§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.~~

(~~2~~1) 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.

(~~3~~2) 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, 201~~3~~4 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.
Reference: Sections 138.6 and 138.7, Labor Code.

§ 9702. Electronic Data Reporting

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

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

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

~~1. a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;~~

~~2. a documented showing that any medical data elements currently being transmitted by the claims administrator or the claims administrator's agent to public or private research or statistical entities shall be reported by the claims administrator to the WCIS ; and~~

~~3. submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the request.~~

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

1. a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;

2. a documented showing that any medical data elements currently being transmitted by the claims administrator or the claims administrator's agent to public or private research or statistical entities shall be reported by the claims administrator to the WCIS;

3. a documented showing that the claims administrator will submit to the WCIS the medical data elements available to the claims administrator or the claims administrator's agents; and

4. submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the request.

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

1. a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;

2. a documented showing that the claims administrator has not contracted with a bill review company to review medical bills submitted by providers in its workers' compensation claims;

3. a documented showing that the claims administrator is unable to transmit medical data to public or private research or statistical entities; and

4. submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within twelve months from the request.

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

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

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

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

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 (~~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:

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
(1) May use Code 90 (Multiple Body Parts) to reflect combined rating for any/all impairments. (2) Use actual permanent disability rating at the time of initial payment of permanent disability benefits. For compromise and release cases and stipulated settlements, use permanent disability estimate as reported to the appropriate rating organization established under Insurance Code § 11750, et seq.	

(e) ~~On and after September 22, 2006, c~~Claims 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	0110
ADA PROCEDURE BILLED CODE	0719
ADA PROCEDURE PAID CODE	0722
ADMISSION DATE ~~(17)~~	0513
ADMISSION HOUR	0622
~~ADMITTING DIAGNOSIS CODE~~ ADMISSION TYPE CODE	~~0535~~ 0577
~~ADMISSION TYPE CODE~~ ADMITTING DIAGNOSIS CODE	~~0577~~ 0535
APPLICATION ACKNOWLEDGMENT CODE	0111
~~BASIS OF COST DETERMINATION CODE~~	~~0564~~
~~BATCH CONTROL NUMBER~~	~~0532~~
BILL ADJUSTMENT AMOUNT~~(17)~~	0545
BILL ADJUSTMENT GROUP CODE ~~(5)(17)~~	0543
BILL ADJUSTMENT REASON CODE ~~(17)~~	0544
BILL ADJUSTMENT UNITS ~~(17)~~	0546
BILL FREQUENCY TYPE CODE	0505

BILL SUBMISSION REASON CODE	0508
BILLED DRG CODE	0548
BILLING FORMAT CODE	0503
BILLING PROVIDER CITY	0540
BILLING PROVIDER COUNTRY CODE	0569
BILLING PROVIDER FEIN	0629
BILLING PROVIDER FIRST NAME	0529
BILLING PROVIDER LAST/GROUP NAME	0528
BILLING PROVIDER NATIONAL PROVIDER ID ~~(17)~~	0634
BILLING PROVIDER POSTAL CODE	0542
BILLING PROVIDER PRIMARY ADDRESS	0538
BILLING PROVIDER PRIMARY SPECIALTY CODE ~~(4)~~	0537
BILLING PROVIDER SECONDARY ADDRESS	0539
BILLING PROVIDER STATE CODE	0541
BILLING PROVIDER STATE LICENSE NUMBER ~~(4)(7)~~	0630
BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	0523
BILLING TYPE CODE ~~(17)~~	0502
CLAIM ADMINISTRATOR CLAIM NUMBER	0015
CLAIM ADMINISTRATOR FEIN	0187
CLAIM ADMINISTRATOR MAILING POSTAL CODE	0014
CLAIM ADMINISTRATOR NAME	0188
COMPOUND DRUG INDICATOR	0762
CONDITION CODE	0556
CONTRACT LINE TYPE CODE	0741
CONTRACT TYPE CODE	0515
DATE INSURER PAID BILL ~~(9)(11)~~	0512
DATE INSURER RECEIVED BILL ~~(12~~)	0511
DATE OF BILL ~~(17)~~	0510
DATE OF INJURY	0031
DATE PROCESSED	0108
DATE TRANSMISSION SENT	0100
DAYS/UNITS BILLED~~(17)~~	0554
DAYS/UNITS CODE ~~(17)~~	0553
DAY(S)/UNIT(S) PAID	0580
DIAGNOSIS CODE	0522
DIAGNOSIS POINTER	0557
DISCHARGE DATE ~~(17)~~	0514
DISCHARGE HOUR	0623
DISPENSE AS WRITTEN CODE	0562
~~DME BILLING FREQUENCY CODE~~	~~0567~~
~~DRG CODE~~	~~0518~~
DRUG NAME	0563
DRUGS/SUPPLIES BILLED AMOUNT	0572
DRUGS/SUPPLIES DISPENSING FEE	0579
DRUGS/SUPPLIES NUMBER OF DAYS	0571
DRUGS/SUPPLIES QUANTITY DISPENSED	0570
ELEMENT ERROR NUMBER	0116
ELEMENT NUMBER	0115
EMPLOYEE FIRST NAME	0044
EMPLOYEE LAST NAME	0043
EMPLOYEE MIDDLE NAME/INITIAL	0045
~~EMPLOYEE EMPLOYMENT VISA~~	~~0152~~

~~EMPLOYEE GREEN CARD~~	~~0013~~
~~EMPLOYEE PASSPORT NUMBER~~	~~0156~~
EMPLOYEE SOCIAL SECURITY NUMBER ~~(10)~~	0042
EMPLOYER FEIN	0016
EMPLOYER NAME	0018
FACILITY CITY	0686
FACILITY CODE	0504
FACILITY COUNTRY CODE	0689
~~FACILITY FEIN~~	~~0679~~
~~FACILITY MEDICARE NUMBER~~	~~0681~~
FACILITY NAME ~~(17)~~	0678
FACILITY NATIONAL PROVIDER ID ~~(17)~~	0682
FACILITY POSTAL CODE ~~(17)~~	0688
FACILITY PRIMARY ADDRESS	0684
FACILITY SECONDARY ADDRESS	0685
FACILITY STATE CODE	0687
FACILITY STATE LICENSE NUMBER	0680
~~HCPCS BILL PROCEDURE CODE~~	~~0737~~
HCPCS LINE PROCEDURE BILLED CODE	0714
HCPCS LINE PROCEDURE PAID CODE	0726
HCPCS MODIFIER BILLED CODE	0717
HCPCS MODIFIER PAID CODE	0727
~~HCPCS PRINCIPLE PROCEDURE BILLED CODE~~	~~0626~~
HIPPS RATE CODE	0625
INSURER FEIN	0006
INSURER NAME	0007
INSURER POSTAL CODE	0616
~~INTERCHANGE VERSION ID~~	~~0105~~
JURISDICTION CLAIM NUMBER	0005
JURISDICTION MODIFIER BILLED CODE ~~(8)~~	0718
JURISDICTION MODIFIER PAID CODE ~~(8)~~	0730
JURISDICTION PROCEDURE BILLED CODE ~~(8)(13)(17)~~	0715
JURISDICTION PROCEDURE PAID CODE ~~(8)(9)(13)~~	0729
JURISDICTION TRACKING NUMBER	0743
LINE ITEM PRIOR ACTUAL AMOUNT PAID	0761
LINE NUMBER ~~(18)~~	0547
LUMP SUM PAYMENT SETTLEMENT CODE	0293
MANAGED CARE ORGANIZATION FEIN (1)(17)	0704
MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	0208
MANAGED CARE ORGANIZATION NAME	0209
~~MANAGED CARE ORGANIZATION POSTAL CODE~~	~~0712~~
NDC BILLED CODE ~~(17)~~	0721
NDC PAID CODE	0728
ORIGINATOR TRANSACTION IDENTIFICATION BATCH CONTROL NUMBER	0532
ORIGINAL TRANSMISSION DATE	0102
ORIGINAL TRANSMISSION TIME	0103
OTHER PROCEDURE CODE	0736
OUTPATIENT REASON FOR VISIT CODE	0520
PAID DRG CODE	0549
PLACE OF SERVICE BILL CODE ~~(17)~~	0555
PLACE OF SERVICE LINE CODE ~~(17)~~	0600

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

TOTAL CHARGE PER BILL ~~(16)~~	0501
~~TOTAL CHARGE PER LINE – PURCHASE~~	~~0566~~
~~TOTAL CHARGE PER LINE – RENTAL~~	~~0565~~
TOTAL CHARGE PER LINE ~~(17)~~	0552
TRANSACTION TRACKING NUMBER	0266
UNIQUE BILL ID NUMBER	0500
~~(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, 201~~3~~4. California Specific requirements are included in the California EDI Implementation Guide for Medical Bill payment Records Version 2.0, dated the designated effective date (see Section 9701(c)(2)).

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

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

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

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

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

(2) Reserved.

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

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

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

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

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

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

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

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

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

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

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

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

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