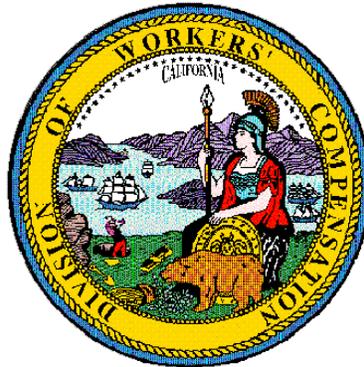


**Workers' Compensation Information System
(WCIS)
California EDI Implementation Guide
for
Medical Bill Payment Records
Version 1.0
July 2005**



**CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS
John Rea, acting director
DIVISION OF WORKERS' COMPENSATION**

June 1, 2005

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 its 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.

The 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 claims. 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/wcis.htm. I hope the start-up 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 process, and this guide is a key element of that communication.

Sincerely,

Andrea L. Hoch
DWC administrative director

**Workers' Compensation Information System
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Section A

Electronic Data Interface in California – An Overview

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Electronic Data Interchange – EDI

Electronic Data Interchange (EDI) is the computer-to-computer exchange of data or information in a standardized format. In workers' compensation, EDI refers to the electronic transmission of claims information from Claims Administrators (insurers, self-administered self-insured employers, and third party administrators) to a State Workers' Compensation Agency.

Data are transmitted in a format standardized by the International Association of Industrial Accident Boards and Commissions (IAIABC). 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 P – IAIABC Information.) All data elements to be collected are reviewed for a valid business need, and definitions and formats are standardized.

EDI 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, 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 allows states to evaluate the effectiveness and efficiency of their workers' compensation system by providing comprehensive and readily accessible information on all claims. This information can then be made available to state policy makers considering any changes to the system.
- **Avoids costs in paper handling**
EDI 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 has built-in 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 helps Claims Administrators cut costs by having a single system for internal data management and reporting.

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. 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 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.

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 shed light on the differences between adjudicated and non-adjudicated cases.

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 employer, or a third-party administrator.

In brief, Claims Administrators are required to submit the following:

First Reports: First Reports of Injury (FROI) have been transmitted by EDI to the DWC since March 1, 2000. First Reports must be transmitted to the WCIS no later than 5 days after 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 10 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 Reports: Medical Bill Payment Reports began to be transmitted to the DWC in January, 2006. Medical Bill Payment Reports must be transmitted to the DWC within 90 days after the Medical Bill Payment is made by Insurers to medical service and equipment providers. The required data elements are listed in Section L-Required data Elements of this guide and in the California Medical Data Dictionary (<http://www.dir.ca.gov/DWC/wcis.htm>). See also Section E – WCIS Regulations, which a reference to the full 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

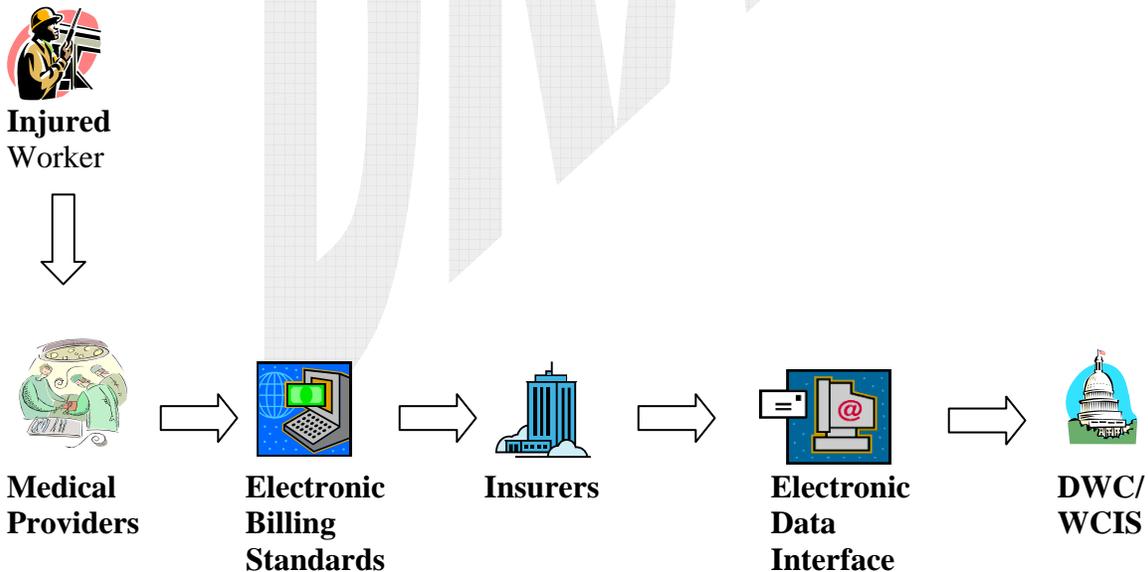
California workers' medical bill payment records are handled by diverse organizations: large multi-state insurance companies, smaller specialty insurance carriers, self-insured employers, third-party administrators handling claims on behalf of self-insured employers, as well as bill review companies. 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 Section I – Transmission modes.

Following the IAIABC standards the WCIS supports the American National Standards Institute (ANSI) file format. The adopted ANSI file format is more fully described in Section H – Supported transactions and ANSI file structure and in the IAIABC *EDI Implementation Guides for Medical Bill Payment Records, Reporting July 2004*. (www.iaiabc.org).

Claim administrators that wish to avoid the details of EDI can choose among several firms that sell EDI-related software products, consulting, and related services. These are described in Section J – EDI Service Providers.

After a worker is injured, Medical Bill Payment Records are transmitted either by paper or through the use of EDI flows 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



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 – Test, Pilot, and Production Phases of medical EDI.

Stage One: EDI Trading Partner Profile

The claims administrator first provides an EDI Trading Partner Profile to the DWC at least 30 (thirty) days before first submission of EDI data. The Trading Partner Profile form is provided in Section F. The Trading Partner Profile is used to prepare the WCIS for data transmission: what file format to expect, where to send an acknowledgement, when to transmit reports, and similar information.

Stage Two: Testing

The claims administrator next runs a preliminary test by transmitting a batch file to ensure the WCIS system can read and interpret the data. The claims administrator passes the structural test when the minimum technical requirements are met: WCIS recognizes the sender, the file format is correct, and the claims administrator can receive electronic acknowledgements from the WCIS.

Stage Three: Pilot

After a batch test file is successfully transmitted, the claims administrator transmits real detailed medical bill payment data, in test status. During the detailed test phase, the claims administrator's submissions are analyzed for data completeness, validity, and accuracy. The claims administrator 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 claims administrator must meet minimum data quality requirements in order to complete the pilot 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).

Section B

Where to Get Help – Contacting WCIS and Other Information Resources

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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 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.

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 you 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 USPS. When initially contacting the WCIS, be sure to provide your company name so that you may be directed to the appropriate WCIS contact person.

By phone:

510-286-6753

510-286-6763

510-286-6772

By fax: (415) 703-5911

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

By USPS: WCIS EDI Unit

Attn: Name of WCIS Contact (if known)

Department of Industrial Relations

IS Department

1515 Clay Street, 19th 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* will be 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 you in your efforts to report medical data via EDI. A 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, 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.

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 on our 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 *EDI Implementation Guides for Medical Bill Payment Records, July 2004*.

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.iaiaabc.org.

Section C

Implementing Medical EDI – A Manager’s Guide

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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 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 (IS) manager, while others designate the Claims manager as medical EDI implementation team leader. Regardless of who is assigned primary responsibility, make sure that all effected systems, procedures, and maintenance activities are included as you designed and implemented 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 have an IS department that is familiar with EDI or that is 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, record layouts, 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 transmission mode for medical data

You will also need to choose a transmission mode from the two that WCIS supports: Value Added Networks (VAN) and or File Transfer Protocol (FTP) files. See Section I – Transmission modes- for further information.

Detailed Information about the required ANSI format can also be found in Section H – Supported transactions and ANSI file structure and in the *EDI Implementation Guide for Medical Billing Payment Reports, July 2002* published by the IAIABC at:

http://www.iaiaabc.org/EDI/implementation_guide_index.htm.

The 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 be readily accessible on your electronic systems. Give your IS department a copy of Section L – Required medical data elements. Have the IS department indicate which ones are readily accessible, which are available but accessible with difficulty, and which are not captured at this time.

If all the medical data are electronically available and readily accessible, then you are in great shape. If not, your claims and IS departments 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 beginning in March, 2000. The second phase added the SROI's in July, 2000. A third requirement, an annual summary of payments on each active claim, went into effect January, 2001. The latest requirement of reporting all medical payments went into effect January, 2006.

As of February, 2005 the DWC was receiving FROI data from 205 Trading Partners and SROI data from 80 Trading Partners. Implementing the requirements of the EDI transmission of the FROI's and SROI's may have provided your organization a basic framework in which to implement the requirements of the Medical Bill Payment Reports.

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.

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 – 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 it is transmitted to WCIS. For example, the medical data may first be processed in a claim reporting center, then to a data entry clerk, to a claims adjuster, and then through an IS 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, VAN or FTP, 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, pilot 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 - Test, pilot, 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 test, pilot 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.

Test, pilot, 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 reports, and other pertinent information necessary for EDI.

Step two of the process is to test a batch file. A successful test includes the WCIS verifying the medical transmissions match the WCIS technical specifications and that you can receive and process a 997 acknowledgment in return. Stage two tests for the basic EDI connectivity between your system and the WCIS system (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 and respond to the “error messages” it contains (see Section G for more detail).

Upon the successful completion of step three, the DWC will issue you a written determination that you have demonstrated capability to transmit complete, valid, and accurate medical data. 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 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 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

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L.C. §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 director shall issue a report on the development of the system, and recommendations for any necessary legislative action, no later than July 1, 1995, and shall, upon request, make the report available to the Governor, the Legislature, and the public.

L.C. §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) 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.
 - (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.
 - (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 pre-employment 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 – 8 CCR §9701-9703

Pertinent WCIS Regulations

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

DRAFT

Section F

Trading partner profile

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Who should complete the trading partner profile?

A separate trading partner profile form must be completed for each trading partner transmitting EDI medical records to WCIS. Each trading partner has a unique identification composed of the trading partner's "Master FEIN" and postal code. The identification information must be reported in the header record of every transmission. The trading partner identification, in conjunction with the sender information, transmission date, time of transmission, batch control number, and reporting period are used to identify communication parameters for the return of acknowledgments to the trading partners.

For many businesses, the claim administrator FEIN (federal tax identification number) provided on each transaction will always be the same as the insurer identification master FEIN. Other insurers may authorize multiple FEIN's for claim administrators or medical bill reviewers as senders. If the transactions for an insurer with multiple claim administrator FEIN's or bill reviewer FEIN's share the same transmission specifications, the data can be sent under the same sender identification.

For example, a single parent insurance organization might wish to send transactions for two subsidiaries batched together within transmissions. 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 transactions from both subsidiaries, identified by the appropriate claim administrator FEIN or if necessary each bill review company FEIN on each transaction.

The WCIS uses the insurer FEIN and if appropriate the claims administrator FEIN and bill review company FEIN to process individual transmissions. Transmissions for unknown claim administrators or bill review companies 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 claim administrator FEIN's and bill review company FEIN's whose data will be reported under a given Trading Partners Master FEIN. The trading partner profile form contains only one FEIN: multiple FEIN's for claims administrators and bill review companies 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 insurer FEIN reported by that trading partner will be the master FEIN and the only trading partner sender identification.

C. Trading Partner Transmission Specifications:

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	Expected Days of Transmission (circle any that apply)	Production Response Period
Medical Bill Payment 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	

DWC Use Only – Special Transmission Specifications For This Profile:

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

Name: California Division of Workers' Compensation

FEIN: 943160882

Physical Address: 1515 Clay Street, 19th Floor

City: Oakland State: CA Zip Code: 94612

Mailing Address: 1515 Clay Street, 19th Floor

City: Oakland State: CA Zip Code: 94612

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: (Varies by trading partner) FAX: (Varies by trading partner)

E-mail Address: wcis@dir.ca.gov E-mail Address: wcis@dir.ca.gov

RECEIVER'S VAN or FTP ELECTRONIC MAILBOX(s):

Network: _____ Network: _____

	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)

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

Electronic Data Interchange Trading Partner Profile

**INSTRUCTIONS FOR COMPLETING
TRADING PARTNER PROFILE**

Each Claims Administrator 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.

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 code (Zip+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 agreement 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.

Zip Code: The 9-position zip 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 agreement. If this address is the same as the physical address, indicate "Same as above".

Claims Administrator Type: Indicate any functions that describe the Claims Administrator. If "other", please specify.

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 CONTACT (E-mail) The e-mail address of the contact.

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 claims administrator must select one of the following two transmission modes through which the WCIS can accept transactions: EDI transactions sent through a value added network (VAN), or EDI transactions sent through a File Transfer Protocol (FTP). When selecting complete section C1 and either C2 or C3.

SECTION C1: VAN and FTP TRANSFERS:

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 claims administrator for each transaction set.

TRANSACTION

TYPE: Indicates the types of EDI transmissions accepted by Division of Workers' Compensation.

MODE OF

TRANSMISSION: DWC will accept the ANSI X12 VERSION 4010 contained in the IAIABC Implementation Guide for Medical Bill Payment Records, July 4, 2002. The WCIS will transmit detailed acknowledgements utilizing the acknowledgement format that corresponds to the format of the original transaction.

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 claims administrator 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 claims administrator's mailbox on the specified VAN.

NETWORK:

USER ID: This is the identifier of the claims administrator's entity to the VAN.

SECTION C3: FTP users:

USER NAME: Specify a user name.

PASSWORD: Specify a password.

NETWORK
IP

ADDRESS: Optional.

E-MAIL

ADDRESS: Specify an e-mail address.

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 code (Zip+4), uniquely identifies DWC as a trading partner.

Physical
Address:

The street address of DWC. The 9-position zip 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 VAN

ELECTRONIC

MAILBOXES:

This section specifies DWC's mailboxes, which claims administrators can use to transmit EDI transactions to DWC. Separate mailbox information may be provided for receiving production versus test data.

NETWORK: The name of the VAN or FTP service on which the DWC's mailbox can be accessed.

NETWORK

MAILBOX

ACCT ID:

The name of the DWC mailbox on the specified VAN or FTP.

NETWORK:

USER ID:

This is the identifier of the DWC's entity to the VAN or 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 claims administrator'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.

Section G

Test, pilot and production phases of medical EDI

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Overview of the four step process

This section is a suggested step-by-step guide on how to become a successful EDI trading partner (TP) in the California workers' compensation system. Attaining EDI capability is a four step process, beginning with completing a trading partner profile, followed by sending a test batch level transmission (to make sure your system and the WCIS system can "communicate" with each other), then completing a pilot phase (where your EDI detailed medical bill payment record transmissions are tested for validity and accuracy), and then attaining full 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 test phase

Purpose

The purpose of the test phase is to ensure the electronic transmissions meet the required technical specifications. The WCIS needs to recognize and process your batch transmissions and your system needs to recognize and process 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.
- **Batch format** of report files sent by the trading partner is structurally correct.
- **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.

- No errors in header or trailer records
- Correct ANSI structure
- TP can receive electronic acknowledgment (997) reports.

Test procedure

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

1. Prepare a test file

Trading partners using the VAN or FTP transmission modes will be sending medical data to the WCIS in batches. A batch consists of three parts:

- A header record, which identifies the sender, the receiver, test/production status, the time and date sent, etc.
- One or more transaction sets (ST-SE transactions)
- A trailer record, which identifies the number of transactions in the batch.

The WCIS suggest the test file consist of one batch of several (number to be determined) production-quality reports of real medical claims. The DWC\WCIS has developed a several Medical Bill Payment scenarios for California including Medical Provider Networks and reevaluations to be included in the batch of test files. For medical reports: Submit original reports (bill submission reason code (BSRC) "00")

Note: The trading partner may also be required to send additional BSRC (01, 05) while testing, your WCIS contact person will have the additional information.

2. Send the test file

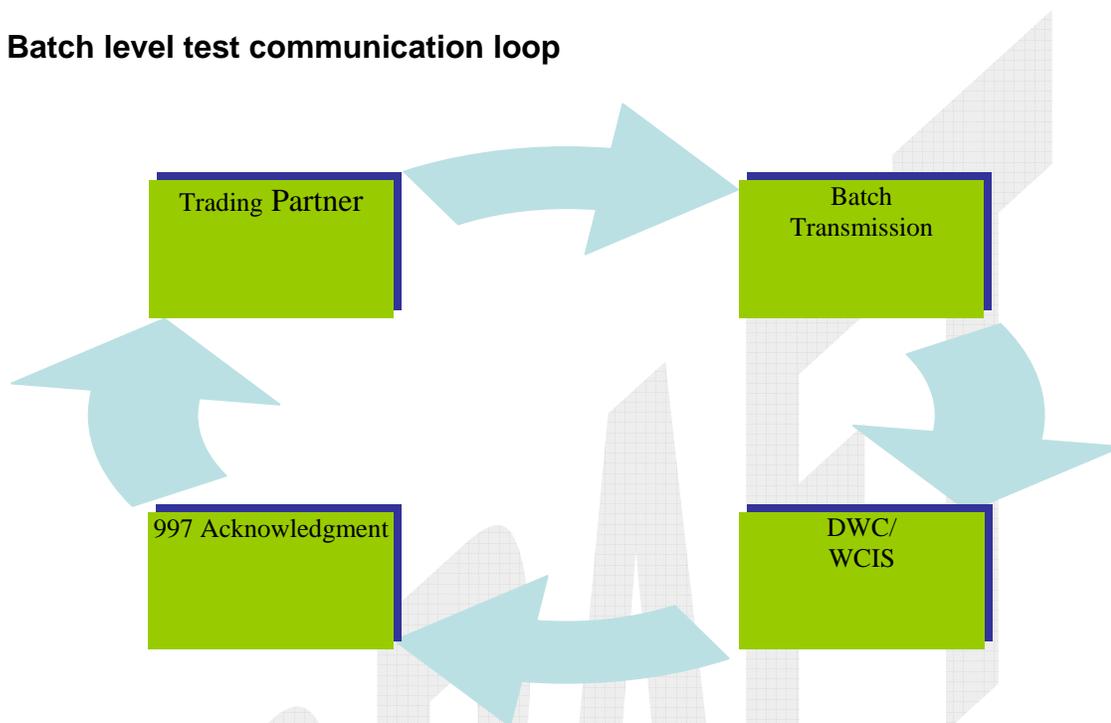
Send the test file to WCIS. The test data you send, if successful, will be posted to our test database. They will not be posted to the WCIS production database.

Note: This means that any live California medical claims sent as test data will have to be re-sent to WCIS, either during pilot or production, in order to be posted to the WCIS production database.

3. Wait for electronic 997 acknowledgment from WCIS

Trading partners must be able to receive and process both structural and detailed electronic acknowledgments from WCIS. When a test file has been processed, an electronic 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 header is not recognized by WCIS, no acknowledgment will be sent. The 997 structural acknowledgment sent during the test phase. Information about errors in the individual medical records will be included in the 824 detailed acknowledgment which follows in the next phase.

Batch level test communication loop



Transmission 997 acknowledgment structural edits

Trading partners should receive an electronic 997 acknowledgment within 48 hours of sending the test transmission. If you do not receive an acknowledgment within 48 hours, contact the person identified in your WCIS Trading Partner agreement. The DWC/WCIS utilizes the 997 functional acknowledgment transaction set within the context of an Electronic Data Interchange (EDI) environment. The transaction set is used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the 837 Transaction Set.

Error Code	Error Message
100	Mandatory Element Missing
111	Invalid Date
112	Invalid Time
113	Invalid String
116	Element Too Short
117	Element Too Long
200	Mandatory Component
300	Mandatory Segment
330	Unexpected Segment

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

4. Process the acknowledgment and correct any errors

If you receive an error acknowledgment (application acknowledgement code = BR “batch rejected”), you will need to check the batch file format and make corrections before re-transmitting the file to WCIS. If the acknowledgment has a BA code (“batch accepted”), skip to step six.

5. Re-transmit corrected file to WCIS

Send the corrected batch file to the DWC. If the test fails again, repeat steps two through five until your test file is accepted by WCIS (no BR code). 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.

6. 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. The WCIS contact person will notify you by phone or e-mail when the DWC system is ready to accept your pilot data and you may then begin step 3 of the process at your earliest convenience.

Step 3. Complete the pilot phase

Overview

During the pilot 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 pilot 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), claims administrators 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, Release 1* (<http://www.iaiaabc.org>) and the California medical data dictionary (<http://www.dir.ca.gov/DWC/wcis.htm>) 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 pilot 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 prefers the pilot be conducted in two steps, which may be conducted concurrently if desired. Each step has its own data quality criteria:

1. Reports are first transmitted to WCIS via EDI, and they are tested for **completeness** and **validity** using automatic built-in data edits on the WCIS system. See section M – Data edits for more detail.

DWC suggests you transmit medical bill payment records for **at least 30 live medical claims** to WCIS. These claims should meet or exceed the following two data quality criteria:

- Initially during the pilot phase, the first transmission of medical reports should contain no more than 10 percent errors. During the final part of the pilot phase, before production, medical reports should contain zero errors.

Note: Trading partners whose claim volume is too low to reasonably send 30 medical reports may send fewer medical reports. Your WCIS contact will be able to advise you on how many medical reports to send.

The medical data reporting requirements for each data element are listed in section L – Required medical data elements of this guide.

2. If the criteria of zero errors during the pilot phase cannot be attained. The DWC suggests a random subset of the EDI reports will be manually crosschecked against the corresponding paper reports for **accuracy**. The claims administrator 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.iaiaabc.org)..

Bill submission reason codes piloted

Following are the bill submission reason codes (BSRC) are utilized in California:

Original	00
Cancel	01
Replace	05

Medical EDI pilot procedure

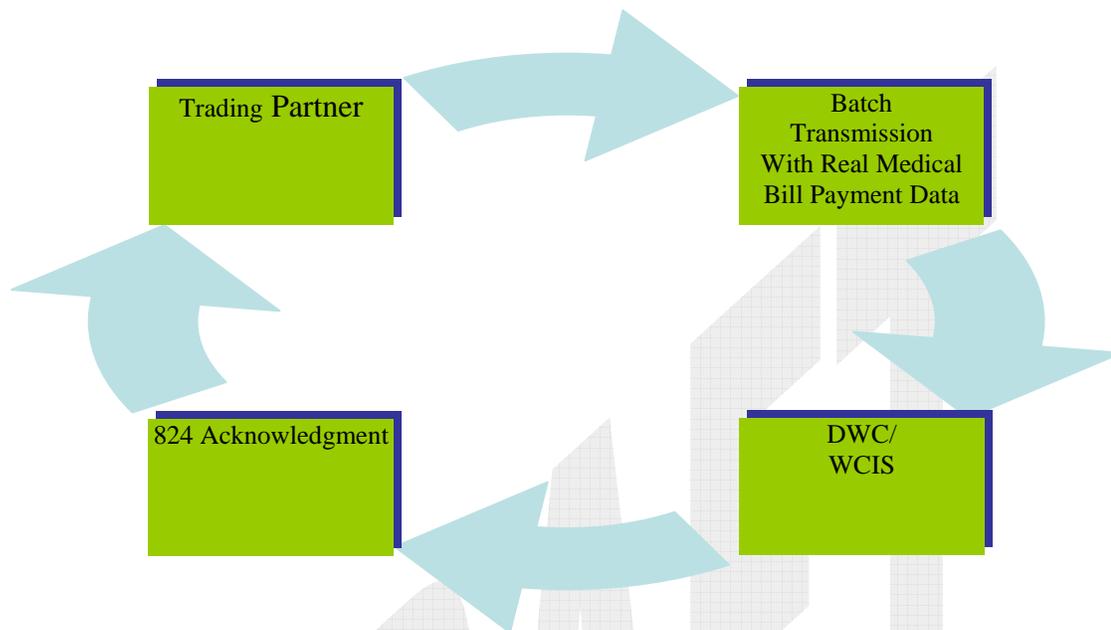
1. Prepare pilot test file(s)

The data will be checked for data quality by the WCIS contact person after at least 30 medical reports have been received by WCIS. (Trading partners with an active claims volume too low to accumulate 30 sent medical reports within a few weeks period will have their data quality evaluated using a smaller number of reports. Let your WCIS contact person know if you think you fall into this category.)

2. Transmit pilot test data

You may begin transmitting pilot data as soon as the WCIS contact person has notified you the WCIS is ready to receive your pilot detailed medical bill payment records.

File level test communication loop



3. Wait for electronic acknowledgment from WCIS

The data 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 M – Data edits of this guide.

Each field in a transaction is validated using the edit rules. The DWC/WCIS Medical Bill Payment Medical Provider Networks and reevaluations as well as other 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, if possible, continue to process the record in which the error occurred until 20 errors per medical bill have been detected. The 824 detailed acknowledgements will contain information about all detected errors for each transmission.

You should receive a detail acknowledgment (824) from the WCIS within 48 hours of your data transmission. The acknowledgment will identify which data elements in which records were in error.

Transmission 824 acknowledgment data edits

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)
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
056	Detail record count is not equal to the number of records received
057	Duplicate transmission/transaction
058	Code/ID invalid
061	Event table criteria not met
062	Required segment not present
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
118	Trading partner not approved to submit data for Insurer

4. Process the acknowledgment

If the acknowledgment indicates 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.

Note: When making corrections, all data elements in the affected ST-SE transaction originally submitted need to be submitted again. Be sure to include the claim administrator claim number (DN 15).

5. Repeat steps two through four until completeness and validity criteria are met.

Parallel pilot procedure

1. Optional parallel pilot analysis

An optional step is to submit the paper reports 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 pilot phase.

2. Prepare paper copies of reports

Make one copy of a completed CMS 1500, UB92, pharmaceutical, or dental forms for each original medical report submitted in the EDI portion of the pilot. See section R - Standard medical forms. Fill out a WCIS pilot batch identification form. The form allows the DWC to link your EDI medical reports to your paper medical reports.

3. Send paper reports to DWC

Send the paper medical forms and the completed WCIS pilot batch 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

4. Wait for parallel pilot analysis report

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

Moving from Pilot to Production Status

Once the data quality criteria of the EDI pilot phase have been met, the trading partner will be approved for production status. The DWC/WCIS will send a written authorization from the division to submit medical bill payment record data to WCIS.

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 transmission until 20 errors are detected per bill processed and then send the 824 acknowledgment.

Data quality reports

The WCIS automatically monitors the quality of data received during pilot and 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 these 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.

WCIS PILOT BATCH 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 REPORTS MAILED _____

NUMBER OF PAPER MEDICAL REPORTS MAILED _____

PREPARED BY _____

PHONE _____

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

**WCIS PARALLEL PILOT PHASE
ATTN: WCIS Contact Person
EDI Unit, Information Systems
1515 Clay Street, 19th Floor
Oakland, CA 94612**

Section H

Supported transactions and ANSI file structure

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California ANSI 824 loop, segment, data element summary	55

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 claim 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, 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 Set 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 right most 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: Principle 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.

Delimiters:

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

California ANSI 837 loop, segment, data element summary

ST Transaction Set Header		
Segment	ST	Transaction Set Control Number
Segment	BGN	Beginning Segment
Data Element	532	Batch Control Number
Data Element	100	Date Transmission Sent
Data Element	101	Time Transmission Sent
LOOP	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	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	2000A	Sender Information
Segment	DTP	Date/Time Period
Data Element	615	Reporting Period
LOOP	2010AA	Insurer/Self Insured/Claim Admin. Info.
Segment	MN1	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	2010C	Employer Name Insured Information
Segment	DTP	Date/Time Period
Data Element	31	Date of Injury
Loop ID	2010CA	Claimant Information
Segment	MN1	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 Code
Data Element	503	Billing Format Code
Data Element	526	Release of Information Code
Data Element	507	Provider Agreement Code
Data Element	508	Bill Reason Submission Code
Segment	TP	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 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
Segment	REF	Transaction Tracking Number
Data Element	266	Transaction Tracking Number
Segment	HI	Diagnosis
Data Element	521	Principle Diagnosis Code
Data Element	535	Admitting Diagnosis Code
Data Element	522	ICD_9 Diagnosis Code
Segment	HI	Institutional Procedure Codes
Data Element	626	HCPCS Principle Procedure Billed Code
Data Element	550	Principle Procedure Date
Data Element	737	HCPCS Billed Procedure Code
Data Element	524	Procedure Date

Loop ID	2310A	Billing Provider Information
Segment	MN1	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
Loop ID	2310B	Rendering Bill Provider Information
Segment	MN1	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
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.
Loop ID	2310D	Facility Information
Segment	MN1	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
Loop ID	2310F	Managed Care Organization Information
Segment	MN1	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

Loop ID:	2400	Service Line Information (continued)
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 Dates
Segment	DTP	Prescription Date
Data Element	604	Prescription Line Date
Segment	QTY	Quantity
Data Element	570	Drugs Supplied Quantity
Data Element	571	Drugs/Supplied Number of Days
Segment	AMT	Dispensing Fee Amount
Data Element	579	Drugs/Supplied Dispensing Fee
Segment	AMT	Drug/Supply Billed Amount
Data Element	572	Drug/Supply Billed Amount
Loop ID	2420	Rendering Line Provider Name
Segment	MN1	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 Number
Data Element	592	Rendering Line Provider National 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
SE Transaction Set Trailer		
Segment		Transaction Set Trailer

California ANSI 824 segment and data element summary

The medical bill payment detailed acknowledgment (824) reports back to the trading partner either an acceptance (TA) or rejection (TR) 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).

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
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

Transmission modes

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Value added networks (VAN)

A value added network (VAN) is a commercially-owned network providing specific services which are 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.

File Transfer Protocol

The WCIS will poll trading partner file transfer protocol (FTP) servers to receive and send data. 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 PGP. Trading partners will provide a secure FTP server accessible by WCIS. The WCIS will only pull data and push acknowledgement to trading partner FTP servers.

Data transmission with FTP

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

Step 1. 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, follow the steps below.

Step 2. Generate a PGP key

WCIS uses PGP for encryption and authentication. PGP is an encryption program available from PGP Corporation (<http://www.pgp.com>) and the international PGP home page (<http://www.pgpi.org>). PGP is also available from previous versions of security programs offered by Network Associates (<http://www.nai.com>), which had acquired the license to distribute PGP.

If a trading partner does not have a PGP key, it will need to generate its own unique set of PGP keys. The PGP program will create a set of public and private keys based on information entered into the program.

Step 3. Exchange PGP public keys

The PGP public keys are required for encryption to provide data security. Data sent to WCIS is encrypted by public key of the WCIS and files are signed by the trading partner’s private key. The exchange of public keys ensures the recipient is the only one able to read the file and that the sender

is the only one that could have sent the data. Security requirements necessitate that private keys and passwords are not shared.

Step 4. Import WCIS PGP public key

Import the WCIS public key into the PGP program. Implicitly trusting the key will facilitate communications without the inconvenience of having to verify the key each time it is used.

FTP name and Internet address

The FTP server must have a static network Internet address. The FTP server must be accessible either by a domain name (e.g.; ftp.tradingpartner.com) or an Internet address (e.g.; 10.10.10.10). Enter the network internet address information in C2 on the trading partner profile form. If the address of the FTP server changes, update your trading partner profile information.

FTP server account and password

The WCIS requires an account and password on your FTP server. The account and password is entered in C2 on the trading partner profile form. Make sure it is set and does not change. If the account and password is changed, update your trading partner profile information.

Polling processes

The WCIS will periodically poll trading partner FTP servers. An FTP client program will log onto the trading partner server and it will download all files in a directory named inbox on the FTP server. After all the files are retrieved, the client program will delete all files in the directory on the FTP server. Files received will be unencrypted by WCIS with its private key and the trading partner's digital signature will be verified.

WCIS will send the 997 and 824 acknowledgment files to trading partners by FTP or e-mail. Files sent by email shall be sent to the trading partner's email address, which is listed in C3 of the trading partner profile form. If the email address is blank on the form, acknowledgements shall be sent by FTP into a directory named outbox on the FTP server.

Naming conventions

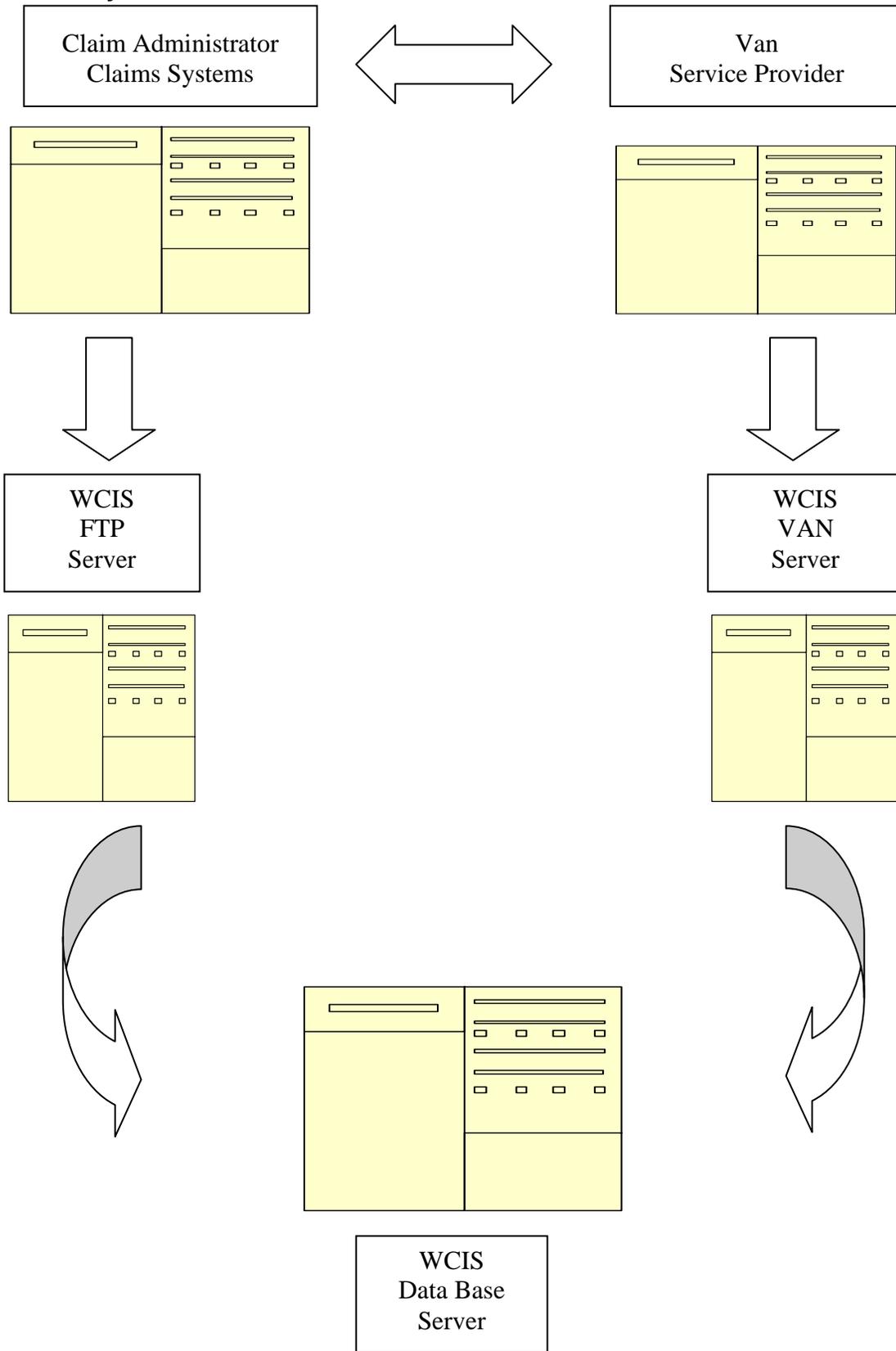
Files shall follow the following conventions:

- Data file names shall be unique and shall begin with the letter F
- Data files must be encrypted with PGP and signed
- Acknowledgement files shall be unique and shall begin with the letter O
- Acknowledgement files are not encrypted.

More on PGP

A history of the PGP program and frequently asked questions about PGP is available at the international PGP home page (<http://www.pgpi.org>).

Pathway transmissions



Section J

EDI Service Providers

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Introduction to EDI service providers

Claims administrators 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 claims administrators 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/DWC/WCIS.htm>).

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/or software products:

<p>Claims Harbor http://www.claimsharbor.com 1900 Emery Street Atlanta, GA 30318 Telephone: (941) 739-7753 Email: jcarpenter@claimsharbor.com</p>	<p>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</p>
<p>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</p>	<p>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</p>
<p>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</p>	<p>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</p>

continued:

<p>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</p>	<p>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</p>
<p>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</p>	<p>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</p>
<p>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</p>	<p>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</p>
<p>Insurance Services Office, Inc. http://wcis.iso.com 545 Washington Blvd. Jersey City, NJ 07310-1686 Telephone: (609) 799-1800</p>	

continued:

<p>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</p>	<p>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</p>
<p>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</p>	<p>Aimset Corporation www.aimset.com 50 Woodside Plaza, Suite 511 Redwood City, California 94061 Telephone: 650-281-7997 E-mail: info@aimset.com</p>

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

Events that trigger required medical EDI reports

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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. dates of injury after a certain period).

It 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, and for the re-submission of a medical bill rejected due to an error. The re-submitted corrected transmission will include all the necessary ANSI structural components necessary to match the replacement bill with the original bill.

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
OO	Original		T = Test P=Production	07/01/05		Periodic	TBD by Trading Partners			Within 90 days of date paid	Daily Weekly Monthly Quarterly
O1	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'
O5	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 L Required Medical Data Elements

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Medical Data Elements by Name and Source

The Medical Data Elements Table 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 in the Workers Compensation System the data information is located. In the case of the CMS 1500 and UB92, 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 92	IA	Payor	HCP	JLB	SNDR
110	ACKNOWLEDGMENT TRANSACTION SET ID			x				X
513	ADMISSION DATE		17					
535	ADMITTING DIAGNOSIS CODE		76					
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					
542	BILLING PROVIDER POSTAL CODE	33	1					
537	BILLING PROVIDER PRIMARY SPECIALTY CODE				x	x		
630	BILLING PROVIDER STATE LICENSE NUMBER						x	
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER						x	
502	BILLING TYPE CODE				x	x		
15	CLAIM ADMINISTRATOR CLAIM NUMBER				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	86					
31	DATE OF INJURY	14	2					
108	DATE PROCESSED			x				X
100	DATE TRANSMISSION SENT			x				X

California Medical Data Elements by Source								
DN	DATA ELEMENT NAME	CMS 1500	UB 92	IA	Payor	HCP	JLB	SNDR
554	DAYS/UNITS BILLED	24G	46					
553	DAYS/UNITS CODE					x		
557	DIAGNOSIS POINTER	24 E						
514	DISCHARGE DATE		33-36		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					x	x	
44	EMPLOYEE FIRST NAME	2	12					
43	EMPLOYEE LAST NAME	2	12					
45	EMPLOYEE MIDDLE NAME/INITIAL	2	12					
153	EMPLOYEE GREEN CARD					x	x	
156	EMPLOYEE PASSPORT NUMBER					x	x	
42	EMPLOYEE SOCIAL SECURITY NUMBER					x	x	
504	FACILITY CODE		4					
679	FACILITY FEIN					x		
681	FACILITY MEDICARE NUMBER					x		
678	FACILITY NAME	32	1					
688	FACILITY POSTAL CODE	32	1					
680	FACILITY STATE LICENSE NUMBER						x	
737	HCPCS BILL PROCEDURE CODE	24D	81-85					
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 PRINCIPLE PROCEDURE BILLED CODE		80					
522	ICD-9 CM DIAGNOSIS CODE	21 1-4	68-75					
6	INSURER FEIN				x			
7	INSURER NAME		50					
105	INTERCHANGE VERSION ID							
5	JURISDICTION CLAIM NUMBER				x			
718	JURISDICTION MODIFIER BILLED CODE	24D				x		

California Medical Data Elements by Source								
DN	DATA ELEMENT NAME	CMS 1500	UB 92	IA	Payor	HCP	JLB	SNDR
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 IDENTIFICATION NUMBER						x	
209	MANAGED CARE ORGANIZATION NAME				x	x		
712	MANAGED CARE ORGANIZATION POSTAL CODE				x	x		
721	NDC BILLED CODE	24C				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	PRINCIPLE DIAGNOSIS CODE		67					
550	PRINCIPLE PROCEDURE DATE		80					
524	PROCEDURE DATE		81					
507	PROVIDER AGREEMENT CODE				x	x		
99	RECIEVER ID			x				X
526	RELEASE OF INFORMATION CODE					x		
642	RENDERING BILL PROVIDER FEIN	25						
638	RENDERING BILL PROVIDER LAST/GROUP NAME	31	82					
656	RENDERING BILL PROVIDER POSTAL CODE	32	1					
651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE					x	x	
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER						x	
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER						x	
586	RENDERING LINE PROVIDER FEIN					x		
589	RENDERING LINE PROVIDER LAST/GROUP NAME					x		
592	RENDERING LINE PROVIDER NATIONAL ID				x	x		
593	RENDERING LINE PROVIDER POSTAL CODE					x		
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE				x	x		
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER						x	

California Medical Data Elements by Source								
DN	DATA ELEMENT NAME	CMS 1500	UB 92	IA	Payor	HCP	JLB	SNDR
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			
509	SERVICE BILL DATE(S) RANGE	18	6					
605	SERVICE LINE DATE(S) RANGE	24A	45					
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				
500	UNIQUE BILL ID NUMBER				x			

Medical Data Element Requirement Table

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 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 makes a conditional data element mandatory.

The 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 on the Event Table. A requirement code is entered at each cell marked by the intersection of a Bill Submission Reason code column and each data element row. (See Section K –Events That Trigger Reporting).

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Reason Submission 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	
5	JURISDICTION CLAIM NUMBER	C	O	O	If a first report of injury has been filed and a jurisdiction claim number is available.
715	JURISDICTION PROCEDURE BILLED CODE	M	O	O	
718	JURISDICTION MODIFIER BILLED CODE	C	O	O	If the general jurisdictional procedure is modified
729	JURISDICTION PROCEDURE PAID CODE	M	O	O	
730	JURISDICTION 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	

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Reason Submission Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger
45	EMPLOYEE MIDDLE NAME	O	O	O	
152	EMPLOYEE EMPLOYMENT VISA	C	O	O	If Employee Social Security number and Employee Green Card number is not available. (see DN42)
153	EMPLOYEE GREEN CARD	C	O	O	If Employee Social Security 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.
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	
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 a value for DN 504 with 2nd digit equal to 1
521	PRINCIPLE DIAGNOSIS CODE	C	O	O	If DN 503 equals "A"
550	PRINCIPLE PROCEDURE DATE	C	O	O	If DN 503 equals "A"
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	See definition for DN 513
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

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Reason Submission Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger
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 a value for DN 504 with 2nd digit equal to 1
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	M	O	O	
630	BILLING PROVIDER STATE LICENSE NUMBER	M	O	O	
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
563	DRUG NAME	C	O	O	If present
570	DRUGS/SUPPLIES QUANTITY DISPENSED	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
571	DRUGS/SUPPLIES NUMBER OF DAYS	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
572	DRUGS/SUPPLIES BILLED AMOUNT	C	O	O	If a pharmaceutical bill or If the Billing Format Code, DN 503, value is "B" and Billing Type Code, DN 502, value is "RX".
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 If the Billing Format Code, DN 503, value is "B" and Billing Type Code, DN 502, value is "RX".
728	NDC PAID CODE	C	O	O	If different then DN721
527	PRESCRIPTION BILL DATE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Reason Submission Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger
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	M	O	O	
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
592	RENDERING LINE PROVIDER NATIONAL ID	C	O	O	When available
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 649
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

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Reason Submission Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger
503	BILLING FORMAT CODE	M	M	M	
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	M	O	O	
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	M	O	O	
522	ICD-9 CM DIAGNOSIS CODE	M	O	O	
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
555	PLACE OF SERVICE BILL CODE	C	C	O	If DN503 equals "B"
557	DIAGNOSIS POINTER	M	O	O	
567	DME BILLING FREQUENCY CODE	C	O	O	Required for DME rental billings
526	RELEASE OF INFORMATION CODE	O	O	O	
547	LINE NUMBER	M	O	O	
524	PROCEDURE DATE	M	O	O	
552	TOTAL CHARGE PER LINE – OTHER	M	O	O	
565	TOTAL CHARGE PER LINE – RENTAL	C	O	O	If DME is rented
566	TOTAL CHARGE PER LINE – PURCHASE	C	O	O	If DME is purchased

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Reason Submission Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger
554	DAYS/UNITS BILLED	C	O	O	If an amount is billed
553	DAYS/UNITS CODE	C	O	O	If an amount is billed
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	M	O	O	
626	HCPCS PRINCIPLE 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.
737	HCPCS BILL PROCEDURE CODE	C	O	O	If DN626 is present
714	HCPCS LINE PROCEDURE BILLED CODE	M	O	O	
717	HCPCS MODIFIER BILLED CODE	C	O	O	If the general HCPCS procedure is modified
726	HCPCS LINE PROCEDURE PAID CODE	C	O	O	If different than DN714
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

Section M

Data edits

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California adopted IAIABC data edits

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 July 2004* for more information on the standard IAIABC edits.

CALIFORNIA ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES														
		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
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													
542	BILLING PROVIDER POSTAL CODE									x				
537	BILLING PROVIDER PRIMARY SPECIALTY CODE									x				

CALIFORNIA ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES														
ERROR MESSAGES		028	029	030	033	034	039	040	041	058	063	073	074	075
DN	DATA ELEMENT NAME	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
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										
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	029	030	033	034	039	040	041	058	063	073	074	075
DN	DATA ELEMENT NAME	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
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						x						
504	FACILITY CODE									x				
679	FACILITY FEIN	x						x						
681	FACILITY MEDICARE NUMBER			X				x						
678	FACILITY NAME													
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 PRINCIPLE PROCEDURE BILLED CODE									x				
522	ICD-9 CM DIAGNOSIS CODE									x				
6	INSURER FEIN	x					x	x						
7	INSURER NAME													
105	INTERCHANGE VERSION ID									x				

CALIFORNIA ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES														
ERROR MESSAGES		028	029	030	033	034	039	040	041	058	063	073	074	075
DN	DATA ELEMENT NAME	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
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	PRINCIPLE DIAGNOSIS CODE									X				
550	PRINCIPLE PROCEDURE DATE		X			X			X					
524	PROCEDURE DATE		X			X			X				X	X
507	PROVIDER AGREEMENT CODE									X				
99	RECIEVER ID									X				

CALIFORNIA ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES														
		ERROR MESSAGES												
		028	029	030	033	034	039	040	041	058	063	073	074	075
DN	DATA ELEMENT NAME	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
526	RELEASE OF INFORMATION CODE									x				
642	RENDERING BILL PROVIDER FEIN	x						x						
638	RENDERING BILL PROVIDER LAST/GROUP NAME													
656	RENDERING BILL PROVIDER POSTAL 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 ID			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				
733	SERVICE ADJUSTMENT AMOUNT	x												
731	SERVICE ADJUSTMENT GROUP CODE									x				
732	SERVICE ADJUSTMENT REASON CODE									x				
509	SERVICE BILL DATE(S) RANGE		x			x			x					
605	SERVICE LINE DATE(S) RANGE		x			x			x					
104	TEST/PRODUCTION INDICATOR									x				

CALIFORNIA ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES														
ERROR MESSAGES		028	029	030	033	034	039	040	041	058	063	073	074	075
DN	DATA ELEMENT NAME	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
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 medical 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
111	APPLICATION ACKNOWLEDGE CODE	Must be one of the following alpha values (BA or BR or TA or TE or TR)	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
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
629	BILLING PROVIDER FEIN	Nine digits with the second and third digits separated by a blank space	058

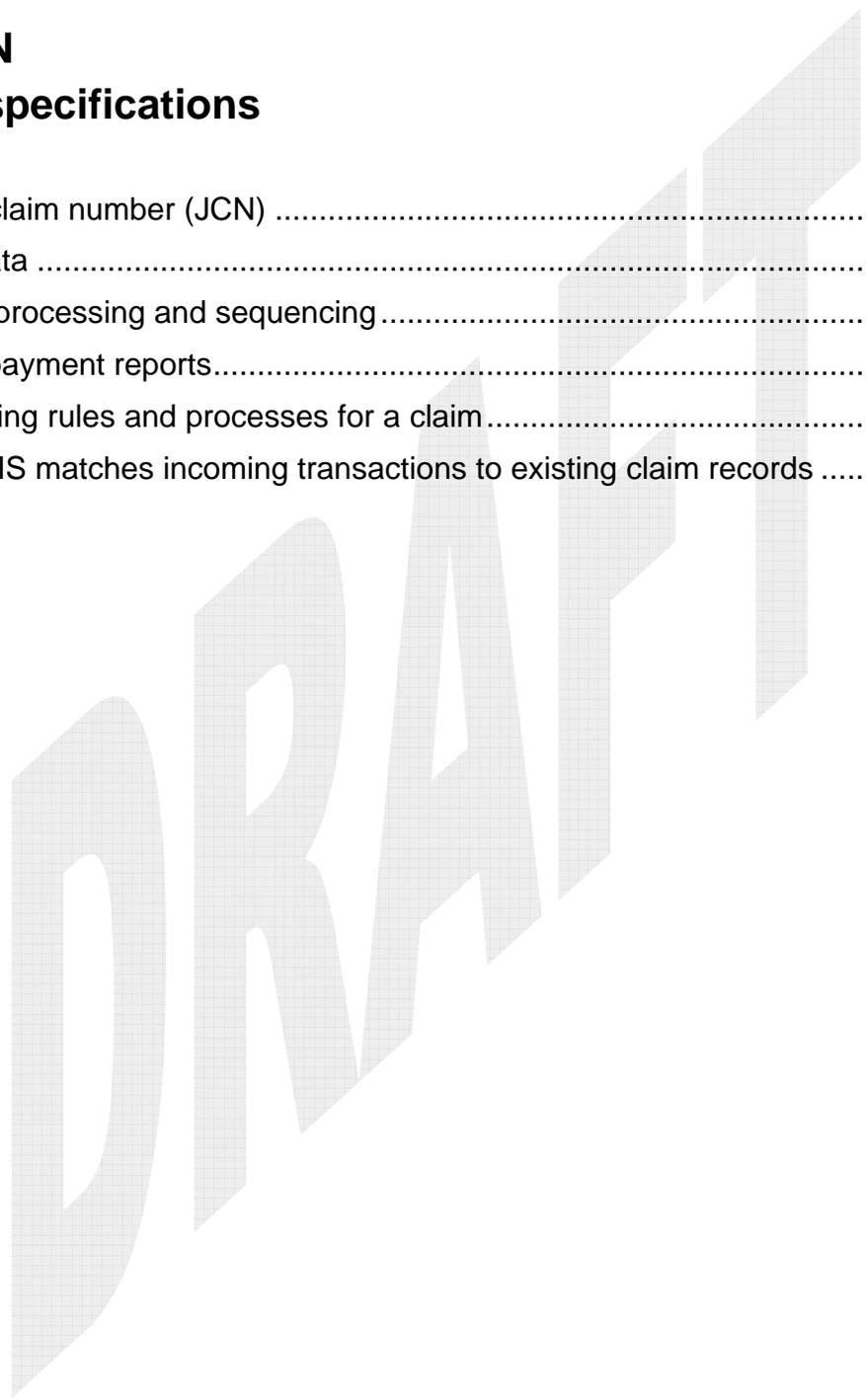
California Specific Data Edits			
DN	DATA ELEMENT NAME	EDIT	Error Code
542	BILLING PROVIDER POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	058
502	BILLING TYPE CODE	Must be one of the following alpha values (DM or MO or RX)	058
187	CLAIM ADMINISTRATOR FEIN	Nine digits with the second and third digits separated by a blank space	058
515	CONTRACT TYPE CODE	Must be two digit numeric and one of the following values (01 or 09)	058
554	DAYS/UNITS BILLED	Must be numeric	058
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	058
115	ELEMENT NUMBER	Must be numeric 2 digits or 3 digits	058
42	EMPLOYEE SOCIAL SECURITY NUMBER	Must be numeric with nine digits	
504	FACILITY CODE	Must be numeric with 2 digits, not less than 11 or more than 99	058
679	FACILITY FEIN	Nine digits with the second and third digits separated by a blank space	058
688	FACILITY POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	058
6	INSURER FEIN	Nine digits with the second and third digits separated by a blank space	058
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	058
704	MANAGED CARE ORGANIZATION FEIN	Nine digits with the second and third digits separated by a blank space	058
712	MANAGED CARE ORGANIZATION POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	058
555	PLACE OF SERVICE BILL CODE	Must be numeric with 2 digits, not less than 11 or more than 99	058
600	PLACE OF SERVICE LINE CODE	Must be numeric with 2 digits, not less than 11 or more than 99	058
561	PRESCRIPTION LINE NUMBER	Must be numeric, not less than 1 or more than 99	058
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 digits with the second and third digits separated by a blank space and the second part must be numeric with at least 5 digits and no more than 9 digits	058
642	RENDERING BILL PROVIDER FEIN	Nine digits with the second and third digits separated by a blank space	058
656	RENDERING BILL PROVIDER POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	058
586	RENDERING LINE PROVIDER FEIN	Nine digits with the second and third digits separated by a blank space	058
593	RENDERING LINE PROVIDER POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	058
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 digits with the second and third digits separated by a blank space and the second part must be numeric with at least 5 digits and no more than 9 digits	058

California Specific Data Edits			
DN	DATA ELEMENT NAME	EDIT	Error Code
733	SERVICE ADJUSTMENT AMOUNT	Must have 2 decimal points	058
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
528	BILLING PROVIDER LAST/GROUP NAME	Must not consist solely of any of the following non-case sensitive strings: "unk", "unknown", "dk", "don't know", "na", "n/a"	058
188	CLAIM ADMINISTRATOR NAME	Must not consist solely of any of the following non-case sensitive strings: "unk", "unknown", "dk", "don't know", "na", "n/a"	058
563	DRUG NAME	Must not consist solely of any of the following non-case sensitive strings: "unk", "unknown", "dk", "don't know", "na", "n/a"	058
44	EMPLOYEE FIRST NAME	Must be alpha and not consist solely of any of the following non-case sensitive strings: "unk", "unknown", "dk", "don't know", "na", "n/a"	058
43	EMPLOYEE LAST NAME	Must be alpha and not consist solely of any of the following non-case sensitive strings: "unk", "unknown", "dk", "don't know", "na", "n/a"	058
45	EMPLOYEE MIDDLE NAME	Must be alpha and not consist solely of any of the following non-case sensitive strings: "unk", "unknown", "dk", "don't know", "na", "n/a"	058
678	FACILITY NAME	Must not consist solely of any of the following non-case sensitive strings: "unk", "unknown", "dk", "don't know", "na", "n/a"	058
7	INSURER NAME	Must not consist solely of any of the following non-case sensitive strings: "unk", "unknown", "dk", "don't know", "na", "n/a"	058
209	MANAGED CARE ORGANIZATION NAME	Must not consist solely of any of the following non-case sensitive strings: "unk", "unknown", "dk", "don't know", "na", "n/a"	058
638	RENDERING BILL PROVIDER LAST/GROUP NAME	Must not consist solely of any of the following non-case sensitive strings: "unk", "unknown", "dk", "don't know", "na", "n/a"	058
589	RENDERING LINE PROVIDER LAST/GROUP NAME	Must not consist solely of any of the following non-case sensitive strings: "unk", "unknown", "dk", "don't know", "na", "n/a"	058

Section N

System specifications

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Jurisdiction claim number (JCN)

The IAIABC DN 5, jurisdiction claim number (JCN), is either a 12 or 22 digit number created by WCIS to uniquely identify each claim. It is provided to the claims administrator on their acknowledgment of the first report of injury. The revised WCIS system creates a 22 digit JCN and the old 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 all new claims reported to the revised system will receive a 22 digit JCN.

The JCN requirements are conditional for the medical requirements (See section – L required medical data elements). The IAIABC matched data elements, claim administrator claim number (DN 15) and insurer FEIN (DN 6), will be utilized in place of the JCN under specific circumstances. For information on future changes to the JCN requirements, see the *WCIS e-News #1*.

Corrected data

WCIS regulations require each claim administrator to submit to the WCIS any changed or corrected data elements as defined by the California adopted IAIABC (DN508) bill reason submission code (BSRC) (See Section K). Replacement reports (BSRC=05) are sent in response to an acknowledgement (TE) from WCIS indicating no match of the claim administrator claim number (DN 15) and insurer FEIN (DN 6) with the existing first report of injury data. The re-submitted corrected transmission (BSRC=00) are sent in response to an 824 acknowledgement containing error messages (TR) from the DWC. When re-submitting a replace (BSRC=05) or re-submitting a corrected transmission (BSRC=00) for a medical bill payment report, the sender must resubmit all medical bill payment report data elements, not just the data elements being changed (DN15) or corrected (See Section L – Required medical data elements).

Transaction processing and sequencing

WCIS processes batches (GE functional group) within a transmission and transactions (ST/SE transaction set) within a batch in the order they are received. If submitting more than one transaction for a single claim in the same batch or transmission, it is important that WCIS receive the transactions in the proper sequence. Transactions should be submitted in logical business order or in the order they were entered into the claim administrator's system. If the claim administrator is not sure of the business order, the following general sort procedure is suggested:

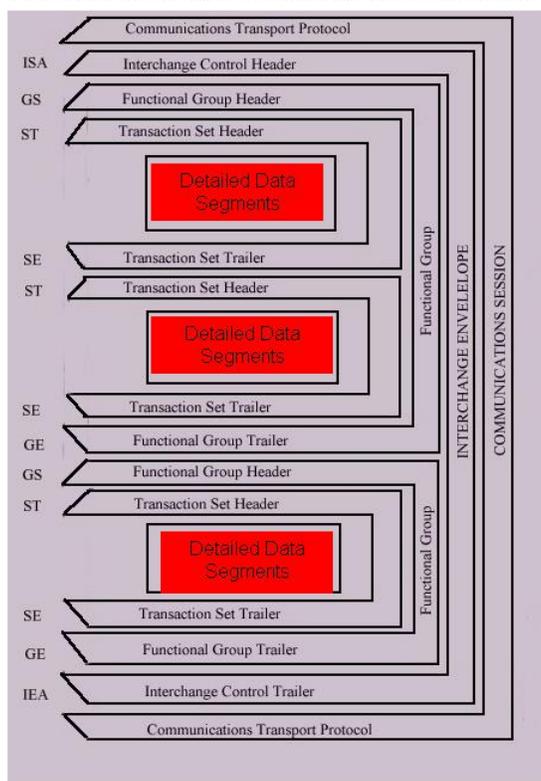
- Primary sort order is date the insurer paid bill, DN512. Multiple transactions for a claim should be sorted by DN512 dates so that WCIS processes the oldest 512 date first.

Batch duplicates occur when one or more batches (GE functional group) in the same or different transmission 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. The DWC will continue to check non-duplicates (GE functional groups) throughout the entire x12 interchange envelope (ISA interchange control header).

Bill duplicates occur when one or more transactions (ST/SE transaction set) from the same sender, in the same or different batch contain the same information (Claim administrator FEIN, claim administrator claim number, unique bill identification number, service bill date range, date of bill and transaction tracking number). The DWC will continue to check non-duplicate bills (ST/SE transaction set) throughout all functional groups (GE functional group) included in the entire x12 interchange envelope (ISA interchange).

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



Medical bill payment reports

Bill submission reason codes are used to define the specific purpose of a transmission. 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. The DWC will treat the resubmitted corrected medical bill payment report transmissions as if they were originals (00). Medical bill

payment report bill submission reason codes are grouped in the following tables to clarify their purpose and to demonstrate a logical order for their use.

The bill submission reason code used to report the initial medical bill payment report sent to WCIS.

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 when a match is not found on the DWC/WCIS database. Resubmitted corrected medical bill payment report transmissions should be transmitted utilizing BSRC = 00. Replace medical bill payment report transmissions which inform the WCIS of a change in DN15 Claims Administrator Claim Number should be transmitted utilizing BSRC = 05.

BSRC code	BSRC name
01	Cancellation
05	Replace

WCIS matching rules and processes for a claim

Primary:

1. Jurisdiction claim number, DN 5

Secondary match for medical bill payment reports to the FROI:

- 2a. 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

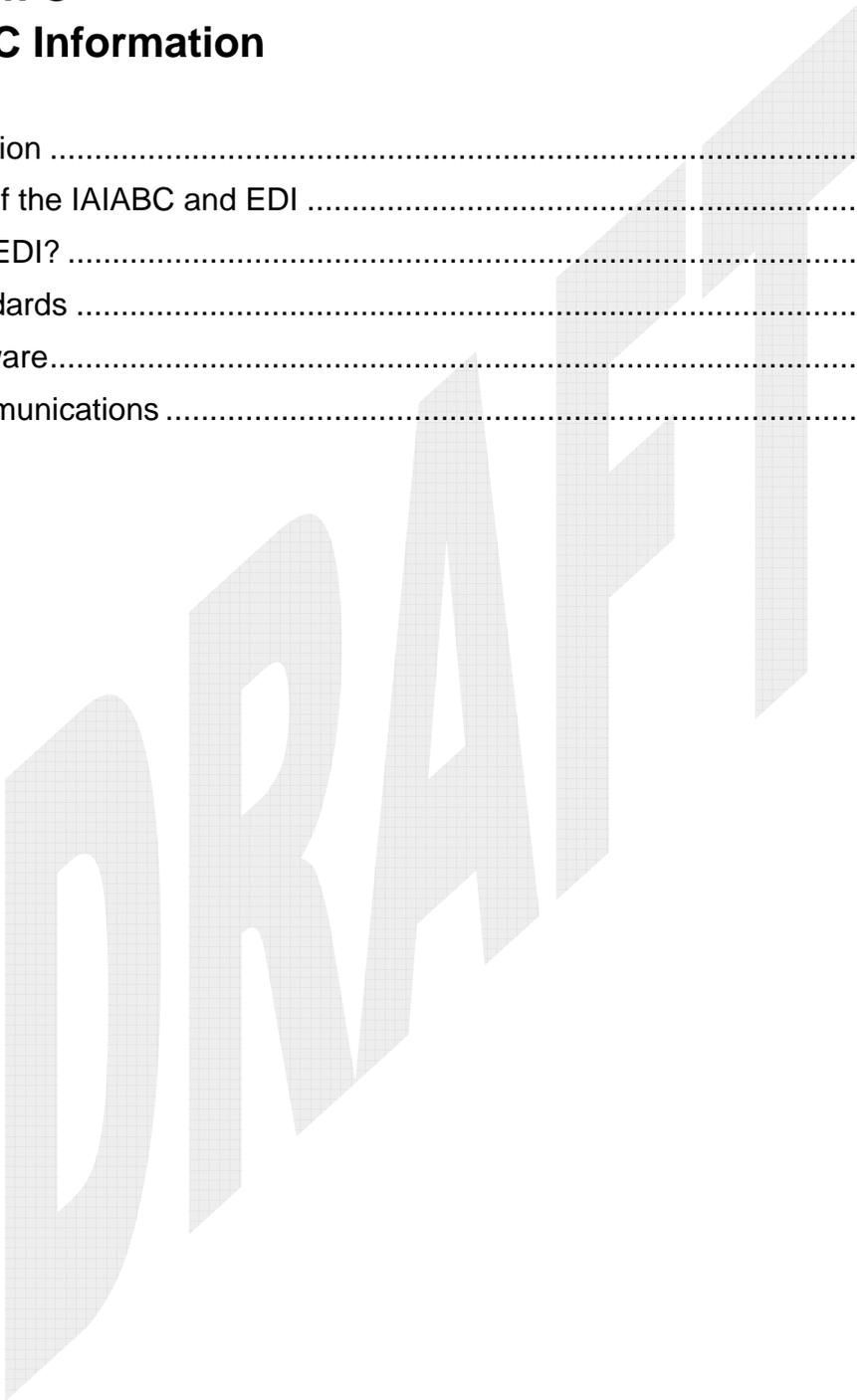
How WCIS matches incoming transactions to existing claim records

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).

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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.

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 the First Report of Injury (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 key components to EDI:

(1) 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 3rd 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 P

Code Lists

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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 www.IAIABC.org.

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>

Health Care Financing Administration Common Procedural Coding System

Source: Health Care Financing Administration Common Procedural Coding System (HCPCS)

Available At:

Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Abstract:

HCPCS is Health Care Financing Administration's (HCFA) coding scheme to group procedures performed for payment providers.

International Classification of Diseases Clinical Mod (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 or morbidity and mortality information for statistical purposes and the indexing of hospital records by disease and operations.

Current Procedural Terminology (CPT) Codes

Source: Physician's 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

National Drug Code

Source: Blue Book, Price Alert, National Drug Data File

Available At:

First Databank
The Hearst Corporation
1111 Bayhill Drive
San Bruno, CA 94066

Abstract:

The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

Health Care Financing Administration (HCFA)

Source: Health Care Financing Administration (HCFA) Code Lists

Available At:

Health Care Financing Administration
Bureau of Program Operations
Office of Medicare Benefits Administration
Director, Division of Utilization Analysis
6325 Security Boulevard
Baltimore, MD 21207

Abstract:

Code lists maintained by the Health Care Financing Administration

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 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 HCFA for adult Medicare billing. For other patients 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 CODE

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 BILL CODE
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 CODE

REVENUE PAID CODE

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

Source: National Health Care Claim Payment/Advice Committee Bulletins

Available At: National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

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 angiocardiology
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 erythropoietin < 10,000 units
635 = Drugs requiring specific identification erythropoietin > 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 = Lithotripsy 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 electromyogram
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

- 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 Implementation Guide for Medical Bill Payment Records, Release 1, July 4, 2002.
Available at: <http://www.iaiacb.org>

Source: National Health Care Claim Payment/Advice Committee Bulletins
Available at: Blue Cross/Blue Shield Association
Interplan Teleprocessing Services Division
676 N. St. Clair Street
Chicago, IL 60611

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

Section Q

MEDICAL EDI GLOSSARY AND ACRONYMS

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Medical Bill Payment Records Glossary

ACQUIRED FILE

Definition: A claim previously administered by a different claim administrator

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

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Definition: Federal Agency that administers the Medicare, Medicaid and Child Health Insurance programs. Further information may be obtained at <http://www.hcfa.gov>.

Revision Date: 04/28/99

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.iaiaabc.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
VPN	Virtual Private Network
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
BRSC	Bill Reason Submission Code

Section R

Standard Medical Forms

Standardized Billing / Electronic Billing	125
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American Dental Association	128
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DRAFT

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 health care providers.

CMS Form 1450 or UB92 means the health insurance claim form maintained by CMS for use by health 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



CARRIER

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA ELIGIBLE <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME			
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 _____ DATE _____			14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE			17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)			20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
24. DATE(S) OF SERVICE To From MM DD YY MM DD YY			23. PRIOR AUTHORIZATION NUMBER			25. FEDERAL TAX I.D. NUMBER SSN EIN			
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>			
28. PATIENT'S ACCOUNT NO.			28. PATIENT'S ACCOUNT NO.			28. TOTAL CHARGE \$			
29. AMOUNT PAID \$			29. AMOUNT PAID \$			29. BALANCE DUE \$			
30. 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 _____			31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			32. 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 9/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0935-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM CMCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

CMS Form 1450 or UB92

APPROVED OMB NO. 0938-0279

1 12 PATIENT NAME 14 BIRTH-DATE 15 SEX 16 MD 17 DATE 18 HR 19 MIN 20 SEC 21 D HR 22 STAT 23 MEDICAL RECORD NO. 24 25 26 27 28 29 30 31 32 OCCURRENCE DATE 33 CODE 34 OCCURRENCE DATE 35 CODE 36 OCCURRENCE DATE 37 CODE 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100	2 3 PATIENT CONTROL NO. 4 TYPE OF BILL 5 FED. TAX NO. 6 STATEMENT COVERS PERIOD FROM 7 TO 8 COV D 9 N-C D 10 C D 11 L R D 12 13 PATIENT ADDRESS 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
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101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

UB-92 HCFA-1450 CORRIGENDUM ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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) <input type="checkbox"/> Statement of Actual Services - OR - <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> 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? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																											
5. Subscriber Name (Last, First, Middle Initial, Suffix)																											
6. Date of Birth (MM/DD/CCYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Subscriber Identifier (SSN or ID#)																							
9. Plan/Group Number		10. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F		15. Subscriber Identifier (SSN or ID#)																							
16. Plan/Group Number		17. Employer Name																									
PATIENT INFORMATION																											
18. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other								19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS																			
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																											
21. Date of Birth (MM/DD/CCYY)		22. Gender <input type="checkbox"/> M <input type="checkbox"/> 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 _____																											
ANCILLARY CLAIM/TREATMENT INFORMATION																											
38. Place of Treatment (Check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other								39. Number of Enclosures (00 to 99) Radiographs: <input type="checkbox"/> One (integral) <input type="checkbox"/> Model(s) <input type="checkbox"/>																			
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)								41. Date Appliance Placed (MM/DD/CCYY)																			
42. Months of Treatment Remaining				43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)				44. Date Prior Placement (MM/DD/CCYY)																			
45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																											
46. Date of Accident (MM/DD/CCYY)						47. Auto Accident State																					
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)																											
48. Name, Address, City, State, Zip Code																											
49. Provider ID		50. License Number		51. SSN or TIN																							
52. Phone Number () -																											
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																					

NCDPD Universal Claim Form

I.D. _____ GROUP I.D. _____

NAME _____ PLAN NAME _____

PATIENT NAME _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____

PATIENT DATE OF BIRTH MM DD CCYY _____ PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____

PHARMACY NAME _____

ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____

CITY _____ PHONE NO. () _____

STATE & ZIP CODE _____ FAX NO. () _____

FOR OFFICE USE ONLY

WORKERS COMP. INFORMATION

EMPLOYER NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

CARRIER I.D. (6) _____ EMPLOYER PHONE NO. _____

DATE OF INJURY MM DD CCYY _____ CLAIM (7) REFERENCE I.D. _____

1 Sample Form - Not For Distribution

PREScription / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PREScriBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

2 Sample Form - Not For Distribution

PREScription / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PREScriBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

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NCPDP UNIVERSAL CLAIM FORM (UCF)

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