CHANGE TRACKING GUIDE

Section	Date of Change	Change Description
Data Submission Procedures	10/3/2022	ETR record must be the first record in the file
Validating a Submission	9/16/2024	Added Provider Postal (Zip+4) Code to edits

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MEDICAL DATA CALL – INTRODUCTION

A. Overview

As indicated in Circular Letter 662, dated March 4, 2022, as of January 1, 2023, the Wisconsin Compensation Rating Bureau ("WCRB") will collect Wisconsin medical data directly from its member insurers and will no longer utilize the National Council on Compensation Insurance, Inc. ("NCCI") as its medical data collection vendor. All members insurers participating in the Wisconsin Medical Data Call are required to report their Wisconsin State medical data (i.e. transactions with jurisdiction state code 48) directly to WCRB instead of reporting it to NCCI.

The information in these guidelines contain instructions and other helpful information for reporting medical data information to WCRB. These guidelines can be found on our website located at www.wcrb.org.

The WI Medical Data Call Reporting Guidelines applies to data submitted to WCRB. Data providers are required to comply with the instructions and guidelines. As much as possible, WCRB has followed existing NCCI specifications for collecting WI medical data. However, differences exist, and these guidelines sets the requirements for reporting medical data to WCRB.

B. Purpose of the Medical Data Call

Since 2009, WCRB has collected medical data and has utilized NCCI as its data collection vendor. The reasons for collecting medical data are as follows:

- Enhance WCRB's ability to provide information to legislative committees
- Improve WCRB's research relating to industry cost drivers
- Allow WCRB to compare its results with other Data collection organizations.

C. Adoption of NCCI Medical Data Call Framework

NCCI has established a process for the reporting and collection of medical data based on the Workers Compensation Insurance Organizations WCMED file format currently being used for submissions to NCCI. That process has been accepted by carriers for use by NCCI states and has been implemented in those states. NCCI has shared the formats and timelines for the Medical Data Call with all independent bureaus and has advised those bureaus that they are at liberty to adopt and use any portion(s) thereof.

D. Medical Data Call Contact Information

If you have any questions about the WI Medical Data Call, please contact WCRB:

Mail: Wisconsin Compensation Rating Bureau
20700 Swenson Drive – Suite 100
Waukesha, WI 53186
Attn: Webmaster

Phone: (262) 796-4420

E-mail: medical.data@wcrb.org

PART 1 – GENERAL RULES

A. Scope and Effective Date

All medical transactions are based on the detail included on bills for medical services provided to injured workers for their workplace injuries. All medical transactions with a Jurisdiction State of Wisconsin are reportable. This includes all workers' compensation claims, including medical-only claims, and federal act claims which are associated with a Wisconsin policy and are reported to WCRB on the Unit Statistical Reports. The Jurisdiction State corresponds to the state under whose Workers' Compensation Act the claimant's benefits are being paid.

The Wisconsin Medical Data Call is intended to transition the reporting of Wisconsin medical data from submission via NCCI to submission directly to WCRB by January 1, 2023. WCRB will be ready to receive medical data submissions beginning October 1, 2022.

On October 1, 2022, data reporters that are ready to begin reporting to WCRB MAY begin submitting medical data directly to WCRB via the Compensation Data Exchange (CDX) Website instead of reporting to NCCI. Once medical data reporting to WCRB begins, all subsequent submissions must be sent to WCRB. This includes any corrections and / or replacement of previous data submissions, regardless of transaction dates, should be reported to the WCRB even if the correction or replacement is of transactional data that had been previously reported to NCCI. No Wisconsin data should be submitted to NCCI after the first submission is made directly to the WCRB.

As of January 1, 2023, **ALL** medical data submissions **MUST** be reported to WCRB via CDX Website and should not be reported to NCCI.

Data reporters that have been submitting data on a quarterly basis will continue to follow the same schedule as NCCI.

- January – March medical transactions are due June 30th
- April – June medical data transaction are due September 30th
- July – September medical data transactions are due December 31st
- October – December medical data transactions are due March 31st of following year.

Data reporters that have been submitting data monthly will continue to follow the same schedule as NCCI. Three monthly medical data submissions are expected per quarter, with the entire quarter's medical data due at the end of the following quarter. (e.g., for third quarter, report July by October, August by November, September by December – with the entire third quarter due by December 31st.)

B. General

These guidelines contain copyrighted material of National Council on Compensation Insurance, Inc. (NCCI), used with permission.

These guidelines are to be used for reporting WI medical data to the WCRB. When reporting data for jurisdictions other than those specified in "Jurisdiction State Code" reporting requirement in the WI Medical Data Records Layouts and Data Dictionary document to other entities, refer to the respective reporting manuals of those other entities.

C. Participation / Eligibility

Participation is required for carrier groups with at least 1.0% market share in the state of Wisconsin in any of the most recent three years. Participation is re-evaluated everyyear. Carrier groups with less than 1.0% market share may voluntarily submit data. Questions regarding participation/eligibility of a carrier should be addressed to WCRB. See Medial Data Call Contact Information under the INTRODUCTION Section for WCRB contact information.

1. Carrier Group Participation

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

2. Reporting Responsibility

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

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

Regardless of who submits the Call to WCRB, the data submitter must report the standard record layout in its entirety with all data elements populated. Refer to the WI Medical Data Record Layouts and Data Dictionary document for more information.

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

3. Mergers and Acquisitions

If a carrier/group is required to report the Call prior to a merger or acquisition, the obligation to continue to report the Call remains. If a carrier/group that was not

previously required to report the call merges with or becomes acquired by a reporting carrier/group, the acquired carrier/group is not required to report as part of that carrier/group until a future participation evaluation deems it eligible. However, voluntary reporting of the data is permissible at any time.

Example of Merger and Acquisition Scenarios

If. . .	And. . .	Then. . .
Carrier A currently reports the Call	Merges with Carrier B, that does not report the Call	Only Carrier A reports the Call unless a future participation evaluation deems AB eligible
Carrier A does not currently report the Call	Merges with Carrier B, that currently reports the Call	Only Carrier B reports the Call unless a future participation evaluation deems AB eligible
Carrier A currently reports the Call	Merges with Carrier B, that currently reports the Call	Both Carrier A and Carrier B continue to report the Call
Carrier A currently reports the Call as part of reporting Group B	Leaves Group B	Both Carrier A and Group B continue to report the Call
Carrier A does not currently report the Call	Merges with Carrier B, that does not currently report the Call	Neither Carrier A nor B reports the Call unless a future participation evaluation deems AB eligible

D. Reporting Frequency and Duration

1. Frequency of Reporting

Medical data transactions are required to be reported as described in Scope and Effective Date under PART 1 – General Rules above. Generally, all medical transactions that occur within a specific quarter, based on the Transaction Date, must be reported by the end of the following quarter. WCRB accepts monthly or quarterly submissions. Below are examples of monthly and quarterly submission schedules:

Monthly: Three monthly data submissions are submitted, with the entire quarter's data due at the end of the following quarter (e.g., for third quarter, the monthly reporting of July data by October, August data by November, September data by December – with the entire quarter's data due by December 31st).

Quarterly: One submission is reported by the end of the following quarter (example: third quarter is due by December 31) but can be reported as early as October.

2. **Duration of Reporting**

Medical Data Call transactions are required to be reported until transactions no longer occur for the claim or 30 years from the claim Accident Date, whichever comes first. Voluntary reporting of claims older than 30 years are encouraged to the extent possible.

Example 1:
Reporting duration for claim with an accident date prior to second quarter 2019
A medical transaction occurs in April 2019 for a claim whose accident date is May 1989. The medical transaction should be reported with the third quarter 2019 submission. No further reporting of medical transactions for this claim is required. However, medical transactions for claims older than 30 years are encouraged to be reported to the extent possible.

Example 2:
Reporting duration for claim with an accident date on or after second quarter 2019
A medical transaction occurs in May 2019 for a claim whose accident date is April 2019. The medical transaction is initially reported with the third quarter 2019 submission. All subsequent transactions for this claim are reported through April 1, 2049. Reporting of transactions occurring after April 1, 2049, will be accepted but are not required.

E. Data Submission Procedures

Medical Data Call transactions are to be submitted electronically to WCRB through CDX. Carriers that are currently submitting policies and Unit Statical Reports to WCRB may already be using CDX for these submissions. For more information on using CDX, please visit the CDX section under Products Overview at www.cdxworkcomp.org.

CDX requires an Electronic Transmission Report (ETR) record to be included in every submission. One, and only one, ETR Record is expected for each file submitted. The ETR Record must be the first record in the file. For ETR record layout, see Electronic Transmission Record Specifications (ETR) document under the Data Specifications Manual link at www.wcio.org

CDX has specific file naming conventions for all files (submissions). For medical data call file conventions, please refer to File Naming Convention in the CDX Users Guide. The CDX User Guide link is located in the CDX section under Products Overview at www.cdxworkcomp.org

If additional information is required or you have any questions regarding reporting through CDX, please contact WCRB using one of the methods listed in the Medical Data Call Contact Information in the **INTRODUCTION** section above.

F Business Exclusion Options

It is expected that 100% of medical transactions from workers' compensation claims in the state of Wisconsin will be reported in the Medical Data Call. WCRB does recognize that in certain limited circumstances this can be very difficult, if not impossible, for participants (carrier groups) to comply with reporting 100% of the expected medical transactions.

Accordingly, a carrier group participating in the Call may exclude data for claims that represent up to 15% of gross premium (direct premium gross of deductibles) for the state of Wisconsin from its reporting requirement. This option may be utilized for small subsidiaries and/or business segments (e.g., coverage providers, branches, TPAs) where it may be more difficult for these entities to establish the required reporting infrastructure. The exclusion option must be based on a business segment, not claim type or characteristics. All requests for such exclusions must be presented to WCRB for acceptance. Refer to Requests for Business Exclusion in this section.

The 15% exclusion does not apply to:

- Medical services provided (pharmacy, hospital fees, negotiated fees, etc.)
- Claim characteristics such as claim status (e.g., open, closed)
- Claim types such as specific injury types (medical only, death, permanent total disability, catastrophic, etc.)

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

Example: Need to Exercise Business Exclusion Option
A carrier group has a TPA that does not process medical bills electronically. The premium associated with this TPA represents less than 15% of the participant's gross premium. The carrier group may exclude the TPA's transactions from Call reporting.

Note: If a participant has unique circumstances that cannot be accounted for within the exclusion option, contact the WCRB via email at medical.data@wcrb.org to submit documentation describing these circumstances. WCRB will address these situations on a case-by-case basis.

1. **Requests for Business Exclusion**
   Participants in the Call are required to submit their basis for exclusion to WCRB for review. The requests can be submitted to the WCRB starting on January 1, 2023.

   All exclusion requests must include the following documentation:

   a. The nature of what data is to be excluded (e.g., any vendors or entities).
   b. An explanation as to why you are using the exclusion option.
   c. Output used to demonstrate that the excluded segment(s) will be less than 15% of premium. Refer to Methods of Determining Gross Premium for Business Exclusion in this section of the guidelines for premium determination methods (including examples).
   d. Contact information for the individual responsible for the review documentation.

   Refer to the Appendix of these guidelines for a Business Exclusion Request Form, worksheets, and submission instructions.

2. Methods of Determining Gross Premium for Business Exclusions

The measurement of the 15% business exclusion is based on direct workers' compensation premiums, gross of deductibles. Below are four methods for estimating the proportion of business excluded; any of these four are acceptable to WCRB.

Some methods use the NAIC Direct Premium, which is reported in the "Exhibit of Premiums and Losses (Statutory Page 14)" in the most recently available NAIC Annual Statement. This premium can be either written or earned premium, whichever is more convenient. This premium is net of deductibles.

There are four methods carriers may use to estimate the exclusion percentage:

Method 1 — Carriers with Large Deductible Direct Premium less than 0.3% of their total premium (NAIC Direct Premiums) may determine their estimated exclusion using Direct Premium, without adjustment.

Example: Premium determination (Method 1)

A participant with Large Deductible Direct Premium less than 0.3% of its total needs to exclude business for two small subsidiaries. The participant determines the exclusion on July 1, 2021 utilizing Direct Written Premium to determine the percentage of excluded premium.

Column A Entities for Proposed Exclusion	Column B Entities' Calendar Year Written Premium for Wisconsin	Column C Carrier Group Calendar Year Written Premium for Wisconsin	Column D Entities' Written Premium as % of Carrier Group (Col. B / Col. C)
Subsidiary #1	$1,500,000		
Subsidiary #2	$2,000,000		
TOTAL	**$3,500,000**	**$357,500,000**	**1.0%**

The following steps are performed to determine whether the proposed exclusions are less than 15% of the total gross written premium:

1. Based on premium data that it maintains; the carrier group determines the Calendar Year Direct Premiums Written in Wisconsin for each subsidiary to be excluded. It enters the information in Column B.
2. Add up the data in Column B to get the Wisconsin premium proposed to be excluded.

3. Determine the most recently completed Calendar Year Direct Premiums Written in Wisconsin — the participant finds this information on Schedule T of its current NAIC Annual Statement (due on April 1 of each year). This information is entered on the Total line in Column C.
4. Calculate percentages for Column D (equals Column B divided by Column C).
5. Compare the Total line percentage to the 15% requirement. In this case, the proposed exclusion is less than 15%, so it is allowable.

Refer to the Appendix of these guidelines for Premium Verification Worksheet and Instructions – Method 1.

Method 2 — Carrier groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums) may use the table **Large Deductible Net to Gross Ratio**, included in this section, to determine their estimated exclusion using Direct Premium.

Determine the Large Deductible Net Ratio by calculating the ratio of excluded Large Deductible Direct Premium to total Direct Premium for Wisconsin. Use this net ratio to look up the gross ratio using the Large Deductible Net to Gross Ratio table below. Calculate the ratio of excluded non-Large Deductible Direct Premium to total Direct Premium. Add the corresponding Gross Ratio found in the table to the ratio of excluded non-Large Deductible Direct Premium (if any) to determine the percentage of excluded Direct Premium.

Large Deductible Net to Gross Ratio	
Net Ratio	Gross Ratio
0.0%	0.0%
0.1%	0.5%
0.2%	1.0%
0.3%	1.5%
0.4%	2.0%
0.5%	2.5%
0.6%	2.9%
0.7%	3.4%
0.8%	3.9%
0.9%	4.3%
1.0%	4.8%
1.1%	5.3%
1.2%	5.7%
1.3%	6.2%
1.4%	6.6%
1.5%	7.1%
1.6%	7.5%
1.7%	8.0%
1.8%	8.4%
1.9%	8.8%
2.0%	9.3%
2.1%	9.7%
2.2%	10.1%
2.3%	10.5%
2.4%	10.9%
2.5%	11.4%
2.6%	11.8%
2.7%	12.2%
2.8%	12.6%
2.9%	13.0%
3.0%	13.4%
3.1%	13.8%
3.2%	14.2%
3.3%	14.6%
3.4%	15.0%
3.5%	15.4%

Example: Premium determination (Method 2)

A participant with Large Deductible Direct Premium greater than 0.3% of its total must exclude one of its medical data providers. The participant has the following premium values:

- Total Direct Premium in Wisconsin is $1,000,000
- Large Deductible Direct Premium to be excluded for Wisconsin is $20,000
- Non-Large Deductible Direct Premium to be excluded for Wisconsin is $40,000

The following steps are performed to determine whether the proposed exclusion is less than 20% of the total gross written premium:

1. Calculate the Large Deductible Net Ratio — $20,000 (Large Deductible Direct Premium to be excluded) divided by $1,000,000 (Total Direct Premium), multiplied by 100 equals a Large Deductible Net Ratio of 2.0% ($20,000 / $1,000,000 x 100 = 2.0%)
2. Use the Large Deductible Net Ratio of 2.0% and the table to determine the corresponding gross ratio of 9.3%
3. Calculate the excluded non-Large Deductible ratio — $40,000 (non-Large Deductible Direct Premium to be excluded) divided by $1,000,000 (Total Direct Premium), multiplied by 100 equals an excluded non-Large Deductible ratio of 4.0% ($40,000 / $1,000,000 x 100 = 4.0%)
4. Determine the percentage of excluded premium — 4.0% (excluded non-Large Deductible ratio) added to 9.3% (Large Deductible gross ratio) equals excluded premium of 13.3% (4.0% + 9.3% = 13.3%)
5. Compare the excluded premium percentage to the 15% requirement; in this case, the proposed exclusion is less than 15%, so it is allowable

Refer to the Appendix of these guidelines for Premium Verification Worksheet and Instructions – Method 2.

Method 3 — Another option for carrier groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums) is to use the following Gross Premium Estimation Worksheet.

In the following table, fill in Items A, B, C, and D, and use the formulas to complete the worksheet. Only include premium from Wisconsin.

Premium Verification Worksheet – Method 3			
Item	**Description**	**Formula**	**Amount**
	NAIC Direct Written Premium:		
A	Total including Large Deductible		
B	Large Deductible		
C	Large Deductible to be excluded		
D	Non-Large Deductible to be excluded		
	Estimated Gross Premium:		
E	Large Deductible to be excluded	5 times C (5 x C)	
F	Total Excluded	Sum of D and E (D + E)	
G	Add-on for Large Deductible business	4 times B (4 x B)	
H	Estimated Total	Sum of A and G (A + G)	
I	Ratio	F divided by H (F / H)	

If the ratio (I) is 15% or less, the exclusion is acceptable.

Example: Premium determination (Method 3)

A participant with Large Deductible Direct Premium greater than 0.3% of its total must exclude one of its medical data providers. The participant has the following premium values:

- Total Direct Premium including Large Deductible for Wisconsin Wisconsin is $1,000,000
- Large Deductible Direct Premium for Wisconsin is $300,000
- Large Deductible Direct Premium to be excluded for Wisconsin is $20,000
- Non-Large Deductible Direct Premium to be excluded for Wisconsin is $40,000

Premium Verification Worksheet – Method 3			
Item	**Description**	**Formula**	**Amount**
	NAIC Direct Written Premium:		
A	Total including Large Deductible		1,000,000
B	Large Deductible		300,000
C	Large Deductible to be excluded		20,000
D	Non-Large Deductible to be excluded		40,000
	Estimated Gross Premium:		
E	Large Deductible to be excluded	5 times C (5 x C)	100,000
F	Total Excluded	Sum of D and E (D + E)	140,000
G	Add-on for Large Deductible business	4 times B (4 x B)	1,200,000
H	Estimated Total	Sum of A and G (A + G)	2,200,000
I	Ratio	F divided by H (F / H)	6.4%

The following steps are performed to determine whether the proposed exclusions are less than 15% of the total gross written premium:

1. From its records, the carrier group determines its Direct Written Premium for all Large Deductible policies, excluded Large Deductible policies, excluded non-Large Deductible policies, and the total for all policies including Large Deductibles
2. Input these values into the Amount column of the applicable row (Items A through D) of the Premium Verification Worksheet
3. Calculate Items E through I of the Premium Verification Worksheet
4. Compare the excluded premium percentage (Item I) to the 15% requirement; in this case, the proposed exclusion is less than 15%, so it is allowable

Refer to the Appendix of these guidelines for Premium Verification Worksheet and Instructions – Method 3.

Method 4 — Use the gross (of deductible) premium in Unit Statistical Plan data (reported in the Premium Amount field of the Exposure Record). Calculate the ratio of total gross premium on business to be excluded to total gross premium on all business and compare the excluded premium percentage to the 15% requirement. Only include premium from the state of Wisconsin.

3. **Other Premium Determination Methods**
   Contact WCRB for guidance if the methods described in this section are not appropriate for determining the exclusion percentage. The methods are not appropriate if they do not closely approximate prospective premium distribution in the current calendar year (e.g., a significant shift has occurred in a participant's book(s) of business since the last NAIC reporting; or the participant writes a significant number of large deductible policies).

4. **Business Exclusion Request Form**
   An example of the Business Exclusion Request Form is provided in the Appendix of these guidelines. Excel templates will be made available on the wcrb.org website.

PART 2 – REPORTING RULES

A. Original Reports

Medical Call data is the detailed line information of a bill, also referred to as a medical transaction, reported to WCRB as an individual record. The Original report is the first reporting of the medical transaction, identified by Transaction Code 01-Original in the record layout (Positions 44-45). For record reporting details, refer to the Medical Data Call Record Layouts and Data Dictionary document.

All medical transactions (existing claims and new claims) that occur within a specific quarter, based on Transaction Date (Positions 61-68), must be reported in that quarter's submission. Historical data for existing claims is not to be reported.

Quarterly submissions are due to WCRB at the end of the following quarter. For example, medical transactions that occur in September are reported in the third quarter submission due to the WCRB by December 31 of the reporting year. For details on quarterly and monthly reporting options, refer to Reporting Frequency and Duration in the PART 1 - General Rules section of these guidelines.

B. Record Replacements and Cancellations

Medical data providers may delete or change previously reported records (whether the records were reported in earlier submissions to either the WCRB or to NCCI, or as a prior record in the current submission). Since Medical Data Call reporting is done at the individual line level of a bill, it is not necessary to resubmit every line of a bill if only one line must be deleted or changed.

Transaction Code (Positions 44-45) is used to identify these changes as follows:

Transaction Code 02 – Cancellation – Deletes a record
Transaction Code 03 – Replacement – Changes a record

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

Note: Replacement records cannot be used when there are changes to key fields. Refer to Section 2 below for procedures to correct a record involving a change in any of the key fields.

1. Record Deletions

A record or multiple records that have been previously reported can be deleted from the WCRB's database via a cancellation record. The Cancellation transaction (Transaction Code 02) deletes all records, whether one or multiple, for a given key field combination (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number).

To delete a previously submitted record, submit a cancellation record with the following:

- All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) populated. The key fields must match those reported on the previous record to which the cancellation applies.
- Transaction Code 02-Cancellation (Positions 44-45).
- Transaction Date (Positions 61-68) reported as the date the cancellation is performed. This date must be after the transaction date on the previous record to which the cancellation applies.

Example: Deleting a single record
Carrier 99990 submits an erroneous record (A). To remove it from the database, the carrier submits a cancellation record (B) with the same key fields and Transaction Code 02. The Transaction Date of the cancellation record is the date when the cancellation is performed.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID #	(12) Line ID #	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/# of Units
A	99990	0006	01	20071210	1001	1	20071203	00000010000	00000010000	0000001
B	99990	0006	02	20071217	1001	1	20071203	00000010000	00000010000	0000001

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

2. Key Field Changes

To change a key field on a previously submitted record, a cancellation record must first be submitted to remove the record from the database. Refer to Deleting a Record in this section of these guidelines for details.

After deleting the previously reported record, submit a new record with the following:

- All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) populated with the corrected information and the previously reported information for any key fields that are not being changed.
- Transaction Code 01-Original (Positions 44-45).
- Transaction Date (Positions 61-68) reported as the date the key field change was made.

Example: Key field change

Carrier 99990 submits an original record (A) with an erroneous Claim Number Identifier of 1000. To change the claim number identifier, the carrier first submits a cancellation record (B) with all the key fields as previously reported (including Claim Number Identifier 1000), Transaction Code 02, and Transaction Date as the date the cancellation was performed. After submitting the cancellation, the carrier submits a new record (C) with the corrected Claim Number Identifier and all the other key fields as previously reported, Transaction Code 01, and Transaction Date as the date the change was performed.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/# of Units
A	99990	1000	01	20071210	1001	1	20071203	00000010000	00000010000	0000001
B	99990	1000	02	20071217	1001	1	20071203	00000010000	00000010000	0000001
C	99990	0001	01	20071217	1001	1	20071203	00000010000	00000010000	0000001

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

3. Record Changes

A record or multiple records that have been previously reported can be changed via a replacement record. The replacement record shows the current cumulative values for all data elements rather than the change in value.

Changes via a replacement record can only be made to non-key fields. To change key fields, refer to Key Field Changes in this section.

To change a non-key field for a previously reported record (original or replacement), submit a replacement record with the following:

- All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) populated. The key fields must match those reported on the previous record to which the change applies.
- Transaction Code 03-Replacement (Positions 44-45).
- Transaction Date (Positions 61-68) reported as the date the information was changed in the system of the administering entity.
- The current cumulative values for all non-key fields (not the change in value).

Note: The replacement record must include all data elements even if they do not change.

Example: Changing an amount field due to an additional reimbursement

Carrier 99990 submits a record (A) for a medical transaction. One week later, the carrier makes an additional reimbursement of $1,000. To change the transaction, the carrier submits a replacement record (B) with the same key fields as the record being changed, Transaction Code 03, and the current cumulative value (not the change in value) for all non-key fields including the Paid Amount, which reflects the total after reimbursement. The Transaction Date of the replacement record is the date the additional reimbursement was made in the system of the administering entity.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/# of Units
A	99990	0001	01	20071210	1001	1	20071203	00000009999	00000008999	0000001
B	99990	0001	03	20071217	1001	1	20071203	00000009999	00000009999	0000001

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

Example: Changing a quantity field due to a previously reported error

Carrier 99990 submits a record with an error in the Quantity/Number of Units field (A). To correct the error, the carrier submits a replacement record (B) with the same key fields as the record being corrected, Transaction Code 03, and the current cumulative value (not the change in value) for all non-key fields including Quantity/# of Units, which reflects the corrected value. The Transaction Date of the replacement record is the date the change was made in the system of the administering entity.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID #	(12) Line ID #	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/# of Units
A	99990	0001	01	20071210	1001	1	20071203	00000010000	00000010000	0000001
B	99990	0001	03	20071217	1001	1	20071203	00000010000	00000010000	0000002

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

4. Multiple Field Changes

Changes may be made to multiple fields in a record by submitting a single replacement record that includes the following:

- All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) populated. The key fields must match those reported on the previously reported original or replacement record to which the changes apply.
- Transaction Code 03-Replacement (Positions 44-45).
- Transaction Date (Positions 61-68) reported as the date the information was changed in the system of the administering entity.
- The current cumulative values for all non-key fields (not the change in value).

Note: The replacement record must include all data elements even if they do not change.
Note: Replacement records cannot be used when there are changes to key fields. Refer to Section 2 above for procedures to correct a record involving a change in any of the key fields.

Example: Changing multiple fields
Carrier 99990 must change the Service Date, Amount Charged by Provider, and Paid Amount (A). The carrier submits a replacement record (B) with the same key fields as the record being changed, Transaction Code 03, and the current cumulative value (not the change in values) for all non-key fields including Service Date, Amount Charged by Provider, Paid Amount, and Quantity / # of Units. The Transaction Date of the replacement record is the date the change was made in the system of the administering entity.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/ # of Units
A	99990	0001	01	20071210	1001	1	20071203	00000010000	00000000000	0000001
B	99990	0001	03	20080115	1001	1	20071215	00000020000	00000020000	0000002

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

C. File Replacements

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

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

Example: A data submitter wants to replace a file reported in first quarter 2019. The first day of the quarter is 01/01/2019. WCRB will not accept a replacement file submitted on or after 10/01/2019.

1. Deleting Files

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

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

2. Replacing Files

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

Example: Replacing a file submitted in error
A file is submitted on February 21, 2013 and contains 5,000 records for fourth quarter 2012. On February 23, 2013, the data provider realizes that 500 of the transactions for which records were submitted were reported with Transaction Date 20121209 (12/09/2012) but actually occurred on 01/09/2013 (first quarter). To replace the entire file, the data provider submits a new file with the 4,500 records for fourth quarter 2012. The File Control Record for the replacement file is completed as follows:

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

The 500 records reported in error must be submitted with first quarter 2013 data with the corrected Transaction Date.

Note: A Replacement (R) file received by WCRB nine months or more from the first day of the reporting quarter will be rejected.

Example: A data submitter wants to replace a file reported in first quarter 2019. The first day of the quarter is 01/01/2019. WCRB will not accept a replacement file submitted on or after 10/01/2019.

D. Duplicate Records

Duplicate records are two or more records that refer to a single service that was performed by a medical provider. Duplicates can affect medical analysis by overstating utilization. Therefore, submitters are responsible for filtering out duplicates before sending data to WCRB.

WCRB will review submissions for records with the same key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) and the same Transaction Code. If the key fields and Transaction Code are the same, WCRB will keep the record with the latest Transaction Date. If the Transaction Date is also the same, WCRB will keep the latest record submitted.

1. True Duplicates (Repeating a Single Bill or Line)

It is possible to have records that are truly duplicates but do not share all key fields. This can occur if a service provider sends a second bill (notice) for a service that was not paid. The payer’s system might create two records with different Bill Identification Numbers although they are for a single service. In this situation, the data submitter must filter out the duplicate records. Do not submit both records since it will overstate utilization.

There are three options to accomplish this:

Option # 1 - Do not submit the second record to WCRB. The original record will be considered the current record on the database.

Option # 2 - If both records are created in the same quarter and the first has not yet been reported, do not submit the first record to WCRB. The second record, once submitted, will be considered the current record on the database.

Option # 3 - Cancel the original record and submit a new original record. The second record will be considered the current record on the database. For details, refer to Record Replacements and Cancellations above.

Note: It is possible that the duplicate bill includes additional lines (e.g., follow-up visits, prescriptions). Report the additional lines in accordance with standard reporting procedures.

2. Multiples of a Procedure Code

It is possible to have a situation where a service provider performs the same service multiple times. These instances are not considered true duplicates (single service billed multiple times) and must be reported to WCRB. For example, a claimant receives an X-ray, and the service provider requests a second X-ray that repeats the first. Both procedures would be reported.

E. Dispensing Fees

Dispensing fees are charges assessed when providers issue drugs or supplies to claimants. These dispensing fees include overhead, supplies, labor, etc. to fill a prescription. When reporting to WCRB, include these fees along with the cost of the medication or supply.

Add the dispensing fee to the Amount Charged and Paid Amount in the record for the item dispensed, unless state regulations require the fees to be itemized as a separate record. For example, if a pharmacy charges $50 for a medication, with an additional $1 dispensing fee, one record with an Amount Charged of $51 would be reported.

1. Reporting Dispensing Fees Separately

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

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

Example: Reporting dispensing fees separately

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

F. Inpatient Hospital Services

Inpatient hospital bills contain many services over multiple days. When reporting inpatient hospital bills to WCRB, only one transaction is required.

See WI Medical Data Call Record Layouts and Data Dictionary for reporting specifications.

G. Paid Procedure Code Reporting

Medical billings can contain procedure codes billed by the medical provider that are not directly involved in the reimbursement calculation for the services rendered. For the Medical Data Call, the Paid Procedure Code (Positions 153–177) identifies the procedure associated with the reimbursement paid on a line item or bill. The Secondary Procedure Code (Positions 290–314) field identifies the related procedures billed by the medical provider.

For example, for an inpatient hospital bill, the billed services are often coded using Hospital Revenue Codes, and yet, according to the state fee schedule, the reimbursement is based on a Diagnosis-Related Group (DRG). In these cases, the DRG should be reported as the Paid Procedure Code for every line to which the DRG reimbursement applies. The Secondary Procedure Code field should reflect the underlying CPT/HCPCs or Revenue Code billed by the hospital.

The examples in this section illustrate the reporting of Paid Procedure Codes and Secondary Procedure Codes.

1. DRG Reimbursement (Multiple Dates of Service) Example

A billing for inpatient shoulder surgery shows charges at the Revenue Code level. For this example, assume that applicable state regulations indicate that the appropriate reimbursement is based on a DRG code. The DRG may have been supplied in the PPS code field (FL 71) on the UB-04 form or it is derived by the billing review software.

When reporting the bill transactions on the Medical Data Call, every record should report the DRG as the Paid Procedure Code when applicable. Each record reports a single Revenue Code as the Secondary Procedure Code along with the associated billed charges as the Amount Charged by Provider (Positions 186-196). The DRG reimbursement applies to the entire bill. The Paid Amount (Positions 197-207) may be reported on one transaction (reflecting a bill level reimbursement), and all other transactions for the bill are reported as $0.

The following is an example of correct reporting when multiple dates of services are audited separately:

Example: Correct Reporting – Services Audited Separately

Line Identification Number	Service From Date	Service To Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130604	20130606	508	0111	00000129138	00000468372
2	20130604	20130606	508	0250	00000196255	00000000000
3	20130604	20130606	508	0270	00000147265	00000000000
4	20130604	20130606	508	0360	00000551900	00000000000
5	20130604	20130606	508	0370	00000345900	00000000000
6	20130604	20130606	508	0710	00000133800	00000000000

Alternatively, when one cannot proportion this reimbursement among the entire billed lines, one can report the total DRG reimbursement as the Paid Amount on a single transaction.

The following is an example of correct reporting when multiple dates of services are bundled together:

Example: Correct Reporting – Bundled Billing

Line Identification Number	Service From Date	Service To Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130604	20130606	508	0111	00000129138	00000468372

The following is an example of incorrect reporting when multiple services are audited separately – in this case, Hospital Revenue Codes were used as the Paid Procedure Codes instead of the correct DRG codes:

Example: Incorrect Reporting – Services Audited Separately

Line Identification Number	Service From Date	Service To Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130604	20130606	0111		00000129138	00000468372
2	20130604	20130606	0250		00000196255	00000000000
3	20130604	20130606	0270		00000147265	00000000000
4	20130604	20130606	0360		00000551900	00000000000
5	20130604	20130606	0370		00000345900	00000000000
6	20130604	20130606	0710		00000133800	00000000000

2. DRG Reimbursement (Single Service Date) Example

Alternatively, inpatient hospital transactions reimbursed under a DRG can be reported on a per-day basis. Because the DRG determined the reimbursement, report the DRG as the Paid Procedure Code. When submitting transactions for individual service dates of an inpatient stay, report the daily reimbursement amount on one of the bill lines for the day as the Paid Amount. The Paid Amount on all other transactions with the same Service Date (Positions 129-136) is reported as $0 because the daily reimbursement amount was already included on another bill line. Note that the sum of the Paid Amounts will equal the total reimbursement for the entire bill.

The following is an example of correct reporting for a single service date when services are audited separately:

Example: Correct Reporting – Single Service Date

Line Identification Number	Service Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130604	508	0111	00000043046	00000156124
2	20130604	508	0250	00000117753	00000000000
3	20130604	508	0270	00000147265	00000000000
4	20130604	508	0360	00000551900	00000000000
5	20130604	508	0370	00000345900	00000000000
6	20130604	508	0710	00000133800	00000000000
7	20130605	508	0111	00000043046	00000156124
8	20130605	508	0250	00000051027	00000000000
9	20130606	508	0111	00000043046	00000156124
10	20130606	0250	00000027475	00000000000	00000000000

The following is an example of incorrect reporting for a single service date when services are audited separately:

Example: Incorrect Reporting – Single Service Date

Line Identification Number	Service Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130604	0111		00000043046	00000156124
2	20130604	0250		00000117753	00000000000
3	20130604	0270		00000147265	00000000000
4	20130604	0360		00000551900	00000000000
5	20130604	0370		00000345900	00000000000
6	20130604	0710		00000133800	00000000000
7	20130605	0111		00000043046	00000156124
8	20130605	0250		00000051027	00000000000
9	20130606	0111		00000043046	00000156124
10	20130606	0250		00000027475	00000000000

3. DRG Reimbursement with Implant Example

The standard DRG reimbursement does not always cover the entire bill, especially bills charging for services or equipment that are expected to vary greatly in cost. Implants and prosthetics are one category of devices that often are not subject to the DRG calculation and, instead, are reimbursed separately.

When reporting the bill line transactions reimbursed according to the DRG, report the applicable DRG in the Paid Procedure Code. For bill line transactions that are not reimbursed under the DRG, report the procedure code (typically a Hospital Revenue Code) used to determine the reimbursement for that bill line in the Paid Procedure Code field and the associated reimbursement in the Paid Amount field.

The following is an example of correct reporting when an implant was billed and reimbursed separately:

Example: Correct Reporting – DRG Reimbursement With Implant

Line Identification Number	Service From Date	Service To Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130118	20120120	460	0110	00000130000	00001541298
2	20130118	20120120	460	0250	00000427703	00000000000
3	20130118	20120120	460	0270	00000025700	00000000000
4	20130118	20120120	460	0271	00000042500	00000000000
5	20130118	20120120	460	0272	00000151900	00000000000
6[1]	20130118	20120120	0278		00004415600	00001388978
7	20130118	20120120	460	0300	00000002000	00000000000
8	20130118	20120120	460	0305	00000003000	00000000000
9	20130118	20120120	460	0360	00001580000	00000000000
10	20130118	20120120	460	0370	00000069200	00000000000
11	20130118	20120120	460	0710	00000050000	00000000000

[1]Line ID Number 6 with Paid Procedure Code 0278 in the Implant Revenue code.

The following is an example of incorrect reporting when an implant was billed and reimbursed separately:

Example: Incorrect Reporting – DRG Reimbursement with Implant

Line Identification Number	Service From Date	Service To Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20130118	20120120	0110		00000130000	00001541298
2	20130118	20120120	0250		00000427703	00000000000
3	20130118	20120120	0270		00000025700	00000000000
4	20130118	20120120	0271		00000042500	00000000000
5	20130118	20120120	0272		00000151900	00000000000
6[2]	20130118	20120120	0278		00004415600	00001388978
7	20130118	20120120	0300		00000002000	00000000000
8	20130118	20120120	0305		00000003000	00000000000
9	20130118	20120120	0360		00001580000	00000000000
10	20130118	20120120	0370		00000069200	00000000000
11	20130118	20120120	0710		00000050000	00000000000

[2]Line ID Number 6 with Paid Procedure Code 0278 in the Implant Revenue code.

4. EAPG Reimbursement Example

A billing for an Ambulatory Surgical Center surgery shows that facility charges were billed using CPT codes. In Wisconsin, the fee schedule indicates that the appropriate reimbursement is based on an Enhanced Ambulatory Payment Group (EAPG) code.

When reporting the bill transaction on the Medical Data Call, every record should report the EAPG as the Paid Procedure Code when applicable. Each record reports a single CPT code as the Secondary Procedure Code along with the associated billed charges as the Amount Charged by Provider. The EAPG paid amount can either be reported on a single transaction or apportioned to the individual bill lines.

The following is an example of correct reporting when bills are charged with CPT codes and the reimbursement is based on EAPG codes:

Example: Correct Reporting—EAPG Reimbursement

Line Identification Number	Service Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20180604	38	29877	00000043046	00000156124
2	20180604	38	12017	00000117753	00000000000

The following is an example of incorrect reporting when bills are charged with CPT codes and the reimbursement is based on EAPG codes:

Example: Incorrect Reporting—EAPG Reimbursement

Line Identification Number	Service Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	20180604	29877		00000043046	00000043046
2	20180604	12017		00000117753	00000117753

PART 3 – EDITING AND OTHER VALIDATION PROCEDURES

A. Editing Process

WCRB's editing process is performed to ensure that the medical data provider's data is consistent with reporting requirements and that it meets quality standards. The edit process for the Medical Data Call is based on three quality components:

1. Completeness test (e.g., are the data elements appropriately populated?)
2. Validation test (e.g., are the data elements populated with valid values?)
3. Reasonableness test (e.g., is the distribution of data elements reasonable?)

These tests will be performed within each data element and across Call elements where needed.

B. Validating a Submission

Using data element tolerance levels, the editing process determines the overall quality of the Medical Data Call. Data element tolerance levels are defined as follows:

a. Critical (C) – Indicates that the data element is of critical importance. Elements in this category have a very low tolerance for missing or invalid data. For example, a tolerance of .1% would indicate that the data element can only be missing or invalid for 100 out of 100,000 records. Records with missing or invalid critical elements above this tolerance level are not viable for Call use.
b. Priority (P) – Indicates that the data element is very important but the record can still be of some value even with this data element missing. An example of a Priority - tolerance level is in the range of 1%-5%.
c. Low (L) – Indicates that the record is still useful when this data element is missing. An example of a Low tolerance level is in the range of 10% - 20%.
d. Relational (R) – Indicates the relationship of one data element in relation to another data element as a reasonability test.
e. Required – Indicates that the data element must be provided for file acceptance and data processing.
f. Required – Electronic Transmission Record (ETR) - Indicates that the ETR contains all the data elements required for file acceptance and data processing.
g. Required – File Control Record – Indicates that the File Control Record contains all the data elements required for file acceptance and data processing.

Below are the edits and their associated tolerance levels that will be performed on each data element:

Field No.	Data Element	Tolerance/Edit
1	Carrier Code*	Required for file acceptance
2	Policy Number Identifier*	Required for file acceptance
3	Policy Effective Date*	Required for file acceptance
4	Claim Number Identifier*	Required for file acceptance
5	Transaction Code	Required for file acceptance
6	Jurisdiction State Code	**C**
7	Claimant Gender Code	**L**
8	Birth Year	**L**
9	Accident Date	**C**
10	Transaction Date	Required for file acceptance
11	Bill Identification Number*	Required for file acceptance—Must be unique
12	Line Identification Number*	Required for file acceptance—Must be unique
13	Service Date	**R**—Must be populated if Service From Date and Service To Date are missing. Must be valid if populated.
14	Service From Date	**R** —Must be populated if Service Date is missing. Must be valid if populated.
15	Service To Date	**R**—Must be populated if Service Date is missing and Service From Date is populated. Must be valid if populated.
16	Paid Procedure Code	**P**—Must be formatted correctly. Codes validated against procedure codes
17	Paid Procedure Code Modifier	**P**—Validated against a table of valid values. Cannot be missing for every record
18	Amount Charged by Provider	**C**—Must be greater than zero
19	Paid Amount	**C**—Must be greater than or equal to zero
20	Primary ICD -- Diagnostic Code	**P**—Codes validated against valid ICD -- Diagnostic codes
21	Secondary ICD -- Diagnostic Code	**L**—Cannot be missing for every record
22	Provider Taxonomy Code	**P**—Must be a valid code
23	Provider Identification Number	**P**—Priority tolerance where required by state mandate
24	Provider Zip Code	**P**
25	Network Service Code	**P**
26	Quantity/Number of Units per Procedure Code	**P**—Must be numeric
27	Place of Service Code	**P**—Must be a valid code
28	Secondary Procedure Code	**R**—Must be valid if populated
29	Provider Postal (Zip+4) Code	**P**

* This data element is considered a key field and must be reported the same as on the original record for all records related to a medical transaction (line). Refer to the WI Medical Data Call Structure, Record Layouts and Data Dictionary document.

1. Edit Types

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

- Submission edits ensure that the file record length is correct, data provider information is valid, a File Control Record exists, and the record count balances
- Field edits ensure that the data contained in each data field is acceptable
- Logical edits verify that the data makes sense in relation to one or more other fields on the same report
- Relational edits compare the data in a specific field on the report with another data field contained in the same report submission and/or with a corresponding medical report that was previously submitted and already stored on WCRB's database

2. File Acceptance

Every Medical Data Call file received by WCRB goes through three stages of editing. File Acceptance, the first stage of the editing process, includes submission, field, and relational level edits to determine whether WCRB can process the file. Refer to Edit Types in this section for edit type descriptions.

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

File Acceptance submission level edits determine whether the:

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

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

To ensure the completeness and validity of the required fields, field and relational level edits are also performed during this stage on any field that is identified as “Required for File Acceptance.” Refer to Validating a Submission in this section for data element tolerance descriptions. The required fields include the - key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) plus Transaction Code and Transaction Date.

- Field edits ensure the completeness and validity of each data element. For example, Carrier Code cannot be missing and must be a valid NCCI Carrier Code.
- Relational edits check for acceptable relationships between elements on different records, either within the submission or on WCRB’s database. For example, a Cancellation record (Transaction Code 02) must have an associated Original record (Transaction Code 01) or Replacement record (Transaction Code 03) in the submission or on WCRB’s database.

When a required field fails an edit, the percentage of edit failure occurrences are counted and compared to tolerance levels. If the percentage of edit failure occurrences is greater than the tolerance, the file will be rejected, and the medical data provider is notified that the file was rejected. If the number of edit failure occurrences is below tolerance, WCRB will return those records that failed to the data submitter.

Data providers should review all rejected files and all returned records to identify and correct issues in their source systems.

Once a file passes the File Acceptance stage, all records, except those returned, will be processed.

File Acceptance		
Edit Types	**Description**	**Edit Failure Results**
Submission	Enables WCRB to process the file	Reject file
Field (required fields)	Ensures complete and valid entry	Greater than tolerance = Reject file Below tolerance = Return record
Relational (required fields)	Determines if the relationship between fields in different records is acceptable	Return record

For details on all Medical Call edits, refer to the WI Medical Data Call Edit Matrix document.

3. Quality Tracking

Quality Tracking is the second stage of the editing process. It is at this stage that a data provider can gauge the quality of the data they are reporting.

In this stage, the data elements of each submission are checked for completeness and validity using field, logical, and relational edits:

- Field edits ensure the completeness and validity of each data element. For example, Birth Year cannot be missing, and the year must be a valid year.
- Logical edits check the relationship between elements within the same record. For example, Birth Year must be before Accident Date.
- Relational edits check for acceptable relationships between elements on different records, either within the submission or on WCRB's database. For example, if an Original record (Transaction Code 01) already resides on WCRB's database, a new Original with the same key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number, and Line Identification Number) and the same Transaction Code and Transaction Date will invoke an edit.

Refer to Edit Types in this section for edit type descriptions.

Each data element is evaluated against one or more edits and either passes or fails each edit. For each data element, if any edit fails, the transaction is counted and the number of transactions that fail are evaluated against a tolerance level (Critical, Priority, Low, or Relational). Refer to Validating a Submission in this Part for data element tolerance descriptions.

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

WCRB will not reject or return records during this editing stage. WCRB may, however, contact the data reporter to address any systematic reporting issues that are observed in the data.

File Acceptance		
Edit Types	**Description**	**Edit Failure Results**
Field (required fields)	Ensures complete and valid entry	Count occurrences
Logical	Determines if the relationship between fields in the same record is acceptable	Count occurrences
Relational (required fields)	Determines if the relationship between fields in different records is acceptable	Count occurrences

For details on all Medical Call edits, refer to the WI Medical Data Call Edit Matrix document.

4. Quarter End Validation

Quarter End Validation is the third and final stage of the editing process. This stage begins in the due quarter.

During the Quarter End Validation stage, Quality Tracking edits for all the medical data providers reporting for the carrier group are summarized for the entire quarter's data, developing quality statistics across all submissions. Refer to Quality Tracking in this section for details. Additional - relational edits are performed in this stage.

Relational edits check the entire submission for completeness and reasonability. For example, an office visit is the most common Place of Service; therefore, WCRB would expect to see the Place of Service code reported and reported more frequently than other Place of Service codes.

The Quality Tracking and additional - edit failures are aggregated, and the results are provided at the Group level. For each data element, if any edit fails, the transaction is counted and the number of transactions that fail are evaluated against a tolerance level (Critical, Priority, or Low). Refer to Validating a Submission in this section for data element tolerance descriptions.

WCRB will not reject or return records during this editing stage.

File Acceptance		
Edit Types	**Description**	**Edit Failure Results**
Quality Tracking (Field, Logical, Relational)	Refer to Quality Tracking in this section for details	Count occurrences
Relational (required fields)	Determines if submission meets anticipated values	Display anticipated values

For details on all Medical Call edits, refer to the WI Medical Data Call Edit Matrix document.

C. WI Medical Data Call Edit Matrix

1. WI Medical Data Call Edit Matrix—All Edits in Production

The WI Medical Data Call Edit Matrix—All Edits in Production contains details on the enhanced editing process that currently takes place in WCRB's database. This online edit matrix is the most comprehensive resource for information on WCRB's Medical Data Call editing and can be used when monitoring quality tracking and quarter end validation to obtain the details on each edit. It is updated frequently to ensure the most current editing information.

The WI Medical Data Call Edit Matrix—All Edits in Production can be found in the WI Medical Data Call Edit Matrix document.

2. WI Medical Data Call Edit Matrix—Future Edit Enhancements

The WI Medical Data Call Edit Matrix—Future Edit Enhancements contains edits scheduled for future implementation. This edit matrix provides you with lead time and projected implementation dates for planned changes to Medical Data Call editing. This advanced information can be used for planning purposes.

The WI Medical Data Call Edit Matrix—Future Edit Enhancements has not been established since all the edits are currently contained in the WI Medical Data Call Edit Matrix document.

3. Online Edit Matrix Updates

When changes are made to the WI Medical Data Call Edit Matrix, the carrier's designated Medical Data Call contact will be notified via email.

PART 4 – GLOSSARY

TERM	DEFINITION
Adjustment	A change to the paid amount on a previously reported *record*. Adjustments do not include changes due to data reporting errors.
Administering Entity	The *insurance carrier*, *Third Party Administrator*, bill review vendor, or other entity that receives the *bill* from a medical *service provider* and that pays for the medical transaction.
Ambulatory Payment Classification (APC)	A grouping used in the determination of facility fee payments. Ambulatory payment classifications categorize outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.
Ambulatory Surgical Center (ASC)	A state-licensed facility that is used mainly to perform outpatient surgery, has a staff of physicians, has continuous physician and nursing care, and does not provide for overnight stays. An ambulatory surgical center can bill for facility fees much like a hospital, but generally has a separate fee schedule.
APC	*See Ambulatory Payment Classification*
ASC	*See Ambulatory Surgical Center*
ASCII	(American Standard Code for Information Interchange) standard code for representing characters as binary numbers. In addition to printable characters, the ASCII code includes control characters to indicate carriage return, backspace, and the like.
Bill	A listing (lines) of charges for medical services. A bill may consist of multiple lines.
Calendar Year Premium	Associated with premium within a given calendar year period. Calendar year premium is final at the end of the period and does not change from valuation to valuation.
Cancellation	A Medical Data Call *transaction* that allows the *medical data provider* to completely remove a previously submitted record or multiple records from WCRB's database.
Carrier	See *Insurance Carrier*
Carrier Group	Insurance companies under a common ownership
Claim	A demand to recover from a loss or damage covered by a policy of insurance. A Medical Data Call claim (identified by claim number) includes one or more *bills* for medical services.
Claimant	The person who makes a *claim*. The claimant receives the medical services listed on the *bill*(s) for the associated claim.
CMS-1500 Form	The standard claim form of the Centers for Medicare and Medicaid Services used by non-institutional providers or suppliers to bill Medicare carriers and durable medical equipment regional carriers (DMERCs) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. It is also used for billing of some Medicaid State Agencies.

Count Occurrences	A mechanism for tracking record level edits that pass or fail. During File Acceptance processing, all edits with an outcome of "Count Occurrences" that fail will cause the record to be rejected and returned to the data submitter. Quality Tracking edits with an outcome of "Count Occurrences" that fail will always be displayed as a percentage of the total records. Quarter End Validation edits with an outcome of "Count Occurrences" that fail will be displayed as a percentage of total records when the result exceeds the tolerance level.
Coverage Provider (or Coverage Provider Group)	See *Insurance Carrier*.
Data Element	The smallest unit of physical data for which attributes are defined.
Deductible	A clause in an insurance policy that relieves the *insurer* of responsibility in dollars, percentage of the total, or percentage of the loss before paying the loss.
Field	An area designated for a particular category of data.
File	An organized, named collection of related records packaged collectively and reported electronically to WCRB. For Medical Call data, a file may only include the data from one *reporting group*, but data for multiple carrier codes within the reporting group is acceptable.
Gross Premium	In company language, the premium before deducting any premium paid for reinsurance and, in some cases, before paying any return premium.
Health Maintenance Organization (HMO)	An organization of medical care providers that offers a specified range of medical care in return for a set fee. See also *Preferred Provider Organization*.
HMO	*See Health Maintenance Organization*
Individual Reporter	A *medical data provider* that reports data only for its own carrier code. Data will not be included in a *file* for other carrier codes.
Insurance Carrier	The company that issues the insurance *policy*. Also referred to as the coverage provider, insurance carriers include private carriers, state funds, and self-insured groups.
Insured	The policyholder. In *workers' compensation insurance*, the insured is the person or organization (employer) that is protected (covered) by the insurance *policy* and is entitled to recover benefits under its terms. The insured is designated in Item 1 of the policy Information Page.
Insurer	The *insurance carrier* or other organization, such as a syndicate, pool, or association, providing insurance coverage and services.
Line	A single charge for a medical service or services listed on a *bill*. Also referred to as line item detail.
Medical Data Provider	Any unique data reporting entity that is certified to send Medical Call data to WCRB. This includes, but may not be limited to, *insurance carriers*, *Third Party Administrators (TPAs)*, bill review vendors, and pharmacy vendors. See also *Reporting Group*.

Medical/Service Provider	See *Service Provider.*
Patient	The person receiving medical services. For a workers' compensation *claim*, the patient is also the *claimant*.
Payer	The entity that ultimately pays for medical services.
Policy	The formal written contract of insurance between the employer (insured) and the *insurance carrier* (insurer).
PPO	See *Preferred Provider Organization*
Preferred Provider Organization (PPO)	A network of medical care providers contracted by the *insurer* to provide various medical care services to covered employees for specified fees. The covered employees have the option to go to the network of medical care providers or to go outside of the network for medical care services for reasonable and customary fees after a set *deductible* is met. See also *Health Maintenance Organization*.
Quarterly Submission	The data *file*, or files that represent the *reporting groups*' aggregate submission for a given three-month (quarter) period.
Provider	See *Service Provider*.
Record	A collection of related data elements that are treated as one unit.
Record Layout	Defines the parameters for each data *field* contained in the *record* that is submitted electronically, including the data field's starting and ending positions on the record and the field's specific type/class (i.e., alpha, numeric, or alpha/numeric). The consistent parameters allow for efficient processing, so the data contained within can be sorted, formatted, and customized.
Reporting Group	An affiliated insurance company or an assembly of affiliated insurance companies *(Affiliate Group)* and their designated *medical data providers* that report Medical Call data to WCRB.
Service Provider	*Service provider*, or medical service provider, refers to the individual or group that furnishes a *patient* with various medical services (e.g., physician, clinic, hospital, pharmacy). Refer Taxonomy Code for the source link to the accepted Provider Taxonomy Code list in the WI Medical Data Call Record Layouts and Data Dictionary.
Special Characters	Refers to the additional characters other than letters A–Z and numbers 0–9.
Statistical Agent	Company associations that collect workers' compensation data and prepare it according to rating regulation requirements on behalf of their members. Most state workers' compensation laws permit companies to join together for this purpose.
Submission	A *file* transmitted to WCRB for a given *reporting group*. Also referred to as a transmission.
Subsidiary	A corporation that is either wholly owned by another corporation or controlled by a corporation or business entity that owns a majority of its voting shares.
Third Party Administrator (TPA)	An organization hired to perform one or more of the business functions of another company, which may include reporting insurance data to the *statistical agent*.
TPA	See *Third Party Administrator*

Transaction	Refers to either of the following: • The *line* item of a medical *bill*. Referred to as a medical transaction in these guidelines. Use this definition for Transaction Date. • The general term given to data transmitted from one computer system to another for the purpose of accessing, querying, or updating a record, file, or database. Use this definition for Transaction Code.
Transmission	See *Submission*.
UB-04 Form	The basic form that Centers for Medicare and Medicaid Services prescribes for the Medicare program. It is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act (ASCA), Public Law 107105, and the implementing regulation at 42 CFR 424.32.
Unit Statistical Data	The statistical documentation that *insurance carriers* submit to WCRB for the purpose of reporting workers' compensation insurance data. It includes premium and losses by state at a classification code level.
Utilization	The frequency that a particular medical procedure is performed.
Workers' Compensation Insurance	Statutory coverage for employers subject to the workers' compensation law of a state. It provides benefits to employees who are injured during the course of their employment. WCRB***'s WI Basic*** contains rules, classifications with descriptions, rates/loss costs for each classification, and state-specific exceptions for writing workers' compensation insurance.

PART 5 – APPENDIX

A. Overview

The following examples are included in the Appendix:

- Business Exclusion Request Form Example --
- Premium Verification Worksheets and Instructions - For use with Premium Determination Methods 1 - 3

B. Business Exclusion Request Form Example

Mandatory participants in the Call are required to submit their basis for exclusion to WCRB for review annually. All requests for review must include the output used to demonstrate that the excluded segment(s) will be less than 15% of gross premium. For details on the methods for premium determination and examples, refer to Business Exclusion Option in the General Rules section of these guidelines.

Date Prepared:
Carrier Group Name:
Carrier Group Number:
Preparer's Contact Information
Name:
Address:
Phone:
Email:

Exclusions – Complete the following steps:

1. Document the nature and reason for all proposed exclusions. If more space is needed, please attach a separate page with the explanation(s) to this form.

   Note: The exclusion option must be based on business segment, not on claim type or characteristics.

   The 15% exclusion does not apply to:
   - Medical services provided (pharmacy, hospital fees, negotiated fees, etc.)
   - Claim characteristics such as claim status (e.g., open, closed) or deductible programs (e.g., large deductibles)
   - Claim types such as specific injury types (medical only, death, permanent total disability, catastrophic, etc.)

2. Document the carriers (by carrier code) that are handled by each excluded business segment in wisconsin.

3. For each applicable carrier, provide an estimate of the percentage of paid losses handled by each excluded business segment.

4. If using Premium Determination Methods 1, 2 or 3, complete the corresponding Premium Verification Worksheet. If using Premium Determination Method 3, complete the Gross Premium Estimation Worksheet.

   Note: If the methods described are not appropriate for determining the exclusion percentage, contact WCRB for guidance. The methods are not appropriate if they would not closely approximate prospective premium distribution in the current calendar year (e.g., a significant shift has occurred in a participant's book(s) of business since the last NAIC reporting or the participant writes a significant number of large deductible policies).

5. Completed requests should be sent to the Wisconsin Compensation Rating Bureau, 20700 Swenson Drive Suite 100 Waukesha, WI 53186, ATTN: WCRB Webmaster or emailed to medical.data@wcrb.org.

C. Premium Verification Worksheets and Instructions

1. Worksheet – Method 1

Use this worksheet to determine if proposed exclusions are less than or equal to 15% of the group's total written premium when using Premium Determination Method 1. Only include premium from Wisconsin or Federal Act.

For details on Premium Determination Method 1 and all other premium determination methods, refer to Business Exclusion Option in the General Rules section of these guidelines.

Column A **Entities for Proposed Exclusion**	**Column B** **Entities' Calendar Year Written Premium**	**Column C** **Carrier Group Calendar Year Written Premium**	**Column D** **Entities' Written Premium as % of Carrier Group (Col. B / Col. C)**
TOTAL			

2. Worksheet Instructions – Method 1

1. In Column A, list the entities excluded from Wisconsin.
2. In Column B, enter the Calendar Year Written Premium for Wisconsin for each excluded entity.
3. In Column B of the Total row, enter the sum of the premium for the excluded entities.
4. In Column C of the Total row, enter the Carrier Group's Calendar Year Written Premium for wisconsin (as reported in the NAIC Annual Statement—Statutory Page 14).
5. In Column D of the Total row, divide Column B by Column C, and enter the result as a percentage. Round to one decimal. This value must be equal to or less than 15%.

3. Worksheet – Method 2

Use this worksheet to determine whether proposed exclusions are less than or equal to 15% of the group's total written premium when using Premium Determination Method 2. This method is an option for affiliate groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums.) Only include premium from Wisconsin or Federal Act.

For details on Premium Determination Method 2 and all other premium determination methods, refer to Business Exclusion Option in the General Rules section of these guidelines.

Premium Verification Worksheet – Method 2			
Item	**Description**	**Formula**	**Amount**
	NAIC Direct Written Premium:		
A	Total		
B	Large Deductible to be excluded		
C	Non-Large Deductible to be excluded		
	Estimated Gross Premium:		
D	Net Ratio	B divided by A (B / A)	
E	Gross Ratio	From table (Refer to Business Exclusion Option in the **General Rules** section of these guidelines	
F	Non-Large Deductible Ratio	C divided by A (C / A)	
G	Ratio	Sum of E and F (E+F)	

4. Worksheet Instructions – Method 2

1. Fill in Items A, B and C.
2. Determine the Net Ratio (D).
3. Use the Net Ratio to determine the Gross Ratio (E) from the table. Refer to Business Exclusion Option in the General Rules section of these guidelines.
4. Use the formulas to complete the worksheet.
5. If the ratio (G) is 15% or less, the exclusion is acceptable.

5. Worksheet – Method 3

Use this worksheet to determine if proposed exclusions are less than or equal to 15% of the group's total written premium when using Premium Determination Method 3. This method is an option for affiliate groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums.) Only include premium from Wisconsin or Federal Act.

For details on Premium Determination Method 3 and all other premium determination methods, refer to Business Exclusion Option in the General Rules section of these guidelines.

Premium Verification Worksheet – Method 3			
Item	**Description**	**Formula**	**Amount**
	NAIC Direct Written Premium:		
A	Total including Large Deductible		
B	Large Deductible		
C	Large Deductible to be excluded		
D	Non-Large Deductible to be excluded		
	Estimated Gross Premium:		
E	Large Deductible to be excluded	5 times C (5 x C)	
F	Total Excluded	Sum of D and E (D + E)	
G	Add-on for Large Deductible business	4 times B (4 x B)	
H	Estimated Total	Sum of A and G (A + G)	
I	Ratio	F divided by H (F / H)	

6. Worksheet Instructions – Method 3

1. Fill in Items A, B, C. D.
2. Use the formulas to complete the worksheet.
3. If the ratio (I) is 15% or less, the exclusion is acceptable.