§9701. Definitions.

The following definitions apply in this article:

- (a) Bona Fide Statistical Research. The analysis of existing workers' compensation data for the purpose of developing or contributing to basic knowledge regarding the California workers' compensation system.
- (b) California EDI Implementation Guide for First and Subsequent Reports of Injury. Contains California specific reporting requirements and information excerpted from the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, by the International Association of Industrial Accident Boards and Commissions. The California EDI Implementation Guide for First and Subsequent Reports of Injury is posted on the Division's Web site at http://www.dir.ca.gov/dwc/WCIS.htm, and is available from the Division of Workers' Compensation upon request.
- (1) For reporting prior to November 15, 2011, use the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 2.1, dated February 2006, which is incorporated by reference.
- (2) For reporting on or after November 15, 2011, use the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 3.0, dated November 15, 2011, which is incorporated by reference.
- (c) California EDI Implementation Guide for Medical Bill Payment Records. Contains the California-specific protocols and excerpts from the IAIABC EDI Implementation Guide for Medical Bill Payment Records, explains the technical design and functionality of the WCIS system, testing options for the trading partners, instructions regarding the medical billing data elements, and reporting standards and requirements. The California EDI Implementation Guide for Medical Bill Payment Records is posted on the Division's Web site at http://www.dir.ca.gov/dwc/WCIS.htm, and is available from the Division of Workers' Compensation upon request-
- (1) For reporting prior to November 15, 2011, use the California EDI Implementation Guide for Medical Bill Payment Records, Version 1.0, dated December 2005, which is incorporated by reference.
- (21) For reporting on or after prior to November 15, 2011 ______(OAL to insert date twelve months after date of filing approved regulation with the Secretary of State), use the California EDI Implementation Guide for Medical Bill Payment Records, Version 1.1, dated November 15, 2011, which is incorporated by reference.
- (32) For reporting on or after ______(OAL to insert date twelve months after date of filing approved regulation with the Secretary of State), use the California EDI Implementation Guide for Medical Bill Payment Records, Version 2.0

- Dated (OAL to insert date twelve months after date of filing approved regulation with the Secretary of State), which is incorporated by reference. This Guide adopts ASC (Accredited Standards Committee) X12 Implementation Acknowledgement for Health Care insurance (999) dated February 2011.
- (d) California Jurisdiction Code. A California-specific code that identifies a medical procedure, service, or product that is not identified by a current HCPCS code. California Jurisdiction Codes are either set forth and/or incorporated by reference in California Code of Regulations, title 8, section 9795, regarding reasonable fees for medical-legal expenses, section 9789.11, regarding fees for physician services rendered on or after July 1, 2004 and before January 1, 2014, sections 9789.12.1-9789.19, regarding fees for physician services rendered on or after January 1, 2014, or in California EDI Implementation Guide for Medical Bill Payment, Release 1.1.2.0, Section IX, subsections entitled "Lump sum bundled lien bill payment" and "Lump sum lien bills data elements," regarding medical lien lump sum payments or settlements. The California EDI Implementation Guide for Medical Bill Payment, Release 2.0 is incorporated by reference in subdivision (e)(2). Section 9789.11, regarding fees for physician services rendered on or after July 1, 2004, or in section 9702(e), footnote 13, regarding medical lien lump sum payments or settlements.
- (e) Claim. An injury as defined in Division 4 of the Labor Code, occurring on or after March 1, 2000, that has resulted in the receipt of one or more of the following by a claims administrator:
- (1) Employer's Report of Occupational Injury or Illness, as required by California Code of Regulations, title 8, sections 14004-14005.
- (2) Doctor's First Report of Occupational Injury or Illness, as required by California Code of Regulations, title 8, sections 14006-14007.
- (3) Application for Adjudication filed with the Workers' Compensation Appeals Board under Labor Code section 5500 and California Code of Regulations, title 8, section 10408.
- (4) Any information indicating that the injury requires medical treatment by a physician as defined in Labor Code section 3209.3.
- (f) Claims Administrator. A self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, California Insurance Guarantee Association (CIGA), or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.
- (g) Claims Administrator's Agents. Any entity contracted by the claims administrator to assist in adjusting the claim(s) including third party administrators, bill reviewers, utilization review vendors, and electronic data interchange vendors.

- (h) Closed Claim. A claim in which future payment of indemnity benefits and/or provision of medical benefits cannot be reasonably expected to be due.
- (i) Data Elements. Information identified by data number (DN) and defined in the dictionary of the IAIABC EDI Implementation Guide, Release 1. Data elements set forth in California Code of Regulations, title 8, section 9702 must be transmitted on all claims, where applicable, as indicated in section 9702. The data elements set forth in the IAIABC EDI Implementation Guide, Release 1 that are not enumerated in section 9702 are optional and may, but need not be, submitted on any or all claims.
- (j) Electronic Data Interchange. ("EDI"). A computer to computer exchange of data or information in a standardized format acceptable to the Administrative Director.
- (k) Health Care Organization ("HCO"). Any entity certified as a health care organization by the Administrative Director pursuant to Labor Code sections 4600.5 and 4600.6.
- (*l*) HCPCS. Acronym for the Healthcare Common Procedure Coding System.
- (m) IAIABC EDI Implementation Guide, Release 1. EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, by the International Association of Industrial Accident Boards and Commissions. The IAIABC EDI Implementation Guide, Release 1, can be obtained from the IAIABC at either the IAIABC website at http://www.iaiabc.org, or the IAIABC office located at 5610 Medical Circle, Suite 24, Madison, WI, 53719-1295; Telephone: (608) 663-6355.
- (n) IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0, IAIABC EDI Implementation Guide for Medical Bill Payment Records by the International Association of Industrial Accident Boards and Commissions. The IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1, can be obtained from the IAIABC at either the IAIABC website at http://www.iaiabc.org, or the IAIABC office located at 5610 Medical Circle, Suite 24, Madison, WI, 53719-1295; Telephone: (608) 663-6355. The IAIABC EDI Implementation Guide for Medical Bill Payment Records Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 20134 can be obtained from the IAIABC at either the IAIABC website at http://www.iaiabc.org, or the IAIABC office located at 5610 Medical Circle, Suite 24, Madison, WI, 53719-1295; Telephone: (608) 663-6355.
- (1) For reporting prior to November 15, 2011, use the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1, July 4, 2002, which is incorporated by reference. For reporting prior to the designated effective date (see subdivision (c)(1)), use the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009, which is incorporated by reference.

- (2) For reporting on or after the designated effective date (see subdivision(c)(2)), use the IAIABC EDI Implementation Guide for Medical Bill Payment Records Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0, dated February 1, 2014 which is incorporated by reference. November 15, 2011, use the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009, which is incorporated by reference.
- (o) Indemnity Benefits. Payments conferred, including those made by settlement, for any of the following: temporary disability indemnity, permanent disability indemnity, death benefits, vocational rehabilitation maintenance allowance, and employer-paid salary in lieu of compensation.
- (p) Individually Identifiable Information. Any data concerning an injury or claim that is linked to a uniquely identifiable employee, employer, claims administrator, or any other person or entity.
- (q) International Association of Industrial Accident Boards and Commissions ("IAIABC"). A professional association of workers' compensation specialists, located at 5610 Medical Circle, Suite 24, Madison, Wisconsin 53719-1295, which is, in addition to other activities, engaged in the production and publication of EDI standards for filing workers' compensation information. Note: IAIABC asserts ownership of such EDI standards which are published in various ways and include Implementation Guides with instructions on their use, technical and business specifications and coding information to permit the transfer of data between regulatory bodies and regulated entities in a uniform and consistent manner.
- (r) WCIS. The Workers' Compensation Information System established pursuant to sections 138.6 and 138.7 of the Labor Code.

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

§ 9702. Electronic Data Reporting

- (a) Each claims administrator shall transmit data elements, by electronic data interchange in the manner set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records, to the WCIS by the dates specified in this section. Each claims administrator shall, at a minimum, provide complete, valid, accurate data for the data elements set forth in this section. The data elements required in subdivisions (b), (c), (d) and (e) are taken from California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records. Claims administrators shall only transmit the data elements that are set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records. Each transmission of data elements shall include appropriate header and trailer records as set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records.
- (1) The Administrative Director, upon written request, may grant a claims administrator either a partial or total variance in reporting all or part of the data elements required pursuant to subdivision (e) of this section. Any variance granted by the Administrative Director under this subdivision shall be set forth in writing.
- (A) A partial variance requested on the basis that the claims administrator is unable to transmit some of the required data elements to the WCIS shall be granted for a six month period only if all of the following are shown:
- 1. a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;
- 2. a documented showing that any medical data elements currently being transmitted by the claims administrator or the claims administrator's agent to public or private research or statistical entities shall be reported by the claims administrator to the WCIS; and
- 3. submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the request.
- (B) A partial variance requested on the basis that the claims administrator is unable to report some of the required data elements to the WCIS because the data elements are not available to the claims administrator or the claims administrator's agent shall be granted for a six month period only if all of the following are shown:

1. a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;
2. a documented showing that any medical data elements currently being transmitted by the claims administrator or the claims administrator's agent to public or private research or statistical entities shall be reported by the claims administrator to the WCIS;
3. a documented showing that the claims administrator will submit to the WCIS the medical data elements available to the claims administrator or the claims administrator's agents; and
4. submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the request.
(C) A total variance shall be granted for a twelve month period if all of the following are shown:
1. a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;
2. a documented showing that the claims administrator has not contracted with a bill review company to review medical bills submitted by providers in its workers' compensation claims;
3. a documented showing that the claims administrator is unable to transmit medical data to public or private research or statistical entities; and
4. submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within twelve months from the request.
(2) "Undue hardship" shall be determined based upon a review of the documentation submitted by the claims administrator. The documentation shall include: the claims administrator's total required expenses; the reporting cost per claim if transmitted in house; and the total cost per claim if reported by a vendor. The costs and expenses shall be itemized to reflect costs and expenses related to reporting the data elements listed in subdivision (e) only.
(3) The variance period for reporting data elements under subdivisions (a)(1)(A)and (B) shall not be extended. The variance period for reporting data elements under subdivision (a)(1)(C) may be extended for additional twelve month periods if the claims administrator resubmits a written request for a variance. A claims administrator granted a variance shall submit to the WCIS all data elements that were required to be submitted

under subdivision (e) during the variance period except for data elements that were not known to the claims administrator, the claims administrator's agents, or not captured on

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

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

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

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

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

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

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

Agency/Jurisdiction Claim Number (DN 5) is required when changing a Claim Administrator Claim Number (DN 15); it is optional for other transmissions under this subsection.

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

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

PAYMENT/ADJUSTMENT WEEKLY AMOUNT	87
PAYMENT/ADJUSTMENT WEEKS PAID	90
PERMANENT IMPAIRMENT BODY PART CODE (1) (2)	83
PERMANENT IMPAIRMENT PERCENTAGE (2)	84
RETURN TO WORK QUALIFIER	71
SALARY CONTINUED INDICATOR	67
WAGE	62
WAGE PERIOD	63
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⁽¹⁾ May use Code 90 (Multiple Body Parts) to reflect combined rating for any/all impairments.

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

DATA ELEMENT NAME	DN
ACKNOWLEDGMENT TRANSACTION SET ID	<u>0</u> 110
ADA PROCEDURE BILLED CODE	<u>0719</u>
ADA PROCEDURE PAID CODE	<u>0722</u>
ADMISSION DATE (17)	<u>0</u> 513
ADMISSION HOUR	<u>0622</u>
ADMITTING DIAGNOSIS CODE ADMISSION TYPE CODE	0535
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	<u>0535</u>
APPLICATION ACKNOWLEDGMENT CODE	<u>0</u> 111
BASIS OF COST DETERMINATION CODE	<u>0</u> 564
BATCH CONTROL NUMBER	<u>0532</u>
BILL ADJUSTMENT AMOUNT (17)	<u>0</u> 545
BILL ADJUSTMENT GROUP CODE (5)(17)	<u>0</u> 543
BILL ADJUSTMENT REASON CODE (17)	<u>0</u> 544
BILL ADJUSTMENT UNITS (17)	<u>0</u> 546
BILL FREQUENCY TYPE CODE	<u>0505</u>

⁽²⁾ Use actual permanent disability rating at the time of initial payment of permanent disability benefits. For compromise and release cases and stipulated settlements, use permanent disability estimate as reported to the appropriate rating organization established under Insurance Code § 11750, et seq.

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DISPENSE AS WRITTEN CODE 0562 DME BILLING FREQUENCY CODE 0567 DRG CODE 0518 DRUG NAME 0563 DRUGS/SUPPLIES BILLED AMOUNT 0572 DRUGS/SUPPLIES DISPENSING FEE 0579 DRUGS/SUPPLIES NUMBER OF DAYS 0571 DRUGS/SUPPLIES QUANTITY DISPENSED 0570 ELEMENT ERROR NUMBER 0116 ELEMENT NUMBER 0115 EMPLOYEE FIRST NAME 0044 EMPLOYEE MIDDLE NAME/INITIAL 0045	DISCHARGE DATE (17)	<u>0</u> 514
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DRUGS/SUPPLIES QUANTITY DISPENSED 0570 ELEMENT ERROR NUMBER 0116 ELEMENT NUMBER 0115 EMPLOYEE FIRST NAME 0044 EMPLOYEE LAST NAME 0043 EMPLOYEE MIDDLE NAME/INITIAL 0045	DRUGS/SUPPLIES DISPENSING FEE	<u>0</u> 579
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EMPLOYEE PASSPORT NUMBER 91-56 EMPLOYEE SOCIAL SECURITY NUMBER (+0) 0942 EMPLOYER FEIN 0016 EMPLOYER FEIN 0018 EMPLOYER NAME 0018 FACILITY CITY 0886 FACILITY CODE 0590 FACILITY COUNTRY CODE 0689 FACILITY WEDICARE NUMBER 9684 FACILITY WEDICARE NUMBER 9684 FACILITY NATIONAL PROVIDER ID (+7) 0682 FACILITY NOTIONAL PROVIDER ID (+7) 0688 FACILITY POSTAL CODE (+7) 0688 FACILITY POSTAL CODE (+7) 0688 FACILITY SECONDARY ADDRESS 0684 FACILITY SECONDARY ADDRESS 0685 FACILITY STATE LICENSE NUMBER 0680 HCPCS BILL PROCEDURE EODE 9734 HCPCS LINE PROCEDURE BILLED CODE 9714 HCPCS LINE PROCEDURE PAID CODE 9726 HCPCS MODIFIER BILLED CODE 9726 HCPCS MODIFIER PAID CODE 9726 HCPCS PRINCIPLE PROCEDURE BILLED CODE 9727 HCPCS SPRINCIPLE PROCEDURE BILLED CODE (**) 9721	EMPLOYEE GREEN CARD	00 13
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LUMP SUM PAYMENT SETTLEMENT CODE 0293 MANAGED CARE ORGANIZATION FEIN (1)(17) 0704 MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER 0208 MANAGED CARE ORGANIZATION NAME 0209 MANAGED CARE ORGANIZATION POSTAL CODE 0712 NDC BILLED CODE (17) 0721 NDC PAID CODE 0728 ORIGINATOR TRANSACTION IDENTIFICATION 0532 BATCH CONTROL NUMBER 0102 ORIGINAL TRANSMISSION DATE 0102 ORIGINAL TRANSMISSION TIME 0103 OTHER PROCEDURE CODE 0736 OUTPATIENT REASON FOR VISIT CODE 0520 PAID DRG CODE 0549 PLACE OF SERVICE BILL CODE (17) 0555	<u>LINE ITEM PRIOR ACTUAL AMOUNT PAID</u>	<u>0761</u>
MANAGED CARE ORGANIZATION FEIN (1)(17) 0704 MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER 0208 MANAGED CARE ORGANIZATION NAME 0209 MANAGED CARE ORGANIZATION POSTAL CODE 0712 NDC BILLED CODE (17) 0721 NDC PAID CODE 0728 ORIGINATOR TRANSACTION IDENTIFICATION 0532 BATCH CONTROL NUMBER 0102 ORIGINAL TRANSMISSION DATE 0102 ORIGINAL TRANSMISSION TIME 0103 OTHER PROCEDURE CODE 0736 OUTPATIENT REASON FOR VISIT CODE 0520 PAID DRG CODE 0549 PLACE OF SERVICE BILL CODE (17) 0555	LINE NUMBER (18)	<u>0</u> 547
MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER 0208 MANAGED CARE ORGANIZATION NAME 0209 MANAGED CARE ORGANIZATION POSTAL CODE 0712 NDC BILLED CODE (17) 0721 NDC PAID CODE 0728 ORIGINATOR TRANSACTION IDENTIFICATION 0532 BATCH CONTROL NUMBER 0102 ORIGINAL TRANSMISSION DATE 0102 ORIGINAL TRANSMISSION TIME 0103 OTHER PROCEDURE CODE 0736 OUTPATIENT REASON FOR VISIT CODE 0520 PAID DRG CODE 0549 PLACE OF SERVICE BILL CODE (17) 0555	<u>LUMP SUM PAYMENT SETTLEMENT CODE</u>	<u>0293</u>
MANAGED CARE ORGANIZATION NAME 0209 MANAGED CARE ORGANIZATION POSTAL CODE 0712 NDC BILLED CODE (17) 0721 NDC PAID CODE 0728 ORIGINATOR TRANSACTION IDENTIFICATION 0532 BATCH CONTROL NUMBER 0102 ORIGINAL TRANSMISSION DATE 0102 ORIGINAL TRANSMISSION TIME 0103 OTHER PROCEDURE CODE 0736 OUTPATIENT REASON FOR VISIT CODE 0520 PAID DRG CODE 0549 PLACE OF SERVICE BILL CODE (17) 0555		<u>0</u> 704
MANAGED CARE ORGANIZATION POSTAL CODE 9712 NDC BILLED CODE (17) 9721 NDC PAID CODE 9728 ORIGINATOR TRANSACTION IDENTIFICATION 0532 BATCH CONTROL NUMBER 9102 ORIGINAL TRANSMISSION DATE 9102 ORIGINAL TRANSMISSION TIME 9103 OTHER PROCEDURE CODE 9736 OUTPATIENT REASON FOR VISIT CODE 9520 PAID DRG CODE 9549 PLACE OF SERVICE BILL CODE (17) 9555	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	<u>0</u> 208
NDC BILLED CODE (17) 0721 NDC PAID CODE 0728 ORIGINATOR TRANSACTION IDENTIFICATION 0532 BATCH CONTROL NUMBER 0 ORIGINAL TRANSMISSION DATE 0102 ORIGINAL TRANSMISSION TIME 0103 OTHER PROCEDURE CODE 0736 OUTPATIENT REASON FOR VISIT CODE 0520 PAID DRG CODE 0549 PLACE OF SERVICE BILL CODE (17) 0555	MANAGED CARE ORGANIZATION NAME	<u>0</u> 209
NDC PAID CODE 0728 ORIGINATOR TRANSACTION IDENTIFICATION 0532 BATCH CONTROL NUMBER 0 ORIGINAL TRANSMISSION DATE 0102 ORIGINAL TRANSMISSION TIME 0103 OTHER PROCEDURE CODE 0736 OUTPATIENT REASON FOR VISIT CODE 0520 PAID DRG CODE 0549 PLACE OF SERVICE BILL CODE (17) 0555	MANAGED CARE ORGANIZATION POSTAL CODE	<u>0</u> 712
ORIGINATOR TRANSACTION IDENTIFICATION 0532 BATCH CONTROL NUMBER 0102 ORIGINAL TRANSMISSION DATE 0103 OTHER PROCEDURE CODE 0736 OUTPATIENT REASON FOR VISIT CODE 0520 PAID DRG CODE 0549 PLACE OF SERVICE BILL CODE (17) 0555	NDC BILLED CODE (17)	<u>0</u> 721
BATCH CONTROL NUMBER 0102 ORIGINAL TRANSMISSION DATE 0103 ORIGINAL TRANSMISSION TIME 0103 OTHER PROCEDURE CODE 0736 OUTPATIENT REASON FOR VISIT CODE 0520 PAID DRG CODE 0549 PLACE OF SERVICE BILL CODE (17) 0555	NDC PAID CODE	<u>0</u> 728
ORIGINAL TRANSMISSION DATE 0102 ORIGINAL TRANSMISSION TIME 0103 OTHER PROCEDURE CODE 0736 OUTPATIENT REASON FOR VISIT CODE 0520 PAID DRG CODE 0549 PLACE OF SERVICE BILL CODE (17) 0555	ORIGINATOR TRANSACTION IDENTIFICATION	0532
ORIGINAL TRANSMISSION TIME 0103 OTHER PROCEDURE CODE 0736 OUTPATIENT REASON FOR VISIT CODE 0520 PAID DRG CODE 0549 PLACE OF SERVICE BILL CODE (17) 0555	BATCH CONTROL NUMBER	
OTHER PROCEDURE CODE 0736 OUTPATIENT REASON FOR VISIT CODE 0520 PAID DRG CODE 0549 PLACE OF SERVICE BILL CODE (17) 0555	ORIGINAL TRANSMISSION DATE	<u>0</u> 102
OUTPATIENT REASON FOR VISIT CODE0520PAID DRG CODE0549PLACE OF SERVICE BILL CODE (17)0555	ORIGINAL TRANSMISSION TIME	<u>0</u> 103
PAID DRG CODE 0549 PLACE OF SERVICE BILL CODE (17) 0555	OTHER PROCEDURE CODE	<u>0</u> 736
PLACE OF SERVICE BILL CODE (17) 0555	OUTPATIENT REASON FOR VISIT CODE	0520
	PAID DRG CODE	0549
	PLACE OF SERVICE BILL CODE (17)	<u>0</u> 555
	PLACE OF SERVICE LINE CODE (17)	<u>0</u> 600

DDEGCDIDWION DILL DAWE(0) DANGE	0507
PRESCRIPTION BILL DATE(S) RANGE	<u>0</u> 527
PRESCRIPTION LINE DATE	<u>0</u> 604
PRESCRIPTION LINE NUMBER	<u>0</u> 561
PRESENT ON ADMISSION INDICATOR	0533
PRINCIPAL DIAGNOSIS CODE (17)	<u>0</u> 521
PRINCIPAL PROCEDURE CODE	<u>0</u> 525
PRINCIPAL PROCEDURE DATE	<u>0</u> 550
PRIOR ACTUAL AMOUNT PAID	<u>0760</u>
PROCEDURE DATE	<u>0</u> 524
PROCEDURE DESCRIPTION	<u>0551</u>
PROVIDER AGREEMENT CODE (3)	<u>0</u> 507
PROVIDER AGREEMENT LINE CODE	<u>0742</u>
RECEIVER ID	<u>00</u> 99
REFERRING PROVIDER FIRST NAME	<u>0691</u>
REFERRING PROVIDER LAST/GROUP NAME	<u>0690</u>
REFERRING PROVIDER NATIONAL PROVIDER ID (17)	<u>0</u> 699
RELEASE OF INFORMATION CODE	<u>526</u>
RENDERING BILL PROVIDER COUNTRY CODE (17)	<u>0657</u>
RENDERING BILL PROVIDER FEIN	0642
RENDERING BILL PROVIDER FIRST NAME	0639
RENDERING BILL PROVIDER LAST/GROUP NAME	<u>0</u> 638
RENDERING BILL PROVIDER NATIONAL PROVIDER ID (7)(17)	<u>0</u> 647
RENDERING BILL PROVIDER POSTAL CODE	<u>0656</u>
RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE (17)	<u>0</u> 651
RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER (7)	<u>0649</u>
RENDERING BILL PROVIDER STATE LICENSE NUMBER (7) (17)	0643
RENDERING LINE PROVIDER NATIONAL PROVIDER ID (7)(17)	<u>0</u> 592
RENDERING LINE PROVIDER NATIONAL PROVIDER ID (7)(17) RENDERING LINE PROVIDER FEIN	
	<u>0</u> 592
RENDERING LINE PROVIDER FEIN	0592 0586
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME	<u>0</u> 592 <u>0586</u> <u>0587</u>
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6)	0592 0586 0587 0589
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE	0592 0586 0587 0589 0593
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6)	0592 0586 0587 0589 0593 0595
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7)	0592 0586 0587 0589 0593 0595 0599
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD	0592 0586 0587 0589 0593 0595 0599 0615
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE	0592 0586 0587 0589 0593 0595 0599 0615 0559
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID	0592 0586 0587 0589 0595 0595 0615 0559 0576
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE	0592 0586 0587 0589 0593 0595 0599 0615 0559 0576 0098
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17)	0592 0586 0587 0589 0593 0595 0599 0615 0559 0576 0098 0733 0731
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17) SERVICE ADJUSTMENT REASON CODE (5) (17)	0592 0587 0587 0589 0593 0595 0599 0615 0559 0576 0098 0733 0731 0732
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17) SERVICE ADJUSTMENT REASON CODE (5) (17) SERVICE ADJUSTMENT UNITS (17)	0592 0586 0587 0589 0593 0595 0599 0615 0559 0576 0098 0733 0731
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17) SERVICE ADJUSTMENT REASON CODE (5) (17)	0592 0587 0587 0589 0593 0595 0599 0615 0559 0576 0098 0733 0731 0732 0734
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17) SERVICE ADJUSTMENT REASON CODE (5) (17) SERVICE ADJUSTMENT UNITS (17) SERVICE BILL DATE(S) RANGE (14)	0592 9586 0587 0589 0593 0595 0599 0615 0559 0576 0098 0733 0731 0732 0734 0509
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17) SERVICE ADJUSTMENT REASON CODE (5) (17) SERVICE ADJUSTMENT UNITS (17) SERVICE BILL DATE(S) RANGE (14) SERVICE LINE DATE(S) RANGE (9) (17)	0592 0586 0587 0589 0593 0595 0599 0615 0559 0576 0098 0733 0731 0732 0734 0509 0605
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17) SERVICE ADJUSTMENT REASON CODE (5) (17) SERVICE ADJUSTMENT UNITS (17) SERVICE BILL DATE(S) RANGE (14) SERVICE LINE DATE(S) RANGE (9) (17) SUPERVISING PROVIDER LAST/GROUP NAME	0592 0587 0587 0589 0593 0595 0599 0615 0559 0576 0098 0733 0731 0732 0734 0509 0605 0659 0658
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17) SERVICE ADJUSTMENT REASON CODE (5) (17) SERVICE ADJUSTMENT UNITS (17) SERVICE BILL DATE(S) RANGE (14) SERVICE LINE DATE(S) RANGE (9) (17) SUPERVISING PROVIDER LAST/GROUP NAME SUPERVISING PROVIDER NATIONAL PROVIDER ID (17)	0592 0587 0587 0589 0593 0595 0599 0615 0559 0576 0098 0731 0732 0734 0509 0605 0659 0667
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17) SERVICE ADJUSTMENT REASON CODE (5) (17) SERVICE ADJUSTMENT UNITS (17) SERVICE BILL DATE(S) RANGE (14) SERVICE LINE DATE(S) RANGE (9) (17) SUPERVISING PROVIDER LAST/GROUP NAME SUPERVISING PROVIDER NATIONAL PROVIDER ID (17) SUPERVISING PROVIDER PRIMARY SPECIALTY CODE	0592 0587 0587 0589 0593 0595 0599 0615 0559 0576 0098 0731 0732 0734 0509 0605 0659 0667 0671
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17) SERVICE ADJUSTMENT REASON CODE (5) (17) SERVICE ADJUSTMENT UNITS (17) SERVICE BILL DATE(S) RANGE (14) SERVICE LINE DATE(S) RANGE (9) (17) SUPERVISING PROVIDER FIRST NAME SUPERVISING PROVIDER NATIONAL PROVIDER ID (17) SUPERVISING PROVIDER PRIMARY SPECIALTY CODE TEST/PRODUCTION INDICATOR	0592 0587 0587 0589 0593 0595 0599 0615 0559 0576 0098 0733 0731 0732 0734 0509 0605 0659 0667 0671 0104
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17) SERVICE ADJUSTMENT REASON CODE (5) (17) SERVICE ADJUSTMENT UNITS (17) SERVICE BILL DATE(S) RANGE (14) SERVICE LINE DATE(S) RANGE (9) (17) SUPERVISING PROVIDER FIRST NAME SUPERVISING PROVIDER NATIONAL PROVIDER ID (17) SUPERVISING PROVIDER PRIMARY SPECIALTY CODE TEST/PRODUCTION INDICATOR	0592 0587 0589 0589 0599 0615 0599 0615 0559 0576 0098 0733 0731 0732 0734 0509 0605 0659 0658 0667 0104 0109
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17) SERVICE ADJUSTMENT REASON CODE (5) (17) SERVICE ADJUSTMENT UNITS (17) SERVICE BILL DATE(S) RANGE (14) SERVICE LINE DATE(S) RANGE (9) (17) SUPERVISING PROVIDER FIRST NAME SUPERVISING PROVIDER NATIONAL PROVIDER ID (17) SUPERVISING PROVIDER PRIMARY SPECIALTY CODE TEST/PRODUCTION INDICATOR TIME PROCESSED TIME TRANSMISSION SENT	0592 0587 0589 0589 0599 0615 0559 0576 0098 0733 0731 0732 0734 0509 0605 0659 0667 0671 0104 0109 0101
RENDERING LINE PROVIDER FEIN RENDERING LINE PROVIDER FIRST NAME RENDERING LINE PROVIDER LAST/GROUP NAME (6) RENDERING LINE PROVIDER POSTAL CODE RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6) RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7) REPORTING PERIOD REVENUE BILLED CODE REVENUE PAID CODE SENDER ID SERVICE ADJUSTMENT AMOUNT (17) SERVICE ADJUSTMENT GROUP CODE (5)(17) SERVICE ADJUSTMENT REASON CODE (5) (17) SERVICE ADJUSTMENT UNITS (17) SERVICE BILL DATE(S) RANGE (14) SERVICE LINE DATE(S) RANGE (9) (17) SUPERVISING PROVIDER FIRST NAME SUPERVISING PROVIDER NATIONAL PROVIDER ID (17) SUPERVISING PROVIDER PRIMARY SPECIALTY CODE TEST/PRODUCTION INDICATOR	0592 0587 0589 0589 0599 0615 0599 0615 0559 0576 0098 0733 0731 0732 0734 0509 0605 0659 0658 0667 0104 0109

TOTAL CHARGE PER BILL (16)	<u>0</u> 501
TOTAL CHARGE PER LINE – PURCHASE	<u>0566</u>
TOTAL CHARGE PER LINE RENTAL	<u>0565</u>
TOTAL CHARGE PER LINE (17)	<u>0</u> 552
TRANSACTION TRACKING NUMBER	<u>0</u> 266
UNIQUE BILL ID NUMBER	<u>0</u> 500

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

(14) For a medical lien lump sum payment or settlement use the date of lien filing.

(15) For a medical lien lump sum payment or settlement use the settled or ordered amount.

(16) For a medical lien lump sum payment or settlement use the amount in dispute.

(17) Not required for a mixed medical lien lump sum payment or settlement.

(18) For a mixed bill medical lien lump sum payment or settlement assign a value = 00.

- (1) Each claims administrator shall submit all medical bills data including interpreter bills within ninety (90) calendar days of the medical bill payment or the date of the final determination that payment for billed medical services will be denied.
- (2) Each claims administrator shall submit all medical lien lump sum payments or settlements following the filing of a lien claim for the payment of such medical services pursuant to Labor Code sections 4903 and 4903.1 within ninety (90) calendar days of the medical lien lump sum payment or settlement.
- (3) Data transmission shall follow the requirements set forth in IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2.0 dated February 1, 20134. California Specific requirements are included in the California EDI Implementation Guide for Medical Bill payment Records Version 2.0, dated the designated effective date (see Section 9701(c)(2)).
- (f) Notwithstanding the requirement in Subsection (b) to submit data elements omitted from the first report within 60 days from the date of transmission of the first report, when a claims administrator becomes aware of an error or need to update data elements previously transmitted, or learns of information that was previously omitted, the claims administrator shall transmit the corrected, updated or omitted data to WCIS no later than the next submission of data for the affected claim.
- (g) No later than January 31 of every year, claims administrators shall report for each claim the total paid in any payment category in the previous calendar year by submitting the following data elements:

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

- (h) Final reports (MTC = FN) are required only for claims where indemnity benefits are paid. For medical-only claims, the final report may be reported under this section or on the annual report (MTC = AN) with claim status = "closed."
- (i)(1) A claims administrator's obligation to submit copies of benefit notices to the Administrative Director pursuant to Labor Code section 138.4 is satisfied upon written determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under subdivision (d) and continued compliance with that subsection.
- (2) Reserved.
- (3) On and after September 22, 2006, a claims administrator's obligation to submit an Annual Report of Inventory pursuant to California Code of Regulations, title 8, section 10104 is satisfied upon determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under subdivisions (b), (d), (e), and (g), and continued compliance with those subsections.
- (j) The data submitted pursuant to this section shall not have any application to, nor be considered in, nor be admissible into, evidence in any personal injury or wrongful death action, except as between an employee and the employee's employer. Nothing in this subdivision shall be construed to expand access to information held in the WCIS beyond that authorized in California Code of Regulations, title 8, section 9703 and Labor Code section 138.7.
- (k) Each claims administrator required to submit data under this section shall submit to the Administrative Director an EDI Trading Partner Profile at least thirty days prior to its first transmission of EDI data. Each claims administrator shall advise the Administrative Director of any subsequent changes and/or corrections made to the information provided in the EDI Trading Partner Profile by filing a corrected copy of the EDI Trading Partner Profile with the Administrative Director.
- (*l*)(1) The Administrative Director may grant a claims administrator either a partial or total variance in reporting all or part of the data elements required under this section upon a documented showing that compliance with the reporting deadlines would cause undue hardship to the claims administrator.
- (2) "Undue hardship" shall be determined based upon a review of the documentation submitted by the claims administrator. The documentation shall include:
- (A) A statement explaining why the claims administrator is unable to transmit required data elements to the WCIS.
- (B) The claims administrator's estimated expenses necessary to meet the reporting requirements of this section.

- (C) The reporting cost per claim if transmitted directly by the claims administrator and the total cost per claim if reported by a vendor.
- (D) Submission of a plan documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the date of the request.
- (3) Any variance granted by the Administrative Director under this subdivision shall be set forth in writing and shall be for a period of six (6) months.
- (4) The variance period for reporting data elements under this subdivision may be extended for additional six (6) month period if the claims administrator resubmits a written request for an extension of the variance.
- (5) Upon expiration of the variance period, a claims administrator granted a variance shall submit to the WCIS all data elements that were required to be submitted under this section during the variance period except for data elements that were not known to the claims administrator, the claims administrator's agents, or not captured on the claims administrator's electronic data systems. The data shall be submitted in an electronic format acceptable to the Division.

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