DISCOUNT DATA SPECIFICATIONS

Time Period

- Include all medical claims incurred **7/1/2014-6/30/2015 and paid through August 31, 2015.** Please note that for Inpatient claims, admission date should be considered the incurred date.

Data Content

- Include Commercial Group claims only
- Include all claims from all providers except as noted in exclusions below
    - Include claims for both contracted and non-contracted providers
    - Include high cost claims - do not exclude any claim because of high dollar amounts
    - Include all claims for services covered under medical benefits, regardless of the discount percentage amount
    - Include claims that are paid through networks that your organization rents if these rental networks are normally part of the product offering you make to your customers
    - Include any additional claim expenses/credits passed back to employer groups as a result of provider reimbursement agreements such as withholds, bonuses, and pay for performance arrangements.
- All adjudication adjustments for a claim should be applied to that claim before the claim is summarized
- Exclude the following:
    - Claims for members age 65 or older where age is measured as the difference between the date of service and member's birth date rounded down to the integer
    - All Medicare Supplement, Medicare Advantage and Individual claims
    - All Medicare and Medicaid claims
    - All claims with COB where your organization is the secondary payer
    - All mail order prescription drug, retail prescription drug, dental and vision hardware claims not covered under medical benefits
    - Payments for interest expense, regulatory fees and prompt pay penalties
    - Claims paid through custom network arrangements established for specific customers that are not generally available to other groups
    - Claim lines that include ineligible services and related charges as defined below in "Data Layout"
    - All capitation paid as well as any claim lines and/or encounter data associated with or paid through capitated arrangements
    - All surcharges and covered life assessments such as NYCHRA
    - All network access fees including access fees for rental networks

DATA AGGREGATION METHODOLOGY

All terminology shown in italics will be further defined in the "Data Layout" section of this document

1. Data should be separated into one of the following three groups based on type of service:
   A. Inpatient Facility (facility charges only; does not include associated professional charges)
   B. Outpatient Facility (facility charges only; does not include associated professional charges)
   C. Professional and Other services (including professional charges associated with facility claims)

2. Service lines should be summarized into an **Event**. An Event is defined according to the type of service it is associated with:
   A. Inpatient Facility Event = Admission
      - If a patient is transferred to a different facility, a new admission record should be created
   B. Outpatient Facility Event = "Case" or "Procedure"
      - Determining whether an Outpatient Event should be reported as either a Case or Procedure is based on the Revenue Codes and logic shown in Appendix C of this document
      - If the Event type is a Case, make sure the Case includes all service lines incurred in a facility by the claimant in one day
      - If the Event type is not "Case" and there are multiple dates of service on the claim, assume all claim lines are incurred on the minimum service date (i.e., first day of service) listed on the claim
   C. Professional and Other Services Event = "Procedure"

   For Inpatient and Outpatient Facility Events, there are situations where Emergency Room visits turn into Inpatient Admissions. In addition, it is also possible that an Emergency Room visit could have an Outpatient Surgery related to it. As such, a hierarchy to define types of Events is needed:
   - If any portion of an Event occurs in an Inpatient setting, then the claim and all charges associated with it should be classified as Inpatient
   - If an Event is not an Inpatient Admission and has any Revenue Codes that indicate Emergency Room services, it should be classified as an Emergency Room case
   - If an Event is not an Inpatient Admission or Emergency Room case and has any Revenue Codes that indicate Outpatient Surgery, the entire claim shall be considered Outpatient Surgery

   When summarizing service lines associated with admissions and cases to the Event level, a claim identification number or similar field should be used to identify all service lines that should be included in the Event.

3. Each Event should be assigned a *Benefit/Contract Status Indicator* and *Pay as Billed Provider Indicator* as defined below in the "Data Layout" section

4. Each Inpatient Event should also be assigned a *Catastrophic Indicator* based on the Total *Contracted Amount* level of the Event. If the Total *Contracted Amount* for the Inpatient Event equals or exceeds $150,000, the Event is considered a catastrophic claim. There are two categories of catastrophic claims: one for claims with Total Contracted Amounts between $150,000.00 and $299,999.99 and a second for claims equal to or exceeding $300,000.

5. Events are then aggregated as specified in the layout and output in different records according to "Group By" categories specified in Appendix A of this document

Specific instructions on how to categorize Events as well as a list of fields and definitions are provided below.

DATA LAYOUT

DATA SUBMISSION FILE FORMATS

Files should be submitted in text format. All fields requested in this document are summarized in Appendix A. Along with field descriptions, Appendix A also shows the Start Position (SPOS) and End Position (EPOS) of each of the requested fields.

FIELD DEFINITIONS

The information presented in this section applies to all types of claims (Inpatient, Outpatient and Professional/Other). After this section, there is a definition and instruction section that addresses additional instructions and fields by claim type (Inpatient, Outpatient and Professional/Other claims).

All indicators in the data should be mutually exclusive. That is, when aggregating amounts on any given field, the sum of data for charge and utilization fields will be the actual total for that field (i.e., no double counting).

Organization Name

Name of organization providing data

Service Period

Dates of service represented by data submission in format MMDDYY-MMDDYY. First date should be the start date and second date should be end date. As an example, for **mid-year 2015** data, this field would be populated as **07012014-06302015**. If period is not equal to 12 months, it should be disclosed on the actuarial certification

3 Digit Patient Zip Code

All of the records in this data submission should include the patient's residential 3-digit Zip Code. If the patient's residential zip code is not available, the zip code of the employee to which the member is related should be used. If there is no patient or employee zip code available, a dummy zip code of "ZZZ" should be submitted.

Product Indicator

The "Product Indicator" will be used to identify and differentiate submitted data for each product a carrier would potentially offer an employer group. It is assumed that each carrier will inventory and appropriately differentiate their products for reimbursement differences. Data should be aggregated separately for each unique product a carrier wishes to submit for evaluation.

Positions 1 through 3 of the Product Indicator should indicate the product type (PPO, HMO, POS, EPO, TRA) and positions 4 and 5 should be used as a suffix (e.g., 01, 02, 03) in case a carrier submits more than one product of the given type. Please note that no formal naming convention is prescribed for the remaining fifteen positions in this submission. This should allow carriers flexibility in providing product indicators that most appropriately reflect their product portfolio. It is expected that each carrier will provide a translation table or key for the "Product Indicator" field in their data submission. The format under which a carrier should submit this information is provided as Appendix G of this document. This key should allow users to easily identify products. It is recommended that both the product's marketing name and description be supplied along with the "Product Indicator" on this key.

For purpose of illustration, examples of characteristics that could cause reimbursement to vary among products are shown below. This is neither an all-inclusive list nor are the items shown intended to be addressed by all carriers. Also, there are other examples that may require product differentiation. As stated above, it is expected that each carrier will appropriately identify key characteristics that differentiate products in their portfolio and provide Product Indicators reflecting these differences.

- Product type: PPO vs. Open Access POS vs. Gatekeeper POS vs. EPO etc.
- Group's Funding Arrangement: Fully Insured vs. Self-Insured
- Multiple Networks available in the same area
- Product with Multiple In-Network Benefit Levels vs. Open Access PPO

Please note above that products with multiple in-network benefit levels or provider tiers should be reported separately from other products (i.e., tiered product should be reported separately from open access PPO).

Benefit/Contract Status Indicator

The "Benefit/Contract Status Indicator" indicates whether a claim is paid using in-network or out-of-network benefits as well as whether the claim is paid to a contracted or non-contracted provider. The table below shows the categories and codes to be used for this indicator.

Code	Notes
IC	Services where the provider is **contracted** with the health plan and benefits are paid at an **in-network** benefit level
OC	Services where the provider is **contracted** with the health plan and benefits are paid at an **out-of-network** benefit level. An example of this is when a plan has a "wrap" network for out-of-network claims
IX	Services where the provider is **not contracted** with the health plan and benefits are paid at an **in-network** benefit level. Examples of when this code should be used include ER services used at a non-contracted hospital in a state where it is mandated that all ER claims are paid in-network or when hospital based physicians or anesthesiologists are not contracted but paid as in-network
OX	Services where the provider is **not contracted** with the health plan and benefits are paid at an **out-of-network** benefit level

Please note that for products with multiple in-network benefit levels or provider tiers, all in-network providers should be reported as IC regardless of their in-network tier. Tiered products should be reported separately from other products (i.e., tiered product should be reported separately from open access PPO).

Detailed data will only be collected for Benefit/Contract Status Indicator "IC". Data for "OC", "IX", and "OX" claims will be aggregated at the 3-Digit zip code, Product and Type of Service (Inpatient, Outpatient or Professional) level.

There may be some facility admissions where the Benefit/Contract Status indicator for a facility changes during the admission. In these cases, the admission should be classified with the Benefit/Contract Status indicator in effect for the facility on the first day of the admission.

Group Size Indicator

Employers with up to, and including, 100 employees should be classified as Small Group. Employers with more than 100 employees should be classified as Large Group.

Pay as Billed Provider Indicator

Claims that a carrier requests be considered for Pay as Billed status should be indicated with a "Y" in this field. Carriers should be prepared to substantiate these requests **at the provider level** with proof that the provider either routinely files claims with Submitted Charges = Contracted Charges or the provider does not file Submitted Charges. Explanation for all claims coded as "Pay as Billed" should be provided in the actuarial certification provided with the data.

FIELDS FOR INPATIENT FACILITY CLAIMS
For Benefit/Contract Status "IC" (In-Network/Contracted) Only

- All admissions and claims, including high cost claims, should be included
- When coding inpatient facility claims, use coding system MS-DRG v30
- Data should be included for all discharges, including due to death of the patient
- This is for facility claims only. No professional fees associated with facility services should be included
- Include data for all inpatient facility types (hospital, rehabilitation center, skilled nursing facility and mental health hospitals)
- Exclude utilization and charge data for any unpaid, non-covered days associated with ineligible charges as defined below
- Incurred dates for Inpatient Claims should be represented by the date of admission.
- There may be some admissions where the Benefit/Contract Status indicator for a facility changes during the admission. In these cases, the admission should be classified with the Benefit/Contract Status indicator in effect for the facility on the first day of the admission.

Catastrophic Indicator
Indicator set to "0" for Inpatient Events (admissions) with between $150,000 and $299,999.99 of total *Contracted Amount*. The indicator should be set to "1" for Inpatient Events (admissions) with total *Contracted Amount* equal to or exceeding $300,000. Utilization and claim charges submitted with a Catastrophic Indicator = "0" or "1" should include all utilization and claim amounts associated with the Inpatient Event, not just excess portion of the Inpatient Event that exceeds the high cost threshold.

As an example, if a 25 covered day inpatient event with $300,000 in contracted amounts occur, the entire claim ($300,000 in contracted amount and all 25 covered days) should be summarized into one event and included with a catastrophic indicator of "1".

All charges and utilization for claims coded with a Catastrophic Indicator of "0" or "1" should be excluded from the aggregation of non-catastrophic claims (Catastrophic Indicator = "N") so that double counting is avoided.

DRG
Based on the discharge DRG. For this submission, use coding system MS-DRG v30. Carriers should ensure one DRG version is used for all inpatient data and should not submit data with a mix of DRG versions.

If a carrier must submit data based on a version other than MS-DRG v30, it is important that the carrier ensure that all inpatient claims are based on this alternate version and that there is not a mix of data where some claims are coded as MS-DRG v30.

DRG Version Indicator
Indicates DRG version submitted in the data. Appendix J shows coding to be used for this field. This field should be coded for all records submitted in the Inpatient claims data file.

MDC

Use standard MDC definitions. Include data for all MDCs. Some claims can be mapped to more than one MDC. Admissions at Skilled Nursing Facilities should be coded as MDC 95. For all admissions where the MDC is unknown or ungroupable, MDC 99 should be used.

Number of Admissions

If a patient is transferred to a different facility, a new admission record should be created. Please ensure that your admission counts are net of any reversals (negative adjustments). Reversals should offset admission counts and financial data in your dataset and should not be counted as additional admissions.

# of Covered Days

Total number of covered inpatient days related to the admissions defined above. All non-covered days should be excluded from the day count. For claims where the admission and discharge date are the same, Number of Covered days should be set to 1. There should be no IP claims with 0 days. Please ensure that your day counts are net of any reversals (negative adjustments). Reversals should offset day counts and financial data in your dataset and should not be counted as additional days.

Financial Data

The definitions provided below are intended to standardize terminology as it relates to this claim charge data submission for Provider Reimbursement Analysis.

Submitted Charges	All charges submitted by the provider for payment
Ineligible Charges	Sometimes referred to as "Non-covered Charges". These are charges not covered due to denial of services, claim duplication, medical policy, ineligible members or the plan of benefits. Detailed descriptions of types of Submitted Charges that are considered Ineligible are provided below.
Reasonable & Customary Cutback Amount	These are reductions to the charges as a result of limiting reimbursement to R&C levels. These amounts should only be considered for IX and OX claims.
Eligible Billed Charges	Sometimes referred to as "Covered Charges". Eligible Billed Charges = (Submitted Charges less Ineligible Charges) before application of fee schedules or contractual reimbursement provisions
Negotiated Savings	Sometimes referred to as "Provider Discount". Savings resulting from fee schedules or contractual reimbursement provisions. Reductions that result in member balance billing should not be included as Negotiated Savings

Contracted Amount	Sometimes referred to as "Allowed Amount". Contracted Amount = (Eligible Billed Charges less Negotiated Savings resulting from fee schedules or contractual reimbursement provisions) prior to member cost sharing.
Paid Amount	Sometimes referred to as "Plan Paid Amount". This is the Contracted Amount reduced for member cost sharing. It represents the actual amount paid by the health plan.

Contracted Amount =

Submitted Charges
Minus
Ineligible Charges
Minus
Negotiated Savings

Paid Amount =

Contracted Amount
Minus
Member Cost Sharing Amounts

Ineligible Charges
These are charges for services ***not*** considered eligible for payment under the plan. Examples include:

- Duplicate bills
- Pending or denied claims
- A type of service that is not covered by the plan of benefits:
  - For example, if cosmetic surgery is not covered under the plan and a claim is submitted that includes cosmetic procedures, the charges for these procedures would be considered ineligible charges
  - Claim lines with the non-covered cosmetic procedure above would be excluded from this data submission
- Services incurred in excess of plan limits
  - For example, if the plan imposes a 40 visit annual limit on outpatient mental health visits and a claim is submitted for a 41st visit, the charges for this visit would be considered ineligible
  - Another example is a plan that covers up to 5 inpatient days for a certain diagnosis and a claim is submitted for 6 days, the charges for the 6th day would be considered ineligible
  - The visits/days and associated charges not covered in the examples above would be excluded from all Claim data in this data submission
  - Should only exclude services that are not covered due to the plan limit
- Services incurred in excess of standard reimbursement limits
- Claims denied or reduced due to medical management/medical necessity decisions such as length of stay cutbacks and medical claim review
- Pre-Existing Condition Exclusions

As illustrated in the examples above, all claim lines, units and Submitted Charges associated with Ineligible Charges should be excluded prior to summarizing data into the Events described above in "Data Aggregation Methodology".

All claim lines and related Submitted Charges for services which are covered by a plan but are "bundled" through business rules/edits in a carrier's claim processing system should be included as Eligible Billed Charges. These amounts should not be treated as denied claims.

Actual, Adjusted and Projected Data

In order to provide accurate historical information as well as projections for future periods, data is to be provided in three categories as outlined below. Please note that values should be provided for all actual, adjusted and projected fields regardless of whether a carrier is making adjustments or projections. To aid users of the data, two fields are provided that should be used to indicate if adjusted data different than actual is submitted or if projected data different than adjusted is submitted:

- The field "AdjCopyof Actual" should be coded as "Y" for all records if Adjusted is always a copy of Actual. If Adjusted is always or sometimes different than Actual, this field should be populated as "N" for all records.
- The field "ProCopyof Adj" should be coded as "Y" for all records if Projected is always a copy of Adjusted. If Projected is always or sometimes different than Adjusted, this field should be populated as "N" for all records.

A - **Actual**: Historical claims incurred and paid in the requested time periods with no adjustments. All data submissions require an actuarial certification that confirms that no adjustments have been made to the historical data included in the "*Actual*" fields. *"Actual"* data should be reported for all utilization data (admissions, days, cases and procedures) and financial data (Eligible Billed Charges, Negotiated Savings and Contracted Amount).

B - **Adjusted**: "*Adjusted"* data is historical data that has been changed or modified to more accurately reflect a carrier's actual discounts. Examples of when the "*Adjusted*" fields might be used:

- A carrier has access to a new network in a specific area due to acquisition or merger
- A carrier changes rental network partners used in an area
- A carrier has little or no experience in a new product and uses "*Actual Contracted Amount"* data from an established product with "adjustments" for provider contract differences to represent the new product's "*Adjusted Contracted Amount"*
- A carrier needs to adjust *"Contracted Amounts"* for claim expenses/credits not available in their data warehouse that are passed back to employer groups as a result of provider reimbursement agreements such as withholds, bonuses, and pay for performance arrangements
- A carrier cannot explicitly remove access fees from their data and instead uses an assumption/adjustment method to remove access fees

It is expected that a product for which "*Adjusted Contracted Amount"* data is provided would be based on the "*Actual Contracted Amount*" data of a similar product or network. In the case of new networks from acquisition/merger or changes in rental network partners, it is possible that the "*Adjusted"* data is simply "*Actual"* data from the new network (before merger or selection as a partner) to be substituted for the carriers *"Actual"* data.

For all claim types, *"Adjusted"* data should be reported for all utilization data (admissions, days, cases and procedures) and financial data (Eligible Billed Charges, Negotiated Savings and Contracted Amount), even if only one of the fields is affected by the network change. All methods used to create *"Adjusted"* data should be disclosed in the Actuarial Certification (Appendix I).

C – **Projected**: Includes any adjustments to the data file that are based on finalized future changes to provider discounts for which historical data is not representative of future discount results based on finalized contract changes. The most common reason for supplying "*Projected*" data is recognition of recent changes in provider discounts that have yet to be recognized in the *"Actual"* or *"Adjusted"* data provided. Projections should also be used to recognize the impact of contractual fee escalators and/or multi-year guarantees a carrier has with providers. Appendix H gives other examples of situations where *"Projected"* data would be submitted. Carriers should only project discounts for providers for whom a change in discount will occur.

"Projected" data is different from *"Adjusted"* data as *"Adjusted"* data is intended to reflect the same time period as *"Actual"* data while *"Projected"* data is intended to reflect claims in a future period.

The following presents additional guidance around submission of *"Projected"* data:

- Appendix H must be completed and submitted for all geographic areas where *"Projected"* data is provided.
- **In all cases, "*Projected*" data should only be provided for contracts or changes that have been negotiated and finalized. Projections should not be based on negotiation targets or situations that are "likely" to occur.**
- Projections should be submitted for any 3-digit zip code where a change will occur and should include all known changes in that 3 digit zip code, not just discount improvements. Both discount improvements and deterioration should be reflected in *"Projected"* data.
- Discount changes in any 3-digit zip code should be calculated such that the overall *"Projected Discount"* for that zip code reflects the percentage of claims serviced by providers affected by the event justifying the projection
    - "*Projected Discounts*" should only be calculated for providers affected by the event justifying the projection
    - Provider specific *"Actual/Adjusted Discounts"* should be used for claims serviced by providers that are not affected by the event justifying the projection
    - The overall "*Projected Discount*" for a 3-digit zip code should represent a blend of the "*Projected Discount*" for providers affected by the event justifying the projection and the *"Actual/Adjusted Discounts"* of those providers not affected by the event
    - The discount changes submitted on Appendix H should reflect the discount change over all providers and claims in the 3-digit zip code.
    - An example of this calculation is shown on page 9.

For each data submission, the timeframe of the submission and effective dates of claims that drive the "*Projected*" data must be recognized. For this data submission, a projection period of **1/1/2016 – 12/31/2016** should be used**.** All "*Projected*" changes that are effective after **1/1/2016** should be pro-rated for the number of months it will impact discounts in **2016**. In this way, the projected discount will

represent the expected discount over the period **1/1/2016 - 12/31/2016**. Only contracts executed by September 30**, 2015** (3 months after the ending incurred date for this submission) for future effective dates should be considered for projections.

"*Projected*" amounts should only differ from the "*Actual*"/"*Adjusted*" data it is based upon for *Negotiated Savings* and *Contracted Amounts*. While "*Projected*" fields for all utilization (admissions, days, cases and procedures) and Eligible Billed Charge data should not differ from the "*Actual*"/"*Adjusted*" data, we require that "*Projected"* amounts for all fields be provided to ensure that the intended discount amount is determined.

"*Projected*" *Contracted Amounts* should be calculated such that the discount off of **7/1/2014-6/30/2015** *Eligible Billed Charges* is the discount that is expected to be achieved in the prospective period (**1/1/2016-12/31/2016**)**.** In order to complete this calculation, a standardized billed charge trend should be used. For the **7/1/2014-6/30/2015, paid through August 31, 2015** data submission**,** the billed charge trends are shown in Appendix B. These trends should be assumed for all discount projections regardless of geographical area. Milliman has also provided appropriate caveats and disclosures for the use of these billed charge trends that should be communicated to field staff.

An illustration of how the projection should be calculated and reported is shown on the next page using a projection period of **1/1/2015 – 12/31/2015** and a historical period of **1/1/2014 – 12/31/2014**. **Please note that for discount projections based on mid-year historical data (i.e., historical data period begins in July of one year and ends in June of the next), 18 months of the billed charge trend should be used in the calculation.** In addition to this example, two examples of how the Expected Change in Contracted Amount and Discount Projection are calculated for contracts where all or a portion of the reimbursement is based on a Percentage of Billed Charge method are also provided below.

Projections when Reimbursed as Percentage of Billed Charges - Example 1
A provider is reimbursed at 50% of billed charges for OP services. No change in the percentage of charges reimbursed for OP Services occurs in the projection period (it remains 50%). While the percentage of billed charges does not change, the amount reimbursed will increase by the same rate as billed charges. In this situation, the Expected Change in Contracted Amount is expected to increase by the prescribed billed trend of 6%.

Projections when Reimbursed as Percentage of Billed Charges - Example 2

A provider is reimbursed 50% of billed charges for OP services. A contract change occurs where OP services are now reimbursed at 52% of billed charges. The Expected Change in Contracted Amount should be calculated as:

((1 + Prescribed Billed Trend)
Multiplied by
(1 - New Percentage of Billed Charge Reimbursement)
Divided by
(1 - Prior Percentage of Billed Charge Reimbursement))
Minus 1

OR

(1.06 * (1 - 0.52) / (1 - 0.50)) – 1 = **1.8%**

Illustration of Projected Data Submission

		(A)	(B)	(C)
		Actual 1/14 -12/14		
3-digit Zip Code		**Actual Eligible Billed**	**Actual Contracted**	**Actual Discount**
AAA	Inpatient - Hospital 1	400	200	50.0%
AAA	Outpatient - Hospital 1	375	180	52.0%
AAA	Inpatient - Hospital 2	210	141	32.9%
AAA	Outpatient - Hospital 2	230	125	45.7%
AAA	Inpatient - Hospital 3	50	35	30.0%
AAA	Outpatient - Hospital 3	60	42	30.0%
AAA	Inpatient Total	660	376	43.0%
AAA	Outpatient Total	665	347	47.8%
Formulas				1- (B)/(A)

Example: ***Three hospitals service all facility claims in 3-digit zip code AAA***
Hospital 1 signed a new contract for 0% Inpatient increase effective 1/1/2015, Outpatient is reimbursed at % of charges and is not changing
Hospital 2 has a multi-year guarantee that requires an 11.0% increase to both Inpatient and Outpatient reimbursement on 1/1/2015
Hospital 3 is reimbursed as a % of charges and has no change from 2014 to 2015

Key data and calculation of 1/1/2015 - 12/31/2015 projected is as follows:

Projection needed for:	**(D)** **Actual Discount**	**(E)** **Expected Change in Contracted Amounts 1/15 - 12/15**	**(F)** **Prescribed Billed Charge Trend**	**(G)** **Projected Discount 1/15 - 12/15**
Inpatient - Hospital 1	50.0%	**0.0%**	**6.0%**	52.8%
Inpatient - Hospital 2	32.9%	**11.0%**	**6.0%**	29.7%
Outpatient - Hospital 2	45.7%	**11.0%**	**6.0%**	43.1%
Formulas	**(C) above**	**Carrier determines**	**Prescribed in Data Specifications**	**1 - ((1 - D) x (1 + E)/(1 + F)**

		(H)	(I)	(J)
		Calculation of Projected Amounts		
	Actual or Projected	**Eligible Billed**	**Contracted**	**Discount**
Inpatient - Hospital 1	**Projected**	**400**	**189**	**52.8%**
Outpatient - Hospital 1	Actual	375	180	52.0%
Inpatient - Hospital 2	**Projected**	**210**	**148**	**29.7%**
Outpatient - Hospital 2	**Projected**	**230**	**131**	**43.1%**
Inpatient - Hospital 3	Actual	50	35	30.0%
Outpatient - Hospital 3	Actual	60	42	30.0%
Total Inpatient		660	371	43.7%
Total Outpatient		665	353	46.9%
Formulas		from (A)	(1 - (J)) x (H)	from (G) if expect a change, otherwise from (C)

Populate Projected Contracted Amount fields for affected areas and types of service so that 1/15 - 12/15 expected discount is achieved
Please note that for purposes of Projected data submission, you should make no changes to Eligible Billed Charges

		(K)	(L)	(M)
		Projected 1/15 - 12/15		
Area		**Projected Eligible Billed**	**Projected Contracted**	**Projected Discount**
AAA	Inpatient	660	***371***	43.7%
AAA	Outpatient	665	***353***	46.9%
Formulas		from (A)	from (I)	from (J)

<u>Key Observations</u>
Projected Eligible Billed Charges = Actual Eligible Billed Charges
Projected Contracted Amount Calculated so that Projected Contracted Amount divided by Historical Eligible Billed Charges equal Projected Discount in (G) above

FIELDS FOR OUTPATIENT FACILITY CLAIMS
For Benefit/Contract Status "IC" (In-Network/Contracted) Only

For Inpatient and Outpatient Facility Events, there are situations where Emergency Room visits turn into Inpatient Admissions. In addition, it is also possible that an Emergency Room visit could have an Outpatient Surgery related to it. As such, a hierarchy to define types of Events is needed. Please refer to page 2 of this document for classification of facility events into Inpatient and Outpatient categories.

- All claims should be included
- This is for facility claims only. No professional fees associated with facility services should be included.
- If a carrier is unable to separate the facility and professional components of a claim, all lines of the claim should be included as Outpatient Facility events (use Appendix C to determine if the event type should be summarized into a Case or included by Procedure). For these events, a modifier of "GF" (Global Fee) should be used to indicate that the facility and professional components of the claim are both included in Outpatient Facility.
- Carriers should use the actuarial certification to disclose the number of Outpatient Facility events and associated Eligible Billed charges where the following occur:
    - Facility and professional utilization and/or charges cannot be separated and
    - a CPT Code Modifier of "GF" is not used (see definition of CPT Code Modifier below)
- Include data for all outpatient facility types (hospital, independent/freestanding labs and centers, ambulatory surgery centers, rehabilitation center, and mental health hospitals)
- Any Professional claims with Revenue Codes and/or CPT/HCPCS codes in the ranges defined as "Ancillary" Outpatient Facility claims (see Appendix C) should be excluded from Professional claims and included as Outpatient Facility "Ancillary" claims
- For claim lines coded with Revenue Codes 960-989, the following criteria should be used to determine if the claim line should be included in Outpatient Facility or Professional claims:
    - If the claim line has a Revenue Code between 960 and 989 **AND** has a CPT/HCPCS code coded on the claim line, the claim line should be included as a Professional claim and the CPT/HCPCS code should be reported as prescribed for Professional claims
    - Otherwise, the claim should be categorized as an Outpatient Facility claims
- Exclude utilization and charge data for any unpaid, non-covered services associated with ineligible charges as defined above

For the most part, Outpatient Facility Claims use the same definitions as Inpatient Facility Claims. Several Inpatient Facility Claim fields are not collected for Outpatient Facility Claims. They are: Catastrophic Indicator, DRG, MDC, Number of Admissions and Number of Covered Days.

Outpatient Facility Claim fields that are different than fields for other claim types and their related definitions are as follows:

Outpatient Type of Service
There are six types of services for outpatient facility claims. Appendix C defines the types of services for outpatient facility claims and also describes how to count the number of services for each category

CPT Code and CPT Code Modifiers
For Radiology and Pathology services, there are situations where a service will have both a Revenue Code and CPT code. In order to ensure consistent collection and treatment of data among carriers, this data submission requires that the combination of CPT Code and Modifier (as defined in Appendix E of this document) be submitted as aggregation variables for any Outpatient Facility Radiology or Pathology services coded with both a Revenue Code and CPT code.

Number of Services
The requested counting methods for each Outpatient Type of Service are shown in Appendix C. Please ensure that your numbers of service counts are net of any reversals (negative adjustments). Reversals should offset service counts and financial data in your dataset and should not be counted as additional services.

FIELDS FOR PROFESSIONAL CLAIMS
For Benefit/Contract Status "IC" (In-Network/Contracted) Only

- All claims should be included
- This is for professional claims only. For claims where there is a facility (technical) and professional component, only the professional component should be included.
- If a carrier is unable to separate the facility and professional components of a claim, all lines of the claim should be included as Outpatient Facility events (see page 9 for coding of these claims)
- Any Professional claims with Revenue Codes and/or CPT/HCPCS codes in the ranges defined as "Ancillary" Outpatient Facility claims should be excluded from Professional claims and included as Outpatient Facility "Ancillary" claims (see Appendix C for these codes)
- For claim lines coded with Revenue Codes 960-989, the following criteria should be used to determine if the claim line should be included in Outpatient Facility or Professional claims:
    - If the claim line has a Revenue Code between 960 and 989 **AND** has a CPT/HCPCS code coded on the claim line, the claim line should be included as a Professional claim
    - Otherwise, the claim should be categorized as an Outpatient Facility claims
- Exclude utilization and charge data for any unpaid, non-covered services associated with ineligible charges as defined above

For Professional claims, data for 300 specific CPT/HCPCS codes has been requested. Codes not specified in this list of 300 should be grouped into ranges based on the first character of the code. Appendix D outlines the requested codes and ranges.

In addition, data by modifier associated with specified and grouped CPT/HCPCS codes has been requested. Appendix D shows the modifiers by CPT code range that should be submitted. As carriers may have homegrown modifiers or CPT/HCPCS codes, it is required that each carrier affirm that they have been diligent in researching homegrown codes and mapping them appropriately into the CPT/HCPCS and modifier combinations requested.

Where fields have similar names, Professional Claims use the same definitions as Outpatient Facility Claims. Professional Claim fields that are different than fields for other claim types and their related definitions are as follows:

CPT Code
Appendix D of this document includes both the 300 specified codes as well as the grouping of codes not specified.

CPT Code Modifier
Defined in Appendix E. Modifiers to be submitted for Professional claims vary by code range as shown in Appendix D

Number of Procedures
For all codes, code ranges and modifier combinations, the number of procedures equals the number of claim lines that the code and modifier combination occur. Please ensure that your procedure counts are net of any reversals (negative adjustments). Reversals should offset procedures and financial data in your dataset and should not be counted as additional claim lines.

FIELDS FOR ALL CLAIMS WITH BENEFIT/CONTRACT STATUS OF "OC", "IX" or "OX"

- Definitions should be the same as used above in the Inpatient, Outpatient and Professional definitions
- Data will be aggregated at the 3-Digit Zip Code, Product and Type of Service level for these claims

Noncontracted Savings Indicator for Negotiated Savings with Noncontracted Providers
Default value is "N". The Noncontracted Savings Indicator should be set to "Y" for claims categorized with Benefit/Contracting Status of IX or OX where:

- A carrier is able to negotiate a contracted savings with the noncontracted provider and
- The provider cannot balance bill the member for the contracted savings.

Please note that all claims submitted should be coded with an indicator for this field and that this field should not be left blank.

Type of Service Indicator
Indicates whether the record represents Inpatient (I), Outpatient (O) or Professional/Other claims (P). Claims with Revenue codes and/or CPT/HCPCS codes defined as Outpatient Facility "Ancillary" on Appendix C should be labeled as Outpatient (O).

Appendix A – Detailed Data Layout
INPATIENT FACILITY CLAIMS ("IC" Claims Only)

	Field	Notes/Sample Values	Start Position	End Position	Aggregation Function
		REQUIRED FIELDS			
1	Organization Name	Name of organization providing data	1	70	Group by
2	Service Period	Dates of service represented by data submission in format MMDDYY-MMDDYY. First date should be the start date and second date should be end date. As an example, **mid-year 2015** data, this field would be populated as **070114-063015**. If period is not equal to 12 months, it should be disclosed on the actuarial certification	71	83	Group by
3	3 Digit Patient ZIP Code	Use patient's residential zip code. If the patient's zip code is not available, use employee zip code. If neither the patient or employee zip code are available, zip code should be set to "ZZZ"	84	86	Group by
4	Product Indicator	See page 3 for instructions	87	106	Group by
5	Benefit/Contract Status Indicator	This level of detail only required for "IC" claims. IC claims are services rendered by contracted providers where the benefit is paid at in-network levels	107	108	Group by
6	Group Size Indicator	S = Small Group L = Large Group U = Unknown See page 5 for instructions.	109	109	Group by
7	Pay as Billed Provider Indicator	Y= Claims carrier requests to be considered Pay as Billed N= Other	110	110	Group by
8	Catastrophic Indicator	0 = IP Event with total contracted amount between $150,000 and $299,999.99 1 = IP Event with total contracted amount equal to or more than $300,000 N = All other IP events	111	111	Group by
9	Diagnosis Related Groups (DRG)	Based on discharge DRG. Use coding system MS-DRG v30	112	114	Group by
10	DRG Version Indicator	Indicates the DRG version submitted in the data. Should be populated with a value for all records. See Appendix J for coding	115	118	Group by

Appendix A – Detailed Data Layout
INPATIENT FACILITY CLAIMS ("IC" Claims Only)

	Field	Notes/Sample Values	Start Position	End Position	Aggregation Function
		instructions.			
11	Major Diagnostic Category (MDC)	Report data for all MDCs. Should be based on DRG submitted	119	120	Group by
12	***Actual*** Data Filler	Indicates beginning of "Actual" financial fields. Fill field with "AC"	121	122	
13	***Actual*** Number of Admissions	If a patient is transferred to a different facility, a new admission record should be created. Please ensure that your admission counts are net of any reversals (negative adjustments). Reversals should offset admission counts and financial data in your dataset and should not be counted as additional admissions.	123	142	Sum
14	***Actual*** Number of Covered Days	Total number of covered inpatient days related to the admissions defined above. All non-covered days should be excluded from the day count. For claims where the admission and discharge date are the same, Number of Covered days should be set to 1. There should be no IP claims with 0 days. Please ensure that your day counts are net of any reversals (negative adjustments). Reversals should offset day counts and financial data in your dataset and should not be counted as additional days.	143	162	Sum
15	***Actual*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	163	182	Sum
16	***Actual*** Negotiated Savings $	Savings due to negotiated discount	183	202	Sum
17	***Actual*** Contracted $	Total negotiated reimbursement amount the provider receives from all sources for these services	203	222	Sum
18	***Actual*** Paid $	Sometimes referred to as "Plan Paid Amount". This is the Contracted Amount reduced for member cost sharing. It represents the actual amount paid by the health plan.	223	247	Sum
19	***Filler 1***	Future Use	248	272	
20	***Filler 2***	Future Use	273	297	
21	***Filler 3***	Future Use	298	322	
22	***AdjCopyofActual***	If Adjusted is a copy of Actual data, code as "Y". Otherwise code as "N".	323	323	Group by
23	***Adjusted*** Data Filler	Indicates beginning of "Adjusted"	324	325	

Appendix A – Detailed Data Layout
INPATIENT FACILITY CLAIMS ("IC" Claims Only)

	Field	Notes/Sample Values	Start Position	End Position	Aggregation Function
		financial fields. Fill field with "AD"			
24	***Adjusted*** Number of Admissions	If a patient is transferred to a different facility, a new admission record should be created. Please ensure that your admission counts are net of any reversals (negative adjustments). Reversals should offset admission counts and financial data in your dataset and should not be counted as additional admissions.	326	345	Sum
25	***Adjusted*** Number of Covered Days	Total number of covered inpatient days related to the admissions defined above. All non-covered days should be excluded from the day count. For claims where the admission and discharge date are the same, Number of Covered days should be set to 1. There should be no IP claims with 0 days. Please ensure that your day counts are net of any reversals (negative adjustments). Reversals should offset day counts and financial data in your dataset and should not be counted as additional days.	346	365	Sum
26	***Adjusted*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	366	385	Sum
27	***Adjusted*** Negotiated Savings $	Savings due to negotiated discount	386	405	Sum
28	***Adjusted*** Contracted $	Total negotiated reimbursement amount the provider receives from all sources for these services	406	425	Sum
29	***Filler 4***	Future Use	426	450	
30	***Filler 5***	Future Use	451	475	
31	***Filler 6***	Future Use	476	500	
32	***Filler 7***	Future Use	501	525	
33	***ProCopyofAdj***	If Projected is a copy of Adjusted data, code as "Y". Otherwise code as "N".	526	526	Group by
34	***Projected*** Data Filler	Indicates beginning of "Projected" financial fields. Fill field with "PR"	527	528	
35	***Projected*** Number of Admissions	If a patient is transferred to a different facility, a new admission record should be created. Please ensure that your admission	529	548	Sum

Appendix A – Detailed Data Layout
INPATIENT FACILITY CLAIMS ("IC" Claims Only)

	Field	Notes/Sample Values	Start Position	End Position	Aggregation Function
		counts are net of any reversals (negative adjustments). Reversals should offset admission counts and financial data in your dataset and should not be counted as additional admissions.			
36	***Projected*** Number of Covered Days	Total number of covered inpatient days related to the admissions defined above. All non-covered days should be excluded from the day count. For claims where the admission and discharge date are the same, Number of Covered days should be set to 1. There should be no IP claims with 0 days. Please ensure that your day counts are net of any reversals (negative adjustments). Reversals should offset day counts and financial data in your dataset and should not be counted as additional days.	549	568	Sum
37	***Projected*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	569	588	Sum
38	***Projected*** Negotiated Savings $	Savings due to negotiated discount	589	608	Sum
39	***Projected*** Contracted $	Total negotiated reimbursement amount the provider receives from all sources for these services	609	628	Sum
40	***Filler 8***	Future Use	629	653	
41	***Filler 9***	Future Use	654	678	
42	***Filler 10***	Future Use	679	703	
43	***Filler 11***	Future Use	704	728	
44	***Filler 12***	Future Use	729	753	
45	***Filler 13***	Future Use	754	778	
46	***Filler 14***	Future Use	779	803	
47	***Filler 15***	Future Use	804	828	

Appendix A – Detailed Data Layout
OUTPATIENT FACILITY CLAIMS ("IC" Claims Only)

	Field	Notes/Sample Values	Start Position	End Position	Aggregation Function
REQUIRED FIELDS					
1	Organization Name	Name of organization providing data	1	70	Group by
2	Service Period	Dates of service represented by data submission in format MMDDYY-MMDDYY. First date should be the start date and second date should be end date. As an example, for **mid-year 2015** data, this field would be populated as **070114-063015**. If period is not equal to 12 months, it should be disclosed on the actuarial certification	71	83	Group by
3	3 Digit Patient ZIP Code	Use patient's residential zip code. If the patient's zip code is not available, use employee zip code. If neither the patient or employee zip code are available, zip code should be set to "ZZZ"	84	86	Group by
4	Product Indicator	See page 3 for instructions	87	106	Group by
5	Benefit/Contract Status Indicator	This level of detail only required for "IC" claims. IC claims are services rendered by contracted providers where the benefit is paid at in-network levels	107	108	Group by
6	Group Size Indicator	S = Small Group L = Large Group U = Unknown See page 5 for instructions.	109	109	Group by
7	Pay as Billed Provider Indicator	Y= Claims carrier requests to be considered Pay as Billed N= Other	110	110	Group by
8	Outpatient Type of Service	See Appendix C for definitions	111	112	Group by
9	CPT Code	For Radiology or Pathology claims with a Revenue Code and CPT code, claims should be aggregated on each CPT code and Modifier combination as described in Appendix E	113	117	Group by
10	CPT Code Modifier	For Radiology or Pathology claims with a Revenue Code and CPT code, claims should be aggregated on each CPT code and Modifier combination as described in Appendix E	118	119	Group by
11	***Actual*** Data Filler	Indicates beginning of "Actual" financial fields. Fill field with "AC"	120	121	

Appendix A – Detailed Data Layout
OUTPATIENT FACILITY CLAIMS ("IC" Claims Only)

	Field	Notes/Sample Values	Start Position	End Position	Aggregation Function
12	***Actual*** Number of Services	Number of Cases or Number of Services – depends on Outpatient Type of Service – see Appendix C for instructions. Please ensure that your numbers of service counts are net of any reversals (negative adjustments). Reversals should offset service counts and financial data in your dataset and should not be counted as additional services.	122	141	Sum
13	***Actual*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	142	171	Sum
14	***Actual*** Negotiated Savings $	Savings due to negotiated discount	172	191	Sum
15	***Actual*** Contracted $	Total negotiated reimbursement amount the provider receives from all sources for these services	192	211	Sum
16	***Actual*** Paid $	Sometimes referred to as "Plan Paid Amount". This is the Contracted Amount reduced for member cost sharing. It represents the actual amount paid by the health plan.	212	236	
17	***Filler 1***	Future Use	237	261	
18	***Filler 2***	Future Use	262	286	
19	***Filler 3***	Future Use	287	311	
20	***AdjCopyofActual***	If Adjusted is a copy of Actual data, code as "Y". Otherwise code as "N".	312	312	Group by
21	***Adjusted*** Data Filler	Indicates beginning of "Adjusted" financial fields. Fill field with "AD"	313	314	
22	***Adjusted*** Number of Services	Number of Cases or Number of Services – depends on Outpatient Type of Service – see Appendix C for instructions. Please ensure that your numbers of service counts are net of any reversals (negative adjustments). Reversals should offset service counts and financial data in your dataset and should not be counted as additional services.	315	334	Sum
23	***Adjusted*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	335	354	Sum
24	***Adjusted*** Negotiated Savings $	Savings due to negotiated discount	355	376	Sum

Appendix A – Detailed Data Layout
OUTPATIENT FACILITY CLAIMS ("IC" Claims Only)

	Field	Notes/Sample Values	Start Position	End Position	Aggregation Function
25	***Adjusted*** Contracted $	Total negotiated reimbursement amount the provider receives from all sources for these services	377	394	Sum
26	***Filler 4***	Future Use	395	419	
27	***Filler 5***	Future Use	420	444	
28	***Filler 6***	Future Use	445	465	
29	***Filler 7***	Future Use	466	490	
30	***ProCopyofAdj***	If Projected is a copy of Adjusted data, code as "Y". Otherwise code as "N".	491	491	
31	***Projected*** Data Filler	Indicates beginning of "Projected" financial fields. Fill field with "PR"	492	493	Group by
32	***Projected*** Number of Services	Number of Cases or Number of Services – depends on Outpatient Type of Service – see Appendix C for instructions. Please ensure that your numbers of service counts are net of any reversals (negative adjustments). Reversals should offset service counts and financial data in your dataset and should not be counted as additional services.	494	513	Sum
33	***Projected*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	514	533	Sum
34	***Projected*** Negotiated Savings $	Savings due to negotiated discount	534	553	Sum
35	***Projected*** Contracted $	Total negotiated reimbursement amount the provider receives from all sources for these services	554	573	Sum
36	***Filler 8***	Future Use	574	598	
37	***Filler 9***	Future Use	599	623	
38	***Filler 10***	Future Use	624	648	
39	***Filler 11***	Future Use	649	673	
40	***Filler 12***	Future Use	674	698	
41	***Filler 13***	Future Use	699	723	
42	***Filler 14***	Future Use	724	748	
43	***Filler 15***	Future Use	749	773	

Appendix A – Detailed Data Layout
PROFESSIONAL CLAIMS ("IC" Claims Only)

	Field	Notes/Sample Values	Start Position	End Position	Aggregation Function
REQUIRED FIELDS					
1	Organization Name	Name of organization providing data	1	70	Group by
2	Service Period	Dates of service represented by data submission in format MMDDYY-MMDDYY. First date should be the start date and second date should be end date. As an example, for **mid-year 2015** data, this field would be populated as **070114-063015**. If period is not equal to 12 months, it should be disclosed on the actuarial certification	71	83	Group by
3	3 Digit Patient ZIP Code	Use patient's residential zip code. If the patient's zip code is not available, use employee zip code. If neither the patient or employee zip code are available, zip code should be set to "ZZZ"	84	86	Group by
4	Product Indicator	See page 3 for instructions	87	106	Group by
5	Benefit/Contract Status Indicator	This level of detail only required for "IC" claims. IC claims are services rendered by contracted providers where the benefit is paid at in-network levels	107	108	Group by
6	Group Size Indicator	S = Small Group L = Large Group U = Unknown See page 5 for instructions.	109	109	Group by
7	Pay as Billed Provider Indicator	Y= Claims carrier requests to be considered Pay as Billed N= Other	110	110	Group by
8	CPT Code	See Appendices D for a list of CPT/HCPCS codes and modifiers	111	115	Group by
9	CPT Code Modifier	See Appendices D for a list of CPT/HCPCS codes and modifiers	116	117	Group by
10	***Actual*** Data Filler	Indicates beginning of "Actual" financial fields. Fill field with "AC"	118	119	
11	***Actual*** Number of Procedures	Number of Cases or Number of Procedures. Please ensure that your procedure counts are net of any reversals (negative adjustments). Reversals should offset procedures and financial data in your dataset and should not be counted as additional claim lines.	120	139	Sum
12	***Actual*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	140	159	Sum

Appendix A – Detailed Data Layout
PROFESSIONAL CLAIMS ("IC" Claims Only)

	Field	Notes/Sample Values	Start Position	End Position	Aggregation Function
13	***Actual*** Negotiated Savings $	Savings due to negotiated discount	160	179	Sum
14	***Actual*** Contracted $	Total negotiated reimbursement amount the provider receives from all sources for these services	180	199	Sum
15	***Actual*** Paid $	Sometimes referred to as "Plan Paid Amount". This is the Contracted Amount reduced for member cost sharing. It represents the actual amount paid by the health plan.	200	224	
16	***Filler 1***	Future Use	225	249	
17	***Filler 2***	Future Use	250	274	
18	***Filler 3***	Future Use	275	299	
19	***AdjCopyofActual***	If Adjusted is a copy of Actual data, code as "Y". Otherwise code as "N".	300	300	Group by
20	***Adjusted*** Data Filler	Indicates beginning of "Adjusted" financial fields. Fill field with "AD"	301	302	
21	***Adjusted*** Number of Procedures	Number of Procedures. Please ensure that your procedure counts are net of any reversals (negative adjustments). Reversals should offset procedures and financial data in your dataset and should not be counted as additional claim lines.	303	322	Sum
22	***Adjusted*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	323	342	Sum
23	***Adjusted*** Negotiated Savings $	Savings due to negotiated discount	343	362	Sum
24	***Adjusted*** Contracted $	Total negotiated reimbursement amount the provider receives from all sources for these services	363	382	Sum
25	***Filler 4***	Future Use	383	407	
26	***Filler 5***	Future Use	408	432	
27	***Filler 6***	Future Use	433	457	
28	***Filler 7***	Future Use	458	482	
29	***ProCopyofAdj***	If Projected is a copy of Adjusted data, code as "Y". Otherwise code as "N".	483	483	Group by
30	***Projected*** Data Filler	Indicates beginning of "Projected" financial fields. Fill field with "PR"	484	485	
31	***Projected*** Number of Procedures	Number of Procedures. Please ensure that your procedure counts are net of any reversals (negative adjustments). Reversals should offset procedures and financial data in your dataset and should	486	505	Sum

Appendix A – Detailed Data Layout
PROFESSIONAL CLAIMS ("IC" Claims Only)

	Field	Notes/Sample Values	Start Position	End Position	Aggregation Function
		not be counted as additional claim lines.			
32	***Projected*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	506	525	Sum
33	***Projected*** Negotiated Savings $	Savings due to negotiated discount	526	545	Sum
34	***Projected*** Contracted $	Total negotiated reimbursement amount the provider receives from all sources for these services	546	565	Sum
35	***Filler 8***	Future Use	566	590	
36	***Filler 9***	Future Use	591	615	
37	***Filler 10***	Future Use	616	640	
38	***Filler 11***	Future Use	641	665	
39	***Filler 12***	Future Use	666	690	
40	***Filler 13***	Future Use	691	715	
41	***Filler 14***	Future Use	716	740	
42	***Filler 15***	Future Use	741	765	

Appendix A – Detailed Data Layout
ALL CLAIMS WITH BENEFIT STATUS "OC", "IX", or "OX"

	Field	Notes/Sample Values	Start Position	End Position	Aggregation Function
		REQUIRED FIELDS			
1	Organization Name	Name of organization providing data	1	70	Group by
2	Service Period	Dates of service represented by data submission in format MMDDYY-MMDDYY. First date should be the start date and second date should be end date. As an example, for **mid-year 2015** data, this field would be populated as **070114-063015**. If period is not equal to 12 months, it should be disclosed on the actuarial certification	71	83	Group by
3	3 Digit Patient ZIP Code	Use patient's residential zip code. If the patient's zip code is not available, use employee zip code. If neither the patient or employee zip code are available, zip code should be set to "ZZZ"	84	86	Group by
4	Product Indicator	See page 3 for instructions	87	106	Group by
5	Benefit/Contract Status Indicator	"OC" – Claims for providers that contracted with the health plan and paid at Out-of-Network benefit levels (e.g., wrap network) "IX" – Claims for providers that are not contracted with the health plan and paid at In-Network benefit levels (e.g., Anesthesia, ER or Ambulance claim paid as In-Network to a provider not in the contracted with the health plan) "OX" – Claims for providers that are not contracted with the health plan and paid at Out-of-Network benefit levels	107	108	Group by
6	Group Size Indicator	S = Small Group L = Large Group U = Unknown See page 5 for instructions.	109	109	Group by
7	Type of Service Indicator	"I" for Inpatient, "O" for Outpatient and "P" for Professional	110	110	Group by
8	Noncontracted Savings Indicator	"Y" if Negotiated Savings for Noncontracted Provider (IX or OX) that cannot be balanced billed to member	111	111	Group by
9	***Actual*** Data Filler	Indicates beginning of "Actual" financial fields. Fill field with "AC"	112	113	
10	***Actual*** Reasonable and Customary Cutback $	These are reductions to the charges as a result of limiting reimbursement to R&C levels. These amounts should only be considered for IX and OX claims.	114	133	Sum

Appendix A – Detailed Data Layout
ALL CLAIMS WITH BENEFIT STATUS "OC", "IX", or "OX"

11	***Actual*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	134	153	Sum
12	***Actual*** Negotiated Savings $	Savings due to negotiated discount	154	173	Sum
13	***Actual*** Contracted $	Total negotiated reimbursement amount the provider receives from all sources for these services	174	193	Sum
14	***Actual*** Paid $	Sometimes referred to as "Plan Paid Amount". This is the Contracted Amount reduced for member cost sharing. It represents the actual amount paid by the health plan.	194	218	
15	***Filler 1***	Future Use	219	243	
16	***Filler 2***	Future Use	244	268	
17	***Filler 3***	Future Use	269	293	
18	***AdjCopyofActual***	If Adjusted is a copy of Actual data, code as "Y". Otherwise code as "N".	294	294	Group by
19	***Adjusted Data Filler***	Indicates beginning of "Adjusted" financial fields. Fill field with "AD"	295	296	
20	***Adjusted Eligible Billed $***	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	297	313	Sum
21	***Adjusted Negotiated Savings $***	Savings due to negotiated discount	314	333	Sum
22	***Adjusted Contracted $***	Total negotiated reimbursement amount the provider receives from all sources for these services	334	353	Sum
23	***Filler 4***	Future Use	354	378	
24	***Filler 5***	Future Use	379	413	
25	***Filler 6***	Future Use	414	438	
26	***Filler 7***	Future Use	439	463	
27	***ProCopyofAdj***	If Projected is a copy of Adjusted data, code as "Y". Otherwise code as "N".	464	464	Group by
28	***Projected Data Filler***	Indicates beginning of "Projected" financial fields. Fill field with "PR"	465	466	
29	***Projected Eligible Billed $***	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	467	486	Sum
30	***Projected Negotiated Savings $***	Savings due to negotiated discount	487	506	Sum
31	***Projected Contracted $***	Total negotiated reimbursement amount the provider receives from all sources for these services	507	526	Sum
32	***Filler 8***	Future Use	527	551	
33	***Filler 9***	Future Use	552	576	

Appendix A – Detailed Data Layout
ALL CLAIMS WITH BENEFIT STATUS "OC", "IX", or "OX"

34	***Filler 10***	Future Use	577	601	
35	***Filler 11***	Future Use	602	626	
36	***Filler 12***	Future Use	627	651	
37	***Filler 13***	Future Use	652	676	
38	***Filler 14***	Future Use	677	701	
39	***Filler 15***	Future Use	702	726	

Appendix B – Billed Trends to Use in Projections

Billed Charge Trend Estimates from Milliman

Milliman has agreed to provide billed charge trend estimates that must be used by carriers who wish to submit projected discounts in their discount data submissions. The estimates are based on billed charge increases observed in national claims data.

Milliman will provide separate national billed charge trends for Inpatient, Outpatient and Professional claims in each UDS version.

The estimates are established solely for the purpose of standardizing the billed charge trends and must be used by carriers in discount projections. There are some cautions to the use of this data:

- No adjustments have been made to these estimates for future Claims or contingencies. As such, these billed trend charge estimates are not intended to be the basis of any financial projections or guarantees (including premiums, discount guarantees, etc.) where the projection of billed charges is needed
- We realize that billed charges and billed charge trends within a geographic area can vary significantly from national charges and trends. Since the trend estimates provided by Milliman will be at a national level, the estimates provided may not be appropriate for a specific state or geographic area

The current billed charge levels required to be used are shown in the table below:

	Billed Trend
IP	6%
OP	6%
Professional	3%

Appendix C - Outpatient Facility Type of Service Codes

FOR CLAIM LINES CODED WITH REVENUE CODES 960-989, see Page 9 for instructions

Type of Service	Code	Notes
Emergency Room	ER	Revenue Codes 450-459, 981 If a claim has any ER revenue code, all outpatient facility charges for the claim should be classified as ER. Charges for ER visits resulting in an inpatient admission should be included with inpatient charges All claims lines related to an ER Claim should be summarized to the Case level. The "Number of Services" reported should be the number of ER Cases (summarized at the claim identification number level)
Surgery	SR	Revenue Codes 360-369, 490-499, 963, 964, 975 If a claim is not classified as ER, and has a surgery revenue code, then all facility charges for that claim should be classified as surgery All claims lines related to an Outpatient Surgery Claim should be summarized to the Case level. The "Number of Services" reported should be the number of Outpatient Surgery Cases (summarized at the claim identification number level)
Radiology	XR	Revenue Codes 320-359, 400-409, 610-619, 972-974 If the carrier is unable to separate the facility and professional components of a claim, all lines of the claim should be included as Outpatient Facility. For these events, a modifier of "GF" (Global Fee) should be used to indicate that the facility and professional components of the claim are both included in the Outpatient facility. CPT/HCPCS codes 70000-79999 should be submitted per Appendix E. Include all claim lines with a Radiology revenue code. For claim lines reported with both a Radiology Revenue Code and a CPT code, the CPT code and modifier as described in Appendix E should be submitted. The "Number of Services" reported should be the number of services/claim lines with the Radiology Revenue Codes shown above
Pathology	LB	Revenue Codes 300-319, 921, 923, 925, 971 If the carrier is unable to separate the facility and professional components of a claim, all lines of the claim should be included as Outpatient Facility. For these events, a modifier of "GF" (Global Fee) should be used to indicate that the facility and professional components of the claim are both included in the Outpatient facility. CPT/HCPCS codes 36415-36419 and 80000-89999 should be submitted per Appendix E. Include all claim lines with a Pathology revenue code. For claim lines reported with both a Pathology Revenue Code and a CPT code, the CPT code and modifier as described in Appendix E should be submitted. The "Number of Services" reported should be the number of services/claim lines with the Pathology Revenue Codes shown above
Ancillary	AC	All claims (whether Outpatient or Professional) with Revenue Codes and/or CPT/HCPCS Codes in the following ranges. Please make sure to exclude these claim lines from Professional claims. **Revenue Codes:**

		Ambulance: 540 – 549 DME: 290-299, 946-947 Home Health: 235, 550-608, 640-662, 984, 989 **CPT/HCPCS Codes** CPT–4 Codes 99500–99602; HCPCS Codes G0151–G0156, G0248–G0250, S5035–S5116, S5121–S5126, S5135–S5151, S5180–S5181, S5497–S5502, S5517–S5523, S9122–S9131, S9200–S9379, S9395, S9420–S9425, S9490–S9526, S9535–S9810, T1000–T1005, T1019–T1022, T1030–T1031, T1502, T2022–T2023, T2042–T2046 HCPCS Codes A4206–A4640, A4653, A4930–A5511, A6550–A7527, A9190–A9300, B4034–C1004, C1008, C1063, C1068–C1071, C1075–C1078, C1103, C1105, C1109, C1115–C1116, C1118–C1121, C1123–C1154, C1156–C1163, C1170–C1172, C1175–C1177, C1179–C1184, C1302–C1303, C1306–C1311, C1315–C1318, C1321–C1324, C1336–C1337, C1351–C1359, C1363–C1364, C1721–C1773, C1776–C1779, C1781–C1788, C1816–C1817, C1881–C1900, C2614, C2618–C2621, C2626–C2630, C2700–C3004, C3800–C3801, C4000–C4607, C8501, C8505–C8513, C8518–C8521, C8724–C8777, C9007–C9010, E0100–E8002, K0001–K0116, K0138–K0411, K0419–K0439, K0452–K0547, K0549–L4398, S1001–S1016, S1030–S1040, S5016–S5021, S5025, S5503, S5560–S5571, S8055, S8095–S8105, S8120–S8490, S8999–S9007, V2600–V2615, V5336 HCPCS Codes A0021–A0999, Q3019–Q3020, S0209–S0215, T2001–T2007, T2049 HCPCS Codes C1005–1007, C1780, C1789, C1813–C1815, C1818, C2622, C3400–C3510, C3851, C6050–C6210, C8514–C8516, C8530, C8534, K0440–K0451, L5000–L9900, Q1001–Q1005, V2623–V2632 The “Number of Services” reported should be the number of services/claim lines associated with the Revenue Codes and/or CPT/HCPCS codes shown above
Other	ZZ	A facility claim that is not an Inpatient claim and has a Revenue code that is not indicated in any of the categories above The “Number of Services” reported should be the number of services/claim lines associated with ZZ claims

Appendix D – Requested Professional CPT and HCPCS Procedure Codes

Code	Description	Modifiers to Report
00170	Anesthesia	NONE
00400	Anesthesia	NONE
00740	Anesthesia	NONE
00790	Anesthesia	NONE
00810	Anesthesia	NONE
00840	Anesthesia	NONE
01400	Anesthesia	NONE
01480	Anesthesia	NONE
01961	Maternity-Csection	NONE
01967	Maternity-Normal	NONE
11100	Biopsy, skin lesion	50, 51, 52, AS, AN, ZZ
11750	Removal of nail bed	50, 51, 52, AS, AN, ZZ
12001	Repair superficial wound(s)	50, 51, 52, AS, AN, ZZ
17000	Destruct premalg lesion	50, 51, 52, AS, AN, ZZ
17003	Destruct premalg les, 2-14	50, 51, 52, AS, AN, ZZ
17110	Destruct b9 lesion, 1-14	50, 51, 52, AS, AN, ZZ
19103	Bx breast percut w/device	50, 51, 52, AS, AN, ZZ
19318	Reduction of large breast	50, 51, 52, AS, AN, ZZ
20550	Inj tendon sheath/ligament	50, 51, 52, AS, AN, ZZ
20610	Drain/inject, joint/bursa	50, 51, 52, AS, AN, ZZ
22554	Neck spine fusion	50, 51, 52, AS, AN, ZZ
22612	Lumbar spine fusion	50, 51, 52, AS, AN, ZZ
22630	Lumbar spine fusion	50, 51, 52, AS, AN, ZZ
22842	Insert spine fixation device	50, 51, 52, AS, AN, ZZ
22845	Insert spine fixation device	50, 51, 52, AS, AN, ZZ
22851	Apply spine prosth device	50, 51, 52, AS, AN, ZZ
27130	Total hip arthroplasty	50, 51, 52, AS, AN, ZZ
27447	Total knee arthroplasty	50, 51, 52, AS, AN, ZZ
28296	Correction of bunion	50, 51, 52, AS, AN, ZZ
29824	Shoulder arthroscopy/surgery	50, 51, 52, AS, AN, ZZ
29826	Shoulder arthroscopy/surgery	50, 51, 52, AS, AN, ZZ
29827	Arthroscop rotator cuff repr	50, 51, 52, AS, AN, ZZ
29877	Knee arthroscopy/surgery	50, 51, 52, AS, AN, ZZ
29880	Knee arthroscopy/surgery	50, 51, 52, AS, AN, ZZ
29881	Knee arthroscopy/surgery	50, 51, 52, AS, AN, ZZ
29888	Knee arthroscopy/surgery	50, 51, 52, AS, AN, ZZ
30140	Resect inferior turbinate	50, 51, 52, AS, AN, ZZ
30520	Repair of nasal septum	50, 51, 52, AS, AN, ZZ
31231	Nasal endoscopy, dx	50, 51, 52, AS, AN, ZZ
31237	Nasal/sinus endoscopy, surg	50, 51, 52, AS, AN, ZZ
31255	Removal of ethmoid sinus	50, 51, 52, AS, AN, ZZ
31267	Endoscopy, maxillary sinus	50, 51, 52, AS, AN, ZZ
31575	Diagnostic laryngoscopy	50, 51, 52, AS, AN, ZZ

Appendix D – Requested Professional CPT and HCPCS Procedure Codes

Code	Description	Modifiers to Report
33533	CABG, arterial, single	50, 51, 52, AS, AN, ZZ
36415	Routine venipuncture	50, 51, 52, AS, AN, ZZ
36478	Endovenous laser, 1st vein	50, 51, 52, AS, AN, ZZ
36561	Insert tunneled cv cath	50, 51, 52, AS, AN, ZZ
42820	Remove tonsils and adenoids	50, 51, 52, AS, AN, ZZ
43235	Uppr gi endoscopy, diagnosis	50, 51, 52, AS, AN, ZZ
43239	Upper GI endoscopy, biopsy	50, 51, 52, AS, AN, ZZ
43644	Lap gastric bypass/roux-en-y	50, 51, 52, AS, AN, ZZ
44970	Laparoscopy, appendectomy	50, 51, 52, AS, AN, ZZ
45378	Diagnostic colonoscopy	50, 51, 52, AS, AN, ZZ
45380	Colonoscopy and biopsy	50, 51, 52, AS, AN, ZZ
45384	Lesion remove colonoscopy	50, 51, 52, AS, AN, ZZ
45385	Lesion removal colonoscopy	50, 51, 52, AS, AN, ZZ
47562	Laparoscopic cholecystectomy	50, 51, 52, AS, AN, ZZ
47563	Laparo cholecystectomy/graph	50, 51, 52, AS, AN, ZZ
49505	Prp i/hern init reduc >5 yr	50, 51, 52, AS, AN, ZZ
50590	Fragmenting of kidney stone	50, 51, 52, AS, AN, ZZ
52000	Cystoscopy	50, 51, 52, AS, AN, ZZ
52332	Cystoscopy and treatment	50, 51, 52, AS, AN, ZZ
54150	Circumcision w/regionl block	50, 51, 52, AS, AN, ZZ
55250	Removal of sperm duct(s)	50, 51, 52, AS, AN, ZZ
55866	Laparo radical prostatectomy	50, 51, 52, AS, AN, ZZ
57288	Repair bladder defect	50, 51, 52, AS, AN, ZZ
57454	Bx/curett of cervix w/scope	50, 51, 52, AS, AN, ZZ
58150	Total hysterectomy	50, 51, 52, AS, AN, ZZ
58558	Hysteroscopy, biopsy	50, 51, 52, AS, AN, ZZ
58563	Hysteroscopy, ablation	50, 51, 52, AS, AN, ZZ
58662	Laparoscopy, excise lesions	50, 51, 52, AS, AN, ZZ
59025	Fetal non-stress test	50, 51, 52, AS, AN, ZZ
59400	Obstetrical care	50, 51, 52, AS, AN, ZZ
59410	Obstetrical care	50, 51, 52, AS, AN, ZZ
59426	Antepartum care only	50, 51, 52, AS, AN, ZZ
59510	Cesarean delivery	50, 51, 52, AS, AN, ZZ
59514	Cesarean delivery only	50, 51, 52, AS, AN, ZZ
62310	Inject spine c/t	50, 51, 52, AS, AN, ZZ
62311	Inject spine l/s (cd)	50, 51, 52, AS, AN, ZZ
63030	Low back disk surgery	50, 51, 52, AS, AN, ZZ
63042	Laminotomy, single lumbar	50, 51, 52, AS, AN, ZZ
63047	Removal of spinal lamina	50, 51, 52, AS, AN, ZZ
63075	Neck spine disk surgery	50, 51, 52, AS, AN, ZZ
64475	Inj paravertebral l/s	50, 51, 52, AS, AN, ZZ
64476	Inj paravertebral l/s add-on	50, 51, 52, AS, AN, ZZ
64483	Inj foramen epidural l/s	50, 51, 52, AS, AN, ZZ
64493	INJ PARAVERT F JNT L/S 1 LEV	50, 51, 52, AS, AN, ZZ
64494	INJ PARAVERT F JNT L/S 2 LEV	50, 51, 52, AS, AN, ZZ
64721	Carpal tunnel surgery	50, 51, 52, AS, AN, ZZ
66984	Cataract surg w/iol, 1 stage	50, 51, 52, AS, AN, ZZ

Appendix D – Requested Professional CPT and HCPCS Procedure Codes

Code	Description	Modifiers to Report
69436	Create eardrum opening	50, 51, 52, AS, AN, ZZ
70450	Ct head/brain w/o dye	26, 50, 51, 52, AS, AN, ZZ
70486	Ct maxillofacial w/o dye	26, 50, 51, 52, AS, AN, ZZ
70544	Mr angiography head w/o dye	26, 50, 51, 52, AS, AN, ZZ
70551	Mri brain w/o dye	26, 50, 51, 52, AS, AN, ZZ
70553	Mri brain w/o & w/dye	26, 50, 51, 52, AS, AN, ZZ
71010	Chest x-ray	26, 50, 51, 52, AS, AN, ZZ
71020	Chest x-ray	26, 50, 51, 52, AS, AN, ZZ
71250	Ct thorax w/o dye	26, 50, 51, 52, AS, AN, ZZ
71260	Ct thorax w/dye	26, 50, 51, 52, AS, AN, ZZ
71275	Ct angiography, chest	26, 50, 51, 52, AS, AN, ZZ
72100	X-ray exam of lower spine	26, 50, 51, 52, AS, AN, ZZ
72141	Mri neck spine w/o dye	26, 50, 51, 52, AS, AN, ZZ
72146	Mri chest spine w/o dye	26, 50, 51, 52, AS, AN, ZZ
72148	Mri lumbar spine w/o dye	26, 50, 51, 52, AS, AN, ZZ
72156	Mri neck spine w/o & w/dye	26, 50, 51, 52, AS, AN, ZZ
72158	Mri lumbar spine w/o & w/dye	26, 50, 51, 52, AS, AN, ZZ
72192	Ct pelvis w/o dye	26, 50, 51, 52, AS, AN, ZZ
72193	Ct pelvis w/dye	26, 50, 51, 52, AS, AN, ZZ
72194	Ct pelvis w/o & w/dye	26, 50, 51, 52, AS, AN, ZZ
73030	X-ray exam of shoulder	26, 50, 51, 52, AS, AN, ZZ
73221	Mri joint upr extrem w/o dye	26, 50, 51, 52, AS, AN, ZZ
73562	X-ray exam of knee, 3	26, 50, 51, 52, AS, AN, ZZ
73610	X-ray exam of ankle	26, 50, 51, 52, AS, AN, ZZ
73630	X-ray exam of foot	26, 50, 51, 52, AS, AN, ZZ
73718	Mri lower extremity w/o dye	26, 50, 51, 52, AS, AN, ZZ
73721	Mri jnt of lwr extre w/o dye	26, 50, 51, 52, AS, AN, ZZ
74150	Ct abdomen w/o dye	26, 50, 51, 52, AS, AN, ZZ
74160	Ct abdomen w/dye	26, 50, 51, 52, AS, AN, ZZ
74170	Ct abdomen w/o & w/dye	26, 50, 51, 52, AS, AN, ZZ
74183	Mri abdomen w/o & w/dye	26, 50, 51, 52, AS, AN, ZZ
76536	Us exam of head and neck	26, 50, 51, 52, AS, AN, ZZ
76645	Us exam, breast(s)	26, 50, 51, 52, AS, AN, ZZ
76700	Us exam, abdom, complete	26, 50, 51, 52, AS, AN, ZZ
76705	Echo exam of abdomen	26, 50, 51, 52, AS, AN, ZZ
76770	Us exam abdo back wall, comp	26, 50, 51, 52, AS, AN, ZZ
76801	Ob us < 14 wks, single fetus	26, 50, 51, 52, AS, AN, ZZ
76805	Ob us >/= 14 wks, sngl fetus	26, 50, 51, 52, AS, AN, ZZ
76811	Ob us, detailed, sngl fetus	26, 50, 51, 52, AS, AN, ZZ
76815	Ob us, limited, fetus(s)	26, 50, 51, 52, AS, AN, ZZ
76816	Ob us, follow-up, per fetus	26, 50, 51, 52, AS, AN, ZZ
76817	Transvaginal us, obstetric	26, 50, 51, 52, AS, AN, ZZ
76830	Transvaginal us, non-ob	26, 50, 51, 52, AS, AN, ZZ
76856	Us exam, pelvic, complete	26, 50, 51, 52, AS, AN, ZZ
76942	Echo guide for biopsy	26, 50, 51, 52, AS, AN, ZZ
77052	Comp screen mammogram add-on	26, 50, 51, 52, AS, AN, ZZ
77057	Mammogram, screening	26, 50, 51, 52, AS, AN, ZZ

Appendix D – Requested Professional CPT and HCPCS Procedure Codes

Code	Description	Modifiers to Report
77290	Set radiation therapy field	26, 50, 51, 52, AS, AN, ZZ
77295	Set radiation therapy field	26, 50, 51, 52, AS, AN, ZZ
77300	Radiation therapy dose plan	26, 50, 51, 52, AS, AN, ZZ
77334	Radiation treatment aid(s)	26, 50, 51, 52, AS, AN, ZZ
77413	Radiation treatment delivery	26, 50, 51, 52, AS, AN, ZZ
77418	Radiation tx delivery, imrt	26, 50, 51, 52, AS, AN, ZZ
77427	Radiation tx management, x5	26, 50, 51, 52, AS, AN, ZZ
78451	HT MUSCLE IMAGE SPECT SING	26, 50, 51, 52, AS, AN, ZZ
78452	HT MUSCLE IMAGE SPECT MULT	26, 50, 51, 52, AS, AN, ZZ
78453	HT MUSCLE IMAGE PLANAR SING	26, 50, 51, 52, AS, AN, ZZ
78454	HT MUSC IMAGE PLANAR MULT	26, 50, 51, 52, AS, AN, ZZ
78465	Heart image (3d), multiple	26, 50, 51, 52, AS, AN, ZZ
78478	Heart wall motion add-on	26, 50, 51, 52, AS, AN, ZZ
78480	Heart function add-on	26, 50, 51, 52, AS, AN, ZZ
78815	Pet image w/ct, skull-thigh	26, 50, 51, 52, AS, AN, ZZ
80048	Metabolic panel total ca	26, 50, 51, 52, AS, AN, ZZ
80050	General health panel	26, 50, 51, 52, AS, AN, ZZ
80053	Comprehen metabolic panel	26, 50, 51, 52, AS, AN, ZZ
80061	Lipid panel	26, 50, 51, 52, AS, AN, ZZ
80076	Hepatic function panel	26, 50, 51, 52, AS, AN, ZZ
81002	Urinalysis nonauto w/o scope	26, 50, 51, 52, AS, AN, ZZ
83036	Glycosylated hemoglobin test	26, 50, 51, 52, AS, AN, ZZ
84153	Assay of psa, total	26, 50, 51, 52, AS, AN, ZZ
84439	Assay of free thyroxine	26, 50, 51, 52, AS, AN, ZZ
84443	Assay thyroid stim hormone	26, 50, 51, 52, AS, AN, ZZ
85025	Complete cbc w/auto diff wbc	26, 50, 51, 52, AS, AN, ZZ
87621	Hpv, dna, amp probe	26, 50, 51, 52, AS, AN, ZZ
87880	Strep a assay w/optic	26, 50, 51, 52, AS, AN, ZZ
88142	Cytopath, c/v, thin layer	26, 50, 51, 52, AS, AN, ZZ
88175	Cytopath c/v auto fluid redo	26, 50, 51, 52, AS, AN, ZZ
88304	Tissue exam by pathologist	26, 50, 51, 52, AS, AN, ZZ
88305	Tissue exam by pathologist	26, 50, 51, 52, AS, AN, ZZ
88307	Tissue exam by pathologist	26, 50, 51, 52, AS, AN, ZZ
88342	Immunohistochemistry	26, 50, 51, 52, AS, AN, ZZ
90378	Rsv ig, im, 50mg	NONE
90471	Immunization admin	NONE
90472	Immunization admin, each add	NONE
90633	Hep a vacc, ped/adol, 2 dose	NONE
90649	H papilloma vacc 3 dose im	NONE
90658	Flu vaccine, 3 yrs & >, im	NONE
90669	Pneumococcal vacc, ped <5	NONE
90700	Dtap vaccine, < 7 yrs, im	NONE
90715	Tdap vaccine >7 im	NONE
90716	Chicken pox vaccine, sc	NONE
90734	Meningococcal vaccine, im	NONE
90765	Ther/proph/diag iv inf, init	NONE
90767	Tx/proph/dg addl seq iv inf	NONE

Appendix D – Requested Professional CPT and HCPCS Procedure Codes

Code	Description	Modifiers to Report
90772	Ther/proph/diag inj, sc/im	NONE
90801	Psy dx interview	NONE
90805	Psytx, off, 20-30 min w/e&m	NONE
90806	Psytx, off, 45-50 min	NONE
90807	Psytx, off, 45-50 min w/e&m	NONE
90847	Family psytx w/patient	NONE
90862	Medication management	NONE
92004	Eye exam, new patient	NONE
92012	Eye exam established pat	NONE
92014	Eye exam & treatment	NONE
92015	Refraction	NONE
92083	Visual field examination(s)	NONE
92133	CMPTR OPHTH IMG OPTIC NERVE	NONE
92134	CPTR OPHTH DX IMG POST SEGMT	NONE
92135	Ophth dx imaging post seg	NONE
92250	Eye exam with photos	NONE
92507	Speech/hearing therapy	NONE
92980	Insert intracoronary stent	NONE
93000	Electrocardiogram, complete	NONE
93010	Electrocardiogram report	NONE
93015	Cardiovascular stress test	NONE
93307	Echo exam of heart	NONE
93320	Doppler echo exam, heart	NONE
93325	Doppler color flow add-on	NONE
93350	Echo transthoracic	NONE
93452	LEFT HRT CATH W/VENTRCLGRPHY	NONE
93510	Left heart catheterization	NONE
93545	Inject for coronary x-rays	NONE
93556	Imaging, cardiac cath	NONE
93565	INJECT L VENTR/ATRIAL ANGIO	NONE
93566	INJECT R VENTR/ATRIAL ANGIO	NONE
93568	INJECT PULM ART HRT CATH	NONE
93880	Extracranial study	NONE
93970	Extremity study	NONE
93971	Extremity study	NONE
94010	Breathing capacity test	NONE
94060	Evaluation of wheezing	NONE
95004	Percut allergy skin tests	NONE
95117	Immunotherapy injections	NONE
95165	Antigen therapy services	NONE
95810	Polysomnography, 4 or more	NONE
95811	Polysomnography w/cpap	NONE
95900	Motor nerve conduction test	NONE
95903	Motor nerve conduction test	NONE
95904	Sense nerve conduction test	NONE
96365	THER/PROPH/DIAG IV INF INIT	NONE
96367	TX/PROPH/DG ADDL SEQ IV INF	NONE

Appendix D – Requested Professional CPT and HCPCS Procedure Codes

Code	Description	Modifiers to Report
96372	THER/PROPH/DIAG INJ SC/IM	NONE
96413	Chemo, iv infusion, 1 hr	NONE
96415	Chemo, iv infusion, addl hr	NONE
97001	Pt evaluation	NONE
97010	Hot or cold packs therapy	NONE
97012	Mechanical traction therapy	NONE
97014	Electric stimulation therapy	NONE
97032	Electrical stimulation	NONE
97035	Ultrasound therapy	NONE
97110	Therapeutic exercises	NONE
97112	Neuromuscular reeducation	NONE
97124	Massage therapy	NONE
97140	Manual therapy	NONE
97530	Therapeutic activities	NONE
98940	Chiropractic manipulation	NONE
98941	Chiropractic manipulation	NONE
98942	Chiropractic manipulation	NONE
98943	Chiropractic manipulation	NONE
99199	Special service/proc/report	NONE
99202	Office/outpatient visit, new	NONE
99203	Office/outpatient visit, new	NONE
99204	Office/outpatient visit, new	NONE
99205	Office/outpatient visit, new	NONE
99211	Office/outpatient visit, est	NONE
99212	Office/outpatient visit, est	NONE
99213	Office/outpatient visit, est	NONE
99214	Office/outpatient visit, est	NONE
99215	Office/outpatient visit, est	NONE
99222	Initial hospital care	NONE
99223	Initial hospital care	NONE
99231	Subsequent hospital care	NONE
99232	Subsequent hospital care	NONE
99233	Subsequent hospital care	NONE
99238	Hospital discharge day	NONE
99239	Hospital discharge day	NONE
99242	Office consultation	NONE
99243	Office consultation	NONE
99244	Office consultation	NONE
99245	Office consultation	NONE
99253	Inpatient consultation	NONE
99254	Inpatient consultation	NONE
99255	Inpatient consultation	NONE
99282	Emergency dept visit	NONE
99283	Emergency dept visit	NONE
99284	Emergency dept visit	NONE
99285	Emergency dept visit	NONE
99291	Critical care, first hour	NONE

Appendix D – Requested Professional CPT and HCPCS Procedure Codes

Code	Description	Modifiers to Report
99294	Ped critical care, subseq	NONE
99296	Neonate critical care subseq	NONE
99299	Ic, lbw infant 1500-2500 gm	NONE
99385	Prev visit, new, age 18-39	NONE
99386	Prev visit, new, age 40-64	NONE
99391	Per pm reeval, est pat, inf	NONE
99392	Prev visit, est, age 1-4	NONE
99393	Prev visit, est, age 5-11	NONE
99394	Prev visit, est, age 12-17	NONE
99395	Prev visit, est, age 18-39	NONE
99396	Prev visit, est, age 40-64	NONE
99431	Initial care, normal newborn	NONE
99460	INIT NB EM PER DAY HOSP	NONE
99469	NEONATE CRIT CARE SUBSQ	NONE
99472	PED CRITICAL CARE SUBSQ	NONE
99479	IC LBW INF 1500-2500 G SUBSQ	NONE
A9500	Tc99m sestamibi	NONE
A9502	Tc99m tetrofosmin	NONE
G0202	Screeningmammographydigital	NONE
J0696	Ceftriaxone sodium injection	NONE
J0881	Darbepoetin alfa, non-esrd	NONE
J0885	Epoetin alfa, non-esrd	NONE
J1561	Gamunex	NONE
J1566	Immune globulin, powder	NONE
J1567	Immune globulin intravenous	NONE
J1569	Gammagard	NONE
J1745	Infliximab injection	NONE
J2353	Octreotide injection, depot	NONE
J2469	Palonosetron HCl	NONE
J2505	Injection, pegfilgrastim 6mg	NONE
J3487	Zoledronic acid	NONE
J3490	Drugs unclassified injection	NONE
J9035	Bevacizumab injection	NONE
J9045	Carboplatin injection	NONE
J9055	Cetuximab injection	NONE
J9170	Docetaxel	NONE
J9201	Gemcitabine HCl	NONE
J9206	Irinotecan injection	NONE
J9263	Oxaliplatin	NONE
J9264	Paclitaxel protein bound	NONE
J9265	Paclitaxel injection	NONE
J9310	Rituximab cancer treatment	NONE
J9355	Trastuzumab	NONE
Codes Not Specified Above		
0XXXX	Unspecified Codes in 00000-09999	NONE
1XXXX	Unspecified Codes in 10000-19999	50, 51, 52, AS, AN, ZZ
2XXXX	Unspecified Codes in 20000-29999	50, 51, 52, AS, AN, ZZ

Appendix D – Requested Professional CPT and HCPCS Procedure Codes

Code	Description	Modifiers to Report
3XXXX	Unspecified Codes in 30000-39999	50, 51, 52, AS, AN, ZZ
4XXXX	Unspecified Codes in 40000-49999	50, 51, 52, AS, AN, ZZ
5XXXX	Unspecified Codes in 50000-59999	50, 51, 52, AS, AN, ZZ
6XXXX	Unspecified Codes in 60000-69999	50, 51, 52, AS, AN, ZZ
7XXXX	Unspecified Codes in 70000-79999	26, 50, 51, 52, AS, AN, ZZ
8XXXX	Unspecified Codes in 80000-89999	26, 50, 51, 52, AS, AN, ZZ
9XXXX	Unspecified Codes in 90000-99999	NONE
AXXXX	Unspecified HCPCS Codes AXXXX	NONE
BXXXX	Unspecified HCPCS Codes BXXXX	NONE
CXXXX	Unspecified HCPCS Codes CXXXX	NONE
EXXXX	Unspecified HCPCS Codes EXXXX	NONE
GXXXX	Unspecified HCPCS Codes GXXXX	NONE
JXXXX	Unspecified HCPCS Codes JXXXX	NONE
KXXXX	Unspecified HCPCS Codes KXXXX	NONE
LXXXX	Unspecified HCPCS Codes LXXXX	NONE
QXXXX	Unspecified HCPCS Codes QXXXX	NONE
SXXXX	Unspecified HCPCS Codes SXXXX	NONE
ZZZZZ	Claim lines with invalid CPT Code	NONE

If codes exist outside the CPT/HCPCS ranges shown above, create another grouping using the first character of the CPT/HCPCS code followed by 4 X's. As an example, if a code begins with T, create a grouping TXXXX for all claim lines with these codes.

Appendix E –Modifiers to be Submitted by CPT Code Range

CPT Code Range	Modifiers to be Submitted	Note
10000 – 69999	• Bilateral Procedures (50) • Multiple Procedures (51) • Reduced Services (52) • Assistant Surgeon (AS) • Anesthesiologist (AN) • Primary Surgeon, Uncoded, Other or Unknown (ZZ)	**These modifiers apply to the submission of Professional claims only.** Based on standard coding of CPT Modifiers, Bilateral Procedure are coded with Modifier 50, Multiple Procedures are coded with Modifier 51, Reduced Services are coded with Modifier 52, Anesthesia by a surgeon is typically coded with Modifier 47 and Assistant Surgeon is typically coded with Modifier 80, 81 or 82. Carriers must affirm that they have been diligent in identifying any homegrown modifiers used in their claim processing. All homegrown codes must be mapped to the 3 codes shown (AS, AN, ZZ)
Radiology 70000 – 79999 Pathology 80000 – 89999	• Bilateral Procedure (50) • Multiple Procedures (51) • Reduced Services (52) • Global Fee (GF) • Technical Component (TC) • Professional Component (PC) • Uncoded, Other or Unknown (ZZ)	**These modifier rules apply to the submission of both Outpatient Facility and Professional claims.** Based on standard coding of CPT Modifiers, the Technical Component is typically coded as Modifier "TC" and the Professional Component is typically coded as Modifier "26". Global Fee (GF) modifiers must be identified by the carrier Modifiers 26 or PC should not appear in Outpatient Facility data as these indicate the Professional services. Likewise, modifiers TC and GF should not appear in Professional data as these modifiers indicate Outpatient facility charges. Carriers must affirm that they have been diligent in identifying any homegrown modifiers used in their claim processing. All homegrown codes must be mapped to the 4 codes shown (GF, TC, PC, ZZ)
All other codes	• None submitted	Modifiers for CPT codes not falling into the specific ranges noted in the categories above should not be submitted

Appendix F – Control Total/Reconciliation

The following schedule should be provided for each product for which a "Product Indicator" is provided.

ACTUAL CLAIMS RECONCILIATION	**Product 1**	**Product 2**	**Product 3**	
Fee for Service Claims Included				
Total Submitted Charges				
- Total Ineligible Charges				
= Total Eligible Billed Charges				
- Negotiated Savings				
= Total Contracted Amount				
- Member Cost-Sharing Amounts				
= Plan Paid Amount				
Other Excluded Claims				
Capitation Paid - Mental Health/Substance Abuse				
Capitation Paid - Chiropractor/Physical Therapy				
Capitation Paid - Other				
Total Capitation				
Other Key Summaries				
Aggregate Total of Supplemental Provider Payments included in Allowed				
Total Eligible Billed Charges where Pay as Billed Indicator = "Y"				
Total Eligible Billed Charges where Patient 3-Digit Zip Code = "ZZZ"				

ADJUSTED CLAIMS RECONCILIATION	**Product 1**	**Product 2**	**Product 3**	
Fee for Service Claims Included				
Total Submitted Charges				
- Total Ineligible Charges				
= Total Eligible Billed Charges				
- Negotiated Savings				
= Total Contracted Amount				
Other Excluded Claims				
Capitation Paid - Mental Health/Substance Abuse				
Capitation Paid - Chiropractor/Physical Therapy				
Capitation Paid - Other				
Total Capitation				
Other Key Summaries				
Aggregate Total of Supplemental Provider Payments included in Allowed				
Total Eligible Billed Charges where Pay as Billed Indicator = "Y"				
Total Eligible Billed Charges where Patient 3-Digit Zip Code = "ZZZ"				

PROJECTED CLAIMS RECONCILIATION	**Product 1**	**Product 2**	**Product 3**	
Fee for Service Claims Included				
Total Submitted Charges				
- Total Ineligible Charges				
= Total Eligible Billed Charges				
- Negotiated Savings				
= Total Contracted Amount				
Other Excluded Claims				
Capitation Paid - Mental Health/Substance Abuse				
Capitation Paid - Chiropractor/Physical Therapy				
Capitation Paid - Other				
Total Capitation				
Other Key Summaries				
Aggregate Total of Supplemental Provider Payments included in Allowed				
Total Eligible Billed Charges where Pay as Billed Indicator = "Y"				
Total Eligible Billed Charges where Patient 3-Digit Zip Code = "ZZZ"				

Appendix G - Product Key

Product Name and Description	Product Indicator
Open Choice	PPO01Choice
Open Choice Plus	PPO02ChoicePlus
Managed Options	POS01Options
Gatekeeper Plus	POS02GKPlus

* Positions 1 through 3 should indicate product type (HMO, EPO, PPO, POS, TRA)
Positions 4 through 5 should be used to differentiate offerings within product type
Positions 6 through 15 should be used to indicate product name

Appendix H - Projection Documentation

PLEASE REFER TO PAGES 10 AND 11 FOR INSTRUCTIONS ON COMPLETING THIS FORM

		1/16-12/16 Projected Discount Change* (+) means discount improvement (-) means discount deterioration				Annual Trend Applied to Eligible Billed Charges			% of Area Eligible Billed Charges Affected by Change				
Three Digit ZIP(s)	**Product Indicator**	**IP**	**OP**	**Prof**	**Change to Total Discount**	**IP**	**OP**	**Prof**	**IP**	**OP**	**Prof**	**Total**	**Discount Improvement Plan Details**
AXY	PPO01	2.00%	2.00%	0.00%	1.00%	6.00%	6.00%	0.00%	50.00%	41.00%	0.00%	22.75%	Renegotiated key facility contracts
AZY	PPO01	1.00%	1.00%	2.00%	1.50%	6.00%	6.00%	3.00%	15.00%	20.00%	100.00%	52.55%	Renegotiated key facility contracts Introduce New Physician Fee Schedule
VCX	POS01	0.00%	0.00%	4.00%	2.00%	0.00%	0.00%	3.00%	0.00%	0.00%	75.00%	33.75%	Introduce New Physician Fee Schedule

All projections and reasons for projections should be thoroughly explained in the Actuarial Certification (Appendix I)

* Changes should reflect absolute change in discount
(e.g., if discount expected to improve from 55% to 57%, Change in Discount is 2%; if discount expected to deteriorate from 63% to 60%, Change in Discount is -3%)
Change in discount should reflect expected changes in both Contracted Amount and Eligible Billed
Contracted amount should only be trended at 0% if carrier has a signed contract stating that contracted amounts will remain unchanged

Common Discount Change Plan Detail Reason Types
Non-Par Hospital Contracting
Free Standing Surgi Centers Contracting
Change Stop Loss Provisions
Introduce New Physician Fee Schedule
Reduce Existing Physician Fee Schedule
Provider acquired by another provider
Par hospital re-contracting
Addition or loss of major hospital(s) in a location
Addition or loss of major group practice(s) in a location
Renegotiated major contract changes with existing network providers
Recognize negotiated escalators in multi-year contracts
This is not intended to be an exhaustive list. Please add other descriptive types as needed.

Appendix I
Disclosure of Compliance with Data Standards

In certifying your compliance with the "Disclosure Items" below, please be sure to be specific and disclose any portion of your submission that deviates from the request. Please do not answer "Yes" to a statement unless your organization is compliant with the statement for 100% of your submission. All deviations, regardless of perceived size, must be disclosed.

Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
1	Data is reported by member 3-digit zip code. Data has not been combined for multiple three-digit zip codes			
2	For each product submitted, data includes 12 months of claims, incurred **7/1/2014-6/30/2015, paid through 8/31/2015.**			
3	All indicators in the data are mutually exclusive so that when amounts for charge and utilization fields are summed, the result is the actual total for that field.			
4	Data is submitted in the format outlined in Appendix A			
5	Data includes all claims (other than those exclusions outlined on page 1) regardless of provider contracting status, claim dollar amount or discount percentage			
6	Data excludes all surcharges and covered life assessments (e.g., NYCHRA in New York)			

Appendix I
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Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
7	Access fees are excluded from all claims. If access fees could not be removed explicitly, please submit data as "Adjusted" and provide your methodology in the box requesting explanation of Adjusted data below			
8	Data has been assembled as outlined on page 2 "Data Aggregation Methodology"			
9	A product indicator for each product submitted has been provided And Appendix G has been included with the submission			
10	Benefit/Contract Status Indicator has been submitted			
11	MDC and DRG have been provided for all inpatient claims			
12	DRG data has been submitted under coding system MS-DRGv30 and DRG Indicator Field has been coded properly in your data submission			

Appendix I
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Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
13	For a covered admission where the admission and discharge date are equal, the number of covered days is set to 1. There are no IP Admissions with 0 days			
14	Days and billed charges associated with non-covered days during a hospital admission have been excluded from the data submission			
15	Reversals offset submitted data for admissions, days, OP Services, procedures and dollar amount fields and are not treated as additional utilization/dollar amounts			
16	Financial data has been submitted as defined on page 7 for Eligible Billed Charges, Negotiated Savings, Contracted Amount and Paid Amount			
17	Reductions for Reasonable and Customary amounts that result in member balance billing are not included in Negotiated Savings And Contracted Amount = Eligible Billed Charges – Negotiated Savings			

Appendix I
Disclosure of Compliance with Data Standards

In certifying your compliance with the "Disclosure Items" below, please be sure to be specific and disclose any portion of your submission that deviates from the request. Please do not answer "Yes" to a statement unless your organization is compliant with the statement for 100% of your submission. All deviations, regardless of perceived size, must be disclosed.

Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
18	Ineligible billed charges (as defined on page 7) have been excluded and Eligible Billed Charges = Submitted Charges – Ineligible Charges for all claims			
19	All financial and utilization data labeled as "Actual" represents historical claims without adjustment			
20	"Adjusted Data" has been provided for claim expenses/credits not available in your data warehouse that are passed back to employer groups as a result of provider reimbursement agreements such as withholds, bonuses, and pay for performance arrangements			
21	"Adjusted" data and "Projected" data have been explained in the space provided below and Appendix H has been submitted for "Projected" data			

Appendix I
Disclosure of Compliance with Data Standards

In certifying your compliance with the "Disclosure Items" below, please be sure to be specific and disclose any portion of your submission that deviates from the request. Please do not answer "Yes" to a statement unless your organization is compliant with the statement for 100% of your submission. All deviations, regardless of perceived size, must be disclosed.

Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
22	Contract changes included in "Projected" data were signed prior to the "cutoff" date of September 30, 2015			
23	The impact of newly signed contracts effective in a future time are only included in "Projected" data and are not included in "Adjusted" data			
24	Outpatient events for which facility and professional claims cannot be separated have been indicated with a modifier of "GF". If unable to label claims with modifier of "GF", please provide the total utilization and eligible billed charges for Outpatient events where facility and professional claims cannot be separated			
25	Ancillary claims as defined in Appendix C have been included in Outpatient Facility claims and excluded from Professional claims			
26	All homegrown modifier codes have been mapped to comply with modifier definitions shown in Appendix E			

Appendix I
Disclosure of Compliance with Data Standards

In certifying your compliance with the "Disclosure Items" below, please be sure to be specific and disclose any portion of your submission that deviates from the request. Please do not answer "Yes" to a statement unless your organization is compliant with the statement for 100% of your submission. All deviations, regardless of perceived size, must be disclosed.

Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
27	Appendix F has been completed for all products submitted. Total Submitted Charges represent all fee for service claims for a product after the criteria for inclusion/exclusion on page 1 is applied			
28	Has this submission kept separate the data for benefit plans with in-network only and in-network/out-of-network benefits?			
29	The Group Size Indicator field was populated using the definition found on page 5.			

Please provide explanation for any claims included that have a Pay-as-Billed Indicator of "Y"

Please provide explanation and the methodology used to calculate any "Adjusted" claim or utilization data included in this data submission. Explanation should be provided by geographic area. Examples of reasons to provide "Adjusted" data can be found on pages 7 and 8 of this document.

Please provide explanation and the methodology used to calculate any "Projected" claim or utilization data included in this data submission. Explanation should be provided by geographic area. Please address the level at which the projected discounts were calculated and applied (3 digit zip code or MSA). Appendix H should also be provided for each geographic area where "Projected" data is submitted

Please disclose and explain any other deviations from this data specification that have not been addressed above

Please disclose any reliance you have made on other parties in completing this data submission as well as any other areas of concerns you may have as they relate to guidance offered under Actuarial Standard of Practice (ASOP) #23, Data Quality

By signing below, I certify that I have reviewed the data submitted. Based on my thorough review, I believe it presents a fair and accurate representation of the provider reimbursement arrangements of this organization, as reflected in book-of-business claims data. Except as disclosed above, we have followed the procedures outlined by in this document to fulfill the data request.

Carrier Name

Signature of Actuary | Printed Name

Title | Date

Appendix J –DRG Version Coding

The DRG Version Identifier is a 4 character field with format V### where:

V: Grouper Version Type Code

- A: CMS (Medicare grouper)
- B: All Payor (sometimes called "New York" grouper)
- C: All Payor Refined (APR grouper)
- D-J: reserved for future use
- K-Z: Other (to be specified in the actuarial certification)

###: Version number (e.g., "A270" is the Medicare grouper effective 10/1/2009)
The first two digits relate to the DRG version number (for example, MS-DRG v27 is coded as 27). The last digit is a placeholder as sometimes there are corrections released during a year. If a correction is released, the last digit would change from ‘0’ to the correction number of the DRG release used (i.e., A271)

Change Log

1) Changes from Mid Year 2010 to Calendar Year 2010 Specification

a) Description of Modifier 50 changed from Multiple Procedures to Bilateral Procedure
   i) Two instances on page 36

b) Description of Modifier 51 changed from Bilateral Procedure to Multiple Procedures
   i) Two instances on page 36

2) Changes from Calendar Year 2010 to Mid Year 2011 Specification

a) Version and Date in Header Changed to Version MY2011.1 and September 28, 2011 (all pages)

b) Dates changed to 7/1/2010 – 6/30/2011, paid through August 31, 2011
   (1) Page 1 – Time Period Defined
   (2) Page 10 - Projection
   (3) Page 43 - Certification

c) Service Period Changed from 01012010-12312010 to 070110-063011
   (1) Page 3, 16, 20, 23, 26

d) Treatment of Providers in Products with Multiple In-Network Tiers
   (1) Page 4 – Add verbiage regarding Multiple In Network Tier Products to Product Indicator definition
   (2) Page 4 – Clarify all In-Network Providers in Multiple Tier Products reported as IC

e) Addition of DRG Version Indicator Field to Inpatient Claims Layout
   (1) Description on Page 6
   (2) Field added to Inpatient Claim Layout on Page 16
   (3) Updated Certification to ask signer if version is provided on Page 44
   (4) Added Appendix J on page 48

f) Treatment of Negotiated Claims with Noncontracted Providers
   (1) Page 15 – Added description of field and instructions for population of field
   (2) Page 26 – Field added to layout

g) Projected Data Submission Dates
   (1) Page 10 – updated dates to reflect projection period and instructions for mid-year 2011
   (2) Page 10 – note added to use 18 months of billed trend for projections based on mid-year historical data

h) Filler Fields
   (1) Page 17, 18, 19, 21, 22, 24, 25, 27

i) Always Submit Adjusted and Projected Data
   (1) Page 8 – Added verbiage to always include Adjusted and Projected data and to indicate if Adjusted is a copy of Actual and/or if Projected is a copy of Adjusted data
   (2) Page 17,21, 24, 27 – Add field AdjCopy of Actual
   (3) Page 18,22, 24, 27 - Add field ProCopyofAdj

j) Added the following CPT Codes to Appendix D
   (1) 64493, 64494, 78451, 78452, 78453, 78454, 96365, 96367, 96372, 92133, 92134, 93452, 93565, 93566, 93568, 99460, 99469, 99472, 99479

k) Appendix H – Projections
   (1) Change projection period to “1/2012 – 12/2012”

3) Changes from Mid Year 2011 to Calendar Year 2011 Specification

a) Version and Date in Header Changed to Version CY2011.1 and March 13, 2012 (all pages)

b) Dates changed from 7/1/2010 – 6/30/2011, paid through August 31, 2011 to 1/1/2011 – 12/31/2011, paid through February 29, 2011
   (1) Page 1 – Time Period Defined
   (2) Page 11 - Projection
   (3) Page 52 - Certification

c) Service Period Changed from 070110-063011 to 01012011-12312011
   (1) Page 3, 18, 22, 25, 28

d) Projected Data Submission Dates
   (1) Page 11 – updated dates to reflect projection period and instructions for calendar year 2012
   (2) Page 11 – note added to use 12 months of billed trend for projections based on calendar year historical data
   (3) Page 11 – change "Only contracts executed by September 30, 2011.." to "Only contracts executed by March 31, 2012…"

e) Handling of outpatient claims with more than one date of service
   (1) Page 2 - If the Event type is not "Case" and there are multiple dates of service on the claim, assume all claim lines are incurred on the minimum service date (i.e., first day of service) listed on the claim

f) Change in professional billed charge trend assumption used in projections
   (1) Page 30 – Changed Professional trend assumption from 4% to 3%

g) Added request to report modifier 52 to specification for CPT codes 10000-69999
   (1) Pages 33-42 – added Modifier 52 to list of modifiers to separately report
   (2) Page 44 – CPT Code Ranges 10000-69999 added Reduced Services (Modifier 52) to request

h) Replaced Appendix I with new version including proprietary/non-proprietary columns
   (1) Deleted prior table pages 47-51
   (2) Added new table on page 52

i) Updated Projected Discount example to reflect Calendar Year 2012 projection
   (1) All tables on page 13 updated to use historical period of Calendar Year 2011 and Projection Period of Calendar Year 2012
   (2) Verbiage on page 11 updated from "a projection period of **calendar year 2011** and a historical period of **calendar year 2010**" to from "a projection period of **calendar year 2012** and a historical period of **calendar year 2011**"

4) Changes from Calendar Year 2011 to Mid-Year 2012 Specification

a) Version and Date in Header Changed to Version MY2012.1 and November 6, 2012 (all pages)

b) Dates changed from 1/1/2011 – 12/31/2011, paid through February 29, 2011 to 7/1/2011 – 6/30/2012, paid through August 31, 2012
   (1) Page 1 – Time Period Defined
   (2) Page 11 - Projection
   (3) Page 52 - Certification

c) Service Period Changed from 01012011-12312011 to 070111-063012
   (1) Page 3, 18, 22, 25, 28

d) Projected Data Submission Dates

(1) Page 11 – updated dates to reflect projection period and instructions for calendar year 2013
(2) Page 11 – note added to use 18 months of billed trend for projections based on mid-year historical data
(3) Page 11 – change from "Only contracts executed by March 31, 2012…" to "Only contracts executed by September 30, 2012.."

e) Change in Appendix B wording to strengthen recommended trends to be required trends (August 16 Teleconference minutes item #2)
f) Replaced Appendix I with new version where items are numbered (Agenda Item # 35)
g) Added two additional explicit disclosures on Appendix I (Agenda Item # 29) - see items 22 and 23 on Appendix I
h) Added CPTs J1561 and J1569 to the CPT code list for Professional claims

5) Changes from Mid-Year 2012 to Calendar Year 2012 Specification

a) Version and Date in Header Changed to Version FY2012.1 and April 8, 2013 (all pages)
b) Dates changed from 7/1/2011 – 6/30/2012, paid through August 31, 2012 to 1/1/2012 – 12/31/2012, paid through February 28, 2013
(1) Page 1 – Time Period Defined
(2) Page 10 - Projection
(3) Page 43 - Certification
c) Service Period Changed from 070111-063012 to 01012012-12312012
(1) Page 3, 16, 20, 23, 26
d) Projected Data Submission Dates
(1) Page 11 – change from "Only contracts executed by September 30, 2012 …" to "Only contracts executed by March 31, 2013..."
(2) Page 47 – change from "date of September 30, 2012" to "date of March 31, 2013"

6) **Changes from Calendar Year 2012 to Mid-Year 2013 Specification**

a) Version and Date in Header Changed to Version MY2013.1 and August 14, 2013 (all pages)
b) Dates changed from 1/1/2012 – 12/31/2012, paid through February 28, 2013 to 7/1/2012 – 06/30/2013, paid through August 31, 2013
(1) Page 1 – Time Period Defined
(2) Page 3 – Service Period
(3) Page 10 – Projection
(4) Page 17, 21, 24, 27 – Claims Submission Data Elements
(5) Page 43 - Certification
c) Service Period Changed from 01012012-12312012 to 07012012-06302013
(1) Page 3, 16, 20, 23, 26
d) Projected Data Submission Dates
(1) Page 11 – change from "Only contracts executed by March 31, 2013…" to "Only contracts executed by September 30, 2013.."
(2) Page 47 – change from "date of March 31, 2013" to "date of September 30, 2013
e) Appendix I – Page 4
f) Updated the MS-DRG Version from v27 to v30
i) Pages 6, 17 and 44
g) Updated Appendix C to include CPT codes for when Independent Lab/Rad providers submit claims without revenue codes and/or are contracted with global fees to allow for proper bucketing into the respective Lab/Rad OP bucket.

i) Page 29

h) Change inclusions/exclusions (page 1) to include "all claims covered under the medical benefit"
   i) 6th bullet point
   ii) 15th bullet point

i) Change catastrophic indicator to include 2 categories, category 0 for claims between $150 and $300k and category 1 for claims equal to or exceeding $300k in contracted amount
   i) Page 3
   ii) Page 6
   iii) Page 17

7) **Changes from Mid-Year 2013 Specification to Calendar Year 2013 Specification**
   a) Version and Date in Header Changed to Version FY2013.1 and March 20, 2014 (all pages)
   b) Dates changed from 7/1/2012 – 6/30/2013, paid through August 31, 2013 to 1/1/2013 – 12/31/2013, paid through February 28, 2014
      (1) Page 1 – Time Period Defined
      (2) Page 3 – Service Period
      (3) Page 10 – Projection
      (4) Page 17, 21, 24, 27 – Claims Submission Data Elements
      (5) Page 44 - Certification
   c) Service Period Changed from 07012012-06302013 to 01012013-12312013
      (1) Page 3, 17, 21, 24, 27
   d) Projected Data Submission Dates
      (1) Page 11 – change from "Only contracts executed by September 30, 2013…" to "Only contracts executed by March 31, 2014..."
      (2) Page 47 – change from "date of September 30, 2013" to "date of March 31, 2014
   e) Appendix I – Page 4: Change "cutoff" date to March 31, 2014
   f) Appendix B: Change proposed billed charge trends to 6% IP/8% OP/4% Professional

8) **Changes from Calendar Year 2013 Specification to Midyear 2014 Specification**
   a) Version and Date in Header Changed to Version MY2014.1 and August 8, 2014 (all pages)
   b) Dates changed from 1/1/2013 – 12/31/2013, paid through February 28, 2014 to 7/1/2013 – 6/30/2014, paid through August 31, 2014
      (1) Page 1 – Time Period Defined
      (2) Page 3 – Service Period
      (3) Page 10 – Projection
      (4) Page 17, 21, 24, 27 – Claims Submission Data Elements
      (5) Page 44 - Certification
   c) Service Period Changed from 01012013-12312013 to 07012013-06302014
      (1) Page 3, 17, 21, 24, 27
   d) Projected Data Submission Dates
      (1) Page 10 – change from "Only contracts executed by March 31, 2014..." to "Only contracts executed by September 30, 2014…"
      (2) Page 48 – change from "date of March 31, 2014" to "date of September 30, 2014
   e) Page 16: Modified Noncontracted Savings Indicator text to more clearly define when the indicator should be set to "Y"
   f) Appendix I – Change "cutoff" date to September 30, 2014
   g) Appendix I – Added item 28 that addresses handling of in-network only products.

9) Changes from Mid-Year 2014 Specification to Calendar Year 2014 Specification

a) Version and Date in Header Changed to Version FY2014.1 and May 21, 2015 (all pages)
b) Dates changed from 7/1/2013 – 6/30/2014, paid through August 31, 2014 to 1/1/2014 – 12/31/2015, paid through February 28, 2015
   i) Page 1 – Time Period Defined
   ii) Page 11 – Projection
   iii) Page 46 - Certification
c) Service Period Changed from 07012013-06302014 to 01012014-12312014
   i) Page 3, 17, 21, 24, 27
d) Projected Data Submission Dates
   i) Page 11 – change from "Only contracts executed by September 30, 2014..." to "Only contracts executed by March 31, 2015…"
   ii) Page 50 – change from "date of September 30, 2014" to "date of March 31, 2015
e) Changed "mid-year" to "calendar year"
   i) Page 3, 17, 21, 24, 27
f) Added information for Group Size Indicator
   i) Page 5, 17, 21, 24, 27
g) Added information for R&C Cutback field
   i) Page 7, 27
h) Added information for Paid Amount field
   i) Page 8, 18, 22, 25, 29, 48
i) Corrected time period in example on page 11
j) Update Start Positions and End Positions on Appendix A
k) Added 'Plan Paid Amount' to Appendix F
l) Added disclosure item to Appendix I for population of Group Size Indicator field.

10) Changes from Calendar Year 2014 Specification to Mid-Year 2015 Specification

a) Version and Date in Header Changed to Version MY2015.1 and September 2, 2015 (all pages)
b) Dates changed from 1/1/2014 – 12/31/2014, paid through February 28, 2015 to 7/1/2014 – 6/30/2015, paid through August 31, 2015
   i) Page 1 – Time Period Defined
   ii) Page 11 – Projection
   iii) Page 45 - Certification
c) Service Period Changed from 01012014-12312014 to 07012013-06302014
   i) Page 3, 11, 17, 21, 24, 27
d) Projected Data Submission Dates
   i) Page 10 – change from "Only contracts executed by March 31, 2015…" to "Only contracts executed by September 30, 2015..."
   ii) Page 49 – change from "date of March 31, 2015" to "date of September 30, 2015
e) Changed "calendar year 2014" to "mid-year 2015"
   i) Page 3, 17, 21, 24, 27
f) Updated dates and exhibits for projected discounts
   i) Page 10, 11, 13, 44
g) Added the word "Discount" to title on page 1