Workers' Compensation Information System (WCIS)

California EDI Implementation Guide for Medical Bill Payment Records

Version 1.1
November 15, 2011

CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS
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DIVISION OF WORKERS' COMPENSATION
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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.

This 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 current revision of medical record EDI reporting in California is smooth and painless, both for the Division and its EDI trading partners.

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

Sincerely,

Carrie Nevans
Acting Administrative Director

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Section A: Electronic data interchange in California – an overview

Electronic data interchange – EDI

Electronic data interchange (EDI) is the computer-to-computer exchange of data or information in a standardized format. In California workers' compensation, medical EDI refers to the electronic transmission of detailed medical bill payment records information from trading partners, i.e. senders, to the California Division of Workers' Compensation.

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

Benefits of EDI within workers' compensation

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

Workers' compensation information system history

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

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

The WCIS has four main objectives:

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

California EDI requirements

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

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

- **Subsequent reports**: Subsequent Reports of Injury (SROI) have been transmitted by EDI to the DWC since July 1, 2000. Subsequent reports must be submitted within 15 business days of whenever benefit payments to an employee are started, changed, suspended, restarted, stopped, delayed, denied, closed, reopened, or upon notification of employee representation.

- **Medical bill/payment records**: Medical bill payment reporting regulations were adopted on March 22, 2006. The regulations require medical services with a date of service on or after September 22, 2006 and a date of injury on or after March 1, 2000 to be transmitted to the DWC within 90 calendar days of the medical bill payment or the date of the final determination that payment for billed medical services would be denied. The medical services are required to be reported to the WCIS by all claims administrators handling 150 or more total claims per year. The required data elements are listed in Section K. See also Section E, which references the complete DWC/WCIS regulations.

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

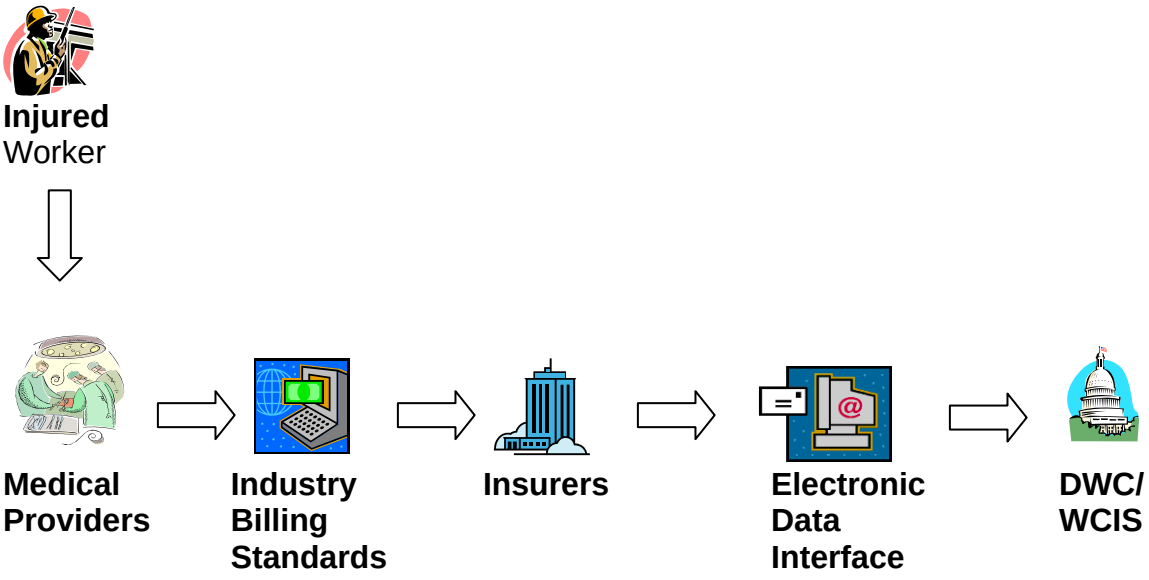
Sending Data to the WCIS

California workers' compensation medical bill payment records are processed by diverse organizations: large multi-state insurance companies, smaller specialty insurance carriers, self-insured employers or insurers, third-party administrators handling claims on behalf of self-insured employers, as well as bill review companies. The organizations have widely differing technological capabilities, so the WCIS is designed to be as flexible as possible in supporting EDI medical transmissions. 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 and completely specified in Section 5 of the *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009* (www.iaiabc.org).

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

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



Five steps of EDI - from testing to production

Attaining full production medical EDI reporting with the DWC is a five step process. Each step of the process is described in more detail in Section G

Step one: Sender submits Trading Partner Profile

The trading partner first provides a completed EDI trading partner profile form to the DWC at least 30 (thirty) days before the first submission of electronic data. The form is contained in Section F. The trading partner profile is used to establish communications protocols between the WCIS and each trading partner with respect to: what file format to expect, where to send an acknowledgment, when to transmit medical bills and similar information. Send the completed trading partner profile by email to WCIS@dir.ca.gov or fax to 510-286-6862.

Step two: Sender tests FTP connectivity

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

Step three: Sender transmits numerous ANSI 837 bill types

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

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

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

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

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

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

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

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

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

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

California Division of Workers' Compensation

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

WCIS web site

Visit the WCIS web site – http://www.dir.ca.gov/dwc/wcis.htm – to:

- download the latest version of the California EDI Implementation Guide for Medical Bill Payment Records,
- get answers to frequently asked questions,
- review archived WCIS e-news letters, and
- download power point training materials.

WCIS contact person

Each WCIS trading partner will be assigned an individual contact person at the DWC. The assigned person will help answer trading partner questions about medical EDI in the California WCIS, work with the trading partner during the testing process, and be an ongoing source of support during production.

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

By phone:

510-286-6753 Trading Partner Letters C, G-H, M, P-R

510-286-6763 Trading Partner Letters B, D-F, N-O, W-Y

510-286-6772 Trading Partner Letters A, I-L, S-V, Z

By fax: (510) 286-6862

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

By Mail: WCIS EDI Unit
Attn: Name of WCIS contact (if known)
Department of Industrial Relations
1515 Clay Street, 18th Floor
Oakland, CA 94612

WCIS e-news
WCIS e-news is an email newsletter sent out periodically to inform WCIS trading partners of announcements and technical implementations. The WCIS e-news is archived on the WCIS web site. Interested parties who are not already receiving WCIS e-news can register at the WCIS website to be added to the WCIS e-news mailing list.

EDI service providers

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

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

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

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

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

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

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

IAIABC

The International Association of Industrial Accident Boards and Commissions (IAIABC) is the organization that sets the national standards for the transmission of workers' compensation medical data via EDI. The IAIABC published the standards in the *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 2009.*

For more information about the IAIABC and how to access the IAIABC EDI Implementation Guides, visit the IAIABC web site at: www.iaiabc.org.

Section C: Implementing medical EDI – a managers' guide

Get to know the basic requirements

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

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

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

Assign responsibilities for implementing medical EDI

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

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

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

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

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.

The FTP transmission mode for medical data

The WCIS supports File Transfer Protocol (FTP) transmissions using Secure Sockets Layer (SSL) and Pretty Good Privacy (PGP) encryption (See Section I).

Summary information about the required ANSI format is contained in Section H and detailed information about ANSI formats is included in Section 5 of the *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009,* published by the IAIABC at:

http://www.iaiabc.org This *IAIABC Guide* is essential if you are programming your own EDI system.

Make sure your computer system contains all the required data

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

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 information beginning in March, 2000. The second phase added the SROI information in July, 2000. A third requirement, an annual summary of payments on each active claim, went into effect January, 2001. The initial requirement for reporting all medical payments became effective March 22, 2006 for medical services provided on or after September 22, 2006, to employees injured on or after March 1, 2000. Implementing the requirements of the EDI transmission of the FROI and SROI information may have provided your organization a basic framework in which to implement the requirements of the medical bill payment records.

Handling error messages sent by WCIS

The DWC will transmit "error messages" from the WCIS back to you if the medical data transmitted to the DWC do 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).

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 L – Data edits. Data that violate the edit rules will cause medical data transmissions to be rejected with error messages.

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

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

Updating software and communications services

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

Most systems will need at least the following:

- software/services to identify events that trigger required medical reports,
- software/services to gather required medical data elements from your databases,
- software/services to format the data into an approved medical EDI file format,
- an electronic platform to transmit the medical data to the DWC and receive acknowledgments, 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 acknowledgments, when the trading partner plans to transmit medical bills, and other pertinent information necessary for EDI.

Successful testing includes tests for basic EDI connectivity between the trading partners system and the WCIS system, the WCIS verifying the medical transmissions match the WCIS technical specifications, and that the trading partner has the capability to receive and process acknowledgments from the WCIS. (See Section G).

Upon the successful completion of the five-step testing process and after a period of routinely transmitting your medical data via EDI to the WCIS for at least 30 days, the DWC will confirm by e-mail that each trading partner demonstrated the capability to transmit complete, valid, and accurate medical data in production status.

The IAIABC maintains the EDI standards adopted by the California Division of Workers' Compensation. For further information, contact the IAIABC.

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 section 138.6. Development of workers' compensation information system

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

(b) The information system shall do the following:

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

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

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

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

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

Labor Code section 138.7. "Individually identifiable information"; restricted access

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

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

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

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

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

(4) The administrative director shall adopt regulations allowing reasonable access to individually identifiable information by other persons or public or private entities for the purpose of bona fide statistical research. This research shall not divulge individually identifiable information concerning a particular employee, employer, claims administrator, or any other person or entity. The regulations adopted pursuant to this paragraph shall include provisions guaranteeing the confidentiality of individually identifiable information. Within a reasonable period of time after the research for which the information was obtained has been completed, the data collected shall be modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.

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

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

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

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

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

(c) Except as provided in subdivision (b), individually identifiable information obtained by the division is privileged and is not subject to subpoena in a civil proceeding unless, after reasonable notice to the division and a hearing, a court determines that the public

interest and the intent of this section will not be jeopardized by disclosure of the information. This section shall not operate to restrict access to information by any law enforcement agency or district attorney's office or to limit admissibility of that information in a criminal proceeding.

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

Section E: WCIS regulations – Title 8 CCR sections 9700-9704

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

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 federal tax identification number ("Master FEIN") and postal code. The identification information must be reported in the ISA header record of every transmission. The trading partner identification, in conjunction with the sender information, transmission date, transmission time, batch control number, and reporting period are used to identify communication parameters for the return of acknowledgments to the trading partners.

For some senders, the insurer FEIN (federal tax identification number) provided in each ST-SE transaction set will always be the same as the sender identification master FEIN. Other senders may have multiple FEINs for insurers or claims administrators. The transactions for a sender with multiple insurer FEINs or claims administrator FEINs can be sent under the same sender identification master FEIN.

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

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

State of California
Department of Industrial Relations

DIVISION OF WORKERS' COMPENSATION

MEDICAL

ELECTRONIC DATA INTERCHANGE TRADING PARTNER PROFILE

PART A. Trading Partner Background Information:

Date:

Sender Name:_____

Sender Master FEIN: _____

Physical Address: _____

City: _____ State: _____

Postal Code: _____

Mailing Address: _____

City: _____ State: _____

Postal Code: _____

Trading partner type (check all that apply):
__ Self Administered Insurer
__ Self Administered, Self-Insured (employer) __ Other (Please specify):____
__ Third Party Administrator of Insurer
__ Third Party Administrator of Self-Insured (employer)

PART B. Trading Partner Contact Information:

Business Contact:	Technical Contact:
Name: _____	Name: _____
Title: _____	Title: _____
Phone: _____	Phone: _____
FAX: _____	FAX: _____
E-mail Address: _____	E-mail Address: _____

PART C. Trading Partner Transmission Specifications:

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

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

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

Part C2 - FTP ACCOUNT INFORMATION FOR MEDICAL BILL

Sender/Trading Partner Name: _____

Sender/Trading Partner E-mail: _____

	DWC Use Only
User Name: (A-Z, a-z, 0-9) _____ **For PGP user only:** suffix of ***@wcismed_pgp*** will be required after your user name.	
Password: (8 characters min.) _____	
Transmission Modes: (choose one) _____ **PGP+SSL** _____ **SSL**	
Source Public Network IP Address: (limit to 6 max.) _____	
File Naming Convention: **Prefix:** (max. 4 characters) _____ **Unique Identifier:** (choose one) ___ **Sequence** ___ **Date/Time** ___ **Date/Sequence** ___ **Other** _____	

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

Name: *California Division of Workers' Compensation*

FEIN: *943160882*

Physical Address: *1515 Clay Street, Suite 1800*

City: *Oakland* State: CA Postal Code: *94612-1489*

Mailing Address: *P.O. Box 420603*

City: *San Francisco* State: *CA* Postal Code: *94142-0603*

Business Contact:	Technical Contact:
Name: *(Varies by trading partner)*	Name: *(Varies by trading partner)*
Title: *(Varies by trading partner)*	Title: *(Varies by trading partner)*
Phone: *(Varies by trading partner)*	Phone: *(Varies by trading partner)*
FAX: 510-286-6862	FAX: 510-286-6862
E-mail Address: *wcis@dir.ca.gov*	E-mail Address: *wcis@dir.ca.gov*

RECEIVER'S ANSI X12 TRANSMISSION SPECIFICATIONS:

Segment Terminator: ~ ISA Information: TEST PROD

Data Elements Separator: * Sender/Receiver Qualifier: *ZZ ZZ*

Sub-Element Separator: : Sender/Receiver ID: *(Use Master FEINs)*

Date/Time Transmission Sent (DN100 & DN101):(Format: CCYYMMDDHHMM)

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

Electronic Data Interchange Trading Partner Profile

INSTRUCTIONS FOR COMPLETING TRADING PARTNER PROFILE

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

PART A. TRADING PARTNER BACKGROUND INFORMATION:

NAME: The name of your business entity corresponding with the Master FEIN.

Master FEIN: The Federal Employer's Identification Number of your business entity. The FEIN, along with the 9-position postal code (postal+4) in the trading partner address field, will be used to identify a unique trading partner.

Physical Address: The street address of the physical location of your business entity. It will represent where materials may be received regarding "this" Trading Partner Profile if using a delivery service other than the U.S. Postal Service.

City: The city portion of the street address of your business entity.

State: The 2-character standard state abbreviation of the state portion of the street address of your business entity.

Postal Code: The 9-position postal code of the street address of your business entity. This field, along with the Trading Partner FEIN, will be used to uniquely identify a trading partner.

Mailing Address: The mailing address used to receive deliveries via the U. S. Postal Service for your business entity. This should be the mailing address that would be used to receive materials pertaining to "this" Trading Partner Profile. If this address is the same as the physical address, indicate "Same as above".

Trading Partner Type: Indicate any functions that describe the trading partner. If "other", please specify.

PART B. TRADING PARTNER CONTACT INFORMATION:

This section provides the ability to identify individuals within your business entity who can be used as contacts. Room has been provided for two contacts: business and technical.

BUSINESS CONTACT: The individual most familiar with the overall data extraction and transmission process within your business entity. He/she may be the project manager, business systems analyst, etc. This individual should be able to track down the answers to any issues that may arise from your trading partner that the technical contact cannot address.

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

BUSINESS/TECHNICAL CONTACT (Name) The name of the contact.

BUSINESS/TECHNICAL CONTACT (Title) The title of the contact.

BUSINESS/TECHNICAL CONTACT (Phone) The telephone number of the contact.

BUSINESS/TECHNICAL CONTACT (FAX) The telephone number of the FAX machine for the contact.

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

PART C. TRANSMISSION SPECIFICATIONS:

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

One profile should be completed for each set of transactions with common transmission requirements. Although one profile will satisfy most needs, it should be noted that if transmission parameters vary by transaction set IDs, a trading partner could specify those differences by providing more than one profile.

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

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

TRANSMISSION
MODE: EDI transactions are sent through File Transfer Protocol (FTP).

FTP TRANSFERS:

Part C1:
TRANSACTION SETS FOR THIS PROFILE:

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

TRANSACTION
TYPE: Indicates the 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 EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009. The WCIS will transmit detailed 824 acknowledgments, matching DN98 (Sender ID), DN100 (Date transmission sent), and DN 101 (Time transmission sent) from the inbound 837 to the DN99 (Receiver ID), DN 102 (Original date transmission sent) and DN103 (Original time transmission sent) in the outbound detailed 824. The DN101 (time transmission sent) in the BHT segment(s) of the 837 must be identical to the time in the ISA10 interchange time and GS05 Time in the 837 headers where the standard format is HHMM.

EXPECTED
TRANSMISSION
DAYS OF WEEK: Indicate expected transmission timing for each transaction type by circling the applicable day or days. Transmission days of week information will help DWC to forecast WCIS usage during the week. Note that DWC reserves the right to impose restrictions on a trading partner's transmission timing in order to control system utilization.

PRODUCTION
RESPONSE
PERIOD: DWC will indicate here the maximum period of elapsed time within which a sending trading partner may expect to receive an acknowledgment for a given transaction type.

Part C2 - FTP ACCOUNT INFORMATION FOR MEDICAL BILL

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

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

PASSWORD: Specify a password.

TRANSMISSION MODES: Choose one: PGP+SSL or SSL

SOURCE PUBLIC NETWORK IP ADDRESS:

File Naming Convention: Specify Prefix and Unique Identifier

PART D. RECEIVER INFORMATION (to be completed by DWC):

This section contains DWC's trading partner information.

Name:	The business name of California Division of Workers' Compensation.
FEIN:	The Federal Employer's Identification Number of DWC. This FEIN, combined with the 9-position postal code (postal+4), uniquely identifies DWC as a trading partner.
Physical Address:	The street address of DWC. The 9-position postal code of this street address, combined with the FEIN, uniquely identifies DWC as a trading partner.
Mailing Address:	The address DWC uses to receive deliveries via the U.S. Postal Service.
Contact Information:	This section identifies individuals at DWC who can be contacted with issues pertaining to this trading partner. The TECHNICAL CONTACT is the individual that should be contacted for issues regarding the actual transmission process. The BUSINESS CONTACT can address non-technical issues regarding the WCIS.

RECEIVER'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	The character to be used as a sub-element separator

SEPARATOR:	is specified here.
SENDER/RECEIVER QUALIFIER:	This will be the trading partner's ANSI ID Code Qualifier as specified in an ISA segment. Separate Qualifiers are provided to exchange Production and Test data, if different identifiers are needed.
SENDER/RECEIVER ID:	The ID Code that corresponds with the ANSI Sender/Receiver Qualifier (ANSI ID Code Qualifier). Separate Sender/Receiver IDs are provided to exchange Production and Test data, if different identifiers are needed.
DATE/TIME OF TRANSMISSION:	The DN100_Date Transmission Sent in the BHT segment(s) of the 837 must be identical to the time in the ISA09 interchange date and GS04 date in the 837 headers where the standard format is CCYYMMDD. The DN101_Time Transmission Sent in the BHT segment(s) of the 837 must be identical to the time in the ISA10 interchange time and GS05 Time in the 837 headers where the standard format is HHMM.

Section G: Testing and production phases of medical EDI

Overview of the five step process

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

Step one: Complete a medical EDI trading partner profile

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

Step two: Sender tests FTP connectivity

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

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

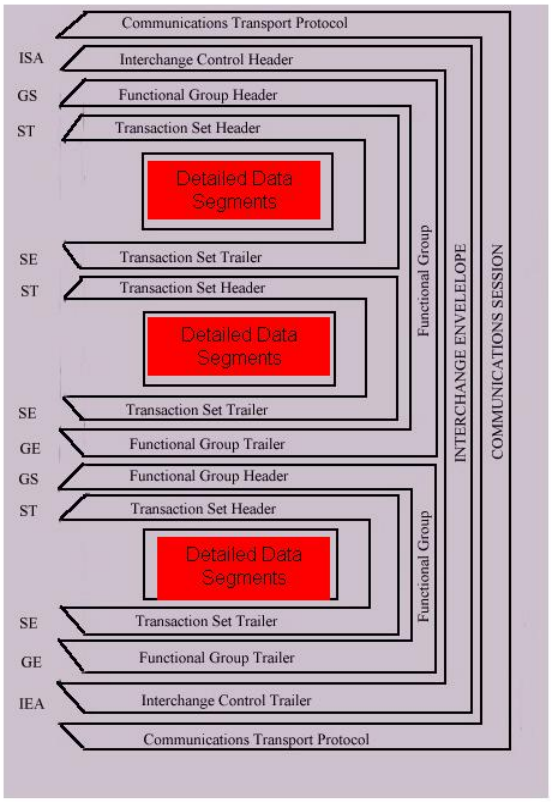
Step three: Sender transmits numerous ANSI 837 bill types

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

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

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

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



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

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

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

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

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

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

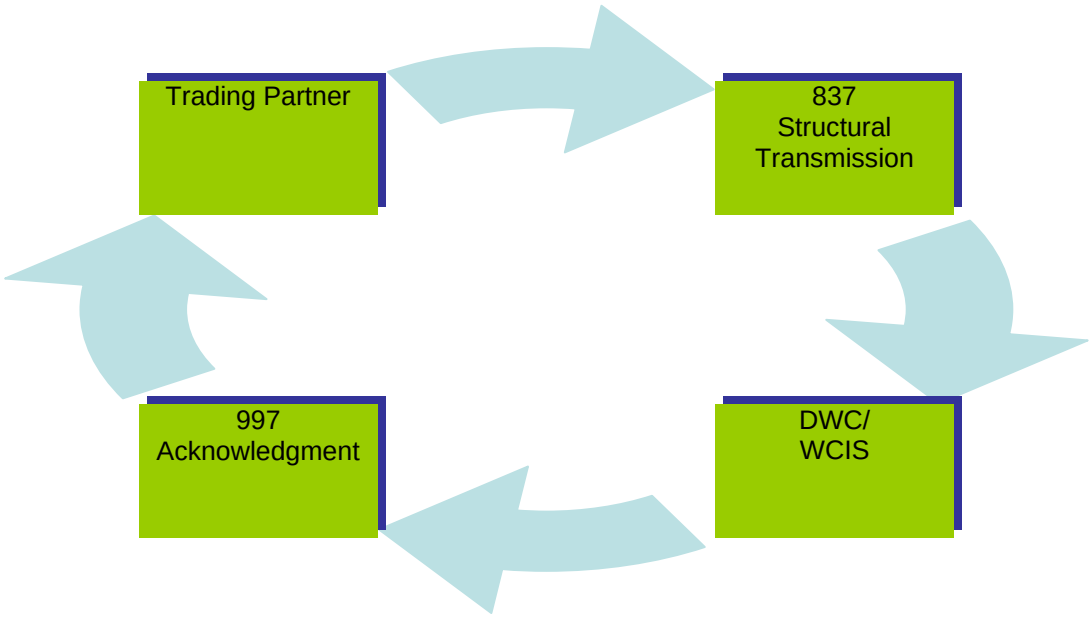
Trading partners must be able to both receive and process structural electronic acknowledgments from WCIS. When a structural test file has been received and processed by the DWC/WCIS, an electronic 997 acknowledgment will be transmitted to the trading partner by WCIS. The acknowledgment will report whether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

Process the 997 functional acknowledgment and correct any errors

If the 997 functional acknowledgment contains an application acknowledgment code = R (Transmission rejected) or E (Transmission accepted with errors), check the ANSI 837 file format and make corrections before re-transmitting the file to WCIS.

Send the corrected ANSI 837 file to the DWC. If the test fails again, repeat steps three and four until your test file is accepted by WCIS. You may send as many test files as you need to. The WCIS contact person assigned to you is available if you have any questions or problems during the process. If the acknowledgment code = A ("837 transmission accepted"), skip to step five.

Structural testing communication loop



Transmission 997 acknowledgment error messages

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

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

997 Segment	Error Code	Error Message
AK4_Data Element Note	1	Mandatory data element missing
AK4_Data Element Note	3	Too many data elements
AK4_Data Element Note	4	Data element too short
AK4_Data Element Note	5	Data element too long
AK4_Data Element Note	6	Invalid character in data element
AK4_Data Element Note	8	Invalid date
AK4_Data Element Note	9	Invalid time

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

010 ST Transaction Set Header

020 AK1 Functional Group Response Header

030 AK2 Transaction Set Response Header

040 AK3 Data Segment Note

050 AK4 Data Element Note

060 AK5 Transaction Set Response Trailer

070 AK9 Functional Group Response Trailer

080 SE Transaction Set Trailer

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

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

After an 837 structural test file is successfully transmitted, the trading partner transmits real detailed medical bill payment data, in test status. During detailed testing, the trading partner's submissions are analyzed for data completeness, validity and accuracy. The trading partner must meet minimum data quality requirements in order to complete the detailed testing stage. The trading partner will receive an 824 detailed acknowledgment containing information about each 837 transmission.

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

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

- **Complete data** – In order to evaluate the effectiveness and efficiency of the California workers' compensation system (one of the purposes of WCIS set forth in the 1993 authorizing statute), trading partners must submit all required medical bill payment data elements for the required reporting periods.

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

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

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

Data quality criteria

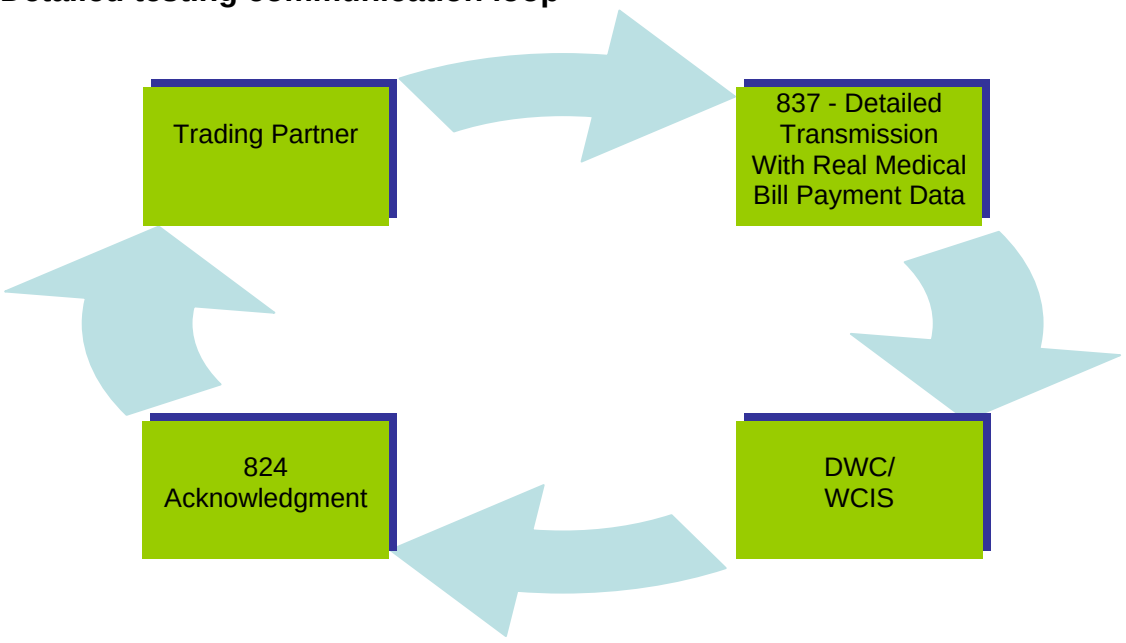
The DWC procedure sequentially tests for structural errors and then tests for detailed errors. Records transmitted to WCIS via EDI are tested for completeness, accuracy and validity using both structural and detailed data edits that are built into the WCIS data processing system (See Section K).

If the criteria of zero errors during the detailed testing phase cannot be attained, the DWC suggests a random subset of the EDI bill payment records be manually crosschecked against the corresponding paper bills for accuracy. The sender may be asked to justify any mismatches between the paper and EDI reports to help clarify errors in the 837 transmissions. A cross-walk of data elements contained on the CMS 1500 and the UB92 are provided in Section K and in the *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009* (www.iaiabc.org).

Prepare detailed test file(s)

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

Detailed testing communication loop



Electronic acknowledgment from WCIS

The data sent to WCIS will automatically be subjected to EDI data quality edits. The edits consist of the IAIABC standard edits listed in Section L. Each field in a transaction is validated using the edit rules. The DWC/WCIS medical bill payment specific scenarios will be tested for validity and accuracy. If a data element fails to pass any data validation edit, an error message will be generated for that data element. The 824 detailed acknowledgments will contain information about all detected errors for each 837 transmission.

You should receive a detail acknowledgment (824) from the WCIS within five business days of your data transmission. The acknowledgment will identify each data elements in which an error was detected (See Section H).

Detailed 824 acknowledgment error messages

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

Process the detailed 824 acknowledgment

If the acknowledgment indicates correctable 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 J and Section L).

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

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

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

Production Status

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

- All data quality errors will result in a Transaction Rejected (TR) 824 acknowledgment

Data Quality Reports

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

Section H: Supported transactions and ANSI file structure

Supported transactions

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

Health care claim transaction sets (837 & 824)

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

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

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

ANSI definitions

Loop:
A group of segments that may be repeated. The hierarchy of the looping structure is insurer, 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". The extended character set defined as: Lowercase letters: “a” through “z”. At least one non-space character is **required**. The significant characters should be left-justified. Trailing spaces should be suppressed.

Example: Claim administrator claim number AN1709MPN05

ID Identification code: Specific code taken from a pre-defined list of codes maintained by the Accredited Standards Committee (ASC) X12 or some other body recognized by the DWC/WCIS.

Example: Place of service code 11

R Decimal number: Numeric value containing explicit decimal point. The decimal point must appear as part of the data stream if at any place other than the rightmost end of the number. Leading zeros should be suppressed. Trailing zeros following the decimal point should be suppressed. If a decimal point is not included in the number, none will be assumed. Do not use commas in the decimal number.

Example: Principal diagnosis code 519.2

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

Delimiters:

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

California ANSI 837 loop, segment and data element summary

ST Transaction Set Header		
Segment	ST	Transaction Set Control Number
Segment	BHT	Beginning of Hierarchy Transaction
Data Element	532	Batch Control Number
Data Element	100	Date Transmission Sent
Data Element	101	Time Transmission Sent
LOOP ID	1000A	Sender Information
Segment	NM1	Identification code
Data Element	98	Sender Identification (FEIN only)
Segment	N4	Identification code
Data Element	98	Sender Identification (Postal Code only)
LOOP ID	1000B	Receiver Information
Segment	NM1	Identification code
Data Element	99	Receiver Identification (FEIN only)
Segment	N4	Identification code
Data Element	99	Receiver Identification (Postal Code only)
LOOP ID	2000A	Source of Hierarchical Information
Segment	DTP	Date/Time Period
Data Element	615	Reporting Period
LOOP ID	2010AA	Insurer/Self Insured/Claim Admin. Info.
Segment	NM1	Insurer/Self Insured/Claim Admin. Info.
Data Element	7	Insurer Name
Data Element	6	Insurer FEIN
Data Element	188	Claim Administrators Name
Data Element	187	Claim Administrators FEIN
LOOP ID	2000B	Employer Hierarchical Information

LOOP ID	2010BA	Employer Named Insurer Information
Segment	NM1	Employer Name
Loop ID	2000C	Claimant Hierarchical Information
Segment	DTP	Date/Time Period
Data Element	31	Date of Injury
Loop ID	2010CA	Claimant Information
Segment	NM1	Claimant Information
Data Element	43	Employee Last Name
Data Element	44	Employee First Name
Data Element	45	Employee Middle Name/Initial
Data Element	42	Employee Social Security Number
Data Element	153	Employee Green Card
Data Element	156	Employee Passport Number
Data Element	152	Employee Employment Visa
Loop ID	2010CA	Claimant Information (Continued)
Segment	REF	Claimant Claim Number
Data Element	15	Claim Administrators Claim Number
Data Element	5	Jurisdiction Claim Number
Loop ID	2300	Billing Information (Repeat > 1)
Segment	CLM	Billing Information
Data Element	523	Billing Provider Unique Bill ID Number
Data Element	501	Total Charge per Bill
Data Element	502	Billing Type Code
Data Element	504	Facility Code
Data Element	555	Place of Service Bill Code
Data Element	503	Billing Format Code
Data Element	526	Release of Information Code
Data Element	507	Provider Agreement Code
Data Element	508	Bill Submission Reason Code
Segment	DTP	Date/Time Period
Data Element	511	Date Insurer Received Bill
Data Element	513	Admission Date
Data Element	514	Discharge Date
Data Element	509	Service Bill Date(s) Ranges
Data Element	527	Prescription Bill Date
Data Element	510	Date of Bill
Data Element	512	Date the Insurer Paid Bill
Segment	CN1	Contract Information
Data Element	515	Contract Type Code
Data Element	518	DRG Code

Segment	AMT	Total Amount Paid
Data Element	516	Total Amount Paid Per Bill
Segment	REF	Unique Bill ID
Data Element	500	Unique Bill Identification Number
Segment	REF	Transaction Tracking Number
Data Element	266	Transaction Tracking Number
Segment	HI	Diagnosis
Data Element	521	Principal Diagnosis Code
Data Element	535	Admitting Diagnosis Code
Data Element	522	ICD_9 Diagnosis Code
Segment	HI	Institutional Procedure Codes
Data Element	626	HCPCS Principal Procedure Billed Code
Data Element	525	ICD_9 CM Principal Procedure Billed Code
Data Element	550	Principal Procedure Date
Data Element	737	HCPCS Billed Procedure Code
Data Element	736	ICD_9 CM Billed Procedure Code
Data Element	524	Procedure Date
Loop ID	2310A	Billing Provider Information
Segment	NM1	Billing Provider Information
Data Element	528	Billing Provider Last/Group Name
Data Element	629	Billing Provider FEIN
Segment	PRV	Billing Provider Specialty Information
Data Element	537	Billing Provider Primary Specialty Code
Segment	N4	Billing Provider City, State, and Postal Code
Data Element	542	Billing Provider Postal Code
Segment	REF	Billing Provider Secondary ID Number
Data Element	630	Billing Provider State License Number
Data Element	634	Billing Provider National Provider ID
Loop ID	2310B	Rendering Bill Provider Information
Segment	NM1	Rendering Bill Provider Information
Data Element	638	Rendering Bill Provider Last/Group Name
Data Element	642	Rendering Bill Provider FEIN
Segment	PRV	Rendering Bill Provider Specialty Info
Data Element	651	Rendering Bill Provider Primary Specialty Code
Segment	N4	Rendering Bill Provider City, State, Postal Code
Data Element	656	Rendering Bill Provider Postal Code
Data Element	657	Rendering Bill Provider Country Code
Segment	REF	Rendering Bill Provider Secondary ID Number
Data Element	649	Rendering Bill Provider Specialty License Number
Data Element	643	Rendering Bill Provider State License Number
Data Element	647	Rendering Bill Provider National Provider ID
Loop ID	2310C	Supervising Provider Information
Segment	REF	Supervising Provider National Provider ID
Data Element	667	Supervising Provider National Provider ID

Loop ID	2310D	Facility Information
Segment	NM1	Facility Information
Data Element	678	Facility Last/Group Name
Data Element	679	Facility FEIN
Segment	N4	Facility City, State, and Postal Code
Data Element	688	Facility Postal Code
Segment	REF	Facility Secondary ID Number
Data Element	680	Facility State License Number
Data Element	681	Facility Medicare Number
Data Element	682	Facility National Provider ID
Loop ID	2310E	Referring Provider Information
Segment	REF	Referring Provider National Provider ID
Data Element	699	Referring Provider National Provider ID
Loop ID	2310F	Managed Care Organization Information
Segment	NM1	Managed Care Organization Information
Data Element	209	Managed Care Organization Last/Group Name
Data Element	704	Managed Care Organization FEIN
Segment	N4	Managed Care Organization City, State, and Postal Code
Data Element	712	Managed Care Organization Postal Code
Segment	REF	Managed Care Organization Identification Number
Data Element	208	Managed Care Organization Identification Number
Loop ID	2320	Subscriber Insurance
Segment	CAS	Bill Level Adjustment Reasons Amount
Data Element	543	Bill Adjustment Group Code
Data Element	544	Bill Adjustment Reason Code
Data Element	545	Bill Adjustment Amount
Data Element	546	Bill Adjustment Units
Loop ID:	2400	Service Line Information
Segment	LX	Service Line Information
Data Element	547	Line Number

Segment	SV1	Procedure Code Billed
Data Element	721	NDC Billed Code
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	715	Jurisdiction Procedure Billed Code
Data Element	718	Jurisdiction 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	Jurisdiction Procedure Billed Code
Data Element	718	Jurisdiction Modifier Billed Code
Data Element	552	Total Charge per Line
Segment	SV3	Dental Service
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	552	Total Charge per Line
Data Element	600	Place of Service Line Code
Segment	SV4	Prescription Drug Information
Data Element	561	Prescription Line Number
Data Element	721	NDC Billed Code
Data Element	563	Drug Name
Data Element	562	Dispense as Written Code
Data Element	564	Basis of Cost Determination
Segment	SV5	Durable Medical Equipment
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	553	Days/Units Code
Data Element	554	Days/Units Billed
Data Element	565	Total Charge per Line Rental
Data Element	566	Total Charge per Line Purchase
Data Element	567	DME Billing Frequency Code
Segment	DTP	Service Date(s)
Data Element	605	Service Line Date(s) Range
Segment	DTP	Prescription Date
Data Element	604	Prescription Line Date
Segment	QTY	Quantity
Data Element	570	Drugs/Supplies Quantity Dispensed
Data Element	571	Drugs/Supplies Number of Days

Segment	AMT	Dispensing Fee Amount
Data Element	579	Drugs/Supplies Dispensing Fee
Segment	AMT	Drug/Supplies Billed Amount
Data Element	572	Drug/Supplies 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 Identification Number
Data Element	592	Rendering Line Provider National Provider ID
Data Element	599	Rendering Line Provider State License Number
Loop ID	2430	Service Line Adjustment
Segment	SVD	Service Line Adjudication
Data Element	574	Total Amount Paid per Line
Data Element	726	HCPCS Line Procedure Paid Code
Data Element	727	HCPCS Modifier Paid Code
Data Element	728	NDC Paid Code
Data Element	729	Jurisdiction Procedure Paid Code
Data Element	730	Jurisdiction Modifier Paid Code
Data Element	576	Revenue Paid Code
Data Element	547	Line Number
Segment	CAS	Service Line Adjustment
Data Element	731	Service Adjustment Group Code
Data Element	732	Service Adjustment Reason Code
Data Element	733	Service Adjustment Amount
Data Element	734	Service Adjustment Units
SE Transaction Set Trailer		
Segment		Transaction Set Trailer

California ANSI 824 loop, segment and data element summary

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

ST Transaction Set Header		
Segment	ST	Transaction Set Control Number
Segment	BGN	Beginning Segment
Data Element	105	Interchange Version Identification
Data Element	100	Date Transmission Sent
Data Element	101	Time Transmission Sent
Loop ID:	N1A	Sender Information
Segment	N1	Sender Identification
Data Element	98	Sender Identification (FEIN)
Segment	N4	Geographic Location
Data Element	98	Sender Identification (Postal Code)
Loop ID:	N1B	Receiver Information
Segment	N1	Receiver Identification
Data Element	99	Receiver Identification (FEIN)
Segment	N4	Geographic Location
Data Element	99	Receiver Identification (Postal Code)
Loop ID:	OTI	Original Identification Transaction
Segment	OTI	Original Transaction Identifier
Data Element	111	Application Acknowledgment Code
Data Element	500	Unique Bill Identification Number
Data Element	532	Batch Control Number
Data Element	102	Original Transmission Date
Data Element	103	Original Transmission Time
Data Element	110	Acknowledgment Transaction Set Identifier
Segment	DTM	Processing Date
Data Element	108	Date Processed
Data Element	109	Time Processed
Segment	LM	Code Source Information
Loop ID:	LQ	Industry Code
Segment	LQ	Industry Code
Data Element	116	Element Error Number

Segment	RED	Related Data
Data Element	6	Insurer FEIN
Data Element	187	Claim Administrator FEIN
Data Element	15	Claim Administrator Claim Number
Data Element	500	Unique Bill Identification Number
Data Element	266	Transaction Tracking Number
Data Element	115	Element Number
Data Element	547	Line Number

SE Transaction Set Trailer

Segment	Transaction Set Trailer

Section I: The FTP transmission modes

Data transmission with file transfer protocol (FTP)

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

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

After the trading partner profile form is completed (See Section F), follow the steps below.

FTP server account user name and password

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

FTP communication ports

The WCIS FTP server requires the following communications ports to be opened for FTPS transmissions: 21 and 1024-1224. FTPS uses TCP ports 1024 and above as data channels. The high-numbered ports are assigned sequentially by the server per session.

FTP over SSL

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

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

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

FTP Server name and IP address

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

Trading partner source IP address

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

Testing FTP connectivity

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

Sending data through FTP

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

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

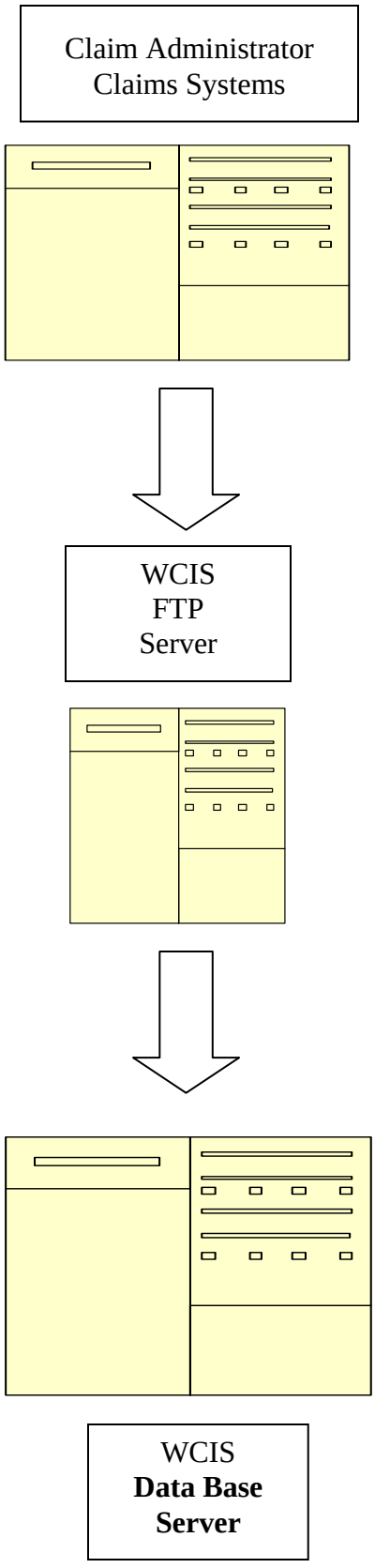
Receiving acknowledgment files through FTP

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

File naming conventions

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

Pathway transmissions



Section J: California-adopted IAIABC data elements

Numerically-sorted list of California-adopted IAIABC data elements

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

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

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

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

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

Section K: Required medical data elements

Medical data elements by name and source

The Medical Data Elements by Source 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 the data source in the workers' compensation system. In the case of the CMS 1500 and UB04, the fields on the medical paper forms are identified. The table also includes information on which entity in the system has access to each data element. The entities include Insurance Agents (IA), Payers, Health Care Providers (HCP), Jurisdictional Licensing Boards (JLB), and Senders (SNDR).

California Medical Data Elements by Source

DN	DATA ELEMENT NAME	CMS 1500	UB 04	IA	Payer	HCP	JLB	SNDR
110	ACKNOWLEDGMENT TRANSACTION SET ID			x				x
513	ADMISSION DATE		12					
535	ADMITTING DIAGNOSIS CODE		69					
111	APPLICATION ACKNOWLEDGMENT CODE			x				x
564	BASIS OF COST DETERMINATION CODE				x			
532	BATCH CONTROL NUMBER							x
545	BILL ADJUSTMENT AMOUNT				x			
543	BILL ADJUSTMENT GROUP CODE				x			
544	BILL ADJUSTMENT REASON CODE				x			
546	BILL ADJUSTMENT UNITS				x			
508	BILL SUBMISSION REASON CODE				x			
503	BILLING FORMAT CODE				x			
629	BILLING PROVIDER FEIN	25	5					
528	BILLING PROVIDER LAST/GROUP NAME	33	1					
634	BILLING PROVIDER NATIONAL PROVIDER ID	33A	56					
542	BILLING PROVIDER POSTAL CODE	33	1					
537	BILLING PROVIDER PRIMARY SPECIALTY CODE	33B	81(B3)		x	x		
630	BILLING PROVIDER STATE LICENSE NUMBER						x	
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER					x		
502	BILLING TYPE CODE				x	x		
15	CLAIM ADMINISTRATOR CLAIM NUMBER	11			x	x		
187	CLAIM ADMINISTRATOR FEIN				x	x		
188	CLAIM ADMINISTRATOR NAME				x	x		
515	CONTRACT TYPE CODE				x	x		
512	DATE INSURER PAID BILL				x			
511	DATE INSURER RECEIVED BILL				x			
510	DATE OF BILL	31	45(23)					
31	DATE OF INJURY	14	31					

California Medical Data Elements by Source								
DN	DATA ELEMENT NAME	CMS 1500	UB 04	IA	Payer	HCP	JLB	SNDR
108	DATE PROCESSED			X				x
100	DATE TRANSMISSION SENT			X				x
554	DAYS/UNIT(S) BILLED	24G	46					
553	DAYS/UNIT(S) CODE					x		
557	DIAGNOSIS POINTER	24 E						
514	DISCHARGE DATE		32-34					
562	DISPENSE AS WRITTEN CODE					x		
567	DME BILLING FREQUENCY CODE					x		
518	DRG CODE					x		
563	DRUG NAME					x		
572	DRUGS/SUPPLIES BILLED AMOUNT					x		
579	DRUGS/SUPPLIES DISPENSING FEE					x		
571	DRUGS/SUPPLIES NUMBER OF DAYS					x		
570	DRUGS/SUPPLIES QUANTITY DISPENSED					x		
116	ELEMENT ERROR NUMBER			x				x
115	ELEMENT NUMBER			x				x
152	EMPLOYEE EMPLOYMENT VISA	1a	60		x	x		
44	EMPLOYEE FIRST NAME	2	8					
153	EMPLOYEE GREEN CARD	1a	60		x	x		
43	EMPLOYEE LAST NAME	2	8					
45	EMPLOYEE MIDDLE NAME/INITIAL	2	8					
156	EMPLOYEE PASSPORT NUMBER	1a	60		x	x		
42	EMPLOYEE SOCIAL SECURITY NUMBER	1a	60		x	x		
504	FACILITY CODE		4(2-3)					
679	FACILITY FEIN	32b	5			x		
681	FACILITY MEDICARE NUMBER	32	51			x		
678	FACILITY NAME	32	1					
682	FACILITY NATIONAL PROVIDER ID	32a	51		x	x		
688	FACILITY POSTAL CODE	32	1					
680	FACILITY STATE LICENSE NUMBER	32b				x		
737	HCPCS BILL PROCEDURE CODE		74(a-e)					
714	HCPCS LINE PROCEDURE BILLED CODE	24D	44					
726	HCPCS LINE PROCEDURE PAID CODE				x			
717	HCPCS MODIFIER BILLED CODE	24D	44					
727	HCPCS MODIFIER PAID CODE				x			
626	HCPCS PRINCIPAL PROCEDURE BILLED CODE		74					
522	ICD-9 CM DIAGNOSIS CODE	21 1-4	67(A-Q)					
525	ICD-9 CM PRINCIPAL PROCEDURE CODE		74					

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

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

Medical data element requirement table

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

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

Specific requirements depend upon the type of transaction reported; original (00), cancel (01), or replacement (05). The transaction type is identified by the Bill Submission Reason Code (BSRC) (See Section M). 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 that makes a conditional data element mandatory.

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

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

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

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

MEDICAL DATA ELEMENT REQUIREMENT TABLE					
Bill Submission Reason Codes					
(Does not apply to medical lien lump sum payments or settlements)					
		Original	Cancellation	Replace	
DN	**Data Element Name**	**00**	**01**	**05**	**Mandatory Trigger**
727	HCPCS MODIFIER PAID CODE	C	O	O	If different from HCPCS Modifier Billed Code (DN717)
626	HCPCS PRINCIPAL PROCEDURE BILLED CODE	C	O	O	If Billing Format Code, (DN503), is "A" and the code value is not an ICD-9 code For surgical bills only
736	ICD_9 CM PROCEDURE CODE	C	O	O	If ICD-9 CM Principal Procedure Code (DN525) is present and more than one procedure is performed
522	ICD-9 CM DIAGNOSIS CODE	C	O	O	If Principal Diagnosis Code (DN521) is present and more than one diagnosis occurs or if Billing Code Format (DN503) = equals “B” and HCPCS Line Procedure Billed Code (DN714) or Jurisdiction Procedure Billed Code (DN715) is present or a drug is dispensed by a physician during an office visit
525	ICD-9 CM PRINCIPAL PROCEDURE CODE	C	O	O	If Billing Format Code, (DN503), is "A" and the code value is not a HCPCS code. For surgical bills only
6	INSURER FEIN	M	M	M	
7	INSURER NAME	M	O	O	
5	JURISDICTION CLAIM NUMBER	C	O	O	If the first report of injury has been filed and a jurisdiction claim number is available
718	JURISDICTION MODIFIER BILLED CODE	C	O	O	If the Jurisdiction Procedure Billed Code (DN715) is modified
730	JURISDICTION MODIFIER PAID CODE	C	O	O	If different from Jurisdiction Modifier Billed Code (DN718)
715	JURISDICTION PROCEDURE BILLED CODE	C	O	O	If the Jurisdiction Procedure Billed Code (DN715) is not a HCPCS procedure code
729	JURISDICTION PROCEDURE PAID CODE	C	O	O	If different from DN715
547	LINE NUMBER	M	O	O	
704	MANAGED CARE ORGANIZATION FEIN	C	O	O	For HCO claims, use the FEIN of the sponsoring organization
208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	O	O	O	
209	MANAGED CARE ORGANIZATION NAME	O	O	O	
712	MANAGED CARE ORGANIZATION POSTAL CODE	O	O	O	
721	NDC BILLED CODE	C	O	O	If a pharmaceutical bill or a drug is dispensed by a physician during an office visit

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

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

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

Section L: Data edits

California-adopted IAIABC data edits and error messages

The California adopted IAIABC data elements edit matrix provides the standard data edits and error codes the WCIS applies to the ANSI 837 EDI medical bill payment transmissions. The error codes will be transmitted back to each trading partner in the 824 acknowledgments. See the *IAIABC EDI Implementation Guides for Medical Bill Payment Records*, *Release 1.1, July 2009* for more information on the standard IAIABC edits.

CALIFORNIA-ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

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

CALIFORNIA-ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

	ERROR MESSAGES	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	033 Must be <= Date of injury	034 Must be >= Date of injury	039 No match on database	040 All digits cannot be the same	041 Must be <= Current date	058 Code/ID valid	063 Invalid Event Sequence/Relationship	073 Must be >= Date payer received bill	074 Must be >= From Service Date	075 Must be <= 'Thru Service date
DN	**DATA ELEMENT NAME**													
630	BILLING PROVIDER STATE LICENSE NUMBER			x										
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER			x										
502	BILLING TYPE CODE									x				
15	CLAIM ADMINISTRATOR CLAIM NUMBER			x			x							
187	CLAIM ADMINISTRATOR FEIN	x					x	x						
188	CLAIM ADMINISTRATOR NAME													
515	CONTRACT TYPE CODE									x				
512	DATE INSURER PAID BILL		x			x			x			x		
511	DATE INSURER RECEIVED BILL		x			x			x					
510	DATE OF BILL		x			x			x					
31	DATE OF INJURY		x						x					
108	DATE PROCESSED		x						x					
100	DATE TRANSMISSION SENT		x						x					
554	DAYS/UNITS BILLED	x												
553	DAYS/UNITS CODE									x				
557	DIAGNOSIS POINTER	x												
514	DISCHARGE DATE		x			x			x					
562	DISPENSE AS WRITTEN CODE									x				
567	DME BILLING FREQUENCY CODE									x				
518	DRG CODE									x				
563	DRUG NAME													
572	DRUGS/SUPPLIES BILLED AMOUNT	x												
579	DRUGS/SUPPLIES DISPENSING FEE	x												
571	DRUGS/SUPPLIES NUMBER OF DAYS	x												
570	DRUGS/SUPPLIES QUANTITY DISPENSED	x												

CALIFORNIA-ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

	ERROR MESSAGES	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	033 Must be <= Date of injury	034 Must be >= Date of injury	039 No match on database	040 All digits cannot be the same	041 Must be <= Current date	058 Code/ID valid	063 Invalid Event Sequence/Relationship	073 Must be >= Date payer received bill	074 Must be >= From Service Date	075 Must be <= 'Thru Service date
DN	**DATA ELEMENT NAME**													
116	ELEMENT ERROR NUMBER									x				
115	ELEMENT NUMBER									x				
152	EMPLOYEE EMPLOYMENT VISA			x										
44	EMPLOYEE FIRST NAME													
43	EMPLOYEE LAST NAME													
45	EMPLOYEE MIDDLE NAME													
153	EMPLOYEE GREEN CARD			x										
156	EMPLOYEE PASSPORT NUMBER			x										
42	EMPLOYEE SOCIAL SECURITY NUMBER	x												
504	FACILITY CODE									x				
679	FACILITY FEIN	x						x						
681	FACILITY MEDICARE NUMBER			x				x						
678	FACILITY NAME													
682	FACILITY NATIONAL PROVIDER ID			x						x				
688	FACILITY POSTAL CODE									x				
680	FACILITY STATE LICENSE NUMBER			x				x						
737	HCPCS BILL PROCEDURE CODE									x				
714	HCPCS LINE PROCEDURE BILLED CODE									x				
726	HCPCS LINE PROCEDURE PAID CODE									x				
717	HCPCS MODIFIER BILLED CODE									x				
727	HCPCS MODIFIER PAID CODE									x				
626	HCPCS PRINCIPAL PROCEDURE BILLED CODE									x				
522	ICD_9 CM DIAGNOSIS CODE									x				
525	ICD_9 CM PRINCIPAL PROCEDURE CODE									x				
736	ICD_9 CM PROCEDURE CODE									x				

CALIFORNIA-ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

DN	DATA ELEMENT NAME	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	033 Must be <= Date of injury	034 Must be >= Date of injury	039 No match on database	040 All digits cannot be the same	041 Must be <= Current date	058 Code/ID valid	063 Invalid Event Sequence/Relationship	073 Must be >= Date payer received bill	074 Must be >= From Service Date	075 Must be <= 'Thru Service date
6	INSURER FEIN	x					x	x						
7	INSURER NAME													
105	INTERCHANGE VERSION ID									x				
5	JURISDICTION CLAIM NUMBER			x										
718	JURISDICTION MODIFIER BILLED CODE									x				
730	JURISDICTION MODIFIER PAID CODE									x				
715	JURISDICTION PROCEDURE BILLED CODE									x				
729	JURISDICTION PROCEDURE PAID CODE									x				
547	LINE NUMBER	x												
704	MANAGED CARE ORGANIZATION FEIN	x						x						
208	MANAGED CARE ORGANIZATION ID NUMBER			x										
209	MANAGED CARE ORGANIZATION NAME													
712	MANAGED CARE ORGANIZATION POSTAL CODE									x				
721	NDC BILLED CODE									x				
728	NDC PAID CODE									x				
102	ORIGINAL TRANSMISSION DATE		x						x					
103	ORIGINAL TRANSMISSION TIME	x												
555	PLACE OF SERVICE BILL CODE									x				
600	PLACE OF SERVICE LINE CODE									x				
527	PRESCRIPTION BILL DATE		x			x			x					
604	PRESCRIPTION LINE DATE		x			x			x					
561	PRESCRIPTION LINE NUMBER			x										
521	PRINCIPAL DIAGNOSIS CODE									x				
550	PRINCIPAL PROCEDURE DATE		x			x			x					

CALIFORNIA-ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

	ERROR MESSAGES	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	033 Must be <= Date of injury	034 Must be >= Date of injury	039 No match on database	040 All digits cannot be the same	041 Must be <= Current date	058 Code/ID valid	063 Invalid Event Sequence/Relationship	073 Must be >= Date payer received bill	074 Must be >= From Service Date	075 Must be <= 'Thru Service date
DN	**DATA ELEMENT NAME**													
524	PROCEDURE DATE		x			x			x				x	x
507	PROVIDER AGREEMENT CODE									x				
99	RECEIVER ID									x				
699	REFERRING PROVIDER NATIONAL PROVIDER ID			x						x				
526	RELEASE OF INFORMATION CODE									x				
642	RENDERING BILL PROVIDER FEIN	x						x						
638	RENDERING BILL PROVIDER LAST/GROUP NAME													
647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID			x						x				
656	RENDERING BILL PROVIDER POSTAL CODE									x				
657	RENDERING BILL PROVIDER COUNTRY CODE									x				
651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE									x				
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER			x										
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER			x										
592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID			x						x				
586	RENDERING LINE PROVIDER FEIN	x						x						
589	RENDERING LINE PROVIDER LAST/GROUP NAME													
593	RENDERING LINE PROVIDER POSTAL CODE									x				
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE									x				
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER			x										
615	REPORTING PERIOD		x						x					
559	REVENUE BILLED CODE									x				
576	REVENUE PAID CODE									x				
98	SENDER ID									x				

CALIFORNIA-ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES															
	ERROR MESSAGES	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	033 Must be <= Date of injury	034 Must be >= Date of injury	039 No match on database	040 All digits cannot be the same	041 Must be <= Current date	058 Code/ID valid	063 Invalid Event Sequence/Relationship	073 Must be >= Date payer received bill	074 Must be >= From Service Date	075 Must be <= 'Thru Service date
DN	**DATA ELEMENT NAME**													
733	SERVICE ADJUSTMENT AMOUNT	x												
731	SERVICE ADJUSTMENT GROUP CODE									x				
732	SERVICE ADJUSTMENT REASON CODE									x				
734	SERVICE ADJUSTMENT UNITS	x												
509	SERVICE BILL DATE(S) RANGE		x			x			x					
605	SERVICE LINE DATE(S) RANGE		x			x			x					
667	SUPERVISING PROVIDER NATIONAL PROVIDER ID			x						x				
104	TEST/PRODUCTION INDICATOR									x				
109	TIME PROCESSED	x												
101	TIME TRANSMISSION SENT	x												
516	TOTAL AMOUNT PAID PER BILL	x												
574	TOTAL AMOUNT PAID PER LINE	x												
501	TOTAL CHARGE PER BILL	x												
566	TOTAL CHARGE PER LINE - PURCHASE	x												
565	TOTAL CHARGE PER LINE - RENTAL	x												
552	TOTAL CHARGE PER LINE	x												
266	TRANSACTION TRACKING NUMBER	x												
500	UNIQUE BILL ID NUMBER			x										

Section M: System specifications

Agency claim number/Jurisdiction claim number (JCN)

The Agency Claim Number (DN5) is most often referred to as the Jurisdiction Claim Number (JCN). The JCN is 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. Before the WCIS system was revised in 2004, the original system created a 12-digit JCN. The revised system is backward compatible and will continue to accept the 12-digit JCN for claims originally reported to the old system. All new claims reported to the revised system will receive a 22-digit JCN.

The JCN is a conditional data element for the medical data requirements (See Section K) and is used to match medical bills to the WCIS FROI database. When a JCN is not available, the claim administrator claim number (DN15) and insurer FEIN (DN6) will be utilized to match claims in the WCIS database in place of the JCN.

Transaction processing and sequencing

Bill submission reason codes (BSRC) are used to define the specific purpose of a transmission. The DWC/WCIS only accepts three BSRC: 00, 01 and 05. The codes are grouped in the following tables to clarify their purpose and to demonstrate a logical order for use.

The bill submission reason code used to report the initial medical bill payment report sent to WCIS is BSRC = 00.

BSRC code	BSRC name
00	Original

After the initial medical bill payment report has been filed, the following medical bill payment report bill submission reason codes can be submitted to reflect cancellations or replacements. The originals of all corrected medical bill payment records previously accepted are canceled utilizing BSRC = 01. All corrected medical bill reports should be reported immediately. Replacement medical bill payment report transmissions that inform the WCIS of a change in DN15 --- Claim Administrator Claim Number -- should be transmitted utilizing BSRC = 05. All replacement medical bill reports should be reported immediately.

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

The DWC/WCIS utilizes DN111, Application Acknowledgment Code (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	AAC meaning
TA	Transaction accepted
TR	Transaction rejected
TE	Transaction accepted with errors (only for unmatched transactions on the FROI database)
BA	Batch Accepted
BR	Batch Rejected

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

WCIS regulations require each claims administrator to submit to the WCIS any corrected data elements. When re-submitting a corrected transmission (BSRC=00) in response to a transaction rejected (TR), the sender must report all medical bill payment data elements, not just the data elements being corrected (See Section K). The following five steps outline the procedure:

1. Sender transmits original bill, including all lines, utilizing a BSRC "00".
2. DWC/WCIS sends a 997 and a “TR” 824 acknowledgment 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. DWC/WCIS sends a 997 and a “TA” 824 acknowledgment to sender.

Updating data elements (BSRC=01)(AAC=TA)

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

1. Sender transmits original bill, including all lines, utilizing a BSRC "00".
2. DWC/WCIS sends a 997 and a “TA” 824 acknowledgment 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. DWC/WCIS sends a 997 and a “TA” 824 acknowledgment to sender.
6. Sender transmits the updated bill, including all lines, as a BSRC "00". *
7. DWC/WCIS sends a 997 and “TA” 824 acknowledgment to sender.

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

Replacing a Claim Administrator Claim Number (BSRC=05)(AAC=TA)

Replacement reports (BSRC=05) are sent to WCIS indicating a change in the claim administrator claim number (DN15) (See Section J). The replacement transmission (BSRC=05) may or may not be sent in response to an 824 acknowledgment containing error messages (TE) 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 K). The following four steps outline the procedure:

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

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

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

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

Matching transmissions, transactions and duplicate medical bills

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

Inbound 837 transmissions are matched to outbound 824 transmissions utilizing the DN98 (Sender ID), DN100 (Date transmission sent), and DN101 (Time transmission sent) from the inbound 837 to the DN99 (Receiver ID), DN102 (Original date transmission sent), and DN103 (Original time transmission sent) in the outbound 824. The DWC\WCIS requires each sender to utilize a standard format of HHMM for DN101 (Time transmission sent) in the BHT segment of the 837. The DN101 (Time transmission sent) in the BHT segment(s) of the 837 must be identical to the time in the ISA10 interchange time and GS05 Time in the 837 headers where the standard format is HHMM.

Bill-level duplicates occur when the information on the claim administrator FEIN, claim administrator claim number, unique bill identification number, and line numbers in a ST-SE transaction set are repeated. The DWC will check for duplicate bills in all ST-SE transaction sets included in each X12 interchange envelope (ISA-IEA interchange). The DWC also checks each bill for duplicates against the entire database. Duplicate medical bills that are not correctly coded with the appropriate claim adjustment reason code (18, or B13) will cause an error (See Section G). The DWC will transmit a 057_duplicate transmission error code with the unique bill id number in the bad data field of the matching 824 acknowledgement.

WCIS medical matching rules and processes for a claim

Primary:

1. Jurisdiction claim number (JCN)

Secondary match for medical bill payment reports to the FROI:

2. Claim administrator claim number
   Insurer FEIN

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

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

Unmatched Transactions (AAC=TE)

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

1. The DWC retains the transmission and continuously searches for a match (FROI).
2. If no matching FROI is found, the DWC will send an 824 acknowledgment indicating the transaction was accepted with errors (TE). The error code will be 039 (no match on database) when the Claim Administrator Claim Number (DN15) and Insurer FEIN (DN6) cannot be matched
3. The DWC continues to retain the transmission and continues to search for a matching (FROI).

Section N: Code lists and state license numbers

Code sources

This section provides information on where to obtain source codes and current valid codes for several data elements. These valid code lists are provided as a convenience for our data providers, and are intended to be a simple repetition of code lists available elsewhere.

Rendering bill provider country code – DN657

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

Postal code

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

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

Healthcare financing administration common procedural coding system (HCPCS)

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

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

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

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

Source: International Classification of Diseases, Ninth Revision, Clinical Modification

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

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

Current procedural terminology (CPT) codes

Source: Physicians' Current Procedural Terminology (CPT) Manual
Available at:

Order Department
American Medical Association
515 North State Street
Chicago, IL 60610

https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?childName=nochildcat&parentCategory=cat220008&productId=prod240142&categoryName=Data+Files&start=1&parentId=cat220008
Abstract:
Current Procedural Terminology (CPT) codes are the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs.

National drug code (NDC)

Source: Master Drug Database v 2.5.

Available at:

Wolters Kluwer Health – Medi-Span
8425 Woodfield Crossing Blvd., Ste 490
Indianapolis, IN 46240

http://www.fda.gov/cder/ndc/
Abstract:
The National Drug Code (NDC) is a coding convention established by the Food and Drug Administration (FDA) to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

Diagnosis related groups (DRG)

Source: Federal Register and Health Insurance Manual 15 (HIM 15)
Available at:
Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402
http://www.ahd.com/drgs.html

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

Provider taxonomy codes

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

Facility/Place of service codes

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

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

Revenue billed/paid code

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

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

Claim adjustment group codes

Source: *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009.*
Available at: http://www.iaiabc.org

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

Claim adjustment reason codes

Source: *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009.*
Available at: http://www.iaiabc.org

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

California state medical license numbers

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

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

National plan and provider enumeration system

Source: Centers for Medicare and Medicaid Services

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

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

Section O: Lump sum bundled lien bill payment

California law allows the filing of a lien against any sum to be paid as compensation for the "reasonable expense incurred by or on behalf of the injured employee" for medical treatment (see Labor Code section 4903 and 4903.1). The DWC\WCIS has adopted IAIABC medical lien codes as the standard for reporting bundled lump sum medical bills (See 8 C.C.R. § 9702(e)). The six codes below, describe the type of Medical Lien Lump Sum Payments or Settlements made by the claims payer after the filing of a lien with the Workers' Compensation Appeals Board (WCAB). Reportable lump sum medical liens originate from medical bills filed on DWC WCAB Form 6. The medical lien form is located at http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCForm6.pdf

Code	Description
MDS10	Lump sum settlement for multiple bills where the amount of reimbursement is in dispute between the claims payer and the healthcare provider.
MDO10	Final order or award of the Workers' Compensation Appeals Board requires a lump sum payment for multiple bills where the amount of reimbursement is in dispute between the claims payer and the healthcare provider
MDS11	Lump sum settlement for multiple bills where liability for a claim was denied but finally accepted by the claims payer
MDO11	Final order or award of the Workers' Compensation Appeals Board requires a lump sum payment for multiple bills where claims payer is found to be liable for a claim which it had denied liability.
MDS21	Lump sum settlement for a single medical bill where the amount of reimbursement is in dispute between the claims payer and the healthcare provider.
MDO21	Final order or award of the Workers' Compensation Appeals Board requires a lump sum payment for a single medical bill where the amount of reimbursement is in dispute between the claims payer and the healthcare provider

Medical bill reporting process bundled lump sum medical bills

1. Sender transmits all original disputed medical bill(s), including all lines, utilizing a BSRC "00".
2. The DWC sends a 997 "A" and a "TA" 824 acknowledgement to sender.
3. Sender changes the value of data elements (Lien Settlement amount) on the original bill(s) submitted in step 1.
4. Sender transmits the updated bill (Lien Settlement), with all individual lines on all bills bundled as one medical lien lump sum payment or settlement, as a BSRC "00".
5. DWC sends a 997 "A" and a "TA" 824 acknowledgement to sender.

Medical lien lump sum data requirements

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

Appendix A: Major changes in the medical implementation guide

List of changes from version 1.0 to version 1.1 by section

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

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

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

Section D: No Change

Section E: No Change

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

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

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

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

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

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

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

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

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

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

Added new Section O: Lump sum bundled lien bill payment

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

Section Q: Deleted the Medical EDI glossary and acronyms

Section R: Deleted the Standard Medical Forms.

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