California Division of Workers' Compensation Medical Billing and Payment Guide

~~2011~~ Version 1.1

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Introduction

This manual is adopted by the Administrative Director of the Division of Workers' Compensation pursuant to the authority of Labor Code sections §§ 4603.3, 4603.4, 4603.5 and 5307.3. It specifies the billing, payment and coding rules for paper and electronic medical treatment bill submissions in the California workers' compensation system. Such bills may be submitted either on paper or through electronic means. Entities that need to adhere to these rules include, but are not limited to, Health Care Providers, Health Care Facilities, Claims Administrators, Billing Agents/Assignees and Clearinghouses.

Labor Code §4603.4 (a)(2) requires claims administrators to accept electronic submission of medical bills. The effective date is 10-18-2012. 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 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.

For electronic billing, parties must also consult the Division of Workers' Compensation Medical Billing and Payment Companion Guide which sets forth rules on the technical aspects of electronic billing.

Health Care Providers, Health Care Facilities, Claims Administrators, Billing Agents/Assignees and Clearinghouses that submit bills on paper must adhere to the rules relating to use of the standardized billing forms for bills submitted on or after 10-15-2011.

The Division would like to thank all those who participated in the development of this guide. Many members of the workers' compensation, medical, and EDI communities attended meetings and assisted in putting this together. Without them, this process would have been much more difficult.

Section One – Business Rules

1.0 Standardized Billing / Electronic Billing Definitions

(a) "Assignee" means a person or entity that has purchased the right to payments for medical goods or services from the health care provider or health care facility and is authorized by law to collect payment from the responsible payer.

(b) "Authorized medical treatment" means medical treatment in accordance with Labor Code section 4600 that was authorized pursuant to Labor Code section 4610 and which has been provided or ~~authorized~~ prescribed by the treating physician.

(c) "Balance forward bill" is a bill that includes a balance carried over from a previous bill along with additional services or a summary of accumulated unpaid balances.

(d) "Bill" means:

(1) the uniform billing form found in Appendix A setting forth the itemization of services provided along with the required reports and/or supporting documentation as described in Section One – 3.0 Complete Bills; or

(2) the electronic billing transmission utilizing the standard formats found in Section Two – Transmission Standards 2.0 Electronic Standard Formats, 2.1 Billing, along with the required reports and/or supporting documentation as described in Section One – 3.0 Complete Bills.

(e) "Billing Agent" means a person or entity that has contracted with a health care provider or health care facility to process bills for services provided by the health care provider or health care facility.

(f) "California Electronic Medical Billing and Payment Companion Guide" is a separate document which gives detailed information for electronic billing and payment. The guide outlines the workers' compensation industry national standards and California jurisdictional procedures necessary for engaging in Electronic Data Interchange (EDI) and specifies clarifications where applicable. It will be referred to throughout this document as the "Companion Guide".

(g) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(h) "Clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that provides either of the following functions:

(1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

(i) "Complete Bill" means a bill submitted on the correct uniform billing form/format, with the correct uniform billing code sets, filled out in compliance with the form/format requirements of Appendix A and/or the Companion Guide with the required reports and/or supporting documentation as set forth in Section One – 3 0.

(j) "CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(k) "Duplicate bill" means a bill that is exactly the same as a bill that has been previously submitted with no new services added, except that the duplicate bill may have a different "billing date."

(l) "Electronic Standard Formats" means the ASC X12N standard formats developed by the Accredited Standards Committee X12N Insurance Subcommittee of the American National Standards Institute and the retail pharmacy specifications developed by the National Council for Prescription Drug Programs ("NCPDP") identified in Section Two - Transmission Standards, which have been and adopted by the Secretary of Health and Human Services under HIPAA.. See the Companion Guide for specific format information.

(m) "Explanation of Review" (EOR) means the explanation of payment or the denial of the payment as defined ~~using the standard code set found~~ in Appendix B~~ – 1.0~~. Paper EORs conform to Appendix B - 3.0. Electronic EORs are issued using the ASC X12N/005010X221 Health Care Claim Payment/Advice (835). EORs use the following standard codes:

(1) DWC Bill Adjustment Reason Codes provide California specific workers' compensation explanations of a payment, reduction or denial for paper bills. They are found in Appendix B – 1.0 DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk.

(2) Claims Adjustment Group Codes represent the general category of payment, reduction, or denial for electronic bills. The most current, valid codes should be used as appropriate for workers' compensation. These codes are obtained from the Washington Publishing Company http://www.wpc-edi.com.

(3) Claims Adjustment Reason Codes (CARC) represent the national standard explanation of payment, reduction or denial information. These codes are obtained from the Washington Publishing Company http://www.wpc-edi.com. A subset of the CARCs is adopted for use in responding to electronic bills in workers' compensation in Appendix B – 1.0 DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk.

(4) Remittance Advice Remark Codes (RARC) represent supplemental explanation for a payment, reduction or denial. These are always used in conjunction with a Claims Adjustment Reason Code. These codes are obtained from the Washington Publishing Company http://www.wpc-edi.com. A subset of the RARCs is adopted for use in responding to electronic bills in workers' compensation in Appendix B – 1.0 DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk.

(n) "Health Care Provider" means a provider of medical treatment, goods and services, including but not limited to a physician, a non-physician or any other person or entity who furnishes medical treatment, goods or services in the normal course of business.

(o) "Health Care Facility" means any facility as defined in Section 1250 of the Health and Safety Code, any surgical facility which is licensed under subdivision (b) of Section 1204 of the Health and Safety Code, any outpatient setting as defined in Section 1248 of the Health and Safety Code, any surgical facility accredited by an accrediting agency approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, or any ambulatory surgical center or hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act.

(p) "Itemization of services" means the list of medical treatment, goods or services provided using the codes required by Section One – 3.0 to be included on the uniform billing form or electronic claim format.

(q) "Medical Treatment" means the treatment, goods and services as defined by Labor Code Section 4600.

(r) "National Provider Identification Number" or "NPI" means the unique identifier assigned to a health care provider or health care facility by the Secretary of the United States Department of Health and Human Services.

(s) "NCPDP" means the National Council for Prescription Drug Programs.

(t) Official Medical Fee Schedule (OMFS) means all of the fee schedules found in Article 5.3 of Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations (Sections 9789.10 - 9789.111), adopted pursuant to Section 5307.1 of the Labor Code for all medical services, goods, and treatment provided pursuant to Labor Code Section 4600. These include the following schedules: Physician's services; Inpatient Facility; Outpatient Facility; Clinical Laboratory; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); Ambulance; and Pharmaceutical.

(u) "Physician" has the same meaning specified in Labor Code Section 3209.3: physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.

(1) "Psychologist" means a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

(2) "Acupuncturist" means a person who holds an acupuncturist's certificate issued pursuant to Chapter 12 (commencing with Section 4925) of Division 2 of the Business and Professions Code.

(v) "Required report" means a report which must be submitted pursuant to title 8, California Code of Regulations sections 9785 – 9785.4 or pursuant to the OMFS. These reports include the Doctor's First Report of Injury, PR-2, PR-3, PR-4 and their narrative equivalents, as well as any report accompanying a "By Report" code billing.

(w) "Supporting Documentation" means those documents, other than a required report, necessary to support a bill. These include, but are not limited to an invoice required for payment of the DME item being billed. ~~For paper bills, supporting~~ Supporting documentation includes any written authorization for services that may have been received. ~~by the physician.~~

(x) "Treating Physician" means the primary treating physician or secondary physician as defined by section 9785(a)(1), (2).

(y) "Uniform Billing Forms" are the CMS 1500, UB-04, NCPDP Universal Claim Form and the ADA 2006 set forth in Appendix A.

(z) "Uniform Billing Codes" are defined as:

(1) "California Codes" means those codes adopted by the Administrative Director for use in the Physician's Services section of the Official Medical Fee Schedule (Title 8, California Code of Regulations §§ 9789.10-11).

(2) "CDT-4 Codes" means the current dental codes, nomenclature, and descriptors prescribed by the American Dental Association in "Current Dental Terminology, Fourth Edition."

(3) "CPT-4 Codes" means the procedural terminology and codes contained in the "Current Procedural Terminology, Fourth Edition," as published by the American Medical Association and as adopted in the appropriate fee schedule contained in sections 9789.10-9789.100.

(4) "Diagnosis Related Group (DRG)" or "Medicare Severity-Diagnosis Related Codes" (MS-DRG) means the inpatient classification schemes used by CMS for hospital inpatient reimbursement. The DRG/MS-DRG systems classify patients based on principal diagnosis, surgical procedure, age, presence of co-morbidities and complications and other pertinent data.

(5) "HCPCS" means CMS' Healthcare Common Procedure Coding System, a coding system which describes products, supplies, procedures and health professional services and includes, the American Medical Association's (AMA's) Physician "Current Procedural Terminology, Fourth Edition," (CPT-4) codes, alphanumeric codes, and related modifiers.

(6) "ICD-9-CM Codes" means the diagnosis and procedure codes in the International Classification of Diseases, Ninth Revision, Clinical Modification published by the U.S. Department of Health and Human Services.

(7) "NDC" means the National Drug Codes of the Food and Drug Administration.

(8) "Revenue Codes" means the 4-digit coding system developed and maintained by the National Uniform Billing Committee for billing inpatient and outpatient hospital services, home health services and hospice services.

(9) "UB-04 Codes" means the code structure and instructions established for use by the National Uniform Billing Committee (NUBC).

(aa) "Working days" means Mondays through Fridays but shall not include Saturdays, Sundays or the following State Holidays.

(1) January 1st ("New Year's Day".)

(2) The third Monday in January ("Dr. Martin Luther King, Jr. Day.")

(3) The third Monday in February ("Washington Day" or "President's Day.")

(4) March 31st ("Cesar Chavez Day.")

(5) The last Monday in May ("Memorial Day.")

(6) July 4th ("Independence Day.")

(7) The first Monday in September ("Labor Day.")

(8) November 11th ("Veterans Day.")

(9) The third Thursday in November ("Thanksgiving Day.")

(10) The Friday After Thanksgiving Day

(11) December 25th ("Christmas Day.")

(12) If January 1st, March 31st, July 4th, November 11th, or December 25th falls upon a Sunday, the Monday following is a holiday. If November 11th falls upon a Saturday, the preceding Friday is a holiday.

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2.0 Standardized Medical Treatment Billing Format

(a) On and after October 15, 2011, all health care providers, health care facilities and billing agents/assignees shall submit medical bills for payment on the uniform billing forms or utilizing the format prescribed in this section, completed as set forth in Appendix A. All information on the paper version of the uniform billing forms shall be typewritten when submitted. However, for bills submitted as a Request for Second Review, the NUBC Condition Code Qualifier 'BG' followed by the NUBC Condition Code 'W3' and related information indicating a first level appeal, may be handwritten on the CMS 1500 form or the UB-04 form. The words "Request for Second Review" may be handwritten on the ADA 2006 claim form or the NCPDP WC/PC Claim Form version 1.1. Format means a document containing all the same information using the same data elements in the same order as the equivalent uniform billing form.

(1) "Form CMS-1500" means the health insurance claim form maintained by CMS, revised August 2005, for use by health care providers.

(2) "CMS Form 1450" or "UB-04" means the health insurance claim form maintained by NUBC, adopted February 2005, for use by health facilties and institutional care providers as well as home health providers.

(3) "American Dental Association, Version 2006" means the uniform dental claim form approved by the American Dental Association for use by dentists.

(4) "NCPDP Workers' Compensation/Property & Causualty Claim Form, version ~~1.0 – 5/2008~~ 1.1 – 05/2009", means the claim form adopted by the National Council for Prescriptions Drug Programs, Inc. for pharmacy bills for workers' compensation.

(b) On and after October 18, 2012, all health care providers, health care facilities and billing agents/assignees providing medical treatment may electronically submit medical bills to the claims administrator for payment. All claims administrators must accept bills submitted in this manner. The bills shall conform to the electronic billing standards and rules set forth in this Medical Billing and Payment Guide and the Companion Guide. Parties may engage in electronic billing and remittance prior to the effective date of the regulation upon mutual agreement and are encouraged to do so.

3.0 Complete Bills

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

(1) The correct uniform billing form/format for the type of health care provider.

(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. Nothing in this paragraph precludes the claims administrator from populating missing information fields if the claims administrator has previously received the missing information.

(4) A complete bill includes required reports and supporting documentation specified in subdivision (b).

(b) All required reports and supporting documentation sufficient to support the level of service or code that has been billed must be submitted as follows:

(1) A Doctor's First Report of Occupational Injury (DLSR 5021), must be submitted when the bill includes 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 provider uses the following Modifiers – 22, – 23 and – 25.

(6) A descriptive report of the procedure, drug, DME or other item must be submitted when the provider 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 either professional or facility Surgery Services fees.

(9) An invoice or other proof of documented paid costs must be provided when required by the OMFS 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. (This does not prohibit the claims administrator from requesting additional appropriate information during further bill processing.)

(11) ~~For paper bills, any~~ Any evidence of ~~written~~ authorization for the services that may have been received ~~by the physician~~.

(12) The prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician.

(c) For paper bills, if the required reports and supporting documentation are not submitted in the same mailing envelope as the bill, then a header or ~~attachement~~ attachment cover sheet as defined in Section One – 7.3 for electronic attachments must be submitted.

4.0 Billing Agents/Assignees

(a) Billing agents and assignees shall submit bills in the same manner as the original rendering provider would be required to do had the bills been submitted by the provider directly.

(b) The original rendering provider information will be provided in the fields where that information is required along with identifying information about the billing agent/assignee submitting the bill.

(c) The billing agent/assignee has no greater right to reimbursement than the principal or assignor. The billing guides and rules do not themselves confer a right to bill; they provide direction for billing agents and assignees that are legally entitled to submit bills under other provisions of law.

5.0 Duplicate Bills, Bill Revisions and Balance Forward Billing

(a) A duplicate bill is one that is exactly the same as a bill that has been previously submitted with no new services added, except that the duplicate bill may have a different billing date. A duplicate bill shall not be submitted after an explanation of review has been provided. ~~Duplicate bills~~ A duplicate bill shall not be submitted prior to expiration of the time allowed for payment unless requested by the claims administrator or its agent. For the time frame for payment of paper submissions see ~~6.0 (b)~~ 6.1 and 6.2, and for time frame for payment of electronic submission see 7.1(b). Resubmission of a duplicate bill shall be clearly marked as a duplicate in accordance with the following:

(1) CMS 1500: See 1.1 Field Table CMS 1500, Field 10d.

(2) UB-04: See 2.1 Field Table UB-04, UB-04 Form Locator 18-28.

(3) NCPDP WC/PC Claim Form: There is no applicable field for duplicate reports. Trading Partners may work out a mutually acceptable way of indicating a duplicate bill.

(4) ADA Dental Claim Form: the word “Duplicate” should be written in Field 1.

(5) ASC X12N/005010X222 Health Care Claim: Professional (837): Loop 2300, Segment HI, Condition Information.

(6) ASC X12N/005010X223 Health Care Claim: Institutional (837): Loop 2300, Segment HI, Condition Information.

(7) ASC X12N/005010X224 Health Care Claim: Dental (837): Loop 2300, Segment K301, Fixed Format Information.

(8) National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Version D.0: there is no applicable section of the format for duplicate bills. Trading partners may work out a mutually acceptable way of indicating a duplicate bill.

(b) 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 using the appropriate NUBC Condition Code 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.

(c) 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. Also included as a "balance forward bill" is a summary of accumulated unpaid balances.

The entire balance forward bill may be rejected until a bill is submitted that does not carry over any previously billed charges.

Use DWC Bill Adjustment Reason Code G56 (crosswalks to CARC 18) to reject this type of bill.

~~(c)~~(d) A bill which has been previously submitted in one manner (paper or electronic) may not subsequently be submitted in the other manner.

6.0 ~~Medical Treatment~~ Bill~~ing and~~ Processing and Payment Requirements for Non-Electronically Submitted Medical Treatment Bills.

Upon receipt of a medical bill submitted by a health care provider, health care facility or billing agent/assignee, the claims administrator shall promptly evaluate and take appropriate action on the bill. The claims administrator is not required to respond or issue any notice in relation to a duplicate bill if the claims administrator has issued an explanation of review on the original bill.

6.1 Timeframes: Original Treatment Bills That Are Uncontested.

Any complete bill submitted in other than electronic form or format for uncontested medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be paid by the claims administrator within 45 days of receipt, or within 60 days if the employer is a governmental entity. The claims administrator shall issue an explanation of review concurrently with the payment.

6.2 Timeframes: Original Treatment Bills That Are Contested, Denied, Or Considered Incomplete.

(a) If the non-electronic bill or a portion of the bill is contested, denied, or considered incomplete, the claims administrator shall so notify the health care provider, health care facility or billing agent/assignee in the explanation of review. The explanation of review must be issued within 30 days of receipt of the bill and must provide notification of the items being contested, the reason for contesting those items and the remedies open to the health care provider, health care facility or billing agent/assignee. The explanation of review will be deemed timely if sent by first class mail and postmarked on or before the thirtieth day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth day after receipt.

(b) If a portion of the non-electronic bill is uncontested, payment of the uncontested amount shall be issued within 45 days of receipt of the bill, or within 60 days of receipt of the bill if the employer is a governmental entity. The claims administrator shall issue an EOR concurrently with the payment.

6.3 Explanation of Review on Original Treatment Bills That Are Contested, Denied, Or Considered Incomplete.

~~(a) Any complete bill submitted in other than electronic form or format for uncontested medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer not paid by the claims administrator within 45 working days of receipt, or within 60 working days if the employer is a governmental entity, shall be increased 15%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill unless the health care provider, health care facility or billing agent/assignee is notified within 30 working days of receipt that the bill is contested, denied or considered incomplete. The increase and interest are self-executing and shall apply to the portion of the bill that is neither timely paid nor objected to.~~

~~(b) A claims administrator who objects to all or any part of a bill for medical treatment shall notify the health care provider, health care facility or billing agent/assignee of the objection within 30 working days after receipt of the bill and any required report or supporting documentation necessary to support the bill and shall pay any uncontested amount within 45 working days after receipt of the bill, or within 60 working days if the employer is a governmental entity. If the required report or supporting documentation necessary to support the bill is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill, report, and/or supporting documentation whichever is received later. If the claims administrator receives a bill and believes that it has not received a required report and/or supporting documentation to support the bill, the claims administrator shall so inform the health care provider, health care facility or billing agent/assignee within 30 working days of receipt of the bill. An objection will be deemed timely if sent by first class mail and postmarked on or before the thirtieth working day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth working day after receipt. Any notice of objection shall include or be accompanied by all of the following:~~

(a) The explanation of review shall address all of the required data items and all of the relevant situational data items listed in Appendix B, Table 3.0 and communicate the reason(s) the bill is contested, denied, or considered incomplete, including:

(1) A clear and concise explanation of the basis for the objection to each contested procedure and charge using the DWC Bill Adjustment Reason codes and DWC Explanatory Messages contained in Appendix B, 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk.

(2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the information required.

(3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection.

~~(4) A statement that the health care provider, health care facility, or billing agent/assignee may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board.~~

~~(5) To adjudicate contested charges before the Workers' Compensation Appeals Board, the health care provider, health care facility or billing agent/assignee must file a lien. Liens are subject to the statute of limitations spelled out in Labor Code § 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.~~

~~(c)~~(b) An objection to charges from a hospital, outpatient surgery center, or independent diagnostic facility shall be deemed sufficient if the provider is advised, within the thirty ~~working~~ day period specified in subdivision (b), 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.

~~(d)~~(c) This section does not prohibit a claims administrator from conducting a retrospective utilization review as allowed by Labor Code section 4610 and Title 8, California Code of Regulations §§9792.6 – 9792.10.

~~(e)~~(d) This section does not prohibit the claims administrator or health care provider, health care facility or billing agent/assignee from using alternative forms or procedures provided such forms or procedures are specified in a written agreement between the claims administrator and the health care provider, health care facility or billing agent/assignee, as long as the alternative billing format provides all the required information set forth in this Medical Billing and Payment Guide.

~~(f)~~(e) All individually identifiable health information contained on a uniform billing form shall not be disclosed by either the claims administrator or submitting health provider or health care facility except where disclosure is permitted by law or necessary to confer compensation benefits as defined in Labor Code Section 3207.

~~(g) Explanations of Review shall use the DWC Bill Adjustment Reason codes and descriptions listed in Appendix B Standard Explanation of Review – 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk. The Explanations of Review shall contain all the required elements listed in Appendix B Standard Explanation of Review – 3.0 Field Table for Paper Explanation of Review.~~

6.4 Penalty

(a) Any non-electronically submitted bill determined to be complete, not paid within 45 days (60 days for a governmental entity) or objected to within 30 days, shall be subject to audit penalties per Title 8, California Code of Regulations section 10111.2 (b) (10), (11).

(b) Any non-electronically submitted complete bill for uncontested medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer not paid by the claims administrator within 45 days of receipt, or within 60 days if the employer is a governmental entity, shall be increased 15%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill unless the health care provider, health care facility or billing agent/assignee is notified within 30 days of receipt that the bill is contested, denied or considered incomplete. The increase and interest are self-executing and shall apply to the portion of the bill that is neither timely paid nor objected to.

6.5 Timeframes: Treatment Bills that are Submitted as a Request for Second Review

Where a bill is submitted as a Request for Second Review, the claims administrator shall promptly evaluate and take appropriate action on the bill. The claims administrator must respond to the Request for Second Review within 14 days of receiving the request by issuing a final written determination on the bill utilizing the explanation of review specified in Appendix B. Payment of any balance not in dispute shall be made within 21 days of receipt of the request for second review. This time limit may be extended by mutual written agreement.

7.0 ~~Medical Treatment~~ Bill~~ing and~~ Bill Processing and Payment Requirements for Electronically Submitted Medical Treatment Bills

7.1 Timeframes

When a medical treatment bill has been submitted electronically, the claims administrator must transmit the Acknowledgments and Payment/Advice as set forth below using the specified transaction sets. These transactions are used to notify the provider regarding the entire bill or portions of the bill including: acknowledgment, payment, adjustments to the bill, requests for additional information, rejection of the bill, objection to the bill, or denial of the bill.

(a) Acknowledgements.

(1) Interchange Acknowledgment (ASC X12 TA1) – within one working day of the receipt of an electronically submitted bill, the claims administrator shall send an Interchange Acknowledgment using the TA 1 transaction set, as defined in Companion Guide Chapter 9.

(2) ASC X12C/005010X231 - Implementation Acknowledgment for Health Care Insurance (999) – within one working day of the receipt of an electronically submitted bill, the claims administrator shall send an electronic acknowledgment using the 005010X231 transaction set as defined in Companion Guide Chapter 9.

(3) ASC X12C/005010X214 Health Care Claim Acknowledgment (277) – within two working days of receipt of an electronically submitted bill, the claims administrator shall send a Health Care Claim Acknowledgement 005010X214 electronic notice of whether or not the bill submission is complete. The 005010X214 details what errors are present, and if necessary, what action the submitter should take. A bill may be rejected if it is not submitted in the required electronic standard format or if it is not complete as set forth in Section One – 3.0, except as provided in 7.1(a)(3)(A)(i) which requires the pending of bills that have a missing attachment or claim number. Such notice must use the 005010X214 transaction set as defined in Companion Guide Chapter 9 and must include specific information setting out the reason for rejection.

(A) 005010X214 Claim Pending Status Information

(i) A bill submitted, but missing an attachment, or the injured worker's claim number, shall be held as pending for up to five working days while the attachment and/or claim number is provided, prior to being rejected as incomplete. If the issue is a missing claim number, during the five working day timeframe the claims administrator shall, if possible, promptly locate and affix the claim number to the bill for processing and payment. All other timeframes are suspended during the time period the bill is pending. The payment timeframe resumes when the claim number is determined, or when the missing attachment is received. The "pending" period suspends the 15 working-day timeframe during the period that the bill is pending, but upon matching the claim number, or receiving the attachment, the timeframe resumes. The 15 working day time period to pay the bill does not begin anew. An extension of the five working day pending period may be mutually agreed upon.

(ii) If a bill is placed in pending status due to a missing attachment or claim number, a Health Care Claim Acknowledgement 005010X214 pending notice shall be sent to the submitter/provider indicating that the bill has been put into pending status and indicating the specific reason for doing so using the appropriate 005010X214 code values.

(iii) If the required information is not received by the claims administrator within the five working days, or the claims administrator is not able to locate and affix the claim number, the bill may be rejected as being incomplete utilizing the ASC X12N/005010X214.

(B) Bill rejection error messages include the following:

(i) Invalid form or format – indicate which form should be used.

(ii) Missing. Information- indicate specifically which information is missing by using the appropriate 277 Claim Status Category Code with the appropriate Claim Status Code.

(iii) Invalid data – Indicate specifically which information is invalid by using the appropriate Claim Status Category Code with the appropriate Claim Status Code

(iv) Missing attachments – indicate specifically which attachment(s) are missing.

(v) Missing required documentation – indicate specifically what documentation is missing.

(vi) Injured worker's claim of injury is denied.

(vii) There is no coverage by the claims administrator.

(C) The submitted bill is complete and has moved into bill review.

(b) Payment and Remittance Advice / Denial / Objection.

Except for bills that have been rejected at the Acknowledgment stage, the ASC X12N/005010X221 Health Care Claim Payment/Advice (835) must be transmitted to the provider within 15 working days of receipt of the electronic bill, extended by the number of days the bill was placed in pending status under 7.1(a)(3)(A), if any. The 005010X221 should be issued to notify the provider of the payment, denial of payment, or objection to the entire bill or portions of the bill as set forth below. The 005010X221 serves as the Explanation of Review, and notice of denial or objection. Uncontested portions of the bill must be paid within 15 working days of receipt of the bill.

(1) Complete Bill - Payment for Uncontested Medical Treatment.

ASC X12N/005010X221 Health Care Claim Payment/Advice (835) – If the electronically submitted bill has been determined to be complete, payment for uncontested medical treatment provided or ~~authorized~~ prescribed by the treating physician selected by the employee or designated by the employer shall be made by the claims administrator within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Labor Code §5307.1. Nothing prevents the parties from agreeing to submit bills electronically that are being paid per contract rates under Labor Code § 5307.11. Remittance advice shall be sent using the 005010X221 payment transaction set as defined in Companion Guide Chapter 9. Explanations of Review are embedded in the 005010X221 and shall use the Claims Adjustment Reason Codes and Remittance Advice Remarks listed in Appendix B – 1.0.

(2) Objection to Bill / Denial of Payment.

The ASC X12N/005010X221 Health Care Claim Payment/Advice (835) is utilized to object to a bill, to deny a bill, and to notify the provider of the adjustment of charges, if the bill has not been rejected at the Acknowledgment stage. A claims administrator who objects to all or any part of an electronically submitted bill for medical treatment shall notify the health care provider, health care facility or assignee of the objection within 15 working days after receipt of the complete bill and shall pay any uncontested amount within 15 working days after receipt of the complete bill. If the claims administrator receives a bill and believes that the report and/or supporting documentation is/are not sufficient to support the bill, the claims administrator shall so inform the health care provider within 15 working days of receipt of the bill utilizing the 005010X221. If the bill was placed in pending status during the Acknowledgment stage, the 15 working day time frame is extended by the number of days the bill was held in pending status under 7.1(a)(3)(A). Any contested portion of the billing shall be paid in accordance with Labor Code section 4603.2.

7.2 Penalty

(a) Any electronically submitted bill determined to be complete, not paid or objected to within the 15 working day period, shall be subject to audit penalties per Title 8, California Code of Regulations section 10111.2 (b) (10), (11).

(b) In addition, any electronically submitted complete bill that is not paid within 45 ~~working~~ days of receipt, or within 60 ~~working~~ days if the employer is a governmental entity, shall be increased 15%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill unless the health care provider, health care facility or billing agent/assignee is notified within 30 ~~working~~ days of receipt that the bill is contested, denied or considered incomplete. The increase and interest are self-executing and shall apply to the portion of the bill that is neither timely paid nor objected to.

7.3 Electronic Bill Attachments

(a) Required reports and/or supporting documentation to support a bill as defined in Complete Bill Section 3.0 shall be submitted in accordance with this section. Unless otherwise agreed by the parties, all attachments to support an electronically submitted bill must either have a header or attached cover sheet that provides the following information:

(1) Claims Administrator - the name shall be the same as populated in the 005010X222, 005010X223, or 005010X224. Loop 2010BB, NM103.

(2) Employer - the name shall be the same as populated in the 005010X222, 005010X223, or 005010X224, Loop 2010BA, NM103.

(3) Unique Attachment Indicator Number - the Unique Attachment Indicator Number shall be the same as populated in the 005010X222, 005010X223, or 005010X224, Loop 2300, PWK Segment: Report Type Code, the Report Transmission Code, Attachment Control Qualifier (AC) and the unique Attachment Control Number. It is the combination of these data elements that will allow a claims administrator to appropriately match the incoming attachment to the electronic medical bill. Refer to the Companion Guide Chapter 2 for information regarding the Unique Attachment Indicator Number Code Sets.

(4) Billing Provider NPI Number – the number must be the same as populated in Loop 2010AA, NM109. If the provider is ineligible for an NPI, then this number is the provider's atypical billing provider ID. This number must be the same as populated in Loop 2010AA, REF02.

(5) Billing Provider Name.

(6) Bill Transaction Identification Number – This shall be the same number as populated in the ASC 005010X222, 005010X223, or 005010X224 transactions, Loop 2300 Claim Information, CLM01.

(7) Document type – use Report Type codes as set forth in Appendix C of the Companion Guides.

(8) Page Number/Number of Pages the page numbers reported should include the cover sheet.

(9) Contact Name/Phone Number including area code.

(b) All attachments to support an electronically submitted bill shall contain the following information in the body of the attachment or on an attached cover sheet:

(1) Patient's name

(2) Claims Administrator's name

(3) Date of Service

(4) Date of Injury

(5) Social Security number (if available)

(6) Claim number (if available)

(7) Unique Attachment Indicator Number

(c) All attachment submissions shall comply with the rules set forth in Section One – 3.0 Complete Bills and Section Three – Security Rules. They shall be submitted according to the protocols specified in the Companion Guide Chapter 8 or other mutually agreed upon methods.

(d) Attachment submission methods:

(1) FAX

(2) Electronic submission – if submitting electronically, the Division strongly recommends using the ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) transaction set. Specifications for this transaction set are found in the Companion Guide Chapter 8. The Division is not mandating the use of this transaction set. Other methods of transmission may be mutually agreed upon by the parties.

(3) E-mail – must be encrypted

(e) Attachment types

(1) Reports

(2) Supporting Documentation

(3) Written Authorization

(4) Misc. (other type of attachment)

7.4 Timeframes: Treatment Bills that are Submitted as a Request for Second Review

Where an electronic bill is submitted as a Request for Second Review, the claims administrator shall promptly evaluate and take appropriate action on the bill. The claims administrator must respond to the Request for Second Review within 14 days of receiving the request by issuing a final written determination on the bill utilizing the explanation of review specified in Appendix B. The claims administrator shall issue the ASC X12/005010X221 Payment/Advice (835) Technical Report Type 3 as its explanation of review for an electronic bill that is a Request for Second Review. Payment of any balance not in dispute shall be made within 21 days of receipt of the Request for Second Review. This time limit may be extended by mutual written agreement.

7.4 Miscellaneous

(a) This Medical Billing and Payment Guide does not prohibit a claims administrator from conducting a retrospective utilization review as allowed by Labor Code section 4610 and Title 8, California Code of Regulations §§9792.6 et seq.

(b) This Medical Billing and Payment Guide does not prohibit a claims administrator or health care provider, health care facility or billing agent/assignee from using alternative forms/format or procedures provided such forms/format or

procedures are specified in a written agreement between the claims administrator and the health care provider, health care facility, billing agent/assignee or clearinghouse, as long as the alternative billing and transmission format provides all the required information set forth in Section One - Appendix A or the Companion Guide.

(c) Individually identifiable health information submitted on an electronic bill and attachments shall not be disclosed by either the claims administrator or submitting health provider, health care facility, billing agent/assignee or clearinghouse except where disclosure is permitted by law or necessary to confer compensation benefits as defined in Labor Code Section 3207.

7.5 Trading Partner Agreements

(a) Health care providers, health care facilities and billing agents/assignees choosing to submit their bills electronically must enter into a Trading Partner agreement either directly with the claims administrator or with the clearinghouse that will handle the claims administrator's electronic transactions.

Trading partner agreement means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

(b) The purpose of a Trading Partner Agreement is to memorialize the rights, duties and responsibilities of the parties when utilizing electronic transactions for medical billing.

(c) Business Associate - any entity which is not covered under paragraph (a) that is handling electronic transactions on behalf of another.

8.0 Request for Second Review of Bill

A health care provider, health care facility or billing agent/assignee who disputes the amount paid by the claims administrator on the original bill submitted may submit a Request for Second Review within 90 days of service of the explanation of review in accordance with title 8, section 9792.5.4 et seq. and relevant provisions of this guide and the Electronic Medical Billing and Payment Companion Guide .

Appendices for Section One

Appendix A. Standard Paper Forms

How to use the following forms

The following forms are the only forms to be used for paper billing of California workers' compensation medical treatment services and goods unless there is a written contract agreed to by the parties specifying something different. Following each form is a table indicating the fields to be filled out on the form. The table is in field order and indicates the field number, field description, the field type (required, situational, optional or not applicable) and any comments.

Fields designated as "required," notated by "R", must be provided or the bill will be considered incomplete.

Fields designated as "situational," notated by "S" are only required if the circumstances warrant it. The bill will be considered incomplete if the situation requires a field to be filled and it hasn't been.

Fields designated as "optional," notated by "O," do not need to be filled in, but if they are, the bill is still considered to be complete.

Fields designated as "not applicable," notated by "N," should be left blank. If they are not left blank, the bill will still be considered complete.

1.0 CMS 1500

The CMS 1500 form (version 08/05) may be obtained from the U.S. Government Bookstore at http://bookstore.gpo.gov/collections/cms1500-form.jsp or from a variety of private vendors.
The National Uniform Claim Committee (NUCC) has a reference manual for the CMS 1500 form. The manual is incorporated within this guide by reference: 1500 Health Insurance Claim Form Reference Instruction Manual For Form Version 08/05, Version 6.0 07/10. It is recommended that you review this manual carefully. Copies of the manual may be obtained directly from NUCC at: http://www.nucc.org/index.php?option=com_content&task=view&id=33&Itemid=42 .

Billings must conform to the Reference Instruction Manual and this guide. Wherever the NUCC Reference Instruction Manual differs from the instructions in this guide, the rules in this guide prevail.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLKLUNG ☐ (SSN) OTHER ☐ (ID)

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

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

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE

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

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not on active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 8126). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq, and 30 USC 901 et seq, 38 USC 613, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Publication of Notices of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-31, as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in litigations; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

1.1 Field Table CMS 1500

CMS 1500 Box #	CMS 1500 Field Description	Workers' Compensation Requirements (Required/ Situational/ Optional / Not Applicable)	California Workers' Compensation Instructions
0	CARRIER NAME AND ADDRESS	R	Enter the Name and Address of the Payer to whom this bill is being sent.
1	MEDICARE, MEDICAID, TRICARE CHAMPUS, CHAMPVA, GROUP HEALTH PLAN, FECA, BLACK LUNG, OTHER	R	Enter 'X' in Box Other.
1a	INSURED'S I.D. NUMBER	R	Enter the patient's Social Security Number. If the patient does not have a Social Security Number, enter the following 9 digit number: '999999999'.
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	R	
3	PATIENT'S BIRTH DATE, SEX	R	
4	INSURED'S NAME (Last Name, First Name, Middle Initial)	R	Enter the name of the Employer.
5	PATIENT'S ADDRESS (No., Street), CITY, STATE, ZIP CODE, TELEPHONE	R	
6	PATIENT RELATIONSHIP TO INSURED	R	Enter 'X' in Box 'Other'.
7	INSURED'S ADDRESS (No., Street), CITY, STATE, ZIP CODE, TELEPHONE	S	Required when the bill is the first indication of the work related incident and the claim number is not entered in Box 11. Enter the physical address where the employee works.
8	PATIENT STATUS	N	
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	S	Required if applicable.
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	S	Required if applicable.
9b	OTHER INSURED'S DATE OF BIRTH, SEX	S	Required if applicable.
9c	EMPLOYER'S NAME OR SCHOOL NAME	S	Required if applicable.
9d	INSURANCE PLAN NAME OR PROGRAM NAME	S	Required if applicable.
10a	IS PATIENT'S CONDITION RELATED TO: EMPLOYMENT	R	Enter 'X' in Box 'YES'.
10b	IS PATIENT'S CONDITION RELATED TO: AUTO ACCIDENT|__|PLACE (State)	N	
10c	IS PATIENT'S CONDITION RELATED TO: OTHER ACCIDENT	N	
10d	RESERVED FOR LOCAL USE	S	Required when submitting a bill that is a duplicate or an appeal. (Original Reference Number must be entered in Box 22 for these conditions). Enter the NUBC Condition Code Qualifier 'BG' followed by the appropriate NUBC Condition Code for resubmission. W2 - Duplicate of the original bill W3 - Level 1 Appeal (Request for Second Review) W4 - Level 2 Appeal W5 - Level 3 Appeal Example: BGW3 Note: Do not use condition codes when submitting revised or corrected bill.
11	INSURED'S POLICY GROUP OR FECA NUMBER	S	Enter claim number, if known, or if claim number is not known then enter the value of 'Unknown' to indicate unknown claim number. This box requires one of the above values and cannot be left blank or may result in the bill being rejected.
11a	INSURED'S DATE OF BIRTH, SEX	N	
11b	EMPLOYER'S NAME OR SCHOOL NAME	N	

CMS 1500 Box #	CMS 1500 Field Description	Workers' Compensation Requirements (Required/ Situational/ Optional / Not Applicable)	California Workers' Compensation Instructions
11c	INSURANCE PLAN NAME OR PROGRAM NAME	S	Required when the Employer Department Name/Division is applicable and is different than Box 4.
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	S	Required if applicable.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	O	
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	N	
14	DATE OF CURRENT ILLNESS, OR INJURY OR PREGNANCY	R	For Specific Injury: Enter the date of incident or exposure. For Cumulative Injury or Occupational Disease: Enter the last date of occupational exposure to the hazards of the occupational disease or cumulative injury.
15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	S	
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	O	
17	NAME OF REFERRING PROVIDER OR OTHER SOURCE	S	Required when other providers are associated with the bill.
17a	OTHER ID #	S	Required when other providers are associated with the bill and do not have an NPI# Enter '0B' qualifier followed by the State License Number of the provider.
17b	NPI #	S	If known.
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	S	
19	RESERVED FOR LOCAL USE	S	Box 19 is also to be used to communicate the Attachment Information, if applicable. Attachment Information is required in Box 19 and on supporting document(s) associated with this bill, when the document (s) is submitted separately from the bill. Refer to California Workers' Compensation Companion Guide regarding Attachment Information data requirements. Enter the three digit ID qualifier PWK, the appropriate two digits Report Type Code, e.g. Radiology Report Code = RR, the appropriate two digit Transmission Type Code, e.g. FAX =FX, followed by the unique Attachment Control identification number. Do not enter spaces between qualifiers and data. Example: PWKRRFX1234567. When the documentation represents a Jurisdictional Report, then use the Report Type Code 'OZ', and enter the Jurisdictional Report Type Code in front of the Attachment Control Number. Example: PWKOZFXJ1999234567 Summary: Enter the first qualifier and number/code/information in Box 19. After the first item, enter three blank spaces and then the next qualifier and number/code/information.
20	OUTSIDE LAB?	S	Use when billing for diagnostic tests (refer to CMS instructions).
21.1	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	R	
21.2	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	S	
21.3	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	S	
21.4	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	S	

CMS 1500 Box #	CMS 1500 Field Description	Workers' Compensation Requirements (Required/ Situational/ Optional / Not Applicable)	California Workers' Compensation Instructions
22	MEDICAID RESUBMISSION CODE | ORIGINAL REF. NUMBER	S	Required when the bill is a resubmission. Enter the Original Reference Number assigned to the bill by the Claims Administrator. When the Original Reference Number is entered and a Condition Code is not present in 10d the Bill is considered a Revised Bill for reconsideration. When resubmitting a bill as a revision or a reconsideration, enter the appropriate NUBC Bill Frequency Codes left justified in the left-hand side of the field. Both codes are needed. There is no frequency code for a duplicate bill. The values will be: 7 – Replacement of prior claim (bill) 8 – Void/cancel of prior claim (bill) The Resubmission Code is not intended for use for original bill submissions.
23	PRIOR AUTHORIZATION NUMBER	S	Required if a prior authorization, referral, concurrent review, or voluntary certification number was received. Enter the number/name as assigned by the payer for the current service. Do not enter hyphens or spaces within the number.
24A	DATE(S) OF SERVICE	R	
24B	PLACE OF SERVICE	R	
24C	EMG	N	
24D	PROCEDURES, SERVICES, OR SUPPLIES	R	
24E	DIAGNOSIS CODE POINTER	R	
24F	$ CHARGES	R	
24G	DAYS OR UNITS	R	
24H	EPSDT/FAMILY PLAN	N	
24I Grey	ID QUAL	S	Required when the Rendering Provider is a health care provider. Enter 'ZZ' Qualifier for Taxonomy Code of the Rendering Provider.
24J Grey	RENDERING PROVIDER ID. #	S	Required when the Rendering Provider is a health care provider. Enter the Taxonomy Code of the Rendering Provider.
24J	NPI#	S	Required when the Rendering Provider is different from the provider reported in Box 33 and the provider is eligible for an NPI.
24 Grey	GREY AREA SUPPLEMENTAL DATA	S	Required when supplemental data is being submitted.
25	FEDERAL TAX ID. NUMBER	R	
26	PATIENT'S ACCOUNT NO.	R	
27	ACCEPT ASSIGNMENT?	N	
28	TOTAL CHARGE	R	
29	AMOUNT PAID	N	
30	BALANCE DUE	N	
31	SIGNATURE OF PHYSICIAN OR SUPPLIER	O	
32	SERVICE FACILITY LOCATION INFORMATION	R	
32a	NPI #	S	Required if entity populated in Box 32 is a licensed health care provider eligible for an NPI #. Enter the NPI # of the service facility location in field 32A
32b	OTHER ID #	S	Enter state license number if service facility location is not eligible for an NPI.
33	BILLING PROVIDER INFO & PH #	R	Required as provided in 1500 Health Insurance Claim Form Reference Manual, however, if an assignee is to be the payee, identify here.
33a	NPI #	S	
33b	OTHER ID #	S	

2.0 UB-04

The National Uniform Billing Committee Official UB-04 Data Specifications Manual 2011, Version 5.0, July 2010, including the UB-04 form revised 2005, is incorporated within this guide by reference. Copies of the manual may be obtained directly from NUBC at:
http://www.nubc.org/become.html

You must become a subscriber in order to obtain this manual.

Billings must conform to the Specification Manual. However, wherever the NUBC Data Specifications Manual differs from the instructions in this guide, the rules in this guide prevail.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37	
a																a
b																b

38		39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID	
A									A
B									B
C									C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS		81CC			
		a			
		b			
		c			
		d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 NOTICE: **THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

2.1 Field Table UB-04

UB-04 Form Loc	UB-04 Field Description	Workers' Compensation Requirements (Required/Situational/ Not Applicable)	California Workers' Compensation Instructions
01	Billing Provider Name, Address and Telephone Number	R	
02	Pay-to Name and Address	S	
03a	Patient Control Number	R	
03b	Medical/Health Record Number	S	
04	Type of Bill	R	When reporting a corrected bill use Type of Bill 7 - Replacement of a Prior Claim. When submitting a bill for an appeal or as a duplicate enter the appropriate NUBC Condition Code in Form Locator 18-28 to indicate bill resubmission type.
05	Federal Tax Number	R	
06	Statement Covers Period	R	
07	Reserved for Assignment by the NUBC	N	
08a	Patient Identifier	R	Enter the patient's Social Security Number. If the patient does not have a Social Security Number, enter the following 9 digit number: '999999999'.
08b	Patient Name	R	
09	Patient Address	R	
10	Patient Birth Date	R	
11	Patient Sex	R	
12	Admission/Start of Care Date	R	
13	Admission Hour	S	
14	Priority (Type) of Visit	S	Required when patient is being admitted to hospital for inpatient services.
15	Point of Origin for Admission or Visit	S	Required for all inpatient admissions and outpatient registration for diagnostic testing services.
16	Discharge Hour	S	Required on all final inpatient claims/encounters.
17	Patient Status	S	Required for all inpatient admissions and outpatient registration for diagnostic testing services.
18-28	Condition Codes	S	Required when Condition information applies to the bill. Required when submitting a bill that is a duplicate or an appeal (Original Reference Number must be entered in Form Locator 64 for these conditions). Appropriate resubmission codes are: W2 - Duplicate of the original bill W3 - Level 1 Appeal (Request for Second Review) W4 - Level 2 Appeal W5 - Level 3 Appeal Note: Do not use condition codes when submitting revised or corrected bill.
29	Accident State	N	
30	Reserved for Assignment by the NUBC	N	

UB-04 Form Loc	UB-04 Field Description	Workers' Compensation Requirements	California Workers' Compensation Instructions
31-34a,b	Occurrence Codes and Dates	R	At least one Occurrence Code must be entered with value of '04' Accident/Employment Related. The Occurrence Date must be the Date of Occupational Injury/Illness. For Specific Injury: Enter the date of incident or exposure. For Cumulative Injury or Occupational Disease: Enter the last date of occupational exposure to the hazards of the occupational disease or cumulative injury.
35-36a,b	Occurrence Span Codes and Dates	S	
37	Reserved for Assignment by the NUBC	N	
38	Responsible Party Name and Address	R	Enter the Workers' Compensation Payer responsible for payment of the bill including name address, city, state, and zip code.
39-41a-d	Value Codes and Amounts	S	
42	Revenue Codes	R	
43	Revenue Description	R	Enter the standard abbreviated description of the related revenue code categories included on this bill. When REV Code is for RX, the description requires NDC Number/ Dispense As Written Code/Units.
44	HCPCS/Accommodation Rates/HIPPS Rate Codes	S	
45	Service Date	S	
46	Service Units	R	
47	Total Charges	R	
48	Non-covered Charges	N	
49	Reserved for Assignment by the NUBC	N	
50a	Payer Name	R	
51a	Health Plan Identification Number	N	Not Used.
52a	Release of Information Certification Indicator	O	
53a	Assignment of Benefits Certification Indicator	R	Enter a value of 'Y' - Yes.
54a	Prior Payments - Payer	N	
55a	Estimated Amount Due-Payer	N	
56	National Provider identifier -Billing Provider	S	Required if the facility is eligible for an NPI.
57	Other (Billing) Provider Identifier	S	Required to enter the Medicare Provider ID number if the facility has been assigned a Medicare Provider ID Number. For providers that do not have a Medicare Provider ID Number, required to enter the State License Number.
58a	Insured's Name	R	Enter the name of the Employer.
59a	Patient's Relationship to Insured	R	Enter a value of '20' Employee.

UB-04 Form Loc	UB-04 Field Description	Workers' Compensation Requirements	California Workers' Compensation Instructions
60a	Insured's Unique Identifier	R	Enter the patient's Social Security Number. If the patient does not have a Social Security Number, enter the following 9 digit number: '999999999'.
61a	Insured's Group Name	S	Required when the Employer Department Name/Division is different than Form Locator 58a.
62a	Insured's' Group Number	S	Enter claim number, if known, or if claim number is not known then enter the value of 'Unknown' to indicate unknown claim number. This box requires one of the above values and cannot be left blank or may result in the bill being rejected.
63a	Treatment Authorization Code	S	Enter the authorization number assigned by the payer indicated in Form Locator 50, if known.
64a	Document Control Number	S	
65a	Employer Name (of the Insured)	R	Enter the name of the Employer.
50-65b,c	Other Insured Information	S	Required if applicable.
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	R	
67	Principal Diagnosis Code and Present on Admission Indicator	R	
68	Reserved for Assignment by the NUBC	N	
69	Admitting Diagnosis Code	S	
70a-c	Patient's Reason for Visit	S	
71	Prospective Payment System (PPS) Code	S	Required when the bill is for inpatient admissions.
72a-c	External Cause of Injury (ECI) Code	S	
73	Reserved for Assignment by the NUBC	N	
74a-e	Other Procedure Codes and Dates	S	
75	Reserved for Assignment by the NUBC	N	
76	Attending Provider Name and Identifiers (NPI)	S	
76	Attending Provider Name and Identifiers (QUAL)	S	
76	Attending Provider Name and Identifiers (ID)	S	
76	Attending Provider Name and Identifiers (LAST/FIRST)	S	
77	Operating Physician Name and Identifiers (NPI)	S	
77	Operating Physician Name and Identifiers (QUAL)	S	
77	Operating Physician Name and Identifiers (ID)	S	
77	Operating Physician Name and Identifiers (LAST/FIRST)	S	
78-79	Other Provider Name and Identifiers (NPI)	S	
78-79	Other Provider Name and Identifiers (QUAL)	S	

UB-04 Form Loc	UB-04 Field Description	Workers' Compensation Requirements	California Workers' Compensation Instructions
80	Remark Field	S	Required when the bill is the first indication of the work related incident and the claim number is not submitted. Enter the physical address where the employee works.
81	Code-Code Field	R	Enter the Taxonomy Code of the Billing Provider. Use the 'B3' qualifier followed by the 10 digit taxonomy code of the Billing Provider. Refer to California Workers' Compensation Companion Guide regarding Attachment Information data requirements. Attachment Information is required in Box 81 with a Code-Code of 'AC' when there is supporting documentation associated with this bill, and the documentation is submitted separately from the bill. Enter 'AC' in the Code Field followed by the appropriate two digit Report Type Code, e.g. Radiology Report Code = RR, the appropriate two digit Transmission Type Code, e.g. FAX =FX, followed by the unique Attachment Control Identification Number. Do not enter spaces between codes and data. Example: ACRRFX1234567. When the documentation represents a Jurisdictional Report, then use the Report Type Code 'OZ', followed by the Jurisdictional Report Type Code in front of the Attachment Control Number. Example:ACOZFXJ1999234567

3.0 National Council for Prescription Drug Programs "NCPDP" Workers' Compensation/Property & Casualty Universal Claim Form ("WC/PC UCF")

The Division adopts and incorporates by reference the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Version ~~1.0, 05/2008~~ 1.1 – 05/2009 as the prescribed paper billing form for pharmacy services.

The Division adopts and incorporates by reference the NCPDP *Manual Claims Form Reference Implementation Guide Version 1.Ø, October 2008,* except for pages 13-36 relating to the Universal Claim Form, which must be used in the completion of the WC/PC UCF.

The NCPDP WC/PC UCF and *Manual Claims Form Reference Implementation Guide* are available for purchase through the NCPDP approved vendor, CommuniForm, at:
http://www.communiform.com/ncpdp/.
Telephone number: (800) 869-6508.

Contact information will also be posted on the NCPDP website http://www.ncpdp.org.

The Division is providing additional instruction for the following data elements:

17 - Claim Reference Number
32 - Pharmacy ID Number
40 - Prescriber ID Number
99 - Usual & Customary Charge
106 - Patient Paid Amount

The California workers' compensation NCPDP WC/PC UCF Additional Instruction Requirements are defined in Table 3.1 of this section.

1-WC/P&C Indicator: 2-Date of Billing: mm dd ccyy

National Council for Prescription Drug Programs

NCPDP

WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM
Version 1.1 - 05/2009

FOR OFFICE USE ONLY
15 (Document Control Number)

PATIENT

3-Last: 4-First:
5-Address:
6-City: 7-State:
8-Zip: 9-Tel #:
10-D.O.B.: mm dd ccyy 11-D.O.I.: mm dd ccyy
12-I.D.: 13-Qualifier: 14-Gender:

CARRIER

16-Jurisdictional State:
17-Claim Ref #:
18-Name:
19-Address:
20-City: 21-State:
22-Zip:

EMPLOYER

23-Name:
24-Address:
25-City: 26-State:
27-Zip: 28-Tel #.:
29-Contact Name:

SIGNATURE OF PROVIDER
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

30-(Signed) 31-(Date)

ATTENTION PROVIDER!

ATTESTATION STATMENT!

PHARMACY

32-ID: 33-Qual:
34-Name:
35-Address:
36-City: 37-State:
38-Zip:
39-Tel #:

PRESCRIBER

40-ID: 41-Qual:
42-Last:
43-First:
44-Address:
45-City: 46-State:
47-Zip:
48-Tel #:

PAYEE

49-ID: 50-Qual:
51-Name:
52-Address:
53-City: 54-State:
55-Zip:
56-Tel #:

JURISDICTION

57-Jurisdiction #1:
58-Jurisdiction #2:
59-Jurisdiction #3:
60-Jurisdiction #4:
61-Jurisdiction #5:

CLAIM

62-Prescription/ Service Ref. #	63-Qual.	64-Fill #	65-Date Written mm dd ccyy	66-Date of Service mm dd ccyy	67-Submission Clarification	68-Prescription Origin

69 -Product/Service ID	70-Qual.	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth #. Submitted	75-PA. Type

76-Description	77-Strength	78- Unit Of Measure	79-Other Coverage	80-Delay Reason

COB 81-Other Payer ID	82-Qual	83-Other Payer Date MM DD CCYY	84-Other Payer Rejects	DUR 85-Reason / 86-Service / 87-Result

88-Level of Effort	89-Procedure Modifier	90-Dosage Form Description Code	91-Dispensing Unit Form Indicator	92-Route of Administration	93-Ingredient Component Count

COMPOUND

	94-Product Name	95-Product ID	96-Qual	97-Ingredient Qty	98-Ingredient Drug Cost	99-Basis Cost
1						
2						
3						
4						
5						
6						
7						

Pricing (Format (1,234.56)

100-Usual & Customary Charge	101-Basis of Cost Det.	102-Ingredient Cost Submitted	103-Dispensing Fee Submitted	104-Other Amount Submitted	105-Sales Tax Submitted	106-Gross Amount Due (Submitted)

107-Patient Paid Amount	108-Other Payer Amount Paid	109-Other Payer Patient Resp. Amt.	110-Net Amount Due	

Workers' Compensation/Property and Casualty Universal Claim Form (Reverse)

The provider agrees to the following:

- Certifies that required beneficiary signatures, or legally authorized signatures of beneficiaries, are on file;
- That the submitted claim is accurate, complete, and truthful; and
- That it will research and correct claim discrepancies.

Hawaii - "Charges are in accordance with Chapter 256, HRS, and any related rules."
New Hampshire - "I certify that the narrative descriptions of the principal and secondary diagnosis and the major procedures performed are accurate and complete to the best of my knowledge."

For more instructions on this form, see the NCPDP *Manual Claim Forms Reference Implementation Guide* available at www.ncpdp.org

Code List

For fields not listed below, or more values which may be available, see the *NCPDP Manual Claim Forms Reference Implementation Guide* or the NCPDP *External Code List.*

01 - Workers Compensation/Property & Casualty indicator
- "WC" - Workers' Compensation
- "PC" - Property & Casualty

13 - Patient ID Qualifier
- "blank" - Not Specified
- "01" - SSN
- "02" - Driver's License
- "03" - US Military ID
- "99" - Other

14 - Patient Gender Code
- "0" - Not Specified
- "1" - Male
- "2" - Female

33 - Service Provider ID Qualifier
- "blank" - Not Specified
- "01" - NPI
- "05" - Medicaid
- "07" - NCPDP
- "99" - Other

41 - Prescriber ID Qualifier
- "01" - NPI
- "08" - State License
- "12" - DEA
- "99" - Other

50 - Pay To Qualifier
- "00" - Not Specified
- "01" - NPI
- "11" - Federal Tax ID

63 - Prescription/Service Reference # Qualifier
- "1" - Rx Billing
- "2" - Service Billing

67 - Submission Clairification Code
- "1" - No Override
- "2" - Other Override
- "3" - Vacation Supply
- "4" - Lost Prescription
- "5" - Therapy Change
- "6" - Starter Dose
- "7" - Medically Necessary
- "8" - Process Compound for Approved Ingredients
- "9" - Encounters
- "10" - Meets Plan Limitations
- "11" - Certification on File
- "12" - DME Replacement Indicator
- "13" - Payer Recognized Emergency/Disaster Assistance Request
- "14" - Long Term Care Leave of Absence
- "15" - Long Term Care Replacement Medication
- "16" - Long Term Care Emergency Box or Automated Dispensing Machine

67 - Submission Clarification Code (Continued)
- "17" - Long Term Care Emergency Supply Remainder
- "18" - Long Term Care Patient Admit / Readmit Indicator
- "19" - Split Billing
- "99" - Other

68 - Prescription Origin Code
- "0" - Not Known
- "1" - Written
- "2" - Telephone
- "3" - Electronic
- "4" - Facsimile
- "5" - Pharmacy

70 & 96 - Product/Service ID Qualifier
- "00" - Not Specified
- "01" - UPC
- "02" - HRI
- "03" - NDC
- "04" - HIBCC
- "06" - DUR/PPS
- "07" - CPT4
- "08" - CPT5
- "09" - HCPCS
- "10" - PPAC
- "11" - NAPPI
- "12" - GTIN
- "15" - GCN
- "28" - FDB Med Name ID
- "29" - FDB Routed Med ID
- "30" - FDB Routed Dosage Form Med ID

73 - Dispense as Written (DAW) / Product Selection
- "0" - No Product Selection Indicated
- "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
- "9" - Substitution Allowed by Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product to be Dispensed

75- Prior Authorization Type Code
- "0" - Not Specified
- "1" - Prior Authorization
- "2" - Medical Certification
- "3" - EPSDT
- "4" - Exemption from Copay and/or Coinsurance
- "5" - Exemption from Rx
- "6" - Family Planning Indicator
- "7" - TANF (Temporary Assistance for Needy Families)
- "8" - Payer Defined Exemption
- "9" - Emergency Preparedness

78 - Unit of Measure
- "EA" - Each
- "GM" - Gram
- "ML" - Milliliter

79 - Other Coverage Code
- "0" - Not Specified by patient
- "1" - No Other Coverage
- "2" - Other Coverage Exists - Payment Collected
- "3" - Other Coverage Billed - Claim Not Covered
- "4" - Other Coverage Exists - Payment Not Collected
- "8" - Claim is billing for patient financial responsibility only

80 - Delay Reason Code
- "1" - Proof of eligibility unknown or unavailable
- "2" - Litigation
- "3" - Authorization delays
- "4" - Delay in certifying provider
- "5" - Delay in supplying billing forms
- "6" - Delay in delivery of custom-made appliances
- "7" - Third party processing delay
- "8" - Delay in eligibility determination
- "9" - Original claims rejected or denied due to a reason unrelated to the billing limitation rules
- "10" - Administration delay in the prior approval process
- "11" - Other
- "12" - Received late with no exceptions
- "13" - Substantial damage by fire, etc to provider records
- "14" - Theft, sabotage/other willful acts by employee

82 - Other Payer ID Qualifier
- "01" - National Payer ID
- "02" - HIN
- "03" - BIN
- "04" - NAIC
- "05" - Medicare Carrier Number
- "99" - Other

84 - Other Payer Reject Codes (For values refer to current External Code List)

85 - Reason for Service &
86 - Professional Service Code &
87 - Result of Service Code (For values refer to current NCPDP External Code List)

88 - DUR/PPS Level of Effort
- "0" - Not Specified
- "11" - Level 1 (Lowest)
- "12" - Level 2
- "13" - Level 3
- "14" - Level 4
- "15" - Level 5 (Highest)

89 - Procedure Modifier (values Centers for Medicare & Medicaid Services 7500 Security Blvd. Baltimore, MD 21244)

92 - Route of Administration (Systemized Nomenclature of Medicine Clinical Terms® SNOMED CT) SNOMET CT® terminology which is available from the College of American Pathologists, Northfield, IL: http://www.snomed.org

99 - Compound Ingredient Basis of Cost Determination &
101 - Basis of Cost Determination (For values refer to NCPDP Reference Guide or current External Code List)

** DO NOT PRINT**
Proof 10-28-11
Workers Comp
Universal Claim
BackerRev_2.ai
** DO NOT PRINT**

3.1 Field Table NCPDP

NCPDP WORKERS' COMPENSATION/PROPERTY AND CASUALTY UCF USAGE INSTRUCTIONS

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields (Required/ Situational/Optional/ Not Applicable)	NCPDP D.0 Data Element	Comments	California Workers' Compensation Instructions
1	WC/P&C Indicator	R	N/A	Code qualifying whether the claim submitted is for Workers' Compensation or Property & Casualty	
2	Date of Billing	R	N/A	Date the invoice was created. Used only by those entities creating the paper invoice and submitting for payment Format: MMDDCCYY	
3	Patient Last Name	R	311-CB	Individual Last Name	
4	Patient First Name	R	310-CA	Individual First Name	
5	Patient Street Address	R	322-CM	Free-form text for address information	
6	Patient City	R	323-CN	Free-form text for city name	
7	Patient State	R	324-CO	Standard State/Province Code as defined by appropriate government agency	
8	Patient Zip	R	325-CP	Code defining international postal zone excluding punctuation and blanks (zip code for US)	
9	Patient Phone Number	S	326-CQ	Ten-digit phone number of patient	
10	Patient Date of Birth	R	304-C4	Date of birth of patient Format: MMDDCCYY	
11	Date of Injury	R	434-DY	Date on which the injury occurred Format: MMDDCCYY	For Specific Injury: Enter the date of incident or exposure. For Cumulative Injury or Occupational Disease: Enter the last date of occupational exposure to the hazards of the occupational disease or cumulative injury.

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields (Required/ Situational/Optional/ Not Applicable)	NCPDP D.0 Data Element	Comments	California Workers' Compensation Instructions
12	Patient ID	R	332-CY	Patient ID	
13	Patient ID Qualifier	R	331-CX	Code qualifying the Patient ID (332-CY) Valid values for WC/PC UCF are blank, Ø1, Ø2, Ø3, Ø4 and Ø5 99	
14	Patient Gender	R	305-C5	Code indicating the gender of the individual	
15	Document Control Number	O	N/A	Internal number used by the payer or processor to further identify the claim for imaging purposes – Document archival, retrieval and storage. Not to be used by the pharmacy	
16	Jurisdictional State	S	N/A	Postal State Abbreviation identifying the state which has jurisdiction over the payment of benefits and medical claims. Typically, the Jurisdictional State is the state where the worker was injured.	
17	Claim Reference Number	S	435-DZ	Identifies the claim number assigned by the Workers' Compensation program	Enter the claim number assigned by the workers' compensation Payer, if known. If claim number is not known, then enter the value of 'Unknown'
18	Carrier Name	R	811-1H	Name of the carrier	
19	Carrier Street Address	R	807-1D	Address of the carrier	
20	Carrier City	R	809-1F	This field identifies the name of the city in which the carrier is located	
21	Carrier State	R	810-1G	State of the carrier	
22	Carrier Zip	R	813-1J	Zip code of the carrier, expanded. Note: Excludes punctuation and blanks	
23	Employer Name	R	315-CF	Complete name of	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields (Required/ Situational/Optional/ Not Applicable)	NCPDP D.0 Data Element	Comments	California Workers' Compensation Instructions
				employer	
24	Employer Street Address	R	316-CG	Free-form text for address information	
25	Employer City	R	317-CH	Free-form text for city name	
26	Employer State	R	318-CI	Standard State/Province Code as defined by appropriate government agency	
27	Employer Zip	R	319-CJ	Code defining international postal zone excluding punctuation and blanks (zip code for US)	
28	Employer Phone Number	O	320-CK	Ten-digit phone number of employer	
29	Employer Contact Name	S	321-CL	Employer primary contact	
30	Signature of Provider	S	N/A	Enter the legal signature of the pharmacy or service representative. "Signature on File" or "SOF" acceptable	
31	Date of Provider Signature	S	N/A	Enter either the 6-digit date (MMDDYY), 8-digit date (MMDDCCYY) or alphanumeric date (e.g. January 1, 2008) the form was signed	
32	Pharmacy ID	R	201-B1	ID assigned to a pharmacy or provider	Enter the Pharmacy NPI number
33	Pharmacy ID Qualifier	R	202-B2	Code qualifying the "Service Provider ID" (201-B1)	
34	Pharmacy Name	R	833-5P	Name of pharmacy	
35	Pharmacy Address	R	829-5L	The street address for a pharmacy	
36	Pharmacy City	R	831-5N	City of pharmacy	
37	Pharmacy State	R	832-6F	State abbreviation of pharmacy	
38	Pharmacy Zip	R	835-5R	This field identifies the expanded zip code of the pharmacy. Note: excludes punctuation and blanks. This left-justified field contains the five-digit zip code and may include the four-digit expanded	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields (Required/ Situational/Optional/ Not Applicable)	NCPDP D.0 Data Element	Comments	California Workers' Compensation Instructions
				zip code where the pharmacy is located.	
39	Pharmacy Telephone	R	834-5Q	Telephone number of the pharmacy	
40	Prescriber ID	R	411-DB	ID assigned to the prescriber	Enter Prescribing Doctor NPI, if none available; Enter Prescribing Doctor State License number, if none available; Enter other value as qualified by NCPDP
41	Prescriber ID Qualifier	R	466-EZ	Code qualifying the Prescriber ID (411-DB)	
42	Prescriber Last Name	R	427-DR	Individual last name	
43	Prescriber First Name	R	364-2J	Individual first name	
44	Prescriber Street Address	R	365-2K	Free-form text for prescriber address information	
45	Prescriber City	R	366-2M	Free-form text for prescriber city name	
46	Prescriber State	R	367-2N	Standard state/province code as defined by appropriate government agency.	
47	Prescriber Zip	R	368-2P	Code defining international postal zone excluding punctuation and blanks	
48	Prescriber Telephone	O	498-PM	Ten-digit phone number of the prescriber	
49	Payee ID	R	119-TT V D.0	Identifying number of the entity to receive payment for claim	
50	Payee ID Qualifier	R	118-TS V D.0	Code qualifying the Pay-To ID (119-TT)	
51	Payee Name	R	120-TU V D.0	Name of the entity to receive payment for claim	
52	Payee Street Address	R	121-TV V D.0	Street address of the entity to receive payment for claim	
53	Payee City	R	122-TW V D.0	City of the entity to receive payment for claim	
54	Payee State	R	123-TX	Standard	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields (Required/ Situational/Optional/ Not Applicable)	NCPDP D.0 Data Element	Comments	California Workers' Compensation Instructions
			V D.0	state/province code as defined by appropriate government agency	
55	Payee Zip	R	124-TY V D.0	Code defining international postal zone excluding punctuation and blanks (zip code for US)	
56	Payee Telephone	R	N/A	Telephone number of the payee	
57	Jurisdiction Field #1	S	N/A	Text-field with constraints Used to support state specific requirements in a specified format as approved and defined by NCPDP see IG for specific criteria.	
58	Jurisdiction Field #2	S	N/A	Text-field with constraints	
59	Jurisdiction Field #3	S	N/A	Text-field with constraints	
60	Jurisdiction Field #4	S	N/A	Text-field with constraints	
61	Jurisdiction Field #5	S	N/A	Text-field with constraints	
62	Prescription Service Reference #	R	402-D2	Reference number assigned by the provider for the dispensed drug/product and/or service provided	
63	Prescription Service Reference # Qualifier	R	455-EM	Indicates the type of billing submitted	
64	Fill #	R	403-D3	The code indicating whether the prescription is original or refill	
65	Date Written	R	414-DE	Date prescription was written Format: CCYYMMDD	
66	Date of Service	R	401-D1	Identifies date the prescription was filled or professional service rendered Format: CCYYMMDD	
67	Submission Clarification	S	420-DK	Code indicating that the pharmacist is clarifying the submission	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields (Required/ Situational/Optional/ Not Applicable)	NCPDP D.0 Data Element	Comments	California Workers' Compensation Instructions
68	Product/Service ID	R	407-D7	ID of the product dispensed or service provided. When the claim is for a compound where individual ingredients are submitted, this field must not be populated.	
69	Product/Service ID Qualifier	R	436-E1	Code qualifying the value in Product/Service ID (407-D7)	
70	Quantity Dispensed	R	442-E7	Quantity dispensed expressed in metric decimal units Format: 9999999.999	
71	Days Supply	R	405-D5	Estimated number of days the prescription will last	
72	DAW Code	R	408-D8	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed	
73	Prior Authorization # Submitted	S	462-EV	Number submitted by the provider to identify the prior authorization	
74	Prior Authorization Type	S	461-EU	Code clarifying the Prior Authorization Number Submitted (462-EV) or benefit/plan exemption	
75	Description	R	601-20	Description of product being submitted	
76	Strength	R	601-24	The strength of the product	
77	Unit of Measure	R	600-28	NCPDP standard product billing codes	
78	Other Coverage	S	308-C8	Code indicating whether or not the patient has other insurance coverage	
79	Delay Reason	S	357-NV	Code to specify the reason that submission of the transaction has been delayed	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields (Required/ Situational/Optional/ Not Applicable)	NCPDP D.0 Data Element	Comments	California Workers' Compensation Instructions
80	Other Payer ID	S	340-7C	Coordination of Benefits Segment ID assigned to the payer	
81	Other Payer ID Qualifier	S	339-6C	Coordination of Benefits Segment Code qualifying the Other Payer ID (340-7C)	
82	Other Payer Date	S	443-E8	Coordination of Benefits Segment	
83	Other Payer Rejects	S	472-6E	The error encountered by the previous Other Payer in Reject Code (511-FB)	
84	DUR/PPS Codes Reason	S	439-E4	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service	
85	DUR/PPS Codes Service	S	440-E5	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered	
86	DUR/PPS Codes Result	S	441-E6	Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.	
87	Level of Effort	S	474-8E	Code identifying the level of effort as determined by the complexity of decision-making or resources	
88	Procedure Modifier	S	459-ER	Identifies special circumstances related to the performance of the service	
89	Compound Dosage Form Description Code	S	450-EF	Dosage form of the complete compound mixture	
90	Compound Dispensing Unit Form Indicator	S	451-EG	NCPDP standard product billing code	
91	Compound Route of Administration	S	995-E2	This is an override to the default route	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields (Required/ Situational/Optional/ Not Applicable)	NCPDP D.0 Data Element	Comments	California Workers' Compensation Instructions
				referenced for the product. For a multi-ingredient compound, it is the route of the complete mixture	
92	Compound Ingredient Compound Count	S	447-EC	Count of compound product IDs (both active and inactive) in the compound mixture submitted	
93	Compound Product Name	S	N/A	Description of product being submitted	
94	Compound Product ID	S	489-TE	Product identification of an ingredient being used in a compound	
95	Compound Product ID Qualifier	S	488-RE	Code qualifying the type of product dispensed	
96	Compound Ingredient Quantity	S	448-ED	Amount expressed in metric decimal units of the product included in the compound mixture Format: 9999999.999	
97	Compound Ingredient Drug Cost	S	449-EE	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in Compound Ingredient Quantity (Field 448-ED) Format: 9999999.999	
98	Compound Basis Cost	S	490-UE	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	
99	Usual & Customary Charge	R	426-DQ	Amount charged cash customers for the prescription exclusive of dispensing fee, sales tax or other amounts claimed (Note: dispensing fee is to be entered in Field 102.) Format: 9999999.99	Required for California: Enter the pharmacy's usual and customary price
100	Basis of Cost Determination	R	423-DN	Code indicating the method by which Ingredient Cost	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields (Required/ Situational/Optional/ Not Applicable)	NCPDP D.0 Data Element	Comments	California Workers' Compensation Instructions
				Submitted (Field 409-D9) was calculated	
101	Ingredient Cost Submitted	S	409-D9	Submitted product component cost of the dispensed prescription. This amount is included in the Gross Amount Due (430-DU) Format: 9999999.99	
102	Dispensing Fee Submitted	R	412-DC	Dispensing fee submitted by the pharmacy. This amount is included in the Gross Amount Due (430-DU) Format: 9999999.99	
103	Other Amount Submitted	S	480-H9	Amount representing the additional incurred costs for a dispensed prescription or service. Format: 9999999.99	
104	Sales Tax Submitted	S	481-HA & 482-GE	Flat sales tax submitted for prescription. This amount is included in the Gross Amount Due (430-DU) Or Percentage sales tax submitted Format: 9999999.99	
105	Gross Amount Due (Submitted)	R	430-DU	Total price claimed from all sources. Format: 9999999.99	
106	Patient Paid Amount	S	433-DX	Amount the pharmacy received from the patient for the prescription dispensed. Format: 9999999.99	Not Applicable for California
107	Other Payer Amount Paid	S	431-DV	Amount of any payment known by the pharmacy from other sources Format: 9999999.99	
108	Other Payer Patient Responsibility Amount	S	352-NQ	The patient's cost share from a previous payer. Format: 9999999.99	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields (Required/ Situational/Optional/ Not Applicable)	NCPDP D.0 Data Element	Comments	California Workers' Compensation Instructions
109	Net Amount Due	R	N/A	Total of all pharmacy services amount due less any other paid amounts. Format: 99999999.99	

4.0 ADA 2006

The Division adopts and incorporates by reference the ADA 2006 Dental Claim Form (including instructions on reverse of form) as the mandatory standard billing form for dental bills submitted in a paper format. The Division adopts and incorporates by reference the CDT 2011-2012: ADA Practical Guide to Dental Procedure Codes, including the ADA 2006 Dental Claim Form. The book and form may be purchased from:

American Dental Association
http://www.ada.org/
211 East Chicago Ave.
Chicago, IL 60611-2678

Or on the web at:

http://www.ada.org/

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐M ☐F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐M ☐F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐M ☐F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN

52. Phone Number ( ) – 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56A. Provider Specialty Code

57. Phone Number ( ) – 58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

4.1 Field Table ADA 2006

American Dental Association 2006 Paper Claim Form			
Paper Field	**2006 ADA Claim Form Field Description**	**Workers' Compensation Paper Fields R/S/O/NA**	**Comments**
1		S	When a duplicate bill is ~~being~~ submitted, the word "Duplicate" shall be written in this field. When a Request for Second Review is submitted, the words "Request for Second Review" shall be written in this field.
2	Predetermination/Preauthorization Number Enter the Claim Reference Number (CRN) of the original bill when resubmitting a bill.	S	Enter Certification or Authorization Number Provided By Payer
PRIMARY PAYER INFORMATION			
	Name		Workers' Compensation Payer Name & Address
	Address		
	City		
	State		
	Zip Code		
3	Phone Number	R	
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	Primary Subscriber Name (Employer)	R	Employer Name and Address
	Address	R	
	City		
	State		
	Zip Code		
	Telephone Number, If Known		
13	Date of Birth	N/A	
14	Gender	N/A	
15	Subscriber ID (SSN)- Workers' Compensation Claim Number	S	Workers' Compensation Claim Number, If Known
16	Plan / Group Number- Unique Patient Bill Identifier Number Assigned by Provider	R	Unique Patient Bill Identifier Number

17	Employer Name	N/A	
18	Relationship to Primary Subscriber	O	Check "Other" Box
19	Student Status	N/A	
Paper Field	**2006 ADA Claim Form Field Description**	**Workers' Compensation Paper Fields R/S/O/NA**	**Comments**
	Patient's Last Name		
	Patient's First Name		
	Patient's Middle Name		
	Address		
	City		
	State		
	Zip Code		
20	Telephone Number, If Known	R	
21	Patient Date of Birth	R	
22	Gender	R	
23	Patient ID Number (Social Security Number)	R	Social Security Number
	RECORD OF SERVICES PROVIDED		
24	Date of Service	R	
25	Area of oral Cavity	S	
26	Tooth System	S	
27	Tooth Number's) or Letter(s)	S	
28	Tooth Surface	S	
29	Procedure code	R	
30	Description of service provided.	R	
31	Fees	R	
32	Other fees	N/A	
33	Total Fees	R	
	MISSING TEETH INFORMATION		
34	Report missing teeth on each claim submission.	S	
35	Remarks (Attachment Control Number and or Notes)	S	
	AUTHORIZATIONS		
36	Authorization Signature 1	N/A	
37	Authorization Signature 2	N/A	
	ANCILLARY CLAIM/TREATMENT INFORMATION		
38	Place of Treatment	R	Place of Service
39	Indicate the number of enclosures	S	
40	Is Treatment for Orthodontics	R	
41	Date Appliance Placement	S	
42	Months of treatment remaining	S	
43	Replacement of Prosthesis?	S	
44	Date Prior Placement	S	
45	Treatment Resulting From	R	

46	Date of Accident	R	For Specific Injury: Enter The date of incident or exposure. For cumulative Injury or Occupational
Paper Field	**2006 ADA Claim Form Field Description**	**Workers' Compensation Paper Fields R/S/O/NA**	**Comments**
			Disease: Enter the last date of occupational exposure to the hazards of the occupational disease or cumulative injury.
47	Auto Accident State	S	
	Name		
	Address		
	City		
	State		
	Zip Code		
48		R	
49	Provider ID -NPI Number	S	NPI Number Required if Billing Provider is eligible for an NPI
50	License Number (state license)	S	State License Number Required if Billing Provider is not eligible for an NPI
51	SSN or TIN	R	
52	Phone number of the entity listed in box 48.	R	
TREATING DENTIST AND TREATMENT LOCATION INFORMATION			
			If signed enter Y in CLMO6 Field or N if not signed
53	Signed (Treating Dentist) and Date	R	
54	Provider ID -NPI Number	R	
55	License Number (state license)	S	
56	Address	R	
	City		
	State		
	Zip Code		
56a	Provider Specialty Code	R	Enter Provider Taxonomy Code
57	Phone number	S	
58	Additional Provider ID	S	

Appendix B. Standard Explanation of Review

This Appendix provides Explanation of Review (EOR) instructions for both paper and electronic EORs. The Explanation of Review is required to be used for both the original bill review determination and the final written determination that is issued by the claims administrator after processing a request for second review.

Paper Explanation of Review

The paper EOR must include all of the data elements indicated as "R" (required) in Appendix B - 3.0 Table for Paper Explanation of Review. For data elements listed as "S" (situational) the data element is required where the circumstances described are applicable. Data elements listed as "O" (optional) may be included in the EOR but are not required. The payer may include additional messages and data in order to provide further detail to the provider. The Division of Workers' Compensation has not developed a standard paper form or format for the EOR. Payers providing paper EORs may use any format as long as all required and relevant situational data elements are present.

The 3.0 Field Table for Paper Explanation of Review specifies use of the DWC Bill Adjustment Reason Codes and DWC Explanatory Messages as situational data elements (Fields 41 and 52.) The Table 1.0 DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk includes the DWC Bill Adjustment Reason Codes, a description of the billing problem the code is describing, the Explanatory Message, and any special instructions or additional information required when using that code. The paper EOR does not utilize the Claims Adjustment Reason Codes or the Remittance Advice Remark Codes. These are included in the table in order to provide a crosswalk between the DWC Bill Adjustment Reason Codes and the corollary CARC and RARC codes used in electronic EORs. The claims administrator shall utilize additional narrative explanatory language to supplement the DWC Bill Adjustment Reason Codes where necessary to fully explain why the bill is adjusted, denied, or considered incomplete.

Electronic Explanation of Review

The electronic EOR is conveyed to the provider by transmission of the ASC X12/005010X221 Payment/Advice (835) Technical Report Type 3. Electronic EORs must comply with the 005010X221 and the related workers' compensation instructions found in the California Division of Workers' Compensation Electronic Billing and Payment Companion Guide, Chapter 7.

The Table 1.0 DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk includes the DWC Bill Adjustment Reason Codes, a description of the billing problem the code is describing, the Explanatory Message, and any special instructions or additional information required when using that code. The national standard 005010X221 does not support use of the DWC Bill Adjustment Reason Codes. The 005010X221 utilizes the Claims Adjustment Reason Codes (CARCs) and the Remittance Advice Remark Codes (RARCs) to convey EOR information from the payer to the provider. For workers' compensation, Table 1.0 DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk sets forth a subset of the CARCs and RARCs that are to be used in the 005010X221 transmission. The table provides a crosswalk between the DWC Bill Adjustment Reason Codes and

DWC explanatory messages and the corollary CARC and RARC combinations used in electronic EORs.

For instructions relating to use of CARC Codes 191, 214, 221 or W1 refer to the California Division of Workers' Compensation Electronic Billing and Payment Companion Guide, Chapter 7 for specific workers' compensation instructions.

When receiving an electronic EOR via 005010X221, medical providers can determine the DWC Bill Adjustment Reason Code from the combination of CARC and RARC. In most cases, each CARC/RARC combination only maps to one DWC Bill Adjustment Reason Code. The DWC Matrix Crosswalk is presented in two different orders for the convenience of both paper and electronic EOR receivers. The first is presented in DWC Bill Adjustment Reason Code order (Table1.0). The second is in CARC order (Table 2.0).

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
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.		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).		
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.	W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code	N448	This drug/service/ supply is not included in the fee schedule or contracted/legislate d fee arrangement.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
					Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).		
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.		220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
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 re-imbursement rate and/or payment rules were derived.	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).		
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.	162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.	M118	Alert: Letter to follow containing further information
G6	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.		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
					Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).		
G7	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.	97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.		
G8	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 Physician's Fee Schedule General Instructions for Separate Procedures rule.		97	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.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G9	Provider submitted bill with no supporting or lack of sufficient identification or documentation for the unlisted or BR Service reported.	The unlisted or BR service was not received or 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		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N350	Missing/incomplete/ invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure. [Note: If specific document-ation is needed, use the specific RARC for the report needed.]
G10	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 document-ation or report necessary for bill processing.	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N29	Missing documentation/ orders/notes/ summary/report/ chart. [Note: Only use RARC N29 if none of the more specific RARC report type codes below apply. (G11 – G52)]

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G11		.		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M30	Missing pathology report.
G12				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N236	Incomplete/invalid pathology report.
G13				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N240	Incomplete/invalid radiology report.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G14				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M31	Missing radiology report.
G15				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N451	Missing Admission Summary Report.
G16				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N452	Incomplete/Invalid Admission Summary Report.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G17			If the payer needs document-ation supporting a prescription that was Dispensed As Written, a request for additional information should be sent to the prescribing physician.	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M118	Alert: Letter to follow containing further information
G18				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N456	Incomplete/Invalid Physician Order.
G19				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N455	Missing Physician Order.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G20				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N497	Missing Medical Permanent Impairment or Disability Report
G21				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N498	Incomplete/Invalid Medical Permanent Impairment or Disability Report
G22				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N499	Missing Medical Legal Report

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G23				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N500	Incomplete/Invalid Medical Legal Report
G24				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N501	Missing Vocational Report
G25				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N502	Incomplete/Invalid Vocational Report

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G26				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N503	Missing Work Status Report
G27				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N504	Incomplete/Invalid Work Status Report
G28				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N453	Missing Consultation Report

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G29				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N454	Incomplete/Invalid Consultation Report
G30				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N26	Missing Itemized Bill/ Statement
G31				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N455	Missing Physician's Report- Delete Comments

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G32				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N456	Incomplete/Invalid Physician Report
G33				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N394	Incomplete/invalid progress notes/ report.
G34				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N393	Missing progress notes/report.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G35				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N396	Incomplete/invalid laboratory report.
G36				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N395	Missing laboratory report.
G37				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N458	Incomplete/Invalid Diagnostic Report.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G38				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N457	Missing Diagnostic Report.
G39				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N460	Incomplete/Invalid Discharge Summary.
G40				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N459	Missing Discharge Summary.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G41				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N462	Incomplete/Invalid Nursing Notes.
G42				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N461	Missing Nursing Notes.
G43				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N464	Incomplete/Invalid support data for claim.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G44				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N463	Missing support data for claim.
G45				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N466	Incomplete/Invalid Physical Therapy Notes.
G46				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N465	Missing Physical Therapy Notes.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G47				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N468	Incomplete/Invalid Report of Tests and Analysis Report.
G48				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N467	Missing Report of Tests and Analysis Report.
G49				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N493	Missing Doctor First Report of Injury

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G50				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N494	Incomplete/invalid Doctor First Report of Injury.
G51				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N495	Missing Supplemental Medical Report
G52				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N496	Incomplete/invalid Supplemental Medical Report.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G53				175 176 CARC 175 and 176 may be used with any of the listed RARC Codes	Prescription is incomplete Prescription is not current	N378 N388 N349 N389 M123	Missing/incomplete/ invalid prescription quantity Missing/incomplete/ invalid prescription number The administration method and drug must be reported to adjudicate this service. Duplicate prescription number submitted. Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
G54	Provider's documentation and/or code does not support level of 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.	150	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.
G55	Provider bills for service that is not related to the diagnosis.	This service appears to be unrelated to the patient's diagnosis.		11	The diagnosis is inconsistent with the procedure.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G56	Provider bills a duplicate charge.	This appears to be a duplicate charge for a bill previously reviewed, or this appears to be a "balance forward bill" containing a duplicate charge and billing for a new service.	Indicate date original charge was reviewed for payment. This code may be used to reject a bill that is a complete duplicate or to reject an entire bill that fits the definition of "balance forward bill" under section 5.0 (c).	18	Duplicate claim/service.		
G57	Service or procedure requires prior authorization and none was identified.	This service requires prior authorization and none was identified.		197	Precertification/ authorization/ notification absent.		
G58	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.	97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.	N390	This service/report cannot be billed separately.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G59	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	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
G60	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.		191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
					jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).		
G61	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.		112	Service not furnished directly to the patient and/or not documented.		
G62	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.	40	Charges do not meet qualifications for emergent/urgent care.		
G63	Provider bills for services outside his/her scope of practice.	The billed service falls outside your scope of practice.		8	The procedure code is inconsistent with the provider type/specialty (taxonomy).		
G64	Provider charge of professional and/or technical	Provider charge of professional and/or technical	Indicate name of other provider who	134	Technical fees removed from charges.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
	component is submitted after global payment made to another provider.	component is submitted after global payment made to another provider.	received global payment.				
G65	Provider charge of professional and/or technical component is submitted after global payment made to another provider.	Provider charge of professional and/or technical component is submitted after global payment made to another provider.	Indicate name of other provider who received global payment.	89	Professional fees removed from charges.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.
G66	Timed code is billed without documentation.	Documentation of the time spent performing this service is needed for further review.		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N443	Missing/incomplete/ invalid total time or begin/end time.
G67	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.	131	Claim specific negotiated discount.		
G68	Charge submitted for service in excess of pre-	Service exceeds pre-authorized approval. Please		198	Precertification/ authorization exceeded.	N435	Exceeds number/frequency approved /allowed

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
	authorization.	provide documentation and/or additional authorization for the service not included in the original authorization.					within time period without supporting documentation.
G69	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.	38	Services not provided or authorized by designated (network/primary care) providers.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G70	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.	39	Services denied at the time authorization/ pre-certification was requested.	N175	Missing review organization approval.
G71	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.	216	Based on the findings of a review organization		
G72	Charge being submitted for Retrospective Review	This charge is being sent to Retrospective Review as there is no indication that prior authorization has been sought.		15	The authorization number is missing, invalid, or does not apply to the billed service	N175	Missing review organization approval
G73	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.		15	The authorization number is missing, invalid, or does not apply to the billed service.		
G74	Provider bills and does not provide requested documentation or the documentation was insufficient or	Requested documentation to support the bill was absent or incomplete.	Identify the necessary items.	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/	N66	Missing/incomplete/ invalid documentation.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
	incomplete				incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)		
G75	Provider bills payer/employer when there is no claim on file	Bill payment denied as the patient cannot be identified as having a claim against this claims administrator.		A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	MA61	Missing/in-complete/invalid social security number or health insurance claim number.
G76	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.		50	These are non-covered services because this is not deemed a `medical necessity' by the payer.		
G77	Provider submits bill to incorrect payer/contractor	Claim not covered by this payer/ contractor. You must send the claim to the correct payer/contractor.		109	Claim not covered by this payer/ contractor. You must send the claim to the correct payer/ contractor. (CARC) 109 is to be used with qualifier PR in NM1 to indicate the employer entity.		
G78	Provider bills for multiple services with no or inadequate information to support this many	Payment adjusted because the payer deems the information submitted does not support this many		151	Payment adjusted because the payer deems the information submitted does not support this		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
	Services.	Services.			Many/frequency of services.		
G79	Bill exceeds or is received after $10,000 cap has been reached on a delayed claim	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.	.	119	Benefit maximum for this time period or occurrence has been reached.	N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made. For additional clarification to the provider, use Remark Code N437 – Alert: If the injury claim is accepted, these charges will be reconsidered.
G80	Bill is submitted that is for a greater amount than remains in the $10,000 cap.	Until the employee's claim is accepted or rejected, liability for medical treatment is limited to $10,000 (Labor Code § 5402(c)). 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, your bill will then be reconsidered. This determination must be made by 90 days from the date of injury but may be made sooner.		119	Benefit maximum for this time period or occurrence has been reached.	N437	Alert: If the injury claim is accepted, these charges will be reconsidered.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G81	Payer is paying self-executing penalties and interest to the provider due to late payment.	This bill has been paid beyond the time frame required under L.C. 4602.3. Per Section 7.2 (b) penalties and interest are self-executing	Add 15% penalty and appropriate interest to the payment.	225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837) Note: for CA workers' compensation, ignore the parenthetical section.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
PHYSICAL MEDICINE							
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.		8	The procedure code is inconsistent with the provider type/specialty (taxonomy).		
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 1 (h).		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N435	Exceeds number/ frequency approved /allowed within time period without support documentation.
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 1 (b). Payment has been made in accordance with Physician Fee Schedule guidelines		119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
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.		107	The related or qualifying claim/ service was not identified on this claim.	N122	Add-on code cannot be billed by itself.
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 1 (a).		119	Benefit maximum for this time period or occurrence has been reached.	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
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 1 ©		119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
PM7	Provider bills more than four physical medicine procedures and/or chiropractic manipulation and/or acupuncture codes during the same visit without prior authorization.	No more than four physical medicine procedures including Chiropractic Manipulation and Acupuncture codes are reimbursable during the same visit without prior authorization pursuant to Physical Medicine rule 1 (d).		151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
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.		59	Processed based on multiple or concurrent procedure rules.		
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).		59	Processed based on multiple or concurrent procedure rules.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
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).		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	N435	Exceeds number/frequency approved /allowed within time period without support documentation.
PM11	Physical Therapist charged for E/M codes which are limited to physicians, nurse practitioners, and physician assistants.	Charge was denied as Physical Therapists may not bill Evaluation and Management services.		170	Payment is denied when performed/ billed by this type of provider.		
PM12	Pre-surgical visits in excess of 24 are charged without prior authorization for additional visits.	Charge is denied as there is a 24 visit limitation on pre-surgical Physical Therapy, Chiropractic and Occupational Therapy encounters for	Optional: Provide Utilization Review phone number.	198	Precertification/ authorization exceeded.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
		injuries on/after January 1, 2004 without prior authorization for additional visits.					

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
SURGERY							
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.		59	Processed based on multiple or concurrent procedure rules.		
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.		97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.		
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.		97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
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 Section, rule 7 re: Arthroscopic Services.		59	Processed based on multiple or concurrent procedure rules.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
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 Surgery Section, rule 10 (b) (1).		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	N22	This procedure code was added/changed because it more accurately describes the services rendered.
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 Surgery Section of the Physician's Fee Schedule).		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
					adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).		
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 Surgery Section of the Physician's Fee Schedule).		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
					Segment (loop 2110 Service Payment information REF).		
S8	Surgeon's bill does not include operative report	The surgeon's bill has been rejected as we have not received the operative report. Resubmit bill with the operative report for reconsideration.		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M29	Missing operative note/report.
S9	Operative Report does not cite the billed procedure.	Incomplete/invalid operative report (billed service is not identified in the Operative Report)		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N233	Incomplete/invalid operative report.
S10	Surgeon's bill includes separate charge for delivery of local anesthetic.	Administration of Local Anesthetic is included in the Surgical Service per Surgery Section, rule 16.		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If	N514	Consult plan benefit documents/guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
					adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).		
S11	Procedure does not normally require an Assistant surgeon or multiple surgeons 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.	54	Multiple physicians/ assistants are not covered in this case.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
ANESTHESIA							
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.		97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.
A2	No anesthesia records provided for payment determination.	Please submit anesthesia records for further review.		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N463	Missing support data for claim.
A3	Insufficient information provided for payment determination.	Please submit complete/valid anesthesia records for further review.		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N464	Incomplete/invalid support data for claim.
A4	Insufficient information provided for payment determination.	Please submit anesthesia records time units for further review.		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised	N203	Missing/incomplete/ invalid anesthesia time/units

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
					of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)		
A5	Documentation does not describe emergency status.	Qualifying circumstances for emergency status not established.		40	Charges do not meet qualifications for emergent/urgent care.		
A6	Documentation does not describe physical status/condition.	Patient's physical status/condition not identified. Please provide documentation using ASA Physical Status indicators.		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N439 N440	Missing anesthesia physical status report/indicators. Incomplete/invalid anesthesia physical status report/indicators

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
E/M							
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.	95	Plan procedures not followed.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
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).		150	Payer deems the information submitted does not support this level of service.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.
EM3	Documentation does not support billing for Prolonged Services code.	Documentation provided does not justify payment for a Prolonged Evaluation and Management service.		152	Payer deems the information submitted does not support this length of service.		
CLINICAL LAB							
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.		97	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.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
PHARMACY							
P1	Charge for Brand Name was submitted without "No Substitution" documentation.	Payment was made for a generic equivalent as "No Substitution" documentation was absent.		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	N447	Payment is based on a generic equivalent as required documentation was not provided.
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.		91	Dispensing fee adjustment.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
DME							
DME1	Billed amount exceeds formula using documented actual cost for DMEPOS	Payment for this item was based on the documented actual cost.		108	Rent/purchase guidelines were not met.	N446	Incomplete/invalid document for actual cost or paid amount.
DME2	Billed amount exceeds formula using documented actual cost for DMEPOS	Payment for this item was based on the documented actual cost.		108	Rent/purchase guidelines were not met.	N445	Missing document for actual cost or paid amount.
DME3	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.		108	Rent/purchase guidelines were not met.		
DME4	Billed amount exceeds formula using documented actual cost for DMEPOS	Payment for this item was based on the documented actual cost.		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
					Service Payment information REF).		
SPECIAL SERVICES							
SS1	A physician, other than the Primary Treating Physician or designee submits a Progress and or Permanent and Stationary Report for reimbursement.	The Progress report and or Permanent and Stationary Report were disallowed as you are not the Primary Treating Physician or his/her designee.		B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N450	Covered only when performed by the primary treating physician or the designee.
SS2	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.		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	N390	This service/report cannot be billed separately.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
SS3	No request was made for Chart Notes or Duplicate Report.	Chart Notes/ Duplicate Reports were not requested		96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N390	This service/report cannot be billed separately.
SS4	Missed appointment is billed.	No payment is being made, as none is necessarily owed		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	N441	This missed appointment is not covered.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
FACILITY							
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.		197	Precertification/ authorization/ notification absent.		
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.		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.	W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer	N442	Payment based on an alternate fee schedule.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
					to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).		
F4	No payment required under Outpatient Facility Fee Schedule	Service not paid under Outpatient Facility Fee Schedule.		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.
F5	Billing submitted without HCPCS codes	In accordance with OPPS guidelines billing requires HCPCS coding.		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract	M20	Missing/incomplete/ invalid HCPCS.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
					Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).		
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.		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
MISC.							
M1	Bill submitted for non compensable claim	Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/ treatment.		214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.		
M2	Appeal /Reconsideration /Request for Second Review	No additional reimbursement allowed after review of ~~a~~Appeal/ Reconsideration /Request for Second Review.		193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
M3	Third Party Subrogation	Reduction/denial based on subrogation of a third party settlement.		215	Based on subrogation of a third party settlement		
M4	Claim is under investigation	Extent of injury not finally adjudicated. Claim is under investigation.		221	Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).		
M5	Medical Necessity Denial. You may submit a request for an appeal/ Reconsideration	Medical Necessity Denial. You may submit a request for an appeal/ reconsideration/ Request for Second Review in the future if it is determined that the service was		50	These are non-covered services because this is not deemed a `medical necessity' by the payer.		

		medically necessary.					

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
M6	Appeal/ Reconsideration /Request for Second Review denied based on medical necessity.	Appeal/ Reconsideration /Request for Second Review denied based on medical necessity.		50	These are non-covered services because this is not deemed a `medical necessity' by the payer.	N10	Payment based on the findings of a review organization/ professional consult/manual adjudication/ medical or dental advisor.
M7	This claim is the responsibility of the employer. Please submit directly to employer.			109	Claim not covered by this payer/ contractor. You must send the claim to the correct payer/ contractor. (CARC) 109 is to be used with qualifier PR in NM1 to indicate the employer entity.		

2.0 Matrix List in CARC Order

DWC Bill Adjustment Reason Code	CARC	RARC
G59	4	
G63	8	
PM1	8	
G55	11	
G72	15	N175
G73	15	
G9	16	N350
G10	16	N29
G11	16	M30
G12	16	N236
G13	16	N240
G14	16	M31
G15	16	N451
G16	16	N452
G17	16	M118
G18	16	N456
G19	16	N455
G20	16	N497
G21	16	N498
G22	16	N499
G23	16	N500
G24	16	N501
G25	16	N502
G26	16	N503
G27	16	N504
G28	16	N453
G29	16	N454
G30	16	N26
G31	16	N455
G32	16	N456
G33	16	N394

DWC Bill Adjustment Reason Code	CARC	RARC
G34	16	N393
G35	16	N396
G36	16	N395
G37	16	N458
G38	16	N457
G39	16	N460
G40	16	N459
G41	16	N462
G42	16	N461
G43	16	N464
G44	16	N463
G45	16	N466
G46	16	N465
G47	16	N468
G48	16	N467
G49	16	N493
G50	16	N494
G51	16	N495
G52	16	N496
G66	16	N443
PM2	16	N435
S8	16	M29
S9	16	N233
A2	16	N463
A3	16	N464
A4	16	N203
A6	16	N439 N440
G56	18	
G75	31	
G69	38	
G70	39	N175
G62	40	
A5	40	
F2	40	

DWC Bill Adjustment Reason Code	CARC	RARC
G4	45	
G76	50	
M5	50	
M6	50	N10
S11	54	N130
PM8	59	
PM9	59	N130
S1	59	
S4	59	N130
G65	89	N130
P2	91	
EM1	95	M15
SS3	96	N390
G7	97	
G8	97	M15
G58	97	N390
S2	97	
S3	97	M144
A1	97	N130
CL1	97	M15
PM4	107	N122
DME1	108	N446
DME2	108	N445
DME3	108	
G77	109	
M7	109	
G61	112	
G79	119	N436
G80	119	N437
PM3	119	N362
PM5	119	N130
PM6	119	N362
G67	131	
G64	134	
G54	150	N22

DWC Bill Adjustment Reason Code	CARC	RARC
EM2	150	N130
G78	151	
PM7	151	N362
EM3	152	
G5	162	M118
PM11	170	
G53	175 176	N378 N388 N349 N389 M123
G60	191	
M2	193	
G57	197	
F1	197	
G68	198	N435
PM12	198	
M1	214	
M3	215	
G71	216	
G3	220	
M4	221	
G81	225	
G74	226	N66
SS1	B7	N450
G1	W1	
G2	W1	N448
G6	W1	N130
PM10	W1	N435
S5	W1	N22
S6	W1	N130
S7	W1	N130
S10	W1	N514

DWC Bill Adjustment Reason Code	CARC	RARC
P1	W1	N447
DME4	W1	
SS2	W1	N390
SS4	W1	N441
F3	W1	N442
F4	W1	130
F5	W1	M20
F6	W1	N444

3.0 Table for Paper Explanation of Review

California DWC Paper EOR Requirements			
Data Item No.	**Field Description**	**Workers' Compensation Data Requirements R/S/O**	**Comments**
1	Date of Review	R	Date of Review
2	Method of Payment	S	If there is a payment, indicate if Paper Check or EFT
3	Payment ID Number	S	If there is a payment, indicate Paper Check Number or EFT Tracer Number
4	Payment Date	S	If there is a payment, indicate the payment date.
5	Payer Name	R	
6	Payer Address	R	
7	Payer Identification Number	O	Payer Identification Number (FEIN).
8	Payer Contact Name	S	Required if there is no payment or payment less than billed charges: Additional claim ~~administration~~ administrator contact ~~Information~~ information e.g., Adjustor ID reference for ~~appeal~~ billing dispute contact
9	Payer Contact Phone Number	S	Required if there is no payment or payment less than billed charges: Additional claim ~~administration~~ administrator contact ~~Information~~ information e.g., Adjustor ID reference for ~~appeal~~ billing dispute contact
10	Jurisdiction	O	The state that has jurisdictional authority over the claim
11	Pay-To Provider Name	R	
12	Pay-To Provider Address	R	
13	Pay-To Provider TIN	R	
14	Pay- To Provider State License Number	S	If additional payee ID information is required. This applies only to billing provider health entities
15	Patient Name	R	Patient Name
16	Patient Social Security Number	R	
17	Patient Address	O	
18	Patient Date of Birth	O	
19	Employer Name	R	Employer Name
20	Employer ID	R	Employer ID assigned by Payer
21	Employer Address	O	
22	Rendering Provider Name	R	
23	Rendering Provider ID	R	Rendering Provider NPI Number
24	PPO/MPN Name	S	Required if a PPO / MPN reduction is used
25	PPO/MPN ID Number	S	State License Number or Certification Number
26	Claim Number	R	Workers' Compensation Claim Number assigned by payer
27	Date of Accident	R	
28	Payer Bill Review Contact Name	R	
29	Payer Bill Review Phone Number	R	
Bill Payment Information			
30	Bill Submitter's Identifier	R	Patient Control /Unique Bill Identification Number assigned by provider

31	Payment Status Code	R	Payment Status Code Indicates if the bill is being Paid, Denied, or a Reversal of Previous Payment. Payment Status Codes: Paid = (1) Denied = (4) Reversal of Previous Payment = (22)
Paper Field	**Field Description**	**Workers' Compensation Data Requirements R/S/O**	**Comments**
32	Total Charges	R	
33	Total Paid	S	If there is a payment, indicate the total paid.
34	Payer Bill ID Number	R	The tracking number assigned by payer/bill review entity
35	Bill Frequency Type	S	Required if Institutional bill
36	Diagnostic Related Group Code	S	Required if payment is based on DRG
37	Service Dates	R	
38	Date Bill Received	R	
Bill Level Adjustment Information- Situational			
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 adjustments.			
39	DWC Bill Adjustment Reason Code(s) and DWC Explanatory Message(s)	S	Refer to Section One, Appendix B, Table 1.0 for DWC Bill Adjustment Reason Codes and DWC Explanatory Messages
40	Adjustment Amount	S	
41	Adjustment Quantity	S	
Service Payment Information			
42	Paid Procedure Code	R	The service code used for the actual review, revenue, HCPCS/CPT, or NDC. Includes modifiers if applicable
43	Charge Amount	R	
44	Paid Amount	R	A zero amount is acceptable
45	Revenue Code	S	Required when used in the review in addition to the HCPCS/CPT procedure code
46	Paid Units	R	
47	Billed Procedure Code	S	Required if different from the procedure code used for the review
48	Billed Units	S	Required if different from the units used for the review
49	Date of Service	R	
50	Prescription Number	S	Required for Retail Pharmacy and DME only
Service Level Adjustment			
51	DWC Bill Adjustment Reason Code(s) and DWC Explanatory Message(s)	S	Refer to Section One, Appendix B, Table 1.0 for DWC Bill Adjustment Reason Codes and DWC Explanatory Messages Descriptors.
52	Adjustment Amount	S	
53	Adjustment Quantity	S	
Notification of Time Limits for Provider to Seek Review of Disputed Payment Amount			
54	Notification of Provider Remedies	R	The Explanation of Review must contain the following language: **TIME LIMITS TO DISPUTE PAYMENT AMOUNT** **Request for Second Review** After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the explanation of review.

			The Request for Second Review must conform to the requirements of the Division of Workers' Compensation Medical Billing and Payment Guide, and regulations at title 8, California Code of Regulations section 9792.5.4 et seq. If the dispute is the amount of payment and the health care provider, health care facility, or billing agent/assignee does not request a second review within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. **Request for Independent Bill Review** After a health care provider, health care facility, or billing agent/assignee submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, a health care provider, health care facility, or billing agent/assignee that still disputes the amount paid may submit a request for independent bill review within 30 days of service of the EOR. The Request for Independent Bill Review must conform to the requirements of title 8, California Code of Regulations section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent/assignee fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final.

Section Two – Transmission Standards

For electronic transactions on or after October 18, 2012, the Division adopts the electronic standard formats and related implementation guides set forth below, as the mandatory transaction standards for electronic billing, acknowledgment, remittance and documentation, except for standards identified as optional.

The Division has adopted HIPAA – compliant standards wherever feasible.

1.0 California Electronic Medical Billing and Payment Companion Guide

The Companion Guide is a separate document which contains detailed information for electronic billing and payment. Compliance with the Companion Guide is mandatory as it has been adopted as a regulation. The Companion Guide may be downloaded from the Division's website: http://www.dir.ca.gov/dwc/dwc_home_page.htm .

2.0 Electronic Standard Formats

2.1 Billing:

(a) Dental Billing:

ASC X12N/005010X224
Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Dental (837)
MAY 2006

ASC X12N/005010X224A1
Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Dental (837)
Errata Type 1
October 2007

ASC X12N/005010X224E1
Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Dental (837)
Errata
January 2009

ASC X12N/005010X224A2
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Dental (837)

Errata
June 2010

(b) Professional Billing:

ASC X12N/005010X222
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Professional (837)
MAY 2006

ASC X12N/005010X222E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Professional (837)
January 2009

ASC X12N/005010X222A1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Professional (837)
Errata
June 2010

(c) Institutional/Hospital Billing:

ASC X12N/005010X223
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Institutional (837)
MAY 2006

ASC X12N/005010X223A1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Institutional (837)
Errata Type 1
OCTOBER 2007

ASC X12N/005010X223E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Institutional (837)
Errata
JANUARY 2009

ASC X12N/005010X223A2
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3
Health Care Claim: Institutional (837)
Errata
June 2010

(d) Retail Pharmacy Billing:

(i) National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide Version D, Release 0 (Version D.0), August 2007
(ii) National Council for Prescription Drug Programs (NCPDP) Batch Standard Implementation Guide, Version 1, Release 2 (Version 1.2), January 2006

2.2 Acknowledgment:

(a) Initial electronic responses to 005010X222, 005010X223, or 005010X224 transactions:

(i) The TA1 Interchange Acknowledgment contained in the adopted ASC X12N 837 standards.
(ii) ASC X12C/005010X231
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Implementation Acknowledgement for Health Care Insurance (999)
June 2007

ASC X12N/005010X231A1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Implementation Acknowledgment for Health Care Insurance (999)
June 2010

(b) Electronic responses to NCPDP Pharmacy transactions:
The Responses contained in the adopted NCPDP Telecommunication Standard Version D.0 and the NCPDP Batch Standard Implementation Guide 1.2.

(c) Electronic Acknowledgment:

ASC X12N/5010X214
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Acknowledgment (277)
JANUARY 2007

ASC X12N/0050X214E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Acknowledgment (277)
April 2008

ASC X12N/0050X214E2
Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Acknowledgment (277)
January 2009

2.3 Payment/Advice/Remittance:

ASC X12N/005010X221
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Payment/Advice (835)
APRIL 2006

ASC X12N/005010X221E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Payment/Advice (835)
Errata
JANUARY 2009

ASC X12N/005010X221A1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Payment/Advice (835)
Errata
June 2010

2.4 Documentation / Attachments to Support a Claim:

(a) Optional standard for transmitting documentation:

ASC X12N/005010X210
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Additional Information to Support a Health Care Claim or Encounter (275)
February 2008

ASC X12N/005010X210E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Additional Information to Support a Health Care Claim or Encounter (275)
Errata
January 2009

(b) Optional transaction standard to request additional documentation:

ASC X12N/005010X213
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Request for Additional Information (277)
July 2007

ASC X12N/005010X213E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Request for Additional Information (277)
Errata
April 2008

ASC X12N/005010X213E2
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Request for Additional Information (277)
Errata
January 2009

3.0 Obtaining Transaction Standards/Implementation Guides

All transaction standards / implementation guides (except NCPDP retail pharmacy) can be purchased from:

Data Interchange Standards Association (DISA)
7600 Leesburg Pike, Suite 430 Falls Church, VA 22043 USA
Email: info@disa.org

Or on the Internet at http://store.x12.org

NCPDP Telecommunication Standard Implementation Guide can be purchased from:

National Council for Prescription Drug Programs, Inc. (NCPDP)
9240 E. Raintree Dr.
Scottsdale, Arizona 85260-7518
(480) 477-1000
(480) 767-1042 - Fax

Or on the Internet at www.ncpdp.org