DEFINITIONS OF CLAIM AND DATA FILES SUBMITTED TO THE WA-APCD

A. INTRODUCTION

RCW 43.371.070(1)(a)[1] requires the data suppliers to submit the following claim and data files[2] to the statewide all-payer claims database (WA-APCD):

1. Covered medical services claims
2. Pharmacy claims
3. Dental claims
4. Member eligibility and enrollment data
5. Provider data with necessary identifiers

The law further directs the Office of Financial Management (OFM) to define the claim and data files that data suppliers must submit to the WA-APCD in rule. Paper 1 provides background information for this rule. The paper examines how other states with established APCDs have defined their claim and data files and identifies considerations for developing the WA-APCD definitions for claim and data files. Paper 1 is divided into the following sections:

Appendices and References

[1] RCW 43.371.070 was amended during the 2015 legislative session in Chapter 246, Laws of 2015 (Engrossed Substitute Senate Bill 5084). The amendment to this statute included three additional topics for which rules should be adopted. The bill did not amend subsection (1)(a), which is the subject of this paper.

[2] In database management systems (like an APCD), data files are the files that store the database information (such as claim and encounter, member eligibility and provider data), whereas other files, such as index files and data dictionaries, store administrative information, known as metadata. Source: www.webopedia.com

OFM also received technical input on developing definitions for claim and data files from the Washington Health Alliance. This information is available on the OFM health care price transparency website at http://www.ofm.wa.gov/healthcare/pricetransparency. See the report "Washington Health Alliance All-Payer Claim Database Data Policy Advisory Committee Summary of Recommendations," Pages 3–6.

B. DEFINING CLAIM AND DATA FILES IN OTHER STATES

Both definitions and technical specifications for claim and data files are necessary to manage an APCD. The definitions of the claim and data files specify the type of information that must be included in the data file. The technical specifications specify the data elements and layout for the information in the data file.

In Maine and Vermont, the definitions for the claim and data files and the technical specifications are included in rule. Any changes to the definitions for the claim and data files or the technical specifications are subject to the rule-making process.

In some states, such as Colorado, there is a high-level definition of the claims and data file in the rule that incorporates the data submission guide (DSG) by reference[3]. The details of the definition, such as residency requirements, and the technical specifications are found in the DSG. Changes to the claim and data file definitions or technical specifications are not subject to the rule-making process.

Other states use a combination of definitions of claim and data file in rule and technical specifications in the DSG. The definitions in rule are detailed. Changes to the definitions of claim and data files must go through the rule-making process. However, changes to the technical specifications in the DSG are not subject to the rule-making process.

[3] See Appendix A. Definitions for data submission guide.

C. FINDINGS FOR CLAIM AND DATA FILE DEFINITIONS IN OTHER STATES

All the states with APCDs require that medical claims, eligibility and pharmacy data files be submitted to their APCDs. Most of the states require provider data files be submitted. Six states require that dental data files be submitted. (See Table 1.)

Table 1: Claim and data files defined in other states

STATE	MEDICAL CLAIMS	ELIGIBILITY	DENTAL	PHARMACY	PROVIDER
Arkansas	•	•	•	•	•
Colorado	•	•		•	•
Connecticut[4]	•	•	•	•	•
Kansas	•	•	•	•	
Maine	•	•	•	•	
Maryland	•	•		•	•
Massachusetts	•	•	•	•	•
Minnesota	•	•		•	•
New Hampshire	•	•	•	•	
Oregon	•	•		•	•
Rhode Island	•			•	•
Tennessee	•	•		•	
Utah	•	•		•	•
Vermont	•	•		•	

Source: APCD Council

C.1 Covered medical services file

None of the states has a specific definition for the term "covered medical services file," as required in the Washington state law, but they do have definitions for medical claims data file or medical claims file[5]. In their definitions, the states list the type of information that has to be included in the data file for each claim. States may include some or all of the following in their definitions:

- **Member demographics** – includes name, date of birth, gender, address, ZIP, phone number, relationship to insured, insurance information such as group number, plan name.
- **Member encrypted unique identifier** – is assigned to de-identified data so records can be linked longitudinally**.**
- **Provider information** – includes name, address and national provider identifier (NPI)[6] for referring physician and the health care provider providing the service.

[4] Connecticut is implementing an APCD. The other states on the list already have APCDs.

[5] See Appendix B: Definition for medical claims file and medical claims data file.

[6] The NPI is a unique identification number issued to covered health care providers in the United States by the Centers for Medicare & Medicaid Services (CMS). Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA). The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty. https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/downloads/npi_fs_geninfo_010906.pdf

- **Clinical diagnosis/procedure codes** – includes International Classification of Diseases (ICD) codes for diagnosis[7] and Current Procedural Terminology (CPT) codes for treatment and modifiers[8].
- **Charge and payment information**
  - » Form 1500 – the paper claim form used by noninstitutional health care providers. Includes outside lab charges, line item charge amount, total claim charge amount and balance due.
  - » UB04 – the paper claim form used by hospitals and institutions. Includes total charges, prior payments, estimated amount due and noncovered charges[9].
  - » EDI 837 – the transaction set used for electronic claims processing. Includes data elements for purchased service charge amount (this is used for outside lab charges), line item charge amount, total claim charge amount, patient amount paid, payer amount paid. There is no data element for balance due in 837P.
- **Encounter data**[10]
- **Behavioral or mental health claims**
- **Residency.** Some states, such as Oregon, include residency provisions in their definitions of medical claims file. The residency provision may stipulate that claims are:
  - » From all residents of the state.
  - » From all nonresidents of the state who received services in the state.
  - » For services provided in the state.
- **Resubmission of the claim** – resubmission code and original reference number
- **Status of the claim**. Some states also specify in the definition the status of the claims that are included in the data file in several ways. For example:
  - » all paid claims and encounters
  - » all adjudicated claims for each billed service[11]

[7] ICDs are an international set of codes that represent diagnoses of patients' medical conditions as determined by physicians. ICD codes are input in a claim for billing. ICD codes are also used to classify diseases and other health problems recorded on many types of health and vital records, including death certificates and health records. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics. ICD-10 codes are the updated international set of codes based on the preceding ICD-9 codes. The U.S. Department of Health and Human Services has announced the implementation of ICD-10 on Oct. 1, 2015. All health care providers, including physicians (regardless of whether they are Medicare or Medicaid providers), as well as clearinghouses and all payers, are covered by the HIPAA and are required to transition to ICD-10. Providers will continue to use ICD-9-CM through Sept. 30, 2015. http://www.who.int/classifications/icd/en/

[8] A CPT code is a five-digit numeric code used to describe medical, surgical, radiology, laboratory, anesthesiology and evaluation/management services of physicians, hospitals and other health care providers. There are approximately 7,800 CPT codes. CPT codes are published by the American Medical Association. http://compliance.med.ufl.edu/compliance-tips/what-is-a-cpt-code/

[9] See Appendix G: Form 1500, UB-04, EDI 837, Labor and Industries.

[10] The Washington State Health Care Authority (HCA) defines an encounter as a single health care service, or a period of examination or treatment. Kaiser Permanente, a health care insurer in Washington state that primarily uses encounter data, says that encounter data is all data created during the course of a medical interaction. This includes chart notes, orders, results, vitals, location data, provider data and traditional claim-like data. The difference between encounter and claims is that claims are one type of encounter data. The encounter data that Kaiser has, since it has very few traditional claims, are clinical data from its electronic medical records system.

[11] Claims adjudication refers to the determination of the insurer's payment or financial responsibility after the member's insurance benefits are applied to a medical claim. When claims are processed, the payer will notify the provider of the details of the adjudication in the form of an explanation of benefits or remittance advice. A denied claim refers to a

» all nondenied adjudicated claims for each billed service
» submitted, nondenied, adjudicated claims data for each billed service

C.2 Pharmacy claims file

The states that collect pharmacy claims[12] require that some or all the following information be included in a pharmacy claims file:

- Member demographics
- Charge and payment information for nondenied adjudicated claims for each prescription filled
- Provider information
- National drug codes[13]
- Residents and nonresidents receiving service in the state

Oregon has a pharmacy eligibility definition related to its pharmacy claims file that states that pharmacy eligibility file means a data set containing demographic information for each individual enrolled member eligible for pharmacy benefits for one or more days of coverage at any time during a calendar month for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEBB group health insurance plan, or for services provided in Oregon.

C.3 Dental claims file

Connecticut and Maine have definitions for dental claims file[14]. Their definitions require service-level remittance information, including:

- Member demographics
- Provider information
- Charge and payment information
- Dental terminology codes from all paid claims and encounters (Connecticut)
- Dental terminology codes from all nondenied adjudicated claims for each billed service (Maine)

claim that has been processed and which the insurer has found to be not payable. Denied claims can usually be corrected and/or appealed for reconsideration. A rejected claim refers to a claim that has not been processed by the insurer due to an error in the information provided. Common causes for a claim to be rejected include inaccurate personal information (e.g., name and identification number do not match) or errors in information provided (e.g., truncated procedure code, invalid diagnosis codes, etc.) A rejected claim has not been processed so it cannot be appealed. Instead, rejected claims need to be researched, corrected and resubmitted. For claims that have secondary or tertiary insurances, the primary payer's adjudication information must be forwarded, with the electronic claim, for the coordination of benefits. http://medicaloffice.about.com/od/billingbasics/a/Understanding-Claims-Adjudication.htm

[12] See Appendix C: Definitions for pharmacy claims file.

[13] Drug products are identified and reported using a unique, three-segment number, called the national drug code (NDC), which serves as a universal product identifier for drugs. Each listed drug product is assigned a unique 10-digit, three-segment number. This number identifies the labeler, product and trade package size. See www.fda.gov/Drugs/InformationOnDrugs.

[14] See Appendix D: Definitions for dental claims file.

C.4 Member eligibility and enrollment data file

All the states require information be submitted for member eligibility, and have definitions for member eligibility file[15]. No state defines enrollment data.

The states' definitions for member eligibility file include:

- Member demographics
- Details for the member's health care coverage (medical, pharmacy, dental)
- Time frame for coverage. Most states consider a member eligible if the member has one or more days of coverage during the reporting period.

Massachusetts' definition of member eligibility file requires more detail, including:

- Member identifiers
- Member demographics
- Race, ethnicity and language information
- Plan type
- Benefit codes
- Enrollment start and end dates
- Behavioral and mental health, substance abuse and chemical dependency and prescription drug benefit indicators

C.5 Definitions for provider data with necessary identifiers

Two states have a definition of provider file and one state has a definition of medical provider file[16].

- In Colorado, provider file means additional information about the individuals and entities that submitted claims that are included in the medical claims file and is submitted according to the requirements contained in the submission guide.
- In Connecticut, provider file means additional information as set forth in the submission guide about the health care providers that is included in a medical claims data file or dental claims data file.
- In Oregon, medical provider file means a data set containing information about health care providers providing health care services, equipment or supplies to enrolled members during the reporting period.

[15] See Appendix E: Definitions for member eligibility file.
[16] See Appendix F: Definitions for provider file.

Colorado further defines the three providers in its data submission guide as follows:

- A provider means a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy.
- A billing provider means a provider or other entity that submits claims to health care claims processors for health care services directly performed or provided to a subscriber or member by a service provider.
- A service provider means the provider who directly performed or provided a health care service to a subscriber of member

The data elements that Colorado collects to identify providers include:

- Provider ID – unique identified for the provider as assigned by the reporting entity
- Provider tax ID
- Provider entity: F for facility, G for provider, I for independent practice association (IPA), P for practitioner
- Provider information – first, middle and last name, address, suffix, specialty
- Provider DEA number17
- Provider NPI number
- Provider state license number

Oregon collects the same provider data elements and adds three elements for participants in a Q-Corp[18] initiative: provider Medicaid number, provider CMS UPIN[19] and provider date of birth.

[17] A DEA number (DEA registration number) is a number assigned to a health care provider (such as a medical practitioner, pharmacist, dentist or veterinarian) by the U.S. Drug Enforcement Administration allowing the provider to write prescriptions for controlled substances. Legally, the DEA number is to be used solely for tracking controlled substances. It is often used by the industry, however, as a general prescriber number that is a unique identifier for anyone who can prescribe medication. https://en.wikipedia.org/wiki/DEA_number

[18] The Oregon Health Care Quality Corporation **(**Q Corp**)** is an independent, nonprofit organization dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information. See www.q-corp.org.

[19] The unique physician identification number (UPIN) directory contains selected information on physicians, doctors of osteopathy, limited licensed practitioners and some nonphysician practitioners who are enrolled in the Medicare Program. The data elements in the file (UPIN, full name, specialty, physician license state code, ZIP code, Medicare provider billing number and state) are extracted from the UPIN database and approved for public release in the CMS system of records. The file is updated quarterly, with updates being available usually by Jan. 15, April 15, July 15 and Oct. 15. Each update file is considered as a replacement file. See https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/NonIdentifiableDataFiles/UniquePhysicianIdentificationDirectory.html.

D. CONSIDERATIONS FOR WA-APCD CLAIM AND DATA FILE DEFINITIONS

Table 2 identifies the other considerations and related questions and issues that will be discussed in the rule-making process for this rule. This list is not exhaustive, and OFM welcomes input from stakeholders.

Table 2: Considerations for definitions of claim and data files

CONSIDERATION	QUESTIONS/ISSUES
1. Should definitions for claim and data files be in rule? In the DSG?	RCW 43.371.070(1)(a) requires certain definitions be in rule. Incorporating a DSG by reference may not adequately meet this requirement.
2. What are the impacts of the claim and data file definitions?	Are the claim and data file definitions broad enough to include the claims data from the variety of data suppliers listed in RCW 43.371.030(1), including the Washington State Department of Labor and Industries? Will the claim and data file definitions require the collection of data elements that are not standard for claims or APCD? Do the definitions have any inadvertent impacts?
3. Residency	Do we need to address residency to reflect cross-border medical care, snowbirds, persons working in other states but their health insurance is with a Washington based company, out-of-state students and other residency issues?
4. Unique language in Washington claim and data file terms	"Covered" in "covered medical files." Is there an impact of using "covered" in the term rather than just medical files? Other states have definitions for member eligibility but do not specifically address enrollment data. What does enrollment data mean? "With necessary identifiers." Three states have definitions for provider file but do not list necessary identifiers. Their DSGs contain data elements that identify their providers. Do we want to define three providers — provider, billing provider, service provider — like Colorado does?
5. Should we define the term "data submission guide"?	See Appendix A: Definitions for data submission guide. If so, what should be included in the WA-APCD definition?
6. National standards for APCD data elements See http://www.apcdcouncil.org/standards.	The advantages of meeting national standards for APCD data elements are: • Makes it easier for health care data suppliers who may supply data to multiple state APCDs to prepare data submission files. • Facilitates the development of the initial DSG in a timely manner by the lead organization and data vendor. • Enables regional research if there are common data elements among the states. • Allows input of additional data elements.

CONSIDERATION	QUESTIONS/ISSUES
	Should we adopt national standards for APCD data elements? If so, should we adopt the national data standards in whole or in part? If we adopt national standards for APCD data elements, should we be able to collect data elements beyond those included in the national data standards? Are there disadvantages to requiring standardization?
7. Other definitions	Are there other terms that need to be defined to further explain the claims and data file definitions? For example, some states define claims.
8. Other considerations?	*Please add your questions, issues, comments and send to OFM at apcd@ofm.wa.gov.*

APPENDIX A
Definitions for data submission guide

STATE	DEFINITIONS FOR DATA SUBMISSION GUIDE
Colorado	Submission guide means the document "Colorado All-Payer Claims Database Data Submission Guide" developed by the administrator that sets forth the required schedules, data file format, record specifications, data elements, definitions, code tables and edit specifications for payer submission of eligibility data files, medical and pharmacy claims data files and provider data files to the APCD dated August 20111 version 3, which is hereby incorporated by reference.
Connecticut	Submission guide means the document published by the exchange that sets forth the data elements, formats, minimum thresholds and other specifications for reporting entities' submission of eligibility data files, medical claims data files, dental claims data files, pharmacy claims data files and provider files to the exchange. The submission guide is incorporated in these policies and procedures by reference.

APPENDIX B
Definitions for medical claims data file and medical claims file

STATE	DEFINITIONS
Colorado	Medical claims data file means a file that includes data about medical claims and other encounter information, according to the requirements contained in the submission guide.
Connecticut	Medical claims data file means a data file composed of service-level remittance information including, but not limited to, member demographics, provider information, charge and payment information and clinical diagnosis/procedure codes from all paid claims and encounters.
Maine	Medical claims file means a data file composed of service-level remittance information including, but not limited to, member demographics, provider information, charge/payment information and clinical diagnosis/procedure codes from all nondenied adjudicated claims for each billed service.
New Hampshire	Medical claims file means a data file composed of service-level remittance information for all nondenied adjudicated claims for each billed service including, but not limited to: (1) member demographics; (2) provider information; (3) charge/payment information; and (4) clinical diagnosis/procedure codes.
Oregon	Medical claims file means a data set composed of health care service-level remittance information for all adjudicated claims for each billed service including, but not limited to, member demographics, provider information, charge/payment information and clinical diagnosis/ procedure codes for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEBB group health insurance plan, or for services provided in Oregon.
Rhode Island	Medical claims file means all submitted and nondenied adjudicated claims for each billed service paid by an insurer as defined in §1.18 on behalf of a member as defined in §1.20 regardless of where the service was provided. This data file includes, but is not limited to, service-level remittance information including, but not limited to, member encrypted unique identifier, provider information, charge/payment information and clinical diagnosis/procedure codes as will be described further in the RIAPCD Technical Specification Manual.
Tennessee	Medical claims file means a data file composed of service-level remittance information for all nondenied adjudicated claims for each billed service including, but not limited to: (1) member demographics; (2) provider information; (3) charge/payment information; and (4) clinical diagnosis/procedure codes.
Vermont	Medical claims file means a data file composed of service-level remittance information for all nondenied adjudicated claims for each billed service including, but not limited to, member demographics, provider information, charge/payment information and clinical diagnosis/procedure codes, and must include all claims related to behavioral or mental health.

APPENDIX C
Definitions for pharmacy claims file

STATE	DEFINITIONS FOR PHARMACY CLAIMS FILE
Colorado	Pharmacy file means a file that includes data about medical claims and other encounter information, according to the requirements contained in the submission guide.
Connecticut	Pharmacy claims data file means a data file composed of service-level remittance information including, but not limited to, member demographics, provider information, charge/payment information and national drug codes from all paid claims for each prescription filled.
Maine	Pharmacy claims file means a data file composed of service-level remittance information including, but not limited to, member demographics, provider information, charge/payment information and national drug codes from all nondenied adjudicated claims for each prescription filled.
New Hampshire	Pharmacy claims file means a data file containing service-level remittance information from all nondenied adjudicated claims for each prescription including, but not limited to: (1) member demographics; (2) provider information; (3) charge/payment information; and (4) national drug codes.
Oregon	Pharmacy claims file means a data set containing service-level remittance information from all adjudicated claims including, but not limited to, enrolled member demographics, provider information, charge/payment information and national drug codes for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEBB group health insurance plan, or for services provided in Oregon.
Tennessee	Pharmacy claims file means a data file containing service-level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to: (1) member demographics; (2) provider information; (3) charge/payment information; and (4) national drug codes.
Vermont	Pharmacy claims file means a data file containing service-level remittance information from all nondenied adjudicated claims for each prescription including, but not limited to, member demographics, provider information, charge/payment information and national drug codes.

APPENDIX D
Definitions for dental claims file

STATE	DEFINITIONS FOR DENTAL CLAIMS FILE
Connecticut	Dental claims data file means a data file composed of service-level remittance information including, but not limited to, member demographics, provider information, charge/payment information and dental terminology codes from all paid claims and encounters.
Maine	Dental claims file means a data file composed of service-level remittance information including, but not limited to, member demographics, provider information, charge/payment information and current dental terminology codes from all nondenied adjudicated claims for each billed service.

APPENDIX E
Definitions for member eligibility file

STATE	DEFINITIONS FOR MEMBER ELIGIBILITY FILE
Colorado	Eligibility data file means a file that includes data about a person who receives health care coverage from a payer according to the requirements contained in the submission guide.
Connecticut	Eligibility data file means a data file composed of demographic information for each member who is eligible to receive medical, pharmacy or dental coverage provided or administered by a reporting entity for one or more days of coverage during the reporting period. Member means the subscriber or an individual on a subscriber's plan who is: (1) a Connecticut resident or (2) covered by a health plan issued in Connecticut in the individual or small group market, except to the extent that such health plan is grandfathered from the risk adjustment requirements of Section 1343 of the Patient Protection and Affordable Care Act. For purposes of this definition, a Connecticut resident is an individual whose address is within the state of Connecticut, regardless of where the service is provided or the state where coverage is issued. For the avoidance of doubt, any student enrolled in a student plan at a Connecticut college or university is a Connecticut resident.
Maine	Member eligibility file means a data file composed of demographic information for each individual member eligible for medical, pharmacy or dental insurance benefits for one or more days of coverage any time during the reporting month.
Massachusetts	Member eligibility file means a file that includes data about a person who receives health care coverage from a payer, including, but not limited to, subscriber and member identifiers; member demographics; race, ethnicity and language information; plan type; benefit codes; enrollment start and end dates; and behavioral and mental health, substance abuse and chemical dependency and prescription drug benefit indicators.
New Hampshire	Member eligibility file means a data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.
Oregon	Eligibility file means a data set containing demographic information for each individual enrolled member eligible for medical benefits for one or more days of coverage at any time during a calendar month for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEBB group health insurance plan, or for services provided in Oregon. Pharmacy eligibility file means a data set containing demographic information for each individual enrolled member eligible for pharmacy benefits for one or more days of coverage at any time during a calendar month for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEBB group health insurance plan, or for services provided in Oregon.
Tennessee	Member eligibility file means a data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.
Vermont	Member eligibility file means a data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.

APPENDIX F
Definitions for provider file

STATE	DEFINITIONS FOR PROVIDER FILE
Colorado	Provider file means a file that includes additional information about the individuals and entities that submitted claims that are included in the medical claims file and is submitted according to the requirements contained in the submission guide.
Connecticut	Provider file means a data file that includes additional information as set forth in the submission guide about the health care providers that are included in a medical claims data file or dental claims data file.
Maine	Provider means a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy. Service provider means the provider who directly performed or provided a health care service to a subscriber or member.
Oregon	Medical provider file means a data set containing information about health care providers providing health care services, equipment or supplies to enrolled members during the reporting period.

APPENDIX G
Form 1500, UB-04, EDI 837, Washington Labor and Industries Paper Claims

The health care industry uses two paper forms to submit claims manually: Form 1500 and UB-04. Form1500 is the universal claim form used by noninstitutional health care providers (private practices, etc.) to bill Medicare for Part B-covered services and some Medicaid-covered services, and is accepted by most health insurance providers. The Form 1500 is maintained by the National Uniform Claim Committee (NUCC) and has been updated to include national provider identifiers (NPIs), or unique numbers required by the Health Insurance Portability and Accountability Act (HIPAA). Form CMS-1500 contains all the basic information needed to submit an accurate claim. This includes fields for the patient's demographic information and insurance information, and boxes in which to provide medical codes and corresponding dates of service. Certain boxes are used exclusively for Medicare and/or Medicaid. Different payers may provide different instructions on how to complete a certain item.

Form UB-04, also maintained by the NUCC, is very similar to the CMS-1500, but is used by institutional health care providers, such as hospitals. Like the CMS-1500, the UB-04 is used in lieu of electronic claims when the facility meets any number of exceptions granted by the Administration Simplification Compliance Act (ASCA). It is also similar to the CMS-1500 in that certain payers may not require all fields, or data elements, to be completed.

Since processing paper claims requires more manual interaction with forms and data, the opportunity for human error increases compared to electronic claims. These errors are costly for the health care provider, often resulting in form resubmission (a time-consuming process) and payment delays.

Electronic Claims

Today, most health care claims are processed electronically using electronic data interchange (EDI)[20]. EDI is the transfer of data from one computer system to another by standardized message formatting, without the need for human intervention.

The EDI 837 transaction set is the format established to meet HIPAA requirements for the electronic submission of health care claim information. The 837 transaction set is divided into three groups: 837P for professionals, 837I for institutions and 837D for dental practices. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing and/or payment of health care services in a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists and pharmacies, and entities providing medical information to meet regulatory requirements.

Washington State Department of Labor and Industries

RCW 43.371.030 (1) requires the Washington State Department of Labor and Industries (L&I) [21] to submit claims data to the WA-APCD.

For paper claims processing, L&I uses Form 1500, UB-04 and forms specific to L&I, including:

- F245-100-000 Statement for Pharmacy Services
- F245-010-000 Statement for Compound Prescription
- F248-160-000 Statement for Home Nursing Services
- F245-072-000 Statement for Miscellaneous Services — includes claims for dental and glasses

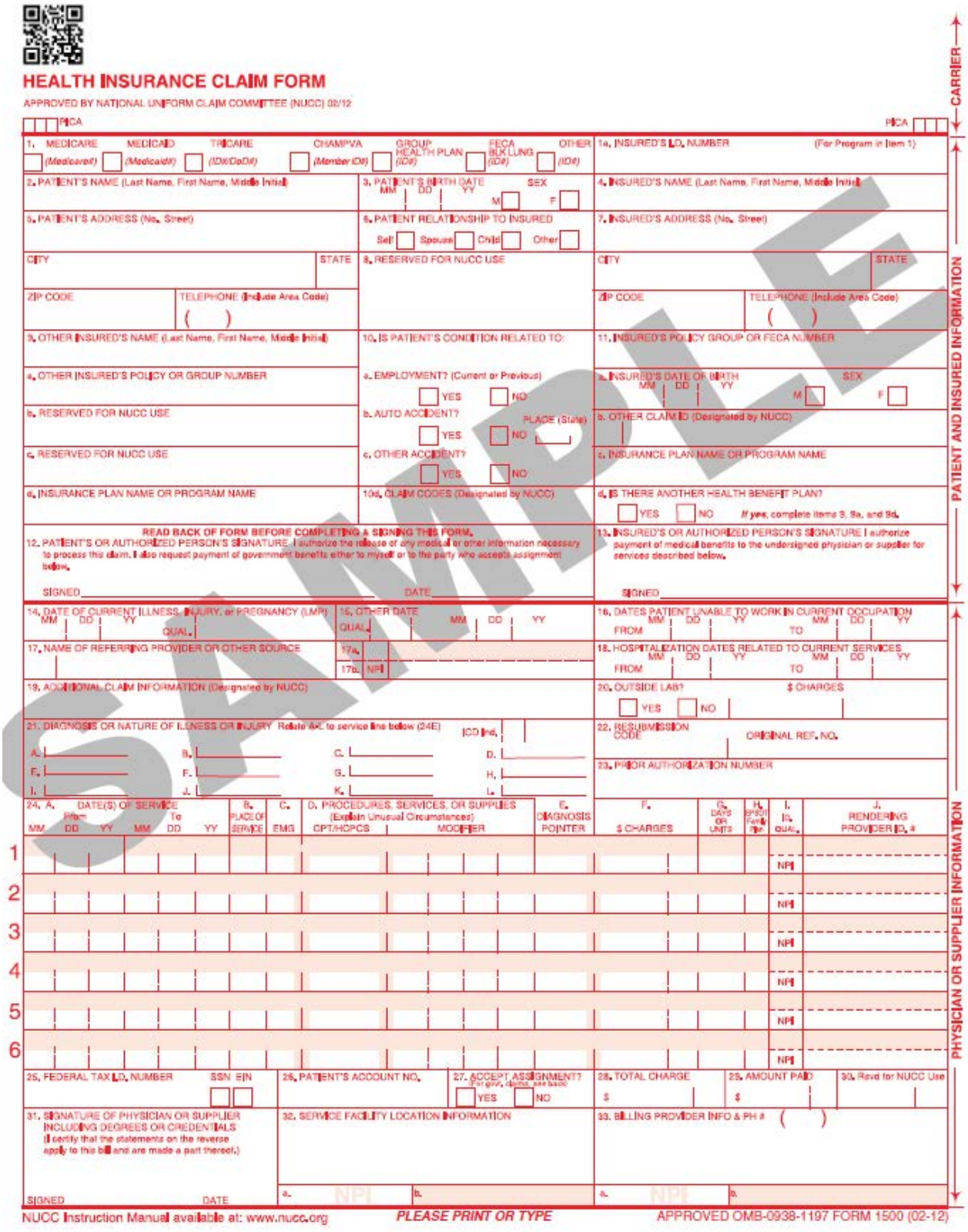
These forms and instructions for completing them are included in Appendix B.6, Pages 24–31.

For electronic data processing, L&I uses the EDI 837 transaction set, specifically EDI 837P and EDI 837I. L&I uses a cross reference from the EDI 837 transaction set to the L&I Medical Information Payment System.

[20] http://www.edibasics.com/what-is-edi/

[21] For more information on Labor and Industries, see http://www.lni.wa.gov/.

FORM 1500 FOR PAPER CLAIM PROCESSING



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

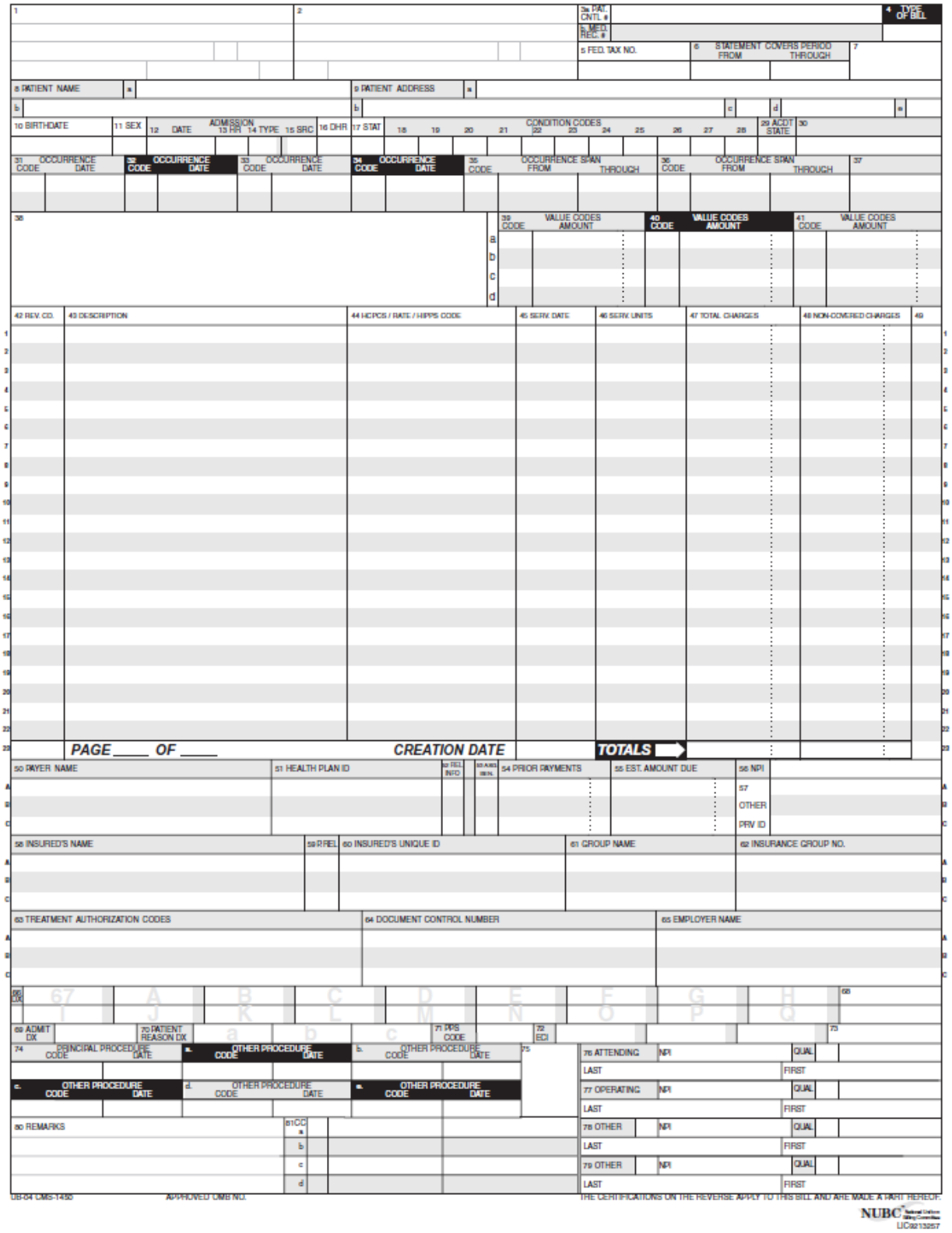
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

UB-04 FOR PAPER CLAIM PROCESSING



L&I F245-100-000 Statement for Pharmacy Services

Mail completed forms to:
Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

Statement For Pharmacy Services

- We do not reimburse for private insurance co-payments.
- Read the instructions on the back before you start. Please print clearly.
- When you submit this bill, you are certifying that the prescription information is correct.
- We must receive this statement within 12 months of the date of service or claim allowance.

Injured Worker Reimbursement:
Receipts are required for injured worker reimbursement. Did you attach your receipts? ☐ Yes ☐ No

Worker and Pharmacy Information:

		Worker's SSN (for ID only)	Claim number
Pharmacy name & physical address		Worker's name (Last, First, Middle Initial)	
		Worker's mailing address	
		City / State / Zip Code	
Pharmacy L&I provider number or NPI	DEA number	Pharmacy billing date	Employer name

Prescription Information:

Date Rx written	Prescribing provider name				Prescribing provider number
Prescription number	Date filled	Refill number	Days supply	Quantity	Dispense as written selection code (DAW 0,1, or 6)
National Drug Code		Drug name			Drug utilization review codes CNFLT: INTRV: OUTCM:
Remarks:				Prescription clarification code	Total Prescription Cost:

Date Rx written	Prescribing provider name				Prescribing provider number
Prescription number	Date filled	Refill number	Days supply	Quantity	Dispense as written selection code (DAW 0,1, or 6)
National Drug Code		Drug name			Drug utilization review codes CNFLT: INTRV: OUTCM:
Remarks:				Prescription clarification code	Total Prescription Cost:

Date Rx written	Prescribing provider name				Prescribing provider number
Prescription number	Date filled	Refill number	Days supply	Quantity	Dispense as written selection code (DAW 0,1, or 6)
National Drug Code		Drug name			Drug utilization review codes CNFLT: INTRV: OUTCM:
Remarks:				Prescription clarification code	Total Prescription Cost:

Injured Worker Signature:
These expenses are related to my worker's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Injured Worker name (please print) Injured Worker's signature

F245-100-000 Statement for Pharmacy Services 08-2014

RESET

Complete each section.

Injured Worker Reimbursement:

Did you attach your receipts?	Check the appropriate box for attaching receipt. Receipts are required for injured worker reimbursements. Send copies of the receipts only. Be sure to write your claim number on each receipt.

Worker Information:

Worker's social security number	Worker's social security number. Used to verify claim number.
Claim number	Claim number prescription should be billed to.
Worker's name	Worker's legal name in the last, first, middle initial format.
Worker's mailing address	Worker's mailing address (can be a PO Box).
Employer's name	Worker's employer at the time of injury.

Pharmacy Information:

Pharmacy name & address	Pharmacy name and physical location.
Pharmacy L&I provider number or NPI	Pharmacy's L&I provider number or L&I registered NPI.
NCPDC number	National Council for Prescription Drug Programs number.
Pharmacy billing date	Date prescription was filled.

Prescription Information:

Date Rx written	Date prescription was written.
Prescribing provider name	Prescribing provider's name.
Prescribing provider number	Give one of the following numbers for the prescription provider: L&I provider number; NPI; Washington state license number; or DEA number.
Prescription number	Prescription number.
Date filled	Date prescription filled.
Refill number	If the prescription is a refill, enter refill number (0-99). If original prescription, enter "0".
Days supply	Number of days supply. If the directions say "as needed" or has a dose range, estimate days supply using maximum dosage per day.
Quantity	Total units of medication prescribed. Use the NCPDP billing unit standard format such as "each", "ml", or "gm".
Dispense as written selection code	0 = no product selection mandated 1 = substitution not allowed by prescriber 6 = override for emergency supply. For instate pharmacies only when dispensing emergency supply of a non-preferred drug prescribed by a non-endorsing provider.
National Drug Code	National drug identification code. The code must be entered in a 5-4-2 format. For example, NDC code 0005-3250-23 should be entered 00005 3250 23. NDC code 50419 127 12 should be entered 501419 0127 12.
Drug name	Drug name.
Drug utilization review codes	Enter the appropriate conflict, intervention, and outcome codes.
Remarks	Pertinent information related to prescription.
Prescription clarification code	Enter appropriate value for a refill-too-soon.
Total prescription cost	Total cost of prescription.

Injured Worker Signature:

Injured worker signature	Injured worker signature is only required if the worker is requesting reimbursement.

Need more help or more information?

Go to www.Lni.wa.gov and click on Medical Providers or call the Preferred Drug Line at 888-443-6798.

Need more forms? Go to www.Lni.wa.gov and click on Get a Form or Publication.

F245-100-000 Statement for Pharmacy Services 08-2014

L&I F245- 010-000 STATEMENT FOR COMPOUND PRESCRIPTION

Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

Statement for Compound Prescription

- We do not reimburse for private insurance co-payments. Call 800-848-0811 for instructions.
- Read the instructions on the back before you start.
- When you submit this bill, you are certifying that the prescription information is correct.
- We must receive this statement within 12 months of the date of service or claim allowance.

☐ Request to reimburse the worker (Pharmacist signature required below)

		Worker's SSN (for ID only)	Claim number
Pharmacy name & physical address		Worker's name (Last, First, Middle Initial)	
		Worker's mailing address	
		City / State / Zip Code	
Pharmacy L&I provider number or NPI	DEA number	Pharmacy billing date	Employer name

Prescription Detail

Date Rx written	Prescribing provider name			Prescribing provider number or NPI	
Prescription number	Date filled	Refill number	Days supply	Quantity: Doses: / Grams: / Milliliters:	
Compound drug code: 00990000000	Total no. of ingredients	Dispense as written selection code (DAW 0,1, or 6)		Compounding time	
Rx filled for: ☐ Antibiotic IV therapy ☐ Pain cocktail ☐ Topical preparation ☐ Total parental nutrition ☐ Other therapy					
Drug cost: $	Dispensing fee: $	Professional fee: $	Total Rx cost: $		

Compound Itemization

If more than 10 drugs were used, attach additional itemization.

	NDC	Name	Strength	Quantity	Drug cost/unit	Drug cost
1.						$
2.						$
3.						$
4.						$
5.						$
6.						$
7.						$
8.						$
9.						$
10.						$

The injured worker has paid for the above services and prescriptions.

Pharmacist name (please print) _____ Pharmacist signature

F245-010-000 Statement for Compound Prescription 02-2014

RESET

Instructions for completing Statement for Compound Prescription

Pharmacy name & physical address	Enter the pharmacy name and physical address
Pharmacy L&I provider number or NPI	Enter the pharmacy's L&I provider or NPI
DEA number	Enter the pharmacy's DEA number
Worker's SNN	Enter the worker's social security number. This is used for ID only.
Claim number	Enter the worker's claim number.
Worker's name	Enter the worker's name.
Worker's mailing address	Enter the worker's mailing address.
Pharmacy billing date	Enter the date the pharmacy is billing the department.
Employer name	Enter the worker's employer's name.

Prescription Detail

Date Rx written	Enter the date the prescription was written.
Prescribing provider name	Enter the name of the prescribing provider's name.
Prescribing provider number	Enter the L&I provider number or NPI of the prescribing provider.
Prescription number	Enter the pharmacy's prescription number.
Date filled	Enter the date the prescription was filled.
Refill number	If the prescription is a refill, enter the refill number (0-99). If original prescription, enter "0".
Days supply	Enter the number of days supply. If the directions say "as needed" or has a dose range, estimate the days supply using maximum dosage per day.
Quantity	Total units of medication prescribed. Use the NCPDP billing unit standard form such as "each", "ml", or "gm".
Total no. of ingredients	The number NDC/UPC ingredients used in the prescription.
Dispense as written selection code	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed. Valid values: 0 = no product selection mandated 1 = substitution not allowed by prescriber 6 = override for emergency supply. For instate pharmacies only when dispensing emergency supply of a non-preferred drug prescribed by a non-endorsing provider.
Compounding time	Time required to combine the ingredients in the prescription. List in minutes.
Rx filled for	Check the appropriate box.
Drug cost	Total charge for the filled prescription.
Dispensing fee	The fee for services provided by the pharmacist.
Professional fee	Fee for compounding time.
Total Rx cost	Total charge for filled prescription (drug cost + professional fee + applicable tax).

Compound Itemization

Each column must be completed per line item.

Enter the NDC; name; strength; quantity (number of units supplied); drug cost/unit; and the total drug cost for each drug used.

If more than 10 drugs were used, attach additional itemization.

F245-010-000 Statement for Compound Prescription 02-2014

L&I F248-160-000 STATEMENT FOR HOME NURSING SERVICES

Mail completed forms to:
Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

STATEMENT FOR HOME NURSING SERVICES
Instructions on next page

Worker Information (Please print)

Name (Last, First, Middle Initial)			Claim No. / Date of injury
Home address (not PO Box)		Apt #	Social Security No. (for ID only)
City	State	ZIP	Phone no.

Provider Information (Please print)

Provider name			L&I provider number / NPI
Address			Federal Tax ID/Employer ID Number
City	State	ZIP	Phone no.
Name of referring physician or other source	Referring provider number/NPI		Referral ID

Billing Information
Is this bill to reimburse the injured worker? ☐ Yes (Receipt and signature required) ☐ No

From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Units	Hourly/ Day rate	Charges
									Total Charge	$

Worker Signature:
These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Signature (Required for worker reimbursement) Date

Provider Signature:
I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Signature Date

RESET

F248-160-000 Statement for Home Nursing Services 11-2013

Instructions for completing the Statement for Miscellaneous Services:

Worker Information:

Claim number	Give the worker's claim number.
Name	Write the worker's legal name in the last, first, middle initial format.
Date of injury	Date of injury.
Home address	Give the most current physical address of the worker.
Social Security Number	Write the worker's Social Security Number. Used to verify claim number only.
Phone number	Write the worker's phone number.

Provider Information:

L&I provider number	Give the provider's L&I provider number.
Provider name	Write the provider's name as registered with L&I.
Provider address	Write the provider's physical address.
NPI	Give the provider's NPI.
Federal Tax ID	Write the Federal Tax ID (EIN) for the billing provider. This must match the EIN on file with the agency.
Phone number	Give the phone number where the agency can call if there any questions about your bill.
Name of referring physician or other source	Write the name of the referring physician or other source for the services provided.
Referring provider number/NPI	Write the L&I provider number or NPI of the referring provider
Referral ID	Write the referral ID number.

Bill Information:

Is this bill to reimburse the injured worker?	Check the appropriate box. If this bill is to reimburse a worker, receipts are required. Send copies of your receipts. Receipts must be itemized and legible. No credit card slips.

Use one line for each service provided. Complete each applicable field.

From date of service	Starting date of service.
To date of service	Ending date of service.
POS	Place of service. See the list below for the appropriate two-digit code.
Proc Code	Procedure code.
Mod	Modifier code if applicable.
Diagnosis	Diagnosis code. Enter the primary diagnosis code for each service.
Description	Give a brief description of services provided.
Units	Enter the number of units for service.
Charges	Enter the charge for each service provided.
Total charges	Enter the total charges for your bill.

Place of Service Codes

03. School
04. Homeless shelter
05. Indian Health Service free-standing facility
06. Indian Health Service provider-based facility
07. Tribal 638 free-standing facility
08. Tribal 638 provider-based facility
09. Correctional facility
11. Office
12. Patient's home
14. Group home
15. Mobile unit
16. Temporary lodging
17. Walk-in retail health center
20. Urgent care facility
21. Inpatient hospital
22. Outpatient hospital
23. Emergency room - hospital
24. Ambulatory surgical center
25. Birthing center
26. Military treatment facility
31. Skilled nursing facility
32. Nursing facility
33. Custodial care facility
34. Hospice
41. Ambulance - land
42. Ambulance - air or water
49. Independent clinic rehabilitation facility
50. Federally qualified hlth ctr
51. Inpatient psychiatric facility
52. Psychiatric facility partial hospitalization
53. Community mental health ctr
54. Intermediate care facility/mentally retarded
55. Residential substance abuse trmt center
56. Psychiatric residential trmt ctr
57. Non-residential substance abuse treatment center
60. Mass immunization center
61. Comprehensive inpatient rehabilitation facility
62. Comprehensive outpatient
65. End stage renal disease treatment facility
71. State or local public health clinic
72. Rural health clinic
81. Independent laboratory
99. Other unlisted facility

L&I F245-072-000 STATEMENT FOR MISCELLANEOUS SERVICES

Mail completed forms to:
Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

STATEMENT FOR MISCELLANEOUS SERVICES
Instructions on next page

Type of Service:
☐ Dental Service ☐ Glasses ☐ Home Health / Nursing Home ☐ Medical Equipment/ Prosthetics-Orthotics
☐ Transportation ☐ Vocational/Retraining ☐ Other:

Worker Information (Please print)

Name (Last, First, Middle Initial)			Claim No. / Date of injury
Home address (not PO Box)	Apt #		Social Security No. (for ID only)
City	State	ZIP	Phone no.

Provider Information (Please print)

Provider name			L&I provider number/NPI / Your Patient Account Number
Address			Federal Tax ID/Employer ID Number
City	State	ZIP	Phone no.
Name of referring physician or other source	Referring provider number/NPI		Referral ID

Billing Information

Is this bill to reimburse the injured worker?
☐ Yes (Receipt and signature required) ☐ No

For glasses, is the old prescription available?
☐ Yes ☐ No

For inpatient services:
Date admitted: Date discharged:

From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing: No. of hrs/day	Home Nursing: Hourly/ Day rate	Charges	Units

Total Charge
$

Worker Signature:
These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Signature (Required for worker reimbursement) Date

Provider Signature:
I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Signature Date

F245-072-000 Statement for Miscellaneous Services 01-2014

RESET

Instructions for completing the Statement for Miscellaneous Services:

Type of Service:
Check the appropriate box for the type of service for which you are billing. If your type of service is not listed, check the "Other" box and list the type of service you provided.

Worker Information:

Claim number	Give the worker's claim number.
Name	Write the worker's legal name in the last, first, middle initial format.
Date of injury	Date of injury.
Home address	Give the most current physical address of the worker.
Social Security Number	Write the worker's Social Security Number. Used to verify claim number only.
Phone number	Write the worker's phone number.

Provider Information:

L&I provider number/NPI	Give the provider's L&I provider number or provider's NPI.
Provider name	Write the provider's name as registered with L&I.
Provider address	Write the provider's physical address.
Your Patient Account Number	Write the number you use to identify your patient's account. This field is optional and not used by L&I.
Federal Tax ID	Write the Federal Tax ID (EIN) for the billing provider. This must match the EIN on file with the agency.
Phone number	Give the phone number where the agency can call if there any questions about your bill.
Name of referring physician or other source	Write the name of the referring physician or other source for the services provided.
Referring provider number/NPI	Write the L&I provider number or NPI of the referring provider
Referral ID	Write the referral ID number.

Bill Information:

Is this bill to reimburse the injured worker?	Check the appropriate box. If this bill is to reimburse a worker, receipts are required. Send copies of your receipts. Receipts must be itemized and legible. No credit card slips.
For glasses, is the old prescription available?	Check the appropriate box.
For inpatient services	Write date of admission and the date of discharge in the mm/dd/yy format.

Use one line for each service provided. Complete each applicable field.

From date of service	Starting date of service.
To date of service	Ending date of service.
POS	Place of service. See the list below for the appropriate two-digit code.
Proc Code	Procedure code.
Mod	Modifier code if applicable.
Diagnosis	Diagnosis code. Enter the primary diagnosis code for each service.
Description	Give a brief description of services provided.
Dental tooth number	Tooth number dental services were provided for.
Home nursing	Give the number of hours you are billing for. Give your hourly or daily rate for your services.
Charges	Enter the charge for each service provided.
Units	Enter the number of units for service.

Place of Service Codes

03. School
04. Homeless shelter
05. Indian Health Service free-standing facility
06. Indian Health Service provider-based facility
07. Tribal 638 free-standing facility
08. Tribal 638 provider-based facility
09. Correctional facility
11. Office
12. Patient's home
14. Group home
15. Mobile unit
16. Temporary lodging
17. Walk-in retail health center
20. Urgent care facility
21. Inpatient hospital
22. Outpatient hospital
23. Emergency room - hospital
24. Ambulatory surgical center
25. Birthing center
26. Military treatment facility
31. Skilled nursing facility
32. Nursing facility
33. Custodial care facility
34. Hospice
41. Ambulance - land
42. Ambulance - air or water
49. Independent clinic rehabilitation facility
50. Federally qualified hlth ctr
51. Inpatient psychiatric facility
52. Psychiatric facility partial hospitalization
53. Community mental health ctr
54. Intermediate care facility/mentally retarded
55. Residential substance abuse trmt center
56. Psychiatric residential trmt ctr
57. Non-residential substance abuse treatment center
60. Mass immunization center
61. Comprehensive inpatient rehabilitation facility
62. Comprehensive outpatient
65. End stage renal disease treatment facility
71. State or local public health clinic
72. Rural health clinic
81. Independent laboratory
99. Other unlisted facility

F245-072-000 Statement for Miscellaneous Services 01-2014

REFERENCES

1. **Colorado**
   Statute:
   http://www.leg.state.co.us/CLICS/CLICS2010A/csl.nsf/fsbillcont3/7772EFE1E998E627872576B700617FA4?Open&file=1330_enr.pdf
   Rule: http://www.civhc.org/getmedia/2a315773-cbcd-4f75-805a-759d3cf96888/Rules-Governing-Data-Submissions-to-APCD-2011-08-24.pdf.aspx/

2. **Connecticut**
   Statute: http://www.cga.ct.gov/2012/ACT/Pa/pdf/2012PA-00166-R00HB-05038-PA.pdf

3. **Maine**
   Statute: http://www.mainelegislature.org/legis/statutes/22/title22sec8703.html
   Rule: https://mhdo.maine.gov/claims.htm

4. **Massachusetts**
   Statute: http://chiamass.gov/relevant-regulations-5
   Rule: http://chiamass.gov/assets/docs/g/chia-regs/957-8.pdf

5. **Oregon**
   Statute: http://www.oregon.gov/oha/ohpr/Pages/Statutes-Health%20Care%20Data%20Reporting.aspx

   Rule: http://www.oregon.gov/oha/OHPR/rulemaking/notices/409-025_PermComplete_2.1.13.pdf

6. **Tennessee**
   Statute: http://state.tn.us/sos/acts/106/pub/pc0611.pdf
   Rule: http://www.state.tn.us/sos/rules/0780/0780-01/0780-01-79.20100908.pdf

7. **Vermont**
   Statute:
   http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=221&Section=09410
   Rule: http://gmcboard.vermont.gov/sites/gmcboard/files/REG_H-2008-01.pdf