WCIS Advisory Committee Meeting

Medical Bill Payment Data

Presenters
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Division of Workers’ Compensation
Oakland, California
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Outline of Presentation

• Count of reported bills
• Reporters
• Outstanding IRRs
• Reporting issues
• Data Quality
• Question Time
Count of Reported Bills

The table below shows accepted bills for the last 6 reporting years.

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>Bill Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>16,126,848</td>
</tr>
<tr>
<td>2012</td>
<td>15,004,317</td>
</tr>
<tr>
<td>2013</td>
<td>15,718,329</td>
</tr>
<tr>
<td>2014</td>
<td>15,821,499</td>
</tr>
<tr>
<td>2015</td>
<td>16,621,133</td>
</tr>
<tr>
<td>2016*</td>
<td>4,816,259</td>
</tr>
<tr>
<td>2016**</td>
<td>3,714,284</td>
</tr>
</tbody>
</table>

* Using CA Version 1.0 and 1.1 Jan-April 5
** Using CA Version 2.0 April 6 – Oct
Data Reporters

- The following table indicates some sender that reported data in CA Version 1.1 are not reporting in CA Version 2.0.
- The WCIS team will start contacting claims administrators whose data is missing.

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>2014</th>
<th>2015</th>
<th>2016*</th>
<th>2016**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senders</td>
<td>45</td>
<td>50</td>
<td>37</td>
<td>38</td>
</tr>
<tr>
<td>Insurers</td>
<td>1,649</td>
<td>1,589</td>
<td>1,254</td>
<td>706</td>
</tr>
<tr>
<td>Claims Admins</td>
<td>338</td>
<td>447</td>
<td>351</td>
<td>385</td>
</tr>
</tbody>
</table>

* Using CA Version 1.0 and 1.1
** Using CA Version 2.0.
Timeliness of Reporting

- Pursuant to CCR §9702(e) claims administrators are required to submit their medical bills to WCIS within ninety days of bill payment /denial.
- 2015 showed a marked improvement for timely reporting of medical bills.

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>Days from Bill Payment to Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 91</td>
</tr>
<tr>
<td>2013</td>
<td>76.9</td>
</tr>
<tr>
<td>2014</td>
<td>76.2</td>
</tr>
<tr>
<td>2015</td>
<td>85.6</td>
</tr>
</tbody>
</table>
Reporting Pharmacy Bills without NDC codes

• This IRR added 2 new qualifiers, HC = Health Care Financing Administration Common and ER = Jurisdiction Specific Procedure and Supply Codes for SV402-1.

“Required
SV402-1  = N4, use DN0721 NDC Billed Code
SV402-1  = HC, use DN0714 HCPCS Line Procedure Billed Code
SV402-1  = ER, use DN0715 Jurisdiction Procedure Billed Code”

• As a stop gap, until IRRMED836 is implemented, California will use HCPCS code in the SV4 segment with the prefix HC_ as shown in the example below.

SV4*123456*N4:HC_A6219***1*****Y~
IRRMed836

- The objective of this IRR is to create a way to report dispensing/compounding fee on professional bills.
- The proposed IRR uses the existing structure of the IAIABC 837 standard.
- Stakeholders input on the IRR is crucial to find a solution that works for all.
Application of IRRMED836 Example

• Reporting dispensing fee for physician dispensed compound drug – Proposed example
  LX*1~
  SV1*N4:01234567891*30.25*UN*2*01**1~ *(charged amount for the reported 1st ingredient)*
  DTP*472*RD8*20150323-20150323~
  LIN**N4:01234567891~ *(NDC of 1st ingredient/ Component)*
  CTP****2*UN~ *(unit of measurement for this component)*
  REF*VY*654321~ *(link used to piece together components of a compound drug i.e. lines 1 and 2)*
  SVD*XX*23.25*N4:01234567891~
  SVD*XX*7.00*HC: S9430~ *(dispensing fee for all components)*

  LX*2~
  SV1*N4:19012345678*28.1*UN*60*01**1~ *(charged amount for the reported 2nd ingredient)*
  DTP*472*RD8*20150323-20150323~
  LIN**N4: 19012345678 ~ *(NDC of 2nd ingredient)*
  CTP****60*UN~ *(unit of measurement for this component)*
  REF*VY*654321~ *(link used to piece together components of a compound drug i.e. lines 1 and 2)*
  SVD*XX*22.35*N4:19012345678~
Compound Drug Reporting

• Two ways to report compound drugs on professional bills
  As stated in the currently approved CA medical guide.
  As stated in the CA medical guide currently in rulemaking.

• Database entry when compound drug is reported in the currently approved way. Not possible to tell if all three NDC’s shown are component s of a compound drug or not.

<table>
<thead>
<tr>
<th>BILL_ID</th>
<th>LINE_NUM</th>
<th>NDC_BILL_CD</th>
<th>HCPCS_LINE_PROC_BILL_CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>125853979</td>
<td>1</td>
<td>38779007800</td>
<td></td>
</tr>
<tr>
<td>125853979</td>
<td>2</td>
<td>37803036803</td>
<td></td>
</tr>
<tr>
<td>125853979</td>
<td>3</td>
<td></td>
<td>99070</td>
</tr>
<tr>
<td>125853979</td>
<td>4</td>
<td>76420000200</td>
<td></td>
</tr>
<tr>
<td>125853979</td>
<td>5</td>
<td></td>
<td>S9430</td>
</tr>
</tbody>
</table>
Compound Drug Reporting (cont’d.)

• Database entry when compound drug is reported using LIN Segment:

<table>
<thead>
<tr>
<th>BILL_ID</th>
<th>LINE_NUM</th>
<th>NDC_BILL_CD</th>
<th>LINK_SEQ_NUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>181036115</td>
<td>1</td>
<td>38779273909</td>
<td>103049</td>
</tr>
<tr>
<td>181036115</td>
<td>2</td>
<td>38779008109</td>
<td>103049</td>
</tr>
<tr>
<td>181036115</td>
<td>3</td>
<td>38779052109</td>
<td>103049</td>
</tr>
<tr>
<td>181036115</td>
<td>4</td>
<td>38779038608</td>
<td>103049</td>
</tr>
<tr>
<td>181036115</td>
<td>5</td>
<td>51927333800</td>
<td>103049</td>
</tr>
</tbody>
</table>
California Version 1.1 unmatched data

Distribution of Unmatched Data

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>Bill Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2,407,821</td>
</tr>
<tr>
<td>2014</td>
<td>4,939,263</td>
</tr>
<tr>
<td>2015</td>
<td>3,447,692</td>
</tr>
<tr>
<td>2016*</td>
<td>1,162,986</td>
</tr>
</tbody>
</table>

* January to April 5th

• Bills are getting rejected when submitting subsequent payments where the original 00 is unmatched.
Un-match data (cont’d.)

• To avoid rejection of subsequent bills whose 00 original is in the “orphanage” contact your WCIS EDI contact to get header information moved from the 4010 to the 5010 database.

• Use the JCN search site

• [https://www.dir.ca.gov/dwc/jcn/JCNsearch.asp](https://www.dir.ca.gov/dwc/jcn/JCNsearch.asp)
Reporting Issues

• Multiple ST/SE with one bill in each ST/SE in the same 837 file.
Reporting Issues (cont’d.)

- **Insurer 1**
  - **Employer 1**: Claim 1 with 3 bills
    - HL*1**20*1~
    - CLM*1*1.10***01:B***********N***00~
    - CLM*2*2.20***01:B***********N***00~
    - CLM*3*3.30***01:B***********N***00~
  - **Employer 2**: Claim 2 with 2 bills
    - HL*4*2*CL*0~
    - CLM*4*4.40***01:B***********N***00~
    - CLM*5*5.50***01:B***********N***00~
  - **Insurer 2**: Claim 3 with 5 bills
    - HL*5**20*1~
    - HL*6*5*EM*0~
    - HL*7*6*CL*0~
    - CLM*6*6.60***01:B***********N***00~
    - CLM*7*7.70***01:B***********N***00~
    - CLM*8*8.80***01:B***********N***00~
    - CLM*9*9.90***01:B***********N***00~
    - CLM*10*10.10***01:B***********N***00~
Reporting Issues (cont’d.)

• 824 structure from WCIS is being questioned by Trading Partner and is being discussed.

• DN0266 -Transaction Tracking Number should be unique for a sender.

• Sequencing errors

  Subsequent BSRCs are being reported when BSRC 00 Original is not accepted.
Validation Changes

The following validation errors in WCIS were corrected:

Removed 001 *Mandatory field not present* since these two data elements are not in the currently approved CA Medical Guide. Currently in rulemaking and not yet adopted.

- DN0048 Employee City
- DN0050 Employee Postal Code

Error 001 Mandatory field not present was removed from:

- DN0525 – Principal Procedure Code for institutional bills;
- DN0622 – Admission Hour on some inpatient bills
Validation Changes (cont’d.)

• Error 064 Invalid data relationship was removed from DN0535 – Admitting Diagnosis Code for outpatient bills
• To avoid rejection of bills denied for invalid billed and paid procedure codes at the line level, validation is bypassed when service adjustment reason code 181 is reported.
• An upcoming change when the new CA Medical Guide currently in rulemaking takes effect. Error 001-Mandatory field not present is applied to DN0537 Billing Provider Primary Specialty Code
5010 Data Acknowledgment Summary
April 6, 2016 to August 30, 2016

<table>
<thead>
<tr>
<th>Description</th>
<th>Counts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Bills</td>
<td>4,194,678</td>
</tr>
<tr>
<td>Accepted Bills</td>
<td>2,854,385</td>
</tr>
<tr>
<td>Rejected Bills</td>
<td>1,340,293</td>
</tr>
<tr>
<td>Item Reject (IR)</td>
<td></td>
</tr>
<tr>
<td>Bills</td>
<td>1,340,293</td>
</tr>
<tr>
<td>Data Elements</td>
<td>2,139,368</td>
</tr>
</tbody>
</table>
Data Quality Report

Matching with FROI:
- DN0015 Claim Admin Claim Number
- + DN0005 JCN
- + DN0006 Insurer FEIN

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Error Code</th>
<th>Number of Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN0015 Claim Admin Claim Number</td>
<td>039 – No Match on database</td>
<td>573,022</td>
</tr>
</tbody>
</table>
Data Quality Report (cont’d.)

Matching with FROI:

DN0015 Claim Admin Claim Number
+ DN0005 JCN
+ DN0006 Insurer FEIN

Current Information shows only DN0015 Claim Admin Claim Number is in error
RED*DN15+DN5+DN6=ABC12345+20161234567+123456789**IB**GJ0015~

Additional Information to show error for DN0006 Insurer FEIN and DN0005 JCN
RED*DN15+DN5+DN6=ABC12345+20161234567+123456789**IB**GJ0006~
RED*DN15+DN5+DN6=ABC12345+20161234567+123456789**IB**GJ0005~
Data Quality Reports (cont’d.)

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Error Code</th>
<th>Number of Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN0714 HCPCS Line Procedure Billed Code</td>
<td>058 Invalid Code</td>
<td>14,040</td>
</tr>
<tr>
<td>DN0715 Jurisdiction Procedure Billed Code</td>
<td>058 Invalid Code</td>
<td>8,608</td>
</tr>
<tr>
<td>DN0721 NDC Billed Code</td>
<td>058 Invalid Code</td>
<td>62,999</td>
</tr>
<tr>
<td>DN0726 HCPCS Procedure Paid Code</td>
<td>058 Invalid Code</td>
<td>12,900</td>
</tr>
<tr>
<td>DN0728 NDC Paid Code</td>
<td>058 Invalid Code</td>
<td>36,354</td>
</tr>
<tr>
<td>DN0729 Jurisdiction Procedure Paid Code</td>
<td>058 Invalid Code</td>
<td>9,682</td>
</tr>
</tbody>
</table>

- Consistent periodic update of all code tables is done.
- NDC codes- The WCIS subscribes to Medispan weekly data download
Data Quality Report (cont’d.)

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Error Code</th>
<th>Number of Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN0689 Facility Country Code</td>
<td>058 – Invalid Code</td>
<td>79,725</td>
</tr>
</tbody>
</table>

Erroneous Reporting
N4*San Francisco*CA*94120*US ~
N4*San Francisco*CA*94121*USA~

Error Information
RED*US **GJ*0569~
RED*USA**GJ*0689~

Change to:
N4*San Francisco*CA*94120*US~
N4*San Francisco*CA*94120~
Data Element | Error Code | Number of Errors
--- | --- | ---
DN0541 Billing Provider State Code | 001 – Mandatory field not present | 41,620
DN0542 Billing Provider Postal Code | 001 – Mandatory field not present | 53,112

Erroneous Reporting
N4*San Francisco~

Change to:
N4*San Francisco*CA*94120~

Error Information
RED*NONE**GJ*0541~
RED*NONE**GJ*0542~
## Data Quality Report (cont’d.)

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Error Code</th>
<th>Number of Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN0208 Managed Care Organization ID Number</td>
<td>058 – Invalid Code</td>
<td>80,778</td>
</tr>
<tr>
<td>DN0208 Managed Care Organization ID Number</td>
<td>064 – Invalid Data Relationship</td>
<td>18,771</td>
</tr>
<tr>
<td>DN0209 Managed Care Organization Name</td>
<td>064 – Invalid Data Relationship</td>
<td>18,315</td>
</tr>
<tr>
<td>DN0704 Managed Care Organization FEIN</td>
<td>064 – Invalid Data Relationship</td>
<td>19,056</td>
</tr>
</tbody>
</table>

Related to DN0507 Provider Agreement Code equals P
Data Quality Report (cont’d.)

Erroneous Reporting 1
CLM*123.45*733.53***11:A:1************P***00~
NM1*Y2*2*Best Managed Care*****75*C25~
REF * EI*123456789~

Error Information
RED*C25**GJ*0208~

Erroneous Reporting 2
CLM*123.45*733.53***11:A:1************P***00~

Missing Loop 2310F MCO Information

Error Information
RED*NONE**GJ*0208~
RED*NONE**GJ*0209~
RED*NONE**GJ*0704~
When to report MCO Information?
  When DN0507 Provider Agreement Code = ‘P’
How to report DN0507 Provider Agreement Code?
  P = When both injured worker and medical provider are within DWC approved Medical Provider Network (MPN) plan
  H = HMO
  Y = When Service provided under a PPO
  N = No agreement
Where to find MCO ID?
  http://www.dir.ca.gov/dwc/mpn/ListApprovedMPN.pdf
  or
  The 10th to 13th digits of the MPN approval number
Where to find MCO FEIN?
  The 1st – 9th digits of the MPN Approval Number
Data Quality Report (cont’d.)

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Error Code</th>
<th>Number of Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN0515 Contract Type Code</td>
<td>064 Invalid Data Relationship</td>
<td>3,191</td>
</tr>
<tr>
<td>DN0741 Contract Line Type Code</td>
<td>064 Invalid Data Relationship</td>
<td>36,665</td>
</tr>
</tbody>
</table>

Related when DN0507 Provider Agreement Code is P, H or Y
Erroneous Reporting
CLM*321.45*125.53***11:B**********Y***00

Missing bill level CN1 Segment
LX*1~

Missing line level CN1 Segment

Error Information
RED*NONE WHEN DN0507 = Y*IB**GJ*0515~
RED*NONE WHEN DN0507 = Y**IB**GJ*0741~

Change to:
CLM*321.45*125.53***11:B**********Y***00~
CN1*04~
LX*1~
CN1*04~
Data Quality Report (cont’d.)

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Error Code</th>
<th>Number of Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN0527 Prescription Bill Date</td>
<td>111 Must be a valid content</td>
<td>18,708</td>
</tr>
<tr>
<td>DN0605 Service Line Date(s) Range</td>
<td>071 – Must be &gt;= Service Date</td>
<td>146,741</td>
</tr>
</tbody>
</table>

DN0527 Prescription Bill Date related to DN0604 Prescription Line Date

DN0510 Date of Bill related to DN0605 Service Line Date(s) Range
Data Quality Report (cont’d.)

Erroneous Prescription Bill Reporting
DTP*471*RD8*20160520-20160525~
LX*1~ DTP*471*D8*20160518~
LX*2~ DTP*471*D8*20160526~

Error Information
RED*20160520**IB**GJ*0527~
RED*20160526**IB**GJ*0527~

Error Information
REF*FJ*2~
RED*DN0510 DATE OF BILL 2016520 IS BEFORE DN605 SERVICE LINE DATE FROM **IB**GJ*0605~
Data Quality Report (cont’d.)

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Error Code</th>
<th>Number of Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN0557 Diagnosis Pointer</td>
<td>064 Invalid Data Relationship</td>
<td>71,000</td>
</tr>
</tbody>
</table>

Related to Non-Institutional Diagnosis
DN0522 Diagnosis Code
Data Quality Report (cont’d.)

Erroneous Reporting 1
HI*BK:78001*BF:78002*BF:78003*BF:78009~
SV1*HC:44213*1100*UN*1*21*49*1:7***************N~

Error Information
RED*7**IB**GJ*0557~

Erroneous Reporting 2

*Missing HI Diagnosis Codes Segment*
SV1*HC:44213*1100*UN*1*21*49*1***************N~

Error Information
RED*NONE**IB**GJ*0522~
RED*1**IB**GJ*557~
## Data Quality Report (cont’d.)

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Error Code</th>
<th>Number of Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bill Level Balancing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DN0501 Total Charge Per Bill</td>
<td>064 – Invalid Data Relationship</td>
<td>66,278</td>
</tr>
<tr>
<td>DN0516 Total Paid Per Bill</td>
<td></td>
<td>1,346</td>
</tr>
<tr>
<td><strong>Line Level Balancing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DN0552 Total Charge Per Line</td>
<td>064 – Invalid Data Relationship</td>
<td>179,367</td>
</tr>
<tr>
<td>DN0572 Drugs/Supplies Billed Amount</td>
<td></td>
<td>2,032</td>
</tr>
</tbody>
</table>
Data Quality Report (cont’d.)

Rule 1 except lien bills

Professional, dental and Institutional bills
RED*288!=366.75 RULE DN0501=SUM OF DN0552**IB**GJ*0501~

Prescription bills
RED*288!=366.75 RULE DN0501=SUM OF DN0572**IB**GJ*0501~

Rule 2 except lien bills

RED*133!=333.75 RULE DN0516=SUM OF DN0574**IB**GJ*0516~
Data Quality Report (cont’d.)

Rule 3  on all bill types

RED*288!=133+155+2325 RULE DN501=SUM(DN516+DN545+DN733)**IB**GJ*0501~

Rule 4 except lien bills. Occurs independently for each individual service line when
Sum of DN0545 Bill Adjustment Amount = 0

Professional, dental and Institutional bills
  RED*288!=366.75 RULE DN0552=DN0574+SUM OF DN0733**IB**GJ*0552~

Prescription bills
  RED*288!=366.75 RULE DN0572=DN0574+SUM OF DN0733**IB**GJ*0572~
Reporting Prescription Bills with Pharmacy Dispensing Fee Segment

LX*1~
SV4*123456*N4:00378443001***1******Y~
DTP*472*D8*20110613~
DTP*471*D8*20110611~
QTY*QB*30~
QTY*SP*30~
AMT*D7*15~ ➔ dispensing fee segment reported in LX*1 only. Not part of balancing
AMT*PB*48~ ➔ Charge amount
SVD*XX*32*N4:00378443001~ ➔ Amount Paid
CAS*PI*217*31**91*-15~ ➔ Adjustment amount
31 for the drug and 15 for dispensing fee

LX*2~
SV4*123456*N4:49884077905***1******Y~
DTP*472*D8*20110613~
DTP*471*D8*20110611~
QTY*QB*30~
QTY*SP*30~
AMT*PB*50~ ➔ Charge amount
SVD*XX*38.29*N4:00378443001~ ➔ Amount Paid
CAS*PI*217*11.71~ ➔ Adjustment amount
Negative adjustment increase payment
Balancing Prescription Bills with Pharmacy Dispensing Fee

**Bill Level**

<table>
<thead>
<tr>
<th>DN0501</th>
<th>Total Charge Per Bill</th>
<th>98.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN0516</td>
<td>Total Amount Paid</td>
<td>70.29</td>
</tr>
<tr>
<td>DN0545</td>
<td>Bill Adjustment Amount</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Service Line Level**

**Line 1**

<table>
<thead>
<tr>
<th>DN0572</th>
<th>Drug/Supplies Billed Amount</th>
<th>48.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN0574</td>
<td>Amount Paid Per Line</td>
<td>32.00</td>
</tr>
<tr>
<td>DN0733</td>
<td>Service Adjustment Amount</td>
<td>31.00</td>
</tr>
<tr>
<td>DN0733</td>
<td>Service Adjustment Amount</td>
<td>-15.00</td>
</tr>
</tbody>
</table>

**Line 2**

<table>
<thead>
<tr>
<th>DN0572</th>
<th>Drug/Supplies Billed Amount</th>
<th>50.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN0574</td>
<td>Amount Paid Per Line</td>
<td>38.29</td>
</tr>
<tr>
<td>DN0733</td>
<td>Service Adjustment Amount</td>
<td>11.71</td>
</tr>
</tbody>
</table>

**Notes on reporting on AMT*D7 dispensing fee segment:**
- Report dispensing fee as negative adjustment in CAS segment to reflect increased payment.
- Subtract dispensing fee from payment to get actual amount paid for the service.

**Rule 1: Medical Bill Charge Amounts**

Sum of DN0572 Drug/Supplies Billed Amount

= DN0501 Total Charge Per Bill

Ex. 48.00 + 50.00 = 98.00

**Rule 2: Medical Bill Payment Amounts**

Sum of DN0574 Amount Paid Per Line

= DN0516 Total Amount Paid

Ex. 32.00 + 38.29 = 70.29

**Rule 3: Medical Bill Charge/Payment/Adjustment Amounts**

DN0516 Total Amount Paid

+ Sum of DN0545 Bill Adjustment Amount

+ Sum of DN0733 Service Adjustment Amount

= DN0501 Total Charge Per Bill

Ex. 70.29 + 0 + (31.00 - 15.00 + 11.71) = 98.00

**Rule 4: Line Level Balancing**

Occurs independently for each service line if the sum of DN0545 Bill Adjustment Amount = 0

Sum of DN0574 Amount Paid Per Line

+ Sum of DN0733 Service Adjustment Amount

= DN0572 Drug/Supplies Billed Amount

Ex. Line 1: 32.00 + (31.00 - 15.00) = 48.00

Line 2: 38.29 + 11.71 = 50.00
What is in the pipeline?

• Monthly outstanding IR report by sender.
• Monthly Acknowledgment reports.
• Data inconsistency reports.

WCIS - Medical Bill Payment Data
WCIS Trading Partner Contacts

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