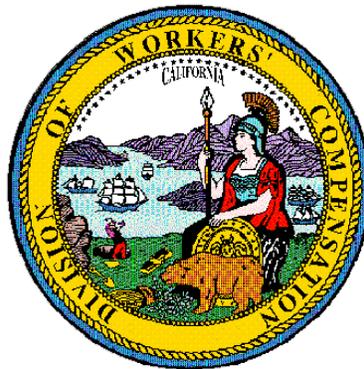


**Workers' Compensation Information System
(WCIS)
California EDI Implementation Guide
for
Medical Bill Payment Records
Version 1.0
December 2005**



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

December 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 a newly developed system for receiving workers' compensation medical bill payment records data via EDI. The detailed medical data will be integrated with other data in the workers' compensation information system (WCIS) to provide a rich resource of information for analyzing the performance of California's workers' compensation system.

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 medical bill payment records. Some organizations already have substantial experience transmitting EDI data to the DWC with first and subsequent reports of injury. For existing and new trading partners, the medical implementation guide can serve as a reference for California-specific medical record protocols. Although, the California DWC adheres to national EDI standards, the California medical record implementation guide does have minor differences from other states.

The *California EDI Implementation Guide for Medical Bill Payment Records* will be posted on our Web site at www.dir.ca.gov/dwc. I hope the start-up of 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,

Carrie Nevans
Acting DWC administrative director

**Workers' Compensation Information System
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CALIFORNIA EDI IMPLEMENTATION GUIDE
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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, medical EDI refers to the electronic transmission of detailed medical bill payment records 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 O – IAIABC Information.) All data elements to be collected have been 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 the workers' compensation system by providing comprehensive and readily accessible information on all claims. The information can then be made available to state policy makers considering any changes to the system.
- **Avoids costs in paper handling**
EDI 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 automated data quality checking procedures that are triggered when data are received by the state agency. Many claims administrators adopt the national standard data-checking procedures for in-house systems to reduce the costly data-correction efforts that result when erroneous data are passed among the parties to a claim.
- **Simplifies reporting requirements for multi-state insurers**
EDI 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 examine and explain any 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.

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 six months from the effective date of the regulations. 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>). See also Section E – WCIS Regulations, which reference the complete DWC\WCIS regulations.

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

Sending Data to the WCIS

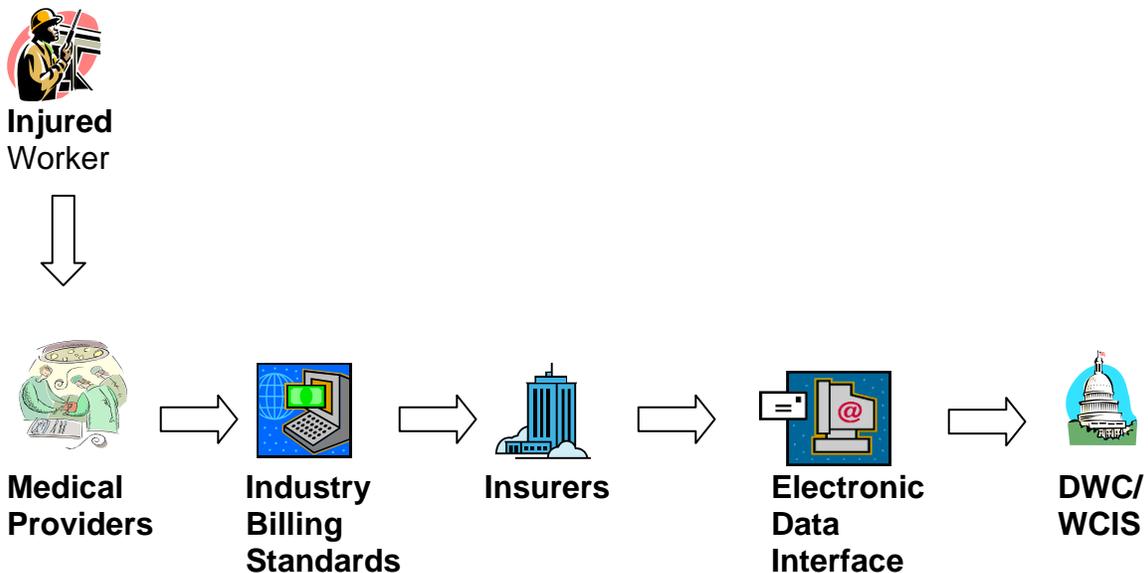
California workers' medical bill payment records are processed by diverse organizations: large multi-state insurance companies, smaller specialty insurance carriers, self-insured employers, third-party administrators handling claims on behalf of self-insured employers, as well as bill review companies. 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 California adopted ANSI file format is summarized in Section H – Supported transactions and ANSI file structure and completely specified in Section 5 the IAIABC *EDI Implementation Guides for Medical Bill Payment Records, Reporting July 2004*. (www.iaiaabc.org).

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

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

Flow of Medical Data in the California Workers Compensation System



Four stages of EDI - from testing to production

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

Stage one: EDI trading partner profile

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

Stage two: structural testing

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

Stage three: detailed testing

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

Stage four: production

During production, data transmissions will be monitored for completeness, validity, and accuracy. Each trading partner will be routinely sent reports describing their data quality. The data edits are more fully described in Section M – Data edits and in the IAIABC *EDI Implementation Guides for Medical Bill Payment Records, Reporting July 2004*. (www.iaiaabc.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> – 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 the trading partner during the testing process, and be an ongoing source of support during production.

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

By phone:

510-286-6753

510-286-6763

510-286-6772

By fax: (415) 703-5911

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

By Mail: WCIS EDI Unit

Attn: Name of WCIS contact (if known)

Department of Industrial Relations

IS Department

1515 Clay Street, 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 is archived on the WCIS web site. Interested parties who are not already receiving WCIS e-news can register at the WCIS website to be added to the WCIS e-news mailing list.

EDI service providers

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

- software that works with existing computer systems to transmit medical data automatically,
- systems consulting, to help get your computer systems EDI-ready, and
- data transcription services, which accept paper forms, 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 managers’ 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

Assign responsibilities for implementing medical EDI

Implementing medical EDI will affect your information systems, claims processing practices and other business procedures. Some organizations appoint the information systems manager, while others designate the claims manager as medical EDI implementation team leader. Regardless of who is assigned primary responsibility, make sure that all 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 are familiar with EDI or are efficient in bringing new technology on-line. Make a realistic assessment of your organization's capabilities when deciding whether or not to internally develop the needed EDI capacity.

Other organizations may choose to out source with vendors for dedicated EDI software or services. Typically, EDI vendor products interface with your organization's data to produce medical EDI transactions in the required ANSI format. The benefit is that no one in your organization has to learn all the intricacies of EDI – the service provider takes care of file formats, 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

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.

Summary information about the required ANSI format can be found in Section H – Supported transactions and ANSI file structure and detailed information about ANSI formats is included in section 5 of the IAIABC *EDI Implementation Guide for Medical Billing Payment Reports, July 2002* published by the IAIABC at:

http://www.iaabc.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. Review Section L – Required medical data elements and determine which data elements are readily accessible, which are available but accessible with difficulty, and which are not captured at this time. An example of none internally captured required data element may be medical provider state license numbers issued, maintained, and distributed by the California Department of Consumer Affairs (see Section P).

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

Developing a comprehensive EDI system

The California DWC EDI requirements have gone into effect in multiple phases. The first phase consisted of EDI transmissions of FROI's 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 goes into effect six months from the effective date of the WCIS regulations.

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 (see Section G - Testing and production phases of medical EDI).

Benefits of adding “data edits”

Medical bill payment record data transmitted to the WCIS will be subjected to “edit rules” to assure that the medical data are valid. The edit rules are detailed in Section M – 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 information systems department. Any error messages would typically be passed through the same channel in the opposite direction.

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

Updating software and communications services

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

Most systems will need at least the following:

- ◆ software/services to identify events that trigger required medical reports,
- ◆ software/services to gather required medical data elements from your databases,
- ◆ software/services to format the data into an approved medical EDI file format,
- ◆ an electronic platform, 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 and production stages of EDI with the WCIS. Internally debugging the “data edit” and “error response” systems in advance will decrease the number of error messages associated with transmitting invalid or inaccurate data to the WCIS. More detail is included in Section G - Testing and production phases of medical EDI.

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

Testing and production stages of medical EDI transmission

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

Step two of the process is to test a structural 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 detailed acknowledgment and respond to any “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 the workers' compensation industry.

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

Send us an e-mail, addressed to:

wcis@dir.ca.gov.

Section D

Authorizing statutes – Labor Code §138.6, 138.7

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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 that 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

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 some senders, the insurer FEIN (federal tax identification number) provided on each ST-SE transaction set will always be the same as the sender identification master FEIN. Other senders may have multiple FEIN's for insurers or claim administrators. If the transactions for a sender with multiple insurer FEIN's or claim administrator FEIN's share the same transmission specifications, the data can be sent under the same sender identification master FEIN.

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

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

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



State of California
Department of Industrial Relations

DIVISION OF WORKERS' COMPENSATION

ELECTRONIC DATA INTERCHANGE TRADING PARTNER PROFILE

A. Trading Partner Background Information:

Name: _____

Master FEIN: _____

Physical Address: _____

City: _____ State: _____

Zip Code: _____

Mailing Address: _____

City: _____ State: _____

Zip Code: _____

Trading partner type (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Self Administered Insurer | <input type="checkbox"/> Service Bureau |
| <input type="checkbox"/> Self Administered, Self-Insurer (employer) | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Third Party Administrator of insurer | |
| <input type="checkbox"/> Third Party Administrator of self-insurer | |

B. Trading Partner Contact Information:

Business Contact:

Technical Contact:

Name: _____

Name: _____

Title: _____

Title: _____

Phone: _____

Phone: _____

FAX: _____

FAX: _____

E-mail Address: _____

E-mail Address: _____

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

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".

Trading Partner Type: Indicate any functions that describe the Trading partner. 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 trading partner 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 trading partner 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 trading partner will specify the electronic mailbox to which data can be transmitted. Separate mailbox information may be provided for transmitting production versus test data.

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

NETWORK
MAILBOX

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

NETWORK:

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

SECTION C3: FTP users:

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 trading partners 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 trading partner's ANSI ID Code Qualifier as specified in an ISA segment. Separate Qualifiers are provided to exchange Production and Test data, if different identifiers are needed.

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

Section G

Testing and production phases of medical EDI

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Overview of the four step process

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

Step 1. Complete a medical EDI trading partner profile

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

Step 2. Complete the structural test phase

Purpose

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

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

Test criteria

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

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

Test procedure

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

Prepare a test file

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

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

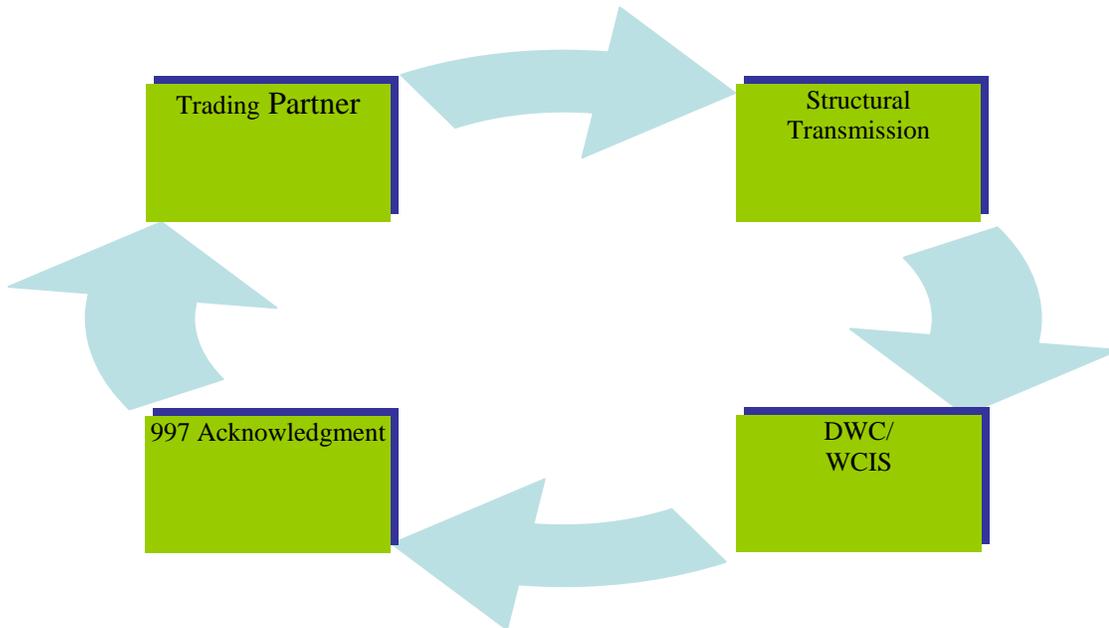
Send the test file

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

Wait for an electronic 997 acknowledgment from WCIS

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

Structural level test communication loop



Transmission 997 acknowledgment error messages

Trading partners should receive an electronic 997 acknowledgment within 48 hours of sending the test transmission. If you do not receive an 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 997 functional acknowledgment indicates 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

Process the 997 functional acknowledgment and correct any errors

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

Re-transmit corrected file to WCIS

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

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

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

Step 3. Complete the detailed test phase

Overview

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

Purpose

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

“Each claim administrator shall, at a minimum, provide **complete, valid, accurate data** for the data elements set forth in this section.”

- **Complete data** – In order to evaluate the effectiveness and efficiency of the California workers’ compensation system (one of the purposes of WCIS set forth in the 1993 authorizing statute), trading partners must submit all required medical bill payment data elements for the required reporting periods
- **Valid data** – Valid means the data are what they are purported to be. For example, data in the date of injury field must be date of injury and not some other date. Data must consist of allowable values, e.g., date of injury cannot be Sep. 31, 1999, a non-existent date. At a more subtle level, each trading partner must have the same understanding of the meaning of each data element and submit data with that meaning only. Review the definitions for each required data element in the data dictionary of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1 (<http://www.iaabc.org>) and the California medical data dictionary (<http://www.dir.ca.gov/dwc>) to be sure your use of the data element matches that assigned by the IAIABC and the California DWC. If your meaning or use of a data element differs, you will need to make changes to conform to the California adopted IAIABC standards.
- **Accurate data** – Accurate means free from errors. There is little value in collecting and utilizing data unless there are assurances the data are accurate (see section M - Data edits).

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

Data quality criteria

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

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

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

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

Bill submission reason codes

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

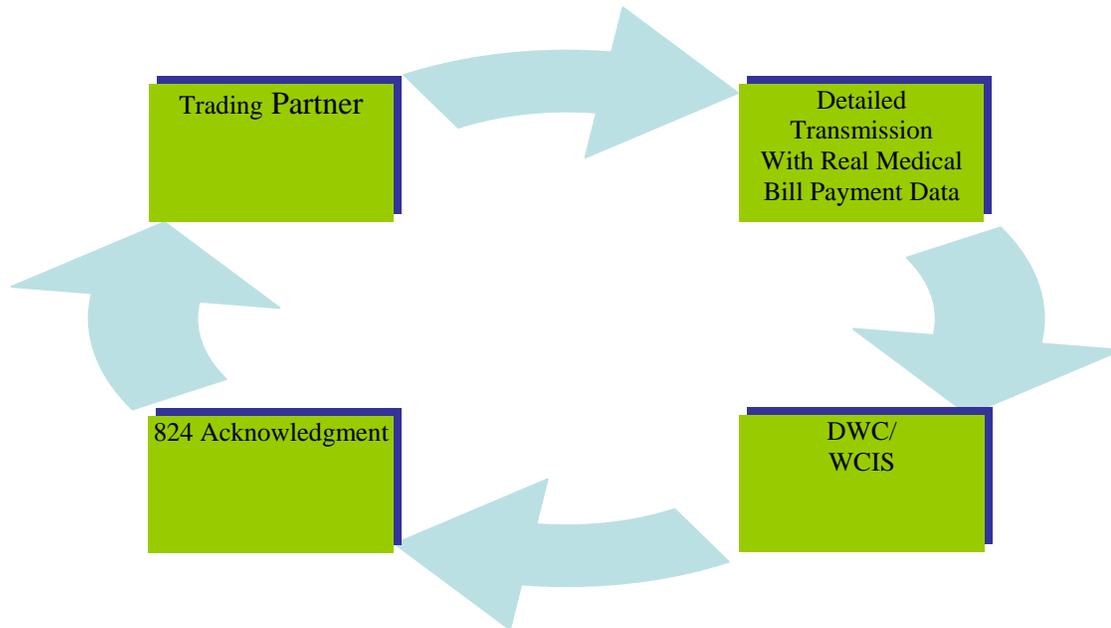
Original	00
Cancel	01
Replace	05

Medical EDI detailed test procedure

Prepare detailed test file(s)

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

Detailed level test communication loop



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 DWCVWCIS medical bill payment specific scenarios will be tested for validity and accuracy. If a data element fails to pass any data validation edit, an error message will be generated for that data element. The WCIS will process the ST-SE transaction set in which the error occurred until 20 errors per ST-SE transaction set have been detected. The 824 detailed acknowledgements will contain information about all detected errors for each 837 transmission.

You should receive a detail acknowledgment (824) from the WCIS within 48 hours of your data transmission. The only exception is when the transaction does not have a match on the database (see section N). The acknowledgment will identify which data elements in which the error was detected (see section H).

Detailed 824 acknowledgment error messages

Error Code	Message
001	Mandatory field not present
028	Must be numeric (0-9)
029	Must be a valid date (CCYYMMDD)
030	Must be A-Z, 0-9, or spaces
031	Must be a valid time (HHMMSS)
033	Must be <= date of injury
034	Must be >= date of injury
039	No match on database
040	All digits cannot be the same
041	Must be <= current date
057	Duplicate transmission/transaction
058	Code/ID invalid
061	Event table criteria not met
063	Invalid event sequence/relationship
064	Invalid data relationship
073	Must be >= date payer received bill
074	Must be >= from date of service
075	Must be <= thru service date

Process the detailed 824 acknowledgment

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

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

Parallel pilot procedure

Optional parallel standard paper form 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 detailed test phase.

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 paper identification form. The form allows the DWC to link your EDI medical reports to your paper medical reports.

Send paper reports to DWC

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

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

Wait for parallel pilot analysis report

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

Moving from test to production status

Once the data quality criteria of the EDI testing phases 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 ST-SE transaction set until 20 errors are detected and then send the 824 acknowledgment.

Data quality reports

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

Trading partner profile

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

WCIS PAPER PILOT IDENTIFICATION FORM

TO: _____
WCIS Contact

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

NAME _____

ADDRESS _____

FEIN _____

ZIP CODE _____

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

TOTAL NUMBER OF EDI MEDICAL TRANSACTIONS SENT _____

DATE PAPER MEDICAL 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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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: Principal diagnosis code 519.2

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

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	BHT	Beginning of Hierarchy Transaction
Data Element	532	Batch Control Number
Data Element	100	Date Transmission Sent
Data Element	101	Time Transmission Sent

LOOP ID	1000A	Sender Information
Segment	NM1	Identification code
Data Element	98	Sender Identification (FEIN only)
Segment	N4	Identification code
Data Element	98	Sender Identification (Postal Code only)

LOOP ID	1000B	Receiver Information
Segment	NM1	Identification code
Data Element	99	Receiver Identification (FEIN only)
Segment	N4	Identification code
Data Element	99	Receiver Identification (Postal Code only)

LOOP ID	2000A	Source of Hierarchical Information
Segment	DTP	Date/Time Period
Data Element	615	Reporting Period

LOOP ID	2010AA	Insurer/Self Insured/Claim Admin. Info.
Segment	NM1	Insurer/Self Insured/Claim Admin. Info.
Data Element	7	Insurers Name
Data Element	6	Insurers FEIN
Data Element	188	Claim Administrators Name
Data Element	187	Claim Administrators FEIN

LOOP ID	2000B	Employer Hierarchical Information
---------	-------	-----------------------------------

LOOP ID	2010BA	Employer Named Insurer Information
Segment	NM1	Employer Name

Loop ID	2000C	Claimant Hierarchical Information
Segment	DTP	Date/Time Period
Data Element	31	Date of Injury

Loop ID	2010CA	Claimant Information
Segment	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 Submission Reason Code
Segment	DTP	Date/Time Period
Data Element	511	Date Insurer Received Bill
Data Element	513	Admission Date
Data Element	514	Discharge Date
Data Element	509	Service Bill Date 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	Principal Diagnosis Code
Data Element	535	Admitting Diagnosis Code
Data Element	522	ICD_9 Diagnosis Code

Segment	HI	Institutional Procedure Codes
Data Element	626	HCPCS Principal Procedure Billed Code
Data Element	525	ICD_9 CM Principal Procedure Billed Code
Data Element	550	Principal Procedure Date
Data Element	737	HCPCS Billed Procedure Code
Data Element	736	ICD_9 CM Billed Procedure Code
Data Element	524	Procedure Date
Loop ID	2310A	Billing Provider Information
Segment	NM1	Billing Provider Information
Data Element	528	Billing Provider Last/Group Name
Data Element	629	Billing Provider FEIN
Segment	PRV	Billing Provider Specialty Information
Data Element	537	Billing Provider Primary Specialty Code
Segment	N4	Billing Provider City, State, and Postal Code
Data Element	542	Billing Provider Postal Code
Segment	REF	Billing Provider Secondary ID Number
Data Element	630	Billing Provider State License Number
Loop ID	2310B	Rendering Bill Provider Information
Segment	NM1	Rendering Bill Provider Information
Data Element	638	Rendering Bill Provider Last/Group Name
Data Element	642	Rendering Bill Provider FEIN
Segment	PRV	Rendering Bill Provider Specialty Info.
Data Element	651	Rendering Bill Provider Primary Specialty Code
Segment	N4	Rendering Bill Provider City, State, Postal Code
Data Element	656	Rendering Bill Provider Postal Code
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	NM1	Facility Information
Data Element	678	Facility Last/Group Name
Data Element	679	Facility FEIN
Segment	N4	Facility City, State, and Postal Code
Data Element	688	Facility Postal Code
Segment	REF	Facility Secondary ID Number
Data Element	680	Facility State License Number
Data Element	681	Facility Medicare Number

Loop ID	2310F	Managed Care Organization Information
Segment	NM1	Managed Care Organization Information
Data Element	209	Managed Care Organization Last/Group Name
Data Element	704	Managed Care Organization FEIN
Segment	N4	Managed Care Organization City, State, and Postal Code
Data Element	712	Managed Care Organization Postal Code
Segment	REF	Managed Care Organization Identification Number
Data Element	208	Managed Care Organization Identification Number
Loop ID	2320	Subscriber Insurance
Segment	CAS	Bill Level Adjustment Reasons Amount
Data Element	543	Bill Adjustment Group Code
Data Element	544	Bill Adjustment Reason Code
Data Element	545	Bill Adjustment Amount
Data Element	546	Bill Adjustment Units
Loop ID:	2400	Service Line Information
Segment	LX	Service Line Information
Data Element	547	Line Number
Segment	SV1	Procedure Code Billed
Data Element	721	NDC Billed Code
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	715	Jurisdictional Procedure Billed Code
Data Element	718	Jurisdictional Modifier Billed Code
Data Element	552	Total Charge per Line
Data Element	553	Days/Units Code
Data Element	554	Days/Units Billed
Data Element	600	Place of Service Line Code
Data Element	557	Diagnosis Pointer
Segment	SV2	Institutional Service Revenue Procedure Code
Data Element	559	Revenue Billed Code
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	715	Jurisdictional Procedure Billed Code
Data Element	718	Jurisdictional Modifier Billed Code
Data Element	552	Total Charge per Line
Segment	SV3	Dental Service
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	552	Total Charge per Line
Data Element	600	Place of Service Line Code

Segment	SV4	Prescription Drug Information
Data Element	561	Prescription Line Number
Data Element	721	NDC Billed Code
Data Element	563	Drug Name
Data Element	562	Dispense as Written Code
Data Element	564	Basis of Cost Determination
Segment	SV5	Durable Medical Equipment
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	553	Days/Units Code
Data Element	554	Days/Units Billed
Data Element	565	Total Charge per Line Rental
Data Element	566	Total Charge per Line Purchase
Data Element	567	DME Billing Frequency Code
Segment	DTP	Service Date(s)
Data Element	605	Service Line 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	NM1	Rendering Line Provider Information
Data Element	589	Rendering Line Provider Last/Group Name
Data Element	586	Rendering Line Provider FEIN
Segment	PRV	Rendering Line Provider Specialty Information
Data Element	595	Rendering Line Provider Primary Specialty Code
Segment	N4	Rendering Provider City, State, and Postal Code
Data Element	593	Rendering Line Provider Postal Code
Segment	REF	Rendering Line Provider Secondary ID 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), rejection (TR), or accepted with errors (TE) of the health care claim transaction set (837). The following outline summarizes the loop, segment, and data element structure of the medical bill payment detailed acknowledgment (824). More detailed information can be found in IAIABC EDI Implementation Guides for Medical Bill Payment Records, Release 1.

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

Data transmission with FTP

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

Trading partner profile

Complete the trading partner profile form in section F – trading partner profile. Be sure to indicate the transmission mode is FTP. Acknowledgments will be returned by FTP. After the trading partner profile form is completed, follow the steps below.

FTP server account and password

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

FTP communication ports

The WCIS FTP server requires the following communications ports to be opened for FTPS transmissions: 20, 21, 990, and 1024-65535. FTPS uses ports 1024 and above as data channels. The high-numbered ports are assigned sequentially by the server per session.

FTP server root certificate

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

FTP Server name and IP address

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

Trading partner source IP address

Access to the WCIS FTP server will be restricted to source IP addresses that are entered on the trading partner profile form. Trading partners may provide up to two source IP addresses. The source IP addresses must be public addresses. Although some network systems use private addresses for internal networks (e.g.; 10.0.0.0, 172.16.0.1 and 192.168.1.1), WCIS will require the public IP address that private addresses are translated to.

Testing FTP connectivity

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

Sending data through FTP

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

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

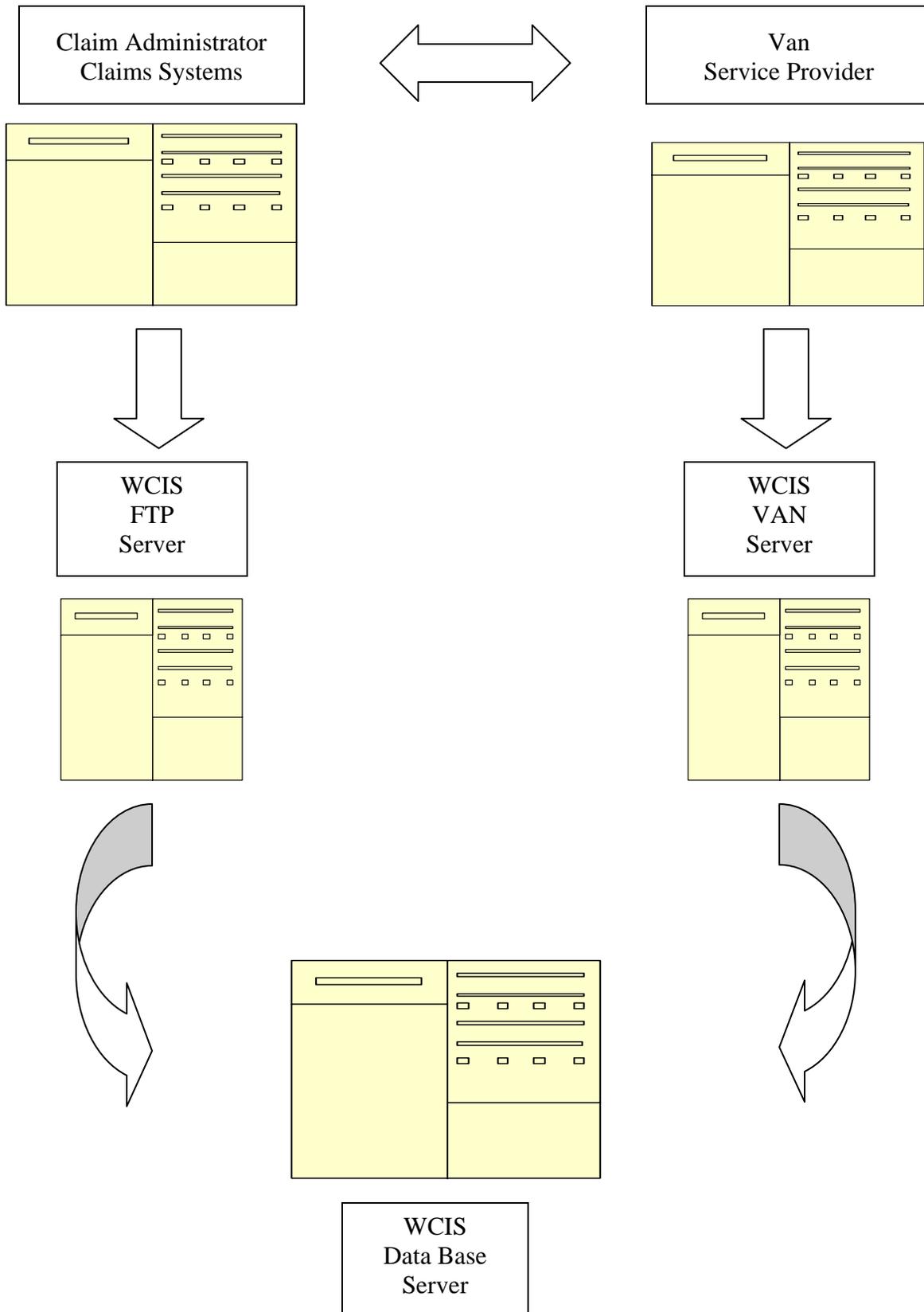
Receiving acknowledgment files through FTP

WCIS will place functional and detailed acknowledgement files (997 and 824) on the WCIS FTP server in the trading partner's root directory. Trading partners may delete acknowledgement files after they have retrieved the files.

File naming conventions

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

Pathway transmissions



Section J

EDI service providers

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Introduction to EDI service providers

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

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

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

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

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

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

<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 including the re-submission of a medical bill rejected due to an error.

01 = Cancellation

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

05 = Replace

This is only utilized to replace DN15 Claim Administrator Claim Number.

Report trigger criteria:

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

California Event Table											
EVENT			PRODUCTION LEVEL IND.	IMPLEMENTATION DATE		REPORT TRIGGER CRITERIA	REPORT TRIGGER VALUE	EFFECTIVE DATE		REPORT DUE	
BILL SUBMISSION REASON	REPORT TYPE	SUBMISSION DESCRIPTION REASON		FROM	TO			FROM	TO	CRITERIA	VALUE
OO	Original		T = Test P=Production			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					
714	HCPCS LINE PROCEDURE BILLED CODE	24D	44					
726	HCPCS LINE PROCEDURE PAID CODE				x			
717	HCPCS MODIFIER BILLED CODE	24D	44					
727	HCPCS MODIFIER PAID CODE				x			
626	HCPCS PRINCIPAL PROCEDURE BILLED CODE		80					
522	ICD-9 CM DIAGNOSIS CODE	21 1-4	68- 75					
525	ICD-9 CM PRINCIPAL PROCEDURE CODE		80					
736	ICD-9 CM PROCEDURE CODE		81					
6	INSURER FEIN				x			
7	INSURER NAME		50					
105	INTERCHANGE VERSION ID							

California Medical Data Elements by Source								
DN	DATA ELEMENT NAME	CMS 1500	UB 92	IA	Payor	HCP	JLB	SNDR
5	JURISDICTION CLAIM NUMBER				x			
718	JURISDICTION MODIFIER BILLED CODE	24D				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 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	PRINCIPAL DIAGNOSIS CODE		67					
550	PRINCIPAL PROCEDURE DATE		80					
524	PROCEDURE DATE		81					
507	PROVIDER AGREEMENT CODE				x	x		
99	RECEIVER 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		

California Medical Data Elements by Source								
DN	DATA ELEMENT NAME	CMS 1500	UB 92	IA	Payor	HCP	JLB	SNDR
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE				x	x		
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER						x	
615	REPORTING PERIOD				x			
559	REVENUE BILLED CODE		42					
576	REVENUE PAID CODE				x			
98	SENDER ID			X				X
733	SERVICE ADJUSTMENT AMOUNT				x			
731	SERVICE ADJUSTMENT GROUP CODE				x			
732	SERVICE ADJUSTMENT REASON CODE				x			
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				

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

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Reason Submission Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger
5	JURISDICTIONAL CLAIM NUMBER	C	O	O	If the first report of injury has been filed and a jurisdictional claim number is available
715	JURISDICTIONAL PROCEDURE BILLED CODE	C	O	O	If the procedure is included in the California Official Medical Fee Schedule
718	JURISDICTIONAL MODIFIER BILLED CODE	C	O	O	If DN715 is modified
729	JURISDICTIONAL PROCEDURE PAID CODE	C	O	O	If different than DN715
730	JURISDICTIONAL MODIFIER PAID CODE	C	O	O	If different than DN718
6	INSURER FEIN	M	M	M	
7	INSURER NAME	M	O	O	
187	CLAIM ADMINISTRATOR FEIN	C	O	O	If the Claim Administrator FEIN is different then Insurer FEIN, DN 6
188	CLAIM ADMINISTRATOR NAME	C	O	O	If the Claim Administrator name is different then Insurer name, DN 7
15	CLAIM ADMINISTRATOR CLAIM NUMBER	M	M	M	
31	DATE OF INJURY	M	O	O	
43	EMPLOYEE LAST NAME	M	O	O	
44	EMPLOYEE FIRST NAME	M	O	O	
45	EMPLOYEE MIDDLE NAME	O	O	O	
153	EMPLOYEE GREEN CARD	C	O	O	If Employee Social Security number is not available. (see DN42)
152	EMPLOYEE EMPLOYMENT VISA	C	O	O	If Employee Social Security number or Employee Green Card number is not available. (see DN42)
156	EMPLOYEE PASSPORT NUMBER	C	O	O	If Employee Social Security number, Employee Green Card Number, or Employee Employment Visa is not available. (see DN42)
42	EMPLOYEE SOCIAL SECURITY NUMBER	M	O	O	Can use default values of all 9's if injured worker is not a United States citizen and has no other identification (DN153, DN152, DN156)
704	MANAGED CARE ORGANIZATION FEIN	C	O	O	For HCO claims use the FEIN of the sponsoring organization.
209	MANAGED CARE ORGANIZATION NAME	O	O	O	
712	MANAGED CARE ORGANIZATION POSTAL CODE	O	O	O	

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Submission Reason Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger
208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	O	O	O	
504	FACILITY CODE	C	C	O	If DN 503 equals "A"
515	CONTRACT TYPE CODE	C	O	O	If DN 518 is present, then use value 01 or 09
518	DRG CODE	C	O	O	If DN 503 equals "A" and if included in the California Inpatient Hospital Fee Schedule
521	PRINCIPAL DIAGNOSIS CODE	C	O	O	If DN 503 equals "A"
550	PRINCIPAL PROCEDURE DATE	C	O	O	If DN 503 equals "A" and if DN525 or DN626 is present
513	ADMISSION DATE	C	O	O	If Billing Format Code, DN 503, is "A" and patient has been admitted
514	DISCHARGE DATE	C	O	O	If Billing Format Code, DN 503, is "A" and patient has been discharged
535	ADMITTING DIAGNOSIS CODE	C	O	O	If Billing Format Code, DN 503, is "A" and patient has been admitted
679	FACILITY FEIN	C	O	O	If DN 503 equals "A"
678	FACILITY NAME	C	O	O	If service performed in a licensed facility
688	FACILITY POSTAL CODE	C	O	O	If service performed in a licensed facility
680	FACILITY STATE LICENSE NUMBER	O	O	O	
681	FACILITY MEDICARE NUMBER	O	O	O	
559	REVENUE BILLED CODE	C	O	O	If a value for DN 504 with 2nd digit equal to 1
576	REVENUE PAID CODE	C	O	O	If different than DN559
629	BILLING PROVIDER FEIN	C	O	O	If different from DN 642
528	BILLING PROVIDER LAST/GROUP NAME	C	O	O	If different from DN 638
542	BILLING PROVIDER POSTAL CODE	C	O	O	If different than DN656
630	BILLING PROVIDER STATE LICENSE NUMBER	C	O	O	If different than DN643(see WCIS regulations)
537	BILLING PROVIDER PRIMARY SPECIALTY CODE	O	O	O	
502	BILLING TYPE CODE	C	O	O	If DN 503 equals "B" and prescriptions or durable medical equipment are billed

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Submission Reason Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger
563	DRUG NAME	C	O	O	If present
570	DRUGS/SUPPLIES QUANTITY DISPENSED	C	O	O	If DN 502, value is "RX" or "MO".
571	DRUGS/SUPPLIES NUMBER OF DAYS	C	O	O	If DN 502, value is "RX" or "MO".
572	DRUGS/SUPPLIES BILLED AMOUNT	C	O	O	If DN 502, value is "RX" or "MO".
579	DRUGS/SUPPLIES DISPENSING FEE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
562	DISPENSE AS WRITTEN CODE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
564	BASIS OF COST DETERMINATION CODE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
721	NDC BILLED CODE	C	O	O	If a pharmaceutical bill or a drug is dispensed by a physician during an office visit.
728	NDC PAID CODE	C	O	O	If different then DN721
527	PRESCRIPTION BILL DATE	C	O	O	If different than DN604
604	PRESCRIPTION LINE DATE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
561	PRESCRIPTION LINE NUMBER	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
638	RENDERING BILL PROVIDER LAST/GROUP NAME	M	O	O	
656	RENDERING BILL PROVIDER POSTAL CODE	M	O	O	
642	RENDERING BILL PROVIDER FEIN	M	O	O	
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER	M	O	O	
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER	C	O	O	If different then DN643
651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	M	O	O	
586	RENDERING LINE PROVIDER FEIN	C	O	O	If different from DN 642
589	RENDERING LINE PROVIDER LAST/GROUP NAME	C	O	O	If different from DN 638
593	RENDERING LINE PROVIDER POSTAL CODE	C	O	O	If different from DN 656

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Submission Reason Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger
592	RENDERING LINE PROVIDER NATIONAL ID	C	O	O	When available (see WCIS regulations)
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	C	O	O	If different from DN 651
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER	C	O	O	If different from DN 643
500	UNIQUE BILL ID NUMBER	M	M	O	
266	TRANSACTION TRACKING NUMBER	M	O	O	
501	TOTAL CHARGE PER BILL	M	O	O	
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	C	C	O	If DN501 is present
503	BILLING FORMAT CODE	M	M	O	
507	PROVIDER AGREEMENT CODE	M	O	O	Enter the value "P" if the injured workers medical treatment is provided within a Medical Provider Network approved by the DWC.
508	BILL SUBMISSION REASON CODE	M	M	M	
509	SERVICE BILL DATE(S) RANGE	C	O	O	If different than DN605
510	DATE OF BILL	O	O	O	
511	DATE INSURER RECEIVED BILL	M	O	O	
512	DATE INSURER PAID BILL	M	O	O	
516	TOTAL AMOUNT PAID PER BILL	C	O	O	If different than DN501
522	ICD-9 CM DIAGNOSIS CODE	C	O	O	If DN521 is present and more then one diagnosis occurs or if DN503 = B and DN714 or DN715 or a drug is dispensed by a physician during an office visit.
544*	BILL ADJUSTMENT REASON CODE	C	O	O	If paid amount is not equal to billed amount
543*	BILL ADJUSTMENT GROUP CODE	C	O	O	If paid amount is not equal to billed amount
545	BILL ADJUSTMENT AMOUNT	C	O	O	If paid amount is not equal to billed amount
546	BILL ADJUSTMENT UNITS	C	O	O	If paid amount is not equal to billed amount

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Submission Reason Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger
555	PLACE OF SERVICE BILL CODE	C	C	O	If DN503 equals "B"
557	DIAGNOSIS POINTER	C	O	O	If DN503 equals "B" and DN715 or DN714 is present or a drug is dispensed by a physician during an office visit.
567	DME BILLING FREQUENCY CODE	C	O	O	If DN502 = DM and DN565 is present
526	RELEASE OF INFORMATION CODE	O	O	O	
547	LINE NUMBER	M	O	O	
524	PROCEDURE DATE	C	O	O	If DN 503 equals "A" and more than one surgical procedure was performed
552	TOTAL CHARGE PER LINE – OTHER	C	O	O	If DN502 not equal to RX or MO or DM
565	TOTAL CHARGE PER LINE – RENTAL	C	O	O	If Durable Medical Equipment is rented
566	TOTAL CHARGE PER LINE – PURCHASE	C	O	O	If Durable Medical Equipment is purchased
554	DAYS/UNITS BILLED	C	O	O	If DN715 or DN714 are present or DN502 = DM, or a drug is dispensed by a physician during an office visit.
553	DAYS/UNITS CODE	C	O	O	If DN715 or DN714 are present or DN502 = DM or a drug is dispensed by a physician during an office visit.
574	TOTAL AMOUNT PAID PER LINE	C	O	O	If paid amount is not equal to billed amount
600	PLACE OF SERVICE LINE CODE	C	O	O	If different from DN 555 and not a pharmacy bill
605	SERVICE LINE DATE(S) RANGE	C	O	O	If not a pharmacy bill submitted on universal claim form/NCPDP format
525	ICD-9 CM PRINCIPAL PROCEDURE CODE	C	O	O	If Billing Format Code, DN 503, is "A" and the code value is not a HCPCS code. For surgical bills only.
626	HCPCS PRINCIPAL PROCEDURE BILLED CODE	C	O	O	If Billing Format Code, DN 503, is "A" and the code value is not an ICD-9 code. For surgical bills only.
736	ICD_9 CM PROCEDURE CODE	C	O	O	If DN525 is present and more than one procedure is performed
737	HCPCS BILL PROCEDURE CODE	C	O	O	If DN626 is present and more than one procedure is performed
714	HCPCS LINE PROCEDURE BILLED CODE	C	O	O	If DN502 not equal RX or MO, and if DN715 or DN721 not present
717	HCPCS MODIFIER BILLED CODE	C	O	O	If DN714 is modified
726	HCPCS LINE PROCEDURE PAID CODE	C	O	O	If different than DN714

Bill Submission Reason Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger
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
* Adjustments to DN501, DN552, DN565, DN566, or DN572 in accordance with the California Official Medical Fee Schedule, the California Inpatient Hospital Fee Schedule, or any other Official DWC Fee Schedule (pharmaceuticals etc.) can use Bill\Service Adjustment Group Code = "MA" and Bill\Service Adjustment Reason Code = '45" for medical bill payment record reporting purposes to the DWC\WCIS.					

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												
		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
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												
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 PRINCIPAL PROCEDURE BILLED CODE									x				
522	ICD_9 CM DIAGNOSIS CODE									x				
525	ICD_9 CM PRINCIPAL PROCEDURE CODE									x				
736	ICD_9 CM PROCEDURE CODE									x				
6	INSURER FEIN	x					x	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
7	INSURER NAME													
105	INTERCHANGE VERSION ID									x				
5	JURISDICTION CLAIM NUMBER			x										
718	JURISDICTION MODIFIER BILLED CODE									x				
730	JURISDICTION MODIFIER PAID CODE									x				
715	JURISDICTION PROCEDURE BILLED CODE									x				
729	JURISDICTION PROCEDURE PAID CODE									x				
547	LINE NUMBER	x												
704	MANAGED CARE ORGANIZATION FEIN	x						x						
208	MANAGED CARE ORGANIZATION ID NUMBER			x										
209	MANAGED CARE ORGANIZATION NAME													
712	MANAGED CARE ORGANIZATION POSTAL CODE									x				
721	NDC BILLED CODE									x				
728	NDC PAID CODE									x				
102	ORIGINAL TRANSMISSION DATE		x						x					
103	ORIGINAL TRANSMISSION TIME	x												
555	PLACE OF SERVICE BILL CODE									x				
600	PLACE OF SERVICE LINE CODE									x				
527	PRESCRIPTION BILL DATE		x			x			x					
604	PRESCRIPTION LINE DATE		x			x			x					
561	PRESCRIPTION LINE NUMBER			x										
521	PRINCIPAL DIAGNOSIS CODE									x				
550	PRINCIPAL PROCEDURE DATE		x			x			x					
524	PROCEDURE DATE		x			x			x				x	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
507	PROVIDER AGREEMENT CODE									x				
99	RECEIVER ID									x				
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					

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
605	SERVICE LINE DATE(S) RANGE		x			x			x					
104	TEST/PRODUCTION INDICATOR									x				
109	TIME PROCESSED	x												
101	TIME TRANSMISSION SENT	x												
516	TOTAL AMOUNT PAID PER BILL	x												
574	TOTAL AMOUNT PAID PER LINE	x												
501	TOTAL CHARGE PER BILL	x												
566	TOTAL CHARGE PER LINE - PURCHASE	x												
565	TOTAL CHARGE PER LINE - RENTAL	x												
552	TOTAL CHARGE PER LINE -OTHER	x												
266	TRANSACTION TRACKING NUMBER	x												
500	UNIQUE BILL ID NUMBER			x										

California specific data edits

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

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

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

Section N

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 in the acknowledgment of the first report of injury by the DWC. 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 is a conditional data element for the medical requirements (See section – L required medical data elements). The data elements, claim administrator claim number (DN 15) and insurer FEIN (DN 6), will be utilized to match claims in the WCIS database in place of the JCN under specific circumstances. For information on future changes to the JCN requirements, see the *WCIS e-News #1*.

Transaction processing and sequencing

Bill submission reason codes (BSRC) are used to define the specific purpose of a transmission. The bill submission reason code (00) must be used with the initial medical bill payment report sent. The remaining bill submission reason codes (01, 05) must be preceded by the initial medical bill payment report. Medical bill payment report bill submission reason codes are grouped in the following tables to clarify their purpose and to demonstrate a logical order for use.

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

BSRC code	BSRC name
00	Original

After the initial medical bill payment report has been filed, the following medical bill payment report bill submission reason codes can be submitted to reflect cancellations or replacements. Resubmitted corrected medical bill payment report transmissions should be transmitted utilizing BSRC = 00. Replacement 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

824 detailed application acknowledgment codes

The California DWC\WCIS utilizes DN111_ application acknowledgment codes (AAC) in the ANSI 824 to inform the Trading partner of the accepted or rejected status of each 837 transmission to the DWC.

AAC code	ACC meaning
TA	Transaction accepted
TR	Transaction rejected
TE	Transaction accepted with errors

Corrected data element (BSRC=00)(ACC=TR)

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

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

Corrected medical bill (BSRC=01)(ACC=TA)

WCIS regulations require each claim administrator to submit to the WCIS any changed data elements to maintain complete, accurate, and valid data. To update the value of data elements contained in transmission already accepted by the DWC\WCIS, the sender transmits a BSRC = 01 to cancel the original transmission (BSRC=00), and then transmits a different BSRC = 00 containing the updated data. The updated transmission (BSRC=00) is not sent in response to an 824 acknowledgement containing error messages (TR) from the DWC\WCIS. When submitting a transmission (BSRC=00) to update the value of a data element, the sender must report all medical bill payment data elements, not just the data elements being updated (See Section L – Required medical data elements). The following seven steps outline the procedure:

1. Sender transmits original bill, including all lines, utilizing a BSRC "00".
2. Receiver sends a 997 and a "TA" 824 acknowledgement to sender.
3. Sender changes the value of data elements on the original bill.

4. Sender cancels incorrect original bill by transmitting a BSRC "01".
5. Receiver sends a 997 and a "TA" 824 acknowledgement to sender.
6. Sender transmits the updated bill, including all lines, as a BSRC "00".
7. Receiver sends a 997 and "TA" 824 acknowledgement to sender.

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

Replacement of a claims administrator claim number (BSRC=05)(ACC=TA)

Replacement reports (BSRC=05) are sent to WCIS indicating a change in the claim administrator claim number (DN 15) (see section K). The replacement transmission (BSRC=05) may or may not be sent in response to an 824 acknowledgement containing error messages (TR) from the DWC\WCIS (see "Unmatched transactions below).

When submitting a replacement transmission (BSRC=05) to indicate a change in the claims administrators claim number, the sender must only resubmit a limited number of data elements (See Section L – Required medical data elements). The following four steps outline the procedure:

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

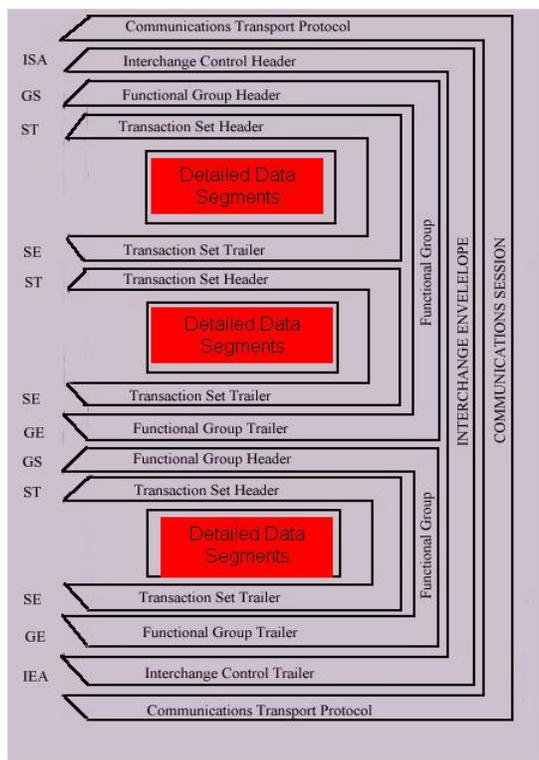
Duplicate transmissions, transactions, and medical bills

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

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

Bill duplicates occur when one or more ST-SE transaction sets from the same sender, contain the same information on the claim administrator FEIN, claim administrator claim number, and unique bill identification number. The DWC will check for duplicate bills in all ST-SE transaction sets throughout all GS-GE functional groups included in each x12 interchange envelope (ISA-IEA interchange).

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



WCIS matching rules and processes for a claim

Primary:

1. Jurisdiction claim number

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

Unmatched Transactions (ACC=TE)

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

1. The DWC retains the transmission and continuously searches for a match (FROI).

2. If no match (FROI) or BSRC = 01 the DWC sends an 824 acknowledgment indicating transaction accepted with errors (TE). The error code will be 039_nomatch on database.
3. The DWC continues to retain the transmission and searches for a match (FROI).
4. The DWC plans to produce data quality reports within 30 days to send to all trading partners.

More on how WCIS matches incoming transactions to existing claim records

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

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

Section O

IAIABC Information

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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 third party to collect the data.

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

Communications

Communications is the technology that allows data to flow between one computer and another. The EDI telecommunications process involves a computer application to formulate the customized business partner's data. Communications technology is divided into software and network choices. The number of choices depends on the "How" you choose to implement EDI. The two aspects of "How" are:

The communications software you choose will be dictated by your choice of communications network and whether you are communicating with the same structure or need a translator between systems. The primary objective of communications relative to EDI is to transport information between business partners in a cost effective and efficient manner. A second critical objective is to assure the privacy and confidentiality of the information while it is being electronically exchanged.

Section P

Code lists and state license numbers

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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: Centers for Medicare & Medicaid Services (CMS)

Available at:

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

Abstract:

HCPCS is the Centers for Medicare & Medicaid Services (CMS) 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.

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 codes

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 bill 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 bill 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 bill 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 bill 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 bill 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 bill 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 bill 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 bill 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 bill 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 bill 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 bill 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 bill 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.iaiaabc.org>

California state medical license numbers

- Source: CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS
- Available at:
CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS (DCA)
400 R Street
Sacramento, CA
<http://www.dca.ca.gov>
- Abstract: The California DCA licenses medical providers including: Acupuncture, Behavioral Sciences, Chiropractic, Dental, Medical, Occupational Therapy, Optometry, Osteopathic, Pharmacy, Physical Therapy, Podiatry, Psychiatric Technicians, Psychology, Registered Nursing, Respiratory Care, Speech-Language Pathology and Audiology, Vocational Nursing, Hearing Aid Dispensers, Dental Auxiliaries, Physician Assistant, Registered Dispensing, and Opticians

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

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
ANSI	American National Standards Institute
IAIABC	International Association of Industrial Accident Boards and Commissions
IS	Information Systems
FEIN	Federal Employers Identification Number
TP	Trading Partner
BSRC	Bill Submission Reason Code

Section R

Standard Medical Forms

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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			SEX 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)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)															
CITY			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY			STATE												
ZIP CODE			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE			TELEPHONE (INCLUDE AREA CODE)												
TELEPHONE (Include Area Code) ()			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER															
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>												
3. OTHER INSURED'S POLICY OR GROUP NUMBER			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME															
b. OTHER INSURED'S DATE OF BIRTH MM DD YY			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME															
c. EMPLOYER'S NAME OR SCHOOL NAME			10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9a-d.															
d. 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 _____															
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			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															
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE			17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO			\$ CHARGES															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)			22. MEDICAID RESUBMISSION CODE			ORIGINAL REF. NO.															
1. _____			3. _____			23. PRIOR AUTHORIZATION NUMBER															
2. _____			4. _____																		
24. DATE(S) OF SERVICE		B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPSDT Family Plan		I BMS		J COB		K RESERVED FOR LOCAL USE	
MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER														
1																					
2																					
3																					
4																					
5																					
6																					
25. FEDERAL TAX I.D. NUMBER			28. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		29. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #															
SIGNED _____ DATE _____						PIN# _____			GRP# _____												

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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)																			
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

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 1842-1105-8227

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 _____

QUAL (5)

ADDRESS _____ SERVICE PROVIDER I.D. _____
 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. _____

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.
 PATIENT / AUTHORIZED REPRESENTATIVE _____

**ATTENTION RECIPIENT
PLEASE READ
CERTIFICATION
STATEMENT ON
REVERSE SIDE**

1 Sample Form - Not For Distribution 1

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

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

2 Sample Form - Not For Distribution 2

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

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

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)
 (PERF)

SCREENS: BOX 10%, TEXT 11%.

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