

§9701. Definitions.

The following definitions apply in this article:

(a) Bona Fide Statistical Research. The analysis of existing workers' compensation data for the purpose of developing or contributing to basic knowledge regarding the California workers' compensation system.

(b) California EDI Implementation Guide for First and Subsequent Reports of Injury. Contains California specific reporting requirements and information excerpted from the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, by the International Association of Industrial Accident Boards and Commissions. The California EDI Implementation Guide for First and Subsequent Reports of Injury is posted on the Division's Web site at <http://www.dir.ca.gov/dwc/WCIS.htm>, and is available from the Division of Workers' Compensation upon request.

(1) For reporting prior to November 15, 2011, use the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 2.1, dated February 2006, which is incorporated by reference.

(2) For reporting on or after November 15, 2011, use the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 3.0, dated November 15, 2011, which is incorporated by reference.

(c) California EDI Implementation Guide for Medical Bill Payment Records. Contains the California-specific protocols and excerpts from the IAIABC EDI Implementation Guide for Medical Bill Payment Records, explains the technical design and functionality of the WCIS system, testing options for the trading partners, instructions regarding the medical billing data elements, and reporting standards and requirements. The California EDI Implementation Guide for Medical Bill Payment Records is posted on the Division's Web site at <http://www.dir.ca.gov/dwc/WCIS.htm>, and is available from the Division of Workers' Compensation upon request.

~~(1) For reporting prior to November 15, 2011, use the California EDI Implementation Guide for Medical Bill Payment Records, Version 1.0, dated December 2005, which is incorporated by reference.~~

~~(21) For reporting on or after prior to November 15, 2011 _____ (OAL to insert date twelve months after date of filing approved regulation with the Secretary of State), use the California EDI Implementation Guide for Medical Bill Payment Records, Version 1.1, dated November 15, 2011, which is incorporated by reference.~~

~~(32) For reporting on or after _____ (OAL to insert date twelve months after date of filing approved regulation with the Secretary of State), use the California EDI Implementation Guide for Medical Bill Payment Records, Version 2.0~~

Dated _____ (OAL to insert date twelve months after date of filing approved regulation with the Secretary of State), which is incorporated by reference. This Guide adopts ASC (Accredited Standards Committee) X12 Implementation Acknowledgement for Health Care insurance (999) dated February 2011.

(d) California Jurisdiction Code. A California-specific code that identifies a medical procedure, service, or product that is not identified by a current HCPCS code. California Jurisdiction Codes are either set forth and/or incorporated by reference in California Code of Regulations, title 8, section 9795, regarding reasonable fees for medical-legal expenses, section 9789.11, regarding fees for physician services rendered on or after July 1, 2004 and before January 1, 2014, sections 9789.12.1-9789.19, regarding fees for physician services rendered on or after January 1, 2014, or in California EDI Implementation Guide for Medical Bill Payment, Release 1.1.2.0, Section IX, subsections entitled "Lump sum bundled lien bill payment" and "Lump sum lien bills data elements," regarding medical lien lump sum payments or settlements. The California EDI Implementation Guide for Medical Bill Payment, Release 2.0 is incorporated by reference in subdivision (e)(2). Section 9789.11, regarding fees for physician services rendered on or after July 1, 2004, or in section 9702(e), footnote 13, regarding medical lien lump sum payments or settlements.

(e) Claim. An injury as defined in Division 4 of the Labor Code, occurring on or after March 1, 2000, that has resulted in the receipt of one or more of the following by a claims administrator:

- (1) Employer's Report of Occupational Injury or Illness, as required by California Code of Regulations, title 8, sections 14004-14005.
- (2) Doctor's First Report of Occupational Injury or Illness, as required by California Code of Regulations, title 8, sections 14006-14007.
- (3) Application for Adjudication filed with the Workers' Compensation Appeals Board under Labor Code section 5500 and California Code of Regulations, title 8, section 10408.
- (4) Any information indicating that the injury requires medical treatment by a physician as defined in Labor Code section 3209.3.

(f) Claims Administrator. A self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, California Insurance Guarantee Association (CIGA), or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(g) Claims Administrator's Agents. Any entity contracted by the claims administrator to assist in adjusting the claim(s) including third party administrators, bill reviewers, utilization review vendors, and electronic data interchange vendors.

(h) Closed Claim. A claim in which future payment of indemnity benefits and/or provision of medical benefits cannot be reasonably expected to be due.

(i) Data Elements. Information identified by data number (DN) and defined in the dictionary of the IAIABC EDI Implementation Guide, Release 1. Data elements set forth in California Code of Regulations, title 8, section 9702 must be transmitted on all claims, where applicable, as indicated in section 9702. The data elements set forth in the IAIABC EDI Implementation Guide, Release 1 that are not enumerated in section 9702 are optional and may, but need not be, submitted on any or all claims.

(j) Electronic Data Interchange. ("EDI"). A computer to computer exchange of data or information in a standardized format acceptable to the Administrative Director.

(k) Health Care Organization ("HCO"). Any entity certified as a health care organization by the Administrative Director pursuant to Labor Code sections 4600.5 and 4600.6.

(l) HCPCS. Acronym for the Healthcare Common Procedure Coding System.

(m) IAIABC EDI Implementation Guide, Release 1. EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, by the International Association of Industrial Accident Boards and Commissions. The IAIABC EDI Implementation Guide, Release 1, can be obtained from the IAIABC at either the IAIABC website at <http://www.iaiacb.org>, or the IAIABC office located at 5610 Medical Circle, Suite 24, Madison, WI, 53719-1295; Telephone: (608) 663-6355.

(n) IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0, IAIABC EDI Implementation Guide for Medical Bill Payment Records by the International Association of Industrial Accident Boards and Commissions. ~~The IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1, can be obtained from the IAIABC at either the IAIABC website at <http://www.iaiacb.org>, or the IAIABC office located at 5610 Medical Circle, Suite 24, Madison, WI, 53719-1295; Telephone: (608) 663-6355.~~ The IAIABC EDI Implementation Guide for Medical Bill Payment Records Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2013~~4~~ can be obtained from the IAIABC at either the IAIABC website at <http://www.iaiacb.org>, or the IAIABC office located at 5610 Medical Circle, Suite 24, Madison, WI, 53719-1295; Telephone: (608) 663-6355.

(1) ~~For reporting prior to November 15, 2011, use the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1, July 4, 2002, which is incorporated by reference. For reporting prior to the designated effective date (see subdivision (c)(1)), use the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009, which is incorporated by reference.~~

(2) For reporting on or after the designated effective date (see subdivision(c)(2)), use the IAIABC EDI Implementation Guide for Medical Bill Payment Records Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0, dated February 1, 2014 which is incorporated by reference. ~~November 15, 2011, use the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009, which is incorporated by reference.~~

(o) Indemnity Benefits. Payments conferred, including those made by settlement, for any of the following: temporary disability indemnity, permanent disability indemnity, death benefits, vocational rehabilitation maintenance allowance, and employer-paid salary in lieu of compensation.

(p) Individually Identifiable Information. Any data concerning an injury or claim that is linked to a uniquely identifiable employee, employer, claims administrator, or any other person or entity.

(q) International Association of Industrial Accident Boards and Commissions ("IAIABC"). A professional association of workers' compensation specialists, located at 5610 Medical Circle, Suite 24, Madison, Wisconsin 53719-1295, which is, in addition to other activities, engaged in the production and publication of EDI standards for filing workers' compensation information. Note: IAIABC asserts ownership of such EDI standards which are published in various ways and include Implementation Guides with instructions on their use, technical and business specifications and coding information to permit the transfer of data between regulatory bodies and regulated entities in a uniform and consistent manner.

(r) WCIS. The Workers' Compensation Information System established pursuant to sections 138.6 and 138.7 of the Labor Code.

Authority: Sections 133, 138.6 and 138.7, Labor Code.

Reference: Sections 138.6 and 138.7, Labor Code.

§ 9702. Electronic Data Reporting

(a) Each claims administrator shall transmit data elements, by electronic data interchange in the manner set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records, to the WCIS by the dates specified in this section. Each claims administrator shall, at a minimum, provide complete, valid, accurate data for the data elements set forth in this section. The data elements required in subdivisions (b), (c), (d) and (e) are taken from California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records. Claims administrators shall only transmit the data elements that are set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records. Each transmission of data elements shall include appropriate header and trailer records as set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records.

~~(1) — The Administrative Director, upon written request, may grant a claims administrator either a partial or total variance in reporting all or part of the data elements required pursuant to subdivision (e) of this section. Any variance granted by the Administrative Director under this subdivision shall be set forth in writing.~~

~~(A) — A partial variance requested on the basis that the claims administrator is unable to transmit some of the required data elements to the WCIS shall be granted for a six month period only if all of the following are shown:~~

- ~~1. — a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;~~
- ~~2. — a documented showing that any medical data elements currently being transmitted by the claims administrator or the claims administrator's agent to public or private research or statistical entities shall be reported by the claims administrator to the WCIS ; and~~
- ~~3. — submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the request.~~

~~(B) — A partial variance requested on the basis that the claims administrator is unable to report some of the required data elements to the WCIS because the data elements are not available to the claims administrator or the claims administrator's agent shall be granted for a six month period only if all of the following are shown:~~

1. ~~— a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;~~
2. ~~— a documented showing that any medical data elements currently being transmitted by the claims administrator or the claims administrator’s agent to public or private research or statistical entities shall be reported by the claims administrator to the WCIS;~~
3. ~~— a documented showing that the claims administrator will submit to the WCIS the medical data elements available to the claims administrator or the claims administrator’s agents; and~~
4. ~~— submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the request.~~

~~(C) — A total variance shall be granted for a twelve month period if all of the following are shown:~~

1. ~~— a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;~~
2. ~~— a documented showing that the claims administrator has not contracted with a bill review company to review medical bills submitted by providers in its workers’ compensation claims;~~
3. ~~— a documented showing that the claims administrator is unable to transmit medical data to public or private research or statistical entities; and~~
4. ~~— submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within twelve months from the request.~~

~~(2) — “Undue hardship” shall be determined based upon a review of the documentation submitted by the claims administrator. The documentation shall include: the claims administrator’s total required expenses; the reporting cost per claim if transmitted in house; and the total cost per claim if reported by a vendor. The costs and expenses shall be itemized to reflect costs and expenses related to reporting the data elements listed in subdivision (e) only.~~

~~(3) — The variance period for reporting data elements under subdivisions (a)(1)(A) and (B) shall not be extended. The variance period for reporting data elements under subdivision (a)(1)(C) may be extended for additional twelve month periods if the claims administrator resubmits a written request for a variance. A claims administrator granted a variance shall submit to the WCIS all data elements that were required to be submitted under subdivision (e) during the variance period except for data elements that were not known to the claims administrator, the claims administrator’s agents, or not captured on~~

~~the claims administrator's electronic data systems. The data shall be submitted in an electronic format acceptable to the Division.~~

(b) Each claims administrator shall submit to the WCIS on each claim, within ten (10) business days of knowledge of the claim, each of the following data elements known to the claims administrator:

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|--------------------------------------|----|
| DATA ELEMENT NAME | DN |
| ACCIDENT DESCRIPTION /CAUSE | 38 |
| CAUSE OF INJURY CODE | 37 |
| CLAIM ADMINISTRATOR ADDRESS LINE 1 | 10 |
| CLAIM ADMINISTRATOR ADDRESS LINE 2 | 11 |
| CLAIM ADMINISTRATOR CITY | 12 |
| CLAIM ADMINISTRATOR CLAIM NUMBER | 15 |
| CLAIM ADMINISTRATOR POSTAL CODE | 14 |
| CLAIM ADMINISTRATOR STATE | 13 |
| CLASS CODE (3) | 59 |
| DATE DISABILITY BEGAN | 56 |
| DATE LAST DAY WORKED | 65 |
| DATE OF HIRE (1) | 61 |
| DATE OF INJURY | 31 |
| DATE OF RETURN TO WORK | 68 |
| DATE REPORTED TO CLAIM ADMINISTRATOR | 41 |
| DATE REPORTED TO EMPLOYER | 40 |
| EMPLOYEE ADDRESS LINE 1 (1) | 46 |
| EMPLOYEE ADDRESS LINE 2 (1) | 47 |
| EMPLOYEE CITY (1) | 48 |
| EMPLOYEE DATE OF BIRTH | 52 |
| EMPLOYEE DATE OF DEATH | 57 |
| EMPLOYEE FIRST NAME | 44 |
| EMPLOYEE LAST NAME | 43 |
| EMPLOYEE MIDDLE INITIAL (1) | 45 |
| EMPLOYEE PHONE (1) | 51 |
| EMPLOYEE POSTAL CODE (1) | 50 |
| EMPLOYEE STATE (1) | 49 |
| EMPLOYER ADDRESS LINE 1 | 19 |
| EMPLOYER ADDRESS LINE 2 | 20 |
| EMPLOYER CITY | 21 |
| EMPLOYER FEIN | 16 |
| EMPLOYER NAME | 18 |
| EMPLOYER POSTAL CODE | 23 |
| EMPLOYER STATE | 22 |
| EMPLOYMENT STATUS CODE (1) | 58 |
| GENDER CODE | 53 |
| INDUSTRY CODE | 25 |
| INITIAL TREATMENT CODE | 39 |
| INSURED REPORT NUMBER | 26 |
| INSURER FEIN | 6 |
| INSURER NAME | 7 |
| JURISDICTION | 4 |

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| MAINTENANCE TYPE CODE | 2 |
| MAINTENANCE TYPE CODE DATE | 3 |
| MARITAL STATUS CODE (2) | 54 |
| NATURE OF INJURY CODE | 35 |
| NUMBER OF DEPENDENTS (2) | 55 |
| OCCUPATION DESCRIPTION | 60 |
| PART OF BODY INJURED CODE | 36 |
| POLICY EFFECTIVE DATE | 29 |
| POLICY EXPIRATION DATE | 30 |
| POLICY NUMBER | 28 |
| POSTAL CODE OF INJURY SITE | 33 |
| SALARY CONTINUED INDICATOR | 67 |
| SELF INSURED INDICATOR | 24 |
| SOCIAL SECURITY NUMBER (4 4) | 42 |
| THIRD PARTY ADMINISTRATOR FEIN | 8 |
| THIRD PARTY ADMINISTRATOR NAME | 9 |
| TIME OF INJURY | 32 |
| WAGE (1) | 62 |
| WAGE PERIOD (1) | 63 |
| (1) Required only when provided to the claims administrator. | |
| (2) Death Cases Only. | |
| (3) Required for insured claims only; optional for self-insured claims. | |
| (4) If the Social Security Number (DN 42) is not known, use a string of eight zeros followed by a six. | |

Data elements omitted under this subsection because they were not known by the claims administrator shall be submitted within sixty (60) days from the date of the first report under this subsection.

(c) Each transmission of data elements listed under subdivisions (b), (d), (e), (f), or (g) of this section shall also include the following elements for data linkage:

| | |
|---|----|
| DATA ELEMENT NAME | DN |
| AGENCY/JURISDICTION CLAIM NUMBER (2) (3) (4) | 5 |
| CLAIM ADMINISTRATOR CLAIM NUMBER (2) (3) (4) | 15 |
| DATE OF INJURY (3) | 31 |
| INSURER FEIN (4) | 6 |
| JURISDICTION (1) | 4 |
| MAINTENANCE TYPE CODE (1) | 2 |
| MAINTENANCE TYPE CODE DATE (1) | 3 |
| SOCIAL SECURITY NUMBER (3) | 42 |
| THIRD PARTY ADMINISTRATOR FEIN (4) | 8 |
| TRANSACTION SET ID (1) | 1 |
| (1) Jurisdiction (DN 4), Maintenance Type Code (DN 2), Maintenance Type Code Date (DN 3), and Transaction Set ID (DN 1) are required for transmissions under subdivisions (b), (d), (f), and (g). | |
| (2) The Agency/Jurisdiction Claim Number (DN 5) will be provided by WCIS upon receipt of the first report under subdivision (b). The | |

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| <p>Agency/Jurisdiction Claim Number (DN 5) is required when changing a Claim Administrator Claim Number (DN 15); it is optional for other transmissions under this subsection.</p> <p>(3) The Date of Injury (DN 31), Social Security Number (DN 42), and Claim Administrator Claim Number (DN 15) need not be submitted if the Agency/Jurisdiction Claim Number (DN 5) accompanies the transmission, except for transmissions required under Subsection (f). If the Social Security Number (DN 42) is not known, use a string of eight zeros followed by a six.</p> <p>(4) If the Agency/Jurisdiction Claim Number (DN 5) is not provided, trading partners must provide the Claim Administrator Claim Number (DN 15) and the Third Party Administrator FEIN (DN 8), or, if there is no third party administrator, the Insurer FEIN (DN 6).</p> | |
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(d) Each claims administrator shall submit to the WCIS within fifteen (15) business days the following data elements, whenever indemnity benefits of a particular type and amount are started, changed, suspended, restarted, stopped, delayed, or denied, or when a claim is closed or reopened, or when the claims administrator is notified of a change in employee representation. Submissions under this subsection are required only for claims with a date of injury on or after July 1, 2000, and shall not include data on routine payments made during the course of an uninterrupted period of indemnity benefits.

| DATA ELEMENT NAME | DN |
|--|----|
| BENEFIT ADJUSTMENT CODE | 92 |
| BENEFIT ADJUSTMENT START DATE | 94 |
| BENEFIT ADJUSTMENT WEEKLY AMOUNT | 93 |
| CLAIM ADMINISTRATOR POSTAL CODE | 14 |
| CLAIM STATUS | 73 |
| CLAIM TYPE | 74 |
| DATE DISABILITY BEGAN | 56 |
| DATE OF MAXIMUM MEDICAL IMPROVEMENT | 70 |
| DATE OF REPRESENTATION | 76 |
| DATE OF RETURN/ RELEASE TO WORK | 72 |
| EMPLOYEE DATE OF DEATH | 57 |
| INSURED REPORT NUMBER | 26 |
| LATE REASON CODE | 77 |
| NUMBER OF BENEFIT ADJUSTMENTS | 80 |
| NUMBER OF DEATH DEPENDENT/PAYEE RELATIONSHIPS | 82 |
| NUMBER OF DEPENDENTS | 55 |
| NUMBER OF PAID TO DATE/REDUCED EARNINGS/RECOVERIES | 81 |
| NUMBER OF PAYMENTS/ADJUSTMENTS | 79 |
| NUMBER OF PERMANENT IMPAIRMENTS | 78 |
| PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES AMOUNT | 96 |
| PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES CODE | 95 |
| PAYMENT/ADJUSTMENT CODE | 85 |
| PAYMENT/ADJUSTMENT DAYS PAID | 91 |
| PAYMENT/ADJUSTMENT END DATE | 89 |
| PAYMENT/ADJUSTMENT PAIDTO DATE | 86 |
| PAYMENT/ADJUSTMENT START DATE | 88 |

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| PAYMENT/ADJUSTMENT WEEKLY AMOUNT | 87 |
| PAYMENT/ADJUSTMENT WEEKS PAID | 90 |
| PERMANENT IMPAIRMENT BODY PART CODE (1) (2) | 83 |
| PERMANENT IMPAIRMENT PERCENTAGE (2) | 84 |
| RETURN TO WORK QUALIFIER | 71 |
| SALARY CONTINUED INDICATOR | 67 |
| WAGE | 62 |
| WAGE PERIOD | 63 |
| (1) May use Code 90 (Multiple Body Parts) to reflect combined rating for any/all impairments. | |
| (2) Use actual permanent disability rating at the time of initial payment of permanent disability benefits. For compromise and release cases and stipulated settlements, use permanent disability estimate as reported to the appropriate rating organization established under Insurance Code § 11750, et seq. | |

(e) ~~On and after September 22, 2006, eClaims administrators handling one hundred and fifty (150) or more total claims per year shall submit to the WCIS on each claim with a date of service on or after September 22, 2006, the following data elements for all medical services for which the claims administrator has received a billing or other report of provided medical services. The California EDI Implementation Guide for Medical Bill Payment Records sets forth the specific California reporting requirements. The data elements required in this subdivision are taken from California EDI Implementation Guide for Medical Bill Payment Records and the IAIABC EDI Implementation Guide for Medical Bill Payment Records. The claims administrator shall submit the data within ninety (90) calendar days of the medical bill payment or the date of the final determination that payment for billed medical services will be denied. Each claims administrator shall transmit the data elements by electronic data interchange in the manner set forth in the California EDI Implementation Guide for Medical Bill Payment Records and the IAIABC EDI Implementation Guide for Medical Bill Payment Records.~~

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|--|--------------------------------|
| DATA ELEMENT NAME | DN |
| ACKNOWLEDGMENT TRANSACTION SET ID | <u>0110</u> |
| <u>ADA PROCEDURE BILLED CODE</u> | <u>0719</u> |
| <u>ADA PROCEDURE PAID CODE</u> | <u>0722</u> |
| ADMISSION DATE (47) | <u>0513</u> |
| <u>ADMISSION HOUR</u> | <u>0622</u> |
| ADMITTING DIAGNOSIS CODE <u>ADMISSION TYPE CODE</u> | 0535 <u>0577</u> |
| ADMISSION TYPE CODE <u>ADMITTING DIAGNOSIS CODE</u> | 0577 <u>0535</u> |
| APPLICATION ACKNOWLEDGMENT CODE | <u>0111</u> |
| BASIS OF COST DETERMINATION CODE | <u>0564</u> |
| BATCH CONTROL NUMBER | <u>0532</u> |
| BILL ADJUSTMENT AMOUNT (47) | <u>0545</u> |
| BILL ADJUSTMENT GROUP CODE (5)(47) | <u>0543</u> |
| BILL ADJUSTMENT REASON CODE (47) | <u>0544</u> |
| BILL ADJUSTMENT UNITS (47) | <u>0546</u> |
| <u>BILL FREQUENCY TYPE CODE</u> | <u>0505</u> |

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| BILL SUBMISSION REASON CODE | 0508 |
| <u>BILLED DRG CODE</u> | 0548 |
| BILLING FORMAT CODE | 0503 |
| <u>BILLING PROVIDER CITY</u> | 0540 |
| <u>BILLING PROVIDER COUNTRY CODE</u> | 0569 |
| BILLING PROVIDER FEIN | 0629 |
| <u>BILLING PROVIDER FIRST NAME</u> | 0529 |
| BILLING PROVIDER LAST/GROUP NAME | 0528 |
| BILLING PROVIDER NATIONAL PROVIDER ID (47) | 0634 |
| BILLING PROVIDER POSTAL CODE | 0542 |
| <u>BILLING PROVIDER PRIMARY ADDRESS</u> | 0538 |
| BILLING PROVIDER PRIMARY SPECIALTY CODE (4) | 0537 |
| <u>BILLING PROVIDER SECONDARY ADDRESS</u> | 0539 |
| <u>BILLING PROVIDER STATE CODE</u> | 0541 |
| BILLING PROVIDER STATE LICENSE NUMBER (4)(7) | 0630 |
| BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER | 0523 |
| <u>BILLING TYPE CODE (47)</u> | 0502 |
| CLAIM ADMINISTRATOR CLAIM NUMBER | 0015 |
| CLAIM ADMINISTRATOR FEIN | 0187 |
| CLAIM ADMINISTRATOR <u>MAILING</u> POSTAL CODE | 0014 |
| CLAIM ADMINISTRATOR NAME | 0188 |
| <u>COMPOUND DRUG INDICATOR</u> | 0762 |
| <u>CONDITION CODE</u> | 0556 |
| <u>CONTRACT LINE TYPE CODE</u> | 0741 |
| CONTRACT TYPE CODE | 0515 |
| DATE INSURER PAID BILL (9)(14) | 0512 |
| DATE INSURER RECEIVED BILL (42) | 0511 |
| DATE OF BILL (47) | 0510 |
| DATE OF INJURY | 0031 |
| DATE PROCESSED | 0108 |
| DATE TRANSMISSION SENT | 0100 |
| DAYS/UNITS BILLED(47) | 0554 |
| DAYS/UNITS CODE (47) | 0553 |
| <u>DAY(S)/UNIT(S) PAID</u> | 0580 |
| DIAGNOSIS CODE | 0522 |
| DIAGNOSIS POINTER | 0557 |
| DISCHARGE DATE (47) | 0514 |
| <u>DISCHARGE HOUR</u> | 0623 |
| DISPENSE AS WRITTEN CODE | 0562 |
| DME BILLING FREQUENCY CODE | 0567 |
| DRG CODE | 0518 |
| DRUG NAME | 0563 |
| DRUGS/SUPPLIES BILLED AMOUNT | 0572 |
| DRUGS/SUPPLIES DISPENSING FEE | 0579 |
| DRUGS/SUPPLIES NUMBER OF DAYS | 0571 |
| DRUGS/SUPPLIES QUANTITY DISPENSED | 0570 |
| ELEMENT ERROR NUMBER | 0116 |
| ELEMENT NUMBER | 0115 |
| EMPLOYEE FIRST NAME | 0044 |
| EMPLOYEE LAST NAME | 0043 |
| EMPLOYEE MIDDLE NAME/INITIAL | 0045 |
| <u>EMPLOYEE EMPLOYMENT VISA</u> | 0152 |

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| EMPLOYEE GREEN CARD | 0013 |
| EMPLOYEE PASSPORT NUMBER | 0156 |
| EMPLOYEE SOCIAL SECURITY NUMBER (40) | 0042 |
| EMPLOYER FEIN | 0016 |
| EMPLOYER NAME | 0018 |
| FACILITY CITY | 0686 |
| FACILITY CODE | 0504 |
| FACILITY COUNTRY CODE | 0689 |
| FACILITY FEIN | 0679 |
| FACILITY MEDICARE NUMBER | 0681 |
| FACILITY NAME (47) | 0678 |
| FACILITY NATIONAL PROVIDER ID (47) | 0682 |
| FACILITY POSTAL CODE (47) | 0688 |
| FACILITY PRIMARY ADDRESS | 0684 |
| FACILITY SECONDARY ADDRESS | 0685 |
| FACILITY STATE CODE | 0687 |
| FACILITY STATE LICENSE NUMBER | 0680 |
| HCPCS BILL PROCEDURE CODE | 0737 |
| HCPCS LINE PROCEDURE BILLED CODE | 0714 |
| HCPCS LINE PROCEDURE PAID CODE | 0726 |
| HCPCS MODIFIER BILLED CODE | 0717 |
| HCPCS MODIFIER PAID CODE | 0727 |
| HCPCS PRINCIPLE PROCEDURE BILLED CODE | 0626 |
| HIPPS RATE CODE | 0625 |
| INSURER FEIN | 0006 |
| INSURER NAME | 0007 |
| INSURER POSTAL CODE | 0616 |
| INTERCHANGE VERSION ID | 0105 |
| JURISDICTION CLAIM NUMBER | 0005 |
| JURISDICTION MODIFIER BILLED CODE (8) | 0718 |
| JURISDICTION MODIFIER PAID CODE (8) | 0730 |
| JURISDICTION PROCEDURE BILLED CODE (8)(13)(17) | 0715 |
| JURISDICTION PROCEDURE PAID CODE (8)(9)(13) | 0729 |
| JURISDICTION TRACKING NUMBER | 0743 |
| LINE ITEM PRIOR ACTUAL AMOUNT PAID | 0761 |
| LINE NUMBER (48) | 0547 |
| LUMP SUM PAYMENT SETTLEMENT CODE | 0293 |
| MANAGED CARE ORGANIZATION FEIN (1)(17) | 0704 |
| MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER | 0208 |
| MANAGED CARE ORGANIZATION NAME | 0209 |
| MANAGED CARE ORGANIZATION POSTAL CODE | 0712 |
| NDC BILLED CODE (47) | 0721 |
| NDC PAID CODE | 0728 |
| ORIGINATOR TRANSACTION IDENTIFICATION BATCH CONTROL NUMBER | 0532 |
| ORIGINAL TRANSMISSION DATE | 0102 |
| ORIGINAL TRANSMISSION TIME | 0103 |
| OTHER PROCEDURE CODE | 0736 |
| OUTPATIENT REASON FOR VISIT CODE | 0520 |
| PAID DRG CODE | 0549 |
| PLACE OF SERVICE BILL CODE (47) | 0555 |
| PLACE OF SERVICE LINE CODE (47) | 0600 |

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| <u>PRESCRIPTION BILL DATE(S) RANGE</u> | <u>0527</u> |
| PRESCRIPTION LINE DATE | <u>0604</u> |
| PRESCRIPTION LINE NUMBER | <u>0561</u> |
| <u>PRESENT ON ADMISSION INDICATOR</u> | <u>0533</u> |
| PRINCIPAL DIAGNOSIS CODE (17) | <u>0521</u> |
| PRINCIPAL PROCEDURE CODE | <u>0525</u> |
| PRINCIPAL PROCEDURE DATE | <u>0550</u> |
| <u>PRIOR ACTUAL AMOUNT PAID</u> | <u>0760</u> |
| PROCEDURE DATE | <u>0524</u> |
| <u>PROCEDURE DESCRIPTION</u> | <u>0551</u> |
| PROVIDER AGREEMENT CODE (3) | <u>0507</u> |
| <u>PROVIDER AGREEMENT LINE CODE</u> | <u>0742</u> |
| RECEIVER ID | <u>0099</u> |
| <u>REFERRING PROVIDER FIRST NAME</u> | <u>0691</u> |
| <u>REFERRING PROVIDER LAST/GROUP NAME</u> | <u>0690</u> |
| REFERRING PROVIDER NATIONAL PROVIDER ID (17) | <u>0699</u> |
| RELEASE OF INFORMATION CODE | 526 |
| RENDERING BILL PROVIDER COUNTRY CODE (17) | 0657 |
| RENDERING BILL PROVIDER FEIN | 0642 |
| <u>RENDERING BILL PROVIDER FIRST NAME</u> | <u>0639</u> |
| RENDERING BILL PROVIDER LAST/GROUP NAME | <u>0638</u> |
| RENDERING BILL PROVIDER NATIONAL PROVIDER ID (7)(17) | <u>0647</u> |
| RENDERING BILL PROVIDER POSTAL CODE | 0656 |
| RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE (17) | <u>0651</u> |
| RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER (7) | 0649 |
| RENDERING BILL PROVIDER STATE LICENSE NUMBER (7)(17) | <u>0643</u> |
| RENDERING LINE PROVIDER NATIONAL PROVIDER ID (7)(17) | <u>0592</u> |
| RENDERING LINE PROVIDER FEIN | <u>0586</u> |
| <u>RENDERING LINE PROVIDER FIRST NAME</u> | <u>0587</u> |
| RENDERING LINE PROVIDER LAST/GROUP NAME (6) | <u>0589</u> |
| RENDERING LINE PROVIDER POSTAL CODE | 0593 |
| RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) | <u>0595</u> |
| RENDERING LINE PROVIDER STATE LICENSE NUMBER (6)(7) | <u>0599</u> |
| REPORTING PERIOD | <u>0615</u> |
| REVENUE BILLED CODE | <u>0559</u> |
| REVENUE PAID CODE | <u>0576</u> |
| SENDER ID | <u>0098</u> |
| SERVICE ADJUSTMENT AMOUNT (17) | <u>0733</u> |
| SERVICE ADJUSTMENT GROUP CODE (5)(17) | <u>0731</u> |
| SERVICE ADJUSTMENT REASON CODE (5)(17) | <u>0732</u> |
| SERVICE ADJUSTMENT UNITS (17) | <u>0734</u> |
| SERVICE BILL DATE(S) RANGE (14) | <u>0509</u> |
| SERVICE LINE DATE(S) RANGE (9)(17) | <u>0605</u> |
| <u>SUPERVISING PROVIDER FIRST NAME</u> | <u>0659</u> |
| <u>SUPERVISING PROVIDER LAST/GROUP NAME</u> | <u>0658</u> |
| SUPERVISING PROVIDER NATIONAL PROVIDER ID (17) | <u>0667</u> |
| <u>SUPERVISING PROVIDER PRIMARY SPECIALTY CODE</u> | <u>0671</u> |
| TEST/PRODUCTION INDICATOR | <u>0104</u> |
| TIME PROCESSED | <u>0109</u> |
| TIME TRANSMISSION SENT | <u>0101</u> |
| TOTAL AMOUNT PAID PER BILL (2)(15) | <u>0516</u> |
| TOTAL AMOUNT PAID PER LINE (2)(17) | <u>0574</u> |

| | |
|---|------|
| TOTAL CHARGE PER BILL (16) | 0501 |
| TOTAL CHARGE PER LINE — PURCHASE | 0566 |
| TOTAL CHARGE PER LINE — RENTAL | 0565 |
| TOTAL CHARGE PER LINE (17) | 0552 |
| TRANSACTION TRACKING NUMBER | 0266 |
| UNIQUE BILL ID NUMBER | 0500 |
| <p>(1) For HCO claims use the FEIN of the sponsoring organization in DN 0704.</p> <p>(2) Not required on non-denied bills if amount paid equals amount charged.</p> <p>(3) For MPN claims use code P “Participation Agreement”</p> <p>(4) Does not apply if billing provider is an organization.</p> <p>(5) Required if charged and paid amounts differ.</p> <p>(6) Optional if rendering provider equals billing provider.</p> <p>(7) To be provided if available. The National Provider Identifier is assigned by the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (“CMS”).</p> <p>(8) Use codes that are either set forth and/or incorporated by reference in California Code of Regulations, title 8, section 9795, regarding reasonable fees for medical legal expenses, and section 9789.11, regarding fees for physician services rendered after January 1, 2004.</p> <p>(9) For payments made pursuant to California Code of Regulations, title 8, section 10536, the data edit date the insurer paid the bill (DN 512) must be \geq date the insurer received the bill (Error Code 073 is waived to allow payment of services); the data edit service line date(s) range (DN 605) must be \leq the current date (Error Code 041 is waived to allow payment of services).</p> <p>(10) If the Employee is not a United States citizen and has no other form of identification (DN 153, DN 152, or DN 156), use either a string of eight zeros followed by a six or a string of nine consecutive nines.</p> <p>(11) For medical lien lump sum payments or settlements use the date final payment was made.</p> <p>(12) For medical lien lump sum payments or settlements use the date on the first medical bill received.</p> <p>(13) Use the following codes for reporting a medical lien lump sum payment or settlement:</p> <p>MDS10 — Lump sum payment or settlement for multiple bills where the amount of reimbursement is in dispute between the claims payer and the healthcare provider.</p> <p>MDO10 — Final order or award of the Workers’ Compensation Appeals Board requires a lump sum payment for multiple bills where the amount of reimbursement is in dispute between the claims payer and the healthcare provider</p> <p>MDS11 — Lump sum payment or settlement for multiple bills where liability for a claim was denied but finally accepted by the claims payer</p> <p>MDO11 — Final order or award of the Workers’ Compensation Appeals Board requires a lump sum payment for multiple bills where claims payer is found to be liable for a claim which it had denied liability.</p> <p>MDS21 — Lump sum payment or settlement for a single medical bill where the amount of reimbursement is in dispute between the claims payer and the healthcare provider.</p> <p>MDO21 — Final order or award of the Workers’ Compensation Appeals Board requires a lump sum payment for a single medical bill where the amount of reimbursement is in dispute between the claims payer and the healthcare provider.</p> | |

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|---|--|
| (14) For a medical lien lump sum payment or settlement use the date of lien filing. | |
| (15) For a medical lien lump sum payment or settlement use the settled or ordered amount. | |
| (16) For a medical lien lump sum payment or settlement use the amount in dispute. | |
| (17) Not required for a mixed medical lien lump sum payment or settlement. | |
| (18) For a mixed bill medical lien lump sum payment or settlement assign a value = 00. | |

(1) Each claims administrator shall submit all medical bills data including interpreter bills within ninety (90) calendar days of the medical bill payment or the date of the final determination that payment for billed medical services will be denied.

(2) Each claims administrator shall submit all medical lien lump sum payments or settlements following the filing of a lien claim for the payment of such medical services pursuant to Labor Code sections 4903 and 4903.1 within ninety (90) calendar days of the medical lien lump sum payment or settlement.

(3) Data transmission shall follow the requirements set forth in IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2.0 dated February 1, 2013~~4~~. California Specific requirements are included in the California EDI Implementation Guide for Medical Bill payment Records Version 2.0, dated the designated effective date (see Section 9701(c)(2)).

(f) Notwithstanding the requirement in Subsection (b) to submit data elements omitted from the first report within 60 days from the date of transmission of the first report, when a claims administrator becomes aware of an error or need to update data elements previously transmitted, or learns of information that was previously omitted, the claims administrator shall transmit the corrected, updated or omitted data to WCIS no later than the next submission of data for the affected claim.

(g) No later than January 31 of every year, claims administrators shall report for each claim the total paid in any payment category in the previous calendar year by submitting the following data elements:

| DATA ELEMENT NAME | DN |
|---|----|
| PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES AMOUNT | 96 |
| PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES CODE | 95 |
| PAYMENT/ADJUSTMENT CODE | 85 |
| PAYMENT/ADJUSTMENT END DATE | 89 |
| PAYMENT/ADJUSTMENT PAID TO DATE | 86 |
| PAYMENT/ADJUSTMENT START DATE | 88 |

(h) Final reports (MTC = FN) are required only for claims where indemnity benefits are paid. For medical-only claims, the final report may be reported under this section or on the annual report (MTC = AN) with claim status = “closed.”

(i)(1) A claims administrator’s obligation to submit copies of benefit notices to the Administrative Director pursuant to Labor Code section 138.4 is satisfied upon written determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under subdivision (d) and continued compliance with that subsection.

(2) Reserved.

(3) On and after September 22, 2006, a claims administrator’s obligation to submit an Annual Report of Inventory pursuant to California Code of Regulations, title 8, section 10104 is satisfied upon determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under subdivisions (b), (d), (e), and (g), and continued compliance with those subsections.

(j) The data submitted pursuant to this section shall not have any application to, nor be considered in, nor be admissible into, evidence in any personal injury or wrongful death action, except as between an employee and the employee’s employer. Nothing in this subdivision shall be construed to expand access to information held in the WCIS beyond that authorized in California Code of Regulations, title 8, section 9703 and Labor Code section 138.7.

(k) Each claims administrator required to submit data under this section shall submit to the Administrative Director an EDI Trading Partner Profile at least thirty days prior to its first transmission of EDI data. Each claims administrator shall advise the Administrative Director of any subsequent changes and/or corrections made to the information provided in the EDI Trading Partner Profile by filing a corrected copy of the EDI Trading Partner Profile with the Administrative Director.

(l)(1) The Administrative Director may grant a claims administrator either a partial or total variance in reporting all or part of the data elements required under this section upon a documented showing that compliance with the reporting deadlines would cause undue hardship to the claims administrator.

(2) “Undue hardship” shall be determined based upon a review of the documentation submitted by the claims administrator. The documentation shall include:

(A) A statement explaining why the claims administrator is unable to transmit required data elements to the WCIS.

(B) The claims administrator’s estimated expenses necessary to meet the reporting requirements of this section.

(C) The reporting cost per claim if transmitted directly by the claims administrator and the total cost per claim if reported by a vendor.

(D) Submission of a plan documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the date of the request.

(3) Any variance granted by the Administrative Director under this subdivision shall be set forth in writing and shall be for a period of six (6) months.

(4) The variance period for reporting data elements under this subdivision may be extended for additional six (6) month period if the claims administrator resubmits a written request for an extension of the variance.

(5) Upon expiration of the variance period, a claims administrator granted a variance shall submit to the WCIS all data elements that were required to be submitted under this section during the variance period except for data elements that were not known to the claims administrator, the claims administrator's agents, or not captured on the claims administrator's electronic data systems. The data shall be submitted in an electronic format acceptable to the Division.

Authority: Sections 133, 138.4, 138.6, and 138.7, Labor Code.

Reference: Section 138.4, 138.6, and 138.7, Labor Code.