California Division of Workers' Compensation Medical Billing and Payment Companion Guides

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Purpose of the Electronic Medical Billing and Payment Companion Guides

This guide has been created for use in conjunction with Health Insurance Portability and Accountability Act (HIPAA), American National Standards Institute (ANSI), and the National Council for Prescription Drug Programs (NCPDP) national standard implementation guides. The ANSI national standard implementation guides are incorporated by reference. It is not to be a replacement for those national standard implementation guides but rather is to be used as an additional source of information. This companion guide contains data clarifications derived from specific business rules that apply to processing bills and payments electronically within California's workers' compensation system. Wherever the national standard differs from the California rules, the California rules prevail. Throughout this document you will see references to jurisdictional rules or edits, these always refer to the California rules for California workers' compensation purposes.

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Documentation Change Control

Documentation change control is maintained in this document through the use of the Change Control Table shown below. All changes made to this companion guide after the creation date are noted along with the date and reason for the change.

Change Control Table

Date	Page(s)	Change	Reason
05/15/2007	All	Versions 0.16	Revised document and added additional required California specific conditions

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Chapter 1 Introduction

California Labor Code 4603.4 mandates that California employers accept electronic bills for medical goods and services. The statute also provides that the regulations which establish electronic billing rules be consistent with HIPAA to the extent possible. The health care provider, health care facility, or third-party biller/assignee use the HIPAA adopted ANSI ASC X12N 837 (ANSI 837) Professional, Institutional or Dental transaction data to submit medical bill transactions or the NCPDP Telecommunication 5.1 to submit pharmacy bill transactions to the appropriate claims administrator associated with the employer of the injured employee to whom the services are provided. The Claims Administrator, or their authorized agent, validates the Electronic Data Interchange (EDI) file according to the guidelines provided in the prescribed national standard format implementation guide, this companion guide, and the jurisdiction data requirements. Problems associated with the processing of the EDI file are to be reported using acknowledgment techniques described in this companion guide. The Claims Administrator will use the HIPAA adopted ANSI ASC X12N 835 Remittance Advice to report an explanation of payments, reductions, and denial to the health care provider, health care facility, or third-party biller/assignee.

The Administrative Simplification provisions of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) include requirements that national standards for electronic health care transactions and national identifiers for Health Care Providers (Provider), health plans, and Employers be established. These standards are adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

Health care providers, health care facilities, or third-party biller/assignees, Claims Administrators, clearinghouses, or other electronic data submission entities shall use this guideline in conjunction with HIPAA adopted ANSI ASC X12N national implementation guides, the NCPDP Telecommunication 5.1, and other ANSI national implementation guides. The ANSI ASC X12N implementation guides can be accessed at http://www.wpc-edi.com/Insurance_40.asp. The NCPDP Telecommunication 5.1 is available from NCPDPD at www.ncpdp.org. Other ANSI implementation guides are available from industry publishing sources.

This guide outlines the workers' compensation industry and jurisdictional procedures necessary for engaging in Electronic Data Interchange (EDI) and specifies clarifications where applicable. Wherever there is a difference between the national standard and this guide, the rules from this guide prevail.

When coordination of a solution is required, California DWC is working with the Texas Department of Industrial Relations, Division of Workers' Compensation and the IAIABC EDI Medical Committee and Provider to Payer Subcommittee to work with national standard setting organizations and committees to address workers' compensation needs.

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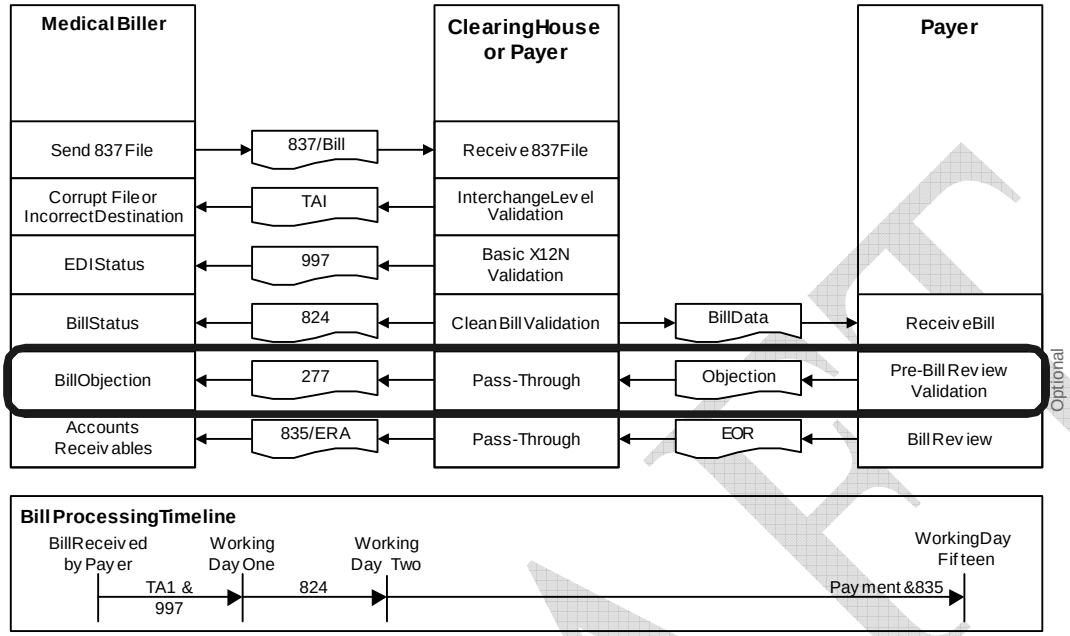
Chapter 2 Editing and Validation Flow and Timing Diagrams

The process chart below shows how an incoming workers' compensation ANSI 837 Professional, Institutional or Dental transaction might be validated and processed by the receiver. The diagram shows the four error reports that are generated by the receiver and the remittance advice for those bills that are fully processed.



Process steps:

1. **Interchange Level Validation**: Basic file format and the trading partner information from the Interchange Header are validated. If the file is corrupt or is not the expected type, the file is rejected. If the trading partner information is invalid or unknown, the file is rejected. A TA1 (Interchange Acknowledgment) is returned to indicate the outcome of the validation. A rejected EDI file is not passed on to the next step.
2. **Basic X12N Validation**: A determination will be made as to whether the transaction set contains a valid X12N 837. A 997 (Functional Acknowledgment) will be returned to the submitter. The 997 contains ACCEPT or REJECT information. If the file contains syntactical errors, the locations of the errors are reported. Bills that are part of a rejected transaction set are not passed on to the next step.
3. **Clean Bill Validation**: The standard and jurisdiction specific edits are run against each bill within the transaction set. An ANSI 824 (Application Advice) is returned to acknowledge acceptance or rejection of each bill in the transaction set. Bills that are rejected are not passed on to the next step.
4. **Pre-Adjudication Validation**: This is an optional step to be negotiated between the Claims Administrator and Health care provider, health care facility, or third-party biller/assignee. Any edits that the Claims Administrator applies that are not part of the standard or jurisdiction bill edits are applied at this point. An ANSI X12N unsolicited 277 is returned to the Health care provider, health care facility, or third-party biller/assignee to report any bills that are objected to by the Claims Administrator. An ANSI 277 entry is not returned for bills that pass this validation step. Bills that are objected to are not passed on to the next step.
5. **Bill Review**: The bill passes through bill review and any post-bill review approval process. An ANSI 835 Remittance Advice will be returned. The ANSI 835 contains the check or electronic Fund Transfer (EFT) payment information plus the adjudication information for each bill paid by the check or EFT.

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Chapter 3 Transmission Responses

HIPAA provides the health care community the ability to standardize transactions. It also provides the potential to standardize front-end edits and the acceptance/rejection reports associated with those edits. The acceptance/rejection reports indicate acceptance of transmissions and transactions or, when rejected, the specific errors within EDI transaction format syntax. When a report is generated, the type of report returned is dependent on the edit level that is invalid.

Each EDI file contains three levels where edits (data validation processes) are processed. Rejection of an entire batch or a single bill transaction is designated by the edit level in which the error occurs. The three levels are:

- Interchange Level Validation
- Basic X12N Validation
- Clean Bill Validation

In the description below, the three levels and their affiliated acceptance/rejection reports are discussed.

Interchange Level Validation

This level of validation is used to provide feedback to the sender of any interchange level problems. The edit checks the ISA, GS, GE and IEA level segments, described in a separate section of this companion guide, and the data content within these segments. Edits determine if the data is valid and if a trading partner relationship exists. Errors at this level result in rejection of the entire transmission. File rejection errors are reported in the TA1. If the EDI file passed the initial Interchange Level Validation, it moves on to the Basic X12N Validation.

ANSI ASC X12 TA1 - Interchange Acknowledgment

The ANSI ASC X12N Interchange Acknowledgment, or TA1, is used to provide the sender a positive or negative confirmation of the transmission of the interchange control envelope portion of the EDI file transmission. The TA1 reports the syntactical analysis of the interchange header and trailer. If invalid (i.e. the data is corrupt or the trading partner relationship does not exist) the edit will reject and a TA1, along with the data, will be returned. The entire transmission is rejected at the header level.

Basic X12N Validation

This edit is used to check for basic syntax problems for all transactions within each functional group. These edits check the ST and SE level segments and the data content within these segments. These segments consist of the entire detailed information within a transaction. Any X12N syntax error that occurs at this level will result in the entire transaction set being rejected. However, if the functional group consists of additional transactions without errors, these may be processed.

ANSI ASC X12N 997 - Functional Acknowledgment

The ANSI ASC X12N 997, or Functional Acknowledgment, is used to provide the sender a positive or negative confirmation of the structure of the 837 EDI file. If the EDI file contained syntactical errors, the segment(s) and element(s) where the error(s) occurred may be reported.

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Clean Bill Validation

This level of validation is used to check the bills for standard and jurisdictional specific rules. Any errors that occur at this level will result in a specific bill being rejected. If the batch consists of additional bills without errors, these may be processed.

ANSI ASC X12 824-Application Advice

The ANSI ASC X12N 824 Application Advice, or Detail Acknowledgment, is used to provide the sender with a positive or negative confirmation of each bill transaction within the EDI file. The ANSI 824 details acceptance of a bill transaction or, if rejected, information on errors that are present and, if necessary, what action the submitter should take.

Claims Administrators are required to acknowledge electronic billing transactions at the Item or transaction level (bill level) within one business day of receipt. The ANSI 824 Detail Acknowledgment format supports multiple types of acknowledgment; for example Accept, Accept with Errors, or Partially Accept. The California workers' compensation implementation allows only for three types of acknowledgment actions, Accept, Accept with Errors, or Reject: The usage of the ANSI 824 Application Acknowledgement Codes is defined as follows:

Application Acknowledgement Code IA: Accept:

Use this code when no error or informational messages are present and all data is accepted for further processing.

When processing an electronic bill associated with an attachment, an attachment indicator is required. The PWK Claim Supplemental Information (Attachment) segment indicates that an attachment is expected, the type of attachment, and by what delivery method i.e. electronic, email or fax. The attachment indicator is transmitted in Loop 2300 of the ANSI 837 PWK Claim Supplemental Information (Attachment) Segment. If the Claims Administrator does not receive the indicated attachment within the 5 working day period specified, the bill will be denied and an ANSI 835 would be generated with the appropriate ANSI reason code.

Application Acknowledgement Code IE: Accept with Errors:

Use this code when all bill data is accepted for further processing and there is no claim number present in Loop 2010CA Segment REFO2. If the Claims Administrator is not able to match the bill to a claim within the 5 working day period specified, the bill will be denied and an ANSI 835 would be generated with the appropriate ANSI reason code.

Application Acknowledgement Code IR: Reject

Use this code when the bill is rejected due to errors. Informational messages may also be present. No data is accepted for further processing. Submitter must correct and resubmit the (transaction set, batch or item) that was in error.

ANSI ASC X12N 835-Remittance Advice

An ANSI ASC X12N 835 Remittance Advice is provided as a replacement for, or in addition to, a paper remittance advice or Explanation of Benefits (EOB). After claim adjudication and payment or denial, an ANSI 835 Remittance Advice is delivered to the Health care provider, health care facility, or third-party biller/assignee. The ANSI 835 contains information related to payees, payers, dollar amounts and payments. Please see the ANSI 835 Implementation Guide for details on the ANSI 835 transactions.

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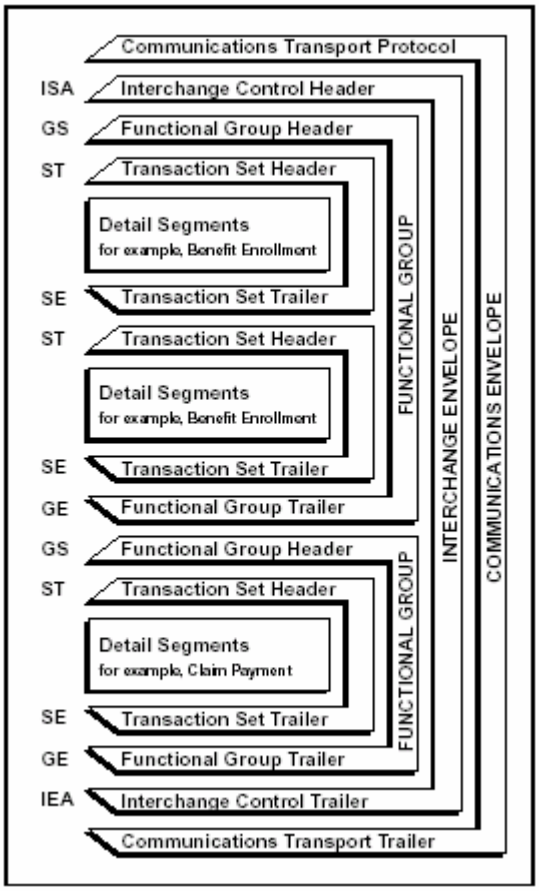
Transaction Description - V4010.A1

X12 Interchange Control Structure

An EDI file is made up of several groups of data organized into a hierarchy of envelopes. The outer-most envelope is generally invisible and is called the Communications Envelope. The next envelope is the Interchange Envelope, which begins with the ISA Interchange Control Header segment and ends with the IEA Interchange Control Trailer segment. Within the ISA Envelope, one or more Functional Groups are submitted. The Functional Group begins with the GS Functional Group Header segment and ends with the GE Functional Group Trailer segment. The Functional Group contains one or more Transaction Sets. The Transaction Set begins with the ST Transaction Set Header segment and ends with ST Transaction Set Trailer.



Interchange Control (ISA/IEA)

The Interchange Control (ISA/IEA) identifies both the sender's and receiver's identifiers, the date and time of the file transfer, and the segment terminators/delimiters used by the sender. If any errors are found in the ISA Interchange Control Header, the entire ISA/IEA Interchange and the Functional Group within it are rejected.

The California workers' compensation implementation requires the use of the Federal Employer Identification Number (FEIN) as the unique identifier for the sender and receiver in the Interchange Control envelope.

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ISA Envelope

Segment / Element	ANSI R/S	ANSI DN	Length	Data Type	Value	Description
ISA	**R**		**Interchange Control Header**			
ISA01	R	I01	2	ID	00	Authorization Information Qualifier
ISA02	R	I02	10	AN		Authorization Information
ISA03	R	I03	2	ID		Security Information Qualifier
					00	No Security Information Present
					01	Password
ISA04	R	I04	10	AN		Security Information
ISA05	R	I05	2	ID		Interchange ID Qualifier
					01	Duns (Dun & Bradstreet)
					14	Duns Plus Suffix
					20	Health Industry Number (HIN)
					27	Carrier Identification Number (HCFA)
					28	Fiscal Intermediary Identification Number (HCFA)
					29	Medicare Provider and Supplier Identification Number (HCFA)
					30	U.S. Federal Tax Identification Number
					33	National Association of Insurance Commissioners Company Code (NAIC)
					ZZ	Mutually Defined
ISA06	R	I06	15	AN		Interchange Sender ID
ISA07	R	I05	2	ID		Interchange ID Qualifier
					01	Duns (Dun & Bradstreet)
					14	Duns Plus Suffix
					20	Health Industry Number (HIN)
					27	Carrier Identification Number (HCFA)
					28	Fiscal Intermediary Identification Number (HCFA)
					29	Medicare Provider and Supplier Identification Number (HCFA)
					30	U.S. Federal Tax Identification Number
					33	National Association of Insurance Commissioners Company Code (NAIC)
					ZZ	Mutually Defined
ISA08	R	I07	15	AN		Interchange Receiver ID
ISA09	R	I08	6	DT		Interchange Date (YYMMDD)
ISA10	R	I09	4	TM		Interchange Time (HHMM)
ISA11	R	I10	1	ID		Interchange Control Standards Identifier
					U	U.S. EDI Community of ASC X12, TDCC, and UCS
ISA12	R	I11	5	ID	00401	Interchange Control Version Number
ISA13	R	I12	9	N0		Interchange Control Number
ISA14	R	I13	1	ID		Acknowledgment Requested
					0	No Acknowledgment Requested
					1	Interchange Acknowledgment Requested
ISA15	R	I14	1	ID		Usage Indicator
					P	Production Data
					T	Test Data
ISA16	R	I15	1	AN	:	Component Element Separator

ISA Envelope

Segment / Element	ANSI R/S	ANSI DN	Length	Data Type	Value	Description
IEA	**R**		**Interchange Control Trailer**			
IEA01	R	I16	1/5	N0		Number of Included Functional Groups
IEA02	R	I12	9	N0		Interchange Control Number

Functional Group (GS/GE)

The Functional Group (GS/GE) identifies the type of transaction being sent, identifiers for the sender and receiver of the transactions, as well as the sender's Group Control Number.

The sender and receiver identification numbers in the Functional Group envelope are the FEIN of the sender and receiver.

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GS Envelope

Segment / Element	ANSI R/O	ANSI DN	Length	Data Type	Value	Description
GS	**R**		**Functional Group Header**			
GS01	R	479	2	ID		Functional Identifier Code
					HC	Health Care Claim (837)
					PI	Patient Information (275)
					HS	Eligibility, Coverage or Benefit Inquiry (270)
					HB	Eligibility, Coverage or Benefit Information (271)
					HN	Health Care Claim Status Notification (277)
					HP	Health Care Claim Payment/Advice (835)
GS02	R	142	2/15	AN		Application Sender's Code
GS03	R	124	2/15	AN		Application Receiver's Code
GS04	R	373	8	DT		Functional group creation date (CCYYMMDD)
GS05	R	337	4/8	TM		Functional group creation time (HHMM)
GS06	R	28	1/9	N0		Group Control Number
GS07	R	455	1	ID	X	Responsible Agency Code
GS08	R	480	1/12	AN		Version / Release / Industry Identifier Code (value varies by content)
					004010X098WC	Health Care Claim Professional and Pharmacy
					004010X096WC	Health Care Claim Institutional
					004010X097WC	Health Care Claim Dental
					004010X091WC	Health Care Claim Payment/Advice (835)
					004010X092	270 / 271
					004010X093WC	276 / 277 Health Care Claim Status Request and Response
					004050X151	Patient Information (275)

GE	**R**		**Functional Group Trailer**			
GE01	R	97	1/6	N0		Number of Transaction Sets Included
GE02	R	28	1/9	N0		Group Control Number

Chapter 4 California Workers' Compensation Requirements

Compliance

Labor Code §4603.4 (a) (2) requires claims administrators to accept electronic submission of medical bills. The effective date is as specified in the body of this manual. The entity submitting the bill has the option of submitting bills on paper or electronically.

If an entity chooses to submit bills electronically it must be able to receive an electronic response from the claims administrator. This includes electronic acknowledgements, notices and electronic Explanations of Review.

Nothing in this document prevents the parties from utilizing Electronic Funds Transfer (EFT) to facilitate payment of electronically submitted bills. Use of Electronic Funds transfer is optional, but encouraged by the Division. EFT is not a pre-condition for electronic billing

Health care providers, health care facilities, or third-party biller/assignees and Claims Administrators must be able to exchange in the prescribed standard formats and may exchange information in non-prescribed formats by mutual agreement.

Privacy, Confidentiality, and Security

Health care providers, health care facilities, or third-party biller/assignees, Claims Administrators, and their agents must comply with all applicable Federal and state requirements regarding privacy, confidentiality, and security of confidential data.

National Standard Formats

Billing Formats

The national standard formats for billing and remittance are those formats adopted by Federal HIPAA rules based on ANSI standards. The current implementation adopts the 4010A version of the ANSI 837 billing formats for Professional billing (837P), Institutional billing (837I), and Dental billing (837D), and the ANSI 835 format for Remittance. The Federal HIPAA national standard format for electronic pharmacy billing is the NCPDP Telecommunication Standard Version 5.1.

The file and bill level acknowledgment formats, and the attachment format, are based on ANSI Standards, but have not yet been adopted by HIPAA. The Division is adopting these ANSI standards for the purposes of electronic billing. The acknowledgement formats are mandatory, the attachment format is optional. The ANSI TA1 version 4010A is used to communicate the syntactical analysis of the interchange header and trailer. The ANSI 997 Functional Acknowledgment, version 4010A is used to communicate acceptance or rejection of a transmission (file). The ANSI 824 version 4010A Application Advice or Detail Acknowledgment, is used to communicate acceptance or rejection of a bill transaction with an accepted file. The ANSI 275 version 4050A Additional Information to Support a Health Care Claim or Encounter is used to transmit electronic documentation associated with an electronic medical bill.

Other formats not adopted by rule are used in ancillary processes related to electronic billing and reimbursement. The use of these formats is voluntary and the companion guide is presented as a tool to facilitate their use in workers' compensation.

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Prescribed Formats

Format	Corresponding Paper Form	Function
837P version 4010A1	CMS-1500	Professional Billing
837I version 4010A1	UB-04	Institutional/Hospital Billing
837D version 4010A1	ADA-2006	Dental Billing
NCPDP 5.1	NCPDP UCF	Pharmacy Billing
835 version 4010A1	None	Explanation of Review (EOR)
TA1 version 4010A1	None	Interchange Acknowledgement
997 version 4010A1	None	File Level Acknowledgment
824 version 4010A1	None	Bill Level Acknowledgment

Ancillary Formats

Format	Corresponding Process	Function
ISA version 4010A1	None	Interchange Header/Footer
GS version 4010A1	None	Functional Group Header/Footer
837Rx version 4010A1	None	Alternate Pharmacy Billing Format
270 version 4010A1	Claim/Coverage Verification Request	Eligibility Request
271 version 4010A1	Claim/Coverage Verification Response	Eligibility Response
275 version 4050A1	Documentation/Attachments	Documentation/Attachments
276 version 4010A1	Bill Status Request	Claim Status Request
277 version 4010A1	Bill Status Response	Claim Status Response

Usage

California workers' compensation implementation of the national standard formats aligns with HIPAA usage and requirements in most circumstances. When the usage designation (Required/Situational) is different from the HIPAA implementation but the function of the Loop, Segment, or Field is the same, the workers' compensation usage column in the spreadsheet tool in this companion guide will reflect the usage for California workers' compensation.

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting Req.	Occurrence	Length	Data Type	Value	EOR Data Reference #	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)

When the usage is different, and the defined workers' compensation conditions are different than the defined HIPAA conditions, the workers' compensation usage is defined as Jurisdiction Situational (J). Each jurisdiction using the standard implementation and companion guides defines the specific jurisdiction conditions for the Loop, Segment, or Field. The specific conditions for California workers' compensation are defined in this chapter.

The Loop, Segment, and Field requirements are defined by usage designators. Elements are Required (R), Situational (S), or Not Used (N) in the HIPAA implementation guides. Required elements are mandatory

without exception. Situational elements are conditional and the national standard implementation guides define the conditions that make the element mandatory. Not used elements are omitted.

Usage is applied in a hierarchal manner based on Loop (primary), Segment (secondary), and Field (tertiary). When a Loop is required, all required Segments must be present and all Situational Segments must be present if the defined condition is met. If a Loop is situational and the defined condition is not met, the Segments within the Loop are omitted. If a situational Loop is submitted, all required Segments must be present and all Situational Segments must be present if the defined condition is met. The same logic applies to Field level requirements for required and situational Segments.

When the workers' compensation implementation uses an element in a manner that is different than the standard implementation, the usage designator is Jurisdictional (J). The jurisdiction defines the use of the element for the implementation of Electronic Billing in that specific jurisdiction. When an element is Jurisdictional, the Division defines the conditions for the use of the element in this companion guide.

Standard Elements

The workers' compensation companion guide includes, and addresses, Loops, Segments, and Fields that are required on paper forms in the medical billing process. Some elements in the electronic formats do not map directly to paper form fields. To the extent possible, electronic requirements align with paper billing requirements.

The national standard formats also include elements that do not relate directly to workers' compensation processes, for example, coordination of benefits. When workers' compensation industry use, or future California workers' compensation requirements, are identified, related Loops, Segments, and Fields usage are addressed in the companion guide. Only those elements in the workers' compensation companion guide are required for this implementation. Usage designation of elements not identified in this companion guide is assumed to be Not Used (N). Trading partners may choose to accept this element by mutual agreement.

HIPAA Not Used

Elements identified as Not Used (N) in HIPAA implementation guides are not used in this implementation unless designated as Jurisdictional (J) element. Trading partners may reject transmissions or transactions that include Not Used (N) elements.

Workers' Compensation Not Used

Specific elements are identified as Not Used (N) for the workers' compensation implementation. Trading partners may enter into a mutual agreement to accept these elements, or the Claims Administrator may choose to allow bills containing such elements to be processed rather than rejecting them. Trading partners that reject transmissions or transactions that include elements with usage designations of Not Used (N) for workers' compensation are compliant with the implementation of this companion guide.

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HIPAA/Workers' Compensation Gap Analysis

The HIPAA/Workers' Compensation Gap Analysis identifies occurrences at the Loop, Segment, Field, and Code(s) level where the workers' compensation usage is different than in the HIPAA implementation. Specific direction is provided in this companion guide for the usage and conditions for the California workers' compensation implementation.

The HIPAA/Workers' Compensation Gap Analysis addresses two categories of formats; 837 billing format, and 835 remittance format.. There is also a HIPAA/Workers' Compensation Gap Analysis that exists for Report Type Codes (PWK Segment), Claims Adjustment Reason and Remittance Remarks code sets due to specific workers' compensation requirements. Specific direction is provided in this companion guide for the usage of jurisdictional codes sets when usage is different than in the HIPAA implementation.

When coordination of a solution is required to adapt HIPAA approved standards, codes fields, etc. for workers' compensation,, the Division is working with the International Association of Industrial Accident Boards and Commissions (IAIABC) EDI Medical Committee and Provider to Payer Subcommittee and the Texas Department of Industrial Relations, Division of Workers' Compensation to work with national standard setting organizations and committees to address workers' compensation needs.

The International Association of Industrial Accident Boards & Commissions (IAIABC) is a not-for-profit trade association representing government agencies charged with the administration of workers' compensation systems throughout the United States, Canada, and other nations and territories.

The following HIPAA Workers' Compensation Gap Analysis Table addresses five specific elements in the ANSI 837 billing formats, and seven elements in the ANSI 835 remittance format and one element in the GS Functional Group that requires coordination of a solution through the IAIABC in order to facilitate a national standard for workers' compensation. Pending such a national standard, the rules spelled out in later chapters of this guide represent California's requirements for these elements.

HIPAA/Workers' Compensation Gap Analysis Table

Format	Loop/Segment/Field	HIPAA/WC Usage	California and Texas IAIABC Gap Analysis Resolution
837 Professional, Dental, Institutional	2300 Claim Information CLM Claim Information CLM19 Claim Submission Reason Code	HIPAA Not Used, WC Jurisdictional	Claim Submission Reason Code is required when CLM05-3 Bill Resubmission Reason Code indicates the transaction is a resubmission. Valid values for CLM19 are part of an existing ANSI Code Set. Request IAIABC coordinate with ANSI to allow use of the field for workers' compensation.
837 Professional, Dental, Institutional	2300 PWK Paper Attachment Reference	HIPAA Not Used, WC Jurisdictional	Additional Report Type Codes were identified. IAIABC submitted the additional report type codes to the ANSI X12 Committee for approval. June 2007 ANSI X12 Committee approved 7 new report type codes for workers' compensation (5010). There are 2 other jurisdictional report type codes pending approval.
837 Professional, Dental, Institutional, Pharmacy GS Functional	Functional Group envelope (GS-GE) in field GS08 Transaction Set header (TS) Transmission Type Identification Reference	HIPAA Not Used, WC Jurisdictional	Version Control Identification Naming Convention: HIPAA standards provide for a twelve character naming convention to identify the format and version for electronic medical billing and reimbursement formats, and associated process formats. For example, 004010X097A1 is the version of the ANSI 837 format adopted by HIPAA for professional,

Group Envelope Transaction Set Header (TS)	Segment (REF) in Field REF02		institutional, dental and pharmacy billing. The value is populated in the Functional Group envelope (GS and GE Segments) in field GS08. It is also populated in certain formats in the Transaction Set Header (TS) Transmission Type Identification Reference Segment (REF) in field REF02. Providing for a workers' compensation indicator ensures consistent implementation of workers' compensation requirements and minimizes impact on standard translator applications. A WC indicator is populated in place of the A1 HIPAA addendum indicator in provider to carrier file submitted in workers' compensation adopted formats based on HIPAA and/or ANSI electronic formats. For example, the workers' compensation standard for professional billing based on the HIPAA adopted format would be 004010X097WC. The WC would communicate, in this circumstance, that the implementation is based on a workers' compensation standard. California and Texas have requested through the IAIABC to adopt the WC Version Control Identification Naming Convention.
837 Dental	2010AA Billing Provider PER Contact Information	HIPAA Not Used, WC Jurisdictional	Billing Provider Contact Information required when it is different than the Sender Contact Information. Request IAIABC coordinate with ANSI to allow use of Segment for workers' compensation.
837 Dental	2010AA Pay to Provider PER Contact Information	HIPAA Not Used, WC Jurisdictional	Pay to Provider Contact Information required when it is different than the Sender Contact Information. Request IAIABC coordinate with ANSI to allow use of Segment for workers' compensation.
835	2100 Bill Payment Information DTM Date Time Segment Date of Accident (Injury)	HIPAA Not Used, WC Jurisdictional	Date of Accident (Date of Injury) is required for workers' compensation. Request IAIABC to coordinate with ANSI to allow the use of Segment for 835 processing.
835	2110 Service Payment Information REF Reference Information - Prescription Information	HIPAA Not Used, WC Jurisdictional	Prescription Information is required for pharmacy remittance information. Request IAIABC to coordinate with ANSI to allow the use of Segment for 835 processing.
835	2100 Bill Payment Information CAS01 Claim Adjustment Group Codes	HIPAA Not Used, WC Jurisdictional	ANSI Claims Adjustment Group Code MA is an inactive code that is used for State EDI medical reporting (IAIABC 837 Release 1). Request IAIABC to coordinate with ANSI to activate the use of the Claims Adjustment Group Code MA for 835 processing.
835	2100 Bill Level Adjustments 2110 Service Line Adjustments CAS Claim Adjustment Reason Codes	HIPAA Not Used, WC Jurisdictional	Additional Claim Adjustment Reason Codes are required for workers' compensation. Request IAIABC to coordinate with ANSI to adopt the California and Texas jurisdictional Claim Adjustment Reason Codes for 835 processing.
835	2110 LQ Remark Codes	HIPAA Not Used, WC Jurisdictional	Additional Remittance Remark Codes are required for workers' compensation. Request IAIABC to coordinate with ANSI to adopt the California jurisdictional Remittance Remark for 835 processing.
835	2100 REF02 Other Claim Related Identification – Jurisdictional EOR/EOB	HIPAA Not Used, WC Jurisdictional	Paper explanation of benefits (EOB) or explanation of reimbursement (EOR) processes in California include jurisdiction statements that are required on a paper EOB to

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	Statement Code		provide health care providers, health care facilities, or third party biller/assignees with specific information regarding jurisdiction direction or limitations. A Jurisdictional statement code specific to the jurisdiction is required for workers' compensation. California and Texas are recommending a code set be created and administered by IAIABC to represent each jurisdiction's code or codes that communicate similar information but do not meet the function of a Claim Adjustment Reason Code.
835 GS Functional Group Envelope	Functional Group envelope (GS-GE) in field GS08	HIPAA Not Used, WC Jurisdictional	Version Control Identification Naming Convention: HIPAA standards provide for a twelve character naming convention to identify the format and version for electronic medical billing and reimbursement formats, and associated process formats. For example, 004010X09!A1 is the version of the ANSI 835 format adopted by HIPAA. The value is populated in the Functional Group envelope (GS and GE Segments) in field GS08. Providing for a workers' compensation indicator ensures consistent implementation of workers' compensation requirements and minimizes impact on standard translator applications. A WC indicator is populated in place of the A1 HIPAA addendum indicator For example, the workers' compensation standard for electronic reimbursement based on the HIPAA adopted format would be 004010X091WC. The WC would communicate, in this circumstance, that the implementation is based on a workers' compensation standard. California and Texas have requested through the IAIABC to adopt the WC Version Control Identification Naming Convention.

Complete Electronic Medical Bill

A complete electronic medical bill transaction as defined in California Division of Workers' Compensation the Medical Billing and Payment Guide Section One – 3.0

(a) All bills being submitted for payment, whether electronically or on paper must be complete before payment time frames begin.

(b) To be complete a submission must consist of the following:

(1) The correct uniform billing form for the type of health care provider, health care facility, or third party biller/assignees.

(2) The correct uniform billing codes for the applicable portion of the OMFS under which the services are being billed.

(3) The uniform billing form/format must be filled out according to the requirements specified for each format in Appendix A and/or the Companion Guide.

(c) The correct uniform billing form for the type of health care provider, health care facility, or third party biller/assignee

The correct uniform billing codes for the applicable portion of the OMFS under which the services are being billed.

The uniform billing form/format must be filled out according to the requirements specified for each format in Appendix A for the Medical Billing and Payment Guide.

All required reports and supporting documentation must be submitted as follows:

(1) (1) A Doctor's First Report of Occupational Injury (DLSR 5021), must be submitted when the bill is for Evaluation and Management services and a Doctor's First Report of Occupational Injury is required under Title 8, California Code of Regulations § 9785.

(2) A PR-2 report or its narrative equivalent must be submitted when the bill is for Evaluation and Management services and a PR-2 report is required under Title 8, California Code of Regulations § 9785.

(3) A PR-3, PR-4 or their narrative equivalent must be submitted when the bill is for Evaluation and Management services and the injured worker's condition has been declared permanent and stationary with permanent disability or a need for future medical care. (Use of Modifier – 17)

(4) A narrative report must be submitted when the bill is for Evaluation and Management services for a consultation.

(5) A report must be submitted when the health care provider, health care facility, or third party biller/assignee uses the following Modifiers – 19, – 21, – 22, – 23 and – 25.

(6) A descriptive report of the procedure, drug, DME or other item must be submitted when the health care provider, health care facility, or third party biller/assignee uses any code that is payable "By Report".

(7) A descriptive report must be submitted when the Official Medical Fee Schedule indicates that a report is required.

(8) An operative report is required when the bill is for Surgery Services.

(9) An invoice must be provided when one is required for reimbursement.

(10) Appropriate additional information reasonably requested by the claims administrator or its agent to support a billed code when the request was made prior to submission of the billing. Supporting documentation should be sufficient to support the level of service or code that has been billed.

Health care provider, health care facility, or third-party biller/assignee Agent/Claims Administrators Agent

Claims Administrators and health care providers, health care facilities, or third-party biller/assignees are responsible for the acts or omissions of their agents.

Use of non-standard formats by mutual agreement between the health care provider, health care facility, or third-party biller/assignee and the Claims Administrator is permissible.

This guide does not regulate the formats utilized between health care providers, health care facilities, or third-party biller/assignees and their agents. It also does not regulate the formats utilized between Claims Administrators and their agents. Finally, it does not dictate the method of connectivity between parties and their own agents.

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Identification Numbers

Trading Partner Identification

Workers' compensation standards require the use of the Federal Employer Identification Number (FEIN) to identify Trading Partners (sender/receiver) in electronic billing and reimbursement transmissions.

Claims Administrator Identification

Claims Administrators, and their agents, are also identified through the use of the FEIN. Claims Administrator information is available through direct contact with the Claims Administrator.

Provider Identification

Provider roles and identification numbers are addressed in Health Care Provider section below.

Injured Employee/Claim Identification

The injured employee is identified by Social Security Number, date of birth, and date of injury. Social Security Number (SSN) fields are required in electronic billing and reimbursement formats. When a SSN is not available, the health care provider, health care facility, or third-party biller/assignee must report a default 9 digit code of 999999999 in the SSN Field.

The Claims Administrator Claim Number is a situational element on an electronic billing transaction. The health care provider, health care facility, or third-party biller/assignee should submit these identification numbers if they are known. However, if a bill is submitted electronically without a claim number, it will be pended for 5 workings days while the claims administrator attempts to match a claim number to the bill. If after the 5 working day timeframe expires, the claims administer cannot match a claim number to the bill, the bill may be rejected. An extension of the 5 day timeframe may be granted upon mutual agreement of the parties. If the health care provider, health care facility, or third-party biller/assignee obtains the claim number during the 5 working day period, s/he or it may submit it to the claims administrator.

Bill Identification

HIPAA implementation guides refer to a bill as a "claim" for electronic billing transactions. Workers' compensation refers to these transactions as "bill" transactions to minimize confusion with the workers' compensation use of the word "claim" in referring to a unique Injured Employee and injury.

The health care provider, health care facility, or third-party biller/assignee, assigns a unique identification number to the electronic bill transaction. For ANSI 837 transactions, the bill transaction identification number is populated in Loop 2300 Claim Information CLM Health Claim Segment CLM01 Claim (Bill) Submitter's Identifier field. This standard HIPAA implementation allows for a patient account number but "strongly recommends that submitters use completely unique number for this field for each individual claim."

The NCPDP Telecommunication Standard Version 5.1 format structure does not identify a bill in the same manner as the ANSI 837 formats, i.e. a bill as a set of lines. The unique electronic bill transaction identification number for pharmacy billing is based on the individual prescription and is located in 402-D2 of the NCPDP 5.1 format.

Document Identification

The ANSI 275 Additional Information to Support a Health Care Claim or Encounter is the recommended standard electronic format for submitting electronic documentation and is addressed in a later chapter of this companion guide.

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Attachments are identified in the ANSI 837 format in PWK Claim Supplemental Information (Attachment) Segment. The PWK Claim Supplemental Information (Attachment) Segment indicates that an attachment is expected, the type of attachment, and by what delivery method i.e. electronic, email or fax. Bills containing services that require supporting documentation as defined by the Division in the Medical Billing and Payment Guide Section One – 3.0 must be properly annotated in the PWK Attachment Segment. Bill transactions that include services that require documentation and are submitted without the PWK annotation documentation will be rejected. An ANSI 824 reject incomplete error message should be generated.

Documentation related to electronic medical bills may be submitted by facsimile (fax), electronic mail (email) or by electronic transmission using the recommended format or a mutually agreed upon format. Required documentation related to electronic medical bills must be submitted within five (5) working days of submission of the electronic medical bill. If required documentation related to an electronic medical bill is not received within the five (5) working day timeframe the bill will be rejected**.** An ANSI 835 should be generated with the appropriate ANSI reason code for denial due to lack of documentation.

The PWK Segment and the associated documentation identify the type of documentation through use of ANSI standard Report Type Codes. The PWK Segment and the associated documentation also identify the method of submission of the documentation through the use of ANSI Report Transmission Codes.

Finally, a unique Attachment Control Number shall be assigned to the documentation. The Attachment Control Number populated on the document shall include the Report Type Code, the Report Transmission Code, Attachment Control Qualifier (AC) and the Attachment Control Number. For example, operative note (report type code OB) sent by fax is identified as OBFXAC12345. ANSI code sets are provided as a reference below. Jurisdictions codes, when present, are also included in this document.

Specifications and requirements for documentation are addressed in Chapter 11 – 275 Documentation/Medical Attachments.

Claims Administrator Validation Edits

Claims Administrators may apply validation edits based on the Medical Billing and Payment Guide.

Claims Administrators use the ANSI 824 Application Advice format, referred to in this companion guide as a Detail Acknowledgment format, to communicate transaction (bill) rejections. ANSI 824 error rejection codes are used to indicate the reason for the transaction rejection.

Decimals

Decimals are not populated in diagnosis code or unit fields. Unit values are presented as whole numbers without decimal points. The value is determined on the definition of the service, procedure, supply, or medication. Partial units are billed as defined by the applicable source, statute, or Division rule.

All percentages should be presented in decimal format.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

Date Format

All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD and the default SSN value where the date format is MMDDYY. The only values acceptable for the “CC” (century) value are 18, 19, or 20.

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Date fields that include hours should use the following format: CCYYMMDDHHMM. Use military format: 00 to 23 to indicate hours and 00 to 59 to indicate minutes. For example, an admission date of 200206262115 defines the date and time of June 26, 2002 at 9:15 p.m.

No spaces or character delimiters should be used in presenting dates or times.

Dates that are logically invalid (e.g. 20011301) may be rejected. Dates must be valid within the context of the transaction. Validation edits against the dates identified below apply to transmissions (files) and transactions (bills).

Date of Birth

The Injured Employee's date of birth must be less than (before) the date the Claims Administrator processes the transmission or the transaction.

Date of Injury

The Injured Employee's date of injury must be greater (after) than the Injured Employees date of birth.

Transmission Dates

Transmission dates must be

- greater than the Injured Employees date of birth,
- greater than Employee's date of injury,
- less than or equal to the date the Claims Administrator processed the transmission.

Bill Dates

Admission/Discharge Dates must be

- greater than the Injured Employee's date of birth,
- greater than or equal to the Injured Employee's date of injury,
- less than or equal to the date the Claims Administrator processed the transmission,
- less than or equal to the transmission date.

ICD-9 Principal Procedure and subsequent ICD-9 Procedure Dates must be

- greater than the Injured Employee's date of birth,
- greater than the Injured Employee's date of injury,
- less than or equal to the date the Claims Administrator processed the transmission,
- less than or equal to the transmission date.

Date of Service

Date(s) of Service must be

- less than or equal to the date the Claims Administrator processed the transmission,
- greater than the Injured Employee's date of birth,
- greater than or equal to the Injured Employee's date of injury.

Transmission/Transaction Dates

Date Sent

The date an electronic transaction is sent is the date reflected in the Interchange Control Header ISA Segment Interchange Date. This date is used to identify the health care provider, health care facility, or third party biller/assignee Date Sent for electronic medical bill transactions, the Acknowledgment Date for Claims

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Administrator 824 Detail Acknowledgment transactions, and the remittance date for Claims Administrator 835 Remittance Advice transactions.

Date Received

The Date Sent, the Interchange Control Header ISA Segment Interchange Date, is considered the Date Received for the purposes of electronic billing and reimbursement transactions, unless the receiver can show that the transmission was not received, was rejected, or the date the transmission was submitted is different than the Interchange Control Header ISA Segment Interchange Date. The Received Date is used to track timely processing of electronic medical bill transactions, electronic reconsideration/appeal transactions, acknowledgment transactions, and timeliness of payments.

Invoice Date

In the manual paper medical bill processing model, the paper bill included a date the bill was generated for timely filing purposes. The Invoice Date is the Date Sent for electronic billing and is reflected in the Interchange Control Header ISA Segment Interchange Date.

Date Paid

The standard electronic formats and industry practices use the term Date Paid to represent the date the Claims Administrator paid or denied a medical bill, or acknowledged receipt of a refund. It is also referred to as the Claims Administrators "final action". Use of the term Date Paid in this context does not assume a dollar amount is paid.

The current implementation assumes the Date Paid is the Date Sent for ANSI 835 Remittance Advice. The coordination of the electronic Remittance transactions and paper checks or Electronic Funds transfer may affect the reported Date Paid in the IAIABC 837 format for State Medical EDI submissions.

Identifier Fields

Identifiers, such as the NDC numbers, Federal Employer Identification Number or Social Security Number should be transmitted without dashes or hyphens.

Phone numbers should be presented as a contiguous number string, without dashes or parenthesis markers. For example, the phone number (999) 555-1212 should be presented as 9995551212. Area codes should always be included.

Hierarchical Structure

For California workers' compensation, it is assumed that these formats are used to communicate information at the transaction level, with the exception of the 997 acknowledgment file. To that end, the parent/child hierarchical structure requires each file to contain the necessary hierarchical levels, parent/child qualifiers, and parent-child relationships. Each transmission must contain at least one Billing Provider (parent) with at least one Employer (child). Each Employer (parent) must contain at least one Injured Employee (child).

Beneath the hierarchical levels, the same logic applies to Injured Employees, bills, and lines. Each Injured Employee record must contain at least one bill transaction; each bill transaction must contain at least one detail line. The maximum number of bills and lines is determined by format standard.

Sample Hierarchical Structure

Hierarch. ID #	Parent Hierarch. ID #	Hierarchical Level Code	Description	Child Code
1	None	20 Billing/Pay to	1st Billing Provider	1

		Provider		
2	1	22 Subscriber	1st Employer of 1st Billing Provider	1
3	2	23 Patient	1st Injured Employee of 1st Employer of 1st Billing Provider	0
4	2	23	2nd Injured Employee of 1st Employer of 1st Billing Provider	0
5	2	23	3rd Injured Employee of 1st Employer of 1st Billing Provider	0
6	1	22	2nd Employer of 1st Billing Provider	1
7	6	23	1st Injured Employee of 2nd Employer of 1st Billing Provider	0
8	6	23	2nd Injured Employee of 2nd Employer of 1st Billing Provider	0
9	1	22	3rd Employer of 1st Billing Provider	1
10	9	23	1st Injured Employee of 3rd Employer of 1st Billing Provider	0
11	None	20	2nd Billing Provider	1
12	11	22	1st Employer of 2nd Billing Provider	1
13	12	23	1st Injured Employee of 1st Employer of 2nd Billing Provider	0
14	12	23	2nd Injured Employee of 1st Employer of 2nd Billing Provider	0

Code Sets

Code sets utilized in electronic billing and reimbursement and other ancillary processes are prescribed by the applicable national standard implementation guide and Division's Medical Billing and Payment Guide. Participants are required to utilize current, valid codes based on the date the service or process occurred (i.e. medical service, payment/denial processing, etc.).

The current implementation of electronic billing and reimbursement processes for workers' compensation may utilize jurisdiction and/or workers' compensation specific values that are not present in national standard code sets. The IAIABC is coordinating efforts to update national standard implementation guides and code sets to address workers' compensation industry needs. Until such time as these jurisdiction or workers' compensation codes are added to national standard code sets, the definition and use of these codes shall be in accordance with this companion guide.

Reference Appendix I Code Set Matrix for a comprehensive list of code sets used in the workers' compensation implementation of electronic billing and reimbursement processes.

Claim Resubmission Code - ANSI 837 Billing Formats

The Division prescribes the use of codes 07 Duplicate Bill, 15 Revised Bill, and code 30 Appeal/Reconsideration in the Claim Frequency Type Code to indicate the bill is a resubmission transaction. The value is populated in Loop 2300 Claim Information CLM Health Claim Segment of ANSI 837 billing formats. The prescribed values below are required in field CLM19 Bill Submission Reason Code and indicate the category of resubmission when CLM05-3 Claim Frequency Type is populated with code 7 to indicate the bill transaction is a resubmission.

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Duplicate Bill Transactions

Duplicate bill, 07, transactions shall be submitted no earlier than thirty (30) working days after the Claims Administrator has acknowledged receipt of a complete electronic bill transaction and prior to receipt of an ANSI 835 Remittance transaction. The 07 bill must use the same bill identification numbers as the original transaction.

Duplicate bills shall contain all the same information as the original bill including the same bill identification numbers as the original transaction. No new dates of service or itemized services may be included.

The Claims Administrator may reject a bill transaction with a 07 indicator if (1) the 07 bill is received within thirty (30) working days after acknowledgment, (2) the bill has been processed and an 835 transaction has been generated, or (3) the Claims Administrator does not have a corresponding accepted original transaction with the same bill identification numbers. If the Claims Administrator does not reject the 07 bill transaction within one business day, the 07 bill transaction may be denied for the reasons listed above through the use of an 835 Remittance transaction.

Revised Bill Transactions

When there is an error or a need to make a coding correction, a revised bill may be submitted to replace a previously submitted bill. Revised bills shall be marked as revised, code 15 in the field designated for that information. Revised bills shall include the original dates of service and the same itemized services rendered as the original bill. No new dates of service may be included.

The bill transaction with a 15 resubmission code indicator must use the same bill identification numbers as the original transaction.

The Claims Administrator may reject a revised bill transaction with a code 15 indicator if (1) the bill has been processed and an ANSI 835 transaction has been generated, or (2) the Claims Administrator does not have a corresponding accepted original transaction with the same bill identification numbers. If the Claims Administrator does not reject the revised bill transaction within one business day, the revised bill (15) transaction may be denied for the reasons listed above through the use of an 835 Remittance transaction.

Appeal/Reconsideration Bill Transactions

Appeal/Reconsideration bill transactions may be submitted after receipt of an ANSI 835 Remittance transaction for the corresponding accepted original bill. The same bill identification number is to be used on both the original and appeal reconsideration bill to associate the transactions. All elements, fields, and values in the appeal/reconsideration bill transaction, except the code 30 qualifier, must be the same as the original bill transaction.

The Claims Administrator may reject a bill transaction with an 30 indicator if (1) the bill information does not match the corresponding original bill transaction, (2) the Claims Administrator does not have a corresponding accepted original transaction, (3) the original bill transaction has not been completed (no corresponding ANSI 835 Remittance transaction). Corresponding documentation related to appeals/reconsideration is required in accordance with the rules for initial bill submission.. The Claims Administrator may deny appeal/ reconsideration bill transactions for missing documentation. If the Claims Administrator does not reject the appeal/reconsideration bill transaction within two business days because it's incomplete, the bill transaction may be denied for the reasons listed above through the use of an ANSI 835 Remittance transaction. The Claims Administrator may also deny the appeal/reconsideration bill transaction through the use of an ANSI 835 Remittance transaction if the documentation is not submitted within the required time frame.

Balance Forward Billing

Balance forward billing is not permissible. Balance forward bills are bills that include a balance carried over from a previous bill along with additional services.

Participant Roles

Roles in the HIPAA implementation of the national standard implementation guides are generally the same in workers' compensation. The Employer, Insured, Injured Employee and Patient are the roles that are used differently in workers' compensation and are addressed later in this section.

Trading Partner

Trading Partners are entities that have established EDI relationships and exchange information electronically in standard or mutually agreed upon formats. Trading Partners are both Senders and Receivers depending on the electronic process (i.e. Billing v. Acknowledgment).

Sender

A Sender is the entity submitting a transmission to the receiver, or the Trading Partner. The health care provider, health care facility, or third-party biller/assignee, is the Sender in the electronic billing process. The Claims Administrator, or their agent, is the Sender in the electronic acknowledgment or remittance processes.

Receiver

A Receiver is the entity that accepts a transmission submitted by a Sender. The health care provider, health care facility, or third-party biller/assignee, is the Receiver in the electronic acknowledgment or remittance processes. The Claims Administrator, or their agent, is the Receiver in the electronic billing process.

Employer

The Employer, as the policyholder of the workers' compensation coverage, is the Subscriber in the workers' compensation implementation of the HIPAA electronic billing and reimbursement formats.

Subscriber

The Subscriber is the individual or entity that purchases or is covered by a policy. In this implementation, the workers' compensation policy is obtained by the Employer, who is considered the Subscriber.

Insured

The Insured is the group or individual to whom the insurance policy covers. In managed care, the Insured may be the patient, the patient's employer, or a group health plan. In this implementation, the Employer is considered the Insured entity.

Injured Employee

The Injured Employee is always considered to be the Patient. In managed care, there are many relationships a Patient may have to the insured. For example, the Patient may be the child, spouse, or employee of the Insured. In this implementation, only the Injured Worker is considered to be the Patient.

Patient

The Patient is considered the Injured Employee in the workers' compensation implementation of electronic billing and reimbursement processes.

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Health Care Provider, Health Care Facility, or Third-Party Biller/Assignee Role/Identification Numbers

Billing Provider

The Billing Provider is the individual or entity submitting the electronic medical bill transaction and to whom payment should be made. When the Billing Provider is the same individual or entity as the Rendering Provider, the Rendering Provider information may be omitted.

Pay to Provider

The Pay to Provider is the individual or entity that receives payment for the services included in the electronic medical bill transaction. The Pay to Provider information is only populated when the individual or entity receiving payment is different than the individual or entity identified in the Billing Provider information.

Rendering Provider

The Rendering Provider is the individual or entity that provided the services included in the electronic medical bill transaction. California workers' compensation requirements mandate that the Rendering Provider is the licensed health care provider who provided the services or the licensed health care provider supervising the non-licensed health care provider who provided the service. When the Billing Provider is the same individual or entity as the Rendering Provider, the Provider information may be populated in the Billing Provider Loop and the Rendering Provider Loop may be omitted.

Attending Provider

The Attending Provider is a term used for hospital billing and represents the provider that is responsible for the care of a patient in a hospital setting. The Attending Provider may be the Billing, Rendering, or Referring Provider based on the billing transaction and role.

Referring Provider

The Referring Provider is the Provider directing care (i.e. the treating doctor), or another Provider providing treatment to the Injured Employee, who referred the Injured Employee to the Provider of the services included in the electronic medical bill transaction.

Supervising Provider

The Supervising Provider is the Provider who supervised the rendering of a service included in the electronic medical bill. In the workers' compensation implementation, the Supervising Provider is used when one licensed health care provider is supervised by a different licensed health care provider, for example an anesthesiologist supervising a Certified Registered Nurse Anesthetist (CRNA). When a licensed health care provider is supervising a non-licensed health care provider, the supervising provider is considered the Rendering Provider.

Facility

The Facility is the laboratory, facility, or location where the services were rendered or took place.

Dispensing Pharmacy

The Dispensing Pharmacy is the pharmacy or mail order pharmacy that provided the medications or supplies included in the electronic pharmacy bill transaction.

Prescribing Physician

The Prescribing Physician is the Provider responsible for determining the medical necessity and prescribing the medications or supplies provided by the Dispensing Pharmacy. The Prescribing Physician is considered the Referring Provider for electronic pharmacy bill transactions.

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Home Health Care

A Home Health Care Provider is an organization and is considered the Billing Provider for electronic billing purposes. Home health care is billed using the UB-04 paper billing form or in the ANSI 837 Institutional electronic billing format. The licensed primary physician responsible on a Home Health Agency Plan of Treatment is reported as the Attending Physician in the ANSI 837 Institutional electronic billing format. The individual or organization that rendered the care to the Injured Employee is reported as the Other Provider for Home Health Care services in the ANSI 837 Institutional electronic billing format, when the individual is different than Billing Provider. The licensed Provider rendering the home health service, or the licensed individual supervising an unlicensed Provider rendering the home health service, is considered the Other Provider

Bill v. Line Providers

The providers listed above are identified as providers responsible for all services included in the electronic bill transaction. National standard formats, paper billing forms, and CMS policies allow for health care providers, health care facilities, or third party biller/assignees to be identified at the Bill Level as well as the Line Level. Bill level Health Care Providers are assumed to have provided all services identified at the line level unless Line Level Providers are identified in the electronic bill transaction.

National Provider Identification Number

The Centers for Medicare and Medicaid Services (CMS) administers the National Provider Identification Number (NPI). The NPI is used as the unique provider identifier in standard electronic health transactions. The NPI replaces national (i.e. Medicare number, Universal Provider Identification Number-UPIN) and proprietary health plan identification numbers. It is a HIPAA requirement and is required for California workers' compensation medical billing as prescribed by the Division.

State License Number

State License Numbers are administered by each state licensing or certifying board. California workers' compensation requires state license numbers for all electronic billing transactions. When a health care provider, health care facility, or third party biller/assignee does not have a State License Number, the field is submitted with the Provider Type Prefix Code and the Jurisdiction where the services were rendered.. Currently the State License Number is submitted as three separate components in one field, Provider Type Prefix Code + State License Number + Jurisdiction Issuing State License.

NCPDP Number

The National Council for Prescription Drug Programs (NCPDP) administers the unique identification number for mail order and free-standing pharmacies. Formerly administered by the National Association of Pharmacy Boards (NABP), the identifier previously referred to as the NABP number is the NCPDP number.

DEA Number

The Drug Enforcement Administration (DEA) assigns a registration number to physicians related to prescribing controlled substances. The DEA number is currently used as an identification number to identify the Prescribing Physician on pharmacy bills. California workers' compensation requires the DEA number to be submitted in electronic pharmacy billing transactions in addition to the NPI number for Provider identification.

Medicare Number

The Medicare Number is an identification number administered by CMS to identify hospitals and similar entities for statistical research and reimbursement purposes. The Medicare Number is replaced by the NPI for managed care and Medicare billing processes in 2007 and for California workers' compensation as described in the Medical Billing and Payment Guide.

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Taxonomy Code

The Healthcare Provider Taxonomy Codes (HPTC) set is a data code set designed for use in classifying health care providers, health care facilities, or third party biller/assignees according to Provider type or practitioner specialty. Taxonomy codes apply to both individuals and organizations or facilities.

California Workers' Compensation Specific Requirements

The requirements in this section identify California workers' compensation specific requirements that apply to more than one electronic format. Requirements that are related to a specific format are identified in the chapter related to that format.

ANSI HIPAA Electronic File Formats

The directions for the elements identified below apply to multiple or all ANSI HIPAA electronic file formats.

Claim Filing Indicator

The Claim Filing Indicator in Loop 2000B Subscriber Information SBR Subscriber Information Segment field SBR09 Claim Filing Indicator Code is populated as WC, Workers' Compensation Health Claim, for California workers' compensation electronic billing transactions using the ANSI 837 formats.

Transaction Set Purpose Code

The Transaction Set Purpose Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction Segment field BHT02 in ANSI 837 formats is designated as 00 Original. Claims Administrators are required to acknowledge acceptance or rejection of transmissions (files) and transactions (bills). Transmissions that are rejected by the Claims Administrator are corrected by the health care provider, health care facility, or third party biller/assignee and are submitted, after correction, as 00 Original transmissions.

Transaction Type Code

The Transaction Type Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction Segment field BHT06 in ANSI 837 formats is designated as CH Chargeable. Currently, there is not a requirement for health care providers, health care facilities, or third party biller/assignees to report electronic medical billing data to the Division. Therefore, code RP Reporting is not appropriate for this implementation.

FEIN/NPI

The FEIN is populated in the NM1 Individual or Organizational Name Segment; field NM109, with the appropriate qualifier in field NM108 when required. When the entity is a health care provider, health care facility, or third party biller/assignee, the NPI is populated in the NM1 Segment and the FEIN is populated in the associate REF Reference Identification Segment with the appropriate qualifier. This logic follows the HIPAA implementation guide usage of the FEIN and NPI fields.

State License Numbers

Current medical bill data reported to the Division contains state license information. In order to continue analysis of medical bill data, the Division will continue to collect the state license in the current defined format. The state license and NPI are required for electronic billing transactions. When no license is available, for example for provider types who are not licensed by the state, the state license field is submitted with the appropriate Provider Type Prefix followed by the Jurisdiction. Where the services were rendered. The license value is omitted.

NCPDP Telecommunication Standard 5.1 Pharmacy Formats

Issues related to electronic pharmacy billing transactions are addressed in Chapter 7. The chapter addresses both the NCPDP 5.1 and the ANSI 837 Pharmacy format.

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All Electronic Formats

Referring Provider

The Referring Provider information is a Situational (S) requirement in the HIPAA and workers' compensation implementations of electronic billing. California workers' compensation requirements define the conditions for populating the Referring Provider as (1) mandatory when the service involved a referral and (2) when the services were performed and billed at an Ambulatory Surgery Center (ASC) or Hospital Out Patient Department. The Referring Provider for ASC services is the operating physician. The Referring Provider for pharmacy services is the prescribing physician.

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Chapter 5 Companion Guide 837 Professional

This companion guide for the ANSI 837 Professional Healthcare Claim transaction has been created for use in conjunction with the *ANSI ASC X12N 837 Professional Healthcare Claim Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N 837 Professional Healthcare Claim Implementation Guide*, but rather used as an additional source of information. Wherever the national standard differs from the California rules, the California rules prevail.

Directions on California specific requirements are provided in Appendix A of Section One of the Medical Billing and Payment Guide. When California and workers' compensation specific usage is different than the HIPAA implementation it is identified in the HIPAA/Workers' Compensation Gap Analysis, also in Chapter 4 in this companion guide.

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 837 Professional Healthcare Claim transaction is available through the Washington Publishing Company, www.wpc-edi.com. The California workers' compensation direction for the use of the ANSI 837 Professional Implementation Guide is below.

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Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
TS	**Transaction Set**										
TS	**ST**	**R**	**R**		**1**	**Transaction Set Header**					
	ST01	R	R			3	ID	837		Transaction Set Identifier Code	
	ST02	R	R			4/9	AN			Transaction Set Control Number	
TS	**BHT**	**R**	**R**		**1**	**Beginning of Hierarchical Transaction**					
	BHT01	R	R			4	ID	0019		Hierarchical Structure Code	
	BHT02	R	R			2	ID	00		Transaction Set Purpose Code	
	BHT03	R	R			1/30	AN			Originator Transaction Identifier	
	BHT04	R	R			8	DT			Transaction Set Creation Date	
	BHT05	R	R			4/8	TM			Transaction Set Creation Time	
	BHT06	R	R			2	ID	CH		Claim or Encounter Indicator	
TS	**REF**	**R**	**R**		**1**	**Transmission Type Identification**					
	REF01	R	R			2/3	ID	87		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Type Code 004010X098A1	
1000A	**Sender Information**										
1000A	**NM1**	**R**	**R**		**1**	**Submitter Name**					
	NM101	R	R			2/3	ID	41		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								2		Non Person Entity- (Company Name)	
	NM103	R	R			1/35	AN			Organization Name (Company Name)	
	NM108	R	R			2	ID	46		Identification Code Qualifier (ETIN)	
	NM109	R	R			2/80	AN			Identification Code	
1000A	**PER**	**R**	**R**		**2**	**Contact Information**					
	PER01	R	R			2	ID	IC		Contact Function Code	
	PER02	R	R			1/60	AN			Contact Name	
	PER03	R	R			2	ID	TE		Communication Number Qualifier	
	PER04	R	R			1/80	AN			Telephone Number	
	PER05	S	S			2	ID			Communication Number Qualifier	
										Use at the discretion of the submitter	
	PER06	S	S			1/80	AN			Communication Number	
	PER07	S	S			2	ID			Communication Number Qualifier	
										Use at the discretion of the submitter	
	PER08	S	S			1/80	AN			Communication Number	
1000B	**Receiver Information**										
1000B	**NM1**	**R**	**R**		**1**	**Receiver Name**					
	NM101	R	R			2/3	ID	40		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								2		Non Person Entity- (Company Name)	
	NM103	R	R			1/35	AN			Organization Name (Company)	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	NM108	R	R			2	ID	46		Identification Code Qualifier (ETIN)	
	NM109	R	R			2/80	AN			Identification Code	
2000A	**Billing/Pay-to Provider Hierarchical Level (Repeat >1)**										
2000A	**HL**	**R**	**R**		**1**	**Hierarchical Level**					
	HL01	R	R			12	AN			Hierarchical ID Number	
	HL03	R	R			2	ID	20		Hierarchical Level Code	
	HL04	R	R			1	ID	1		Hierarchical Child Code	
2000A	**PRV**	**S**	**J**		**1**	**Provider Taxonomy Code**					
						Required for California and Texas					
	PRV01	R	R			2	ID			Provider Code	
								BI		BI=Billing	
	PRV02	R	R			2/3	ID	ZZ		Reference Identification Code	
	PRV03	R	R			1/30	AN		10d	Provider Specialty Code	
2010AA	**Billing Provider Information**										
2010AA	**NM1**	**R**	**R**		**1**	**Billing Provider Name**					
	NM101	R	R			2	ID	85		Entity Identifier Code (Billing Provider)	
	NM102	R	R			1	ID			Entity Type Qualifier	
								1		Person	
								2		Company	
	NM103	R	R			1/35	AN		33	Last Name or Organization Name	
	NM104	S	S			1/25	AN		33	First	
	NM105	S	S			1/25	AN		33	Middle	
	NM107	S	S			1/10	AN		33	Suffix	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
									33a	National Provider Identifier (NPI) =XX	
										If billing entity is a non health care provider (non NPI number) then NM108 Code Qualifier 24 or 34 is required	
										TAX ID Code Qualifiers	
								24		Employer's Identification Number	
								34		Social Security Number	
	NM109	R	R			2/80	AN		25 or 33a	Identification Code 25 - Employer's Identification Number (FEIN) 33a - National Provider Identifier (NPI)	
2010AA	**N3**	**R**	**R**		**1**	**Address**					
	N301	R	R			1/55	AN		33	Address Line	
	N302	S	S			1/55	AN		33	Address Line 2	
2010AA	**N4**	**R**	**R**		**1**	**City State Zip**					
	N401	R	R			2/30	AN		33	City	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	N402	R	R			2	ID		33	State	
	N403	R	R			3/15	ID		33	Zip	
	N404	S	S			2/3	ID			Country Code	
2010AA	**REF**	**S**	**S**		**1**	**Tax ID**					
						Required segment when NPI Identifier Code XX is present in NM109					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								EI		Federal Tax ID	
								SY		Social Security Number	
	REF02	R	R			1/30	AN		25	TAX ID or SSN	
2010AA	**REF**	**S**	**J**		**1**	**State License**					
						California and Texas required field when billing entity is a health care provider.					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		33b	State License Number	
2010AA	**PER**	**S**	**S**		**2**	**Contact Information**					
						Required if this information is different than that contained in Loop 1000A Submitter PER segment					
	PER01	R	R			2	ID	IC		Contact Function Code	
	PER02	R	R			1/60	AN		33	Contact Name	
	PER03	R	R			2	ID	TE		Communication Number Qualifier	
	PER04	R	R			1/80	AN		33	Telephone Number	
	PER05	S	S			2	ID			Communication Number Qualifier	
										Use at the discretion of the billing provider	
	PER06	S	S			1/80	AN			Communication Number	
	PER07	S	S			2	ID			Communication Number Qualifier	
										Use at the discretion of the billing provider	
	PER08	S	S			1/80	AN			Communication Number	
2010AB	**Pay-to Provider Information (Use if pay-to is different from billing)**										
2010AB	**NM1**	**S**	**S**		**1**	**Pay-to Provider Name**					
						Required if the Pay-to Provider is a different entity than the Billing Provider					
	NM101	R	R			2	ID	87		Entity Identifier Code (Pay-to Provider)	
	NM102	R	R			1	ID			Entity Type Qualifier	
								1		Person	
								2		Non-Entity Person (Company)	
	NM103	R	R			1/35	AN			Last Name or Organization Name	
	NM104	S	S			1/25	AN			First	
	NM105	S	S			1/25	AN			Middle	
	NM108	S	S			2	ID	XX		Identification Code Qualifier	
										National Provider Identifier (NPI) =XX	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
										If billing entity is a non health care provider (non NPI number) then NM108 Code Qualifier 24 or 34 is required	
										TAX ID Code Qualifiers	
								24		Employer's Identification Number	
								34		Social Security Number	
	NM109	S	S			2/80	AN			Identification Code	
2010AB	**N3**	**R**	**R**		**1**	**Address**					
	N301	R	R			1/55	AN			Address Line	
	N302	S	S			1/55	AN			Address Line	
2010AB	**N4**	**R**	**R**		**1**	**City State Zip**					
	N401	R	R			2/30	AN			City	
	N402	R	R			2	ID			State	
	N403	R	R			3/15	ID			Zip	
	N404	S	S			2/3	ID			Country Code	
2010AB	**REF**	**S**	**S**		**1**	**Tax ID**					
						Required segment when NPI Identifier Code XX is present in NM109					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								EI		Federal Tax ID	
								SY		Social Security Number	
	REF02	R	R			1/30	AN			TAX ID or SSN	
2010AB	**REF**	**S**	**J**		**1**	**State License**					
						California and Texas Required Field when billing entity is a health care provider.					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			State License Number	
2000B	**Subscriber Detail (Repeat > 1) Workers' Compensation Subscriber is Employer**										
2000B	**HL**	**R**	**R**		**1**	**Subscriber (Employer) Hierarchical Level**					
	HL01	R	R			1/12	AN			Hierarchical ID Number	
	HL02	R	R			1/12	AN			Hierarchical Parent ID Number	
	HL03	R	R			2	ID	22		Hierarchical Level Code	
	HL04	R	R			1	ID	1		Hierarchical Child Code	
2000B	**SBR**	**R**	**R**		**1**	**Subscriber (Employer) Information**					
	SBR01	R	R			1	ID	P		P for Primary Payer	
	SBR03	S	S			1/30	AN			WC Policy Number, If Available	
	SBR04	S	S			1/60	AN		11b	Employer Name / Department / Division	
	SBR09	S	J			1/2	ID	WC	1	Claim Filing Indicator Code: California and Texas Requirement	
2010BA	**Subscriber Information (Insured) Workers' Compensation Insured is Employer**										

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
2010BA	**NM1**	**R**	**R**		**1**	**Subscriber Name**					
	NM101	R	R			2	ID	IL		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								2		Non Person Entity	
	NM103	R	R			1/35	AN		4	Organization Name (Employer Name)	
2010BA	**N3**	**S**	**J**		**1**	**Address**					
						California and Texas Required Field					
	N301	R	R			1/55	AN		7	Address	
	N302	S	S			1/55	AN		7	Address	
2010BA	**N4**	**S**	**J**		**1**	**City State Zip**					
						California and Texas Required Field					
	N401	R	R			2/30	AN		7	City	
	N402	R	R			2	ID		7	State	
	N403	R	R			3/15	ID		7	Zip	
	N404	S	S			2/3	ID			Country Code	
2010BB	**Payer Information**			**Repeat 1**							
2010BB	**NM1**	**R**	**R**		**1**	**Payer Name**					
	NM101	R	R			2/3	ID	PR		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								2		Non Person Entity	
	NM103	R	R			1/35	AN		11c	The Payer Name	
	NM108	R	R			2	ID	PI		Identification Code Qualifier	
										Payer Identification Code is defined in the ISA Segment as well as specified in the Trading Partner Agreement	
	NM109	R	R			2/80	AN			Payer Identification Code	
2010BB	**N3**	**S**	**S**		**1**	**Address**					
						Payer Address is required when the submitter intends for the bill to be printed on paper at the next EDI location, e.g., a clearinghouse	
	N301	R	R			1/55	AN			Address	
	N302	S	S			1/55	AN			Address	
2010BB	**N4**	**S**	**S**		**1**	**City State Zip**					
						Payer Address is required when the submitter intends for the bill to be printed on paper at the next EDI location)e.g., a clearinghouse	
	N401	R	R			2/30	AN			City	
	N402	R	R			2	ID			State	
	N403	R	R			3/15	ID			Zip	
	N404	S	S			2/3	ID			Country Code	
2000C	**Patient Hierarchical Level (Repeat >1)**										
2000C	**HL**	**S**	**J**			**Patient Hierarchical Level**					

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
						This HL is required when the patient is different person than the subscriber. The Employer is the Subscriber in Workers' Compensation					
	HL01	R	R			12	AN			Hierarchical ID Number	
	HL02	R	R			12	AN			Hierarchical Parent ID Number	
	HL03	R	R			2	ID	23		Hierarchical Level Code	
	HL04	R	R			1	ID	0		Hierarchical Child Code	
2000C	**PAT**	**R**	**R**		**1**	**Patient Information**					
	PAT01	R	R			2	ID	20	6	Patients Relationship to Insured	
2010CA	**Patient Information**										
2010CA	**NM1**	**R**	**R**		**1**	**Patient Name**					
	NM101	R	R			2	ID	QC		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								1		Person	
	NM103	R	R			1/35	AN		2	Last Name	
	NM104	R	R			1/25	AN		2	First Name	
	NM105	S	S			1/25	AN		2	Middle Name	
	NM107	S	S			1/10	AN			Name Suffix	
	NM108	R	R			2	ID	MI		Identification Code Qualifier	
	NM109	R	R			2/80	AN		1a	Social Security Number	
2010CA	**N3**	**R**	**R**		**1**	**Address**					
	N301	R	R			1/55	AN		5	Address	
	N302	S	S			1/55	AN		5	Address	
2010CA	**N4**	**R**	**R**		**1**	**City State Zip**					
	N401	R	R			2/30	AN		5	City	
	N402	R	R			2	ID		5	State	
	N403	R	R			3/15	ID		5	Zip	
	N404	S	S			2/3	ID			Country Code	
2010CA	**DMG**	**R**	**R**		**1**	**Demographic Information**					
	DMG01	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DMG02	R	R			1/35	AN		3	Birth Date	
	DMG03	R	R			1	ID		3b	Gender Code	
2010CA	**REF**	**S**	**S**		**1**	**Property & Casualty Claim Number**					
						Required if Claim Number is Known					
	REF01	R	R			2/3	ID	Y4		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		11	Workers' Compensation Claim Number	
2300	**Claim Information (Repeat 100)**										
2300	**CLM**	**R**	**R**		**1**	**Claim Information**					
	CLM01	R	R			1/38	AN		26	Claim Submitter Identifier (Provider Unique Bill Identification Number)	
	CLM02	R	R			1/18	R		28	Monetary Amount (Total Claim Charge Amount)	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	CLM05-1	R	R			1/2	ID		24b	Facility Code Value (Facility Type Code)	
	CLM05-3	R	R			1	ID		22	Bill Resubmission Code	
	CLM06	R	R			1	ID	Y/N	31	Provider Signature on File	
	CLM07	R	R			1	ID	A	27	Enter value "A" to indicate provider acceptance of assignment	
	CLM08	R	R			1	ID	N	13	Benefit Assignment Indicator	
	CLM09	R	R			1	ID	I	12	Release of Information Code	
	CLM10	S	S			1	ID			Patient Signature Source Code	
	CLM11	S	S				ID			Related Causes Information	
	CLM11-1	R	R			2/3	ID	EM	10a	Related Causes Code 1 EM= Employment	
	CLM11-2	S	S			2/3	ID		10b	Related Causes Code 2	
	CLM11-3	S	S			2/3	ID		10c	Related Causes Code 3	
	CLM11-4	S	S			2/2	ID		10b	State or Province Code	
	CLM11-5	S	S			2/3	ID			Country Code	
	CLM19	N	J			2/2	ID		22	Claims Submission Reason Codes	
								7		Duplicate Bill	
								15		Revised Bill	
								30		Appeal/Reconsideration	
2300	**DTP**	**S**	**S**		**10**	**Date Onset of Similar Symptoms or Illness**					
	DTP01	R	R			3	ID	438		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		15	Onset of Similar Symptoms or Illness	
2300	**DTP**	**S**	**J**		**1**	**Date of Accident (Date of Injury or Illness)**					
						California and Texas Requirement					
	DTP01	R	R			3	ID	439		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		14	Accident Date	
2300	**DTP**	**S**	**S**		**5**	**Disability Begin Date**					
	DTP01	R	R			3	ID	360		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		16	Disability Begin	
2300	**DTP**	**S**	**S**		**5**	**Disability End Date**					
	DTP01	R	R			3	ID	361		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		16	Disability End	
2300	**DTP**	**S**	**S**		**1**	**Date of Admission**					
	DTP01	R	R			3	ID	435		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	

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	DTP03	R	R			1/35	AN		18	Admission Date	
2300	**DTP**	**S**	**S**		**1**	**Date of Discharge**					
	DTP01	R	R			3	ID	096		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		18	Discharge Date	
2300	**PWK**	**S**	**S**		**10**	**Paper Work (Attachment Reference)**					
	PWK01	R	R			2/2	ID		19	Report Type Code	
	PWK02	R	R			1/2	ID		19	Deliver type code	
	PWK05	S	R			2	ID	AC		Identification Code Qualifier	
	PWK06	S	R			2/80	AN		19	Attachment Control Number	
2300	**CN1**	**S**	**S**		**1**	**Contract Information**					
						Required if billing capitated services or contractually obligated to provide contract information on this bill					
	CN101	R	R			2	ID			Contract Type Code	
	CN102	R	R			1/18	R			Contract Amount	
2300	**AMT**	**S**	**S**		**1**	**Patient Amount Paid**					
	AMT01	R	R			2	ID	F5		Amount Qualifier Code	
	AMT02	R	R			1/18	R		29	Patient Amount Paid	
2300	**REF**	**S**	**S**		**2**	**Prior Authorization or Referral Number**					
	REF01	R	R			2/3	ID	G1	23	Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Prior Authorization Number	
2300	**REF**	**S**	**S**		**1**	**Clearing House Generated Tracking Number**					
	REF01	R	R			2/3	ID	D9		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Original Reference Number	
2300	**REF**	**S**	**S**		**1**	**Original Reference Number (ICN/DCN)**					
	REF01	R	R			2/3	ID	F8		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Original Reference Number-Payer's Unique Bill Identification Number	
2300	**NTE**	**S**	**S**		**1**	**Note/ Specific Instructions (Remarks)**					
	NTE01	R	R			3	ID			Note Reference Code	
	NTE02	R	R			1/80	AN		24	Note Text	
2300	**HI**	**S**	**S**		**1**	**Health Care Information Codes**					
	HI01	R	R						21.1	Principal Diagnosis 1	
	HI01-1	R	R			1/3	ID	BK		Code List Qualifier Code	
	HI01-2	R	R			1/30	AN			Code	
	HI02	S	S						21.2	Diagnosis 2	
	HI02-1	R	R			1/3	ID	BF		Code List Qualifier Code	
	HI02-2	R	R			1/30	AN			Code	
	HI03	S	S						21.3	Diagnosis 3	
	HI03-1	R	R			1/3	ID	BF		Code List Qualifier Code	
	HI03-2	R	R			1/30	AN			Code	
	HI04	S	S						21.4	Diagnosis 4	
	HI04-1	R	R			1/3	ID	BF		Code List Qualifier Code	

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	HI04-2	R	R			1/30	AN			Code	
2310A	**Referring Provider**										
2310A	**NM1**	**S**	**S**		**1**	**Referring Physician Name**					
						Required if claim involved a referral					
	NM101	R	R			2	ID	DN		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								1		Person	
								2		Non- Person Entity	
	NM103	R	R			1/35	AN		17	Last Name or Organization Name	
	NM104	S	S			1/25	AN		17	First Name	
	NM105	S	S			1/25	AN		17	Middle Name	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
	NM109	R	R			2/80	AN		17b	National Provider Identifier	
2310A	**PRV**	**S**	**S**		**1**	**Provider Specialty Code**					
	PRV01	R	R			2	ID	RF		Provider Code (Referring)	
	PRV02	R	R			2/3	ID	ZZ		Reference Identification Qualifier	
	PRV03	R	R			1/30	AN			Taxonomy code	
2310A	**REF**	**S**	**J**		**1**	**State License Number**					
						Required Field for California					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		17a	State License	
2310B	**Rendering Provider**										
2310B	**NM1**	**S**	**S**		**1**	**Rendering Physician Name**					
						Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively					
	NM101	R	R			2	ID	82		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								1		Person	
								2		Non- Person Entity (Company)	
	NM103	R	R			1/35	AN		31	Last Name or Organization Name	
	NM104	S	S			1/25	AN		31	First Name	
	NM105	S	S			1/25	AN		31	Middle Name	
	NM107	S	S			1/10	AN		31	Name Suffix	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
	NM109	R	R			2/80	AN		33a	National Provider Identifier (Non Shaded Area)	
2310B	**PRV**	**S**	**S**		**1**	**Provider Specialty Code**					
											Red Change
	PRV01	R	R			2	ID	PE		Provider Code (performing)	
	PRV02	R	R			2/3	ID	ZZ		Reference Identification Qualifier	
	PRV03	R	R			1/30	AN			Taxonomy Code	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
2310B	**REF**	**S**	**J**		**1**	**State License Number**					
											RED CHANGE
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		33b	State License Number (Shaded Area)	
										Jurisdiction specific requirement	RedChange
2310D	**Facility / Service location**										
2310D	**NM1**	**S**	**S**		**1**	**Name**					
						This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay to Provider) loops					
	NM101	R	R			2/3	ID			Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								2		Non-Person Entity (Laboratory/Facility Name)	
	NM103	S	R			1/35	AN		32	Organization Name	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
	NM109	R	R			2/80	AN		32a	National Provider Identifier	
2310D	**N3**	**R**	**R**		**1**	**Address**					
	N301	R	R			1/55	AN		32	Address	
	N302	S	S			1/55	AN		32	Address	
2310D	**N4**	**R**	**R**		**1**	**City State Zip**					
	N401	R	R			2/30	AN		32	City	
	N402	R	R			2	ID		32	State	
	N403	R	R			3/15	ID		32	Zip	
	N404	S	S			2/3	ID			Country Code	
2310D	**REF**	**S**	**J**		**1**	**State License Number**					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		32b	Service Facility State License Number	
										Jurisdiction specific requirement; California requires State License Number when Service Facility is a health care provider.	
2320	**Other Subscriber Information (repeat max 10)**										
	The 2320 and 2330 loops are required if there has been a prior payment by a payer other than the employer's insurer										
2320	**SBR**	**S**	**S**		**1**	**Other Subscriber Information**					
	SBR01	R	R			1	ID			Payer Responsibility Sequence Code	
								P		Primary	
								S		Secondary	
								T		Tertiary	
	SBR02	R	R			2/2	ID			Individual Relationship Code	
	SBR03	S	S			1/30	AN			Group or Policy Number	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	SBR04	S	S			1/60	AN			Group or Plan Name	
	SBR05	R	R			1/3	ID			Insurance Type Code	
	SBR09	S	S			1/2	ID			Claim Filing Indicator Code	
2320	**CAS**	**S**	**S**		**5**	**Claim Level Adjustments**					
						Use if claim level adjustments have been made by the prior payer					
	CAS01	R	R			1/2	ID			Group code	
	CAS02	R	R			1/5	ID			Claim Adjustment Reason Code 1	
	CAS03	R	R			1/18	R			Adjustment Amount 1	
	CAS04	S	S			1/15	R			Adjustment Quantity 1	
	CAS05	S	S			1/5	ID			Claim Adjustment Reason Code 2	
	CAS06	S	S			1/18	R			Adjustment Amount 2	
	CAS07	S	S			1/15	R			Adjustment Quantity 2	
	CAS08	S	S			1/5	ID			Claim Adjustment Reason Code 3	
	CAS09	S	S			1/18	R			Adjustment Amount 3	
	CAS10	S	S			1/15	R			Adjustment Quantity 3	
	CAS11	S	S			1/5	ID			Claim Adjustment Reason Code 4	
	CAS12	S	S			1/18	R			Adjustment Amount 4	
	CAS13	S	S			1/15	R			Adjustment Quantity 4	
	CAS14	S	S			1/5	ID			Claim Adjustment Reason Code 5	
	CAS15	S	S			1/18	R			Adjustment Amount 5	
	CAS16	S	S			1/15	R			Adjustment Quantity 5	
	CAS17	S	S			1/5	ID			Claim Adjustment Reason Code 6	
	CAS18	S	S			1/18	R			Adjustment Amount 6	
	CAS19	S	S			1/15	R			Adjustment Quantity 6	
2320	**AMT**	**S**	**S**		**1**	**Coordination of Benefits (COB) Payer Paid Amount**					
	AMT01	R	R			2	ID	D		Amount Qualifier Code	
	AMT02	R	R			1/18	R			Patient Amount Paid	
2320	**AMT**	**S**	**S**		**1**	**Coordination of Benefits (COB) Patient Paid Amount**					
	AMT01	R	R			2	ID	F5		Amount Qualifier Code	
	AMT02	R	R			1/18	R			Patient Amount Paid	
2330A	**Other Subscriber Name**										
2330A	**NM1**	**R**	**R**		**1**	**Other Subscriber Name**					
						Required when Loop ID 2320-Other Subscriber Information is used. Otherwise, this loop is not used					
	NM101	R	R			2	ID	IL		Entity Identifier Code (Insured or Subscriber)	
	NM102	R	R			1	ID			Entity Type Qualifier	
								1		Person	
								2		Non- Peson Entity (Company)	
	NM103	R	R			1/35	AN			Last Name or Organization Name	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	NM104	S	S			1/25	AN			First	
	NM105	S	S			1/25	AN			Middle	
	NM108	R	R			2	ID	MI		Member Identification Number	
	NM109	R	R			2/80	AN			Other Subscriber Primary Identification	
2330A	**N3**	**S**	**S**		**1**	**Address**					
						Required when available					
	N301	R	R			1/55	AN			Address Line	
	N302	S	S			1/55	AN			Address Line	
2330A	**N4**	**S**	**S**		**1**	**City State Zip**					
						Required when available					
	N401	R	R			2/30	AN			City	
	N402	R	R			2	ID			State	
	N403	R	R			3/15	ID			Zip	
	N404	S	S			2/3	ID			Country Code	
2330A	**REF**	**S**	**S**		**3**	**Other Subscriber Secondary Identification Number**					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Reference Identification	
2330B	**Other Payer Name**										
2330B	**NM1**	**R**	**R**		**1**	**Other Payer Name**					
						Required when Loop ID 2320-Other Subscriber Information is used. Otherwise, this loop is not used					
	NM101	R	R			2	ID	PR		Entity Identifier Code (Payer)	
	NM102	R	R			1	ID			Entity Type Qualifier	
								2		Non- Person Entity (Company)	
	NM103	R	R			1/35	AN			Organization Name (Company)	
	NM108	R	R			2	ID	PI		Payer Identification Code Qualifier	
	NM109	R	R			2/80	AN			Other Payer Primary Identification	
2330B	**PER**	**S**	**S**		**2**	**Contact Information**					
	PER01	R	R			2	ID	IC		Contact Function Code	
	PER02	R	R			1/60	AN			Contact Name	
	PER03	R	R			2	ID	TE		Communication Number Qualifier	
	PER04	R	R			1/80	AN			Telephone Number	
	PER05	S	S			2	ID			Communication Number Qualifier	
										Use at the discretion of the billing provider	
	PER06	S	S			1/80	AN			Communication Number	
	PER07	S	S			2	ID			Communication Number Qualifier	
										Use at the discretion of the billing provider	
	PER08	S	S			1/80	AN			Communication Number	
2330B	**DTP**	**S**	**S**		**1**	**Claim Adjudication Date**					
						Required if available, this is the date of the prior payment					

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	DTP01	R	R			3	ID	573		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN			Date Claim Paid	
2330B	**REF**	**S**	**S**		**2**	**Other Payer Secondary Identification**					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								2U		Payer Identification Number	
								F8		Payer's Claim Number	
								FY		Claim Office Number	
								NF		National Association of Insurance Commissioners (NAIC) Code	
								TJ		Federal Taxpayer's Identification Number	
	REF02	R	R			1/30	AN			Other Payer Secondary Identifier	
2400	**Service Lines (Repeat Max 50)**										
2400	**LX**	**R**	**R**		**1**	**Service Line Number**					
	LX01	R	R			1/6	N0			Line Number	
2400	**SV1**	**R**	**R**		**1**	**Professional Service**					
	SV101	R	R							Product or Service	
	SV101-1	R	R			2	ID			Product or Service ID Qualifier	
								HC		CPT/HCPCS Codes	
								IV		Home Infusion EDI Coalition Product Service Code	
								ZZ		OMFS Codes (California Only)	
	SV101-2	R	R			1/48	AN		24d	CPT/HCPCS/OMFS Procedure Code	
	SV101-3	S	S			2	AN		24dm1	Modifier 1	
	SV101-4	S	S			2	AN		24dm2	Modifier 2	
	SV101-5	S	S			2	AN		24dm3	Modifier 3	
	SV101-6	S	S			2	AN		24dm4	Modifier 4	
	SV102	R	R			1/18	R		24f	Line Item Charge	
	SV103	R	R			2	ID			Unit or Basis for Measurement Code	
								UN		Units	
								MJ		Minutes	
								F2		International Unit (pharmaceutical dispensed by gram)	
	SV104	R	R			1/15	R		24g	Service Unit	
	SV105	S	S			2	AN		24b	Place of Service	
	SV107-1	R	R			1/2	N0		24e	Diagnosis Code Pointer 1	
	SV107-2	S	S			1/2	N0			Diagnosis Code Pointer 2	
	SV107-3	S	S			1/2	N0			Diagnosis Code Pointer 3	
	SV107-4	S	S			1/2	N0			Diagnosis Code Pointer 4	
2400	**SV5**	**S**	**N**		**1**	**Durable Medical Equipment Service**					

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
						Data field not used for Workers' Compensation. Report DME products using the SV1 segment					
	SV501-1	R	N			2	ID	HC		Product or Service ID Qualifier	
	SV501-2	R	N			1/48	ID			HCPCS Procedure Code	
	SV502	R	N			2	ID	UN		Unit or Basis for Measurement Code	
	SV503	R	N			1/15	R			Unit Count	
	SV504	R	N			1/18	R			DME Rental Amount	
	SV505	R	N			1/18	R			DME Purchase Amount	
	SV506	R	N			1	ID			Rental Payment Frequency Code	
2400	**DTP**	**R**	**R**		**1**	**Service Date**					
	DTP01	R	R			3	ID	472		Date/Time Qualifier	
	DTP02	R	R			2/3	ID			Date Time Period Format Qualifier	
								RD8		Date Expressed in Format (Indicate Begin and End Dates)	
	DTP03	R	R			1/35	AN		24a	Service Date	
2410	**Drug Identification (repeat max 25)**										
	For Workers' Compensation (repeat 1) New 5010 version is limited to 1 repeat										
2410	**LIN**	**S**	**S**		**1**	**Drug Identification**					
						Required to specify billing/reporting for drugs provided that are referenced as part of the service(s) described in SV1					
	LIN02	R	R			2	ID	N4		Drug Information	
	LIN03	R	R			1/48	ID		24d_1	NDC Code (w/o the dash)	
2410	**CTP**	**S**	**S**		**1**	**Drug Pricing**					
	CTP03	R	S			1/17	R			Unit Price (required if different from SV102)	
	CTP04	R	S			1/15	R			Quantity (required if different from SV104)	
	CTP05-1	R	S			2/2	ID			Unit of Measure (required if CTP04 populated)	
								F2		International Unit	
								GR		Gram	
								ML		Milliliter	
								UN		Unit	
2410	**REF**	**S**	**S**		**1**	**Prescription Number**					
						Required if dispensing of the drug has been done with an assigned RX number					
	REF01	R	R			2	ID	XZ		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Prescription Number	
2420A	**Rendering Line Provider**										
2420A	**NM1**	**S**	**S**		**1**	**Provider Name**					
						Required if the Rendering Provider NM1 information is different than that carried in the 2310B loop, or if the Rendering provider					

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	2007 CMS-1500 Paper Field	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
						information is carried at the Billing/ Pay -to Provider loop level 2010AA/AB and this particular service line has a different Rendering provider than given in 2010AA/AB					
	NM101	R	R			2	ID	82		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								1		Person	
								2		Company	
	NM103	R	R			1/35	AN			Last Name or Organization Name	
	NM104	S	S			1/25	AN			First Name	
	NM108	R	R			1/2	ID	XX	24Ia	Identification Code Qualifier	
	NM109	R	R			2/80	AN		24j_2	National Provider Identifier (Non Shaded Area)	
2420A	**PRV**	**S**	**S**		**1**	**Rendering Line Provider Taxonomy Code**					
	PRV01	R	R			1/3	ID	PE		Provider Code (Rendering Line)	
	PRV02	R	R			2/3	AN	ZZ		Reference Identification Qualifier	
	PRV03	R	R			1/30	AN			Taxonomy code	
2420A	**REF**	**S**	**J**		**1**	**State License**					
	REF01	R	R			2/3	ID	0B	24i_1	ID Qualifier	
	REF02	R	R			1/30	AN		24j_1	State License	
2420A	**REF**	**S**	**S**		**1**	**Federal Tax ID**					
	REF01	R	R			2/3	ID	SY		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		25	Federal Tax ID	
TS	**SE**	**R**	**R**		**1**	**Transaction Set Trailer**					
	SE01	R	R			1/10	N			Number of Included Segments	
	SE02	R	R			4/9	AN			Transaction Set Control Number (ST02)	

Chapter 6 Companion Guide 837 Institutional

This companion guide for the ANSI 837 Institutional Healthcare Claim transaction has been created for use in conjunction with the *ANSI ASC X12N Institutional Healthcare Claim Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N 837 Institutional Healthcare Claim Implementation Guide*, but rather used as an additional source of information. Wherever the national standard differs from the California rules, the California rules prevail.

Directions on California specific requirements are provided in Appendix A of Section One of the Medical Billing and Payment Guide. When California and workers' compensation specific usage is different than the HIPAA implementation it is identified in the HIPAA/Workers' Compensation Gap Analysis, also in Chapter 4 in this companion guide.

California requirements that are specific to 837 Institutional billing are identified in this chapter.

Diagnosis Related Grouping (DRG) Information

DRG information is used in the CMS reimbursement methodology for inpatient hospital services. The field, DRG HI01-2, is required for inpatient hospital services.

Principal/Other Procedure Code

The ICD-9 Procedure Codes identify Home IV Therapy and inpatient surgical services. The ICD-9 Procedure Code is used to identify DRG information. The ICD-9 Principal Procedure and subsequent ICD-9 Procedure Codes are required for Home IV Therapy services or when surgical procedures are provided as part of inpatient hospital services.

HCPCS Codes for Outpatient Services

Healthcare Common Procedure Coding System (HCPCS) includes Level I codes, also referred to as CPT or Common Procedural Terminology Code, and Level II codes, also referred to as HCPCS. HCPCS (Level I and Level II) are used in the CMS Ambulatory Payment Classification (APC) reimbursement methodology. HCPCS codes are required on outpatient services for revenue codes that require or conditionally require HCPCS codes in Medicare policies, the Hospital Outpatient Prospective Payment System (OPPS), and APC requirements.

The SV2 Institutional Service Line Segment allows for more than one code set to be populated in the Composite Medical Procedure Product/Service qualifier and identification number in fields SV202-1 and SV202-2. For the California workers' compensation implementation of electronic billing, only the HCPCS code qualifier and HCPCS codes may be used in these fields.

Admitting Diagnosis Code

The Admitting ICD-9 Diagnosis code is required for inpatient services. When the services are outpatient hospital services, the Patient Reason for Visit qualifier is used to indicate the diagnosis related to the outpatient service.

Attachment Control Number

Attachment Control Number is part of a series of values that allows a health care provider, health care facility, or third party biller/assignee to relate documentation to an electronic bill transaction. Documentation, or attachments, is identified in the ANSI 837 format in PWK Claim Supplemental Information (Attachment) Segment. Bills containing services that require supporting documentation as defined by the Division must be properly annotated in the PWK Attachment Segment.

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If documentation is associated with a bill transaction, the PWK Attachment Segment is populated with Report Type Code, the Report Transmission Code, the Attachment Control Qualifier Code, and the Attachment Control Number.

Document Control Number

The Document Control Number is an internal control number assigned by a Claims Administrator, or their agent, to a bill transaction to facilitate retrieval or association of a bill transaction.

Original Reference Number

The Original Reference Number, also referred to as the Internal Control Number (ICN) or Document Control Number (DCN), is the control number assigned to the original bill transaction by the Claims Administrator to identify a unique bill transaction.

Medical Record Number

The Medical Record Number is a unique number assigned to the patient (Injured Employee) by the health care provider, health care facility, or third party biller/assignee to assist in retrieval of medical records. The Segment, REF Reference Identification - Medical Record Number is required for California 837 Institutional billing.

Line Level Date of service

The Line Level Date of Service is defined as Jurisdictional requirement. The California workers' compensation implementation requires the Segment on outpatient hospital services.

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 837 Institutional Healthcare Claim transaction is available through the Washington Publishing Company, www.wpc-edi.com. The California workers' compensation direction for the use of the ANSI 837 Institutional Implementation Guide is below.

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Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
TS	**Transaction Set**										
TS	**ST**	**R**	**R**		**1**	**Transaction Set Header**					
	ST01	R	R			3	ID	837		Transaction Set Identifier Code	
	ST02	R	R			4/9	AN			Transaction Set Control Number	
TS	**BHT**	**R**	**R**		**1**	**Beginning of Hierarchical Transaction**					
	BHT01	R	R			4	ID	0019		Hierarchical Structure Code	
	BHT02	R	R			2	ID	00		Transaction Set Purpose Code	
	BHT03	R	R			1/30	AN			Originator Transaction Identifier	
	BHT04	R	R			8	DT			Transaction Set Creation Date	
	BHT05	R	R			4/8	TM			Transaction Set Creation Time	
	BHT06	R	R			2	ID	CH		Claim or Encounter Indicator	
TS	**REF**	**R**	**R**		**1**	**Transmission Type Identification**					
	REF01	R	R			2	ID	87		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Type Code 004010X096A1	
1000A	**Sender Information**										
1000A	**NM1**	**R**	**R**		**1**	**Submitter Name**					
	NM101	R	R			2	ID	41		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								2		Non-Person Entity	
	NM103	R	R			1/35				Organization Name (Company Name)	
	NM108	R	R			2	ID	46		Identification Code Qualifier	
	NM109	R	R			2/80	AN			Identification Code	
1000A	**PER**	**R**	**R**		**1**	**Contact Information**					
	PER01	R	R			2	ID	IC		Information Contact	
	PER02	R	R			1/60	AN			Contact Name	
	PER03	R	R			2	ID	TE		Communication Number Qualifier	
	PER04	R	R			1/80	AN			Telephone number	
	PER05	S	S			2	ID			Communication Number Qualifier	
	PER06	S	S			1/80	AN			Communication Number	
	PER07	S	S			2	ID			Communication Number Qualifier	
	PER08	S	S			1/80	AN			Communication Number	
1000B	**Receiver Information**										
1000B	**NM1**	**R**	**R**		**1**	**Receiver Name**					
	NM101	R	R			2	ID	40		Entity Identifier Code	
	NM102	R	R			1	ID	2		Entity Type Qualifier	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	NM103	R	R			1/35	AN			Organization Name	
	NM108	R	R			2	ID	46		Identification Code Qualifier (ETIN)	
	NM109	R	R			2/80	AN			Identification Code	
2000A	**Billing/Pay-to Provider Hierarchical Level (Repeat >1)**										
2000A	**HL**	**R**	**R**		**1**						
	HL01	R	R			12	N			Hierarchical ID Number	
	HL03	R	R			2	ID	20		Hierarchical Level Code	
	HL04	R	R			1	ID	1		Hierarchical Child Code	
2000A	**PRV**	**S**	**J**		**1**	**Provider Taxonomy Code**					
						Required for California and Texas					
	PRV01	R	R			2	ID	BI		Provider Code	
								BI		BI=Billing	
	PRV02	R	R			2/3	ID	ZZ		Reference Identification Code	
	PRV03	R	R			1/30	AN			Provider Taxonomy Code	
2010AA	**Billing Provider Information**										
2010AA	**NM1**	**R**	**R**		**1**	**Billing Provider Name**					
	NM101	R	R			2	ID	85		Entity Identifier Code	
	NM102	R	R			1	ID	2		Entity Type Qualifier (Non-Person Entity)	
	NM103	R	R			1/35	AN		1	Organization Name	
	NM108	R	R			2	ID			Identification Code Qualifier	
								XX	56	National Provider Identifier (NPI) =XX	
										If billing entity is a non health care provider (non NPI number) then NM108 Code Qualifier 24 or 34 is required	
										TAX ID Code Qualifiers	
								24		Employer's Identification Number	
								34		Social Security Number	
	NM109	R	R			2/80	AN		5	Identification Code	
2010AA	**N3**	**R**	**R**		**1**	**Address**					
	N301	R	R			1/55	AN		1	Address Line	
	N302	S	S			1/55	AN		1	Address Line	
2010AA	**N4**	**R**	**R**		**1**	**City State Zip**					
	N401	R	R			2/30	AN		1	City	
	N402	R	R			2	ID		1	State	
	N403	R	R			3/15	ID		1	Zip	
	N404	S	S			2/3	ID			Country Code	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
2010AA	**REF**	**S**	**S**		**1**	**Tax ID**					
						Required field when NPI Identifier Code XX is present in NM108					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								EI		Federal Tax ID	
								SY		Social Security Number	
	REF02	R	R			1/30	AN		5	Identification Code	
2010AA	**REF**	**S**	**J**		**1**	**Provider Identification**					
						California requires either State License Number or Medicare Number conditional of Inpatient or Outpatient Qualifiers					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								0B		State License Number	
								1C		Medicare Provider Number	
	REF02	R	R			1/30	AN		57	Identification Code	
2010AA	**PER**	**S**	**S**		**2**	**Contact Information**					
						Required if this information is different than that contained in Loop 1000A Submitter PER segment					
	PER01	R	R			2	ID	IC		Information Contact	
	PER02	R	R			1/60	AN		1	Contact Name	
	PER03	R	R			2	ID	TE		Communication Number Qualifier	
	PER04	R	R			1/80	AN		1	Telephone number	
	PER05	S	S			2	ID			Communication Number Qualifier	
	PER06	S	S			1/80	AN		1	Communication Number	
	PER07	S	S			2	ID			Communication Number Qualifier	
	PER08	S	S			1/80	AN		1	Communication Number	
2010AB	**Pay-to Provider Information (Use if pay-to is different from billing)**										
2010AB	**NM1**	**S**	**S**		**1**	**Pay-to Provider Name**					
						Required if the Pay-to Provider is a different entity than the Billing Provider					Pay to Provider New Field UB04
	NM101	R	R			2	ID	87		Entity Identifier Code (Pay-to Provider)	
	NM102	R	R			1	ID	2		Entity Type Qualifier (Non-Person Entity)	
	NM103	R	R			1/35	AN		2	Organization Name	
	NM108	R	R			2	ID			Identification Code Qualifier	
								XX		National Provider Identifier (NPI) =XX	
										If billing entity is a non health care provider (non NPI number) then NM108 Code Qualifier 24 or 34 is required	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
										TAX ID Code Qualifiers	
								24		Employer's Identification Number	
								34		Social Security Number	
	NM109	R	R			2/80	AN			Identification Code	
2010AB	**N3**	**R**	**R**		**1**	**Address**					
	N301	R	R			1/55	AN		2	Address Line	
	N302	S	S			1/55	AN		2	Address Line	
2010AB	**N4**	**R**	**R**		**1**	**City State Zip**					
	N401	R	R			2/30	AN		2	City	
	N402	R	R			2	ID		2	State	
	N403	R	R			3/15	ID		2	Zip	
	N404	S	S			2/3	ID			Country Code	
2010AB	**REF**	**S**	**S**		**1**	**Tax ID**					
						Required field when NPI Identifier Code XX is present in NM108					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								EI		Federal Tax ID	
								SY		Social Security Number	
	REF02	R	R			1/30	AN		5	Identification Code	
2010AB	**REF**	**S**	**J**		**1**	**Provider Identification**					
						California requires either State License Number or Medicare Number conditional of Inpatient or Outpatient Qualifiers					
						Texas requires State License Number					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								0B		State License Number	
								1C		Medicare Number	
	REF02	R	R			1/30	AN			ID Number	
2000B	**Subscriber Detail (Repeat >1) Workers' Compensation Subscriber is Employer**										
2000B	**HL**	**R**	**R**		**1**						
	HL01	R	R			12	N			Hierarchical ID Number	
	HL02	R	R			12	N			Hierarchical Parent ID Number	
	HL03	R	R			2	ID	22		Hierarchical Level Code	
	HL04	R	R			1	ID	1		Hierarchical Child Code	
2000B	**SBR**	**R**	**R**		**1**						
	SBR01	R	R			1	ID	P		P for Primary Payer	
	SBR03	S	S			1/30	AN			WC Policy Number, If Available	
	SBR04	S	J			1/60	AN		58	Employer Name: Required for California and Texas	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	SBR09	S	J			1/2	ID	WC		Claim Filing Indicator Code : California and Texas Requirement	
2010BA	**Employer**										
2010BA	**NM1**	**R**	**R**		**1**	**Subscriber Name**					
	NM101	R	R			2	ID	IL		Entity Identifier Code	
	NM102	R	R			1	ID	2		Entity Type Qualifier (Non-Person Entity)	
	NM103	R	R			1/35	AN		65a	Employer Name	
2010BA	**N3**	**S**	**J**		**1**	**Address**					
						Address California and Texas Required Field					
	N301	R	R			1/55	AN		65b	Employer Address	
	N302	S	S			1/55	AN			Address Line 2	
2010BA	**N4**	**S**	**J**		**1**	**City State Zip**					
						City State Zip California and Texas Required Field					
	N401	R	R			2/30	AN		65c	City	
	N402	R	R			2	ID		65c	State	
	N403	R	R			3/15	ID		65c	Zip	
	N404	S	S			2/3	ID			Country Code	
2010BC	**Payer Information**										
2010BC	**NM1**	**R**	**R**		**1**	**Payer Name**					
	NM101	R	R			2	ID	PR		Entity Identifier Code	
	NM102	R	R			1	ID	2		Entity Type Qualifier	
	NM103	R	R			1/35			38	Payer Name	
	NM108	R	R			2	ID	PI		Identification Code Qualifier	
										Payer Identification Code is defined in the ISA Segment as well as specified in the Trading Partner Agreement	
	NM109	R	R			2/80	AN			Payer Identification Code	
2010BC	**N3**	**S**	**S**		**1**	**Address**					
						Payer Address is required when the submitter intends for the bill to be printed on paper at the next EDI location)e.g., a clearinghouse					
	N301	R	R			1/55	AN		38	Payer Address	
	N302	S	S			1/55	AN		38	Address Line 2	
2010BC	**N4**	**S**	**S**		**1**	**City State Zip**					
						Payer Address is required when the submitter intends for the bill to be printed on paper at the next EDI location)e.g., a clearinghouse					
	N401	R	R			2/30	AN		38	City	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	N402	R	R			2	ID		38	State	
	N403	R	R			3/15	ID		38	Zip	
	N404	S	S			2/3	ID			Country Code	
2000C	**Patient Hierarchical Level**										
2000C	**HL**	**S**	**J**		**1**	**Patient Hierarchical Level**					
						This HL is required when the patient is different person than the subscriber . The Employer is the Subscriber in Workers' Compensation. California and Texas Required Field					
	HL01	R	R			12	N			Hierarchical ID Number	
	HL02	R	R			12	N			Hierarchical Parent ID Number	
	HL03	R	R			2	ID	23		Hierarchical Level Code	
	HL04	R	R			1	ID	0		Hierarchical Child Code	
2000C	**PAT**	**R**	**R**		**1**	**Patient Information**					
	PAT01	R	R			2	ID	20	59a	Patients Relationship to Insured	
2010CA	**Patient Information**										
2010CA	**NM1**	**R**	**R**		**1**	**Patient Name**					
	NM101	R	R			2	ID	QC		Entity Identifier Code	
	NM102	R	R			1	ID	1		Entity Type Qualifier (person)	
	NM103	R	R			1/35	AN		8b	Last Name	
	NM104	R	R			1/25	AN		8a	First Name	
	NM105	S	S			1/25	AN		8a	Middle Name	
	NM108	R	R			2	ID	MI		Reference Identification Qualifier	
	NM109	R	R			2/80	AN		60a	Social Security Number	
2010CA	**N3**	**R**	**R**		**1**	**Address**					
	N301	R	R			1/55	AN		9a	Address	
	N302	S	S			1/55	AN		9a	Address	
2010CA	**N4**	**R**	**R**		**1**	**City State Zip**					
	N401	R	R			2/30	AN		9b	City	
	N402	R	R			2	ID		9c	State	
	N403	R	R			3/15	ID		9d	Zip	
	N403	S	S			2/3	ID		9e	Country Code	
2010CA	**DMG**	**R**	**R**		**1**	**Demographic Information**					
	DMG01	R	R			2	ID	D8		Date Time Period Format Qualifier	
	DMG02	R	R			1/35	AN		10	Birth Date	
	DMG03	R	R			1	ID		11	Gender Code	
2010CA	**REF**	**S**	**S**		**1**	**Property & Casualty Claim Number**					
						Required if Claim Number is Known					
	REF01	R	R			2/3	ID	Y4		Reference Identification	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
										Qualifier	
	REF02	R	R			1/30	AN		62a	Workers' Compensation Claim Number	
2300	**Claim Information (100)**										
2300	**CLM**	**R**	**R**		**1**	**Claim Information**					
	CLM01	R	R			1/38	AN			Claim Submitter Identifier (Provider Unique Bill Identification Number)	
	CLM02	R	R			1/18	R		47	Total Charges Per Bill	
	CLM05-1	R	R			1/2	ID		4 pos 1-2	Facility Type Code (place of service)	
	CLM05-2	R	R			1/2	ID			Facility Code Qualifier	
	CLM05-3	R	R			1	ID		4 pos 3	Claim Frequency Code	
	CLM06	R	R			1	ID	Y/N	NA	Provider Signature on File	
	CLM07	S	S			1	ID	A		Medicare Assignment Code	
									53	Enter value "A" to indicate provider acceptance of assignment	
	CLM08	R	R			1	ID	N	53	Benefit Assignment Indicator	
	CLM09	R	R			1	ID	I	52	Release of Information Code	
	CLM18	R	R			1	ID	N		Explanation of Benefits Indicator	
	CLM19	N	J			2/2	AN			Claims Submission Reason Codes	
								7		Duplicate Bill	
								15		Revised Bill	
								30		Appeal/Reconsideration	
2300	**DTP**	**S**	**S**		**1**	**Discharge Hour**					
	DTP01	R	R			3	ID	096		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	TM		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		16	Discharge Hour	
2300	**DTP**	**R**	**R**		**1**	**Statement From - Thru Dates**					
	DTP01	R	R			3	ID	434		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	RD8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		6	Statement From - Thru	
2300	**DTP**	**S**	**S**		**1**	**Admission Date / Hour**					
	DTP01	R	R			3	ID	435		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	DT		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		12-13	Admission Date and Hour	
2300	**CL1**	**S**	**S**		**1**	**Claim Codes**					

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	CL101	S	S			1	ID		14	Admit Type Code	
	CL102	S	S			1	ID		15	Admit Source Code	
	CL103	S	S			1/2	ID		17	Discharge Status	
2300	**PWK**	**S**	**S**		**10**	**Paper Work (Attachments)**					
	PWK01	R	R			2/2	ID			Report Type Code	
	PWK02	R	R			1/2	ID			Deliver type code	
	PWK05	S	R			2	ID	AC		Identification Code Qualifier	
	PWK06	S	R			2/80	AN		64b	Attachment Control Number	
2300	**CN1**	**S**	**S**			**Contract Information**					
						Required if billing capitated services or contractually obligated to provide contract information on this bill					
	CN101	R	R			2	ID			Contract Type Code	
	CN102	R	R			1/18	R			Contract Amount	
2300	**REF**	**S**	**S**		**1**	**Clearing House Generated Tracking Number**					
	REF01	R	R			2/3	ID	D9		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			CH assigned tracking number	
2300	**REF**	**S**	**S**		**1**	**Document Control Number**					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								DD		Document Identification Code	
	REF02	R	R			1/30	AN			Document Control Number	
2300	**REF**	**S**	**S**		**1**	**Prior Authorization**					
	REF01	R	R			2/3	ID	G1		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		63a	Prior Authorization Number	
2300	**REF**	**S**	**J**		**1**	**Medical Record Number**					
	REF01	R	R			2/3	ID	EA		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		3b	Medical Record Identification Number	
2300	**REF**	**S**	**S**		**1**	**Original Reference Number (ICN/DCN)**					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								F8		Original Reference Number	
	REF02	R	R			1/30	AN		64a	Original Reference Number	
2300	**NTE**	**S**	**S**		**10**	**Notes/ Special Instructions**					
	NTE01	R	R			3	ID			Note Reference Code	
	NTE02	R	R			1/80	AN		80	Note Text	
2300	**HI**	**S**	**S**		**1**	**Principal, Admitting, E-Code Diagnosis Information**					
	HI01	R	R							Health Care Code Information	
	HI01-1	R	R			1/2	ID	BK		Code List Qualifier Code	
	HI01-2	R	R			1/30	AN		67	Principal Diagnosis	

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	HI02	S	S							Health Care Code Information	
	HI02-1	R	R			1/2	ID			Code List Qualifier Code	
								BJ		Admitting Diagnosis	
								ZZ		Patient Reason For Visit	
	HI02-2	R	R			1/30	AN		69/70	Admitting Diagnosis Required for Inpatient 69/ Outpatient Visit 70	
	HI03	S	S							Health Care Code Information	
	HI03-1	R	R			1/2	ID	BN		Code List Qualifier Code	
	HI03-2	R	R			1/30	AN		72	E-code	
2300	**HI**	**S**	**J**		**1**	**DRG**					
	HI01	R	R							Health Care Code Information	
	HI01-1	R	R			1/2	ID	DR		Code List Qualifier Code	
	HI01-2	R	R			1/30	AN		73	Diagnosis Related Group (DRG) Field is required for Inpatient Billing	
2300	**HI**	**S**	**S**		**2**	**Other Diagnosis**					
	HI01	R	R							Health Care Code Information	
	HI01-1	R	R			1/2	ID	BF		Code List Qualifier Code	
	HI01-2	R	R			1/30	AN		67a	Diagnosis	
	HI02	S	S							Health Care Code Information	
	HI02-1	R	R			1/2	ID	BF		Code List Qualifier Code	
	HI02-2	R	R			1/30	AN		67b	Diagnosis	
	HI03	S	S							Health Care Code Information	
	HI03-1	R	R			1/2	ID	BF		Code List Qualifier Code	
	HI03-2	R	R			1/30	AN		67c	Diagnosis	
	HI04	S	S							Health Care Code Information	
	HI04-1	R	R			1/2	ID	BF		Code List Qualifier Code	
	HI04-2	R	R			1/30	AN		67d	Diagnosis	
	HI05	S	S							Health Care Code Information	
	HI05-1	R	R			1/2	ID	BF		Code List Qualifier Code	
	HI05-2	R	R			1/30	AN		67e	Diagnosis	
	HI06	S	S							Health Care Code Information	
	HI06-1	R	R			1/2	ID	BF		Code List Qualifier Code	
	HI06-2	R	R			1/30	AN		67f	Diagnosis	
	HI07	S	S							Health Care Code Information	
	HI07-1	R	R			1/2	ID	BF		Code List Qualifier Code	
	HI07-2	R	R			1/30	AN		67g	Diagnosis	
	HI08	S	S							Health Care Code Information	

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	HI08-1	R	R			1/2	ID	BF		Code List Qualifier Code	
	HI08-2	R	R			1/30	AN		67h	Diagnosis	
	HI09	S	S							Health Care Code Information	
	HI09-1	R	R			1/2	ID	BF		Code List Qualifier Code	
	HI09-2	R	R			1/30	AN		67i	Diagnosis	
	HI010	S	S							Health Care Code Information	
	HI010-1	R	R			1/2	ID	BF		Code List Qualifier Code	
	HI010-2	R	R			1/30	AN		67j	Diagnosis	
	HI011	S	S							Health Care Code Information	
	HI011-1	R	R			1/2	ID	BF		Code List Qualifier Code	
	HI011-2	R	R			1/30	AN		67k	Diagnosis	
	HI012	S	S							Health Care Code Information	
	HI012-1	R	R			1/2	ID	BF		Code List Qualifier Code	
	HI012-2	R	R			1/30	AN		67l	Diagnosis	
2300	**HI**	**S**	**S**		**1**	**Principal Procedure**					
	HI01	R	R							Health Care Code Information	
	HI01-1	R	R			1/2	ID			Code List Qualifier Code	
								BP		HCPCS Code	
								BR		ICD-9-CM Code	
	HI01-2	R	R			1/30	AN		74	Procedure Code	
	HI01-3	S	S			1/2	ID	D8		Date Time Period Format Qualifier	
	HI01-4	S	S			1/35	AN		74	Date	
2300	**HI**	**S**	**S**		**2**	**Other Procedures**					
	HI01	R	R							Health Care Code Information	
	HI01-1	R	R			1/2	ID			Code List Qualifier Code	
								BO		HCPCS Code	
								BQ		ICD-9-CM Code	
	HI01-2	R	R			1/30	AN		74a	Procedure Code	
	HI01-3	S	S			1/2	ID	D8		Date Time Period Format Qualifier	
	HI01-4	S	S			1/35	AN		74a	Date	
	HI02	S	S							Health Care Code Information	
	HI02-1	R	R			1/2	ID			Code List Qualifier Code	
								BO		HCPCS Code	
								BQ		ICD-9-CM Code	
	HI02-2	R	R			1/30	AN		74b	Procedure Code	
	HI02-3	S	S			1/2	ID	D8		Date Time Period Format Qualifier	
	HI02-4	S	S			1/35	AN		74b	Date	
	HI03	S	S							Health Care Code Information	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	HI03-1	R	R			1/2	ID			Code List Qualifier Code	
								BO		HCPCS Code	
								BQ		ICD-9-CM Code	
	HI03-2	R	R			1/30	AN		74c	Procedure Code	
	HI03-3	S	S			1/2	ID	D8		Date Time Period Format Qualifier	
	HI03-4	S	S			1/35	AN		74c	Date	
	HI04	S	S							Health Care Code Information	
	HI04-1	R	R			1/2	ID			Code List Qualifier Code	
								BO		HCPCS Code	
								BQ		ICD-9-CM Code	
	HI04-2	R	R			1/30	AN		74d	Procedure Code	
	HI04-3	S	S			1/2	ID	D8		Date Time Period Format Qualifier	
	HI04-4	S	S			1/35	AN		74d	Date	
	HI05	S	S							Health Care Code Information	
	HI05-1	R	R			1/2	ID			Code List Qualifier Code	
								BO		HCPCS Code	
								BQ		ICD-9-CM Code	
	HI05-2	R	R			1/30	AN		74e	Procedure Code	
	HI05-3	S	S			1/2	ID	D8		Date Time Period Format Qualifier	
	HI05-4	S	S			1/35	AN		74E	Date	
2300	**HI**	**S**	**S**		**2**	**Occurrence Span Codes and Dates**					
	HI01	R	R							Health Care Code Information	
	HI01-1	R	R			1/3	ID	BI		Code List Qualifier Code	
	HI01-2	R	R			1/30	AN		35a	Occurrence Span Code	
	HI01-3	R	R			2/3	ID	RD8		Date Time Period Format Qualifier	
	HI01-4	R	R			1/35	AN		35a	From Thru Dates	
	HI02	S	S							Health Care Code Information	
	HI02-1	R	R			1/3	ID	BI		Code List Qualifier Code	
	HI02-2	R	R			1/30	AN		36a	Occurrence Span Code	
	HI02-3	R	R			2/3	ID	RD8		Date Time Period Format Qualifier	
	HI02-4	R	R			1/35	AN		36a	From Thru Dates	
	HI03	S	S							Health Care Code Information	
	HI03-1	R	R			1/3	ID	BI		Code List Qualifier Code	
	HI03-2	R	R			1/30	AN		35b	Occurrence Span Code	
	HI03-3	R	R			2/3	ID	RD8		Date Time Period Format Qualifier	
	HI03-4	R	R			1/35	AN		35b	From Thru Dates	
	HI04	S	S							Health Care Code Information	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	HI04-1	R	R			1/3	ID	BI		Code List Qualifier Code	
	HI04-2	R	R			1/30	AN		36b	Occurrence Span Code	
	HI04-3	R	R			2/3	ID	RD8		Date Time Period Format Qualifier	
	HI04-4	R	R			1/35	AN		36b	From Thru Dates	
2300	**HI**	**S**	**J**		**2**	**Occurrence Codes and Dates**					
						Use first occurrence code for the Date of Injury/Accident					
	HI01	R	R							Health Care Code Information	
	HI01-1	R	R			2	ID	BH		Code List Qualifier Code	
	HI01-2	R	R			2	AN	04	31a	Occurrence Code	
										Accident/Employment Related	
	HI01-3	R	R			2	ID	D8		Date Time Period Format Qualifier	
	HI01-4	R	R			8	D		31a	Date of accident	
	HI02	S	S							Health Care Code Information	
	HI02-1	R	R			2	ID	BH		Code List Qualifier Code	
	HI02-2	R	R			2	AN		32a	Occurrence Code	
	HI02-3	R	R			2	ID	D8		Date Time Period Format Qualifier	
	HI02-4	R	R			8	D		32a	Date	
	HI03	S	S							Health Care Code Information	
	HI03-1	R	R			2	ID	BH		Code List Qualifier Code	
	HI03-2	R	R			2	AN		33a	Occurrence Code	
	HI03-3	R	R			2	ID	D8		Date Time Period Format Qualifier	
	HI03-4	R	R			8	D		33a	Date	
	HI04	S	S							Health Care Code Information	
	HI04-1	R	R			2	ID	BH		Code List Qualifier Code	
	HI04-2	R	R			2	AN		34a	Occurrence Code	
	HI04-3	R	R			2	ID	D8		Date Time Period Format Qualifier	
	HI04-4	R	R			8	D		34a	Date	
	HI05	S	S							Health Care Code Information	
	HI05-1	R	R			2	ID	BH		Code List Qualifier Code	
	HI05-2	R	R			2	AN		31b	Occurrence Code	
	HI05-3	R	R			2	ID	D8		Date Time Period Format Qualifier	
	HI05-4	R	R			8	D		31b	Date	
	HI06	S	S							Health Care Code Information	
	HI06-1	R	R			2	ID	BH		Code List Qualifier Code	
	HI06-2	R	R			2	AN		32b	Occurrence Code	
	HI06-3	R	R			2	ID	D8		Date Time Period Format Qualifier	
	HI06-4	R	R			8	D		32b	Date	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	HI07	S	S							Health Care Code Information	
	HI07-1	R	R			2	ID	BH		Code List Qualifier Code	
	HI07-2	R	R			2	AN		33b	Occurrence Code	
	HI07-3	R	R			2	ID	D8		Date Time Period Format Qualifier	
	HI07-4	R	R			8	D		33b	Date	
	HI08	S	S							Health Care Code Information	
	HI08-1	R	R			2	ID	BH		Code List Qualifier Code	
	HI08-2	R	R			2	AN		34b	Occurrence Code	
	HI08-3	R	R			2	ID	D8		Date Time Period Format Qualifier	
	HI08-4	R	R			8	D		34b	Date	
2300	**HI**	**S**	**S**		**2**	**Value Information Codes and Amounts**					
	HI01	R	R							Health Care Code Information	
	HI01-1	R	R			2	ID	BE		Code List Qualifier Code	
	HI01-2	R	R			2	AN		39a	Value Code	
	HI01-5	R	R			1/18	R		39a	Monetary Amount	
	HI02	S	S							Health Care Code Information	
	HI02-1	R	R			2	ID	BE		Code List Qualifier Code	
	HI02-2	R	R			2	AN		40a	Value Code	
	HI02-5	R	R			1/18	R		40a	Monetary Amount	
	HI03	S	S							Health Care Code Information	
	HI03-1	R	R			2	ID	BE		Code List Qualifier Code	
	HI03-2	R	R			2	AN		41a	Value Code	
	HI03-5	R	R			1/18	R		41a	Monetary Amount	
	HI04	S	S							Health Care Code Information	
	HI04-1	R	R			2	ID	BE		Code List Qualifier Code	
	HI04-2	R	R			2	AN		39b	Value Code	
	HI04-5	R	R			1/18	R		39b	Monetary Amount	
	HI05	S	S							Health Care Code Information	
	HI05-1	R	R			2	ID	BE		Code List Qualifier Code	
	HI05-2	R	R			2	AN		40b	Value Code	
	HI05-5	R	R			1/18	R		40b	Monetary Amount	
	HI06	S	S							Health Care Code Information	
	HI06-1	R	R			2	ID	BE		Code List Qualifier Code	
	HI06-2	R	R			2	AN		41b	Value Code	
	HI06-5	R	R			1/18	R		41b	Monetary Amount	
	HI07	S	S							Health Care Code Information	
	HI07-1	R	R			2	ID	BE		Code List Qualifier Code	
	HI07-2	R	R			2	AN		39c	Value Code	
	HI07-5	R	R			1/18	R		39c	Monetary Amount	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	HI08	S	S							Health Care Code Information	
	HI08-1	R	R			2	ID	BE		Code List Qualifier Code	
	HI08-2	R	R			2	AN		40c	Value Code	
	HI08-5	R	R			1/18	R		40c	Monetary Amount	
	HI09	S	S							Health Care Code Information	
	HI09-1	R	R			2	ID	BE		Code List Qualifier Code	
	HI09-2	R	R			2	AN		41c	Value Code	
	HI09-5	R	R			1/18	R		41c	Monetary Amount	
	HI10	S	S							Health Care Code Information	
	HI10-1	R	R			2	ID	BE		Code List Qualifier Code	
	HI10-2	R	R			2	AN		39d	Value Code	
	HI10-5	R	R			1/18	R		39d	Monetary Amount	
	HI11	S	S							Health Care Code Information	
	HI11-1	R	R			2	ID	BE		Code List Qualifier Code	
	HI11-2	R	R			2	AN		40d	Value Code	
	HI11-5	R	R			1/18	R		40d	Monetary Amount	
	HI12	S	S							Health Care Code Information	
	HI12-1	R	R			2	ID	BE		Code List Qualifier Code	
	HI12-2	R	R			2	AN		41d	Value Code	
	HI12-5	R	R			1/18	R		41d	Monetary Amount	
2300	**HI**	**S**	**S**		**2**	**Condition Codes**					
	HI01	R	R							Health Care Code Information	
	HI01-1	R	R			2	ID	BG		Code List Qualifier Code	
	HI01-2	R	R			2	AN		18	Condition Code	
	HI02	S	S							Health Care Code Information	
	HI02-1	R	R			2	ID	BG		Code List Qualifier Code	
	HI02-2	R	R			2	AN		19	Condition Code	
	HI03	S	S							Health Care Code Information	
	HI03-1	R	R			2	ID	BG		Code List Qualifier Code	
	HI03-2	R	R			2	AN		20	Condition Code	
	HI04	S	S							Health Care Code Information	
	HI04-1	R	R			2	ID	BG		Code List Qualifier Code	
	HI04-2	R	R			2	AN		21	Condition Code	
	HI05	S	S							Health Care Code Information	
	HI05-1	R	R			2	ID	BG		Code List Qualifier Code	
	HI05-2	R	R			2	AN		22	Condition Code	
	HI06	S	S							Health Care Code Information	
	HI06-1	R	R			2	ID	BG		Code List Qualifier Code	
	HI06-2	R	R			2	AN		23	Condition Code	
	HI07	S	S							Health Care Code Information	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	HI07-1	R	R			2	ID	BG		Code List Qualifier Code	
	HI07-2	R	R			2	AN		24	Condition Code	
	HI08	S	S							Health Care Code Information	
	HI08-1	R	R			2	ID	BG		Code List Qualifier Code	
	HI08-2	R	R			2	AN		25	Condition Code	
	HI09	S	S							Health Care Code Information	
	HI09-1	R	R			2	ID	BG		Code List Qualifier Code	
	HI09-2	R	R			2	AN		26	Condition Code	
	HI10	S	S							Health Care Code Information	
	HI10-1	R	R			2	ID	BG		Code List Qualifier Code	
	HI10-2	R	R			2	AN		27	Condition Code	
	HI11	S	S							Health Care Code Information	
	HI11-1	R	R			2	ID	BG		Code List Qualifier Code	
	HI11-2	R	R			2	AN		28	Condition Code	
2300	**QTY**	**S**	**N**		**1**	**Covered Days**					
	QTY01	R	N			2	ID	CA		Quantity Qualifier	
	QTY02	R	N			1/15	N		NA	Covered Days Count	
	QTY03-1	R	N			2	ID	DA		Unit or Basis for Measurement Code	
2300	**QTY**	**S**	**N**		**1**	**Non-Covered Days**					
	QTY01	R	N			2	ID	NA		Quantity Qualifier	
	QTY02	R	N			1/15	N		NA	Non-covered Days	
	QTY03-1	R	N			2	ID	DA		Unit or Basis for Measurement Code	
2300	**QTY**	**S**	**N**		**1**	**Co-insured Days**					
	QTY01	R	N			2	ID	CD		Quantity Qualifier	
	QTY02	R	N			1/15	N		NA	Co-insured Days	
	QTY03-1	R	N			2	ID	DA		Unit or Basis for Measurement Code	
2300	**QTY**	**S**	**N**		**1**	**Life-time Reserve Days**					
	QTY01	R	N			2	ID	LA		Quantity Qualifier	
	QTY02	R	N			1/15	N		NA	Life-time Reserve Days	
	QTY03-1	R	N			2	ID	DA		Unit or Basis for Measurement Code	
2310A	**Attending Provider**										
	Attending Provider is the licensed health care provider that performed the service (other than Operating Provider) or the licensed health care provider supervising a non-licensed health care provider.										
2310A	**NM1**	**S**	**J**		**1**	**Attending Physician Name**					
	NM101	R	R			2	ID	71		Entity Identifier Code	
	NM102	R	R			1	ID	1		Entity Type Qualifier (Person)	
	NM103	R	R			1/35	AN		76	Last Name	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	NM104	R	R			1/25	AN		76	First Name	
	NM105	S	S			1/25	AN		76	Middle Name	
	NM107	S	S			1/10	AN		76	Title	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
	NM109	R	R			2/80	AN		76	National Provider Number	
2310A	**PRV**	**S**	**S**		**1**	**Provider Specialty Code**					
	PRV01	R	R			2	ID	AT/SU		Provider Code (Attending or Supervising)	
	PRV02	R	R			2/3	ID	ZZ		Reference Identification Qualifier	
	PRV03	R	R			1/30	AN		81a	Taxonomy code ; Required for California and Texas on UB04	
2310A	**REF**	**S**	**J**		**1**	**State License Number**					
						California requires State License Number					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		76	State License Number	
2310B	**Operating Provider Name**										
	Populate when a surgical procedure is listed.										
2310B	**NM1**	**S**	**S**		**1**	**Other Provider Name**					
	NM101	R	R			2	ID	72		Entity Identifier Code	
	NM102	R	R			1	ID	1		Entity Type Qualifier (Person)	
	NM103	R	R			1/35	AN		77	Last Name	
	NM104	R	R			1/25	AN		77	First Name	
	NM105	S	S			1/25	AN		77	Middle Name	
	NM107	S	S			1/10	AN			Title Name	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
	NM109	R	R			2/80	AN		77	National Provider Identifier (NPI)	
2310B	**PRV**	**S**	**S**		**1**	**Provider Specialty Code**					
	PRV01	R	R			2	ID	OP		Provider Code (Operating Provider)	
	PRV02	R	R			2/3	ID	ZZ		Reference Identification Qualifier	
	PRV03	R	R			1/30	AN		81b	Taxonomy code ; Required for California and Texas on UB04	
2310B	**REF**	**S**	**J**		**1**	**State License Number**					
						California requires State License Number					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		77	State License Number	
2310C	**Other Provider Name (5010 Other Operating Physician Name)**										

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
2310C	**NM1**	**S**	**S**		**1**	**Name**					
	NM101	R	R			2	ID	73		Entity Identifier Code	For 4010A1 use qualifier 73. For 5010 use qualifier ZZ
								ZZ	78 or 79	Other Operating Physician	
	NM102	R	R			1	ID	1		Entity Type Qualifier (1=Person)	
	NM103	R	R			1/35	AN		78 or 79	Last Name	
	NM104	R	R			1/25	AN		78 or 79	First Name	
	NM105	S	S			1/25	AN		78 or 79	Middle Name	
	NM107	S	S			1/10	AN			Name Suffix	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
	NM109	R	R			2/80	AN		78 or 79	National Provider Identifier (NPI)	
2310C	**PRV**	**S**	**S**		**1**	**Provider Specialty Code**					
	PRV01	R	R			2	ID	OT/ PE		Provider Code (Other Provider/ Performing Provider)	
	PRV02	R	R			2/3	ID	ZZ		Reference Identification Qualifier	
	PRV03	R	R			1/30	AN		81c	Taxonomy code ; Required for California and Texas on UB04	
2310C	**REF**	**S**	**J**		**1**	**State License Number**					
						California requires State License Number					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		78 or 79	State License Number	
2310D	**Rendering Provider Name** **X12 5010 Only**										
	This segment will become effective when 5010 version is approved										
2310D	**NM1**	**S**	**S**		**1**	**Name**					
	NM101	R	R			2	ID	82	78 or 79	Entity Identifier Code (Rendering Provider)	
	NM102	R	R			1	ID	1		Entity Type Qualifier (1=person)	
	NM103	R	R			1/35	AN		78 or 79	Last Name	
	NM104	S	S			1/25	AN		78 or 79	First Name	
	NM105	S	S			1/25	AN		78 or 79	Middle Name	
	NM107	S	S			1/10	AN			Title Name	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	NM109	R	R			2/80	AN		78 or 79	National Provider Identifier (NPI)	
2310D	**REF**	**S**	**J**		**1**	**State License Number**					
						California requires State License Number					
	REF01	R	R			2/3	ID	0B	78 or 79	Reference Identification Qualifier	
	REF02	R	R			1/30	AN		78 or 79	State License Number	
2310E	**Facility / Service location**										
2310E	**NM1**	**S**	**S**		**1**	**Name**					
						This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay to Provider) loops					
	NM101	R	R			2	ID	FA		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								2		Non- Person Entity	
	NM103	R	R			1/35	AN			Organization Name	
	NM108	S	R			2	ID	XX		Identification Code Qualifier	
	NM109	S	R			2/80	AN			National Provider Identifier	
2310E	**N3**	**R**	**R**		**1**	**Address**					
	N301	R	R			1/55	AN			Address	
	N302	S	S			1/55	AN			Address	
2310E	**N4**	**R**	**R**		**1**	**City State Zip**					
	N401	R	R			2/30	AN			City	
	N402	R	R			2	ID			State	
	N403	R	R			3/15	ID			Zip	
	N404	S	S			2/3	ID			Country Code	
2310E	**REF**	**S**	**J**		**1**	**State License Number**					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Service Facility State License Number	
										Jurisdiction specific requirement; California requires State License Number when Service Facility is a health care provider.	
2310F	**Referring Provider Name** **X12 5010 Only**										
	This segment will become effective when 5010 version is approved										
2310F	**NM1**	**S**	**S**		**1**	**Name**					
	NM101	R	R			2	ID	DN	78 or 79	Entity Identifier Code	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	NM102	R	R			1	ID	1		Entity Type Qualifier (Person)	
	NM103	R	R			1/35	AN		78 or 79	Last Name	
	NM104	S	S			1/25	AN		79 or 79	First Name	
	NM105	S	S			1/25	AN		80 or 79	Middle Name	
	NM107	S	S			1/10	AN		81 or 79	Title Name	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
	NM109	R	R			2/80	AN		81 or 79	National Provider Identifier (NPI)	
2310F	**REF**	**S**	**J**		**1**	**State License Number**					
						California requires State License Number					
	REF01	R	R			2/3	ID	0B	81 or 79	Reference Identification Qualifier	
	REF02	R	R			1/30	AN		81 or 79	State License Number	
2320	**Other Subscriber Information (repeat max 10)**										
	The 2320 and 2330 loops are required if there has been a prior payment by a payer other than the employer's insurer										
2320	**SBR**	**S**	**S**		**1**	**Other Subscriber Information**					
	SBR01	R	R			1	ID			Payer Responsibility Sequence Code	
								P		Primary	
								S		Secondary	
								T		Tertiary	
	SBR02	R	R			2/2	ID			Individual Relationship Code	
	SBR03	S	S			1/30	AN			Group or Policy Number	
	SBR04	S	S			1/60	AN			Group or Plan Name	
	SBR08	N	J							Employment Status Code	
	SBR09	S	J			1/2	ID	WC		Claim Filing Indicator Code: California and Texas Requirement	
2320	**CAS**	**S**	**S**		**5**	**Claim Level Adjustments**					
						Use if claim level adjustments have been made by the prior payer					
	CAS01	R	R			1/2	ID			Group code	
	CAS02	R	R			1/5	ID			Claim Adjustment Reason Code 1	
	CAS03	R	R			1/18	R			Adjustment Amount 1	
	CAS04	S	S			1/15	R			Adjustment Quantity 1	
	CAS05	S	S			1/5	ID			Claim Adjustment Reason Code 2	
	CAS06	S	S			1/18	R			Adjustment Amount 2	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	CAS07	S	S			1/15	R			Adjustment Quantity 2	
	CAS08	S	S			1/5	ID			Claim Adjustment Reason Code 3	
	CAS09	S	S			1/18	R			Adjustment Amount 3	
	CAS10	S	S			1/15	R			Adjustment Quantity 3	
	CAS11	S	S			1/5	ID			Claim Adjustment Reason Code 4	
	CAS12	S	S			1/18	R			Adjustment Amount 4	
	CAS13	S	S			1/15	R			Adjustment Quantity 4	
	CAS14	S	S			1/5	ID			Claim Adjustment Reason Code 5	
	CAS15	S	S			1/18	R			Adjustment Amount 5	
	CAS16	S	S			1/15	R			Adjustment Quantity 5	
	CAS17	S	S			1/5	ID			Claim Adjustment Reason Code 6	
	CAS18	S	S			1/18	R			Adjustment Amount 6	
	CAS19	S	S			1/15	R			Adjustment Quantity 6	
2320	**AMT**	**S**	**S**		**1**	**Coordination of Benefits (COB) Payer Paid Amount**					
	AMT01	R	R			2	ID	D		Amount Qualifier Code	
	AMT02	R	R			1/18	R			Patient Amount Paid	
2320	**AMT**	**S**	**S**		**1**	**Coordination of Benefits (COB) Patient Paid Amount**					
	AMT01	R	R			2	ID	F5		Amount Qualifier Code	
	AMT02	R	R			1/18	R			Patient Amount Paid	
2330A	**Other Subscriber Name**										
2330A	**NM1**	**R**	**R**		**1**	**Other Subscriber Name**					
						Required when Loop ID 2320-Other Subscriber Information is used. Otherwise, this loop is not used					
	NM101	R	R			2	ID	IL		Entity Identifier Code (Insured or Subscriber)	
	NM102	R	R			1	ID			Entity Type Qualifier	
								1		person	
								2		company	
	NM103	R	R			1/35	AN			Last	
	NM104	S	S			1/25	AN			First	
	NM105	S	S			1/25	AN			Middle	
	NM108	R	R			2	ID	MI		Member Identification Number	
	NM109	R	R			2/80	AN			Other Subscriber Primary Identification	
2330A	**N3**	**S**	**S**		**1**	**Address**					
	N301	R	R			1/55	AN			Address Line	
	N302	S	S			1/55	AN			Address Line	
2330A	**N4**	**S**	**S**		**1**	**City State Zip**					

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	N401	R	R			2/30	AN			City	
	N402	R	R			2	ID			State	
	N403	R	R			3/15	ID			Zip	
	N404	S	S			2/3	ID			Country Code	
2330A	**REF**	**S**	**S**		**3**	**Tax ID**					
	REF01	R	R			2/3	ID	SY		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Social Security Number	
2330B	**Other Payer Name**										
2330B	**NM1**	**R**	**R**		**1**	**Other Payer Name**					
	NM101	R	R			2	ID	PR		Entity Identifier Code (Payer)	
	NM102	R	R			1	ID			Entity Type Qualifier	
								2		Non- Person Entity	
	NM103	R	R			1/35	AN			Organization Name	
	NM108	R	R			2	ID	PI		Payer Identification	
	NM109	R	R			2/80	AN			Other Payer Primary Identification	
2330B	**N3**	**S**	**S**		**1**	**Address**					
						Required if available					
	N301	R	R			1/55	AN			Address Line	
	N302	S	S			1/55	AN			Address Line	
2330B	**N4**	**S**	**S**		**1**	**City State Zip**					
						Required if available					
	N401	R	R			2/30	AN			City	
	N402	R	R			2	ID			State	
	N403	R	R			3/15	ID			Zip	
	N404	S	S			2/3	ID			Country Code	
2330B	**DTP**	**S**	**S**		**1**	**Claim Adjudication Date**					
						Required if available, this is the date of the prior payment					
	DTP01	R	R			3	ID	573		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			8	D			Date Claim Paid	
2330B	**REF**	**S**	**S**		**1**	**Other Payer Secondary Identification**					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								2U		Payer Identification Number	
								F8		Payer's claim number	
								FY		Claim Office Number	
								NF		National Association of Insurance Commissioners (NAIC) Code	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
								TJ		Federal Taxpayer's Identification Number	
	REF02	R	R			1/30	AN			Other Payer Secondary Identifier	
2400	**Service Line Number (Repeat >1)**										
2400	**LX**	**R**	**R**		**1**	**Service Line Number**					
	LX01	R	R			1/6	N0			Line Number	
2400	**SV2**	**R**	**R**			**Service Line**					
	SV201	R	R			4	ID		42	Revenue Code	
	SV202	S	S							Composite Medical Procedure Identifier	
										Required if service line billed with a HCPCS or jurisdictional code.	
	SV202-1	R	R			2	ID			Product or Service ID Qualifier	
								HC		HCPCS	
								IV		Home Infusion EDI Coalition (HIEC) Product/Service	
								ZZ		Mutually Defined	
	SV202-2	R	R			1/48	ID		44	HCPCS Procedure Code	
	SV202-3	S	S			2	ID		44	Modifier 1	
	SV202-4	S	S			2	ID		44	Modifier 2	
	SV202-5	S	S			2	ID		44	Modifier 3	
	SV202-6	S	S			2	ID		44	Modifier 4	
	SV203	R	R			1/18	R		47	Total Charge Amount Per Line	
	SV204	R	R			2	ID			Unit or Basis for Measurement Code	
								DA		Days	
								F2		Dosage amount when variable within a single NDC	
								UN		Unit	
	SV205	R	R			1/15	R		46	Unit Count	
2400	**DTP**	**S**	**J**		**1**	**Service Date**					
	DTP01	R	R			3	ID	472			
	DTP02	R	R			2/3	ID			Date Time Period Format Qualifier	
								D8		single date	
								RD8		date range	
	DTP03	R	R			1/35	AN		46	Service Date	
2410	**Drug Identification (Repeat 25)**										
2410	**LIN**	**S**	**S**		**1**	**Drug Identification**					
	LIN02	R	R			2	ID	N4		Drug Information	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UB04 Paper Field	Element Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	LIN03	R	R			1/48	ID		43	NDC code in 5-4-2 format (w/o the dash)	
2410	**CTP**	**S**	**S**		**1**	**Drug Pricing**					
	CTP03	R	S			1/17	R			Unit Price (required if different from SV102)	
	CTP04	R	S			1/15	R			Quantity (required if different from SV104)	
	CTP05-1	R	S			2/2	ID			Unit of Measure (required if CTP04 populated)	
								F2		International Unit	
								GR		Gram	
								ML		Milliliter	
								UN		Unit	
2410	**REF**	**S**	**S**		**1**	**Prescription Number**					
	REF01	R	R			2	ID	XZ		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		43	Prescription Number	
TS	**SE**	**R**	**R**			**Transaction Set Trailer**					
	SE01	R	R			1/10	N			Number of Included Segments	
	SE02	R	R			4/9	AN			Transaction Set Control Number (ST02)	

Chapter 7 Companion Guide Pharmacy

This companion guide for the ANSI ASC X12N 837 Pharmacy Healthcare Claim transaction and the NCPDP Telecommunication Standard Version 5.1 has been created for use in conjunction with the *ANSI ASC X12N 837 Implementation Guide and the NCPDP Telecommunication Standard Version 5.1 Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N 837 Implementation Guide or the NCPDP Telecommunication Standard Version 5.1 Implementation Guide*, but rather used as an additional source of information. Wherever the national standard differs from the California rules, the California rules prevail.

The Division has adopted the NCPDP Telecommunications Standard Version 5.1 as the prescribed format for electronic pharmacy billing**.**

Billing Date

The prescription date is generally used to identify the date the bill was generated, Billing Date, by the dispensing pharmacy. The NCPDP 5.1 does not contain a specific element that represents the date the bill was generated. For the California workers' compensation implementation, the date dispensed is considered the Billing Date. The prescription date is communicated in the Claim Segment of the NCPDP 5.1 Date of Service value 401-D1.

The direction and mapping for the ANSI 837 Pharmacy Healthcare Claim format is included in the link identified below.

Provider Roles

Provider roles pertaining to ANSI 837 billing formats are described in the Health Care Provider Roles/Identification Numbers section of Chapter 4 California Workers' Compensation Requirements of this companion guide.

Pharmacy Billing Agents

The current versions of the NCPDP UCF and 5.1 do not support the use of pharmacy billing agents, such as third party billing agents or pharmacy benefit managers (PBM). The form and format do not currently support a designated field, an identifier, or a qualifier to flag an entity as a pharmacy billing agent. When the dispensing pharmacy is the billing entity, the FEIN and NCPDP Number are that of the dispensing pharmacy. Until such time as the form and format are modified, the billing entity is identified through the use of the FEIN when the dispensing pharmacy is not the billing entity. The dispensing pharmacy is identified though the use of the NCPDP Number. Reference section NCPDP Telecommunications Standard Version 5.1 498-PP Field for specific direction on identifying the billing entity in the current format and UCF.

NCPDP Universal Claim Form

The Division adopted the NCPDP Universal Claim Form (UCF) as the prescribed paper billing form for pharmacy services. To the extent possible, the Division aligned the paper billing requirements with the electronic billing requirements.

Fill Number v. Number of Fills Remaining

The NCPDP UCF and the NCPDP 5.1 collect the Fill Number, rather than the number of refills remaining.

Compound Medications:

Division rules, paper billing forms, and the NCPDP 5.1 require components of a compound medications be identified. Compound medications in the NCPDP 5.1 are identified through the use of the Compound Code identifier "2" in Field 406-D6.

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NDC Codes

The Division prescribes the use of National Drug Codes (NDC) as the code set for pharmacy billing. Other code sets, such as HCPCS codes for supplies or Universal Product Codes (UPC) are not appropriate for billing in the California workers' compensation system. The Division does not currently prescribe the use of a specific NDC format. Currently the ten-digit or eleven-digit NDC code may be used in the California workers' compensation pharmacy billing.

Brand v. Generic

The NCPDP UCF and 5.1 contain a code set to indicate dispensed as written status. Some dispensed as written codes do indicate the generic availability status. However, the name of the medication, and the brand/generic status of the NDC code, is not communicated for each medication. Claims Administrators may obtain this information from purchased NDC code sets or from their agents/vendor partners.

NCPDP Telecommunications Standard Version 5.1 498-PP Field

The data populated in field 498-PP will be populated using a comma delimited format in the following order:

Pay To ID # (see Field 498-PF), Pay To ID Qualifier (See Code List), Jurisdictional Defined Field 1 Prescribing Physician Secondary Identification Number (State License Number for California,), Jurisdictional Defined Field 2 Prescribing Physician Identification Qualifier, Jurisdictional Defined Field 3 Generic NDC code (as defined above), END

The jurisdictional defined fields can be used for information that is required but does not have an NCPDP 5.1 field. The 498-PP field is 500 characters long.

Changes to NCPDP Forms and Formats

The Division, the IAIABC EDI Medical Committee, and the NCPDP are working to address issues related to implementing the paper pharmacy billing form, the NCPDPD Universal Claim Form (UCF), and the NCPDP 5.1. The current mapping and technical specifications are provided for discussion purposes pending final action by the NCPDP. The current information will be adopted if the changes to the UCF and 5.1 are not finalized prior to the publish date of this companion guide. Changes may be incorporated in a subsequent release once they are finalized.

Reference Information

This companion guide for the NCPDP Telecommunication 5.1 pharmacy transaction has been created for use in conjunction with the *NCPDP Telecommunication 5.1 Implementation Guide*. It should not be considered a replacement for the *NCPDP Telecommunication 5.1 Implementation Guide*, but rather used as an additional source of information.

The HIPAA implementation guide for the NCPDP Telecommunications 5.1 electronic pharmacy billing transaction is available through the National Council for Prescription Drug Programs (NCPDP), www.ncpdp.org.

The California workers' compensation direction for the use of the ANSI 837 Pharmacy Health Care Claim Implementation Guide and the NCPDP Telecommunication Standard Version 5.1 is below.

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Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
TS	**Transaction Set**											
TS	**ST**	**R**	**R**			**Transaction Set Header**						
	ST01	R	R			3	ID	837			Transaction Set Identifier Code	
	ST02	R	R			4/9	AN				Transaction Set Control Number	
TS	**BHT**	**R**	**R**			**Beginning of Hierarchical Transaction**						
	BHT01	R	R			4	ID	0019			Hierarchical Structure Code	
	BHT02	R	R			2	ID	00			Transaction Set Purpose Code	
	BHT03	R	R			1/30	AN				Originator Transaction Identifier	
	BHT04	R	R			8	DT		3		Transaction Set Creation Date	
	BHT05	R	R			4/8	TM				Transaction Set Creation Time	
	BHT06	R	R			2	ID	CH			Claim or Encounter Indicator	
TS	**REF**	**R**	**R**			**Transmission Type Identification**						
	REF01	R	R			2/3	ID	87			Reference Identification Qualifier	
	REF01	R	R			1/30	AN				Type Code 004010X098A1	
1000A	**Sender Information**											
1000A	**NM1**	**R**	**R**		**1**	**Submitter Name**						
	NM101	R	R			2/3	ID	41			Entity Identifier Code	
	NM102	R	R			1	ID				Entity Type Qualifier	
								2			Non Person Entity- (Company Name)	
	NM103	R	R			1/35	AN				Organization Name (Company Name)	
	NM108	R	R			2	ID	46			Identification Code Qualifier (ETIN)	
	NM109	R	R			2/80	AN				Identification Code	
1000A	**PER**	**R**	**R**		**1**	**Contact Information**						
	PER01	R	R			2	ID	IC			Contact Function Code	
	PER02	R	R			1/60	AN				Contact Name	
	PER03	R	R			2	ID	TE			Communication Number Qualifier	
	PER04	R	R			1/80	AN				Telephone Number	
	PER05	S	S			2	ID				Communication Number Qualifier	
											Use at the discretion of the submitter	
	PER06	S	S			1/80	AN				Communication Number	
	PER07	S	S			2	ID				Communication Number	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
											Qualifier	
											Use at the discretion of the submitter	
	PER08	S	S			1/80	AN				Communication Number	
1000B	**Receiver Information**											
1000B	**NM1**	**R**	**R**		**1**	**Receiver Name**						
	NM101	R	R			2/3	ID	40			Entity Identifier Code	
	NM102	R	R			1	ID	2			Entity Type Code (Non-Person Entity)	
	NM103	R	R			1/35	AN				Name of Receiver	
	NM108	R	R			2	ID	46			Identification Code Qualifier	
	NM109	R	R			2/80	AN				EIN Electronic Identification Number	
2000A	**Billing/Pay-to Provider Hierarchical Level**											
2000A	**HL**	**R**	**R**		**1**							
	HL01	R	R			12	AN				Hierarchical ID Number	
	HL03	R	R			2	ID	20			Hierarchical Level Code	
	HL04	R	R			1	ID	1			Hierarchical Child Code	
2000A	**PRV**	**S**	**J**		**1**	**Provider Taxonomy Code**						
						Required for California and Texas						
	PRV01	R	R			2	ID	BI			Provider Code	
	PRV02	R	R			2/3	ID	ZZ			Reference Identification Code	
	PRV03	R	R			1/30	AN				Provider Specialty Code (Taxonomy Code)	
2010AA	**Billing Provider Information**											
2010AA	**NM1**	**R**	**R**		**1**	**Billing Provider Name**						
	NM101	R	R			2	ID	85			Entity Identifier Code	
	NM102	R	R			1	ID				Entity Type Qualifier	
								1			Person	
								2			Company	
	NM103	R	R			1/35	AN		12	498-PF	Last	
	NM104	S	S			1/25	AN				First	
	NM105	S	S			1/25	AN				Middle	
	NM107	S	S			1/10	AN				Suffix	
	NM108	S	S			2	ID		17	498-PP	Identification Code Qualifier	Position 2 on Template
								XX			National Provider Identifier (NPI) =XX	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
											If billing entity is a non health care provider (non NPI number) then NM108 Code Qualifier 24 or 34 is required	
											TAX ID Code Qualifiers	
								24			Employer's Identification Number	
								34			Social Security Number	
	NM109	S	S			2/80	AN		16	498-PP	Identification Code	Position 1 on Template
2010AA	**N3**	**R**	**R**		**1**	**Address**						
	N301	R	R			1/55	AN		13	498-PG	Address Line	
	N302	S	S			1/55	AN		13	498-PG	Address Line	
2010AA	**N4**	**R**	**R**		**1**	**City State Zip**						
	N401	R	R			2/30	AN		14	498-PH	City	
	N402	R	R			2	ID		15	498-PJ	State	
	N403	R	R			3/15	ID		15	498-PK	Zip	
	N404	S	S			2/3	ID				Country Code	
2010AA	**REF**	**S**	**S**		**1**	**Tax ID**						
						Required field when NPI Identifier Code XX is present in NM108						
	REF01	R	R			2/3	ID		17	498-PP	Reference Identification Qualifier	Position 2 on Template
								EI			Federal Tax ID	
								SY			Social Security Number	
	REF02	R	R			1/30	AN		16	498-PP	Identification Code	Position 1 on Template
2010AA	**REF**	**S**	**J**		**1**	**State License (Not required for Dispensing Pharmacy - CA, TX)**						
	REF01	R	R			2/3	ID	0B	17		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		16		State License Number	
2010AA	**PER**	**S**	**J**		**2**	**Contact Information**						
						Required if this information is different than that contained in Loop 1000A Submitter PER segment						
	PER01	R	R			2	ID	IC			Contact Function Code	
	PER02	R	R			1/60	AN				Contact Name	
	PER03	R	R			2	ID	TE			Communication Number Qualifier	
	PER04	R	R			1/80	AN		18	498-PM	Telephone Number	
	PER05	S	S			2	ID				Communication Number Qualifier	
											Use at the discretion of	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
											the billing provider	
	PER06	S	S			1/80	AN				Communication Number	
	PER07	S	S			2	ID				Communication Number Qualifier	
											Use at the discretion of the billing provider	
	PER08	S	S			1/80	AN				Communication Number	
2010AB	**Pay-to Provider Information**											
	Required if the Pay-to Provider is a different entity than the Billing Provider											
2010AB	**NM1**	**S**	**S**		**1**	**Pay-to Provider Name**						
	NM101	R	R			2	ID	87			Entity Identifier Code (Pay-to Provider)	
	NM102	R	R			1	ID				Entity Type Qualifier	
								1			Person	
								2			Company	
	NM103	R	R			1/35	AN		12	498-PF	Last	
	NM104	S	S			1/25	AN				First	
	NM105	S	S			1/25	AN				Middle	
	NM108	R	R			2	ID		17	498-PP	Identification Code Qualifier	Position 2 on Template
								XX			National Provider Identifier (NPI) =XX	
											If billing entity is a non health care provider (non NPI number) then NM108 Code Qualifier 24 or 34 is required	
											TAX ID Code Qualifiers	
								24			Employer's Identification Number	
								34			Social Security Number	
	NM109	S	S			2/80	AN		16	498-PP	Identification Code	
2010AB	**N3**	**R**	**R**			**Address**						
	N301	R	R			1/55	AN		13	498-PG	Address Line	
	N302	S	S			1/55	AN		13	498-PG	Address Line	
2010AB	**N4**	**R**	**R**			**City State Zip**						
	N401	R	R			2/30	AN		14	498-PH	City	
	N402	R	R			2	ID		15	498-PJ	State	
	N403	R	R			3/15	ID		15	498-PK	Zip	
	N404	S	S			2/3	ID				Country Code	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
2010AB	**REF**	**S**	**S**			**Tax ID**						
						Required field when NPI Identifier Code XX is present in NM108						
	REF01	R	R			2/3	ID		17	498-PP	Reference Identification Qualifier	Position 2 on Template
								EI			Federal Tax ID	
								SY			Social Security Number	
	REF02	R	R			1/30	AN		16	498-PP	Identification Code	Position 1 on Template
2010AB	**REF**	**S**	**J**			**State License (Not required for Dispensing Pharmacy - TX/CA)**						
	REF01	R	R			2/3	ID	0B	17		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		16		State License Number	
2000B	**Subscriber (Employer) Detail**											
2000B	**HL**	**R**	**R**			**Subscriber (Employer) Hierarchical Level**						
	HL01	R	R			1/12	AN				Hierarchical ID Number	
	HL02	R	R			1/12	AN				Hierarchical Parent ID Number	
	HL03	R	R			2	ID	22			Hierarchical Level Code	
	HL04	R	R			1	ID	1			Hierarchical Child Code	
2000B	**SBR**	**R**	**R**			**Subscriber (Employer) Information**						
	SBR01	R	R			1	ID	P			P for Primary Payer	
	SBR03	S	S			1/30	AN				WC Policy Number, If Available	
	SBR04	S	S			1/60	AN		21	315-CF	Employer Name: Required for California and Texas	
	SBR09	S	J			1/2	ID	WC			Claim Filing Indicator Code	
											California and Texas Required Field	
2010BA	**Subscriber Information (Insured)**					**Workers' Compensation Insured is Employer**						
2010BA	**NM1**	**R**	**R**			**Subscriber (Employer) Name**						
	NM101	R	R			2	ID	IL			Entity Identifier Code	
	NM102	R	R			1	ID	2			Entity Type Qualifier (Non- Person Entity)	
	NM103	R	R			1/35	AN				Employer Name	
2010BA	**N3**	**S**	**J**		**1**	**Address**						
						Address California and Texas Required Field						
	N301	R	R			1/55	AN		22	316-CG	Address	
	N302	S	S			1/55	AN		22	316-CG	Address	
2010BA	**N4**	**S**	**J**		**1**	**City State Zip**						
						City State Zip						

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
						California and Texas Required Field						
	N401	R	R			2/30	AN		23	317-CH	City	
	N402	R	R			2	ID		24	318-CI	State	
	N403	R	R			3/15	ID		25	319-CJ	Zip	
	N404	S	S			2/3	ID				Country Code	
2010BB	**Payer Information**											
2010BB	**NM1**	**R**	**R**			**Payer Name**						
	NM101	R	R			2/3	ID	PR			Entity Identifier Code	
	NM102	R	R			1	ID	2			Entity Type Qualifier (company)	
	NM103	R	R			1/35	AN		26		The Payer; Employer, TPA, etc.	
	NM108	R	R			2	ID	PI			Identification Code Qualifier	
											Payer Identification Code is defined in the ISA Segment as well as specified in the Trading Partner Agreement	
											On NCPDP 5.1-Payer ID code will identify payer to whom transaction is submitted.	
	NM109	R	R			2/80	AN		26	327-CR	Payer Identification Code	
2010BB	**N3**	**S**	**S**			**Address**						
						Payer Address is required when the submitter intends for the bill to be printed on paper at the next EDI location e.g. clearinghouse						
	N301	R	R			1/55	AN		26		Address	
	N302	S	S			1/55	AN		26		Address	
2010BB	**N4**	**S**	**S**			**City State Zip**						
						Payer Address is required when the submitter intends for the bill to be printed on paper at the next EDI location e.g. clearinghouse						
	N401	R	R			2/30	AN		26		City	
	N402	R	R			2	ID		26		State	
	N403	R	R			3/15	ID		26		Zip	
	N404	S	S			2/3	ID				Country Code	
2000C	**Patient Hierarchical Level**											
2000C	**HL**	**S**	**J**		**1**	**Patient Hierarchical Level**						
						This HL is required when the patient is different person than the subscriber . The Employer is the Subscriber in Workers' Compensation. California and Texas Required Field						
	HL01	R	R			12	AN				Hierarchical ID Number	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	HL02	R	R			12	AN				Hierarchical Parent ID Number	
	HL03	R	R			2	ID	23			Hierarchical Level Code	
	HL04	R	R			1	ID	0			Hierarchical Child Code	
2000C	**PAT**	**R**	**R**			**Patient Information**						
	PAT01	R	R			2	ID				Patients Relationship to Insured	
								20			Employee	
2100CA	**Patient Information**											
2100CA	**NM1**	**R**	**R**			**Patient Name**						
	NM101	R	R			2	ID	QC			Entity Identifier Code	
	NM102	R	R			1	ID	1			Entity Type Qualifier (Person)	
	NM103	R	R			1/35	AN		6	311-CB	Last Name	
	NM104	R	R			1/25	AN		6	310-CA	First Name	
	NM105	S	S			1/25	AN				Middle Name	
	NM107	S	S			1/10	AN				Name Suffix	
	NM108	R	R			2	ID	MI		331-CX	Identification Code Qualifier	
	NM109	R	R			2/80	AN		1	332-CY	Social Security Number	
2010CA	**N3**	**R**	**R**			**Address**						
	N301	R	R			1/55	AN				Address	
	N302	S	S			1/55	AN				Address	
2010CA	**N4**	**R**	**R**			**City State Zip**						
	N401	R	R			2/30	AN				City	
	N402	R	R			2	ID				State	
	N403	R	R			3/15	ID				Zip	
	N404	S	S			2/3	ID				Country Code	
2010CA	**DMG**	**R**	**R**			**Demographic Information**						
	DMG01	R	R			2/3	ID	D8			Date Time Period Format Qualifier	
	DMG02	R	R			1/35	AN		9	304-C4	Birth Date	
	DMG03	R	R			1	ID		10	305-C5	Gender Code	
2010CA	**REF**	**S**	**S**			**Property & Casualty Claim Number**						
						Enter Claim Number if Know						
	REF01	R	R			2/3	ID	Y4			Reference Identification Qualifier	
	REF02	R	R			1/30	AN		29	435-DZ	Workers' Compensation Claim Number	
2300	**Claim Information**											

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
2300	**CLM**	**R**	**R**			**Claim Information**						
	CLM01	R	R			1/38	AN				Claim Submitter Identifier (Provider Unique Bill Identification Number)	
	CLM02	R	R			1/18	R				Total Submitted Charges	
	CLM05-1	R	R			1/2	ID	01			Facility Type Code 01=RX (Place of Service)	
	CLM05-3	R	R			1	ID				Claim Frequency Type Code	
	CLM06	R	R			1	ID	Y/N			Provider Signature on File	
	CLM07	R	R			1	ID	A			Enter value "A" to indicate provider acceptance of assignment	
	CLM08	R	R			1	ID	N			Benefit Assignment Indicator	
	CLM09	R	R			1	ID	I			Release of Information Code	
	CLM10	R	R			1	ID				Patient Signature Source Code	
	CLM11	S	S				ID				Related Causes Information	
	CLM11-1	R	R			2/3	ID	EM			Related Causes Code 1	
	CLM11-2	S	S			2/3	ID				Related Causes Code 2	
	CLM11-3	S	S			2/3	ID				Related Causes Code 3	
	CLM11-4	S	S			2	ID				State or Province Code	
	CLM11-5	S	S			2/3	ID				Country Code	
	CLM19	N	J			2/2	ID				Claims Submission Reason Codes	
								7			Duplicate Bill	
								15			Revised Bill	
								30			Appeal/Reconsideration	
2300	**DTP**	**S**	**S**		**1**	**Date Onset of Similar Symptoms or Illness**						
	DTP01	R	R			3	ID	438			Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8			Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN				Onset of Similar Symptoms or Illness	
2300	**DTP**	**S**	**J**		**1**	**Date of Accident (Date of Injury or Illness)**						
						California and Texas Required Field						
	DTP01	R	R			3	ID	439			Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8			Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		28	434-	Accident Date	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
										DY		
2300	**PWK**	**S**	**S**		**10**	**Attachment Reference**						
	PWK01	R	R			2/2	ID				Report Type Code	
	PWK02	R	R			1/2	ID				Deliver type code	
	PWK05	S	R			2	ID	AC			Identification Code Qualifier	
	PWK06	S	R			2/80	AN				Attachment Control Number	
2300	**CN1**	**S**	**S**			**Contract Information**						
						Required if billing capitated services or contractually obligated to provide contract information on this bill						
	CN101	R	R			2	ID				Contract Type Code	
	CN102	R	R			1/18	R				Contract Amount	
2300	**AMT**	**S**	**J**			**Patient Amount Paid**						
						Jurisdiction Specific Rules						California the segment is not required/ Texas segment is situational
	AMT01	R	R			2	ID	F5			Amount Qualifier Code	
	AMT02	R	R			1/18	R		61 & 95	433-DX	Patient Amount Paid	
2300	**REF**	**S**	**S**		**1**	**Prior Authorization**						
	REF01	R	R			2/3	ID	G1	41 & 75	462-EV	Reference Identification Qualifier	
	REF02	R	R			1/30	AN		40 & 74	461-EU	Prior Authorization Number	
2300	**REF**	**S**	**S**		**1**	**Clearing House Generated Tracking Number**						
	REF01	R	R			2/3	ID	D9			Reference Identification Qualifier	
	REF02	R	R			1/30	AN				Number assigned by ch/van/etc.	
2300	**NTE**	**S**	**S**		**20**	**Remarks**						
	NTE01	R	R			3	ID				Note Reference Code	
	NTE02	R	R			1/80	AN				Note Text	
2300	**HI**	**S**	**J**		**25**	**Health Care Information Codes**						
						Required on all bills except bills for which there are no diagnoses or when a pharmacist does not have access to the diagnosis. This segment is not used for California or Texas Workers' Compensation RX						
	HI01	R	R								Principal Diagnosis 1	
	HI01-1	R	R			1/3	ID	BK			Code List Qualifier Code	
	HI01-2	R	R			1/30	AN				Code	
	HI02	S	S								Diagnosis 2	
	HI02-1	R	R			1/3	ID	BF			Code List Qualifier Code	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	HI02-2	R	R			1/30	AN				Code	
	HI03	S	S								Diagnosis 3	
	HI03-1	R	R			1/3	ID	BF			Code List Qualifier Code	
	HI03-2	R	R			1/30	AN				Code	
	HI04	S	S								Diagnosis 4	
	HI04-1	R	R			1/3	ID	BF			Code List Qualifier Code	
	HI04-2	R	R			1/30	AN				Code	
2310D	**Facility / Service location (Dispensing Pharmacy)**											Rendering Provider
	Required if billing entity is different than dispensing pharmacy											
2310D	**NM1**	**S**	**S**		**1**	**Name**						
	NM101	R	R			2/3	ID	FA			Entity Identifier Code (FA)=Facility	
	NM102	R	R			1	ID	2			Entity Type Qualifier (Non-Person Entity)	On UCF and NCPDP 5.1 - pharmacy information derived from NCPDP or NPI Number.
	NM103	S	S			1/35	AN				Name	
	NM108	R	J			2	ID	XX	5	202-B2	Identification Code Qualifier	
									4	201-B1	NPI Number	
											Texas Requires NPI	
								G2	4	201-B1	NCPDP Number	
											California Requires NCPDP	In Ref segment
	NM109	R	R			2/80	AN		4	201-B1	Identification Code	
2310D	**N301**	**R**	**R**		**1**	**Address**						
	N301	R	R			1/55	AN				Address	
	N302	R	R			1/55	AN				Address	
2310D	**N4**	**R**	**R**		**1**	**City State Zip**						
	N401	R	R			2/30	AN				City	
	N402	R	R			2	ID				State	
	N403	R	R			3/15	ID				Zip	
	N404	S	S			2/3	ID				Country Code	
2310D	**REF**	**S**	**J**		**1**	**State License Number (Not required for Dispensing)**						
	REF01	R	R			2/3	ID	0B			Reference Identification Qualifier	
	REF02	R	R			1/30	AN		32b		Service Facility State License Number	
											Jurisdiction specific requirement; California requires State License Number when Service Facility is a health care	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
											provider.	
2320	**Other Subscriber Information (repeat max 10)**											
	The 2300 and 2330 loops are required if there has been a prior payment by a payer other than the employer's insurer											
2320	**SBR**	**S**	**S**		**1**	**Other Subscriber Information**						
	SBR01	R	R			1	ID				Payer Responsibility Sequence Code	
								P			Primary	
								S			Secondary	
								T			Tertiary	
	SBR02	R	R			2/2	ID				Individual Relationship Code	
	SBR03	S	S			1/30	AN				Group or Policy Number	
	SBR04	S	S			1/60	AN				Group or Plan Name	
	SBR05	R	R			1/3	ID				Insurance Type Code	
	SBR09	S	S			1/2	ID				Claim Filing Indicator Code	
2320	**CAS**	**S**	**S**		**5**	**Claim Level Adjustments**						
	CAS01	R	R			1/2	ID				Group code	
	CAS02	R	R			1/5	ID				Claim Adjustment Reason Code	
	CAS03	R	R			1/18	R				Adjustment Amount	
	CAS04	S	S			1/15	R				Adjustment Quantity	
	CAS05	S	S			1/5	ID				Claim Adjustment Reason Code	
	CAS06	S	S			1/18	R				Adjustment Amount	
	CAS07	S	S			1/15	R				Adjustment Quantity	
	CAS08	S	S			1/5	ID				Claim Adjustment Reason Code	
	CAS09	S	S			1/18	R				Adjustment Amount	
	CAS10	S	S			1/15	R				Adjustment Quantity	
	CAS11	S	S			1/5	ID				Claim Adjustment Reason Code	
	CAS12	S	S			1/18	R				Adjustment Amount	
	CAS13	S	S			1/15	R				Adjustment Quantity	
	CAS14	S	S			1/5	ID				Claim Adjustment Reason Code	
	CAS15	S	S			1/18	R				Adjustment Amount	
	CAS16	S	S			1/15	R				Adjustment Quantity	
	CAS17	S	S			1/5	ID				Claim Adjustment Reason Code	
	CAS18	S	S			1/18	R				Adjustment Amount	
	CAS19	S	S			1/15	R				Adjustment Quantity	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
2320	**AMT**	**S**	**S**			**Coordination of Benefits (COB) Payer Paid Amount**						
	AMT01	R	R			2	ID	D			Amount Qualifier Code	
	AMT02	R	R			1/18	R				Patient Amount Paid	
2320	**AMT**	**S**	**S**			**Coordination of Benefits (COB) Patient Paid Amount**						
	AMT01	R	R			2	ID	F5			Amount Qualifier Code	
	AMT02	R	R			1/18	R				Patient Amount Paid	
2330A	**Other Subscriber Name**											
	Required when Loop ID 2320 Other Subscriber Information is used. Otherwise, this loop is not used											
2330A	**NM1**	**R**	**R**		**1**	**Other Subscriber Name**						
	NM101	R	R			2	ID	IL			Entity Identifier Code (Insured or Subscriber)	
	NM102	R	R			1	ID				Entity Type Qualifier	
								1			person	
								2			company	
	NM103	R	R			1/35	AN				Last	
	NM104	S	S			1/25	AN				First	
	NM105	S	S			1/25	AN				Middle	
	NM108	R	R			2	ID	MI			Member Identification Number	
	NM109	R	R			2/80	AN				Other Subscriber Primary Identification	
2330A	**N3**	**S**	**S**			**Address**						
						Required when information is available						
	N301	R	R			1/55	AN				Address Line	
	N302	S	S			1/55	AN				Address Line	
2330A	**N4**	**S**	**S**			**City State Zip**						
						Required when information is available						
	N401	R	R			2/30	AN				City	
	N402	R	R			2	ID				State	
	N403	R	R			3/15	ID				Zip	
	N404	S	S			2/3	ID				Country Code	
2330A	**REF**	**S**	**S**			**Tax ID**						
	REF01	R	R			2/3	ID	EI or SY			Reference Identification Qualifier	
	REF02	R	R			1/30	AN				TAX ID (EI for TIN, SY for SSN)	
2330B	**Other Payer Name**											
	Required when Loop ID 2320 Other Subscriber Information is used. Otherwise, this loop is not used											
2330B	**NM1**	**R**	**R**		**1**	**Other Payer Name**						
	NM101	R	R			2	ID	PR			Entity Identifier Code (Payer)	
	NM102	R	R			1	ID				Entity Type Qualifier	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
								2			Non- Person Entity	
	NM103	R	R			1/35	AN				Organization Name	
	NM108	R	R			2	ID	PI			Payer Identification	
	NM109	R	R			2/80	AN				Other Payer Primary Identification	
2330B	**N3**	**S**	**S**		**1**	**Address**						
						Required if available						
	N301	R	R			1/55	AN				Address Line	
	N302	S	S			1/55	AN				Address Line	
2330B	**N4**	**S**	**S**		**1**	**City State Zip**						
						Required if available						
	N401	R	R			2/30	AN				City	
	N402	R	R			2	ID				State	
	N403	R	R			3/15	ID				Zip	
	N404	S	S			2/3	ID				Country Code	
2330B	**DTP**	**S**	**S**		**1**	**Claim Adjudication Date**						
						Required if available, this is the date of the prior payment						
	DTP01	R	R			3	ID	573			Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8			Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN				Date Claim Paid	
2330B	**REF**	**S**	**S**			**Other Payer Secondary Identification**						
	REF01	R	R			2/3	ID				Reference Identification Qualifier	
								2U			Payer Identification Number	
								F8			payer's claim number	
								FY			Claim Office Number	
								NF			National Association of Insurance Commissioners (NAIC) Code	
								TJ			Federal Taxpayer's Identification Number	
	REF02	R	R			1/30	AN				Other Payer Secondary Identifier	
2400	**Service Lines**											
2400	**LX**	**R**	**R**		**50**	**Service Line Number**						
	LX01	R	R			1/6	N0				Line Number	
2400	**SV1**	**R**	**R**			**Professional Service**						
	SV101	R	R								Composite Medical Procedure Identifier	
	SV101-1	R	R			2	ID				Product or Service ID Qualifier	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
								HC			HCPCS	
								IV			Home Infusion EDI Coalition (HIEC) Product/Service	
								ZZ			Mutually Defined	
	SV101-2	R	R			1/48	AN				CPT/HCPCS/OMFS Procedure Code	
	SV101-3	S	S			2	AN				Modifier 1	
	SV101-4	S	S			2	AN				Modifier 2	
	SV101-5	S	S			2	AN				Modifier 3	
	SV101-6	S	S			2	AN				Modifier 4	
	SV102	R	R			1/18	R		60 & 94	430-DU	Line Item Charge	
	SV103	R	R			2	ID				Unit or Basis for Measurement Code	
								F2			Dosage amount when variable within a single NDC	
								UN			Units	
								MJ			Minutes	
	SV104	R	R			1/15	R		35 & 69	442-E7	Service Unit	
	SV105	S	S			2	AN				Place of Service	
	SV107-1	R	R			1/2	N0				Diagnosis Code Pointer 1	
	SV107-2	S	S			1/2	N0				Diagnosis Code Pointer 2	
	SV107-3	S	S			1/2	N0				Diagnosis Code Pointer 3	
	SV107-4	S	S			1/2	N0				Diagnosis Code Pointer 4	
2400	**DTP**	**R**	**R**			**Service Date**						
	DTP01	R	R			3	ID	472			Date/Time Qualifier	
	DTP02	R	R			2/3	ID	RD8			Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		33 & 67	401-D1	Service Date	
2400	**K3**	**R**	**R**			**File Information (additional NCPDP Information)**						
	K301	R	R			1/80	AN				NCPDP Data	
2410	**Drug Identification**											
2410	**LIN**	**R**	**R**		**25**	**Drug Identification**						
	LIN02	R	R			2	ID	N4			Drug Information	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	UCF Paper Field	NCPDP 5.1	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	LIN03	R	R			1/48	ID		37 & 71	407-D7 & 498-PP	NDC code in 5-4-2 format (w/o the dash)	
2410	**CTP**	**S**	**S**		**1**	**Drug Pricing**						
	CTP03	R	S			1/17	R				Unit Price (required if different from SV102)	
	CTP04	R	S			1/15	R				Quantity (required if different from SV104)	
	CTP05-1	R	S			2/2	ID				Unit of Measure (required if CTP04 populated)	
								F2			International Unit	
								GR			Gram	
								ML			Milliliter	
								UN			Unit	
2410	**REF**	**R**	**R**			**Prescription Number**						
	REF01	R	R			2	ID	XZ	31 & 65	455-EM	Reference Identification Qualifier	
	REF02	R	R			1/30	AN		30 & 64	402-D2	Prescription Number	
2420E	**Ordering (Prescribing) Provider Name**											
2420E	**NM1**	**S**	**S**			**Ordering Provider Name**						
	NM101	R	R			2	ID	DK			Entity Identifier Code	
	NM102	R	R			1	ID	1			Entity Type Qualifier (Person)	
	NM103	R	R			1/35	AN			427-DR	Last Name	
	NM104	S	R			1/25	AN				First Name	
	NM105	S	S			1/25	AN				Middle Name	
	NM108	R	J			2	ID		43 & 77	466-EZ	Identification Code Qualifier	
								XX			NPI Number	
								DH			DEA Number: California & Texas Required field	
								0B			State License Number (Florida)	
	NM109	R	R			2/80	AN		42 & 76	411-DB	Identification Code	
TS	**SE**	**R**	**R**			**Transaction Set Trailer**						
	SE01	R	R			1/10	N				Number of Included Segments	
	SE02	R	R			4/9	AN				Transaction Set Control Number (ST02)	

Chapter 8 Companion Guide 837 Dental

This companion guide for the ANSI ASC X12N 837 Dental Healthcare Claim transaction has been created for use in conjunction with the *ANSI ASC X12N 837 Dental Claim Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N 837 Dental Claim Implementation Guide*, but rather used as an additional source of information. Wherever the national standard differs from the California rules, the California rules prevail.

Dentist License Number

The dentist license number is populated in the applicable REF Reference Identification – State License Segment. The REF Reference Identification-Dentist License Number is not required for the California worker's compensation implementation. The dentist license number may be populated in the REF Dentist License Number Segment if the health care provider, health care facility, or third party biller/assignee chooses.

Dental Procedure Codes

Services provided by a dentist are billed using the ANSI 837 Dental format. HCPCS Codes are not supported in this format. American Dental Association Current Dental Terminology (CDT) Codes, also referred to as Codes on Dental Procedures and Nomenclature, are used in ANSI HIPAA 837 Dental transactions. Health care providers, health care facilities, or third party biller/assignees may contact the Division if dental services are provided by a dentist, such as some oral surgery procedures, and ADA CDT codes describing the procedure are not available.

Provider Contact information

The ANSI 837 Dental transaction specifications indicate that the Billing Provider and Pay to Provider PRV Provider Contact Information Segments are "not used". The workers' compensation implementation used these fields to capture Billing Provider and Pay to Provider contact name and phone number information. These segments are required for California workers' compensation.

Patient Paid Amount

The AMT Patient Paid Amount Segment is not used in the California workers' compensation implementation of ANSI 837 Dental transactions.

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 837 4010 A1 Dental Healthcare Claim transaction is available through the Washington Publishing Company, www.wpc-edi.com. The California workers' compensation direction for the use of the ANSI HIPAA 837 Dental Implementation Guide is below.

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Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	Paper Field ADA 2006 Form	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
TS	**Transaction Set**										
TS	**ST**	**R**	**R**		**1**	**Transaction Set Header**					
	ST01	R	R			3	ID	837		Transaction Set Identifier Code	
	ST02	R	R			4/9	AN			Transaction Set Control Number	
TS	**BHT**	**R**	**R**		**1**	**Beginning of Hierarchical Transaction**					
	BHT01	R	R			4	ID	0019		Hierarchical Structure Code	
	BHT02	R	R			2	ID	00		Transaction Set Purpose Code	
	BHT03	R	R			1/30	AN			Originator Transaction Identifier	
	BHT04	R	R			8	DT			Transaction Set Creation Date	
	BHT05	R	R			4/8	TM			Transaction Set Creation Time	
	BHT06	R	R			2	ID	CH		Claim or Encounter Indicator	
TS	**REF**	**R**	**R**		**1**	**Transmission Type Identification**					
	REF01	R	R			2	ID	87		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Type Code 004010X097A1	
1000A	**Sender Information**										
1000A	**NM1**	**R**	**R**		**1**	**Submitter Name**					
	NM101	R	R			2	ID	41		Entity Identifier Code	
	NM102	R	R			1	ID	2		Entity Type Qualifier	
	NM103	R	R			1/35				Name of Sender	
	NM108	R	R			2	ID	46		Identification Code Qualifier	
	NM109	R	R			2/80	AN			EIN Electronic Identification Number	
1000A	**PER**	**R**	**R**		**1**	**Contact Information**					
	PER01	R	R			2	ID	IC		Contact Function Code	
	PER02	R	R			1/60	AN			Contact Name	
	PER03	R	R			2	ID	TE		Communication Number Qualifier	
	PER04	R	R			1/80	AN			Telephone Number	
	PER05	S	S			2	ID			Communication Number Qualifier	
										Use at the discretion of the submitter	
	PER06	S	S			1/80	AN			Communication Number	
	PER07	S	S			2	ID			Communication Number Qualifier	
										Use at the discretion of the submitter	
	PER08	S	S			1/80	AN			Communication Number	
1000B	**Receiver Information**										
1000B	**NM1**	**R**	**R**		**1**	**Receiver Name**					
	NM101	R	R			2	ID	40		Entity Identifier Code	
	NM102	R	R			1	ID	2		Entity Type Qualifier (Non-Person Entity)	
	NM103	R	R			1/35				Name of Receiver	

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	NM108	R	R			2	ID	46		Identification Code Qualifier (ETIN)	
	NM109	R	R			2/80	AN			Identification Code	
2000A	**Billing/Pay-to Provider Hierarchical Level**										
2000A	**HL**	**R**	**R**		**1**						
	HL01	R	R			12	N			Hierarchical ID Number	
	HL03	R	R			2	ID	20		Hierarchical Level Code	
	HL04	R	R			1	ID	1		Hierarchical Child Code	
2000A	**PRV**	**S**	**J**		**1**	**Provider Taxonomy Code**					
						Required for California and Texas					
	PRV01	R	R			2	ID	BI		BI=Billing	
	PRV02	R	R			2/3	ID	ZZ		Reference Identification Code	
	PRV03	R	R			1/30	AN		56a	Provider Specialty Code	
2010AA	**Billing Provider Information**										
2010AA	**NM1**	**R**	**R**		**1**	**Billing Provider Name**					
	NM101	R	R			2	ID	85		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								1		Person	
								2		Non- Person Entity (Company)	
	NM103	R	R			1/35	AN		48	Last	
	NM104	S	S			1/25	AN		48	First	
	NM105	S	S			1/25	AN		48	Middle	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
									49	National Provider Identifier (NPI) =XX	
										If billing entity is a non health care provider (non NPI number) then NM108 Code Qualifier 24 or 34 is required	
										TAX ID Code Qualifiers	
								24	51	Employer's Identification Number	
								34	51	Social Security Number	
	NM109	R	R			2/80	AN			Identification Code	
2010AA	**N3**	**R**	**R**		**1**	**Address**					
	N301	R	R			1/55	AN		48	Address Line	
	N302	S	S			1/55	AN		48	Address Line	
2010AA	**N4**	**R**	**R**		**1**	**City State Zip**					
	N401	R	R			2/30	AN		48	City	
	N402	R	R			2	ID		48	State	
	N403	R	R			3/15	ID		48	Zip	
	N404	S	S			2/3	ID			Country Code	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	Paper Field ADA 2006 Form	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
2010AA	**REF**	**S**	**S**			**Tax ID**					
						Required segment when NPI Identifier Code XX is present in NM108					
	REF01	R	R			2/3	ID	EI or SY		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		51	TAX ID (EI for TIN, SY for SSN)	
2010AA	**REF**	**S**	**J**		**1**	**State License**					
						California and Texas required segment when billing entity is a health care provider.					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		50	State License Number	
2010AA	**REF**	**S**	**J**		**1**	**Dentist License Number**					
						California and Texas required segment when the dentist license number is different than the state license number.					
	REF01	R	R			2/3	ID	1E		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Dentist License Number	
2010AA	**PER**	**N**	**J**		**1**	**Contact Information**					
						California and Texas required segment if this information is different than that contained in Loop 1000A Submitter PER segment					
	PER01	N	R			2	ID	IC		Contact Function Code	
	PER02	N	R			1/60	AN		48	Contact Name	
	PER03	N	R			2	ID	TE		Communication Number Qualifier	
	PER04	N	R			1/80	AN		48	Telephone Number	
	PER05	N	R			2	ID			Communication Number Qualifier	
	PER06	N	S			1/80	AN			Communication Number	
	PER07	N	S			2	ID			Communication Number Qualifier	
										Use at the discretion of the billing provider	
	PER08	N	S			1/80	AN			Communication Number	
2010AB	**Pay-to Provider Information (Use if pay-to is different from billing)**										
2010AB	**NM1**	**S**	**S**		**1**	**Pay-to Provider Name**					
	NM101	R	R			2	ID	87		Entity Identifier Code (Pay-to Provider)	
	NM102	R	R			1	ID			Entity Type Code (Pay-to Provider)	
								1		Person	
								2		Non-Entity Person (Company)	
	NM103	R	R			1/35	AN			Last Name or Organization Name	
	NM104	S	S			1/25	AN			First	
	NM105	S	S			1/25	AN			Middle	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
									49	National Provider Identifier (NPI)	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	Paper Field ADA 2006 Form	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
										=XX	
										If billing entity is a non health care provider (non NPI number) then NM108 Code Qualifier 24 or 34 is required	
										TAX ID Code Qualifiers	
								24	51	Employer's Identification Number	
								34	51	Social Security Number	
	NM109	R	R			2/80	AN			Identification Code	
2010AB	**N3**	**R**	**R**		**1**	**Address**					
	N301	R	R			1/55	AN			Address Line	
	N302	S	S			1/55	AN			Address Line	
2010AB	**N4**	**R**	**R**		**1**	**City State Zip**					
	N401	R	R			2/30	AN			City	
	N402	R	R			2	ID			State	
	N403	R	R			3/15	ID			Zip	
	N404	S	S			2/3	ID			Country Code	
2010AB	**REF**	**S**	**S**		**1**	**Tax ID**					
	REF01	R	R			2/3	ID	EI or SY		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			TAX ID (EI for TIN, SY for SSN)	
2010AB	**REF**	**S**	**J**		**1**	**State License**					
						California and Texas required segment when billing entity is a health care provider.					
	REF02	R	R			1/30	AN			State License Number	
2010AB	**PER**	**N**	**J**		**1**	**Contact Information**					
						California and Texas required segment if the information is different than that contained in Loop 1000A Submitter PER segment					
	PER01	N	R			2	ID	IC		Contact Function Code	
	PER02	N	R			1/60	AN			Contact Name	
	PER03	N	R			2	ID	TE		Communication Number Qualifier	
	PER04	N	R			1/80	AN			Telephone Number	
	PER05	N	R			2	ID			Communication Number Qualifier	
	PER06	N	S			1/80	AN			Communication Number	
	PER07	N	S			2	ID			Communication Number Qualifier	
										Use at the discretion of the billing provider	
	PER08	N	S			1/80	AN			Communication Number	
2000B	**Subscriber Detail (Repeat > 1)**					**Workers' Compensation Subscriber is Employer**					
2000B	**HL**	**R**	**R**			**Subscriber (Employer) Hierarchical Level**					
	HL01	R	R			1/12	AN			Hierarchical ID Number	
	HL02	R	R			1/12	AN			Hierarchical Parent ID Number	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	Paper Field ADA 2006 Form	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	HL03	R	R			2	ID	22		Hierarchical Level Code	
	HL04	R	R			1	ID	1		Hierarchical Child Code	
2000B	**SBR**	**R**	**R**		**1**	**Subscriber (Employer) Information**					
	SBR01	R	R			1	ID	P		P for Primary Payer	
	SBR03	S	S			1/30	AN			WC Policy Number, If Available	
	SBR04	S	S			1/60	AN		12	Employer Name	
	SBR09	S	J			1/2	ID	WC		Claim Filing Indicator Code	
										California and Texas Requirement	
2010BA	**Subscriber Information (Insured) Workers' Compensation Insured is Employer**										
2010BA	**NM1**	**R**	**R**		**1**	**Subscriber (Employer) Name**					
	NM101	R	R			2	ID	IL		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								2		Non Person Entity	
	NM103	R	R			1/35	AN		12	Employer Name	
2010BA	**N3**	**S**	**J**		**1**	**Address**					
						California and Texas Required Segment					
	N301	R	R			1/55	AN		7	Address	
	N302	S	S			1/55	AN		7	Address	
2010BA	**N4**	**S**	**J**		**1**	**City State Zip**					
						California and Texas Required Segment					
	N401	R	R			2/30	AN		12	City	
	N402	R	R			2	ID		12	State	
	N403	R	R			3/15	ID		12	Zip	
	N404	S	S			2/3	ID			Country Code	
2010BB	**Payer Information**										
2010BB	**NM1**	**R**	**R**		**1**	**Payer Name**					
	NM101	R	R			2/3	ID	PR		Entity Identifier Code	
	NM102	R	R			1	ID	2		Entity Type Qualifier (Non-Person Entity)	
	NM103	R	R			1/35	AN		3	Payer Name	
	NM108	R	R			2	ID	PI		Identification Code Qualifier	
										Payer Identification Code is defined in the ISA Segment as well as specified in the Trading Partner Agreement	
	NM109	R	R			2/80	AN			Payer Identification Code	
2010BB	**N3**	**S**	**S**		**1**	**Address**					

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	Paper Field ADA 2006 Form	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
						Payer Address is required when the submitter intends for the bill to be printed on paper at the next EDI location)e.g., a clearinghouse					
	N301	R	R			1/55	AN			Address	
	N302	S	S			1/55	AN			Address	
2010BB	**N4**	**S**	**S**		**1**	**City State Zip**					
						Payer Address is required when the submitter intends for the bill to be printed on paper at the next EDI location)e.g., a clearinghouse					
	N401	R	R			2/30	AN			City Name	
	N402	R	R			2	ID			State	
	N403	R	R			3/15	ID			Zip	
	N404	S	S			2/3	ID			Country Code	
2000C	**Patient Hierarchical Level (Repeat >1)**										
2000C	**HL**	**S**	**J**			**Patient Hierarchical Level**					
						This HL is required when the patient is different person than the subscriber. The Employer is the Subscriber in Workers' Compensation					
	HL01	R	R			12	N			Hierarchical ID Number	
	HL02	R	R			12	N			Hierarchical Parent ID Number	
	HL03	R	R			2	ID	23		Hierarchical Level Code	
	HL04	R	R			1	ID	0		Hierarchical Child Code	
2000C	**PAT**	**R**	**R**			**Patient Information**					
	PAT01	R	R			2	ID	20	18	Patients Relationship to Insured	
2010CA	**Patient Information**										
2010CA	**NM1**	**R**	**R**			**Patient Name**					
	NM101	R	R			2	ID	QC		Entity Identifier Code	
	NM102	R	R			1	ID	1		Entity Type Qualifier (Person)	
	NM103	R	R			1/35	AN		20	Last Name	
	NM104	R	R			1/25	AN		20	First Name	
	NM105	S	S			1/25	AN		20	Middle Name	
	NM107	S	S			1/10	AN			Name Suffix	
	NM108	R	R			2	ID	MI	23	Identification Code Qualifier	
	NM109	R	R			2/80	AN		8	Social Security Number	
2010CA	**N3**	**R**	**R**			**Address**					
	N301	R	R			1/55	AN			Address	
	N302	S	S			1/55	AN			Address	
2010CA	**N4**	**R**	**R**			**City State Zip**					
	N401	R	R			2/30	AN		20	City	
	N402	R	R			2	ID		20	State	
	N403	R	R			3/15	ID		20	Zip	
	N404	S	S			2/3	ID			Country Code	
2010CA	**DMG**	**R**	**R**			**Demographic Information**					

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	DMG01	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DMG02	R	R			1/35	AN		21	Birth Date	
	DMG03	R	R			1	ID		22	Gender Code	
2010CA	**REF**	**S**	**S**			**Property & Casualty Claim Number**					
	REF01	R	R			2/3	ID	Y4		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		15	Enter Workers' Compensation Claim Number if Known	
2300	**Claim Information**										
2300	**CLM**	**R**	**R**			**Claim Information**					
	CLM01	R	R			1/38	AN			Claim Submitter Identifier (Provider Unique Bill Identification Number)	
	CLM02	R	R			1/18	R		33	Total Submitted Charges	
	CLM05-1	R	R			1/2	ID		38	Facility Type Code (place of service)	
	CLM05-3	R	R			1	ID			Claim Frequency Type Code	
	CLM06	R	R			1	ID	Y/N	53	Provider Signature Indicator	
	CLM07	R	R			1	ID	A		Enter value "A" to indicate provider acceptance of assignment	
	CLM08	R	R			1	ID	N		Benefit Assignment Indicator	
	CLM09	R	R			1	ID	I		Release of Information Code	
	CLM10	S	S			1	ID			Patient Signature Source Code	
	CLM11	S	S				ID			Related Causes Information	
	CLM11-1	R	R			2/3	ID	EM	45	Related Causes Code 1 EM= Employment	
	CLM11-2	S	S			2/3	ID			Related Causes Code 2	
	CLM11-3	S	S			2/3	ID			Related Causes Code 3	
	CLM11-4	S	S			2/2	ID			State or Province Code	
	CLM11-5	S	S			2/3	ID			Country Code	
	CLM19	N	J			2/2	AN			Claims Submission Reason Codes	
								7		Duplicate Bill	
								15		Revised Bill	
								30		Appeal/Reconsideration	
2300	**DTP**	**S**	**S**		**1**	**Date of Admission**					
	DTP01	R	R			3	ID	435		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN			Admission Date	
2300	**DTP**	**S**	**S**		**1**	**Date of Discharge**					
	DTP01	R	R			3	ID	096		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN			Discharge Date	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	Paper Field ADA 2006 Form	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
2300	**DTP**	**S**	**J**		**1**	**Date of Accident**					
						California and Texas Required Segment					
	DTP01	R	R			3	ID	439		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN			Accident Date	
2300	**DTP**	**S**	**S**		**1**	**Date of Appliance Placement**					
	DTP01	R	R			3	ID	452	41	Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		41	Appliance Placement	
2300	**DTP**	**S**	**J**		**1**	**Date of Service**					
						California and Texas Required Segment					
	DTP01	R	R			3	ID	472	41	Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		41	Date of Service	
2300	**DN1**	**S**	**S**		**1**	**Orthodontic Information**					
	DN101	S	S			1/15	N			Orthodontic Total Months of Treatment	
	DN102	S	S			1/15	N		42	Orthodontic Treatment Months Remaining	
	DN103	S	S			1	ID	Y or N	40	Services in this claim are part of DN101/DN102	
2300	**DN2**	**S**	**S**		**1**	**Tooth Summary**					
	DN201	R	R			1/30	AN			Tooth Number	
	DN202	R	R			1/2	ID			Tooth Status Code	
2300	**PWK**	**S**	**S**		**10**	**Attachment Reference**					
	PWK01	R	R			2/2	ID			Report Type Code	
	PWK02	R	R			1/2	ID			Deliver type code	
	PWK05	S	R			2	ID	AC		Identification Code Qualifier	
	PWK06	S	R			2/80	AN		35	Attachment Control Number	
2300	**AMT**	**S**	**N**			**Patient Amount Paid**					
	AMT01	R	R			2	ID	F5		Amount Qualifier Code	
	AMT02	R	R			1/18	R			Patient Amount Paid	
2300	**REF**	**S**	**S**		**1**	**Prior Authorization**					
	REF01	R	R			2/3	ID	G3		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		2	Prior Authorization Number	
2300	**REF**	**S**	**S**		**1**	**Original Reference Number (ICN/DCN)**					
	REF01	R	R			2/3	ID	F8		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Original Reference Number-Payer Unique Bill Identification Number	
2300	**REF**	**S**	**S**		**1**	**Clearing House Generated Tracking Number**					
	REF01	R	R			2/3	ID	D9		Reference Identification Qualifier	

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	REF02	R	R			1/30	AN			Number assigned by ch/van/etc.	
2300	**NTE**	**S**	**S**		**1**	**Remarks**					
	NTE01	R	R			3	ID	ADD		Note Reference Code	
	NTE02	R	R			1/80	AN			Note Text	
2310A	**Referring Provider**										
	Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively										
2310A	**NM1**	**S**	**S**		**1**	**Referring Physician Name**					
	NM101	R	R			2	ID	DN		Entity Identifier Code	
	NM102	R	R			1	ID	1		1=person, 2=company	
	NM103	R	R			1/35	AN			Last Name	
	NM104	S	R			1/25	AN			First Name	
	NM105	S	S			1/25	AN			Middle Name	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
	NM109	R	R			2/80	AN			National Provider Identifier	
2310A	**PRV**	**S**	**S**		**1**	**Provider Specialty Code**					
	PRV01	R	R			2	ID	RF		Provider Code (Referring)	
	PRV02	R	R			2/3	ID	ZZ		Reference Identification Qualifier	
	PRV03	R	R			1/30	AN			Taxonomy code	
2310A	**REF**	**S**	**J**		**1**	**State License Number**					
						Required Field for California					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			State License	
2310B	**Rendering Provider**										
2310B	**NM1**	**S**	**S**		**1**	**Rendering Physician Name**					
						Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively					
	NM101	R	R			1/3	ID	82		Entity Identifier Code	
	NM102	R	R			1	ID	1		Entity Type Qualifier (Person)	
	NM103	R	R			1/35	AN		53	Last Name	
	NM104	S	S			1/25	AN		53	First Name	
	NM105	S	S			1/25	AN		53	Middle Name	
	NM107	S	S			1/10	AN		53	Name Suffix	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
	NM109	R	R			2/80	AN		54	National Provider Identifier (Non Shaded Area)	
2310B	**PRV**	**R**	**R**		**1**	**Provider Specialty Code**					
						Required Field for California and Texas					
	PRV01	R	R			1/3	ID	PE		Provider Code (performing)	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	Paper Field ADA 2006 Form	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	PRV02	R	R			2/3	ID	ZZ		Reference Identification Qualifier	
	PRV03	R	R			1/30	AN		58	Taxonomy Code	
2310B	**REF**	**S**	**J**		**1**	**State License Number**					
						Required Field for California					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		55	State License Number (Shaded Area)	
2310C	**Facility / Service location**										
	This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay to Provider) loops										
2310C	**NM1**	**S**	**S**		**1**	**Name**					
	NM101	R	R			2	ID	FA		Entity Identifier Code	
	NM102	R	R			1	ID	2		Entity Type Identifier (Non-Person Entity)	
	NM103	S	R			1/35	AN		56	Organization Name	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
	NM109	R	R			2/80	AN			National Provider Identifier	
2310C	**N3**	**R**	**R**		**1**	**Address**					
	N301	R	R			1/55	AN		56	Address	
	N302	S	S			1/55	AN		56	Address	
2310C	**N4**	**R**	**R**		**1**	**City State Zip**					
	N401	R	R			2/30	AN		56	City	
	N402	R	R			2	ID		56	State	
	N403	R	R			3/15	ID		56	Zip	
2310C	**REF**	**S**	**J**		**1**	**State License Number**					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		32b	Service Facility State License Number	
										Jurisdiction specific requirement; California requires State License Number when Service Facility is a health care provider.	
	N404	S	S			2/3	ID			Country Code	
2310D	**Assisting Surgeon Name**										
2310D	**NM1**	**S**	**S**		**1**	**Assisting Surgeon Name**					
	NM101	R	R			1/3	ID	DD		Entity Identifier Code	
	NM102	R	R			1	ID	1		Entity Type Qualifier (Person)	
	NM103	R	R			1/35	AN			Last Name	
	NM104	S	S			1/25	AN			First Name	
	NM105	S	S			1/25	AN			Middle Name	
	NM107	S	S			1/10	AN			Name Suffix	
	NM108	R	R			2	ID	XX		Identification Code Qualifier	
	NM109	R	R			2/80	AN			National Provider Identifier	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	Paper Field ADA 2006 Form	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
2310D	**PRV**	**S**	**S**		**1**	**Provider Specialty Code**					
						Required Field for California and Texas					
	PRV01	R	R			1/3	ID	AS		Provider Code (performing)	
	PRV02	R	R			2/3	ID	ZZ		Reference Identification Qualifier	
	PRV03	R	R			1/30	AN			Taxonomy Code	
2310D	**REF**	**S**	**J**		**1**	**State License Number**					
						Required Field for California					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			State License Number (Shaded Area)	
2320	**Other Subscriber Information (repeat max 10)**										
	The 2320 and 2330 loops are required if there has been a prior payment by a payer other than the employer's insurer										
2320	**SBR**	**S**	**S**		**1**	**Other Subscriber Information**					
	SBR01	R	R			1	ID			Payer Responsibility Sequence Code	
								P		Primary	
								S		Secondary	
								T		Tertiary	
	SBR02	R	R			2/2	ID			Individual Relationship Code	
	SBR03	S	S			1/30	AN			Group or Policy Number	
	SBR04	S	S			1/60	AN			Group or Plan Name	
	SBR05	R	R			1/3	ID			Insurance Type Code	
	SBR09	S	J			1/2	ID	WC		Claim Filing Indicator Code: California and Texas Requirement	
2320	**CAS**	**S**	**S**		**5**	**Claim Level Adjustments**					
						Use if claim level adjustments have been made by the prior payer					
	CAS01	R	R			1/2	ID			Group code	
	CAS02	R	R			1/5	ID			Claim Adjustment Reason Code	
	CAS03	R	R			1/18	R			Adjustment Amount	
	CAS04	S	S			1/15	R			Adjustment Quantity	
	CAS05	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS06	S	S			1/18	R			Adjustment Amount	
	CAS07	S	S			1/15	R			Adjustment Quantity	
	CAS08	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS09	S	S			1/18	R			Adjustment Amount	
	CAS10	S	S			1/15	R			Adjustment Quantity	
	CAS11	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS12	S	S			1/18	R			Adjustment Amount	
	CAS13	S	S			1/15	R			Adjustment Quantity	
	CAS14	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS15	S	S			1/18	R			Adjustment Amount	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	Paper Field ADA 2006 Form	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	CAS16	S	S			1/15	R			Adjustment Quantity	
	CAS17	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS18	S	S			1/18	R			Adjustment Amount	
	CAS19	S	S			1/15	R			Adjustment Quantity	
2320	**AMT**	**S**	**S**			**Coordination of Benefits (COB) Payer Paid Amount**					
	AMT01	R	R			2	ID	D		Amount Qualifier Code	
	AMT02	R	R			1/18	R			Patient Amount Paid	
2320	**AMT**	**S**	**S**			**Coordination of Benefits (COB) Patient Paid Amount**					
	AMT01	R	R			2	ID	F5		Amount Qualifier Code	
	AMT02	R	R			1/18	R			Patient Amount Paid	
2330A	**Other Subscriber Name**										
2330A	**NM1**	**R**	**R**		**1**	**Other Subscriber Name**					
						Required when Loop ID 2320-Other Subscriber Information is used. Otherwise, this loop is not used					
	NM101	R	R			2	ID	IL		Entity Identifier Code (Insured or Subscriber)	
	NM102	R	R			1	ID			Entity Type Qualifier	
								1		Person	
								2		Non- Peson Entity (Company)	
	NM103	R	R			1/35	AN			Last	
	NM104	S	S			1/25	AN			First	
	NM105	S	S			1/25	AN			Middle	
	NM108	R	R			2	ID	MI		Member Identification Number	
	NM109	R	R			2/80	AN			Other Subscriber Primary Identification	
2330A	**N3**	**S**	**S**			**Address**					
						Required if available					
	N301	R	R			1/55	AN			Address Line	
	N302	S	S			1/55	AN			Address Line	
2330A	**N4**	**S**	**S**			**City State Zip**					
						Required if available					
	N401	R	R			2/30	AN			City	
	N402	R	R			2	ID			State	
	N403	R	R			3/15	ID			Zip	
	N404	S	S			2/3	ID			Country Code	
2330A	**REF**	**S**	**S**			**Tax ID**					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								EI		Federal Tax ID	
								SY		Social Security Number	
	REF02	R	R			1/30	AN			Tax ID	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	Paper Field ADA 2006 Form	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
2330B	**Other Payer Name**										
2330B	**NM1**	**R**	**R**		**1**	**Other Payer Name**					
						Required when Loop ID 2320-Other Subscriber Information is used. Otherwise, this loop is not used					
	NM101	R	R			2	ID	PR		Entity Identifier Code (Payer)	
	NM102	R	R			1	ID			Entity Type Qualifier (Non-Person Entity)	
								2		Non- Person Entity (Company)	
	NM103	R	R			1/35	AN			Organization Name (Company)	
	NM108	R	R			2	ID	PI		Payer Identification	
	NM109	R	R			2/80	AN			Other Payer Primary Identification	
2330B	**PER**	**S**	**S**		**1**	**Contact Information**					
						Required if available					
	PER01	R	R			2	ID	IC		Contact Function Code	
	PER02	R	R			1/60	AN			Contact Name	
	PER03	R	R			2	ID	TE		Communication Number Qualifier	
	PER04	R	R			1/80	AN			Telephone Number	
	PER05	S	S			2	ID			Communication Number Qualifier	
										Use at the discretion of the billing provider	
	PER06	S	S			1/80	AN			Communication Number	
	PER07	S	S			2	ID			Communication Number Qualifier	
										Use at the discretion of the billing provider	
	PER08	S	S			1/80	AN			Communication Number	
2330B	**DTP**	**S**	**S**		**1**	**Claim Adjudication Date**					
						Required if available, this is the date of the prior payment					
	DTP01	R	R			3	ID	573		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	D8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN			Date Claim Paid	
2330B	**REF**	**S**	**S**			**Other Payer Secondary Identification**					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								2U		Payer Identification Number	
								F8		payer's claim number	
								FY		Claim Office Number	
								NF		National Association of Insurance Commissioners (NAIC) Code	
								TJ		Federal Taxpayer's Identification Number	
	REF02	R	R			1/30	AN			Other Payer Secondary Identifier	
2400	**Service Lines (repeat max 50)**										
2400	**LX**	**R**	**R**			**Service Line Number**					

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	Paper Field ADA 2006 Form	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	LX01	R	R			1/6	N0			Line Number	
2400	**SV3**	**R**	**R**			**Dental Service**					
	SV301	R	R							Product or Service	
	SV301-1	R	R			2	ID	AD		Product or Service ID Qualifier	
	SV301-2	R	R			1/48	AN		29	Procedure Code	
	SV301-3	S	S			2	AN			Modifier 1	
	SV301-4	S	S			2	AN			Modifier 2	
	SV301-5	S	S			2	AN			Modifier 3	
	SV301-6	S	S			2	AN			Modifier 4	
	SV302	R	R			1/18	R		31	Line Item Charge	
	SV303	S	S			2	AN		38	Facility Code Value	
	SV304	S	S							Oral Cavity Designation Code	
	SV304-1	R	R			1/3	ID		25	Oral Cavity Designation Code 1	
	SV304-2	S	S			1/3	ID			Oral Cavity Designation Code 2	
	SV304-3	S	S			1/3	ID			Oral Cavity Designation Code 3	
	SV304-4	S	S			1/3	ID			Oral Cavity Designation Code 4	
	SV304-5	S	S			1/3	ID			Oral Cavity Designation Code 5	
	SV305	S	S			1	AN			Prosthesis, Crown or Inlay Code	
	SV306	R	R			1/15	R			Procedure Count	
2400	**TOO**	**S**	**S**			**Tooth Information**					
	TOO01	R	R			1/3	ID	JP		Code List Qualifier (NSTNS)	
	TOO02	S	S			1/30	AN		27	Tooth Number	
	TOO03	S	S							Tooth Surface	
	TOO03-1	R	R			1/2	ID		28	Tooth Surface Code	
	TOO03-2	S	S			1/2	ID		28	Tooth Surface Code	
	TOO03-3	S	S			1/2	ID		28	Tooth Surface Code	
	TOO03-4	S	S			1/2	ID		28	Tooth Surface Code	
	TOO03-5	S	S			1/2	ID		28	Tooth Surface Code	
2400	**DTP**	**S**	**R**			**Service Date**					
						Required for workers' compensation.					
	DTP01	R	R			3	ID	472		Date/Time Qualifier	
	DTP02	R	R			2/3	ID	RD8		Date Time Period Format Qualifier	
	DTP03	R	R			1/35	AN		24	Service Date	
2420A	**Rendering Line Provider**										
2420A	**NM1**	**S**	**S**			**Provider Name**					
	NM101	R	R			2/3	ID	82		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								1		Person	
	NM103	R	R			1/35	AN			Last Name	
	NM104	S	S			1/25	AN			First Name	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting	Occurrence	Length	Data Type	Value	Paper Field ADA 2006 Form	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	NM105	S	S			1/25	AN			Middle Name	
	NM107	S	S			1/10	AN			Suffix	
	NM108	R	R			1/2	ID	XX		Identification Code Qualifier	
	NM109	R	R			2/80	AN			National Provider Identifier	
2420A	**PRV**	**S**	**S**		**1**	**Rendering Line Provider Taxonomy Code**					
	PRV01	R	R			1/3	ID	PE		Provider Code (Rendering Line)	
	PRV02	R	R			2/3	AN	ZZ		Reference Identification Qualifier	
	PRV03	R	R			1/30	AN			Taxonomy code	
2420A	**REF**	**S**	**J**			**State License**					
						California Required Field					
	REF01	R	R			2/3	ID	0B		ID Qualifier	
	REF02	R	R			1/30	AN		50	State License	
2420A	**REF**	**S**	**S**			**Federal Tax ID**					
	REF01	R	R			2/3	ID	SY		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Federal Tax ID	
2420C	**Assistant Surgeon**										
2420C	**NM1**	**S**	**S**			**Assistant Surgeon Name**					
	NM101	R	R			2	ID	DD		Entity Identifier Code (Assistant Surgeon)	
	NM102	R	R			1	ID	1		Entity Type Qualifier (Person)	
	NM103	R	R			1/35	AN			Last Name	
	NM104	S	R			1/25	AN			First Name	
	NM105	S	S			1/25	AN			Middle Name	
	NM107	S	S			1/10	AN			Suffix	
	NM108	S	R			1/2	ID	XX		Identification Code Qualifier	
	NM109	S	R			2/80	AN			National Provider Identifier	
2420C	**REF**	**S**	**J**			**State License**					
						California Required Field					
	REF01	R	R			2/3	ID	0B		ID Qualifier	
	REF02	R	R			1/30	AN			State License	
2420C	**REF**	**S**	**S**			**Federal Tax ID**					
	REF01	R	R			2/3	ID	SY		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Federal Tax ID	
TS	**SE**	**R**	**R**			**Transaction Set Trailer**					
	SE01	R	R			1/10	N			Number of Included Segments	
	SE02	R	R			4/9	AN			Transaction Set Control Number (ST02)	

Chapter 9 Companion Guide 835 Payment & Remittance Advice

This companion guide for the ANSI ASC X12N 835 Healthcare Claim Payment/Advice transaction has been created for use in conjunction with the *ANSI ASC X12N 835 Healthcare Claim Payment and Remittance Advice Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N 835 Healthcare Claim Payment and Remittance Advice Implementation Guide*, but rather used as an additional source of information. Wherever the national standard differs from the California rules, the California rules prevail.

Claim Adjustment Group Code

The Division defines the specific set of ANSI Claim Adjustment Group Codes that can be used in the ANSI 835 format. The ANSI Group Code represents the general category of payment, reduction, or denial. For example, the ANSI Group Code CO Contractual Obligation might be used in conjunction with an ANSI Claims Adjustment Reason Code for a network contract reduction.

The Division specified ANSI Group Code transmitted in the ANSI 835 is the same code that is transmitted in the IAIABC 837 Medical EDI reporting format. The Division accepts specified ANSI Group Codes that are valid on the date the Claims Administrator paid, denied, or acknowledged receipt of a refund. The Division does not validate for ANSI Claim Adjustment Reason Group Code/ANSI Reason Code agreement in Medical EDI reporting.

HIPAA Gap Analysis Claim Adjustment Group Code

The Claim Adjustment Group Code MA is not an active ANSI Claim Adjustment Group Code and is identified in the HIPAA Workers' Compensation Gap Analysis. The Division prescribes to the use of four specific Claim Adjustment Group Codes: (1) CO Contractual Obligation, (2) MA Jurisdictional Regulatory (3) OA Other Adjustment (4) PI Payer Initiated Reduction. the use of the IAIABC 837 Implementation Guide Release 1 for Medical EDI reporting .The IAIABC 837 Release 1 uses the inactive ANSI Group Code MA for Medical EDI State Reporting. The California Electronic Bill initiative is aligned to support the IAIABC 837 Medical EDI State Reporting Requirements.

Claim Adjustment Reason Code

The Medical Billing and Payment Guide requires Claims Administrators to provide the explanation of review (EOR) in the "form and manner prescribed by the Division." The ANSI 835 requires the use of ANSI Claim Adjustment Reason Codes, which also includes jurisdictional codes (W2-W26) as the electronic means of providing specific payment, reduction, or denial information. The Division prescribes specific ANSI Claim Adjustment Reason Codes in conjunction with specific ANSI Claims Adjustment Group Codes in the ANSI 835 format. As a result, use of the ANSI 835 eliminates the use of proprietary reduction codes and free form text used on paper Explanation of Review (EOR). Accordingly, Claims Administrators that provide the specified Division ANSI 835 Claim Adjustment Reason Code information in the transmission are compliant with the Medical Billing and Payment Guide.

Remittance Remark Codes

The ANSI 835 format supports the use of ANSI Remittance Advice Remark Codes that also includes jurisdictional codes (WC1 –WC43) to provide supplemental explanation for a payment, reduction or denial already described by an ANSI Reason Code. The use of ANSI Remark Codes is not mandated, however it is strongly advised that Remittance Remark Codes be used with the Claims Adjustment Reason Codes as appropriate, to further clarify reasons for payment, reduction or denial. As a result, the use of the ANSI 835 eliminates the use of proprietary reduction codes and free form text used on paper Explanation of Review (EOR) forms. ANSI Remark Codes are not associated with an ANSI Group or Reason Code in the same manner that an ANSI Reason Code is associated with an ANSI Group Code.

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HIPAA Gap Analysis Claim Adjustment Reason and Remittance Remark Codes

Workers' Compensation requires additional Claims Adjustment Reason and Remittance Remark Codes that are not present in the HIPAA Code sets. The jurisdictional Claims Adjustment Reason Codes (W2-W26) and Remittance Remark Codes (WC1-WC43) are defined in Appendix B ANSI Claim Adjustment Reason Codes. California is coordinating with the IAIABC in working with the ANSI X12 Committee to adopt the jurisdictional Claim Adjustment and Remittance Remark Codes.

California Jurisdictional EOR Statement ID Qualifier:

California paper Explanation of Review (EOR) process includes a jurisdiction statement that is required on a paper EOR to provide health care providers, health care facilities, or third party biller/assignees with specific information regarding jurisdiction direction or limitations. The California required EOR statement is reflected as jurisdictional code WCA in the ANSI 835. The jurisdictional code WCA is populated in the ANSI 835, Other Claim Related Identification, and REF Segment in Loop 2100. The existing Reference Identification Qualifier "CE" Class of Contract Code is to be used as the qualifier in REF01 Segment for workers' compensation to indicate the jurisdictional value of WCA in REF02 represents the California EOR statement. California's Jurisdictional ANSI 835 WCA REF02 code equates to the following EOR statement (Labor Code § 4903.5):

Treating physician or authorized health care provider, health care facility, or third party biller/assignee may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board by filing a lien. Liens are subject to the statute of limitations spelled out in Labor Code § 4903.5.

> 4903.5. (a) No lien claim for expenses as provided in subdivision (b) of Section 4903 may be filed after six months from the date on which the appeals board or a workers' compensation administrative law judge issues a final decision, findings, order, including an order approving compromise and release, or award, on the merits of the claim, after five years from the date of the injury for which the services were provided, or after one year from the date the services were provided, whichever is later.
> (b) Notwithstanding subdivision (a), any health care provider, health care service plan, group disability insurer, employee benefit plan, or other entity providing medical benefits on a nonindustrial basis, may file a lien claim for expenses as provided in subdivision (b) of Section 4903 within six months after the person or entity first has knowledge that an industrial injury is being claimed.

An objection to charges from a hospital, outpatient surgery center, or independent diagnostic facility shall be deemed sufficient if the health care provider, health care facility, or third party biller/assignee is advised, within the thirty working day period specified above, that a request has been made for an audit of the billing, when the results of the audit are expected, and contains the name, address, and telephone number of the person or office to contact for additional information concerning the audit.

Any contested charge for medical treatment provided or authorized by the treating physician which is determined by the appeals board to be payable shall carry interest at the same rate as judgments in civil actions from the date the amount was due until it is paid.

Product/Service ID Qualifier

The Product/Service Identification Number transmitted in the inbound electronic billing format is returned in the ANSI 835 SVC Service Payment Information Segment with the appropriate qualifier. For example, a Revenue Code billed with a HCPCS on a UB-04 is transmitted to the Claims Administrator. The Revenue Code qualifier and Revenue Code are returned in the ANSI 835, not the HCPCS Code.

Reference Information

The HIPAA Implementation Guide for the ANSI ASC X12 835 Healthcare Claim Payment and Remittance Advice transaction is available through the Washington Publishing Company, www.wpc-edi.com. The California workers' compensation direction for the use of the ANSI HIPAA 835 Healthcare Payment and Remittance Advice Implementation Guide is below.

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Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting Req	Occurrence	Length	Data Type	Value	EOR Data Reference #	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
TS	**Transaction Set**										
TS	**ST**	**R**	**R**		**1**	**Transaction Set Header**					
	ST01	R	R			3	ID	835		Transaction Set Identifier Code	
	ST02	R	R			4/9	AN			Transaction Set Control Number	
TS	**BPR**	**R**	**R**		**1**	**Financial Information**					
	BPR01	R	R			1/2	ID		2	Transaction Handling Code	
								C		Payment Accompanies Remittance Advice	
								I		Remittance Information Only	
	BPR02	R	R			1/18	R			Total Actual Payment Amount	
	BPR03	R	R			1	ID	C		Credit/Debit Flag Code	
	BPR04	R	R			3	ID		3	Payment Method Code	
								CHK		Paper Check	
								ACH		EFT via ACH	
								FWT		EFT via Wire Transfer	
								NON		Non-Payment Data	
	BPR05	S	S			1/10	ID			Payment Format Code	
								CCP		Cash Concentration/Disbursement plus Addenda (CC+)(ACH)	
								CTX		ACH Payment Format Code	
	BPR06	S	S			2	ID	01		(DFI) ID Number Qualifier	
	BPR07	S	S			3/12	AN			Sender (DFI) Identification Number	
	BPR08	S	S			1/3	ID	DA		Sender Account Number Qualifier	
	BPR09	S	S			1/35	AN			Sender Account Number	
	BPR10	S	S			10	AN			Originating Company Identifier	
	BPR11	S	S			9	AN			Originating Company Supplemental Code	
	BPR12	S	S			2	ID	01		Receiving (DFI) ID Number Qualifier	
	BPR13	S	S			3/12	AN			Receiving (DFI) Identification Number	
	BPR14	S	S			1/3	ID			Receiving Account Number Qualifier	
								DA		Deposit Account	
								SG		Savings Account	
	BPR15	S	S			1/35	AN			(DFI) Receiving Account Number for ACH or FWT	
	BPR16	S	S			8	DT		5	Check Issue or ACH/FWT Effective Date	
TS	**TRN**	**R**	**R**		**1**	**Reassociation Trace Number**					
	TRN01	R	R			1/2	ID	1		Trace Type Code	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting Req	Occurrence	Length	Data Type	Value	EOR Data Reference #	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	TRN02	R	R			1/30	AN		4	Check or EFT Trace Number	
	TRN03	R	R			10	AN			Originating Company Identifier	
	TRN04	S	S			1/30	AN			Reference Identification	
TS	**REF**	**S**	**S**		**1**	**Receiver Identification**					
						Use this segment only when the receiver of the transaction is other than the payee (e.g., Clearing House or billing service ID).					
	REF01	R	R			2	ID	EV		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Reference Identification	
TS	**DTM**	**R**	**R**		**1**	**Production Date (Date of Review)**					
	DTM01	R	R			3	ID	405		Production	
	DMT02	R	R			8	DT		1	Date Expressed as CCYYMMDD	
1000A	**Payer Identification**										
1000A	**N1**	**R**	**R**		**1**	**Identification**					
	N101	R	R			2/3	ID	PR		Entity Identifier Code	
	N102	S	R			1/60	AN		6	Name	
										Payer Name is required for Workers' Compensation	
	N103	S	S			2	ID	XV	8	Identification Code Qualifier	
										Required when the National Plan ID mandate is effective	
	N104	S	S			2/80	AN			Identification Code	
1000A	**N3**	**R**	**R**		**1**	**Payer Address**					
	N301	R	R			1/55	AN	R	7	Address Line 1	
	N302	S	S			1/55	AN	S		Address Line 2	
1000A	**N4**	**R**	**R**		**1**	**City State Zip**					
	N401	R	R			2/30	AN		7	City Name	
	N402	R	R			2	ID		7	State or Province Code	
	N403	R	R			3/15	ID		7	Postal Code	
1000A	**REF**	**S**	**J**		**1**	**Payer Identification**					
						Use this REF segment whenever additional payer identification numbers are required. The ID numbers available in the TRN and N1 segments should be used before using the REF segment					
	REF01	R	R			2/3	ID	EO		Reference Identification Qualifier	
	REF02	R	R			1/30	AN			Submitter Identification Number (Carrier FEIN)	
1000A	**PER**	**S**	**S**		**1**	**Contact Information**					
						Additional Payer Administrative Communication Contact Information e.g., Claim Adjustor					

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting Req	Occurrence	Length	Data Type	Value	EOR Data Reference #	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	PER01	R	R			2	ID	CX		Contact Function Code	
	PER02	S	S			1/60	AN		9	Contact Name	
	PER03	S	S			2	ID	TE		Communications Number Qual	
	PER04	S	S			1/80	AN		10	Communication Number	
	PER05	S	S			2	ID			Communications Number Qual	
	PER06	S	S			1/80	AN			Communication Number	
	PER07	S	S			2	ID			Communications Number Qual	
	PER08	S	S			1/80	AN			Communication Number	
1000B	**Payee Identification**										
1000B	**N1**	**R**	**R**		**1**	**Identification**					
	N101	R	R			2/3	ID	PE		Entity Identifier Code	
	N102	S	R			1/60	AN		12	Name	
										California and Texas Required Field	
	N103	R	R			2	ID	FI		Identification Code Qualifier	
	N104	R	R			2/80	AN		14	Identification Code (Federal Tax ID)	
1000B	**N3**	**S**	**S**		**1**	**Payee Address**					
	N301	R	R			1/55	AN		13	Address Line 1	
	N302	S	S			1/55	AN			Address Line 2	
1000B	**N4**	**S**	**S**		**1**	**City State Zip**					
	N401	R	R			2/30	AN		13	City Name	
	N402	R	R			2	ID		13	State or Provide Code	
	N403	R	R			3/15	ID		13	Postal Code	
	N404	S	S			2/3	ID			Country Code	
1000B	**REF**	**S**	**J**		**1**	**State License**					
						California and Texas required field when billing entity is a health care provider.					
	REF01	R	R			2/3	ID	0B		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		14a	State License Number	
2000	**Header Number (Repeat >1)**										
2000	**LX**	**S**	**S**		**1**	**Header Number**					
	LX01	R	R			1/6	N0			Number assigned for differentiation within a transaction set	
2000	**TS3**	**S**	**S**		**1**	**Provider Summary Information**					
						This segment may be used to identify provider subsidiaries whose remittance information is contained in the 835 transactions transmitted to a single provider entity (i.e., the corporate office of a hospital chain. For this purpose, TS301					

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting Req	Occurrence	Length	Data Type	Value	EOR Data Reference #	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
						identifies the subsidiary provider					
	TS301	R	R			1/30	AN			Reference Identification (NPI Number if Available or State License Number)	
	TS302	R	R			1/2	AN			Facility Type Code	
	TS303	R	R			8	DT			Fiscal Period date	
	TS304	R	R			1/15	R			Quantity (Total Claim Count)	
	TS305	R	R			1/18	R			Total Charge Amount	
	TS309	S	S			1/18	R			Total Provider Payment Amount	
2100	**Bill Payment Information Repeat > 1**										
2100	**CLP**	**R**	**R**		**1**	**Bill Level Data**					
	CLP01	R	R			1/38	AN		31	Bill Submitter's Identifier (Patient Control Number)	
	CLP02	R	R			1/2	ID		32	Claim Status Code	
								1		Paid	
								4		Denied	
								22		Reversal or Previous Payment	
	CLP03	R	R			1/18	R		33	Total Charge Amount	
	CLP04	R	R			1/18	R		34	Total Payment Amount	
	CLP06	R	R			2	ID	WC	35	Claim Filing Indicator Code WC=Workers' Compensation Health Claim	
	CLP07	S	S			1/30	AN		36	Payer Control Number (Bill Control Number)	
	CLP08	S	S			1/2	AN			Facility Type Code (from CLM05-1 of the 837)	
	CLP09	S	S			1	ID		37	Claim Frequency Type Code (Institutional Bills Only)	
	CLP11	S	S			3/4	ID		38	Diag. Related Group Code (Institutional Bills Only)	
	CLP12	S	S			1/15	R			Diagnosis Related Group (DRG) Weight	
	CLP13	S	S			1/10	R			Discharge Fraction	
2100	**CAS**	**S**	**S**		**99**	**Bill Level Adjustments**					
						Required if using adjustments reason codes and amounts as needed for an entire bill or for a particular service within the bill being paid. The Bill Level Adjustment is used when an adjustment cannot be made to a single service line. The bill level adjustment is not a roll up of the line adjustments. The total adjustment is the sum of the bill and line level adjustment					

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting Req	Occurrence	Length	Data Type	Value	EOR Data Reference #	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	CAS01	R	R			1/2	ID		41	Bill Adjustment Group Code	
	CAS02	R	R			1/5	ID		42	Claim Adjustment Reason Code	
	CAS03	R	R			1/18	R		43	Monetary Amount	
	CAS04	S	S			1/15	R		44	Units Adjusted	
	CAS05	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS06	S	S			1/18	R			Monetary Amount	
	CAS07	S	S			1/15	R			Units Adjusted	
	CAS08	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS09	S	S			1/18	R			Monetary Amount	
	CAS10	S	S			1/15	R			Units Adjusted	
	CAS11	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS12	S	S			1/18	R			Monetary Amount	
	CAS13	S	S			1/15	R			Units Adjusted	
	CAS14	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS15	S	S			1/18	R			Monetary Amount	
	CAS16	S	S			1/15	R			Units Adjusted	
	CAS17	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS18	S	S			1/18	R			Monetary Amount	
	CAS19	S	S			1/15	R			Units Adjusted	
2100	**NM1**	**R**	**R**		**1**	**Patient Name**					
	NM101	R	R			2/3	ID	QC		Entity Identifier Code (patient)	
	NM102	R	R			1	ID	1		Entity Type Qualifier (person)	
	NM103	R	R			1/35	AN		15	Last Name	
	NM104	R	R			1/25	AN			First Name	
	NM105	S	S			1/25	AN			Middle Name	
	NM107	S	S			1/10	AN			Name Suffix	
	NM108	S	R			2	ID	34		Identification Code Qualifier	
	NM109	S	R			2/80	AN		16	Social Security Number	
2100	**NM1**	**S**	**R**		**1**	**Employer (Insured Name)**					
						Worker's Compensation Required Segment					
	NM101	R	R			2/3	ID	IL		Entity Identifier Code (insured)	
	NM102	R	R			1	ID	2		Entity Type Qualifier (company)	
	NM103	S	R			1/35	AN		19	Organization Name	
	NM108	R	R			2	ID	MI		Identification Code Qualifier	
	NM109	R	R			2/80	AN		20	Identification Code	
										Payer Assigned ID Number	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting Req	Occurrence	Length	Data Type	Value	EOR Data Reference #	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
										for Insured	
2100	**NM1**	**S**	**S**		**1**	**Service Provider Name (Rendering Provider)**					
						This segment is required when the rendering provider is different from the Payee					
	NM101	R	R			2/3	ID	82		Entity Identifier Code	
	NM102	R	R			1	ID			Entity Type Qualifier	
								1		Person	
								2		Non- Person Entity (Company)	
	NM103	R	R			1/35	AN		21	Last Name or Organization Name	
	NM104	S	S			1/25	AN			First	
	NM105	S	S			1/25	AN			Middle	
	NM107	S	S			1/10	AN			Suffix	
	NM108	R	R			2	ID	SL/XX		Identification Code Qualifier	
										State License Number to be used until NPI Number mandate date is effective	
	NM109	R	R			2/80	AN		22	SL =State License Number XX=NPI Number	
2100	**REF**	**S**	**S**		**1**	**PPO/MPN Plan Identification**					
	REF01	R	R			2	ID			Reference Identification Qualifier	
								CE		Class of Contract Code	
	REF02	R	R			1/30	AN		25	Reference Identification	
2100	**REF**	**S**	**J**		**1**	**WC Claim Number**					
						California and Texas Required Segment					
	REF01	R	R			2	ID			Reference Identification Qualifier	
								Y4		Original Reference Number	
	REF02	R	R			1/30	AN		27	Reference Identification	
										Workers' Compensation Claim Number	
2100	**DTM**	**N**	**J**		**1**	**Date of Accident**					
	DTM01	R	R			3	ID	439		Date/Time Qualifier	
	DTM02	R	R			8	DT		28	Date	
2100	**DTM**	**S**	**S**		**1**	**From Service Date**					
	DTM01	R	R			3	ID	232		Date/Time Qualifier	
	DTM02	R	R			8	DT		39	Date	
2100	**DTM**	**S**	**S**		**1**	**Thru Service Date**					
	DTM01	R	R			3	ID	233		Date/Time Qualifier	
	DTM02	R	R			8	DT		39	Date	
2100	**DTM**	**S**	**J**		**1**	**Bill Received Date (Date Payer Received Bill)**					
	DTM01	R	R			3	ID	050		Date/Time Qualifier	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting Req	Occurrence	Length	Data Type	Value	EOR Data Reference #	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	DTM02	R	R			8	DT		40	Date	
2100	**PER**	**S**	**J**		**1**	**Bill Contact Information (Payer/Bill Review Contact)**					
	PER01	R	R			2	ID	CX		Contact Function Code	
	PER02	S	S			1/60	AN		29	Contact Name	
	PER03	S	R			2	ID	TE		Communications Number Qualifier	
	PER04	S	R			1/80	AN		30	Communication Number	
	PER05	S	S			2	ID			Communications Number Qualifier	
	PER06	S	S			1/80	AN			Communication Number	
	PER07	S	S			2	ID			Communication Number Qualifier	
	PER08	S	S			1/80	AN			Communication Number	
2110	**Service Payment Information Repeat > 999**										
2110	**SVC**	**S**	**S**		**1**	**Service Payment**					
	SVC01	R	R						45	Composite Medical Procedure Identifier	
	SVC01-1	R	R			2	ID			Product/ Service ID Qualifier	
								AD		ADA Codes	
								ER		WC Jurisdiction Code OMFS (California)	
								HC		HCPCS / CPT code	
								IV		Home Infusion EDI Product Service	
								N4		NDC Code	
								NU		NUBC Revenue Code	
								ZZ		HIPPS Skilled Nursing Facility Rate Code	
	SVC01-2	R	R			1/48	AN			Product/Service ID	
	SVC01-3	S	S			2	AN			Procedure Modifier	
	SVC01-4	S	S			2	AN			Procedure Modifier	
	SVC01-5	S	S			2	AN			Procedure Modifier	
	SVC01-6	S	S			2	AN			Procedure Modifier	
	SVC02	R	R			1/18	R		46	Charge amount	
	SVC03	R	R			1/18	R		47	Payment amount	
	SVC04	S	S			1/48	AN		47a	Revenue Code	
	SVC05	S	S			1/15	R		48	Units paid	
	SV06	S	S						49	Billed Product/Service	
										Required if the adjudicated service code in SVC01 was altered from the billed service code, SVC06 is used to reflect the original service code.	
	SVC06-1	R	R			2	ID			Billed Product/Service ID Qualifier.	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting Req	Occurrence	Length	Data Type	Value	EOR Data Reference #	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
								AD		ADA Codes	
								ER		WC Jurisdiction Code OMFS (California)	
								HC		HCPCS / CPT code	
								IV		Home Infusion EDI Product Service	
								N4		NDC Code	
								NU		NUBC Revenue Code	
								ZZ		HIPPS Skilled Nursing Facility Rate Code	
	SVC06-2	R	R			1/48	AN			Billed Product/Service ID	
	SVC06-3	S	S			2	AN			Billed Procedure Modifier	
	SVC06-4	S	S			2	AN			Billed Procedure Modifier	
	SVC06-5	S	S			2	AN			Billed Procedure Modifier	
	SVC06-6	S	S			2	AN			Billed Procedure Modifier	
	SVC07	S	S			1/15	R		50	Units billed	
2110	**DTM**	**S**	**S**		**3**	**Service Date**					
	DTM01	R	R			3	ID	472		Date/Time Qualifier	
	DTM02	R	R			8	DT		51	Date	
2110	**REF**	**N**	**J**		**1**	**Prescription Number**					
						Required if not identified in CLP01					
	REF01	R	R			2/3	ID	WZ		Reference Identification Qualifier	
	REF02	R	R			1/30	AN		52	Rx Number	
2110	**CAS**	**S**	**S**		**99**	**Service Level Adjustments**					
	CAS01	R	R			1/2	ID		53	Bill Adjustment Group Code	
										Refer to ANSI Jurisdiction Companion Guide for specific Group Codes and Claims Adjustment Reason Codes	
	CAS02	R	R			1/5	ID		54	Claim Adjustment Reason Code	
	CAS03	R	R			1/18	R		55	Adjustment Amount	
	CAS04	S	S			1/15	R		56	Adjustment Quantity	
	CAS05	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS06	S	S			1/18	R			Monetary Amount	
	CAS07	S	S			1/15	R			Units Adjusted	
	CAS08	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS09	S	S			1/18	R			Monetary Amount	
	CAS10	S	S			1/15	R			Units Adjusted	
	CAS11	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS12	S	S			1/18	R			Monetary Amount	

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting Req	Occurrence	Length	Data Type	Value	EOR Data Reference #	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)
	CAS13	S	S			1/15	R			Units Adjusted	
	CAS14	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS15	S	S			1/18	R			Monetary Amount	
	CAS16	S	S			1/15	R			Units Adjusted	
	CAS17	S	S			1/5	ID			Claim Adjustment Reason Code	
	CAS18	S	S			1/18	R			Monetary Amount	
	CAS19	S	S			1/15	R			Units Adjusted	
2110	**REF**	**S**	**S**		**10**	**Service Identification**					
	REF01	R	R			2/3	ID			Reference Identification Qualifier	
								1S		Ambulatory Patient Group (APG) Number	
								6R		Provider Control Number	
								BB		Authorization Number	
								E9		Attachment Code	
								G1		Prior Authorization Number	
								G3		Predetermination of Benefits Identification Number	
								LU		Location Number	
								RB		Rate code number	
	REF02	R	R			1/30	AN			Reference Identification	
2110	**AMT**	**S**	**S**		**12**	**Service Identification**					
	AMT01	R	R			1/3	ID			Amount Qualifier Code	
								B6		Allowed - Actual	
								T		Tax	
	AMT02	R	R			1/18	R			Reference Identification Qualifier	
2110	**LQ**	**S**	**S**		**99**	**Remark Codes**					
	LQ01	R	R		1	1/3	ID			Qualifier Code	
								HE		Claim Payment Remark Codes	
								RX		RX NCPDP Reject/Payment Codes	
	LQ02	R	R			1/30	ID		57	Remark Code	
TS	**SE**	**R**	**R**			**Transaction Set Trailer**					
	SE01	R	R			1/10	N			Number of Included Segments	
	SE02	R	R			4/9	AN			Transaction Set Control Number (ST02)	

The Explanation of Review (EOR) mapping to the ANSI 835 is below.

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California EOR / 835 MAPPING

Field	ANSI X12 835			EOR Data Elements 835 Field Descriptions	Workers' Compensation Paper Fields R/S/O	Comments
	Loop	Field	Qual			
Header						
1	Header	DTM02	405	Date of Review	Required	Production Date
2	Header	BPR01		Purpose	Required	Advisory Review or Paid Review
3	Header	BPR04		Method of Payment	Required	Paper Check or EFT
4	Header	TRN02		Payment ID Number	Required	Paper Check Number or EFT Tracer Number
5	Header	BPR16		Payment Date	Required	
6	1000A	N102	PR	Payer Name	Required	
7	1000A	N3 N4		Payer Address	Required	
8	1000A	N104 REF02	XV-EO	Payer Identification Number	Required	Payer ID is defined in ISA Segment and Trading Partner Agreement
9	1000A	PER02		Payer Contact Name	Situational	1000A PER provides additional Claim Administration contact Information e.g., Adjustor ID The 2100 PER reference specifically used for Bill Review Administrative Contact Information e.g. appeal contact
10	1000A	PER04	TE	Payer Contact Phone Number	Situational	
11				Jurisdiction		
12	1000B	N102	PE	Pay-To Provider Name	Required	
13	1000B	N3 N4		Pay-To Provider Address	Required	
14	1000B	N103	FI	Pay-To Provider TIN	Required	
14a	1000B	REF02	SL	Pay- To Provider State License Number	Situational	If additional payee ID information is required. This applies only to billing provider health entities
15	2100	NM1	QC	Patient Name	Required	Patient Name
16	2100	NM109	23	Patient Social Security Number	Required	
17				Patient Address		
18				Patient Date of Birth		
19	2100	NM1 03	IL	Employer Name	Required	Use the "Insured" as the Employer
20	2100	NM109	MI	Employer ID	Required	Employer ID assigned by Payer
20a				Employer Address		
21	2100	NM102	82	Rendering Provider Name	Required	
22	2100	NM109	XX	Rendering Provider ID	Required	Rendering Provider NPI Number
23	2100	NM103	Y2	PPO/MPN Name	Situational	Required if a PPO / MPN reduction is used
24	2100	NM109	XX	PPO/MPN ID Number	Situational	State License Number or Certification Number
25				Not Applicable	NA	
26				Not Applicable	NA	
27	2100	REF02	F8	Claim Number	Required	Workers' Compensation Claim Number assigned by payer
28	2100	DTM02	439	Date of Accident	Required	
29	2100	PER02		Payer Bill Review Contact Name	Required	
30	2100	PER04	TE	Payer Bill Review Phone Number	Required	

California EOR / 835 MAPPING

Field	ANSI X12 835			EOR Data Elements 835 Field Descriptions	Workers' Compensation Paper Fields R/S/O	Comments
	Loop	Field	Qual			
Bill Payment Information						
31	2100	CLP01		Bill Submitter's Identifier	Required	Patient Control /Unique Account Control Number assigned by provider
32	2100	CLP02	1 or 4	Payment Status	Required	Indicates if the bill is being Paid or Denied: 1= Paid 4= Denied
33	2100	CLP03		Total Charges	Required	
34	2100	CLP04		Total Paid	Required	
35	2100	CLP06	WC	Claim Filing Indicator Code	Required	
36	2100	CLP07		Payer Bill ID Number	Required	The tracking number assigned by payer/bill review entity
37	2100	CLP09		Bill Frequency Type	Situational	Required if Institutional bill
38	2100	CLP11		Diagnostic Related Group Code	Situational	Required if payment is based on DRG
39	2100	DTM02	232/233	Service Dates	Required	
40	2100	DTM02	50	Date Bill Received	Required	
Bill Level Adjustment Information- Situational						
Payer must use this CAS segment to report bill level adjustments that cause the amount paid to differ from the amount originally charged. The Bill Level Adjustment is used when an adjustment cannot be made to a single service line. The bill level adjustment is not a roll up of the line adjustments. The total adjustment is the sum of the bill and line level adjustment						
41	2100	CAS01		Bill Adjustment Group Codes	Situational	The reduction amount maps to a CAS group code and adjustment code. Refer to Jurisdiction Specific California eBill Companion Guide Appendix B for Bill Adjustment Group, Reason and Remittance Codes
42	2100	CAS02		Adjustment Reason Codes	Situational	Bill Adjustment Reason Codes
43	2100	CAS03		Adjustment Amount	Situational	
44	2100	CAS04		Adjustment Quantity	Situational	
Service Payment Informormation						
45	2110	SVC01		Composite Medical Procedure Code Identifier	Situational	If billed procedure code is split, an additional line or lines are added that reflect the additional paid procedure codes and dollar amounts.
46	2110	SVC02		Charge Amount	Situational	
47	2110	SVC03		Paid Amount	Situational	
47a	2110	SVC04		Revenue Code	Situational	
48	2110	SVC05		Paid Units	Situational	
49	2110	SVC06		Billed Procedure Code	Situational	The service code used for the actual review, revenue, CPT, or NDC. Includes modifiers if applicable
50	2110	SVC07		Billed Units	Situational	
51	2110	DTP02	472	Date of Service	Required	

Field	ANSI X12 835			EOR Data Elements 835 Field Descriptions	Workers' Compensation Paper Fields R/S/O	Comments
	Loop	Field	Qual			
52	2110	REF02	XZ	Prescription Number	Situational	Required for Retail Pharmacy and DME only. Qualifier code borrowed from the 837. Not actually part of the 835 spec. IAIABC Request / Consideration- Jurisdiction Specific
Service Level Adjustment						
53	2110	CAS01		Bill Adjustment Group Codes	Situational	The reduction amount maps to a CAS group code and adjustment code
54	2110	CAS02		Adjustment Reason Codes	Situational	Bill Adjustment Reason Codes
55	2110	CAS03		Adjustment Amount	Situational	
56	2110	CAS04		Adjustment Quantity	Situational	More detailed reduction codes w/o specific dollar amount are collected into the LQ segments.
57	2110	LQ		Remittance Code	Situational	
58	2110	SVC04		Revenue Code	Situational	Required when supplied on an Institutional bill in addition to the CPT procedure code

Chapter 10 Companion Guide Acknowledgment Transaction Sets

This companion guide for the acknowledge transaction sets has been created for use in conjunction with the *ANSI ASC X12N Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N Implementation Guide*, but rather used as an additional source of information. Wherever the national standard differs from the California rules, the California rules prevail.

TA1 Interchange Acknowledgment

The TA1 Interchange Acknowledgment format is mandated for California workers' compensation process. The information regarding the format is offered as a tool to facilitate effective communication between health care providers, health care facilities, or third party biller/assignees and Claims Administrators.

The California workers' compensation direction for the use of the ANSI TA1 Interchange Acknowledgment is below.

DRAFT

Segment / Element	ANSI R/O	ANSI DN	Length	Data Type	Value	Description
TA1	**R**		**Interchange Acknowledgment**			
TA101	R	I12	9	N0		Interchange Control Number
TA102	R	I08	6	DT		Interchange Date (YYMMDD)
TA103	R	I09	4	TM		Interchange Time (HHMM)
TA104	R	I17	1	ID		Interchange Acknowledgment Code
					A	No Errors.
					E	Accepted But Errors Are Noted.
					R	Rejected Because of Errors.
TA105	R	I18	3	ID		Interchange Note Code
					000	No error
					001	The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
					002	This Standard as Noted in the Control Standards Identifier is Not Supported.
					003	This Version of the Controls is Not Supported
					004	The Segment Terminator is Invalid
					005	Invalid Interchange ID Qualifier for Sender
					006	Invalid Interchange Sender ID
					007	Invalid Interchange ID Qualifier for Receiver
					008	Invalid Interchange Receiver ID
					009	Unknown Interchange Receiver ID
					010	Invalid Authorization Information Qualifier Value
					011	Invalid Authorization Information Value
					012	Invalid Security Information Qualifier Value
					013	Invalid Security Information Value
					014	Invalid Interchange Date Value
					015	Invalid Interchange Time Value
					016	Invalid Interchange Standards Identifier Value
					017	Invalid Interchange Version ID Value
					018	Invalid Interchange Control Number Value
					019	Invalid Acknowledgment Requested Value
					020	Invalid Test Indicator Value
					021	Invalid Number of Included Groups Value
					022	Invalid Control Structure
					023	Improper (Premature) End-of-File (Transmission)
					024	Invalid Interchange Content (e.g., Invalid GS Segment)
					025	Duplicate Interchange Control Number
					026	Invalid Data Element Separator
					027	Invalid Component Element Separator
					028	Invalid Delivery Date in Deferred Delivery Request
					029	Invalid Delivery Time in Deferred Delivery Request
					030	Invalid Delivery Time Code in Deferred Delivery Request
					031	Invalid Grade of Service Code

997 Functional Acknowledgment

Reference Information

The California workers' compensation direction for the use of the ANSI 997 Functional (Transmission Level) Acknowledgment Implementation Guide is below.

DRAFT

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
TS	**Transaction Set**							
TS	**ST**			**1**	**Transaction Set Header**			
	ST	143	R		3	ID	997	Transaction Set Identifier Code
	ST	329	R		4/9	AN		Transaction Set Control Number
TS	**AK1**			**1**	**Functional Group Response Header**			
	AK101	479	R		2	ID		Functional Identifier Code
							HC	Health Care Claim (837)
							PI	Patient Information (275)
							HS	Eligibility, Coverage or Benefit Inquiry (270)
							HB	Eligibility, Coverage or Benefit Information (271)
							HR	Health Care Claim Status Request (276)
							HN	Health Care Claim Status Notification (277)
							HP	Health Care Claim Payment/Advice (835)
	AK102	28	R		1/9	N0		Group Control Number
AK2	**Transaction Set Response Loop**							
AK2	**AK2**			**999999**	**Transaction Set Response Header**			
	AK201	143	R		3	ID		Transaction Set Identifier Code
							837	Health Care Claim
							275	Patient Information
							270	Eligibility, Coverage or Benefit Inquiry
							271	Eligibility, Coverage or Benefit Information
							276	Health Care Claim Status Request
							277	Health Care Claim Status Notification
							835	Health Care Claim Payment/Advice
	AK202	329	R		4/9	AN		Transaction Set Control Number
AK2/AK3	**Data Segment Loop**							
AK2/AK3	**AK3**			**999999**	**Data Segment Note**			
	AK301	721	R		2/3	ID		Segment ID Code
	AK302	719	R		1/6	N0		Segment Position in Transaction Set
	AK303	447	S		1/6	AN		Loop Identifier Code
	AK304	720	S		1/3	ID		Segment Syntax Error Code
							1	Unrecognized segment ID
							2	Unexpected segment
							3	Mandatory segment missing
							4	Loop Occurs Over Maximum Times
							5	Segment Exceeds Maximum Use
							6	Segment Not in Defined Transaction Set
							7	Segment Not in Proper Sequence
							8	Segment Has Data Element Errors
AK2/AK3	**AK4**			**99**	**Data Element Note**			
	AK401	C030	R					Position in Segement
	AK401-1	722	R		1/2	N0		Element Position in Segment
	AK401-2	1528	S		1/2	N0		Component Data Element Position in Composite

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
	AK402	725	S		1/4	N0		Data Element Reference Number
	AK403	723	R		1/3	ID		Data Element Syntax Error Code
							1	Mandatory data element missing
							2	Conditional required data element missing.
							3	Too many data elements.
							4	Data element too short.
							5	Data element too long.
							6	Invalid character in data element.
							7	Invalid code value.
							8	Invalid Date
							9	Invalid Time
							10	Exclusion Condition Violated
	AK404	724	S		1/99	AN		Copy of Bad Data Element Value
AK2	**AK5**			**1**	**Transaction Set Response Trailer**			
	AK501	717	R		1	ID		Transaction Set Acknowledgment Code
							A	Accepted
							E	Accepted But Errors Were Noted
							R	Rejected
	AK502	718	S		1/3	ID		Transaction Set Syntax Error Code
							1	Transaction Set Not Supported
							2	Transaction Set Trailer Missing
							3	Transaction Set Control Number in Header and Trailer Do Not Match
							4	Number of Included Segments Does Not Match Actual Count
							5	One or More Segments in Error
							6	6 Missing or Invalid Transaction Set Identifier
							7	Missing or Invalid Transaction Set Control Number
							23	Transaction Set Control Number Not Unique within the Functional Group
	AK503	718	S		1/3	ID		Transaction Set Syntax Error Code
	AK504	718	S		1/3	ID		Transaction Set Syntax Error Code
	AK505	718	S		1/3	ID		Transaction Set Syntax Error Code
	AK506	718	S		1/3	ID		Transaction Set Syntax Error Code
TS	**AK9**			**1**	**Transaction Set Response Trailer**			
	AK901	715	R		1	ID		Functional Group Acknowledge Code
							A	Accepted
							E	Accepted, But Errors Were Noted.
							P	Partially Accepted, At Least One Transaction Set Was Rejected
							R	Rejected
	AK902	97	R		1/6	N0		Number of Transaction Sets Included
	AK903	123	R		1/6	N0		Number of Received Transaction Sets
	AK904	2	R		1/6	N0		Number of Accepted Transaction Sets

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
	AK905	716	S		1/3	ID		Functional Group Syntax Error Code
							1	Functional Group Not Supported
							2	Functional Group Version Not Supported
							3	Functional Group Trailer Missing
							4	Group Control Number in the Functional Group Header and Trailer Do Not Agree
							5	Number of Included Transaction Sets Does Not Match Actual Count
							6	Group Control Number Violates Syntax
	AK906	716	S		1/3	ID		Functional Group Syntax Error Code
	AK907	716	S		1/3	ID		Functional Group Syntax Error Code
	AK908	716	S		1/3	ID		Functional Group Syntax Error Code
	AK909	716	S		1/3	ID		Functional Group Syntax Error Code
TS	**SE**			**1**	**Transaction Set Trailer**			
	SE01	96	R		1/10	N0		Number of Included Segments
	SE02	329	R		4/9	AN		Transaction Set Control Number

824 Application Acknowledgment

The ANSI 824 Application Advice, referred to in this companion guide as a Detail Acknowledgment supports three levels of acknowledgment: Transaction Set, Batch, and Item (transaction). California workers' compensation requirements do not mandate acknowledgment at the Transaction Set or Batch level. Health Care Providers and Claims Administrators, or their agents, may choose to exchange Transaction Set or Batch level acknowledgments.

Claims Administrators are required to acknowledge electronic billing transactions at the Item or transaction level (bill level) within one business day of receipt. The ANSI 824 Detail Acknowledgment format supports multiple types of acknowledgment; for example: Accept, Accept with Errors, or Partially Accept. The California workers' compensation implementation allows only for three types of acknowledgment actions: Accept, Accept with Errors, or Reject. The usage of the ANSI 824 Application Acknowledgement Codes is defined as follows:

Application Acknowledgement Code IA: Accept:
Use this code when no error or informational messages are present and all data is accepted for further processing.

When processing an electronic bill associated with an attachment, an attachment indicator is required. The PWK Claim Supplemental Information (Attachment) Segment indicates that an attachment is expected, the type of attachment, and by what delivery method i.e. electronic, email or fax. The attachment indicator is transmitted in Loop 2300 of the ANSI 837 PWK Claim Supplemental Information (Attachment) Segment. If the Claims Administrator does not receive the indicated attachment within the five (5) working day specified period the bill will be denied and an ANSI 835 would be generated with the appropriate ANSI reason code.

Application Acknowledgement Code IE: Accept with Errors:
Use this code when all bill data is accepted for further processing and there is no claim number present in Loop 2010CA Segment REFO2. If the Claims Administrator is not able to match the bill to a claim within the five (5) working day specified period, the bill will be denied and an ANSI 835 would be generated with the appropriate ANSI reason code.

Application Acknowledgement Code IR: Reject
Use this code when the bill is rejected due to errors. Informational messages may also be present. No data is accepted for further processing. Submitter must correct and resubmit the transaction set, batch or item that was in error.

Reference Information
The California workers' compensation direction for the use of the ANSI 824 Application Advice/Detail (Transaction/Bill Level) Acknowledgment Implementation Guide is below.

DRAFT

Loop	Segment / Element	ANSI DN	ANSI R/S	Occurrence	Length	Data Type	Value	Description	
TS	**Transaction Set**								
TS	**ST**			**1**	**Transaction Set Header**				
	ST01	143	R		3	ID	824	Transaction Set Identifier Code	
	ST02	329	R		4/9	N		Transaction Set Control Number	
TS	**BGN**			**1**	**Beginning Segment**				
	BGN01	353	R		2	ID	11	Transaction Set Purpose Code (Response)	
	BGN02	127	R		1/30	AN		Transaction Set Identifier Code	
	BGN03	373	R		8	DT		Date Transmission Sent	
	BGN04	337	R		4/8	TM		Time Transmission Sent	
	BGN06	127	S		1/30	AN		Referenced Interchange Control Number	837, and the submitter of the 824 knows the BHT03 value in the original transaction set to which this 824 is responding) New 5010 Version field length is 1/50
1000A	**Submitter Information**								
1000A	**N1**			**1**	**Submitter Name**				
	N101	98	R		2/3	ID	41	Entity Identifier Code (Submitter)	
	N102	93	R		1/60	AN		Name	
	N103	66	R		2	ID	FI	Identification Code	
	N104	67	R		2/80	AN		Submitter ID (FEIN)	
1000A	**REF**		**S**	**1**	**Submitter Secondary Identifier**				Required when the Submitter is submitting on behalf of a sub-component, such as a branch or sub-component, such as a branch or department within the submitter organization.
	REF01	128	R		3	ID	3L	Reference ID Qualifier (Branch Identifier)	
	REF02	127	R		1/30	AN		Submitter Branch Identifier Code	
1000A	**PER**		**S**	**1**	**Submitter EDI Contact Information**				Required when contact information is other than indicated in the Trading Partner Agreement.
	PER01	366	R		2	ID	IC	Contact Function Code	
	PER02	93	S		1/60	AN		Payer Contact Name	
	PER03	365	S		2	ID	TE	Communication Number Qualifier	
	PER04	364	S		1/80	AN		Telephone Number	
	PER05	365	S		2	ID		Communication Number Qualifier	
	PER06	364	S		1/80	AN		Communication Number	
	PER07	365	S		2	ID		Communication Number Qualifier	
	PER08	364	S		1/80	AN		Communication Number	
1000B	**Receiver Information**								
1000B	**N1**			**1**	**Receiver name**				
	N101	98	R		2/3	ID	40	Entity Identifier Code (Receiver)	
	N103	66	R		2	ID	FI	Identification Code	

Loop	Segment / Element	ANSI DN	ANSI R/S	Occurrence	Length	Data Type	Value	Description	
	N104	67	R		2/80	AN		Receiver ID (FEIN)	
2000	**Original Identification Transaction (Repeat > 1)**								To identify the edited transaction set and the level at which the results of the edit are reported, and to indicate the accepted, rejected, or accepted with change edit result. For response to 837, one OTI loop per rejected bill.
2000	**OTI**			**1**	**Original Transaction Identifier**				
	OTI01	110	R		2	ID		Application Acknowledgment Code	
							First character		
							T	Transaction Set.	
							B	Batch	
							I	Item (a single 837 transaction)	
							Second character		
							A	Accept	
							C	Accept with Data Content Change	
							E	Accept with Errors	
							P	Partial Accept/Reject	
							R	Reject	
	OTI02	128	R		2/3	ID		Reference Number Qualifier	
							BT	Batch Number	
							IX	Item number	OTI03 contains Unique Bill ID Number.
							TN	Transaction Set Reference Number	OTI03 contains the original ST02 value
	OTI03	127	R		1/30	AN		Reference Number	New 5010 Version 1/50 length
	OTI06	373	S		8	DT		Original Transmission Date (GS04)	
	OTI07	337	S		4/8	TM		Original Transmission Time (GS05)	
	OTI08	28	S		1/9	N		Original Group Control Number (GS06)	
	OTI09	329	S		4/9	AN		Original Transaction Set Control Number (ST02)	
	OTI10	143	S		3	ID	837	Original Transaction Set Type	
	OTI11	480	S		1/12	AN		Original Version/Release/Industry ID Code (GS08)	
2000	**REF**		**S**	**1**	**Additional Reference Identification**				Required when additional information is necessary to identify the portion (or all) of the transaction set
	REF01	128	R		2/3	ID		Reference Identification Qualifier	
	REF02	127	R		1/30	AN		Additional Reference Identification Number	
2000	**DTM**		**S**	**1**	**Reference Date**				Required when an additional date is necessary to identify the portion (or all) of the transaction set
	DTM01	374	R		3	ID		Date/Time Qualifier	
	DTM02	373	R		8	DT		Date	
2000	**AMT**		**S**	**1**	**Reference Amount**				Required when monetary

Loop	Segment / Element	ANSI DN	ANSI R/S	Occurrence	Length	Data Type	Value	Description	
	AMT01	522	R		1/3	ID		Amount Qualifier Code	information is necessary to identify the portion (or all) of the transaction set that is being reported
	AMT02	782	R		1/18	R		Amount	
2000	**QTY**		**S**	**1**	**Reference Quantity**				Required when quantity information is necessary to identify the portion (or all) of the transaction set that is being reported
	QTY01	673	R		2	ID		Quantity Qualifier Code	
	QTY02	380	R		1/15	R		Quantity	
2100C	**NM1**		**R**	**1**	**Reference Name**				Required when names are necessary to identify the portion (or all) of the transaction set that is being reported
	NM101	98	R		2/3	ID		Entity Identifier Code	
	NM102	1065	R		1	ID		Entity Type Qualifier (1=person, 2=company)	
	NM103	1035	R		1/35	AN		Name Last or Organization Name	
	NM104	1036	S		1/35	AN		Name First	
	NM105	1037	S		1/25	AN		Name Middle	
	NM108	66	S		2	ID		Identification Code Qualifier	
	NM109	67	S		2/80	AN		EIN Electronic Identification Number	
2100	**Error or Informational Message Location (Repeat > 1)**								
2100	**TED**		**R**	**1**	**Technical Error Description**				
	TED01	647	R		1/3	ID	024	Application Error Condition Code	Value chosen to make segment compliant with X12 syntax
	TED03	721	S		2/3	ID		Original Segment ID Code	Segment ID within the original transaction set
	TED04	719	S		1/6	N		Original Segment Position in Transaction Set	Segment position within the original transaction set
	TED05	722	S		1/2	N		Original Element Position in Segment	
	TED07	724	S		1/99	AN		Copy of Bad Data Element	
	TED08	961	S		1/99	AN		Data Element New Content	Required when OTI01 second character is equal to "C"
2100	**NTE**		**S**	**1**	**Situational Context Location**				
	NTE01	363	R		3	ID	ZZZ	Note Reference Code	
	NTE02	352	R		1/80	AN		Used to clarify the data elements and their content	
2100	**RED**		**R**	**1**	**Related Data**				
	RED01	352	R		1/80	AN		Error Description	
	RED03	559	R		2	ID	94	Agency Qualifier Code	'94' used to maintain conformance with the X12 standard
	RED05	1270	R		2	ID		Code identifying a specific error code list	

Loop	Segment / Element	ANSI DN	ANSI R/S	Occurrence	Length	Data Type	Value	Description	
							ZZ	Mutually Defined	
	RED06	1271	R		1/30	AN		Error Code	
TS	**SE**		**R**	**1**	**Transaction Set Trailer**				
	SE01	96	R		1/10	N		Transaction Segment Count	
	SE02	329	R		4/9	AN		Transaction Set Control Number (same as ST02)	

California ANSI 824 Error Codes

Code	Description
E001	Missing/Invalid submitter identifier
W001	Missing/Invalid submitter identifier
E002	Missing/Invalid receiver identifier
W002	Missing/Invalid receiver identifier
E003	Missing/Invalid member identifier
W003	Missing/Invalid member identifier
E004	Missing/Invalid subscriber identifier
W004	Missing/Invalid subscriber identifier
E005	Missing/Invalid patient identifier
W005	Missing/Invalid patient identifier
E006	Missing/Invalid plan sponsor identifier
W006	Missing/Invalid plan sponsor identifier
E007	Missing/invalid payee identifier
W007	Missing/invalid payee identifier
E008	Missing/Invalid TPA/broker identifier
W008	Missing/Invalid TPA/broker identifier
E009	Missing/Invalid premium receiver identifier
W009	Missing/Invalid premium receiver identifier
E010	Missing/Invalid premium payer identifier
W010	Missing/Invalid premium payer identifier
E011	Missing/Invalid payer identifier
W011	Missing/Invalid payer identifier
E012	Missing/Invalid billing provider identifier
W012	Missing/Invalid billing provider identifier
E013	Missing/Invalid pay to provider identifier
W013	Missing/Invalid pay to provider identifier
E014	Missing/Invalid rendering provider identifier
W014	Missing/Invalid rendering provider identifier
E015	Missing/Invalid supervising provider identifier
W015	Missing/Invalid supervising provider identifier
E016	Missing/Invalid attending provider identifier
W016	Missing/Invalid attending provider identifier
E017	Missing/Invalid other provider identifier
W017	Missing/Invalid other provider identifier
E018	Missing/Invalid operating provider identifier
W018	Missing/Invalid operating provider identifier
E019	Missing/Invalid referring provider identifier
W019	Missing/Invalid referring provider identifier
E020	Missing/Invalid purchased service provider identifier
W020	Missing/Invalid purchased service provider identifier
E021	Missing/Invalid service facility identifier
W021	Missing/Invalid service facility identifier
E022	Missing/Invalid ordering provider identifier
W022	Missing/Invalid ordering provider identifier
E023	Missing/Invalid assistant surgeon identifier
W023	Missing/Invalid assistant surgeon identifier
E024	Amount/Quantity out of balance

California ANSI 824 Error Codes

Code	Description
W024	Amount/Quantity out of balance
E025	Duplicate
W025	Duplicate
E026	Billing date predates service date
W026	Billing date predates service date
E027	Business application currently not available
W027	Business application currently not available
E028	Sender not authorized for this transaction
W028	Sender not authorized for this transaction
E029	Number of errors exceeds permitted threshold
W029	Number of errors exceeds permitted threshold
E030	Required loop missing
W030	Required loop missing
E031	Required segment missing
W031	Required segment missing
E032	Required element missing
W032	Required element missing
E033	Situational loop missing
W033	Situational loop missing
E034	Situational segment missing
W034	Situational segment missing
E035	Situational element missing
W035	Situational element missing
E036	Data too long
W036	Data too long
E037	Data too short
W037	Data too short
E038	Invalid external code value
W038	Invalid external code value
E039	Data value out of sequence
W039	Data value out of sequence
E040	Not Used data element present
W040	Not Used data element present
E041	Too many sub-elements in composite
W041	Too many sub-elements in composite
E042	Unexpected segment
W042	Unexpected segment
E043	Missing data
W043	Missing data
E044	Out of range
W044	Out of range
E045	Invalid date
W045	Invalid date
E046	Not matching
W046	Not matching
E047	Invalid combination
W047	Invalid combination

California ANSI 824 Error Codes

Code	Description
E048	Customer identification number does not exist
W048	Customer identification number does not exist
E049	Duplicate batch
W049	Duplicate batch
E050	Incorrect data
W050	Incorrect data
E051	Incorrect date
W051	Incorrect date
E052	Duplicate transmission
W052	Duplicate transmission
E053	Invalid claim amount
W053	Invalid claim amount
E054	Invalid identification code
W054	Invalid identification code
E055	Missing or invalid issuer identification
W055	Missing or invalid issuer identification
E056	Missing or invalid item quantity
W056	Missing or invalid item quantity
E057	Missing or invalid item identification
W057	Missing or invalid item identification
E058	Missing or unauthorized transaction type code
W058	Missing or unauthorized transaction type code
E059	Unknown claim number
W059	Unknown claim number
E060	Bin segment contents not in MIME format
W060	Bin segment contents not in MIME format
E061	Missing/invalid MIME header
W060	Missing/Invalid MIME header
E062	Missing/Invalid MIME boundary
W062	Missing/Invalid MIME boundary
E063	Missing/Invalid MIME transfer encoding
W063	Missing/Invalid MIME transfer encoding
E064	Missing/Invalid MIME content type
W064	Missing/Invalid MIME content type
E065	Missing/Invalid MIME content disposition (filename)
W065	Missing/Invalid MIME content disposition (filename)
E066	Missing/Invalid file name extension
W066	Missing/Invalid file name extension
E067	Invalid MIME base64 encoding
W067	Invalid MIME base64 encoding
E068	Invalid MIME quoted-printable encoding
W068	Invalid MIME quoted-printable encoding
E069	Missing/Invalid MIME line terminator (should be CR+LF)
W069	Missing/Invalid MIME line terminator (should be CR+LF)
E070	Missing/Invalid "end of MIME" headers
W070	Missing/Invalid "end of MIME" headers
E071	Missing/Invalid CDA in first MIME body parts

California ANSI 824 Error Codes

Code	Description
W071	Missing/Invalid CDA in first MIME body parts
E072	Missing/Invalid XML tag
W072	Missing/Invalid XML tag
E073	Unrecoverable XML error
W073	Unrecoverable XML error
E074	Invalid Data format for HL7 data type
W074	Invalid Data format for HL7 data type
E075	Missing/Invalid required LOINC answer part(s) in the CDA
W075	Missing/Invalid required LOINC answer part(s) in the CDA
E076	Missing/Invalid Provider information in the CDA
W076	Missing/Invalid Provider information in the CDA
E077	Missing/Invalid Patient information in the CDA
W077	Missing/Invalid Patient information in the CDA
E078	Missing/Invalid Attachment Control information in the CDA
W078	Missing/Invalid Attachment Control information in the CDA
E079	Missing/Invalid LOINC
W079	Missing/Invalid LOINC
E080	Missing/Invalid LOINC Modifier
W080	Missing/Invalid LOINC Modifier
E081	Missing/Invalid LOINC code for this attachment type
W081	Missing/Invalid LOINC code for this attachment type
E082	Missing/Invalid LOINC Modifier for this attachment type
W082	Missing/Invalid LOINC Modifier for this attachment type
E083	Data element should not be used for this transaction based on situational requirements
W083	Data element should not be used for this transaction based on situational requirements

Chapter 11 Companion Guide 275 Additional Information to Support a Health Care Claim or Encounter (Documentation/Medical Attachment)

This companion guide for the ANSI ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter transaction has been created for use in conjunction with the *ANSI ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter Implementation Guide*, but rather used as an additional source of information. Wherever the national standard differs from the California rules, the California rules prevail.

Method of Transmission

The ANSI 275 Additional Information to Support a Health Care Claim or Encounter is a national standard electronic format for submitting electronic documentation. Health care providers, health care facilities, or third party biller/assignees and Claims Administrators may agree to exchange documentation in this format or a different format by mutual agreement. The components required to link the documentation to the appropriate bill must be present in all formats.

Health care providers, health care facilities, or third party biller/assignees may elect to submit documentation associated with electronic bill transactions through facsimile (fax) or electronic mail (email) in accordance with the Medical Billing and Payment Guide.

Documentation Requirements

"Medical documentation" includes, but is not limited to, medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results. Documentation requirements for California workers' compensation billing are defined in the Medical Billing and Payment Guide in Section One – 3.0.

When documentation related to electronic medical bill transactions is being submitted electronically, it is identified in the ANSI 837 formats in the PWK Claim Supplemental Information (Attachment) Segment. Bills containing services that require supporting documentation as defined by the Division must be properly annotated in the PWK Attachment Segment. Bill transactions that include services that require documentation and are submitted without the PWK annotation documentation will be rejected. An ANSI 824 reject incomplete error message would be generated.

Required documentation related to electronic medical bills must be submitted within five (5) working days of submission of the electronic medical bill. If required documentation related to an electronic medical bill is not received within the Division specified timeframe the bill will be rejected. An ANSI 835 would be generated with the appropriate ANSI reason code for denial due to lack of documentation.

The PWK Segment and the associated documentation identify the type of documentation through use of ANSI standard Report Type Codes. The PWK Segment and the associated documentation also identify the method of submission of the documentation through the use of ANSI Report Transmission Codes. Finally a unique Attachment Control Number is assigned to the documentation. The Attachment Control Number populated on the document shall include the Report Type Code, the Report Transmission Code, Attachment Control Qualifier (AC) and the Attachment Control Number. For example, operative note (report type code OB) sent by fax is identified as OBFXAC12345. ANSI code sets are provided below as a reference. Jurisdictions codes, when present, are also included in this document.

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Electronic Bill California Attachment/PWK Segment Code Definitions							
PWK01	**Attachment Report Type Code**	**PWK02**	**Report Transmission Code**	**PWK05**	**Identification Code Qualifier**	**PWK06**	**Identification Code: Attachment Control Number**
Code	**Definition**	**Code**	**Definition**	**Code**	**Definition**	**Code**	**Definition**
77	Support Data for Verification: REFERRAL: use this code to indicate a completed referral form	BM	By Mail (California only allows codes EL,EM or FX)	AC	Code designating the system/method of code structure used for Identification Code. Required if PWK02= "BM" "EL" "EM" or "FX"	Attachment Control Number	Unique Attachment Identification Number identifying an attachment (s) related to a specific bill. Required if PWK02= "BM" "EL" "EM" or "FX". Field Character Length 2/80
AS	Admission Summary	EL	Electronically Only: Use to indicate that attachment is being transmitted in a separate X12 functional group				
B2	Prescription Order	EM	E-Mail				
B3	Physician Order	FX	By Fax				
B4	Referral Form						
CT	Certification						
DA	Dental Models						
DG	Diagnostic Report						
DS	Discharge Summary						
EB	Explanation Of Benefits						
MT	Models						
NN	Nursing Notes						
OB	Operative Notes						
OZ	Support Data for Claim						
PN	Physical Therapy Notes						
PO	Prosthetics or Orthotics Certification						
PZ	Physical Therapy Certification						
RB	Radiology Films						
RR	Radiology Reports						
RT	Report of Tests and Analysis Report						

Electronic Bill California Attachment/PWK Segment Code Definitions							
PWK01	**Attachment Report Type Code**	**PWK02**	**Report Transmission Code**	**PWK05**	**Identification Code Qualifier**	**PWK06**	**Identification Code: Attachment Control Number**
Code	**Definition**	**Code**	**Definition**	**Code**	**Definition**	**Code**	**Definition**
J1	Doctor First Report of Injury						
J2	Supplemental Medical Report						
J3	Medical Permanent Impairment						
J4	Medical Legal Report						
J5	Vocational Report						
J6	Work Status Report						
J7	Consultation Report						
J8	Permanent Disability Report						
J9	Itemized Statement						

Documentation Identification

All attachments accompanying an electronically submitted bill must either have a header or attached cover sheet that provides the following information:

- Claims Administrator
- Employer
- NPI Number
- Date(s) of Electronic Submission of Original Bill
- Electronic Bill Identification Number (s)
- Attachment Control Number (Document Identification Number)
- Number of Documents
- Page Number/ Number of Pages

The data elements are populated in the header or attached cover sheet as identified below:

Category of Information	Element	Usage (R/S)
Claims Administrator	Claims Administrator Name	R
Employer	Employer Name	R
Provider	NPI Number	R
Dates	Date(s) of Submission of Original Bill	R
Bills	Electronic Bill Identification Number(s)	R
Document	ANSI Report Type Code	R
	ANSI Report Transmission Code	R
	ANSI Attachment Control Qualifier (AC)	R
	ANSI Attachment Control Number	R
	Number of Documents	R
	Page Number/Number of Pages	R

All Attachments accompanying an electronically submitted bill shall contain the following information in the body of the attachment:

1) Injured Employee Name
2) Claims Administrator's Name
3) Date(s) of Service
4) Date of Injury
5) Social Security Number (if available)
6) Claim Number (if available)
7) Attachment Control Number

Additional directions for specific elements identified above are provided in the following section.

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Injured Employee Name

The Injured Employee Last and First Name are required on all documentation submitted through ANSI 275 transactions.

Injured Employee Identification Number

The Injured Employee Identification Number is the Social Security Number (SSN) as defined in Chapter 4 California Workers' Compensation Requirements of this companion guide. The Injured Employee Identification Number is required on all documents submitted through ANSI 275 transactions.

Claims Administrator Claim Number

The Claims Administrator Claim Number for the Injured Employee's workers' compensation claim is required on documentation when it is known to the Health care provider, health care facility, or third party biller/assignee. The Claims Administrator Claim Number may not be known during the initial period of treatment post injury.

If the Claims Administrator Claim Number is unknown, the Injured Employee Name and Date of Injury are required on the documentation

Date of Injury

The Date of Injury for the Injured Employee's workers' compensation claim is required on on all documentation related to electronic bill transactions.

Claims Administrator Name

The Claims Administrator Name is required on all documentation related to electronic bill transactions.

Provider Identification Numbers

The Health care provider, health care facility, or third party biller/assignee's NPI is required on all documentation submitted related to electronic bill transactions. All attachments accompanying an electronically submitted bill must have the Health care provider, health care facility, or third party biller/assignee's NPI number in the header or attached cover sheet.

Date of Service

The Date, or Dates, of Service related to the electronic medical bill transactions and the documentation is required on documentation. The first page of a multiple page attachment must contain the Date or Dates of Service related to all pages of the document. The date or dates of service on subsequent pages may relate to specific dates of service included in that particular page of the documentation.

Electronic Bill Identification Number (s)

The Electronic Bill Identification Number is the unique Provider Bill Identification Number, populated in the CLM01 Claim Submitter Identifier Field in the CLM Claim Information Segment of Loop 2300 Claim Information. The HIPAA implementation of the ANSI 837 formats allows for a patient account number in this field but "strongly recommends that submitters use completely unique number for this field for each individual claim." California also recommends, but does not mandate, a completely unique number for each individual claim.

The NCPDP Telecommunication Standard Version 5.1 format structure does not identify a bill in the same manner as the ANSI 837 formats, i.e. a bill as a set of lines. The unique electronic bill transaction identification number for pharmacy billing is based on the individual prescription and is located in 402-D2 of the NCPDP 5.1 format.

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When the electronic bill transaction is a resubmission, the Bill Identification Number in the bill transaction and in the documentation relates to the original bill submission Bill Transaction Identification Number.

The documentation must contain the Bill Transaction Identification Number or numbers of bill transactions associated with the submitted documentation.

ANSI Identifiers

Report Type Codes

ANSI Report Type Codes identify the title, type, category, or content of documentation associated with an electronic bill transaction. For example, OB is the Report Type Code representing operative notes.

Report Transmission Code

ANSI Report Transmission Codes define the timing, transmission method or format by which documentation is to be sent. For example, FX is the Report Transmission Code representing submission by fax.

The PWK Segment in ANSI 837 formats requires an identification code qualifier to designate the identification number in the corresponding field. The ANSI identification code qualifier for document identification numbers, the Attachment Control Number, is AC Attachment Control Qualifier.

These three elements are required on all documentation immediately preceding the Document Identification Number (Attachment Control Number) in a continuous data string. For example, operative note 12345 sent by fax is identified as OBFXAC12345.

Attachment Control Number (Document Identification Number)

The Attachment Control Number in the context of ANSI standard formats. The Attachment Control Number represents a unique identification number for the document associated with an electronic bill transaction. The Attachment Control Number applies to all pages associated with a multiple page document.

Multiple documents may be associated with an electronic medical bill transaction. The ANSI 837 formats support a maximum of ten (10) occurrences of a PWK Attachment Segment related to a single electronic bill transaction.

The Attachment Control Number is required on all documentation.

Page Number

The page number of each individual page and the total number of pages included in the document is required on each page of the document (i.e. page 3 of 4). This page number/number of pages may be included in additional areas of the page but it is always required in the header or attached cover sheet in the order described in this section of the companion guide.

Associating Documentation to Electronic Bill Transactions

Documentation associated with electronic medical bill transactions identifies the specific transactions or transactions as defined in the preceding section. The documentation is associated to the electronic bill transactions or transactions in this manner.

ANSI 837 electronic bill transactions are associated to the documentation through the use of the PWK Claim Supplementation Information (Paperwork) Segment. The PWK Segment identifies the type of documentation through use of ANSI standard Report Type Codes and the method of submission through the use of ANSI Report Transmission Codes. A unique Attachment Control Number is assigned to the documentation. The Attachment Control Number populated on the document shall include the Report Type Code, the Report Transmission Code, Attachment Control Qualifier (AC) and the Attachment Control Number.

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Reference Information

The California workers' compensation directions for the use of the ANSI 275 Additional Information to Support a Health Care Claim or Encounter (Documentation) Implementation Guide is below.

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Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
TS	**Transaction Set**							
TS	**ST**		**R**	**1**	**Transaction Set Header**			
	ST01	143	R		3	ID	275	Transaction Set Identifier Code (Patient Information)
	ST02	329	R		4/9	N		Transaction Set Control Number
	ST03	1705	S		1/35	AN	004050X151	Implementation Convention Reference
TS	**BGN**		**R**	**1**	**Beginning Segment**			
	BGN01	353	R		2	ID		Transaction Set Purpose Code
							01	Add (submitting an attachment to an 837)
							11	Response (in response to a 277 Request)
	BGN02	127	R		1/50	AN		Submission Identifier Code
	BGN03	373	R		8	DT		Transaction Set Creation Date
1000A	**Transaction Receiver**							
1000A	**NM1**		**R**	**1**	**Transaction Receiver**			
	NM101	98	R		2	ID	40	Entity Identifier Code (Receiver)
	NM102	1065	R		1	ID	2	Entity Type Qualifier (Non- Person Entity)
	NM103	1035	R		1/60	AN		Name Last or Organization Name
	NM108	66	R		1/2	ID		Identification Code Qualifier
							46	Electronic Transmitter Identification Number (ETIN)
							XV	National Plan ID
	NM109	67	R		2/80	AN		Identification Number
1000A	**PER**		**S**	**1**	**Response Contact**			
	PER01	366	R		2	ID	IC	Information Contact
	PER02	93	R		1/60	AN		Name
	PER03	365	S		2	ID		Communication Number Qualifier
	PER04	364	S		1/256	AN		Communication Number
	PER05	365	S		2	ID		Communication Number Qualifier
	PER06	264	S		1/256	AN		Communication Number
	PER07	365	S		2	ID		Communication Number Qualifier
	PER08	364	S		1/256	AN		Communication Number
1000B	**Submitter Information**							
1000B	**NM1**		**R**	**1**	**Submitter Information**			
	NM101	98	R		2	ID	41	Entity Identifier Code (Submitter)
	NM102	1065	R		1	ID	2	Entity Type Qualifier (Non- Person Entity)
	NM103	1035	R		1/60	AN		Name Last or Organization Name
	NM108	66	R		1/2	ID		Identification Code Qualifier
							46	Electronic Transmitter Identification Number (ETIN)
	NM109	67	R		2/80	AN		Identification Number
1000C	**Provider Information**							
1000C	**NM1**		**R**	**1**	**Provider Name**			
	NM101	98	R		2	ID	1P	Provider

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
	NM102	1065	R		1	ID		Entity Type Qualifier
							1	Person
							2	Non-Person Entity
	NM103	1035	R		1/60	AN		Name Last or Organization Name
	NM104	1036	S		1/35	AN		Name First
	NM105	1037	S		1/25	AN		Name Middle
	NM107	1039	S		1/10	AN		Name Suffix
	NM108	66	R		2	ID		Identification Code Qualifier
							24	Employer's Identification Number
							34	Social Security Number
							FI	Federal taxpayer's Identification Number
							XX	National Provider Identification Number
	NM109	67	R		2/80	AN		Identification Number
1000D	**Patient Information**							
1000D	**NM1**		**R**	**1**	**Patient Name**			
	NM101	98	R		2	ID	QC	Patient
	NM102	1065	R		1	ID	1	Entity Type Qualifier
	NM103	1035	R		1/60	AN		Name Last or Organization Name
	NM104	1036	S		1/35	AN		Name First
	NM105	1037	S		1/25	AN		Name Middle
	NM107	1039	S		1/10	AN		Name Suffix
	NM108	66	R		2	ID	MI	Identification Code Qualifier
	NM109	67	R		2/80	AN		Member Identification Number
1000D	**REF**		**R**	**1**	**Patient Account Number**			
	REF01	128	R		2	ID	EJ	Reference Identification Qualifier
	REF02	127	R		1/50	AN		Patient Account Number (CLM01 in the 837)
1000D	**REF**		**S**	**1**	**Institutional Type of Bill**			
	REF01	128	R		3	ID	BLT	Reference Identification Qualifier
	REF02	127	R		1/50	AN		Billing Type (CLM05 in the 837)
1000D	**REF**		**S**	**1**	**Medical Record Number**			
	REF01	128	R		3	ID	EA	Reference Identification Qualifier
	REF02	127	R		1/50	AN		Medical Record Number
1000D	**REF**		**S**	**1**	**Claim Number**			
	REF01	128	R		3	ID	D9	Reference Identification Qualifier (Claim Number)
	REF02	127	R		1/50	AN		Claim Number
1000D	**DTP**		**S**	**1**	**Institutional Claim Service Date**			
	DTP01	374	R		3	ID	434	Date/Time Qualifier
	DTP02	1250	R		2/3	ID	RD8	Date Time Period Format Qualifier
	DTP03	1251	R		1/35	AN		Statement From and Through Dates
2000A	**Assigned Number (Repeat > 1)**							
2000A	**LX**		**R**	**1**	**Assigned Number**			
	LX01	554	R		1/6	N0		sequence number of the segments that follow

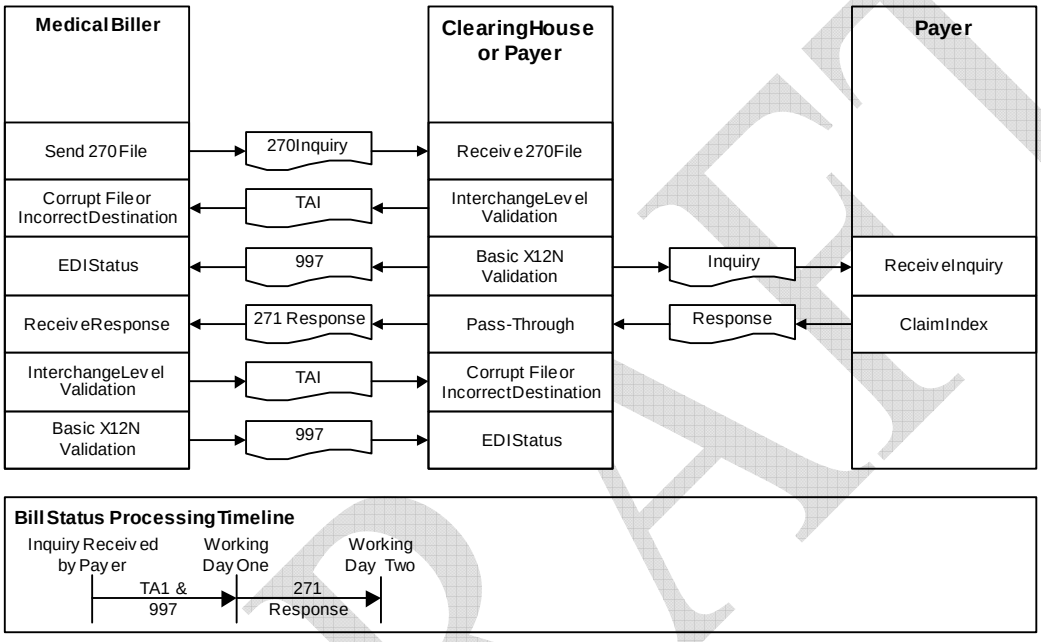
Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
2000A	**TRN**		**S**	**1**	**Payer's Control Number/Provider's Control Number**			
	TRN01	481	R		1/2	ID		Trace Type Code
							1	275 to support an 837 within the same transaction
							2	when responding to a 277 request
	TRN02	127	R		1/50	AN		Payer or Provider's Control Number
2000A	**STC**		**S**	**1**	**Status Information**			
					This segment is not used when sending a 275 to support an 837 within the same interchange.			
					This segment must be used to return the question that originally was sent on the 277 Request for Additional Information.			
	STC01		R					Health Care Claim Status
	STC01-1	1271	R		1/30	AN		Status Category Code
	STC01-2	1271	R		1/30	AN		Additional Information Request Code
	STC01-4	1270	R		3	ID	LOI	Code List Qualifier Code
	STC10		S					Health Care Claim Status
	STC10-1	1271	R		1/30	AN		Status Category Code
	STC10-2	1271	R		1/30	AN		Additional Information Request Code
	STC10-4	1270	S		3	ID	LOI	Code List Qualifier Code
	STC11		S					Health Care Claim Status
	STC11-1	1271	R		1/30	AN		Status Category Code
	STC11-2	1271	R		1/30	AN		Additional Information Request Code
	STC11-4	1270	S		3	ID	LOI	Code List Qualifier Code
2000A	**REF**		**S**	**1**	**Service Line Item Identification**			
					This segment is required when the additional information is associated with the service line or revenue line information.			
	REF01	128	R		2/3	ID		Reference Identification Qualifier
							6R	Provider Control Number
							FJ	Line Item Control Number
	REF02	127	R		1/50	AN		Line Item Control Number
2000A	**REF**		**S**	**1**	**Product or Service Line Information**			
					This segment is required when the Service Line Item Identification REF Segment is used.			
	REF01	128	R		2/3	ID		Reference Identification Qualifier
							CPT	Current Procedural Terminology Code
							F8	Original Reference Number
							FO	Drug Formulary Number
							PRT	Product Type
							YJ	Revenue Source
							ZZ	Dental Procedure Code (CDT)
	REF02	127	R		1/50	AN		Service Identification Code
	REF04		S					Used for both a proc code and a revenue
	REF04-1	128	R		2/3	AN	YJ	Revenue Source
	REF04-2	127	R		1/50	AN		Revenue Code
2100A	**Professional Date of Service**							

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
2100A	**DTP**		**S**	**1**	**Professional Date of Service**			
	DTP01	374	R		3	ID	472	Date/Time Qualifier
	DTP02	1250	R		2/3	ID	RD8	Date Time Period Format Qualifier
	DTP03	1251	R		1/35	AN		Professional Service Date
2100B	**Date Additional Information Was Submitted**							
2100B	**DTP**		**R**	**1**	**Date Additional Information Was Submitted**			
	DTP01	374	R		3	ID	368	Date/Time Qualifier
	DTP02	1250	R		3	ID	D8	Date Time Period Format Qualifier
	DTP03	1251	R		8	DT		Date Information was Submitted
2100B	**CAT**		**R**	**1**	**Category of Patient Information Service**			
	CAT01	755	R		2	ID	AE	Report Type Code (Attachment)
	CAT02	756	R		2	ID		Attachment Information Format Code
							HL	Health Industry Level 7
							IA	Electronic Image
	CAT03	799	S		1/30	AN		Version Identification Code
2110B	**Electronic Format Identification**							
2110B	**EFI**		**R**	**1**	**Electronic Format Identification**			
	EFI01	786	R		2	ID	05	Security Level Code (Personal)
2110B	**BIN**		**R**	**1**	**Binary Data**			
	BIN01	784	R		1/15	N0		Length of Binary Data
	BIN02	785	R			B		Binary Data
TS	**SE**		**R**	**1**	**Transaction Set Trailer**			
	SE01	96	R		1/10	N		Transaction Segment Count
	SE02	329	R		4/9	AN		Transaction Set Control Number (same as ST02)

Appendix A- Other EDI Data Exchanges

270-271 Health Care Eligibility Benefit Inquiry and Response

The 270 and 271 transaction set is used in the group health industry to inquire about eligibility benefit status of a subscriber. The 270 transaction is the inquiry and the 271 transaction is the reply. The 270/271 transaction set described in this companion guide has been adapted for use in workers' compensation as a mechanism to perform claim indexing. The 270/271 Health Eligibility Inquiry and Response formats are not mandated for California workers' compensation process. They are offered as a tool to facilitate effective communication between health care providers, health care facilities, or third party biller/assignees and Claims Administrators.



ANSI 270 Request

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 270 Healthcare Eligibility Inquiry transaction is available through the Washington Publishing Company, www.wpc-edi.com. The California workers' compensation direction for the use of the ANSI HIPAA 270 Healthcare Eligibility Inquiry Implementation Guide is below.

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Loop	Segment / Element	ANSI DN	ANSI R/S	Occurrence	Length	Data Type	Value	Description
TS	**Transaction Set**							
TS	**ST**		**R**	**1**	**Transaction Set Header**			
	ST01	143	R		3	ID	270	Eligibility, Coverage or Benefit Inquiry
	ST02	329	R		4/9	AN		Transaction Set Control Number
TS	**BHT**		**R**	**1**	**Beginning of Hierarchical Transaction**			
	BHT01	1005	R		4	ID	0022	Hierarchical Structure Code
	BHT02	353	R		2	ID	13	Transaction Set Purpose Code (Request)
	BHT03	127	S		1/30	AN		Submitter Transaction Identifier, is required to be used if the transaction is processed in Real Time.
	BHT04	373	R		8	DT		Transaction Set Creation Date
	BHT05	337	R		4/8	TM		Transaction Set Creation Time
2000A	**Information Source Level (repeat > 1)**							
2000A	**HL**		**R**	**1**	**Information Source Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	N		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		1/2	ID	20	Hierarchical Level Code (Information Source)
	HL04	736	R		1	ID	1	Hierarchical Child Code
2100A	**Information Source Name (repeat 1)**							
2100A	**NM1**		**R**	**1**	**Information Source Name**			
	NM101	98	R		2	ID		Entity Identifier Code (Payer)
							2B	Third-Party Administrator
							36	Employer
							GP	Gateway Provider
							P5	Plan Sponsor
							PR	Payer
	NM102	1065	R		1	ID	2	Entity Type Qualifier (2=company)
	NM103	1035	R		1/35	AN		Name of Information source
	NM108	66	R		2	ID		Identification Code Qualifier
							FI	Federal taxpayer's Identification Number
							NI	NAIC Identification
							PI	Payer Identification
							XV	National Payer Identification Number
	NM109	67	R		2/80	AN		Identification Number
2000B	**Information Receiver Level (repeat > 1)**							
2000B	**HL**			**1**	**Information Receiver Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	21	Hierarchical Level Code (Information Receiver)
	HL04	736	R		1	ID	1	Hierarchical Child Code
2100B	**Information Receiver Level (repeat 1)**							

Loop	Segment / Element	ANSI DN	ANSI R/S	Occurrence	Length	Data Type	Value	Description
2100B	**NM1**		**R**	**1**	**Receiver Name**			
	NM101	98	R		2/3	ID		Entity Identifier Code
							1P	Provider
							2B	Third-Party Administrator
							36	Employer
							80	Hospital
							FA	Facility
							GP	Gateway Provider
							P5	Plan Sponsor
	NM102	1065	R		1	ID		Entity Type Qualifier
							1	Person
							2	Non-Person Entity
	NM103	1035	R		1/35	AN		Name Last or Organization Name
	NM104	1036	S		1/25	AN		Name First
	NM105	1037	S		1/25	AN		Name Middle
	NM107	1039	S		1/10	AN		Name Suffix
	NM108	66	R		2	ID		Identification Code Qualifier
							FI	Federal taxpayer's Identification Number
							XX	National Provider Identification Number
	NM109	67	R		2/80	AN		Identification Number
2100B	**REF**		**S**	**1**	**Additional Identification Number**			
	REF01	128	R		3	ID	0B	Reference Identification Qualifier
	REF02	127	R		1/30	AN		State License Number
2100B	**N3**		**S**	**1**	**Receiver Address**			
	N301	166	R		1/55	AN		Address Line
	N302	166	S		1/55	AN		Additional Address Line
2100B	**N4**		**S**	**1**	**Receiver Geographic Location**			
	N401	19	S		2/30	AN		City Name
	N402	156	S		2	ID		State or Province Code
	N403	116	S		3/15	ID		Postal Code
	N404	26	S		2/3	ID		Country Code
2100B	**PER**		**S**	**1**	**Receiver Contact Information**			
	PER01	366	R		2	ID	IC	Contact Function Code
	PER02	93	S		1/60	AN		Payer Contact Name
	PER03	365	S		2	ID	TE	Communication Number Qualifier
	PER04	364	S		1/80	AN		Phone Number
	PER05	365	S		2	ID	FX	Communication Number Qualifier
	PER06	264	S		1/80	AN		Fax Number
2100B	**PRV**		**S**	**1**	**Receiver Provider Information**			
	PRV01	R	R		2	ID	BI	Provider Code
	PRV02	R	R		2/3	ID	ZZ	Reference ID Qualifier (provider specialty code)
	PRV03	R	R		1/30	AN		Provider Specialty Code
2000C	**Subscriber (Employer) Level (repeat > 1)**							

Loop	Segment / Element	ANSI DN	ANSI R/S	Occurrence	Length	Data Type	Value	Description
2000C	**HL**			**1**	**Subscriber Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	22	Hierarchical Level Code (Subscriber)
	HL04	736	R		1	ID	1	Hierarchical Child Code
2100C	**NM1**		**R**	**1**	**Subscriber (Employer) Name**			
	NM101	98	R		2	ID	IL	Entity Identifier Code (Insured or Subscriber)
	NM102	1065	R		1	ID	2	Entity Type Qualifier (2=company)
	NM103	1035	R		1/35	AN		Name of Subscriber (Employer)
2100C	**N3**		**S**	**1**	**Address**			
	N301	166	R		1/55	AN		Address Line
	N302	166	S		1/55	AN		Additional Address Line
2100C	**N4**		**S**	**1**	**Geographic Location**			
	N401	19	S		2/30	AN		City Name
	N402	156	S		2	ID		State or Province Code
	N403	116	S		3/15	ID		Postal Code
	N404	26	S		2/3	ID		Country Code
2000D	**Dependent (Patient) Level (repeat > 1)**							
2000D	**HL**		**R**	**1**	**Dependent Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	23	Hierarchical Level Code (Dependent)
	HL04	736	R		1	ID	0	Hierarchical Child Code
2000D	**TRN**		**S**	**1**	**Trace Number**			
	TRN01	481	R		1/2	ID	1	Trace Type Code (Current Transaction Trace Numbers)
	TRN02	127	R		1/30	AN		Trace Number
	TRN03	509	R		10	AN		IRS or DUNS of the trace number assigner
	TRN04	127	S		1/30	AN		Trace Assigning Entity Additional Identifier
2100D	**Patient (Employee) Information**							
2100D	**NM1**		**R**	**1**	**Patient (Employee) Name**			
	NM101	98	R		2	ID	03	Entity Identifier Code (Dependent)
	NM102	1065	R		1	ID	1	Entity Type Qualifier (1=person)
	NM103	1035	R		1/35	AN		Name Last
	NM104	1036	S		1/25	AN		Name First
	NM105	1037	S		1/25	AN		Name Middle
	NM107	1039	S		1/10	AN		Name Suffix
2100D	**REF**		**R**	**1**	**Social Security Number**			
	REF01	128	R		3	ID	SY	Reference Identification Qualifier
	REF02	127	R		1/30	AN		Social Security Number
2100D	**REF**		**S**	**1**	**Claim Number to Verify**			
	REF01	128	R		2/3	ID	1L	Reference Identification Qualifier
	REF02	127	R		1/30	AN		The Workers' Compensation Claim number

Loop	Segment / Element	ANSI DN	ANSI R/S	Occurrence	Length	Data Type	Value	Description
2100D	**N3**		**S**	**1**	**Address**			
	N301	166	R		1/55	AN		Address Line
	N302	166	S		1/55	AN		Additional Address Line
2100D	**N4**		**S**	**1**	**Geographic Location**			
	N401	19	S		2/30	AN		City Name
	N402	156	S		2	ID		State or Province Code
	N403	116	S		3/15	ID		Postal Code
	N404	26	S		2/3	ID		Country Code
2100D	**DMG**		**R**	**1**	**Demographic Information**			
	DMG01	R	S		2	ID	D8	Date Time Period Format Qualifier
	DMG02	R	S		1/35	AN		Birth Date
	DMG03	R	S		1	ID		Gender Code
2100D	**DTP**		**R**	**1**	**Injury Date**			
	DTP01	374	R		3	ID	439	Date/Time Qualifier (Claim Statement Period Start)
	DTP02	1250	R		3	ID	D8	Date Time Period Format Qualifier
	DTP03	1251	R		8	AN		Date of Injury
2110D	**Eligibility Inquiry Information (repeat max 99)**							
2110D	**EQ**		**R**	**1**	**Eligibility or Benefit Inquiry**			
	EQ01	1365	R		1/2	ID	30	Service Type Code (Health Benefit Plan Coverage)
	EQ03	1207	S		3	ID	EMP	Coverage Level Code
	EQ04	1336	S		2	ID	WC	Insurance Type Code
TS	**SE**		**R**	**1**	**Transaction Set Trailer**			
	SE01	96	R		1/10	N		Transaction Segment Count
	SE02	329	R		4/9	AN		Transaction Set Control Number (same as ST02)

ANSI 271 Response

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 271 Healthcare Eligibility Response transaction is available through the Washington Publishing Company, www.wpc-edi.com. The California workers' compensation direction for the use of the ANSI HIPAA 271 Healthcare Eligibility Response Implementation Guide is below.

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Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
TS	**Transaction Set**							
TS	**ST**		**R**	**1**	**Transaction Set Header**			
	ST01	143	R		3	ID	271	Eligibility, Coverage or Benefit Inquiry
	ST02	329	R		4/9	AN		Transaction Set Control Number
TS	**BHT**		**R**	**1**	**Beginning of Hierarchical Transaction**			
	BHT01	1005	R		4	ID	0022	Hierarchical Structure Code
	BHT02	353	R		2	ID	11	Transaction Set Purpose Code (Response)
	BHT03	127	S		1/30	AN		Submitter Transaction Identifier. Required if sent in the original 270 transaction.
	BHT04	373	R		8	DT		Transaction Set Creation Date
	BHT05	337	R		4/8	TM		Transaction Set Creation Time
2000A	**Information Source Level (repeat > 1)**							
2000A	**HL**		**R**	**1**	**Information Source Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL03	735	R		2	ID	20	Hierarchical Level Code (Information Source)
	HL04	736	R		1	ID	1	Hierarchical Child Code
2000A	**AAA**		**S**	**1**	**System Level Request Validation**			
					Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.			
	AAA01	1073	R		1	ID		Valid Request Indicator
							N	No, Request is invalid, Inquiry is rejected
							Y	Yes, Request is valid, but inquiry is still rejected
	AAA03	901	R		2	ID		Reject Reason Code
							04	Authorized Quantity Exceeded
							41	Authorization/Access Restrictions
							42	Unable to Respond at Current Time
							79	Invalid Participant Identification
	AAA04	889	R		1	ID		Follow-up Action Code
							C	Please Correct and Resubmit
							N	Resubmission Not Allowed
							P	Please Resubmit Original Transaction
							R	Resubmission Allowed
							S	Do Not Resubmit; Inquiry Initiated to a Third Party
							Y	Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly
2100A	**Information Source Name**							
2100A	**NM1**		**R**	**1**	**Name**			
	NM101	98	R		2	ID		Entity Identifier Code (Payer)
							2B	Third-Party Administrator
							36	Employer
							GP	Gateway Provider
							P5	Plan Sponsor
							PR	Payer

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
	NM102	1065	R		1	ID	2	Identification Code Qualifier (Non- Person Entity)
	NM103	1035	R		1/35	AN		Name of Receiver
	NM108	66	R		2	ID		Identification Code Qualifier
							FI	Federal taxpayer's Identification Number
							NI	NAIC Identification
							PI	Payer Identification
							XV	National Payer Identification Number
	NM109	67	R		2/80	AN		Identification Number
2100A	**PER**		**S**	**1**	**Contact Information**			
	PER01	366	R		2	ID	IC	Contact Function Code
	PER02	93	R		1/60	AN		Payer Contact Name
	PER03	365	R		2	ID	TE	Communication Number Qualifier
	PER04	364	R		1/80	AN		Phone Number
	PER05	365	S		2	ID		Communication Number Qualifier
	PER06	364	S		1/80	AN		Communication Number
	PER07	365	S		2	ID		Communication Number Qualifier
	PER08	364	S		1/80	AN		Communication Number
2100A	**AAA**		**S**	**1**	**System Level Request Validation**			
					Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.			
	AAA01	1073	R		1	ID		Valid Request Indicator
							N	No, Request is invalid, Inquiry is rejected
							Y	Yes, Request is valid, but inquiry is still rejected
	AAA03	901	R		2	ID		Reject Reason Code
							04	Authorized Quantity Exceeded
							41	Authorization/Access Restrictions
							42	Unable to Respond at Current Time
							79	Invalid Participant Identification
							80	No Response received - Transaction Terminated
							T4	Payer Name or Identifier Missing
	AAA04	889	R		1	ID		Follow-up Action Code
							C	Please Correct and Resubmit
							N	Resubmission Not Allowed
							P	Please Resubmit Original Transaction
							R	Resubmission Allowed
							S	Do Not Resubmit; Inquiry Initiated to a Third Party
							W	Please Wait 30 Days and Resubmit
							X	Please Wait 10 Days and Resubmit
							Y	Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly
2000B	**Information Receiver Level (repeat > 1)**							
2000B	**HL**			**1**	**Information Receiver Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	21	Hierarchical Level Code (Information Receiver)
	HL04	736	R		1	ID	1	Hierarchical Child Code
2100B	**Information Receiver Level (repeat > 1)**							
2100B	**NM1**		**R**	**1**	**Receiver Name**			
	NM101	98	R		2	ID		Entity Identifier Code
							1P	Provider
							2B	Third-Party Administrator
							36	Employer
							80	Hospital
							FA	Facility
							GP	Gateway Provider
							P5	Plan Sponsor
							PR	Payer
	NM102	1065	R		1	ID		Entity Type Qualifier
							1	Person
							2	Non-Person Entity
	NM103	1035	R		1/60	AN		Name Last or Organization Name
	NM104	1036	S		1/35	AN		Name First
	NM105	1037	S		1/25	AN		Name Middle
	NM107	1039	S		1/10	AN		Name Suffix
	NM108	66	R		2	ID	FI	Identification Code Qualifier
	NM109	67	R		2/80	AN		Federal Taxpayer's Identification Number
2100B	**REF**		**S**	**1**	**Additional Identification Number**			
	REF01	128	R		3	ID	0B	Reference Identification Qualifier
	REF02	127	R		1/30	AN		State License Number
2100B	**AAA**		**S**	**1**	**System Level Request Validation**			
					Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.			
	AAA01	1073	R		1	ID		Valid Request Indicator
	AAA03	901	R		2	ID		Reject Reason Code
							15	Required application data missing
							41	Authorization/Access Restrictions
							43	Invalid/Missing Provider Identification
							44	Invalid/Missing Provider Name
							45	Invalid/Missing Provider Specialty
							46	Invalid/Missing Provider Phone Number
							47	Invalid/Missing Provider State
							48	Invalid/Missing Referring Provider Identification Number
							50	Provider Ineligible for Inquiries
							51	Provider Not on File
							79	Invalid Participant Identification
							97	Invalid or Missing Provider Address
							T4	Payer Name or Identifier Missing

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
	AAA04	889	R		1	ID		Follow-up Action Code
							C	Please Correct and Resubmit
							N	Resubmission Not Allowed
							R	Resubmission Allowed
							S	Do Not Resubmit; Inquiry Initiated to a Third Party
							W	Please Wait 30 Days and Resubmit
							X	Please Wait 10 Days and Resubmit
							Y	Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly
2000C	**Subscriber (Employer) Level (repeat > 1)**							
2000C	**HL**			**1**	**Subscriber Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	22	Hierarchical Level Code (Subscriber)
	HL04	736	R		1	ID	1	Hierarchical Child Code
2100C	**NM1**		**R**	**1**	**Subscriber (Employer) Name**			
	NM101	98	R		2	ID	IL	Entity Identifier Code (Insured or Subscriber)
	NM102	1065	R		1	ID	2	Entity Type Qualifier (2=company)
	NM103	1035	R		1/35	AN		Name of Subscriber (Employer)
2100C	**N3**		**S**	**1**	**Address**			
	N301	166	R		1/55	AN		Address Line
	N302	166	S		1/55	AN		Additional Address Line
2100C	**N4**		**S**	**1**	**Geographic Location**			
	N401	19	S		2/30	AN		City Name
	N402	156	S		2	ID		State or Province Code
	N403	116	S		3/15	ID		Postal Code
	N404	26	S		2/3	ID		Country Code
2100C	**PER**		**S**	**1**	**Contact Information**			
	PER01	366	R		2	ID	IC	Contact Function Code
	PER02	93	S		1/60	AN		Payer Contact Name
	PER03	365	S		2	ID	TE	Communication Number Qualifier
	PER04	364	S		1/80	AN		Telephone Number
	PER05	365	S		2	ID		Communication Number Qualifier
	PER06	364	S		1/80	AN		Communication Number
	PER07	365	S		2	ID		Communication Number Qualifier
	PER08	364	S		1/80	AN		Communication Number
2100C	**AAA**		**S**	**1**	**System Level Request Validation**			
					Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.			
	AAA01	1073	R		1	ID		Valid Request Indicator
	AAA03	901	R		2	ID		Reject Reason Code
							15	Required application data missing
							42	Unable to Respond at Current Time
							43	Invalid/Missing Provider Identification
							45	Invalid/Missing Provider Specialty

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
							47	Invalid/Missing Provider State
							48	Invalid/Missing Referring Provider Identification Number
							49	Provider is Not Primary Care Physician
							51	Provider Not on File
							52	Service Dates Not Within Provider Plan Enrollment
							56	Inappropriate Date
							57	Invalid/Missing Date(s) of Service
							58	Invalid/Missing Date-of-Birth
							60	Date of Birth Follows Date(s) of Service
							61	Date of Death Precedes Date(s) of Service
							62	Date of Service Not Within Allowable Inquiry Period
							63	Date of Service in Future
							64	Invalid/Missing Patient ID
							65	Invalid/Missing Patient Name
							66	Invalid/Missing Patient Gender Code
							67	Patient Not Found
							68	Duplicate Patient ID Number
							71	Patient Birth Date Does Not Match That for the Patient on the Database
							72	Invalid/Missing Subscriber/Insured ID
							73	Invalid/Missing Subscriber/Insured Name
							74	Invalid/Missing Subscriber/Insured Gender Code
							75	Subscriber/Insured Not Found
							76	Duplicate Subscriber/Insured ID Number
							77	Subscriber Found, Patient Not Found
							78	Subscriber/Insured Not in Group/Plan Identified
	AAA04	889	R		1	ID		Follow-up Action Code
							C	Please Correct and Resubmit
							N	Resubmission Not Allowed
							R	Resubmission Allowed
							S	Do Not Resubmit; Inquiry Initiated to a Third Party
							W	Please Wait 30 Days and Resubmit
							X	Please Wait 10 Days and Resubmit
							Y	Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly
2000D	**Dependent (Patient) Level (repeat > 1)**							
2000D	**HL**		**R**	**1**	**Dependent Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	23	Hierarchical Level Code (Dependent)
	HL04	736	R		1	ID	0	Hierarchical Child Code
2000D	**TRN**		**S**	**1**	**Trace Number**			
					Use this segment to echo the trace number from the 270 request.			

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
	TRN01	481	R		1/2	ID	1	Trace Type Code (Current Transaction Trace Numbers)
	TRN02	127	R		1/30	AN		Trace Number
	TRN03	509	R		10	AN		IRS or DUNS of the trace number assigner
	TRN04	127	S		1/30	AN		Trace Assigning Entity Additional Identifier
2100D	**Patient Information**							
	Use of these segments is required if the transaction is not rejected. Social security number, claim number and address information is required if available from the information source's database.							
2100D	**NM1**		**R**	**1**	**Information Source Name**			
	NM101	98	R		2	ID	03	Entity Identifier Code (Dependent)
	NM102	1065	R		1	ID	1	Entity Type Qualifier (1=person)
	NM103	1035	R		1/35	AN		Name of Receiver
	NM104	1036	S		1/35	AN		Name First
	NM105	1037	S		1/25	AN		Name Middle
	NM107	1039	S		1/10	AN		Name Suffix
2100D	**REF**		**S**	**1**	**Social Security Number**			
	REF01	128	R		3	ID	SY	Reference Identification Qualifier
	REF02	127	R		1/30	AN		Social Security Number
2100D	**REF**		**S**	**1**	**Claim Number**			
	REF01	128	R		3	ID	1L	Reference Identification Qualifier
	REF02	127	R		1/30	AN		The Workers' Compensation Claim number
2100D	**N3**		**S**	**1**	**Address**			
					Do not return address information from the 270 request.			
	N301	166	R		1/55	AN		Address Line
	N302	166	S		1/55	AN		Additional Address Line
2100D	**N4**		**S**	**1**	**Geographic Location**			
	N401	19	S		2/30	AN		City Name
	N402	156	S		2	ID		State or Province Code
	N403	116	S		3/15	ID		Postal Code
	N404	26	S		2/3	ID		Country Code
2100D	**PER**		**S**	**1**	**Contact Information**			
	PER01	366	R		2	ID	IC	Contact Function Code
	PER02	93	S		1/60	AN		Payer Contact Name
	PER03	365	S		2	ID	TE	Communication Number Qualifier
	PER04	364	S		1/80	AN		Telephone Number
	PER05	365	S		2	ID		Communication Number Qualifier
	PER06	364	S		1/80	AN		Communication Number
	PER07	365	S		2	ID		Communication Number Qualifier
	PER08	364	S		1/80	AN		Communication Number
2100D	**AAA**		**S**	**1**	**System Level Request Validation**			
					Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.			
	AAA01	1073	R		1	ID		Valid Request Indicator
	AAA03	901	R		2	ID		Reject Reason Code
							15	Required application data missing

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
							42	Unable to Respond at Current Time
							43	Invalid/Missing Provider Identification
							45	Invalid/Missing Provider Specialty
							47	Invalid/Missing Provider State
							48	Invalid/Missing Referring Provider Identification Number
							49	Provider is Not Primary Care Physician
							51	Provider Not on File
							52	Service Dates Not Within Provider Plan Enrollment
							56	Inappropriate Date
							57	Invalid/Missing Date(s) of Service
							58	Invalid/Missing Date-of-Birth
							60	Date of Birth Follows Date(s) of Service
							61	Date of Death Precedes Date(s) of Service
							62	Date of Service Not Within Allowable Inquiry Period
							63	Date of Service in Future
							64	Invalid/Missing Patient ID
							65	Invalid/Missing Patient Name
							66	Invalid/Missing Patient Gender Code
							67	Patient Not Found
							68	Duplicate Patient ID Number
							71	Patient Birth Date Does Not Match That for the Patient on the Database
	AAA04	889	R		1	ID		Follow-up Action Code
							C	Please Correct and Resubmit
							N	Resubmission Not Allowed
							R	Resubmission Allowed
							S	Do Not Resubmit; Inquiry Initiated to a Third Party
							W	Please Wait 30 Days and Resubmit
							X	Please Wait 10 Days and Resubmit
							Y	Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly
2100D	**DMG**		**S**	**1**	**Demographic Information**			
					Required if this is available from the Information Source's database			
	DMG01	R	S		2	ID	D8	Date Time Period Format Qualifier
	DMG02	R	S		1/35	AN		Birth Date
	DMG03	R	S		1	ID		Gender Code
2100D	**DTP**		**R**	**1**	**Injury Date**			
	DTP01	374	R		3	ID	439	Date/Time Qualifier (Claim Statement Period Start)
	DTP02	1250	R		3	ID	D8	Date Time Period Format Qualifier
	DTP03	1251	R		1/35	AN		Date of Injury
2110D	**Eligibility Inquiry Information (repeat max 99)**							
2110D	**EB**		**R**	**1**	**Eligibility or Benefit Inquiry**			
	EB01	1390	R		1/2	ID		Eligibility or Benefit Information

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
							1	Active Coverage
							6	Inactive
2110D	**AAA**		**S**	**1**	**System Level Request Validation**			
					Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.			
	AAA01	1073	R		1	ID		Valid Request Indicator
	AAA03	901	R		2	ID		Reject Reason Code
							15	Required application data missing
							52	Service Dates Not Within Provider Plan Enrollment
							53	Inquired Benefit Inconsistent with Provider Type
							54	Inappropriate Product/Service ID Qualifier
							55	Inappropriate Product/Service ID
							56	Inappropriate Date
							57	Invalid/Missing Date(s) of Service
							60	Date of Birth Follows Date(s) of Service
							61	Date of Death Precedes Date(s) of Service
							62	Date of Service Not Within Allowable Inquiry Period
							63	Date of Service in Future
							69	Inconsistent with Patient's Age
							70	Inconsistent with Patient's Gender
	AAA04	889	R		1	ID		Follow-up Action Code
2110D	**MSG**		**S**	**10**	**Message Text**			
	MSG01	933	R		1/264	AN		Free Form Message Text
TS	**SE**		**R**	**1**	**Transaction Set Trailer**			
	SE01	96	R		1/10	N		Transaction Segment Count
	SE02	329	R		4/9	AN		Transaction Set Control Number (same as ST02)

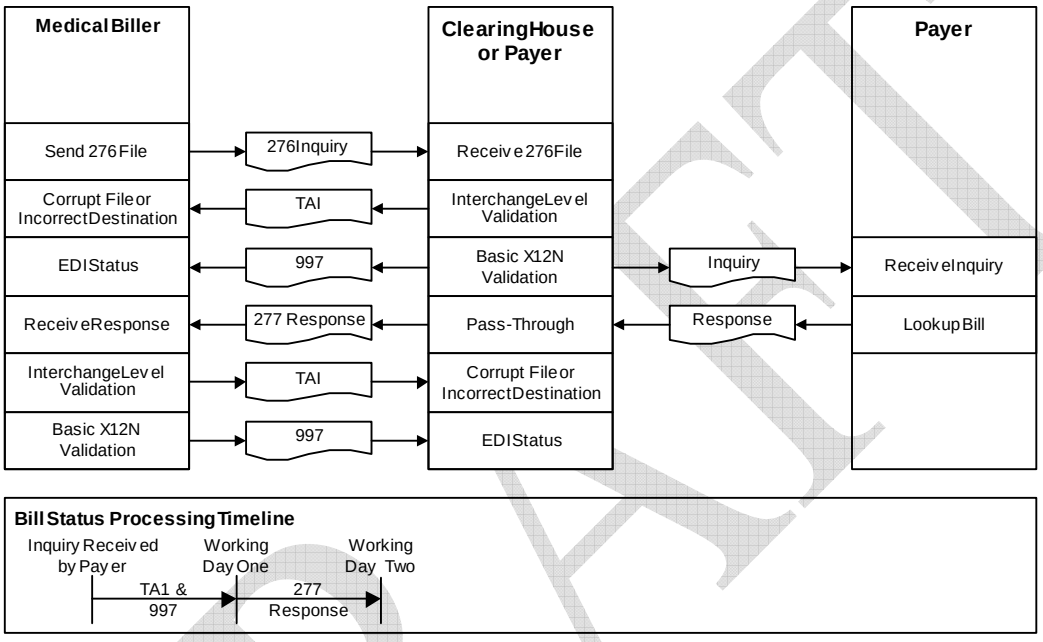
California ANSI 271 Codes

Service Type Codes

Code	Text	Code	Text	Code	Text	Code	Text	Code	Text
1	Medical Care	32	Plan Waiting Period	61	In-vitro Fertilization	90	Mail Order Prescription Drug	AJ	Alcoholism
2	Surgical	33	Chiropractic	62	MRI/CAT Scan	91	Brand Name Prescription Drug	AK	Drug Addiction
3	Consultation	34	Chiropractic Office Visits	63	Donor Procedures	92	Generic Prescription Drug	AL	Vision (Optometry)
4	Diagnostic X-Ray	35	Dental Care	64	Acupuncture	93	Podiatry	AM	Frames
5	Diagnostic Lab	36	Dental Crowns	65	Newborn Care	94	Podiatry - Office Visits	AN	Routine Exam
6	Radiation Therapy	37	Dental Accident	66	Pathology	95	Podiatry - Nursing Home Visits	AO	Lenses
7	Anesthesia	38	Orthodontics	67	Smoking Cessation	96	Professional (Physician)	AQ	Nonmedically Necessary Physical
8	Surgical Assistance	39	Prosthodontics	68	Well Baby Care	97	Anesthesiologist	AR	Experimental Drug Therapy
9	Other Medical	40	Oral Surgery	69	Maternity	98	Professional (Physician) Visit - Office	BA	Independent Medical Evaluation
10	Blood Charges	41	Routine (Preventive) Dental	70	Transplants	99	Professional (Physician) Visit - Inpatient	BB	Partial Hospitalization (Psychiatric)
11	Used Durable Medical Equipment	42	Home Health Care	71	Audiology Exam	A0	Professional (Physician) Visit - Outpatient	BC	Day Care (Psychiatric)
12	Durable Medical Equipment Purchase	43	Home Health Prescriptions	72	Inhalation Therapy	A1	Professional (Physician) Visit - Nursing Home	BD	Cognitive Therapy
13	Ambulatory Service Center Facility	44	Home Health Visits	73	Diagnostic Medical	A2	Professional (Physician) Visit - Skilled Nursing Facility	BE	Massage Therapy
14	Renal Supplies in the Home	45	Hospice	74	Private Duty Nursing	A3	Professional (Physician) Visit - Home	BF	Pulmonary Rehabilitation
15	Alternate Method Dialysis	46	Respite Care	75	Prosthetic Device	A4	Psychiatric	BG	Cardiac Rehabilitation
16	Chronic Renal Disease (CRD) Equipment	47	Hospital	76	Dialysis	A5	Psychiatric - Room and Board	BH	Pediatric
17	Pre-Admission Testing	48	Hospital - Inpatient	77	Ontological Exam	A6	Psychotherapy	BI	Nursery
18	Durable Medical Equipment Rental	49	Hospital - Room and Board	78	Chemotherapy	A7	Psychiatric - Inpatient	BJ	Skin
19	Pneumonia Vaccine	50	Hospital - Outpatient	79	Allergy Testing	A8	Psychiatric - Outpatient	BK	Orthopedic
20	Second Surgical Opinion	51	Hospital - Emergency Accident	80	Immunizations	A9	Rehabilitation	BL	Cardiac
21	Third Surgical Opinion	52	Hospital - Emergency Medical	81	Routine Physical	AA	Rehabilitation - Room and Board	BM	Lymphatic
22	Social Work	53	Hospital - Ambulatory Surgical	82	Family Planning	AB	Rehabilitation - Inpatient	BN	Gastrointestinal
23	Diagnostic Dental	54	Long Term Care	83	Infertility	AC	Rehabilitation - Outpatient	BP	Endocrine
24	Periodontics	55	Major Medical	84	Abortion	AD	Occupational Therapy	BQ	Neurology
25	Restorative	56	Medically Related Transportation	85	AIDS	AE	Physical Medicine	BR	Eye
26	Endodontics	57	Air Transportation	86	Emergency Services	AF	Speech Therapy	BS	Invasive Procedures
27	Maxillofacial Prosthetics	58	Ambulance	87	Cancer	AG	Skilled Nursing Care		
28	Adjunctive Dental Services	59	Licensed Ambulance	88	Pharmacy	AH	Skilled Nursing Care - Room and Board		
30	Health Benefit Plan Coverage Use this code if only a single category of benefits can be supported.	60	General Benefits	89	Free Standing Prescription Drug	AI	Substance Abuse		

276/277 Claim Status Request and Response

The 276 and 277 transaction set is used in the group health industry to inquire about the current status of a specified healthcare bill or bills. The 276 transaction is the inquiry and the 277 transaction is the reply. It is possible to use these transaction sets unchanged in workers' compensation bill processing. The 276/277 Claim (Bill) Status formats are not mandated for California workers' compensation process. They are offered as a tool to facilitate effective communication between health care providers, health care facilities, or third party biller/assignees and Claims Administrators.



ANSI 276 Inquiry

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 276 Claim (Bill) Status Request/Inquiry transaction is available through the Washington Publishing Company, www.wpc-edi.com. The California workers' compensation direction for the use of the ANSI HIPAA 276 Claim Status Request/Inquiry Implementation Guide is below.

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Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
TS	**Transaction Set**							
TS	**ST**		**R**	**1**	**Transaction Set Header**			
	ST01	143	R		3	ID	276	Health Care Claim Status Request
	ST02	329	R		4/9	AN		Transaction Set Control Number
TS	**BHT**		**R**	**1**	**Beginning of Hierarchical Transaction**			
	BHT01	1005	R		4	ID	0010	Hierarchical Structure Code
	BHT02	353	R		2	ID	13	Transaction Set Purpose Code (Request)
	BHT04	373	R		8	DT		Transaction Set Creation Date
	BHT05	337	N		4/8	TM		Transaction Set Creation Time
2000A	**Information Source Level (repeat > 1)**							
2000A	**HL**		**R**	**1**	**Information Source Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	N		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	20	Hierarchical Level Code (Information Source)
	HL04	736	R		1	ID	1	Hierarchical Child Code
2100A	**Payer Name (repeat > 1)**							
2100A	**NM1**		**R**	**1**	**Payer Name**			
	NM101	98	R		2	ID	PR	Entity Identifier Code (Payer)
	NM102	1065	R		1	ID	2	Entity Type Qualifier (Non - Person Entity)
	NM103	1035	R		1/35	AN		Name of Receiver
	NM108	66	R		2	ID		Identification Code Qualifier
							FI	Federal taxpayer's Identification Number
							NI	NAIC Identification
							PI	Payer Identification
							XV	National Payer Identification Number
	NM109	67	R		2/80	AN		Identification Number
2100A	**PER**		**S**	**1**	**Payer Contact Information**			
	PER01	366	R		2	ID	IC	Contact Function Code
	PER02	93	S		1/60	AN		Payer Contact Name
	PER03	365	S		2	ID	TE	Communication Number Qualifier
	PER04	364	S		1/80	AN		Telephone Number
	PER05	365	S		2	ID		Communication Number Qualifier
	PER06	364	S		1/80	AN		Communication Number
	PER07	365	S		2	ID		Communication Number Qualifier
	PER08	364	S		1/80	AN		Communication Number
2000B	**Information Receiver Level (repeat > 1)**							
2000B	**HL**		**R**	**1**	**Information Receiver Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	21	Hierarchical Level Code (Information Receiver)
	HL04	736	R		1	ID	1	Hierarchical Child Code

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
2100B	**Information Receiver Level (repeat > 1)**							
2100B	**NM1**		**R**	**1**	**Information Receiver Level**			
	NM101	98	R		2	ID	41	Entity Identifier Code (Submitter)
	NM102	1065	R		1	ID		Entity Type Qualifier
							1	Person
							2	Non-Person Entity
	NM103	1035	R		1/35	AN		Name Last or Organization Name
	NM104	1036	S		1/25	AN		Name First
	NM105	1037	S		1/25	AN		Name Middle
	NM107	1039	S		1/10	AN		Name Suffix
	NM108	66	R		2	ID		Identification Code Qualifier
							FI	Federal taxpayer's Identification Number
							XX	National Provider Identification Number
	NM109	67	R		2/80	AN		Identification Number
2000C	**Service Provider Level (repeat > 1)**							
2000C	**HL**		**R**	**1**	**Service Provider Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	19	Hierarchical Level Code (Provider of Service)
	HL04	736	R		1	ID	1	Hierarchical Child Code
2100C	**Provider Name (repeat > 1)**							
2100C	**NM1**		**R**	**1**	**Provider Name**			
	NM101	98	R		2	ID	1P	Entity Identifier Code (Provider)
	NM102	1065	R		1	ID		Entity Type Qualifier
							1	Person
							2	Non-Person Entity
	NM103	1035	R		1/35	AN		Name Last or Organization Name
	NM104	1036	S		1/25	AN		Name First
	NM105	1037	S		1/25	AN		Name Middle
	NM107	1039	S		1/10	AN		Name Suffix
	NM108	66	R		2	ID		Identification Code Qualifier
							FI	Federal taxpayer's Identification Number
							XX	National Provider Identification Number
	NM109	67	R		2/80	AN		Identification Number
2000D	**Subscriber (Employer) Level (repeat > 1)**							
2000D	**HL**		**R**	**1**	**Subscriber Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	22	Hierarchical Level Code (Subscriber)
	HL04	736	R		1	ID	1	Hierarchical Child Code

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
2100D	**Subscriber Name (Employer) (repeat 1)**							
2100D	**NM1**		**R**	**1**	**Subscriber Name**			
	NM101	98	R		2	ID	IL	Entity Identifier Code (Insured/Employer)
	NM102	1065	R		1	ID	2	Entity Type Qualifier (Non-Person Entity)
	NM103	1035	R		1/35	AN		Name Last or Organization Name
	NM108	66	R		2	ID		Identification Code Qualifier
							24	Employer's Identification Number
							MI	Member Identification Number
							ZZ	Mutually Defined
	NM109	67	R		2/80	AN		Identification Number
2000E	**Dependent (Patient / Employee) Level (repeat > 1)**							
2000E	**HL**		**S**	**1**	**Dependent (Patient / Employee) Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	23	Hierarchical Level Code (Dependent)
	HL04	736	R		1	ID	0	Hierarchical Child Code
2000E	**DMG**		**R**	**1**	**Demographic Information**			
	DMG01	1250	R		2/3	ID	D8	Date Time Period Format Qualifier
	DMG02	1251	R		1/35	AN		Birth Date
	DMG03	1068	R		1	ID		Gender Code
2100E	**Dependent (Patient / Employee) Name (repeat > 1)**							
2100E	**NM1**		**S**	**1**	**Dependent (Patient / Employee) Name**			
	NM101	98	R		2/3	ID	QC	Entity Identifier Code (Patient)
	NM102	1065	R		1	ID	1	Entity Type Qualifier (Person)
	NM103	1035	R		1/35	AN		Last Name
	NM104	1036	S		1/25	AN		First Name
	NM105	1037	S		1/25	AN		Middle Name
	NM108	66	S		2	ID	MI	Identification Code Qualifier
	NM109	67	S		2/80	AN		Patient Primary Identifier
2200E	**Claim Submitter Trace Number (repeat 1)**							
2200E	**TRN**		**R**	**1**	**Claim Submitter Trace Number**			
	TRN01	481	R		1/2	ID		Trace Type Code
							1	Current Transaction Trace Numbers
	TRN02	127	R		1/30	AN		Trace Number
2200E	**REF**		**S**	**1**	**Payer's Claim Number**			
	REF01	128	R		2/3	ID	1K	Payer's Claim Number
	REF02	127	R		1/30	AN		Payer Claim Control Number (ICN, DCN, and CCN)
2200E	**REF**		**S**	**1**	**Institutional Bill Type Identification**			
	REF01	128	R		2/3	ID	BLT	Reference Identification Qualifier (Billing Type)
	REF02	127	R		1/30	AN		Institutional Bill Type Identification (837, CLM05)
2200E	**REF**		**S**	**1**	**Medical Record Identification**			

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
	REF01	128	R		2/3	ID	EA	Reference Identification Qualifier
	REF02	127	R		1/30	AN		Medical Record Identification
2200E	**AMT**		**S**	**1**	**Total Submitted Charges**			
	AMT01	522	R		1/3	ID	T3	Amount Qualifier Code (Total Submitted Charges)
	AMT02	782	R		1/18	R		Total Claim Charge Amount
2200E	**DTP**		**S**	**1**	**Institutional Claim Statement Period**			
	DTP01	374	R		3	ID	232	Date/Time Qualifier (Claim Statement Period Start)
	DTP02	1250	R		2/3	ID	RD8	Date Time Period Format Qualifier
	DTP03	1251	R		1/35	AN		Claim Service Period
2210E	**Service Line Information (repeat > 1)**							
2210E	**SVC**		**S**	**1**	**Service Line Information**			
					Use this segment to request status information about a service line			
	SVC01-1	235	R		2	ID		Product or Service ID Qualifier
							AD	American Dental Association Codes
							CI	Common Language Equipment Identifier (CLEI)
							HC	(HCPCS) Codes
							N4	National Drug Code in 5-4-2 Format
							NU	(NUBC) UB92 Codes
	SVC01-2	234	R		1/48	ID		Procedure Code
	SVC01-3	1339	S		2	ID		Modifier 1
	SVC01-4	1339	S		2	ID		Modifier 2
	SVC01-5	1339	S		2	ID		Modifier 3
	SVC01-6	1339	S		2	ID		Modifier 4
	SVC02	782	R		1/18	R		Line Item Charge Amount
	SVC04	234	S		1/48	AN		Revenue Code
	SVC07	380	S		1/15	R		Original Units of Service Count
2210E	**REF**		**S**	**1**	**Service Line Item Identification**			
	REF01	128	R		3	ID	FJ	Reference Identification Qualifier
	REF02	127	R		1/30	AN		Line Item Control Number
2210E	**DTP**		**S**	**1**	**Service Line Date**			
	DTP01	374	R		3	ID	472	Date/Time Qualifier
	DTP02	1250	R		2/3	ID	RD8	Date Time Period Format Qualifier
	DTP03	1251	R		1/35	AN		Service Line Dates
TS	**SE**		**R**	**1**	**Transaction Set Trailer**			
	SE01	96	R		1/10	N		Transaction Segment Count
	SE02	329	R		4/9	AN		Transaction Set Control Number (same as ST02)

ANSI 277 Response

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 277 Claim (Bill) Status Response transaction is available through the Washington Publishing Company, www.wpc-edi.com. The California workers' compensation direction for the use of the ANSI HIPAA 277 Claim (Bill) Status Response Implementation Guide is below.

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Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
TS	**Transaction Set**							
TS	**ST**		**R**	**1**	**Transaction Set Header**			
	ST01	143	R		3	ID	277	Health Care Claim Status Notification
	ST02	329	R		4/9	AN		Transaction Set Control Number
TS	**BHT**		**R**	**1**	**Beginning of Hierarchical Transaction**			
	BHT01	1005	R		4	ID	0010	Hierarchical Structure Code
	BHT02	353	R		2	ID	08	Transaction Set Purpose Code (Status)
	BHT03	127	R		1/30	AN		Originator Application Transaction Identifier
	BHT04	373	R		8	DT		Transaction Set Creation Date
	BHT05	337	N		4/8	TM		Transaction Set Creation Time
	BHT06	640	R		2	ID	DG	Transaction Type Code (Response)
2000A	**Information Source Level (repeat > 1)**							
2000A	**HL**		**R**	**1**	**Information Source Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	N		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	20	Hierarchical Level Code (Information Source)
	HL04	736	R		1	ID	1	Hierarchical Child Code
2100A	**Payer Name (repeat > 1)**							
2100A	**NM1**		**R**	**1**	**Payer Name**			
	NM101	98	R		2/3	ID	PR	Entity Identifier Code (Payer)
	NM102	1065	R		1	ID	2	Entity Type Qualifier (Non- Person Entity)
	NM103	1035	R		1/35	AN		Payer Name
	NM108	66	R		2	ID		Identification Code Qualifier
							PI	Payer Identification
							XV	National Payer Identification Number
	NM109	67	R		2/20	AN		Identification Number
2100A	**PER**		**S**	**1**	**Payer Contact Information**			
	PER01	366	R		2	ID	IC	Contact Function Code
	PER02	93	S		1/60	AN		Payer Contact Name
	PER03	365	R		2	ID	TE	Communication Number Qualifier
	PER04	364	R		1/80	AN		Telephone Number
	PER05	365	S		2	ID		Communication Number Qualifier
	PER06	264	S		1/80	AN		Communication Number
	PER07	365	S		2	ID		Communication Number Qualifier
	PER08	364	S		1/80	AN		Communication Number
2000B	**Information Receiver Level (repeat > 1)**							
2000B	**HL**		**R**	**1**	**Information Receiver Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	21	Hierarchical Level Code (Information Receiver)
	HL04	736	R		1	ID	1	Hierarchical Child Code

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
2100B	**Information Receiver Level (repeat > 1)**							
2100B	**NM1**		**R**	**1**	**Information Receiver Level**			
	NM101	98	R		2	ID	41	Entity Identifier Code (Submitter)
	NM102	1065	R		1	ID		Entity Type Qualifier
							1	Person
							2	Non-Person Entity
	NM103	1035	R		1/35	AN		Name Last or Organization Name
	NM104	1036	S		1/25	AN		Name First
	NM105	1037	S		1/25	AN		Name Middle
	NM106	1038	S		1/10	AN		Name Prefix
	NM107	1039	S		1/10	AN		Name Suffix
	NM108	66	R		2	ID		Identification Code Qualifier
							46	Electronic Transmitter Identification Number (ETIN)
							FI	Federal Taxpayer's Identification Number
							XX	National Provider ID
	NM109	67	R		2/80	AN		Identification Number
2000C	**Service Provider Level (repeat > 1)**							
2000C	**HL**		**R**	**1**	**Service Provider Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	19	Hierarchical Level Code (Provider of Service)
	HL04	736	R		1	ID	1	Hierarchical Child Code
2100C	**Provider Name (repeat > 1)**							
2100C	**NM1**		**R**	**1**	**Provider Name**			
	NM101	98	R		2	ID	1P	Entity Identifier Code (Provider)
	NM102	1065	R		1	ID		Entity Type Qualifier
							1	Person
							2	Non-Person Entity
	NM103	1035	R		1/35	AN		Name Last or Organization Name
	NM104	1036	S		1/25	AN		Name First
	NM105	1037	S		1/25	AN		Name Middle
	NM107	1039	S		1/10	AN		Name Suffix
	NM108	66	R		2	ID		Identification Code Qualifier
							FI	Federal Taxpayer's Identification Number
							XX	National Provider ID
	NM109	67	R		2/80	AN		Identification Number
2000D	**Subscriber (Employer) Level (repeat > 1)**							
2000D	**HL**		**R**	**1**	**Subscriber Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	R		1/12	AN		Hierarchical Parent ID Number

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
	HL03	735	R		2	ID	22	Hierarchical Level Code (Subscriber)
	HL04	736	R		1	ID	1	Hierarchical Child Code
2100D	**Subscriber (Employer) Name (repeat > 1)**							
2100D	**NM1**		**R**	**1**	**Subscriber (Employer) Name**			
	NM101	98	R		2	ID	IL	Entity Identifier Code (Insured/Employer)
	NM102	1065	R		1	ID	2	Entity Type Qualifier (Non-Person Entity)
	NM103	1035	R		1/35	AN		Name Last or Organization Name
	NM108	66	R		2	ID		Identification Code Qualifier
							24	Employer's Identification Number
							MI	Member Identification Number
							ZZ	Mutually Defined
	NM109	67	R		2/80	AN		Identification Number
2000E	**Dependent (Patient / Employee) Level (repeat > 1)**							
2000E	**HL**		**S**	**1**	**Dependent (Patient / Employee) Level**			
	HL01	628	R		1/12	AN		Hierarchical ID Number
	HL02	734	S		1/12	AN		Hierarchical Parent ID Number
	HL03	735	R		2	ID	23	Hierarchical Level Code (Dependent)
	HL04	736	S		1	ID	0	Hierarchical Child Code
2000E	**DMG**		**R**	**1**	**Demographic Information**			
	DMG01	1250	R		2/3	ID	D8	Date Time Period Format Qualifier
	DMG02	1251	R		1/35	AN		Birth Date
	DMG03	1068	R		1	ID		Gender Code
2100E	**Dependent (Patient / Employee) Name (repeat > 1)**							
2100E	**NM1**		**S**	**1**	**Dependent (Patient / Employee) Name**			
	NM101	R	R		2	ID	QC	Entity Identifier Code
	NM102	R	R		1	ID	1	1=person+I72
	NM103	1035	R		1/35	AN		Last Name
	NM104	1036	R		1/25	AN		First Name
	NM105	1037	S		1/25	AN		Middle Name
	NM108	66	R		2	ID	MI	Identification Code Qualifier
	NM109	67	R		2/80	AN		Member Identification Number
2200E	**Claim Submitter Trace Number (repeat 1)**							
2200E	**TRN**		**R**	**1**	**Claim Submitter Trace Number**			
	TRN01	481	R		1/2	ID		Trace Type Code
							2	Referenced Transaction Trace Numbers
	TRN02	127	R		1/30	AN		Trace Number
2200E	**STC**		**R**	**1**	**Claim Level Status Information**			
	STC01		R					Health Care Claim Status
	STC01-1	1271	R		1/30	AN		Health Care Claim Status Category Code
	STC01-2	1271	R		1/30	AN		Health Care Claim Status Code

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
	STC01-3	98	S		2/3	ID		further modifies the status code in STC01-2.
	STC02	373	R		8	DT		Status Information Effective Date
	STC04	782	R		1/18	R		Total Claim Charge Amount
	STC05	782	R		1/18	R		Claim Payment Amount
	STC06	373	S		8	DT		Adjudication or Payment Date
	STC07	591	S		3	ID		Payment Method Code
							ACH	Automated Clearing House
							BOP	Financial Institution Option
							CHK	Check
							FWT	Federal Reserve Funds/Wire Transfer
							NON	Non-Payment Data
	STC08	373	S		8	DT		Check Issue or EFT Effective Date
	STC09	429	S		1/16	AN		Check or EFT Trace Number
	STC10		S					Use this element if a second claim status is needed.
	STC10-1	1271	R		1/30	AN		Health Care Claim Status Category Code
	STC10-2	1271	R		1/30	AN		Health Care Claim Status Code
	STC10-3	98	S		2/3	ID		further modifies the status code in STC10-2.
	STC11		S					Use this element if a third claim status is needed.
	STC11-1	1271	R		1/30	AN		Health Care Claim Status Category Code
	STC11-2	1271	R		1/30	AN		Health Care Claim Status Code
	STC11-4	1270	S		2/3	ID		further modifies the status code in STC11-2.
2200E	**REF**		**S**	**1**	**Payer's Claim Number**			
	REF01	128	R		2/3	ID	1K	Payer's Claim Number
	REF02	127	R		1/30	AN		Payer Claim Control Number (ICN, DCN, and CCN)
2200E	**REF**		**S**	**1**	**Institutional Bill Type Identification**			
	REF01	128	R		3	ID	BLT	Reference Identification Qualifier (Billing Type)
	REF02	127	R		1/30	AN		Institutional Bill Type Identification (837, CLM05)
2200E	**REF**		**S**	**1**	**Medical Record Identification**			
	REF01	128	R		3	ID	EA	Reference Identification Qualifier
	REF02	127	R		1/30	AN		Medical Record Identification
2200E	**DTP**		**S**	**1**	**Institutional Claim Statement Period**			
	DTP01	374	R		3	ID	232	Date/Time Qualifier (Claim Statement Period Start)
	DTP02	1250	R		2/3	ID	RD8	Date Time Period Format Qualifier
	DTP03	1251	R		1/35	AN		Claim Service Period
2220E	**Service Line Information (repeat > 1)**							
2220E	**SVC**		**S**	**1**	**Service Line Information**			
					Use this segment to report status information about a service line			
	SVC01-1	235	R		2	ID		Product or Service ID Qualifier
							AD	American Dental Association Codes
							CI	Common Language Equipment Identifier (CLEI)
							HC	(HCPCS) Codes
							N4	National Drug Code in 5-4-2 Format
							NU	(NUBC) UB92 Codes

Loop	Segment / Element	ANSI DN	ANSI R/O	Occurrence	Length	Data Type	Value	Description
	SVC01-2	234	R		1/48	ID		Procedure Code
	SVC01-3	1339	S		2	ID		Modifier 1
	SVC01-4	1339	S		2	ID		Modifier 2
	SVC01-5	1339	S		2	ID		Modifier 3
	SVC01-6	1339	S		2	ID		Modifier 4
	SVC02	782	R		1/18	R		Line Item Charge Amount
	SVC03	782	R		1/18	R		Line Item Provider Payment Amount
	SVC04	234	S		1/48	AN		Revenue Code
	SVC07	380	S		1/15	R		Original Units of Service Count
2220E	**STC**		**R**	**1**	**Service Line Status Information**			
	STC01-1	1271	R		1/30	AN		Health Care Claim Status Category Code
	STC01-2	1271	R		1/30	AN		Health Care Claim Status Code
	STC01-3	98	S		2/3	ID		further modifies the status code in STC01-2.
	STC02	373	R		8	DT		Status Information Effective Date
	STC04	782	S		1/18	R		Total Claim Charge Amount
	STC05	782	S		1/18	R		Claim Payment Amount
	STC10		S					Use this element if a second claim status is needed.
	STC10-1	1271	R		1/30	AN		Health Care Claim Status Category Code
	STC10-2	1271	R		1/30	AN		Health Care Claim Status Code
	STC10-3	98	S		2/3	ID		further modifies the status code in STC10-2.
	STC11		S					Use this element if a third claim status is needed.
	STC11-1	1271	R		1/30	AN		Health Care Claim Status Category Code
	STC11-2	1271	R		1/30	AN		Health Care Claim Status Code
	STC11-3	1270	S		2/3	ID		further modifies the status code in STC11-2.
2220E	**REF**		**S**	**1**	**Service Line Item Identification**			
	REF01	128	R		3	ID	FJ	Reference Identification Qualifier
	REF02	127	R		1/30	AN		Line Item Control Number
2220E	**DTP**		**S**	**1**	**Service Line Date**			
	DTP01	374	R		3	ID	472	Date/Time Qualifier
	DTP02	1250	R		2/3	ID	D8	Date Time Period Format Qualifier
	DTP03	1251	R		1/35	AN		Service Line Date
TS	**SE**		**R**	**1**	**Transaction Set Trailer**			
	SE01	96	R		1/10	N		Transaction Segment Count
	SE02	329	R		4/9	AN		Transaction Set Control Number (same as ST02)

ANSI 277 STC Code Set

Reference Information

The HIPAA Code Set for the ANSI ASC X12 277 Claim (Bill) Status Response transactions is available through the Washington Publishing Company, www.wpc-edi.com. The code set is below.

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California ANSI 277 STC Codes

Code	Text	Note
0	Cannot provide further status electronically.	
1	For more detailed information, see remittance advice.	
2	More detailed information in letter.	
3	Claim has been adjudicated and is awaiting payment cycle.	
4	This is a subsequent request for information from the original request.	
5	This is a final request for information.	
6	Balance due from the subscriber.	
7	Claim may be reconsidered at a future date.	
8	No payment due to contract/plan provisions.	Note: Inactive as of ASC X12 Version 4020. Refer to 107 for new verbiage.
9	No payment will be made for this claim.	
10	All originally submitted procedure codes have been combined.	Note: Inactive as of ASC X12 Version 4020. Refer to 12 for new verbiage.
11	Some originally submitted procedure codes have been combined.	Note: Inactive as of ASC X12 Version 4020. Refer to 12 for new verbiage.
12	One or more originally submitted procedure codes have been combined.	Note: Changed as of 6/01
13	All originally submitted procedure codes have been modified.	Note: Inactive as of ASC X12 Version 4020. Refer to 15 for new verbiage.
14	Some all originally submitted procedure codes have been modified.	Note: Inactive as of ASC X12 Version 4020. Refer to 15 for new verbiage.
15	One or more originally submitted procedure code have been modified.	Note: Changed as of 6/01
16	Claim/encounter has been forwarded to entity.	
17	Claim/encounter has been forwarded by third party entity to entity.	
18	Entity received claim/encounter, but returned invalid status.	
19	Entity acknowledges receipt of claim/encounter.	Note: Changed as of 6/01
20	Accepted for processing.	Note: Changed as of 6/01
21	Missing or invalid information.	Note: Changed as of 6/01
22	... before entering the adjudication system.	Note: Changed as of 6/01
23	Returned to Entity.	Note: Changed as of 6/01
24	Entity not approved as an electronic submitter.	Note: Changed as of 6/01
25	Entity not approved.	Note: Changed as of 6/01
26	Entity not found.	Note: Changed as of 6/01
27	Policy canceled.	Note: Changed as of 6/01
28	Claim submitted to wrong payer.	Note: Inactive as of ASC X12 Version 4020. Refer to 116 for new verbiage.
29	Subscriber and policy number/contract number mismatched.	
30	Subscriber and subscriber id mismatched.	
31	Subscriber and policyholder name mismatched.	
32	Subscriber and policy number/contract number not found.	
33	Subscriber and subscriber id not found.	
34	Subscriber and policyholder name not found.	
35	Claim/encounter not found.	
37	Predetermination is on file, awaiting completion of services.	
38	Awaiting next periodic adjudication cycle.	
39	Charges for pregnancy deferred until delivery.	
40	Waiting for final approval.	

California ANSI 277 STC Codes

Code	Text	Note
41	Special handling required at payer site.	
42	Awaiting related charges.	
44	Charges pending provider audit.	
45	Awaiting benefit determination.	
46	Internal review/audit.	
47	Internal review/audit - partial payment made.	
48	Referral/authorization.	Note: Changed as of 2/01
49	Pending provider accreditation review.	
50	Claim waiting for internal provider verification.	
51	Investigating occupational illness/accident.	
52	Investigating existence of other insurance coverage.	
53	Claim being researched for Insured ID/Group Policy Number error.	
54	Duplicate of a previously processed claim/line.	
55	Claim assigned to an approver/analyst.	
56	Awaiting eligibility determination.	
57	Pending COBRA information requested.	
59	Non-electronic request for information.	
60	Electronic request for information.	
61	Eligibility for extended benefits.	
64	Re-pricing information.	
65	Claim/line has been paid.	
66	Payment reflects usual and customary charges.	
67	Payment made in full.	
68	Partial payment made for this claim.	
69	Payment reflects plan provisions.	Note: Inactive as of ASC X12 Version 4020. Refer to 107 for new verbiage.
70	Payment reflects contract provisions.	Note: Inactive as of ASC X12 Version 4020. Refer to 107 for new verbiage.
71	Periodic installment released.	
72	Claim contains split payment.	
73	Payment made to entity, assignment of benefits not on file.	
78	Duplicate of an existing claim/line, awaiting processing.	
81	Contract/plan does not cover pre-existing conditions.	
83	No coverage for newborns.	
84	Service not authorized.	
85	Entity not primary.	
86	Diagnosis and patient gender mismatch.	Note: Changed as of 2/00
87	Denied: Entity not found.	
88	Entity not eligible for benefits for submitted dates of service.	
89	Entity not eligible for dental benefits for submitted dates of service.	
90	Entity not eligible for medical benefits for submitted dates of service.	
91	Entity not eligible/not approved for dates of service.	
92	Entity does not meet dependent or student qualification.	
93	Entity is not selected primary care provider.	
94	Entity not referred by selected primary care provider.	
95	Requested additional information not received.	
96	No agreement with entity.	
97	Patient eligibility not found with entity.	

California ANSI 277 STC Codes

Code	Text	Note
98	Charges applied to deductible.	
99	Pre-treatment review.	
100	Pre-certification penalty taken.	
101	Claim was processed as adjustment to previous claim.	
102	Newborn's charges processed on mother's claim.	
103	Claim combined with other claim(s).	
104	Processed according to plan provisions.	
105	Claim/line is capitated.	
106	This amount is not entity's responsibility.	
107	Processed according to contract/plan provisions.	Note: Changed as of 6/01
108	Coverage has been canceled for this entity.	
109	Entity not eligible.	
110	Claim requires pricing information.	
111	At the policyholder's request these claims cannot be submitted electronically.	
112	Policyholder processes their own claims.	
113	Cannot process individual insurance policy claims.	
114	Should be handled by entity.	
115	Cannot process HMO claims	
116	Claim submitted to incorrect payer.	
117	Claim requires signature-on-file indicator.	
118	TPO rejected claim/line because payer name is missing.	
119	TPO rejected claim/line because certification information is missing	
120	TPO rejected claim/line because claim does not contain enough information	
121	Service line number greater than maximum allowable for payer.	
122	Missing/invalid data prevents payer from processing claim.	
123	Additional information requested from entity.	
124	Entity's name, address, phone and id number.	
125	Entity's name.	
126	Entity's address.	
127	Entity's phone number.	
128	Entity's tax id.	
129	Entity's Blue Cross provider id	
130	Entity's Blue Shield provider id	
131	Entity's Medicare provider id.	
132	Entity's Medicaid provider id.	
133	Entity's UPIN	
134	Entity's CHAMPUS provider id.	
135	Entity's commercial provider id.	
136	Entity's health industry id number.	
137	Entity's plan network id.	
138	Entity's site id .	
139	Entity's health maintenance provider id (HMO).	
140	Entity's preferred provider organization id (PPO).	Note: Changed as of 6/01
141	Entity's administrative services organization id (ASO).	
142	Entity's license/certification number.	
143	Entity's state license number.	
144	Entity's specialty license number.	
145	Entity's specialty code.	

California ANSI 277 STC Codes

Code	Text	Note
146	Entity's anesthesia license number.	
147	Entity's qualification degree/designation (e.g. RN, PhD, MD)	Note: New as of 2/97
148	Entity's social security number.	
149	Entity's employer id.	
150	Entity's drug enforcement agency (DEA) number.	
152	Pharmacy processor number.	
153	Entity's id number.	
154	Relationship of surgeon & assistant surgeon.	
155	Entity's relationship to patient	
156	Patient relationship to subscriber	
157	Entity's Gender	
158	Entity's date of birth	
159	Entity's date of death	
160	Entity's marital status	
161	Entity's employment status	
162	Entity's health insurance claim number (HICN).	
163	Entity's policy number.	
164	Entity's contract/member number.	
165	Entity's employer name, address and phone.	
166	Entity's employer name.	
167	Entity's employer address.	
168	Entity's employer phone number.	
169	Entity's employer id.	Note: Inactive for version 004060. Duplicates code 149.
170	Entity's employee id.	
171	Other insurance coverage information (health, liability, auto, etc.).	
172	Other employer name, address and telephone number.	
173	Entity's name, address, phone, gender, DOB, marital status, employment status and relation to subscriber.	Note: Changed as of 2/00
174	Entity's student status.	
175	Entity's school name.	
176	Entity's school address.	
177	Transplant recipient's name, date of birth, gender, relationship to insured.	Note: Changed as of 2/00
178	Submitted charges.	
179	Outside lab charges.	
180	Hospital s semi-private room rate.	
181	Hospital s room rate.	
182	Allowable/paid from primary coverage.	
183	Amount entity has paid.	
184	Purchase price for the rented durable medical equipment.	
185	Rental price for durable medical equipment.	
186	Purchase and rental price of durable medical equipment.	
187	Date(s) of service.	
188	Statement from-through dates.	
189	Hospital admission date.	
190	Hospital discharge date.	
191	Date of Last Menstrual Period (LMP)	Note: New as of 2/97
192	Date of first service for current series/symptom/illness.	

California ANSI 277 STC Codes

Code	Text	Note
193	First consultation/evaluation date.	Note: New as of 2/97
194	Confinement dates.	
195	Unable to work dates.	
196	Return to work dates.	
197	Effective coverage date(s).	
198	Medicare effective date.	
199	Date of conception and expected date of delivery.	
200	Date of equipment return.	
201	Date of dental appliance prior placement.	
202	Date of dental prior replacement/reason for replacement.	
203	Date of dental appliance placed.	
204	Date dental canal(s) opened and date service completed.	
205	Date(s) dental root canal therapy previously performed.	
206	Most recent date of curettage, root planing, or periodontal surgery.	
207	Dental impression and seating date.	
208	Most recent date pacemaker was implanted.	
209	Most recent pacemaker battery change date.	
210	Date of the last x-ray.	
211	Date(s) of dialysis training provided to patient.	
212	Date of last routine dialysis.	
213	Date of first routine dialysis.	
214	Original date of prescription/orders/referral.	Note: New as of 2/97
215	Date of tooth extraction/evolution.	
216	Drug information.	
217	Drug name, strength and dosage form.	
218	NDC number.	
219	Prescription number.	
220	Drug product id number.	
221	Drug days supply and dosage.	
222	Drug dispensing units and average wholesale price (AWP).	
223	Route of drug/myelogram administration.	
224	Anatomical location for joint injection.	
225	Anatomical location.	
226	Joint injection site.	
227	Hospital information.	
228	Type of bill for UB-92 claim.	Note: Changed as of 6/01
229	Hospital admission source.	
230	Hospital admission hour.	
231	Hospital admission type.	
232	Admitting diagnosis.	
233	Hospital discharge hour.	
234	Patient discharge status.	
235	Units of blood furnished.	
236	Units of blood replaced.	
237	Units of deductible blood.	
238	Separate claim for mother/baby charges.	
239	Dental information.	
240	Tooth surface(s) involved.	
241	List of all missing teeth (upper and lower).	

California ANSI 277 STC Codes

Code	Text	Note
242	Tooth numbers, surfaces, and/or quadrants involved.	
243	Months of dental treatment remaining.	
244	Tooth number or letter.	
245	Dental quadrant/arch.	
246	Total orthodontic service fee, initial appliance fee, monthly fee, length of service.	
247	Line information.	
248	Accident date, state, description and cause.	
249	Place of service.	
250	Type of service.	
251	Total anesthesia minutes.	
252	Authorization/certification number.	
253	Procedure/revenue code for service(s) rendered. Please use codes 454 or 455.	Note: Deleted as of 2/97
254	Primary diagnosis code.	
255	Diagnosis code.	
256	DRG code(s).	
257	ADSM-III-R code for services rendered.	
258	Days/units for procedure/revenue code.	
259	Frequency of service.	
260	Length of medical necessity, including begin date.	Note: New as of 2/97
261	Obesity measurements.	
262	Type of surgery/service for which anesthesia was administered.	
263	Length of time for services rendered.	
264	Number of liters/minute & total hours/day for respiratory support.	
265	Number of lesions excised.	
266	Facility point of origin and destination - ambulance.	
267	Number of miles patient was transported.	
268	Location of durable medical equipment use.	
269	Length/size of laceration/tumor.	
270	Subluxation location.	
271	Number of spine segments.	
272	Oxygen contents for oxygen system rental.	
273	Weight.	
274	Height.	
275	Claim.	
276	UB-92/HCFA-1450/HCFA-1500 claim form.	Note: Changed as of 6/01
277	Paper claim.	
278	Signed claim form.	
279	Itemized claim.	
280	Itemized claim by provider.	
281	Related confinement claim.	
282	Copy of prescription.	
283	Medicare worksheet.	
284	Copy of Medicare ID card.	
285	Vouchers/explanation of benefits (EOB).	
286	Other payer's Explanation of Benefits/payment information.	
287	Medical necessity for service.	
288	Reason for late hospital charges.	

California ANSI 277 STC Codes

Code	Text	Note
289	Reason for late discharge.	
290	Pre-existing information.	
291	Reason for termination of pregnancy.	
292	Purpose of family conference/therapy.	
293	Reason for physical therapy.	
294	Supporting documentation.	
295	Attending physician report.	
296	Nurse's notes.	
297	Medical notes/report.	Note: New as of 2/97
298	Operative report.	
299	Emergency room notes/report.	
300	Lab/test report/notes/results.	Note: New as of 2/97
301	MRI report.	
302	Refer to codes 300 for lab notes and 311 for pathology notes	Note: Removed prior to 2/97
303	Physical therapy notes. Please use code 297:6O (6 'OH' - not zero)	Note: Deleted as of 2/97
304	Reports for service.	
305	X-ray reports/interpretation.	
306	Detailed description of service.	
307	Narrative with pocket depth chart.	
308	Discharge summary.	
309	Code was duplicate of code 299	Note: Removed prior to 2/97
310	Progress notes for the six months prior to statement date.	
311	Pathology notes/report.	
312	Dental charting.	
313	Bridgework information.	
314	Dental records for this service.	
315	Past perio treatment history.	
316	Complete medical history.	
317	Patient's medical records.	
318	X-rays.	
319	Pre/post-operative x-rays/photographs.	Note: New as of 2/97
320	Study models.	
321	Radiographs or models.	
322	Recent fm x-rays.	
323	Study models, x-rays, and/or narrative.	
324	Recent x-ray of treatment area and/or narrative.	
325	Recent fm x-rays and/or narrative.	
326	Copy of transplant acquisition invoice.	
327	Periodontal case type diagnosis and recent pocket depth chart with narrative.	
328	Speech therapy notes. Please use code 297:6R	Note: Deleted as of 2/97
329	Exercise notes.	
330	Occupational notes.	
331	History and physical.	
332	Authorization/certification (include period covered).	Note: New as of 2/97
333	Patient release of information authorization.	
334	Oxygen certification.	

California ANSI 277 STC Codes

Code	Text	Note
335	Durable medical equipment certification.	
336	Chiropractic certification.	
337	Ambulance certification/documentation.	
338	Home health certification. Please use code 332:4Y	Note: Deleted as of 2/97
339	Enteral/parenteral certification.	
340	Pacemaker certification.	
341	Private duty nursing certification.	
342	Podiatric certification.	
343	Documentation that facility is state licensed and Medicare approved as a surgical facility.	
344	Documentation that provider of physical therapy is Medicare Part B approved.	
345	Treatment plan for service/diagnosis	
346	Proposed treatment plan for next 6 months.	
347	Refer to code 345 for treatment plan and code 282 for prescription	Note: Removed prior to 2/97
348	Chiropractic treatment plan.	
349	Psychiatric treatment plan. Please use codes 345:5I, 5J, 5K, 5L, 5M, 5N, 5O (5 'OH' - not zero), 5P	Note: Deleted as of 2/97
350	Speech pathology treatment plan. Please use code 345:6R	Note: Deleted as of 2/97
351	Physical/occupational therapy treatment plan. Please use codes 345:6O (6 'OH' - not zero), 6N	Note: Deleted as of 2/97
352	Duration of treatment plan.	
353	Orthodontics treatment plan.	
354	Treatment plan for replacement of remaining missing teeth.	
355	Has claim been paid?	
356	Was blood furnished?	
357	Has or will blood be replaced?	
358	Does provider accept assignment of benefits?	
359	Is there a release of information signature on file?	
360	Is there an assignment of benefits signature on file?	
361	Is there other insurance?	
362	Is the dental patient covered by medical insurance?	
363	Will worker's compensation cover submitted charges?	
364	Is accident/illness/condition employment related?	
365	Is service the result of an accident?	
366	Is injury due to auto accident?	
367	Is service performed for a recurring condition or new condition?	
368	Is medical doctor (MD) or doctor of osteopath (DO) on staff of this facility?	
369	Does patient condition preclude use of ordinary bed?	
370	Can patient operate controls of bed?	
371	Is patient confined to room?	
372	Is patient confined to bed?	
373	Is patient an insulin diabetic?	
374	Is prescribed lenses a result of cataract surgery?	
375	Was refraction performed?	
376	Was charge for ambulance for a round-trip?	

California ANSI 277 STC Codes

Code	Text	Note
377	Was durable medical equipment purchased new or used?	
378	Is pacemaker temporary or permanent?	
379	Were services performed supervised by a physician?	
380	Were services performed by a CRNA under appropriate medical direction?	Note: Changed as of 10/99
381	Is drug generic?	
382	Did provider authorize generic or brand name dispensing?	
383	Was nerve block used for surgical procedure or pain management?	
384	Is prosthesis/crown/inlay placement an initial placement or a replacement?	
385	Is appliance upper or lower arch & is appliance fixed or removable?	
386	Is service for orthodontic purposes?	
387	Date patient last examined by entity	Note: New as of 2/97
388	Date post-operative care assumed	Note: New as of 2/97
389	Date post-operative care relinquished	Note: New as of 2/97
390	Date of most recent medical event necessitating service(s)	Note: New as of 2/97
391	Date(s) dialysis conducted	Note: New as of 2/97
392	Date(s) of blood transfusion(s)	Note: New as of 2/97
393	Date of previous pacemaker check	Note: New as of 2/97
394	Date(s) of most recent hospitalization related to service	Note: New as of 2/97
395	Date entity signed certification/recertification	Note: New as of 2/97
396	Date home dialysis began	Note: New as of 2/97
397	Date of onset/exacerbation of illness/condition	Note: New as of 2/97
398	Visual field test results	Note: New as of 2/97
399	Report of prior testing related to this service, including dates	Note: New as of 2/97
400	Claim is out of balance	Note: New as of 2/97
401	Source of payment is not valid	Note: New as of 2/97
402	Amount must be greater than zero	Note: New as of 2/97
403	Entity referral notes/orders/prescription	Note: New as of 2/97
404	Specific findings, complaints, or symptoms necessitating service	Note: New as of 2/97
405	Summary of services	Note: New as of 2/97
406	Brief medical history as related to service(s)	Note: New as of 2/97
407	Complications/mitigating circumstances	Note: New as of 2/97
408	Initial certification	Note: New as of 2/97
409	Medication logs/records (including medication therapy)	Note: New as of 2/97
410	Explain differences between treatment plan and patient's condition	Note: New as of 2/97
411	Medical necessity for non-routine service(s)	Note: New as of 2/97
412	Medical records to substantiate decision of non-coverage	Note: New as of 2/97
413	Explain/justify differences between treatment plan and services rendered.	Note: New as of 2/97
414	Need for more than one physician to treat patient	Note: New as of 2/97
415	Justify services outside composite rate	Note: New as of 2/97

California ANSI 277 STC Codes

Code	Text	Note
416	Verification of patient's ability to retain and use information	Note: New as of 2/97
417	Prior testing, including result(s) and date(s) as related to service(s)	Note: New as of 2/97
418	Indicating why medications cannot be taken orally	Note: New as of 2/97
419	Individual test(s) comprising the panel and the charges for each test	Note: New as of 2/97
420	Name, dosage and medical justification of contrast material used for radiology procedure	Note: New as of 2/97
421	Medical review attachment/information for service(s)	Note: New as of 2/97
422	Homebound status	Note: New as of 2/97
423	Prognosis	Note: Inactive for 004030, since 10/99. LOINC codes have the ability to ask for prognosis.
424	Statement of non-coverage including itemized bill	Note: New as of 2/97
425	Itemize non-covered services	Note: New as of 2/97
426	All current diagnoses	Note: New as of 2/97
427	Emergency care provided during transport	Note: New as of 2/97
428	Reason for transport by ambulance	Note: New as of 2/97
429	Loaded miles and charges for transport to nearest facility with appropriate services	Note: New as of 2/97
430	Nearest appropriate facility	Note: New as of 2/97
431	Provide condition/functional status at time of service	Note: New as of 2/97
432	Date benefits exhausted	Note: New as of 2/97
433	Copy of patient revocation of hospice benefits	Note: New as of 2/97
434	Reasons for more than one transfer per entitlement period	Note: New as of 2/97
435	Notice of Admission	Note: New as of 2/97
436	Short term goals	Note: New as of 2/97
437	Long term goals	Note: New as of 2/97
438	Number of patients attending session	Note: New as of 2/97
439	Size, depth, amount, and type of drainage wounds	Note: New as of 2/97
440	why non-skilled caregiver has not been taught procedure	Note: New as of 2/97
441	Entity professional qualification for service(s)	Note: New as of 2/97
442	Modalities of service	Note: New as of 2/97
443	Initial evaluation report	Note: New as of 2/97
444	Method used to obtain test sample	Note: New as of 2/97
445	Explain why hearing loss not correctable by hearing aid	Note: New as of 2/97
446	Documentation from prior claim(s) related to service(s)	Note: New as of 2/97
447	Plan of teaching	Note: New as of 2/97
448	Invalid billing combination. See STC12 for details. This code should only be used to indicate an inconsistency between two or more data elements on the claim. A detailed explanation is required in STC12 when this code is used.	Note: New as of 2/97
449	Projected date to discontinue service(s)	Note: New as of 2/97
450	Awaiting spend down determination	Note: New as of 2/97
451	Preoperative and post-operative diagnosis	Note: New as of 2/97
452	Total visits in total number of hours/day and total number of hours/week	Note: New as of 2/97
453	Procedure Code Modifier(s) for Service(s) Rendered	Note: New as of 2/97
454	Procedure code for services rendered.	Note: New as of 2/97

California ANSI 277 STC Codes

Code	Text	Note
455	Revenue code for services rendered.	Note: New as of 2/97
456	Covered Day(s)	Note: New as of 2/97
457	Non-Covered Day(s)	Note: New as of 2/97
458	Coinsurance Day(s)	Note: New as of 2/97
459	Lifetime Reserve Day(s)	Note: New as of 2/97
460	NUBC Condition Code(s)	Note: New as of 2/97
461	NUBC Occurrence Code(s) and Date(s)	Note: New as of 2/97
462	NUBC Occurrence Span Code(s) and Date(s)	Note: New as of 2/97
463	NUBC Value Code(s) and/or Amount(s)	Note: New as of 2/97
464	Payer Assigned Claim Control Number	Note: New as of 2/97, Changed as of 10/04
465	Principal Procedure Code for Service(s) Rendered	Note: New as of 2/97
466	Entities Original Signature	Note: New as of 2/97
467	Entity Signature Date	Note: New as of 2/97
468	Patient Signature Source	Note: New as of 2/97
469	Purchase Service Charge	Note: New as of 2/97
470	Was service purchased from another entity?	Note: New as of 2/97
471	Were services related to an emergency?	Note: New as of 2/97
472	Ambulance Run Sheet	Note: New as of 2/97
473	Missing or invalid lab indicator	Note: New as of 6/98
474	Procedure code and patient gender mismatch	Note: Changed as of 2/00
475	Procedure code not valid for patient age	Note: Changed as of 2/00
476	Missing or invalid units of service	Note: New as of 6/98
477	Diagnosis code pointer is missing or invalid	Note: New as of 6/98
478	Claim submitter's identifier (patient account number) is missing	Note: New as of 6/98
479	Other Carrier payer ID is missing or invalid	Note: New as of 6/98
480	Other Carrier Claim filing indicator is missing or invalid	Note: New as of 6/98
481	Claim/submission format is invalid.	Note: New as of 10/98
482	Date Error, Century Missing	Note: New as of 2/99
483	Maximum coverage amount met or exceeded for benefit period.	Note: New as of 6/99
484	Business Application Currently Not Available	Note: New as of 2/00
485	More information available than can be returned in real time mode. Narrow your current search criteria.	Note: New as of 2/01
486	Principle Procedure Date	Note: New as of 10/01
487	Claim not found, claim should have been submitted to/through 'entity'	Note: New as of 2/02
488	Diagnosis code(s) for the services rendered.	Note: New as of 6/02
489	Attachment Control Number	Note: New as of 10/02
490	Other Procedure Code for Service(s) Rendered	Note: New as of 2/03
491	Entity not eligible for encounter submission	Note: New as of 2/03
492	Other Procedure Date	Note: New as of 2/03
493	Version/Release/Industry ID code not currently supported by information holder	Note: New as of 2/03
494	Real-Time requests not supported by the information holder, resubmit as batch request	Note: New as of 2/03
495	Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and re-submit.	Note: New as of 9/03

California ANSI 277 STC Codes

Code	Text	Note
496	Submitter not approved for electronic claim submissions on behalf of this entity	Note: New as of 2/04
497	Sales tax not paid	Note: New as of 6/04
498	Maximum leave days exhausted	Note: New as of 6/04
499	No rate on file with the payer for this service for this entity	Note: New as of 6/04
500	Entity's Postal/Zip Code	Note: New as of 6/04
501	Entity's State/Province	Note: New as of 6/04
502	Entity's City	Note: New as of 6/04
503	Entity's Street Address	Note: New as of 6/04
504	Entity's Last Name	Note: New as of 6/04
505	Entity's First Name	Note: New as of 6/04
506	Entity is changing processor/clearinghouse. This claim must be submitted to the new processor/clearinghouse	Note: New as of 6/04
507	HCPCS	Note: New as of 10/04
508	ICD9	Note: New as of 10/04
509	E-Code	Note: New as of 10/04
510	Future date	Note: New as of 10/04
511	Invalid character	Note: New as of 10/04
512	Length invalid for receiver's application system	Note: New as of 10/04
513	HIPPS Rate Code for services Rendered	Note: New as of 10/04
514	Entities Middle Name	Note: New as of 10/04
515	Managed Care review	Note: New as of 10/04
516	Adjudication or Payment Date	Note: New as of 10/04
517	Adjusted Repriced Claim Reference Number	Note: New as of 10/04
518	Adjusted Repriced Line item Reference Number	Note: New as of 10/04
519	Adjustment Amount	Note: New as of 10/04
520	Adjustment Quantity	Note: New as of 10/04
521	Adjustment Reason Code	Note: New as of 10/04
522	Anesthesia Modifying Units	Note: New as of 10/04
523	Anesthesia Unit Count	Note: New as of 10/04
524	Arterial Blood Gas Quantity	Note: New as of 10/04
525	Begin Therapy Date	Note: New as of 10/04
526	Bundled or Unbundled Line Number	Note: New as of 10/04
527	Certification Condition Indicator	Note: New as of 10/04
528	Certification Period Projected Visit Count	Note: New as of 10/04
529	Certification Revision Date	Note: New as of 10/04
530	Claim Adjustment Indicator	Note: New as of 10/04
531	Claim Disproportionate Share Amount	Note: New as of 10/04
532	Claim DRG Amount	Note: New as of 10/04
533	Claim DRG Outlier Amount	Note: New as of 10/04
534	Claim ESRD Payment Amount	Note: New as of 10/04
535	Claim Frequency Code	Note: New as of 10/04
536	Claim Indirect Teaching Amount	Note: New as of 10/04
537	Claim MSP Pass-through Amount	Note: New as of 10/04
538	Claim or Encounter Identifier	Note: New as of 10/04
539	Claim PPS Capital Amount	Note: New as of 10/04
540	Claim PPS Capital Outlier Amount	Note: New as of 10/04
541	Claim Submission Reason Code	Note: New as of 10/04

California ANSI 277 STC Codes

Code	Text	Note
542	Claim Total Denied Charge Amount	Note: New as of 10/04
543	Clearinghouse or Value Added Network Trace	Note: New as of 10/04
544	Clinical Laboratory Improvement Amendment	Note: New as of 10/04
545	Contract Amount	Note: New as of 10/04
546	Contract Code	Note: New as of 10/04
547	Contract Percentage	Note: New as of 10/04
548	Contract Type Code	Note: New as of 10/04
549	Contract Version Identifier	Note: New as of 10/04
550	Coordination of Benefits Code	Note: New as of 10/04
551	Coordination of Benefits Total Submitted Charge	Note: New as of 10/04
552	Cost Report Day Count	Note: New as of 10/04
553	Covered Amount	Note: New as of 10/04
554	Date Claim Paid	Note: New as of 10/04
555	Delay Reason Code	Note: New as of 10/04
556	Demonstration Project Identifier	Note: New as of 10/04
557	Diagnosis Date	Note: New as of 10/04
558	Discount Amount	Note: New as of 10/04
559	Document Control Identifier	Note: New as of 10/04
560	Entity's Additional/Secondary Identifier	Note: New as of 10/04
561	Entity's Contact Name	Note: New as of 10/04
562	Entity's National Provider Identifier (NPI)	Note: New as of 10/04
563	Entity's Tax Amount	Note: New as of 10/04
564	EPSDT Indicator	Note: New as of 10/04
565	Estimated Claim Due Amount	Note: New as of 10/04
566	Exception Code	Note: New as of 10/04
567	Facility Code Qualifier	Note: New as of 10/04
568	Family Planning Indicator	Note: New as of 10/04
569	Fixed Format Information	Note: New as of 10/04
570	Free Form Message Text	Note: New as of 10/04
571	Frequency Count	Note: New as of 10/04
572	Frequency Period	Note: New as of 10/04
573	Functional Limitation Code	Note: New as of 10/04
574	HCPCS Payable Amount Home Health	Note: New as of 10/04
575	Homebound Indicator	Note: New as of 10/04
576	Immunization Batch Number	Note: New as of 10/04
577	Industry Code	Note: New as of 10/04
578	Insurance Type Code	Note: New as of 10/04
579	Investigational Device Exemption Identifier	Note: New as of 10/04
580	Last Certification Date	Note: New as of 10/04
581	Last Worked Date	Note: New as of 10/04
582	Lifetime Psychiatric Days Count	Note: New as of 10/04
583	Line Item Charge Amount	Note: New as of 10/04
584	Line Item Control Number	Note: New as of 10/04
585	Line Item Denied Charge or Non-covered Charge	Note: New as of 10/04
586	Line Note Text	Note: New as of 10/04
587	Measurement Reference Identification Code	Note: New as of 10/04
588	Medical Record Number	Note: New as of 10/04
589	Medicare Assignment Code	Note: New as of 10/04
590	Medicare Coverage Indicator	Note: New as of 10/04

California ANSI 277 STC Codes

Code	Text	Note
591	Medicare Paid at 100% Amount	Note: New as of 10/04
592	Medicare Paid at 80% Amount	Note: New as of 10/04
593	Medicare Section 4081 Indicator	Note: New as of 10/04
594	Mental Status Code	Note: New as of 10/04
595	Monthly Treatment Count	Note: New as of 10/04
596	Non-covered Charge Amount	Note: New as of 10/04
597	Non-payable Professional Component Amount	Note: New as of 10/04
598	Non-payable Professional Component Billed Amount	Note: New as of 10/04
599	Note Reference Code	Note: New as of 10/04
600	Oxygen Saturation Qty	Note: New as of 10/04
601	Oxygen Test Condition Code	Note: New as of 10/04
602	Oxygen Test Date	Note: New as of 10/04
603	Old Capital Amount	Note: New as of 10/04
604	Originator Application Transaction Identifier	Note: New as of 10/04
605	Orthodontic Treatment Months Count	Note: New as of 10/04
606	Paid From Part A Medicare Trust Fund Amount	Note: New as of 10/04
607	Paid From Part B Medicare Trust Fund Amount	Note: New as of 10/04
608	Paid Service Unit Count	Note: New as of 10/04
609	Participation Agreement	Note: New as of 10/04
610	Patient Discharge Facility Type Code	Note: New as of 10/04
611	Peer Review Authorization Number	Note: New as of 10/04
612	Per Day Limit Amount	Note: New as of 10/04
613	Physician Contact Date	Note: New as of 10/04
614	Physician Order Date	Note: New as of 10/04
615	Policy Compliance Code	Note: New as of 10/04
616	Policy Name	Note: New as of 10/04
617	Postage Claimed Amount	Note: New as of 10/04
618	PPS-Capital DSH DRG Amount	Note: New as of 10/04
619	PPS-Capital Exception Amount	Note: New as of 10/04
620	PPS-Capital FSP DRG Amount	Note: New as of 10/04
621	PPS-Capital HSP DRG Amount	Note: New as of 10/04
622	PPS-Capital IME Amount	Note: New as of 10/04
623	PPS-Operating Federal Specific DRG Amount	Note: New as of 10/04
624	PPS-Operating Hospital Specific DRG Amount	Note: New as of 10/04
625	Predetermination of Benefits Identifier	Note: New as of 10/04
626	Pregnancy Indicator	Note: New as of 10/04
627	Pre-Tax Claim Amount	Note: New as of 10/04
628	Pricing Methodology	Note: New as of 10/04
629	Property Casualty Claim Number	Note: New as of 10/04
630	Referring CLIA Number	Note: New as of 10/04
631	Reimbursement Rate	Note: New as of 10/04
632	Reject Reason Code	Note: New as of 10/04
633	Related Causes Code	Note: New as of 10/04
634	Remark Code	Note: New as of 10/04
635	Repriced Approved Ambulatory Patient Group	Note: New as of 10/04
636	Repriced Line Item Reference Number	Note: New as of 10/04
637	Repriced Saving Amount	Note: New as of 10/04
638	Repricing Per Diem or Flat Rate Amount	Note: New as of 10/04
639	Responsibility Amount	Note: New as of 10/04

California ANSI 277 STC Codes

Code	Text	Note
640	Sales Tax Amount	Note: New as of 10/04
641	Service Adjudication or Payment Date	Note: New as of 10/04
642	Service Authorization Exception Code	Note: New as of 10/04
643	Service Line Paid Amount	Note: New as of 10/04
644	Service Line Rate	Note: New as of 10/04
645	Service Tax Amount	Note: New as of 10/04
646	Ship, Delivery or Calendar Pattern Code	Note: New as of 10/04
647	Shipped Date	Note: New as of 10/04
648	Similar Illness or Symptom Date	Note: New as of 10/04
649	Skilled Nursing Facility Indicator	Note: New as of 10/04
650	Special Program Indicator	Note: New as of 10/04
651	State Industrial Accident Provider Number	Note: New as of 10/04
652	Terms Discount Percentage	Note: New as of 10/04
653	Test Performed Date	Note: New as of 10/04
654	Total Denied Charge Amount	Note: New as of 10/04
655	Total Medicare Paid Amount	Note: New as of 10/04
656	Total Visits Projected This Certification Count	Note: New as of 10/04
657	Total Visits Rendered Count	Note: New as of 10/04
658	Treatment Code	Note: New as of 10/04
659	Unit or Basis for Measurement Code	Note: New as of 10/04
660	Universal Product Number	Note: New as of 10/04
661	Visits Prior to Recertification Date Count CR702	Note: New as of 10/04
662	X-ray Availability Indicator	Note: New as of 10/04
663	Entity's Group Name	Note: New as of 10/04
664	Orthodontic Banding Date	Note: New as of 10/04
665	Surgery Date	Note: New as of 10/04
666	Surgical Procedure Code	Note: New as of 10/04
667	Real-Time requests not supported by the information holder, do not resubmit	Note: New as of 2/05
668	Missing Endodontics treatment history and prognosis	Note: New as of 6/05
669	Dental service narrative needed.	Note: New as of 10/05
670	Funds applied from a Health Savings Account (HSA) for this claim	Note: New as of 6/06
671	Funds may be available from a Health Savings Account (HSA) for this claim	Note: New as of 6/06

Appendix B – ANSI Claim Adjustment Reason Codes

Claim Adjustment Group Code

The Division has defined the specific set of ANSI Claim Adjustment Group Codes that can be used in the ANSI 835 format. These definitions can be found in the DWC ANSI Matrix Crosswalk in Appendix B of Section One of the Medical Billing and Payment Guide. The ANSI Group Code represents the general category of payment, reduction, or denial. For example, the ANSI Group Code "CO" Contractual Obligation might be used in conjunction with an ANSI Claims Adjustment Reason Code for a network contract reduction.

The Division specified ANSI Group Code transmitted in the ANSI 835 is the same code that is transmitted in the IAIABC 837 Medical EDI reporting format. The Division accepts specified ANSI Group Codes that are valid on the date the Claims Administrator paid, denied, or acknowledged receipt of a refund.

HIPAA Gap Analysis Claim Adjustment Group Code

The Claim Adjustment Group Code MA is not an active ANSI Claim Adjustment Group Code and is identified in the HIPAA Workers' Compensation Gap Analysis. The Division requires the use of four specific Claim Adjustment Group Codes: (1) CO Contractual Obligation, (2) MA Jurisdictional Regulatory (3) OA Other Adjustment (4) PI Payer Initiated Reduction. The Division requires the use of the IAIABC 837 Implementation Guide Release 1 for Medical EDI reporting. The IAIABC 837 Release 1 uses the inactive ANSI Group Code "MA" for Medical EDI State Reporting. The California Electronic Bill rules are aligned to support the IAIABC 837 Medical EDI State Reporting Requirements.

Reference Information

The California workers' compensation direction for the use of the ANSI Claim Adjustment Group Code is found in the DWC ANSI Matrix Crosswalk in Appendix B of Section One of the Medical Billing and Payment Guide.

The ASC X12 Claim Adjustment Status Code Committee maintains ANSI Claim Adjustment Group Codes and ANSI Claim Adjustment Reason Codes sets adopted by HIPAA. The current code sets are available from the Washington Publishing Company, http://www.wpc-edi.com/codes/claimadjustment.

Claim Adjustment Reason Code

Labor Code 4603.2 (b) (1) (B) requires Claims Administrators to provide an explanation of items being contested in the "manner prescribed by the administrative director." This process is described in the Medical Billing and Payment Guide, Appendix B. The ANSI 835 requires the use of ANSI code as the electronic means of providing specific payment, reduction, or denial information. The Division requires specific ANSI Claim Adjustment Reason Codes in conjunction with specified ANSI Group Codes in the ANSI 835 format. As a result, use of the ANSI 835 eliminates the use of proprietary reduction codes and free form text used on paper Explanations of Review (EOR). Accordingly, Claims Administrators that provide the specified Division ANSI 835 Claim Adjustment Reason Code information in the transmission are compliant with the Medical Billing and Payment Guide.

Reference Information

The California workers' compensation direction for the use of the ANSI Claim Adjustment Reason Code is following this section in the DWC ANSI Matrix Crosswalk instructions.

The ASC X12 Claim Adjustment Status Code Committee maintains ANSI Claim Adjustment Group Codes and ANSI Claim Adjustment Reason Codes sets adopted by HIPAA. The current code sets are available from the Washington Publishing Company, http://www.wpc-edi.com/codes/claimadjustment.

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Remittance Remark Codes

The ANSI 835 format supports the use of specific ANSI Remittance Advice Remark Codes that also includes jurisdictional codes (WC1 –WC43) to provide supplemental explanation for a payment, reduction or denial already described by an ANSI Reason Code. The use of ANSI Remark Codes is not mandated, however it is strongly advised that Remittance Remark Codes be used with the Claims Adjustment Reason Codes as appropriate, to further clarify reasons for payment, reduction or denial. As a result, the use of the ANSI 835 eliminates the use of proprietary reduction codes and free form text used on paper Explanation of Review (EOR) forms. ANSI Remark Codes are not associated with an ANSI Group or Reason Code in the same manner that an ANSI Reason Code is associated with an ANSI Group Code.

HIPAA Gap Analysis Claim Adjustment Reason and Remittance Remark Codes

Workers' Compensation requires additional Claims Adjustment Reason and Remittance Remark Codes that are not present in the HIPAA Code sets. The jurisdictional Claims Adjustment Reason Codes (W2-W26) and Remittance Remark Codes (WC1-WC43) are defined in the following sections. California and Texas are coordinating with the IAIABC in working with the ANSI X12 Committee to adopt the jurisdictional Claim Adjustment and Remittance Remark Codes.

Reference Information

The California workers' compensation direction for the use of the ANSI Claim Adjustment Reason Code and Remittance Remark Codes follows this section under DWC ANSI Matrix Crosswalk instructions.

The ASC X12 Claim Adjustment Status Code Committee maintains ANSI Claim Adjustment Group Codes, ANSI Claim Adjustment Reason Codes and Remittance Remark Code sets adopted by HIPAA. The current code sets are available from the Washington Publishing Company, http://www.wpc-edi.com/codes/claimadjustment

DWC ANSI Matrix Crosswalk Instructions

The DWC ANSI Matrix Crosswalk maps the DWC Bill Adjustment Reason Codes to the ANSI Claim Adjustment Group Codes, ANSI /Jurisdictional Claim Adjustment Reason Codes, and ANSI/ Jurisdictional Remittance Advice Remark Codes. The use of ANSI Remark Codes is not mandated, however it is strongly advised that Remittance Remark Codes be used with the Claims Adjustment Reason Codes as appropriate, to further clarify reasons for payment, reduction or denial. These are the only acceptable ANSI/ Jurisdictional code sets to be used for California Workers' Compensation purposes unless there is a written contract agreed to by the parties specifying something different. The following table is divided into sections that correspond with the different fee schedules or sections of fee schedules being used for medical billing. General explanations may be used for any section, but the section specific codes should only be used for bills being submitted under that section.

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DWC ANSI Matrix Crosswalk

California DWC ANSI Matrix Crosswalk

	I. General Explanations							
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
G1	Provider's charge exceeds fee schedule allowance.	The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.		MA	W1	Workers Compensation State Fee Schedule Adjustment	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
G2	The OMFS does not include a code for the billed service.	The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service	Indicate code for comparable service.	OA	W13 *	The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service		
G3	The OMFS does not list the code for the billed service	The Official Medical Fee Schedule does not list this code. No payment is being made at this time. Please resubmit your claim with the OMFS code(s) that best describe the service(s) provided and your supporting documentation.		PI	W14*	The Fee Schedule does not list this code. No payment is being made at this time. Please resubmit your claim with the fee schedule code(s) that best describe the service(s) provided and your supporting documentation.		

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G4	Billed charges exceed amount identified in your contract.	This charge was adjusted to comply with the rate and rules of the contract indicated.	Requires name of specific contractual agreement from which the reimbursement rate and/or payment rules were derived.	CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
G5	No standard EOR message applies.	This charge was adjusted for the reasons set forth in the attached letter.	Message to be used when **no** standard EOR message applies and additional communication is required to provide clear and concise reason(s) for adjustment/denial.	PI	W15*	This charge was adjusted for the reasons set forth in correspondence to follow	M118	Alert: Letter to follow containing further information.
G6	No standard EOR message applies.	This charge was adjusted for the reasons set forth in the message below.	Message to be used when **no** standard EOR message applies and additional communication is required to provide clear and concise reason(s) for adjustment/denial.	PI	No mapping		Not Applicable for 835 Transaction	
G7	Provider charges for service that has no value.	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.		MA	W16*	According to the Fee Schedule this service has a relative value of zero and therefore no payment is due.		

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G8	Provider bills for a service included within the value of another.	No separate payment was made because the value of the service is included within the value of another service performed on the same day.	Requires identification of the specific payment policy or rules applied. For example: CPT coding guidelines, CCI Edits, fee schedule ground rules.	MA	W24*	No separate payment was made because the value of the service is included within the value of another service performed on the same day.		
G9	Provider billed for a separate procedure that is included in the total service rendered.	A charge was made for a "separate procedure" that does not meet the criteria for separate payment. See OMFS General Instructions for Separate Procedures rule.		MA	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
G10	Provider submitted bill with no supporting documentation.	No documentation of unlisted or "by report" BR code was received with the billing for this service. Please resubmit your bill with the appropriate supporting documentation. See OMFS General Instructions for Procedures Without Unit Values.		MA	16	Claim/service lacks information which is needed for adjudication.	WC1*	No documentation of unlisted or "by report" BR code was received with the billing for this service. Please resubmit your bill with the appropriate supporting documentation. See Fee Schedule General Instructions for Procedures Without Unit Values.

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (Jurisdictional code)	ANSI Remittance Remark Code Description
G11	Provider's billing lacks sufficient identification or documentation for the unlisted or BR service reported.	The unlisted or BR service was not sufficiently identified or documented. We are unable to make a payment without supplementary documentation giving a clearer description of the service. See OMFS General Instructions for Procedures Without Unit Values.	If you have need for a specific document, indicate it along with this EOR.	PI	16	Claim/service lacks information which is needed for adjudication.	WC2*	The unlisted or BR service was not sufficiently identified or documented. We are unable to make a payment without supplementary documentation giving a clearer description of the service. See Fee Schedule General Instructions for Procedures Without Unit Values.
							M29	Missing operative report.
							M30	Missing pathology report.
							M31	Missing radiology report.
G12	Provider's documentation does not support level service billed.	The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.	Indicate alternate OMFS code on which payment amount is based.	PI	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	WC3*	The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.
G13	Provider bills for service that is not related to the diagnosis.	This service appears to be unrelated to the patient's diagnosis.		OA	11	The diagnosis is inconsistent with the procedure.		

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G14	Provider bills a duplicate charge.	This appears to be a duplicate charge. This charge has been previously reviewed.	Indicate date original charge was reviewed for payment.	OA	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.
G15	Service or procedure requires prior authorization and none was identified.	This service requires prior authorization and none was identified.		PI	197	Payment adjusted for absence of precertification/ authorization.	WC4*	This service requires prior authorization and none was identified.
G16	Provider bills separately for report included as part of another service.	Reimbursement for this report is included with other services provided on the same day; therefore a separate payment is not warranted.	Message shall not be used to deny separately reimbursable special and/or duplicate reports requested by the payer.	OA	W17*	Reimbursement for this report is included with other services provided on the same day; therefore a separate payment is not warranted.		
G17	Provider bills inappropriate modifier code.	The appended modifier code is not appropriate with the service billed.	If modifier is incorrect, billed OMFS code should still be considered for payment either without use of the modifier or with adjustment by the reviewer to the correct modifier, when the service is otherwise payable. Indicate alternative modifier if assigned.	OA	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G18	Billing is for a service unrelated to the work illness or injury.	Payment for this service has been denied because it appears to be unrelated to the claimed work illness or injury.		PI	191	Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation carrier.		
G19	Billed code is not supported by documentation provided.	The code billed does not accurately represent the service described in the documentation received with the bill. Reimbursement was made for a service that is supported by the documentation submitted with the billing.	Indicate alternative OMFS code that best describes the service or procedure used to adjust the bill.	PI	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	N22	This procedure code was added/changed because it more accurately describes the services rendered.
G20	Provider did not document the service that was performed.-	The charge was denied as the report/documentation does not indicate that the service was performed.		PI	W18*	The charge was denied as the report/documentation does not indicate that the service was performed.		

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G21	Provider inappropriately billed for emergency services.	Reimbursement was made for a follow-up visit, as the documentation did not reflect an emergency.	For use in cases where the emergency physician directs the patient to return to the emergency department for non-emergent follow-up medical treatment.	PI	40	Charges do not meet qualifications for emergent/urgent care.		
G22	Provider bills for services outside his/her scope of practice.	The billed service falls outside your scope of practice.		OA	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.
G23	Bill is submitted without necessary documentation needed for bill processing.	We cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible.	Identify documentation or report necessary for bill processing.	PI	16	Claim/service lacks information which is needed for adjudication.	WC43*	We cannot review this service without necessary documentation. Please resubmit with necessary documentation.
							M29	Missing operative report.
							M30	Missing pathology report.
							M31	Missing radiology report.

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G24	Provider charge of professional and/or technical component is submitted after global payment made to another provider.	The charge for both the technical and professional component of this service have already been paid to another provider.	Indicate name of other provider who received global payment.	OA	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	WC5*	The charge for both the technical and professional component of this service have already been paid to another provider.
G25	Timed code is billed without documentation.	Documentation of the time spent performing this service is needed for further review.		MA	16	Claim/service lacks information which is needed for adjudication.	WC6*	Documentation of the time spent performing this service is needed for further review.
G26	Charge is for a different amount than what was pre-negotiated.	Payment based on individual pre-negotiated agreement for this specific service.	Identify name of specific contracting entity, authorization # if provided, and pre- negotiated fee or terms. This EOR is for individually negotiated items/services. Use EOR G4 for comprehensive contractual agreements.	CO	131	Claim specific negotiated discount.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.
G27	Charge submitted for service in excess of pre-authorization.	Service exceeds pre-authorized approval. Please provide documentation and/or additional authorization for the service not included in the original authorization.		PI	198	Payment Adjusted for exceeding precertification/ authorization.	N188	The approved level of care does not match the procedure code submitted.

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G28	Charge is made by provider outside of HCO or MPN.	Payment is denied as the service was provided outside the designated Network.	Indicate name of HCO or MPN designated network. This message is not to be used to deny payment to out-of-network providers when the employee is legally allowed to treat out-of-network. For example: when the employer refers the injured worker to the provider or when the service was preauthorized.	PI	38	Services not provided or authorized by designated (network/primary care) providers.		
G29	Charge denied during Prospective or Concurrent Utilization Review	This charge is denied as the service was not authorized during the Utilization Review process. If you disagree, please contact our Utilization Review Unit.	Optional: Provide Utilization Review phone number.	PI	39	Services denied at the time authorization/pre-certification was requested.	N175	Missing Review Organization Approval.
G30	Charge denied during a Retrospective Utilization Review.	This charge was denied as part of a Retrospective Review. If you disagree, please contact our Utilization Review Unit.	Optional: Provide Utilization Review phone number.	PI	W9*	Unnecessary medical treatment based on peer review.	N175	Missing Review Organization Approval.
G31	Provider bills with missing, invalid or inappropriate authorization number	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.		PI	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.

DWC ANSI Matrix Crosswalk

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G32	Provider bills and does not provide requested documentation or the documentation was insufficient or incomplete	Payment adjusted because requested information was not provided or was insufficient/ incomplete.		PI	17	Payment adjusted because requested information was not provided or was insufficient/ incomplete.	WC7*	Missing/incomplete/insufficient requested documentation
G33	Provider bills payer/employer when there is no claim on file	Claim denied as patient cannot be identified as our insured.		PI	31	Claim denied as patient cannot be identified as our insured.		
G34	Provider bills for services that are not medically necessary	These are non-covered services because this is not deemed a `medical necessity' by the payer.		PI	50	These are non-covered services because this is not deemed a `medical necessity' by the payer.		
G35	Provider submits bill to incorrect payer/contactor	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		PI	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		
G36	Provider bills for multiple services with no or inadequate information to support this many services	Payment adjusted because the payer deems the information submitted does not support this many services.		MA	151	Payment adjusted because the payer deems the information submitted does not support this many services.		

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G37	Bill exceeds or is received after $10,000 cap has been reached on a delayed claim..	Payment is being denied as this claim has not been accepted and the mandatory $10,000 medical reimbursements have been made. Should the claim be accepted, your bill will then be reconsidered. This determination must be made by 90 days from the date of injury but may be made sooner.		MA	W26*	This claim has not been accepted and the mandatory medical reimbursements have been made. Should the claim be accepted, your bill will then be reconsidered. The determination must be made by 90 days from the date of injury.		
G38	Bill is submitted that is for a greater amount than remains in the $10,000 cap.	Your bill is being partially paid as this payment will complete the Labor Code 5402(c) mandatory $10,000 reimbursement. Should the claim be accepted, the remainder of your bill will then be reconsidered. Acceptance or denial of the claim must be made no later than 90 days from the date of injury but may be made sooner.		MA	W26*	Until the employee's claim is accepted or rejected, liability for medical treatment is limited according to jurisdictional guidelines. Your bill is being partially paid as this payment will complete the mandatory reimbursement limit per jurisdictional guidelines. Should the claim be accepted, the remainder of your bill will then be reconsidered. Acceptance or denial of the claim must be made no later than 90 days from the date of injury		

DWC ANSI Matrix Crosswalk

II. Physical Medicine and Rehabilitation Section Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
PM1	Non-RPT provider bills Physical Therapy Assessment and Evaluation code.	This charge was denied as the Physical Therapy Assessment and Evaluation codes are billable by Registered Physical Therapists only.		MA	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	WC8*	This charge was denied as the Physical Therapy Assessment and Evaluation codes are billable by Registered Physical Therapists only.
PM2	Provider bills both E/M or A/E, and test and measurement codes on the same day.	Documentation justifying charges for both test and measurements and evaluation and management or assessment and evaluation on the same day is required in accordance with physical medicine rule l (h).		OA	16	Claim/service lacks information which is needed for adjudication.	WC9*	Documentation justifying charges for both test and measurements and evaluation and management or assessment and evaluation on the same day is required in accordance with jurisdictional guidelines
PM3	Provider bills three or more modalities only, in same visit.	When billing for modalities only, you are limited to two modalities in any single visit pursuant to physical medicine rule l (b). Payment has been made in accordance with Physician Fee Schedule guidelines		MA	151	Payment adjusted because the payer deems the information submitted does not support this many services.	WC10*	When billing for modalities only, you are limited to two modalities in any single visit pursuant to jurisdictional physical medicine rule guidelines. Payment has been made in accordance with Physician Fee Schedule guidelines

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
PM4	Provider bills “additional 15 minute” code without billing the “initial 30 minute” base code.	This physical medicine extended time service was billed without the "initial 30 minutes" base code.		OA	152	Payment adjusted because the payer deems the information submitted does not support this length of service.	WC11*	This physical medicine extended time service was billed without the "initial 30 minutes" base code.
PM5	Provider bills a second physical therapy A/E within 30 days of the last evaluation.	Only one assessment and evaluation is reimbursable within a 30 day period. The provider has already billed for a physical therapy evaluation within the last 30 days. See physical medicine rule l (a).		MA	W19*	Payment adjusted because the payer deems the information submitted does not support the frequency of service.	WC12*	Only one assessment and evaluation is reimbursable within a 30 day period. The provider has already billed for a physical therapy evaluation within the last 30 days.
PM6	Provider billing exceeds 60 minutes of physical medicine or acupuncture services.	Reimbursement for physical medicine procedures, modalities, including Chiropractic Manipulation and acupuncture codes are limited to 60 minutes per visit without prior authorization pursuant to physical medicine rule l (c)		MA	152	Payment adjusted because the payer deems the information submitted does not support this length of service.	WC13*	Reimbursement for physical medicine procedures, modalities, including Chiropractic Manipulation and acupuncture codes are limited to 60 minutes per visit without prior authorization pursuant to jurisdictional guidelines

DWC ANSI Matrix Crosswalk

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PM7	Provider bills for more than four physical medicine codes during a single visit	No more than four physical medicine procedures or modalities including, Chiropractic Manipulation and Acupuncture codes, are reimbursable during the same visit without prior authorization pursuant to physical medicine rule I (d).		MA	151	Payment adjusted because the payer deems the information submitted does not support this many services.	WC14*	No more than four physical medicine procedures including Chiropractic Manipulation and Acupuncture codes are reimbursable during the same visit without prior authorization pursuant to jurisdictional guidelines
PM8	Provider bills full value for services subject to the multiple service cascade.	Physical medicine rule 1 (e) regarding multiple services (cascade) was applied to this service.		MA	59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	WC15*	Jurisdictional guidelines regarding multiple services (cascade) was applied to this service.
PM9	Provider bills office visit in addition to physical medicine/acupuncture code or OMT/CMT code at same visit. Specified special circumstances not applicable.	Billing for evaluation and management service in addition to physical medicine/acupuncture code or OMT/CMT code resulted in a 2.4 unit value deduction from the treatment codes in accordance with physical medicine rule 1(g).		MA	151	Payment adjusted because the payer deems the information submitted does not support this many services.	WC16*	Billing for evaluation and management service in addition to physical medicine/acupuncture code or OMT/CMT code resulted in a 2.4 unit value deduction from the treatment codes in accordance with jurisdictional guidelines

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
PM10	Provider fails to note justification for follow-up E/M charge during treatment.	Payment for this service was denied because documentation of the circumstances justifying both a follow-up evaluation and management visit and physical medicine treatment has not been provided as required by physical medicine rule 1 (f).		MA	151	Payment adjusted because the payer deems the information submitted does not support this many services.	WC17*	Payment for this service was denied because documentation of the circumstances justifying both a follow-up evaluation and management visit and physical medicine treatment has not been provided as required by jurisdictional guidelines
PM11	Physical Therapist /Occupationsal Therapists charged for E/M codes which are limited to physicians, nurse practitioners, and physician assistants.	Charge was denied as Physical Therapists/ Occupational Therapists may not bill Evaluation and Management services.		OA	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	WC18*	Charge was denied as Physical Therapists may not bill Evaluation and Management services.
PM12	Visits in excess of 24 are charged without prior authorization for additional visits.	Charge is denied as there is a 24 visit limitation on Physical Therapy, Chiropractic and Occupational Therapy encounters for injuries on/after January 1, 2004 without prior authorization for additional visits. If you object contact the claims administrator or its U.R. unit.	Optional: Provide Utilization Review phone number.	OA	198	Payment Adjusted for exceeding precertification/ authorization.		

DWC ANSI Matrix Crosswalk

III. Surgery Section Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
S1	Physician billing exceeds fee schedule guidelines for multiple surgical services.	Recommended payment reflects Physician Fee Schedule Surgery Section, Rule 7 guidelines for multiple or bi-lateral surgical services.		MA	59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)		
S2	Physician billed for initial casting service included in value of fracture or dislocation reduction allowed on the same day.	The value of the initial casting service is included within the value of a fracture or dislocation reduction service.		MA	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	WC19*	The value of the initial casting service is included within the value of a fracture or dislocation reduction service.
S3	Physician bills office visit or service which is not separately reimbursable as it is within the global surgical period.	The visit or service billed, occurred within the global surgical period and is not separately reimbursable.		OA	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	WC20*	The visit or service billed, occurred within the global surgical period and is not separately reimbursable.
S4	Multiple arthroscopic services to same joint same session are billed at full value.	Additional arthroscopic services were reduced to 10 percent of scheduled values pursuant to surgery ground rule 7 re: Arthroscopic Services.		MA	59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	WC21*	Additional arthroscopic services were reduced to 10 percent of scheduled values pursuant to jurisdictional surgery guidelines

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
S5	Physician bills initial visit in addition to starred service, which constituted the major service.	This initial visit was converted to code 99025 in accordance with the starred service surgical ground rule 10 (b) (1).		MA	W1	Workers Compensation State Fee Schedule Adjustment	WC22*	This initial visit was converted to code 99025 in accordance with the jurisdictional surgical guidelines
S6	Assistant Surgeon charged greater than 20% of the surgical procedure.	Assistant Surgeon services have been reimbursed at 20% of the surgical procedure. (See Modifier 80 in the Surgical Section of the Physician's Fee Schedule).		MA	W1	Workers Compensation State Fee Schedule Adjustment	WC23*	Assistant Surgeon services have been reimbursed at 20% of the surgical procedure per jurisdictional surgical guidelines
S7	Non-physician assistant charged greater than 10% of the surgical procedure.	Non-physician assistant surgeon has been reimbursed at 10% of the surgical procedure. (See Modifier 83 in the Surgical Section of the Physician's Fee Schedule).		MA	W1	Workers Compensation State Fee Schedule Adjustment	WC24*	Non-physician assistant surgeon has been reimbursed at 10% of the surgical procedure per jurisdictional surgical guidelines
S8	Procedure does not normally require an Assistant Surgeon and no documentation was provided to substantiate a need in this case.	Assistant Surgeon services have been denied as not normally warranted for this procedure according to the listed citation.	Identify the reference source listing of approved Assistant Surgeon services.	PI	54	Multiple physicians/assistants are not covered in this case.	WC25*	Assistant Surgeon services have been denied as not normally warranted for this procedure according to jurisdictional guidelines
S9	Procedure does not normally require two surgeons and no documentation was provided to substantiate a need in this case.	Two Surgeon service is not warranted for this procedure according to the listed citation. Please provide documentation that supports the need for two surgeons.	Identify the reference source listing of approved Two Surgeon services.	PI	54	Multiple physicians/assistants are not covered in this case.	WC26*	Two Surgeon service is not warranted for this procedure according to the listed citation. Please provide documentation that supports the need for two surgeons.

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
S10	Operative Report does not cite the billed procedure.	Incomplete/invalid operative report (billed service is not identified in the Operative Report)		OA	16	Claim/service lacks information which is needed for adjudication.	N233	Incomplete/invalid operative report.
S11	Surgeon's bill includes separate charge for delivery of local anesthetic.	Administration of Local Anesthetic is included in the Surgical Service per Surgical Section rule 16.		OA	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	WC27*	Administration of Local Anesthetic is included in the Surgical Service per jurisdictional surgical guidelines
IV. Anesthesia Section Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
A1	Physician bills for additional anesthesia time units not allowed by schedule	Modifier -47 was used to indicate regional anesthesia by the surgeon. In accordance with the Physician Fee Schedule, time units are not reimbursed.		MA	152	Payment adjusted because the payer deems the information submitted does not support this length of service.	WC28*	Modifier -47 was used to indicate regional anesthesia by the surgeon. In accordance with the Fee Schedule, time units are not reimbursed.
A2	Insufficient information provided for payment determination.	Please submit anesthesia records and/or time units for further review.		OA	16	Claim/service lacks information which is needed for adjudication.	N203	Missing/incomplete/invalid anesthesia time/units
A3	Documentation does not describe emergency status.	Qualifying circumstances for emergency status not established.		PI	40	Charges do not meet qualifications for emergent/urgent care.		

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
A4	Documentation does not describe physical status/condition.	Patient's physical status/condition not identified. Please provide documentation using ASA Physical Status indicators.		OA	16	Claim/service lacks information which is needed for adjudication.	WC29*	Patient's physical status/condition not identified. Please provide documentation using ASA Physical Status indicators.
V. Evaluation and Management Section								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
EM1	Physician bills for office visit which is already included in a service performed on the same day.	No reimbursement was made for the E/M service as the documentation does not support a separate significant, identifiable E&M service performed with other services provided on the same day.	This EOR should only be used if documentation does not support the use of modifier 25, 57, or 59.	OA	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	WC30*	No reimbursement was made for the E/M service as the documentation does not support a separate significant, identifiable E&M service performed with other services provided on the same day.
EM2	Documentation does not support Consultation code.	The billed service does not meet the requirements of a Consultation (See the General Information and Instructions Section of the Physician's Fee Schedule).		MA	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	WC31*	The billed service does not meet the requirements of a Consultation

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DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
EM3	Documentation does not support billing for Prolonged Services code.	Documentation provided does not justify payment for a Prolonged Evaluation and Management service.		PI	152	Payment adjusted because the payer deems the information submitted does not support this length of service.	WC32*	Documentation provided does not justify payment for a Prolonged Evaluation and Management service.
VI. Clinical Laboratory Section Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
CL1	Physician bills for individual service normally part of a panel.	This service is normally part of a panel and is reimbursed under the appropriate panel code.		OA	W20*	This service is normally part of a panel and is reimbursed under the appropriate panel code.		
VII. Pharmacy								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
P1	Charge for Brand Name was submitted without “No Substitution” documentation.	Payment was made for a generic equivalent as “No Substitution” documentation was absent.		MA	W1	Workers Compensation State Fee Schedule Adjustment	WC33*	Payment was made for a generic equivalent as “No Substitution” documentation was absent.
P2	Provider charges a dispensing fee for over-the-counter medication or medication administered at the time of the visit.	A dispensing fee is not applicable for over-the-counter medication or medication administered at the time of a visit.		MA	91	Dispensing fee adjustment.	WC34*	A dispensing fee is not applicable for over-the-counter medication or medication administered at the time of a visit.

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VIII. DMEPOS Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (Jurisdictional code)**	**ANSI Remittance Remark Code Description**
DME1	Billed amount exceeds formula using documented actual cost for DMEPOS	Payment for this item was based on the documented actual cost.		MA	108	Payment adjusted because rent/purchase guidelines were not met.	WC35*	Payment for this item was based on the documented actual cost.
DME2	Billing for purchase is received after cost of unit was paid through rental charges.	Charge is denied as total rental cost of DME has met or exceeded the purchase price of the unit.		MA	108	Payment adjusted because rent/purchase guidelines were not met.	M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
IX. Special Services Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
SS1	A physician, other than the Primary Treating Physician or designee submits a progress report for reimbursement.	The Progress report charge was disallowed as you are not the Primary Treating Physician or his/her designee.		MA	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	WC36*	The Progress report charge was disallowed as you are not the Primary Treating Physician or his/her designee.
SS2	A physician, other than the Primary Treating Physician or designee submits a Permanent and Stationary report for reimbursement.	The Permanent and Stationary Report charge was disallowed as you are not the Primary Treating Physician or his/her designee.		MA	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	WC37*	The Permanent and Stationary Report charge was disallowed as you are not the Primary Treating Physician or his/her designee.

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DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
SS3	Non-reimbursable report is billed.	This report does not fall under the guidelines for a Separately Reimbursable Report found in the General Instructions Section of the Physician's Fee Schedule.		MA	W21*	This report does not fall under the jurisdictional guidelines for a Separately Reimbursable Report		
SS4	No request was made for Chart Notes or Duplicate Report.	Chart Notes /Duplicate Reports were not requested		MA	96	Non-covered charge(s).	WC38*	Chart Notes /Duplicate Reports were not requested
SS5	Missed appointment is billed.	No payment is being made, as none is necessarily owed		OA	96	Non-covered charge(s).	WC39*	No payment is being made for missed appointment, as none is necessarily owed
X. Facility Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
F1	Procedure is on the Inpatient Only list. Needs advanced authorization in order to be performed on an outpatient basis.	No reimbursement is being made as this procedure is not usually performed in an outpatient surgical facility. Prior authorization is required but was not submitted.		OA	197	Payment adjusted for absence of precertification/ authorization.	WC40*	No reimbursement is being made as this procedure is not usually performed in an outpatient surgical facility. Prior authorization is required but was not submitted.

DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
F2	Charge submitted for facility treatment room for non-emergent service.	Treatment rooms used by the physician and/or hospital treatment rooms for non-emergency services are not reimbursable per the Physician's Fee Schedule Guidelines.		MA	40	Charges do not meet qualifications for emergent/urgent care.		
F3	Paid under a different fee schedule.	Service not reimbursable under Outpatient Facility Fee Schedule. Charges are being paid under a different fee schedule.	Specify which other fee schedule.	MA	W22*	Service not reimbursable under Outpatient Facility Fee Schedule. Charges are being paid under a different fee schedule.		
F4	No payment required under Outpatient Facility Fee Schedule	Service not paid under Outpatient Facility Fee Schedule.		MA	96	Non-covered charge(s).	WC41*	Service not paid under Outpatient Facility Fee Schedule.
F5	Billing submitted without HCPCS codes	In accordance with OPPS guidelines billing requires HCPCS coding.		MA	W1	Workers Compensation State Fee Schedule Adjustment	M20	Missing/incomplete/invalid HCPCS.
F6	Facility has not filed for High Cost Outlier reimbursement formula.	This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation. The bill will be reimbursed using the regular reimbursement methodology.		MA	W1	Workers Compensation State Fee Schedule Adjustment	WC42*	This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation. The bill will be reimbursed using the regular reimbursement methodology.

DWC ANSI Matrix Crosswalk

X1 Miscellaneous DWC Bill Adjustment Reason Codes and ANSI Claim Adjustment Reason Codes								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
M1	Bill submitted for non compensable claim	Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.		MA	W2*	Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.		
M2	Appeal /Reconsideration	Additional payment made on appeal/reconsideration.		MA	W3 *	Additional payment made on appeal/reconsideration.		
M3	Appeal /Reconsideration	No additional reimbursement allowed after review of appeal/reconsideration.		MA	W4 *	No additional reimbursement allowed after review of appeal/reconsideration.		
M4	Overpayment to health provider	Request of recoupment for an overpayment made to a health care provider.		MA	W5 *	Request of recoupment for an overpayment made to a health care provider.		
M5	Third Party Subrogation	Reduction/denial based on subrogation of a third party settlement.		MA	W6 *	Reduction/denial based on subrogation of a third party settlement.		
M6	Payment of interest /penalty to provider	Payment of interest/penalty to provider.		MA	W7 *	Payment of interest/penalty to provider.		
M7	Claim is under investigation	Extent of injury not finally adjudicated. Claim is under investigation.		MA	W23*	Extent of injury not finally adjudicated. Claim is under investigation		

Appendix C - CMS-1500 2007/837 Mapping

The referenced document maps the paper CMS-1500 Professional paper billing form to the ANSI 837 Professional billing format.

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California 2007 CMS-1500 to ANSI 837P Mapping

Paper Field	ANSI 837			CMS-1500 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	Comments
	Loop	Element	Qual			
1	2000B	SBR09	WC	Coverage	Required	
1a	2010CA	NM109	MI	Insured's ID Number (Employee SSN)	Required	
2	2010CA	NM103	QC	Patient's Last Name	Required	
	2010CA	NM104		Patient's First Name	Required	
	2010CA	NM105		Patient's Middle Name	Situational	
3	2010CA	DMG02		Patient's Birth Date	Required	
3b	2010CA	DMG03		Patient's Gender	Required	
4	2010BA	NM103	IL	Insured Name (Employer)	Required	Employer Name
5	2010CA	N301		Patient's Address	Required	
	2010CA	N401		City		
	2010CA	N402		State		
	2010CA	N403		Zip Code		
				Telephone Number		
6	2000C	PAT01	20	Patient's Relationship to the Insured	Required	
7	2010BA	N301		Insured's Address (Employer)	Required	
	2010BA	N401		City		
	2010BA	N402		State		
	2010BA	N403		Zip Code		
				Telephone Number		
8				Patient Status	N/A	
9				Other Insured	N/A	
10	2300	CLM11-1	EM	Is the Patient's Condition Related to Employment	Required	
10d	2310B	PRV03	ZZ	Rendering Provider Taxonomy Code	Situational	Required if Rendering Provider is a health care provider
11	2010CA	REF02	Y4	Property and Casualty Number (Claim Number)	Situational	California CMS1500 paper submitted form requires a workers compensation claim number if known or if not known a default two digit numeric value 00 is required in the field to indicate unknown claim number
11b	2000B	SBR04		Employer Name	Situational	Employer Department / Division
11c	2010BB	NM103		Insurance Plan Name or Program Name	Required	Payer Name
12	2300	CLM09		Patient's or Authorized Person's Signature on File	Optional	
13				Insured's or Authorized Person's Signature	NA	
14	2300	DTP03	439	Date of Current Illness, Injury or Pregnancy	Required	Date of Accident/ Illness
15	2300	DTP03	438	Date of Similar Illness	Optional	
16	2300	DTP03	360	Dates Patient Unable to Work	N/A	Do not fill in this field. This information should appear only on the medical report
	2300	DTP03	361			
17	2310A	NM103		Name of Referring Physician or Other Source	Situational	
	2310A	NM104				
	2310A	NM105				
17a	2310A	REF02	0B	ID Qualifier and State License Number of Referring Physician	Situational	

California 2007 CMS-1500 to ANSI 837P Mapping

Paper Field	ANSI 837			CMS-1500 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	Comments
	Loop	Element	Qual			
17b	2310A	NM109	XX	NPI Number of the Referring Provider or Ordering Provider	Situational	
18	2300	DTP03	435	Hospitalization Dates Related to Current Services	Situational	
	2300	DTP03	096			
19	2300	PWK01		Reserved for Local Use Workers' Compensation Attachment Control Number*	Situational	Attachment Report Type Code
	2300	PWK02				Attachment Deliver Method Code
	2300	PWK05	AC			Attachment Control Indicator Code
	2300	PWK06				Unique ID number Related to Bill
20				Outside Lab/ Charges	Situational	Use when billing for diagnostic tests
21.1	2300	HI01-2		Diagnosis or Nature of Illness or Injury	Required	
21.2	2300	HI02-2			Situational	
21.3	2300	HI03-2				
21.4	2300	HI04-2				
22	2300	CLM19		Medicaid Resubmission Code/Original Reference Number - Workers' Compensation Code/ Bill Resubmission Indicator	Situational	Required field if resubmitting a bill. Enter the appropriate two digit resubmission code
			07			07=Duplicate
			15			15=Revised
			30			30=Appeal/Reconsideration
23	2300	REF02	G1	Prior Authorization Number	Situational	Enter prior authorization or certification number assigned by payer, if known
24	2300	NTE		Supplemental Information	Optional	
24A	2400	DTP03	472	Dates of Service	Required	
24B	2400	SV105		Place of Service	Required	
24D	2400	SV101-2		Procedures, Services or Supplies and Modifiers	Required	
	2400	SV101-3			Situational	Modifier 1
	2400	SV101-4				Modifier 2
	2400	SV101-5				Modifier 3
	2400	SV101-6				Modifier 4
24D RX	2400	SV101-2		Pharmacy Supplies	RX Required	HCPCS code for RX
	2410	LIN03				Use second line to hold the NDC Number
24D DME	2400	SV101-2		DME Supplies and Modifiers	DME Required	HCPCS code for DME
	2400	SV101-3				Modifiers 1 thru 4. Use modifier to indicate if the DME is a purchase or a rental.
	2400	SV101-4				
	2400	SV101-5				
	2400	SV101-6				
24E	2400	SV107-1		Diagnosis Pointers	Required	
	2400	SV107-2			Situational	
	2400	SV107-3				
	2400	SV107-4				
24F	2400	SV102		Charges	Required	
24G	2400	SV104		Days or Units	Required	
24I	2420A	REF01	0B	ID Qualifier	Situational	

California 2007 CMS-1500 to ANSI 837P Mapping

Paper Field	ANSI 837			CMS-1500 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	Comments
	Loop	Element	Qual			
24J_1	2420A	REF02		Rendering Line Provider State License	Situational	Rendering Line Provider required when different than Rendering Bill Provider.
24J_2	2420A	NM109	XX	Rendering Line Provider NPI	Situational	
25	2010AA	REF02	EI/SY	Federal Tax ID or Social Security Number and Type	Required	Billing Provider
26	2300	CLM01		Patient's Account Number	Required	Enter unique patient account number assigned by provider of services or suppliers account
27	2300	CLM07	Y	Accept Assignment	Required	
28	2300	CLM02		Total Charge	Required	
29	2300	AMT02		Patient Amount Paid	N/A	
30				Balance Due	N/A	
31	2300	CLM06	Y/N	Signature of Physician or Supplier Including Degrees or Credentials	Required	
	2310B	NM103	82			
	2310B	NM104				
	2310B	NM105				
32	2310D	NM103		Service Facility Location Information	Required	Enter name and address of facility where services were rendered (if other than home or office)
32a	2310D	NM109	XX	Service Facility Location NPI Number	Situational	
32b	2310D	REF02		Service Facility Location State License Number	Situational	
33	2010AA	NM103	85	Physician's/Supplier's Billing: Name	Required	
	2010AA	NM104				
	2010AA	NM105				
	2010AA	N301		Address		
	2010AA	N401		City		
	2010AA	N402		State		
	2010AA	N403		Zip Code		
	2010AA	PER04	TE	Phone Number		
33a	2010AA	NM109	XX	NPI Number of Billing Provider	Situational	Required if Billing Provider is a health care entity. When Billing and Rendering Provider are the same, Billing Provider NPI is populated. When Rendering Provider is different than Billing Provider , populate Rendering Provider NPI number
33b	2010AA	REF02	0B	State License Number	Situational	Required if Billing Provider is a health care entity. When Billing and Rendering Provider are the same, Billing Provider state license number is populated. When Rendering Provider is different than Billing Provider, populate Rendering Provider state license number

Paper Field	ANSI 837			CMS-1500 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	Comments
	Loop	Element	Qual			
Attachment Control Number Example HCFA Field 19*						
*An attachment control number is required in box 19 and on supporting document (s) associated with this bill, if the document (s) is submitted separately from the bill. Refer to the eBill Companion Guide for Attachment Control Number Requirements. Enter the two digit codes for report type, method sent and attachment ID code" AC" followed by unique identification number of the attachment (s) related to this specific bill. Example Attachment Control Number : RR ELAC123456 (1) Report Type :Radiology=RR (2) Method Sent: Electronic=EL (3) Attachment Control Indicator =AC (4) Unique Attachment Control Number=123456						

Appendix D – UB04/837 Mapping

The referenced document maps the paper CMS UB-04 paper hospital billing form to the ANSI 837 Institutional billing format.

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California UB-04 to ANSI 837I Mapping

Paper Field	ANSI 837			UB04 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	WC Comments
	Loop	Element	Qual			
1	2010AA	NM103	85	Provider Name	Required	
	2010AA	N301		Address		
	2010AA	N401		City		
	2010AA	N402		State		
	2010AA	N403		Zip Code		
	2010AA	PER04	TE	Telephone Number		
2	2010AB	NM103	85	Pay - to Name	Situational	Required when the pay-to name and address information is different than the Billing Provider information
	2010AB	N301		Address		
	2010AB	N401		City		
	2010AB	N402		State		
	2010AB	N403		Zip Code		
	2010AB	PER04	TE	Telephone Number, Fax, Country Code		
3a	2300	CLM01		Patient Control Number	Required	Enter unique patient control number assigned by Facility
3b	2300	REF02	EA	Medical Record Number	Required	
4	2300	CLM05-1		Type of Bill (Facility -CLM05-1 Claim Frequency Type Code CLM05-3)	Required	If claims frequency type code indicates a resubmission then a bill resubmission code (07, 15 or 30) is required in box 7.
	2300	CLM05-3			Required	Claim Frequency Type Code
5	2010AA	REF02	EI	Federal Tax Number	Required	
6	2300	DTP03	434	Statement Covers Period "From" and "Through"	Required	
7	2300	CLM19		Workers' Compensation Bill Resubmission Code	Situational	Required if bill type frequency code is 7
			07			07=Duplicate
			15			15=Revised
			30			30= Appeal/Reconsideration
8a	2010CA	NM103	QC	Patient's Name (last, first name, middle initial)	Required	Last Name
8b	2010CA	NM104			Required	First Name
	2010CA	NM105			Situational	Middle Name
9a-e	2010CA	N301		Patient's Address	Required	
	2010CA	N401		City		
	2010CA	N402		State		
	2010CA	N403		Zip Code		
	2010CA	N404		Country Code		Required if injured worker lives outside of US.
10	2010CA	DMG02		Birth Date	Required	
11	2010CA	DMG03		Sex	Required	
12	2300	DTP03	435	Admission Date	Required	
13	2300	DTP03	435	Admission Hour	Situational	

California UB-04 to ANSI 837I Mapping

Paper Field	ANSI 837			UB04 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	WC Comments
	Loop	Element	Qual			
14	2300	CL101		Admission Type	Situational	Required for Admissions. Enter the code for the admission type (NUBC)
15	2300	CL102		Admission Source	Situational	
16	2300	DTP03	096	Discharge Hour	Situational	
17	2300	CL103		Patient Status (Discharge Status)	Situational	
18 – 28	2300	HI01-2 thru HI07-2	BG	Condition Codes	Situational	
29				Accident State	N/A	
30				Unlabeled		
31a,b	2300	HI01-2	BH	Occurrence of Code 04	Required	WC=04 related to employment
	2300	HI01-4		Date		Date of Injury
32a,b	2300	HI02-2	BH	Occurrence of Code	Situational	
	2300	HI02-4		Date		
33a,b	2300	HI03-2	BH	Occurrence of Code and Date	Situational	
	2300	HI03-4		Date		
34a,b	2300	HI04-2	BH	Occurrence of Code	Situational	
	2300	HI04-4		Date		
35a,b	2300	HI01-2	BI	Occurrence Span Code	Situational	
	2300	HI01-3		From/Through Date		
36a,b	2300	HI02-2	BI	Occurrence Span Code	Situational	
	2300	HI02-3		From/Through Date		
37				Unlabeled	N/A	
38	2010BC	NM103	PR	Responsible Party Name and Address	Required	Payer Name and Address
	2010BC	N301		Address		
	2010BC	N401		City		
	2010BC	N402		State		
	2010BC	N403		Zip Code		
39a	2300	HI01-2	BE	Value Code	Situational	
	2300	HI01-5		Amount		
39b	2300	HI02-2	BE	Value Code	Situational	
	2300	HI02-5		Amount		
39c	2300	HI03-2	BE	Value Code	Situational	
	2300	HI03-5		Amount		
39d	2300	HI04-2	BE	Value Code	Situational	
	2300	HI04-5		Amount		
40a	2300	HI05-2	BE	Value Code	Situational	
	2300	HI05-5		Amount		
40b	2300	HI06-2	BE	Value Code	Situational	
	2300	HI06-5		Amount		
40c	2300	HI07-2	BE	Value Code	Situational	
	2300	HI07-5		Amount		
40d	2300	HI08-2	BE	Value Code	Situational	
	2300	HI08-5		Amount		
41a	2300	HI09-2	BE	Value Code	Situational	

California UB-04 to ANSI 837I Mapping

Paper Field	ANSI 837			UB04 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	WC Comments
	Loop	Element	Qual			
	2300	HI09-5		Amount		
41b	2300	HI10-2	BE	Value Code	Situational	
	2300	HI10-5		Amount		
41c	2300	HI11-2	BE	Value Code	Situational	
	2300	HI11-5		Amount		
41d	2300	HI12-2	BE	Value Code	Situational	
	2300	HI12-5		Amount		
42	2400	SV201		Revenue Code	Required	
43				Revenue Code Description	Optional	
43 RX	2410	LIN03		Description	RX Required	NDC Number
44	2400	SV202-2		HCPCS/Rates/HIPPS Codes	Situational	Required for RX and DME
	2400	SV202-3				Modifier 1
	2400	SV202-4				Modifier 2
	2400	SV202-5				Modifier 3
	2400	SV202-6				Modifier 4
45	2400	DTP03	472	Service Date	Required	
46	2400	SV205		Units of Service	Required	
47	2400	SV203		Total Charges	Required	Total Amount Charged Per Line
	2300	CLM02				Total Amount Charged Per Bill, last line with revenue code of 0001
48				Non Covered Charges	NA	
49				Unlabeled		
50a				Payer Name	Required	Payer Name
51a				Health Plan ID	NA	Payer Plan Identifier
52a	2300	CLM09		Release of Information Certification Indicator	Required	
53a	2300	CLM08		Assignment of Beneficiary	NA	
54a	2320	AMT02	D	Prior Payments	Situational	Enter amount of prior payment related to these services
55a				Estimated Amount Due from Patient	NA	
56	2010AA	NM109	XX	Billing Provider NPI Number	Situational	Required if billing provider is a health care entity
57a	2010AA	REF02	0B	Billing Provider ID	Situational	State License Number if billing provider is a health care provider and the provider has a state license number
58a	2000B	SBR04		Insured Name	Optional	Employer Department/Division
59a	2000C	PAT01	20	Patient Relationship to Insured	Required	
60a	2010CA	NM109	MI	Insured's Unique ID	Required	Patient Social Security Number
61a				Insured's Group Name	N/A	
62a	2010CA	REF02	Y4	Insurance Group Number	Situational	Workers' Compensation Claim Number
63a	2300	REF02	G1	Treatment Authorization Codes	Situational	

California UB-04 to ANSI 837I Mapping

Paper Field	ANSI 837			UB04 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	WC Comments
	Loop	Element	Qual			
64a	2300	REF02	F8	Document Control Number- (0riginal reference number ICN/DCN)	Situational	Required if bill transaction is a resubmission. Payer's unique bill identification number
64b	2300	PWK01, 02 & PWK05, 06	AC	Attachment Control Number	Situational	Required if documentation associated with transaction.
65a	2010BA	NM103		Employer Name	Required	
65b	2010BA	N301		Employer Address	Required	
65c	2010BA	N401-403		Employer City, State, Zip	Required	
66				Diagnosis Version Qualifier	Required	Indicates if ICD codes used are ICD9 or ICD10
67	2300	HI01-2	BK	Principal Diagnosis Code	Required	For electronic billing with X12 5010 use 'A' prefixed qualifiers for ICD10 codes
67a-q	2300	HI02-2 Thru HI09-2	BF	Other Diagnosis Code	Situational	
68				Unlabeled		
69	2300	HI02-2	BJ	Admitting Diagnosis Code	Situational	Required for Inpatient
70	2300	HI01-2	PR	Patient's Reason for Visit Code	Situational	X12 5010 only
71				Prospective Payment System PPS Code	NA	
72				External Cause of Injury Code	Optional	
73	2300	HI01-2	DR	Unlabeled (Workers' Compensation DRG Code)	Situational	DRG Code
74	2300	HI01-2	BP	Principle Procedure Code	Situational	
	2300	HI01-4		Date		
74a,e	2300	HI02-2Thru HI06-2	BQ	Other Procedure Code/Date	Situational	
75				Unlabeled		
76				Attending Physician	Required	Jurisdiction Specific ID Qualifier
a	2310A	NM109	XX	NPI Number	Required	NPI Number
b	2310A	REF01	0B	2nd Provider ID Qualifier Code	Required	
c	2310A	REF02		2nd Provider ID	Required	State License
d	2310A	NM103	71	Last Name	Required	Physician Last Name
e	2310A	NM104		First	Required	First
	2310A	NM105		Middle	Situational	Middle
77				Operating Physician	Situational	Jurisdiction Specific ID Qualifier
a	2310B	NM109	XX	NPI Number	Situational	NPI Number
b	2310B	REF01	0B	2nd Provider ID Qualifier Code	Situational	
c	2310B	REF02		2nd Provider ID		State License
d	2310B	NM103	72	Last Name	Situational	Physician Last Name
e	2310B	NM104		First		First
	2310B	NM105		Middle		Middle
78				Other Physician Block 1	Situational	Jurisdiction Specific ID Qualifier
a	2310F	NM101	DN	Referring Provider	Situational	Provider Type Qualifier

California UB-04 to ANSI 837I Mapping

Paper Field	ANSI 837			UB04 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	WC Comments
	Loop	Element	Qual			
	2310C		ZZ	Other Operating Physician		
	2310D		82	Rendering Provider		
b		NM109	XX	NPI Number	Situational	Required when NPI Federal Mandate date is effective
c		REF01	0B	2nd Provider ID Qualifier Code	Situational	Jurisdiction Specific ID Qualifier
d		REF02		2nd Provider ID	Situational	State License
e		NM103		Physician Name	Situational	Physician Last Name
f		NM104				First
		NM105				Middle
79				Other Physician Block 2	Situational	
a	2310F	NM101	DN	Referring Provider	Situational	Provider Type Qualifier
	2310C		ZZ	Other Operating Physician		
	2310D		82	Rendering Provider		
b		NM109	XX	NPI Number	Situational	Required when NPI Federal Mandate date is effective
c		REF01	0B	2nd Provider ID Qualifier Code	Situational	
d		REF02		2nd Provider ID	Situational	State License
e		NM103		Physician Name	Situational	Physician Last Name
f		NM104				First
		NM105				Middle
80	2300	NTE02		Remarks	Situational	
81				Code - Code Field		
	2310A	PRV		Qualifier Type Code B3 (Provider Taxonomy Code)	Required	Used to supply taxonomy code for attending physician
	2310B	PRV		Qualifier Type Code B3 (Provider Taxonomy Code)	Situational	Used to supply taxonomy code for operating physician
	2310C	PRV		Qualifier Type Code B3 (Provider Taxonomy Code)	Situational	Used to supply taxonomy code for other provider
	2310D	PRV		Qualifier Type Code B3 (Provider Taxonomy Code)	Situational	Used to supply taxonomy code for rendering physician

Appendix E – Pharmacy UCF/837 and NCPDP 5.1 Mapping

The referenced document maps the paper NCPDP Universal Claim Form paper pharmacy billing form to the NCPDP Telecommunication Standard Version 5.1 and ANSI 837 Pharmacy billing format,

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UCF Field #	Paper UCF Field Label	Actual Field Data	DWC Data Type	NCPDP 5.1	ANSI X12 837		Workers' Compensation UCF Paper Form Instructions
					Loop	Field	
1	I.D.	Injured Worker SS #	Required	332-CY	2100CA	NM109	Enter the injured worker's social security number. If the injured worker does not have a social security number enter "999-99-9999". This field is listed as Patient ID in the 5.1 format.
			Required	331-CX			This is a required field in the NCPDP 5.1 standard. Default value for Social Security Number is "01".
2	Group I.D.	Billing Indicator	Required	301-C1	N/A	N/A	Enter "Agent Billed" if claim is being processed by a third party billing service. If being billed by the provider enter "Provider Billed" This same information would be entered into the 5.1 field for ease of identification by the payer which type of entity is submitting form. Agent Billed will indicate that the pharmacy information will need to be derived from the NCPDP or NPI number and in the 837 format, Loop 2310D will contain the Pharmacy Information.
	Cardholder ID		Required	302-C2			This is a required field in the NCPDP 5.1 standard. However, it can be left blank.
3	(White Space, upper right hand corner)	Billing Date	Required		TS	BHT04	Enter the date the form was created and sent to the carrier or payer.
4	Name	Provider ID Number	Required	201-B1	2310D	NM109	Enter the Pharmacy NCPDP number. This field would also be used on the electronic format when being submitted by a third party billing entity. *These fields will help payers identify who the dispensing provider is when form is being submitted by a third party agent or assignee.*
5	Plan Name	Provider ID Number Qualifier	Required	202-B2	2310D	NM108	Enter 01 if the Provider ID provided in the "Plan Name" field is an NPI number. Enter "07" if the provider ID number provided in the "Plan Name" field is an NCPDP number. Payers would need to use a cross-reference tool to obtain complete provider information if form is being submitted by a third party agent or assignee. This field would also be used on the 5.1 electronic format when being submitted by a third party billing entity. Rules should be written in such a way that this information can not be used to re-direct care.
6	Patient Name	Injured Worker Name	Required	311-CB 310-CA	2100CA	NM103-05	Enter the injured worker's name - Last Name, First Name, Middle Initial
7	Other Coverage Code	*N/A*					*Leave Field Blank*
8	Person Code	*N/A*					*Leave Field Blank*
9	Patient Date of Birth	Injured Worker DOB	Required	304-C4	2010CA	DMG02	Enter the injured worker's date of birth. Format=MM DD CCYY
10	Patient Gender Code	Injured Worker Gender	Required	305-C5	2010CA	DMG03	Enter "1" for male or "2" for female
11	Patient Relationship Code	*N/A*					*Leave Field Blank*

UCF Field #	Paper UCF Field Label	Actual Field Data	DWC Data Type	NCPDP 5.1	ANSI X12 837		Workers' Compensation UCF Paper Form Instructions
					Loop	Field	
12	Pharmacy Name	Payee Name	Required	498-PF	2010AA 2010AB	NM103	Provider/Entity to whom payment should be made. (*If the UCF Paper Field #2 or the NCPDP 5.1 field #301-C1 indicates "Agent Billed" then the dispensing pharmacy data will be derived from the ID number in Field #4.*)
13	Pharmacy Address	Payee Address	Required	498-PG	2010AA 2010AB	N301	Enter the address of the entity receiving payment.
14	Pharmacy City	Payee City	Required	498-PH	2010AA 2010AB	N401	Enter the city of the entity receiving payment.
15	Pharmacy State & Zip Code	Payee State & Zip	Required	498-PJ 498-PK	2010AA 2010AB	N402-03	Enter the state and zip code of the entity receiving payment.
16	Service Provider I.D.	Payee Tax ID #	Required	498-PP	2010AA 2010AB	NM109	Enter the Federal Tax ID # of the entity receiving payment.
17	Qual (5)	Provider Identifier	Required	498-PP	2010AA 2010AB	NM108	Enter "F" for Federal Tax ID.
18	Pharmacy Phone Number	Payee Phone Number	Required	498-PM	2010AA 2010AB	PER04	Enter the telephone number of the entity receiving payment.
19	Pharmacy Fax Number	*N/A*					*Leave Field Blank*
20	Patient Signature	*N/A*					*Leave Field Blank*
21	Employer Name	Employer Name	Required	315-CF	2000B	SBR04	Enter the name of the employer of the injured worker.
22	Employer Address	Employer Address	Required	316-CG	2010BA	N301	Enter the address of the employer of the injured worker.
23	Employer City	Employer City	Required	317-CH	2010BA	N401	Enter the city of the employer of the injured worker.
24	Employer State	Employer State	Required	318-CI	2010BA	N402	Enter the state of the employer of the injured worker.
25	Employer Zip Code	Employer Zip Code	Required	319-CJ	2010BA	N403	Enter the zip code of the employer of the injured worker.
26	Carrier I.D.	Payer Name and Address	Required	327-CR	2010BB	NM103 NM109 N301 N401 N402 N403	Enter the name and address of the employer's workers' compensation insurance carrier, TPA, or designated payer. *(On the UCF Paper form, the text will need to be formatted to fit into the white space provided in this field area. You may only be able to fit in the carrier or payer name and City, St info. In that case a separate mailing page with the complete mailing address may need to be printed.)*
27	Employer Phone No.	Employer Phone No.	Optional	320-CK	N/A	N/A	Enter the telephone number of the employer of the injured worker.
28	Date of Injury	Date of Injury	Required	434-DY	2300	DTP03	Enter the date the injury occurred - MM DD CCYY
29	Claim Reference I.D.	WC Claim Number	Required (if Known)	435-DZ	2010CA	REF02	Enter the claim number assigned by the workers' compensation Payer, if known. Enter the value of "00" if claim number is unknown.
30	1 - Prescription/Serv. Ref. #	Prescription Number	Required	402-D2	2410	REF02	Enter the pharmacy provided prescription number.
31	1 - Qual (8)	Qualifier Indicator	Required	455-EM	2410	REF01	Enter a "1" to indicate RX billing ("XZ" for 837 format prescription number).
32	1 - Date Written	Date script written	Required	414-DE	2300	K3 62-70	Enter the date the prescription was written - MM DD CCYY.
33	1 - Date of Service	Date script filled	Required	401-D1	2400	DTP03	Enter the date the prescription was filled - MM DD CCYY.

UCF Field #	Paper UCF Field Label	Actual Field Data	DWC Data Type	NCPDP 5.1	ANSI X12 837		Workers' Compensation UCF Paper Form Instructions
					Loop	Field	
34	1 - Fill #	Number of times filled	Situational	403-D3	2300	K3 1-2	Enter the number of times the prescription has been filled.
35	1 - Qty Dispensed	Quantity Dispensed	Required	442-E7	2400	SV104	Enter the quantity of the medication dispensed.
36	1 - Days Supply	Days supply	Required	405-D5	2300	K3 71-73	Enter the number of days supply.
37	1 - Product/Service I.D.	NDC number	Required	407-D7	2410	LIN03	Enter the NDC number for the medication dispensed. For compounds enter "96371" as the NDC number. The payers will need to cross reference the NDC number to determine drug name and strength since the UCF does not have space designated for the drug description.
38	1 - Qual (10)	I.D. Qualifier					*Leave Field Blank - default is NDC number*
39	1 - DAW Code	DAW Code	Required	408-D8	2300	K3 4	Enter the appropriate DAW Code: 1=Substitution Not Allowed by Prescriber 2=Substitution Allowed-Patient Requested Product Dispensed 3=Substitution Allowed-Pharmacist Selected Product Dispensed 4=Substitution Allowed-Generic Drug Not in Stock 5=Substitution Allowed-Brand Drug Dispensed as a Generic 6=Override 7=Substitution Not Allowed-Brand Drug Mandated by Law 8=Substitution Allowed-Generic Drug Not Available in Marketplace
40	1 - Prior Auth # Submitted	Prior Authorization #	Situational	461-EU	2300	REF02	Enter the Prior Authorization number when required.
41	1 - PA Type	Prior Auth # Qualifier	Situational	462-EV	2300	REF01	Enter the Qualifier Code for Prior Authorization number: Ø=Not Specified 1=Prior Authorization 8=Payer Defined Exemption
42	1 - Prescriber I.D.	Doctor's Identification #	Required	411-DB	2420E	NM109	Enter the prescribing doctor's identification number - NPI, DEA or State License #. **California Requires prescribing doctor's DEA identification number** (*Payers will need to maintain a cross-referencing list to capture additional information needed on physician when a paper form is submitted.)*
43	1 - Qual (12)	Prescriber ID Qualifier	Required	466-EZ	2420E	NM108	Enter the Prescriber ID# Qualifier Code: Blank=Not Specified Ø1=National Provider Identifier (NPI) Ø7=NCPDP Provider ID Ø8=State License 12=Drug Enforcement Administration (DEA) Number
44	1 - DUR/PPS Codes	*N/A*					*Leave Field Blank*

UCF Field #	Paper UCF Field Label	Actual Field Data	DWC Data Type	NCPDP 5.1	ANSI X12 837		Workers' Compensation UCF Paper Form Instructions
					Loop	Field	
45	1 - Cost Basis	Basis of Cost Determination	Required	423-DN	2300	K3 42-43	Enter the Cost Determination Code 00=Not Specified 01=AWP (Average Wholesale Price) 02=Local Wholesaler 03=Direct 04=EAC (Estimated Acquisition Cost) 05=Acquisition 06=MAC (Maximum Allowable Cost) 07=Usual & Customary 09=Other
46	1 - Provider I.D.	*N/A*					*Leave Field Blank*
47	1 - Qual (15)	*N/A*					*Leave Field Blank*
48	1 - Diagnosis Code	*N/A*					*Leave Field Blank*
49	1 - Qual (16)	*N/A*					*Leave Field Blank*
50	1 - Other Payer Date	*N/A*					*Leave Field Blank*
51	1 - Other Payer I.D.	*N/A*					*Leave Field Blank*
52	1 - Qual (17)	*N/A*					*Leave Field Blank*
53	1 - Other Payer Reject Codes	*N/A*					*Leave Field Blank*
54	1 - Usual & Cust. Charge	*N/A*					Enter the pharmacy's usual and customary charge as defined by statute or rule.
55	1 - Ingredient Cost Submitted	*N/A*					*Leave Field Blank*
56	1 - Dispensing Fee Submitted	*N/A*					*Leave Field Blank*
57	1 - Incentive Amount Submitted	*N/A*					*Leave Field Blank*
58	1 - Other Amount Submitted	*N/A*					*Leave Field Blank*
59	1 - Sales Tax Submitted	*N/A*					*Leave Field Blank*
60	1 - Gross Amt Due Submitted	Gross Amount Due	Required	430-DU	2400	SV102	Enter the gross amount due for this prescription.
61	1 - Patient Paid Amount	Patient Paid Amount	NA	433-DX	2300	AMT02	Not Applicable for California
62	1 - Other Payer Amount Paid	*N/A*					*Leave Field Blank*
63	1 - Net Amount Due	*N/A*					*Leave Field Blank*
64	2 - Prescription/Serv. Ref. #	Prescription Number	Required	402-D2	2410	REF02	Enter the pharmacy provided prescription number.
65	2 - Qual (8)	Qualifier Indicator	Required	455-EM	2410	REF01	Enter a "1" to indicate RX billing ("XZ" for 837 format prescription number).
66	2 - Date Written	Date script written	Optional	414-DE	2300	K3 62-70	Enter the date the prescription was written - MM DD CCYY.
67	2 - Date of Service	Date script filled	Required	401-D1	2400	DTP03	Enter the date the prescription was filled - MM DD CCYY.

UCF Field #	Paper UCF Field Label	Actual Field Data	DWC Data Type	NCPDP 5.1	ANSI X12 837		Workers' Compensation UCF Paper Form Instructions
					Loop	Field	
68	2 - Fill #	Number of times filled	Situational	403-D3	2300	K3 1-2	Enter the number of times the prescription has been filled.
69	2 - Qty Dispensed	Quantity Dispensed	Required	442-E7	2400	SV104	Enter the quantity of the medication dispensed.
70	2 - Days Supply	Days supply	Required	405-D5	2300	K3 71-73	Enter the number of days supply.
71	2 - Product/Service I.D.	NDC number	Required	407-D7	2410	LIN03	Enter the NDC number for the medication dispensed. For compounds enter "96371" as the NDC number. The payers will need to cross reference the NDC number to determine drug name and strength since the UCF does not have space designated for the drug description.
72	2 - Qual (10)	I.D. Qualifier					*Leave Field Blank - default is NDC number*
73	2 - DAW Code	DAW Code	Required	408-D8	2300	K3 4	Enter the appropriate DAW Code: 1=Substitution Not Allowed by Prescriber 2=Substitution Allowed-Patient Requested Product Dispensed 3=Substitution Allowed-Pharmacist Selected Product Dispensed 4=Substitution Allowed-Generic Drug Not in Stock 5=Substitution Allowed-Brand Drug Dispensed as a Generic 6=Override 7=Substitution Not Allowed-Brand Drug Mandated by Law 8=Substitution Allowed-Generic Drug Not Available in Marketplace
74	2 - Prior Auth # Submitted	Prior Authorization #	Situational	461-EU	2300	REF02	Enter the Prior Authorization number when required.
75	2 - PA Type	Prior Auth # Qualifier	Situational	462-EV	2300	REF01	Enter the Qualifier Code for Prior Authorization number: Ø=Not Specified 1=Prior Authorization 8=Payer Defined Exemption
76	2 - Prescriber I.D.	Doctor's Identification #	Required	411-DB	2420E	NM109	Enter the prescribing doctor's identification number - NPI, DEA or State License #. *(Payers will need to maintain a cross-referencing list to capture additional information needed on physician when a paper form is submitted.)*
77	2 - Qual (12)	Prescriber ID Qualifier	Required	466-EZ	2420E	NM108	Enter the Prescriber ID# Qualifier Code: Blank=Not Specified Ø1=National Provider Identifier (NPI) Ø7=NCPDP Provider ID Ø8=State License 12=Drug Enforcement Administration (DEA) Number
78	2 - DUR/PPS Codes	*N/A*					*Leave Field Blank*

UCF Field #	Paper UCF Field Label	Actual Field Data	DWC Data Type	NCPDP 5.1	ANSI X12 837		Workers' Compensation UCF Paper Form Instructions
					Loop	Field	
79	2 - Cost Basis	Basis of Cost Determination	Required	423-DN	2300	K3 42-43	Enter the Cost Determination Code 00=Not Specified 01=AWP (Average Wholesale Price) 02=Local Wholesaler 03=Direct 04=EAC (Estimated Acquisition Cost) 05=Acquisition 06=MAC (Maximum Allowable Cost) 07=Usual & Customary 09=Other
80	2 - Provider I.D.	*N/A*					*Leave Field Blank*
81	2 - Qual (15)	*N/A*					*Leave Field Blank*
82	2 - Diagnosis Code	*N/A*					*Leave Field Blank*
83	2 - Qual (16)	*N/A*					*Leave Field Blank*
84	2 - Other Payer Date	*N/A*					*Leave Field Blank*
85	2 - Other Payer I.D.	*N/A*					*Leave Field Blank*
86	2 - Qual (17)	*N/A*					*Leave Field Blank*
87	2 - Other Payer Reject Codes	*N/A*					*Leave Field Blank*
88	2 - Usual & Cust. Charge	Usual & Customary	Required	426-DQ	2300	K3 34-41	Enter the pharmacy's usual and customary charge as defined by statute or rule**. Required for California**
89	2 - Ingredient Cost Submitted	*N/A*					*Leave Field Blank*
90	2 - Dispensing Fee Submitted	*N/A*					*Leave Field Blank*
91	2 - Incentive Amount Submitted	*N/A*					*Leave Field Blank*
92	2 - Other Amount Submitted	*N/A*					*Leave Field Blank*
93	2 - Sales Tax Submitted	*N/A*					*Leave Field Blank*
94	2 - Gross Amt Due Submitted	Gross Amount Due	Required	430-DU	2400	SV102	Enter the gross amount due for this prescription.
95	2 - Patient Paid Amount	Patient Paid Amount	NA	433-DX	2300	AMT02	Not Applicable to California
96	2 - Other Payer Amount Paid	*N/A*					*Leave Field Blank*
97	2 - Net Amount Due	*N/A*					*Leave Field Blank*

TEMPLATE for the 498-PP Field: The data will be input using a comma delimited format in the following order - Pay To ID # (see Field 498-PF), Pay To ID Qualifier (See Code List), Jurisdictional Defined Field 1, Jurisdictional Defined Field 2, Jurisdictional Defined Field 3, END - - - The jurisdictional defined fields can be used for information that is required but does not have an NCPDP 5.1 field. The 498-PP field is 500 characters long.

EXAMPLE: 87111111,F, , , ,END

Position	UCF Paper Field	NCPDP Field Name	R/O	Type	Min/Max	Comments
1-2	34 & 68	403-D3	R	9(2)	2	Fill Number
3			O	ID	1	Compound
4	39 & 73	408-D8	R	ID	1	Dispense as written code
5			O	ID	1	Submission Clarification Code
6			O	ID	1	Unit Dose Indicator
7-8			O	ID	2	Prior Authorization Type Code
9-16			O	9(6)v99	8	Dispensing Fee Submitted Format Implied
17-24			O	9(6)v99	8	Percentage Sales Tax Amount Submitted
25-31			O	9(3)v9(4)	7	Percentage Sales Tax Rate Submitted Format
32-33			O	ID	2	Percentage Sales Tax Basis Submitted
34-41			R	9(6)v99	8	Usual and Customary Charge
42-43	45 & 79	423-DN	R	ID	2	Basis of Cost Determination
44-45			O	ID	2	Reason for Service Code
46-47			O	ID	2	Professional Service Code
48-49			O	ID	2	Result of Service Code
50-51			O	ID	2	Reason for Service Code
52-53			O	ID	2	Professional Service Code
54-55			O	ID	2	Result of Service Code
56-57			O	ID	2	Reason for Service Code
58-59			O	ID	2	Professional Service Code
60-61			O	ID	2	Result of Service Code
62-69	32 & 66	414-DE	R	D	8	Date Prescription Written
70			O	ID	1	Other Coverage Code
71-73	36 & 70	405-D5	R	9(3)	3	Days Supply
74-80			O	AN	6	Not used at this time

Appendix F - Dental/837 Mapping

The referenced document maps the paper ADA Dental billing form to the ANSI 837 Dental billing format.

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Paper Field	ANSI 837 Version			2006 ADA Claim Form Field Description	Workers' Compensation Paper Fields R/S/O	Comments
	Loop	Element	Qual			
1				Blank	N/A	
2	2300	REF02	G3	Predetermination/Preauthorization Number Enter the Claim Reference Number (CRN) of the original bill when resubmitting a bill.	Situational	Enter Certification or Authorization Number Provided By Payer
PRIMARY PAYER INFORMATION						
3	2010BB	NM103	PR	Name	Required	Workers' Compensation Payer Name & Address
	2010BB	N301		Address		
	2010BB	N401		City		
	2010BB	N402		State		
	2010BB	N403		Zip Code		
	NA	NA	NA	Phone Number		
OTHER COVERAGE (Not Applicable)						
4				Other Dental or Medical Coverage?	N/A	
5				Subscriber Name, Address	N/A	
6				Date of Birth	N/A	
7				Gender	N/A	
8				Subscriber Identifier	N/A	
9				Plan/Group Number	N/A	
10				Relationship to Primary Subscriber	N/A	
11				Other Carrier Name, Address	N/A	
PRIMARY SUBSCRIBER INFORMATION (Employer)						
12	2010BA	NM103	IL	Primary Subscriber Name (Employer)	Required	Employer Name and Address
	2010BA	N301		Address	Required	
	2010BA	N401		City		
	2010BA	N402		State		
	2010BA	N403		Zip Code		
	NA			Telephone Number, If Known		
13				Date of Birth	N/A	
14				Gender	N/A	
15	2010CA	REF02	Y4	Subscriber ID (SSN)- Workers' Compensation Claim Number	Situational	Workers' Compensation Claim Number, If Known
16	2300	CLM01		Plan / Group Number- Unique Patient Bill Identifier Number Assigned by Provider	Required	Patient Account Number
17				Employer Name	N/A	
PATIENT INFORMATION (Injured Worker)						
18	2000C	PAT01		Relationship to Primary Subscriber	Optional	Check "Other" Box
19				Student Status	N/A	
20	2010CA	NM103	QC	Patient's Last Name	Required	
	2010CA	NM104		Patient's First Name		
	2010CA	NM105		Patient's Middle Name		
	2010CA	N301		Address		
	2010CA	N401		City		
	2010CA	N402		State		

Paper Field	ANSI 837 Version			2006 ADA Claim Form Field Description	Workers' Compensation Paper Fields R/S/O	Comments
	Loop	Element	Qual			
	2010CA	N403		Zip Code		
	2010CA	N404		Telephone Number, If Known		
21	2010CA	DMG02		Patient Date of Birth	Required	
22	2010CA	DMG03		Gender	Required	
23	2010CA	NM109		Patient ID Number (Social Security Number)	Required	Social Security Number
RECORD OF SERVICES PROVIDED						
24	2400	DTP03	472	Date of Service	Required	
25	2400	SV304-1		Area of oral Cavity	Situational	
26	2400	TOO01		Tooth System	Situational	
27	2400	TOO02		Tooth Number's) or Letter(s)	Situational	
28	2400	TOO03-1		Tooth Surface	Situational	
29	2400	SV301-2	AD	Procedure code	Required	
30	2400	SV301-7		Description of service provided.	Required	
31	2400	SV302		Fees	Required	
32				Other fees	N/A	
33	2300	CLM02		Total Fees	Required	
MISSING TEETH INFORMATION						
34	2300	NTE02		Report missing teeth on each claim submission.	Situational	
35	2300	PWK06/NTE02		Remarks (Attachment Control Number and or Notes)	Situational	
AUTHORIZATIONS						
36				Authorization Signature 1	N/A	
37				Authorization Signature 2	N/A	
ANCILLARY CLAIM/TREATMENT INFORMATION						
38	2300	CLM05		Place of Treatment	Required	Place of Service
39	2300	PWK06		Indicate the number of enclosures	Situational	
40	2300	DN103		Is Treatment for Orthodontics	Required	
41	2300	DTP03	452	Date Appliance Placement	Situational	
42	2300	DN102		Months of treatment remaining	Situational	
43	NA			Replacement of Prosthesis?	Situational	
44	NA			Date Prior Placement	Situational	
45	2300	CLM11-1	EM	Treatment Resulting From	Required	
46	2300	DTP03	439	Date of Accident	Required	
47	2300	CLM11-4		Auto Accident State	Situational	
BILLING DENTIST OR DENTAL ENTITY						
48	2010AA	NM103	85	Name	Required	
	2010AA	N301		Address		
	2010AA	N401		City		
	2010AA	N402		State		
	2010AA	N403		Zip Code		

Paper Field	ANSI 837 Version			2006 ADA Claim Form Field Description	Workers' Compensation Paper Fields R/S/O	Comments
	Loop	Element	Qual			
	2010AA	PER04	TE	Phone Number		
49	2010AA	NM109	XX	Provider ID -NPI Number	Situational	NPI Number Required if Billing Provider is a Health Care Entity
50	2010AA	REF02	0B	License Number (state license)	Situational	State License Number Required if Billing Provider is a Health Care Entity
51	2010AA	REF02	SY	SSN or TIN	Required	
			EI			
52	2010AA	PER04	TE	Phone number of the entity listed in box 48.	Required	
TREATING DENTIST AND TREATMENT LOCATION INFORMATION						
53	2300	CLM06		Signed (Treating Dentist) and Date	Required	If signed enter Y in CLMO6 Field or N if not signed
	2310B	NM103	82			
	2310B	NM104				
	2310B	NM105				
54	2310B	NM109	XX	Provider ID -NPI Number	Required	Required When Mandate Date is Effective
55	2310B	REF02	0B	License Number (state license)	Required	
56	2310C	N301		Address	Required	
	2310C	N401		City		
	2310C	N402		State		
	2310C	N403		Zip Code		
56a	2310B	PRV03	ZZ	Provider Specialty Code	Required	Enter Provider Taxonomy Code
57	NA			Phone number	Situational	

Appendix G – Scenarios

Reserved for Future Use

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Appendix H – Glossary of Terms

Acknowledgment	Electronic notification to original sender of an electronic file that the file or the transactions within the file were received and accepted or rejected.
ADA	American Dental Association.
ADA-2006	American Dental Association (ADA) standard paper billing form.
AMA	American Medical Association
ANSI	American National Standards Institute is a private, non-profit organization that administers and coordinates the U.S. voluntary standardization and conformity assessment system.
ANSI X12 275	National standard format for attachments/documentation. The 275 format is being reviewed for possible adoption as a HIPAA standard format.
ANSI X12 824	HIPAA compliant national standard detail acknowledgment format.
ANSI X12 835	HIPAA compliant national standard remittance/reimbursement format.
ANSI X12 837	HIPAA compliant national standard billing format for professional services (837P), hospital/facility services (837I), and dental services (837D).
ANSI X12 997	HIPAA compliant national standard functional acknowledgment format.
CDT	Current Dental Terminology coding system used to bill dental services.
Clearinghouse	An entity that processes information received in a nonstandard format or containing nonstandard data content into a standard transaction, or that receives a standard transaction and processes that information into a nonstandard transaction
CMS	Centers for Medicare and Medicaid Services, the federal agency and administers these programs.
CMS-1450	The paper hospital, institutional or facility billing form also referred to as a UB-04 or UB-92, formerly referred to as a HCFA-1450.
CMS-1500	The paper professional billing form formerly referred to as a HCFA or HCFA-1500.

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Code Sets	Tables or lists of codes used for specific purposes. National standard formats may use code sets developed by the standard setting organization (i.e. ANSI Provider Type qualifiers) or by other organizations (i.e. HCPCS codes).
CPT	Current Procedural Terminology is the coding system created and copyrighted by the American Medical Association used to bill professional services.
DEA	Drug Enforcement Agency
DEA Number	Prescriber DEA identifier used for pharmacy billing.
Detail Acknowledgment	Electronic notification to original sender of an electronic file that the transactions within a file were received and accepted or rejected.
DWC	Division of Workers' Compensation.
Electronic Bill	A bill submitted from the health care provider, health care facility, or third-party biller/assignee to the payor electronically.
EFT	Electronic Funds Transfer.
Electronic File	A collection of data stored in a defined electronic format. An electronic file may be a single electronic transaction or a set of transactions.
Electronic Format	The specifications defining the layout of data in an electronic file.
Electronic Record	A group of related data elements. A record may represent a line item, a health care provider, health care facility, or third party biller/assignee, or an employer. One or more records may form a transaction.
Electronic Transaction	A set of information or data stored electronically in a defined format that has a distinct and different meaning as a set. An electronic transaction is made up of one or more electronic records.
Electronic Transmission	Transmission of information by facsimile, electronic mail, electronic data interchange, or any other similar method and does not include telephonic communication. For the purposes of the Electronic Billing rules, electronic transmission generally does not include facsimile or electronic mail.
EOB/EOR	Explanation of Benefits (EOB) or Explanation of Review (EOR) is paper form sent by the Claims Administrator to the health care provider, health care facility, or third party biller/assignee to explain payment or denial of a medical bill. The EOB/EOR might also be used to request a recoupment of an overpayment or acknowledge receipt of a refund.

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Functional Acknowledgment	Electronic notification to original sender of an electronic file that the file was received and accepted or rejected.
HCPCS	Health Care Common Procedure Coding System is the HIPAA code set used to bill durable medical equipment, prosthetics, Orthotics, supplies, and biologics (Level II) as well as professional services (Level I). Level I HCPCS codes are CPT codes.
HIPAA	Health Insurance Portability and Accountability Act, federal legislation that includes provisions that mandate electronic billing in the Medicare system and establishes national standard electronic file formats and code sets.
IAIABC	International Association of Industrial Accident Boards and Commissions.
IAIABC 837	A version of the ANSI 837 electronic file format adopted by IAIABC for Claims Administrator-to-jurisdiction reporting of medical bill payment data.
ICD-9	International Classification of Diseases, the code set administered by the World Health Organization used to identify diagnoses.
MPN	Medical Provider Network
NABP	National Association of Boards of Pharmacy, the organization previously charged with administering pharmacy unique identification numbers.
NABP Number	Identification number assigned to individual pharmacy, now administered by NCPDP.
NCPDP	National Council on Prescription Drug Programs, organization currently administering pharmacy unique identification numbers.
NCPDP Number	Identification number assigned to individual pharmacy, previously referred to as NABP number.
NCPDP Telecommunication 5.1	HIPAA compliant national standard billing format for pharmacy services.
NDC	National Drug Code, code set used to identify medication dispensed by pharmacies.
Network	Provider network
OMFS	Official Medical Fee Schedule
PBM	Pharmacy Benefit Manager.
POC	Proof of Coverage.

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POS	Point of Sale System
PPO	Preferred Provider Organization
Receiver	The entity receiving/accepting an electronic transmission.
Remittance	Remittance is used in the electronic environment to refer to reimbursement or denial of medical bills.
Sender	The entity submitting an electronic transmission.
Switches	Clearinghouses transmitting information between entities that do not convert data. Switches may be a "connection" between entities that do not have a direct interface.
TPA	Third Party Administrator.
Trading Partner	An entity submitting electronic transmissions to the Division in a test or production environment. It is also used to refer to both sides of an electronic transaction.
UB-04	Universal billing form used for hospital billing. Replaces the UB-92 as the CMS-1450 billing form effective May 23, 2007.
UB-92	Universal billing form used for hospital billing, also referred to as a CMS-1450 billing form. Discontinued use as of May 23, 2007
UCF	Universal Claim Form, NCPDP proprietary pharmacy billing form.
Version	Electronic formats may be modified in subsequent releases. Version naming conventions indicate the release or version for a format. Naming conventions are administered by the standard setting organization. Some ANSI formats, for example, are 3050, 4010, and 4050.

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Appendix I Code Set Matrix

The table below provides a matrix of the code sets used in the companion guide.

Code Set	Definition	Publishing Entity
APPLICATION ACKNOWLEDGMENT CODE	A code used to identify the accepted/rejected status of the transaction being acknowledged.	Washington Publishing Company, www.wpc-edi.com/ 747 177th Lane NE Bellevue WA 98008
BASIS OF COST DETERMINATION	Method by which drug cost was calculated. Used for statistical analysis and cost comparison.	National Council for Prescription Drug Programs, (NCPDP) www.**ncpdp**.org 9240 E. Raintree Dr. Scottsdale, Arizona 85260-7518
BILL SUBMISSION REASON CODE	Code indicating bill submission/re-submission type. Determine status and reason for submission; monitors medical costs.	Washington Publishing Company, www.wpc-edi.com/ 747 177th Lane NE Bellevue WA 98008
BILLING TYPE CODE	Code indicating type of bill. Statistical analysis and audit information, tracing medical costs.	National Uniform Billing Committee American Hospital Association www.**nubc**.org/ One North Franklin, Chicago, IL 60606-3421
CDT Code	American Dental Association Codes on Dental Procedure and Nomenclature (Current Dental Terminology) used to identify dental procedure billed & paid.	American Dental Association http://www.ada.org/ 211 East Chicago Ave. Chicago, IL 60611-2678
CLAIM ADJUSTMENT GROUP CODE	Codes indicating general category of payment adjustment at the bill level and service line. Identifies potential litigation; tracking medical costs; used for statistical analysis.	Washington Publishing Company, www.wpc-edi.com/ 747 177th Lane NE Bellevue WA 98008
CLAIM ADJUSTMENT REASON CODE	Codes indicating detailed reason an adjustment was made at the bill and service line levels. Required in order to access the appropriateness of the adjustment or the basis of the adjustment being made.	Washington Publishing Company, www.wpc-edi.com/, 747 177th Lane NE Bellevue WA 98008 Jurisdiction reason codes administered by CA, DWC http://www.dir.ca.gov/dwc/ P.O. Box 71010 Oakland, CA 94612

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Code Set	Definition	Publishing Entity
COUNTRY CODE	Code indicating country of the billing provider's mailing address. Identify provider's location; reimbursement determination.	U.S. Postal Service www.**usps**.com/
DISPENSE AS WRITTEN CODE	A code denoting methodology utilized in dispensing medication. Measuring medical cost trends; managed care certification, impact of medical treatment guidelines.	National Council for Prescription Drug Programs, (NCPDP) www.**ncpdp**.org/ 9240 E. Raintree Dr. Scottsdale, Arizona 85260-7518
DRG CODE	A DRG (Diagnosis Related Group) is a classification of a hospital stay in terms of what was wrong and what was done for a patient. The DRG classification (one of about 500) is determined by an A grouper@ program based on diagnoses and procedures coded in ICD-9 CM and on patient age, sex, length of stay, and other factors. The DRG frequently determines the amount of money that will be reimbursed, independently of the charges that the hospital may have incurred. In the United States, the basic set of DRG codes are those defined by CMS for adult Medicare billing. For other patients types and payers CHAMPUS (Civilian Health and Medical Services of the Uniformed Services), Medicaid, commercial payers for neonate claims, Workers' Compensation, modifier grouper and additional DRG codes are used.	Fee Schedules http://www.dir.ca.gov/dwc/ DWC – Fee Schedules P.O. Box 71010 Oakland, CA 94612
DWC BILL ADJUSTMENT REASON CODE	The DWC Bill Adjustment Reason Codes are a group of codes developed by the California Division of Workers' Compensation to describe the specific reasons why a particular billed code has not been paid or has been paid at a different rate than that which was billed or to request additional information.	The DWC Medical Billing and Payment Guide DWC – Fee Schedules P.O. Box 71010 Oakland, CA 94612
ELEMENT ERROR NUMBER	A number to uniquely identify the edit performed on an element and is part of the error code.	Washington Publishing Company, www.wpc-edi.com/ 747 177th Lane NE Bellevue WA 98008

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Code Set	Definition	Publishing Entity
HCPCS PROCEDURE CODE	HCPCS (Health Care Common Procedure Coding System) code billed and paid. Procedure codes identify treatment rendered for professional services, durable medical equipment, prosthetics, orthotics, and medical supplies.	American Medical Association www.ama-assn.org/ 515 N. State Street Chicago, IL 60610
Hospital Admission Type Code	Code indicating admission priority. Identifies potential reimbursement formulas and pre-authorization of services.	National Uniform Billing Committee American Hospital Association www.**nubc**.org/ One North Franklin, Chicago, IL 60606-3421
Hospital BILL FREQUENCY TYPE CODE	Code indicating claim billing status. Statistical analysis and audit information.	National Uniform Billing Committee American Hospital Association www.**nubc**.org/ One North Franklin, Chicago, IL 60606-3421
Hospital FACILITY CODE	Code indicating type of facility where treatment was rendered. Utilization review, audit, statistical analysis.	National Uniform Billing Committee American Hospital Association www.**nubc**.org/ One North Franklin, Chicago, IL 60606-3421
HOUR	The time claimant was admitted / discharged from the facility. Determine length of stay.	National Uniform Billing Committee American Hospital Association www.**nubc**.org/ One North Franklin, Chicago, IL 60606-3421
ICD-10 CM Diagnosis	International Classification of Diseases, Clinical Modification - used to code and classify diagnoses.	World Health Organization through the National Center for Health Statistics (NCHS) responsible for maintaining codes. CMS provides and updates tables. http://www.cms.hhs.gov/ 7500 Security Boulevard Baltimore, MD 21244
ICD-9 Procedure Code	International Classification of Diseases, Clinical Modification Procedure Codes - classification system for surgical, diagnostic, and therapeutic procedures.	World Health Organization through the National Center for Health Statistics (NCHS) responsible for maintaining codes. CMS provides and updates tables. http://www.cms.hhs.gov/ 7500 Security Boulevard Baltimore, MD 21244

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Code Set	Definition	Publishing Entity
International Classification of Diseases Clinical Mod (ICD-9 CM) Procedure.	The International Classification of Diseases, Ninth Revision, Clinical Modification, describes the classification or morbidity and mortality information for statistical purposes and the indexing of hospital records by disease and operations.	World Health Organization through the National Center for Health Statistics (NCHS) responsible for maintaining codes. CMS provides and updates tables. http://www.cms.hhs.gov/ 7500 Security Boulevard Baltimore, MD 21244
JURISDICTION MODIFIER BILLED AND PAID CODE	Two digit codes attached to HCPCS procedure to modify the defined meaning of the code.	Fee Schedules http://www.dir.ca.gov/dwc/ DWC – Fee Schedules P.O. Box 71010 Oakland, CA 94612
JURISDICTION PROCEDURE BILLED AND PAID CODE	Jurisdictional special code identifying a procedure, service or product billed that is not currently identified by a HCPCS code. Monitoring medical charges, quality of medical care, and utilization.	Fee Schedule http://www.dir.ca.gov/dwc/ DWC – Fee Schedules P.O. Box 71010 Oakland, CA 94612
NDC CODE	NDC (National Drug Code) identifying drugs or pharmaceuticals billed. Monitoring medical charges, quality of medical care, and utilization. The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.	Food and Drug Administration http://www.fda.gov/cder/ndc/ 5600 Fishers Lane, HFD-240 Rockville, MD 20857
NPI	National Provider Identifier (NPI) assigned by CMS, replaces UPIN and other proprietary provider identification numbers for public and provides health care transactions.	Center for Medicare and Medicaid Services (CMS) http://www.cms.hhs.gov/ 7500 Security Boulevard Baltimore, MD 21244
PLACE OF SERVICE	Identifies location where professional services were rendered.	Center for Medicare and Medicaid Services (CMS) http://www.cms.hhs.gov/ 7500 Security Boulevard Baltimore, MD 21244
POSTAL CODE	Postal code (zip code) of provider's mailing address of the billing provider. Identification of provider; monitor health care providers for compliance with fee and treatment guidelines.	U.S. Postal Service www.**usps**.com/

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Code Set	Definition	Publishing Entity
PRESCRIBER DEA NUMBER	Drug Enforcement Agency of the Federal Justice Department assigns a unique number to physicians prescribing controlled substances.	Federal Drug Enforcement Agency www.usdoj.gov/dea/ 2401 Jefferson Davis Highway Alexandria, VA 22301
PROVIDER LICENSE NUMBER	Unique provider identification number assigned by a licensing/certifying entity.	Licensing/certifying boards or commissions.
PROVIDER TAXONOMY CODES	Code indicating primary medical specialty of billing provider. Identification of provider; monitor health care providers for compliance with fee and treatment.	Washington Publishing Company, www.wpc-edi.com/ 747 177th Lane NE Bellevue WA 98008
REMITTANCE ADVICE REMARK CODES	Convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	Washington Publishing Company, www.wpc-edi.com/ 747 177th Lane NE Bellevue WA 98008
REVENUE BILLED & PAID CODE (B5)	Code indicating specific cost center billed and paid. Determines reimbursement and treatment provided or specific cost center paid.	National Uniform Billing Committee American Hospital Association www.**nubc**.org/ One North Franklin, Chicago, IL 60606-3421
Rx NCPDP Number	National Council of Prescription Drug Programs pharmacy identification number	National Council of Prescription Drug Programs www.**ncpdp**.org/ 9240 E. Raintree Dr. Scottsdale, Arizona 85260-7518
STATE CODE	State code of provider's mailing address of the billing provider. Identify provider's location; reimbursement determination.	U.S. Postal Service www.**usps**.com/
Tooth Letter	American Dental Association letter assigned to represent primary teeth.	American Dental Association http://www.ada.org/ 211 East Chicago Ave. Chicago, IL 60611-2678
Tooth Number	American Dental Association number assigned to represent permanent teeth.	American Dental Association http://www.ada.org/ 211 East Chicago Ave. Chicago, IL 60611-2678
Tooth Surface Code	American Dental Association letter used to designate tooth surface.	American Dental Association http://www.ada.org/ 211 East Chicago Ave. Chicago, IL 60611-2678

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Appendix J HIPAA/Workers' Compensation Gap Analysis

The HIPAA/Workers' Compensation Gap Analysis identifies occurrences at the Loop, Segment, Field, and Code(s) level where the workers' compensation usage is different in than the HIPAA implementation. Specific direction is provided in this companion guide for the usage and conditions for the California workers' compensation implementation.

The HIPAA/Workers' Compensation Gap Analysis Tables that follow this section address the following categories; 837 Billing Format, 835 Remittance Format ,GS Functional Group, ANSI Claim Adjustment Reason Codes and ANSI Claim Adjustment Remittance Remark Codes.

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California Division of Workers' Compensation
Electronic Billing and Reimbursement (eBill) Project
California and Texas ANSI 835 HIPAA/Workers' Compensation Gap Analysis

Loop	Segment	Field	HIPAA	WC	Comments	Action
	Required (R), Situational (S), Jurisdictional (J), Not Used (N)					
1000A Payer Identification	N1 Identification - Payer Name	N102 Name	S	R	Required element for CA & TX WC...	Jurisdiction Requirement
1000A Payer Identification	REF Reference Identification - Payer Identification		S	J	Required Segment for CA & TX WC.	Jurisdiction Requirement
1000B Payee Identification	N1 Identification - Payee Name	N102 Name	S	R	Required element for CA & TX WC.	Jurisdiction Requirement
1000B Payee Identification	REF Reference Identification - State License number		S	J	Required Segment for CA & TX WC.	Jurisdiction Requirement
2100 Bill Payment Information	NM1 Individual or Organizational Name - Patient Name	NM108 Identification Code Qualifier	S	R	Required element for CA & TX WC.	Jurisdiction Requirement
2100 Bill Payment Information	NM1 Individual or Organizational Name - Patient (Injured Employee) Name	NM109 Patient SSN	S	R	Required element for CA & TX WC.	Jurisdiction Requirement
2100 Bill Payment Information	NM1 Individual or Organizational Name - Insured (Employer) Name		S	R	Required Segment for CA & TX WC.	Jurisdiction Requirement
2100 Bill Payment Information	NM1 Individual or Organizational Name - Insured (Employer) Name	NM103 Organization Name (Employer)	S	R	Required element for CA & TX WC.	Jurisdiction Requirement
2100 Bill Payment Information	REF Reference Identification - WC Claim Number		S	J	Required Segment for CA & TX WC.	Jurisdiction Requirement
2100 Bill Payment Information	DTM Date Time - Date of Accident (Date of Injury)		N	J	Required Segment for CA & TX WC.	Coordinate with IAIABC to request ANSI consider the use of Segment for 835 processing.
2100 Bill Payment Information	DTM Date Time - Bill Received Date (Date Carrier Received Bill)		S	J	Required Segment for CA & TX WC.	Jurisdiction Requirement
2100 Bill Payment Information	PER Contact Information - Bill Contact Information		S	J	Required Segment for CA & TX WC.	Jurisdiction Requirement
2100 Bill Payment Information	PER Contact Information - Bill Contact Information	PER03 Communications Number Qualifier	S	J	Required element for CA & TX WC.	Jurisdiction Requirement
2100 Bill Payment Information	PER Contact Information - Bill Contact Information	PER04 Communications Number	S	J	Required element for CA & TX WC.	Jurisdiction Requirement
2110 Service Payment Information	REF Reference Identification - Prescription Number		N	J	Required Segment for CA & TX WC.	Coordinate with IAIABC to request ANSI consider the use of Segment for 835 processing.
2100 Bill Payment Information	CAS Claim Adjustment Group Code		S	J	Group Code MA required for California State Reporting. The MA code is an inactive ANSI Code.	Coordinate with IAIABC to request ANSI consider activating the MA Group Code for use in 835 processing.
2100 Bill Payment information	CAS Claim Adjustment Reason Code		S	J	Required Jurisdictional Adjustment Reason Codes for Ca and TX	Coordinate with IAIABC to request ANSI to adopt the California and Texas jurisdictional codes

California Division of Workers' Compensation
Electronic Billing and Reimbursement (eBill) Project
California and Texas ANSI 835 HIPAA/Workers' Compensation Gap Analysis

Loop	Segment	Field	HIPAA	WC	Comments	Action
	Required (R), Situational (S), Jurisdictional (J), Not Used (N)					
2110 Service Payment Information	CAS Claim Adjustment Group Code		S	J	Group Code MA used for California State Reporting. The MA code is an inactive ANSI Code.	Coordinate with IAIABC to request ANSI to activate the MA Group Code for use in 835 processing.
2110 Service Payment information	CAS Claim Adjustment Reason Code		S	J	Required Jurisdictional Adjustment Reason Codes for Ca and TX	Coordinate with IAIABC to request ANSI to adopt the California and Texas jurisdictional codes
2110 Service Payment Information	LQ Remittance Remark Codes		S	J	Required Jurisdictional Remittance Remark Codes for Ca	Coordinate with IAIABC to request ANSI to adopt the California jurisdictional codes
2100 Bill Payment Information	REF Reference Identification Other Claim Related Identification Jurisdiction EOR/EOB Statement ID Qualifier Code		S	J	Required Jurisdictional EOR/EOB Statement ID Code Qualifier for Ca and TX	California and Texas are recommending a code set be created and administered by IAIABC to represent each jurisdiction's code or codes that communicate similar information but do not meet the function of a Claim Adjustment Reason Code
ANSI Gap Analysis GS Functional Group Envelope	GS Functional Group envelope (GS-GE) Segment field GS08	GS08	R	J	Version Control Identification Naming Convention: Providing for a workers' compensation indicator (WC) ensures consistent implementation of workers' compensation requirements and minimizes impact on standard translator applications.	California and Texas have requested through IRR to the IAIABC to adopt the WC Version Control Identification Naming Convention

California Division of Workers' Compensation
Electronic Billing and Reimbursement (eBill) Project
Texas California ANSI 837 HIPAA/Workers' Compensation Gap Analysis

Loop	Segment	Field	HIPAA P/I/D	WC P/I/D	Comments	Action
Professional (P), Institutional/Hospital (I), Dental (D)	***Required (R), Situational (S), Jurisdictional (J), Not Used (N)***					
2000A Billing/Pay to Provider	PRV Provider Information - Provider Taxonomy Code		P/I/D-S	P/I/D-J	Provider Taxonomy Code is required when entity is a health care provider.	Jurisdiction Requirement
2010AA Billing Provider	REF Reference Identification - State License		P/I/D-S	P/I/D-J	State License is required when entity is a health care provider.	Jurisdiction Requirement
2010AA Billing Provider	REF Reference Identification - Dentist License		D-S	D-J	Required when Dentist License Number is different than State License.	Jurisdiction Requirement
2010AA Billing Provider	PER Contact Information - Billing Provider Contact Information		D-N	D-J	Billing Provider Contact Information mandatory when it is different than Sender Contact Information.	Coordinate with IAIABC to request ANSI consider the use of field for Dental billing.
2010AB Pay to Provider	REF Reference Identification - State License		P/I/D-S	P/I/D-J	State License is required when entity is a health care provider.	Jurisdiction Requirement
2010AB Pay to Provider	PER Contact Information - Pay to Provider Contact Information		D-N	D-J	Pay to Provider Contact Information mandatory when it is different than Sender Contact Information.	Coordinate with IAIABC to request ANSI consider the use of field for Dental billing.
2000B Subscriber (Employer) Detail	SBR Subscriber (Employer) Information	SBR04 Employer Name	I-S	I-J	Employer Name required for Texas and California workers' compensation.	Jurisdiction Requirement
2000B Subscriber (Employer) Detail	SBR Subscriber (Employer) Information	SBR09 Claim Filing Indicator	P/I/D-S	P/I/D-J	Populated qualifier WC Workers' Compensation (TX, CA).	Jurisdiction Requirement
2010BA Subscriber (Employer) Information	N3 Address - Employer Address		P/I/D-S	P/I/D-J	Required Segment for TX & CA WC.	Jurisdiction Requirement
2010BA Subscriber (Employer) Information	N4 City, State, Zip - Employer City, State, Zip		P/I/D-S	P/I/D-J	Required Segment for TX & CA WC.	Jurisdiction Requirement
2000C Patient (Injured Employee) Hierarchical Information	HL Patient (Injured Employee) Hierarchical Level		P/I/D-S	P/I/D-J	Required Segment for TX & CA WC.	Jurisdiction Requirement
2300 Claim (Bill) Information	CLM Claim Information	CLM19 Bill Submission Reason Code	P/I/D-N	P/I/D-J	Resubmission codes required when CLM05-3 indicates bill transaction is a resubmission.	Jurisdiction Requirement
2300 Claim (Bill) Information	DTP Date of Accident (Date of Injury or Illness)		P/I/D-S	P/I/D-J	Required Segment for TX & CA WC.	Jurisdiction Requirement
2300 Claim (Bill) Information	DTP Date of Service		D-S	D-J	Required Segment for TX & CA WC.	Jurisdiction Requirement

California Division of Workers' Compensation
Electronic Billing and Reimbursement (eBill) Project
Texas California ANSI 837 HIPAA/Workers' Compensation Gap Analysis

Loop	Segment	Field	HIPAA P/I/D	WC P/I/D	Comments	Action
Professional (P), Institutional/Hospital (I), Dental (D)	***Required (R), Situational (S), Jurisdictional (J), Not Used (N)***					
2300 Claim (Bill) Information	PWK Paperwork - Attachment	PWC05 Identification Code Qualifier	P/I/D-S	P/I/D-R	Required element for TX & CA WC.	Jurisdiction Requirement
2300 Claim (Bill) Information	PWK Paperwork - Attachment	PWC06 Attachment Control Number	P/I/D-S	P/I/D-R	Require element for TX & CA WC.	Jurisdiction Requirement
2300 Claim (Bill) Information	AMT Amount - Patient Paid Amount		D-S	D-N	Not Used (N) in workers' compensation.	Jurisdiction Requirement
2300 Claim (Bill) Information	REF Reference Identification - Medical Record Number		I-S	I-J	Medical Record Number is not required for Texas workers' compensation (optional).	Jurisdiction Requirement
2300 Claim (Bill) Information	HI Health Care Information - DRG Information		I-S	I-J	Diagnosis Related Grouping (DRG) Code required for inpatient billing	Jurisdiction Requirement
2300 Claim (Bill) Information	HI Health Care Information - Occurrence Codes and Dates		I-S	I-J	First Occurrence Code and Date populated with DOI information.	Jurisdiction Requirement
2300 Claim (Bill) Information	QTY Quantity - Covered Days		I-S	I-N	Not Used (N) in workers' compensation.	Jurisdiction Requirement
2300 Claim (Bill) Information	QTY Quantity - Non-covered Days		I-S	I-N	Not Used (N) in workers' compensation.	Jurisdiction Requirement
2300 Claim (Bill) Information	QTY Quantity - Co-insured Days		I-S	I-N	Not Used (N) in workers' compensation.	Jurisdiction Requirement
2300 Claim (Bill) Information	QTY Quantity - Lifetime Reserved Days		I-S	I-N	Not Used (N) in workers' compensation.	Jurisdiction Requirement
2310A Attending Provider Information - Institutional use of Referring Provider Loop	NM1 Individual or Organizational Name - Attending Physician Name (Institutional use of Referring Provider Loop.		I-S	I-J	Attending Provider (Referring Provider) required for all institutional/hospital transactions.	Jurisdiction Requirement
2310A Referring Provider Information	REF Reference Identification - State License		P/D-S	P/D-J	Required Segment for TX & CA WC.	Jurisdiction Requirement
2310B Rendering Provider Information	REF Reference Identification - State License		P/D-S	P/D-J	Required Segment for TX & CA WC.	Jurisdiction Requirement
2310C Facility/Service Location Information - Dental use of Other Provider/Facility Loop	NM1 Individual or Organizational Name - Facility/Service Location Name	NM103 Organization Name	D-S	D-R	Required field for TX & CA WC.	Jurisdiction Requirement
2310C Other Provider (Operating) Information - Institutional use of Other Provider/Facility Loop	REF Reference Information - State License		I-S	I-J	Required Segment for TX & CA WC.	Jurisdiction Requirement
2310D Facility/Service Location Information	NM1 Individual or Organizational Name - Facility/Service Location Name	NM103 Organization Name	P-S	P-R	Required Segment for TX & CA WC. Not required in 4010 version for 837I, 2310D Loop becomes effective for 5010 version.	Jurisdiction Requirement

California Division of Workers' Compensation
Electronic Billing and Reimbursement (eBill) Project
Texas California ANSI 837 HIPAA/Workers' Compensation Gap Analysis

Loop	Segment	Field	HIPAA P/I/D	WC P/I/D	Comments	Action
Professional (P), Institutional/Hospital (I), Dental (D)	***Required (R), Situational (S), Jurisdictional (J), Not Used (N)***					
2310D Assisting Surgeon - Dental use of Facility/Service Location Loop	REF Reference Identification - State License		D-S	D-R	Required Segment for TX & CA WC.	Jurisdiction Requirement
2310E Facility/Service Location Information - Institutional use of Facility/Service Location Loop	NM1 Individual or Organizational Name - Facility/Service Location Name	NM108 Identification Code Qualifier	I-S	I-R	NPI qualifier required for Institutional/Hospital transactions	Jurisdiction Requirement
2310E Facility/Service Location Information - Institutional use of Facility/Service Location Loop	NM1 Individual or Organizational Name - Facility/Service Location Name	NM109 National Provider ID NPI	I-S	I-R	NPI of Facility/Service Location required for Institutional/Hospital transactions	Jurisdiction Requirement
2310F Referring Provider	NM1 Individual or Organizational Name - Referring Provider Name		I-S	I-S	Not required in 4010 version for 837I, 2310F Loop becomes effective for 5010 version	Jurisdiction Requirement
2310F Referring Provider	REF Reference Identification - State License		I-S	I-J	Not required in 4010 version for 837I, 2310F Loop becomes effective for 5010 version	Jurisdiction Requirement
2400 Service Line Information	SV5 Durable Medical Equipment Service		P-S	P-N	Segment Not Used (N) for TX & CA WC.	DME billed in SV1 Professional billing segment.
2400 Service Line Information	DTP Service Date		I-S	I-J	Mandatory if (1) HCPCS codes billed on outpatient services as prescribed by the Division or CMS, (2) MRI, CT Scan, or operating room revenue code billed on inpatient services.	Jurisdiction Requirement
2410 Drug Identification	CTP Drug Pricing	CTP3-CTP5	I-R	I-S	Fields are situational as defined by the Division.	Jurisdiction Requirement
2420A Rendering Line Provider Information	REF Reference Identification - State License		P/D-S	P/D-J	Conditional Segment for TX & CA WC. Mandatory if Rendering Line Provider information is present.	Jurisdiction Requirement
Functional Group Header Envelope (GS-GE) Transaction Set header (TS)	GS08 Version/Release/ Industry Identification Code REF Reference Identification Transaction Set header (TS) Transmission Type Identification Reference Segment (REF) in Field REF02		P/I/D/Pharmacy-R	P/I/D/Pharmacy-J	Version Industry Identification Code and Transmission Type Identification : Providing for a workers' compensation indicator (WC) ensures consistent	Workers' Compensation Version Industry Identification Code and Transmission Type Identification Reference

Loop	Segment	Field	HIPAA P/I/D	WC P/I/D	Comments	Action
Professional (P), Institutional/Hospital (I), Dental (D)	***Required (R), Situational (S), Jurisdictional (J), Not Used (N)***					
					implementation of workers' compensation requirements and minimizes impact on standard translator applications	

HIPAA Reason Gap Analysis

HIPAA /Workers' Compensation Claim Adjustment Reason Code Gap Analysis

Action : Request IAIABC Coordinate with ANSI to adopt California and Texas Jurisdictional Claim Adjustment Reason Codes: (*W13-W23 California additional submitted codes)

California Jurisdictional Proposed ANSI Claim Adjustment Reason Codes

DWC Bill Adjustment Reason Codes	DWC Bill Adjustment Reason Explanatory Message	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Proposed ANSI Codes)	ANSI Claim Adjustment Reason Code Description
M1	Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.	MA	W2*	Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.
M2	Additional payment made on appeal/reconsideration.	MA	W3 *	Additional payment made on appeal/reconsideration.
M3	No additional reimbursement allowed after review of appeal/reconsideration.	MA	W4 *	No additional reimbursement allowed after review of appeal/reconsideration.
M4	Request of recoupment for an overpayment made to a health care provider.	MA	W5 *	Request of recoupment for an overpayment made to a health care provider.
M5	Reduction/denial based on subrogation of a third party settlement.	MA	W6 *	Reduction/denial based on subrogation of a third party settlement.
M6	Payment of interest/penalty to provider.	MA	W7 *	Payment of interest/penalty to provider.
G30	This charge was denied as part of a Retrospective Review. If you disagree, please contact our Utilization Review Unit.	PI	W9 *	Unnecessary medical treatment based on peer review.
G2	The Official Medical Fee Schedule does not include a code for this service. An allowance has been made for a comparable service.	OA	W13 *	The Fee Schedule does not include a code for this service. An allowance has been made for a comparable service.
G3	The Official Medical Fee Schedule does not list this code. No payment is being made at this time. Please resubmit your claim with the OMFS code(s) that best describe the service(s) provided and your supporting documentation.	PI	W14*	The Fee Schedule does not list this code. No payment is being made at this time. Please resubmit your claim with the fee schedule code(s) that best describe the service(s) provided and your supporting documentation.

HIPAA Reason Gap Analysis

DWC Bill Adjustment Reason Codes	DWC Bill Adjustment Reason Explanatory Message	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Proposed ANSI Codes)	ANSI Claim Adjustment Reason Code Description
G5	This charge was adjusted for the reasons set forth in the attached letter.	PI	W15*	This charge was adjusted for the reasons set forth in correspondence to follow
G7	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.	MA	W16*	According to the Fee Schedule this service has a relative value of zero and therefore no payment is due.
G16	Reimbursement for this report is included with other services provided on the same day, therefore a separate payment is not warranted.	OA	W17*	Reimbursement for this report is included with other services provided on the same day, therefore a separate payment is not warranted.
G20	The charge was denied as the report/documentation does not indicate that the service was performed.	PI	W18*	The charge was denied as the report/documentation does not indicate that the service was performed.
PM5	Only one assessment and evaluation is reimbursable within a 30 day period. The provider has already billed for a physical therapy evaluation within the last 30 days. See physical medicine rule I (a).	MA	W19*	Payment adjusted because the payer deems the information submitted does not support the frequency of service.
CL1	This service is normally part of a panel and is reimbursed under the appropriate panel code.	OA	W20*	This service is normally part of a panel and is reimbursed under the appropriate panel code.
SS3	This report does not fall under the guidelines for a Separately Reimbursable Report found in the General Instructions Section of the Physician's Fee Schedule.	MA	W21*	This report does not fall under the jurisdictional guidelines for a Separately Reimbursable Report

HIPAA Reason Gap Analysis

DWC Bill Adjustment Reason Codes	DWC Bill Adjustment Reason Explanatory Message	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Proposed ANSI Codes)	ANSI Claim Adjustment Reason Code Description
F3	Service not reimbursable under Outpatient Facility Fee Schedule. Charges are being paid under a different fee schedule.	MA	W22*	Service not reimbursable under Outpatient Facility Fee Schedule. Charges are being paid under a different fee schedule.
M7	Extent of injury not finally adjudicated. Claim is under investigation	MA	W23*	Extent of injury not finally adjudicated. Claim is under investigation
G8	No separate payment was made because the value of the service is included within the value of another service performed on the same day.	MA	W24	No separate payment was made because the value of the service is included within the value of another service performed on the same day.
G37	Payment is being denied as this claim has not been accepted and the mandatory $10,000 medical reimbursements have been made. Should the claim be accepted, your bill will then be reconsidered. This determination must be made by 90 days from the date of injury but may be made sooner.	MA	W25	This claim has not been accepted and the mandatory medical reimbursements have been made. Should the claim be accepted, your bill will then be reconsidered. The determination must be made by 90 days from the date of injury .
G38	Your bill is being partially paid as this payment will complete the Labor Code 5402(c) mandatory $10,000 reimbursement. Should the claim be accepted, the remainder of your bill will then be reconsidered. Acceptance or denial of the claim must be made no later than 90 days from the date of injury but may be made sooner.	MA	W26	Until the employee's claim is accepted or rejected, liability for medical treatment is limited according to jurisdictional guidelines. Your bill is being partially paid as this payment will complete the mandatory reimbursement limit per jurisdictional guidelines. Should the claim be accepted, the remainder of your bill will then be reconsidered. Acceptance or denial of the claim must be made no later than 90 days from the date of injury

HIPAA Remarks Gap Analysis

HIPAA /Workers' Compensation Remittance Remark Gap Analysis	
Action: Request IAIABC Coordinate with ANSI to adopt California Jurisdictional Remittance Remark Codes	
California Jurisdictional Proposed ANSI Remittance Remark Codes	**California Jurisdictional Remittance Remark Code Descriptions**
WC1*	No documentation of unlisted or “by report” BR code was received with the billing for this service. Please resubmit your bill with the appropriate supporting documentation. See Fee Schedule General Instructions for Procedures Without Unit Values.
WC2*	The unlisted or BR service was not sufficiently identified or documented. We are unable to make a payment without supplementary documentation giving a clearer description of the service. See Fee Schedule General Instructions for Procedures Without Unit Values.
WC3*	The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.
WC4*	This service requires prior authorization and none was identified.
WC5*	The charge for both the technical and professional component of this service have already been paid to another provider.
WC6*	Documentation of the time spent performing this service is needed for further review.
WC7*	Missing/incomplete/insufficient requested documentation.
WC8*	This charge was denied as the Physical Therapy Assessment and Evaluation codes are billable by Registered Physical Therapists only.
WC9*	Documentation justifying charges for both test and measurements and evaluation and management or assessment and evaluation on the same day is required in accordance with jurisdictional guidelines
WC10*	When billing for modalities only, you are limited to two modalities in any single visit pursuant to jurisdictional physical medicine rule guidelines. Payment has been made in accordance with Fee Schedule guidelines.
WC11*	This physical medicine extended time service was billed without the "initial 30 minutes" base code.
WC12*	Only one assessment and evaluation is reimbursable within a 30 day period. The provider has already billed for a physical therapy evaluation within the last 30 days.
WC13*	Reimbursement for physical medicine procedures, modalities, including Chiropractic Manipulation and acupuncture codes are limited to 60 minutes per visit without prior authorization pursuant to jurisdictional guidelines.
WC14*	No more than four physical medicine procedures or modalities including Chiropractic Manipulation and Acupuncture codes are reimbursable during the same visit without prior authorization pursuant to jurisdictional guidelines.
WC15*	Jurisdictional guidelines regarding multiple services (cascade) was applied to this service.
WC16*	Billing for evaluation and management service in addition to physical medicine/acupuncture code or OMT/CMT code resulted in a 2.4 unit value deduction from the treatment codes in accordance with jurisdictional guidelines.
WC17*	Payment for this service was denied because documentation of the circumstances justifying both a follow-up evaluation and management visit and physical medicine treatment has not been provided as required by jurisdictional guidelines.

HIPAA Remarks Gap Analysis

California Jurisdictional Proposed ANSI Remittance Remark Codes	California Jurisdictional Remittance Remark Code Descriptions
WC18*	Charge was denied as Physical Therapists may not bill Evaluation and Management services.
WC19*	The value of the initial casting service is included within the value of a fracture or dislocation reduction service.
WC20*	The visit or service billed, occurred within the global surgical period and is not separately reimbursable.
WC21*	Additional arthroscopic services were reduced to 10 percent of scheduled values pursuant to jurisdictional surgery guidelines.
WC22*	This initial visit was converted to code 99025 in accordance with the jurisdictional surgical guidelines.
WC23*	Assistant Surgeon services have been reimbursed at 20% of the surgical procedure per jurisdictional surgical guidelines.
WC24*	Non-physician assistant surgeon has been reimbursed at 10% of the surgical procedure per jurisdictional surgical guidelines.
WC25*	Assistant Surgeon services have been denied as not normally warranted for this procedure according to jurisdictional guidelines.
WC26*	Two Surgeon service is not warranted for this procedure according to the listed citation. Please provide documentation that supports the need for two surgeons.
WC27*	Administration of Local Anesthetic is included in the Surgical Service per jurisdictional surgical guidelines.
WC28*	Modifier -47 was used to indicate regional anesthesia by the surgeon. In accordance with the Fee Schedule, time units are not reimbursed.
WC29*	Patient's physical status/condition not identified. Please provide documentation using ASA Physical Status indicators.
WC30*	No reimbursement was made for the E/M service as the documentation does not support a separate significant, identifiable E&M service performed with other services provided on the same day.
WC31*	The billed service does not meet the requirements of a Consultation
WC32*	Documentation provided does not justify payment for a Prolonged Evaluation and Management service.
WC33*	Payment was made for a generic equivalent as "No Substitution" documentation was absent.
WC34*	A dispensing fee is not applicable for over-the-counter medication or medication administered at the time of a visit.
WC35*	Payment for this item was based on the documented actual cost.
WC36*	The Progress report charge was disallowed as you are not the Primary Treating Physician or his/her designee.
WC37*	The Permanent and Stationary Report charge was disallowed as you are not the Primary Treating Physician or his/her designee.
WC38*	Chart Notes /Duplicate Reports were not requested.
WC39*	No payment is being made for missed appointment, as none is necessarily owed

HIPAA Remarks Gap Analysis

California Jurisdictional Proposed ANSI Remittance Remark Codes	California Jurisdictional Remittance Remark Code Descriptions
WC40*	No reimbursement is being made as this procedure is not usually performed in an outpatient surgical facility. Prior authorization is required but was not submitted.
WC41*	Service not paid under Outpatient Facility Fee Schedule.
WC42*	This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation. The bill will be reimbursed using the regular reimbursement methodology.
WC43*	We cannot review this service without necessary documentation. Please resubmit with necessary documentation.

California Division of Workers' Compensation
Electronic Billing and Reimbursement (eBill) Project
California and Texas HIPAA Report Type Code Gap Analysis
(Report Type Codes ANSI X12 Data Elements 755)

Loop	Segment	Field	HIPAA	WC	Comments	Action
837 Transaction Set	***Required (R), Situational (S), Jurisdictional (J), Not Used (N)***					
2300	PWK Identification- Paper Work /Attachment	PWK01	N	J	Required element for CA & TX WC. Following represents the additional jurisdictional report type codes that are to be used in the PWK Segment: J1-Doctor's First Report of Injury J2-Supplemental Medical Report J3-Medical Permanent Impairment J4-Medical Legal Report J5-Vocational Report J6-Work Status Report J7-Consultation Report J8-Permanent Disability J9- Itemized Statement	Jurisdiction Requirement