Workers' Compensation Information System (WCIS)

California EDI Implementation Guide for Medical Bill Payment Records

Release 2
January 1, 2014

CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS
Christine Baker, Director

DIVISION OF WORKERS' COMPENSATION
Destie Overpeck, Acting Administrative Director

January 1, 2014

Dear Claims Administrators:

The California Division of Workers' Compensation is pleased to introduce the new version of the CA Implementation Guide for Medical Bill Payment Records Release 2.0. This guide is based on the IABC Release 2 Medical Bill Record with some variation to accommodate California specific rules.

With the new version of the guide California is migrating from using ANSI X12 4010 format to ANSI X12 5010 format for collecting medical bill data. This migration has significant transaction improvements that address the industry's needs. It corrects problems encountered in the 4010 version. In general it is believed to be efficient and easier to implement. Moreover, it puts in synch the CA WCIS data collection with the Divisions electronic billing regulation that went into effect on October 2012. It will also bring the WCIS data collection to the current industry standard of doing business between providers and insurers.

As in the past the Medical bill record data collected by the WCIS will be integrated with the FROI/SROI data the Division currently collects. These two databases will have a wealth of information which can help the Division make informed policy decisions.

The data in WCIS is only as good as what you, our Trading Partner, transmit to it. I urge you to submit complete and accurate data. Reliable data will assist the division make correct decisions that will benefit both the injured worker and the employer community.

The California EDI Implementation Guide for Medical Bill Payment Records will be posted on our web site at http://dir.ca.gov/dwc/wcis.htm. I hope this revised version of the CA Implementation Guide will be useful in your effort to submit the mandated information to the CA WCIS.

The California DWC is dedicated to open communication as a cornerstone of a successful partnership between you and the Division. I hope this Guide will be a useful instrument that will help you submit accurate data.

Sincerely,

Destie Overpeck, Acting Administrative Director
Division of Workers' Compensation

Table of Contents

Section I: Electronic Data Interchange in California

Introduction

This Guide is adopted by the Administrative Director of the Division of Workers' Compensation pursuant to the authority of Labor Code sections §138.6, and §138.7. The Guide contains the California-specific protocols and excerpts from the IAIABC EDI Implementation Guide for Medical Bill Payment Records Release 2, explains the technical design and functionality of the WCIS system, testing options for the trading partners, instructions regarding the medical billing data elements, and reporting standards and requirements. The Guide is posted on the Division's Web site at http://www.dir.ca.gov/dwc/WCIS.htm, and is available from the Division of Workers' Compensation upon request.

Electronic data interchange (EDI) is the computer-to-computer exchange of data or information in a standardized format. In California workers' compensation, medical EDI refers to the electronic transmission of detailed medical bill payment records information from trading partners, i.e. senders, to the California Division of Workers' Compensation.

Medical bill payment data are transmitted in a format standardized by the American National Standards Institute (ANSI). The International Association of Industrial Accident Boards and Commissions (IAIABC) adapted the ANSI file standard to workers' compensation. All data elements to be collected have been reviewed for a valid business need, definitions, formats and are consistent with Labor Code §4603.4 (a) (2) which requires claims administrators to accept electronic submission of medical bills.

California Workers' compensation information system (WCIS) history

The California legislature enacted sweeping reforms to California's workers' compensation system in 1993. The legislature directed the Division of Workers' Compensation (DWC) to put together comprehensive information about workers' compensation in California. The result is the Workers' Compensation Information System (WCIS). The WCIS has 4 components: the First Reports of Injury (FROI) reporting guidelines were implemented March 1, 2000. The Subsequent Reports of Injury (SROI) reporting guidelines were implemented July 1, 2000. Reporting of annual summary of benefits began January 31, 2001.

Medical bill payment reporting regulations were adopted on March 22, 2006. The regulations require medical services with a date of service on or after September 22, 2006 and a date of injury on or after March 1, 2000 to be transmitted to the DWC The

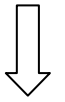
medical services are required to be reported to the WCIS by all claims administrators handling 150 or more total claims per year.

Sending data to the WCIS

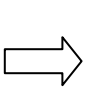
California workers' compensation medical bill payment records are processed by diverse organizations: large multi-state insurance companies, smaller specialty insurance carriers, self-insured employers or insurers, third-party administrators handling claims on behalf of self-insured employers, as well as bill review companies. The organizations have widely differing technological capabilities, so the WCIS is designed to be as flexible as possible in supporting EDI medical transmissions.
Following the IAIABC standards the WCIS supports the American National Standards Institute (ANSI) file format. The California-adopted ANSI loop and segment structure is summarized in Section IV and completely specified in Section 5 of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2, February, 2012 (www.iaiabc.org).

Flow of Medical Data in the California Workers Compensation System

Injured Worker



Medical Providers



Industry Billing Standards

Insurers

Electronic Data Interface

DWC WCIS

WCIS web site

Visit the WCIS web site – http://www.dir.ca.gov/dwc/wcis.htm – to:

- Download the latest version of the California EDI Implementation Guide for Medical Bill Payment Records,
- Get answers to frequently asked questions,
- Review archived WCIS e-news letters

WCIS/IS contact person

Each WCIS trading partner will be assigned an individual contact person at the DWC. The assigned person will help answer trading partner questions about medical EDI in the California WCIS, work with the trading partner during the testing process, and be an ongoing source of support during production.

The WCIS contact person can be reached by phone, e-mail, or mail. When initially contacting the WCIS, be sure to provide your company name so that you will be assigned to the appropriate WCIS contact person.

By phone:

510-286-6753 Trading Partner Letters C, G-H, M, P-R

510-286-6763 Trading Partner Letters B, D-F, N-O, W-Y

510-286-6772 Trading Partner Letters A, I-L, S-V, Z

By fax: (510) 286-6862

By e-mail: wcis@dir.ca.gov

By mail: WCIS EDI Unit
Attn: Name of WCIS contact (if known)
Department of Industrial Relations
1515 Clay Street, 18th Floor
Oakland, CA 94612

WCIS e-news

WCIS e-news is an email newsletter sent out periodically to inform WCIS trading partners of announcements and technical implementations. The WCIS e-news is archived on the WCIS web site. Interested parties who are not already receiving WCIS e-news can register at the WCIS website to be added to the WCIS e-news mailing list.

Section II: Trading partner profile

Who should complete the trading partner profile?

A separate trading partner profile form must be completed for each trading partner transmitting EDI medical records to WCIS. Each trading partner has a unique identification composed of the trading partner's federal tax identification number ("Master FEIN") and physical address postal code. The identification information must be reported in the ISA header record of every transmission. The sender identification, transmission date, and transmission time are used to identify communication parameters for the return of the 824 detailed acknowledgments to the trading partners.

For some senders, the insurer FEIN (federal tax identification number) provided in each ST-SE transaction set will always be the same as the sender identification master FEIN. Other senders may have multiple FEINs for insurers or claims administrators. The transactions for a sender with multiple insurer FEINs or claims administrator FEINs can be sent under the same sender identification master FEIN.

For example, a single parent insurance organization might wish to send transactions for two subsidiary insurers together in one 837 transmission. In such a case, the parent insurance organization could complete one trading partner profile, providing the master FEIN for the parent insurance company in the sender ID, and could then transmit ST-SE transaction sets from both subsidiary insurers, identified by the appropriate insurer FEIN in each ST-SE transaction set within the 837 transmission.

Another example is a single organization that might wish to send transactions for multiple insurers or claims administrators together in one 837 transmission. In such a case, the sending organization could complete one trading partner profile, providing the master FEIN for the sending company in the sender ID, and could then transmit ST-SE transaction sets for the multiple insurers or claims administrators, identified by the appropriate insurer FEIN or claims administrator FEIN in each ST-SE transaction set within the 837 transmission.

State of California
Department of Industrial Relations

DIVISION OF WORKERS' COMPENSATION

MEDICAL ELECTRONIC DATA INTERCHANGE TRADING PARTNER PROFILE

PART A. Trading partner background information:

Effective Date:_____

Sender Name:_____

Sender Master FEIN: _____

Physical Address: _____

City: _____ State: _____

Postal Code: _____

Mailing Address: _____

City: _____ State: _____

Postal Code: _____

Trading partner type (check all that apply):

- **Self-Administered**

____Insurer ____Self-insured Employer

- **Third Party Administrator of**

____Insurer ____Self Insured Employer

- **Other (please specify)**:_____

PART B. Trading partner contact information:

Business Contact:	Technical Contact:
Name: _____	Name: _____
Title: _____	Title: _____
Phone: _____	Phone: _____
FAX: _____	FAX: _____
E-mail Address: _____	**E-mail Address:** _____

PART C. Trading partner transmission specifications:

C1. Profile identifier:
If submitting more than one profile, please specify:
PROFILE NUMBER (1, 2, etc.): _____

DESCRIPTION: _____

Transaction Type	File Format	Expected Days of Transmission(circle any that apply)	Production Response Period
Medical Bill Payment Records	ANSI 837	Daily Monday Tuesday Wednesday Thursday Friday Saturday Sunday Weekly	

C2. SFTP account information

Sender/Trading Partner Name: _____

Sender/Trading Partner E-mail: _____

	DWC Use Only
User Name: (A-Z, a-z, 0-9) _____	
Password: (8 characters min.) _____	
Transmission Mode is SFTP also known as SSH (Secure Shell) File Transfer Protocol.	
Source Public Network IP Address: (limit to 6 max.) _____	
File Naming Convention: Prefix: (max. 4 characters) _____	

Unique Identifier: (choose one) ___ Sequence ___ Date/Time ___ Date/Sequence ___ Other _____	

PART D. Receiver Information (to be completed by DWC):

Name: *California Division of Workers' Compensation*

FEIN: *943160882*

Physical Address: *1515 Clay Street, Suite 1800*

City: *Oakland* State: CA Postal Code: *94612-1489*

Mailing Address: *P.O. Box 420603*

City: *San Francisco* State: *CA* Postal Code: *94142-0603*

Business Contact:	Technical Contact:
Name: *(Varies by trading partner)*	Name: *(Varies by trading partner)*
Title: *(Varies by trading partner)*	Title: *(Varies by trading partner)*
Phone: (Varies by trading Partner)	Phone: *(Varies by trading partner)*
FAX: 510-286-6862	FAX: 510-286-6862
E-mail Address: *wcis@dir.ca.gov*	E-mail Address: *wcis@dir.ca.gov*

RECEIVER'S ANSI X12 TRANSMISSION SPECIFICATIONS:

Segment Terminator: ~ ISA Information: TEST PROD
Data Elements Separator: * Sender/Receiver Qualifier: *ZZ ZZ*
Sub-Element Separator: : Sender/Receiver ID: *(Use Master FEINs)*
Date/Time Transmission Sent (DN100 & DN101):(Format: CCYYMMDDHHMM)

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

Electronic Data Interchange Trading Partner Profile

Instruction for completing trading partner profile

Each trading partner will complete parts A, B and C, providing information as it pertains to them. Part D contains receiver information, and will be completed by the DWC.

PART A. Trading Partner Background Information:

NAME:	The name of your business entity corresponding with the Master FEIN.
MASTER FEIN:	The Federal Employer's Identification Number of your business entity. The FEIN, along with the 9 digits physical address postal code (postal+4) in the trading partner address field, will be used to identify a unique trading partner.
PHYSICAL ADDRESS:	The Street address of the physical location of your business entity. It will represent where materials may be received regarding "this" Trading Partner Profile if using a delivery service other than the U.S. Postal Service.
CITY:	The city portion of the street address of your business entity.
STATE:	The 2-character standard state abbreviation of the state portion of the street address of your business entity.
POSTAL CODE:	The 9-position postal code of the street address of your business entity. This field, along with the Trading Partner FEIN, will be used to uniquely identify a trading partner.
MAILING ADDRESS:	The mailing address used to receive deliveries via the U. S. Postal Service for your business entity. This should be the mailing address that would be used to receive materials pertaining to "this" Trading Partner Profile. If this address is the same as the physical address, indicate "Same as above".
TRADING PARTNER TYPE:	Indicate any functions that describe the trading partner. If "other", please specify

PART B. Trading Partner contact Information:

This section provides the ability to identify individuals within your business entity who can be used as contacts. Room has been provided for two contacts: business and technical.

BUSINESS CONTACT:	The individual most familiar with the overall data extraction and transmission process within your business entity. The individual should be able to track down the answers to any issues that may arise that the technical contact cannot address.
TECHNICAL CONTACT:	The individual that should be contacted if issues regarding the actual transmission process arise.
BUSINESS/ TECHNICAL CONTACT (Name)	The name of the contact.
BUSINESS/ TECHNICAL CONTACT (Title)	The title of the contact.
BUSINESS/ TECHNICAL CONTACT (Phone)	The telephone number of the contact.
BUSINESS/ TECHNICAL CONTACT (FAX)	The telephone number of the FAX machine for the contact.
BUSINESS/ TECHNICAL CONTACT (E-mail)	The e-mail address of the contact.

PART C. Trading Partner transmission specifications:

This section is used to communicate all allowable options for EDI transmissions between the trading partner and the DWC.

C1. Profile identifier

One profile should be completed for each set of transactions with common transmission requirements. Although one profile will satisfy most needs, it should be noted that if transmission parameters vary by transaction set IDs, a trading partner could specify those differences by providing more than one profile.

PROFILE NUMBER:	A number assigned to uniquely identify a given profile.
DESCRIPTION:	A free-form field used to uniquely identify a given profile between trading partners.
TRANSACTION TYPE:	Indicates the type of EDI transmissions accepted by Division of Workers' Compensation.
FILE FORMAT:	DWC will only accept the ANSI X12 VERSION 5010 contained in the IAIABC EDI–Implementation Guide for Medical Bill Payment Records, Release 2, February 1, 2012. The WCIS will transmit detailed 824 acknowledgments, matching DN98 (Sender ID), DN100 (Date transmission sent), and DN 101 (Time transmission sent) from the inbound 837 to the DN99 (Receiver ID), DN 102 (Original date transmission sent) and DN103 (Original time transmission sent) in the outbound detailed 824. The DN101 (time transmission sent) in the BHT segment(s) of the 837 must be identical to the time in the ISA10 interchange time and GS05 time in the 837 headers where the standard format is HHMM.
EXPECTED TRANSMISSION DAYS OF WEEK:	Indicate expected transmission timing for each transaction type by circling the applicable day or days. Note: that DWC reserves the right to impose restrictions on a trading partner's transmission timing in order to control system utilization.
PRODUCTION RESPONSE PERIOD:	The maximum period of elapsed time within which a sending trading partner may expect to receive an acknowledgment for an inbound transmission.

C2. SFTP Account information

NAME: Specify name

E-MAIL ADDRESS: Specify e-mail address

USER NAME: Create your own user name (A-Z, a-z, 0-9).

PASSWORD: Create your own password with minimum eight characters.

TRANSMISSION MODE: SFTP also known as SSH (Secure Shell) File Transfer Protocol

SOURCE PUBLIC NETWORK IP ADDRESS: Must be a public address. Although some network systems use private addresses for internal networks (e.g.; 10.0.0.0, 172.16.0.1 and 192.168.1.1), WCIS requires the public IP address to where the private addresses translate.

FILE NAMING CONVENTION: Specify Prefix and Unique Identifier

PART D. Receiver information (to be completed by DWC):

This section contains DWC's trading partner information.

NAME: The business name of California Division of Workers' Compensation.

FEIN: The Federal Employer's Identification Number of DWC.

PHYSICAL ADDRESS: PARTNER. The street address, city, state, and nine digit postal code of DWC.

MAILING ADDRESS: The Post Office box, city, state, and nine digit postal the DWC uses to receive deliveries via the U.S. Postal Service

TECHNICAL CONTACT: The name, title, phone number, fax number, and e-mail address of the individual.

BUSINESS The name, title, phone number, fax number, and e-mail address of the

CONTACT: individual.

Receiver's ANSI X12 transmission specifications:

SEGMENT TERMINATOR:	The character to be used as a segment terminator is specified here (~).
DATA ELEMENT SEPARATOR:	The character to be used as a data element separator is specified here (*).
SUB-ELEMENT SEPARATOR:	The character to be used as a sub-element separator is specified here (:).
SENDER/RECEIVER QUALIFIER:	This will be the trading partner's ANSI ID Code Qualifier as specified in an ISA segment.
SENDER/RECEIVER ID:	The Master FEIN
DATE/TIME OF TRANSMISSION:	The DN100-Date Transmission Sent in the BHT segment(s) of the 837 must be identical to the time in the ISA09 interchange date and GS04 date in the 837 headers where the standard format is CCYYMMDD. The DN101-Time Transmission Sent in the BHT segment(s) of the 837, must be identical to the time in the ISA10 interchange time and GS05 Time in the 837 headers where the standard format is HHMM.
ISA INFORMATION:	For test files use "T". For production files use "P".

Section III : EDI medical testing

The EDI medical testing process is designed to help trading partners comply with the WCIS electronic data reporting regulations. The Title 8 CCR § 9702(a) states "*Each claims administrator shall, at a minimum, provide **complete**, **valid**, **accurate data** for the data elements set forth in this section*."

- **Complete data** – In order to evaluate the effectiveness and efficiency of the California workers' compensation system, trading partners must submit all required medical bill payment data elements.

- **Valid data** – Valid means the data is consistent with the values assigned by the IAIABC and adopted by the California DWC. Review the usage, purpose, and notes for each required data element in section 2 of the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 to assure your use of the data element matches that assigned by the IAIABC and adopted by the California DWC.

- **Accurate data** – Accurate means free from errors.

Overview of the EDI medical testing process

The EDI medical testing process consists of several phases designed to help each new trading partner to become a successful medical bill reporter in the California Workers' Compensation Information System. The EDI medical testing process begins by completing a trading partner profile and establishing SFTP connectivity with the WCIS, followed by functional transmission testing and transaction level bill testing. More detailed information on each component of the process is provided below. An Information Systems contact person and the WCIS Research Unit are available to work with each trading partner during this process to ensure the transition to production is successful

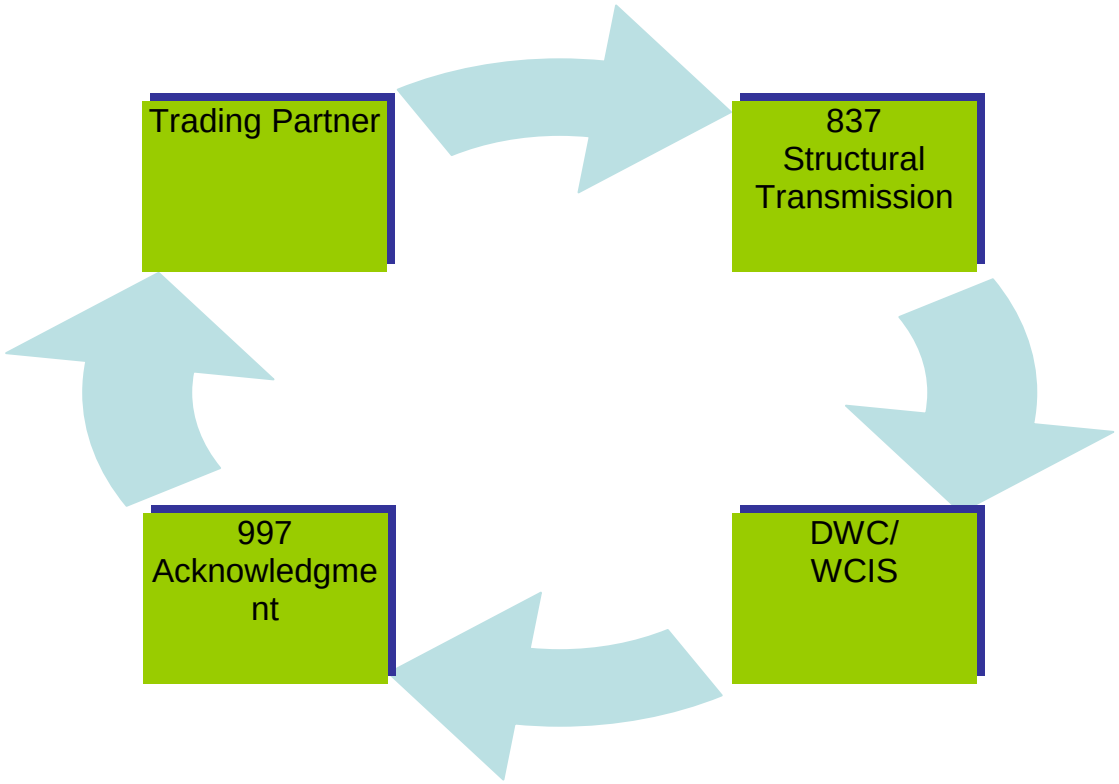
Completing a medical EDI trading partner profile and establishing connectivity

The process begins by completing a trading partner profile form. The WCIS requires the trading partner profile form be submitted to the Division at least 30 days before testing begins. Within 5 days of receiving the completed trading partner profile, the WCIS will email or fax the Secure File Transfer Protocol (SFTP) information form with the WCIS host Address to the technical contact named in the trading partner profile form. Within 7 days of receiving the completed SFTP information form, the WCIS will create a user account, and grant network access and ask the trading partner to send a sample of test file to establish secure connectivity between the WCIS and the Trading Partner.

Transmission/functional EDI medical testing

During the next phase, trading partners test the ability to transmit 837 files to WCIS and receive 997 functional acknowledgement files from WCIS. The trading partner compiles and sends small ANSI 837 files with the required loops, segments, and California data elements. Examples of sample 837 ST-SE transaction sets are available in the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2012 Section 4 Health Care Claims (837) scenarios. After the functional 837 test file has been received and processed by the DWC/WCIS, an ASC X12 997 acknowledgment will be transmitted to the trading partner by WCIS. The 997 acknowledgment reports the status of the transmission as either successful, ”A” in the AK901 position or unsuccessful, “R” in the AK901 position.

Functional EDI medical testing communication loop



The 997 functional acknowledgment EDI medical testing error messages

If the 997 functional acknowledgment contains a functional group acknowledgment code = R (Transmission rejected), the acknowledgement will have one or more of the error codes listed in the tables below. Check the ANSI 837 structural format and make corrections before re-transmitting the 837 file to WCIS. If the functional test fails a second time, contact the WCIS to answer any questions or help with problems encountered during the functional testing. All trading partner test files must receive a 997 acknowledgement with an 'A' transmission accepted without error before the next phase of testing can begin.

Transmission Status test error codes		
997 Segment position	**Error Code**	**Error Message**
AK901_Acknowledgement Status	A	Transmission accepted without errors
AK901_Acknowledgement Status	R	Transmission rejected with errors

Mandatory segments and fields test error codes		
997 Segment position	**Error Code**	**Error Message**
AK304_Data Segment Note	3	Mandatory segment missing
AK403_Data Element Note	1	Mandatory data element missing

Mandatory 837 Segments (AK304=3)	
837 Segment	**837 Segment Description**
ST	Transaction Set Header
BHT	Beginning of Hierarchy Transaction
NM1	Sender Information
NM1	Receiver Information
NM1	Insurer/Self-Insured Name
N4	Insurer/Self-Insured Postal Code
NM1	Employer Name
DTP	Date of Injury
NM1	Claimant Name
REF	Claim Administrator Claim Number
CLM	Bill Record Information
DTP	Date Insurer Received Bill
DTP	Date of Bill
DTP	Date Insurer Paid Bill

AMT	Total Amount Paid Per Bill
REF	Unique Bill Identification Number
REF	Record Transmission Tracking Number
NM1	Billing Provider Name
PRV	Billing Provider Address
N4	Billing Provider City, State, and Postal Code
REF	Billing Provider Tax Identification Number
DTP	Service Date(s)
SE	Transaction Set Trailer

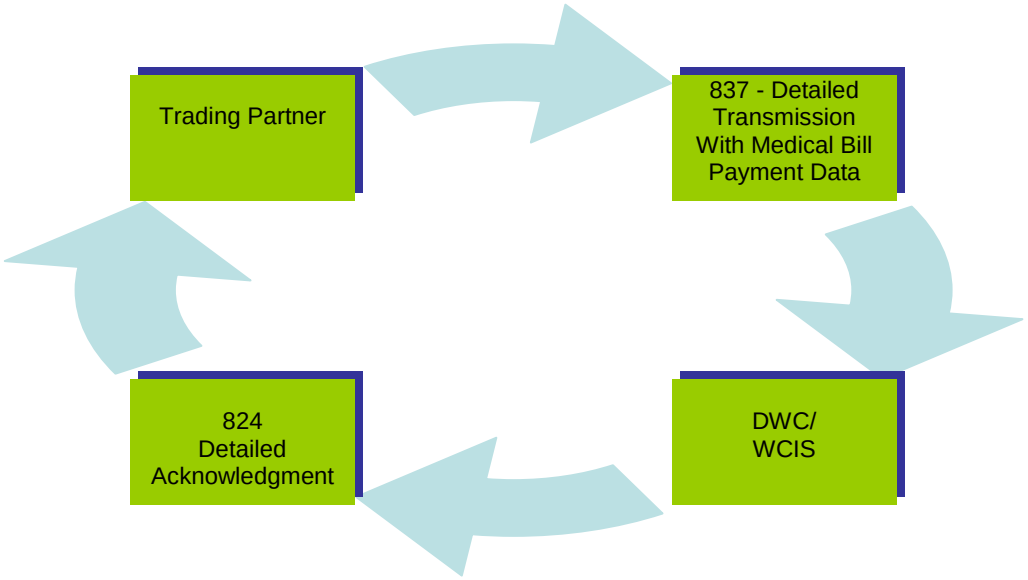
Other 997 test error codes		
997 Segment position	**Error Code**	**Error Message**
AK304-Data Segment Note	2	Unexpected segment
AK304-Data Segment Note	8	Segment has data element errors
AK403-Data Element Note	3	Too many data elements
AK403-Data Element Note	4	Data element too short
AK403-Data Element Note	5	Data element too long
AK403-Data Element Note	6	Invalid character in data element
AK403-Data Element Note	8	Invalid date
AK403-Data Element Note	9	Invalid time

Transaction/bill level EDI medical testing

After successfully completing the transmission/functional tests, the trading partner transmits sample detailed medical bill payment data to the WCIS. During this phase of the test, the trading partner's ability to report complete, valid, and accurate data will be verified. The test file for this phase will include several bills from each bill type with a 00 Original bill submission reason code.

For examples of standard billing types refer to the IAIABC Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2012 Section 4 medical billing scenarios. Not all trading partners are required to test all of the IAIABC billing scenarios. If only certain types of bills are to be tested and reported to the WCIS, contact the WCIS to indicate which medical billing scenarios will be included in the transaction level testing.

Transaction level bill EDI medical testing communication loop



All data sent to the WCIS is subjected to standard IAIABC EDI data edits. If a data element fails to pass any IAIABC data edit, an error message will be generated for that data element. The 824 detailed acknowledgment will contain information about all detected errors for each ST-SE transaction set (batch(es)) and all individual transaction(s) (bill(s)) contained in the 837 transmission. For more detailed information see the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2012 Section 5, Application Advice (824) scenarios.

If the 824 detailed acknowledgment indicates correctable errors, transaction (bill) rejected (IR), the sender will need to make corrections and resend the 837 transmission to the WCIS. When making corrections, all data elements in the affected transaction (bill) originally submitted must be submitted again.

824 application acknowledgment test error messages

Error Code	Message
001	Mandatory field not present
028	Must be numeric (0-9)
029	Must be a valid date (CCYYMMDD)
030	Must be A-Z, 0-9, or spaces
031	Must be a valid time (HHMM)
033	Must be <= date of injury
034	Must be >= date of injury
039	No match on database
040	All digits cannot be the same
041	Must be <= current date
057	Duplicate transaction set/transaction

058	Code/ID invalid
059	Non-match data value not consistent with value previously reported
061	Event table criteria not met
063	Invalid event sequence/relationship
064	Invalid data relationship
073	Must be>= date payer received bill
074	Must be >= from date of service
075	Must be <= thru service date
111	Must be valid content
117	Match value not consistent with value previously reported

Medical bill cancellation, bill correction, bill replacement testing

Once the original bills are accepted by WCIS the trading partner transmits files with bill submission reason code of 01 cancellation, 02 correction and 05 replace for the accepted bills. The cancelled, corrected and replaced medical bills are matched to the original bills previously sent during the detailed medical bill testing phase. For examples of standard cancellations, corrections, replace bill types refer to the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2012 Section 4, scenarios 10, 11, and 12. All trading partners, regardless of bill type being tested, are required to test bill submission reason code of 01 cancellation, 02 corrections and 05 replace.

Testing balancing rules

To comply with the WCIS reporting regulations it is necessary that certain accounting rules be applied to the billed, paid, and adjusted amounts reported in the 837. Specifically, it is necessary that billed, paid, and adjusted amounts be reported at both the bill and line level balance. The following balancing rules are required to complete the testing process. For numerical examples of the balancing rules refer to the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2012 Section 1.3.

⇒ The charged amount(s) reported at the line level must add up to the total charged amount reported at the bill level.

⇒ The paid amount(s) reported at the line level must add up to the total paid amount reported at the bill level.

⇒ The reported total amount paid per bill plus the sum of all the reported bill adjustment amounts must equal the total charge per bill reported for each bill.

⇒ For each service line reported in a bill, that were not adjusted at the bill level, the reported total amount paid per line plus the sum of all the reported service adjustment amounts for the line must equal the total charge at the line level.

Production Status

After successful completion of the EDI medical testing, the trading partner will be officially notified to change the status of the 837 to production and to begin sending the required medical data. During production, data transmissions will be monitored for completeness, validity and accuracy. Annual data quality reports tabulating the number of errors will be sent to each trading partner (http://www.dir.ca.gov/dwc/wcis/WCIS_MedicalBillingReports.html).
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Section IV: Supported transactions and ANSI file structure

Supported transactions

The WCIS utilizes three American National Standards Institute (ANSI) X12 files in the medical EDI. The IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide for reporting medical bill and payment information to workers' compensation jurisdictions are based on the ASC X12 837 Health Care Claims (837) and the ASC X12 824 Application Advice (824) 005010 standards. The WCIS also utilizes the ASC X12 997 Functional acknowledgement. All three ACS X12 files are enveloped in the ISA-IEA interchange control header/trailer, the GS-GE functional group header(s)/trailer(s), and the ST-SE transaction sets which must contain the correctly formatted mandatory segments and fields required by the WCIS medical data elements.

Health care claim transaction sets

The X12 997 functional acknowledgement reports the status of a received IAIABC 837. The 997 functional acknowledgement reports each syntax error encountered while processing the received IAIABC 837. Like all X12 transaction sets, the 997 functional acknowledgement is sent inside a GS/GE envelope. The ST and SE are no different than any other transaction set.

The X12 837 health care claim transaction set is used in California to submit health care claim billing information, encounter information, or both, from providers of health care services to payers (http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling_Regulations.htm). The IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2 is based on the ASC X12 837 Health Care Claims standards (IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2012). The IAIABC Release 2 837 for reporting to jurisdictions is consistent with the ANSI X12 health care claim transaction set(s) used for billing between medical providers and payers.

The IAIABC 824 detailed acknowledgement is used to inform the sender of the detailed status of the IAIABC Release 2 837. Each IAIABC Release 2 837 is edited against the edit matrix, and any errors in content reported back to the sender in the 824 detailed acknowledgement. An IAIABC 824 detailed acknowledgement will be sent to each trading partner after each IAIABC Release 2 837 is evaluated for errors in content.

ANSI definitions

Loop:	A group of segments that may be repeated. The hierarchy of the looping structure is insurer, employer, patient, bill level, and bill service line level. The California adopted loops are defined in the ANSI loop and segment summary.
Segment ID:	Each segment begins with a two or three character segment identifier. The identifier serves as a label for a data segment.
Data Segment:	Each segment consists of a segment identifier, one or more composite data structures or simple data elements each proceeded by a data element separator and succeeded by a segment terminator. The California adopted data segments are summarized in the following ANSI loop and segment summary.
Data Element Name:	The California adopted IAIABC data element names are cross walked to the Compensation Medical Bill ACS X12 data element names in section 6 of the IAIABC Workers' Data Reporting Implementation Guide, Release 2.0 February 1, 2012.
Format:	Type of data element as described below:
AN	A string data element containing a sequence of any characters from the basic or extended character sets with the exception of the delimiters below. Example: Claim Administrator Claim Number LM&TZ908#
ID	Specific code taken from a pre-defined list of codes maintained by the Accredited Standards Committee (ASC) X12 or some other body recognized by the DWC/WCIS. Example: Place of service code 11
R	Numeric value containing explicit decimal point. The decimal point must appear as part of the data stream if at any place other than the rightmost end of the number. Leading zeros should be suppressed. Trailing zeros following the decimal point should be

suppressed. If a decimal point is not included in the number, none will be assumed. Do not use commas in the decimal number.

Example: Bill Adjustment Amount 19.21

Delimiters:

*****	Data element separator
:	Component element separator
~	Segment terminator

Note**:** ANSI 837 Release 2 transaction including the X12 recommended delimiters of asterisk, colon, and tilde. The delimiters cannot be used as part of any data value or string. More detailed information can be found ASC X12 Secretariat, the Data Interchange Standards Association (DISA): Data Interchange Standards Association (DISA) at http://store.x12.org/store/.

California ANSI 997 loop, segment and error summary

ST Transaction Set Header		
Segment	ST	Transaction Set Control Number
Segment	AK1	Functional Group Response Header
Segment	AK2	Transaction Set Response Header
Segment	AK3	Data Segment Note
AK304		Segment Syntax Error Code
Segment	AK4	Data Element Note
AK403		Data Element Syntax Error Code
AK404		Copy of Bad Data Element
Segment	AK5	Transaction Set Response Trailer
AK501		Transaction Set Acknowledgement Code
AK502		Transaction Set Syntax Error Code
Segment	AK9	Functional Group Response Trailer
AK901		Functional Group Acknowledgement Code
AK905		Functional Group Syntax Error Code
SE Transaction Set Trailer		
Segment	SE	Transaction Set Trailer

California ANSI 837 loop, segment and data element summary

ST Transaction Set Header		
Segment	ST	Transaction Set Control Number
Segment	BHT	Beginning of Hierarchy Transaction
Data Element	0532	Originator Transaction Identification Number
Data Element	0100	Date Transmission Sent
Data Element	0101	Time Transmission Sent

LOOP ID	1000A	Sender Information
Segment	NM1	Identification code
Data Element	0098	Sender Identification
LOOP ID	1000B	Receiver Information
Segment	NM1	Identification code
Data Element	0099	Receiver Identification
LOOP ID	2000A	Insurer Hierarchical Level Information
Segment	DTP	Reporting Period
Data Element	0615	Reporting Period
LOOP ID	2010AA	Insurer/Self Insured Information
Segment	NM1	Insurer/Self Insured Information
Data Element	0007	Insurer Name
Data Element	0006	Insurer FEIN
Segment	N4	Insurer/Self-Insured Postal Code
Data Element	0616	Insurer Postal Code
Loop ID	2010AB	Claim Administrator Information
Segment	NM1	Claim Administrator Name
Data Element	0188	Claim Administrators Name
Data Element	0187	Claim Administrators FEIN
Segment	N4	Claim Administrator Postal Code
Data Element	0014	Claim Administrator Mailing Postal Code
LOOP ID	2000B	Employer Hierarchical Information
Segment	HL	Employer Hierarchical Level
LOOP ID	2010BA	Employer Named Insurer Information
Segment	NM1	Employer Name
Data Element	0018	Employer name
Data Element	0016	Employer FEIN
Loop ID	2000C	Claimant Hierarchical Information
Segment	HL	Claimant Hierarchical Level
Segment	DTP	Date of Injury
Data Element	0031	Date of Injury
Loop ID	2010CA	Claimant Information
Segment	NM1	Claimant Information
Data Element	0043	Employee Last Name
Data Element	0044	Employee First Name
Data Element	0045	Employee Middle Name/Initial
Data Element	0042	Employee Social Security Number

Loop ID	2010CA	Claimant Information
Segment	REF	Claimant Claim Number
Data Element	0015	Claim Administrators Claim Number
Data Element	0005	Jurisdiction Claim Number
Loop ID	2300	Billing Information (Repeat > 1)
Segment	CLM	Bill Record Information
Data Element	0523	Billing Provider Unique Bill ID Number
Data Element	0501	Total Charge per Bill
Data Element	0502	Billing Type Code
Data Element	0504	Facility Code
Data Element	0555	Place of Service Bill Code
Data Element	0503	Billing Format Code
Data Element	0505	Bill Frequency Type Code
Data Element	0507	Provider Agreement Code
Data Element	0508	Bill Submission Reason Code
Segment	DTP	Date Insurer Received Bill
Data Element	0511	Date Insurer Received Bill
Segment	DTP	Date and Time of Admission
Data Element	0513	Admission Date
Data Element	0622	Admission Hour
Segment	DTP	Date and Time of Discharge
Data Element	0514	Discharge Date
Data Element	0623	Discharge Hour
Segment	DTP	Service Date(s) Range
Data Element	0509	Service Bill Date(s) Range
Segment	DTP	Date of Prescription
Data Element	0527	Date of Prescription
Segment	DTP	Date of Bill Data Element 0510 Date of Bill
Segment	DTP	Date Insurer Paid Bill
Data Element	0512	Date the Insurer Paid Bill
Segment	CL1	Admission Type
Data Element	0577	Admission Type Code
Segment	CN1	Contract Information
Data Element	0515	Contract Type Code
Segment	AMT	Total Amount Paid Per Bill
Data Element	0516	Total Amount Paid Per Bill
Segment	REF	Unique Bill ID
Data Element	0500	Unique Bill Identification Number
Segment	REF	Transaction Tracking Number
Data Element	0266	Transaction Tracking Number
Segment	REF	Settlement or Award Identifier
Data Element	0293	Lump Sum Payment Settlement Code

Segment	HI	Institutional Bill Principal Diagnosis
Data Element	0521	Principal Diagnosis Code
Data Element	0533	Present on Admission Indicator
Segment	HI	Institutional Bill Admitting Diagnosis
Data Element	0535	Admitting Diagnosis Code
Segment	HI	Institutional Bill Other Diagnosis
Data Element	0522	ICD_9 Diagnosis Code
Data Element	0533	Present on Admission Indicator
Segment	HI	Outpatient Reason for Visit
Data Element	0520	Outpatient Reason for Visit Code
Segment	HI	Non-Institutional Diagnosis Codes
Data Element	0521	Principal Diagnosis Code
Data Element	0522	Diagnosis Code
Segment	HI	Institutional Bill Principal Procedure
Data Element	0525	Principal Procedure Code
Data Element	0550	Principal Procedure Date
Segment	HI	Institutional Bill Other Procedure Codes
Data Element	0736	Other Procedure Code
Data Element	0524	Procedure Date
Segment	HI	Condition Codes
Data Element	0556	Condition Code
Segment	HI	Diagnosis Related Group (DRG) Information
Data Element	0549	Paid DRG Code
Data Element	0548	Billed DRG Code
Loop ID	2310A	Billing Provider Information
Segment	NM1	Billing Provider IName
Data Element	0528	Billing Provider Last/Group Name
Data Element	0629	Billing Provider FEIN
Data Element	0634	Billing Provider National Provider ID
Segment	PRV	Billing Provider Specialty Information
Data Element	0537	Billing Provider Primary Specialty Code
Segment	N3	Billing Provider Address
Data Element	0538	Billing Provider Primary Address
Data Element	0539	Billing Provider Secondary Address
Segment	N4	Billing Provider City, State, and Postal Code
Data Element	0540	Billing Provider City
Data Element	0541	Billing Provider State Code
Data Element	0542	Billing Provider Postal Code
Data Element	0569	Billing Provider Country Code
Segment	REF	Billing Provider Tax Identification Number
Data Element	0629	Billing Provider FEIN
Segment	REF	Billing Provider Secondary ID Number
Data Element	0630	Billing Provider State License Number
Loop ID	2310B	Rendering Bill Provider Information

Segment	NM1	Rendering Bill Provider Name
Data Element	0638	Rendering Bill Provider Last/Group Name
Data Element	0642	Rendering Bill Provider FEIN
Data Element	0647	Rendering Bill Provider National Provider ID
Segment	PRV	Rendering Bill Provider Specialty Info
Data Element	0651	Rendering Bill Provider Primary Specialty Code
Segment	REF	Rendering Bill Provider Secondary Identification
Data Element	0642	Rendering Bill Provider FEIN
Data Element	0643	Rendering Bill Provider State License Number
Loop ID	2310C	Supervising Provider Information
Segment	NM1	Supervising Provider Name
Data Element	0658	Supervising Provider Last/Group Name
Data Element	0659	Supervising Provider First Name
Data Element	0667	Supervising Provider National Provider ID
Segment	PRV	Supervising Provider Specialty Information
Data Element	0671	Supervising Provider Primary Specialty Code
Loop ID	2310D	Service Facility Location Information
Segment	NM1	Service Facility Location Name
Data Element	0678	Facility Last/Group Name
Data Element	0682	Facility National Provider ID
Segment	N3	Service Facility Location Address
Data Element	0684	Facility Primary Address
Data Element	0685	Facility Second Address
Segment	N4	Service Facility Location City, State, and Postal Code
Data Element	0686	Facility City
Data Element	0687	Facility State Code
Data Element	0688	Facility Postal Code
Data Element	0689	Facility Country Code
Segment	REF	Service Facility Location Secondary Identification Number
Data Element	0680	Facility State License Number
Data Element	0683	Facility Service Location ID
Loop ID	2310E	Referring Provider Information
Segment	NM1	Referring Provider Name
Data Element	0690	Referring Provider Last/Group Name
Data Element	0691	Referring Provider First Name
Data Element	0699	Referring Provider National Provider ID
Loop ID	2310F	Managed Care Organization Information
Segment	NM1	Managed Care Organization Information
Data Element	0209	Managed Care Organization Last/Group Name

Data Element	0208	Managed Care Organization Identification Number
Segment	REF	Managed Care Organization Identification Number
Data Element	0704	Managed Care Organization FEIN
Bill Level Adjustment and Amounts		
Segment	SBR	Subscriber Information
Segment	CAS	Bill Level Adjustment Reasons Amount
Data Element	0543	Bill Adjustment Group Code
Data Element	0544	Bill Adjustment Reason Code
Data Element	0545	Bill Adjustment Amount
Data Element	0546	Bill Adjustment Units
Segment	AMT	Prior Payment Amount
Data Element	0760	Prior Actual Amount Paid
Loop ID:	2400	Service Line Information
Segment	LX	Service Line Information
Data Element	0547	Line Number
Segment	SV1	Professional Service Information
Data Element	0721	NDC Billed Code
Data Element	0714	HCPCS Line Procedure Billed Code
Data Element	0717	HCPCS Modifier Billed Code
Data Element	0715	Jurisdiction Procedure Billed Code
Data Element	0718	Jurisdiction Modifier Billed Code
Data Element	0551	Procedure Description
Data Element	0552	Total Charge per Line
Data Element	0553	Days/Units Code
Data Element	0554	Days/Units Billed
Data Element	0600	Place of Service Line Code
Data Element	0557	Diagnosis Pointer
Data Element	0742	Provider Agreement Line Code
Segment	SV2	Institutional Service Information
Data Element	0559	Revenue Billed Code
Data Element	0625	HIPPS Rate Code
Data Element	0714	HCPCS Line Procedure Billed Code
Data Element	0717	HCPCS Modifier Billed Code
Data Element	0715	Jurisdiction Procedure Billed Code
Data Element	0718	Jurisdiction Modifier Billed Code
Data Element	0551	Procedure Description
Data Element	0552	Total Charge per Line
Data Element	0553	Days/Units Code
Data Element	0554	Days/Units Billed
Segment	SV3	Dental Service
Data Element	0714	HCPCS Line Procedure Billed Code
Data Element	0719	ADA Procedure Billed Code
Data Element	0717	HCPCS Modifier Billed Code

Data Element	0551	Procedure Description
Data Element	0552	Total Charge per Line
Data Element	0600	Place of Service Line Code
Segment	SV4	Prescription Drug Information
Data Element	0561	Prescription Line Number
Data Element	0721	NDC Billed Code
Data Element	0563	Drug Name
Data Element	0562	Dispense as Written Code
Data Element	0762	Compound Drug Indicator
Segment	DTP	Service Date(s)
Data Element	0605	Service Line Date(s) Range
Segment	DTP	Prescription Date
Data Element	0604	Prescription Line Date
Segment	QTY	Quantity
Data Element	0570	Drugs/Supplies Quantity Dispensed
Data Element	0571	Drugs/Supplies Number of Days
Segment	CN1	Contract Information
Data Element	0741	Contract Line Type Code
Segment	AMT	Dispensing Fee Amount
Data Element	0579	Drugs/Supplies Dispensing Fee
Segment	AMT	Drug/Supplies Billed Amount
Data Element	0572	Drug/Supplies Billed Amount
Loop ID	2420	Rendering Line Provider Information
Segment	NM1	Rendering Line Provider Name
Data Element	0589	Rendering Line Provider Last/Group Name
Data Element	0586	Rendering Line Provider FEIN
Data Element	0592	Rendering Line Provider National Provider ID
Segment	PRV	Rendering Line Provider Specialty Information
Data Element	0595	Rendering Line Provider Primary Specialty Code
Segment	N4	Rendering Provider City, State, and Postal Code
Data Element	0593	Rendering Line Provider Postal Code
Segment	REF	Rendering Line Provider Secondary ID Number
Data Element	0586	Rendering Line Provider FEIN
Data Element	0599	Rendering Line Provider State License Number
Loop ID	2430	Service Line Adjustment s and Amounts
Segment	SVD	Service Line Adjudication
Data Element	0574	Total Amount Paid per Line
Data Element	0722	ADA Procedure Paid Code
Data Element	0726	HCPCS Line Procedure Paid Code
Data Element	0727	HCPCS Modifier Paid Code
Data Element	0728	NDC Paid Code
Data Element	0729	Jurisdiction Procedure Paid Code
Data Element	0730	Jurisdiction Modifier Paid Code

Data Element	0576	Revenue Paid Code
Data Element	0580	Days/Units Paid
Data Element	0547	Line Number
Segment	CAS	Service Line Adjustment
Data Element	0731	Service Adjustment Group Code
Data Element	0732	Service Adjustment Reason Code
Data Element	0733	Service Adjustment Amount
Data Element	0734	Service Adjustment Units
Segment	AMT	Line Item Prior Payment Amount
Data Element	761	Line Item Prior Actual Amount Paid
SE Transaction Set Trailer		
Segment	SE	Transaction Set Trailer

California ANSI 824 loop, segment and data element summary

The medical bill payment detailed acknowledgement (824) reports back to the trading partner at both the ST-SE transaction set level and the bill level. At the transaction set level each ST-SE will either be accepted (TA) or rejected (TR). Within each accepted ST-SE transaction set, each medical bill will either be accepted (IA), accepted with error (IE), or rejected (IR). The following outline summarizes the loop, segment, and data element structure of the medical bill payment detailed acknowledgement (824). More detailed information can be found in section 3 of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2, February 1, 2012.

ST Transaction Set Header		
Segment	ST	Transaction Set Control Number
Segment	BGN	Beginning Segment
Data Element	0743	Jurisdiction Tracking Number
Data Element	0100	Date Transmission Sent
Data Element	0101	Time Transmission Sent
Data Element	0532	Originator Transaction Identification Number
Loop ID:	N1	Sender Information
Segment	N1	Sender Identification
Data Element	0098	Sender Identification
Loop ID:	N1	Receiver Information
Segment	N1	Receiver Identification
Data Element	0099	Receiver Identification
Loop ID:	OTI	Original Identification Transaction
Segment	OTI	Original Transaction Identifier
Data Element	0111	Application Acknowledgement Code
Data Element	0500	Unique Bill Identification Number
Data Element	0532	Originator Transaction Identification Number
Data Element	0102	Original Transmission Date
Data Element	0103	Original Transmission Time
Data Element	0110	Acknowledgement Transaction Set Identifier
Segment	REF	Line Number
Data Element	0547	Line Number
Segment	DTM	Processing Date
Data Element	0108	Date Processed
Data Element	0109	Time Processed
Loop ID	LM	Code Source Information
Segment	LM	Code Source Information
Loop ID:	LQ	Industry Code
Segment	LQ	Industry Code
Data Element	0116	Element Error Number
Segment	RED	Related Data
SE Transaction Set Trailer		
Segment	SE	Transaction Set Trailer

Section V: The SFTP transmission mode

Data transmission with secure file transfer protocol (SFTP)

Trading partners will send all data files to a SFTP (SSH (Secure Shell) File Transfer Protocol) server hosted by the WCIS. An encrypted transmission tunnel is established during SFTP transfer, which ensures data security. Trading partner login will be authenticated through username, password and source IP address verification. Acknowledgements will be retrieved from the same server.

Trading partners must coordinate certain processes and procedures with WCIS to ensure the efficient and secure transmission of data and acknowledgement files via SFTP.

After the trading partner profile form is completed, follow the steps below.

Step 1. Trading Partner Profile

Complete and submit the Trading Partner Profile form in Section II. Upon receipt of the completed Trading Partner Profile Form the SFTP host address will be provided to trading partners by the WCIS trading partner contact person.

Step 2. SFTP Server name and IP address

The WCIS SFTP server requires a user account and password for access. The account and password is entered in Part C2 on the Trading Partner Profile form. After establishing connectivity, the trading partner must change the password every 90 days. User accounts will be locked out after three unsuccessful logon attempts. Password resets must be coordinated with the WCIS trading partner contact person.

Step 3. SFTP communication port

The WCIS SFTP server requires the communications port 22 to be opened for SFTP transmissions.

Trading partner source IP address

Access to the WCIS SFTP server will be restricted to source IP addresses that are entered on the Trading Partner Profile form. Trading partners may provide up to five source IP addresses. The source IP addresses must be public addresses. Although some network systems use private addresses for internal networks (e.g. 10.0.0.0, 172.16.0.1 and 192.168.1.1), WCIS will require the public IP address to where the private addresses translate. Trading partners must notify the WCIS when source IP addresses change.

Testing SFTP connectivity

The WCIS trading partner contact and the trading partner shall coordinate testing SFTP connectivity. Trading partners shall be asked to send a test file that contains data, but this file will not be processed in the production database. A test acknowledgement file

will then be left in the trading partner's 997 and 824 folder. After connectivity testing is completed, 837 files submission for structural and detailed testing may begin.

Sending data through SFTP

For testing connectivity, trading partners will send data files to the WCIS SFTP server by placing them in a directory named Suspense. Production data files are placed in the inbound directory. The contents of these directories are not visible to the trading partner. Once the file has been uploaded, it cannot be edited by trading partner. If a transmission error occurs, a message will be generated by the trading partner's SFTP program or process.

File names must be unique and follow file naming conventions prescribed below.

Naming convention:

All files must start with a 9 character Trading partner/Sender FEIN

The 10th character is the test/ production indicator a "T" for Test or a "P" for Production

11th through 18th characters are the Date Stamp of 837/997/824 file (8 Date CCYYMMDD)

19th through 24th characters are the Time Stamp of 837/997/824 file (6 Time HHMMSS)

25th through 27th characters are the File layout (837/ 997/ 824)

28th through 30th characters are the three digits counter (000-999)

An error will occur when a file of the same name is submitted while a file of the same name still exists in the directory of the WCIS.

837 file example

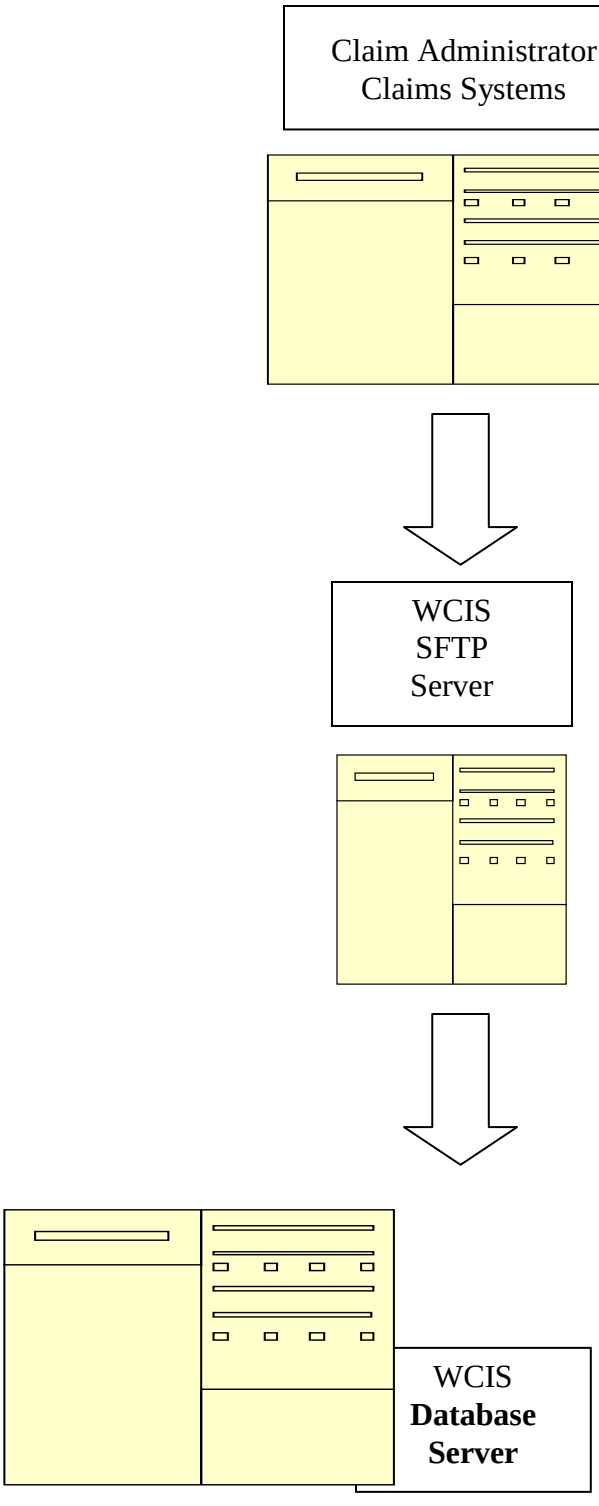
997 file example

824 file example

Receiving acknowledgement files through SFTP

The WCIS will place functional and detailed acknowledgement files (997 and 824) on the WCIS SFTP server in the trading partner's 997 and 824 folders. Trading partners may delete acknowledgement files after the files have been retrieved. The WCIS will periodically review the contents of the trading partner's directory and may delete unauthorized user folders or files older than 14 days.

Pathway transmissions



Section VI: Required medical data elements

Medical data elements by name and source

The Medical Data Elements by Source table alphabetically lists the California-adopted IAIABC data elements that are to be included in the EDI transmission of the medical bills reported to the DWC WCIS. The table includes the IAIABC Data Element Number (DN), the IAIABC data element name and the data source in the workers' compensation system. In the case of the CMS 1500, UB04, Universal Claim Form (NCPDP), and Dental Claim Form the fields on the medical paper forms are identified. The table also includes information on which entity in the system has access to selected data elements. The entities include: Payers, Jurisdictional Licensing Boards (JLB), and Senders (SNDR).

California Medical Data Elements by Source								
DN	**DATA ELEMENT NAME**	**CMS 1500**	**UB 04**	**NCPDP**	**ADA**	**Payer**	**JLB**	**SNDR**
0719	ADA PROCEDURE BILLED CODE				29			
0722	ADA PROCEDURE PAID CODE					x		
0110	ACKNOWLEDGEMENT TRANSACTION SET ID							x
0513	ADMISSION DATE		12					
0622	ADMISSION HOUR		13					
0577	ADMISSION TYPE CODE		14					
0535	ADMITTING DIAGNOSIS CODE		69					
0111	APPLICATION ACKNOWLEDGEMENT CODE							x
0545	BILL ADJUSTMENT AMOUNT					x		
0543	BILL ADJUSTMENT GROUP CODE					x		
0544	BILL ADJUSTMENT REASON CODE					x		
0546	BILL ADJUSTMENT UNITS					x		
0505	BILL FREQUENCY TYPE CODE	22?	4					
0508	BILL SUBMISSION REASON CODE					x		
0548	BILLED DRG CODE					x		
0503	BILLING FORMAT CODE					x		
0540	BILLING PROVIDER CITY	33	1	36	48			
0569	BILLING PROVIDER COUNTRY CODE	33				x		
0629	BILLING PROVIDER FEIN	25	5					
0538	BILLING PROVIDER PRIMARY ADDRESS	33	1	35	48			
0528	BILLING PROVIDER LAST/GROUP NAME	33	1	34	28			
0634	BILLING PROVIDER NATIONAL PROVIDER ID	33A	56	32	49			
0542	BILLING PROVIDER POSTAL	33	1	38	48			

California Medical Data Elements by Source								
DN	**DATA ELEMENT NAME**	**CMS 1500**	**UB 04**	**NCPDP**	**ADA**	**Payer**	**JLB**	**SNDR**
	CODE							
0537	BILLING PROVIDER PRIMARY SPECIALTY CODE	33B	81(B3)					
0539	BILLING PROVIDER SECONDARY ADDRESS	33				x		
0541	BILLING PROVIDER STATE CODE		1	37	48			
0630	BILLING PROVIDER STATE LICENSE NUMBER				50		x	
0523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER					x		
0502	BILLING TYPE CODE					x		
015	CLAIM ADMINISTRATOR CLAIM NUMBER	11				x		
0187	CLAIM ADMINISTRATOR FEIN					x		
0014	CLAIM ADMINISTRATOR MAILING POSTAL CODE					x		
0188	CLAIM ADMINISTRATOR NAME					x		
0762	COMPOUND DRUG INDICATOR							
0556	CONDITION CODE	10D	18-28					
0741	CONTRACT LINE TYPE CODE							
0515	CONTRACT TYPE CODE					x		
0512	DATE INSURER PAID BILL					x		
0511	DATE INSURER RECEIVED BILL					x		
0510	DATE OF BILL	31	6	2				
0031	DATE OF INJURY	14	31	11	46			
0108	DATE PROCESSED							x
0100	DATE TRANSMISSION SENT							x
0554	DAYS/UNIT(S) BILLED	24G	46					
0553	DAYS/UNIT(S) CODE					x		
0580	DAY(S)/UNIT(S) PAID					x		
0557	DIAGNOSIS POINTER	24 E						
0514	DISCHARGE DATE		6					
0623	DISCHARGE HOUR		16					
0562	DISPENSE AS WRITTEN CODE			72				
0563	DRUG NAME			75				
0572	DRUGS/SUPPLIES BILLED AMOUNT			99				
0579	DRUGS/SUPPLIES DISPENSING FEE			102				
0571	DRUGS/SUPPLIES NUMBER OF DAYS			71				
0570	DRUGS/SUPPLIES QUANTITY DISPENSED			70				
0116	ELEMENT ERROR NUMBER							x
0115	ELEMENT NUMBER							x
0044	EMPLOYEE FIRST NAME	2	8	4				

California Medical Data Elements by Source								
DN	**DATA ELEMENT NAME**	**CMS 1500**	**UB 04**	**NCPDP**	**ADA**	**Payer**	**JLB**	**SNDR**
0043	EMPLOYEE LAST NAME	2	8	3				
0045	EMPLOYEE MIDDLE NAME/INITIAL	2	8					
0042	EMPLOYEE SOCIAL SECURITY NUMBER	1a	60		23	x		
0016	EMPLOYER FEIN							
0018	EMPLOYER NAME	4	58a,65a	23	12			
0686	FACILITY CITY							
0504	FACILITY CODE	22	4					
0689	FACILITY COUNTRY CODE							
0678	FACILITY NAME	32	1					
0682	FACILITY NATIONAL PROVIDER ID	32A	51, 56			X?		
0688	FACILITY POSTAL CODE	32	1					
0684	FACILITY PRIMARY ADDRESS	32	1					
0685	FACILITY SECONDARY ADDRESS	32	1					
0683	FACILITY SERVICE LOCATION ID	32	1					
0687	FACILITY STATE CODE							
0680	FACILITY STATE LICENSE NUMBER	32B	57					
0714	HCPCS LINE PROCEDURE BILLED CODE	24D	44					
0726	HCPCS LINE PROCEDURE PAID CODE					x		
0717	HCPCS MODIFIER BILLED CODE	24D	44					
0727	HCPCS MODIFIER PAID CODE					x		
0625	HIPPS RATE CODE		44, 71?					
0522	ICD-9 CM DIAGNOSIS CODE	21 1-4 A-D	67(A-Q)?					
0520	ICD-9 OUTPATIENT REASON FOR VISIT CODE							
0525	ICD-9 CM PRINCIPAL PROCEDURE CODE		74					
0736	ICD-9 CM PROCEDURE CODE		74(A-E)					
0006	INSURER FEIN					x		
0007	INSURER NAME	11C	50	18	3			
0616	INSURER POSTAL CODE					x		
0005	JURISDICTION CLAIM NUMBER					x		
0718	JURISDICTION MODIFIER BILLED CODE	24D	44					
0730	JURISDICTION MODIFIER PAID CODE					x		
0715	JURISDICTION PROCEDURE BILLED CODE	24D	44			x		
0729	JURISDICTION PROCEDURE PAID CODE					x		
0743	JURISDICTION TRACKING NUMBER							x

California Medical Data Elements by Source								
DN	**DATA ELEMENT NAME**	**CMS 1500**	**UB 04**	**NCPDP**	**ADA**	**Payer**	**JLB**	**SNDR**
0761	LINE ITEM PRIOR ACTUAL AMOUNT PAID					x		
0547	LINE NUMBER							x
0293	LUMP SUM PAYMENT/SETTLEMENT CODE					x		
0704	MANAGED CARE ORGANIZATION FEIN					x		
0208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER						x	
0209	MANAGED CARE ORGANIZATION NAME					x		
0721	NDC BILLED CODE	24		68				
0728	NDC PAID CODE					x		
0532	ORIGINATOR TRANSACTION IDENTIFICATION NUMBER							x
0102	ORIGINAL TRANSMISSION DATE							x
0103	ORIGINAL TRANSMISSION TIME							x
0549	PAID DRG CODE					x		
0555	PLACE OF SERVICE BILL CODE				38			
0600	PLACE OF SERVICE LINE CODE	24B						
0527	PRESCRIPTION BILL DATE			1				
0604	PRESCRIPTION LINE DATE			66				
0533	PRESENT ON ADMISSION INDICATOR			67				
0561	PRESCRIPTION LINE NUMBER			62				
0521	PRINCIPAL DIAGNOSIS CODE	21A	67					
0550	PRINCIPAL PROCEDURE DATE		74					
0760	PRIOR ACTUAL AMOUNT PAID					x		
0524	PROCEDURE DATE		74A-E					
0551	PROCEDURE DESCRIPTION					x		
0507	PROVIDER AGREEMENT CODE					x		
0742	PROVIDER AGREEMENT LINE CODE					x		
0099	RECEIVER ID							x
0699	REFERRING PROVIDER NATIONAL PROVIDER ID	17B	78, 79			X?		
0691	REFERRING PROVIDER FIRST NAME				43			
0690	REFERRING PROVIDER LAST/GROUP NAME		78, 79		42			
0642	RENDERING BILL PROVIDER FEIN	25						
0639	RENDERING BILL PROVIDER FIRST NAME		76					
0638	RENDERING BILL PROVIDER	33	76					

California Medical Data Elements by Source								
DN	**DATA ELEMENT NAME**	**CMS 1500**	**UB 04**	**NCPDP**	**ADA**	**Payer**	**JLB**	**SNDR**
	LAST/GROUP NAME							
0647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	33a	76A					
0651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	33b			56A			
0643	RENDERING BILL PROVIDER STATE LICENSE NUMBER						x	
0586	RENDERING LINE PROVIDER FEIN							
0587	RENDERING LINE PROVIDER FIRST NAME							
0589	RENDERING LINE PROVIDER LAST/GROUP NAME							
0592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID					x		
0593	RENDERING LINE PROVIDER POSTAL CODE							
0595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	24J				x		
0599	RENDERING LINE PROVIDER STATE LICENSE NUMBER						x	
0615	REPORTING PERIOD					x		
0559	REVENUE BILLED CODE		42					
0576	REVENUE PAID CODE					x		
0098	SENDER ID							x
0733	SERVICE ADJUSTMENT AMOUNT					x		
0731	SERVICE ADJUSTMENT GROUP CODE					x		
0732	SERVICE ADJUSTMENT REASON CODE					x		
0734	SERVICE ADJUSTMENT UNITS					x		
0509	SERVICE BILL DATE(S) RANGE		6					
0605	SERVICE LINE DATE(S) RANGE	24A	45					
0659	SUPERVISING PROVIDER FIRST NAME							
0658	SUPERVISING PROVIDER LAST/GROUP NAME							
0671	SUPERVISING PROVIDER PRIMARY SPECIALTY CODE							
0667	SUPERVISING PROVIDER NATIONAL PROVIDER ID							
0104	TEST/PRODUCTION INDICATOR							x
0109	TIME PROCESSED							x
0101	TIME TRANSMISSION SENT							x
0516	TOTAL AMOUNT PAID PER BILL					x		
0574	TOTAL AMOUNT PAID PER LINE					x		
0501	TOTAL CHARGE PER BILL	28	47	105	33			

California Medical Data Elements by Source								
DN	**DATA ELEMENT NAME**	**CMS 1500**	**UB 04**	**NCPDP**	**ADA**	**Payer**	**JLB**	**SNDR**
0552	TOTAL CHARGE PER LINE	24F	47		31			
0266	TRANSACTION TRACKING NUMBER							x

Section VII: Medical data element requirement table

The structure of the element requirement table allows for requirement codes to be defined at the data element level (DN) for each bill submission reason code (00, 01, 02, or 05). Further, it provides for data element requirements to differ based on report requirements criteria established in the event table. A requirement code is entered at each cell marked by the intersection of a bill submission reason code column and each data element row.

Bill submission reason code values

The bill submission reason code (BSRC) defines the specific purpose (event) for which the transaction is being sent (triggered). Below are the four BSRC adopted by the WCIS to report the purpose of each transaction reported in the 837.

00 = Original
The code is used to report the first medical EDI record payment action taken by the claim administrator or insurer. A payment action may represent a payment to the health care provider or a denial. Only one original transaction is submitted for any individual medical bill.

01 = Cancellation
The code is used when a '00' original has been submitted which should never have been submitted to the WCIS or when the original transaction contained errors in critical data elements (see the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2012, section 1.4.2.1, page 1.10). It is recommended that the value in DN0500 Unique Bill Identification Number contained in a cancelled medical EDI record not be reused.

02 = Corrected and verified Original Claim
The code is used when the trading partner must correct errors to non-critical data elements on a '00' original or '05' replace transaction. This value is not used if the amount of payment changed due to a subsequent payment action by the claim administrator or insurer.

05 = Replace
The code is used when the trading partner must report a subsequent payment action or denial by the claim administrator or insurer. A '00' original transaction must have been submitted and accepted before a '05' replace transaction is reported

Standard requirement code values:

The standard requirement code values are utilized in the medical data element requirement table to indicate the reporting requirement for each data element for each of the bill submission reason code. Below are the six standard requirement code values adopted by the WCIS.

M Mandatory.
The data element must be present and must be a valid format or the transaction will be rejected.

AA Applicable/Available Item Accepted.
Data should be sent if applicable and/or available. The data may or may not be populated. If the data is applicable to the bill, data must be sent. If present, will be edited for valid value and/or format in the jurisdiction's system.

AR Applicable/Available Item Rejected.
Data should be sent if applicable and/or available. The data may or may not be populated. If the data is applicable to the bill, data must be sent. If present, will be edited for valid value and/or format.

MC Mandatory/Conditional.
The data element becomes mandatory under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory and mandatory rules apply (the data element must be present and must be a valid format or the transaction will be rejected).

NA Not Applicable.
The data element is not applicable to the jurisdiction's requirements for the bill type and may or may not be sent.

F Fatal Technical.
Data elements are essential for a transmission/transaction to be accepted into California's WCIS database or for an acknowledgement to be sent back to the sender. If the data is missing or invalid, the 997 Functional Acknowledgement will reject.

Mandatory trigger:
The mandatory trigger states the condition which makes a data element mandatory.

Legend for bill type code

Bill Type	California Specific Bill Type Code	Line Segment
Professional	P	SV1
Institutional	I	SV2
Dental	D	SV3
Pharmaceutical	RX	SV4
All bills	ALL	SV1, SV2, SV3, SV4

Medical Data Element Requirement Table

		Original	Cancelation	Corrected	Replace		Bill Type(s)*
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0005	JURISDICTION CLAIM NUMBER	MC	MC	MC	MC	Required when the insurance carrier, claim administrator, or reporting entity has received the jurisdictions' assigned claim number.	All
0006	INSURER FEIN	M	M	M	M		All
0007	INSURER NAME	M	NA	M	M		All
0014	CLAIM ADMINISTRATOR MAILING POSTAL CODE	MC	NA	MC	MC	Required when DN0188 (Claim Administrator Name) is reported.	All
0015	CLAIM ADMINISTRATOR CLAIM NUMBER	M	M	M	M		All
0016	EMPLOYER FEIN	M	NA	M	M		All
0018	EMPLOYER NAME	M	NA	M	M		All
0031	DATE OF INJURY	F	F	F	F		All
0042	EMPLOYEE SSN	MC	NA	MC	MC	Required when the employee has SSN.	
0043	EMPLOYEE LAST NAME	M	NA	M	M		All
0044	EMPLOYEE FIRST NAME	M	NA	M	M		All
0045	EMPLOYEE MIDDLE NAME/INITIAL	AA	NA	AA	AA		All
0098	SENDER ID	F	F	F	F		All
0099	RECEIVER ID	F	F	F	F		All
0100	DATE TRANSMISSION SENT	F	F	F	F		All
0101	TIME TRANSMISSION SENT	F	F	F	F		All
0187	CLAIM ADMINISTRATOR FEIN	M	M	M	M		All
0188	CLAIM ADMINISTRATOR NAME	MC	NA	MC	MC	Required when the Claim Administrator is a different entity than the insurer or self-insured reported in Loop 2010AA/NM103/DN0007.	All
0208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	MC	NA	MC	MC	Required if DN0209 (Managed Care Organization Name) is present. Report the DWC assigned MPN approval number.	All

Medical Data Element Requirement Table

		Original	Cancelation	Corrected	Replace		Bill Type(s)*
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0209	MANAGED CARE ORGANIZATION NAME	MC	NA	MC	MC	Required when the service provided was within a Medical Provider network (MPN) approved by DWC and both the provider and the injured worker belong to the same MPN.	All
0255	EMPLOYEE LAST NAME SUFFIX	AA	NA	AA	AA		All
0266	TRANSACTION TRACKING NUMBER	M	M	M	M		All
0293	LUMP SUM PAYMENT/SETTLEMENT CODE	MC	NA	MC	MC	Required when a settlement is paid covering more than one bill.	All
0500	UNIQUE BILL ID NUMBER	F	F	F	F		All
0501	TOTAL CHARGE PER BILL	M	NA	M	M		All
0502	BILLING TYPE CODE	MC	NA	MC	MC	Required when reporting aggregate or summary records.	All
0503	BILLING FORMAT CODE	M	NA	M	M		All
0504	FACILITY CODE	F	NA	F	F		I
0505	BILL FREQUENCY TYPE CODE	M	NA	M	M		I
0507	PROVIDER AGREEMENT CODE	M	NA	M	M		All
0508	BILL SUBMISSION REASON CODE	F	F	F	F		All
0509	SERVICE BILL DATE(S) RANGE	M	NA	M	M		All
0510	DATE OF BILL	M	NA	M	M		All
0511	DATE INSURER RECEIVED BILL	M	NA	M	M		All
0512	DATE INSURER PAID BILL	M	NA	M	M		All
0513	ADMISSION DATE	MC	NA	MC	MC	Required when reporting institutional bills and an inpatient admission was involved.	I
0514	DISCHARGE DATE	MC	NA	MC	MC	Required when reporting institutional bills and an inpatient admission was involved and patient is discharged.	I
0515	CONTRACT TYPE CODE	MC	NA	MC	MC	Required when the medical services provided were paid under a contract term.	All
0516	TOTAL AMOUNT PAID PER BILL	M	NA	M	M		All
0520	OUTPATIENT REASON FOR VISIT CODE	MC	NA	MC	MC	Required when an outpatient visit is involved.	I

Medical Data Element Requirement Table

		Original	Cancelation	Corrected	Replace		Bill Type(s)*
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0521	PRINCIPAL DIAGNOSIS CODE	MC	NA	MC	MC	Required when reporting institutional claims Required when the SV1 Professional Services segment is reported. Required when the SV3 Dental Services segment is reported and the diagnosis code is contained on the dental medical bill received by the claims administrator or insurer.	I,P,D
0522	DIAGNOSIS CODE	MC	NA	MC	MC	Required when an institutional service is reported and other diagnosis other than what is shown on admitting diagnosis is present. Required when the SV1 Professional Services segment is reported. Required when the SV3 Dental Services segment is reported and the diagnosis code is contained on the dental medical bill received by the claims administrator or insurer.	I,P,D
0523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	F	F	F	F		All
0524	PROCEDURE DATE	MC	NA	MC	MC	Required when the corresponding DN0726 (Other Procedure Code) is present.	I
0525	PRINCIPAL PROCEDURE CODE	MC	NA	MC	MC	Required for institutional inpatient surgical bills.	I
0527	PRESCRIPTION DATE	M	NA	M	M		Rx
0528	BILLING PROVIDER LAST/GROUP NAME	M	NA	M	M		
0529	BILLING PROVIDER FIRST NAME	MC	NA	MC	MC	Required when the billing provider is an individual.	All
0532	ORIGINATOR TRANSACTION IDENTIFICATION NUMBER	F	F	F	F		All
0533	PRESENT ON ADMISSION INDICATOR	MC	NA	MC	MC	Required on inpatient hospital bills.	I
0535	ADMITTING DIAGNOSIS CODE	MC	NA	MC	MC	Required when an inpatient admission is involved.	I
0537	BILLING PROVIDER PRIMARY SPECIALTY CODE	AA	NA	AA	AA		All
0538	BILLING PROVIDER PRIMARY ADDRESS	M	NA	M	M		All
0539	BILLING PROVIDER SECONDARY ADDRESS	MC	NA	MC	MC	Required if provider is located in the US and there is a secondary address.	All
0540	BILLING PROVIDER CITY	M	NA	M	M		

Medical Data Element Requirement Table

		Original	Cancelation	Corrected	Replace		Bill Type(s)*
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0541	BILLING PROVIDER STATE CODE	MC	NA	MC	MC	Required if provider is located in the US. Do not send if outside of US.	All
0542	BILLING PROVIDER POSTAL CODE	MC	NA	MC	MC	Required if provider is located in the US. Do not send if outside of US.	All
0543	BILL ADJUSTMENT GROUP CODE	MC	NA	MC	MC	Required when adjustment apply to service lines on a medical bill containing more than one line or when submitting aggregate or summary records.	All
0544	BILL ADJUSTMENT REASON CODE	MC	NA	MC	MC	Required when bill level adjustments, bill level amounts, or prior payment amounts are reported.	All
0545	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	Required when bill level adjustments, bill level amounts, or prior payment amounts are reported.	All
0546	BILL ADJUSTMENT UNITS	MC	NA	MC	MC	Required when the number of service units has been adjusted.	All
0547	LINE NUMBER	MC	MC	MC	MC	Required when reporting service line information is present.	All
0548	BILLED DRG CODE	MC	NA	MC	MC	Required for inpatient bills when the DN0515 Contract Type Code is DRG.	I
0549	PAID DRG CODE	MC	NA	MC	MC	Required for inpatient bills when the DN0515 contract Type Code is DRG	I
0550	PRINCIPAL PROCEDURE DATE	MC	NA	MC	MC	Required when DN0525 (Principal Procedure Code) is present.	I
0551	PROCEDURE DESCRIPTION	MC	NA	MC	MC	Required when additional information is necessary to identify the reported service	I,P, D
0552	TOTAL CHARGE PER LINE	M	NA	M	M		I,P,D
0553	DAYS(S)/UNIT(S) CODE	M	NA	M	M		I,P
0554	DAY(S) /UNIT(S) BILLED	M	NA	M	M		I,P
0555	PLACE OF SERVICE BILL CODE	F	NA	F	F		P,Rx,D
0556	CONDITION CODE	MC	NA	MC	MC	Required when condition codes impact the adjudication of the medical bill.	I
0557	DIAGNOSIS POINTER	M	NA	M	M		P
0559	REVENUE BILLED CODE	M	NA	M	M		I
0561	PRESCRIPTION LINE NUMBER	M	NA	M	M		Rx
0562	DISPENSE AS WRITTEN CODE	M	NA	M	M		Rx
0563	DRUG NAME	AA	NA	AA	AA		Rx
0569	BILLING PROVIDER COUNTRY CODE	MC	NA	MC	MC	Required if the billing provider address is outside the United States.	All
0570	DRUGS/SUPPLIES QUANTITY DISPENSED	M	NA	M	M		Rx,P

Medical Data Element Requirement Table

		Original	Cancelation	Corrected	Replace		Bill Type(s)*
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0571	DRUGS/SUPPLIES NUMBER OF DAYS	M	NA	M	M		Rx, P
0572	DRUGS/SUPPLIES BILLED AMOUNT	M	NA	M	M		Rx,P
0574	TOTAL AMOUNT PAID PER LINE	M	NA	M	M		All
0576	REVENUE PAID CODE	MC	NA	MC	MC	Required for institutional bills and outpatient bills.	I
0577	ADMISSION TYPE CODE	MC	NA	MC	MC	Required when reporting institutional bill and an inpatient admission was involved.	I
0579	DRUGS/SUPPLIES DISPENSING FEE	AR	NA	AR	AR		Rx
0580	DAYS(S)/UNIT(S) PAID	M	NA	M	M		All
0586	RENDERING LINE PROVIDER FEIN	MC	NA	MC	MC	Required when DN0589 (Rendering Line Provider/ Last Group Name) is present and the provider is not eligible for NPI.	All
0587	RENDERING LINE PROVIDER FIRST NAME	MC	NA	MC	MC	Required if DN0589 (Rendering Line Provider/ Last Group Name) is present.	All
0589	RENDERING LINE PROVIDER LAST/GROUP NAME	M	NA	M	M		All
0592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	Required when DN0589 (Rendering Line Provider/ Last Group Name) is present and the provider is eligible for NPI.	All
0595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	M	NA	M	M		All
0586	RENDERING LINE PROVIDER FEIN	MC	NA	MC	MC	Required when DN0589 (Rendering Line Provider/ Last Group Name) is present and the provider is not eligible for NPI.	All
0587	RENDERING LINE PROVIDER FIRST NAME	MC	NA	MC	MC	Required if DN0589 (Rendering Line Provider/ Last Group Name) is present.	All
0589	RENDERING LINE PROVIDER LAST/GROUP NAME	M	NA	M	M		All
0592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	Required when DN0589 (Rendering Line Provider/ Last Group Name) is present and the provider is eligible for NPI.	All
0595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	M	NA	M	M		All
0599	RENDERING LINE PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	Required when DN0592 (Rendering Line Provider National Provider ID) is not reported and the rendering line provider identifier was included on the medical bill received by the insurer or claims administrator.	All
0600	PLACE OF SERVICE LINE CODE	MC	NA	MC	MC	Required when different than the bill level Place of Service.	P,D

Medical Data Element Requirement Table

		Original	Cancelation	Corrected	Replace		Bill Type(s)*
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0604	PRESCRIPTION LINE DATE	M	NA	M	M		Rx
0605	SERVICE LINE DATE(S) RANGE	M	NA	M	M		I,P,Rx
0615	REPORTING PERIOD	M	NA	M	M		All
0616	INSURER POSTAL CODE	M	NA	M	M		All
0622	ADMISSION HOUR	MC	NA	MC	MC	Required when reporting institutional bills and an inpatient admission was involved.	I
0623	DISCHARGE HOUR	MC	NA	MC	MC	Required when reporting institutional bills and an inpatient admission was involved and patient was discharged.	I
0625	HIPPS RATE CODE	MC	NA	MC	MC	Required when the medical bill received by the insurer or claims administrator contained a Health Insurance Prospective Payment System Code for this service line item.	I
0629	BILLING PROVIDER FEIN	M	NA	M	M		All
0630	BILLING PROVIDER STATE LICENSE NUMBER	AA	NA	AA	AA		All
0634	BILLING PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	Required when the provider is eligible to receive an NPI.	All
0638	RENDERING BILL PROVIDER LAST/GROUP NAME	M	NA	M	M		All
0639	RENDERING BILL PROVIDER FIRST NAME	MC	NA	MC	MC	Required when the rendering bill provider is a person	All
0640	RENDERING BILL PROVIDER MIDDLE NAME/INITIAL	AA	NA	AA	AA		All
0642	RENDERING BILL PROVIDER FEIN	MC	NA	MC	MC	Required when the Rendering bill Provider is not eligible for an NPI.	All
0643	RENDERING BILL PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	Required when the provider is not eligible for NPI and DN0642 Rendering Bill Provider FEIN is not present. If provider is not eligible for state licensing enter 999999999.	All
0647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	Required when DN0638 Rendering Bill Provider Last/Group Name is present, and the provider is eligible to receive an NPI.	All
0651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	MC	NA	MC	MC	Required when the rendering bill provider is a person and is present.	All

Medical Data Element Requirement Table

		Original	Cancelation	Corrected	Replace		Bill Type(s)*
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0658	SUPERVISING PROVIDER LAST/GROUP NAME	MC	NA	MC	MC	Required when reporting professional medical bill records where the rendering provider is non-licensed person who was supervised by a licensed health care provider.	All
0659	SUPERVISING PROVIDER FIRST NAME	AA	NA	AA	AA		All
0663	SUPERVISING PROVIDER STATE LICENSE NUMBER	AA	NA	AA	AA		All
0667	SUPERVISING PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	Required when DN0658 Supervising Provider Last/Group Name is present and the provider is eligible to for an NPI.	All
0671	SUPERVISING PROVIDER PRIMARY SPECIALTY CODE	AA	NA	AA	AA		All
0678	FACILITY NAME	MC	NA	MC	MC	Required when the service facility information is different than the billing provider information (when the services were not provided at the billing provider's address).	All
0680	FACILITY STATE LICENSE NUMBER	MC	NA	MC	MC	Required when the Service Facility Location is not eligible for NPI. If Service Facility Location is not eligible for state licensing use 999999999.	All
0682	FACILITY NATIONAL PROVIDER ID	MC	NA	MC	MC	Required when the facility is eligible to receive an NPI and facility information is different from the billing provider information.	All
0683	FACILITY SERVICE LOCATION ID	AA	NA	AA	AA		All
0684	FACILITY PRIMARY ADDRESS	MC	NA	MC	MC	Required when DN678 (Facility Name) is reported.	All
0685	FACILITY SECONDARY ADDRESS	AA	NA	AA	AA		All
0686	FACILITY CITY	MC	NA	MC	MC	Required when DN0678 (Facility Name) is reported.	All
0687	FACILITY STATE CODE	MC	NA	MC	MC	Required when DN0678 (Facility Name) is reported.	All
0688	FACILITY POSTAL CODE	MC	NA	MC	MC	Required when DN0678 (Facility Name) is reported.	All
0689	FACILITY COUNTRY CODE	MC	NA	MC	MC	Required when facility is located outside of the USA.	All
0690	REFERRING PROVIDER LAST/GROUP NAME	MC	NA	MC	MC	Required when the service provided involves a referral.	All
0691	REFERRING PROVIDER FIRST NAME	MC	NA	MC	MC	Required when DN0690 (Referring Provider Last/Group Name)is present.	All

Medical Data Element Requirement Table

		Original	Cancelation	Corrected	Replace		Bill Type(s)*
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0699	REFERRING PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	Required when DN0690 (Referring Provider Last/Group Name) is present and the provider is eligible to receive an NPI.	All
0704	MANAGED CARE ORGANIZATION FEIN	MC	NA	MC	MC	Required if DN0209 (Managed Care Organization Name) is present.	All
0714	HCPCS LINE PROCEDURE BILLED CODE	MC	NA	MC	MC	Required when DN0715 (Jurisdiction Procedure Billed code) and DN0721 (NDC Billed code) are not present.	I,P,D
0715	JURISDICTION PROCEDURE BILLED CODE	MC	NA	MC	MC	Required when DN0714(HCPCS Line Procedure Billed Code) and DN0721 (NDC Billed Code) are not present.	I
0717	HCPCS MODIFIER BILLED CODE	AR	NA	AR	AR		I,P,D
0718	JURISDICTION MODIFIER BILLED CODE	AR	NA	AR	AR		I,P,D
0719	ADA PROCEDURE BILLED CODE	M	NA	M	M		D
0721	NDC BILLED CODE	MC	NA	MC	MC	Required for pharmacy bills. Required for professional bills when DME or other prescription are dispensed by the Rendering Provider.by a retail pharmacy or mail order pharmacy	P,Rx
0722	ADA PROCEDURE PAID CODE	MC	NA	MC	MC	Required for Dental Bills	D
0726	HCPCS LINE PROCEDURE PAID CODE	MC	NA	MC	MC	Required for professional bills and for institutional outpatient bills.	I,P
0727	HCPCS MODIFIER PAID CODE	MC	NA	MC	MC	Required when the HCSPCS procedure reported in DN0726 has been modified.	I,P
0728	NDC PAID CODE	MC	NA	MC	MC	Required for pharmacy bills. Required for professional bills when DME or other prescription are dispensed by the Rendering Provider.	P,Rx
0729	JURISDICTION PROCEDURE PAID CODE	MC	NA	MC	MC	Required for professional bills when DN0726 HCPCS Line Procedure Paid Code is not present. Required for institutional bills when DN0726 HCPCS Line Procedure Paid Code is not present and DN0625 HIPPS Rate Code is not present	P,Rx
0730	JURISDICTION MODIFIER PAID CODE	MC	NA	MC	MC	Required when the Jurisdiction Procedure paid code has been modified.	I,P
0731	SERVICE ADJUSTMENT GROUP CODE	MC	NA	MC	MC	Required when line level adjustments are applied.	All
0732	SERVICE ADJUSTMENT REASON CODE	MC	NA	MC	MC	Required when there is a line level adjustment.	All
0733	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	Required when line level adjustment are applied.	All
0734	SERVICE ADJUSTMENT UNITS	MC	NA	MC	MC	Required when the number of units paid is different than the units billed.	All

Medical Data Element Requirement Table

		Original	Cancelation	Corrected	Replace		Bill Type(s)*
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0736	OTHER PROCEDURE CODE	MC	NA	MC	MC	Required when procedure other than DN0525 Principal Procedure Code is present	I
0741	CONTRACT LINE TYPE CODE	MC	NA	MC	MC	Required if there is a contract between the insurer and the service provider.	All
0742	PROVIDER AGREEMENT LINE CODE	MC	NA	MC	MC	Required when the provider agreement code at the line level is different than the bill level	P,D
0760	PRIOR ACTUAL AMOUNT PAID	NA	NA	NA	MC	Required for lien bills, when reporting bill adjudication actions related to a medical bill that has previously been reported.	All
0762	COMPOUND DRUG INDICATOR	MC	NA	MC	MC	Required when the drug reported in SV402-1 was billed as part of a compound drug.	P,Rx

Section VIII: California adopted IAIABC data edits and California specific data edits and error messages

The Edit Matrix provides the data edits and error codes the WCIS applies to the ANSI 837 EDI medical bill payment transmissions which are not part of the IAIABC data edits. The error codes will be transmitted back to each trading partner in the 824 acknowledgements.

X= California adopted IAIABC data elements and error messages.

C= The California specific data edits.

	ERROR MESSAGE	Mandatory field not present	All digits must be 0-9	Must be a valid date (CCYYMMDD)	Must be A-Z, 0-9, or spaces	Must be a valid time	Must be <= Date of Injury	Must be >= Date of Injury	No match on database	All digits cannot be the same	Must be <= current date	Duplicate Batch/Transaction	Code/ID invalid	Non-match data value not consistent with value previously reported	Invalid event sequence	Invalid data relationship	Must be <= Service Date	Must be > Date of Bill	Must be >= Date Payer Received Bill	Must be >=From Service date	Must be <= To Service Date	Must be valid content	Match data value not consistent with value previously reported	Trading Partner not approved to submit data
DN	**IAIABC Data Element Name**	001	028	029	030	031	033	034	039	040	041	057	058	059	063	064	070	072	073	074	075	111	117	118
0005	JURISDICTION CLAIM NUMBER	X							X															
0006	INSURER FEIN	X	X						X	X													X	
0007	INSURER NAME	X																						
0014	CLAIM ADMINISTRATOR MAILING POSTAL CODE	X							X				X											
0015	CLAIM ADMINISTRATOR CLAIM NUMBER	X			X									C	C									
0016	EMPLOYER FEIN		X							X													X	
0018	EMPLOYER NAME	X																						
0031	DATE OF INJURY	X		X							X										X		X	
0042	EMPLOYEE SSN		X							X													X	
0043	EMPLOYEE LAST NAME	X																						
0044	EMPLOYEE FIRST NAME	C																						

	ERROR MESSAGE	Mandatory field not present	All digits must be 0-9	Must be a valid date (CCYYMMDD)	Must be A-Z, 0-9, or spaces	Must be a valid time	Must be <= Date of Injury	Must be >= Date of Injury	No match on database	All digits cannot be the same	Must be <= current date	Duplicate Batch/Transaction	Code/ID invalid	Non-match data value not consistent with value previously reported	Invalid event sequence	Invalid data relationship	Must be <= Service Date	Must be > Date of Bill	Must be >= Date Payer Received Bill	Must be >=From Service date	Must be <= To Service Date	Must be valid content	Match data value not consistent with value previously reported	Trading Partner not approved to submit data
DN	**IAIABC Data Element Name**	001	028	029	030	031	033	034	039	040	041	057	058	059	063	064	070	072	073	074	075	111	117	118
0045	EMPLOYEE MIDDLE NAME/INITIAL																							
0098	SENDER ID	X							X															X
0099	RECEIVER ID	X							X															
0100	DATE TRANSMISSION SENT	X		X							X													
0101	TIME TRANSMISSION SENT	X	X			X																		
0187	CLAIM ADMINISTRATOR FEIN	X	X						X	X													X	
0188	CLAIM ADMINISTRATOR NAME	X																						
0208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	C							X															
0209	MANAGED CARE ORGANIZATION NAME	C																						
0266	TRANSACTION TRACKING NUMBER	X			X							C												
0293	LUMP SUM PAYMENT/ SETTLEMENT CODE	X												X										
0500	UNIQUE BILL ID NUMBER	X			X							C											X	
0501	TOTAL CHARGE PER BILL	X	X											C										
0502	BILLING TYPE CODE	X												X										
0503	BILLING FORMAT CODE	X												X										
0504	FACILITY	X												X										

DN	IAIABC Data Element Name	ERROR MESSAGE	Mandatory field not present	All digits must be 0-9	Must be a valid date (CCYYMMDD)	Must be A-Z, 0-9, or spaces	Must be a valid time	Must be <= Date of Injury	Must be >= Date of Injury	No match on database	All digits cannot be the same	Must be <= current date	Duplicate Batch/Transaction	Code/ID invalid	Non-match data value not consistent with value previously reported	Invalid event sequence	Invalid data relationship	Must be <= Service Date	Must be > Date of Bill	Must be >= Date Payer Received Bill	Must be >=From Service date	Must be <= To Service Date	Must be valid content	Match data value not consistent with value previously reported	Trading Partner not approved to submit data
	CODE		001	028	029	030	031	033	034	039	040	041	057	058	059	063	064	070	072	073	074	075	111	117	118
0505	BILL FREQUENCY TYPE CODE		X												X										
0507	PROVIDER AGREEMENT CODE		C												X										
0508	BILL SUBMISSION REASON CODE		X										X	C		X								X	
0509	SERVICE BILL DATE(S) RANGE		X		X				X																
0510	DATE OF BILL		X		X				X				C								X				
0511	DATE INSURER RECEIVED BILL		X		X				X										X						
0512	DATE INSURER PAID BILL		X		X				X											X					
0513	ADMISSION DATE		C		X				X												X				
0514	DISCHARGE DATE				X				X												X				
0515	CONTRACT TYPE CODE														X										
0516	TOTAL AMOUNT PAID PER BILL		X	X																					
0520	OUTPATIENT REASON FOR VISIT CODE														X										
0521	PRINCIPAL DIAGNOSIS CODE		X												X										
0522	DIAGNOSIS CODE														X		C								
0523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER		X			X																			
0524	PROCEDURE DATE		X		X																X				
0525	PRINCIPAL PROCEDURE CODE														X										

DN	IAIABC Data Element Name	Mandatory field not present	All digits must be 0-9	Must be a valid date (CCYYMMDD)	Must be A-Z, 0-9, or spaces	Must be a valid time	Must be <= Date of Injury	Must be >= Date of Injury	No match on database	All digits cannot be the same	Must be <= current date	Duplicate Batch/Transaction	Code/ID invalid	Non-match data value not consistent with value previously reported	Invalid event sequence	Invalid data relationship	Must be <= Service Date	Must be > Date of Bill	Must be >= Date Payer Received Bill	Must be >=From Service date	Must be <= To Service Date	Must be valid content	Match data value not consistent with value previously reported	Trading Partner not approved to submit data
	ERROR MESSAGE	001	028	029	030	031	033	034	039	040	041	057	058	059	063	064	070	072	073	074	075	111	117	118
0527	PRESCRIPTION BILL DATE	X		X				X									X							
0528	BILLING PROVIDER LAST/GROUP NAME	X																						
0529	BILLING PROVIDER FIRST NAME	C																						
0532	ORIGINATOR TRANSACTION IDENTIFICATION NUMBER	X			X							C												
0533	PRESENT ON ADMISSION INDICATOR	X												X										
0535	ADMITTING DIAGNOSIS CODE	X												X		X								
0537	BILLING PROVIDER PRIMARY SPECIALTY CODE													X										
0538	BILLING PROVIDER PRIMARY ADDRESS	X																						
0539	BILLING PROVIDER SECONDARY ADDRESS																							
0540	BILLING PROVIDER CITY	X																						
0541	BILLING PROVIDER STATE CODE													X										
0542	BILLING PROVIDER POSTAL CODE													X										
0543	BILL ADJUSTMENT GROUP CODE	X												X										
0544	BILL ADJUSTMENT	X												X										

DN	IAIABC Data Element Name	001	028	029	030	031	033	034	039	040	041	057	058	059	063	064	070	072	073	074	075	111	117	118
	ERROR MESSAGE	Mandatory field not present	All digits must be 0-9	Must be a valid date (CCYYMMDD)	Must be A-Z, 0-9, or spaces	Must be a valid time	Must be <= Date of Injury	Must be >= Date of Injury	No match on database	All digits cannot be the same	Must be <= current date	Duplicate Batch/Transaction	Code/ID invalid	Non-match data value not consistent with value previously reported	Invalid event sequence	Invalid data relationship	Must be <= Service Date	Must be > Date of Bill	Must be >= Date Payer Received Bill	Must be >=From Service date	Must be <= To Service Date	Must be valid content	Match data value not consistent with value previously reported	Trading Partner not approved to submit data
	REASON CODE																							
0545	BILL ADJUSTMENT AMOUNT	X	X																					
0546	BILL ADJUSTMENT UNITS		X																					
0547	LINE NUMBER	X	X																					
0548	BILLED DRG CODE													X										
0549	PAID DRG CODE													X										
0550	PRINCIPAL PROCEDURE DATE	X		X				X												X				
0551	PROCEDURE DESCRIPTION																							
0552	TOTAL CHARGE PER LINE	X	X																					
0553	DAY(S)/UNIT(S) CODE	X												X										
0554	DAY(S) /UNIT(S) BILLED	X	X																					
0555	PLACE OF SERVICE BILL CODE	X												X										
0556	CONDITION CODE													X										
0557	DIAGNOSIS POINTER	X	X											X		X								
0559	REVENUE BILLED CODE	X												X										
0561	PRESCRIPTION LINE NUMBER	X			X																			
0562	DISPENSE AS WRITTEN CODE	X												X										
0563	DRUG NAME																							
0569	BILLING PROVIDER COUNTRY CODE													X										
0570	DRUGS/SUPPLIES	X	X																					

DN	IAIABC Data Element Name	001 Mandatory field not present	028 All digits must be 0-9	029 Must be a valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	031 Must be a valid time	033 Must be <= Date of Injury	034 Must be >= Date of Injury	039 No match on database	040 All digits cannot be the same	041 Must be <= current date	057 Duplicate Batch/Transaction	058 Code/ID invalid	059 Non-match data value not consistent with value previously reported	063 Invalid event sequence	064 Invalid data relationship	070 Must be <= Service Date	072 Must be > Date of Bill	073 Must be >= Date Payer Received Bill	074 Must be >=From Service date	075 Must be <= To Service Date	111 Must be valid content	117 Match data value not consistent with value previously reported	118 Trading Partner not approved to submit data
	QUANTITY DISPENSED																							
0571	DRUGS/SUPPLIES NUMBER OF DAYS	X	X																					
0572	DRUGS/SUPPLIES BILLED AMOUNT	X	X																					
0574	TOTAL AMOUNT PAID PER LINE	X	X																					
0576	REVENUE PAID CODE													X										
0577	ADMISSION TYPE CODE													X										
0579	DRUGS/SUPPLIES DISPENSING FEE		X																					
0580	DAY(S)/UNIT(S) PAID		X											C										
0586	RENDERING LINE PROVIDER FEIN		X							X														
0587	RENDERING LINE PROVIDER FIRST NAME																							
0589	RENDERING LINE PROVIDER LAST/GROUP NAME																							
0592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID													X										
0595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE													X										
0599	RENDERING LINE PROVIDER STATE LICENSE													X										

DN	IAIABC Data Element Name	ERROR MESSAGE	Mandatory field not present	All digits must be 0-9	Must be a valid date (CCYYMMDD)	Must be A-Z, 0-9, or spaces	Must be a valid time	Must be <= Date of Injury	Must be >= Date of Injury	No match on database	All digits cannot be the same	Must be <= current date	Duplicate Batch/Transaction	Code/ID invalid	Non-match data value not consistent with value previously reported	Invalid event sequence	Invalid data relationship	Must be <= Service Date	Must be > Date of Bill	Must be >= Date Payer Received Bill	Must be >=From Service date	Must be <= To Service Date	Must be valid content	Match data value not consistent with value previously reported	Trading Partner not approved to submit data
	NUMBER		001	028	029	030	031	033	034	039	040	041	057	058	059	063	064	070	072	073	074	075	111	117	118
0600	PLACE OF SERVICE LINE CODE														X										
0604	PRESCRIPTION LINE DATE	X		X				X																	
0605	SERVICE LINE DATE(S) RANGE	X		X				X																	
0615	REPORTING PERIOD			X				X																	
0616	INSURER POSTAL CODE	X								X					X										
0622	ADMISSION HOUR	C	X												X										
0623	DISCHARGE HOUR		X												X										
0625	HIPPS RATE CODE														X										
0629	BILLING PROVIDER FEIN	X	X								X														
0630	BILLING PROVIDER STATE LICENSE NUMBER														X										
0634	BILLING PROVIDER NATIONAL PROVIDER ID														X										
0638	RENDERING BILL PROVIDER LAST/GROUP NAME																								
0639	RENDERING BILL PROVIDER FIRST NAME	C																							
0642	RENDERING BILL PROVIDER FEIN	C	x								x														
0643	RENDERING BILL PROVIDER STATE LICENSE NUMBER	C													X										

DN	IAIABC Data Element Name	ERROR MESSAGE	Mandatory field not present	All digits must be 0-9	Must be a valid date (CCYYMMDD)	Must be A-Z, 0-9, or spaces	Must be a valid time	Must be <= Date of Injury	Must be >= Date of Injury	No match on database	All digits cannot be the same	Must be <= current date	Duplicate Batch/Transaction	Code/ID invalid	Non-match data value not consistent with value previously reported	Invalid event sequence	Invalid data relationship	Must be <= Service Date	Must be > Date of Bill	Must be >= Date Payer Received Bill	Must be >=From Service date	Must be <= To Service Date	Must be valid content	Match data value not consistent with value previously reported	Trading Partner not approved to submit data
			001	028	029	030	031	033	034	039	040	041	057	058	059	063	064	070	072	073	074	075	111	117	118
0647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID														X										
0651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	C													X										
0658	SUPERVISING PROVIDER LAST/GROUP NAME																								
0659	SUPERVISING PROVIDER FIRST NAME	C																							
0660	SUPERVISING PROVIDER MIDDLE NAME/INITIAL																								
0667	SUPERVISING PROVIDER NATIONAL PROVIDER ID														X										
0671	SUPERVISING PROVIDER PRIMARY SPECIALTY CODE	C													X										
0678	FACILITY NAME																								
0680	FACILITY STATE LICENSE NUMBER	C													X										
0682	FACILITY NATIONAL PROVIDER ID	C													X										
0684	FACILITY PRIMARY ADDRESS	X																							
0685	FACILITY SECONDARY ADDRESS																								
0686	FACILITY CITY	X																							
0687	FACILITY STATE CODE	C													X										
0688	FACILITY	C													X										

DN	IAIABC Data Element Name	Mandatory field not present	All digits must be 0-9	Must be a valid date (CCYYMMDD)	Must be A-Z, 0-9, or spaces	Must be a valid time	Must be <= Date of Injury	Must be >= Date of Injury	No match on database	All digits cannot be the same	Must be <= current date	Duplicate Batch/Transaction	Code/ID invalid	Non-match data value not consistent with value previously reported	Invalid event sequence	Invalid data relationship	Must be <= Service Date	Must be > Date of Bill	Must be >= Date Payer Received Bill	Must be >=From Service date	Must be <= To Service Date	Must be valid content	Match data value not consistent with value previously reported	Trading Partner not approved to submit data
	ERROR MESSAGE	001	028	029	030	031	033	034	039	040	041	057	058	059	063	064	070	072	073	074	075	111	117	118
	POSTAL CODE																							
0689	FACILITY COUNTRY CODE	C												X										
0690	REFERRING PROVIDER LAST/GROUP NAME	C																						
0691	REFERRING PROVIDER FIRST NAME	C																						
0699	REFERRING PROVIDER NATIONAL PROVIDER ID													X										
0704	MANAGED CARE ORGANIZATION FEIN	C	X						X	X														
0714	HCPCS LINE PROCEDURE BILLED CODE	C												X										
0715	JURISDICTION PROCEDURE BILLED CODE	C							X															
0717	HCPCS MODIFIER BILLED CODE													X										
0718	JURISDICTION MODIFIER BILLED CODE								X															
0719	ADA PROCEDURE BILLED CODE	C												X										
0721	NDC BILLED CODE	X												X										
0722	ADA PROCEDURE PAID CODE													X										
0726	HCPCS LINE PROCEDURE PAID CODE													X										
0727	HCPCS MODIFIER PAID CODE								C					X										
0728	NDC PAID CODE													X										

DN	IAIABC Data Element Name	ERROR MESSAGE	Mandatory field not present	All digits must be 0-9	Must be a valid date (CCYYMMDD)	Must be A-Z, 0-9, or spaces	Must be a valid time	Must be <= Date of Injury	Must be >= Date of Injury	No match on database	All digits cannot be the same	Must be <= current date	Duplicate Batch/Transaction	Code/ID invalid	Non-match data value not consistent with value previously reported	Invalid event sequence	Invalid data relationship	Must be <= Service Date	Must be > Date of Bill	Must be >= Date Payer Received Bill	Must be >=From Service date	Must be <= To Service Date	Must be valid content	Match data value not consistent with value previously reported	Trading Partner not approved to submit data
		001	028	029	030	031	033	034	039	040	041	057	058	059	063	064	070	072	073	074	075	111	117	118
0729	JURISDICTION PROCEDURE PAID CODE								X															
0730	JURISDICTION MODIFIER PAID CODE								X															
0731	SERVICE ADJUSTMENT GROUP CODE	X												X										
0732	SERVICE ADJUSTMENT REASON CODE	X	C											X										
0733	SERVICE ADJUSTMENT AMOUNT	X	X											C										
0734	SERVICE ADJUSTMENT UNITS	C	X																					
0736	OTHER PROCEDURE CODE													X										
0741	CONTRACT LINE TYPE CODE													X										
0742	PROVIDER AGREEMENT LINE CODE													X										
0760	PRIOR ACTUAL AMOUNT PAID		X																					
0761	LINE ITEM PRIOR ACTUAL AMOUNT PAID		X																					
0762	COMPOUND INDICATOR													X										

Section IX: System specifications

Electronic Transmission types

The DWC\WCIS receives from trading partners the 837 transmission specified in the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2012. The DWC\WCIS transmits back to trading partners the 997 functional acknowledgement and the ASC X12 824 Application Advice (824). The 997 functional acknowledgements reports structural errors and the 824 Application Advice reports any errors in the content of the data.

997 Functional processing and sequencing

When the IAIABC Workers' Compensation Medical Bill Data Reporting 837 file is accepted with no errors by the WCIS, AK901 = A, is returned to the trading partner. The following two steps outline the accepted 837 transmission procedure.

1. Sender transmits original 837.
2. The DWC/WCIS sends an "A" in the AK901 in the 997 functional acknowledgement to sender.

The 837 file is rejected by the WCIS, AK901 = R, if any functional errors are detected. The following five steps outline the rejected 837 transmission procedure:

1. Sender transmits original 837 including all required segments and fields.
2. The DWC/WCIS sends an "R" in the AK901 in the 997 functional acknowledgement to sender.
3. Sender corrects all errors in the original 837.
4. Sender transmits the corrected 837, including all required segments and fields.
5. The DWC/WCIS sends an "A" in the AK901 in the 997.

The table below summarizes the acknowledgement codes returned to the sender in the 997 acknowledgement indicating the acceptance\rejection status of the 837.

997 Functional Group Acknowledgement Codes returned to the sender	
A	837 Transmission accepted
R	837 Transmission rejected

837 Detailed Transaction processing and sequencing

Bill submission reason codes (BSRC) are used to define the specific purpose of a transmission. The DWC/WCIS accepts four BSRC: 00, 01, 02 and 05. The codes are grouped in the following tables to clarify their purpose and to demonstrate a logical order for use.

The bill submission reason code used to report the initial medical bill payment report sent to WCIS is BSRC = 00.

BSRC code	BSRC name
00	Original

After the initial medical bill payment report has been filed, BSRC 00 has been filed for the bill, the following medical bill payment report bill submission reason codes can be submitted to reflect cancellations or replacements. The BSRC sequencing is important, if a BSRC 01, 02 or 05 is filled prior to a BSRC 00 for any medical bill payment record an 063_(-invalid sequencing event error) will be returned in the 824 detailed acknowledgment.

The BRSC= 01, cancellation, is used when a '00' original has been submitted which should never have been submitted to the jurisdiction or when the original transaction contained errors in critical data elements DN0006 Insurer Fein and DN0500 Unique Bill ID Number (see IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2012, Section 1.4.2.1). It is recommended that the value in DN0500 Unique Bill Identification Number contained in a cancelled medical EDI record not be reused. All BRSC =01, cancellation, medical bill reports should be reported immediately after the error is discovered.
The BRSC = 02, Corrected and Verified Original Claim, is used when the trading partner must correct errors to non-critical data elements on a '00' original or '05' replace transaction. This value is not used if the amount of payment changed due to a subsequent payment action by the claim administrator or insurer.
The BRSC = 05, replace**,** is used when the trading partner must report a subsequent payment action or denial by the claim administrator or insurer. A '00' original transaction must have been submitted and accepted before a '05' replace transaction is reported. All replace medical bill reports should be reported immediately.

BSRC code	BSRC name
01	Cancellation
02	Corrected and Verified Original Claim
05	Replace

The DWC/WCIS utilizes DN111, Application Acknowledgement Code (AAC), and DN0532 Originator Transaction Identification number in the ANSI 824 to inform the trading partner of the accepted or rejected status of each transaction set and each individual transaction included in the 837 transmission to the DWC. The two levels of

acknowledgement codes are the batch level (ST-SE transaction set) and the bill level (transaction). The table below summarizes the application acknowledgement codes returned to the sender in the ASC X12 824 application advice acknowledgement for each transaction set contained in the 837 transmission to the DWC.

Codes returned to the sender (Transaction/Batch level)	
Application Acknowledgement Code	Application Acknowledgement Code Description
TA	ST-SE transaction set accepted
TR	ST-SE transaction set rejected

Correcting Transaction set (ST-SE) level errors (BSRC=00) (AAC=TR)

All errors occurring in the transaction set header, submitter information, or receiver information will be rejected with a TR**.** The WCIS also checks for duplicates in the ST-SE transaction sets. When re-submitting a corrected ST-SE transaction set (BSRC=00) in response to a batch rejected (TR), the sender must report all medical bill payment data elements, not just the data elements being corrected. The following five steps outline the procedure:

1. Sender transmits original ST-SE transaction set, including all bills/lines, utilizing a BSRC "00".
2. The DWC/WCIS sends an A in the AK901 in the 997 and a TR in the OTI01 in the 824 acknowledgement.
3. Sender corrects the error(s) in the original ST-SE transaction set.
4. Sender transmits the corrected transaction set, including all bills/lines, as an original BSRC = 00.
5. The DWC/WCIS sends an A in the AK901 in the 997 and a TA in the OTI01 in the 824 acknowledgement to sender

The table below summarizes the application acknowledgement codes returned to the sender in the ASC X12 824 application advice acknowledgement for each individual bill/transaction contained in the 837 transmission to the DWC.

Codes returned to the sender (Bill level)	
Application Acknowledgement Code	Application Acknowledgement Code Description
IA	Bill/item accepted
IE	Bill/ Item accepted with error (only for unmatched claims reported in the FROI)
IR	Bill /item rejected

Correcting data elements (BSRC=00) (AAC=TA and IR)

The WCIS regulations require each claims administrator to resubmit to the WCIS all rejected bills with all data elements corrected. When re-submitting a corrected transmission (BSRC=00) in response to a item rejected (IR), the sender must report all

medical bill payment data elements, not just the data elements being corrected. The following five steps outline the procedure:

1. Sender transmits original bill, including all lines, utilizing a BSRC "00".
2. The DWC/WCIS sends an “A” in the AK901 in the 997 and a TA in the OTI01and an IR in a different OTI01 segment in the 824 acknowledgement. 3. Sender corrects errors in the original bill.
4. Sender transmits the corrected bill, including all lines, as an original BSRC "00".
5. The DWC/WCIS sends an “A” in the AK901in the 997 and a TA in the OTI01 and an IA in a different OTI01 for each bill\transaction accepted in the 824 acknowledgement to sender.

Canceling critical data elements (BSRC=01) (AAC=TA and IA)

The WCIS regulations require each claims administrator to submit to the WCIS any changed critical data elements to maintain complete, accurate, and valid data. There are two critical data elements, the DN0006 (Insurer FEIN); and the DN0500 (Unique Bill ID Number). To update the value of a critical data element(s) contained in transmission already accepted by the DWC/WCIS, the sender transmits a BSRC = 01 to cancel the original transmission (BSRC=00). The following five steps outline the procedure:

1. Sender transmits original bill, including all lines, utilizing a BSRC "00".
2. The DWC/WCIS sends an “A” in the AK901 in the 997 and a TA in the OTI01 and an IA in the OTI01 in the 824 acknowledgement to sender.
3. Sender changes the value of a critical data element on the original bill.
4. Sender cancels incorrect original bill by transmitting a BSRC "01".
5. The DWC/WCIS sends an “A” in the AK901 in the 997 and a TA in the OTI01 and an IA in the OTI01in the 824 acknowledgement to sender.

Updating Non critical data elements (BSRC=02) (AAC=TA and IA)

The WCIS regulations require each claims administrator to submit to the WCIS any changed non critical data elements to maintain complete, accurate, and valid data. To update the value of a noncritical data element(s) contained in transmission already accepted by the DWC/WCIS, the sender transmits a BSRC = 02 containing the updated data. The updated transmission (BSRC=02) is not sent in response to an 824 acknowledgement containing error messages (IR) from the DWC/WCIS. When submitting a transmission (BSRC=02) to update the value of a data element, the sender must report all medical bill payment data elements, not just the data elements being updated. The following five steps outline the procedure:

1. Sender transmits original bill, including all lines, utilizing a BSRC "00" or BRSC ”05”.
2. The DWC/WCIS sends an “A” in the AK901 in the 997 and a “TA” in the OTI01 for each ST-SE transaction set accepted and an IA in a subsequent OTI01 for each bill\transaction accepted in the 824 acknowledgement to sender.

3. Sender changes the value of a noncritical data element(s) on the original accepted bill.
4. Sender updates the noncritical data elements in the accepted original bill by transmitting a BSRC "02".
5. The DWC/WCIS sends an “A” in the AK901 in the 997 and a “TA” in the OTI01 and an IA in a different OTI01 in the 824 acknowledgement to sender.

Subsequent Payment Action or Denial (BSRC=05) (AAC=TA AND IA)

Replacement reports (BSRC=05) are sent to WCIS indicating a subsequent payment action or denial by the claim administrator or insurer. A ‘00’ original transaction must have been submitted and accepted before a ‘05’ replace transaction is reported
The updated transmission (BSRC=05) is not sent in response to an 824 acknowledgement containing error messages (IR) from the DWC/WCIS. When submitting a transmission (BSRC=05) to update the payment amounts, the sender must report all medical bill payment data elements, not just the data elements being updated. The following five steps outline the procedure.

1. Sender transmits original bill, including all lines, utilizing a BSRC "00".
2. The DWC/WCIS sends an “A” in the AK901 in the 997 and a “TA” in the OTI01 for each ST-SE transaction accepted and an IA in a subsequent OTI01 for each bill\transaction accepted in the 824 acknowledgement to sender.
3. Sender engages in a subsequent payment action or previously reported medical service or good is denied by the claim administrator or insurer on the original bill.
4. Sender updates the payment amounts in original bill by transmitting a BSRC "05". For the complete list of data elements required in an 05 replace see the IAIABC Workers’ Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2012, section 1.3.1, page 1.11.
5. The DWC/WCIS sends an “A” in the AK901 in the 997 and a “TA” in the OTI01 for each ST-SE transaction set accepted and an IA in a subsequent OTI01 bill\transaction accepted in the 824 acknowledgement to sender.

Matching transmissions, transactions, claims and medical bills

The California DWC\WCIS matches files and data elements at several levels, including 837 to 824 transmissions, transaction sets within an 837, individual injured worker claims between the FROI and medical databases, and individual medical bills between two 837s. The paragraphs below explain each of the matching processes and the data elements utilized in the matching criteria.

Matching 837 Health Care Claim(s) to 824 Application Advice(s)

At the highest level of matching, the inbound 837 transmissions are matched to outbound 824 transmissions utilizing the DN98 (Sender ID), DN100 (Date transmission sent), and DN101 (Time transmission sent), DN532 (Originator Transaction Identification Number) from the inbound 837 to the DN99 (Receiver ID), DN102 (Original

date transmission sent), and DN103 (Original time transmission sent), and_DN532 (Originator Transaction Identification Number) in the outbound 824. The DWC\WCIS requires each sender to utilize a standard format of HHMM for DN101 (Time transmission sent) in the BHT segment of the 837. The DN101 (Time transmission sent) in the BHT segment(s) of the 837 must be identical to the time in the ISA10 interchange time and the GS05 Time in the 837 headers where the standard format is HHMM.

Matching ST- SE Transaction Sets

Individual transaction sets are matched within each 837 to a corresponding transaction set in the 824 advice. Each ST-SE transaction set in each 837 is identified by matching the DB05532 (Originator Transaction Identification Number), DN0100(Date transmission sent), and DN0101(Time transmission sent) _in the 837 to the DN0532(Originator Transaction Identification Number), DN0100(original Date transmission sent), and DN0101 (original Time transmission sent) in the 824.

Matching injured worker claims between the FROI and medical

The FROI Agency Claim Number (DN5) is the Jurisdiction Claim Number (DN5) in the medical reporting. A jurisdiction claim number (JCN) is created by the WCIS to uniquely identify each claim. The JCN is provided to the claims administrator in the acknowledgement of the first report of injury (FROI) by the DWC/WCIS. The WCIS uses the jurisdiction claim number as the primary means for matching medical bills in the 837 to claims previously reported in the First Report of Injury (FROI). If the jurisdiction claim number is not reported in the 837, the WCIS utilizes secondary match criteria of the claim administrator claim number (DN15) and the insurer FEIN (DN6).

Unmatched injured worker claims between the FROI and medical

If the DN5 (Jurisdiction Claim Number) is reported in the medical 837 and no matching DN5 is found in the FROI database, the WCIS will return a TA in the OTI01 for each ST-SE transaction set accepted, and IE in a subsequent OTI01 for each bill\transaction accepted with an error an error code 039 (No Match on Database) in the LQ02, and a copy of the unmatched DN5 in the RED01 of the 824 acknowledgement returned to the sender**.** If the secondary match criteria is utilized and either the DN15 or DN6 reported in the 837 do not match to the DN15 or DN6 reported in the FROI, the WCIS will return a “TA” in the OTI01, an IE in the OTI02, and an error code 039 (no match on database) in the LQ02, and a copy of the unmatched DN6 or DN15 in the RED01 in the 824 acknowledgement returned to the sender**.** If the DWC accepts a transmission with errors, the WCIS continuously searches for a match between the FROI and medical database. If a match is found the status of the claim is changed from unmatched to matched in the WCIS database.

Matching medical bill records

Bill level matching within the WCIS database occurs when medical bills are canceled (BSRC=01), corrected (BSCR= 02), or replaced (BSRC = 05). The matching requirements and possible errors associated with each of the process are outlined below.

The DN6 (Insurer FEIN) and the DN500 (Unique Bill ID Number) are utilized to match the original report (BSRC = 00) to the canceled report (BSRC = 01). The DWC\WCIS requires both the DN6 and the DN500 be identical in both items/bills, the original (00) and the cancelation (01). If either of the critical elements are not matched, the WCIS will return a "TA" in the OTI01, an IR in the OTI01, and an error code 117 (Match Data value not consistent with value previously reported) in the LQ02 and a copy of the unmatched DN6 or DN500 in the RED01 in the 824 acknowledgement returned to the sender.

The DN6 (Insurer FEIN), DN16 (Employer FEIN), and DN500 (Unique Bill ID Number) are utilized to match the original or replacement report (BSRC = 00 or 05) to the corrected report (BSRC = 02). The DWC\WCIS requires the DN500 be identical in both transactions, the original (00) and the corrected (02). If the two DN500s are not matched, the WCIS will return a "TA" in the OTI01, an IR in a subsequent OTI01, and an error code 117 (Match Data value not consistent with value previously reported) in the LQ02 and a copy of the unmatched DN500 in the RED01 in the 824 acknowledgement returned to the sender.

The DN6 (Insurer FEIN), DN16 (Employer FEIN), and DN500 (Unique Bill ID Number) are utilized to match the original or replacement report (BSRC = 00) to the replacement report (BSRC = 05). The DWC\WCIS requires the DN500 be identical in both transactions, the original (00) and the replacement (05). If the two DN500s are not matched, the WCIS will return a "TA" for each ST-SE transaction set accepted in the OTI01, an IR in the subsequent OTI01 for each bill\transaction rejected with an error code 117 (Match Data value not consistent with value previously reported) in the LQ02 and a copy of the unmatched DN500 in the RED01 in the 824 acknowledgement returned to the sender.

Duplicate transaction sets and medical bills

Transaction set duplicates occur when the Originator Transaction Identification Number, sender ID, date transmission sent, and time transmission sent information in 837(s) are matched to a previously accepted DWC ST-SE transaction set. The DWC will reject the entire ST-SE transaction set when a duplicate transaction set is detected. The DWC will transmit an"TR" in the OTI01 in the 824 acknowledgement and error code 057 -duplicate transmission in the LQ02 and a copy of the DN532 (Originator Transaction Identification Number) in the RED01 in the 824 acknowledgement returned to the sender.

Bill-level duplicates occur when the information on the claim administrator FEIN, claim administrator claim number, unique bill identification number, and line numbers on a bill are repeated. The DWC will check for duplicate bills in all ST-SE transaction sets included in each X12 interchange envelope (ISA-IEA interchange). The DWC also checks each bill for duplicates against the entire WCIS database. Duplicate medical bills that are not correctly coded with the appropriate claim adjustment reason code (18, or B13) will cause an error. The DWC will transmit an IR in the OTI01 for each bill/transaction rejected in the 824 acknowledgement with a 057 error in the LQ02 as well as the unique bill ID number in the bad data field of the matching 824 acknowledgement when a duplicate bill is detected.

Balancing processes

The WCIS reporting regulations require each claims administrator shall, at a minimum, provide **complete**, **valid**, and **accurate data** for the data elements set forth in Title 8, California Code of Regulations section 9702." It is necessary that certain accounting rules be applied to the billed, paid, and adjusted amounts to insure the reporting regulations are complied with. Specifically, it is necessary that billed, paid, and adjusted amounts reported at both the bill and line level balance.

Balancing charged amounts at the bill and service line level

The charged amount(s) reported at the line level in the 2400 loop in any of the four service information segments (SV1, SV2, SV3, or SV4) must add up the total amount reported at the bill level in the DN501(Total Charge Per Bill). The data element containing the charged amount in the service information segments SV1, SV2, and SV3, is DN552 (Total Charge Per Line). The data element containing the charged amount in the service information segment SV4 is DN572 (Drugs/Supplies Billed Amount). The DWC will reject the bill and return an error code 064-Invalid data relationship if the charged balancing is not valid. For a numeric example see the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2012, section 1.3.1, page 1.7.

Balancing paid amounts at the bill and service line level

The paid amount(s) reported at the line level in the 2400 loop in all of the service line adjudication segments (SVD) must add up to the total amount reported at the bill level in the DN516 (Total Amount paid Per Bill). The data element containing the paid amount in the service line adjudication segment, SVD, is DN574 (Total Paid Per Line). The DWC will reject the bill and return an error code 064_Invalid data relationship if the paid balancing is not valid. For a numeric example see the IAIABC Workers' Compensation

Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2012, section 1.3.1, page 1.7.

Balancing medical bill charges, payment and adjustment a mounts

The reported Total Amount Paid Per Bill (DN516) plus the sum of all the reported Bill Adjustment Amounts (DN545) must equal the Total Charge Per Bill (DN501) reported for each bill. Furthermore, the reported Total Amount Paid Per Bill (DN516) plus the sum of all the reported Service Adjustment Amounts (DN733) must equal the Total Charge Per Bill (DN501) reported for each bill. In general, positive adjustment amounts decrease the Total Amount Paid Per Bill and negative adjustment amounts increase the Total Amount Paid Per Bill. For a numeric example see the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2012, section 1.3.1, page 1.8.

Balancing at the line level

For bill level transactions that are not adjusted at the bill level and do not contain DN545 (Bill Adjustment Amount), line level balancing is required and occurs independently for each individual service line reported in the transaction. For each service line reported in a bill(s) that is not adjusted at the bill level, the reported Total Amount Paid Per Line plus the sum of all the reported Service Adjustment Amounts (DN733) for the line must equal the total charge at the line level (DN552, and DN572 for each line in the bill. For a numeric example see the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2012, section 1.3.1, page 1.9

Compound drug reporting

Compound drugs can be dispensed through a retail pharmacy or by a physician during an office visit. The DWC\WCIS requires compound drugs dispensed through a retail pharmacy to be reported following the general guidelines in the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2012, on page 4.101 and to utilize the DN762 (Compound drug indicator). The DWC\WCIS requires compound drugs not dispensed by a retail pharmacy to be reported utilizing the SV1 Professional Service segment and the Health Care Financing Administration Common Procedural Coding System (HCPCS) Code, S9430 (Pharmacy compounding and dispensing fee) on the first line of the bill to report any professional fees, such as compounding fees, not associated with the ingredient costs of the compound. , All individual ingredients in each compound must be reported at the line level for both physician dispensed and retail pharmacy compound drug bills.

Lump sum bundled lien bill payment

California law allows the filing of a lien against any sum to be paid as compensation for the “reasonable expense incurred by or on behalf of the injured employee” for medical treatment (see Labor Code section 4903 and 4903.1). Reportable lump sum medical liens originate from medical bills filed on DWC Workers' WCAB Form 6. The medical lien form is located at http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCForm6.pdf.
For the complete list of data elements required in a reportable lump sum medical lien see the IAIABC Workers’ Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2012, section 1.3.1, page 1.13.

Section XI: Code lists and state license numbers

Code source

This section provides information on where to obtain source codes and current valid codes for several data elements. These valid code lists are provided as a convenience for our data providers, and are intended to be a simple repetition of code lists available elsewhere.

Billing provider country code
Available on IAIABC website:
www.iaiabc.org
Contact information:
IAIABC Headquarters
5610 Medical Circle, suite 24
Madison, WI 53719
Phone: 1-608-663-6355
Fax: 1-608-663-1546
Email: hlore@iaiabc.org

Postal code
Available for purchase:
National Zip Code and Post Office Directory, Publication 65
The USPS Domestic Mail Manual
Contact information:
U.S. Postal Service
Washington, DC 20260
New orders:
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
Look up a zip code online: http://zip4.usps.com/zip4/welcome.jsp

Healthcare financing administration common procedural coding system (HCPCS)
Available on Centers for Medicare & Medicaid Services (CMS)
website: http://www.cms.hhs.gov/
Contact information:
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore MD 21244-1850

National Uniform Billing Committee (N75UBC) Condition Codes
Partial Availability on the National Uniform Billing Committee
website: http://www.nucc.org/
Contact Information:
Nancy Spector, NUCC Chair
American Medical Association
515 N. State St.
Chicago, IL 60654
Email: info@nucc.org

Health Insurance Prospective Payment System (HIPPS)
Available on Centers for Medicare and Medicaid Services (CMS)
website:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html
Contact information:
Centers for Medicare & Medicaid Services
7500 Security Boulevard,
Baltimore, MD 21244
Phone: 1(800)633-4227

International classification of diseases clinical modification (ICD-9 CM)

Available on International Classification of Diseases, Ninth Revision, Clinical Modification
website: http://www.cdc.gov/nchs/icd9.htm
Contact information:
National Center of Health Statistics
3311 Toledo Rd
Room 5419
Hyattsville, MD 20782
Phone: 1(800)232-4636

International classification of diseases clinical modification (ICD-10- CM)
Available on International Classification of Diseases, Tenth Revision, Clinical Modification
website:http://www.cdc.gov/nchs/icd/icd10cm.htm
Contact information:
National Center of Health Statistics

3311 Toledo Rd
Room 5419
Hyattsville, MD 20782
Phone: 1(800)232-4636

Current procedural terminology (CPT) codes

Available for purchase:
American Medical Association (AMA)
Contact information:
AMA website: https://catalog.ama-assn.org/Catalog/home.jsp

National drug code (NDC)

Available on U.S. Food and Drug Administration (FDA)
website:http://www.fda.gov/cder/ndc/
Wolters Kluwer Health – Medi-Span
Contact information:
8425 Woodfield Crossing Blvd., Ste 490
Indianapolis, IN

Diagnosis related groups (DRG)

Source: Federal Register and Health Insurance Manual 15 (HIM 15)
Available at:
Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402
http://www.ahd.com/drgs.html

Provider taxonomy codes

Available for purchase:
Washington Publishing Company (WPC)
Contact information:
WPC website: http://www.wpc-edi.com

Facility/Place of service codes
Available on Centers for Medicare & Medicaid Services
website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/downloads/Website_POS_database.pdf
Contact information:
Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244-1850

Revenue billed/paid code
Available for purchase:
National Uniform Billing Committee (NUBC)
Contact information:
NUBC website: http://www.nubc.org

Claim adjustment group codes
Available for purchase:
Washington Publishing Company (WPC)
Contact information:
WPC website: http://www.wpc-edi.com

Claim adjustment reason codes
Available for purchase:
Washington Publishing Company (WPC)
Contact information:
WPC website: http://www.wpc-edi.com

California state medical license numbers
Available on CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS (DCA)
website: http://www.dca.ca.gov/
Contact information:
Department of Consumer Affairs
Consumer Information Division
1625 North Market Blvd., Suite N 112
Sacramento, CA 95834

National plan and provider enumeration system
Available on National Plan & Provider Enumeration System website:https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistrySearch.do?subAction=reset&searchType=ind
Available for purchase:
National Plan & Provider Enumeration System (NPPES)
Contact information:
NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059
1-800-465-3203
NPPES Website: https://nppes.cms.hhs.gov/NPPES/Welcome.do