Workers' Compensation Information System (WCIS)

California EDI Implementation Guide for Medical Bill Payment Records

Version 1.~~0~~1

~~December 2005~~January 2010

(DATE TO BE INSERTED BY OAL – 12 MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE)

CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS
John ~~Rea~~Duncan, ~~acting~~Director

DIVISION OF WORKERS' COMPENSATION
Carrie Nevans, ~~Chief Deputy~~ Acting Administrative Director

~~September 1, 2005~~ January 1, 2010

Dear Claims Administrators:

Welcome to the California Division of Workers' Compensation electronic data interchange (EDI) for medical bill payment records. The California Division of Workers' Compensation (DWC) is pleased to introduce a newly developed system for receiving workers' compensation medical bill payment records data via EDI. The detailed medical data will be integrated with other data in the workers' compensation information system (WCIS) to provide a rich resource of information for analyzing the performance of California's workers' compensation system.

Th~~e~~is manual, *California EDI Implementation Guide for Medical Bill Payment Records*, is intended to be a primary resource for the DWC's "trading partners" – administrators of California workers' compensation medical bill payment records. Some organizations already have substantial experience transmitting EDI data to the DWC with first and subsequent reports of injury. For existing and new trading partners, the medical implementation guide can serve as a reference for California-specific medical record protocols. Although~~,~~ the California DWC adheres to national EDI standards, the California medical record implementation guide does have minor differences from other states.

The *California EDI Implementation Guide for Medical Bill Payment Records* will be posted on our Web site at www.dir.ca.gov/dwc. I hope the ~~start-up of~~ current revision of medical record EDI reporting in California is smooth and painless, both for the Division and its EDI trading partners.

The California DWC is dedicated to open communication as a cornerstone of a successful ~~start-up~~ medical EDI process, and this guide is a key element of that communication.

Sincerely,

Carrie Nevans
~~Acting DWC Chief Deputy~~ Acting ~~a~~Administrative ~~d~~Director

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Section A: Electronic data interfacechange in California – an overview

Electronic data interchange – EDI

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 ~~w~~Workers' ~~c~~Compensation ~~agency~~.

Medical billing d~~D~~data are transmitted in a format standardized by the ~~International Association of Industrial Accident Boards and Commissions (IAIABC)~~ American National Standards Institute (ANSI). The International Association of Industrial Accident Boards and Commissions (IAIABC) adapted the ANSI file standard to workers' compensation. The IAIABC is a professional association of workers' compensation specialists from the public and private sectors and has spearheaded the introduction of EDI in workers' compensation. ~~(For further details, See Section O – IAIABC Information.)~~ All data elements to be collected have been reviewed for a valid business need, and definitions and formats are standardized.

~~EDI Electronic data interchange is in use in workers' compensation nationwide. Currently, over twenty states and more than 200 insurance companies and claims administrators are routinely transmitting data by EDI. Several states have established legal mandates to report data by EDI, including Indiana, Iowa, Kentucky, Montana, Nebraska, New Mexico, Oregon, South Carolina, Texas, and California.~~

Benefits of EDI within workers' compensation

- **Allows state agencies to respond to policy makers' questions regarding their state programs**
  ~~EDI~~ Electronic data interchange allows states to evaluate the effectiveness and efficiency of the workers' compensation system by providing comprehensive and readily accessible information on all claims. The information can then be made available to state policy makers considering any changes to the system.
- **Avoids costs in paper handling**
  ~~EDI~~ Electronic data interchange reduces costs in the processing of paper documents for the claims administrator and the jurisdiction: mail processing costs, duplicated data entry costs, shipping costs, filing costs, and storage costs.
- **Increases data quality**
  ~~EDI~~ Electronic data interchange has built-in automated data quality checking procedures that are triggered when data are received by the state agency. Many claims administrators adopt the national standard data-checking procedures for in-house systems to reduce the costly data-correction efforts that result when erroneous data are passed among the parties to a claim.

- **Simplifies reporting requirements for multi-state insurers**
  ~~EDI~~ Electronic data interchange helps claims administrators cut costs by having a single system for internal data management and reporting across multiple state jurisdictions.

Workers' compensation information system history

The California legislature enacted sweeping reforms to California's workers' compensation system in 1993. The reform legislation was preceded by a vigorous debate among representatives of injured workers, their employers, insurance companies, and medical providers. All parties agreed that changes were due, but they could not reach agreement on the nature of the problems to be corrected nor on the likely impact of alternative reform proposals. One barrier to well-informed debate was the absence of comprehensive, impartial information about the performance of California's workers' compensation system.

Foreseeing that debate about the strengths and weaknesses of the system would continue, the legislature directed the Division of Workers' Compensation (DWC) to put together comprehensive information about workers' compensation in California (S~~s~~ee Section D). The result is the WCIS – the Workers' Compensation Information System. The WCIS has been in development since 1995, and its design has been shaped by a broad-based advisory committee.

The WCIS has four main objectives:
- help DWC manage the workers' compensation system efficiently and effectively,
- facilitate the evaluation of the benefit delivery system,
- assist in measuring benefit adequacy, and
- provide statistical data for further research.

~~Components of the WCIS~~
~~The WCIS encompasses three major components. The core of the system is standard data on every California workers' compensation claim. Historically the data was ere collected in paper form: employer and physician First Reports of Injury (FROI) benefit notices, and similar data. Beginning in 2000, the DWC began to collect standardized electronic data on the FROI via the WCIS EDI system. Beginning in 2006, the WCIS EDI system was expanded to include Medical EDI transmissions (see sSection E).~~

~~The WCIS will also use information from the DWC's existing case tracking system. The DWC has extensive computerized files on adjudicated cases and on claims that have been submitted for disability evaluation. The existing DWC information will be linked with EDI data to help examine and explain any differences between adjudicated and non-adjudicated casesutilizing EAMS (Electronic Adjudication Management System).~~

~~Finally, the WCIS will conduct periodic surveys of a sample of injured workers, employers, and medical providers. The surveys will supplement the standard data, and allow the WCIS to address a wide variety of policy questions.~~

California EDI requirements

California's WCIS regulations define EDI reporting requirements for claims administrators. A claims administrator is an insurer, a self-insured self-administered employer, or a third-party administrator. ~~In~~ A brief~~,~~ summary of what ~~C~~claims ~~A~~administrators are required to submit ~~the~~ follows~~ing~~:

- **First reports**: First Reports of Injury (FROI) have been transmitted by EDI to the DWC since March 1, 2000. FROIs must be submitted to WCIS no later than 10 business days after claim administrator knowledge of the claim.

- **Subsequent reports**: Subsequent Reports of Injury (SROI) have been transmitted by EDI to the DWC since July 1, 2000. Subsequent reports must be submitted within 1~~0~~5 business days of whenever benefit payments to an employee are started, changed, suspended, restarted, stopped, delayed, denied, closed, reopened, or upon notification of employee representation.

- **Medical bill/payment records ~~reports~~**: Medical bill payment reporting ~~reports began to be transmitted to the DWC six months from the effective date of the~~ regulations were adopted on March 22, 2006. The regulations ~~and~~ 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 within 90 calendar days of the medical bill payment or the date of the final determination that payment for billed medical services would be denied. The~~se~~ medical services are required ~~need~~ to be reported to the WCIS by all claims administrators handling 150 or more total claims per year. The required data elements are listed in Section K ~~L-Required data elements of this guide and in the California Medical Data Dictionary (http://www.dir.ca.gov/dwc)~~. See also Section E ~~– WCIS Regulations~~, which references the complete DWC/WCIS regulations.

- **Annual summary of benefits**: An annual summary of benefits must be submitted for every claim with any benefit activity (including medical) during the preceding year, beginning January 31, 2001.

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. ~~The electronic communications options are described more fully in Secion I-Transmission modes.~~

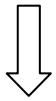
Following the IAIABC standards the WCIS supports the American National Standards Institute (ANSI) file format. The California-adopted ANSI file format is summarized in Section H ~~– Supported transactions and ANSI file structure~~ and completely specified in Section 5 of the *IAIABC EDI Implementation Guides for Medical Bill Payment Records, Release 1.1, Reporting July 1, 20049*. (www.iaiabc.org).

Claims administrators ~~that~~ who wish to avoid the technical details of IAIABC EDI guidelines can choose among several firms that sell EDI related software products, consulting, and related services. ~~See Section J – EDI Service Providers.~~

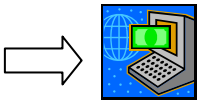
Currently, after a worker is injured, medical bill payment records are either mailed or electronically transmitted from medical providers to the insurers or their representatives and then via the medical EDI transmissions to the California Workers' Compensation Information System (WCIS).

Flow of Medical Data in the California Workers Compensation System

Injured Worker

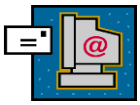


Medical Providers



Industry Billing Standards

Insurers



Electronic Data Interface

DWC/ WCIS

~~Four stages of EDI - from testing to production~~

~~Attaining full production EDI reporting with the DWC is a four stage process. Each stage of the process is described in more detail in Section G – Testing and production phases of medical EDI.~~
~~Stage one: EDI trading partner profile~~

~~The trading partner first provides an EDI trading partner profile to the DWC at least 30 (thirty) days before the first submission of electronic data. The trading partner profile form is in Section F. The trading partner profile is used to establish communications protocols between the WCIS and each trading partner with respect to: what file format to expect, where to send an acknowledgement, when to transmit reports, and similar information.~~
~~Stage two: structural testing~~

~~The trading partner next runs a preliminary test by transmitting an ANSI 837 test file to ensure the WCIS system can read and interpret the data. The trading partner passes the structural test when the minimum technical requirements are met: WCIS recognizes the sender, the ANSI 837 file format is correct, and the trading partner can receive electronic 997 functional acknowledgements from the WCIS.~~
~~Stage three: detailed testing~~

~~After a structural test file is successfully transmitted, the trading partner transmits real detailed medical bill payment data, in test status. During the detailed test phase, the trading partner's submissions are analyzed for data completeness, validity, and accuracy. The trading partner can submit detailed medical bill payment records both by EDI and in hard copy during the pilot. If paper bills are submitted, the DWC uses the parallel reports to conduct a comparison study. The trading partner must meet minimum data quality requirements in order to complete the detailed testing stage.~~
~~Stage four: production~~

~~During production, data transmissions will be monitored for completeness, validity, and accuracy. Each trading partner will be routinely sent reports describing their data quality. The data edits are more fully described in Section M – Data edits and in the IAIABC *EDI Implementation Guides for Medical Bill Payment Records, Reporting July 2004*. (www.iaiabc.org).~~

Five steps of EDI - from testing to production

Attaining full production medical EDI reporting with the DWC is a ~~four stage~~ five step process. Each ~~stage~~ step of the process is described in more detail in Section G – ~~Testing and production phases of medical EDI.~~

Step one: Sender submits Trading Partner Profile

The trading partner first provides a completed EDI trading partner profile form to the DWC at least 30 (thirty) days before the first submission of electronic data. The form is

contained in Section F. The trading partner profile is used to establish communications protocols between the WCIS and each trading partner with respect to: what file format to expect, where to send an acknowledgment, when to transmit medical bills and similar information. Send the completed trading partner profile by email to WCIS@dir.ca.gov or fax to 510-286-6862.

Step two: Sender tests FTP connectivity

Within 5 days of receiving the completed profile, WCIS will email or fax a FTP information form with an IP Address to the technical contact named in trading partner profile form, Part B, Trading Partner Contact Information (See Section F). Within 7 days of receiving completed FTP Information form, WCIS will open a port and ask the trading partner to send a sample test file to ensure the WCIS system can accept and return an electronic file to the trading partner.

Step three: Sender transmits numerous ANSI 837 bill types

The trading partner compiles small ANSI 837 files with the required loops, segments, and data elements which represent different types of medical bills (See Section H). The trading partner passes the structural test when the minimum technical requirements of the ANSI 837 file format are correct.

Step four: Structural Testing - Sender receives and processes a 997 from DWC

The trading partner can receive and process electronic 997 functional acknowledgments from the WCIS. The trading partner tests the internal capability to process the 997 from the DWC and correct any structural errors detected by the WCIS.

Step five: Detailed Testing - Sender receives and processes an 824 from DWC

After an 837 structural test file is successfully transmitted, the trading partner transmits real detailed medical bill payment data, in test status. During detailed testing, the trading partner's submissions are analyzed for data completeness, validity, and accuracy. The trading partner must meet minimum data quality requirements in order to complete detailed testing.

After the structural and detailed testing is successfully completed, the trading partner transmits a cancellation of at least one of the medical bills sent in step three ~~but not all~~. The cancelled bills are matched to the original bills sent in step three and deleted from the WCIS database. The trading partner receives a 997 and 824 ANSI file from the WCIS.

Once the structural and detailed testing is successfully completed, the trading partner transmits a replacement of a claim number sent in step three. The original claim number is matched to the original claim number sent in step three in the WCIS database. The trading partner receives a 997 and 824 ANSI file from the WCIS.

Upon successful completion of the five testing steps, the trading partner may begin to send production data.

During production, data transmissions will be monitored for completeness, validity, and accuracy. The data edits are more fully described in Section L and in the *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009* (www.iaiabc.org).

Section B: Where to get help – contacting WCIS and other information resources

California Division of Workers' Compensation

Starting up a new medical EDI system is not simple. It requires detailed technical information as well as close cooperation between the organizations that send and receive data, the trading partner~~,~~ and ~~the organization that receives data,~~ the California Division of Workers' Compensation (DWC). The following is a list of resources available to trading partners for information and assistance.

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, ~~and~~
- review archived WCIS e-news letters, and
- download power point training materials.

WCIS 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: ~~(415) 703-5911~~ (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
~~IS Department~~
1515 Clay Street, 1~~9~~8th 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.

EDI service providers

Several companies can assist in reporting medical data via EDI. A wide range of products and services are available, including:

- software that works with existing computer systems to transmit medical data automatically,
- systems consulting, to help get your computer systems EDI-ready, and
- data transcription services, which accept paper forms, create electronic files, ~~keypunch the data,~~ and transmit the medical data via EDI.

~~See Section J – EDI service providers for a list of companies known to the DWC to provide EDI services.~~

~~A list of companies known to DWC that provide these services can be found at http://www.dir.ca.gov/DWC/EDIvend.HTM.~~

Claims administrators seeking assistance in implementing EDI may wish to consult one or more of the EDI service providers listed on the DWC website. A list of companies known to DWC that provide these services can be found at http://www.dir.ca.gov/DWC/EDIvend.HTM. Many of these~~se~~ firms offer a full range of EDI-related services: consultation, technical support, value added network (VAN) services, and/or software products. These~~se~~ products and services can make it possible for claims administrators to successfully transmit claims data via EDI and avoid the technical details of EDI.

Another alternative to developing a complete EDI system is to contract for the services of a data collection agent. For a fee, a data collection agent will receive paper forms by fax or mail, enter the data, and transmit it by EDI to state agencies or other electronic commerce trading partners.

The California Division of Workers' Compensation does not have a process for granting "approvals" to any EDI service providers. Listings of providers, which are found on the Division's website, are simply of providers known to the Division. The lists will be updated as additional resources become known.

Appearance on the EDI service provider lists does not in any way constitute an endorsement of the companies listed or a guarantee of the services they provide. Other companies not listed may be equally capable of providing EDI-related services.

Note to suppliers of EDI-related services: Please contact wcis@dir.ca.gov if you wish to have your organization added or removed from DWC's list, or to update your contact information.

~~User groups~~

~~Some organizations may find it useful to communicate with others who are transmitting medical data via EDI to the California Workers' Compensation Information System. Information about users' groups will be posted to the WCIS web site.~~

IAIABC

The International Association of Industrial Accident Boards and Commissions (IAIABC) is the organization that sets the national standards for the transmission of workers' compensation medical data via EDI. The IAIABC published the standards in the *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, ~~Reporting~~ July 20049.*

For more information about the IAIABC and how to access the IAIABC EDI Implementation Guides, ~~See Section O – IAIABC Information, and/or~~ visit the IAIABC web site at: www.iaiabc.org.

Section C: Implementing medical EDI – a managers' guide

Get to know the basic requirements

Starting up a new EDI system can be a complex endeavor. Make sure you understand all that is required *before* investing resources. Otherwise you may end up with a partial rather than a comprehensive solution.

The *California EDI Implementation Guide for Medical Bill Payment Records* has much of the information needed to implement medical EDI in California. As more information becomes available it will be posted ~~on our~~ to the WCIS ~~W~~web site:

www.dir.ca.gov/dwc/wcis.htm

Assign responsibilities for implementing medical EDI

Implementing medical EDI will affect your information systems, claims processing practices and other business procedures. Some organizations appoint the information systems manager, while others designate the claims manager as medical EDI implementation team leader. Regardless of who is assigned primary responsibility, make sure that all ~~e~~affected systems, procedures, and maintenance activities are included as you design~~ed~~ and implement~~ed~~ your EDI procedures.

Many organizations find that implementing EDI highlights the importance of data quality. Addressing data quality problems may require adjustments in your overall business procedures. Your medical EDI implementation team will probably need access to someone with authority to make the adjustments if needed.

Decide whether to~~, or not to,~~ contract with an EDI service provider

Formatting and transmitting electronic medical records by EDI generally requires some specialized automated routines. Programming a complete EDI system also requires in-depth knowledge of EDI standards and protocols.

Some organizations may choose to develop the routines internally, especially if they are familiar with EDI or are efficient in bringing new technology on-line. Make a realistic assessment of your organization's capabilities when deciding whether or not to internally develop the needed EDI capacity.

Other organizations may choose to out source with vendors for dedicated EDI software or services. Typically, EDI vendor products interface with your organization's data to produce medical EDI transactions in the required ANSI format. The benefit is that no one in your organization has to learn all the intricacies of EDI – the service provider takes care of file formats and many other details that may seem foreign to your organization. Some EDI vendors can also provide full-service consulting – helping you update your entire data management process to prepare it for electronic commerce. ~~Some EDI vendors are listed in Section J – EDI service providers.~~

Contracting with an EDI service provider would relieve your organization of the detailed mechanics of EDI – such as file formats and transmission modes – but if you decide to develop your own system you will have some important decisions to make. The decisions will determine the scope and difficulty of the programming work.

~~Choose a~~ The FTP transmission mode for medical data

~~Choose a transmission mode from~~ The ~~two that~~ WCIS supports~~: Value Added Networks (VAN) and or~~ File Transfer Protocol (FTP) ~~files~~ transmissions using Secure Sockets Layer (SSL) and Pretty Good Privacy (PGP) encryption (See Section I).~~ – Transmission modes- for further information.~~

Summary information about the required ANSI format ~~can~~ is contained in Section H~~ – Supported transactions and ANSI file structure~~ and detailed information about ANSI formats is included in Section 5 of the *IAIABC EDI Implementation Guide for Medical Billing Payment ~~Reports~~ Records, Release 1.1, July 1, 200~~2~~9,* published by the IAIABC at:

http://www.iaiabc.org ~~The~~ This *IAIABC ~~EDI Implementation~~ Guide ~~for Medical Billing Payment Reports~~* is essential if you are programming your own EDI system.

Make sure your computer system contains all the required data

Submitting medical data by EDI requires the data to be readily accessible on your electronic systems. Review Section ~~L~~K ~~– Required medical data elements~~ and determine which data elements are readily accessible, which are available but accessible with difficulty, and which are not captured at this time. An example of a required data element not internally captured ~~required date element~~ may be ~~medical provider state~~ facility license numbers, which are issued, maintained, and distributed by the California Department of ~~Consumer Affairs~~ Public Health ~~(see Section P)~~.

If all the medical data are electronically available and readily accessible, then you are in great shape. If not, you will need to develop and implement a plan for capturing, storing, and accessing the necessary medical data electronically**.**

Developing a comprehensive EDI system

The California DWC EDI requirements have gone into effect in multiple phases. The first phase consisted of EDI transmissions of FROI~~'s~~ information beginning in March, 2000. The second phase added the SROI~~'s~~ information in July, 2000. A third requirement, an annual summary of payments on each active claim, went into effect January, 2001. The ~~latest~~ initial requirement ~~e~~for reporting all medical payments ~~goes into effect six months from effective date of the WCIS regulations~~ became effective March 22, 2006 for medical services provided on or after September 22, 2006, to employees injured on or after March 1, 2000. ~~As of February, 2005 the DWC was receiving FROI data from 205 trading partners and SROI dara from 80 trading partners.~~ Implementing the requirements of the EDI transmission of the FROI~~'s~~ and SROI~~'s~~ information may have provided your organization a basic framework in which to implement the requirements of the medical bill payment ~~reports~~ records.

Handling error messages sent by WCIS

The DWC will transmit "error messages" from the WCIS back to you if the medical data transmitted to the DWC does not meet the regulatory requirements to provide complete, valid, and accurate data.

You will need a system for responding to error messages received from the WCIS. Establish a procedure for responding to error messages before you begin transmitting medical data by EDI. Typically errors related to technical problems are common when a system is new, but quickly become rare. Error messages related to data quality and completeness are harder to correct (See Section G ~~- Testing and production phases of medical EDI~~).

Benefits of adding "data edits"

Medical bill payment record data transmitted to the WCIS will be subjected to "edit rules" to assure that the medical data are valid. The edit rules are detailed in Section ~~M~~L – Data edits. Data that violate the edit rules will cause medical data transmissions to be rejected with error messages.

Correcting erroneous data may require going to the original source. In some organizations the data passes through many hands before being ~~it~~ is transmitted to WCIS. For example, the medical data may first be processed in a claim reporting center, then ~~to~~ by a data entry clerk, ~~to~~ followed by a claims adjuster, before finally being transmitted to the WCIS ~~and then through an information systems department~~. Any error messages would typically be passed through the same channel in the opposite direction.

An alternative is to install in your system, as close as possible to the original source of data (medical provider, claims department), data edits that match the WCIS edit rules. As an example, consider a claims reporting center in which claims data are entered directly into a computer system with data edits in place. Most data errors could be caught and corrected between the medical provider and the claims reporting center. Clearly, early detection eliminates the expense of passing bad data through the system and back again.

Updating software and communications services

After the EDI system is designed, begin to purchase or develop system software and/or contract for services as needed.

Most systems will need at least the following:

- software/services to identify events that trigger required medical reports,
- software/services to gather required medical data elements from your databases,
- software/services to format the data into an approved medical EDI file format,
- an electronic platform to transmit the medical data to the DWC and receive acknowledgements, with possible error messages, back from WCIS.

Test your system internally

Most new systems do not work perfectly the first time. Make sure the "data edit" and "error response" parts of the system are thoroughly tested before beginning the testing and production stages of EDI with the WCIS. Internally debugging the "data edit" and "error response" systems in advance will decrease the number of error messages associated with transmitting invalid or inaccurate data to the WCIS. More detail is included in Section G - Testing and production phases of medical EDI.

Include in the internal tests some complex test cases as well as simple ones. For example, test the system with medical bill payment records containing multiple components, like medical treatments, durable medical equipment, and pharmaceuticals. Fix any identified problems before entering into the testing and production phases of medical EDI with the WCIS. The WCIS has procedures in place to help detect errors in your systems so that you can transmit complete, valid, and accurate medical data by the time you achieve production status.

Testing and production stages of medical EDI transmission

The first step is to complete a trading partner profile (See Section F). The profile is used to establish an electronic link between the WCIS and each trading partner: it identifies who the trading partner is; where to send the WCIS acknowledgements, when the trading partner plans to transmit medical bills, and other pertinent information necessary for EDI.

~~Step two of the process is to test a structural file. A s~~Successful testing includes ~~the~~ tests for basic EDI connectivity between the trading partners system and the WCIS system, the WCIS verifying the medical transmissions match the WCIS technical specifications, and that the trading partner has the capability to ~~you can~~ receive and process ~~a 997~~ acknowledgments ~~in return~~ from the WCIS. (See Section G ~~for more detail~~).

~~During the third step of the process real data is transmitted and validated. Testing may include optional, matching medical data on paper reports (CMS 1500, UB92, ADA, Pharmaceutical UCF) to the electronic reports transmitted to the DWC. The DWC will send an 824 acknowledgment containing "error codes" which are generated by the "data edits". To successfully complete stage three the trading partner will need to be able to process the ANSI 824 detailed acknowledgment and respond to any "error messages" it contains (See Section G for more detail).~~

Upon the successful completion of ~~step three,~~ the five-step testing process and after a period of routinely transmitting your medical data via EDI to the WCIS for at least 30 days, the DWC will ~~issue~~ confirm by e-mail that each trading partner ~~you a written determination that you have~~ demonstrated the capability to transmit complete, valid, and accurate medical data in production status. ~~You will then be authorized to move into the production stage - routinely transmitting your medical data via EDI to the WCIS.~~

The IAIABC maintains the EDI standards ~~for~~ adopted by the California Division of Workers' Compensation. For further information, contact the IAIABC ~~(see contact information in Section O).~~

Evaluate your EDI system, and consider future refinements

Many organizations find that implementing EDI brings unexpected benefits. For example, EDI may provide an opportunity to address long-standing data quality, processing, and storage problems.

Arrange a review session after your system has been running for a few months. Users will be able to suggest opportunities for future refinements. Managers from departments not directly affected may also be interested in participating, because EDI will eventually affect many business procedures in the workers' compensation industry.

Please let us know if you have any comments on this manager's guide.

Send us an e-mail, addressed to:

wcis@dir.ca.gov.

Section D: Authorizing statutes – ~~Labor Code §138.6, 138.7~~

~~L.C. §~~Labor Code section 138.6. Development of workers' compensation information system

(a) The administrative director, in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, shall develop a cost-efficient workers' compensation information system, which shall be administered by the division. The administrative director shall adopt regulations specifying the data elements to be collected by electronic data interchange.

(b) The information system shall do the following:

(1) Assist the department to manage the workers' compensation system in an effective and efficient manner.

(2) Facilitate the evaluation of the efficiency and effectiveness of the benefit delivery system.

(3) Assist in measuring how adequately the system indemnifies injured workers and their dependents.

(4) Provide statistical data for research into specific aspects of the workers' compensation program.

(c) The data collected electronically shall be compatible with the Electronic Data Interchange System of the International Association of Industrial Accident Boards and Commissions. The administrative director may adopt regulations authorizing the use of other nationally recognized data transmission formats in addition to those set forth in the Electronic Data Interchange System for the transmission of data required pursuant to this section. The administrative director shall accept data transmissions in any authorized format. If the administrative director determines that any authorized data transmission format is not in general use by claims administrators, conflicts with the requirements of state or federal law, or is obsolete, the administrative director may adopt regulations eliminating that data transmission format from those authorized pursuant to this subdivision

~~L.C. §~~Labor Code section 138.7. "Individually identifiable information"; restricted access

(a) Except as expressly permitted in subdivision (b), a person or public or private entity not a party to a claim for workers' compensation benefits may not obtain individually identifiable information obtained or maintained by the division on that claim. For purposes of this section, "individually identifiable information" means any data

concerning an injury or claim that is linked to a uniquely identifiable employee, employer, claims administrator, or any other person or entity.

(b)(1) The administrative director, or a statistical agent designated by the administrative director, may use individually identifiable information for purposes of creating and maintaining the workers' compensation information system as specified in Section 138.6.

(2) The State Department of Health Services may use individually identifiable information for purposes of establishing and maintaining a program on occupational health and occupational disease prevention as specified in Section 105175 of the Health and Safety Code.

(3)(A) Individually identifiable information may be used by the Division of Workers' Compensation, the Division of Occupational Safety and Health, and the Division of Labor Statistics and Research as necessary to carry out their duties. The administrative director shall adopt regulations governing the access to the information described in this subdivision by these divisions. Any regulations adopted pursuant to this subdivision shall set forth the specific uses for which this information may be obtained.

(B) Individually identifiable information maintained in the workers' compensation information system and the Division of Workers' Compensation may be used by researchers employed by or under contract to the Commission on Health and Safety and Workers' Compensation as necessary to carry out the commission's research. The administrative director shall adopt regulations governing the access to the information described in this subdivision by commission researchers. These regulations shall set forth the specific uses for which this information may be obtained and include provisions guaranteeing the confidentiality of individually identifiable information. Individually identifiable information obtained under this subdivision shall not be disclosed to commission members. No individually identifiable information obtained by researchers under contract to the commission pursuant to this subparagraph may be disclosed to any other person or entity, public or private, for a use other than that research project for which the information was obtained. Within a reasonable period of time after the research for which the information was obtained has been completed, the data collected shall be modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.

(4) The administrative director shall adopt regulations allowing reasonable access to individually identifiable information by other persons or public or private entities for the purpose of bona fide statistical research. This research shall not divulge individually identifiable information concerning a particular employee, employer, claims administrator, or any other person or entity. The regulations adopted pursuant to this paragraph shall include provisions guaranteeing the confidentiality of individually identifiable information. Within a reasonable period of time after the research for which

the information was obtained has been completed, the data collected shall be modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.

(5) This section shall not operate to exempt from disclosure any information that is considered to be a public record pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) contained in an individual's file once an application for adjudication has been filed pursuant to Section 5501.5.

However, individually identifiable information shall not be provided to any person or public or private entity who is not a party to the claim unless that person identifies himself or herself or that public or private entity identifies itself and states the reason for making the request. The administrative director may require the person or public or private entity making the request to produce information to verify that the name and address of the requester is valid and correct. If the purpose of the request is related to preemployment screening, the administrative director shall notify the person about whom the information is requested that the information was provided and shall include the following in 12-point type:

"IT MAY BE A VIOLATION OF FEDERAL AND STATE LAW TO DISCRIMINATE AGAINST A JOB APPLICANT BECAUSE THE APPLICANT HAS FILED A CLAIM FOR WORKERS' COMPENSATION BENEFITS."

Any residence address is confidential and shall not be disclosed to any person or public or private entity except to a party to the claim, a law enforcement agency, an office of a district attorney, any person for a journalistic purpose, or other governmental agency.

Nothing in this paragraph shall be construed to prohibit the use of individually identifiable information for purposes of identifying bona fide lien claimants.

(c) Except as provided in subdivision (b), individually identifiable information obtained by the division is privileged and is not subject to subpoena in a civil proceeding unless, after reasonable notice to the division and a hearing, a court determines that the public interest and the intent of this section will not be jeopardized by disclosure of the information. This section shall not operate to restrict access to information by any law enforcement agency or district attorney's office or to limit admissibility of that information in a criminal proceeding.

(d) It shall be unlawful for any person who has received individually identifiable information from the division pursuant to this section to provide that information to any person who is not entitled to it under this section.

Section E: WCIS regulations – Title 8 CCR § sections 9701~~0~~-9703~~4~~

~~Pertinent WCIS Regulations~~
The regulations pertinent to WCIS are stated in Title 8, California Code of Regulations, ~~S~~sections 9700-9704. They are available at www.dir.ca.gov/t8/ch4_5sb1a1_1.html

Section F: 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 ~~(see page 9, 11, and 35)~~. Each trading partner has a unique identification composed of the trading partner's federal tax identification number ("Master FEIN") and postal code. The identification information must be reported in the ISA header record of every transmission. The trading partner identification, in conjunction with the sender information, transmission date, ~~time of~~ transmission time, batch control number, and reporting period are used to identify communication parameters for the return of 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 FEIN~~'~~s for insurers or claims administrators. ~~If~~ The transactions for a sender with multiple insurer FEIN~~'~~s or claims administrator FEIN~~'~~s ~~share the same transmission specifications, the data~~ 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.

~~The WCIS uses either an insurer FEIN, a claims administrator FEIN, or a bill review company FEIN to process individual 837 transmissions. Transmissions for unknown senders will be rejected by WCIS. For this reason, it is vital for each WCIS trading partner profile to be accompanied by a list of all sender FEIN's who will be sending 837 transmissions under a given Trading Partners Master FEIN. The trading partner profile form contains only one FEIN: multiple FEIN's for all other senders must be submitted on a separate sheet of paper with the trading partner profile. If the list of multiple FEIN's is not provided, WCIS will assume the sender FEIN reported by that trading partner will be the master FEIN and the only trading partner sender identification~~

State of California
Department of Industrial Relations

DIVISION OF WORKERS' COMPENSATION

MEDICAL
ELECTRONIC DATA INTERCHANGE TRADING PARTNER PROFILE

PART A. Trading Partner Background Information:

Date: _____

Sender Name: _____

Sender Master FEIN: _____

Physical Address: _____

City: _____ State: _____

Postal ~~Zip~~Code: _____

Mailing Address: _____

City: _____ State: _____

Postal ~~Zip~~Code: _____

Trading partner type (check all that apply):
__ Self Administered Insurer
~~__ Service Bureau~~
__ Self Administered, Self-Insure~~r~~d (employer) __ Other (Please specify):____
__ Third Party Administrator of ~~I~~insurer
__ Third Party Administrator of S~~s~~elf-~~I~~insure~~r~~d (employer)

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:

Part C1 - Please complete the following:
If submitting more than one profile, please specify:

PROFILE NUMBER (1, 2, etc.): _____
DESCRIPTION: _____

~~Select Transmission Mode to be used for sending data to DWC (check one):~~

~~___ Value Added Network (VAN) -- Complete sections C1 and C2 below.~~
~~___ File Transfer Protocol (FTP) -- Complete sections C1 and C3 below.~~

~~C1 Van and FTP users, please complete the following:~~

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

~~C2 Van users, please complete the following:~~

~~Network: _____~~

	~~Test~~	~~Production~~
~~Mail Box Account Identification~~		
~~User Identification~~		

~~C3 FTP users, please complete the following:~~

~~User Name~~	
~~Password~~	
~~Network IP Address (optional)~~	
~~E-mail Address~~	

Part C2 - FTP ACCOUNT INFORMATION FOR MEDICAL BILL

Sender/Trading Partner Name: _____

Sender/Trading Partner E-mail: _____

	DWC Use Only
User Name: (A-Z, a-z, 0-9) **_____** **For PGP user only:** suffix of ***@wcismed_pgp*** will be required after your user name.	
Password: (8 characters min.) **_____**	
Transmission Modes: (choose one) **_____ PGP+SSL** **_____ SSL**	
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 _____**	

~~DWC Use Only – Special Transmission Specifications For This Profile~~:

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

Name: *California Division of Workers' Compensation*

FEIN: *943160882*

Physical Address: *1515 Clay Street, ~~19~~19th ~~Floor~~ Suite 1800*

City: *Oakland* State: CA PostalZip Code: *94612-1491*89

Mailing Address: ~~1515 Clay Street, 19th Floor~~ *P.O. Box 420603*

City: *~~Oakland~~ San Francisco* State: *CA* ~~Zip~~ PostalCode: *~~9461~~2142-0603*

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 FTP ELECTRONIC MAILBOX(s):~~

~~Network: A.T. & T~~ ~~Network: IBM Global (Advantis)~~

	~~TEST~~	~~PROD~~
~~Mailbox Acct ID~~	~~*(N/A)*~~	~~*(N/A)*~~
~~User ID~~	~~*(N/A)*~~	~~*(N/A)*~~

	~~TEST~~	~~PROD~~
~~Mailbox Acct ID~~	~~*DIRW*~~	~~*DIRW*~~
~~User ID~~	~~*DIRWCIS*~~	~~*DIRWCIS*~~

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

INSTRUCTIONS 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-position ~~zip~~ postal code (~~Zip~~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~~Zip~~ Code: The 9-position ~~zip~~ 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 ~~T~~ 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. He/she may be the project manager, business systems analyst, etc. This individual should be able to track down the answers to any issues that may arise from your trading partner that the technical contact cannot address.

TECHNICAL CONTACT: The individual that should be contacted if issues regarding the actual transmission process arise. This individual may be a telecommunications specialist, computer operator, etc.

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 The e-mail address of the contact.

PART C. TRANSMISSION SPECIFICATIONS:

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

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 ID: A number assigned to uniquely identify a given profile.

PROFILE ID
DESCRIPTION: A free-form field used to uniquely identify a given profile between trading partners. This field becomes critical when more than one profile exists between a given pair of trading partners. It is used for reference purposes.

TRANSMISSION
MODE: ~~The trading partner must select one of the following two transmission modes through which the WCIS can accept transactions:~~ EDI transactions are sent through ~~a~~ a File Transfer Protocol (FTP). ~~When selecting complete section C1 and either C2 or C3.~~

~~Van and~~ FTP TRANSFERS:

~~Section~~ Part C1:
TRANSACTION SETS FOR THIS PROFILE:

This section identifies all the transaction sets described within the profile along with any options the DWC provides to the trading partner for each transaction set.

TRANSACTION
TYPE: Indicates the type~~s~~ of EDI transmissions accepted by Division of Workers' Compensation.

MODE OF
TRANSMISSION: DWC will accept the ANSI X12 VERSION 4010 contained in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July ~~4~~1, 200~~2~~9. The WCIS will transmit detailed 824 acknowledg~~e~~ements, matching ~~utilizing the acknowledgement format that corresponds to the format of the original transaction.~~ 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. Transmission days of week information will help DWC to forecast WCIS usage during the week. 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: DWC will indicate here the maximum period of elapsed time within which a sending trading partner may expect to receive an acknowledgment for a given transaction type.

SECTION C2: VAN users:

ELECTRONIC MAILBOX FOR THIS PROFILE: The trading partner will specify the electronic mailbox to which data can be transmitted. Separate mailbox information may be provided for transmitting production versus test data.

NETWORK: The name of the value added on which the mailbox can be accessed.

NETWORK MAILBOX ACCOUNT ID: The name of the trading partner's mailbox on the specified VAN.

NETWORK: USER ID: This is the identifier of the trading partner's entity to the VAN.

SECTION C3: FTP users:

Part C2 - FTP ACCOUNT INFORMATION FOR MEDICAL BILL

Sender/Trading Partner Name and E-MAIL ADDRESS: Specify name and e-mail address

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

PASSWORD: Specify a password.

TRANSMISSION MODES: Choose one: PGP+SSL or SSL

SOURCE PUBLIC NETWORK IP ADDRESS: Optional

E-MAIL ADDRESS: Specify an e-mail address.

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. This FEIN, combined with the 9-position zip postal code (Zippostal+4), uniquely identifies DWC as a trading partner.

Physical Address: The street address of DWC. The 9-position ~~zip~~ postal code of this street address, combined with the FEIN, uniquely identifies DWC as a trading partner.

Mailing Address: The address DWC uses to receive deliveries via the U.S. Postal Service.

Contact Information: This section identifies individuals at DWC who can be contacted with issues pertaining to this trading partner. The TECHNICAL CONTACT is the individual that should be contacted for issues regarding the actual transmission process. The BUSINESS CONTACT can address non-technical issues regarding the WCIS.

~~RECEIVER ELECTRONIC MAILBOXES:~~ ~~This section specifies DWC's mailboxes, which trading partners can use to transmit EDI transactions to DWC. Separate mailbox information may be provided for receiving production versus test data.~~

~~NETWORK: FTP service on which the DWC's mailbox can be accessed.~~

~~NETWORK MAILBOX ACCT ID: The name of the DWC mailbox on the specified FTP.~~

~~NETWORK: USER ID: This is the identifier of the DWC's entity to the FTP.~~

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. Separate Qualifiers are provided to exchange Production and Test data, if different identifiers are needed.

SENDER/RECEIVER ID: The ID Code that corresponds with the ANSI Sender/Receiver Qualifier (ANSI ID Code Qualifier). Separate Sender/Receiver IDs are provided to exchange Production and Test data, if different identifiers are needed.

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.

Section G: Testing and production phases of medical EDI

Overview of the four step process

The four step process is a step-by-step guide on how to become a successful EDI trading partner in the California workers' compensation system. Attaining DWC\WCIS EDI capability is a four step process, beginning with completing a trading partner profile, followed by a structural test phase, a detailed testing phase, and finally production capability. The steps outlined below are meant to help each trading partner through the process by providing information on what to expect, what could go wrong, and how to fix problems. The DWC is offering the four step process to help facilitate each individual trading partner's adoption of EDI capabilities. A WCIS contact person is available to work with each trading partner during this process to ensure the transition to production is successful.

Step 1. Complete a medical EDI trading partner profile

Completing a trading partner profile form is the first step in reporting medical record EDI data to the WCIS. The WCIS regulations (section 9702(j)) require the profile form be submitted to the division at least 30 days before the first transmission of EDI data, i.e., at least 30 days before the trading partner sends the first "test" transmission (see step 2). See section F – Trading partner profile details on how to complete a trading partner profile form.

Step 2. Complete the structural test phase

Purpose

The purpose of the structural test is to ensure the electronic transmissions meet the required technical specifications. The WCIS needs to recognize and process your ANSI 837 transmissions and your system needs to recognize and process 997 acknowledgment transmissions from the WCIS. The following are checked during the test:

- **Transmission mode** (value added network (VAN) or file transfer protocol (FTP) are functional and acceptable for both receiver and sender.
- **Sender/receiver identifications** are valid and recognized by the receiver and sender.
- **File format** (ANSI X12 837) matches the specified file structural format

Test criteria

In order for your system and the WCIS system to communicate successfully, a number of conditions need to be met.

- Establish Van or FTP connectivity
- No errors in header or trailer records
- Trading partners can send a structurally correct ANSI 837 transmission
- Trading partners can receive and process a 997 functional acknowledgment.

Test procedure

Trading partners using an FTP server should follow the steps given in section I – Transmission modes before sending a test file.

Prepare a test file

Trading partners using the VAN or FTP transmission modes will be sending medical data to the WCIS in ANSI 837 transmission consisting of three parts:

- An ISA-IEA interchange control header/trailer which identifies the sender, the receiver, test / production status, the time and date sent, etc.
- GS-GE functional group header(s)/trailer(s), which among other things, identifies the number of ST-SE transactions in each GS-GE functional group.
- ST-SE transactions which contain the medical data elements (see section L)

Send the test file

Send the test file to WCIS. The structural test data sent will not be posted to the WCIS production database. Any live California medical bill payment records sent as structural test data will have to be re-sent to WCIS during production to be posted to the WCIS production database.

Wait for an electronic 997 acknowledgment from WCIS

Trading partners must be able to both receive and process structural electronic acknowledgments from WCIS. When a structural test file has been received and processed by the DWC\WCIS, an electronic 997 acknowledgment will be transmitted to the trading partner by WCIS. The acknowledgment will report whether the transmission was successful (no errors) or unsuccessful (errors occurred). Please note that if the test file is missing the header, or if the sender identification in the interchange control header is not recognized by WCIS, no acknowledgment will be sent. The 997 functional acknowledgment sent during the structural test phase contains information relating to the structure of the ANSI 837 . Information about errors in the individual medical records will be included in the 824 detailed acknowledgment which follows in the detailed testing phase.

Overview of the five step process

The five step process is a step-by-step guide on how to become a successful EDI trading partner for medical bill reporting in the California workers' compensation system. The five step process begins with completing a trading partner profile, followed by FTP connectivity, structural testing, detailed testing, medical bill cancellation, claim identifier replacement, and finally production capability. The steps outlined below are intended to help each trading partner through the process by providing information on what to expect, what could go wrong, and how to fix problems. The DWC is offering the five step process to help facilitate each individual trading partner's adoption of EDI capabilities. A WCIS contact person is available to work with each trading partner during this process to ensure the transition to production is successful.

Step one: Complete a medical EDI trading partner profile

Completing a trading partner profile form is the first step in reporting medical record EDI data to the WCIS. The WCIS regulations (Title 8 CCR, section 9702(k)) require the profile form be submitted to the Division at least 30 days before the first transmission of EDI data, i.e., at least 30 days before the trading partner sends the first "test" transmission (see step two). See Section F for complete instructions on how to complete a trading partner profile form.

Step two: Sender tests FTP connectivity

Within 5 days of receiving the completed profile, WCIS will email or fax a File Transfer Protocol (FTP) information form with an IP Address to the technical contact named in the trading partner profile form, Part B, Trading Partner Contact Information (See Section F). Within 7 days of receiving the completed FTP information form, WCIS will open a port and ask the trading partner to send a sample of test files to ensure the WCIS system can accept and return an electronic file to the trading partner.

- Transmission mode is File Transfer Protocol (FTP).
- Establish FTP connectivity.

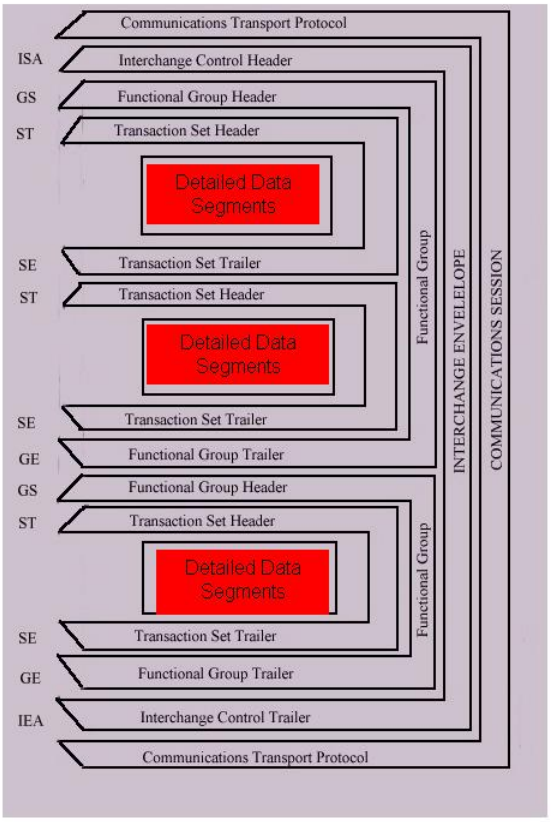
Step three: Sender transmits numerous ANSI 837 bill types

The trading partner compiles small ANSI 837 files with the required loops, segments, and data elements which represent different types of medical bills (See Section H). The trading partner passes the structural test when the minimum technical requirements of the California-adopted IAIABC 837 file format are correct.

Trading partners will be sending medical data to the WCIS in a California-adopted IAIABC 837 transmission consisting of three parts:

- An ISA-IEA interchange control header/trailer which identifies the sender, the receiver, test /production status, the time and date sent, etc.
- GS-GE functional group header(s)/trailer(s), which among other things, identifies the number of ST-SE transactions in each GS-GE functional group.
- ST-SE transactions which contain the medical data elements (See Section ~~K~~J)

Figure 1, as per ANSI X12.5, illustrates a typical format for electronically transmitting a series of business transactions.



The DWC/WCIS suggests the test file consist of one ISA-IEA electronic envelope. The DWC/WCIS has developed several medical bill payment scenarios for California including professional bills, institutional bills, dental bills, pharmaceutical bills, and others to be included in the ST-SE transaction sets. The trading partner will also be required to send three bill submission reason codes (00, 01, and 05) while testing. The WCIS contact person assigned to the trading partner has additional information and is available to answer questions during the testing phase.

Step four: Structural testing - Sender receives and processes a 997 from DWC

The trading partner ~~can~~ must be able to receive and process electronic 997 functional acknowledgments from the WCIS. The trading partner tests the internal capability to process the 997 from the DWC/WCIS and correct any structural errors detected by the WCIS.

The purpose of the structural test is to ensure the electronic transmissions meet the required technical specifications. The WCIS needs to recognize and process ~~you're~~ the trading partner's ANSI 837 transmissions and ~~your~~ the trading partner's system ~~needs~~ must be able to recognize and process 997 acknowledgment transmissions from the WCIS. In order for ~~your~~ the trading partner's system and the WCIS system to communicate successfully, a number of conditions need to be met.

- Sender/receiver identifications are valid and recognized by the receiver and sender
- File format (ANSI X12 837) matches the specified file structural format
- Trading partners can send a structurally correct ANSI 837 transmission
- No errors in ISA-IEA, GS-GE, and ST-SE header/trailer records
- Trading partners can receive and process a 997 functional acknowledgment

~~Send the test file to WCIS.~~ The structural test data sent will not be posted to the WCIS production database. Any live California medical bill payment records sent as structural test data will have to be re-sent to WCIS during production to be posted to the WCIS production database.

Trading partners must be able to both receive and process structural electronic acknowledgments from WCIS. When a structural test file has been received and processed by the DWC/WCIS, an electronic 997 acknowledgment will be transmitted to the trading partner by WCIS. The acknowledgment will report whether the transmission was successful (no errors) or unsuccessful (errors occurred). Please note that if the test file is missing the header, or if the sender identification in the interchange control header is not recognized by WCIS, no acknowledgment will be sent. The 997 functional acknowledgment sent during the structural test phase contains information relating to the structure of the ANSI 837. More, i ~~I~~nformation about errors in the individual medical records will be included in the 824 detailed acknowledgment which follows in the detailed testing phase.

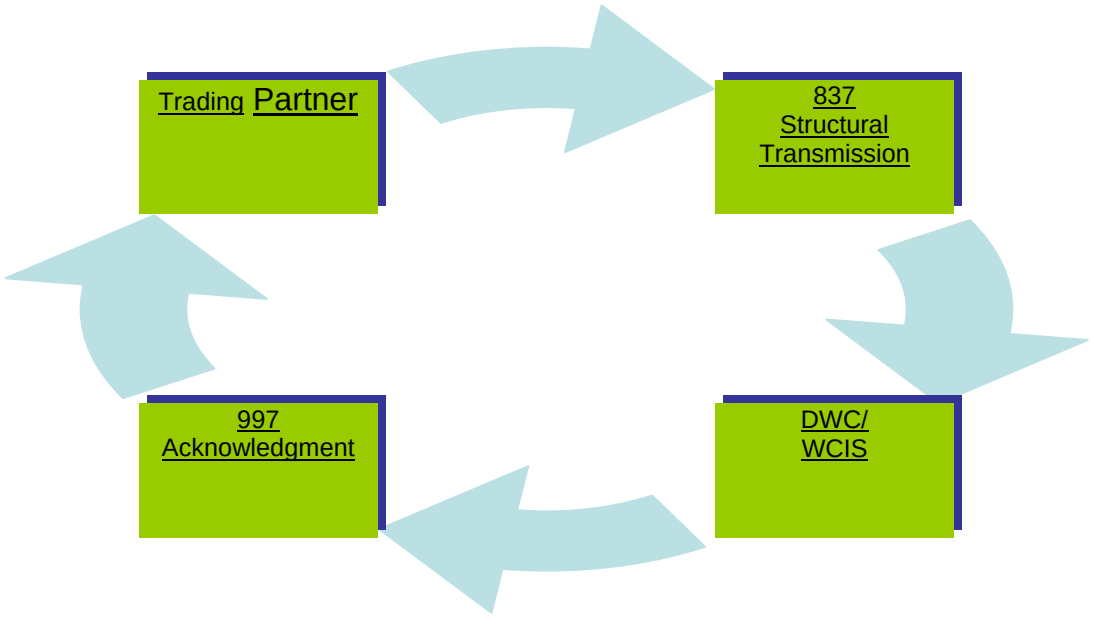
Process the 997 functional acknowledgment and correct any errors

If ~~you receive an error acknowledgment~~ the 997 functional acknowledgement contains an ~~(~~application acknowledgment code = R (Transmission rejected) or E (Transmission accepted with errors), ~~"837 transmission rejected"), you will need to~~ check the ANSI 837 file format and make corrections before re-transmitting the file to WCIS. Send the corrected ANSI 837 file to the DWC. If the test fails again, repeat steps three and four until your test file is accepted by WCIS. You may send as many test files as you need to. The WCIS contact person assigned to you is available if you have any questions or problems during the process. If the acknowledgment code = A ("837 transmission accepted"), skip to step five.

~~Re-transmit corrected file to WCIS~~

~~Send the corrected ANSI 837 file to the DWC. If the test fails again, repeat steps three and four until your test file is accepted by WCIS. You may send as many test files as you need to. The WCIS contact person assigned to you is available if you have any questions or problems during the process.~~

Structural ~~level~~ testing communication loop



Transmission 997 acknowledgment error messages

Trading partners should receive an electronic 997 acknowledgment within 48 hours of sending the test transmission. If ~~you do not receive an~~ the 997 acknowledgment is not received within 48 hours, contact the person identified in your WCIS Trading Partner Profile. The DWC/WCIS utilizes the 997 functional acknowledgment transaction set within the context of an ~~Electronic Data Interchange~~ (EDI) environment. The 997 functional acknowledgment indicates the results of the syntactical analysis of the 837 Transaction Set.

997 Segment	Error Code	Error Message
AK3_Data Segment Note	2	Unexpected segment
AK3_Data Segment Note	3	Mandatory segment missing
AK3_Data Segment Note	8	Segment has data element errors

997 Segment	Error Code	Error Message
AK4_Data Element Note	1	Mandatory data element missing
AK4_Data Element Note	3	Too many data elements
AK4_Data Element Note	4	Data element too short
AK4_Data Element Note	5	Data element too long
AK4_Data Element Note	6	Invalid character in data element

AK4_Data Element Note	8	Invalid date
AK4_Data Element Note	9	Invalid time

The general structure of a 997 functional acknowledgment transaction set is as follows:

010 ST Transaction Set Header

020 AK1 Functional Group Response Header

030 AK2 Transaction Set Response Header

040 AK3 Data Segment Note

050 AK4 Data Element Note

060 AK5 Transaction Set Response Trailer

070 AK9 Functional Group Response Trailer

080 SE Transaction Set Trailer

~~Process the 997 functional acknowledgment and correct any errors~~

~~If you receive an error acknowledgment (application acknowledgement code = R or E (837 transmission rejected)), you will need to check the ANSI 837 file format and make corrections before re-transmitting the file to WCIS. If the acknowledgment code = A ("837 transmission accepted"), skip to step six.~~

~~Re-transmit corrected file to WCIS~~

~~Send the corrected ANSI 837 file to the DWC. If the test fails again, repeat steps two through five until your test file is accepted by WCIS. You may send as many test files as you need to. The WCIS contact person assigned to you is available if you have any questions or problems during the process.~~

~~Notify the division when you are ready to proceed to the pilot phase~~

~~After the DWC system is able to successfully communicate with your system and all the transmitted files are structurally correct, then contact the person identified in your WCIS trading partner agreement and notify the person of your readiness to proceed to step 3. The WCIS contact person will notify you by phone or e-mail when the DWC system is ready to accept your detailed test data to begin the detailed testing phase of the process.~~

~~Step 3. Complete the detailed test phase~~

Overview

During the detailed test phase, trading partners may optionally submit copies of paper medical reports, CMS 1500, UB92, UCF pharmaceutical or dental forms, from the corresponding EDI medical transmissions, which are compared to the electronic data for accuracy, validity and completeness (see section R - Standard medical forms).

Purpose

Testing for data quality, both during the detailed testing phase and during production, will help trading partners comply with section 9702, electronic data reporting of the WCIS regulations (8 CCR §9702(a)):

"Each claim 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 (one of the purposes of WCIS set forth in the 1993 authorizing statute), trading partners must submit all required medical bill payment data elements for the required reporting periods

- Valid data – Valid means the data are what they are purported to be. For example, data in the date of injury field must be date of injury and not some other date. Data must consist of allowable values, e.g., date of injury cannot be Sep. 31, 1999, a non-existent date. At a more subtle level, each trading partner must have the same understanding of the meaning of each data element and submit data with that meaning only. Review the definitions for each required data element in the data dictionary of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1 (http://www.iaiabc.org) and the California medical data dictionary (http://www.dir.ca.gov/dwc) to be sure your use of the data element matches that assigned by the IAIABC and the California DWC. If your meaning or use of a data element differs, you will need to make changes to conform to the California adopted IAIABC standards.

- Accurate data – Accurate means free from errors. There is little value in collecting and utilizing data unless there are assurances the data are accurate (see section M - Data edits).

The detailed testing phase ensures the above requirements are met before a trading partner is allowed to routinely submit electronic medical data to the WCIS in production status.

Data quality criteria

The DWC allows the detailed testing phase to be conducted in two steps, which may be conducted concurrently if desired. Reports are first transmitted to WCIS via EDI, and are tested for completeness and validity using automatic built-in data edits on the WCIS system. See section M – Data edits for more detail.

The DWC\WCIS requires the transmission of medical bill payment records in accordance with various billing scenarios. The medical bill payment record transmissions should contain zero errors before the detailed testing phase is successfully completed. The medical data reporting requirements for each data element are listed in section L – Required medical data elements of this guide.

If the criteria of zero errors during the detailed testing phase cannot be attained. The DWC suggests a random subset of the EDI bill payment records be manually crosschecked against the corresponding paper reports for accuracy. The sender may be asked to justify any mismatches between the paper and EDI reports to help clarify errors in the 837 transmissions.

A cross-walk of data elements contained on the CMS 1500 and the UB92 are provided in section L – Required medical data elements and in the IAIABC *EDI Implementation Guides for Medical Bill Payment Records, Reporting July 2004*. (www.iaiabc.org)..

Bill submission reason codes
Following are the bill submission reason codes (BSRC) are utilized in California (see section K – Events that trigger required medical EDI reports):

Original	00
Cancel	01
Replace	05

Medical EDI detailed test procedure

Prepare detailed test file(s)

Begin transmitting detailed data as soon as the WCIS contact person has notified you the WCIS is ready to receive detailed medical bill payment records. The WCIS suggest the detailed test file consist of one ISA-IEA electronic envelop with several (number to be determined) ST-SE transaction sets. The DWC\WCIS has developed several medical bill payment scenarios for California including Medical Provider Networks (MPN), reevaluations, matching to FROI, and others to be included in the ST-SE transaction sets. The trading partner will also be required to send three bill submission reason codes (00, 01, and 05) while testing, your WCIS contact person will have the additional information

After the DWC system is able to successfully communicate with your system and all the transmitted files are structurally correct, then contact the person identified in your WCIS Trading Partner Profile and notify the person of your readiness to proceed to step five. The WCIS contact person will notify you by phone or e-mail when the DWC system is ready to accept your detailed test data to begin the detailed testing phase of the process.

Step five: Detailed testing - Sender receives and processes an 824 from DWC

After an 837 structural test file is successfully transmitted, the trading partner transmits real detailed medical bill payment data, in test status. During detailed testing, the trading partner's submissions are analyzed for data completeness, validity and accuracy. The trading partner must meet minimum

data quality requirements in order to complete the detailed testing stage. The trading partner will receive an 824 detailed acknowledgment containing information about each 837 transmission.

Testing for data quality, both during the detailed testing phase and during production, will help trading partners comply with section 9702, electronic data reporting of the WCIS regulations (Title 8 CCR section 9702(a)):
"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 (one of the purposes of WCIS set forth in the 1993 authorizing statute), trading partners must submit all required medical bill payment data elements for the required reporting periods

- **Valid** **data** – Valid means the data are what they are purported to be. For example, data in the date of injury field must be date of injury and not some other date. Data must consist of allowable values, e.g., date of injury cannot be Sep. 31, 1999, a non-existent date. At a more subtle level, each trading partner must have the same understanding of the meaning of each data element and submit data with that meaning only. Review the definitions for each required data element in the data dictionary of the *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009* (http://www.iaiabc.org) and the California medical data dictionary (http://www.dir.ca.gov/dwc) to be sure your use of the data element matches that assigned by the IAIABC and the California DWC. If your meaning or use of a data element differs, you will need to make changes to conform to the California-adopted IAIABC standards.

- **Accurate** **data** – Accurate means free from errors. There is little value in collecting and utilizing data unless there are assurances the data are accurate (See Section K).

The detailed testing phase ensures the above requirements are met before a trading partner is allowed to routinely submit electronic medical data to the WCIS in production status.

Data quality criteria

The DWC procedure sequentially tests for structural errors and then tests for detailed errors. Records transmitted to WCIS via EDI are tested for completeness, accuracy and validity using both structural and detailed data edits that are built into the WCIS data processing system (See Section K).

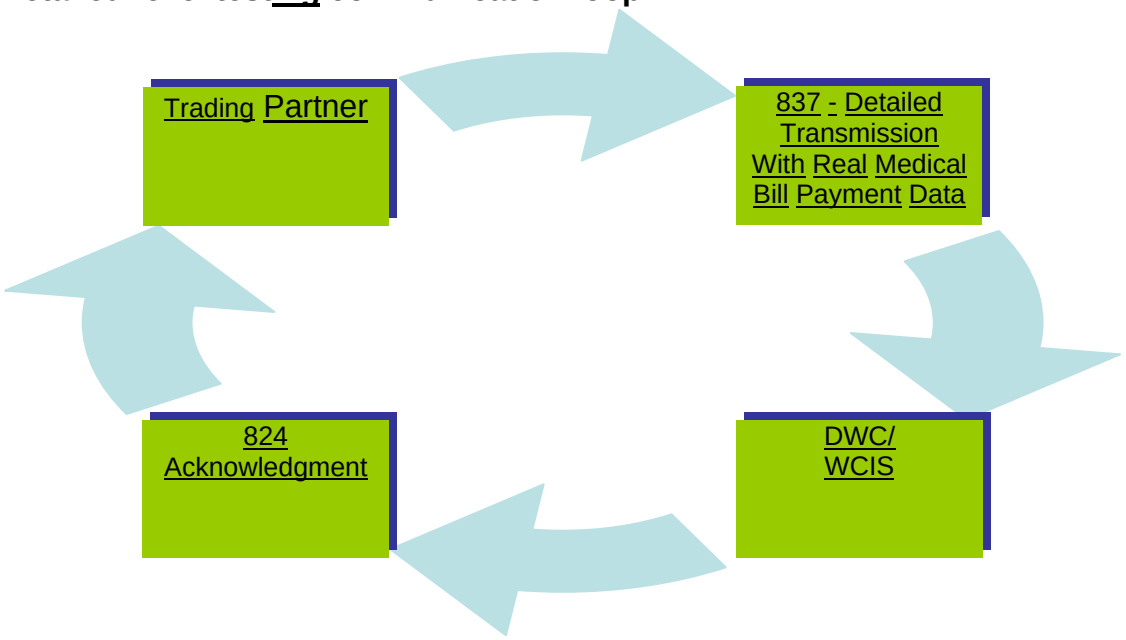
If the criteria of zero errors during the detailed testing phase cannot be attained, the DWC suggests a random subset of the EDI bill payment records be manually crosschecked against the corresponding paper bills for accuracy. The sender may be asked to justify any mismatches between the paper and EDI reports to help clarify errors in the 837 transmissions. A cross-walk of data elements contained

on the CMS 1500 and the UB92 are provided in Section K and in the *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009.* (www.iaiabc.org).

Prepare detailed test file(s)

Begin transmitting detailed data as soon as the WCIS contact person has notified you the WCIS is ready to receive detailed medical bill payment records.

Detailed ~~level~~ testing communication loop



~~Wait for e~~Electronic acknowledgment from WCIS

The data sent ~~you send~~ to WCIS will automatically be subjected to EDI data quality edits. The edits consist of the IAIABC standard edits, ~~(see edit matrices in *IAIABC EDI Implementation Guides for Medical Bill Payment Records, Release 1*), and the California-specific edits, which are~~ listed in Section L. ~~M – Data edits of this guide.~~ Each field in a transaction is validated using the edit rules. The DWC/WCIS medical bill payment specific scenarios will be tested for validity and accuracy. If a data element fails to pass any data validation edit, an error message will be generated for that data element. ~~The WCIS will process all medical bills included in the transmission until 20 errors per medical bill have been detected.~~ The 824 detailed acknowledgements will contain information about all detected errors for each 837 transmission.

You should receive a detail acknowledgment (824) from the WCIS within five business days ~~48 hours~~ of your data transmission. ~~The only exception is when the transaction does not have a match on the database (See Section ML).~~ The acknowledgment will identify each data elements in which an error was detected (See Section H).

Detailed 824 acknowledgment 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 (HHMMSS)~~
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 transmission/transaction
058	Code/ID invalid
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

Process the detailed 824 acknowledgment

If the acknowledgment indicates correctable ~~any~~ errors, transaction rejected (TR), the sender will need to make corrections and send the corrections to the WCIS in order to meet the data quality requirements for validity and completeness. When making corrections, all data elements in the affected ST-SE transaction originally submitted need to be submitted again (See Section ~~L~~J and Section ~~N~~L).

Repeat steps three ~~two~~ through five ~~four~~ until completeness, ~~and~~ validity and accuracy criteria are met.

After the structural and detailed testing is successfully completed, the trading partner transmits a cancellation of the medical bills sent in step three. The cancelled bills are matched to the original bills sent in step three and deleted from the WCIS database. The trading partner receives a 997 and 824 ANSI file from the WCIS.

After the structural and detailed testing is successfully completed, the trading partner transmits a replacement of a claim number sent in step three. The original claim number is matched to the original claim number sent in step three in the WCIS database. The trading partner receives a 997 and 824 ANSI file from the WCIS.

Parallel pilot procedure

Optional parallel standard paper form analysis

An optional step is to submit the paper bills of the corresponding EDI reports to be crosschecked for accuracy. This step may be required by the DWC if the criterion of zero errors is not fulfilled during the detailed test phase.

Prepare paper copies of bills

Make one of a completed original medical report submitted in the EDI portion of the pilot. Fill out a WCIS pilot paper identification form. The form allows the DWC to link your EDI medical reports to your paper medical bills.

Send paper reports to DWC

Send the paper medical forms and the completed WCIS pilot paper identification form to the WCIS contact person assigned to you. Mail the entire packet to:

WCIS Pilot-Parallel Phase
Attn: WCIS Contact
Department of Industrial Relations
EDI Unit, Information Systems
1515 Clay Street, 19th Floor
Oakland, CA 94612

Wait for parallel pilot analysis report

Your WCIS contact will compare the standard paper forms and EDI medical reports for consistency and prepare a "Parallel Pilot Analysis Report." The report describes any discrepancies noted between data sent on the standard paper forms and data sent electronically. A WCIS contact person will phone or schedule a meeting to discuss any discrepancies.

Step 4. Production

Data quality requirements

Data sent to WCIS will continue to be monitored for completeness and validity. The following are guidelines for data quality trading partners should strive to meet or exceed:

- All data quality errors will result in a Transaction Rejected (TR) 824 acknowledgment. The DWC will process all medical bills in each ST-SE transaction set until 20 errors are detected and then send the 824 acknowledgment.

Data quality reports

The WCIS automatically monitors the quality of data received during production from individual trading partners. The system tracks all outstanding errors and produces automated data quality reports. The division plans to provide these reports to each trading partner on a regular basis. The frequency of providing the reports has not yet been determined.

Trading partner profile

Trading partner profiles must be kept up-to-date. The division must be notified of any changes to the trading partner profile, since changes will affect the ability of the WCIS to recognize transmissions. Note: Changing the transmission mode (FTP or VAN) may require re-testing some or all transaction types.

Production Status

After successful completion of the five testing steps, the trading partner may begin to send production data. During production, data transmissions will be monitored for completeness, validity and accuracy. The data edits are more fully described in Section L and in the *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009.* (www.iaiabc.org).

- All data quality errors will result in a Transaction Rejected (TR) 824 acknowledgment. The DWC will process all medical bills in each ST-SE transaction set until 20 errors per bill are detected and then send the 824 acknowledgment.

Data Quality Reports

The WCIS monitors the quality of data received during production. The WCIS tracks outstanding errors and produces automated data quality reports for statewide performance in reporting medical billing data to the WCIS. Statewide data quality reports will be posted to the DWC/WCIS website. Data quality reports for individual trading partners can be provided upon request.

WCIS PAPER PILOT IDENTIFICATION FORM

TO: _____
WCIS Contact

FROM: TRADING PARTNER (the following information must be as it appears on your trading partner profile)

NAME _____

ADDRESS _____

_____

_____

FEIN _____

ZIP CODE _____

DATE(S) ELECTRONIC TRANSMISSION(S) WERE SENT _____

_____

TOTAL NUMBER OF EDI MEDICAL TRANSACTIONS SENT _____

DATE PAPER MEDICAL BILLS MAILED _____

NUMBER OF PAPER MEDICAL BILLS MAILED _____

PREPARED BY _____

PHONE _____

COMPLETE THIS FORM AND RETURN WITH PAPER COPIES OF MEDICAL BILL / PAYMENT FORMS TO:

WCIS PARALLEL PILOT PHASE
ATTN: WCIS Contact Person
EDI Unit, Information Systems
1515 Clay Street, 189th Floor
Oakland, CA 94612

Section H: Supported transactions and ANSI file structure

Supported transactions

The IAIABC has approved the ANSI X12 formats – based on the American National Standards Institute (ANSI) X12 EDI standard. The ANSI X12 is the primary EDI standard for electronic commerce in a wide variety of applications. Data elements are strung together continuously, with special data element identifiers and separator characters delineating individual data elements and records. The ANSI X12 is extremely flexible but also somewhat complex, so most X12 users purchase translation software to handle the X12 formatting. Because X12 protocols are used for many types of business communications, X12 translation software is commercially available. Some claims administrators may already be using X12 translation software for purchasing, financial transactions or other business purposes.

Health care claim transaction sets (837 & 824)

The X12 transaction set contains the format and establishes the data contents of the health care claim transaction set (837) and the bill payment acknowledgment set (824) for use within the context of an EDI environment. The 837 transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediaries and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing and/or payment of health care services within a specific health care/insurance industry segment.

The 824 acknowledgment set is to inform the sender of the status of the health care claim transaction set (837). Each health care claim transaction set (837) is edited for required data elements and against the edit matrix, element requirement table and the event table. Out of those edit processes, each transaction will be determined to be either accepted or rejected. A bill payment acknowledgment set (824) will be sent to each trading partner after each health care claim transaction set (837) is evaluated for errors.

For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, pharmacies, and other entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. This is the same standard that is used to report institutional claim adjudication information for payment to private and public payers.

ANSI definitions

Loop:
A group of segments that may be repeated. The hierarchy of the looping structure is insured~~r~~, employer, patient, bill provider level and bill service line level.

Segment ID:
Groups of logically-related data elements. The record layouts show divisions between segments. Each segment begins with a segment identifier. Each data element within a segment is indicated by the segment identifier plus ascending sequence number. Data segments are defined in the ANSI loop and segment summary.

Segment name/data element name:
Included are loop names, segment names and data element names.

Format:
Type of data element as described below:

AN String: Any characters from the basic or extended character sets. The basic character set defined as: Uppercase letters: "A" through "Z". Digits: "0" through "9". ~~Special characters: ! " & ' ( ) * + , - . / : ; ? = Space character: " "~~ The extended character s~~S~~et defined as: Lowercase letters: "a" through "z" ~~Special characters: % ~ @ [ ] _ { } \ | < > # $.~~ At least one non-space character is **required**. The significant characters should be left-justified. Trailing spaces should be suppressed.

Example: Claim administrator claim number AN1709MPN05

ID Identification code: 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 Decimal number: 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: Principal diagnosis code 519.2

Note: ANSI 837 v.4010 transaction including the X12 recommended delimiters of asterisk, colon, and tilde. Delimiters used in the transaction must be identified in the appropriate position of the ISA segment and must be consistent throughout the transaction. Be aware that the delimiters chosen cannot be used as part of any data value or string. ~~).~~ More detailed information can be found in IAIABC EDI Implementation Guide~~s~~ for Medical Bill Payment Records, Release 1.1, July 1, 2009.

Delimiters:

- ***** Data element delimiter
- **:** Sub data element delimiter
- **~** End of string delimiter

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	532	Batch Control Number
Data Element	100	Date Transmission Sent
Data Element	101	Time Transmission Sent
LOOP ID	1000A	Sender Information
Segment	NM1	Identification code
Data Element	98	Sender Identification (FEIN only)
Segment	N4	Identification code
Data Element	98	Sender Identification (Postal Code only)
LOOP ID	1000B	Receiver Information
Segment	NM1	Identification code
Data Element	99	Receiver Identification (FEIN only)
Segment	N4	Identification code
Data Element	99	Receiver Identification (Postal Code only)
LOOP ID	2000A	Source of Hierarchical Information
Segment	DTP	Date/Time Period
Data Element	615	Reporting Period
LOOP ID	2010AA	Insurer/Self Insured/Claim Admin. Info.
Segment	NM1	Insurer/Self Insured/Claim Admin. Info.
Data Element	7	Insurers Name
Data Element	6	Insurers FEIN
Data Element	188	Claim Administrators Name
Data Element	187	Claim Administrators FEIN
LOOP ID	2000B	Employer Hierarchical Information
LOOP ID	2010BA	Employer Named Insurer Information
Segment	NM1	Employer Name
Loop ID	2000C	Claimant Hierarchical Information
Segment	DTP	Date/Time Period
Data Element	31	Date of Injury
Loop ID	2010CA	Claimant Information
Segment	NM1	Claimant Information
Data Element	43	Employee Last Name

Data Element	44	Employee First Name
Data Element	45	Employee Middle Name/Initial
Data Element	42	Employee Social Security Number
Data Element	153	Employee Green Card
Data Element	156	Employee Passport Number
Data Element	152	Employee Employment Visa

Loop ID	2010CA	Claimant Information (Continued)
Segment	REF	Claimant Claim Number
Data Element	15	Claim Administrators Claim Number
Data Element	5	Jurisdiction Claim Number

Loop ID	2300	Billing Information (Repeat ≥ 1)
Segment	CLM	Billing Information
Data Element	523	Billing Provider Unique Bill ID Number
Data Element	501	Total Charge per Bill
Data Element	502	Billing Type Code
Data Element	504	Facility Code
Data Element	555	Place of Service Bill Code
Data Element	503	Billing Format Code
Data Element	526	Release of Information Code
Data Element	507	Provider Agreement Code
Data Element	508	Bill Submission Reason Code
Segment	DTP	Date/Time Period
Data Element	511	Date Insurer Received Bill
Data Element	513	Admission Date
Data Element	514	Discharge Date
Data Element	509	Service Bill Date(s) Ranges
Data Element	527	Prescription Bill Date
Data Element	510	Date of Bill
Data Element	512	Date the Insurer Paid Bill
Segment	CN1	Contract Information
Data Element	515	Contract Type Code
Data Element	518	DRG Code
Segment	AMT	Total Amount Paid
Data Element	516	Total Amount Paid Per Bill
Segment	REF	Unique Bill ID
Data Element	500	Unique Bill Identification Number
Segment	REF	Transaction Tracking Number
Data Element	266	Transaction Tracking Number
Segment	HI	Diagnosis
Data Element	521	Principal Diagnosis Code
Data Element	535	Admitting Diagnosis Code
Data Element	522	ICD_9 Diagnosis Code
Segment	HI	Institutional Procedure Codes

Data Element	626	HCPCS Principal Procedure Billed Code
Data Element	525	ICD_9 CM Principal Procedure Billed Code
Data Element	550	Principal Procedure Date
Data Element	737	HCPCS Billed Procedure Code
Data Element	736	ICD_9 CM Billed Procedure Code
Data Element	524	Procedure Date
Loop ID	2310A	Billing Provider Information
Segment	NM1	Billing Provider Information
Data Element	528	Billing Provider Last/Group Name
Data Element	629	Billing Provider FEIN
Segment	PRV	Billing Provider Specialty Information
Data Element	537	Billing Provider Primary Specialty Code
Segment	N4	Billing Provider City, State, and Postal Code
Data Element	542	Billing Provider Postal Code
Segment	REF	Billing Provider Secondary ID Number
Data Element	630	Billing Provider State License Number
Data Element	634	Billing Provider National Provider ID
Loop ID	2310B	Rendering Bill Provider Information
Segment	NM1	Rendering Bill Provider Information
Data Element	638	Rendering Bill Provider Last/Group Name
Data Element	642	Rendering Bill Provider FEIN
Segment	PRV	Rendering Bill Provider Specialty Info
Data Element	651	Rendering Bill Provider Primary Specialty Code
Segment	N4	Rendering Bill Provider City, State, Postal Code
Data Element	656	Rendering Bill Provider Postal Code
Data Element	657	Rendering Bill Provider Country Code
Segment	REF	Rendering Bill Provider Secondary ID Number
Data Element	649	Rendering Bill Provider Specialty License Number
Data Element	643	Rendering Bill Provider State License Number
Data Element	647	Rendering Bill Provider National Provider ID
Loop ID	2310C	Supervising Provider Information
Segment	REF	Supervising Provider National Provider ID
Data Element	667	Supervising Provider National Provider ID
Loop ID	2310D	Facility Information
Segment	NM1	Facility Information
Data Element	678	Facility Last/Group Name
Data Element	679	Facility FEIN
Segment	N4	Facility City, State, and Postal Code
Data Element	688	Facility Postal Code
Segment	REF	Facility Secondary ID Number
Data Element	680	Facility State License Number
Data Element	681	Facility Medicare Number
Data Element	682	Facility National Provider ID

Loop ID	2310E	Referring Provider Information
Segment	REF	Referring Provider National Provider ID
Data Element	699	Referring Provider National Provider ID

Loop ID	2310F	Managed Care Organization Information
Segment	NM1	Managed Care Organization Information
Data Element	209	Managed Care Organization Last/Group Name
Data Element	704	Managed Care Organization FEIN
Segment	N4	Managed Care Organization City, State, and Postal Code
Data Element	712	Managed Care Organization Postal Code
Segment	REF	Managed Care Organization Identification Number
Data Element	208	Managed Care Organization Identification Number

Loop ID	2320	Subscriber Insurance
Segment	CAS	Bill Level Adjustment Reasons Amount
Data Element	543	Bill Adjustment Group Code
Data Element	544	Bill Adjustment Reason Code
Data Element	545	Bill Adjustment Amount
Data Element	546	Bill Adjustment Units

Loop ID:	2400	Service Line Information
Segment	LX	Service Line Information
Data Element	547	Line Number
Segment	SV1	Procedure Code Billed
Data Element	721	NDC Billed Code
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	715	Jurisdictional Procedure Billed Code
Data Element	718	Jurisdictional Modifier Billed Code
Data Element	552	Total Charge per Line
Data Element	553	Days/Units Code
Data Element	554	Days/Units Billed
Data Element	600	Place of Service Line Code
Data Element	557	Diagnosis Pointer
Segment	SV2	Institutional Service Revenue Procedure Code
Data Element	559	Revenue Billed Code
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	715	Jurisdictional Procedure Billed Code
Data Element	718	Jurisdictional Modifier Billed Code
Data Element	552	Total Charge per Line
Segment	SV3	Dental Service
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code

Data Element	552	Total Charge per Line
Data Element	600	Place of Service Line Code
Segment	SV4	Prescription Drug Information
Data Element	561	Prescription Line Number
Data Element	721	NDC Billed Code
Data Element	563	Drug Name
Data Element	562	Dispense as Written Code
Data Element	564	Basis of Cost Determination
Segment	SV5	Durable Medical Equipment
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	553	Days/Units Code
Data Element	554	Days/Units Billed
Data Element	565	Total Charge per Line Rental
Data Element	566	Total Charge per Line Purchase
Data Element	567	DME Billing Frequency Code
Segment	DTP	Service Date(s)
Data Element	605	Service Line Date(s) Range
Segment	DTP	Prescription Date
Data Element	604	Prescription Line Date
Segment	QTY	Quantity
Data Element	570	Drugs/Supplies Quantity Dispensed
Data Element	571	Drugs/Supplies Number of Days
Segment	AMT	Dispensing Fee Amount
Data Element	579	Drugs/Suppliesd Dispensing Fee
Segment	AMT	Drug/Suppliesy Billed Amount
Data Element	572	Drug/Suppliesy Billed Amount
Loop ID	2420	Rendering Line Provider Name
Segment	NM1	Rendering Line Provider Information
Data Element	589	Rendering Line Provider Last/Group Name
Data Element	586	Rendering Line Provider FEIN
Segment	PRV	Rendering Line Provider Specialty Information
Data Element	595	Rendering Line Provider Primary Specialty Code
Segment	N4	Rendering Provider City, State, and Postal Code
Data Element	593	Rendering Line Provider Postal Code
Segment	REF	Rendering Line Provider Secondary ID Identification Number
Data Element	592	Rendering Line Provider National Provider ID Number
Data Element	599	Rendering Line Provider State License Number

Loop ID	2430	Service Line Adjustment
Segment	SVD	Service Line Adjudication
Data Element	574	Total Amount Paid per Line
Data Element	726	HCPCS Line Procedure Paid Code
Data Element	727	HCPCS Modifier Paid Code
Data Element	728	NDC Paid Code
Data Element	729	Jurisdiction Procedure Paid Code
Data Element	730	Jurisdiction Modifier Paid Code
Data Element	576	Revenue Paid Code
Data Element	547	Line Number
Segment	CAS	Service Line Adjustment
Data Element	731	Service Adjustment Group Code
Data Element	732	Service Adjustment Reason Code
Data Element	733	Service Adjustment Amount
Data Element	734	Service Adjustment Units

SE Transaction Set Trailer	
Segment	Transaction Set Trailer

California ANSI 824 loop, segment and data element summary

The medical bill payment detailed acknowledgment (824) reports back to the trading partner either an acceptance (TA), rejection (TR), or accepted with errors (TE) of the health care claim transaction set (837). The following outline summarizes the loop, segment, and data element structure of the medical bill payment detailed acknowledgment (824). More detailed information can be found in IAIABC EDI Implementation Guides for Medical Bill Payment Records, Release 1.1, July 1, 2009.

ST Transaction Set Header		
Segment	ST	Transaction Set Control Number
Segment	BGN	Beginning Segment
Data Element	105	Interchange Version Identification
Data Element	100	Date Transmission Sent
Data Element	101	Time Transmission Sent
Loop ID:	N1A	Sender Information
Segment	N1	Sender Identification
Data Element	98	Sender Identification (FEIN)
Segment	N4	Geographic Location
Data Element	98	Sender Identification (Postal Code)
Loop ID:	N1B	Receiver Information
Segment	N1	Receiver Identification
Data Element	99	Receiver Identification (FEIN)
Segment	N4	Geographic Location
Data Element	99	Receiver Identification (Postal Code)

Loop ID:	OTI	Original Identification Transaction
Segment	OTI	Original Transaction Identifier
Data Element	111	Application Acknowledgment Code
Data Element	500	Unique Bill Identification Number
Data Element	532	Batch Control Number
Data Element	102	Original Transmission Date
Data Element	103	Original Transmission Time
Data Element	110	Acknowledgment Transaction Set Identifier
Segment	DTM	Processing Date
Data Element	108	Date Processed
Data Element	109	Time Processed
Segment	LM	Code Source Information

Loop ID:	LQ	Industry Code
Segment	LQ	Industry Code
Data Element	116	Element Error Number
Segment	RED	Related Data
Data Element	6	Insurer FEIN
Data Element	187	Claim Administrator FEIN
Data Element	15	Claim Administrator Claim Number
Data Element	500	Unique Bill Identification Number
Data Element	266	Transaction Tracking Number
Data Element	115	Element Number
Data Element	547	Line Number

SE Transaction Set Trailer

Segment	Transaction Set Trailer

Section I: The FTP ~~T~~transmission modes~~s~~

Value added networks (VAN)

A value added network (VAN) is a commercially-owned network providing specific services restricted to users. Businesses that provide VAN services act as intermediaries during electronic message exchange. VAN users typically purchase leased lines to connect to the network or use a dial-up number to gain access to the network.

The advantages of using a VAN include security, auditing, tracking capabilities and formatting services. Several EDI service providers provide VAN services. Be aware that billing can be complex, and it typically consists of per byte charge and per "envelope" charge, which vary depending on how the user sends the information. It is important to note that the Division of Workers' Compensation does not pay VAN charges for either incoming or outgoing EDI transmissions. VAN messages will not be transmitted if the trading partner does not specify that it will accept charges for both incoming and outgoing transmissions. See section J – EDI service modes for VAN contact information.

Data transmission with Ffile transfer protocol (FTP)

The Internet file transfer protocol is defined in RFC 959 by the Internet Engineering Task Force and the Internet Engineering Steering Group. Data files are confidential through authentication and encryption, using secure socket layer (SSL).

Trading partners will send all data files to an FTPS (FTP over SSL, RFC4217) server hosted by the WCIS. Acknowledgments will be retrieved from the same server. Use of FTPS to encrypt the network connection is required. In addition, trading partners may optionally use PGP (Pretty Good Privacy, RFC4880) to encrypt the files before transmission. A history of the PGP program and frequently asked questions is available at http://www.pgpi.org.

Data transmission with FTP

Certain processes and procedures must be coordinated to ensure the efficient and secure transmission of data and acknowledgement files via FTP.

Trading partner profile

Complete the trading partner profile form in Section F-Trading Partner Profile. Be sure to indicate the transmission mode is FTP. Acknowledgments will be returned by FTP. After the trading partner profile form is completed (Ssee Section F), follow the steps below.

FTP server account user name and password

The WCIS FTP server requires an account user name and password to access it. The account user name and password is are entered in C2 on the trading partner profile form (Part C2). After establishing connectivity, the trading partner may change the password. Password changes and resets can be coordinated with the trading partner contact.

FTP communication ports

The WCIS FTP server requires the following communications ports to be opened for FTPS transmissions: 20, 21, 990 and 1024-122465535. FTPS uses TCP ports 1024 and above as data channels. The high-numbered ports are assigned sequentially by the server per session.

FTP server root certificate

The WCIS server uses a private root certificate for SSL encryption. When a trading partner establishes connectivity with the WCIS FTP server, its private certificate is exchanged. Some FTP client software (e.g.; WS_FTP) acknowledge the private certificate while others do not. If the certificate is not recognized, the WCIS FTP server root certificate will need to be requested by the trading partner from their trading partner contact person and imported into their system. The trading partner software must be compatible with the WCIS FTP server software (i.e.; WS_FTP Server).

FTP over SSL

The WCIS FTP server requires "explicit" security for negotiating communication security for data transfer for SSL. Explicit security supports the "AUTH SLL" security command. The WCIS FTP server software (i.e. WS_FTP Server) only supports the "explicit" security.

The WCIS FTP server uses "passive" mode for transferring data. The server waits for the data connection from the trading partner's FTP client software to initiate the data transfer process.

The WCIS server uses a private root certificate for SSL encryption. When a trading partner establishes connectivity with the WCIS FTP server, its private certificate is exchanged. Some FTP client software (e.g.; WS_FTP, Cute FTP, Smart FTP, and Core FTP) acknowledge the private certificate while others do not. If the certificate is not recognized, the WCIS FTP server's root certificate will need to be requested by the trading partner from their trading partner contact person and imported into their system.

FTP Server name and IP address

The WCIS FTP server name or IP address will be provided to trading partners by their trading partner contact person.

Trading partner source IP address

Access to the WCIS FTP server will be restricted to source IP addresses that are entered on the trading partner profile form. Trading partners may provide up to two 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 that the private addresses translate to.

Testing FTP connectivity

The WCIS trading partner contact and the trading partner shall coordinate testing FTP connectivity. Trading partners shall be asked to send a plain text file for testing. The file should not contain data, but a simple test message. The file should be named test.txt and placed in the trading partner's root directory of the WCIS FTP server.

Sending data through FTP

Trading partners will send data files to the WCIS FTP server by placing them in a directory named inbound. The contents of the directory are not visible by the trading partner.

File names must be unique and follow file naming conventions prescribed below. An error will result when a file of the same name is still in the inbound directory of the WCIS.

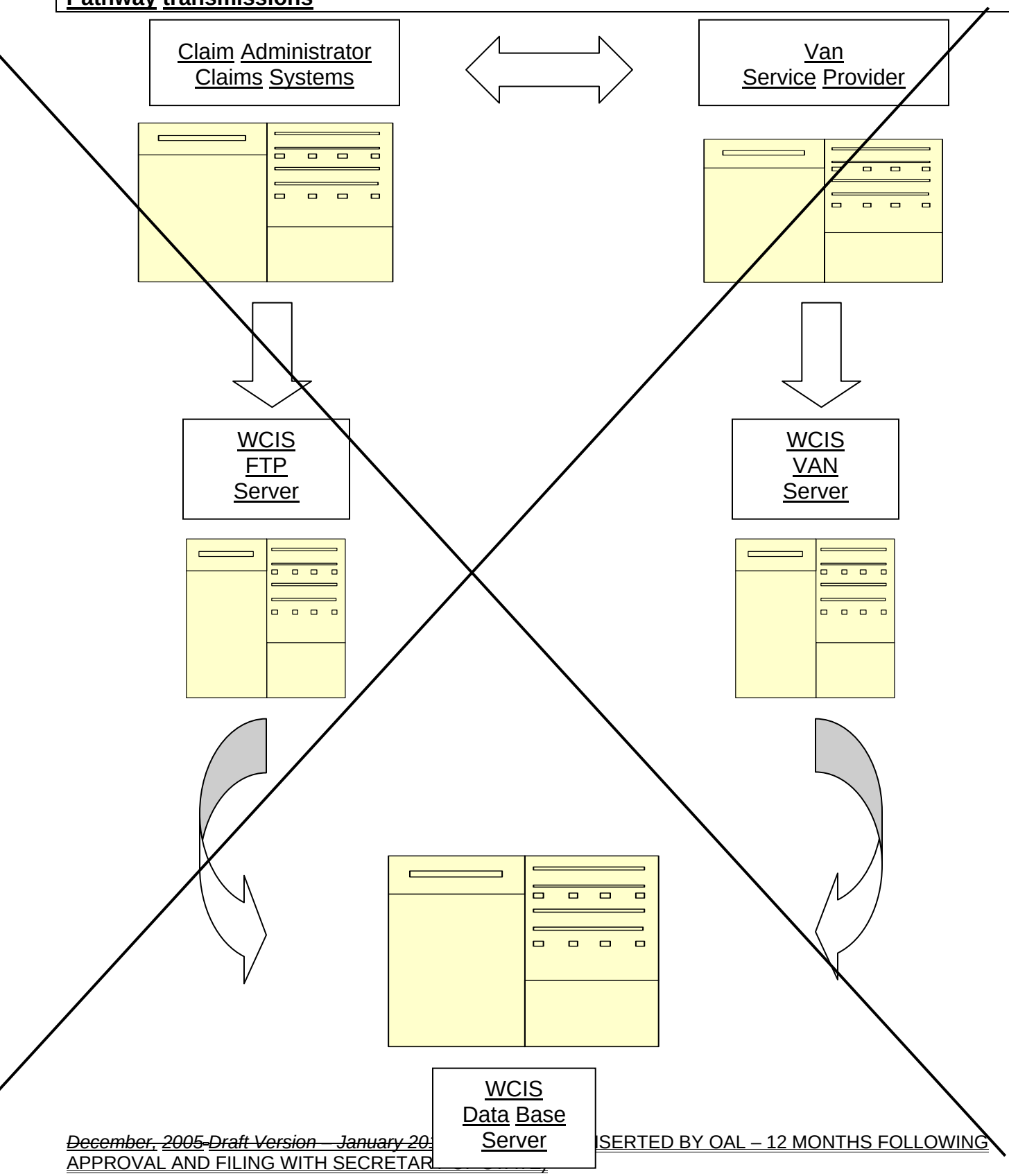
Receiving acknowledgment files through FTP

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

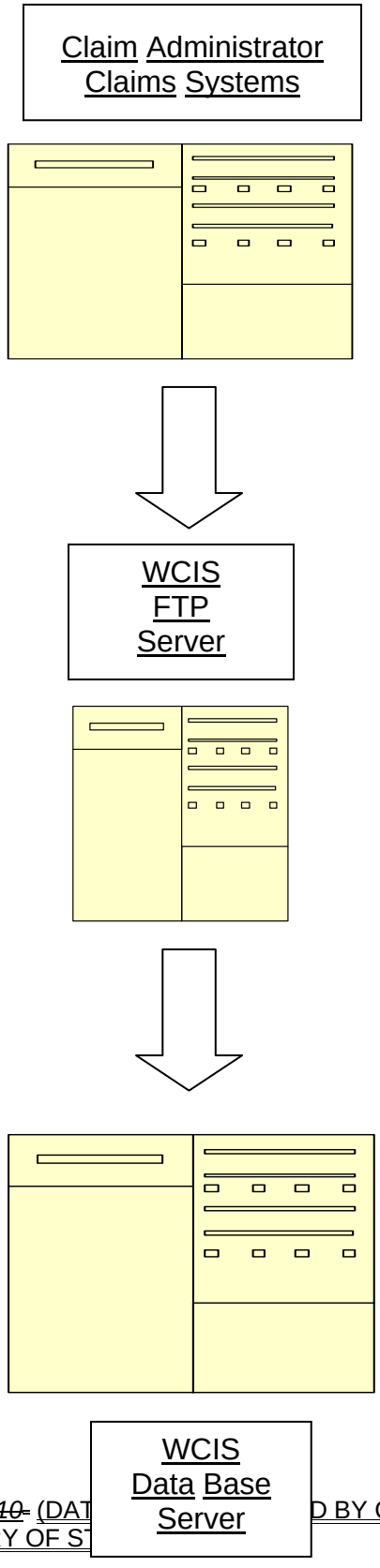
File naming conventions

The DWC/WCIS specific file naming conventions will be specified to each trading partner after the trading partner ~~agreement~~ profile is received by the DWC.

Pathway transmissions



Pathway transmissions



Section J: EDI service providers

Introduction to EDI service providers

Trading partners seeking assistance in implementing medical EDI may wish to consult one or more of the EDI service providers listed on the following pages. Many of these firms offer a full range of EDI-related services: consultation, technical support, value added network (VAN) services, and/or software products. These products and services can make it possible for trading partners to successfully transmit medical bill payment data via EDI, without themselves becoming knowledgeable about record layouts, file formats, event triggers, or other medical EDI details.

Another alternative to developing a complete EDI system is to contract for the services of a data collection agent. For a fee, a data collection agent will receive medical paper forms by fax or mail, enter the data, and transmit the medical bill payment data by EDI to the WCIS or other electronic commerce trading partners.

The California Division of Workers' Compensation does not have a process for granting "approvals" to any EDI service providers. The listings below are simply providers known to the California Division of Workers' Compensation. The lists will be updated as additional resources become known. The most up-to date version of these listings can be accessed through the WCIS home page (http://www.dir.ca.gov).

Appearance on the following lists does not in any way constitute an endorsement of the companies listed or a guarantee of the services they provide. Other companies not listed may be equally capable of providing medical EDI-related services.

Note to suppliers of EDI-related services: Please contact wcis@dir.ca.gov if you wish to have your organization added or removed, or if you wish to update the contact information.

Providers of consultation, technical support, value added network (VAN) service, and software products:

Claims Harbor http://www.claimsharbor.com 1900 Emery Street Atlanta, GA 30318 Telephone: (941) 739-7753 Email: jcarpenter@claimsharbor.com	IBM Global Network / Advantis www.ibm.com/globalnetwork/ IBM Global Services P.O. Box 30021 Tampa, FL 33630 Telephone: (800) 655-8865 E-mail: globalnetwork@info.ibm.com
StellarNet, Inc www.stellarnetinc.com John R. Stevens, CEO 124 Beale Street, Suite 400 San Francisco, CA 94105-1811 Telephone: (415) 882-5700 Fax: (415) 882-5718 E-mail: rtwfast@ibm.net	HealthTech, Inc. www.health-tech.net Mark R. Hughes, President 11730 W. 135th Street, Suite 31 Overland Park, KS 66221 Telephone: (913) 764-9347 Fax: (913) 764-0572 E-mail: mhughes@health-tech.net
MountainView Software Corp. www.mvsc.com Orson Whitmer, Sales Manager 1133 North Main St., Suite 103 Layton, UT 84041 Telephone (888) 533-1122 Fax (801) 544-3138 E-mail: Orson@mvsc.com	Alliance Consulting www.lever8.com One Commerce Square 2005 Market Street 32nd Floor Philadelphia, PA 19103 Telephone 800 706 3339 E-Mail: Get-IT-solved-phi@alliance-consulting.com

continued:

CompData www.CompDataEdex.com Ron Diller P.O. Box 729 Seal Beach, CA 90740-0729 Telephone: (800) 493-6652 Fax: (562) 493-1550 E-mail: Customer@CompDataEdex.com	Red Oak E-Commerce Solutions, Inc. www.roesinc.com Patrick "Pat" Cannon PO Box K-9 Carlisle, IA 50047 Telephone: (866)363-4297 Fax: () (512) 363-4298 E-mail: prcannon@roesinc.com
Valley Oak Systems www.valleyoak.com David Turner, Vice President 3189 Danville Blvd., Suite # 255 Alamo, CA 94507 Telephone: (925) 552-1650 Fax: (925) 552-1656 E-mail: dturner@valleyoak.com	David Corp. www.Davidcorp.com Chris Carpenter, President 130 Battery St, Sixth floor San Francisco, CA 94111 Telephone: (800) 553-2843 Fax: (415) 362-5010 E-mail: support@davidcorp.com
Harbor Healthcare Ventures, LLC 11500 Olympic Blvd, Suite 400 Los Angeles, CA 90049 Telephone: (310) 444-3001 Fax: (310) 444-3002 http://www.hhcv.com	Workcompcentral.com, Inc. www.workcompcentral.com David J. DePaolo, CEO, President 124 Mainsail Court Hueneme Beach, CA 93041 Telephone: (805) 484-0333 Fax: (805) 484-7272 E-mail: david-depaolo@workcompcentral.com
Insurance Services Office, Inc. http://wcis.iso.com 545 Washington Blvd. Jersey City, NJ 07310-1686 Telephone: (609) 799-1800	

continued:

Risk Management Technologies / STARS Marsh Risk & Insurance Services http://www.starsinfo.com Chris Dempsey One California St. San Francisco, CA 94111 Telephone: (415) 743-8293 Fax: (415) 743-7789 E-mail: Christopher.k.dempsey@marshmc.com	Shelter Island Risk Services, LLC Chuck Wight, Regional Manager & VP 174 Corte Alta Novato, CA 94949 Telephone: (415) 382-1424 Fax: (415) 382-2044 E-mail: Cwight@SIRisk.com
PBM Corp. / MCO Advantage LTD. http://www.pbmcorp.com 20600 Chagrin Boulevard Suite 450 Shaker Heights, Ohio 44122 Local Contact Steve Goetz – Dir, Business Development Telephone: (415) 215-5874 Fax: (415) 651-8829 E-mail: stevegoetz@pbmcorp.com	Aimset Corporation www.aimset.com 50 Woodside Plaza, Suite 511 Redwood City, California 94061 Telephone: 650-281-7997 E-mail: info@aimset.com

Organizations providing data collection agent services:

Claims Harbor /Bridium, Inc. (866) 448-1776	Insurance Services Office, Inc. (609) 799-1800
Corporate Systems (800) 927-3343	HealthTech, Inc. (913) 764-9347
Concentra Managed Care, Inc. (972) 364-8000	Risk Management Technologies (415) 743-8293
Alliance Consulting (800) 206-1078	CompData (800) 493-6652
Red Oak E-Commerce Solutions, Inc. (866) 363-4297	Valley Oak Systems (925) 552-1650
Workcompcentral.com, Inc. (805) 484-0333	David Corp. (800) 553-2843

Section K J: Events that trigger required medical EDI reports

Event table definitions

The event table is designed to provide information integral for a sender to understand the DWC/WCIS EDI reporting requirements. It relates EDI information to events and under what circumstances they are initiated. This includes legislative mandates affecting different reporting requirements based on various criteria (i.e.g. dates of injury after a certain period).

It The event table is used and controlled by the receiver to convey the level of EDI reporting currently accepted.

Report type: The report type defines the specific transaction type being sent. (i.e. 837 = medical bill payment records)

BSRC: The bill submission reason code (BSRC) defines the specific purpose (event) for which the transaction is being sent (triggered).

00 = Original
This code is utilized the first time a medical bill is submitted to the jurisdiction including the re-submission of a medical bill rejected due to an correctable error.

01 = Cancellation
The original bill was sent in error. This transaction cancels the original (00).

05 = Replace
This is only utilized to replace DN15 Claim Administrator Claim Number.

Report trigger criteria:

This is a list of events that trigger a specific report and cause it to be submitted. If there are multiple events for a given bill submission reason, each event must be listed separately.

California Event Table											
EVENT			PRODUCTION LEVEL IND.	IMPLEMENTATION DATE		REPORT TRIGGER CRITERIA	REPORT TRIGGER VALUE	EFFECTIVE DATE		REPORT DUE	
BILL SUBMISSION REASON	REPORT TYPE	SUBMISSION DESCRIPTION REASON		FROM	TO			FROM	TO	CRITERIA	VALUE
00	Original		T = Test P=Production			Periodic	TBD by Trading Partners			Within 90 days of date paid	Daily Weekly Monthly Quarterly
01	Cancellation					Bill submission '00' sent to jurisdiction in error	Reversal of an '00' transaction			Immediate	Within 90 days of the original submission Must be greater than date of '00'
05	Replace					Bill submission code '00' has been sent to jurisdiction	Replacement of a claim administrator claim number previously submitted.			Immediate	Must be greater than date of '00'

Section J: California-adopted IAIABC data elements

Numerically-sorted list of California-adopted IAIABC data elements

A numerically-sorted list of California-adopted IAIABC data elements is located in the table below. Alphabetically-sorted lists are located in the data elements by source table (Section K), in the data element requirement table (Section K) and in the data edit table (Section L). Hierarchically-sorted lists are located in the loop, segment and data element summary for the ANSI 837 and the 824 (Section H).

DN	Data Element Name
5	JURISDICTION CLAIM NUMBER
6	INSURER FEIN
7	INSURER NAME
15	CLAIM ADMINISTRATOR CLAIM NUMBER
31	DATE OF INJURY
42	EMPLOYEE SOCIAL SECURITY NUMBER
43	EMPLOYEE LAST NAME
44	EMPLOYEE FIRST NAME
45	EMPLOYEE MIDDLE NAME/INITIAL
98	SENDER ID
99	RECEIVER ID
100	DATE TRANSMISSION SENT
101	TIME TRANSMISSION SENT
102	ORIGINAL TRANSMISSION DATE
103	ORIGINAL TRANSMISSION TIME
104	TEST/PRODUCTION INDICATOR
105	INTERCHANGE VERSION ID
108	DATE PROCESSED
109	TIME PROCESSED
110	ACKNOWLEDGMENT TRANSACTION SET ID
111	APPLICATION ACKNOWLEDGMENT CODE
115	ELEMENT NUMBER
116	ELEMENT ERROR NUMBER
152	EMPLOYEE EMPLOYMENT VISA
153	EMPLOYEE GREEN CARD
156	EMPLOYEE PASSPORT NUMBER
187	CLAIM ADMINISTRATOR FEIN
188	CLAIM ADMINISTRATOR NAME
208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER
209	MANAGED CARE ORGANIZATION NAME
266	TRANSACTION TRACKING NUMBER
500	UNIQUE BILL ID NUMBER

DN	Data Element Name
501	TOTAL CHARGE PER BILL
502	BILLING TYPE CODE
503	BILLING FORMAT CODE
504	FACILITY CODE
507	PROVIDER AGREEMENT CODE
508	BILL SUBMISSION REASON CODE
509	SERVICE BILL DATE(S) RANGE
510	DATE OF BILL
511	DATE INSURER RECEIVED BILL
512	DATE INSURER PAID BILL
513	ADMISSION DATE
514	DISCHARGE DATE
515	CONTRACT TYPE CODE
516	TOTAL AMOUNT PAID PER BILL
518	DRG CODE
521	PRINCIPAL DIAGNOSIS CODE
522	ICD-9 CM DIAGNOSIS CODE
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER
524	PROCEDURE DATE
525	ICD-9 CM PRINCIPAL PROCEDURE CODE
526	RELEASE OF INFORMATION CODE
527	PRESCRIPTION BILL DATE
528	BILLING PROVIDER LAST/GROUP NAME
532	BATCH CONTROL NUMBER
535	ADMITTING DIAGNOSIS CODE
537	BILLING PROVIDER PRIMARY SPECIALTY CODE
542	BILLING PROVIDER POSTAL CODE
543	BILL ADJUSTMENT GROUP CODE
544	BILL ADJUSTMENT REASON CODE
545	BILL ADJUSTMENT AMOUNT
546	BILL ADJUSTMENT UNITS
547	LINE NUMBER
550	PRINCIPAL PROCEDURE DATE
552	TOTAL CHARGE PER LINE
553	DAYS/UNITS CODE
554	DAYS/UNITS BILLED
555	PLACE OF SERVICE BILL CODE
557	DIAGNOSIS POINTER
559	REVENUE BILLED CODE
561	PRESCRIPTION LINE NUMBER
562	DISPENSE AS WRITTEN CODE
563	DRUG NAME
564	BASIS OF COST DETERMINATION CODE

DN	Data Element Name
565	TOTAL CHARGE PER LINE – RENTAL
566	TOTAL CHARGE PER LINE – PURCHASE
567	DME BILLING FREQUENCY CODE
570	DRUGS/SUPPLIES QUANTITY DISPENSED
571	DRUGS/SUPPLIES NUMBER OF DAYS
572	DRUGS/SUPPLIES BILLED AMOUNT
574	TOTAL AMOUNT PAID PER LINE
576	REVENUE PAID CODE
579	DRUGS/SUPPLIES DISPENSING FEE
586	RENDERING LINE PROVIDER FEIN
589	RENDERING LINE PROVIDER LAST/GROUP NAME
592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID
593	RENDERING LINE PROVIDER POSTAL CODE
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER
600	PLACE OF SERVICE LINE CODE
604	PRESCRIPTION LINE DATE
605	SERVICE LINE DATE(S) RANGE
615	REPORTING PERIOD
626	HCPCS PRINCIPAL PROCEDURE BILLED CODE
629	BILLING PROVIDER FEIN
630	BILLING PROVIDER STATE LICENSE NUMBER
634	BILLING PROVIDER NATIONAL PROVIDER ID
638	RENDERING BILL PROVIDER LAST/GROUP NAME
642	RENDERING BILL PROVIDER FEIN
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER
647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER
651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE
656	RENDERING BILL PROVIDER POSTAL CODE
657	RENDERING BILL PROVIDER COUNTRY CODE
667	SUPERVISING PROVIDER NATIONAL PROVIDER ID
678	FACILITY NAME
679	FACILITY FEIN
680	FACILITY STATE LICENSE NUMBER
681	FACILITY MEDICARE NUMBER
682	FACILITY PROVIDER NATIONAL PROVIDER ID
688	FACILITY POSTAL CODE
699	REFERRING PROVIDER NATIONAL PROVIDER ID
704	MANAGED CARE ORGANIZATION FEIN
712	MANAGED CARE ORGANIZATION POSTAL CODE
714	HCPCS LINE PROCEDURE BILLED CODE
715	JURISDICTION PROCEDURE BILLED CODE
717	HCPCS MODIFIER BILLED CODE

DN	Data Element Name
718	JURISDICTION MODIFIER BILLED CODE
721	NDC BILLED CODE
726	HCPCS LINE PROCEDURE PAID CODE
727	HCPCS MODIFIER PAID CODE
728	NDC PAID CODE
729	JURISDICTION PROCEDURE PAID CODE
730	JURISDICTION MODIFIER PAID CODE
731	SERVICE ADJUSTMENT GROUP CODE
732	SERVICE ADJUSTMENT REASON CODE
733	SERVICE ADJUSTMENT AMOUNT
734	SERVICE ADJUSTMENT UNITS
736	ICD-9 CM PROCEDURE CODE
737	HCPCS BILL PROCEDURE CODE

Section ~~L~~K: Required medical data elements

Medical data elements by name and source

The Medical Data Elements by Source Ttable lists the California-adopted IAIABC data elements that are to be included in EDI transmission of medical bill reports to the DWC. The table includes the IAIABC Data Number (DN), the data element name and where the data source in the Wworkers' Ccompensation Ssystem the data information is located. In the case of the CMS 1500 and UB92, UB04 the fields on the medical paper forms are identified. The table also includes information on which entity in the system has access to each data element. The entities include Insurance Agents (IA), Payers, Health Care Providers (HCP), Jurisdictional Licensing Boards (JLB), and Senders (SNDR).

California Medical Data Elements by Source

DN	DATA ELEMENT NAME	CMS 1500	UB 9204	IA	Payeer	HCP	JLB	SNDR
110	ACKNOWLEDGMENT TRANSACTION SET ID			x				x
513	ADMISSION DATE		1712					
535	ADMITTING DIAGNOSIS CODE		7669					
111	APPLICATION ACKNOWLEDGMENT CODE			x				x
564	BASIS OF COST DETERMINATION CODE				x			
532	BATCH CONTROL NUMBER							x
545	BILL ADJUSTMENT AMOUNT				x			
543	BILL ADJUSTMENT GROUP CODE				x			
544	BILL ADJUSTMENT REASON CODE				x			
546	BILL ADJUSTMENT UNITS				x			
508	BILL SUBMISSION REASON CODE				x			
503	BILLING FORMAT CODE				x			
629	BILLING PROVIDER FEIN	25	5					
528	BILLING PROVIDER LAST/GROUP NAME	33	1					
634	BILLING PROVIDER NATIONAL PROVIDER ID	33A	56		x	x		
542	BILLING PROVIDER POSTAL CODE	33	1					
537	BILLING PROVIDER PRIMARY SPECIALTY CODE	33B	81(B3)		x	x		
630	BILLING PROVIDER STATE LICENSE NUMBER						x	
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER					x	x	
502	BILLING TYPE CODE				x	x		
15	CLAIM ADMINISTRATOR CLAIM NUMBER	11			x	x		
187	CLAIM ADMINISTRATOR FEIN				x	x		
188	CLAIM ADMINISTRATOR NAME				x	x		
515	CONTRACT TYPE CODE				x	x		
512	DATE INSURER PAID BILL				x			
511	DATE INSURER RECEIVED BILL				x			
510	DATE OF BILL	31	8645(23)					
31	DATE OF INJURY	14	231					

California Medical Data Elements by Source

DN	DATA ELEMENT NAME	CMS 1500	UB 9204	IA	Payoer	HCP	JLB	SNDR
108	DATE PROCESSED			X				x
100	DATE TRANSMISSION SENT			X				x
554	DAYS/UNIT(S) BILLED	24G	46					
553	DAYS/UNIT(S) CODE					x		
557	DIAGNOSIS POINTER	24 E						
514	DISCHARGE DATE		33-32-3436		x			
562	DISPENSE AS WRITTEN CODE					x		
567	DME BILLING FREQUENCY CODE					x		
518	DRG CODE					x		
563	DRUG NAME					x		
572	DRUGS/SUPPLIES BILLED AMOUNT					x		
579	DRUGS/SUPPLIES DISPENSING FEE					x		
571	DRUGS/SUPPLIES NUMBER OF DAYS					x		
570	DRUGS/SUPPLIES QUANTITY DISPENSED					x		
116	ELEMENT ERROR NUMBER			x				x
115	ELEMENT NUMBER			x				x
152	EMPLOYEE EMPLOYMENT VISA	1a	60		x	x	x	
44	EMPLOYEE FIRST NAME	2	128					
153	EMPLOYEE GREEN CARD	1a	60		x	x	x	
43	EMPLOYEE LAST NAME	2	128					
45	EMPLOYEE MIDDLE NAME/INITIAL	2	128					
156	EMPLOYEE PASSPORT NUMBER	1a	60		x	x	x	
42	EMPLOYEE SOCIAL SECURITY NUMBER	1a	60		x	x	x	
504	FACILITY CODE		4(2-3)					
679	FACILITY FEIN	32b	5			x		
681	FACILITY MEDICARE NUMBER	32	51			x		
678	FACILITY NAME	32	1					
682	FACILITY NATIONAL PROVIDER ID	32a	51		x	x		
688	FACILITY POSTAL CODE	32	1					
680	FACILITY STATE LICENSE NUMBER	32b				x	x	
737	HCPCS BILL PROCEDURE CODE	24D	8174(a-e)					
714	HCPCS LINE PROCEDURE BILLED CODE	24D	44					
726	HCPCS LINE PROCEDURE PAID CODE				x			
717	HCPCS MODIFIER BILLED CODE	24D	44					
727	HCPCS MODIFIER PAID CODE				x			
626	HCPCS PRINCIPAL PROCEDURE BILLED CODE		8074					
522	ICD-9 CM DIAGNOSIS CODE	21 1-4	68-7567(A-Q)					
525	ICD-9 CM PRINCIPAL PROCEDURE CODE		8074					

California Medical Data Elements by Source								
DN	DATA ELEMENT NAME	CMS 1500	UB ~~92~~04	IA	Payee~~r~~	HCP	JLB	SNDR
736	ICD-9 CM PROCEDURE CODE		~~81~~74(a-e)					
6	INSURER FEIN				x			
7	INSURER NAME	11c	50					
~~105~~	~~INTERCHANGE VERSION ID~~							
5	JURISDICTION CLAIM NUMBER				x			
718	JURISDICTION MODIFIER BILLED CODE	24D	44			~~x~~		
730	JURISDICTION MODIFIER PAID CODE				x			
715	JURISDICTION PROCEDURE BILLED CODE	24D	44		x	~~x~~		
729	JURISDICTION PROCEDURE PAID CODE				x			
547	LINE NUMBER				x			
704	MANAGED CARE ORGANIZATION FEIN				x	x	~~x~~	
208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER						~~x~~	
209	MANAGED CARE ORGANIZATION NAME				x	x		
712	MANAGED CARE ORGANIZATION POSTAL CODE				x	x		
721	NDC BILLED CODE	24				x		
728	NDC PAID CODE				x			
102	ORIGINAL TRANSMISSION DATE			x				x
103	ORIGINAL TRANSMISSION TIME			x				x
555	PLACE OF SERVICE BILL CODE					x		
600	PLACE OF SERVICE LINE CODE	24 B						
527	PRESCRIPTION BILL DATE					x		
604	PRESCRIPTION LINE DATE					x		
561	PRESCRIPTION LINE NUMBER					x		
521	PRINCIPAL DIAGNOSIS CODE		67					
550	PRINCIPAL PROCEDURE DATE		~~80~~74					
524	PROCEDURE DATE		~~81~~74					
507	PROVIDER AGREEMENT CODE				x	x		
99	RECEIVER ID			x				x
699	REFERRING PROVIDER NATIONAL PROVIDER ID	17b	78, 79		x	x		
526	RELEASE OF INFORMATION CODE					x		
657	RENDERING BILL PROVIDER COUNTRY CODE	32	1					
642	RENDERING BILL PROVIDER FEIN	25						
638	RENDERING BILL PROVIDER LAST/GROUP NAME	32	76					
647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	32a	76a		x	x		
656	RENDERING BILL PROVIDER POSTAL CODE	32	~~1~~					
651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE					x	x	

California Medical Data Elements by Source								
DN	DATA ELEMENT NAME	CMS 1500	UB ~~92~~04	IA	Pay~~o~~er	HCP	JLB	SNDR
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER	32b	76				x	
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER	32b					x	
586	RENDERING LINE PROVIDER FEIN					x		
589	RENDERING LINE PROVIDER LAST/GROUP NAME					x		
592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID				x	x		
593	RENDERING LINE PROVIDER POSTAL CODE					x		
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	24J_1			x	x		
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER	24J_1					x	
615	REPORTING PERIOD				x			
559	REVENUE BILLED CODE		42					
576	REVENUE PAID CODE				x			
98	SENDER ID			x				x
733	SERVICE ADJUSTMENT AMOUNT				x			
731	SERVICE ADJUSTMENT GROUP CODE				x			
732	SERVICE ADJUSTMENT REASON CODE				x			
734	SERVICE ADJUSTMENT UNITS				x			
509	SERVICE BILL DATE(S) RANGE	~~18~~	6					
605	SERVICE LINE DATE(S) RANGE	24A	45					
667	SUPERVISING PROVIDER NATIONAL PROVIDER ID					x		
104	TEST/PRODUCTION INDICATOR			x				
109	TIME PROCESSED			x				x
101	TIME TRANSMISSION SENT			x				x
516	TOTAL AMOUNT PAID PER BILL				x			
574	TOTAL AMOUNT PAID PER LINE				x			
501	TOTAL CHARGE PER BILL	28	47					
552	TOTAL CHARGE PER LINE	24F	47					
566	TOTAL CHARGE PER LINE – PURCHASE	24F						
565	TOTAL CHARGE PER LINE – RENTAL	24F						
266	TRANSACTION TRACKING NUMBER			x				

Medical data element requirement table

The report type defines the specific transaction type being sent (i.e. 837 = medical bill payment records). The bill submission reason code (BSRC) defines the specific purpose (event) for which the transaction is being sent (triggered).

00 = Original	The~~is~~ code is utilized the first time a medical bill is submitted to the jurisdiction including the re-submission of a medical bill rejected due to a ~~correctable~~ critical error.
01 = Cancellation	The original bill was sent in error ~~or a re-submission of a medical bill with a correctable error previously accepted~~. This transaction cancels the original (00).
05 = Replace	The "replace" is only utilized to replace DN15 Claim Administrator Claim Number.

Specific requirements depend upon the type of transaction reported; original (00), cancel (01), or replacement (05). The transaction type is identified by the Bill Submission Reason Code (BSRC) (See Section M ~~J~~K ~~– Events That Trigger Reporting~~). Each data element is designated as Mandatory (M), Conditional (C), or Optional (O).

M = Mandatory	The data element must be sent and all edits applied to it must be passed successfully or the entire transaction will be rejected.
C = Conditional	The data element becomes mandatory under conditions established by the Mandatory Trigger.
O = Optional	The data element is sent if available. If the data element is sent, the data edits are applied to the data element.

Mandatory Trigger: The trigger~~, which~~ that makes a conditional data element mandatory.

The alphabetically-sorted element requirement table provides a tool to communicate the business data element requirements of the DWC to each trading partner. The structure allows for requirement codes (M, C, or O) to be defined at the data element level (DN) for each bill submission reason code (00, 01, or 05). Further, it provides for data element requirements to differ based on report requirements criteria established ~~e~~in the ~~E~~event ~~T~~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. ~~(See Section J K – Events That Trigger Reporting~~). The following element requirement table does not apply to medical lien lump sum payments or settlements (See Section O).

MEDICAL DATA ELEMENT REQUIREMENT TABLE Bill Submission Reason Codes					
-	-	Original	Cancellation	Replace	-
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
532	BATCH CONTROL NUMBER	M	M	M	-
100	DATE TRANSMISSION SENT	M	M	M	-
101	TIME TRANSMISSION SENT	M	M	M	-
98	SENDER IDENTIFICATION	M	M	M	-
99	RECEIVER IDENTIFICATION	M	M	M	-
615	REPORTING PERIOD	M	M	M	-

MEDICAL DATA ELEMENT REQUIREMENT TABLE Bill Reason Submission Codes					
-	-	Original	Cancellation	Replace	-
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
5	JURISDICTIONAL CLAIM NUMBER	C	O	O	If the first report of injury has been filed and a jurisdictional claim number is available
715	JURISDICTIONAL PROCEDURE BILLED CODE	C	O	O	If the special procedure is included in the California Official Medical Fee Schedule
718	JURISDICTIONAL MODIFIER BILLED CODE	C	O	O	If DN715 is modified
729	JURISDICTIONAL PROCEDURE PAID CODE	C	O	O	If different than DN715
730	JURISDICTIONAL MODIFIER PAID CODE	C	O	O	If different than DN718
6	INSURER FEIN	M	M	M	
7	INSURER NAME	M	O	O	-
187	CLAIM ADMINISTRATOR FEIN	C	O	O	If the Claim Administrator FEIN is different then Insurer FEIN, DN 6
188	CLAIM ADMINISTRATOR NAME	C	O	O	If the Claim Administrator name is different then Insurer name, DN 7
15	CLAIM ADMINISTRATOR CLAIM NUMBER	M	M	M	-
31	DATE OF INJURY	M	O	O	-
43	EMPLOYEE LAST NAME	M	O	O	-
44	EMPLOYEE FIRST NAME	M	O	O	-
45	EMPLOYEE MIDDLE NAME	O	O	O	-

153	EMPLOYEE GREEN CARD	C	O	O	If Employee Social Security number is not available. (see DN42)
152	EMPLOYEE EMPLOYMENT VISA	C	O	O	If Employee Social Security number or Employee Green Card number is not available. (see DN42)
156	EMPLOYEE PASSPORT NUMBER	C	O	O	If Employee Social Security number, Employee Green Card Number, or Employee Employment Visa is not available. (see DN42)
42	EMPLOYEE SOCIAL SECURITY NUMBER	M	O	O	Can use default values of all 9's if injured worker is not a United States citizen and has no other identification (DN153, DN152, DN156)
704	MANAGED CARE ORGANIZATION FEIN	C	O	O	For HCO claims use the FEIN of the sponsoring organization.
209	MANAGED CARE ORGANIZATION NAME	O	O	O	-
712	MANAGED CARE ORGANIZATION POSTAL CODE	O	O	O	-

MEDICAL DATA ELEMENT REQUIREMENT TABLE

Bill Submission Reason Codes

-	-	Original	Cancellation	Replace	-
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	O	O	O	-
504	FACILITY CODE	C	C	O	If DN 503 equals "A"
515	CONTRACT TYPE CODE	C	O	O	If DN 518 is present, then use value 01 or 09
518	DRG CODE	C	O	O	If DN 503 equals "A" and if included in the California Inpatient Hospital Fee Schedule
521	PRINCIPAL DIAGNOSIS CODE	C	O	O	If DN 503 equals "A"
550	PRINCIPAL PROCEDURE DATE	C	O	O	If DN 503 equals "A" and if DN525 or DN626 is present
513	ADMISSION DATE	C	O	O	If Billing Format Code, DN 503, is "A" and patient has been admitted
514	DISCHARGE DATE	C	O	O	If Billing Format Code, DN 503, is "A" and patient has been discharged
535	ADMITTING DIAGNOSIS CODE	C	O	O	If Billing Format Code, DN 503, is "A" and patient has been admitted
679	FACILITY FEIN	C	O	O	If DN 503 equals "A"
678	FACILITY NAME	C	O	O	If service performed in a licensed facility
688	FACILITY POSTAL CODE	C	O	O	If service performed in a licensed facility

680	FACILITY STATE LICENSE NUMBER	O	O	O	
681	FACILITY MEDICARE NUMBER	O	O	O	-
559	REVENUE BILLED CODE	C	O	O	If a value for DN 504 with 2nd digit equal to 1
576	REVENUE PAID CODE	C	O	O	If different than DN559
629	BILLING PROVIDER FEIN	C	O	O	If different from DN 642
528	BILLING PROVIDER LAST/GROUP NAME	C	O	O	If different from DN 638
542	BILLING PROVIDER POSTAL CODE	C	O	O	If different than DN656
630	BILLING PROVIDER STATE LICENSE NUMBER	C	O	O	If different than DN643(see WCIS regulations)
537	BILLING PROVIDER PRIMARY SPECIALTY CODE	O	O	O	-
502	BILLING TYPE CODE	C	O	O	If DN 503 equals "B" and prescriptions or durable medical equipment are billed

MEDICAL DATA ELEMENT REQUIREMENT TABLE

Bill Submission Reason Codes

	-	Original	Cancellation	Replace	-
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
563	DRUG NAME	C	O	O	If present
570	DRUGS/SUPPLIES QUANTITY DISPENSED	C	O	O	If DN 502, value is "RX" or "MO".
571	DRUGS/SUPPLIES NUMBER OF DAYS	C	O	O	If DN 502, value is "RX" or "MO".
572	DRUGS/SUPPLIES BILLED AMOUNT	C	O	O	If DN 502, value is "RX" or "MO".
579	DRUGS/SUPPLIES DISPENSING FEE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
562	DISPENSE AS WRITTEN CODE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
564	BASIS OF COST DETERMINATION CODE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
721	NDC BILLED CODE	C	O	O	If a pharmaceutical bill or a drug is dispensed by a physician during an office visit.
728	NDC PAID CODE	C	O	O	If different then DN721
527	PRESCRIPTION BILL DATE	C	O	O	If different than DN604
604	PRESCRIPTION LINE DATE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
561	PRESCRIPTION LINE NUMBER	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format

638	RENDERING BILL PROVIDER LAST/GROUP NAME	M	O	O	-
656	RENDERING BILL PROVIDER POSTAL CODE	M	O	O	-
642	RENDERING BILL PROVIDER FEIN	M	O	O	-
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER	M	O	O	
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER	C	O	O	If different then DN643
651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	M	O	O	-
586	RENDERING LINE PROVIDER FEIN	C	O	O	If different from DN 642
589	RENDERING LINE PROVIDER LAST/GROUP NAME	C	O	O	If different from DN 638
593	RENDERING LINE PROVIDER POSTAL CODE	C	O	O	If different from DN 656

MEDICAL DATA ELEMENT REQUIREMENT TABLE

Bill Submission Reason Codes

	-	Original	Cancellation	Replace	
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
592	RENDERING LINE PROVIDER NATIONAL ID	C	O	O	When available (see WCIS regulations)
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	C	O	O	If different from DN 651
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER	C	O	O	If different from DN 643
500	UNIQUE BILL ID NUMBER	M	M	O	-
266	TRANSACTION TRACKING NUMBER	M	O	O	
501	TOTAL CHARGE PER BILL	M	O	O	-
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	C	C	O	If DN501 is present
503	BILLING FORMAT CODE	M	M	O	-
507	PROVIDER AGREEMENT CODE	M	O	O	Enter the value "P" if the injured workers medical treatment is provided within a Medical Provider Network approved by the DWC.
508	BILL SUBMISSION REASON CODE	M	M	M	-
509	SERVICE BILL DATE(S) RANGE	C	O	O	If different than DN605

510	DATE OF BILL	O	O	O	-
511	DATE INSURER RECEIVED BILL	M	O	O	-
512	DATE INSURER PAID BILL	M	O	O	-
516	TOTAL AMOUNT PAID PER BILL	C	O	O	If different than DN501
522	ICD-9 CM DIAGNOSIS CODE	C	O	O	If DN521 is present and more then one diagnosis occurs or if DN503 = B and DN714 or DN715 or a drug is dispensed by a physician during an office visit.
544	BILL ADJUSTMENT REASON CODE	C	O	O	If paid amount is not equal to billed amount
543	BILL ADJUSTMENT GROUP CODE	C	O	O	If paid amount is not equal to billed amount
545	BILL ADJUSTMENT AMOUNT	C	O	O	If paid amount is not equal to billed amount
546	BILL ADJUSTMENT UNITS	C	O	O	If paid amount is not equal to billed amount

MEDICAL DATA ELEMENT REQUIREMENT TABLE

Bill Submission Reason Codes

-	-	Original	Cancellation	Replace	-
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
555	PLACE OF SERVICE BILL CODE	C	C	O	If DN503 equals "B"
557	DIAGNOSIS POINTER	C	O	O	If DN503 equals "B" and DN715 or DN714 is present or a drug is dispensed by a physician during an office visit.
567	DME BILLING FREQUENCY CODE	C	O	O	If DN502 = DM and DN565 is present
526	RELEASE OF INFORMATION CODE	O	O	O	
547	LINE NUMBER	M	O	O	-
524	PROCEDURE DATE	C	O	O	If DN 503 equals "A" and more than one surgical procedure was performed
552	TOTAL CHARGE PER LINE – OTHER	C	O	O	If DN502 not equal to RX or MO or DM
565	TOTAL CHARGE PER LINE – RENTAL	C	O	O	If Durable Medical Equipment is rented
566	TOTAL CHARGE PER LINE – PURCHASE	C	O	O	If Durable Medical Equipment is purchased
554	DAYS/UNITS BILLED	C	O	O	If DN715 or DN714 are present or DN502 = DM, or a drug is dispensed by a physician during an office visit.
553	DAYS/UNITS CODE	C	O	O	If DN715 or DN714 are present or DN502 = DM or a drug is dispensed by a physician during an office visit.
574	TOTAL AMOUNT PAID PER LINE	C	O	O	If paid amount is not equal to billed amount
600	PLACE OF SERVICE LINE CODE	C	O	O	If different from DN 555 and not a pharmacy bill

605	SERVICE LINE DATE(S) RANGE	C	O	O	If not a pharmacy bill submitted on universal claim form/NCPDP format
525	ICD-9 CM PRINCIPAL PROCEDURE CODE	C	O	O	If Billing Format Code, DN 503, is "A" and the code value is not a HCPCS code. For surgical bills only.
626	HCPCS PRINCIPAL PROCEDURE BILLED CODE	C	O	O	If Billing Format Code, DN 503, is "A" and the code value is not an ICD-9 code. For surgical bills only.
736	ICD_9 CM PROCEDURE CODE	C	O	O	If DN525 is present and more than one procedure is performed
737	HCPCS BILL PROCEDURE CODE	C	O	O	If DN626 is present and more than one procedure is performed
714	HCPCS LINE PROCEDURE BILLED CODE	C	O	O	If DN502 not equal RX or MO, and if DN715 or DN721 not present
717	HCPCS MODIFIER BILLED CODE	C	O	O	If DN714 is modified
726	HCPCS LINE PROCEDURE PAID CODE	C	O	O	If different than DN714 the line is adjusted

Bill Submission Reason Codes					
-	-	Original	Cancellation	Replace	-
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
727	HCPCS MODIFIER PAID CODE	C	O	O	If different than DN 717
732	SERVICE ADJUSTMENT REASON CODE	C	O	O	If paid amount is not equal to billed amount
731	SERVICE ADJUSTMENT GROUP CODE	C	O	O	If paid amount is not equal to billed amount
733	SERVICE ADJUSTMENT AMOUNT	C	O	O	If paid amount is not equal to billed amount

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Submission Reason Codes					
(Does not apply to medical lien lump sum payments or settlements)					
		Original	Cancellation	Replace	
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
513	ADMISSION DATE	C	O	O	If Billing Format Code, (DN503), equals is "A" and patient has been admitted
535	ADMITTING DIAGNOSIS CODE	C	O	O	If Billing Format Code, (DN503), equals is "A" and patient has been admitted
564	BASIS OF COST DETERMINATION CODE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
532	BATCH CONTROL NUMBER	M	M	M	
545	BILL ADJUSTMENT AMOUNT	C	O	O	If paid amount is not equal to billed amount
543	BILL ADJUSTMENT GROUP CODE	C	O	O	If paid amount is not equal to billed amount
544	BILL ADJUSTMENT REASON CODE	C	O	O	If paid amount is not equal to billed amount
546	BILL ADJUSTMENT UNITS	C	O	O	If paid amount is not equal to billed amount
508	BILL SUBMISSION REASON CODE	M	M	M	
503	BILLING FORMAT CODE	M	M	O	
630	BILLING PROVIDER STATE LICENSE NUMBER	CO	O	O	If different than DN643(see WCIS regulations)
528	BILLING PROVIDER LAST/GROUP NAME	C	O	O	If different from Rendering Bill Provider Last/Group Name (DN638)
629	BILLING PROVIDER FEIN	C	O	O	If different from Rendering Bill Provider FEIN (DN642)
634	BILLING PROVIDER NATIONAL PROVIDER ID	C	O	O	If different from Rendering Bill Provider National Provider ID (DN647)
542	BILLING PROVIDER POSTAL CODE	C	O	O	If different than from Rendering Bill Provider Postal Code (DN656)
537	BILLING PROVIDER PRIMARY SPECIALTY CODE	O	O	O	
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	MC	MC	MO	If Total Charge Per Bill (DN501) is present
502	BILLING TYPE CODE	C	O	O	If Billing Format Code (DN503) equals "B" and prescriptions or durable medical equipment are billed the bill contains one hundred percent pharmaceutical codes or one hundred percent durable medical codes.
15	CLAIM ADMINISTRATOR CLAIM NUMBER	M	M	M	
187	CLAIM ADMINISTRATOR FEIN	C	O	O	If the Claim Administrator FEIN is different then from Insurer FEIN (DN6)
188	CLAIM ADMINISTRATOR NAME	C	O	O	If the Claim Administrator name is different then from Insurer Nname (DN7)
515	CONTRACT TYPE CODE	C	O	O	If DRG Code (DN518) is present, then use value 01 or 09

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Submission Reason Codes					
(Does not apply to medical lien lump sum payments or settlements)					
		Original	Cancellation	Replace	
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
512	DATE INSURER PAID BILL	M	O	O	
511	DATE INSURER RECEIVED BILL	M	O	O	
510	DATE OF BILL	O	O	O	
31	DATE OF INJURY	M	M~~O~~	M~~O~~	
100	DATE TRANSMISSION SENT	M	M	M	
554	DAYS/UNITS BILLED	C	O	O	If Jurisdiction Procedure Billed Code (DN715) or HCPCS Line Procedure Billed Code (DN714) are present or Billing Type Code (DN502) = equals "DM," or a drug is dispensed by a physician during an office visit
553	DAYS/UNITS CODE	C	O	O	If Jurisdiction Procedure Billed Code (DN715) or HCPCS Line Procedure Billed Code (DN714) are present or Billing Type Code (DN502) = equals "DM," or a drug is dispensed by a physician during an office visit
557	DIAGNOSIS POINTER	C	O	O	If Billing Format Code (DN503) equals "B" and HCPCS Line Procedure Billed Code (DN714) or Jurisdiction Procedure Billed Code (DN715) is present or a drug is dispensed by a physician during an office visit
514	DISCHARGE DATE	C	O	O	If Billing Format Code~~,~~ (DN503)~~,~~ equals ~~is~~ "A" and patient has been discharged
562	DISPENSE AS WRITTEN CODE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
567	DME BILLING FREQUENCY CODE	C	O	O	If Billing Type Code (DN502) = equals "DM" and Total Charge per Line - Rental (DN565) is present
518	DRG CODE	C	O	O	If Billing Format Code (DN503) equals "A" and if included in the California Inpatient Hospital Fee Schedule
563	DRUG NAME	C	O	O	If present
572	DRUGS/SUPPLIES BILLED AMOUNT	C	O	O	If Billing Type Code (DN502)~~, value~~ equals ~~is~~ "RX" or "MO"
579	DRUGS/SUPPLIES DISPENSING FEE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
571	DRUGS/SUPPLIES NUMBER OF DAYS	C	O	O	If Billing Type Code (DN502)~~, value~~ equals ~~is~~ "RX" or "MO"
570	DRUGS/SUPPLIES QUANTITY DISPENSED	C	O	O	If Billing Type Code (DN502)~~, value~~ equals ~~is~~ "RX" or "MO"
152	EMPLOYEE EMPLOYMENT VISA	C	O	O	If Employee Social Security N~~n~~umber (DN42) or Employee Green Card N~~n~~umber (DN153) is not available ~~(see DN42)~~

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Submission Reason Codes					
(Does not apply to medical lien lump sum payments or settlements)					
		Original	Cancellation	Replace	
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
44	EMPLOYEE FIRST NAME	M	O	O	
153	EMPLOYEE GREEN CARD	C	O	O	If Employee Social Security Nnumber (DN42) is not available (see DN42)
43	EMPLOYEE LAST NAME	M	O	O	
45	EMPLOYEE MIDDLE NAME	O	O	O	
156	EMPLOYEE PASSPORT NUMBER	C	O	O	If Employee Social Security N~~u~~mber (DN42), Employee Green Card N~~u~~mber (DN153), or Employee Employment Visa (DN152) is not available ~~(see DN42)~~
42	EMPLOYEE SOCIAL SECURITY NUMBER	M	O	O	Can use default values of ~~all 9's~~ "999999999" or "000000006" if injured worker has no SSN, is not a United States citizen and has no other identification (DN153, DN152, DN156). ~~If employee refuses to provide SSN, send "000000007".~~
504	FACILITY CODE	C	C	O	If Billing Format Code (DN503) equals "A"
679	FACILITY FEIN	C	O	O	If Billing Format Code (DN503) equals "A"
681	FACILITY MEDICARE NUMBER	O	O	O	
678	FACILITY NAME	C	O	O	If service performed in a licensed facility
682	FACILITY NATIONAL PROVIDER ID	C	O	O	If facility services are billed on a UB04 format
688	FACILITY POSTAL CODE	C	O	O	If service performed in a licensed facility
680	FACILITY STATE LICENSE NUMBER	~~O~~C	O	O	If service preformed in a licensed facility
737	HCPCS BILL PROCEDURE CODE	C	O	O	If HCPCS Principal Procedure Billed Code (DN626) is present and more than one procedure is performed
726	HCPCS LINE PROCEDURE PAID CODE	C	O	O	If ~~different than DN714 the line is adjusted~~ different from DN714
714	HCPCS LINE PROCEDURE BILLED CODE	C	O	O	If Billing Type Code (DN502) not equal to "RX" or "MO, " and if Jurisdiction Procedure Billed Code (DN715) or NDC Billed Code (DN721) not present or not present when Billing Format Code (DN503) equals "A".
717	HCPCS MODIFIER BILLED CODE	C	O	O	If HCPCS Line Procedure Billed Code (DN714) is modified

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Submission Reason Codes					
(Does not apply to medical lien lump sum payments or settlements)					
		Original	Cancellation	Replace	
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
727	HCPCS MODIFIER PAID CODE	C	O	O	If different ~~than~~ from HCPCS Modifier Billed Code (DN717)
626	HCPCS PRINCIPAL PROCEDURE BILLED CODE	C	O	O	If Billing Format Code, (DN503), is "A" and the code value is not an ICD-9 code For surgical bills only
736	ICD 9 CM PROCEDURE CODE	C	O	O	If ICD-9 CM Principal Procedure Code (DN525) is present and more than one procedure is performed
522	ICD-9 CM DIAGNOSIS CODE	C	O	O	If Principal Diagnosis Code (DN521) is present and more tha~~e~~n one diagnosis occurs or if Billing Code Format (DN503) = equals "B" and HCPCS Line Procedure Billed Code (DN714) or Jurisdiction Procedure Billed Code (DN715) is present or a drug is dispensed by a physician during an office visit
525	ICD-9 CM PRINCIPAL PROCEDURE CODE	C	O	O	If Billing Format Code, (DN503), is "A" and the code value is not a HCPCS code. For surgical bills only
6	INSURER FEIN	M	M	M	
7	INSURER NAME	M	O	O	
5	JURISDICTION~~AL~~ CLAIM NUMBER	C	O	O	If the first report of injury has been filed and a jurisdictiona~~l~~ claim number is available
718	JURISDICTION~~AL~~ MODIFIER BILLED CODE	C	O	O	If the Jurisdiction Procedure Billed Code (DN715) is modified
730	JURISDICTION~~AL~~ MODIFIER PAID CODE	C	O	O	If different ~~than~~ from Jurisdiction Modifier Billed Code (DN718)
715	JURISDICTION~~AL~~ PROCEDURE BILLED CODE	C	O	O	If the Jurisdiction Procedure Billed Code (DN715) is not a HCPCS procedure code ~~included in the California Official Medical Fee Schedule~~
729	JURISDICTION~~AL~~ PROCEDURE PAID CODE	C	O	O	If ~~different than DN715 the line is adjusted~~ different from DN715
547	LINE NUMBER	M	O	O	
704	MANAGED CARE ORGANIZATION FEIN	C	O	O	For HCO claims, use the FEIN of the sponsoring organization
208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	O	O	O	
209	MANAGED CARE ORGANIZATION NAME	O	O	O	
712	MANAGED CARE ORGANIZATION POSTAL CODE	O	O	O	
721	NDC BILLED CODE	C	O	O	If a pharmaceutical bill or a drug is dispensed by a physician during an office visit

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Submission Reason Codes					
(Does not apply to medical lien lump sum payments or settlements)					
		Original	Cancellation	Replace	
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
728	NDC PAID CODE	C	O	O	If ~~different then DN721 the line is adjusted~~ different from DN721
555	PLACE OF SERVICE BILL CODE	C	C	O	If Billing Format Code (DN503) equals "B"
600	PLACE OF SERVICE LINE CODE	C	O	O	If different from Place of Service Bill Code (DN555) and not a pharmacy bill
527	PRESCRIPTION BILL DATE	C	O	O	If different ~~than~~ from Prescription Line Date DN604
604	PRESCRIPTION LINE DATE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
561	PRESCRIPTION LINE NUMBER	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
521	PRINCIPAL DIAGNOSIS CODE	C	O	O	If Billing Format Code (DN503) equals "A"
550	PRINCIPAL PROCEDURE DATE	C	O	O	If Billing Format Code (DN503) equals "A" and if ICD-9 CM Principal Procedure Code (DN525) or HCPCS Principal Procedure Billed Code (DN626) is present
524	PROCEDURE DATE	C	O	O	If Billing Format Code (DN503) equals "A" and more than one surgical procedure was performed
507	PROVIDER AGREEMENT CODE	M	O	O	Enter the value "P" if the injured worker's medical treatment is provided within a Medical Provider Network approved by the DWC. "H" = HMO Agreement. "N" = No Agreement. "Y" = PPO Agreement ~~Enter the value "P" if the injured workers medical treatment is provided within a Medical Provider Network approved by the DWC~~
99	RECEIVER ID~~ENTIFICATION~~	M	M	M	
699	REFERRING PROVIDER NATIONAL PROVIDER ID	C	O	O	When applicable on professional and institutional bills
526	RELEASE OF INFORMATION CODE	O	O	O	
657	RENDERING BILL PROVIDER COUNTRY CODE	C	O	O	If service provided outside the United States
656	RENDERING BILL PROVIDER POSTAL CODE	C~~M~~	O	O	If service provided inside the United States
642	RENDERING BILL PROVIDER FEIN	M	O	O	
638	RENDERING BILL PROVIDER LAST/GROUP NAME	M	O	O	
647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	C~~M~~	O	O	Provide a valid code if available. ~~If not, use string of consecutive nines. See WCIS regulation 9702(e) footnote 7~~

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Submission Reason Codes					
(Does not apply to medical lien lump sum payments or settlements)					
		Original	Cancellation	Replace	
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	M	O	O	
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER	~~C~~O	O	O	~~If different then DN643~~
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER	M	O	O	Provide a valid code if available. If not, use string of consecutive nines "999999999." ~~See WCIS regulation 9702(e) footnote 7~~
586	RENDERING LINE PROVIDER FEIN	C	O	O	If different from Rendering Bill Provider FEIN (DN642)
589	RENDERING LINE PROVIDER LAST/GROUP NAME	C	O	O	If different from Rendering Bill Provider Last/Group Name (DN638)
592	RENDERING LINE PROVIDER NATIONAL ID	C	O	O	If different from Rendering Bill Provider National ID (DN647)
593	RENDERING LINE PROVIDER POSTAL CODE	C	O	O	If different from Rendering Bill Provider Postal Code (DN656)
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	C	O	O	If different from Rendering Bill Provider Primary Specialty Code (DN651)
~~592~~	~~RENDERING LINE PROVIDER NATIONAL ID~~	~~C~~	~~O~~	~~O~~	~~If different from Rendering Bill Provider National ID (DN647)~~
~~593~~	~~RENDERING LINE PROVIDER POSTAL CODE~~	~~C~~	~~O~~	~~O~~	~~If different than from Rendering Bill Provider Postal Code (DN656)~~
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER	C	O	O	If different from DN643
~~586~~	~~RENDERING LINE PROVIDER FEIN~~	~~C~~	~~O~~	~~O~~	~~If different from Rendering Bill Provider FEIN (DN642)~~
~~589~~	~~RENDERING LINE PROVIDER LAST/GROUP NAME~~	~~C~~	~~O~~	~~O~~	~~If different from Rendering Bill Provider Last/Group Name (DN638)~~
615	REPORTING PERIOD	M	M	M	
559	REVENUE BILLED CODE	C	O	O	If a value for Facility Code (DN504) is present with 2nd digit equal to 1
576	REVENUE PAID CODE	C	O	O	If different ~~than~~ from Revenue Billed Code (DN559)
98	SENDER ID~~ENTIFICATION~~	M	M	M	
733	SERVICE ADJUSTMENT AMOUNT	C	O	O	If paid amount is not equal to billed amount
731	SERVICE ADJUSTMENT GROUP CODE	C	O	O	If paid amount is not equal to billed amount
732	SERVICE ADJUSTMENT REASON CODE	C	O	O	If paid amount is not equal to billed amount
734	SERVICE ADJUSTMENT UNITS	C	O	O	If days(s)/units(s) paid not equal to days(s)/units(s) billed at the line level.
509	SERVICE BILL DATE(S) RANGE	C	O	O	If different ~~than~~ from Service Line Date(s) Range (DN605)

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Submission Reason Codes					
(Does not apply to medical lien lump sum payments or settlements)					
		Original	Cancellation	Replace	
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
605	SERVICE LINE DATE(S) RANGE	C	O	O	If n~~N~~ot a pharmacy bill and submitted on universal claim form/NCPDP format
667	SUPERVISING PROVIDER NATIONAL PROVIDER ID	C	0	0	When a non-licensed rendering provider is being directed/supervised by a licensed provider. ~~When applicable on institutional bills~~
101	TIME TRANSMISSION SENT	M	M	M	
516	TOTAL AMOUNT PAID PER BILL	C	O	O	If different ~~than~~ from Total Charge Per Bill (DN501)
574	TOTAL AMOUNT PAID PER LINE	C	O	O	If paid amount is not equal to billed amount
501	TOTAL CHARGE PER BILL	M	O	O	
566	TOTAL CHARGE PER LINE – PURCHASE	C	O	O	If Durable Medical Equipment is purchased
565	TOTAL CHARGE PER LINE – RENTAL	C	O	O	If Durable Medical Equipment is rented
552	TOTAL CHARGE PER LINE –OTHER	C	O	O	If Billing Type Code (DN502) not equal to "RX" or "MO" or "DM"
266	TRANSACTION TRACKING NUMBER	M	O	O	
500	UNIQUE BILL ID NUMBER	M	M	O	

Section ML: Data edits

California-adopted IAIABC data edits and error messages

The California ~~DWC~~ adopted IAIABC data elements edit matrix provides the standard data edits and error codes the WCIS applies to the ANSI 837 EDI medical bill payment transmissions. The error codes will be transmitted back to each trading partner in the 824 acknowledgments. See the *IAIABC EDI Implementation Guides for Medical Bill Payment Records*, *Release 1.1, July 200~~4~~9* for more information on the standard IAIABC edits.

CALIFORNIA-ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

	ERROR MESSAGES	Must be numeric (0-9)	Must be valid date (CCYYMMDD)	Must be A-Z, 0-9, or spaces	Must be <= Date of injury	Must be >= Date of injury	No match on database	All digits cannot be the same	Must be <= Current date	Code/ID valid	Invalid Event Sequence/Relationship	Must be >= Date payer received bill	Must be >= From Service Date	Must be <= 'Thru Service date
DN	**DATA ELEMENT NAME**	028	029	030	033	034	039	040	041	058	063	073	074	075
110	ACKNOWLEDGMENT TRANSACTION SET ID									x				
513	ADMISSION DATE		x			x			x					
535	ADMITTING DIAGNOSIS CODE									x				
111	APPLICATION ACKNOWLEDGMENT CODE													
564	BASIS OF COST DETERMINATION CODE									x				
532	BATCH CONTROL NUMBER	x												
545	BILL ADJUSTMENT AMOUNT	x												
543	BILL ADJUSTMENT GROUP CODE									x				
544	BILL ADJUSTMENT REASON CODE									x				
546	BILL ADJUSTMENT UNITS	x												
508	BILL SUBMISSION REASON CODE									x	x			
503	BILLING FORMAT CODE									x				
629	BILLING PROVIDER FEIN	x						x						
528	BILLING PROVIDER LAST/GROUP NAME													
634	BILLING PROVIDER NATIONAL PROVIDER ID			x						x				
542	BILLING PROVIDER POSTAL CODE									x				
537	BILLING PROVIDER PRIMARY SPECIALTY CODE									x				

CALIFORNIA-ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

DN	DATA ELEMENT NAME	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	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	058 Code/ID valid	063 Invalid Event Sequence/Relationship	073 Must be >= Date payer received bill	074 Must be >= From Service Date	075 Must be <= Thru Service date
	ERROR MESSAGES													
630	BILLING PROVIDER STATE LICENSE NUMBER			x										
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER			x										
502	BILLING TYPE CODE									x				
15	CLAIM ADMINISTRATOR CLAIM NUMBER			x			x							
187	CLAIM ADMINISTRATOR FEIN	x					x	x						
188	CLAIM ADMINISTRATOR NAME													
515	CONTRACT TYPE CODE									x				
512	DATE INSURER PAID BILL		x			x			x			x		
511	DATE INSURER RECEIVED BILL		x			x			x					
510	DATE OF BILL		x			x			x					
31	DATE OF INJURY		x						x					
108	DATE PROCESSED		x						x					
100	DATE TRANSMISSION SENT		x						x					
554	DAYS/UNITS BILLED	x												
553	DAYS/UNITS CODE									x				
557	DIAGNOSIS POINTER	x							~~x~~					
514	DISCHARGE DATE		x			x			x					
562	DISPENSE AS WRITTEN CODE									x				
567	DME BILLING FREQUENCY CODE									x				
518	DRG CODE									x				
563	DRUG NAME													
572	DRUGS/SUPPLIES BILLED AMOUNT	x												
579	DRUGS/SUPPLIES DISPENSING FEE	x												
571	DRUGS/SUPPLIES NUMBER OF DAYS	x												
570	DRUGS/SUPPLIES QUANTITY DISPENSED	x												

CALIFORNIA-ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

	ERROR MESSAGES	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	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	058 Code/ID valid	063 Invalid Event Sequence/Relationship	073 Must be >= Date payer received bill	074 Must be >= From Service Date	075 Must be <= 'Thru Service date
DN	**DATA ELEMENT NAME**													
116	ELEMENT ERROR NUMBER									x				
115	ELEMENT NUMBER									x				
152	EMPLOYEE EMPLOYMENT VISA			x										
44	EMPLOYEE FIRST NAME													
43	EMPLOYEE LAST NAME													
45	EMPLOYEE MIDDLE NAME													
153	EMPLOYEE GREEN CARD			x										
156	EMPLOYEE PASSPORT NUMBER			x										
42	EMPLOYEE SOCIAL SECURITY NUMBER	x												
504	FACILITY CODE									x				
679	FACILITY FEIN	x						x						
681	FACILITY MEDICARE NUMBER			x				x						
678	FACILITY NAME													
682	FACILITY NATIONAL PROVIDER ID			x						x				
688	FACILITY POSTAL CODE									x				
680	FACILITY STATE LICENSE NUMBER			x				x						
737	HCPCS BILL PROCEDURE CODE									x				
714	HCPCS LINE PROCEDURE BILLED CODE									x				
726	HCPCS LINE PROCEDURE PAID CODE									x				
717	HCPCS MODIFIER BILLED CODE									x				
727	HCPCS MODIFIER PAID CODE									x				
626	HCPCS PRINCIPAL PROCEDURE BILLED CODE									x				
522	ICD_9 CM DIAGNOSIS CODE									x				
525	ICD_9 CM PRINCIPAL PROCEDURE CODE									x				
736	ICD_9 CM PROCEDURE CODE									x				

CALIFORNIA-ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

DN	DATA ELEMENT NAME	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	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	058 Code/ID valid	063 Invalid Event Sequence/Relationship	073 Must be >= Date payer received bill	074 Must be >= From Service Date	075 Must be <= 'Thru Service date
	ERROR MESSAGES													
6	INSURER FEIN	x					x	x						
7	INSURER NAME													
105	INTERCHANGE VERSION ID									x				
5	JURISDICTION CLAIM NUMBER			x										
718	JURISDICTION MODIFIER BILLED CODE									x				
730	JURISDICTION MODIFIER PAID CODE									x				
715	JURISDICTION PROCEDURE BILLED CODE									x				
729	JURISDICTION PROCEDURE PAID CODE									x				
547	LINE NUMBER	x												
704	MANAGED CARE ORGANIZATION FEIN	x						x						
208	MANAGED CARE ORGANIZATION ID NUMBER			x										
209	MANAGED CARE ORGANIZATION NAME													
712	MANAGED CARE ORGANIZATION POSTAL CODE									x				
721	NDC BILLED CODE									x				
728	NDC PAID CODE									x				
102	ORIGINAL TRANSMISSION DATE		x						x					
103	ORIGINAL TRANSMISSION TIME	x												
555	PLACE OF SERVICE BILL CODE									x				
600	PLACE OF SERVICE LINE CODE									x				
527	PRESCRIPTION BILL DATE		x			x			x					
604	PRESCRIPTION LINE DATE		x			x			x					
561	PRESCRIPTION LINE NUMBER			x										
521	PRINCIPAL DIAGNOSIS CODE									x				
550	PRINCIPAL PROCEDURE DATE		x			x			x					

CALIFORNIA-ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

DN	DATA ELEMENT NAME	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	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	058 Code/ID valid	063 Invalid Event Sequence/Relationship	073 Must be >= Date payer received bill	074 Must be >= From Service Date	075 Must be <= Thru Service date
524	PROCEDURE DATE		x			x			x				x	x
507	PROVIDER AGREEMENT CODE									x				
99	RECEIVER ID									x				
699	REFERRING PROVIDER NATIONAL PROVIDER ID			x						x				
526	RELEASE OF INFORMATION CODE									x				
642	RENDERING BILL PROVIDER FEIN	x						x						
638	RENDERING BILL PROVIDER LAST/GROUP NAME													
647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID			x						x				
656	RENDERING BILL PROVIDER POSTAL CODE									x				
657	RENDERING BILL PROVIDER COUNTRY CODE									x				
651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE									x				
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER			x										
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER			x										
592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID			x						x				
586	RENDERING LINE PROVIDER FEIN	x						x						
589	RENDERING LINE PROVIDER LAST/GROUP NAME													
593	RENDERING LINE PROVIDER POSTAL CODE									x				
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE									x				
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER			x										
615	REPORTING PERIOD		x						x					
559	REVENUE BILLED CODE									x				
576	REVENUE PAID CODE									x				
98	SENDER ID									x				

CALIFORNIA-ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES															
	ERROR MESSAGES	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	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	058 Code/ID valid	063 Invalid Event Sequence/Relationship	073 Must be >= Date payer received bill	074 Must be >= From Service Date	075 Must be <= 'Thru Service date
DN	**DATA ELEMENT NAME**													
733	SERVICE ADJUSTMENT AMOUNT	x												
731	SERVICE ADJUSTMENT GROUP CODE									x				
732	SERVICE ADJUSTMENT REASON CODE									x				
734	SERVICE ADJUSTMENT UNITS	x												
509	SERVICE BILL DATE(S) RANGE		x			x			x					
605	SERVICE LINE DATE(S) RANGE		x			x			x					
667	SUPERVISING PROVIDER NATIONAL PROVIDER ID			x						x				
104	TEST/PRODUCTION INDICATOR									x				
109	TIME PROCESSED	x												
101	TIME TRANSMISSION SENT	x												
516	TOTAL AMOUNT PAID PER BILL	x												
574	TOTAL AMOUNT PAID PER LINE	x												
501	TOTAL CHARGE PER BILL	x												
566	TOTAL CHARGE PER LINE - PURCHASE	x												
565	TOTAL CHARGE PER LINE - RENTAL	x												
552	TOTAL CHARGE PER LINE ~~- OTHER~~	x												
266	TRANSACTION TRACKING NUMBER	x												
500	UNIQUE BILL ID NUMBER			x										

California specific data edits

The California DWC specific data edits supplement the IAIABC data edits. The error codes will be transmitted back to each trading partner in the 824 acknowledgments. The data edits are the values the California-adopted IAIABC data elements are required to be.

California Specific Data Edits			
DN	**DATA ELEMENT NAME**	**EDIT**	**Error Code**
110	ACKNOWLEDGMENT TRANSACTION SET ID	Must be 3 digit numeric equal to **837**	058
543	BILL ADJUSTMENT GROUP CODE	Must be one of the following alpha values (**CO** or **MA** or **OA** or **PI** or **PR**)	058
544	BILL ADJUSTMENT REASON CODE	Must be numeric with 3 or less digits or 2 digit alpha-numeric	058

California Specific Data Edits			
DN	**DATA ELEMENT NAME**	**EDIT**	**Error Code**
508	BILL SUBMISSION REASON CODE	Must be one of the following numeric values (**00** or **01** or **05**)	058
503	BILLING FORMAT CODE	Must be one of the following alpha values (**A or B**)	058
542	BILLING PROVIDER POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	028
502	BILLING TYPE CODE	Must be one of the following alpha values (**DM** or **MO** or **RX**)	058
554	DAYS/UNITS BILLED	Must be numeric	028
553	DAYS/UNITS CODE	Must be one of the following alpha values (**DA** or **MJ** or **UN**)	058
557	DIAGNOSIS POINTER	Must be one of the following numeric values (**1** or **2** or **3** or **4**)	058
562	DISPENSE AS WRITTEN CODE	Must be one of the following numerical values (**0** or **1** or **2** or **3** or **4** or **5** or **6** or **7** or **8** or **9**)	058
567	DME BILLING FREQUENCY CODE	Must be one of the following numeric values (**1 or 4 or 6**)	058
518	DRG CODE	Must be 3 digit numeric	058
571	DRUGS/SUPPLIED NUMBER OF DAYS	Must be 3 or less digits	028
115	ELEMENT NUMBER	Must be numeric with 1 digit or 2 digits or 3 digits	058
42	EMPLOYEE SOCIAL SECURITY NUMBER	Must be numeric with nine digits	028
504	FACILITY CODE	Must be numeric with 2 digits, not less than 11 or more than 99	028
688	FACILITY POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	028
105	INTERCHANGE VERSION IDENTIFICATION	Alpha numeric of the following value (**MED01**)	058
5	JURISDICTIONAL CLAIM NUMBER	Must be numeric Must be either 12 digits or 22 digits	028
712	MANAGED CARE ORGANIZATION POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	028
555	PLACE OF SERVICE BILL CODE	Must be numeric with 2 digits, not less than 11 or more than 99	028
600	PLACE OF SERVICE LINE CODE	Must be numeric with 2 digits, not less than 11 or more than 99	028
561	PRESCRIPTION LINE NUMBER	Must be numeric, not less than 1 or more than 99	028
507	PROVIDER AGREEMENT CODE	Must be one of the following alpha values (**H or N or P or Y**)	058

99	RECEIVER IDENTIFICATION	Two parts. First part must be 9 and the second part must be numeric with at least 5 digits and no more than 9 digits	028
656	RENDERING BILL PROVIDER POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	028
593	RENDERING LINE PROVIDER POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	028
559	REVENUE BILLED CODE	Must be numeric with three digits	058
576	REVENUE PAID CODE	Must be numeric with three digits	058
98	SENDER IDENTIFICATION	Two parts. First part must be 9 and the second part must be numeric with at least 5 digits and no more than 9 digits	028
731	SERVICE ADJUSTMENT GROUP CODE	Must be one of the following alpha values (**CO** or **OA** or **PI** or **PR**)	058
732	SERVICE ADJUSTMENT REASON CODE	Must be numeric with 3 or less digits or 2 digit alpha-numeric	058

Section ~~N~~M: System specifications

Agency claim number/Jurisdiction claim number (JCN)

The ~~IAIABC~~ Agency Claim Number (DN5)~~,~~ is most often referred to as the ~~j~~Jurisdiction ~~c~~Claim ~~n~~Number (JCN)~~.~~. The JCN is ~~either a 12 or 22 digit number~~ created by WCIS to uniquely identify each claim. It is provided to the claims administrator in the acknowledgment of the first report of injury by the DWC. ~~The revised WCIS system creates a 22-digit JCN and the old~~ Before the WCIS system was revised in 2004, the original system created a 12-digit JCN. The revised system is backward compatible and will continue to accept the 12-digit JCN for claims originally reported to the old system.~~, but a~~ All new claims reported to the revised system will receive a 22-digit JCN.

The JCN is a conditional data element for the medical data requirements (See ~~s~~Section K) and is used to match medical bills to the WCIS FROI database. ~~– L required medical data elements~~). When a JCN is not available, ~~T~~the ~~data elements,~~ claim administrator claim number (DN15) and insurer FEIN (DN6)~~,~~ will be utilized to match claims in the WCIS database in place of the JCN. ~~under specific circumstances. For information on future changes to the JCN requirements, see the *WCIS e-News #1*.~~

Transaction processing and sequencing

Bill submission reason codes (BSRC) are used to define the specific purpose of a transmission. The DWC/WCIS only accepts three BSRC: 00, 01 and 05. ~~The bill submission reason code (00) must be used with the initial medical bill payment report sent. The remaining bill submission reason codes (01, 05) must be preceded by the initial medical bill payment report. Medical bill payment report bill submission reason~~ These 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, the following medical bill payment report bill submission reason codes can be submitted to reflect cancellations or replacements. ~~Resubmitted corrected medical bill payment report transmissions should be transmitted utilizing BSRC = 00~~. The originals of all corrected medical bill payment records previously accepted are canceled utilizing BSRC = 01. All corrected medical bill reports should be reported immediately. Replacement medical bill payment report transmissions that inform the WCIS of a change in DN15 --- Claim Administrator Claim Number -- should be transmitted utilizing BSRC = 05. All replacement medical bill reports should be reported immediately.

BSRC code	BSRC name
01	Cancellation
05	Replace (only used for changes in DN15)

~~824~~ detailed application ~~acknowledgment codes~~

The ~~California~~ DWC/~~W~~WCIS utilizes DN111, A~~a~~pplication A~~a~~cknowledgment C~~c~~ode~~s~~ (AAC), in the ANSI 824 to inform the ~~T~~trading partner of the accepted or rejected status of each 837 transmission to the DWC.

AAC code	AAC meaning
TA	Transaction accepted
TR	Transaction rejected
TE	Transaction accepted with errors (only for unmatched transactions on the FROI database)
BA	Batch Accepted
BR	Batch Rejected

Correcting~~ed~~ data elements (BSRC=00)(AAC=TR)

WCIS regulations require each claims administrator to submit to the WCIS any corrected data elements ~~as defined by the California-adopted IAIABC (DN508) bill submission reason code Bill Submission Reason Code(BSRC) (See Section K).~~ ~~After correcting the data errors in a transmission previously submitted to the DWC\WCIS, the sender transmits a BSRC=00 containing the corrected data. The re-submitted, corrected transmission (BSRC=00) are is sent in response to an 824 acknowledgement containing error messages (TR) from the DWC\WCIS.~~ When re-submitting a corrected transmission (BSRC=00) in response to a transaction rejected (TR), the sender must report all medical bill payment data elements, not just the data elements being corrected (See Section K ~~L – Required medical data elements~~). The following five steps outline the procedure:

1. Sender transmits original bill, including all lines, utilizing a BSRC "00".
2. ~~Receiver~~DWC/WCIS sends a 997 and a "TR" 824 acknowledg~~e~~ement with error~~s~~ to sender.
3. Sender corrects errors in the original bill.
4. Sender transmits the corrected bill, including all lines, as an original BSRC "00".
5. ~~Receiver~~DWC/WCIS sends a 997 and a "TA" 824 acknowledgement to sender.

~~Corrected medical bill~~ Updating data elements (BSRC=01)(AAC=TA)

WCIS regulations require each claims administrator to submit to the WCIS any changed data elements to maintain complete, accurate, and valid data. To update the value of data elements contained in transmission already accepted by the DWC/~~W~~WCIS, the sender transmits a BSRC = 01 to cancel the original transmission (BSRC=00), and then transmits a different BSRC = 00 containing the updated data. The updated transmission (BSRC=00) is not sent in response to an 824 acknowledgment containing error messages (TR) from the DWC/WCIS. When submitting a transmission

(BSRC=00) 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 (See Section K ~~L – Required medical data elements~~). The following seven steps outline the procedure:

1. Sender transmits original bill, including all lines, utilizing a BSRC "00".
2. ~~Receiver~~DWC/WCIS sends a 997 and a "TA" 824 acknowledg~~e~~ment to sender.
3. Sender changes the value of data elements on the original bill.
4. Sender cancels incorrect original bill by transmitting a BSRC "01". *
5. ~~Receiver~~DWC/WCIS sends a 997 and a "TA" 824 acknowledg~~e~~ment to sender.
6. Sender transmits the updated bill, including all lines, as a BSRC "00". *
7. ~~Receiver~~DWC/WCIS sends a 997 and "TA" 824 acknowledg~~e~~ment to sender.

* *Note: The DWC/WCIS will accept a streamlined version where steps 4 and 6 are combined into one 837 transmission.*

Replacing~~ement~~ ~~of~~ a ~~c~~Claim~~s~~ ~~a~~Administrator ~~c~~Claim ~~n~~Number (BSRC=05)(AAC=TA)

Replacement reports (BSRC=05) are sent to WCIS indicating a change in the claim administrator claim number (DN15) (See S~~s~~ection J ~~K~~). The replacement transmission (BSRC=05) may or may not be sent in response to an 824 acknowledgment containing error messages (TR) from the DWC/WCIS (see "Unmatched transactions below). When submitting a replacement transmission (BSRC=05) to indicate a change in the claim~~s~~ administrator~~s~~ claim number, the sender must only resubmit a limited number of data elements (See Section K ~~L – Required medical data elements~~). The following four steps outline the procedure:

1. Sender transmits original bill, including all lines, utilizing a BSRC "00".
2. ~~Receiver~~DWC/WCIS sends a 997 and a "TA" 824 acknowledg~~e~~ment to sender.
3. Sender changes the claim~~s~~ administrator claim number on the original bill.
4. Sender notifies the DWC/~~A~~WCIS of the new claim~~s~~ administrator claim number by transmitting a BSRC "05" with the old and new claim~~s~~ administrator claim number.

Correcting batch level duplicates (BSRC=00)(AAC=BR)

The WCIS checks for batch duplicates in the ST-SE transaction sets. Duplicate batch transmissions occur when the same key information (batch control number, sender ID, date transmission sent, time transmission sent, and reporting period) is sent in a ST-SE transaction set that was previously accepted by the DWC. The DWC will transmit a 057_duplicate transmission error code with the batch control number in the bad data field of the matching 824 acknowledgement. When re-submitting a corrected ST-SE transaction set (BSRC=00) in response to a batch rejected (BR), the sender must report all medical bill payment data elements, not just the data elements being corrected (See Section K – Required medical data elements). The following five steps outline the procedure:

1. Sender transmits original ST-SE transaction set, including all bills/lines, utilizing a BSRC "00".
2. DWC/WCIS sends a 997 and a “BR” 824 acknowledgement with an 057 error to sender.
3. Sender corrects the 057 error(s) in the original ST-SE transaction set. If sent by mistake, do not resend.
4. Sender transmits the corrected transaction set, including all bills/lines, as an original BSRC "00".
5. DWC/WCIS sends a 997 and a “BA” 824 acknowledgement to sender.

Matching transmissions, transactions and duplicate medical bills

Transmission duplicates occur when the ST-SE Transaction sets ISA or GE functional groups in different 837 transmissions contain the same key header information (batch control number, sender ID, date transmission sent, time transmission sent, and reporting period) that was previously accepted by the DWC. The DWC will transmit a 057 duplicate transmission error code with the batch control number a message of “Duplicate Batch/Transaction in the bad data field of the matching 824 acknowledgement.

Inbound 837 transmissions are matched to outbound 824 transmissions utilizing the DN98 (Sender ID), DN100 (Date transmission sent), and DN101 (Time transmission sent) from the inbound 837 to the DN99 (Receiver ID), DN102 (Original date transmission sent), and DN103 (Original time transmission sent) 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 GS05 Time in the 837 headers where the standard format is HHMM.

Duplicate transmissions, transactions and medical bills

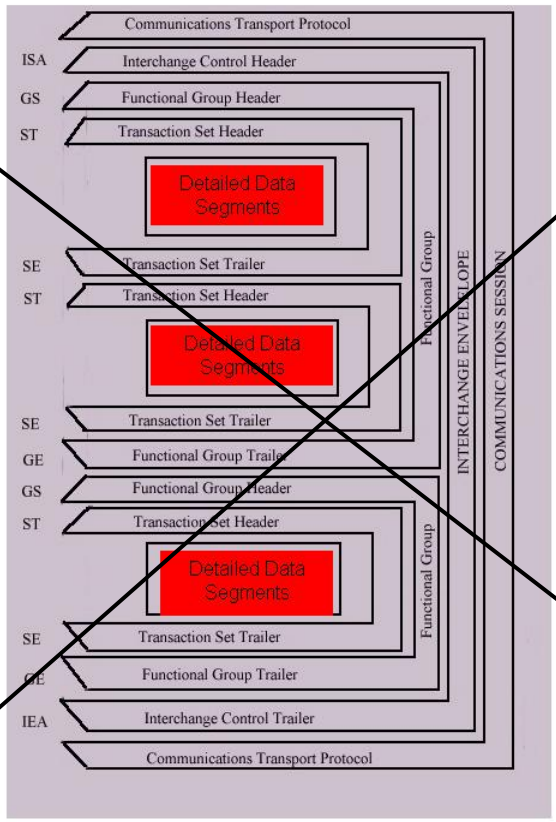
Transmission duplicates occur when the ISA or GE functional groups in different 837 transmissions contain the same key header information (sender ID, date transmission sent, time transmission sent, and interchange version ID) that was previously accepted by the DWC.

Transaction duplicates occur when one or more ST-SE transaction sets contain the same header information; batch control number, date transmission sent, time transmission sent, sender identification, and reporting period.

Bill-level duplicates occur when the information on the claim administrator FEIN, claim administrator claim number, unique bill identification number, and line numbers in a ST-SE transaction set are repeated one or more ST-SE transaction sets from the same sender, contain the same information on the claim administrator FEIN, claim

~~administrator claim number, and unique bill identification number, line number and other data elements~~. The DWC will check for duplicate bills in all ST-SE transaction sets throughout all GS-GE functional groups included in each X12 interchange envelope (ISA-IEA interchange). The DWC will also check each bill for duplicates against the entire database. Duplicate medical bills that are not correctly coded with the appropriate claim adjustment reason code (18,or B13) will ~~be flagged with~~ cause an ~~057~~ error ~~code on the detailed 824 acknowledgment~~ (Ssee Section G). The DWC will transmit a 057_duplicate transmission error code with the unique bill id number in the bad data field of the matching 824 acknowledgement.

Figure 1, as per ANSI X12.5, illustrates a typical format for electronically transmitting a series of business transactions.



WCIS medical matching rules and processes for a claim

Primary:

1. Jurisdiction claim number (JCN)

Secondary match for medical bill payment reports to the FROI:

2~~a~~. Claim administrator claim number
Insurer FEIN ~~(match on insurer FEIN if provided, otherwise match on claim administrator FEIN)~~

~~2b. Employee social security number~~

~~2c. Date of injury~~
~~Employee last name~~
~~Employee middle name~~
~~Employee first name~~

The WCIS uses the jurisdiction claim number as the primary means for matching medical bills in the 837 to claims previously received in the First Report of Injury (FROI) database. Secondary match criteria include the Claim Administrator Claim Number (DN15) and the Insurer FEIN (DN6). "No match on the database" for either DN15 or DN6 will cause an AAC of "TE" in the OTI segment and an error code of 039 in the LQ segment of the 824.

The claims administrator can only change DN15 (Claim Administrator Claim Number) in the medical database by submitting a BSRC = 05. Claims ~~A~~administrators who submit a revised ~~c~~Claim ~~a~~Administrator ~~c~~Claim number in the FROI database should submit an MTC "02." Acquired claims in the FROI use the MTC "AU" and acquired payments in SROI use the MTC "AP~~.~~" (S~~s~~ee the California FROI/SROI Implementation Guide).

Unmatched Transactions (AAC=TE)

The DWC/WCIS matches all medical bill payment record transmissions to the First Reports of Injury (FROI) in the WCIS relational database. If the DWC/WCIS receives an 837 medical bill payment record from a trading partner with no errors and no match in the DWC/WCIS FROI database, the DWC/WCIS procedure is as follows:

1. The DWC retains the transmission and continuously searches for a match (FROI).
2. If no matching FROI is found ~~(FROI) or BSRC = 01~~, the DWC will send~~s~~ an 824 acknowledgment indicating the transaction was accepted with errors (TE). The error code will be 039~~–~~(no match on database) when the ~~DN15 –~~Claim Administrator Claim Number (DN15) ~~or~~ and Insurer FEIN (DN6) cannot be matched~~.~~
3. The DWC continues to retain the transmission and continues to search~~es~~ for a matching (FROI).
4. ~~The DWC plans to produce data quality reports to each trading partner on an annual basis as part of the annual certification process.~~

~~More on how WCIS matches incoming transactions to existing claim records~~

~~The WCIS uses the jurisdiction claim number (JCN) as the primary means for matching transactions representing the same claim. Secondary match data will be used only if a JCN is not provided. For current JCN requirements see section L - Required medical data elements)~~

~~The claim administrator can only change the data elements in match data #2a by submitting a BSRC = 05. All Acquired Claims will be reported in the SROI utilizing the JCN (see the California FROI/SROI Implementation Guide).~~

Section O
IAIABC Information

Introduction

The following information about the International Association of Industrial Accident Boards and Commissions (IAIABC) was produced by the IAIABC. It is reproduced here by permission for users' convenience.

History of the IAIABC and EDI

In April of 1914, just six years after the enactment of the first Workers' Compensation Act in the United States, regulators from federal and state programs gathered in Lansing, Michigan and formed an association. The next year, a Canadian province joined and the International Association of Industrial Accident Boards and Commissions was formed (www.iaiabc.org/files/public/2006History of IAIABC.doc).

Concurrent with the activities of the IAIABC subcommittee reviewing BAIS, the National Association of Insurance Commissioners (NAIC) established a subcommittee to review the subject of data collection. The NAIC subcommittee was established at the same point in time that the IAIABC subcommittee was compiling the results of the second survey directed to the state agencies. Based upon the similarity of purpose in terms of expanded workers' compensation data collection, a joint working group composed of members of the IAIABC subcommittee and the NAIC subcommittee was formed.
In March of 1991, several carriers and associations met with the IAIABC in an effort to truly standardize the electronic reporting process. The result was the formation of the EDI Steering Committee. This working group within the IAIABC proceeded with the concept of moving the data collection project into an implementation phase. At the same time, a technical working group was established – composed primarily of insurance representatives, state agency personnel, and consultants – who have focused on the detail of defining the data elements and developing the format in which the data can be electronically transferred. This group, after reviewing all the various forms presently filed with state agencies, identified distinct phases that the project would follow. These phases reflect the various generic categories into which the various state reporting forms fell and include:
First Report of Injury – the initial report designed to notify the parties of the occurrence of an injury or illness.
Subsequent Payment Record – consists of forms which gather information when benefit payments begin, case progress information, and paid amounts by benefit type when the claim is concluded.
Medical Data – consists of data pertinent to the dates of service, diagnostic and procedure codes, and costs associated with the providing of medical care.
Vocational Rehabilitation Data – monitors the incidence of vocational rehabilitation, the outcomes, and the costs associated with it.
Litigation Data – reflects the incidence of disputes, issues in dispute, outcome results at various adjudication levels, and system costs related to litigation.
Each of these categories represents a separate project phase for the technical working group. Focusing first on FROI, the working groups were able to create a standard reporting format that served the needs of virtually each one of the state agencies.

Efforts have also been directed at establishing the same standardized reporting formats for the Proof of Coverage (POC), the reporting of medical information, and the Subsequent Payment Report which contains all those claim derivatives – including the level and type of benefit payments – that occur following the initial reporting of the claim. Through the passage of time, the transaction standards for FROI and Subsequent Reports have evolved from a Release I to a Release III version.

What is EDI?

Electronic Data Interface (EDI) consists of standardized business practices that permit the flow of information between organizations without the need for human intervention. Imagine that an ambitious ant wanted to get from your left hand to your right hand. It would be a long journey for a little ant. Imagine next that you held a string between your fingers. The ant could cross that string and get there much faster in that situation. Finally, imagine that you took the two ends of the string and moved them together. That is EDI. It is moving the two points together, for instant travel. Using technology, when you communicate with yourself, you are also communicating with all of your necessary trading partners. Someone gathers the information, types it into the computer and the computer does the rest, routing the correct information to the correct systems, regardless of whether the system resides in the room next to you or somewhere across the globe.

The EDI is a member of a family of technologies for communicating business messages electronically. This family includes EDI, facsimile, electronic mail, telex, and computer conferencing systems. Technically speaking, EDI is the computer application to computer application exchange of business data in a structured format. In other words, the purpose of EDI is to take information from one company's application and place it in the computer application of another company.(or in EDI vocabulary – a trading partner.) Here are Three The key components of EDI: (1) are Standards, (2) Software, and (3) Communications.

Standards

Within the component of standards, there are three categories.
Transactions sets – a logical grouping of segments used to convey business data (also referred to as simply a document). These replace paper documents or verbal requests.
Data dictionary - defines the meaning of individual pieces of information (a.k.a. data elements) within a transaction set.
Systems the electronic envelope that all of the information is contained in.

Software

Software solutions for managing the system will be dictated by communications technology and whether you will be reprogramming existing systems and purchasing a

translator, purchasing an off-the-shelf solution, hiring an outside consultant, or using a third party to collect the data.

The EDI translation software component converts the application data to a standard EDI format. The telecommunication software initiates the communication session, establishes protocol, validates security, and transmits the EDI data. The telecommunication network provides the medium to connect two or more computer environments.

Communications

Communications is the technology that allows data to flow between one computer and another. The EDI telecommunications process involves a computer application to formulate the customized business partner's data. Communications technology is divided into software and network choices. The number of choices depends on the "How" you choose to implement EDI. The two aspects of "How" are:
The communications software you choose will be dictated by your choice of communications network and whether you are communicating with the same structure or need a translator between systems. The primary objective of communications relative to EDI is to transport information between business partners in a cost effective and efficient manner. A second critical objective is to assure the privacy and confidentiality of the information while it is being electronically exchanged.

Section PN: Code lists and state license numbers

Code sources

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. ~~All sources and codes are also available at~~ www.IAIABC.org

Rendering bill provider country code – DN657

ISO 3166 Maintenance Agency
c/o International Organization for Standardization
Case postale 56
CH-1211 Genève 20
Telephone: +41 22 749 02 22
Telefax: +41 22 749 01 55
E-mail: countrycodes@iso.org
Web: www.iso.org

Postal~~Zip~~ code

Source: National Zip Code and Post Office Directory, Publication 65
The USPS Domestic Mail Manual
Available At:

U.S. Postal Service
Washington, DC 20260
New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
http://zip4.usps.com/zip4/welcome.jsp

Healthcare financing administration common procedural coding system (HCPCS)

Source: Centers for Medicare & Medicaid Services (CMS)
Available at:

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore MD 21244-1850
http://www.cms.hhs.gov/

Abstract:
Healthcare Common Procedure Coding System (HCPCS) is the Centers for Medicare & Medicaid Services (CMS) coding scheme to group procedures performed for payment providers.

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

Source: International Classification of Diseases, Ninth Revision, Clinical Modification, (ICD-9 CM)
Available at:
U.S. National Center of Health Statistics
Commission of Professional and Hospital Activities
1968 Green Road
Ann Arbor, MI 48105
http://www.cdc.gov/nchs/icd9.htm#RTF

Abstract:
The International Classification of Diseases, Ninth Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and the indexing of hospital records by disease and operations.

Current procedural terminology (CPT) codes

Source: Physicians' Current Procedural Terminology (CPT) Manual
Available at:
Order Department
American Medical Association
515 North State Street
Chicago, IL 60610
https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?childName=nochildcat&parentCategory=cat220008&productId=prod240142&categoryName=Data+Files&start=1&parentId=cat220008
Abstract:
Current Procedural Terminology (CPT) codes are the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs.

National drug code (NDC)

Source: Blue book, Price Alert, National Drug Data File Master Drug Database v 2.5.

Available at:
First Databank
The Hearst Corporation
1111 Bayhill Drive
San Bruno, CA 94066
Wolters Kluwer Health – Medi-Span
8425 Woodfield Crossing Blvd., Ste 490
Indianapolis, IN 46240
http://www.fda.gov/cder/ndc/
Abstract:
The National Drug Code (NDC) is a coding convention established by the Food and Drug Administration (FDA) to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

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

Abstract:
A DRG (Diagnosis Related Group) is a classification of a hospital stay in terms of what was wrong and what was done for a patient. The DRG classification (one of about 500) is determined by utilizing a ~~an~~ A grouper~~@~~ program based on diagnoses and procedures coded in ICD-9 CM and on patient age, sex, length of stay, and other factors. The DRG frequently determines the amount of money that will be reimbursed, independently of the charges that the hospital may have incurred. In the United States, the basic set of DRG codes are those defined by the Health Care Financing Administration (HCFA) for adult Medicare billing. For other patient~~s~~ types and payers -- CHAMPUS (Civilian Health and Medical Services of the Uniformed Services), Medicaid, commercial payers for neonate claims, Workers' Compensation -- modifier grouper and additional DRG codes are used.

Provider taxonomy codes

Source: Washington Publishing Company
Available at: http://www.wpc-edi.com

Facility/Place of service codes

Source: Place of Service Codes for Professional Claims
Available at:
Centers for Medicare and Medicaid Services
CMSO, Mail Stop S2-01-16
7500 Security Blvd
Baltimore, MD 21244-1850
http://www.cms.hhs.gov/MedHCPCSGenInfo

Abstract:
The Centers for Medicare and Medicaid Services develops place of service codes to identify the location where health care services are performed.

~~Type of Facility – 1st Digit~~

~~Hospital~~	~~1~~
~~Skilled Nursing~~	~~2~~
~~Home Health~~	~~3~~
~~Christian Science (Hospital)~~	~~4~~
~~Christian Science (Extended Care)~~	~~5~~
~~Intermediate Care~~	~~6~~
~~Clinic~~	~~7~~
~~Specialty Facility~~	~~8~~
~~Reserved for National Assignment~~	~~9~~

Bill Classification (Except Clinics/Special Facilities – 2nd Digit)

- Inpatient (including Medicare Part A) 1
- Inpatient (Medical Part B only) 2
- Outpatient 3
- Other 4
  - (Other category used for hospital referenced diagnostics services, or home health not under a plan or treatment)
- Intermediate Care Level I 5
- Intermediate Care Level II 6
- Sub acute Inpatient (Revenue Code 19x required) 7
- Swing Beds 8
- Reserved for National Assignment 9

Bill Classification (Clinics Only) – 3rd Digit

- Rural Health Clinic (RHC) 1
- Hospital Based or Independent Renal Dialysis Center 2
- Free Standing 3
- Outpatient Rehabilitation Facility 4
- Comprehensive Outpatient Rehab Facilities (CORF) 5
- Community Mental Health Center (CMHC) 6
- Reserved for National Assignment 7-8
- Other 9

Bill Classification (Special Facilities Only) – 4th Digit

- Hospice (Non-hospital based) 1
- Hospice (Hospital based) 2
- Ambulatory Surgery Center 3
- Free-Standing Birthing Center 4
- Rural Primary Care (Critical Access Hospital) 5
- Reserved for National Assignment 6-8
- Other 9

Place of service line code

Values: 00 – 10 = Unassigned
11 = Office
12 = Home
13 – 20 = Unassigned
21 = Inpatient Hospital
22 = Outpatient Hospital
23 = Emergency Room – Hospital
24 = Ambulatory Surgical Center
25 = Birthing Center
26 = Military Treatment Facility
27 – 30 = Unassigned
31 = Skilled Nursing Facility

32 = Nursing Facility
33 = Custodial Care Facility
34 = Hospice
35 – 40 = Unassigned
41 = Ambulance – Land
42 = Ambulance – Air or Water
43 – 49 = Unassigned
50 = Federally Qualified Health Center
51 = Inpatient Psychiatric Facility
52 = Psychiatric Facility Partial Hospitalization
53 = Community Mental Health Center
54 = Intermediate Care Facility/Mentally Retarded
55 = Residential Substance Abuse Treatment Center
56 = Psychiatric Residential Treatment Center
57 – 60 = Unassigned
61 = Comprehensive Inpatient Rehabilitation Facility
62 = Comprehensive Outpatient Rehabilitation Facility
63 – 64 Unassigned
65 = End Stage Renal Disease Treatment Facility
66 – 70 Unassigned
71 = State or Local Public Health Clinic
72 = Rural Health Clinic
73 – 80 Unassigned
81 = Independent Laboratory
82 – 98 = Unassigned
99 = Other Unlisted Facility

Revenue billed/paid code

Source: National Health Care Claim Payment/Advice Committee Bulletins
Available Aat: National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

Abstract: Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee.

Values: 001 = Total Charge
010 - 069 = Reserved for national assignment
070 - 079 = Reserved for State Use
100 = All inclusive rate and board plus ancillary
101 = All inclusive rate and board
110 = Private room and board general classification
111 = Private room and board medical/surgical/GYN
112 = Private room and board OB
113 = Private room and board pediatric
114 = Private room and board psychiatric
115 = Private room and board hospice
116 = Private room and board detoxification
117 = Private room and board oncology
118 = Private room and board rehabilitation
119 = Private room and board other
120 = Two bed semi-private room & board general classification
121 = Two bed semi-private room & board medical/surgical/GYN
122 = Two bed semi-private room & board OB
123 = Two bed semi-private room & board pediatric
124 = Two bed semi-private room & board psychiatric
125 = Two bed semi-private room & board hospice
126 = Two bed semi-private room & board detoxification
127 = Two bed semi-private room & board oncology
128 = Two bed semi-private room & board rehabilitation
129 = Two bed semi-private room & board other
130 = 3 & 4 bed semi-private room & board general classification
131 = 3 & 4 bed semi-private room & board medical/surgical/GYN
132 = 3 & 4 bed semi-private room & board OB
133 = 3 & 4 bed semi-private room & board pediatric
134 = 3 & 4 bed semi-private room & board psychiatric
135 = 3 & 4 bed semi-private room & board hospice
136 = 3 & 4 bed semi-private room & board detoxification
137 = 3 & 4 bed semi-private room & board oncology
138 = 3 & 4 bed semi-private room & board rehabilitation
139 = 3 & 4 bed semi-private room & board other
140 = Deluxe private general classification
141 = Deluxe private medical/surgical/GYN

Revenue billed code
Revenue paid code (Continued)

142 = Deluxe private OB
143 = Deluxe private pediatric
144 = Deluxe private psychiatric
145 = Deluxe private hospice
146 = Deluxe private detoxification
147 = Deluxe private oncology
148 = Deluxe private rehabilitation
149 = Deluxe private other
150 = Room & board ward general classification
151 = Room & board ward medical/surgical/GYN
152 = Room & board ward OB
153 = Room & board ward pediatric
154 = Room & board ward psychiatric
155 = Room & board ward hospice
156 = Room & board ward detoxification
157 = Room & board ward oncology
158 = Room & board ward rehabilitation
159 = Room & board ward other
160 = Other room & board general classification
164 = Other room & board sterile environment
167 = Other room & board self care
169 = Other room & board other
170 = Nursery general classification
171 = Nursery newborn level 1
172 = Nursery newborn level 2
173 = Nursery newborn level 3
174 = Nursery newborn level 4
179 = Nursery newborn other
180 = Leave of absence general classification
181 = Reserved
182 = Leave of absence patient convenience – charges billable
183 = Leave of absence therapeutic leave
184 = Leave of absence ICF mentally retarded – any reason
185 = Leave of absence nursing home (hospitalization)
189 = Leave of absence other
190 = Sub acute care general classification
191 = Sub acute care level 1
192 = Sub acute care level 2
193 = Sub acute care level 3
194 = Sub acute care level 4
199 = Sub acute care other
200 = Intensive care general classification
201 = Intensive care surgical

Revenue billed code
Revenue paid code (Continued)

202 = Intensive care medical
203 = Intensive care pediatric
204 = Intensive care psychiatric
206 = Intensive care intermediate ICU
207 = Intensive care burn care
208 = Intensive care trauma
209 = Intensive care other
210 = Coronary care general classification
211 = Coronary care myocardial infarction
212 = Coronary care pulmonary care
213 = Coronary care heart transplant
214 = Coronary care intermediate CCU
219 = Coronary care other
220 = Special charges general classification
221 = Special charges admission
222 = Special charges technical support
223 = Special charges UR service charge
224 = Special charges late discharge medically necessary
229 = Special charges other
230 = Incremental nursing charge general classification
231 = Incremental nursing charge nursery
232 = Incremental nursing charge OB
233 = Incremental nursing charge ICU (includes transitional care)
234 = Incremental nursing charge CCU (includes transitional care)
235 = Incremental nursing charge hospice
239 = Incremental nursing other
240 = All inclusive ancillary general classification
249 = All inclusive ancillary other
250 = Pharmacy general classification
251 = Pharmacy generic drugs
252 = Pharmacy non-generic drugs
253 = Pharmacy take home drugs
254 = Pharmacy drugs incident to other diagnostic services
255 = Pharmacy drugs incident to radiology
256 = Pharmacy experimental drugs
257 = Pharmacy non-prescription
258 = Pharmacy IV solutions
259 = Pharmacy other
260 = Therapy general classification
261 = Therapy infusion pump
262 = Therapy IV therapy/pharmacy services
263 = Therapy IV therapy/drug/supply/delivery
264 = Therapy IV Therapy/supplies

Revenue billed code
Revenue paid code (Continued)

269 = Therapy IV other
270 = Medical/surgical supplies general classification
271 = Medical/surgical supplies non-sterile supply
272 = Medical/surgical supplies sterile supply
273 = Medical/surgical supplies take home supplies
274 = Medical/surgical supplies prosthetic/orthotic devices
275 = Medical/surgical supplies pace maker
276 = Medical/surgical supplies intraocular lens
277 = Medical/surgical supplies oxygen – take home
278 = Medical/surgical supplies other implants
279 = Medical/surgical supplies other
280 = Oncology general classification
289 = Oncology other
290 = Durable medical equipment (DME) general classification
291 = Durable medical equipment (DME) rental
292 = Durable medical equipment (DME) purchase of new DME
293 = Durable medical equipment (DME) purchase of old DME
294 = Durable medical equipment (DME) supplies/drugs (HHAs only)
299 = Durable medical equipment (DME) other
300 = Laboratory general classification
301 = Laboratory chemistry
302 = Laboratory immunology
303 = Laboratory renal patient (home)
304 = Laboratory non-routine dialysis
305 = Laboratory hematology
306 = Laboratory bacteriology and microbiology
307 = Laboratory urology
309 = Laboratory other
310 = Laboratory pathological general classification
311 = Laboratory pathological cytology
312 = Laboratory pathological histology
314 = Laboratory pathological biopsy
319 = Laboratory pathological other
320 = Radiology diagnostic general classification
321 = Radiology diagnostic angiocardiography
322 = Radiology diagnostic arthrography
323 = Radiology diagnostic arteriography
324 = Radiology diagnostic chest x-ray
329 = Radiology diagnostic other
330 = Radiology therapeutic general classification
331 = Radiology therapeutic chemotherapy injected
332 = Radiology therapeutic chemotherapy oral
333 = Radiology therapeutic radiation therapy

Revenue billed code
Revenue paid code (Continued)

335 = Radiology therapeutic chemotherapy IV
339 = Radiology therapeutic other
340 = Nuclear medicine general classification
341 = Nuclear medicine diagnostic
342 = Nuclear medicine therapeutic
349 = Nuclear medicine other
350 = CT scan general classification
351 = CT scan head scan
352 = CT scan body scan
359 = CT scan other
360 = Operating room services general classification
361 = Operating room services minor surgery
362 = Operating room services organ transplant (other than kidney)
367 = Operating room services kidney transplant
369 = Operating room other
370 = Anesthesia general classification
371 = Anesthesia incident RAD
372 = Anesthesia incident to other diagnostic services
374 = Anesthesia acupuncture
379 = Anesthesia other
380 = Blood general classification
381 = Blood packed red cells
382 = Blood whole blood
383 = Blood plasma
384 = Blood platelets
385 = Blood Leucocytes
386 = Blood other components
387 = Blood other derivatives (cyoprecipitates)
389 = Blood other
400 = Other imaging services general classification
401 = Other imaging services diagnostic mammography
402 = Other imaging services ultrasound
403 = Other imaging services screening mammography
404 = Other imaging services positron emission tomography
409 = Other imaging services other
410 = Respiratory services general classification
412 = Respiratory services inhalation services
413 = Respiratory services hyperbaric oxygen therapy
419 = Respiratory service other
420 = Physical therapy general classification
421 = Physical therapy visit charge
422 = Physical therapy hour charge
423 = Physical therapy group rate

Revenue billed code
Revenue paid code (Continued)

424 = Physical therapy evaluation or re-evaluation
429 = Physical therapy other
430 = Occupational therapy general classification
431 = Occupational therapy visit charge
432 = Occupational therapy hourly charge
433 = Occupational therapy group rate
434 = Occupational therapy evaluation or re-evaluation
439 = Occupational therapy other
440 = Speech language pathology general classification
441 = Speech language pathology visit charge
442 = Speech language pathology hourly charge
443 = Speech language pathology group rate
444 = Speech language pathology evaluation or re-evaluation
449 = Speech language pathology other
450 = Emergency room general classification
451 = Emergency room EMTALA emergency medical screening services
452 = Emergency room ER beyond EMTALA screening
456 = Emergency room urgent care
459 = Emergency room other
460 = Pulmonary function general classification
469 = Pulmonary function other
470 = Audiology general classification
471 = Audiology diagnostic
472 = Audiology treatment
479 = Audiology other
480 = Cardiology general classification
481 = Cardiology cardiac cath lab
482 = Cardiology stress test
483 = Cardiology echocardiology
489 = Cardiology other
490 = Ambulatory surgical care general classification
499 = Ambulatory other
500 = Outpatient services general classification
509 = Outpatient services other
510 = Clinic general classification
511 = Clinic chronic pain center
512 = Clinic dental
513 = Clinic psychiatric
514 = Clinic OB/GYN
515 = Clinic pediatric
516 = Clinic urgent care
517 = Clinic family practice
519 = Clinic other

Revenue billed code
Revenue paid code (Continued)

520 = Free standing clinic general clinic
521 = Free standing clinic rural health
522 = Free standing clinic rural health home
523 = Free standing clinic family practice
526 = Free standing clinic urgent care
529 = Free standing clinic other
530 = Osteopathic services general classification
531 = Osteopathic services therapy
539 = Osteopathic services other
540 = Ambulance general classification
541 = Ambulance supplies
542 = Ambulance medical transport
543 = Ambulance heart mobile
544 = Ambulance oxygen
545 = Ambulance air
546 = Ambulance neo-natal
547 = Ambulance pharmacy
548 = Ambulance telephone transmission EKG
549 = Ambulance other
550 = Skilled nursing general classification
551 = Skilled nursing visit charge
552 = Skilled nursing hourly charge
559 = Skilled nursing other
560 = Medical social services general classification
561 = Medical social services visit charge
562 = Medical social services hourly charge
569 = Medical social services other
570 = Home health aide general classification
571 = Home health aide visit charge
572 = Home health aide hourly charge
579 = Home health aide other
580 = Other visits general classification (home health)
581 = Other visits visit charge (home health)
582 = Other visits hourly charge (home health)
589 = Other visits other
590 = Units of services general classification (home health)
599 = Units of services other
600 = Oxygen general classification (home health)
601 = Oxygen state/equip/supply/or cont (home health)
602 = Oxygen state/equip/supply under 1LPM (home health)
603 = Oxygen state/equip/supply over 4 LPM (home health)
604 = Oxygen portable add-on (home health)
610 = MRI general classification

Revenue billed code
Revenue paid code (Continued)

611 = MRI brain (including brain stem)
612 = MRI spinal cord (including spine)
619 = MRI other
621 = Medical/surgical supplies incident to radiology (ext of 270 codes)
622 = Medical/surgical supplies incident to other diag svcs(ext 270 code)
623 = Medical/surgical supplies surgical dressings (ext 270 codes)
624 = Medical/surgical supplies investigational device (ext 270 codes)
630 = Drugs requiring specific identification general classification
631 = Drugs requiring specific identification single source drug
632 = Drugs requiring specific identification multiple source drug
633 = Drugs requiring specific identification restrictive prescription
634 = Drugs requiring specific identification erythropoeitin < 10,000 units
635 = Drugs requiring specific identification erythropoeitin > 10,000 units
636 = Drugs requiring specific identification drugs detailed coding
637 = Drugs requiring specific identification self-administrable drugs
640 = Home IV therapy services general classification
641 = Home IV therapy services non-routine nursing
642 = Home IV therapy services IV site care, central line
643 = Home IV therapy services IV start/chg, peripheral line
644 = Home IV therapy services non-routine nursing, peripheral line
645 = Home IV therapy services training patient caregiver, central line
646 = Home IV therapy services training disabled patient, central line
647 = Home IV therapy services training patient/caregiver, peripheral line
648 = Home IV therapy services training disabled patient, peripheral line
649 = Home IV therapy services other
650 = Hospice services general classifications
651 = Hospice services routine home care
652 = Hospice services continuous home care2
653 = Reserved
654 = Reserved
655 = Hospice inpatient care
656 = Hospice general inpatient care (non-respite)
657 = Hospice physician services
659 = Hospice other
660 = Respite care general classification
661 = Respite care hourly charge/skilled nursing
662 = Respite care hourly charge/home health aide/homemaker
670 = Outpatient special residence charges general classification
671 = Outpatient special residence charges hospital based
672 = Outpatient special residence charges contracted
679 = Outpatient special residence charges other
680 – 689 = Not assigned
690 – 699 = Not assigned

Revenue billed code
Revenue paid code (Continued)

700 = Cast room general classification
709 = Cast room other
710 = Recovery room general classification
719 = recovery room other
720 = Labor room/delivery general classification
721 = Labor room/delivery labor
722 = Labor room/delivery delivery
723 = Labor room/ delivery circumcision
724 = Labor room/delivery birthing center
729 = Labor room/delivery other
730 = EKG/ECG general classification
731 = EKG/ECG holter monitor
732 = EKG/ECG telemetry
739 = EKG/ECG other
740 = EEG general classification
749 = EEG other
750 = Gastro-intestinal services general classification
759 = Gastro-intestinal services other
760 = Treatment or observation room general classification
761 = Treatment or observation room treatment
762 = Treatment or observation room observation
769 = Treatment or observation other
770 = Preventative care services general classification
771 = Preventative care services vaccine administration
779 = Preventative care services other
780 = Telemedicine general classification
789 = Telemedicine other
790 = Lithotripsy general classification
799 = Lithotriptsy other
800 = Inpatient renal dialysis general classification
801 = Inpatient renal dialysis hemodialysis
802 = Inpatient renal dialysis peritoneal (non-CAPD)
803 = Inpatient renal dialysis continuous ambulatory peritoneal (CAPD)
804 = Inpatient renal dialysis continuous cycling peritoneal (CCPD)
809 = Inpatient renal dialysis other
810 = Organ acquisition general classification
811 = Organ acquisition living donor
812 = Organ acquisition cadaver donor
813 = Organ acquisition unknown donor
814 = Organ acquisition unsuccessful organ search donor bank chg
819 = Organ acquisition other
820 = Hemodialysis general classification
821 = Hemodialysis composite or other rate

Revenue billed code
Revenue paid code (Continued)

822 = Hemodialysis home supplies
823 = Hemodialysis home equipment
824 = Hemodialysis maintenance 100%
825 = Hemodialysis support services
829 = Hemodialysis other
830 = Peritoneal dialysis general classification
831 = Peritoneal composite or other rate
832 = Peritoneal home supplies
833 = Peritoneal home equipment
834 = Peritoneal maintenance 100%
835 = Peritoneal support services
839 = Peritoneal other
840 = CAPD outpatient general classification
841 = CAPD composite or other rate
842 = CAPD home supplies
843 = CAPD home equipment
844 = CAPD maintenance 100%
845 = CAPD support services
849 = CAPD other
850 = CCPD Outpatient general classification
851 = CCPD composite or other rate
852 = CCPD home supplies
853 = CCPD home equipment
854 = CCPD maintenance 100%
855 = CCPD support services
859 = CCPD other
860 – 869 = Reserved for dialysis (national assignment)
870 – 879 = Reserved for dialysis (state assignment)
890 – 899 = Reserved for national assignment
900 = Psychiatric/psychological treatments general classification
901 = Psychiatric/psychological treatments electroshock treatment
902 = Psychiatric/psychological treatments milieu therapy
903 = Psychiatric/psychological treatments play therapy
904 = Psychiatric/psychological treatments activity therapy
909 = Psychiatric/psychological treatments other
910 = Psychiatric/psychological services general classification
911 = Psychiatric/psychological services rehabilitation
912 = Psychiatric/psychological svc partial hospitalization < intensive
913 = Psychiatric/psychological svc partial hospitalization intensive
914 = Psychiatric/psychological services individual therapy
915 = Psychiatric/psychological services group therapy
916 = Psychiatric/psychological services family therapy
917 = Psychiatric/psychological services bio feedback

Revenue billed code
Revenue paid code (Continued)

918 = Psychiatric/psychological services testing
919 = Psychiatric/psychological other
920 = Other diagnostic services general classification
921 = Other diagnostic services peripheral vascular lab
922 = Other diagnostic services electromyelogram
923 = Other diagnostic services pap smear
924 = Other diagnostic services allergy test
925 = Other diagnostic services pregnancy test
929 = Other diagnostic services other
930 – 939 = Not assigned
940 = Other therapeutic services general classification
941 = Other therapeutic services recreational therapy
942 = Other therapeutic services education/training
943 = Other therapeutic services cardiac rehabilitation
944 = Other therapeutic services drug rehabilitation
945 = Other therapeutic services alcohol rehabilitation
946 = Other therapeutic services complex medical equipment routine
947 = Other therapeutic services complex medical equipment ancillary
949 = Other therapeutic services
950 – 959 = Not assigned
960 = Professional fees general classification
961 = Professional fees psychiatric
962 = Professional fees ophthalmology
963 = Professional fees anesthesiologist (MD)
964 = Professional fees anesthetist (CRNA)
969 = Professional fees other
971 = Professional fees laboratory
972 = Professional fees radiology diagnostic
973 = Professional fees radiology therapeutic
974 = Professional fees radiology nuclear medicine
975 = Professional fees operating room
976 = Professional fees respiratory therapy
977 = Professional fees physical therapy
978 = Professional fees occupational therapy
979 = Professional fees speech pathology
981 = Professional fees emergency room
982 = Professional fees outpatient services
983 = Professional fees clinic
984 = Professional fees medical social services
985 = Professional fees EKG
986 = Professional fees EEG
987 = Professional fees hospital visit
988 = Professional fees consultation

Revenue billed code
Revenue paid code (Continued)

989 = Professional fees private duty nurse
990 = Patient convenience items general classification
991 = Patient convenience items cafeteria/guest tray
992 = Patient convenience items private linen service
993 = Patient convenience items telephone/telegram
994 = Patient convenience items TV/radio
995 = Patient convenience items non-patient room rentals
996 = Patient convenience items late discharge fee
997 = Patient convenience items admission kits
998 = Patient convenience items beauty shop/barber
999 = Patient convenience items other

Claim adjustment group codes

Source: *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 41, 20029.*
Available at: http://www.iaiabc.org

Source: Washington Publishing Company
Available at: http://www.wpc-edi.com

CO — The amount adjusted due to a contractual obligation between the provider and the payer. It is not the patient's responsibility under any circumstances.

MA — The amount adjusted is due to state regulated fee schedules. **Note:** MA is the code value assigned by ANSI for Medicare, this code is not being used by Medicare.

OA — The amount adjusted is due to bundling or unbundling of services.

PI — These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not "reasonable or necessary". The amount adjusted is generally not the patient's responsibility, unless the workers' compensation state law allows the patient to be billed.

PR — The amount adjusted is the patient's responsibility. This will be used for denials, due to workers' compensation coverage issues.

Claim adjustment reason codes

Source: *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 41, 2002 9.*
Available at: http://www.iaiabc.org

Source: Washington Publishing Company
Available at: http://www.wpc-edi.com

California state medical license numbers

Source: CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS
Available at: CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS (DCA)
400 R Street
Sacramento, CA
http://www.dca.ca.gov

Abstract: The California DCA licenses medical providers including: Acupuncture, Behavioral Sciences, Chiropractic, Dental, Medical, Occupational Therapy, Optometry, Osteopathic, Pharmacy, Physical Therapy, Podiatry, Psychiatric Technicians, Psychology, Registered Nursing, Respiratory Care, Speech-Language Pathology and Audiology, Vocational Nursing, Hearing Aid Dispensers, Dental Auxiliaries, Physician Assistant, Registered Dispensing, and Opticians

National plan and provider enumeration system

Source: Centers for Medicare and Medicaid Services

Available at: NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059
1-800-465-3203
https://nppes.cms.hhs.gov/NPPES/Welcome.do

Abstract: The National Medical Provider Enumeration System contains the National Provider Identification Number and Taxonomy Code for Medical Providers.

Section O: California-adopted IAIABC data elements

Numerically-sorted list of California-adopted IAIABC data elements

A numerically-sorted list of California-adopted IAIABC data elements is located in the table below. Alphabetically-sorted lists are located in the data elements by source table (Section K), in the data element requirement table (Section K) and in the data edit table (Section L). Hierarchically-sorted lists are located in the loop, segment and data element summary for the ANSI 837 and the 824 (Section H).

DN	Data Element Name
5	JURISDICTION CLAIM NUMBER
6	INSURER FEIN
7	INSURER NAME
15	CLAIM ADMINISTRATOR CLAIM NUMBER
31	DATE OF INJURY
42	EMPLOYEE SOCIAL SECURITY NUMBER
43	EMPLOYEE LAST NAME
44	EMPLOYEE FIRST NAME
45	EMPLOYEE MIDDLE NAME/INITIAL
98	SENDER ID
99	RECEIVER ID
100	DATE TRANSMISSION SENT
101	TIME TRANSMISSION SENT
102	ORIGINAL TRANSMISSION DATE
103	ORIGINAL TRANSMISSION TIME
104	TEST/PRODUCTION INDICATOR
105	INTERCHANGE VERSION ID
108	DATE PROCESSED
109	TIME PROCESSED
110	ACKNOWLEDGMENT TRANSACTION SET ID
111	APPLICATION ACKNOWLEDGMENT CODE
115	ELEMENT NUMBER
116	ELEMENT ERROR NUMBER
152	EMPLOYEE EMPLOYMENT VISA
153	EMPLOYEE GREEN CARD
156	EMPLOYEE PASSPORT NUMBER
187	CLAIM ADMINISTRATOR FEIN
188	CLAIM ADMINISTRATOR NAME
208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER
209	MANAGED CARE ORGANIZATION NAME
266	TRANSACTION TRACKING NUMBER
500	UNIQUE BILL ID NUMBER

DN	Data Element Name
501	TOTAL CHARGE PER BILL
502	BILLING TYPE CODE
503	BILLING FORMAT CODE
504	FACILITY CODE
507	PROVIDER AGREEMENT CODE
508	BILL SUBMISSION REASON CODE
509	SERVICE BILL DATE(S) RANGE
510	DATE OF BILL
511	DATE INSURER RECEIVED BILL
512	DATE INSURER PAID BILL
513	ADMISSION DATE
514	DISCHARGE DATE
515	CONTRACT TYPE CODE
516	TOTAL AMOUNT PAID PER BILL
518	DRG CODE
521	PRINCIPAL DIAGNOSIS CODE
522	ICD-9 CM DIAGNOSIS CODE
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER
524	PROCEDURE DATE
525	ICD-9 CM PRINCIPAL PROCEDURE CODE
526	RELEASE OF INFORMATION CODE
527	PRESCRIPTION BILL DATE
528	BILLING PROVIDER LAST/GROUP NAME
532	BATCH CONTROL NUMBER
535	ADMITTING DIAGNOSIS CODE
537	BILLING PROVIDER PRIMARY SPECIALTY CODE
542	BILLING PROVIDER POSTAL CODE
543	BILL ADJUSTMENT GROUP CODE
544	BILL ADJUSTMENT REASON CODE
545	BILL ADJUSTMENT AMOUNT
546	BILL ADJUSTMENT UNITS
547	LINE NUMBER
550	PRINCIPAL PROCEDURE DATE
552	TOTAL CHARGE PER LINE
553	DAYS/UNITS CODE
554	DAYS/UNITS BILLED
555	PLACE OF SERVICE BILL CODE
557	DIAGNOSIS POINTER
559	REVENUE BILLED CODE
561	PRESCRIPTION LINE NUMBER
562	DISPENSE AS WRITTEN CODE
563	DRUG NAME
564	BASIS OF COST DETERMINATION CODE

DN	Data Element Name
565	TOTAL CHARGE PER LINE – RENTAL
566	TOTAL CHARGE PER LINE – PURCHASE
567	DME BILLING FREQUENCY CODE
570	DRUGS/SUPPLIES QUANTITY DISPENSED
571	DRUGS/SUPPLIES NUMBER OF DAYS
572	DRUGS/SUPPLIES BILLED AMOUNT
574	TOTAL AMOUNT PAID PER LINE
576	REVENUE PAID CODE
579	DRUGS/SUPPLIES DISPENSING FEE
586	RENDERING LINE PROVIDER FEIN
589	RENDERING LINE PROVIDER LAST/GROUP NAME
592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID
593	RENDERING LINE PROVIDER POSTAL CODE
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER
600	PLACE OF SERVICE LINE CODE
604	PRESCRIPTION LINE DATE
605	SERVICE LINE DATE(S) RANGE
615	REPORTING PERIOD
626	HCPCS PRINCIPAL PROCEDURE BILLED CODE
629	BILLING PROVIDER FEIN
630	BILLING PROVIDER STATE LICENSE NUMBER
634	BILLING PROVIDER NATIONAL PROVIDER ID
638	RENDERING BILL PROVIDER LAST/GROUP NAME
642	RENDERING BILL PROVIDER FEIN
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER
647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER
651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE
656	RENDERING BILL PROVIDER POSTAL CODE
657	RENDERING BILL PROVIDER COUNTRY CODE
667	SUPERVISING PROVIDER NATIONAL PROVIDER ID
678	FACILITY NAME
679	FACILITY FEIN
680	FACILITY STATE LICENSE NUMBER
681	FACILITY MEDICARE NUMBER
682	FACILITY PROVIDER NATIONAL PROVIDER ID
688	FACILITY POSTAL CODE
699	REFERRING PROVIDER NATIONAL PROVIDER ID
704	MANAGED CARE ORGANIZATION FEIN
712	MANAGED CARE ORGANIZATION POSTAL CODE
714	HCPCS LINE PROCEDURE BILLED CODE
715	JURISDICTION PROCEDURE BILLED CODE
717	HCPCS MODIFIER BILLED CODE

DN	Data Element Name
718	JURISDICTION MODIFIER BILLED CODE
721	NDC BILLED CODE
726	HCPCS LINE PROCEDURE PAID CODE
727	HCPCS MODIFIER PAID CODE
728	NDC PAID CODE
729	JURISDICTION PROCEDURE PAID CODE
730	JURISDICTION MODIFIER PAID CODE
731	SERVICE ADJUSTMENT GROUP CODE
732	SERVICE ADJUSTMENT REASON CODE
733	SERVICE ADJUSTMENT AMOUNT
734	SERVICE ADJUSTMENT UNITS
736	ICD-9 CM PROCEDURE CODE
737	HCPCS BILL PROCEDURE CODE

Section PO: 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(b) and 4903.1). The DWC\WCIS has adopted IAIABC medical lien codes as the standard for reporting bundled lump sum medical bills (See 8 C.C.R. § 9702(e)). The six codes below, describe the type of lump sum settlement payment Medical Lien Lump Sum Payments or Settlements made by the claims payer after the filing of a lien with the Workers' Compensation Appeals Board (WCAB). Reportable lump sum medical liens originate from medical bills filed on DWC WCAB Form 6. (The medical lien form is located at http://www.dir.ca.gov/dwc/FORMS/DWCForm6.pdf. http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCForm6.pdf)

Code	Description
MDS10	Lump sum 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 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 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

Medical bill reporting process bundled lump sum medical bills

1. Sender transmits all original disputed medical bill(s), including all lines, utilizing a BSRC "00".
2. The DWC sends a 997 "A" and a "TA" 824 acknowledgement to sender.
3. Sender changes the value of data elements (Lien Settlement amount) on the original bill(s) submitted in step 1.

4. Sender transmits the updated bill (Lien Settlement), with all individual lines on all bills bundled as one ~~lump sum payment~~ medical lien lump sum payment or settlement, as a BSRC "00".
5. DWC sends a 997 "A" and a "TA" 824 acknowledgement to sender.

Medical lien lump sum data requirements

~~Lump sum bundled bill medical lien payments~~ Medical lien lump sum payments or settlements are reported utilizing Bill Submission ~~r~~Reason Code 00 (~~o~~Original). Individual ~~Lump sum medical lien payments~~ medical lien lump sum payments or settlements are required to utilize one of three possible IAIABC 837 file structures in the *IAIABC EDI Implementation Guide for Medical Bill Payment Records*, Release 1.1 July 1, 2009 (http://www.iaiabc.org/i4a/pages/index.cfm?pageid=3349). If the bundled medical bills are being reported as a professional or a pharmaceutical ~~lump sum payment~~ Medical lien lump sum payments or settlements then the SV1 segment is utilized to report the appropriate IAIABC medical lien code (Scenario 10) as a jurisdictional procedure code. If the bundled medical bill(s) are being reported as an institutional ~~lump sum payment~~ medical lien lump sum payments or settlements then the SV2 segment is utilized to report the appropriate IAIABC medical lien code (Scenario 11) as a jurisdictional procedure code. If the bill(s) being reported are mixture of professional, pharmaceutical, or institutional ~~lump sum payments~~ medical lien lump sum payments or settlements then the SVD segment is utilized to report the appropriate IAIABC medical lien code (Scenario 12) as a jurisdictional procedure code.

Appendix A: Major changes in the medical implementation guide

List of changes from version 1.0 to version 1.1 by section

Section A: Deleted Components of the WCIS. Changed the four-step testing procedure to a five-step testing procedure.

Section B: Minor grammatical corrections; EDI Service Provider information in Section B was expanded to include information from the deleted Section J. The listing of EDI Service Providers is now available online. Delete User Groups.

Section C: Updated references to new Sections (J,K,L,M,N,O,P) and to listing of EDI Service Providers, which is now provided online. Removed references to VAN transmission option. Removed references to the optional matching of medical data on paper bills to electronic reports.

Section D: No Change

Section E: No Change

Section F: Updated the Trading Partner Profile to use a WCIS-hosted FTP as the sole transmission mode. Updated WCIS zip code to 94612-1491. Updated date/time transmission sent format to CCYYMMDDHHMM.

Section G: Changed the four-step testing procedure to the five-step testing procedure. Minor updates and corrections. Removed references to VAN transmission option. Removed references to parallel pilot procedure and the WCIS paper pilot identification form.

Section H: Added two national provider loops and segments to 837 file structure. Added five new national provider identification data elements.

Section I: FTP transmission mode updated. Removed references to VAN transmission option.

Section J: Deleted. Information on EDI service providers is available online so it can be updated more easily.

~~Section K: Renamed Section J.~~

Section J: Added new section: California-adopted IAIABC data elements

Section L: Renamed Section K. Added five new national provider identification data elements. Updated the element requirement table and sorted it alphabetically by data element name.

Section M: Renamed Section L Changed the medical provider entity requirements. Added five new national provider identification data elements. Deleted the California-specific edits.

Section N: Renamed Section M. Update procedure for matching medical bills to FROI claims. Clarified the batch rejection rules. Minor grammatical corrections.

Section O: Deleted the IAIABC information, which is available online.

Added new Section ~~P~~ O: Lump sum bundled lien bill payment

Section P: Renamed Section N. Deleted IAIABC code lists. Added web links for code lists and made corrections. Added a reference to the Washington Publishing Company. Added a reference to the National Plan and Provider Enumeration System.

Section Q: Deleted the Medical EDI glossary and acronyms

Section R: Deleted the Standard Medical Forms.

~~Added new Section O: California-adopted IAIABC data elements~~

Added Appendix A: Major changes in the California medical implementation guide.

Section Q

MEDICAL EDI GLOSSARY AND ACRONYMS

Medical bill payment records glossary

ACQUIRED FILE

Definition: A claim previously administered by a different claim administer
Revision Date: 06/07/95

ACKNOWLEDGMENT RECORD (AK1)

Definition: A transaction returned as a result of an original report. It contains enough data elements to identify the original transaction and any technical and business issues found with it.
Revision Date: 09/25/96

AMERICAN NATIONAL STANDARDS INSTITUTE (ANSI)

Definition: A private nonprofit membership organization that acts as administrator and coordinator for the United States private sector voluntary standardization system. Further information can be obtained at http://www.web.ansi.org.
Revision Date: 04/28/99

ANSI ASC X12

Definition: American National Standards Institute, Accredited Standards Committee for Electronic Data Interchange. They are standards development organization. The ANSI X12 organization includes subgroups that specialize in distinct sector of the economy, or support the EDI development process.
Revision Date: 04/28/99

BATCH

Definition: A set of records containing one header record, one or more detailed transaction records, and one trailer record.
Revision Date: 09/25/96, 07/01/97

BILL

Definition: The actual medical bill that a health care provider submits to the carrier that provides medical information pertaining to the work related injury. This medical bill is matched to a workers' compensation claim.
Revision Date: 04/28/99

CARRIER

Definition: The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer.
Revision Date: 05/26/92

CLAIM ADMINISTRATOR

Definition: Insurance Carrier, Third Party Administrator, State Fund, Self-Insured.
Revision Date: 07/01/97

CLAIMANT

Definition: The claimant is the same as the employee and is the person who received the health care. If the claimant is person who has elected coverage, then the claimant will also be the employer.
Revision Date: 04/28/99

CONTRACT MEDICAL

Definition: Contract medical care costs are the actual costs incurred by the carrier under medical contracts with physicians, hospitals, and others, which cannot be allocated for a particular claim.
Revision Date: 08/09/95

DATA ELEMENT

Definition: A single piece of information (e.g. Date of Birth)
Revision Date: 07/01/97

EDIT MATRIX

Definition: Identifies edits to be applied to each data element. Senders will apply them before submitting a transaction and receivers will confirm during processing.
Revision Date: 09/25/96

ELEMENT REQUIREMENT TABLE

Definition: A receiver specific list of requirement codes for each data element depending on the Bill Submission Reason Code.

Revision Date: 09/25/96

EMPLOYEE

Definition: A person receiving remuneration for their services.

Revision Date: 07/01/97

EMPLOYER

Definition: POC: any entity (e.g. DBA, AKA etc) of the insured. Multiple entities can exist for an insured.

Revision Date: 07/01/97

EVENT TABLE

Definition: Table designed to provide information integral for a sender to understand the receiver's EDI reporting requirements. It relates EDI information to events and under what circumstances they are initiated.

FEIN

Definition: Identifies the Federal Employers Identification Number, Corporations/Business US Federal Tax ID, Individuals US Social Security number.

Revision Date: 07/01/97

FORMATS

Definition: The technical method used to exchange information (e.g. IAIABC Flat and Hard Copy, WC Pols, ANSI X12. The business requirements remain constant. The technology is different.

Revision Date: 07/01/97

HCPCS

Definition: Acronym for the Health Care Financing Administration (HCFA) Common Procedure Coding System. This coding list had three levels. **Level I** is the Physicians' Current Procedural Terminology (CPT) codes that are developed and are maintained by the American Medical Association (AMA). These codes are five numeric digits. **Level II** codes contain other codes that are needed in order to report all other medical services and supplies, which are not included within CPT code list. These codes begin with a single alpha character followed by four numeric digits. **Level III** contain codes that are developed and maintained by state Medicare carriers. These codes begin with W through Z followed by four numeric digits.

Revision Date: 04/28/99

HCPCS MODIFIERS

Definition: Health care providers to identify circumstances that alter or enhance the description of the medical service rendered use Modifiers. If the modifier is used with the CPT codes (Level I), the modifier will be two numeric digits (i.e. 22 Unusual Procedural Services). If the modifier is used with the Level II codes, the modifier will be a two alphabetic digits or one alphabetic digit followed by one numeric digit.

Revision Date: 04/28/99

HEADER RECORD (HD1)

Definition: The record that precedes each batch. This and the trailer record are an "envelop" that surround a batch of transactions.

Purpose: To uniquely identify a sender, as well as the date/time a batch is prepared and the transaction set contained within the batch.

Note: See ANSI implementation guide for specifics on transmission process.

Revision Date: 09/25/96, 07/01/97

IAIABC

Definition: International Association of Industrial Accident Boards and Commissions, which is a group comprised of jurisdictions, insurance carriers and vendors who are involved in workers' compensation. Further information may be obtained from http://www.iaiabc.org.

Revision Date: 04/28/99

ICD-9 CM

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification. This is a classification that group related disease entities and procedures for the reporting of statistical information. The clinical modification of the ICD-9 CM was developed by the National Center for Health Statistics for use in the United States. Further information may be obtained at http://www.icd-9-cm.org.

Revision Date: 04/28/99

IMPLEMENTATION DATE, "FROM"

Definition: The effective begin date of the production level indicator for a trading partner.

Revision Date: 09/25/96

IMPLEMENTATION DATE, "THRU"

Definition: The effective end date of the production level indicator for a trading partner.

Revision Date: 09/25/96

IMPLEMENTATION GUIDE

Definition: User-friendly specifications issued by an industry organization such as the IAIABC. Sets the objectives and parameters of Trading Partner Agreements. May also be exchanged between partners for their unique requirements.

Revision Date: 07/01/97

JURISDICTION

Definition: A governmental entity which exercises control over the workers' compensation system by enacting and enforcing laws and regulations. A Jurisdiction is usually referred to by its political boundary, such as the State of Idaho, Commonwealth of Massachusetts, or District of Columbia.

Revision Date: 07/01/97

MEDICAL BILL/PAYMENT REPORT

Definition: The IAIABC's adaptation of the ANSI 837 Transaction Set for use in the workers' compensation environment and includes the IAIABC's flat file layout. The Medical Bill/Payment Report is used to submit health care information, charges, and reimbursements to a jurisdiction from a payer.

Revision Date: 04/28/99

PILOT/PARALLEL

Definition: Dual reporting during test phase (current processing/IAIABC EDI standards). Production data (real claims) are loaded into test system. IAIABC data does not satisfy the receivers' reporting requirements. This is a temporary testing phase as defined by the trading partners with production as the final goal.

Revision Date: 09/25/96, 07/01/97

PRODUCTION

Definition: A trading partner is sending production data (real claims). The data is loaded into the jurisdiction production system. No dual reporting (paper/EDI) to receiving party from sending party. IAIABC data satisfies the receiver's reporting requirements.

Revision Date: 09/25/96

PROVIDER

Definition: In a generic sense, the Provider is the entity that originally submitted the bill or encounter information to the Payer. Specific loops are used for the various types of providers. For example, there are separate loops used for Billing Provider, Rendering Provider, Supervising Provider, Facility Provider, etc.

Revision Date: 04/28/99

QUEUE

Definition: A log of claim events due for transmission. There are several ways to implement this log. For example, it can be an indicator on the main claims administration application which would alter "be read" to "compose a transmission batch", or it can be a separate file with all the necessary information created at the time an event occurs.

Revision Date: 07/01/97

RECORD

Definition: A group of related data elements. One or more records will form a transaction. The Record Type Qualifier identifies a record.

Revision Date: 07/01/97

REPORT

Definition: It is equivalent to a transaction. Refer to diagram under Transmission definition.

Revision Date: 07/01/97

REPORT DUE CRITERIA

Definition: The criteria that determines the latest date that a report must be completed and submitted for a specific trigger to be considered timely. Used in Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT DUE VALUE

Definition: A value that is used to modify or define a Report Due Criteria. Used in the Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT LIMIT NUMBER

Definition: When present, this value reflects the maximum number of periodic reports required. Used in the Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT REQUIREMENT CRITERIA

Definition: Criteria used in conjunction with Report Requirement Effective Date (From and Thru), to determine whether the corresponding event requirements are applicable for a particular claim. An example of Report Requirement Criteria is "Date of Injury" where different events may apply depending on its value; this where the From and Thru dates come into play. They identify the specific event, which applies to a claim. Used in the Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT REQUIREMENT EFFECTIVE DATE, "FROM"

Definition: The first date that a claim meeting the Report Requirement Criteria will be reported for a specific report trigger. Used in the Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT REQUIREMENT EFFECTIVE DATE, "THRU"

Definition: The last date that a claim meeting the Report Requirement Criteria will be reported for a specific report trigger. Used in the Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT TRIGGER CRITERIA

Definition: Criteria used in conjunction with Report Trigger Value to determine if an event must be triggered for a claim covered according to the Report Requirement Criteria, and Report Requirement Effective Dates. If multiple conditions can independently trigger an event, then each condition must be listed separately. An example of Report Requirement Criteria is "Indemnity Benefits Paid" and when associated with the corresponding Report Trigger Value will whether a report must be triggered for a particular claim. Used in the Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT TRIGGER VALUE

Definition: Used in conjunction with Report Trigger Criteria in Event Table. It determines whether a report must be triggered.

Revision Date: 09/25/96, 07/01/97

REQUIREMENT CODE

Definition: Defines the level of reporting required by the receiver

M = Mandatory. The data element must be sent and all edits applied to it must be passed successfully or the entire transaction will be rejected.

C = Conditional. The data element is normally optional, but becomes mandatory under conditions established by the receiver, e.g. If the Benefit Type Code indicates death benefits, then the Date of Death becomes mandatory. The receiver must provide senders with a document describing the specific circumstances, which cause a conditional element to become mandatory.

O = Optional. The data element may not be sent. If it is sent, are applied to it, but unsuccessful edits do not reject the transaction.

Revision Date: 07/01/97

SELF-INSURED

Definition: A jurisdictional approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's workers' compensation claims.

Revision Date: 07/01/97

SUBSCRIBER

Definition: In the ANSI 837 Transaction Set, this would be the owner of the health insurance policy. Generally, in workers' compensation, the claimant's employer at the time of the injury is the subscriber. This is a good illustration of adapting the ANSI 837 Transaction Set to the workers' compensation business need.

Revision Date: 04/28/99

THIRD PARTY ADMINISTRATOR

Definition: A business entity providing claim services on behalf of the insurer or self-insured.

Revision Date: 07/01/97

TRAILER RECORD (TR1)

Definition: A record that designates the end of a batch of transactions. It provides a count of records/transactions contained within a batch.

Revision Date: 09/25/96

TRANSACTION

Definition: Consists of one or more records. It is intended to communicate a bill event.

Revision Date: 07/01/97

TRANSMISSION

Definition: Consists of one or more batches sent or received during a communication session. See diagram on the following page.

Revision Date: 07/01/97

Medical bill payment records common acronyms

EDI	**Electronic Data Interface**
WCIS	**Workers Compensation Information System**
DWC	**Division of Workers Compensation**
FROI	**First Report of Injury**
SROI	**Subsequent Reports of Injury**
VAN	**Value Added Network**
FTP	**File Transfer Protocol**
ANSI	**American National Standards Institute**
IAIABC	**International Association of Industrial Accident Boards and Commissions**
IS	**Information Systems**
FEIN	**Federal Employers Identification Number**
TP	**Trading Partner**
BSRC	**Bill Submission Reason**

Section R: Standard Medical Forms

Standardized billing / electronic billing

Standardized Electronic Billing implies an "Electronic Standard Format". The adopted California standard electronic format is the ASCX12N standard format developed by the Accredited Standards Committee X12N Insurance Subcommittee of the American National Standards Institute (See Section G – Test Pilot and Production Phases of Medical EDI and Section- H – Supported Transactions and ANSI File Structure).

Standard Paper Forms are defined as:

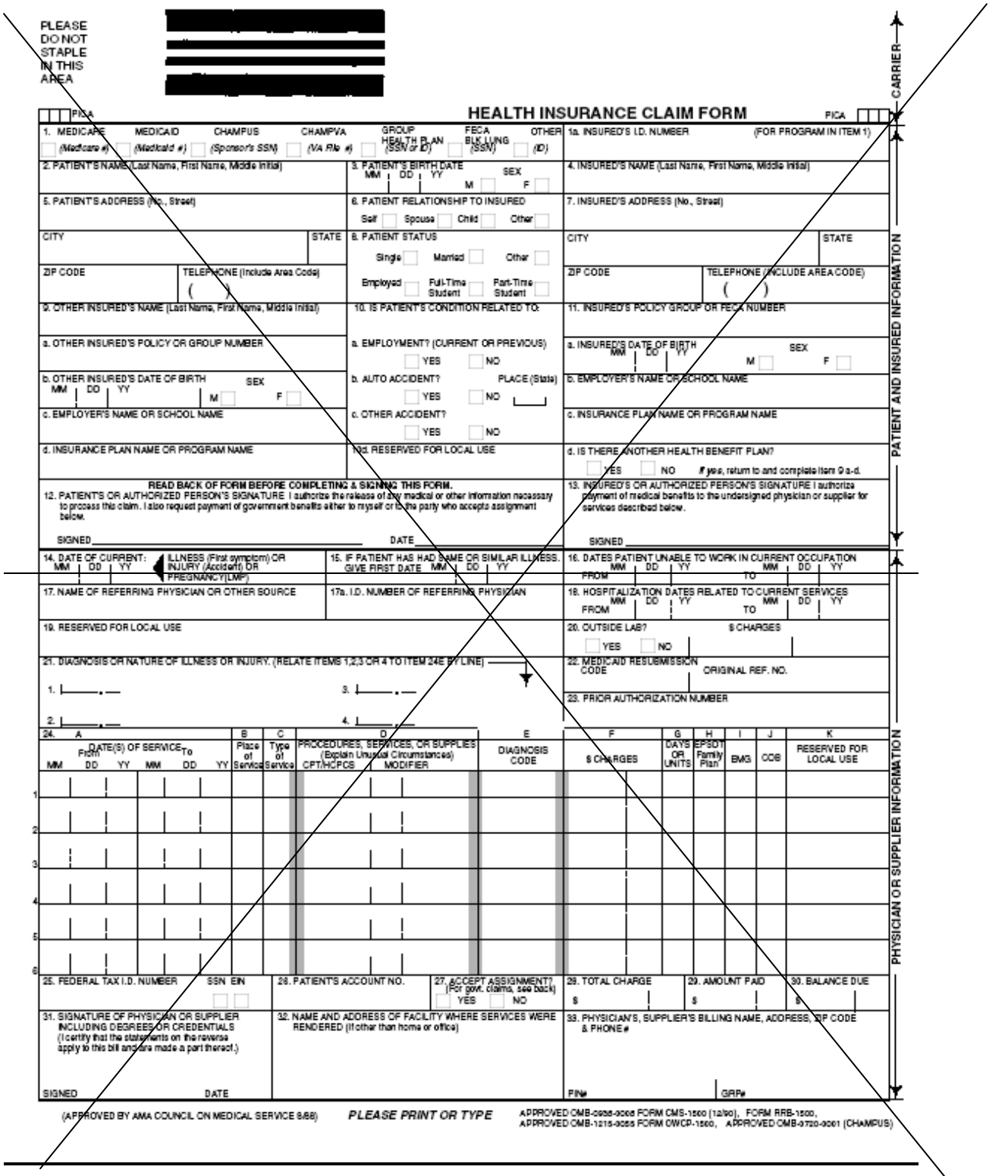
Form HCFA-1500 or form CMS-1500 means the health insurance claim form maintained by Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services (CMS) for use by heath care providers.

CMS form 1450 or UB92 means the health insurance claim form maintained by CMS for use by heath facilities and institutional care providers.

American Dental Association, 1999 Version 2000 means the uniform dental claim form approved by the American Dental Association for use by dentists.

NCPDP universal claim form means the National Council for Prescription Drug Programs (NCPDP) claim form or its electronic counterpart.

~~Form HCFA-1500 or CMS-1500~~



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

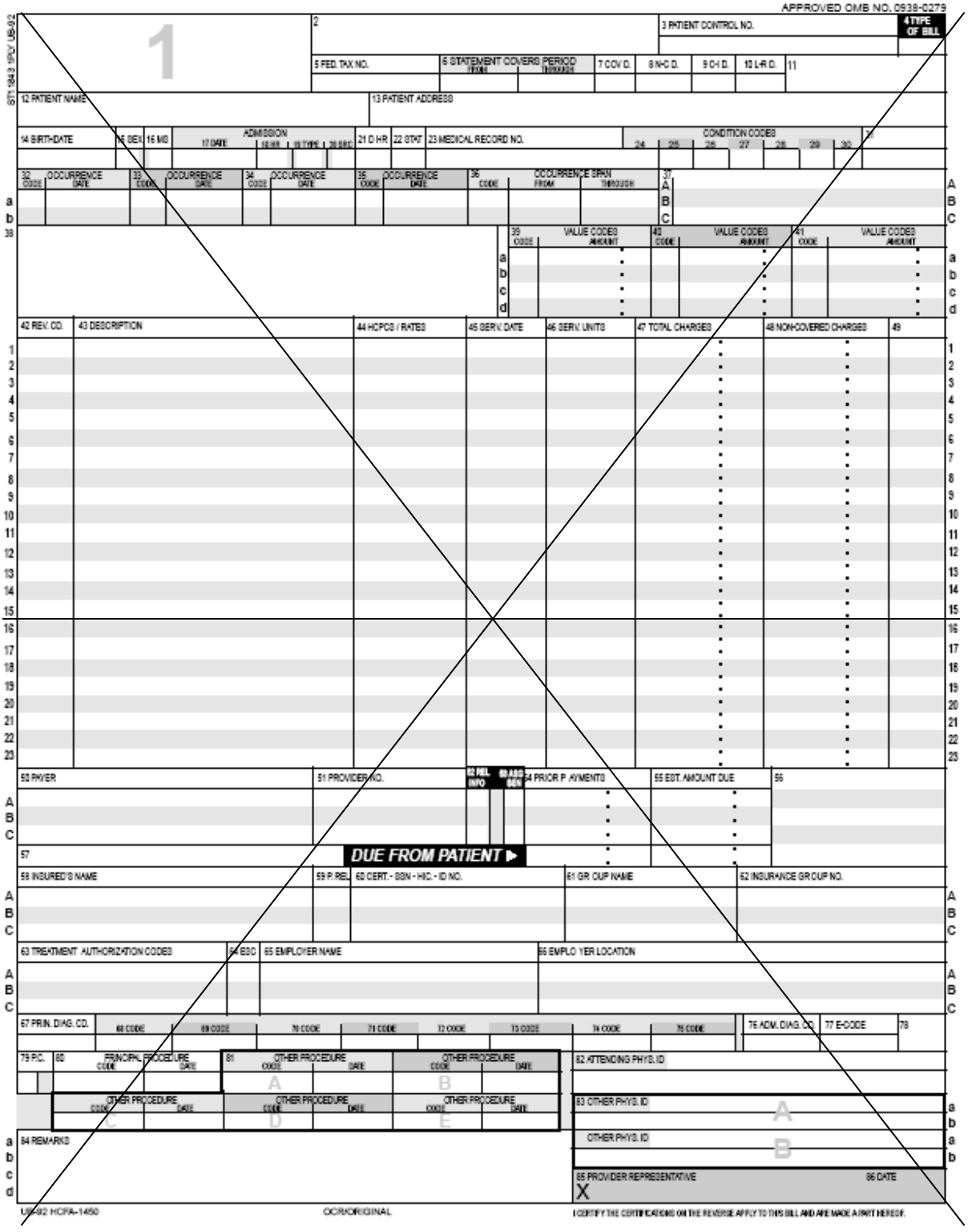
PIN# GRP#

PATIENT AND INSURED INFORMATION

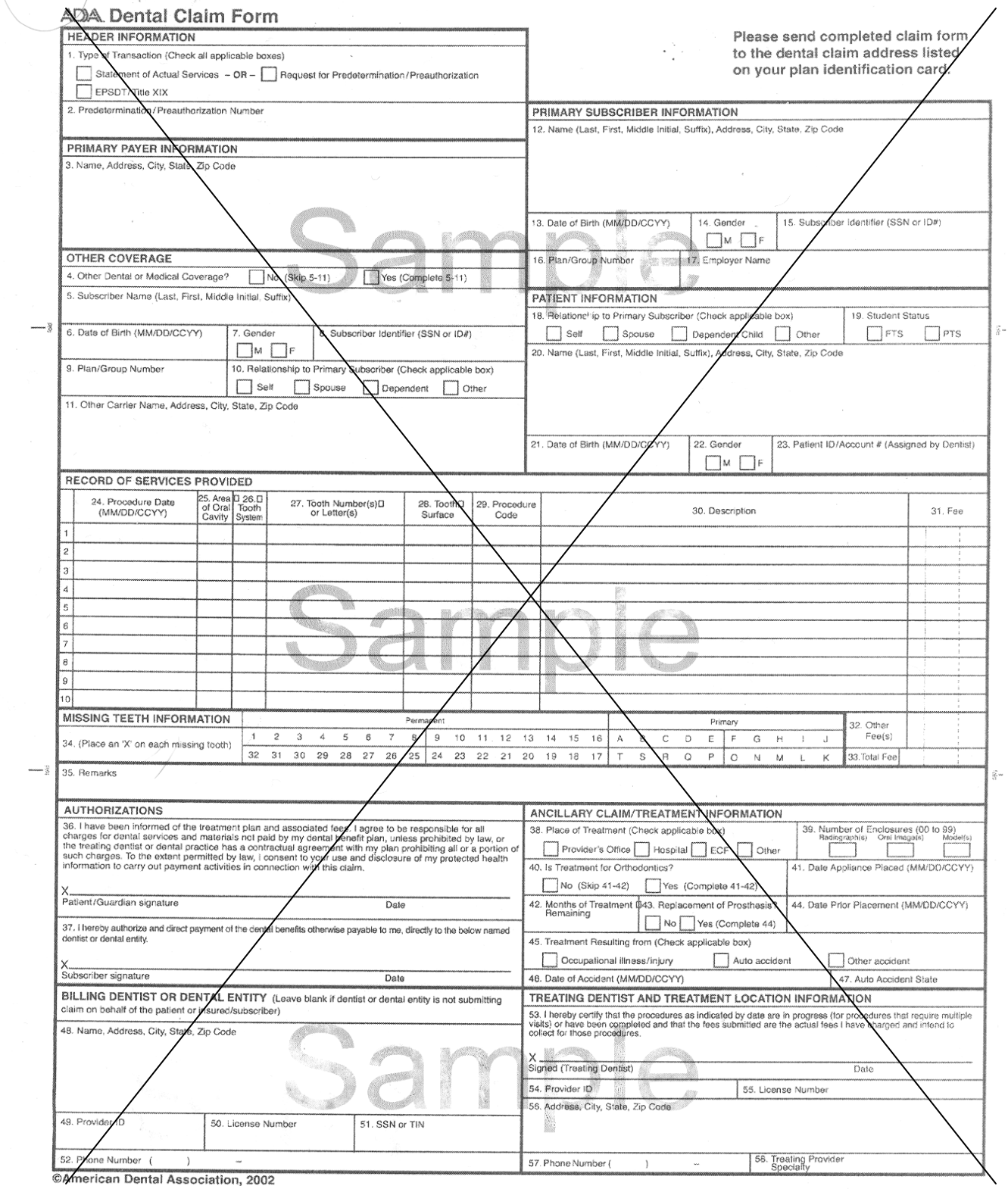
PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

~~CMS form 1450 or UB92~~



American Dental Association



ADA Dental Claim Form

Please send completed claim form to the dental claim address listed on your plan identification card.

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

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

OTHER COVERAGE

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

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

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

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

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

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

RECORD OF SERVICES PROVIDED

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

MISSING TEETH INFORMATION

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

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

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

X_____
Patient/Guardian signature Date

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

X_____
Subscriber signature Date

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

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

49. Provider ID | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) –

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other | 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) Date

54. Provider ID | 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) – | 58. Treating Provider Specialty

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NCDPD Universal Claim Form

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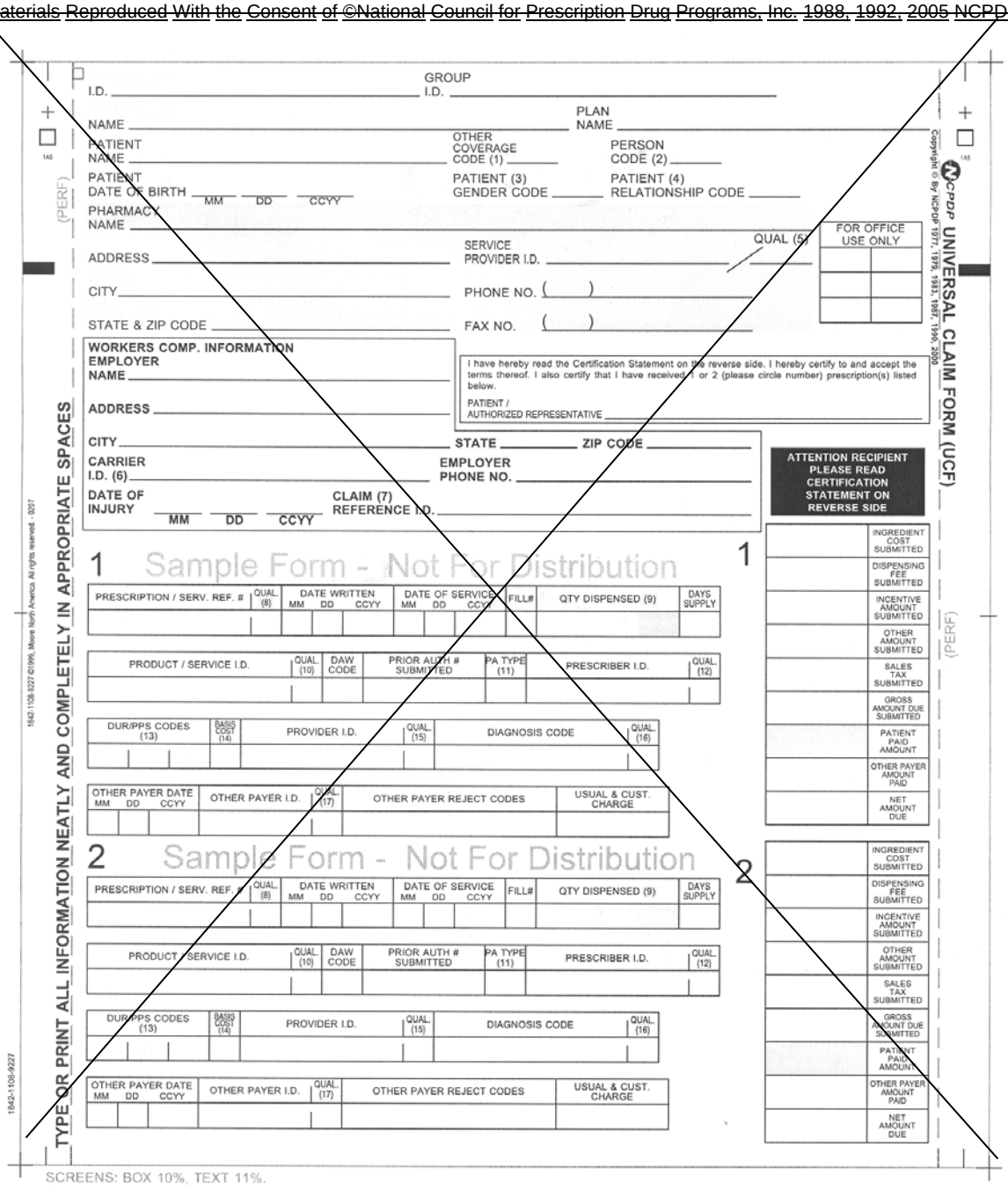

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