fill for Facility Payments Records.)
DATA ELEMENT:	Procedure Code

DEFINITION:	Surgical Procedure Code, if any. Other procedure codes when available.
PROCEDURE:	The code structure must be consistent with the information provided in field 18. This field is required if field 11 is equal to an 02 or 05. This field is optional if field 11 is equal to an 01, 03, or 04. Use ICD-9-CM, HCPCS or CPT-4 codes. Left justify. Use decimal. Blank fill right. If unknown, blank fill.
FIELD SIZE:	1 field, 9 characters
RECORD POSITION:	33—41
FORMAT:	Alphanumeric
REFERENCE:	UB-82, item 84 or HCFA 1500, item 24d

FIELD: 9

REQUIRED:	Facility Payments Reporting Only (Blank fill for Physician Payments Records.)
DATA ELEMENT:	Uniform Identifier for Health Care Facility
DEFINITION:	Medicaid Number, Federal Tax I.D. Number, or Medicare Number.
PROCEDURE:	Character 1: 1 or A = Medicaid Number 2 or B = Tax I.D. Number 3 or C = Medicare Number Characters 2—11: Medicaid Number, Tax I.D. Number, or Medicare Number. Left justify. The Medicaid Number is the preferred number. Data Sources using other numbering systems must provide the Council with a Facility I.D. Dictionary on tape according to a format approved by the Council. The facility I.D. dictionary must have one number for each separately licensed facility.
FIELD SIZE:	1 field, 11 characters
RECORD POSITION:	42—52
FORMAT:	Alphanumeric
REFERENCE:	UB-82, item 6

FIELD: 10

REQUIRED:	Physician Payments Reporting Only (Blank fill for Facility Payments Records.)
DATA ELEMENT:	Identifier of Physician
DEFINITION:	PA State License Number, Social Security Number, or Tax I.D. of the Physician. Other Unique Provider Numbers may be acceptable, however, prior approval must be obtained from the Council.

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PROCEDURE:	Character 1: 1 or A = PA State License 2 or B = S.S. Number 3 or C = Tax I.D. Number 4 or D = Unique Provider Number Characters 2—10 = PA State License, S.S. Number, Tax I.D., Unique Provider Number Characters 11—20 = Physician Last Name Characters 21—22 = Physician First and Middle Initial Left Justify, Blank fill. The Pa. State license number is the preferred number. Data sources using other numbering systems must provide the Council with a dictionary of physician I.D. numbers on tape according to a format approved by the Council. (The approved format is described in Appendix B.) The Physician I.D. dictionary must have one number for each separately licensed physician.
FIELD SIZE:	1 field, 22 characters
RECORD POSITION:	53—74
FORMAT:	Alphanumeric
REFERENCE:	HCFA 1500, item 33.

FIELD: 11

REQUIRED:	Physician Payments Reporting Only (Zero fill for Facility Payments Records.)
DATA ELEMENT:	Type of Professional Service
DEFINITION:	The type of service that the physician performed for which payment is expected.
PROCEDURE:	01 = Medical, Consulting, Psychiatric (Includes drug abuse and alcohol treatment.) 02 = Surgical, Obstetrics 03 = Diagnostic, Radiologic 04 = Anesthetic 05 = Assisted in Surgery
FIELD SIZE:	1 field, 2 characters
RECORD POSITION:	75—76
FORMAT:	Numeric
REFERENCE:	HCFA 1500, item 24c

(242637) No. 282 May 98

FIELD: 12

REQUIRED:	Physician Payments Reporting Only (Zero fill for Facility Payments records.)
DATA ELEMENTS:	Units of Service
DEFINITION:	If available, enter the total number of identical procedures or services, such as hospital visits.
PROCEDURE:	Right justify. Fill with zeroes left.
FIELD SIZE:	1 field, 3 characters
RECORD POSITION:	77—79
FORMAT:	Numeric
REFERENCE:	HCFA 1500, item 24g

FIELD: 13

REQUIRED:	Facility and Physician Payments Reporting
DATA ELEMENT:	Total Charges
DEFINITION:	Total charges pertaining to the current billing period as entered in the statement covers period.
PROCEDURES:	Facility total Charges = Place total charges as stated in the definition above. Physician total Charges = Place the total charge for the procedure or service indicated in fields 11 and 8. When the physician/professional or facility has provided more than one procedure or service, more than one record should be provided. The multiple records should be indicated as follows: 1. In field 1, place the number 3 or 4 which indicates that this record is a continuation of the previous record. 2. Complete the following fields: a. 8 - Procedure Code b. 11 - Type of Professional Service. c. 13 - Total Charges d. 14 - Primary Payor Payments e. 15 - Other Payments 3. All other fields in this record should be duplicated depending upon the format of each field. Right justify. No decimal.
FIELD SIZE:	1 field, 8 characters Character 1—6 = dollars Character 7—8 = cents
RECORD POSITIONS:	80—87

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FORMAT:	Numeric
REFERENCE:	UB-82, item 53 (Last line of this field.) or HCFA 1500, item 24f

FIELD: 14

REQUIRED:	Facility and Physician Payments Reporting
DATA ELEMENT:	Primary Payor Payments
DEFINITION:	Total of all payments made by the payor to the health care facility or professional for services rendered to the patient for the episode of illness indicated in fields 6 and 7.
PROCEDURE:	Facility payments = Place total Primary Payor Payments as stated in the definition above. Physician payments = Place the total Primary Payor Payments for the procedure or service indicated in fields 11 and 8. When the physician/professional or facility has provided more than one procedure or service, more than one record should be provided. The multiple records should be indicated as follows: 1. In field 1, place the number 3 or 4 which indicates that this record is a continuation of the previous record. 2. Complete the following fields: a. 8 - Procedure Code b. 11 - Type of Professional Service c. 13 - Total Charges d. 14 - Primary Payor Payments e. 15 - Other Payments 3. All other fields in this record should be duplicated depending upon the format of each field. Right justify. No decimal.
FIELD SIZE:	1 field, 8 characters Character 1—6 = dollars Character 7—8 = cents
RECORD POSITION:	88—95
FORMAT:	Numeric
REFERENCE:	UB-82, item 55

FIELD: 15

REQUIRED:	Facility and Physician Payments Reporting
DATA ELEMENT:	Other Payments

DEFINITION:	The sum of deductible amounts and co-pay amounts that are attributed to the patients responsibility or other secondary payors.
PROCEDURE:	Facility other payments = Place total of Other Payments as stated in the definition above. Physician other payments = Place the total of Other Payments for the procedure or service indicated in fields 11 and 8. When the physician/professional or facility has provided more than one procedure or service, more than one record should be provided. The multiple records should be indicated as follows: 1. In field 1, place the number 3 or 4 which indicates that this record is a continuation of the previous record. 2. Complete the following fields: a. 8 - Procedure Code b. 11 - Type of Professional Service c. 13 - Total Charges d. 14 - Primary Payor Payments e. 15 - Other Payments 3. All other fields in this record should be duplicated depending upon the format of each field. Right justify. No Decimal.
FIELD SIZE:	1 field 8 characters Character 1—6 = dollars Character 7—8 = cents
RECORD POSITION:	96—103
FORMAT:	Numeric

FIELD: 16

REQUIRED:	Facility and Physician Payments Reporting
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.
PROCEDURE:	Left justify.
FIELD SIZE:	1 field, 17 characters
RECORD POSITION:	104—120
FORMAT:	Alphanumeric
REFERENCE:	UB-82, item 70 or HCFA 1500, item 8

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FIELD: 17

REQUIRED:	Facility Payments Reporting Only (Blank fill for Physician Payments Records.)
DATA ELEMENT:	Patient Control Number
DEFINITION:	Patient's unique alphanumeric number assigned by the carrier to facilitate retrieval of individual case records and posting of the payment. This field is optional.
PROCEDURE:	Left justify.
FIELD SIZE:	1 field, 17 characters
RECORD POSITION:	121—137
FORMAT:	Alphanumeric

FIELD: 18

REQUIRED:	Facility and Physician Payments Reporting
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:	138
FORMAT:	Numeric
REFERENCE:	UB-82, item 82

FIELD: 19

REQUIRED:	Facility and Physician Payments Reporting
DATA ELEMENT:	Patient's Relationship to Insured
DEFINITION:	A code indicating the relationship of the patient to the identified insured.
PROCEDURE:	Use coding as follows: 1 = Self 2 = Spouse 3 = Child 4 = Other Right justify. Zero fill left.
FIELD SIZE:	1 field, 2 characters

RECORD POSITION:	139—140
FORMAT:	Numeric
REFERENCE:	UB-82, item 67 a or HCFA 1500, item 7

FIELD: 20

REQUIRED:	Facility and Physician Payments Reporting
DATA ELEMENT:	Certificate/Social Security Number/Health Insurance Claim/ Identification Number.
DEFINITION:	Insured's unique identification number assigned by the payor organization.
PROCEDURE:	Left justify.
FIELD SIZE:	1 field, 16 characters
RECORD POSITION:	141—156
FORMAT:	Alphanumeric
REFERENCE:	UB-82, item 68 or HCFA 1500, item 6

FIELD: 21

DATA ELEMENT:	Reserve Field
DEFINITION:	To be reserved for future use by the Council.
FIELD SIZE:	1 field filler, 144 characters
RECORD POSITION:	157—300
FORMAT:	Alphanumeric

II. HEADER RECORD

FIELD: 1

DATA ELEMENT:	Data Source Identifier
DEFINITION:	Number identifying the data source. Third party payors - use your payor number.
PROCEDURE:	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
DEFINITIONS:	Name and address of the data source.

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PROCEDURE:	Left justify. Fill with blanks right. Space between lines of name and address.
FIELD SIZE:	1 field, 4 lines, 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

DATA ELEMENT:	Filler
FIELD SIZE:	1 field filler, 157 characters
RECORD POSITION:	144—300
FORMAT:	Alphanumeric

III. TRAILER RECORD

FIELD: 1

DATA ELEMENT:	Number of records on this tape.
DEFINITION:	Total number of records contained on this tape, not including the Header and Trailer Records. This number should count each multi-page as one record.
PROCEDURE:	Right justify.
FIELD SIZE:	1 field, 10 characters
RECORD POSITION:	1—10
FORMAT:	Numeric

FIELD: 2

DATA ELEMENT:	Number of Patients on This Tape.
DEFINITION:	Total number of patients contained on this tape.
PROCEDURE:	Right justify.
FIELD SIZE:	1 field, 10 characters
RECORD POSITION:	11—20
FORMAT:	Numeric

FIELD: 3

DATA ELEMENT:	Total Physician Charges
DEFINITION:	Total of all Physician Charges on this tape.
PROCEDURE:	Sum of all fields 13 (Total Charges) when field 1 is equal to 2. Right justify. The last two digits are for cents.
FIELD SIZE:	1 field, 11 characters
RECORD POSITION:	21—31
FORMAT:	Numeric

FIELD: 4

DATA ELEMENT:	Total Facility Charges
DEFINITION:	Total of all Facility Charges on this tape.
PROCEDURE:	Sum of all fields 13 (Total Charges) when field 1 is equal to 1. Right justify. The last two digits are for cents.
FIELD SIZE:	1 field, 11 characters
RECORD POSITION:	32—42

(242644) No. 282 May 98

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FORMAT:	Numeric

FIELD: 5

DATA ELEMENT:	Total Physician Payments
DEFINITION:	Total of all Physician Payments on this tape.
PROCEDURE:	Sum of all fields 14 (Primary Payor Payments) when field 1 is equal to 2. Right justify. The last two digits are for cents.
FIELD SIZE:	1 field, 11 characters
RECORD POSITION:	43—53
FORMAT:	Numeric

FIELD: 6

DATA ELEMENT:	Total Facility Payments
DEFINITION:	Total of all Facility Payments on this tape.
PROCEDURE:	Sum of all fields 14 (Primary Payor Payments) when field 1 is equal to 1. Right justify. The last two digits are for cents.
FIELD SIZE:	1 field, 11 characters
RECORD POSITION:	54—64
FORMAT:	Numeric

FIELD: 7

DATA ELEMENT:	Total Other Payments (Physician)
DEFINITION:	Total of all Other Payments to Physicians on this tape.
PROCEDURE:	Sum of all fields 15 (Other Payments) when field 1 is equal to 2. Right justify. The last two digits are for cents.
FIELD SIZE:	1 field, 11 characters
RECORD POSITION:	65—75
FORMAT:	Numeric

FIELD: 8

DATA ELEMENT:	Total Other Payments (Facility)
DEFINITION:	Total of all Other Payments to Facilities on this tape.
PROCEDURE:	Sum of all fields 15 (Other Payments) when field 1 is equal to 1.
FIELD SIZE:	1 field, 11 characters
RECORD POSITION:	76—86

FORMAT:	Numeric

FIELD: 9

DATA ELEMENT:	Filler
FIELD SIZE:	1 field filler, 214 characters
RECORD POSITION:	87—300
FORMAT:	Alphanumeric

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	26	125	X(100)	4 lines. 25 characters each.
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.
6	Filler	144	300	X(157)	

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TAPE FORMAT FOR
HOSPITAL/AMBULATORY SERVICE FACILITY PAYMENTS
AND PHYSICIAN PAYMENTS REPORTING
MANUAL HC-87-101B

DATA ELEMENT	DATA ELEMENT DESCRIPTION	POSITION FROM	POSITION TO	PICTURE	FORMAT
1	Record Type		1	9(1)	1 = Facility payments record. 2 = Physician payments record. 3 = Continuing physician payments record. 4 = Continuing facility payments record. 5 = Delivery/ newborn record.
2	Place of Service		2	9(1)	1 = Hospital Inpatient 2 = Hospital Outpatient 3 = Ambulatory Service Facility 4 = Unknown
3	Uniform Patient Identifier	3	11	9(9)	If unknown, zero fill.
4	Patient's Date of Birth	12	19	9(8)	MMDDYYYY. If the patient date of birth is unknown, place the patient's year of birth in this field. Right justify.
5	Patient's Sex		20	X(1)	M = Male, F = Female, U = Unknown 1 = Male, 2 = Female, 3 = Unknown.
6	Date of Admission/ Start of Care/Date of Service	21	26	9(6)	MMDDYY.

DATA ELEMENT	DATA ELEMENT DESCRIPTION	POSITION FROM	POSITION TO	PICTURE	FORMAT
7	Date of Discharge/ End of Care/Last Date of Service	27	32	9(6)	MMDDYY.
8	Procedure Code	33	41	X(9)	Procedure code. Left justify. Use decimal. See manual for instructions.
9	Uniform Identifier of Health Care Facility	42	52	X(11)	Left justify. Blank fill right.
10	Identifier of Physician	53	74	X(22)	Left justify. Blank fill. See Manual for instructions.
11	Type of Professional Service	75	76	9(2)	Type of service performed by the professional: 01 = Medical, Consulting, Psychiatric, (Including drug abuse and alcohol treatment.) 02 = Surgical, Obstetrics 03 = Diagnostic, Radiologic 04 = Anesthetic 05 = Assisted in surgery
12	Units of Service	77	79	9(3)	Right justify. Fill with zeroes left.
13	Total Charges	80	87	9(8)	6 dollar characters, 2 cent characters. Right justify. No decimal.
14	Primary Payor Payments	88	95	9(8)	6 dollar characters, 2 cent characters. Right justify. No decimal.

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DATA ELEMENT	DATA ELEMENT DESCRIPTION	POSITION FROM	TO	PICTURE	FORMAT
15	Other Payments	96	103	9(8)	6 dollar characters, 2 cent characters. Right justify. No decimal.
16	Payor Group Number	104	120	X(17)	Left justify.
17	Patient Control Number	121	137	X(17)	Left justify.
18	Procedure Coding Method Used		138	9(1)	1 - 3 Reserved for state assignment. 4 = CPT-4 5 = HCPCS 6 - 8 = Reserved for national assignment. 9 = ICD-9-CM
19	Patient's Relation-ship to Insured	139	140	9(2)	Right justify. 1 = Self 2 = Spouse 3 = Child 4 = Other
20	Certification/SSN/ Health Insurance Claim Number	141	156	X(16)	Left justify.
21	Reserve Field	157	300	X(144)	To be reserved for future use by the Council.

*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	POSITION TO	PICTURE	FORMAT
		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.
3	Total Physician Charges	21	31	9(11)	Total of all physician charges on this tape.
4	Total Facility Charges	32	42	9(11)	Total of all facility charges on this tape.
5	Total Physician Payments	43	53	9(11)	Total of all physician payments on this tape.
6	Total Facility Payments	54	64	9(11)	Total of all facility payments on this tape.
7	Total Other Payments (Physician)	65	75	9(11)	Total of all physician other payments on this tape.
8	Total Other Payments (Facility)	76	86	9(11)	Total of all facility other payments on this tape.
9	Filler	87	300	9(214)	

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APPENDIX B
FORMAT OF DICTIONARY FOR THE IDENTIFICATION OF PHYSICIANS AND FACILITIES

DATA ELEMENT	DATA ELEMENT DESCRIPTION	POSITION FROM	TO	PICTURE	FORMAT
1	Record Type		1	9(1)	1 = Physician Identifier record 2 = Facility Identifier record
2	Identifier Type		2	9(1)	1 = Tax I.D. Number 2 = Medicare I.D. Number/Social Security Number 3 = Unique Number for Physician (only)
3	Identifier Number	3	20	X(17)	Number identifying the physician or facility. Left justify. Blank fill right.
4	Physician/Facility Name	21	65	X(45)	The Name of the facility or the name of the physician. If name of the physician, place in order as follows: Last name followed by a space, first name followed by a space, middle initial. Blank fill right.
5	Physician/Facility Address	66	150	X(85)	Left justify. Blank fill right. (Include street address, city, state, zip.)

[Next page is 915-1.]

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