PART 1 – MEDICAL DATA CALL STRUCTURE

A. General

Medical Call data is not aggregated at the bill level. Instead, each line of a bill is reported as a separate record. While certain data elements will be repeated on each line, others are distinct per line. These two classifications of data elements are called Bill Header and Bill Detail.

B. Bill Header Data Elements

Bill Header data elements identify the information that is common to all lines of a bill. Therefore, the data in these elements is the same for all records from the same bill.

Note: A bill is identified by the combination of Claim Number and Bill Identification Number.

Bill Header data elements include:

- Carrier Code
- Policy Number Identifier
- Policy Effective Date
- Claim Number Identifier
- Jurisdiction State Code
- Claimant Gender Code
- Birth Year
- Accident Date
- Bill Identification Number
- Service From Date
- Service To Date
- Provider Taxonomy Code
- Provider Identification Number
- Provider Postal (ZIP) Code
- Network Service Code
- Place of Service Code
- Provider Postal (ZIP+4) Code

These elements are typically located on the header (top) section of standard bill forms such as CMS-1500 or UB-04. For specific locations of the data information on these standard forms (if applicable), refer to the Source column Record Layout section below.

C. Bill Detail Data Elements

Bill Detail data elements provide the line level information and, therefore, can differ among the individual records of a bill. Bill Detail data elements include:

- Transaction Code
- Transaction Date
- Line Identification Number
- Service Date
- Paid Procedure Code
- Paid Procedure Code Modifier
- Amount Charged by Provider
- Paid Amount
- Primary ICD -- Diagnostic Code
- Secondary ICD -- Diagnostic Code
- Quantity/Number of Units per Procedure Code
- Secondary Procedure Code

Note: Some detail data elements, such as ICD -- Diagnostic Codes, can act like Bill Header data elements because they may be the same for all lines. However, it is possible for these codes to vary per line.

These elements are typically located on the detail (lower) section of standard bill forms, such as CMS-1500 or UB-04. For specific locations of the data information on these standard forms (if applicable), refer to the Source column in the Part 2 - Record Layouts section below.

D. Key Fields

The following data elements are considered key fields. They must be reported the same as on the original record for any replacement or cancellation record related to a medical transaction (line):

- Carrier Code
- Policy Number Identifier
- Policy Effective Date
- Claim Number Identifier
- Bill Identification Number
- Line Identification Number

Correctly reporting the key fields ensures the accurate linking and unique identification of the cancellation or replacement record to the original record. To change a key field, refer to Record Replacements and Cancellations in Part 2 of the WI Medical Data Call Reporting Guidelines document.

Part 2 - RECORD LAYOUTS

A. Overview

In order for the Wisconsin Compensation Rating Bureau (WCRB) to properly receive data submissions, data providers are required to comply with specific requirements regarding record layouts, data elements, and key fields when reporting Medical Call data. Data files are transmitted in specific record layouts to allow for efficient processing. This allows the data contained within the record layouts to be formatted, sorted, and customized according to the user's specifications.

The record layouts that comprise the Medical Data Call are provided in this section of the document.

B. Medical Data Call Record

Report one Medical Data Call Record for each medical transaction (line) of a bill. For specific data element reporting instructions, refer to the Part 3 -Data Dictionary section below.

Medical Data Call Record Layout						
Field No.	**Field Title/ Description**	**Class**	**Position**	**Bytes**	**Header/ Detail**	**Source**
1	**Carrier Code ***	N	1-5	5	H	Payer
2	**Policy Number Identifier***	AN	6-23	18	H	CMS 11
3	**Policy Effective Date***	N	24–31	8	H	Payer
4	**Claim Number Identifier ***	AN	32–43	12	H	Payer
5	**Transaction Code**	N	44–45	2	D	Payer
6	**Jurisdiction State Code**	N	46–47	2	H	Payer
7	**Claimant Gender Code**	AN	48	1	H	CMS 3 UB 11
8	**Birth Year**	N	49–52	4	H	CMS 3 UB 10
9	**Accident Date**	N	53–60	8	H	CMS 14
10	**Transaction Date**	N	61–68	8	D	Payer
11	**Bill Identification Number ***	AN	69–98	30	H	Payer
12	**Line Identification Number ***	AN	99–128	30	D	Payer
13	**Service Date**	N	129–136	8	D	CMS 24A UB 45
14	**Service From Date**	N	137–144	8	H	CMS 18 UB 6
15	**Service To Date**	N	145–152	8	H	CMS 18 UB 6
16	**Paid Procedure Code**	AN	153–177	25	D	CMS 24D UB 42 UB 44 or Payer
17	**Paid Procedure Code Modifier**	AN	178–185	8	D	CMS 24D UB 44 or Payer
	First Paid Procedure Code Modifier		(178-181)	(4)		
	Second Paid Procedure Code Modifier		(182-185)	(4)		

18	**Amount Charged by Provider**	N	186–196	11	D	CMS 24F UB 47
19	**Paid Amount**	N	197–207	11	D	Payer
20	**Primary ICD -- Diagnostic Code**	AN	208–221	14	H/D	CMS 21 A (D) UB 67 (H)
21	**Secondary ICD -- Diagnostic Code**	AN	222–235	14	H/D	CMS 21 B (D) UB 67 A (H)
22	**Provider Taxonomy Code**	AN	236-255	20	H	Provider or Payer
23	**Provider Identification Number**	AN	256–270	15	H	CMS 33A UB 56
24	**Provider Postal (ZIP) Code**	AN	271–273	3	H	CMS 32 UB 1
25	**Network Service Code**	A	274	1	H	Provider or Payer
26	**Quantity/Number of Units per Procedure Code**	N	275–281	7	D	CMS 24G UB 46
27	**Place of Service Code**	AN	282–289	8	H	CMS 24B UB4**
28	**Secondary Procedure Code**	AN	290–314	25	D	UB 42
29	**Provider Postal (ZIP+4) Code**	AN	315-323	9	H	CMS 32 UB 1
30	**Reserved for Future Use**		324–350	27		

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

** Refer to Place of Service Crosswalk in the Part 4 -Appendix.

Source Notes:

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

Payer: Data is not on a form; it is provided by the entity that pays the bill.

Provider: Data is not on a form; it is provided by the healthcare provider.

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

C. File Control Record

One, and only one, File Control Record is required for each file submitted. The File Control Record does not need to be placed at the beginning or at the end of this file.

File Control Record Layout				
Field No.	**Field Title/ Description**	**Class**	**Position**	**Bytes**
1	**Record Type** Report "SUBCTRLREC" One File Control Record is required for each submission. Format: A 10	A	1-10	10
2	**Submission File Type Code** Report the code that identifies the type of file being submitted. O=Original R=Replacement Format: A, this field cannot be blank.	A	11	1
3	**Carrier Group Code *** Report the NCCI Carrier Group Code that corresponds to the Reporting Group for which the data provider has been certified to report on its behalf. Format: N 5	N	12-16	5
4	**Reporting Quarter Code *** Report the code that corresponds to the quarter when the medical transactions being reported occurred. 1 = First Quarter 2 = Second Quarter 3 = Third Quarter 4 = Fourth Quarter Format: N	N	17	1
5	**Reporting Year *** Report the year that corresponds to the year when the medical transactions being reported occurred. Format: YYYY	N	18-21	4

File Control Record Layout				
Field No.	**Field Title/ Description**	**Class**	**Position**	**Bytes**
6	**Submission File Identifier *†** Report the unique identifier created by the data provider to distinguish the file being submitted from previously submitted files. Format: A/N 30, this field must be left justified and contain blanks in all spaces to the right of the last character if the Submission File Identifier is less than 30 bytes.	AN	22-51	30
7	**Submission Date **** Report the date the file was generated. Format: YYYYMMDD	N	52-59	8
8	**Submission Time **** Report the time the file was generated in military time. Format: HHMMSS (HH = Hours, MM = Minutes, SS = Seconds)	N	60-65	6
9	**Record Total** Report the total number of records in the file, **excluding** the File Control Record. **Note:** Blank rows will be removed during processing and not counted. If blank rows are included in the Record Total, the file will appear out of balance and reject. Format: N 11, this field must be right justified and left zero-filled	N	66-76	11
10	**Reserved for Future Use**		77-350	274

* If this is a replacement submission (Submission File Type Code, Position 11 is R-Replacement), then this field must be reported the same as the submission being replaced. For details, refer to File Replacements in the Part 1 - Reporting Rules in the WI Medical Data Call Reporting Guidelines document.

† Valid characters in the file name include 0 through 9, A through Z, dash '-', underscore '_', or period '.'.

** For replacements (Submission File Type Code R), the combination of Submission Date and Submission Time must be after that of the file being replaced.

D. Electronic Transmission Record (ETR)

One, and only one, ETR Record is required for each file submitted. The ETR Record should be placed at the end of the file. For ETR record layout, see Electronic Transmission Record Specifications (ETR) document under the Data Specifications Manual link at www.wcio.org

Part 3 - DATA DICTIONARY

A. Overview

To assist medical data providers in automating their Medical Data Call reporting systems, the alphabetized Data Dictionary in this section provides metadata such as data element descriptions and reporting format associated with the data elements in the Medical Data Call Record Layout. Refer to the Part 2 - Record Layouts section of this document.

B. Data Dictionary

1. Accident Date

Field No.:	9
Position(s):	53-60
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD
Definition:	The date the claimant was injured.
Reporting Requirement:	Report the date the claimant was injured. The Accident Date must be the same as or after Policy Effective Date (Positions 24-31), and before or the same as Service Date (Positions 129-136) or Service From Date (Positions 137-144) and Service to Date (145-152). In the case of occupational disease or cumulative injury, use the last day that the claimant worked without the disability or the last day of coverage, whichever is earlier.

2. Amount Charged by Provider

Field No.:	18
Position(s):	186-196
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	11
Format:	N 11, this field must be right justified and left zero-filled. There is an implied decimal between positions 194 and 195. If the reported amount does not include digits after the decimal, add 00 to the right of the reported amount. For example: • $123.45 is reported as 00000012345 • $123 is reported as 00000012300
Definition:	The total amount per line billed for the medical service by the service provider.
Reporting Requirement:	Report the total amount per line that was billed by the service provider for the applicable line. This amount is reported prior to any adjustments but includes corrections. If a change to the Amount Charged by Provider occurs to a previously reported record, submit a replacement transaction, Transaction Code 03 (Positions 44-45), and report the current cumulative amount (original amount plus or minus changes) for the applicable line. **Note**: This field should never be a negative value since the total amount charged rather than the change in charged dollars is to be reported. For information on changes to an amount field, refer to Record Replacements and Cancellations in the Part 2 -Reporting Rules in the WI Medical Data Call Reporting Guidelines document.

3. Bill Identification Number

Field No.:	11
Position(s):	69-98
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	30
Format:	A/N 30, exclude non-ASCII characters. This field must be left justified and contain blanks in all spaces to the right of the last character if the Bill Identification Number is less than 30 bytes.
Definition:	A unique number assigned to each bill by the administering entity.
Reporting Requirement:	Report the unique number assigned to the bill that corresponds to this transaction.

4. Birth Year

Field No.:	8
Position(s):	49-52
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	4
Format:	YYYY
Definition:	The actual or estimated (accident year minus claimant age) year the claimant was born.
Reporting Requirement:	Report the year the claimant was born. The Birth Year must be before Accident Date (Positions 53-60).

5. Carrier Code

Field No.:	1
Position(s):	1-5
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	5
Format:	N 5
Definition:	The carrier code assigned to the carrier by NCCI.
Reporting Requirement:	Report the 5-digit NCCI assigned Carrier Code. Do not report the NCCI Group ID, NAIC Carrier Code, or the WCRB carrier or group ID.

6. Claim Number Identifier

Field No.:	4
Position(s):	32-43
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	12
Format:	A/N 12, letters A–Z and numbers 0–9 only (if the Claim Number Identifier is less than 12 bytes, this field must be left justified, and blanks in all spaces to the right of the last character).
Definition:	A set of alphanumeric characters that uniquely identify the claim (letters A–Z and numbers 0–9 only).
Reporting Requirement:	Report the unique set of numbers and/or letters that identify the specific claim that the bill applies to. For the purpose of this requirement, unique means that each time a medical service is provided and billed for a specific claim, the same claim number is reflected on each bill. **The Claim Number Identifier must match the Unit Statistical data claim number.** For older claims where the claim number has changed since reporting the unit statistical data, report the Claim Number Identifier that identifies the claim in your system today. This number must be used consistently for all future reporting of the claim transactions.

7. Claimant Gender Code

Field No.:	7
Position(s):	48
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	1
Format:	A/N
Definition:	A code that corresponds to the claimant's gender.
Reporting Requirement:	Report the code that corresponds to the claimant's gender. Leave blank if unknown.

Code	Description
1	Male
2	Female
3	Other

8. Jurisdiction State Code

Field No.:	6
Position(s):	46-47
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	2
Format:	N 2, Date field is to be right justified and left zero-filled.
Definition:	A code that corresponds to the state under whose Workers' Compensation Act the claimant's benefits are being paid.
Reporting Requirement:	Report the code that corresponds to the state under whose Workers' Compensation Act or Employers Liability Act the claimant's benefits are being paid or Federal Act (Jurisdiction State Code 59.) **Jurisdiction** / **State Code** Wisconsin / 48 Federal Act (USL&HW) / 59 Note: When the jurisdiction state is Wisconsin, all qualifying medical transactions for that state must be reported even when the compliance state (IAIABC State Compliance Code) is not an applicable state. For example, a medical service is provided to a claimant whose benefits are being paid under the Wisconsin Workers' Compensation Act. However, reimbursement for the medical service was determined under California medical billing requirements. Medical transactions for this claimant would be reportable under the Medical Data Call. Federal Act claims are reportable if they are associated with Wisconsin policy and are reported to WCRB on the Unit Statistical Reports.

9. Line Identification Number

Field No.:	12
Position(s):	99-128
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	30
Format:	A/N 30, exclude non-ASCII characters. This field must be left justified and contain blanks in all spaces to the right of the last character if the Line Identification Number is less than 30 bytes.
Definition:	A unique number that the administering entity assigns to each line associated with the Bill Identification Number (Positions 69-98).
Reporting Requirement:	Report the unique number assigned to the line associated with the Bill Identification Number (Positions 69-98) and for which this record applies.

10. Network Service Code

Field No.:	25
Position(s):	274
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	1
Format:	A
Definition:	A code that indicates whether the medical service is provided through a provider network.
Reporting Requirement:	Report the code that indicates whether the service is provided through a provider network regardless of whether a network discount was applied.

Code	Description
B	Pharmacy Benefit Manager
H	HMO – the medical service provider belongs to a Health Maintenance Organization agreement
N	No Agreement – the medical service provider does not belong to a provider network
P	Participation Agreement – the medical service provider is part of an agreement that is not an HMO or PPO
Y	PPO Agreement – the medical service provider belongs to a Preferred Provider Organization agreement

11. Paid Amount

Field No.:	19
Position(s):	197-207
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	11
Format:	N 11, this field must be right justified and left zero-filled. There is an implied decimal between positions 205 and 206. If the reported amount does not include digits after the decimal, add 00 to the right of the reported amount. For example: • $123.45 is reported as 00000012345 • $123 is reported as 00000012300
Definition:	The amount on the bill (line) paid by the coverage provider for the medical service. For information on changes to an amount field, refer to Record Replacements and Cancellations in the Part - Reporting Rules in the WI Medical Data Call Reporting Guidelines document.
Reporting Requirement:	Report the total amount that was paid by the coverage provider for the applicable line. If a change to the Paid Amount occurs to a previously reported record, submit a replacement transaction, Transaction Code 03 (Positions 44-45), and report the current cumulative amount (original amount plus or minus changes) for the applicable line. **Note:** This field should never be a negative value since the total amount paid rather than the change in paid dollars is to be reported.

12. Paid Procedure Code

Field No.:	16
Position(s):	153-177
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	25
Format:	A/N Varies, format according to the requirements for the code list used. Refer to the Procedure Code List Type table in the Reporting Requirement for this field.
Definition:	A code from the jurisdiction-approved code table that identifies the procedure associated with the reimbursement.
Reporting Requirement:	Report the Paid Procedure Code from the jurisdiction-approved code table (refer to the Procedure Code List Type table below) that corresponds to the Line Identification Number (Positions 99–128) as it relates to the reimbursement reported in Paid Amount (Positions 197–207). The Paid Procedure Code must be populated with correct code values, including leading zeros. When a procedure code is reported without leading zeros, that code may be edited as invalid or may match values from other codes sets. For example, if the leading zero is not reported on Hospital Revenue Code 0116 – Room & Board – Private (One Bed), the resulting value appears to be DRG Code 116 – Intraocular Procedures with CC/MCC. Incorrect reporting impacts the pricing of legislative reform. If the bill reflects a procedure code other than the procedure code associated with the reimbursement, report the Paid Procedure Code associated with the reimbursement in this field and the billed procedure code in the Secondary Procedure Code field (Positions 290–314). Refer to Paid Procedure Code Reporting in Part 2 of the WI Medical Data Call Reporting Guidelines document. Report an EAPG or DRG code as the Paid Procedure Code if it is the basis of the reimbursement; otherwise, report the CPT, CDT, HCPCS, or NDC code. For example, an ambulatory surgery center bills for a facility fee using a CPT code. However, the reimbursement is determined by assigning an EAPG code. The EAPG code is reported as the Paid Procedure Code and the CPT code is reported as the Secondary Procedure Code (Positions 290–314). Revenue codes provide only broad classifications; therefore, they should only be reported as a Paid Procedure Code when no other code was used to determine the reimbursement (i.e., CPT, CDT, HCPCS, NDC, EAPG, or DRG.)

Procedure Code List Type		
Code List Type*	**Code Length (Bytes)**	**Description/Formatting**
CPT – Current Procedural Terminology	5	• Codes are either 5 numbers or 4 numbers followed by a single alpha character • Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code**

Procedure Code List Type		
Code List Type*	**Code Length (Bytes)**	**Description/Formatting**
CDT – Current Dental Terminology	5	• Codes are either 5 numbers or a single alpha character followed by 4 numbers • Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code**
HCPCS – Healthcare Common Procedure Coding System	5	• Codes are either 5 numbers or a single alpha character followed by 4 numbers • Level 1 uses the CPT codes while level 2 adds alphanumeric codes for other services such as ambulance or prosthetics • Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes • Must include leading zeros when part of the code**
NDC – National Drug Codes	10 or 11	• 11-byte HIPAA (Health Insurance Portability and Accountability Act) standard codes or 10-byte FDA (Food and Drug Administration) codes • Left justify and blank-fill all spaces to the right of the last number • Do not include dashes • Must include leading zeros when part of the code** • See special requirement for Compound Drugs below
APC- Ambulatory Payment Classification	4	• Numeric codes classify procedures into related groups for outpatient services • Left justify and blank-fill all spaces to right of the last number • Must include leading zeros when part of the code**
DRG – Diagnostic Related Group	3	• Numeric codes classify procedures into related groups for inpatient services • Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code** • DRG Versions 25 and higher will be accepted
Revenue Codes	4	• Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code**

State-Specific	Varied	• Byte length dependent on state rules • Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes • Must include leading zeros when part of the code**

* Report an ACP or DRG code as the Paid Procedure Code if it is the basis of the reimbursement; otherwise, report the CPT, CDT, HCPCS, or NDC code.

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

13. Paid Procedure Code Modifier(s)

Field No.:	17
Position(s):	178-185
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	8 – First Paid Procedure Code Modifier (4), Second Paid Procedure Code Modifier (4)
Format:	*First Paid Procedure Code Modifier* – A/N 4 (Positions 178-181), left justified and blank-filled to the right of the last number or character when the First Paid Procedure Code Modifier(s) is less than 4 bytes. *Second Paid Procedure Code Modifier* – A/N 4 (Positions 182-185), left justified and blank-filled to the right of the last number or character when the Second Paid Procedure Code Modifier(s) is less than 4 bytes. If only one Paid Procedure Code Modifier applies, report in Positions 178-181 and leave Positions 182-185 blank.
Definition:	A code from the jurisdiction-approved code table that identifies the unique circumstances related to the Paid Procedure Code (Positions 153-177) when the circumstance alters a procedure or service but does not change the Paid Procedure Code or its definition.
Reporting Requirement:	Report the Paid Procedure Code Modifier(s) related to the Paid Procedure Code (Positions 153-177). If there are more than two modifiers, report only the modifier(s) that impacts the reimbursement.

14. Place of Service Code

Field No.:	27
Position(s):	282-289
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	8
Format:	A/N 8, this field must be left justified and blank-filled to right of the last number or character when the Place of Service Code is less than 8 bytes. Include leading zeros when part of the code. If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if the system stores 9 for a code that is listed as 09 on the code list, insert a zero to the left of the 9 when reporting to WCRB.
Definition:	A code that indicates where the medical service was performed.

Reporting Requirement:	Report the Place of Service Code from the Place of Service list that indicates where the medical service was performed. **Do not report Place of Service Code 99 (Other Place of Service) when the place of service is unavailable. Instead, leave this field blank.** For facility and hospital services, the Place of Service Crosswalk was developed by NCCI to provide a mapping of the Type of Bill code to the Place of Service code. Refer to the Place of Service Crosswalk in the Part 4 - Appendix section.

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

* Source: Centers for Medicare & Medicaid Services (www.cms.hhs.gov). The codes listed are valid as of the WI Medical Data Call Structure, Record Layouts and Data Dictionary issue date. New codes approved by CMS are valid by definition.

** This is an NCCI-assigned value. CMS does not currently have a code for dispensary.

15. Policy Effective Date

Field No.:	3
Position(s):	24-31
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD
Definition:	The date the policy under which the claim occurred became effective.
Reporting Requirement:	Report the effective date that corresponds to the date shown on the policy Information Page or to endorsements attached. The Policy Effective Date reported must be before or the same as Accident Date (Positions 53-60). **Report the policy effective date applicable at the time of the claim. Do not report the policy inception date.**

16. Policy Number Identifier

Field No.:	2
Position(s):	6-23
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	18
Format:	A/N 18, letters A–Z and numbers 0–9 only (if the Policy Number Identifier is less than 18 bytes, this field must be left justified, and blanks in all spaces to the right of the last character).
Definition:	The unique set of numbers and/or letters that identify the policy under which the claim occurred (letters A–Z and numbers 0–9 only).
Reporting Requirement:	Report the unique set of numbers and/or letters that identify the policy under which the claim occurred. **Policy Number Identifier must match the Unit Statistical data policy number including any prefixes or suffixes.**

17. Primary ICD Diagnostic Code

Field No.:	20
Position(s):	208-221
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	14
Format:	A/N 14, this field must be left justified and contain blanks in all spaces to the right of the last character if the Primary ICD -- Diagnostic Code is less than 14 bytes. Additional formatting rules include (see example): • Report zeros only when part of the code • Capitalize alphabetic characters • Report the decimal only if the code contains characters (including zero) to the right of the decimal

If ICD Diagnostic Code is…	Then valid format is ("_" indicates a space)…
942	942_ _ _ _ _ _ _ _ _ _
942.	942_ _ _ _ _ _ _ _ _ _
942.0	942.0 _ _ _ _ _ _ _ _
372.61	372.61_ _ _ _ _ _ _
043.9	043.9_ _ _ _ _ _ _ _
005.9	005.9_ _ _ _ _ _ _ _
E111	E111_ _ _ _ _ _ _ _ _
S42	S42_ _ _ _ _ _ _ _ _ _
S42.	S42_ _ _ _ _ _ _ _ _ _
S42.0	S42.0_ _ _ _ _ _ _ _
S42.001D	S42.001D_ _ _ _ _

Note:
- If converting codes from a system that does not store a decimal, ensure that the decimal is inserted correctly (not always in the 4th position). For example, 7999 may be 079.99 or 799.9.
- For ICD-9 codes, if the code starts with an E, then the decimal is reported in the fifth position; if it starts with a V, then the decimal is reported in the fourth position. If there is no leading alpha character, then report the decimal at the fourth position, if the length of the code is four characters or more.
- For ICD-10 codes, the decimal point is reported in the 4th position (regardless of the leading alpha character.). If the ICD-10 code is only 3 characters, do not report a decimal.
- If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if 5.9 is listed as 005.9 on the code list, insert two zeros to the left of the 5.

Definition:	A code that identifies the primary diagnosis associated with the medical service rendered.
Reporting Requirement	Report the NCHS (National Center for Health Statistics) or CMS (Centers for Medicare & Medicaid Services) ICD code that identifies the primary diagnosis associated with the medical service rendered. **Note:** WCRB will accept both ICD-9 and ICD-10 codes in this field. **Note:** WCRB does ***not*** recognize ICD-9 code 999.9 (complication of medical care not elsewhere classified) as a valid code.

18. Provider Identification Number

Field No.:	23
Position(s):	256-270
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	15
Format:	A/N 15, this field must be left justified and contain blanks in all spaces to the right of the last character if the Provider Identification Number is less than 15 bytes.
Definition:	A number that uniquely identifies the billing medical provider.
Reporting Requirement:	Report the number that uniquely identifies the medical/service provider (i.e.,state-required number, unique carrier coding scheme, Federal Employer Identification Number, or National Provider Identification) that billed for the service. For example, if a line item of a hospital bill indicates that a Registered Physical Therapist provided therapy to a claimant as an employee of the hospital, report the hospital's Provider Identification Number. For physicians, the National Provider Identification number is the preferred code to be reported. **Note:** In cases where a billing house bills the payer, report the Provider Identification Number of the medical service provider for whom the billing house is submitting the bill. WCRB considers a PBM (Pharmacy Benefit Management) company to be a billing house. Effective 1/1/25: The National Provider Identification (NPI) Number is required for reporting. A unique carrier coding scheme may be used in lieu of a state-required number when reporting to WCRB. However, the unique carrier coding scheme must be used consistently.

19. Provider Postal (ZIP) Code

Field No.:	24
Position(s):	271-273
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	3
Format:	A/N 3
Definition:	The code assigned by the postal service (USPS or other) to the medical/service provider address where the service was performed.

Reporting Requirement:	Report only the first three digits/characters of the postal (ZIP) code for the medical/service provider address where the service was performed. In states where the postal (ZIP) code impacts the reimbursement, report the postal (ZIP) code associated with the reimbursement. If unavailable, report only the first three digits of the postal (ZIP) code of the provider's billing address unless it is a billing house. When the billing address is a billing house and the postal (ZIP) code for the medical/service provider address where the service was performed is not available, leave this field blank. Note: The 3-digit Provider Postal (ZIP) Code may be reported but is not required if the new Provider Postal (ZIP+4) Code (Field 29) is reported. If the Provider Postal (ZIP+4) Code (Field 29) is reported in place of the 3-digit Provider Postal (ZIP) Code (Field 24), please default the Provider Postal (ZIP) Code to 3 blanks. **Note:** WCRB considers a PBM (Pharmacy Benefit Management) company to be a billing house.

20. Provider Postal (ZIP+4) Code

Field No.:	29
Position(s):	315-323
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	9
Format:	A/N 9
Definition:	The standard 5-digit Zone Improvement Plan (ZIP) code with the appended 4-digit code (ZIP+4) assigned by the postal service (USPS or other) to the medical/service provider address where the service was performed.
Reporting Requirement:	If the 9-digit ZIP+4 code is known, report the 9-digit ZIP+4 code. If only the standard 5-digit ZIP code is known, report the 5-digit ZIP code. If the service facility or dispensing pharmacy ZIP code is unavailable, report only the postal (ZIP+4) code of the provider's billing address unless it is a billing house. When the billing address is a billing house and ZIP+4 code for the medical/service provider address where the service was performed is not available, leave this field blank. **Note:** WCRB considers a PBM (Pharmacy Benefit Management) company to be a billing house. WCRB expects that a PBM will have the dispensing pharmacy ZIP Code.

21. Provider Taxonomy Code

Field No.:	22
Position(s):	236-255
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	20
Format:	A/N 20, this field must be left justified and contain blanks in all spaces to the right of the last character if the Provider Type Code is less than 20 bytes.
Definition:	A taxonomy code that identifies the type of provider that billed for and is being paid for the medical service.
Reporting Requirement:	Report the taxonomy code that identifies the type of provider that billed for and is being paid for the medical service. For example, if a line item of a hospital bill indicates that a Registered Physical Therapist provided therapy to a claimant as an employee of the hospital, report the Provider Taxonomy Code associated with the hospital. Or, if an Orthopedic Surgeon provides surgical services to a claimant through a surgical center, but the surgeon receives the payment, report the Provider Taxonomy Code associated with the surgeon. **Note:** When determining the Provider Taxonomy Code based on the Provider Identification Number, use the source for the Provider Identification Number as indicated in Part 2 – Record Layouts of this document. **Note**: In cases where a billing house bills the payer, report the Provider Taxonomy Code associated with the medical service provider that initially submitted the bill. WCRB considers a PBM (Pharmacy Benefit Management) company to be a billing house. Use the Provider Taxonomy list of standard codes maintained by the National Uniform Claim Committee—Code Subcommittee (available at www.nucc.org or The Washington Publishing Company).

22. Quantity/Number of Units Per Procedure Code

Field No.:	26
Position(s):	275-281
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	7
Format:	N 7, rounded up to the nearest whole number. Do not report a decimal. This field must be right justified and left zero-filled.

Definition:	The number of units of service performed or the quantity of drugs dispensed.
Reporting Requirement:	Report the number of units of service performed or the quantity of drugs dispensed that are related to the Paid Procedure Code. (Positions 153-177). Use the base quantity specified by the applicable procedure code to determine the quantity or number to report. **Example: Base size/amount as specified by applicable procedure code** • Supplies – The Paid Procedure Code reported is for surgical gloves. The code specifies that the base quantity is a pair of gloves. For this example, if one pair was used, 0000001 would be reported in this field. • Physical or Occupational Therapy – The Paid Procedure Code specifies that one unit is equal to a base amount of time and that a base amount of time is equal to 15 minutes. For this example, if the therapy was for 15 minutes, the time would be reported as 0000001. **Note:** Additional time spent in therapy is often designated with a distinct procedure code. For Paid Procedure Codes related to medications, the quantity/units depend on the type of drug: • For tablets, capsules, suppositories, non-filled syringes, etc., report the actual number of the drug provided. For example, a bottle of 30 pills would be reported as 0000030. • For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., dispensed in standard packages, report the units as specified by the Procedure Code. For example, a cream is dispensed in a standard tube, which is defined as a unit by the Procedure Code. Report 00000001 (one tube). • For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., that are not dispensed in standard packages, report the amount provided in its standard unit of measurement (e.g., milliliters, grams, ounces). For example, codeine cough syrup dispensed by a pharmacist into a four-ounce bottle would be reported as 00000004. For Paid Procedure Codes related to anesthesia, the quantity/units is reported in minutes. For example, if 220 minutes of anesthesia was provided, report 0000220 in this field.

23. Secondary ICD Diagnostic Code

Field No.:	21
Position(s):	222-235
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	14

<table>
<tr><td>Format:</td><td>A/N 14, this field must be left justified and contain blanks in all spaces to the right of the last character if the Secondary ICD Diagnostic Code is less than 14 bytes. Additional formatting rules include (see example):
• Report zeros only when part of the code
• Capitalize alphabetic characters
• Report the decimal only if the code contains characters (including zero) to the right of the decimal

<table>
<tr><th>If ICD Diagnostic Code is…</th><th>Then valid format is (“_” indicates a space)…</th></tr>
<tr><td>942</td><td>942_ _ _ _ _ _ _ _ _ _ _</td></tr>
<tr><td>942.</td><td>942_ _ _ _ _ _ _ _ _ _ _</td></tr>
<tr><td>942.0</td><td>942.0 _ _ _ _ _ _ _ _</td></tr>
<tr><td>372.61</td><td>372.61_ _ _ _ _ _ _</td></tr>
<tr><td>043.9</td><td>043.9_ _ _ _ _ _ _ _</td></tr>
<tr><td>005.9</td><td>005.9_ _ _ _ _ _ _ _</td></tr>
<tr><td>E111</td><td>E111_ _ _ _ _ _ _ _ _</td></tr>
<tr><td>S42</td><td>S42_ _ _ _ _ _ _ _ _ _</td></tr>
<tr><td>S42.</td><td>S42_ _ _ _ _ _ _ _ _ _</td></tr>
<tr><td>S42.0</td><td>S42.0_ _ _ _ _ _ _ _</td></tr>
<tr><td>S42.001D</td><td>S42.001D_ _ _ _ _ _</td></tr>
<tr><td></td><td></td></tr>
</table>

Note:
• If converting codes from a system that does not store a decimal, ensure that the decimal is inserted correctly (not always in the 4th position). For example, 7999 may be 079.99 or 799.9.
• For ICD-9 codes, if the code starts with an E, then the decimal is reported in the fifth position; if it starts with a V, then the decimal is reported in the fourth position. If there is no leading alpha character, then report the decimal at the fourth position, if the length of the code is four characters or more.
• For ICD-10 codes, the decimal point is reported in the 4th position (regardless of the leading alpha character.) If the ICD-10 code is only 3 characters, do not report a decimal.
• If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if 5.9 is listed as 005.9 on the code list, insert two zeros to the left of the 5.</td></tr>
<tr><td>Definition:</td><td>A code that identifies the secondary diagnosis associated with the medical service rendered.</td></tr>
<tr><td>Reporting Requirement:</td><td>Report the NCHS (National Center for Health Statistics) or CMS (Centers for Medicare & Medicaid Services) ICD code that identifies the secondary diagnosis associated with the medical service rendered.

Note: WCRB will accept both ICD-9 and ICD-10 codes in this field.

Note: WCRB does not recognize ICD-9 code 999.9 (complication of medical care not elsewhere classified) as a valid code.

Note: Leave blank if a secondary diagnosis has not been identified.</td></tr>
</table>

24. Secondary Procedure Code

Field No.:	28
Position(s):	290-314
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	25
Format:	A/N 25, format according to the requirements for the code list used. Refer to the Procedure Code List Type table in the Reporting Requirement for this field.
Definition:	A code from the jurisdiction-approved code table that identifies the billed procedure.
Reporting Requirement:	Report the Secondary Procedure Code from the jurisdiction-approved code table (refer to the Procedure Code List Type table within this description) if the bill reflects a procedure code other than the procedure code associated with the reimbursement. For example, an ambulatory surgery center bills for a facility fee using a CPT code. However, the reimbursement is determined by assigning an EAPG code. The CPT code is reported in this field, and the EAPG code, which is associated with the reimbursement, is reported as the Paid Procedure Code (Positions 153–177). Leave blank if the secondary procedure code is the same as the Paid Procedure Code (Positions 153–177). Refer to Paid Procedure Code Reporting in Part 2 – Reporting Rules in the WI Medial Data Call Reporting Guidelines document for additional instructions and examples. The Secondary Procedure Code must be populated with correct code values, including leading zeros. When a procedure code is reported without leading zeros, that code may be edited as invalid or may match values from other code sets. For example, if the leading zero is not reported on Hospital Revenue Code 0116 – Room & Board – Private (One Bed), the resulting value appears to be DRG Code 116 – Intraocular Procedures with CC/MCC. Incorrect reporting impacts the pricing of legislative reform. Revenue codes provide only broad classifications; therefore, they should only be reported as a Paid Procedure Code when no other code was used to determine the reimbursement (i.e., CPT, CDT, HCPCS, NDC, EAPG or DRG.)

Procedure Code List Type		
Code List Type*	**Code Length (Bytes)**	**Description/Formatting**
CPT – Current Procedural Terminology	5	• Codes are either 5 numbers or 4 numbers followed by a single alpha character • Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code**
CDT – Current Dental Terminology	5	• Codes are either 5 numbers or a single alpha character followed by 4 numbers • Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code**
HCPCS – Healthcare Common Procedure Coding System	5	• Codes are either 5 numbers or a single alpha character followed by 4 numbers • Level 1 uses the CPT codes while level 2 adds alphanumeric codes for other services such as ambulance or prosthetics • Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes • Must include leading zeros when part of the code**
NDC – National Drug Codes	10 or 11	• 11-byte HIPAA (Health Insurance Portability and Accountability Act) standard codes or 10-byte FDA (Food and Drug Administration) codes • Left justify and blank-fill all spaces to the right of the last number • Do not include dashes • Must include leading zeros when part of the code**

Procedure Code List Type		
Code List Type*	**Code Length (Bytes)**	**Description/Formatting**
APC - Ambulatory Payment Classifications	5	• Numeric codes classify procedures into related groups for outpatient services • Left justify and blank-fill all spaces to right of the last number • Must include leading zeros when part of the code**
DRG – Diagnostic Related Group	3	• Numeric codes classify procedures into related groups for inpatient services • Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code** • DRG Versions 25 and higher will be accepted
Revenue Codes	4	• Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code**
State-Specific	Varied	• Byte length dependent on state rules • Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes • Must include leading zeros when part of the code**

* Report an APC or DRG code as the Paid Procedure Code if it is the basis of the reimbursement; otherwise, report the CPT, CDT, HCPCS, or NDC code.

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

25. Service Date

Field No.:	13
Position(s):	129-136
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD
Definition:	The date when the medical provider performed the service.

<table>
<tr><td>Reporting Requirement:</td><td>Report the date the service related to Line Identification Number (Positions 99-129) was performed. If an in-patient hospital payment spanning multiple days was made and the specific service date (line item) detail is unavailable, zero-fill this field and report in Service From Date (Positions 137–144) and Service To Date (Positions 145–152).
<u>Service Date must be the same as or after Accident Date (Positions 53-60).</u>

Example: Bill spans multiple days – line item detail is available
A claimant receives 30 minutes* of physical therapy on January 8, 10, 15, and 17, 2008. The four services are listed as separate lines (Line Identification Number 1 through 4). Report four records, one for each line. For each record, report the individual date the service was performed in the Service Date field (Positions 129-136). There will only be one date reported for each record. In this example, the Service From Date and Service To Date fields will be zero-filled.

<table>
<tr><th>Bill ID (69-98)</th><th>Line ID (99-128)</th><th>Paid Procedure Code (153-177)</th><th>Service Date (129-136)</th><th>Quantity/#Units (275-281)</th></tr>
<tr><td>1001</td><td>1</td><td>97110</td><td>20080108</td><td>0000002</td></tr>
<tr><td>1001</td><td>2</td><td>97110</td><td>20080110</td><td>0000002</td></tr>
<tr><td>1001</td><td>3</td><td>97110</td><td>20080115</td><td>0000002</td></tr>
<tr><td>1001</td><td>4</td><td>97110</td><td>20080117</td><td>0000002</td></tr>
</table>
* For this example, Paid Procedure Code 97110 – Therapeutic Procedure specifies each 15-minute segment as 1 unit. Therefore, each 30 minutes of physical therapy is reported as 2 units.</td></tr>
</table>

26. Service From Date

Field No.:	14
Position(s):	137-144
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD
Definition:	The date when services were initiated.
Reporting Requirement:	Use this field for the starting date of service if an in-patient hospital payment spanning multiple days was made and the specific service date (line item) detail is unavailable. In all other cases, zero-fill this field and report the date of service in Service Date (Positions 129–136). This field is the first date of a date range and must be accompanied by a Service To Date (Positions 145-152). Service From Date must be the same as or after Accident Date (Positions 53-60). Service From Date must not equal Service To Date.

27. Service To Date

Field No.:	15
Position(s):	145-152
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD
Definition:	The date when services were terminated.
Reporting Requirement:	Use this field for the ending date of service if an in-patient hospital payment spanning multiple days was made and the specific service date (line item) detail is unavailable. In all other cases, zero-fill this field and report the date of service in Service Date (Positions 129–136). This field is the last date of a date range and must be accompanied by a Service From Date (Positions 137–144). Service To Date must be after Service From Date (Positions 137–144). Service To Date must not equal Service From Date.

28. Transaction Code

Field No.:	5
Position(s):	44-45
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	2
Format:	N 2, Data field is to be right justified and left zero-filled.
Definition:	A code that identifies the type of transaction that the record represents.
Reporting Requirement:	Report the code that identifies the type of transaction of the record being submitted. **Code** / **Description** 01 – Original – the initial report of the record to WCRB. Only one original (Transaction Code 01) may be submitted for a given transaction. 02 – Cancellation – cancels (deletes) a previously submitted (Transaction Code 01 or 03) record. 03 – Replacement – replaces (changes) a previously submitted (Transaction Code 01 or 03) 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**: When a key field needs to be changed, the original record must be cancelled and a new record submitted with the correct key fields. Refer to Part 2 -Reporting Rules in the WI Medical Data Call Reporting Guidelines document for additional information.

29. Transaction Date

Field No.:	10
Position(s):	61-68
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD
Definition:	The date the information in the transaction was processed as established by the original source of the data. Original source of the data is defined as the entity initially responsible for administering the medical bill(s). This may be an insurer, TPA Bill Review vendor, Pharmacy Benefit Manager, or other entity that is responsible for medical claim management.
Reporting Requirement:	Report the date corresponding to the Transaction Code (Positions 44-45) of the record being submitted.

If Transaction Code is…	**Then report…**
01- Original	The date the information was originally processed by the administering entity. For example: A medical service was performed on 01/15/2019. The medical service provider submitted the bill to a third-party administrator, which processed and paid the bill on 01/21/2019. The medical data provider reports the original transaction to WCRB with its 1st quarter submission on 04/01/2019. The Transaction Date for this original record is 01/21/2019 (reported as 20190121).
02- Cancellation	The date the cancellation was performed in the system of the administering entity.
03- Replacement	The date that the information was changed or corrected in the system of the administering entity. For example: Using the same scenario as described in the example for 01-Original, the administering entity discovers an error on the bill and corrects it in its system on 05/1/2019. The medical data provider reports the replacement transaction to WCRB with its 2nd Quarter submission on 07/01/2019. The Transaction Date for this replacement record is 05/01/2019 (reported as 20190501).

NCCI Medical Data Call
Place of Service Crosswalk

The Place of Service Crosswalk is intended for reporting facility and hospital services that are using Form CMS-1450, which does not contain a Place of Service Code field. With the crosswalk, the Type of Bill on Form CMS-1450 can be mapped to the Place of Service Code on the Medical Data Call, as shown in the following chart.

The Type of Bill, located in Field 4 of the National Uniform Billing Committee (NUBC)-approved UB-04 Claim Form CMS-1450, is a three-digit code (without a leading zero). Each digit defines a different aspect of the medical bill: Type of Facility, Bill Classification, and Frequency of the Bill.

Some providers report the Type of Bill as a four-digit code, with the first digit being a leading zero. Take that into consideration for accurate mapping to the Place of Service Code.

For more details, refer to the Chart Key directly beneath the Place of Service Crosswalk chart.

Place of Service Crosswalk

Type of Bill	Type of Bill Position 1 (Type of Facility)	Type of Bill Position 2 (Bill Classification)	Place of Service Code[1]	Place of Service Description
11X	Hospital	Inpatient	21	Inpatient Hospital
12X	Hospital	Inpatient	21	Inpatient Hospital
13X	Hospital	Outpatient	22/19[2]	On-Campus/Off-Campus Outpatient Hospital
14X	Hospital	Other	22/19[2]	On-Campus/Off-Campus Outpatient Hospital
18X	Hospital	Swing Bed	21	Inpatient Hospital
21X	Skilled Nursing	Inpatient	31	Skilled Nursing Facility
22X	Skilled Nursing	Inpatient	31	Skilled Nursing Facility
23X	Skilled Nursing	Outpatient	32	Nursing Facility
28X	Skilled Nursing	Swing Bed	32	Nursing Facility
32X	Home Health	Inpatient	12	Home
33X	Home Health	Outpatient	12	Home
34X	Home Health	Other	12	Home
41X	Religious Nonmedical	Inpatient	21	Inpatient Hospital
42X	Religious Nonmedical	Inpatient	21	Inpatient Hospital
43X	Religious Nonmedical	Outpatient	22/19[2]	On-Campus/Off-Campus Outpatient Hospital
65X	Intermediate Care	Intermediate Care—Level I	54	Intermediate Care Facility/Mentally Retarded
66X	Intermediate Care	Intermediate Care—Level II	54	Intermediate Care Facility/Mental Retarded
71X	Clinic or Hospital-Based Renal Dialysis Facility	Rural Health Clinic (RHC)	72	Rural Health Clinic
72X	Clinic or Hospital-Based Renal Dialysis Facility	Hospital-Based or Independent Renal Dialysis Facility	65	End-Stage Renal Disease Treatment Facility
73X	Clinic or Hospital-Based Renal Dialysis Facility	Free-Standing Provider-Based Federally Qualified Health Center (FQHC)	49	Independent Clinic

NCCI Place of Service Crosswalk
Revised August 2016