

California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide

Version ~~1.0~~ ~~1.1~~ 1.2
2012



Preface

Purpose of the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide

This guide has been adopted in Title 8, California Code of Regulations section 9792.5.1 as part of the Division of Workers' Compensation billing regulations. It has been created for use in conjunction with the national electronic standards of the Accredited Standards Committee (ASC X12), Technical Reports Type 3 (and all related errata), and the National Council for Prescription Drug Programs (NCPDP) which have been adopted by the U.S. Secretary of Health and Human Services for use pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specified ASC X12 and NCPDP electronic standards have been incorporated by reference into this guide. The standards are copyrighted by the Data Interchange Standards Association (DISA) on behalf of ASC X12 and by the NCPDP, respectively, and must be purchased for use in workers' compensation electronic billing. (See Section 2.2.2 for addresses.)

The California Electronic Medical Billing and Payment Companion Guide is not to be a replacement for the national standard ASCX12 Technical Reports Type 3 and NCPDP implementation guides but rather is to be used as a supplement to the national technical reports and guides. This companion guide supplements the national standards by providing clarifications and specialized instructions derived from specific business rules that apply to processing bills and payments electronically within California's workers' compensation system.

The national standard electronic transaction guides referenced in this guide include the documents listed below.

Standards published and copyrighted by the Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N (shortened titles in parentheses):

- ASC X12N/005010X222 Health Care Claim: Professional (837)
(005010X222 or Health Care Claim: Professional)
 - o ASC X12N/005010X222E1 Health Care Claim: Professional (837)
 - o ASC X12N/005010X222A1 Health Care Claim: Professional (837)
- ASC X12N/005010X223 Health Care Claim: Institutional (837)
(005010X223 or Health Care Claim: Institutional)
 - o ASC X12N/005010X223A1 Health Care Claim: Institutional (837)
 - o ASC X12N/005010X223E1 Health Care Claim: Institutional (837)
 - o ASC X12N/005010X223A2 Health Care Claim: Institutional (837)
- ASC X12N/005010X224 Health Care Claim: Dental (837)
(005010X224 or Health Care Claim: Dental)
 - o ASC X12N/005010X224A1 Health Care Claim: Dental (837)
 - o ASC X12N/005010X224E1 Health Care Claim: Dental (837)
 - o ASC X12N/005010X224A2 Health Care Claim: Dental (837)

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- ASC X12N/005010X221 Health Care Claim Payment/Advice (835)
(005010X221 or Health Care Claim Payment/Advice)
 - o ASC X12N/005010X221E1 Health Care Claim Payment/Advice (835)
 - o ASC X12N/005010X221A1 Health Care Claim Payment/Advice (835)
- ASC X12N/005010X214 Health Care Claim Acknowledgment (277)
(005010X214 or Health Care Claim Acknowledgment)
 - o ASC X12N/005010X214A1 Health Care Claim Acknowledgment (277)
 - o ASC X12N/005010X214E1 Health Care Claim Acknowledgment (277)
 - o ASC X12N/005010X214E2 Health Care Claim Acknowledgment (277)
- ASC X12N/005010X213 Health Care Claim Request for Additional Information (277)
(005010X213 or Health Care Claim Request for Additional Information)
 - o ASC X12N/005010X213E1 Health Care Claim Request for Additional Information (277)
 - o ASC X12N/005010X213E2 Health Care Claim Request for Additional Information (277)
- ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275)
(005010X210 or Additional Information to Support a Health Care Claim or Encounter)
 - o ASC X12N/005010X210E1 Additional Information to Support a Health Care Claim or Encounter (275)
- ASC X12N/005010X212 Health Care Claim Status Request and Response (276/277)
(005010X212 or Health Care Claim Status Request and Response)
 - o ASC X12N/005010X212E1 Health Care Claim Status Request and Response (276/277)
 - o ASC X12N/005010X212E2 Health Care Claim Status Request and Response (276/277)

Standards published and copyrighted by the Accredited Standards Committee X12, Communications and Control Subcommittee, ASC X12C (shortened titles in parentheses):

- ASC X12C/005010X231 Implementation Acknowledgment (999)
(005010X231 or Implementation Acknowledgment)
 - o ASC X12N/005010X231A1 Implementation Acknowledgment (999)

Standards published and copyrighted by the National Council on Prescription Drug Programs:

- NCPDP Telecommunication Standard Implementation Guide D.0
- NCPDP Batch Standard Implementation Guide 1.2

Other Important Billing Rules

Proposed February 2013 (8 CCR § 9792.5.1(b))

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Other important billing rules are contained in:

The California Division of Workers' Compensation Medical Billing and Payment Guide

Billing Regulations: Title 8, California Code of Regulations section 9792.5.0 et seq.

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California Companion Guide Contact Information

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<http://www.dir.ca.gov/dwc/MedicalUnit/imchp.html>

Documentation Change Control

The Companion Guide content is subject to change.

Documentation change control is maintained in this document through the use of the Change Control Table shown below. Each change made to this companion guide after the creation date is noted along with the date and reason for the change.

Change Control Table			
Date	Page(s)	Change	Reason
01/01/2013	Throughout Document	See Rulemaking Documents: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/IBR_Regs.htm	See Rulemaking Documents: Initial Statement of Reasons and Final Statement of Reasons: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/IBR_Regs.htm

Methodology for Updating Companion Guide Document

Please contact the Division of Workers' Compensation Medical Unit at the above address/phone number regarding instructions for submitting change requests, recommendations, and document updates. Changes to this Companion Guide will be made through formal rulemaking in accordance with California Labor Code §§5307.3, 5307.4 and the Administrative Procedure Act, California Government Code §11340 et seq.

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Chapter 1 Introduction and Overview

1.1 HIPAA

The Administrative Simplification Act provisions of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) include requirements that national standards for electronic health care transactions and national identifiers for Health Care Providers (Provider), Health Plans, and Employers be established by the Secretary of the Department of Health and Human Services. These standards were adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. HIPAA does not apply to workers' compensation matters because the federal statute exempts workers' compensation from its coverage. However, the California Legislature has directed workers' compensation electronic billing standards be consistent with HIPAA where feasible. Additional information regarding the formats adopted under HIPAA is included in Chapter 2.

1.2 California Labor Code § 4603.4

California Labor Code § 4603.4 mandates that California employers accept electronic bills for medical goods and services. Electronic billing is optional for medical providers and health facilities. The statute provides that the regulations which establish electronic billing rules be consistent with HIPAA to the extent feasible. The health care provider, health care facility, or billing agent/assignee shall use the HIPAA adopted ASC X12N/005010X222 Health Care Claim: Professional (837), ASC X12N/005010X223 Health Care Claim: Institutional (837) or ASC X12N/005010X224 Health Care Claim: Dental (837) electronic transaction formats to submit medical bill transactions or the NCPDP Telecommunication D.0 and NCPDP Batch Standard 1.2 to submit pharmacy bill transactions to the appropriate claims administrator associated with the employer of the injured employee to whom the services are provided.

In workers' compensation, the payer is the Claims Administrator providing coverage for the employer of the injured employee to whom the services are provided. The Claims Administrator, or its authorized agent, is to validate the Electronic Data Interchange (EDI) file according to the guidelines provided in the prescribed national standard format (the Technical Report Type 3 or NCPDP Implementation Guide), this companion guide, and the jurisdiction data requirements. Problems associated with the processing of the EDI file are to be reported using acknowledgment transactions specified in this companion guide. Problems associated with the processing of the NCPDP Telecommunications D.0 bills are reported via the reject response transactions described in this companion guide. The Claims Administrator will use the HIPAA adopted electronic transaction formats to report an explanation of payments, reductions, and denial to the health care provider, health care facility, or billing agent/assignee. These include the ASC X12N/005010X221 Health Care Claim Payment/Advice (835) and the NCPDP Telecommunication D.0 paid response transaction.

Health care providers, health care facilities, or billing agent/assignees, claims administrators, clearinghouses, or other electronic data submission entities shall use this guideline in conjunction with HIPAA adopted ASC X12N Type 3 Technical Reports (TR3s), the NCPDP Telecommunication D.0, the NCPDP Batch Standard 1.2 and other specified national implementation guides. The ASC X12N TR3s can be accessed by contacting the ~~Data Interchange Standards Association (DIA)~~ Accredited Standards Committee (ASC) X12 at <http://store.x12.org>. The NCPDP Telecommunication D.0 and Batch Standard 1.2 are available from NCPDP at www.ncdp.org.

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This guide is to be used in conjunction with the national standard ASCX12 Technical Reports Type 3 and NCPDP Implementation Guides and specifies clarifications where necessary to adapt the national standards for use in the California workers' compensation system.

When coordination of a solution is required, the California Division of Workers' Compensation works with the International Association of Industrial Accident Boards and Commissions (IAIABC) EDI Medical Committee and Provider to Payer Subcommittee to coordinate with national standard setting organizations and committees to address workers' compensation needs.

Chapter 2 California Workers' Compensation Requirements

2.1 Compliance

California Labor Code § 4603.4 (a) (2) requires claims administrators to accept electronic submission of medical bills. Claims administrators must be able to accept electronic medical bills and adhere to the requirements of this guide by October 18, 2012. The entity submitting the bill has the option of submitting bills on paper or electronically.

If an entity chooses to submit bills electronically it must be able to receive an electronic response from the claims administrator. This includes electronic acknowledgements and electronic remittance advice (Explanation of Review).

Electronic billing rules allow for providers and claims administrators to utilize agents to accomplish the requirement of electronic billing, but these rules do not mandate the method of connectivity; the use of, or connectivity to, clearinghouses or similar types of vendors.

Nothing in this document prevents the parties from utilizing Electronic Funds Transfer (EFT) to facilitate payment of electronically submitted bills. Use of EFT is optional, but encouraged by the Division. EFT is not a pre-condition for electronic billing.

Health care providers, health care facilities, billing agent/assignees choosing to engage in electronic billing and claims administrators must be able to exchange electronic medical bills in the prescribed standard formats and may exchange data in non-prescribed formats by mutual agreement. All data elements required in the prescribed formats must be present in a mutually agreed upon format.

2.1.2 Agents

Electronic billing rules allow for use of agents to accomplish the requirements of electronic billing.

Entities using agents are responsible for the acts or omissions of those agents executed in the performance of services for the entity.

2.1.3 Confidentiality of Medical Information Submitted on Electronic Claims/ Security

Health care providers, health care facilities, billing agent/assignees, claims administrators, and their agents must comply with all applicable Federal and State rules related to security of confidential medical data. Refer to the Appendix D, Security Rule, regarding specific security requirements for electronically maintained or transmitted confidential health information. The Security Rules in Appendix D parallel the HIPAA security rules and are modified only to conform to the workers' compensation environment.

2.2 National Standard Formats

The national standard formats for billing and remittance adopted by the federal Department of Health and Human Services HIPAA rules are specified in 45 CFR Part 162. The formats adopted under California Labor Code § 4603.4 that are aligned with the current federal HIPAA implementation include:

- ASC X12N/005010X222 Health Care Claim: Professional (837) and related errata;
- ASC X12N/005010X223 Health Care Claim: Institutional (837) and related errata;

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- ASC X12N/005010X224 Health Care Claim: Dental (837) and related errata;
- ASC X12N/005010X221 Health Care Claim Payment/Advice (835) and related errata;
- NCPDP Telecommunication Standard Implementation Guide D.0; and
- NCPDP Batch Standard Implementation Guide 1.2

Other national standards formats adopted pursuant to California Labor Code § 4603.4 or suggested for optional use, ~~which are not HIPAA standards but are~~ that are based on national ASCX12 standards, include:

- ASCX12/005010 TA1 Acknowledgment (used to communicate the syntactical analysis of the interchange header and trailer)
- ASC X12C/005010X231 Implementation Acknowledgment (999) (used to communicate acceptance or rejection of a functional group within an interchange)
- ASC X12N/005010X214 Health Care Claim Acknowledgment (277) (used to communicate acceptance or rejection of a bill transaction, and to communicate that the bill has been put into pending status)
- ASC X12N/005010X213 Health Care Claim Request for Additional Information (277) (may be used to request additional attachments that were not originally submitted with the electronic medical bill and that are needed to process the payment)
- ASC X12N/005010X212 Health Care Claim Status Request and Response (276/277) (may be used by the bill submitter to inquire about the current status of a specified bill or bills) (a HIPAA standard)
- ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) (may be used to transmit electronic documentation associated with an electronic medical bill; may accompany the original electronic medical bill, or be in response to a 005010X213 Request for Additional Information)

The NCPDP Telecommunication Standard Version D.0 and the NCPDP Batch Standard Implementation Guide 1.2 contain the corresponding acknowledgment and error messages to be used for NCPDP transactions.

2.2.1 California Prescribed and Optional Formats

For electronic transactions on or after October 18, 2012, the Division incorporates by reference and adopts the electronic standards set forth below, as the mandatory transaction standards for electronic billing, acknowledgment, remittance and documentation, except that standards identified as optional are recommended rather than mandatory. In this Companion Guide, reference to an ASC X12/005010 Technical Report Type 3 includes reference to the related errata unless otherwise specified.

The Division has adopted HIPAA – compliant standards wherever feasible.

(1) Billing:

(a) Professional Billing:

ASC X12N/005010X222

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim: Professional (837)

MAY 2006

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ASC X12N/005010X222E1

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim: Professional (837)

Errata

JANUARY 2009

ASC X12N/005010X222A1

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim: Professional (837)

Errata

June 2010

(b) Institutional/Hospital Billing:

ASC X12N/005010X223

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim: Institutional (837)

MAY 2006

ASC X12N/005010X223A1

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim: Institutional (837)

Errata Type 1

OCTOBER 2007

ASC X12N/005010X223E1

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim: Institutional (837)

Errata

JANUARY 2009

ASC X12N/005010X223A2

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim: Institutional (837)

Type 1 Errata

June 2010

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(c) Dental Billing:

ASC X12N/005010X224

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim: Dental (837)

MAY 2006

ASC X12N/005010X224A1

Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim: Dental (837)

Errata Type 1

OCTOBER 2007

ASC X12N/005010X224E1

Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim: Dental (837)

Errata

JANUARY 2009

ASC X12N/005010X224A2

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim: Dental (837)

Errata

June 2010

(d) Retail Pharmacy Billing:

(i) The Telecommunication Standard Implementation Guide, Version D, Release 1.0 (Version D.0), August 2007, National Council for Prescription Drug Programs.

(ii) The Batch Standard Implementation Guide, Version 1, Release 2 (Version 1.2), January 2006, supporting Telecommunication Standard Implementation Guide, Version D, Release 0) (Version D.0) for the NCPDP Data Record in the Detail Data Record, National Council for Prescription Drug Programs.

(2) Acknowledgment:

(a) Electronic responses to ASC X12N 837 transactions:

(i) The ASC X12C/005010 TA1 Interchange Acknowledgment contained in the adopted 005010X231

(ii) ASC X12C/005010X231

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Implementation Acknowledgment for Health Care Insurance (999)

June 2007

ASC X12C/005010X231A1

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Implementation Acknowledgment for Health Care Insurance (999)

June 2010

(iii) ASC X12N/005010X214

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim Acknowledgment (277)

JANUARY 2007

ASC X12N/0050X214E1

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim Acknowledgment (277)

April 2008

ASC X12N/0050X214E2

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim Acknowledgment (277)

January 2009

(b) Electronic responses to NCPDP Pharmacy transactions:

The Responses contained in the adopted NCPDP Telecommunication Standard Implementation Guide Version D.0 and the Batch Standard Implementation Guide, Version 1, Release 2 (Version 1.2), January 2000.

(3) Remittance:

ASC X12N/005010X221
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Payment/Advice (835)
APRIL 2006

ASC X12N/005010X221E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Payment/Advice (835)
Errata
JANUARY 2009

ASC X12N/005010X221A1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Payment/Advice (835)
Errata
June 2010

(4) Documentation / Attachments to Support a Claim:

(a) Additional Information to Support a Health Care Claim [Optional]

ASC X12N/005010X210
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Additional Information to Support a Health Care Claim (275)
February 2008

ASC X12N/005010X210E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Additional Information to Support a Health Care Claim (275)
Errata
January 2009

(b) Request for Additional Information [Optional]:

ASC X12N/005010X213

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim Request for Additional Information (277)

July 2007

ASC X12N/005010X213E1

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim Request for Additional Information (277)

Errata

April 2008

ASC X12N/005010X213E2

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim Request for Additional Information (277)

Errata

January 2009

(5) Communication Requesting Claims Status and Response [Optional]:

ASC X12N/005010X212

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim Status Request and Response (276/277)

August 2006

ASC X12N/005010X212E1

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim Status Request and Response (276/277)

Errata

April 2008

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ASC X12N/005010X212E2

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim Status Request and Response (276/277)

Errata

January 2009

2.2.2 Source of Prescribed Formats

All ASC X12 transaction standards /Technical Report Type 3 documents can be purchased from:

~~Data Interchange Standards Association (DISA)~~ Accredited Standards Committee (ASC)
X12 at: <http://store.x12.org>

NCPDP Telecommunication Standard Implementation Guide and Batch Standard Implementation Guide can be purchased from:

National Council for Prescription Drug Programs, Inc. (NCPDP)
9240 E. Raintree Dr.
Scottsdale, Arizona 85260-7518
(480) 477-1000
(480) 767-1042 - Fax

Or on the Internet at www.ncdp.org

2.2.3 Summary of Adopted Formats and Correlation to Paper Form

Format	Corresponding Paper Form	Function
005010X222	CMS-1500	Professional Billing
05010X223	UB-04	Institutional/Hospital Billing
005010X224	ADA-2006	Dental Billing
NCPDP D.0	NCPDP WC/PC UCF	Pharmacy Billing
NCPDP Batch 1.2	NCPDP WC/PC UCF	Pharmacy Billing
005010X221	None	Explanation of Review (EOR)
TA1 005010	None	Interchange Acknowledgement
005010X231	None	Implementation Acknowledgment for Health Care Insurance
005010X214	None	Health Care Claim Acknowledgment

2.2.4 Optional Formats

Other formats identified as optional are used in ancillary processes related to electronic billing and reimbursement. The use of these formats is voluntary and the companion guide is presented as a tool to facilitate their use in workers' compensation.

Format	Corresponding Process	Function
005010X210	Documentation/Attachments	Submit documentation to support bill
005010X213	Request for Additional Information	Request for Additional Information
<u>005010X212</u>	<u>Health Care Claim Status Request and Response</u>	<u>Medical Bill Status Request and Response</u>

2.3 Companion Guide Usage

California workers' compensation implementation of the national standard formats aligns with HIPAA usage and requirements in most circumstances. This Companion Guide is intended to convey information

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that is within the framework of the ASC X12N Technical Reports Type 3 (TR3s) and NCPDP Telecommunication Standard Version D.0 Implementation Guide and NCPDP Batch Standard 1.2 adopted for use. The Companion Guides are not intended to convey information that in any way exceeds the requirements or usages of data expressed in the ASC X12 Technical Reports Type 3 (TR3s) or NCPDP Telecommunication Standard Version D.0 Implementation Guide. The Companion Guide supplements the implementation guides by providing additional instruction on situational implementation factors that are different in workers' compensation than the HIPAA implementation.

Detailed information explaining the various components of the use of loops, segments, data elements, and conditions can be found in the appropriate ASC X12N Technical Reports Type 3.

The ASC X12N Technical Reports Type 3 (TR3s) also include elements that do not relate directly to workers' compensation processes, for example, coordination of benefits. If necessary, the identification of these loops, segments and data elements can be described in the trading partner agreements to help ensure efficient processing of standard transaction sets.

2.4 Description of ASC X12 Transaction Identification Numbers

The ASC X12 Transaction Identification requirements are defined in the appropriate ASC X12 Technical Reports Type 3 (TR3s), available through the ~~Data Interchange Standards Association (DISA)~~ Accredited Standards Committee (ASC) X12 at: <http://store.x12.org>. The Division provides the following additional information regarding transaction identification number requirements:

2.4.1. Submitter/Receiver Trading Partner Identification

Workers' compensation standards require the use of the Federal Employer Identification Number (FEIN) or other mutually agreed upon identification numbers to identify Trading Partners (submitter /receiver) in electronic billing and reimbursement transmissions. Trading Partners will exchange the appropriate and necessary identification numbers to be reported based on the applicable transaction format requirements. ~~The submitter and receiver Trading Partner Identification Number (ETIN) requirements are defined in the appropriate ASC X12 Technical Reports Type 3 (TR3s) available through the Data Interchange Standards Association (DISA) at: <http://store.x12.org>.~~

2.4.2 Claims Administrator Identification

Claims Administrators, and their agents, are also identified through the use of the FEIN or other mutually agreed upon identification number. Claims administrator information is available through direct contact with the claims administrator. For 005010X222, 005010X223 and 005010X224 transactions, the Claim Administrator Identification information is populated in Loop 2010BB (Payer Information).

Health care providers will need to obtain payer identification information from their connectivity trading partner agent (i.e. clearinghouses, practice management system, billing agent and or other third party vendor) if they are not directly connecting to a claims administrator.

2.4.3 Health Care Provider Identification

Health Care Providers and Health Care Facilities are required to use the National Provider Identification number (NPI). If the provider or facility does not have an NPI, then the provider or facility must use his/her/its state license number.

2.4.4 Injured Employee Identification ~~(Member ID Number)~~

In California workers' compensation billing, the ~~The~~ injured employee is identified by Social Security Number, date of birth, date of injury and workers' compensation claim number (see below). ~~Social Security Number (SSN) fields are required in electronic billing and reimbursement formats. When~~ If a SSN is not

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available, ~~the health care provider, health care facility, or billing agent/assignee must~~ report a default 9-digit code of 999999999, ~~in the SSN data element.~~

The injured employee's (patient's) Identification Number (Social Security ~~Identification~~ Number) is ~~populated in~~ submitted using the Property and Casualty Patient Identifier REF segment in Loop 2010CA, REF02.

2.4.5 Claim Identification

The workers' compensation claim number assigned by the claim administrator is the claim identification number. This claim identification number is reported in REF02 in Loop 2010CA, in the 005010X222, 005010X223 and 005010X224 transactions, referred to as the Property and Casualty Claim Number.

2.4.6 Bill Identification

The ASC X12N Technical Reports Type 3 (TR3s) refer to a bill as a "claim" for electronic billing transactions. This companion guide refers to these transactions as "bill" in order to avoid confusion, because in workers' compensation, the term "claim" is generally used to refer to a unique injured employee and injury.

The health care provider, health care facility, or billing agent/assignee, assigns a unique identification number to the electronic bill transaction. For 005010X222, 005010X223, or 005010X224 transactions, the bill transaction identification number is populated in Loop 2300 Claim Information CLM Health Claim Segment in CLM01 (Claim (Bill) Submitter's Identifier.) This standard HIPAA implementation allows for a patient account number but strongly recommends that submitters use completely unique number for this data element on each individual bill.

2.4.7 Document/ Attachment Identification

The ASC X12N/005010X210 is the standard electronic format for submitting electronic documentation and is addressed in a later chapter of this companion guide.

Bills containing services that require supporting documentation as defined by the Division in the Medical Billing and Payment Guide Section One – 3.0 must be properly annotated in the PWK Attachment Segment. Bill transactions that include services that require documentation and are submitted without the PWK annotation documentation will be rejected.

Documentation related to electronic medical bills may be submitted by facsimile (Fax), encrypted electronic mail (encrypted email) or by electronic transmission using the prescribed format or a mutually agreed upon format. Documentation related to the electronic bill must be submitted within five working (5) days of submission of the electronic medical bill and must identify the following elements:

- Patient Name (Injured Employee);
- Claims Administrator Name;
- Date of Service;
- Date of Injury;
- Social Security Number (if available);
- Claim Number;
- Unique Attachment Indicator Number

The PWK Segment and the associated documentation identify the type of documentation through use of ASC X12 standard Report Type Codes. The PWK Segment and the associated documentation also identify the method of submission of the documentation through the use of ASC X12N Report Transmission Codes.

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A unique Attachment Indicator Number shall be assigned to all documentation. The Attachment Indicator Number populated on the document shall include Report Type Code, the Report Transmission Code, Attachment Control Qualifier (AC) and the Attachment Control Number. For example, operative note (report type code OB) sent by fax is identified as OBFXAC12345 and a PR-2 (report type code 09) sent by fax is identified as 09FXAC12345. It is the combination of these data elements that will allow an insurance carrier to appropriately match the incoming attachment to the electronic medical bill.

In these situations, when the documentation represents a Jurisdictional Report, the provider should then use the code value of "OZ" (Support Data for Claim) as the Report Type Code in the PWK01 segment and enter in the PWK06 segment the Jurisdictional Report Type Code (e.g. J1=Doctor First Report) in front of the Attachment Control Number. Example: OZFXACJ199923 in PWK06.

Please refer to Appendix ~~EB~~ for a list of Jurisdictional Report Type Codes and associated DWC report type code descriptions.

2.5 Claims Administrator Validation Edits

Claims Administrators may apply validation edits based on California DWC Workers' Compensation Billing and Payment Guide rules, ASC X12N Technical Reports Type 3 (TR3s) requirements, and, to the extent that they have been adopted by the DWC for workers' compensation, Medicare policies or rules. Claims administrators may not apply Medicare policies or rules that have not been adopted by the DWC.

Claims Administrators use the 005010X214 Health Care Claim Acknowledgment transaction, referred to in this companion guide to communicate acceptance or rejection for ASCX12 based electronic bill transactions. The 005010X214 details what errors are present, and if necessary, what action the submitter should take. Error rejection codes are used to indicate the reason for the transaction rejection.

2.6 Description of Formatting Requirements

The ASC X12 formatting requirements are defined in the ASC X12N Technical Reports Type 3 (TR3s), Appendices A.1, available through the ~~Data Interchange Standards Association (DISA)~~ Accredited Standards Committee (ASC) X12 at: <http://store.x12.org>. The Division has provided additional information regarding the 005010X222 or 005010X223 or 005010X224 Hierarchical structure for workers' compensation billing.

The NCPDP Telecommunication D.0 formatting requirements are defined in the NCPDP Telecommunication Standard Implementation Guide Version D.0, available at <http://www.ncdp.org>.

2.6.1 Hierarchical Structure

For information on how the ASC X12 Hierarchical Structure works refer to Section 2.3.2.1 HL Segment of the ASC X12N Technical Reports Type 3 (TR3s) available through the ~~Data Interchange Standards Association (DISA)~~ Accredited Standards Committee (ASC) X12 at: <http://store.x12.org>.

2.7 Description of Transmission/Transaction Dates

The ASC X12 required Transmission/Transaction Dates are defined in the ASC X12N Technical Reports Type 3 (TR3s) available through the ~~Data Interchange Standards Association (DISA)~~ Accredited Standards Committee (ASC) X12 at: <http://store.x12.org>.

2.7.1 Date Sent/Invoice Date

The Invoice Date is the Date Sent for electronic billing and is reflected in the Interchange Control Header ISA Segment Interchange Date. The date in the Control Header ISA Segment must be the actual date the transmission is sent.

2.7.2 Date Received

The Date Sent, the Interchange Control Header ISA Segment Interchange Date, is considered the Date Received for the purposes of electronic billing and reimbursement transactions. The Date Received is used to track timely processing of electronic bills, electronic reconsideration/appeal transactions, acknowledgment transactions, and timeliness of payments.

2.7.3 Paid Date

When the 005010X221 transaction set is used to electronically provide the remittance advice, the Paid Date is the date contained in BPR 16, "Check Issue or EFT Effective Date," in the Financial Information segment.

2.8 Description of Code Sets

Code sets utilized in electronic billing and reimbursement and other ancillary processes are prescribed by the applicable workers' compensation medical fee schedule, ASC X12N Technical Reports Type 3 (TR3s), NCPDP Implementation Guides, Division rule, this companion guide and the California Division of Workers' Compensation Medical Billing and Payment Guide. The code sets are maintained by multiple standard setting organizations.

~~Participants are required to utilize current, valid codes based on the date the service or process occurred (i.e. medical service, payment/denial processing, etc).~~

~~Information regarding Code Sets (Internal Transaction Codes and External Codes) utilized in ASC X12N electronic transactions are available through the Data Interchange Standards Association (DISA) at: <http://store.x12.org>.~~

~~The Claims Adjustment Reason Codes (CARC) and the Remittance Advice Remark Codes (RARC) that have been adopted for use in workers' compensation can be found in the California Division of Workers' Compensation Medical Billing and Payment Guide, Appendix B.~~

~~There is currently no dental fee schedule. Dental Codes have been adopted by incorporation by reference of CDT 2011-2012: ADA Practical Guide to Dental Procedure Codes, of the American Dental Association into the California Division of Workers' Compensation Medical Billing and Payment Guide.~~

~~Also refer to Appendix B Code Set Matrix in this companion guide for a comprehensive list of code set references.~~

2.9 Participant Roles

Roles in the HIPAA implementation are generally the same in workers' compensation. The Employer, Insured, Injured Employee and Patient are the roles that are used differently in workers' compensation and are addressed later in this section.

2.9.1 Trading Partner

Trading Partners are entities that have established EDI relationships and exchange information electronically in standard or mutually agreed upon formats. Trading Partners are both Submitters and Receivers depending on the electronic process (i.e. Billing v. Acknowledgment).

2.9.2 Submitter

A Submitter is the entity submitting a transmission to the receiver, or the Trading Partner. The health care provider, health care facility, or billing agent/assignee, is the Submitter in the 005010X222 or 005010X223 or 005010X224 electronic billing process. The Claims Administrator, or its agent, is the Submitter in the 005010X231 or 005010X214 or 005010X221 electronic acknowledgment or remittance transactions.

2.9.3 Receiver

A Receiver is the entity that accepts a transmission submitted by a Submitter. The health care provider, health care facility, or billing agent/assignee, is the Receiver in the 005010X231 or 005010X214 or 005010X221 electronic acknowledgment or remittance transactions. The Claims Administrator, or its agent, is the Receiver in the 005010X222 or 005010X223 or 005010X224 electronic billing transactions.

2.9.4 Employer

The Employer, as the policyholder of the workers' compensation coverage, is the Subscriber in the workers' compensation implementation of the HIPAA electronic billing and reimbursement formats.

2.9.5 Subscriber

The subscriber or insured is the individual or entity that purchases or is covered by a policy. In this implementation, the workers' compensation policy is obtained by the Employer, who is considered the Subscriber.

2.9.6 Insured

The insured or subscriber is the individual or entity that purchases or is covered by a policy. In group health, the insured may be the patient, or the spouse or parent of the patient. In this implementation, the Employer is considered the Insured entity.

2.9.7 Injured Employee

The Injured Employee is the person who has been injured on the job or has a work related illness and is always considered to be the patient. In group health, there are many relationships a patient may have to the insured. For example, the patient may be the insured, or may be the child or spouse of the insured.

2.9.8 Patient

The patient is the person receiving medical services and is considered the Injured Employee in the workers' compensation implementation of electronic billing and reimbursement processes.

2.10 Health Care Provider Agent/Claims Administrator Agent Roles

Providers, facilities and claims administrators may utilize agents to comply with the electronic billing requirements. Billing agents, electronic billing agents, third party administrators, bill review companies, software vendors, data collection agents, and clearinghouses are examples of companies that may have a role in electronic billing. Entities or persons using agents are responsible for the acts or omissions of those agents executed in the performance of services for the entity or person.

The electronic billing rules require that the claims administrators have the ability to exchange medical billing and reimbursement information electronically with health care providers. The rules do not mandate the use of, or regulate the costs of, agents performing electronic billing functions. Providers and claim administrators are not required by rule to establish connectivity with a clearinghouse or to utilize a specific media/method of connectivity [i.e. Secured File Transfer Protocol (SFTP)].

Use of non-standard formats by mutual agreement between the health care provider, health care facility, or billing agent/assignee and the claims administrator is permissible.

The electronic billing rules do not regulate the formats utilized between providers and their agents, or claims administrators and their agents, or the method of connectivity between those parties.

2.11 Duplicate, Appeal/Reconsideration/Request for Second Review and Corrected Bill Resubmissions

2.11.1 Claim Resubmission Code - ASC X12N 005010X222, 005010X223, or 005010X224 Billing Formats

Health care providers will use the Claim Frequency Type Code of 7 (Resubmission/Replacement) to identify resubmissions of prior medical bills (not including duplicate original submissions). (The NUBC Instruction for the use of Claim Frequency Type Codes can be referenced on the NUBC website at http://www.nubc.org/FL4forWeb2_RO.pdf) The value is populated in Loop 2300 Claim Information CLM Health Claim Segment CLM05-3 Claim Frequency Type Code of the 005010X222, 005010X223, or 005010X224 electronic billing ~~formats transactions~~. The health care provider must also populate the Payer Claim Control Number assigned to the bill by the ~~insurance carrier claims administrator~~ for the bill being replaced, when the payer has provided this number in response to the previous bill submission. This information is populated in Loop 2300 Claim Information, REF Segment 'Payer Claim Control Number' in REF02 of the 005010X222, 005010X223, or 005010X224 electronic billing ~~formats transactions~~.

Health care providers ~~using the 005010X222 or 005010X223 transactions~~ must also populate the appropriate NUBC Condition Code in Loop 2300 the HI Segment 'Condition Information' to identify the type of resubmission on electronically submitted medical bills. The Condition Code is submitted based on the instructions for each bill type, in the HI Segment for 005010X222 and 005010X223 transactions and in the NTE Segment for the 005010X224 transaction (the use of the NTE segment is at the discretion of the sender.) Condition codes provide additional information to the claims administrator when the resubmitted bill is a request for reconsideration/second review. ~~The 005010X224 transaction does not accommodate for reporting of the NUBC Condition Codes, therefore it is not a requirement at this time.~~

2.11.2 Duplicate Bill Transaction Prior To Payment

A Condition Code "W2" (Duplicate of the original bill) is required when submitting a 005010X222 or 005010X223 transaction (bill) that is a duplicate. The Condition Code is populated in Loop 2300 the HI Segment 'Condition Information'. The duplicate bill must be identical to the original bill, with the exception of the added Condition Code. No new dates of service or itemized services may be included. The Condition Code may be submitted in the 005010X224 transaction in the NTE Segment (the use of the NTE segment is at the discretion of the sender.) ~~does not accommodate for reporting of the NUBC Condition Codes, therefore those codes are not a requirement at this time.~~

Duplicate Bill Transaction
- CLM05-3 = Identical value as original. Cannot be "7"; - Condition codes in HI are populated with a condition code qualifier 'BG' and code value:W2=Duplicate - Example: <u>HI*BG;W2~</u> <u>NTE Example: NTE*ADD*BGW2</u> <u>Original Reference Number Payer Claim Control Number</u> does not apply - The resubmitted bill must be identical to the original bill, except for the W2 condition code. No new dates of service or itemized services may be included

Duplicate bill transactions shall be submitted no earlier than fifteen (15) working days after the Claims Administrator has acknowledged receipt of a complete electronic bill transaction and prior to receipt of an ASC X12N/005010X221Health Care Claim Payment/Advice (835) transaction.

The Claims Administrator may reject a bill transaction with a Condition Code W2 indicator if (1) the duplicate bill is received within fifteen (15) working days after transmission of the 005010X231, (2) the bill has been processed and a 005010X221 transaction has been generated, or (3) the Claims Administrator does not have a corresponding accepted original transaction with the same bill identification numbers. The duplicate bill transaction may be denied through the use of a 005010X221 Health Care Claim Payment/Advice transaction. The claims administrator is not required to respond or issue any notice in relation to a duplicate bill if the claims administrator has issued an 0050X221 on the original bill.

2.11.3 Corrected Bill Transactions

A replacement bill is sent when an element of data on the bill was either not previously sent or needs to be corrected.

When identifying elements change, the "correction" is accomplished by a "void" and re-submission process: A bill with CLM05-3 = 8 (Void) must be submitted to cancel the incorrect bill, followed by the submission of a new original bill with the correct information.

Replacement or void of prior bill should not be done until the prior submitted bill has reached final adjudication status. Final adjudication can be determined from remittance advice, web application or when showing a finalized code under Claim Status Category 277 or non electronic means.

Corrected Bill Transaction
• CLM05-3 = 7 indicates a Replacement Bill • Condition codes of W2 to W5 in HI are not used; • REF*F8 includes the claims administrator's Payer Claim Control Number, if assigned by the payer. • A corrected bill shall include the original dates of service and the same itemized services rendered as the original bill. • When identifying elements change, the "correction" is accomplished by a "void" and re-submission process • A bill with CLM05-3 = 8 (Void) must be submitted to cancel the incorrect bill, followed by the submission of a new original bill with the correct information.

The Claims Administrator may reject a revised bill transaction if (1) the Claims Administrator does not have a corresponding adjudicated bill transaction with the same bill identification number or (2) inadequate documentation supporting the request for correction. The revised bill transaction may be denied through the use of a 005010X221 Health Care Claim Payment/Advice transaction.

2.11.4 Appeal/Reconsideration Bill Transactions: Request for Second Review

Electronic submission of Reconsideration transactions is accomplished in the 005010X222, 005010X223, or 005010X224 electronic billing format through the use of Claim Frequency Type Code 7 in Loop 2300 Claim Information CLM Health Claim Segment CLM05-3 Claim Frequency Type Code. The value '7' Replacement of a Prior Claim represents Resubmission transactions.

The Reconsideration Claim Frequency Type Code '7' is used in conjunction with the Payer Claim Control Number assigned to the bill by the claim administrator when the payer has provided this number in response to the previous bill submission. This information is populated in Loop 2300 Claim Information REF02 Payer Claim Control Number of the 005010X222, 005010X223 or 005010X224 electronic billing transactions.

The health care provider using the 005010X222 or 005010X223 transactions must also populate the appropriate condition code to identify the type of resubmission on electronically submitted medical bills. The NUBC Condition codes which apply to reconsiderations and appeals include:

- W3 – 1st Level Appeal is a request for reconsideration or appeal with the claims administrator. This is a Request for Second Review.
- W4 – 2nd Level Appeal is resubmitted after receipt of a jurisdiction decision/order, typically from Medical Fee Dispute resolution.
- W5 – 3rd Level Appeal is resubmitted after receipt of a hearing or other judicial decision and order.

These codes are populated in the Loop 2300 in the HI segment on professional claims and institutional claims. On dental claims, these codes may be populated in Loop 2300, NTE segment (note: the use of the NTE segment is at the discretion of the sender.)

Reconsideration/Second Review bill transactions may only be submitted after receipt of a 005010X221 Health Care Claim Payment/Advice transaction for the corresponding accepted original bill. The same bill identification number is used on both the original and the Reconsideration/Second Review bill transaction to associate the transactions. All elements, fields, and values in the Reconsideration/Second Review bill transaction, except the Reconsideration/Second Review specific qualifiers and Claim Supplemental Information PWK Attachment Segment, must be the same as the original bill transaction. ~~Subsequent Reconsideration bill transactions related to the same original bill transaction may be submitted after receipt of a 005010X221 transaction corresponding to the initial Reconsideration bill transaction. Subsequent Reconsideration bill transactions shall not be submitted prior to the claims administrator taking final action on the original reconsideration request.~~

Corresponding documentation related to appeals/reconsideration/second review is required in accordance with the California rules for initial bill submission. The PWK Segment (Claim Supplemental Information) is required to be properly annotated when submitting an attachment related to an appeal/reconsideration/request for second review.

The ASC X12 Technical Reports Type 3 and the California Division of Workers' Compensation strongly recommend that the value passed in CLM01 (Claim Submitter Identifier) represents a unique identification number specific to the bill transaction. The California Division of Workers' Compensation implementation links the original bill (parent) to the subsequent bill transaction through the use of the provider unique Claim Submitter Identification Number (CLM01). The intent is to link an ~~appeal, or multiple subsequent appeals,~~ an appeal/reconsideration/request for second review to a single original parent bill transaction.

The ASC X12 Technical Reports Type 3 include a ~~REF~~ Reference Identification Number REF segment in Loop 2300 Claim Information that represents the Payer Claim Control Number which is the claims administrator generated unique transaction identification number. This number needs to be included on resubmitted bills to ensure that the payer can match the resubmission request with its original processing action.

<u>Appeal/ Reconsideration/ Request for Second Review Bill Transaction</u>
• CLM05-3 = 7; • Condition codes in HI are populated with a condition code qualifier 'BG' and one of the following codes values must be present: W3= 1st Level Appeal (Request for reconsideration or appeal with the claims administrator: <u>Request for Second Review</u>) W4= 2nd Level Appeal (Resubmitted after receipt of a judicial <u>jurisdictional</u> decision and order , typically from Medical Fee Dispute resolution) W5= 3rd Level Appeal (Resubmitted after receipt of a hearing or other judicial decision and order) • REF*F8 includes the claim administrators Payer Claim Control Number, if assigned by the payer. • The appeal/reconsideration/<u>request for second review</u> bill must be identical to the original bill, with the exception of the added Condition Code, Payer Claim Control Number and the Claim Frequency Type Code. No new dates of service or itemized services may be included. • Supporting Documentation is required. • Loop 2300, PWK Segment must be properly annotated.

The Claims Administrator may reject an appeal/reconsideration/request for second review bill transaction if (1) the bill information does not match the corresponding original bill transaction, (2) the Claims Administrator does not have a corresponding accepted original transaction, (3) the original bill transaction has not been completed (no corresponding 005010X221 Health Care Payment/Advice transaction has been sent), (4) the bill is submitted without the PWK annotation. Corresponding documentation related to appeals/reconsideration/request for second review is required in accordance with the Division's rules for initial bill submission.

The Claims Administrator may deny appeal/reconsideration/request for second review bill transactions for missing documentation. The bill transaction may be denied through the use of a 005010X221 Health Care Claim Payment/Advice transaction.

2.12 Balance Forward Billing

Balance forward billing is not permissible. Balance forward bills are bills that include a balance carried over from a previous bill along with additional services or a summary of accumulated unpaid balances.

2.13 California-Specific Requirements that Relate to Multiple Electronic Formats

The requirements in this section identify California workers' compensation specific requirements that apply to more than one electronic format. Requirements that are related to a specific format are identified in the chapter related to that format.

~~The directions for the elements identified below apply to multiple or all ASC X12N electronic file formats.~~

2.13.1 Claim Filing Indicator

The 005010X222, 005010X223, or 005010X224 Claim Filing Indicator code for workers compensation is 'WC' populated in Loop 2000B Subscriber Information, SBR Subscriber Information Segment field SBR09.

2.13.2 Transaction Set Purpose Code

The Transaction Set Purpose Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction Segment field BHT02 in 005010X222, 005010X223, or 005010X224 transaction is designated as '00' Original. Claims administrators are required to acknowledge acceptance or rejection of transmissions (files) and transactions (bills). Transmissions that are rejected by the claims administrator are corrected by the provider and are submitted, after correction, as '00' Original transmissions.

2.13.3 Transaction Type Code

The Transaction Type Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction Segment field BHT06 in 005010X222, 005010X223, or 005010X224 formats is designated as 'CH' Chargeable. Currently, there is not a requirement for health care providers to report electronic medical billing data to the Division. Therefore, code 'RP' (Reporting) is not appropriate for this implementation.

2.13.4 NCPDP Telecommunication Standard D.0 Pharmacy Format and NCPDP Batch Standard 1.2

Issues related to electronic pharmacy billing transactions are addressed in Chapter 6 Companion Guide Pharmacy.

Chapter 3 ASC X12N/005010X222 Health Care Claim: Professional (837)

The information contained in this companion guide has been created for use in conjunction with the ASC X12N/005010X222 Health Care Claim: Professional (837). It should not be considered a replacement for the 005010X222, but rather used as an additional source of information, supplement to the ASC X12N Technical Report Type 3 where specialized workers' compensation direction is needed.

3.1 Reference Information

The ASC X12N/005010X222 Health Care Claim: Professional (837) is available through the ~~Data Interchange Standards Association (DISA)~~ Accredited Standards Committee (ASC) X12 at: <http://store.x12.org>.

3.2 Trading Partner Agreements

This companion guide is not intended to replace the components of trading partner agreements that define additional transaction parameters beyond the ones described, such as transmission parameters.

~~Trading Partners may utilize non-prescribed electronic formats by mutual agreement. The data elements transmitted pursuant to such a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the ASC X12N Technical Report Type 3 and the California companion guide.~~

The data elements transmitted pursuant to a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the ASC X12 Type 3 Technical Reports and the California companion guide. The workers' compensation field value designations as defined in the companion guide must remain the same as part of any Trading Partner Agreement.

3.3 Workers' Compensation ~~Instructions for ASC X12N/005010X222~~ Health Care Claim: Professional Instructions (837)

Instructions for California specific requirements are also provided in Chapter 2 California Workers' Compensation Requirements. ~~The following table identifies When the application/instructions for California workers' compensation need clarification beyond that are different than the HIPAA implementation, it is identified in the following table:~~

3.3.1 ASC X12N/005010X222 Health Care Claim: Professional (837)

Loop	Segment or Element	Description	California Workers' Compensation Instructions
1000A	PER	Submitter <u>EDI</u> Contact Information	One occurrence of the Communication Number Qualifier must be 'TE' – Telephone Number.
<u>2000B</u>	<u>SBR</u>	<u>Subscriber Information</u>	<u>In workers' compensation, the Subscriber is the Employer.</u>
<u>2000B</u>	<u>SBR04</u>	<u>Name</u>	<u>In workers' compensation, the group name is the employer of the patient/employee.</u>

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Loop	Segment or Element	Description	California Workers' Compensation Instructions
2000B	SBR09	Claim Filing Indicator Code	Value must be 'WC' for Workers' Compensation.
2010BA		Subscriber Name	In Workers' Compensation, the Subscriber is the Employer (e.g. an organization, sole proprietor or company name.)
2010BA	NM102	Entity Type Qualifier	Value must be '2' non-person.
2010BA	NM103	<u>Name</u> Last Or Organization Name	Value must be the name of the Employer.
2010BA	N3	Subscriber Address	Enter employer address
2010BA	N4	Subscriber City/State/Zip Code	Enter employer city/state/zip code
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.
2010CA	REF	Property and Casualty Claim Number	Workers' compensation claim number assigned by the claims administrator. This segment is required. A bill missing a claim number shall be placed in pending status for up to 5 working days to attach claim number.
2010CA	REF01	Reference Identification Qualifier	Value must be 'Y4'.
2010CA	REF02	Workers' Compensation Claim Number <u>Reference Identification</u>	Enter the claim number if known. If not known, then enter the default value 'UNKNOWN'.
2010CA	REF	Property and Casualty Patient Identifier	The patient's Social Security number is required.
2010CA	REF01	Reference Identification Qualifier	Value must be 'SY'.
2010CA	REF02	Reference Identification	Enter the patient's Social Security Number. If the patient does not have a Social Security Number then enter the following 9-digit number '999999999'
2300	CLM11	Related Causes Information Codes	One of the occurrences in CLM11 must have a value of 'EM' – Employment Related.
2300	DTP	Accident Date <u>Date-Accident</u>	Required when the condition reported is for an occupational accident/injury. For Specific Injury: Enter the date of incident or exposure. (<u>Calif. Labor Code §5412.</u>) For Cumulative Injury or Occupational Disease: Enter the last date of occupational exposure to the hazards of the occupational disease or cumulative injury. Enter date upon which the employee first suffered disability therefrom and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment. (<u>Calif. Labor Code §5412.</u>)
2300	DTP	Disability Dates <u>Date – Disability Dates</u>	Do not use Segment. Leave blank.
2300	PWK	Claim Supplemental Information	Required when submitting attachments related to the medical bill. Refer to the California Division of Workers' Compensation Medical Billing and Payment Guide for additional instructions regarding Documentation/Medical Attachment Requirements.
2300	PWK01	Report Type Code	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports, use appropriate 005010 Report Type Code.

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Loop	Segment or Element	Description	California Workers' Compensation Instructions
2300	PWK02	Report Transmission Code	Use appropriate Report Transmission Codes specified in the 5010 Type 3 Technical Report with the exception of the 'BM' – By Mail Code which is not allowed under the California rules.
2300	PWK06	Attachment Control Number	In formatting the attachment control number, When the Report Type Code is 'OZ' and a jurisdictional report is sent, always include the Jurisdictional Report Type Code as the first two characters of the attachment control number. (The Jurisdictional Report Type Codes are set forth in Appendix B.) Examples: Jurisdictional Report: Report Type J1=Doctor's First Report of Injury: Jurisdictional Report: PWK*OZ* BEM ***AC*J1DMN0012~ Standard Report: PWK*OB* BEM ***AC*DMN0012~
2300	NTE	Claim Note	When applicable, identify any additional information that needs to be conveyed in the Claim Note Segment. For example, a comment may require additional information to assist in the proper adjudication of the workers' compensation medical bill that is not identified elsewhere within the transaction data set.
<u>2300</u>	<u>K301</u>	<u>Fixed Format Information</u>	<u>Jurisdiction State Code (State of Compliance Code)</u> <u>Required when the provider knows the state of jurisdiction is different than the billing provider's state (2010AA/N4/N402). Enter the state code qualifier 'LU' followed by the state. 'LUCA' indicates the medical bill is being submitted under California medical billing requirements.</u>
2300	HI	Condition Information	Required when condition information applies to the medical bill. Resubmission Condition Code Required when submitting a bill that is a duplicate or an appeal/reconsideration/request for second review. <u>For workers' compensation purposes, the National Uniform Billing Committee and the National Uniform Claims Committee have approved the following condition codes for resubmissions:</u> Enter the Condition Code Qualifier 'BC' followed by the appropriate recubmission code. W2 - Duplicate of the original bill W3 - Level 1 Appeal (<u>Request for Second Review</u>) W4 - Level 2 Appeal W5 - Level 3 Appeal Example: BCW3 <u>See Section 2.11.4 Appeal/Reconsideration Bill Transaction above for definitions of W3-W5.</u> Note: Do not use condition codes when submitting revised or corrected bills.

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Loop	Segment or Element	Description	California Workers' Compensation Instructions
2310B	PRV	Rendering Provider	Required when loop 2310B is used.
2310B	PRV	<u>Rendering Provider Specialty Code Information</u>	The Rendering Provider Specialty Information is required for California workers' compensation medical bills.
2420A		Rendering Line Provider	Required when loop 2420A is used.
2420A	PRV	Provider Specialty Code	The Rendering Provider Specialty Information is required for California workers' compensation medical bills.

Chapter 4 ASC X12N/005010X223 Health Care Claim: Institutional (837)

The information contained in this companion guide has been created for use in conjunction with the ASC X12N/005010X223 Health Care Claim: Institutional (837) Technical Report Type 3. It should not be considered a replacement for the ASC X12N/005010X223 Health Care Claim: Institutional (837), but rather used as an additional source of information, ~~supplement to the ASC X12N Technical Report Type 3 where specialized workers' compensation direction is needed.~~

4.1 Reference Information

The ASC X12N/005010X223 Health Care Claim: Institutional (837) is available through the ~~Data Interchange Standards Association (DISA)~~ Accredited Standards Committee (ASC) X12 at: <http://store.x12.org>.

4.2 Trading Partner Agreements

This companion guide is not intended to replace the components of trading partner agreements that define additional transaction parameters beyond the ones described.

Trading Partners may utilize non-prescribed electronic formats by mutual agreement. The data elements transmitted pursuant to such a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the ASC X12N Technical Reports Type 3 and the California companion guide.

4.3 Workers' Compensation ~~Instructions for ASC X12N/005010X223~~ Health Care Claim: Institutional Instructions (837)

Instructions for California specific requirements are also provided in Chapter 2 California Workers' Compensation Requirements. When the application/instructions for California ~~837 Institutional~~ workers' compensation need clarification beyond ~~are different than~~ the HIPAA implementation, it is identified in the following table:

4.3.1 ASC X12N/005010X223 Health Care Claim: Institutional (837)

Loop	Segment	Description	California Workers' Compensation Instructions
1000A	PER	Submitter <u>EDI</u> Contact Information	One occurrence of the Communication Number Qualifier must be 'TE' – Telephone Number.
<u>2000B</u>	<u>SBR</u>	<u>Subscriber Information</u>	<u>In workers' compensation, the Subscriber is the Employer.</u>
<u>2000B</u>	<u>SBR04</u>	<u>Name</u>	<u>In workers' compensation, the group name is the employer of the patient/employee.</u>
2000B	SBR09	Claim Filing Indicator Code	Value must be 'WC' - Workers' Compensation.
2010BA	NM1	Subscriber Name	In Workers' Compensation, the Subscriber is the Employer (e.g. an organization, sole proprietor, or company name.)
2010BA	NM102	Entity Type Qualifier	Value must be '2' non-person.
2010BA	NM103	<u>Name</u> Last Or Organization Name	Value must be the name of the Employer.
2010BA	N2	Subscriber Address	Enter Employer address.

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Loop	Segment	Description	California Workers' Compensation Instructions
2010BA	N4	Subscriber City/State/Zip Code	Enter Employer city/state/zip code.)
2000C	PAT01	Patient's Relationship to Subscriber	Value must be '20' – Employee.
2010CA	REF	Property and Casualty Claim Number	Workers' compensation claim number assigned by the claims administrator. This segment is required. A bill missing a claim number shall be placed in pending status for up to 5 working days to attach claim number.
2010CA	REF01	Reference Identification Qualifier	Value must be 'Y4'.
2010CA	REF02	Workers' Compensation Claim Number	Enter the claim number if known. If not known, then enter the default value 'UNKNOWN'.
2010CA	REF	Property And Casualty Patient Identifier	Required to enter the patient's Social Security Number.
2010CA	REF01	Reference Identification Qualifier	Value must be 'SY'.
2010CA	REF02	Reference Identification	Enter the patient's Social Security Number. If the patient does not have a Social Security Number then enter the following 9 digit number: '99999999'.
2300	DTP	Accident Date	Required when the condition reported is for an occupational accident/injury. For Specific Injury: Enter the date of incident or exposure. For Cumulative Injury or Occupational Disease: Enter the last date of occupational exposure to the hazards of the occupational disease or cumulative injury.
2300	PWK	Claim Supplemental Information	Required when submitting attachments related to the medical bill.
2300	PWK01	Report Type Code	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports, use appropriate 005010 Report Type Code.
2300	PWK02	Report Transmission Code	Use appropriate Report Transmission Codes specified in the 5010 Type 3 Technical Report with the exception of the 'BM' – By Mail Code which is not allowed under the California rules.
2300	PWK06	Attachment Control Number	<u>In formatting the attachment control number, When the Report Type Code is 'OZ' and a jurisdiction report is sent, always include the Jurisdictional Report Type Code as the first two characters of the attachment control number. (The Jurisdiction Report Type Codes are set forth in Appendix B.) Examples: Jurisdiction Report: Report Type J1=Doctor's First Report of Injury: Jurisdiction Report: PWK*OZ*BEM***AC*J1DMN0012~ Standard Report: PWK*OB*BEM***AC*DMN0012~</u>
2300	NTE	Billing Note	When applicable, identify any additional information that needs to be conveyed in the Billing Note Segment. For example, a comment may require additional information to assist in the proper adjudication of the workers' compensation medical bill that is not identified elsewhere within the transaction data set.

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Loop	Segment	Description	California Workers' Compensation Instructions
2300	K301	<u>Fixed Format Information</u>	<u>Jurisdiction State Code (State of Compliance Code)</u> <u>Required when the provider knows the state of jurisdiction is different than the billing provider's state (2010AA/N4/N402). Enter the state code qualifier 'LU' followed by the state. 'LUCA' indicates the medical bill is being submitted under California medical billing requirements.</u>
2300	HI01	Occurrence Information	At least one Occurrence Code must be entered with value of '04' - Accident/Employment Related or '11' - illness. The Occurrence Date must be the Date of Occupational Injury or Illness. <u>For Specific Injury: Enter the date of incident or exposure. (Calif. Labor Code §5412.)</u> <u>For Cumulative Injury or Occupational Disease: Enter date upon which the employee first suffered disability therefrom and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment. (Calif. Labor Code §5412.)</u>
2300	HI	Condition Information	Required when Condition Information applies to the medical bill. Recubmission Condition Code: Required when submitting a bill that is a duplicate or an appeal/reconsideration/request for second review. Enter the Condition Code Qualifier 'BC' followed by the appropriate recubmission code. <u>For workers' compensation purposes, the National Uniform Billing Committee has approved the following condition codes for resubmissions:</u> W2 - Duplicate of the original bill W3 - Level 1 Appeal (<u>Request for Second Review</u>) W4 - Level 2 Appeal W5 - Level 3 Appeal <i>Example: BGW3</i> Note: Do not use condition codes when submitting revised or corrected bills.

Chapter 5 Companion Guide ASC X12N/005010X224 Health Care Claim: Dental (837)

The information contained in this companion guide has been created for use in conjunction with the ASC X12N/005010X224 Health Care Claim: Dental (837) Technical Report Type 3. It should not be considered a replacement for the 005010X224, but rather used as an additional source of information, supplement to

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~~the ASC X12N/005010X224 Health Care Claim: Dental (837) Technical Report Type 3 where specialized workers' compensation direction is needed.~~

5.1 Reference Information

The ASC X12N/005010X224 Health Care Claim: Dental (837) is available through the ~~Data Interchange Standards Association (DISA)~~ Accredited Standards Committee (ASC) X12 at: <http://store.x12.org>.

5.2 Trading Partner Agreements

This companion guide is not intended to replace the components of trading partner agreements that define additional transaction parameters beyond the ones described.

Trading Partners may utilize non-prescribed electronic formats by mutual agreement. The data elements transmitted pursuant to such a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the ASC X12N Technical Reports Type 3 and the California companion guide.

5.3 Workers' Compensation ~~Instructions for ASC X12N/005010X224~~ Health Care Claim: Dental Instructions (837)

Instructions for California specific requirements are also provided in Chapter 2 California Workers' Compensation Requirements. When the application/instructions for California ~~Dental~~ workers' compensation need clarification beyond electronic billing are different than the HIPAA implementation, it is identified in the following table:

5.3.1 ASC X12N/005010X224 Health Care Claim: Dental (837)

Loop	Segment	Description	California Workers' Compensation Instructions
1000A	PER	Submitter EDI EDI Contact Information	One occurrence of the Communication Number Qualifier must be 'TE' – Telephone Number.
<u>2000B</u>	<u>SBR</u>	<u>Subscriber Information</u>	<u>In workers' compensation, the Subscriber is the Employer.</u>
<u>2000B</u>	<u>SBR04</u>	<u>Name</u>	<u>In workers' compensation, the group name is the employer of the patient/employee.</u>
2000B	SBR09	Claim Filing Indicator Code	Value must be 'WC' for Workers' Compensation.
2010BA	NM1	Subscriber Name	In Workers' Compensation, the Subscriber is the Employer (e.g., an organization, sole proprietor or company name.)
2010BA	NM102	Entity Type Qualifier	Value must be '2' non-person.
2010BA	NM103	<u>Name</u> Last Or Organization Name	Value must be the name of the Employer.
2010BA	N3	Subscriber Address	In Workers' Compensation, the Subscriber Address is the address of the Employer.
2010BA	N4	Subscriber City/State/Zip code	Enter Employer city/state/zip code.
2000C	PAT01	Patient's Relationship to Subscriber <u>Individual Relationship Code</u>	Value must be '20' - Employee.

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Loop	Segment	Description	California Workers' Compensation Instructions
2010CA	REF	Property and Casualty Claim Number	Workers' compensation claim number assigned by the claims administrator. This segment is required. A bill missing a claim number shall be placed in pending status for up to 5 working days to attach claim number.
2010CA	REF01	Reference Identification Qualifier	Value must be 'Y4'.
2010CA	REF02	Workers' Compensation Claim Number	Enter the claim number if known. If not known, then enter the default value of 'UNKNOWN'.
2010CA	REF	Property And Casualty Patient Identifier	The patient's Social Security number is required.
2010CA	REF01	Reference Identification Qualifier	Value must be 'SY'.
2010CA	REF02	Reference Identification	Enter the patient's Social Security Number. If the patient does not have a Social Security Number then enter the following 9-digit number: '99999999'.
2300	DTP	Accident date - Date - Accident	Required when the condition reported is for an occupational accident/injury. For Specific Injury: Enter the date of incident or exposure. (Calif. Labor Code §5412.) For Cumulative Injury or Occupational Disease: Enter the last date of occupational exposure to the hazards of the occupational disease or cumulative injury. Enter date upon which the employee first suffered disability therefrom and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment. (Calif. Labor Code §5412.)
2300	PWK	Claim Supplemental Information	Required when submitting attachments related to the medical bill.
2300	PWK01	Report Type Code	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports use appropriate 005010 Report Type Code.
2300	PWK02	Report Transmission Code	One of the occurrences in CLM11 must have a value of 'EM' — Employment Related.
2300	PWK06	Attachment Control Number	In formatting the attachment control number, always include the Jurisdictional Report Type Code as the first two characters of the attachment control number. Example Report Type J1=Doctor's First Report of Injury: Jurisdiction Report: PWK*OZ* BEM ***AC*J1DMN0012~ Standard Report: PWK*OB* BEM ***AC*DMN0012~.
2300	K301	Fixed Format Information	Jurisdiction State Code (State of Compliance Code) Required when the provider knows the state of jurisdiction is different than the billing provider's state (2010AA/N4/N402). Enter the state code qualifier 'LU' followed by the state. 'LUCA' indicates the medical bill is being submitted under California medical billing requirements.
2310B		Rendering Provider	Required when loop 2310B is used.

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Loop	Segment	Description	California Workers' Compensation Instructions
2310B	PRV	<u>Rendering Provider Specialty Code</u> <u>Information</u>	The Rendering Provider Specialty Information is required for California workers' compensation medical bills.
2420A		Rendering Line Provider	Required when loop 2420A is used.
2420A	PRV	<u>Rendering Provider Specialty</u> <u>Information</u>	The Rendering Provider Specialty Information is required for California workers' compensation medical bills.

Chapter 6 Companion Guide Pharmacy NCPDP D.0

This companion guide has been created for use in conjunction with the NCPDP Telecommunication Standard Implementation Guide Version D.0 and the NCPDP Batch Standard Implementation Guide Version 1.2. It should not be considered a replacement for the NCPDP guides, but rather used as a supplement to the guides. Wherever the NCPDP national standards differ from the California rules, the California rules prevail. The text below includes cross-references to the data fields of the paper NCPDP Universal Claim Form.

6.1 NCPDP Reference

The NCPDP Telecommunication Standard Implementation Guide Version D.0 that supports the electronic pharmacy billing transaction, along with the NCPDP Data Dictionary (September 1999) and the NCPDP Batch Standard Implementation Guide Version 1.2 are available through the National Council for Prescription Drug Programs (NCPDP), www.ncdp.org.

6.2 Trading Partner Agreements

This companion guide is not intended to replace the components of trading partner agreements that define additional transaction parameters beyond the ones described. The Division does not mandate a method of connectivity or processing method.

Trading Partners may utilize non-prescribed electronic formats by mutual agreement. The data elements transmitted pursuant to such a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the NCPDP Telecommunication Standard Implementation Guide Version D.0 and the NCPDP Batch Standard Implementation Guide Version 1.2 and the California companion guide.

6.3 Pharmacy Invoice Number

The Prescription/Service Reference Number (402-D2) (Field #62 on WC/PC UCF) is the reference number assigned by the provider for the dispensed drug/product and/or service provided and will be used to identify the invoice number for electronic billing. Real time and batch electronic pharmacy bill processing uses the specific prescription number to identify an individual, unique pharmacy transaction. Other fields, such as the Service Provider ID (201-B1) (Field #32 on WC/PC UCF) can be used for uniqueness.

6.4 Billing Date

For electronically submitted pharmacy bills, the date of service is considered the Billing Date, unless other transactional verification information is provided to the claims administrator to confirm the date the bill was transmitted. This date is communicated in the NCPDP Telecommunication Standard Implementation Guide Version D.0 Date of Service field (401-D1) (Field #66 on WC/PC UCF), which is included in the Transaction Header Segment.

6.5 Dispensing Pharmacy Billing and Pharmacy Billing Agents

When the dispensing pharmacy is the billing entity, the Federal Employer Identification Number (FEIN) is reported in the Service Provider ID field (201-B1) at the header level and the NPI Number in the Provider ID field (444-E9) in the Pharmacy Provider Segment.

The current version of the NCPDP Telecommunication Standard Implementation Guide Version D.0 does not support the use of third party billing agents or pharmacy benefit managers (PBM) when they are acting as pharmacy billing agents. The format does not currently support a designated field, an identifier, or a qualifier to flag an entity as a pharmacy billing agent.

When a third party biller or PBM are the billing and payee of the claim(s), the FEIN of the third party biller or PBM will be reported in the Service Provider ID field (201-B1) at the header level and the dispensing pharmacy information will be identified by their NPI number in the Provider ID field (444-E9) in the Pharmacy Provider Segment. It is important that these issues be addressed in the trading partner agreements between the claims administrator, their electronic billing agent, and pharmacy claim submitters.

6.6 Fill Number v. Number of Fills Remaining

The NCPDP Telecommunication Standard Implementation Guide Version D.0 supports the Fill Number (Field 403-D3) (Field #64 on WC/PC UCF) and the Number of Refills Authorized (Field 415-DF).

6.7 Compound Medications

Division rules require components of compound medications be identified. Compound medications in the NCPDP Telecommunication Standard Implementation Guide Version D.0 are identified through the use of the Compound Code (Field 406-D6) (Fields 89 – 98 on WC/PC UCF) value 2(Compound). If the transaction includes a compound medication, the Compound Segment is required.

6.8 Brand v. Generic

The NCPDP Telecommunication Standard Implementation Guide Version D.0 contains a code set to indicate dispensed as written status, Dispense As Written (DAW)/ Product Selection Code (Field 408-D8) (Field #72 on WC/PC UCF). Some dispensed as written codes do indicate the generic availability status. However, the name of the medication, and the brand/generic status of the NDC code, is not communicated for each medication. Claims Administrators may obtain this information from purchased NDC code sets or from their agents/vendor partners.

6.9 Prescribing Physician

For California workers' compensation claims, the Prescribing Physician Identification Number will be the NPI. This data is supported in the NCPDP Telecommunication Standard Implementation Guide Version D.0 in Fields 411-DB (Prescriber ID) (Field # 40 on WC/PC UCF) and 466-EZ (Field # 41 on WC/PC UCF) (Qualifier (12) DEA Number). If the prescribing physician does not have an NPI, the prescribing physician's state license number should be populated. The NCPDP Telecommunication Standard Version D.0 contains qualifiers for all the identifiers detailed.

6.10 California Pharmacy Workers' Compensation Instructions

~~With the exception of the specific instructions below, for electronic transactions the NCPDP Telecommunication Standard Implementation Guide Version D.0 should be used to complete the electronic transaction.~~

Instructions for California specific requirements are also provided in Chapter 2 California Workers' Compensation Requirements. When the application/instructions for California workers' compensation need clarification beyond the HIPAA implementation, it is identified in the following table:

6.10.1 NCPDP Telecommunication Standard Implementation Guide D.0

Segment	Field	Description	California Companion Guide Workers' Compensation Comments or Instructions
INSURANCE	302-C2	CARDHOLDER ID	If the Cardholder ID is not available or not applicable, the value must be 'NA'.
CLAIM	415-DF	NUMBER OF REFILLS AUTHORIZED	This data element is required. If no refills authorized, enter '0'
PRICING	426-DQ	USUAL AND CUSTOMARY CHARGE	This data element is required. Enter the pharmacy's usual and customary price, i.e. the amount charged cash customers for the prescription exclusive of dispensing fee, sales tax or other amounts claimed
PHARMACY PROVIDER	465-EY	PROVIDER ID QUALIFIER	This data element is required. The value must be '05' – NPI Number.
PRESCRIBER	466-EZ	PRESCRIBER ID QUALIFIER	This data element is required. The value must be '01' – NPI Number, however, if prescriber NPI is not available, enter applicable prescriber ID qualifier.
WORKERS' COMPENSATION			The Workers' Compensation Segment is required for workers' compensation claims.
WORKERS' COMPENSATION	435-DZ	CLAIM/REFERENCE ID	This data element is situational (required if claim number known by provider.) Enter the claim number assigned by the workers' compensation claims administrator, if known. If claim number is not known, then enter the value of 'Unknown'. A bill missing a claim number shall be placed in pending status for up to 5 working days to attach claim number.

6.11 Request for Second Review

For electronic pharmacy services billing, the trading partner agreement may include business rules to establish a method for identifying bill transmissions that are a Request for Second Review, or a Request for Second Review may be made using DWC Form SBR-1.

Chapter 7 Companion Guide ASC X12N/005010X221 Health Care Claim Payment/Advice (835)

This companion guide has been created for use in conjunction with the ASC X12N/005010X221 Healthcare Claim Payment/Advice Technical Report Type 3. It should not be considered a replacement for the 005010X221, but rather used as an additional source of information.

The ASC X12N/005010X221 Health Care Claim Payment/Advice (835) Technical Report Type 3 is used by the payer to advise the provider of payment remittance and is also used to convey objections to the bill. Labor Code §4603.2 (b)(1)(B) requires the payer to “~~advise in the manner prescribed by the administrative director,~~” advise the physician, or another provider in an explanation of review, of the “items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees.” In order to provide detailed information to the provider, the Division directs the claims administrator to use the Explanation of Review (EOR) standards set forth in the Medical Billing and Payment Guide, Appendix B Standard Explanation of Review. For electronic billing purposes, this is accomplished by use of the ASC X12N/005010X221 Health Care Claim Payment/Advice (835). The Claim Adjustment Group Codes, the Claim Adjustment Reason Codes and Remittance Advice Remark Codes are the standard code sets required. The Division of Workers’ Compensation has developed jurisdictional DWC Bill Adjustment Reason Codes for use on paper EOR’s which do not have an exact equivalent for use in the 005010X221 format. For informational purposes, a ~~A~~ crosswalk table has been developed showing the relationship between the DWC Bill Adjustment Reason Codes and the CARC/RARC codes ~~for that are used~~ in electronic EOR’s. This table is found in the Medical Billing and Payment Guide, Appendix B – 1.0.

~~This companion guide has been created for use in conjunction with the ASC X12N/005010X221 Healthcare Claim Payment/Advice Technical Report Type 3. It should not be considered a replacement for the 005010X221, but rather used as a supplement to the ASC X12N Technical Report Type 3 where specialized workers’ compensation direction is needed.~~

7.1 Reference Information

The ASC X12N/005010X221 Health Care Claim Payment/Advice (835) is available through the ~~Data Interchange Standards Association (DISA)~~ Accredited Standards Committee (ASC) X12 at: <http://store.x12.org>.

7.2 Trading Partner Agreements

This companion guide is not intended to replace the components of trading partner agreements that define additional transaction parameters beyond the ones described.

Trading Partners may utilize non-prescribed electronic formats by mutual agreement. The data elements transmitted pursuant to such a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the ASC X12N Technical Reports Type 3 (TR3s) and the California companion guide.

7.3 Claim Adjustment Group Codes

The 005010X221 transaction requires the use of Claim Adjustment Group Codes. The most current, valid codes should be used as appropriate for workers' compensation. The Claim Adjustment Group Code represents the general category of payment, reduction, or denial. For example, the Claim Adjustment Group Code 'CO' Contractual Obligation might be used in conjunction with a Claim Adjustment Reason Code for a network contract reduction.

The Claim Adjustment Group Code transmitted in the 005010X221 is the same code that is transmitted in the IAIABC 837 Medical State Reporting EDI reporting format for reporting to the Workers' Compensation Information System pursuant to Labor Code section 138.6. The Division accepts Claim Adjustment Group Codes that were valid on the date the ~~insurance carrier~~ claims administrator paid or denied a bill. The Division does validate for Claim Adjustment Group Code/Claim Adjustment Reason Code agreement in Medical State Reporting EDI processing.

7.4 Claim Adjustment Reason Codes (CARC)

The 005010X221 transaction uses the Claim Adjustment Reason Codes, as the electronic means of providing specific payment, reduction, or denial information. The Division prescribes a specific subset of the Claim Adjustment Reason Codes to be used in the 005010X221 transaction. These codes are set forth in the Medical Billing and Payment Guide, Appendix B – 1.0 California DWC Matrix Crosswalk. As a result, use of the Claim Adjustment Reason Codes eliminates the use of proprietary reduction codes and free form text.

7.4.1 Claim Adjustment Reason Codes 191, 214, 221, W1

The California Division of Workers' Compensation maintains a web site URL at:

http://www.dir.ca.gov/dwc/Laws_Regulations.htm that has links to the text of the statutes and rules used by workers' compensation payers as a basis to reduce or deny a charge. When an entire bill is denied at the Claim level or reduced at the Line level using CARC Codes, 191, 214, 221 or W1, the payer will need to provide the applicable California DWC Statute/Code associated with that CARC code to communicate the basis of the reduction or denial. If one of the CARC codes 191, 214, 221 or W1 is used, then the following California DWC Labor Code reference number is to be reported in the REF02.

CARC 191 Labor Code §3600

CARC 214 Labor Code §3600

CARC 221 Labor Code §5402

CARC W1 Labor Code §5307.1

If an entire bill is denied at the claim level, using one of the above CARC codes, then use ~~the Insurance Policy Number Segment (Loop 2100)~~ Loop 2100 Other Claim Related Information REF segment to report, with an 'IG' qualifier and report the associated California DWC Statute/Code in REF02.

Example #1:

Claim adjustment reason code 191 is applied when an entire bill is denied on the basis that primary liability for the injury or illness being treated is denied per California DWC Labor Code §3600.

- Use Loop 2100 Other Claim Related Information REF Segment to report the Insurance Policy Number (i.e., the applicable California Statute/Code)
- In REF 01, use qualifier IG

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- In REF 02 specify the appropriate code for the applicable statute,

Example: REF*IG*3600~

If a bill is reduced at the line level using one of the above CARC codes, then use Loop 2110 the Healthcare Policy Identification Segment (Loop 2110) to specify the appropriate California ~~DWC~~ Statute/Code for the statute supporting the adjustment. ~~The DWC URL http://www.dir.ca.gov/dwc/Laws_Regulations.htm address must be communicated to the provider in loop 1000A segment PER.~~

Example #2:

Claim adjustment reason code W1 is applied and a line item of a bill is reduced based on the California workers' compensation medical fee schedule rule per California Labor Code §5307.1.

- Use Loop 2100 Healthcare Policy Identification Segment to report the associated California Statute/Code
- In REF01, use qualifier OK
- In REF02, specify the appropriate code for the applicable statute

Example: REF*OK*5307.1~

- ~~The California DWC URL http://www.dir.ca.gov/dwc/Laws_Regulations.htm address must be referred to in loop 1000A segment PER.~~

~~**Example:** PER*IC**UR*http://www.dir.ca.gov/dwc/Laws_Regulations.htm~~

7.5 Remittance Advice Remark Codes (RARC)

The 005010X221 transaction supports the use of Remittance Advice Remark Codes to provide supplemental explanation for a payment, reduction or denial already described by a Claims Adjustment Reason Code. The Division prescribes a specific subset of the RARC to be used in the 005010X221 transaction. These codes are set forth in the Medical Billing and Payment Guide, Appendix B – 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk. Claims administrators should use the appropriate remittance remark codes to provide additional information to the health care provider regarding why a bill was adjusted or denied. Please note that RARC codes are required for certain Claim Adjustment Reason Codes. NCPDP Reject Codes are allowed for NCPDP transactions.

7.6 Claim Level California Jurisdictional EOR Statement ID Qualifier

The California paper Explanation of Review (EOR) process includes a requirement to provide health care providers, health care facilities, or billing agents/assignees with notice of “remedies,” i.e. ~~specific information regarding how to seek Workers' Compensation Appeals Board review of contested charges.~~ review of disputes regarding the amount paid (request for second bill review by claims administrator and request for independent bill review.) For electronic billing/remittance, the California required EOR remedies statement is reflected as a jurisdictional code in the 005010X221 transaction. The jurisdictional code is populated in Loop 2100 Other Claim Related Identification in REF02. The existing Reference Identification Qualifier “CE” Class of Contract Code is to be used as the qualifier in REF01 Segment for workers' compensation to indicate the value in REF02. The Reference Identification value in REF02 is the 2 byte postal state abbreviation “CA” that represents the California EOR statement. California's Jurisdictional REF02 “CA” code value equates to the following EOR statement (~~Labor Code § 4903.5~~):

A treating physician or authorized health care provider, health care facility, or billing agent/assignee may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board by filing a lien. Liens are subject to the statute of limitations spelled out in Labor Code § 4903.5:

(a) No lien claim for expenses as provided in subdivision (b) of Section 4903 may be filed after six months

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from the date on which the appeals board or a workers' compensation administrative law judge issues a final decision, findings, order, including an order approving compromise and release, or award, on the merits of the claim, after five years from the date of the injury for which the services were provided, or after one year from the date the services were provided, whichever is later.

(b) Notwithstanding subdivision (a), any health care provider, health care service plan, group disability insurer, employee benefit plan, or other entity providing medical benefits on a nonindustrial basis, may file a lien claim for expenses as provided in subdivision (b) of Section 4903 within six months after the person or entity first has knowledge that an industrial injury is being claimed.

An objection to charges from a hospital, outpatient surgery center, or independent diagnostic facility shall be deemed sufficient if the health care provider, health care facility, or billing agent/assignee is advised, within the thirty working day period specified above, that a request has been made for an audit of the billing, when the results of the audit are expected, and contains the name, address, and telephone number of the person or office to contact for additional information concerning the audit.

Any contested charge for medical treatment provided or authorized by the treating physician which is determined by the appeals board to be payable shall carry interest at the same rate as judgments in civil actions from the date the amount was due until it is paid.

TIME LIMITS TO DISPUTE PAYMENT AMOUNT

Request for Second Review

The Health Care Claim Payment/Advice (835) ASC X12N/005010X221 is the electronic explanation of review (EOR). After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the explanation of review. The Request for Second Review must conform to the requirements of the Division of Workers' Compensation Medical Billing and Payment Guide, the Electronic Medical Billing and Payment Companion Guide, and regulations at title 8, California Code of Regulations section 9792.5.4 et seq. If the dispute is the amount of payment and the health care provider, health care facility, or billing agent/assignee does not request a second review within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

Request for Independent Bill Review

After a health care provider, health care facility, or billing agent/assignee submits a Request for Second Review, the claims administrator will review the bill and issue the Health Care Claim Payment/Advice (835) ASC X12N/005010X221 which is the electronic explanation of review (EOR). This EOR is the final written determination by the claims administrator on the bill. After the EOR is issued on the second bill review submission, a health care provider, health care facility, or billing agent/assignee that still disputes the amount paid may submit a request for independent bill review within 30 days of service of the EOR. The Request for Independent Bill Review must conform to the requirements of title 8, California Code of Regulations section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent/assignee fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final.

7.7 Product/Service ID Qualifier

The Product/Service Identification Number transmitted in the inbound electronic billing format is returned in the 005010X221 transaction SVC Service Payment Information Segment with the appropriate qualifier. ~~For example, a Revenue Code billed with a HCPCS on a UB-04 is transmitted to the Claims Administrator. The Revenue Code qualifier and Revenue Code are returned in the 005010X221 transaction, not the HCPCS Code.~~

7.8 California 835 Workers' Compensation Instructions

Instructions for California specific requirements are also provided in Chapter 2 California Workers' Compensation Requirements. When the application/instructions for California workers' compensation ~~are~~ different than need clarification beyond the HIPAA implementation, it is identified in the following table:

7.8.1 ASC X12N/005010X221 Health Care Claim Payment/Advice (835)

Loop	Segment or Element	Description	California Companion Guide Workers' Compensation Comments or Instructions
1000A	PER	Submitter <u>Payer Technical</u> Contact Information	
	PER03	Communication Number Qualifier	Value must be 'TE' Telephone Number.
	PER04	Communication Number	Value must be the Telephone Number of the submitter.
1000A	PER	Payer Web Site	If using the 2110 Loop REF Segment HealthCare Policy Identification to communicate the Jurisdictional Statutory/Citation Reason Code, then the PER Payer Web Site Segment is required to communicate the California Jurisdiction URL Statutory/Citation reference.
	PER01	Contact Function Code	Value must be "IC"
	PER03	Communication Number Qualifier	Value must be "UR" to indicate URL
	PER04	Communication Number	Enter the California Jurisdictional URL Statutory/Citation reference site (web link). The value must be http://www.dir.ca.gov/dwc/Laws_Regulations.htm
2100	CLP	Claim Level Data	
	CLP06	Claim Filing Indicator Code	Value must be "WC" – Workers' Compensation
	CLP07	Payer Claim Control Number	Enter payer assigned claim control number (bill control number). The payer assigned claim control number for workers' compensation use is the bill control number.
2100	REF	Other Claim Related Identification	Claim Level Jurisdictional EOR /EOB Code Statement (Labor Code § 4903.5)
	REF01	Reference Identification Qualifier	Value must be "CE" Class of Contract Code
	REF02	Reference Identification	Reference Identification must be the State Jurisdiction 2 digit Postal Code. The State's Jurisdictional Postal code value equates to the EOR/ EOB statement (Labor Code § 4903.5) as defined in Chapter 7, section 7.6 of this companion guide.
2100	REF	Other Claim Related Identification	Insurance Policy Number. If an entire bill is denied at the claim level, using CARC code 191,214,221 or W1, then, use the Insurance Policy Number segment to report the appropriate California DWC Statute Code reference number.
	REF01	Reference Identification Qualifier	Value must be "IC"
	REF02	Reference Identification	Value must be the California DWC Statute code associated with the appropriate CARC code. Refer to the Medical Billing and Payment Guide Appendix B for California DWC Statute Codes associated with CARC Codes 191,214,221, or W1. Example: CARC 191 reason for denial is based on the DWC Labor Code §3600. The REF02 value would be "3600".
2100	REF	Other Claim Related Identification	Corrected Workers' Compensation Claim Number
	REF01	Reference Identification Qualifier	Value must be "1L" Group or Policy Number assigned by the payer
	REF02	Reference Identification	Enter Corrected Workers' Compensation Claim Number assigned by the payer
2100	DTM	Claim Date	Corrected Workers' Compensation Date of Accident/ Injury / Illness
	DTM01	Date/Time Qualifier	Value must be "036" to indicate Corrected Workers' Compensation Date of Accident/Injury / Illness
	DTM02	Date	Enter Corrected Date of Accident/Injury/Illness
2110	REF	HealthCare <u>Healthcare</u> Policy Identification	Jurisdiction Statutory/Citation Reason Code: If a bill is reduced at the line level using CARC Codes 191,214, 221, or W1 use HealthCare Healthcare Policy Identification segment to report the appropriate California DWC Statute Code reference number.
	REF01	Reference Identification Qualifier	Value must be "OK"
	REF02	Reference Identification	Enter Healthcare Policy, including Value must be the California DWC Statute code associated with the

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Loop	Segment or Element	Description	California Companion Guide Workers' Compensation Comments or Instructions
			appropriate CARC code . code —Refer to the Medical Billing and Payment Guide Appendix B section 7.4.1 <u>above</u> for California DWC Statute Codes associated with CARC Codes 191, 214, 221 , <u>191, 214, 221</u> , or W1.

Chapter 8 Companion Guide ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275)

The ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) Technical Report Type 3 contains the recommended (but not required) standard electronic format for submitting documentation to support a bill. Health care providers, health care facilities, or billing agents/assignees and claims administrators may also elect to submit documentation associated with electronic bill transactions through facsimile (fax) or electronic mail (email) in accordance with Chapter 2, section 2.4.7 Document/ Attachment Identification and the Medical Billing and Payment Guide. Health care providers, health care facilities, or billing agents/assignees that engage in electronic billing and all claims administrators must be able to electronically exchange medical and other documentation that is required to be submitted with the bill based on the regulatory requirements.

8.1 Reference Information

The ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) Technical Report Type 3 is available through the ~~Data Interchange Standards Association (DISA)~~ Accredited Standards Committee (ASC) X12 at: <http://store.x12.org>.

8.2 Documentation Requirements

Documentation requirements for California workers' compensation billing are defined in the Medical Billing and Payment Guide in Section One – 3.0 Complete Bills and 7.3 Electronic Bill Attachments.

Chapter 9 Companion Guide Acknowledgments

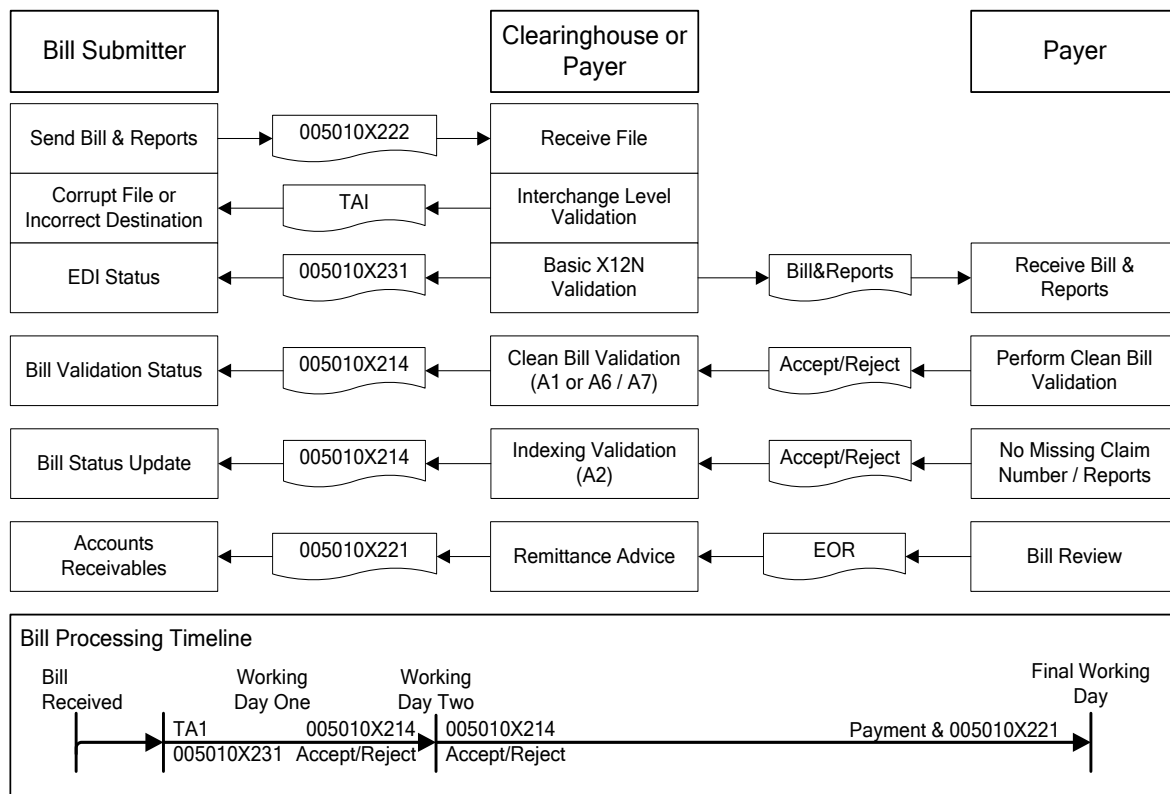
The timeframes for transmitting acknowledgments, payment, and remittance advice, and for placing bills that are missing a claim number or attachment in a “pending status,” are set forth in the Medical Billing and Payment Guide, ~~Chapter 7~~ Section One – Business Rules, section 7.1 Timeframes.

There are several different acknowledgments that are used to respond to the receipt of a bill by a clearinghouse and/or payer. The purpose of these acknowledgments is to provide the following feedback;

- 1) Basic file structure and the trading partner information from the Interchange Header.
- 2) Detailed structure and syntax of the actual bill data as specified by the X12 standard.
- 3) The content of the bill against the jurisdictional clean bill rules.
- 4) Any delays caused by claim number indexing/validation.
- 5) Any delays caused by attachment matching.
- 6) The outcome of the final adjudication, including reassociation to any financial transaction.

9.1 ~~Clean~~ Bill Acknowledgment Flow and Timing Diagrams

The process chart below shows how an incoming 005010X222, 005010X223, or 005010X224 transaction is validated and processed by the receiver. The diagram shows the basic acknowledgments that are generated by the receiver, including those for validation and final adjudication for those bills that pass validation.



9.1.2 Process Steps

1. **Interchange Level Validation:** Basic file format and the trading partner information from the Interchange Header are validated. If the file is corrupt or is not the expected type the file is rejected. If the trading partner information is invalid or unknown, the file is rejected. A TA1 (Interchange Acknowledgment) is returned to indicate the outcome of the validation. A rejected EDI file is not passed on to the next step.
2. **Basic X12 Validation:** A determination will be made as to whether the transaction set contains a valid 837. An ASC X12C/005010X231 Implementation Acknowledgment (999) will be returned to the submitter. The 005010X231 contains ACCEPT or REJECT of the Functional Acknowledgment information. If the file contains syntactical errors, the locations of the errors are reported. Bills that are part of a rejected transaction set are not passed on to the next step.
3. **Clean Bill Validation:** The jurisdictional and payer specific edits are run against each bill within the transaction set. An ASC X12N/005010X214 Health Claim Acknowledgment (277) is returned to accept or reject the bills. Bills that are rejected are not passed on to the next step.
4. **Clean Bill – Missing Claim Number and or Missing Required Report:** Refer to Section 9.2 Clean Bill - Missing Claim Number Pre Adjudication Holding (Pending) Status and Section 9.3 Clean Bill - Missing Report Pre-Adjudication Hold (Pending) Status regarding bill acknowledgment flow and timeline diagrams.
5. **Bill Review:** The bills that pass through bill review and any post-bill review approval process will be reported in the ASC X12N/005010X221 Health Care Claim Payment/Advice (835). The 005010X221 contains the adjudication information from each bill, plus any paper check or EFT payment information.

9.2 ~~Clean~~ Bill-Missing Claim Number Pre-Adjudication Hold (Pending) Status

One of the processing steps that a bill goes through prior to adjudication is to verify that the bill concerns an actual employment-related condition that has been reported to the employer and subsequently reported to the claims administrator. This process, usually called “claim indexing/validation” can cause a delay in the processing of the bill. Once the validation process is complete, a claim number is assigned to the injured worker’s claim. This claim number is necessary for the proper processing of the bill. Until the claim number is provided to the bill submitter, it cannot be included on the 005010X222, 005010X223, or 005010X224 (837) for submission to the payer. In order to prevent medical bills from being rejected due to lack of a claim number, a pre-adjudication hold (pending) period of up to five working days is mandated to enable the payer to attempt to match the bill to an existing claim in their system. If the bill cannot be matched within the five working days, the bill may be rejected as incomplete. If the payer is able to match the bill to an existing claim, it should attach the claim number to the transaction and put it through the adjudication process. The claim number should then be provided to the bill submitter using the ASCX12N 005010X214 for use in future billing. The ASCX12N 005010X214 is also used to inform the bill submitter of the delay and the ultimate resolution of the issue.

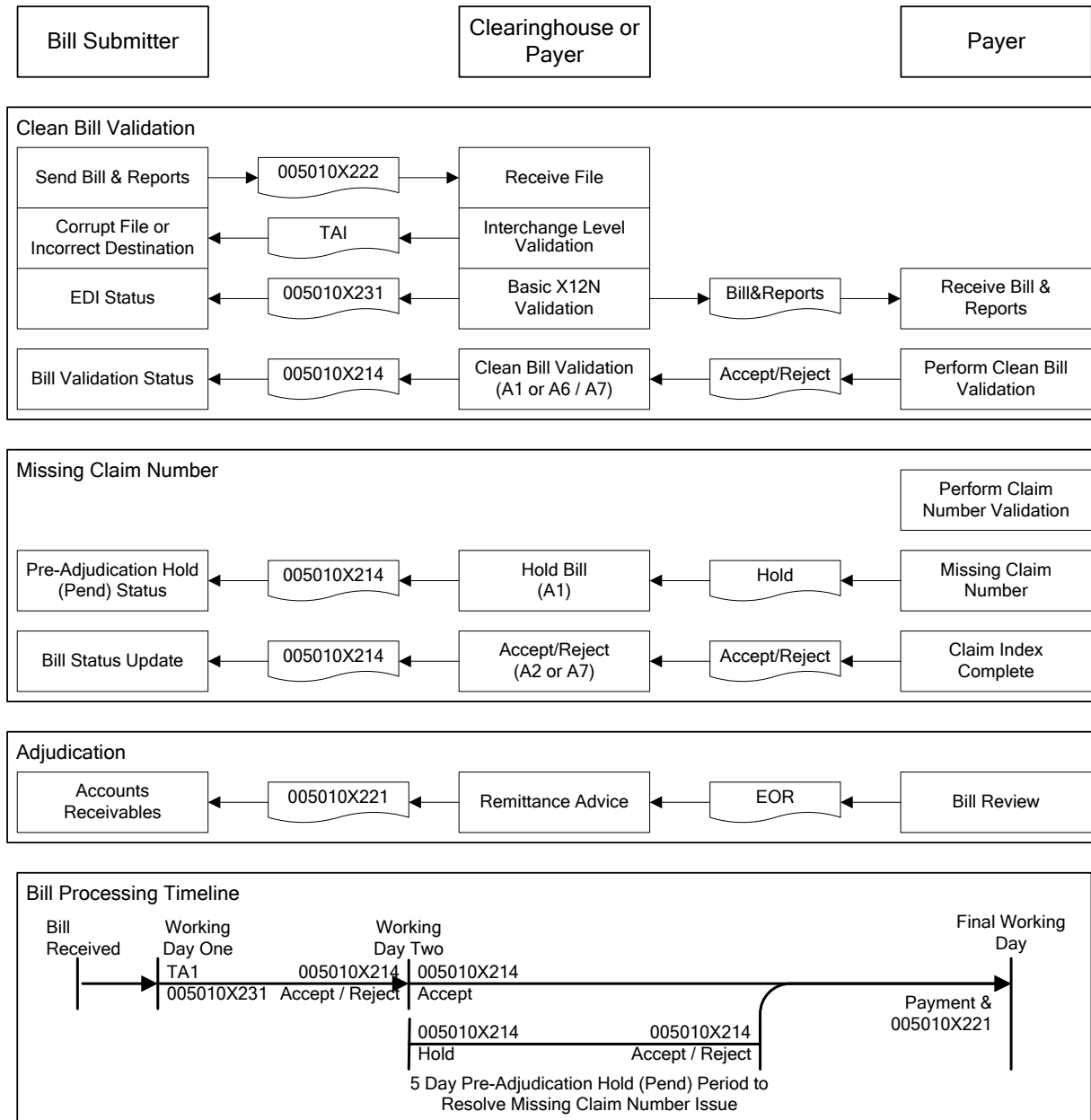
Due to the pre adjudication hold (pending) status a payer may send one STC segment with up to three claim status composites (STC01, STC10, and STC11) in a 005010X214. When a clean claim has a missing claim number and a missing report, the one STC segment in the 005010X214 would have the following three claim status composites: STC01, STC10 and STC11.

An Example: STC* A1:21* 20090830* UWQ* 70* * * * * A1:629* A1:294~

When a clean bill is only missing a claim number or missing a report the one STC segment in the 005010X214 would have the following two claim status composites: STC01 and STC10:

An Example: STC* A1:21* 20090830* UWQ* 70* * * * * A1:629~

A bill submitter could potentially receive two 005010X214 transmissions as a result of the pre adjudication hold (pending) status.



9.2.1 Missing Claim Number - ASC X12N/005010X214 Health Care Claim Acknowledgment (277)

Process Steps

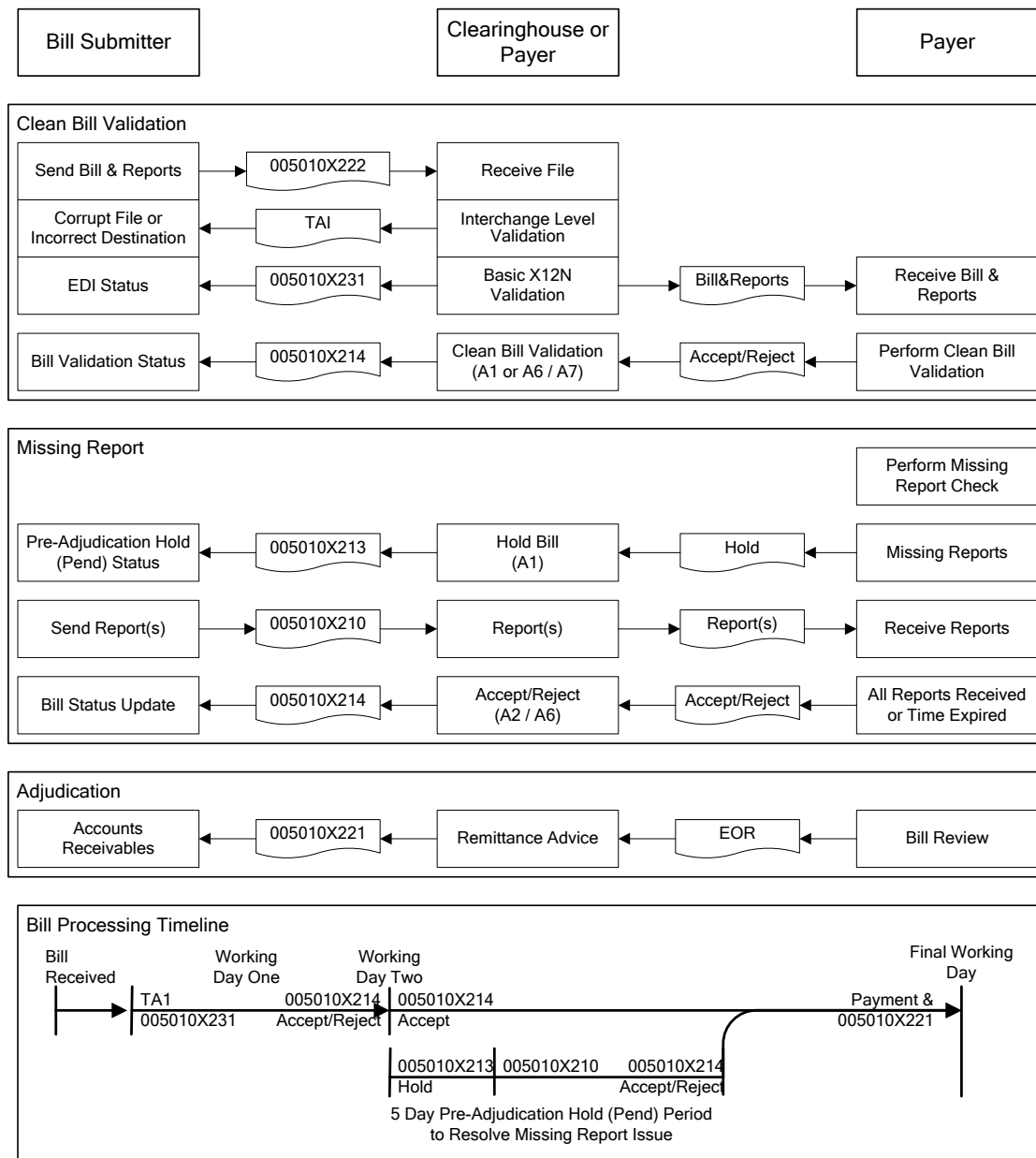
When the 005010X222, 005010X223, or 005010X224 (837) transaction has passed the clean bill validation process and Loop 2010 CA REF02 indicates that the workers' compensation claim number is "unknown" the payer will need to respond with the appropriate 005010X214 response (s) as applicable:

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Claim Number Validation Status	ASC X12N/005010X214 Health Care Claim Acknowledgment (277)
Clean Bill - Missing Claim Number	If the payer needs to pend an otherwise clean bill due to a missing claim number, then use the following Claim Status Category Code and Claim Status Code: STC01-1 = A1 The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication. STC01-2= 21 (Missing or Invalid Information) AND `</p> <p>STC10 -1 = ` A1 The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication. STC10-2 = 629 Property Casualty Claim Number Example: STC *A1:21* 20090830 *UWQ* 70 * * * * A1:629~
Claim Index/Validation Complete	ASC X12N/005010X214 Health Care Claim Acknowledgment (277)
Claim was Found	Once the Claim Indexing/ Validation process has been completed and there is a bill/ claim number match, then use the following Claim Status Category Code with the appropriate Claim Status Code: STC01-1 = A2 Acknowledgment/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system. STC01-2 = 20 Accepted for processing Payer Claim Control Number: Use Loop 2200D REF segment "Payer Claim Control Number with qualifier 1K Identification Number to return the workers' compensation claim number and or the payer bill control number in the REF02: a. Always preface the workers' compensation claim number with the two digit qualifier "Y4" followed by the property casualty claim number. Example: Y412345678 b. If there are two numbers (payer claim control number and the workers' compensation claim number) returned in the REF02, then use a blank space to separate the numbers. The first number will be the payer claim control number assigned by the payer (bill control number). The second number will be the workers' compensation property and casualty claim number assigned by the payer with a "Y4" qualifier followed by the claim number. Example: REF*1K*3456832 Y43333445556~
No Claim Found	After the Claim Indexing/ Validation process has been completed and there is no bill/ claim number match, then use the following Claim Status Category Code with the appropriate Claim Status Code: STC01-1 = A6 Acknowledgment/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected. STC01-2 = 629 Property Casualty Claim Number (No Bill/Claim Number Match)

9.3 Clean Bill-Missing Report Pre - Adjudication Hold (Pending) Status

One of the processing steps that a bill goes through prior to adjudication is to verify if all required documentation has been provided. The bill submitter can send the reports using the ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) or other mechanisms such as fax or e-mail. In order to prevent medical bills from being rejected due to lack of a required piece of documentation coming separately from the bill itself, a pre-adjudication hold (pending) period of up to five working days is mandated to enable the payer to receive and match the bill to the documentation. If the bill cannot be matched within the five working days, or the documentation is not received, the bill may be rejected as incomplete. If the payer is able to match the bill to the documentation within the five working days, it should put the bill through the adjudication process. The ASC X12N/005010X214 Health Care Claim Acknowledgment (277) is used to inform the bill submitter of the delay and the ultimate resolution of the issue.



9.3.1 Missing Report - ASC X12N/005010X214 Health Care Claim Acknowledgment (277)

Process Steps

When a bill submitter sends a 005010X222, 005010X223, or 005010X224 (837) that requires an attachment and Loop 2300 PWK Segment indicates there is a report or other supporting documentation that will be following, the payer will need to respond with the appropriate ASC X12N/005010X214 Health Care Claim Acknowledgment (277) response (s) as applicable:

Bill Status Findings	ASC X12N/005010X214 Health Care Claim Acknowledgment (277) Options+
Clean Bill- Missing Report	When a clean bill is missing a required report, then the payer needs to place the bill in a pre-adjudication hold (pending) status during the specified waiting time period and send the following Claim Status Category Code and Claim Status Code: STC01-1 = A1 The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication. STC01-2 = 21 (Missing or Invalid Information) AND STC10-1 = A1 The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication STC10-2 = Use the appropriate 277 Claim Status Code for missing report type <i>Example: Claim Status Code 294 Supporting documentation</i> <i>Example :STC*A1:21*20090830*UWQ*70*****A1:294~:</i>
Report Received within the 5 working day pre-adjudication hold (pending) period	Use the following Claim Status Category Code and Claim Status Code: STC01-1= A2 Acknowledgment/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system. STC01-2=20 Accepted for processing
No Report Received within the 5 working day pre-adjudication hold (pending) period	Use the following Claim Status Category Code and Claim Status Code. STC01-1= A6 Acknowledgment/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected. STC01-2=294 Supporting documentation

9.4 Transmission Responses

~~9.4.1 ASC X12N TA1 005010 Interchange Acknowledgement~~

~~The ASC X12N Interchange Acknowledgment, or TA1, found within the ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance, is used to provide the bill submitter negative confirmation of the transmission of the interchange control envelope portion of the EDI file transmission. The TA1 reports the syntactical analysis of the interchange header and trailer. If invalid (i.e. the data is corrupt or the trading partner relationship does not exist) the edit will reject and a TA1 will be returned. The entire transaction is rejected at the header level. The TA1 is only returned if the inbound ISA14 is set to a 1 whether or not the interchange is accepted or rejected.~~

~~9.4.2 ASC X12C/005010X231 – Implementation Acknowledgment for Health Care Insurance (999)~~

~~The ASC X12C/005010X231, Implementation Acknowledgment for Health Care Insurance (999), is used to provide the submitter a positive or negative confirmation of the structure of the 837 EDI file. If the 837 file contained syntactical errors, the segment(s) and element(s) where the error(s) occurred will be reported.~~

~~9.4.3 ASC X12N/005010X214 Health Care Claim Acknowledgment (277)~~

~~The word “claim” refers to the bill for medical services or goods, not the injured worker’s claim for workers’ compensation benefits. The ASC X12N/005010X214 Health Care Claim Acknowledgment (277) is used to provide the bill submitter with a positive or negative confirmation of each bill within the EDI file. The 005010X214 details what errors are present, and if necessary, what action the submitter should take. The 005010X214 should be used. Payers need to use the claim status category and claims status codes as prescribed by the 005010X214.~~

~~Most of the segments in the 005010X214 are used to identify which claim or service line is being acknowledged. The STC segment in the 005010X214 relays the status of the claim.~~

~~The STC segment is primarily made up of four fields:~~

~~STC01 the claim status code composite~~

~~STC02 the effective date of the status~~

~~STC03 the action code; accept or reject~~

~~STC04 original claim charge amount~~

~~Note: There are two additional composites that are available (STC10 and STC11) to provide a more bill status message, particularly when there is missing information.~~

~~The STC01 field is made up of four sub fields:~~

~~STC01-1 the status category code. Used to show if the status indicates a reject, accept, etc~~

~~STC01-2 the status code. Usually indicates the bill field that has a problem.~~

~~STC01-3 an optional entity type. Used when STC01-2 is an entity, to further refine the definition of the entity.~~

~~STC01-4 the status code list qualifier code. Always 65 for the 005010X214.~~

~~The following are the most common scenarios and STC01 values:~~

~~1) Claim was accepted and forwarded to another clearing house:~~

~~STC01-1 = A0 (acknowledgment/forwarded)~~

~~STC01-2 = 16 (claim has been forwarded to entity)~~

~~STC01-3 = List the entity~~

~~2) Claim was accepted for further processing (pre adjudication hold pend status):~~

~~STC01-1 = A1 (acknowledgment/received but does not mean the bill was accepted into the payer’s adjudication system)~~

~~STC01-2 = 21 (Missing or Invalid Information)~~

~~STC10-1 = A1 (acknowledgment/received but does not mean the bill was accepted into the payer’s adjudication system)~~

~~STC10-2 = 629 Property Casualty Claim Number~~

~~3) Claim was accepted by the payer for adjudication. An optional response based on level of feedback from the payer.~~

- ~~STC01-1 = A2 (acknowledgment/accepted into adjudication system)~~
~~STC01-2 = 20 (accepted for processing)~~
- ~~4) Claim was accepted and split into multiple claims.~~
~~STC01-1 = A5 (acknowledgment/split)~~
~~STC01-2 = 20 (accepted for processing)~~
- ~~5) Claim was rejected for missing information.~~
~~STC01-1 = A6 (acknowledgment/rejected for missing information)~~
~~STC01-2 = code indicating the missing data~~
~~STC01-3 = optional code indicating the entity type~~
- ~~6) Claim was rejected for invalid information.~~
~~STC01-1 = A7 (acknowledgment/rejected for invalid information)~~
~~STC01-2 = code indicating the invalid data~~
~~STC01-3 = optional code indicating the entity type~~

9.4.1 Acknowledgements

The ASC X12 transaction sets include a variety of acknowledgments to inform the sender about the outcome of transaction processing. Acknowledgments are designed to provide information regarding whether or not a transmission can be processed, based on structural, functional, and/or application level requirements or edits. In other words, the acknowledgments inform the sender regarding whether or not the medical bill can be processed or if the transaction contains all the required data elements.

Under California workers' compensation bill processing rules, claims administrators must return one or more of the following acknowledgments, as appropriate, according to the Bill Acknowledgment Flow and Timing Diagrams found in Section 9.1 and the Medical Billing and Payment Guide, Section One – Business Rules, section 7.1 Timeframes:

- TA1 -- Implementation Acknowledgment
- 005010X231 - Implementation Acknowledgment (999)
- 005010X214 -- Health Care Claim Acknowledgment (277)

Detailed information regarding the content and use of the various acknowledgments can be found in the applicable ASC X12N Type 3 Technical Reports (Implementation Guides).

9.4.2 ASC X12N/005010X213 - Request for Additional Information (277)

The 005010X213, or Health Care Claim Request for Additional Information, is used to request missing required reports or documentation from the submitter. The following are the STC01 values:

Claim was pended; additional documentation required.

STC01-1 = R4 (pended/request for additional supporting documentation)

STC01-2 = The LOINC code indicating the required documentation

Additional information regarding this transaction set may be found in the applicable ASC X12N Type 3 Technical Reports (Implementation Guides).

9.4.43 ASC X12N/005010X221 Health Care Claim Payment/Advice (835)

~~The ASC X12N/005010X221 Health Care Claim Payment/Advice (835) is used as a replacement for a paper remittance advice/explanation of review. The 005010X221 will be delivered to the bill submitter. It is used to communicate claims processing decisions relating to payment, adjustment, or denial of the bill. See Chapter 7 for further detail regarding the 005010X221 transaction.~~ informs the health care provider about the payment action taken by the claims administrator. Additional information regarding this transaction set may be found in Chapter 7 of this companion guide and the applicable *ASC X12N Type 3 Technical Reports (Implementation Guides)*.

9.4.4 ASC X12N/005010X212 Health Care Claim Status Request and Response (276/277)

The 005010X212 transaction set is used in the group health industry to inquire about the current status of a specified healthcare bill or bills. The 276 transaction set identifier code is used for the inquiry and the 277 transaction set identifier code is used for the reply. It is possible to use these transaction sets unchanged in workers' compensation bill processing. Additional information regarding this transaction set may be found in the applicable ASC X12N Type 3 Technical Reports 005010X212 Health Care Claim Status Request and Response (276/277).

Appendix A – Glossary of Terms

Acknowledgment	Electronic notification to original sender of an electronic transmission or the transactions within the transmission were accepted or rejected.
ADA	American Dental Association.
ADA-2006	American Dental Association (ADA) standard paper billing form.
AMA	American Medical Association
<u>ASC X12</u>	<u>The Accredited Standards Committee (ASC) X12, chartered by the American National Standards Institute (ANSI) in 1979, develops electronic data interchange (EDI) standards for a variety of industries.</u>
<u>ASC X12 275</u> ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275)	National standard format for attachments/documentation. The 275 format is being reviewed for possible adoption as a HIPAA standard format. A standard transaction developed by ASC X12 to transmit various types of patient information.
<u>ASC X12 835</u> ASC X12N/005010X221 Health Care Claim Payment/Advice (835)	HIPAA-compliant national standard remittance/reimbursement format. A standard transaction developed by ASC X12 to transmit various types of health care claim payment/advice information.
<u>ASC X12 837</u> ASC X12N/005010X222, 005010X223, 005010X224 (837)	HIPAA-compliant national standard billing format for professional services (837), hospital/facility services (837), and dental services (837). A standard transaction developed by ASC X12 to transmit various types of health care claim information.
ASC X12C/005010X231 Implementation Acknowledgment (999)	HIPAA-compliant national standard implementation acknowledgment transaction.
CDT	Current Dental Terminology coding system used to bill dental services.
Clearinghouse	An entity that processes information received in a nonstandard format or containing nonstandard data content into a standard transaction, or that receives a standard transaction and processes that information into a nonstandard transaction
CMS	Centers for Medicare and Medicaid Services, of U.S. Dept. of Health and Human Services.
CMS-1450	The paper hospital, institutional or facility billing form also referred to as a UB-04.

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CMS-1500	The paper professional billing form formerly referred to as a HCFA or HCFA-1500.
Code Sets	Tables or lists of codes used for specific purposes. National standard formats may use code sets developed by the standard setting organization (i.e. Provider Type qualifiers) or by other organizations (i.e. HCPCS codes).
CPT	Current Procedural Terminology is the coding system created and copyrighted by the American Medical Association used to bill professional services.
DEA	Drug Enforcement Agency
DEA Number	Prescriber DEA identifier used for pharmacy billing.
Detail Acknowledgment	Electronic notification to original sender of an electronic transmission or the transactions within the transmission were accepted or rejected.
DWC	Division of Workers' Compensation of the California Dept. of Industrial Relations.
Electronic Bill	A bill submitted from the health care provider, health care facility, or billing agent/assignee to the payer electronically.
EFT	Electronic Funds Transfer.
Electronic Format	The specifications defining the layout of data in an electronic transmission.
Electronic Record	A group of related data elements. A record may represent a line item, a health care provider, health care facility, or billing agent/assignee, or an employer. One or more records may form a transaction.
Electronic Transaction	A set of information or data stored electronically in a defined format that has a distinct and different meaning as a set. An electronic transaction is made up of one or more electronic records.
Electronic Transmission	Transmission of information by electronic data interchange.
EOB/EOR	Explanation of Benefits (EOB) or Explanation of Review (EOR) is the paper form document or the electronic ASC X12N/005010X221 Health Care Claim Payment/Advice (835) sent by the Claims Administrator to the health care provider, health care facility, or billing agent/assignee to explain payment, adjustment, or denial of a medical bill. The EOB/EOR might also be used to request a recoupment of an overpayment or acknowledge receipt of a refund.
Functional Acknowledgment	Electronic notification to original sender of an electronic transmission that the functional group within the transaction was accepted or rejected.
HCPCS	Health Care Common Procedure Coding System is the HIPAA code set used to bill durable medical equipment, prosthetics, Orthotics , supplies, and biologics (Level II) as well as professional services (Level I). Level I HCPCS codes are CPT codes (<u>© American Medical Association</u>).

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HIPAA	Health Insurance Portability and Accountability Act, federal legislation that includes provisions that mandate electronic billing in the Medicare system and establishes national standard electronic file formats and code sets.
IAIABC	International Association of Industrial Accident Boards and Commissions.
IAIABC 837	A version of the 837 electronic file format adopted by IAIABC for Claims Administrator to jurisdiction reporting of medical bill payment data. An implementation guide developed by the IAIABC based on the ASC X12 standard to transmit various types of health care medical bill and payment information from claim administrators to jurisdictions.
ICD-9	International Classification of Diseases, the code set administered by the World Health Organization used to identify diagnoses.
MPN	Medical Provider Network as defined by California Labor Code § 4614.
NCPDP	National Council for Prescription Drug Programs.
NCPDP WC/PC UCF	National Council for Prescription Drug Programs Workers' Compensation/Property and Casualty Universal Claim Form which is the pharmacy industry standard for pharmacy claims billing on paper forms.
NCPDP Telecommunication D.0	HIPAA compliant national standard billing format for pharmacy services.
NDC	National Drug Code, code set used to identify medication dispensed by pharmacies.
NPI	National Provider Identification Number, obtained from CMS.
OMFS	California Official Medical Fee Schedule, established pursuant to Labor Code § 5307.1.
PBM	Pharmacy Benefit Manager.
PPO	Preferred Provider Organization
Receiver	The entity receiving/accepting an electronic transmission.
Remittance	Remittance is used in the electronic environment to refer to reimbursement or denial of medical bills.
Sender	The entity submitting an electronic transmission.
TPA	Third Party Administrator.
Trading Partner	Parties to an electronic transaction.
UB-04	Universal <u>paper</u> billing form used for hospital <u>facility</u> billing.

Version

Electronic formats may be modified in subsequent releases. Version naming conventions indicate the release or version ~~for a format~~ of the standard being referenced. Naming conventions are administered by the standard setting organization. Some ~~formats~~, ASC X12 versions, for example, are 3050, 4010, 4050 and 5010.

Appendix B – Code Set References

The table below provides a matrix of the code sets referenced in the companion guide.

Code Set	Definition	Publishing Entity
=	=	=
APPLICATION ACKNOWLEDGMENT CODE	A code used to identify the accepted/rejected status of the transaction being acknowledged.	Data Interchange Standards Association (DISA) 7600 Leesburg Pike, Suite 430 Falls Church, VA 22043 USA email info@disa.org http://store.x12.org
BASIS OF COST DETERMINATION	Method by which drug cost was calculated. Used for statistical analysis and cost comparison.	National Council for Prescription Drug Programs, (NCPDP) www.ncdp.org 9240 E. Raintree Dr. Scottsdale, Arizona 85260-7518
BILL SUBMISSION REASON CODE	Code indicating bill submission/re- submission type. Determine status and reason for submission; monitors medical costs.	Data Interchange Standards Association (DISA) 7600 Leesburg Pike, Suite 430 Falls Church, VA 22043 USA email info@disa.org http://store.x12.org
BILLING TYPE CODE	Code indicating type of bill. Statistical analysis and audit information, tracing medical costs.	National Uniform Billing Committee – American Hospital Association www.nubc.org/ One North Franklin, Chicago, IL 60606-3421
CDT Code	American Dental Association Codes on Dental Procedure and Nomenclature (Current Dental Terminology) used to identify dental procedure billed & paid.	American Dental Association http://www.adap.org/ 211 East Chicago Ave. Chicago, IL 60611-2678
CLAIM ADJUSTMENT GROUP CODE	Codes indicating general category of payment adjustment at the bill level and service line. Identifies potential litigation; tracking medical costs; used for statistical analysis.	Washington Publishing Company 10940 NE 33rd Place, Suite 204 Bellevue, WA 98004 (425) 562-2245 – Voice (775) 239-2061 – Fax http://www.wpc-edi.com

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Code Set	Definition	Publishing Entity
=	=	=
CLAIM ADJUSTMENT REASON CODE	Codes indicating detailed reason an adjustment was made at the bill and service line levels.	Washington Publishing Company 10940 NE 33rd Place, Suite 204 Bellevue, WA 98004 (425) 562-2245 Voice (775) 239-2061 Fax http://www.wpc-edi.com
COUNTRY CODE	Code indicating country of the billing provider's mailing address. Identify provider's location; reimbursement determination.	U.S. Postal Service www.usps.com/
DISPENSE AS WRITTEN CODE	A code denoting methodology utilized in dispensing medication; Measuring medical cost trends; managed care certification; impact of medical treatment guidelines.	National Council for Prescription Drug Programs, (NCPDP) www.ncdp.org/ 9240 E. Raintree Dr. Scottsdale, Arizona 85260-7518
DRG CODE or MS-DRG CODE	"Diagnosis Related Group (DRG)" or "Medicare Severity DRG" means Medicare Severity Diagnosis Related Group inpatient classification scheme used by CMS for hospital inpatient reimbursement. The DRG system classifies patients based on principal diagnosis, surgical procedure, presence of comorbidities and complications and other pertinent data.	Center for Medicare and Medicaid Services (CMS) http://www.cms.hhs.gov/ 7500 Security Boulevard Baltimore, MD 21244
DWC BILL ADJUSTMENT REASON CODE	The DWC Bill Adjustment Reason Codes are a group of codes developed by the California Division of Workers' Compensation to describe the specific reasons why a particular billed code has not been paid or has been paid at a different rate than that which was billed or to request additional information.	The DWC Medical Billing and Payment Guide DWC Fee Schedules P.O. Box 71010 Oakland, CA 94612
ELEMENT ERROR NUMBER	A number to uniquely identify the edit performed on an element and is part of the error code.	Data Interchange Standards Association (DISA) 7600 Leesburg Pike, Suite 430 Falls Church, VA 22043 USA email info@disa.org http://store.x12.org

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Code Set	Definition	Publishing Entity
=	=	=
HCPGS PROCEDURE CODE	HCPGS (Health Care Common Procedure Coding System) code billed and paid. Procedure codes identify treatment rendered for professional services, durable medical equipment, prosthetics, orthotics, and medical supplies.	American Medical Association www.ama-assn.org/ 515 N. State Street Chicago, IL 60610
Hospital Admission Type Code	Code indicating admission priority. Identifies potential reimbursement formulas and pre-authorization of services.	National Uniform Billing Committee American Hospital Association www.nubc.org/ One North Franklin, Chicago, IL 60606-3421
Hospital BILL FREQUENCY TYPE CODE	Code indicating claim billing status. Statistical analysis and audit information.	National Uniform Billing Committee American Hospital Association www.nubc.org/ One North Franklin, Chicago, IL 60606-3421
Hospital FACILITY CODE	Code indicating type of facility where treatment was rendered. Utilization review, audit, statistical analysis.	National Uniform Billing Committee American Hospital Association www.nubc.org/ One North Franklin, Chicago, IL 60606-3421
HOUR	The time claimant was admitted / discharged from the facility. Determine length of stay.	National Uniform Billing Committee American Hospital Association www.nubc.org/ One North Franklin, Chicago, IL 60606-3421
ICD-9-CM Diagnosis Code	International Classification of Diseases, Ninth Revision, Clinical Modification, Volumes 1 and 2, describes the classification or morbidity and mortality information for statistical purposes and the indexing of hospital records by disease and operations.	World Health Organization through the Centers for Disease Control, National Center for Health Statistics (NCHS) responsible for maintaining codes. http://www.cdc.gov/nchs/icd.htm
ICD-9-CM Procedure Code	International Classification of Diseases, Ninth Revision, Clinical Modification Volume 3, Procedure Codes—classification system for surgical, diagnostic, and therapeutic procedures.	World Health Organization through the Centers for Disease Control, National Center for Health Statistics (NCHS) responsible for maintaining codes. http://www.cdc.gov/nchs/icd.htm

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Code Set	Definition	Publishing Entity
=	=	=
NDC CODE	NDC (National Drug Code) identifying drugs or pharmaceuticals billed. The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs.	Food and Drug Administration http://www.fda.gov/oc/ndc/ 5600 Fishers Lane, HFD-240 Rockville, MD 20857
NPI	National Provider Identifier (NPI) assigned by CMS.	Center for Medicare and Medicaid Services (CMS) http://www.cms.hhs.gov/ 7500 Security Boulevard Baltimore, MD 21244
PLACE OF SERVICE	Identifies location where professional services were rendered.	Center for Medicare and Medicaid Services (CMS) http://www.cms.hhs.gov/ 7500 Security Boulevard Baltimore, MD 21244
POSTAL CODE	Postal code (zip code) of provider's mailing address of the billing provider. Identification of provider; monitor health care providers for compliance with fee and treatment guidelines.	U.S. Postal Service www.usps.com/
PRESCRIBER DEA NUMBER	Drug Enforcement Agency of the Federal Justice Department assigns a unique number to physicians prescribing controlled substances.	Federal Drug Enforcement Agency www.usdoj.gov/dea/ 2401 Jefferson Davis Highway Alexandria, VA 22301
PROVIDER LICENSE NUMBER	Unique provider identification number assigned by a licensing/certifying entity.	Licensing/certifying boards or commissions.
PROVIDER TAXONOMY CODES	Code indicating primary medical specialty of billing provider. Identification of provider; monitor health care providers for compliance with fee and treatment.	National Uniform Claim Committee www.nucc.org/taxonomy
REMITTANCE ADVICE REMARK CODES	Convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	Washington Publishing Company 10940 NE 33rd Place, Suite 204 Bellevue, WA 98004 (425) 562-2245 Voice (775) 239-2061 Fax http://www.wpc-edi.com

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Code Set	Definition	Publishing Entity
=	=	=
REVENUE BILLED & PAID CODE (B5)	Code indicating specific cost center billed and paid. Determines reimbursement and treatment provided or specific cost center paid.	National Uniform Billing Committee—American Hospital Association www.nubc.org/ One North Franklin, Chicago, IL 60606-3421
Rx NCPDP Number	National Council of Prescription Drug Programs pharmacy identification number	National Council of Prescription Drug Programs www.ncpdp.org/ 9240 E. Raintree Dr. Scottsdale, Arizona 85260-7518
STATE CODE	State code of provider's mailing address of the billing provider. Identify provider's location; reimbursement determination.	U.S. Postal Service www.usps.com/
Tooth Letter	American Dental Association letter assigned to represent primary teeth.	American Dental Association http://www.ada.org/ 211 East Chicago Ave. Chicago, IL 60611-2678
Tooth Number	American Dental Association number assigned to represent permanent teeth.	American Dental Association http://www.ada.org/ 211 East Chicago Ave. Chicago, IL 60611-2678
Tooth Surface Code	American Dental Association letter used to designate tooth surface.	American Dental Association http://www.ada.org/ 211 East Chicago Ave. Chicago, IL 60611-2678

Appendix B – Jurisdictional Report Type Codes and DWC Descriptions

OZ - Jurisdictional List of Report Type Codes	California DWC Description
J1 Doctor First Report of Injury	A Doctor's First Report of Occupational Injury (DLSR 5021), must be submitted when the bill is for Evaluation and Management services and a Doctor's First Report of Occupational Injury is required is the report required under Labor Code § 6409, and Title 8, California Code of Regulations §§ 14003, 14006 and 9785.
J2 Supplemental Medical Report	This is to be used when billing for a "By Report" code or any other additional type of supplemental report. - A medical report to support a billing for a "By Report" code. - A supplemental medical report that does not fit within any of the other Jurisdiction Report Type Codes or the ASC X12 Report Type Codes.
J3 Medical Permanent Impairment Report	Do not use
J4 Medical Legal Report	A Medical-Legal report is a report submitted by a <u>Qualified Medical Evaluator, QME, Agreed Medical Evaluator AME</u> or the Primary Treating Physician when addressing a disputed medical issue <u>and obtained for the purpose of proving or disproving a contest claim. This includes a "supplemental" medical-legal report.</u>
J5 Vocational Report	<u>A report by a vocational expert.</u>
J6 Work Status Report	<u>A report by a medical provider addressing the employee/patient's work status, if the report does not fit within any of the other Jurisdiction Report Type Codes or the ASC X12 Report Type Codes.</u>
J7 Consultation Report	A narrative report must be submitted when the bill is for Evaluation and Management services for a consultation. <u>A report of a consulting physician.</u>
J8 Permanent Disability Report	A PR-3, PR-4 or their narrative equivalent must be submitted when the bill is for Evaluation and Management services and the injured worker's condition has been declared permanent and stationary with permanent disability or a need for future medical care. (Use of Modifier -17) <u>Form PR-3 "Primary Treating Physician's Permanent and Stationary Report (PR-3)" (Title 8, California Code of Regulations § 9785.3) or narrative equivalent (Title 8, California Code of Regulations § 9785(h).)</u> <u>Form PR-4 "Primary Treating Physician's Permanent and Stationary Report (PR-4)" (Title 8, California Code of Regulations § 9785.4) or narrative equivalent (Title 8, California Code of Regulations § 9785(h).)</u>

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J9 <u>Itemized Statement</u>	Itemized Statement
09 Progress Report	A PR-2 report or its narrative equivalent must be submitted when the bill is for Evaluation and Management services and a PR-2 report is required under Title 8, California Code of Regulations § 9785.
10 Continued Treatment	To be used when submitting a Functional Improvement Report.
11 Chemical Analysis	=
13 Certified Test Report	=
06 Initial Assessment	Physical Therapy or Occupational Therapy initial assessment report
21 Recovery Plan	=
A3 Allergies/Sensitivities Document	=

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OZ Jurisdictional List of Report Type Codes	California DWC Description
A4 Autopsy Report	
AM Ambulance Certification	
DB Durable Medical Equipment Prescription	=
DJ Discharge Monitoring Report	=
LA Laboratory Results	=
M1 Medical Record Attachment	=
OD Orders and Treatments Document	=
P4 Pathology Report	=
PY Physician's Report	=
V5 Death Notification	=
XP Photographs	=

Appendix ~~D~~ B – Security Rule

SECURITY RULE TO PROTECT THE CONFIDENTIALITY OF MEDICAL INFORMATION SUBMITTED ELECTRONICALLY

1.0 Introduction

Health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators shall implement procedures and utilize mechanisms to ensure the confidentiality of medical information submitted on electronic claims for payment of medical services. This security rule adapts the rules implementing the federal Health Insurance Portability and Accountability Act of 1996 for use in California workers' compensation electronic billing. (45 Code of Federal Regulations Subtitle A, Subchapter C, Part 164, Subchapter C, §§164.302-164.318 and Appendix.) These rules have been modified slightly for California workers' compensation electronic billing purposes. The changes include the following: this rule is applicable to "health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators" instead of "covered entities;" this rule uses the term "medical information" instead of "protected health information;" this rule refers to "the security rule" instead of "this subpart;" this rule refers to "applicable privacy laws" instead of "requirements of subpart E [of HIPAA rule]." The numbering parallels the HIPAA regulation numbering for the convenience of the public.

2.0 § 164.302 Applicability.

Health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators must comply with the applicable standards, implementation specifications, and requirements of this security rule with respect to electronic medical information.

3.0 § 164.304 Definitions.

As used in this security rule, the following terms have the following meanings:

Access means the ability or the means necessary to read, write, modify, or communicate data/information or otherwise use any system resource.

Administrative safeguards are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic medical information and to manage the conduct of the entity's workforce in relation to the protection of that information.

Authentication means the corroboration that a person is the one claimed.

Availability means the property that data or information is accessible and useable upon demand by an authorized person.

Confidentiality means the property that data or information is not made available or disclosed to unauthorized persons or processes.

Encryption means the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key.

Facility means the physical premises and the interior and exterior of a building(s).

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Information system means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

Integrity means the property that data or information have not been altered or destroyed in an unauthorized manner.

Malicious software means software, for example, a virus, designed to damage or disrupt a system.

Password means confidential authentication information composed of a string of characters.

Physical safeguards are physical measures, policies, and procedures to protect an entity's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

Security or Security measures encompass all of the administrative, physical, and technical safeguards in an information system.

Security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Technical safeguards means the technology and the policy and procedures for its use that protect electronic medical information and control access to it.

User means a person or entity with authorized access.

Workstation means an electronic computing device, for example, a laptop or desktop computer, or any other device that performs similar functions, and electronic media stored in its immediate environment.

4.0 § 164.306 Security standards: General rules.

(a) General requirements. Health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators must do the following:

(1) Ensure the confidentiality, integrity, and availability of all electronic medical information the entity creates, receives, maintains, or transmits.

(2) Protect against any reasonably anticipated threats or hazards to the security or integrity of such information.

(3) Protect against any reasonably anticipated uses or disclosures of such information that are not legally permitted or required.

(4) Ensure compliance with the security rule by its workforce.

(b) Flexibility of approach.

(1) Health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators may use any security measures that allow the entity to reasonably and appropriately implement the standards and implementation specifications as specified in this the security rule.

(2) In deciding which security measures to use, health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators must take into account the following factors:

(i) The size, complexity, and capabilities of the entity.

(ii) The entity's technical infrastructure, hardware, and software security capabilities.

(iii) The costs of security measures.

(iv) The probability and criticality of potential risks to electronic medical information.

(c) Standards. Health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators must comply with the standards as provided in this section and in § 164.308, § 164.310, § 164.312, § 164.314, and § 164.316 with respect to all electronic medical information.

(d) Implementation specifications.

In this security rule:

(1) Implementation specifications are required or addressable. If an implementation specification is required, the word "Required" appears in parentheses after the title of the implementation specification. If an implementation specification is addressable, the word "Addressable" appears in parentheses after the title of the implementation specification.

(2) When a standard adopted in § 164.308, § 164.310, § 164.312, § 164.314, or § 164.316 includes required implementation specifications, health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators must implement the implementation specifications.

(3) When a standard adopted in § 164.308, § 164.310, § 164.312, § 164.314, or § 164.316 includes addressable implementation specifications, health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators must --

(i) Assess whether each implementation specification is a reasonable and appropriate safeguard in its environment, when analyzed with reference to the likely contribution to protecting the entity's electronic medical information; and

(ii) As applicable to the entity --

(A) Implement the implementation specification if reasonable and appropriate; or

(B) If implementing the implementation specification is not reasonable and appropriate --

(1) Document why it would not be reasonable and appropriate to implement the implementation specification; and

(2) Implement an equivalent alternative measure if reasonable and appropriate.

(e) Maintenance. Security measures implemented to comply with standards and implementation specifications adopted under this security rule must be reviewed and modified as needed to continue provision of reasonable and appropriate protection of electronic-medical information as described at § 164.316.

5.0 § 164.308 Administrative safeguards.

(a) Health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators -must, in accordance with § 164.306:

(1)(i) Standard: Security management process. Implement policies and procedures to prevent, detect, contain, and correct security violations.

(ii) Implementation specifications:

(A) Risk analysis (Required). Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic medical information held by the entity.

(B) Risk management (Required). Implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with § 164.306(a).

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(C) Sanction policy (Required). Apply appropriate sanctions against workforce members who fail to comply with the security policies and procedures of the entity.

(D) Information system activity review (Required). Implement procedures to regularly review records of information system activity, such as audit logs, access reports, and security incident tracking reports.

(2) Standard: Assigned security responsibility. Identify the security official who is responsible for the development and implementation of the policies and procedures required by this rule for the entity.

(3)(i) Standard: Workforce security. Implement policies and procedures to ensure that all members of its workforce have appropriate access to electronic medical information, as provided under paragraph (a)(4) of this section, and to prevent those workforce members who do not have access under paragraph (a)(4) of this section from obtaining access to electronic medical information.

(ii) Implementation specifications:

(A) Authorization and/or supervision (Addressable). Implement procedures for the authorization and/or supervision of workforce members who work with electronic medical information or in locations where it might be accessed.

(B) Workforce clearance procedure (Addressable). Implement procedures to determine that the access of a workforce member to electronic medical information is appropriate.

(C) Termination procedures (Addressable). Implement procedures for terminating access to electronic medical information when the employment of a workforce member ends or as required by determinations made as specified in paragraph (a)(3)(ii)(B) of this section.

(4)(i) Standard: Information access management. Implement policies and procedures for authorizing access to electronic medical information that are consistent with the applicable privacy laws.

(ii) Implementation specifications:

(A) Isolating health care clearinghouse functions (Required). If a health care clearinghouse is part of a larger organization, the clearinghouse must implement policies and procedures that protect the electronic medical information of the clearinghouse from unauthorized access by the larger organization.

(B) Access authorization (Addressable). Implement policies and procedures for granting access to electronic medical information, for example, through access to a workstation, transaction, program, process, or other mechanism.

(C) Access establishment and modification (Addressable). Implement policies and procedures that, based upon the entity's access authorization policies, establish, document, review, and modify a user's right of access to a workstation, transaction, program, or process.

(5)(i) Standard: Security awareness and training. Implement a security awareness and training program for all members of its workforce (including management).

(ii) Implementation specifications. Implement:

(A) Security reminders (Addressable). Periodic security updates.

(B) Protection from malicious software (Addressable). Procedures for guarding against, detecting, and reporting malicious software.

(C) Log-in monitoring (Addressable). Procedures for monitoring log-in attempts and reporting discrepancies.

(D) Password management (Addressable). Procedures for creating, changing, and safeguarding passwords.

(6)(i) Standard: Security incident procedures. Implement policies and procedures to address security incidents.

(ii) Implementation specification: Response and Reporting (Required). Identify and respond to suspected or known security incidents; mitigate, to the extent practicable, harmful effects of security incidents that are known to the entity; and document security incidents and their outcomes.

(7)(i) Standard: Contingency plan. Establish (and implement as needed) policies and procedures for responding to an emergency or other occurrence (for example, fire, vandalism, system failure, and natural disaster) that damages systems that contain electronic medical information.

(ii) Implementation specifications:

(A) Data backup plan (Required). Establish and implement procedures to create and maintain retrievable exact copies of electronic medical information.

(B) Disaster recovery plan (Required). Establish (and implement as needed) procedures to restore any loss of data.

(C) Emergency mode operation plan (Required). Establish (and implement as needed) procedures to enable continuation of critical business processes for protection of the security of electronic medical information while operating in emergency mode.

(D) Testing and revision procedures (Addressable). Implement procedures for periodic testing and revision of contingency plans.

(E) Applications and data criticality analysis (Addressable). Assess the relative criticality of specific applications and data in support of other contingency plan components.

(8) Standard: Evaluation. Perform a periodic technical and nontechnical evaluation, based initially upon the standards implemented under this rule and subsequently, in response to environmental or operational changes affecting the security of electronic medical information, that establishes the extent to which an entity's security policies and procedures meet the requirements of this security rule.

(b)(1) Standard: Business associate contracts and other arrangements. Health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators, in accordance with § 164.306, may permit a business associate to create, receive, maintain, or transmit electronic medical information on the entity's behalf only if the entity obtains satisfactory assurances, in accordance with § 164.314(a) that the business associate will appropriately safeguard the information.

(2) This standard does not apply with respect to --

(i) The transmission by health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators of electronic medical information to a health care provider concerning the treatment of an individual.

(3) A health care provider, health care facility, billing agent/assignee, clearinghouse and workers' compensation claims administrator that violates the satisfactory assurances it provided as a business associate of another entity will be in noncompliance with the standards, implementation specifications, and requirements of this paragraph and § 164.314(a).

(4) Implementation specifications: Written contract or other arrangement (Required). Document the satisfactory assurances required by paragraph (b)(1) of this section through a written contract or other arrangement with the business associate that meets the applicable requirements of § 164.314(a).

6.0 § 164.310 Physical safeguards.

Health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators must, in accordance with § 164.306:

(a)(1) Standard: Facility access controls. Implement policies and procedures to limit physical access to its electronic information systems and the facility or facilities in which they are housed, while ensuring that properly authorized access is allowed.

(2) Implementation specifications:

(i) Contingency operations (Addressable). Establish (and implement as needed) procedures that allow facility access in support of restoration of lost data under the disaster recovery plan and emergency mode operations plan in the event of an emergency.

(ii) Facility security plan (Addressable). Implement policies and procedures to safeguard the facility and the equipment therein from unauthorized physical access, tampering, and theft.

(iii) Access control and validation procedures (Addressable). Implement procedures to control and validate a person's access to facilities based on their role or function, including visitor control, and control of access to software programs for testing and revision.

(iv) Maintenance records (Addressable). Implement policies and procedures to document repairs and modifications to the physical components of a facility which are related to security (for example, hardware, walls, doors, and locks).

(b) Standard: Workstation use. Implement policies and procedures that specify the proper functions to be performed, the manner in which those functions are to be performed, and the physical attributes of the surroundings of a specific workstation or class of workstation that can access electronic medical information.

(c) Standard: Workstation security. Implement physical safeguards for all workstations that access electronic medical information, to restrict access to authorized users.

(d)(1) Standard: Device and media controls. Implement policies and procedures that govern the receipt and removal of hardware and electronic media that contain electronic medical information into and out of a facility, and the movement of these items within the facility.

(2) Implementation specifications:

(i) Disposal (Required). Implement policies and procedures to address the final disposition of electronic medical information, and/or the hardware or electronic media on which it is stored.

(ii) Media re-use (Required). Implement procedures for removal of electronic medical information from electronic media before the media are made available for re-use.

(iii) Accountability (Addressable). Maintain a record of the movements of hardware and electronic media and any person responsible therefore.

(iv) Data backup and storage (Addressable). Create a retrievable, exact copy of electronic medical information, when needed, before movement of equipment.

7.0 § 164.312 Technical safeguards.

Health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators must, in accordance with § 164.306:

(a)(1) Standard: Access control. Implement technical policies and procedures for electronic information systems that maintain electronic medical information to allow access only to those persons or software programs that have been granted access rights as specified in § 164.308(a)(4).

(2) Implementation specifications:

(i) Unique user identification (Required). Assign a unique name and/or number for identifying and tracking user identity.

(ii) Emergency access procedure (Required). Establish (and implement as needed) procedures for obtaining necessary electronic medical information during an emergency.

(iii) Automatic logoff (Addressable). Implement electronic procedures that terminate an electronic session after a predetermined time of inactivity.

(iv) Encryption and decryption (Addressable). Implement a mechanism to encrypt and decrypt electronic medical information.

(b) Standard: Audit controls. Implement hardware, software, and/or procedural mechanisms that record and examine activity in information systems that contain or use electronic medical information.

(c)(1) Standard: Integrity. Implement policies and procedures to protect electronic medical information from improper alteration or destruction.

(2) Implementation specification: Mechanism to authenticate electronic medical information (Addressable). Implement electronic mechanisms to corroborate that electronic medical information has not been altered or destroyed in an unauthorized manner.

(d) Standard: Person or entity authentication. Implement procedures to verify that a person or entity seeking access to electronic medical information is the one claimed.

(e)(1) Standard: Transmission security. Implement technical security measures to guard against unauthorized access to electronic medical information that is being transmitted over an electronic communications network.

(2) Implementation specifications:

(i) Integrity controls (Addressable). Implement security measures to ensure that electronically transmitted electronic medical information is not improperly modified without detection until disposed of.

(ii) Encryption (Addressable). Implement a mechanism to encrypt electronic medical information whenever deemed appropriate.

8.0 § 164.314 Organizational requirements.

(a)(1) Standard: Business associate contracts or other arrangements.

(i) The contract or other arrangement between the health care provider, health care facility, billing agent/assignee, clearinghouse and workers' compensation claims administrator and its business associate required by § 164.308(b) must meet the requirements of paragraph (a)(2)(i) or (a)(2)(ii) of this section, as applicable.

(ii) A health care provider, health care facility, billing agent/assignee, clearinghouse or workers' compensation claims administrator is not in compliance with the standards in paragraph (a) of this section if the entity knew of a pattern of an activity or practice of the business associate that constituted a material breach or violation of the business associate's obligation under the contract or other arrangement, unless the entity took reasonable steps to cure the breach or end the violation, as applicable, and, if such steps were unsuccessful --

(A) Terminated the contract or arrangement, if feasible; or

(B) If termination is not feasible, documented the reasons that make termination unfeasible and steps that will be taken to address the breach.

(2) Implementation specifications (Required).

(i) Business associate contracts. The contract between a health care provider, health care facility billing agent/assignee, clearinghouse and workers' compensation claims administrator and a business associate must provide that the business associate will --

(A) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic medical information that it creates, receives, maintains, or transmits on behalf of the entity as required by this security rule;

(B) Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it;

(C) Report to the entity any security incident of which it becomes aware;

(D) Authorize termination of the contract by the entity, if the entity determines that the business associate has violated a material term of the contract.

(ii) Other arrangements.

(A) When an entity and its business associate are both governmental entities, the entity is in compliance with paragraph (a)(1) of this section, if --

(1) It enters into a memorandum of understanding with the business associate that contains terms that accomplish the objectives of paragraph (a)(2)(i) of this section; or

(2) Other law (including regulations adopted by the entity or its business associate) contains requirements applicable to the business associate that accomplish the objectives of paragraph (a)(2)(i) of this section.

(B) If a business associate is required by law to perform a function or activity on behalf of an entity or to provide a service to an entity, the entity may permit the business associate to create, receive, maintain, or transmit electronic medical information on its behalf to the extent necessary to comply with the legal mandate without meeting the requirements of paragraph (a)(2)(i) of this section, provided that the entity attempts in good faith to obtain satisfactory assurances as required by paragraph (a)(2)(ii)(A) of this section, and documents the attempt and the reasons that these assurances cannot be obtained.

(C) The entity may omit from its other arrangements authorization of the termination of the contract by the entity, as required by paragraph (a)(2)(i)(D) of this section if such authorization is inconsistent with the statutory obligations of the entity or its business associate.

9.0 § 164.316 Policies and procedures and documentation requirements.

Health care providers, health care facilities, billing agents/assignees, clearinghouses and workers' compensation claims administrators must, in accordance with § 164.306:

(a) Standard: Policies and procedures. Implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications, or other requirements of this security rule, taking into account those factors specified in § 164.306(b)(2)(i), (ii), (iii), and (iv). This standard is not to be construed to permit or excuse an action that violates any other standard, implementation specification, or other requirements of this security rule. An entity may change its policies and procedures at any time, provided that the changes are documented and are implemented in accordance with this security rule.

(b)(1) Standard: Documentation.

(i) Maintain the policies and procedures implemented to comply with this security rule in written (which may be electronic) form; and

(ii) If an action, activity or assessment is required by this rule to be documented, maintain a written (which may be electronic) record of the action, activity, or assessment.

(2) Implementation specifications:

(i) Time limit (Required). Retain the documentation required by paragraph (b)(1) of this section for 6 years from the date of its creation or the date when it last was in effect, whichever is later.

(ii) Availability (Required). Make documentation available to those persons responsible for implementing the procedures to which the documentation pertains.

(iii) Updates (Required). Review documentation periodically, and update as needed, in response to environmental or operational changes affecting the security of the electronic medical information.

Attachment A to Security Rule

1.0 Security Standards: Matrix

Standards	Sections	Implementation Specifications
		(R)=Required,
		(A)=Addressable
Administrative Safeguards		
Security Management Process	164.308(a)(1)	Risk Analysis (R) Risk Management (R) Sanction Policy (R) Information System Activity Review (R)
Assigned Security Responsibility	164.308(a)(2)	(R)
Workforce Security	164.308(a)(3)	Authorization and/or Supervision (A) Workforce Clearance Procedure Termination Procedures (A)
Information Access Management	164.308(a)(4)	Isolating Health care Clearinghouse Function (R) Access Authorization (A) Access Establishment and Modification (A)
Security Awareness and Training	164.308(a)(5)	Security Reminders (A) Protection from Malicious Software (A) Log-in Monitoring (A) Password Management (A)
Security Incident Procedures	164.308(a)(6)	Response and Reporting (R)
Contingency Plan	164.308(a)(7)	Data Backup Plan (R) Disaster Recovery Plan (R) Emergency Mode Operation Plan (R)
		Testing and Revision Procedure (A) Applications and Data Criticality Analysis (A)
Evaluation	164.308(a)(8)	(R)
Business Associate Contracts and Other Arrangement	164.308(b)(1)	Written Contract or Other Arrangement (R)

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Standards	Sections	Implementation Specifications
		(R)=Required,
		(A)=Addressable
Physical Safeguards		
Facility Access Controls	164.310(a)(1)	Contingency Operations (A) Facility Security Plan (A) Access Control and Validation Procedures (A) Maintenance Records (A)
Workstation Use	164.310(b)	(R)
Workstation Security	164.310(c)	(R)
Device and Media Controls	164.310(d)(1)	Disposal (R) Media Re-use (R) Accountability (A) Data Backup and Storage (A)
Technical Safeguards (see § 164.312)		
Access Control	164.312(a)(1)	Unique User Identification (R) Emergency Access Procedure (R) Automatic Logoff (A) Encryption and Decryption(A)
Audit Controls	164.312(b)	(R)
Integrity	164.312(c)(1)	Mechanism to Authenticate Electronic Medical Information (A)
Person or Entity Authentication	164.312(d)	(R)
Transmission Security	164.312(e)(1)	Integrity Controls (A) Encryption (A)