Part 3.K.3 — Reporting: Detailed claims file

The Contractor shall provide to PEBA and/or its designated representative a detailed paid claims transaction file that is transmitted weekly, in a secure manner, to PEBA and PEBA's data warehouse contractor within seventy-two (72) hours following request for payment to PEBA. The Contractor may be required to modify the contents of this paid claims file to reflect any changes made by PEBA to the Plan. The Contractor shall provide all ICD-10 diagnosis and procedure codes captured during adjudication (maximum of twenty-four ICD codes per claim), including Present on Admission (POA) indicators where available. The Contractor shall supply all digits of any ICD classification captured during the claim adjudication process. The file shall include, at a minimum, the following fields:

a. Subscriber SSN
b. Subscriber BIN
c. Subscriber first name
d. Subscriber last name
e. Subscriber middle initial
f. Enrolled plan code (i.e. Savings Plan, Standard Plan, Medicare Supplemental Plan, MUSC Health Plan)
g. Accounting structure (i.e. PEBA group code, division, internal accounting)
h. Patient SSN
i. Patient first name
j. Patient last name
k. Patient middle initial
l. Patient date of birth
m. Patient relationship to the insured
n. Patient gender
o. Pay to provider identifier
p. Pay to provider NPI
q. Pay to provider name
r. Pay to Provider Specialty
s. Pay to provider zip code
t. Rendering provider identifier
u. Rendering provider NPI
v. Rendering provider name
w. Rendering provider specialty
x. Rendering provider zip code
y. Source of Admission
z. Referring provider identifier (if applicable)
aa. Referring provider NPI (if applicable)
bb. Referring provider name (if applicable)
cc. Referring provider specialty (if applicable)
dd. Referring provider zip code (if applicable)
ee. CPT4 code (if applicable)

ff. CPT4 code modifier 1 (if applicable)
gg. CPT4 code modifier 2 (if applicable)
hh. HCPCS code (if applicable)
ii. HCPCS code modifier 1 (if applicable)
jj. HCPCS code modifier 2 (if applicable)
kk. NDC code (if available and required for all physician administered medications including "dump" codes)
ll. NDC description
mm. Revenue code (if applicable)
nn. UB-04 bill type
oo. DRG Code (if applicable)
pp. Discharge status (if applicable)
qq. APC code (if applicable)
rr. APC payment status code (if applicable)
ss. Claim identification
tt. Claim status (i.e. original submission, positive adjustment, negative adjustment, denied)
uu. Claim adjustment reason
vv. Payment methodology (i.e. DRG, APC, Fee Schedule)
ww. In-network indicator
xx. Fee schedule
yy. Precertification approval
zz. Precertification approval days
aaa. Precertification assessment indicator
bbb. Date of service
ccc. Date claim was paid
ddd. Beginning date of service
eee. Ending date of service
fff. Admission date (if applicable)
ggg. Discharge date (if applicable)
hhh. Claim processed date
iii. Claim received date
jjj. Admission ICD-10 diagnosis (if available)
kkk. Admission ICD-10 POA indicator (if available)
lll. ICD-10 diagnosis codes (primary through twenty-four)
mmm. ICD-10 POA indicator (primary through twenty-four)
nnn. ICD-10 procedure code (primary through ten)
ooo. ICD-10 procedure code date (primary through ten)
ppp. Place of service
qqq. Place of treatment (CMS definitions)
rrr. Type of service
sss. Units of service
ttt. Metric quantity (if physician administered medication)
uuu. Submitted charge
vvv. Not covered amount

www. Not covered reason
xxx. Discount amount
yyy. Medicare/COB indicator
zzz. Medicare covered
aaaa. Medicare paid
bbbb. Other insurance paid
cccc. Plan allowed amount
dddd. Deductible
eeee. Coinsurance
ffff. Copayment
gggg. Per occurrence deductible (if applicable)
hhhh. Plan payment