Workers' Compensation Information System (WCIS)

California Electronic Data Interchange (EDI) Implementation Guide for Medical Bill Payment Records

Version ~~1.1~~ 2.0
(~~November 15, 2011~~ April 6, 2016)

CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS
Christine Baker, Director

DIVISION OF WORKERS' COMPENSATION
Destie Overpeck, Acting Administrative Director

Title 8, California Code of Regulations Section 9701 and 9702

Dear Claims Administrators:

The California Division of Workers' Compensation (DWC) is pleased to introduce the new version of the CA Implementation Guide for Medical Bill Payment Records, Release 2.0. This guide is based on the IAIABC Release 2 Medical Bill Record with some variation to accommodate California specific rules.

With the new version of the guide, California is migrating from using American National Standards Institute (ANSI) X12 4010 format to ANSI X12 5010 format for collecting medical bill data. This migration will bring significant transaction improvements that address the industry's needs, and it corrects problems encountered in the 4010 version. In general, the new version of the guide is believed to be efficient and easier to implement. Moreover, it puts the CA WCIS data collection in synch with the division's electronic billing regulation that went into effect in October 2012. It will also bring the WCIS data collection in compliance with the current industry standard of doing business between providers and insurers.

As in the past, the Medical bill record data collected by the WCIS will be integrated with the data the division currently collects for First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI). These two databases will have a wealth of information that can help the division make informed policy decisions.

The data in WCIS is only as good as what you, our Trading Partner, transmit to it. I urge you to submit complete and accurate data. Reliable data will assist the division make well-founded decisions that will benefit both the injured worker and the employer community.

The California Electronic Data Interchange (EDI) Implementation Guide for Medical Bill Payment Records will be posted on our web site at http://dir.ca.gov/dwc/wcis.htm. I hope this revised version of the CA Implementation Guide will help you submit the mandated information to the CA WCIS.

The California DWC is dedicated to open communication as a cornerstone of a successful partnership between you and the division. I hope this guide will be a useful instrument that will help you submit accurate data.

Sincerely,

Destie Overpeck, Acting Administrative Director
Division of Workers' Compensation

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Section I: Electronic Data Interchange (EDI) in California

Introduction

This guide is adopted by the Administrative Director of the Division of Workers' Compensation (DWC) pursuant to the authority of Labor Code sections §138.6, and §138.7. The guide contains the California-specific protocols and excerpts from the IAIABC EDI Implementation Guide for Medical Bill Payment Records Release 2.0, February 1, 2014. It explains the technical design and functionality of the WCIS system, testing options for the trading partners, instructions regarding the medical billing data elements, and reporting standards and requirements. This guide is posted on the Division's Web site at http://www.dir.ca.gov/dwc/WCIS.htm, and is available from the Division of Workers' Compensation upon request. IAIABC members may get a copy of the IAIABC Release 2.0 guide from the IAIABC website: http://www.iaiabc.org. Non-members may purchase a copy from IAIABC http://www.iaiabc.org.

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

For collecting medical bill payment records data, the WCIS adopts the IAIABC Workers' Compensation Medical Bill Data reporting Implementation Guide Release 2.0 which is based on the ASC X12 837 Health Care Claims (837) and the ASC X12 824 Application Advice (824) 005010 standards (data submission and application level response). The WCIS also adopts ASC X12 999 Implementation Acknowledgments for Health Care Insurance. The ASC X12 999 guide is available for purchase from http://store.x12.org/store/healthcare-5010-consolidated-guides

California Workers' Compensation Information System (WCIS) history

The California legislature enacted sweeping reforms to California's workers' compensation system in 1993. The legislature directed the DWC to put together comprehensive information about workers' compensation in California. The result is the WCIS. The WCIS has four components: the First Reports of Injury (FROI) reporting guidelines were implemented March 1, 2000. The Subsequent Reports of Injury (SROI) reporting guidelines were implemented July 1, 2000. Reporting of annual summary of benefits began January 31, 2001.

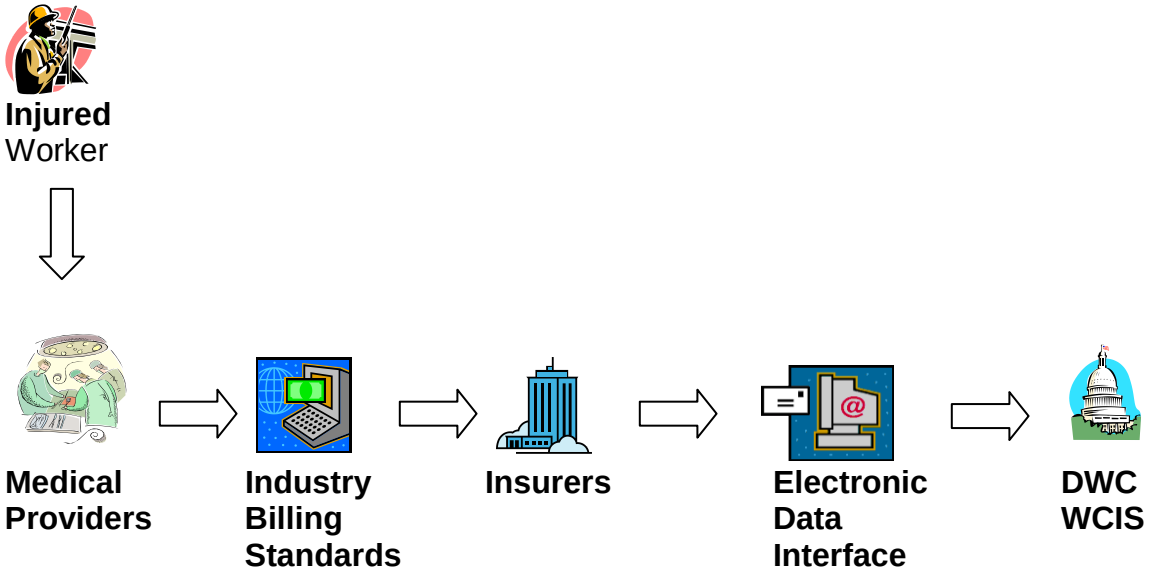
Medical bill payment reporting regulations were adopted on March 22, 2006. The regulations require medical bill payment records for services with a date of service on or after September 22, 2006 and a date of injury on or after March 1, 2000. Medical bill

records shall ~~to~~ be transmitted to the DWC within 90 calendar days of the medical bill payment, ~~*or the date of*~~ the final determination that payment is denied, or the date the claim is settled. ~~The m~~ Medical services are required to be reported to the WCIS by all claims administrators handling 150 or more total claims per year.

Sending data to the WCIS

California workers' compensation medical bill payment records are processed by diverse organizations: large multi-state insurance companies, smaller specialty insurance carriers, self-insured employers or insurers, third-party administrators handling claims on behalf of self-insured employers, as well as bill review companies. The organizations have widely differing technological capabilities, so the WCIS is designed to be as flexible as possible in supporting EDI medical transmissions.

Flow of Medical Data in the California Workers' Compensation System



WCIS web site

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

- download the latest version of the California EDI Implementation Guide for Medical Bill Payment Records
- get answers to frequently asked questions
- review archived WCIS e-news letters

WCIS/Information Systems contact person

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

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

By phone:

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

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

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

~~By fax: (510) 286-6862~~

By e-mail: wcis@dir.ca.gov
By mail: WCIS EDI Unit
Attn: Name of WCIS contact (if known)
Department of Industrial Relations
1515 Clay Street, 18th Floor
Oakland, CA 94612

WCIS e-news
WCIS e-news is an email newsletter sent out periodically to inform WCIS trading partners of announcements and technical implementations. The WCIS e-news is archived on the WCIS web site (http://www.dir.ca.gov/dwc/wcis.htm). Interested parties who are not already receiving WCIS e-news can register at the WCIS website to be added to the WCIS e-news mailing list.

DWC WCIS e.News archive

Section II: Trading Partner Profile

Who should complete the Trading Partner Profile?

A separate Trading Partner Profile form must be completed for each trading partner transmitting EDI medical records to WCIS. Each trading partner will use a unique15 character Sender Identification number composed of the trading partner's 9 digit federal tax identification number ("master FEIN") followed by a "-" and the first 5 digits of the physical address postal code. In the ISA segment, the Sender Identification must be reported in the ISA06 header record of every transmission as the 9 digit Federal Tax Identification followed by a hyphen ('-') followed by the 5 digit postal code of the physical address (e.g. 123456789-12345). The Sender Identification number, Transmission Date, and Transmission Time are used to identify communication parameters for sending 824 detailed acknowledgments to the trading partners.

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

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

Another example would be a single organization that might wish to send transactions for multiple insurers or claims administrators together in one 837 transmission. In such a case, the sending organization could complete one Trading Partner Profile, providing the Master FEIN for the sending company in the sender ID. The sending organization could then transmit ST-SE transaction sets for the multiple insurers or claims administrators identified by the appropriate insurer FEIN or claims administrator FEIN in each ST-SE transaction set within the 837 transmission.

In the following section, you will find the Trading Partner Profile form, parts A through D. Each trading partner will complete parts A, B, and C, providing information as it pertains to them. DWC completes all of Part D with its own information.

State of California
Department of Industrial Relations

DIVISION OF WORKERS' COMPENSATION

MEDICAL ELECTRONIC DATA INTERCHANGE TRADING PARTNER PROFILE
PART A. Trading partner background information:

Effective Date (date agreement becomes effective):_____

Sender Name: _____

Sender Master FEIN: _____

Physical Address: _____

City: _____ State: _____

Postal Code (postal code +4): _____

Mailing Address: _____

City: _____ State: _____

Postal Code (postal code +4): _____

Trading Partner Type (check all that apply):

- **Self-Administered**

____Insurer ____Self-Insured Employer

- **Third Party Administrator of**

____Insurer ____Self-Insured Employer

- **Other (please specify)**:_____

PART B. Trading partner contact information:

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

PART C. Trading partner transmission specifications:

C1. Profile identifier:
If submitting more than one profile, please specify:
PROFILE NUMBER (1, 2, etc.): _____

DESCRIPTION: _____

C2. SFTP account information

Sender/Trading Partner Name: _____

Sender/Trading Partner E-mail: _____

	DWC Use Only
User Name: (A-Z, a-z, 0-9) (To be provided by WCIS contact) _____	
Password: (*8 characters min*.) (To be provided by WCIS contact) _____	
Transmission Mode is SFTP also known as SSH (Secure Shell) File Transfer Protocol.	
Source Public Network IP Address: (*limit to 6 max.)* _____ _____ _____ _____ _____ _____	

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

Name: California Division of Workers' Compensation

FEIN: 943160882

Physical Address: 1515 Clay Street, Suite 1800

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

Mailing Address: P.O. Box 420603

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

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

RECEIVER'S ANSI X12 TRANSMISSION SPECIFICATIONS:

Segment Terminator: ~ ISA Information: TEST PROD

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

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

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

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

Instructions for completing the Trading Partner Profile

Each trading partner will complete parts A, B, and C, providing information as it pertains to them. DWC will complete Part D.

PART A. Trading partner background information:

Effective Date:	Date the agreement becomes effective.
Sender Name:	The name of your business entity corresponding to the Master FEIN of your business entity.
Sender Master FEIN :	The Federal Employer's Identification Number of your business entity. Please note that the FEIN, followed by a "-" along with the five digit physical address postal code in the trading partner address field, will be used as a unique identifier to identify you as a trading partner.
Physical Address:	The street address of the physical location of your business entity. DWC will send materials to this address, unless you provide a different address for the mailing address.
City:	The city portion of the street address of your business entity.
State:	The two-character standard state abbreviation.
Postal Code (postal code +4):	The nine-digit postal code. ~~This field, along with the Trading Partner FEIN, will be used to uniquely identify a trading partner.~~
Mailing Address:	The mailing address used to receive deliveries via the U.S. Postal Service for your business entity. This should be the mailing address that would be used to receive materials pertaining to this Trading Partner Profile. If this address is the same as the physical address, indicate "Same as above".
City:	The city portion of the street address of your business mailing address.
Postal Code (postal code +4):	The nine-digit postal code of the mailing address of your business entity.
Trading Partner Type:	Indicate any functions that describe the trading partner. If "other," please specify.

PART B. Trading partner contact Information:

This section provides DWC with the ability to identify individuals within your business entity who can be used as contacts. You may provide one business and one technical contact.

Business Contact : The individual most familiar with the overall data extraction and process within your business entity. The individual should be able to track down the answers to any issues that may arise that the technical contact cannot address.

Technical Contact: The individual who should be contacted for issues regarding the actual transmission process.

PART C. Trading partner transmission specifications:

C1. Profile identifier

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

C2. SFTP Account information

Name:	Specify name.
E-Mail Address:	Specify e-mail address.
User Name:	~~Create your own user name (using lower or upper case letters and/or numbers).~~ To be provided by WCIS contact.
Password:	~~Create your own password (using a minimum of eight characters).~~ To be provided by WCIS contact.
Transmission Mode:	SFTP, also known as SSH (Secure Shell) File Transfer Protocol.
Source Public Network IP Address	Must be a public IP address. Although some network systems use private address for internal networks, e.g., 10.0.0.0, 172.16.0.1 and 192.168.1.1, WCIS requires the public IP address corresponding to where the private addresses translate.

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

This section contains DWC's trading partner information. The DWC will complete the Technical Contact and Business Contact text fields, which will vary depending on the trading partner

Technical Contact:	The name, title, phone number, ~~fax number~~, and e-mail address of the individual at the DWC.
Business Contact :	The name, title, phone number, ~~fax number~~, and e-mail address of the individual at the DWC.

Receiver's ANSI X12 transmission specifications:

Segment Terminator:	To indicate segment terminator use the tilde (~).
Date Element Separator:	To indicate a data element separator use an asterisk (*).

Sub-Element Separator:	To indicate a sub-element separator use a colon (:).
Sender/Receiver Qualifier:	This will be the trading partner's ANSI ID Code Qualifier, as specified in an ISA segment.
Sender/Receiver ID:	The Master FEIN.
Date/Time ISA Information:	The DN0100 — Date Transmission ~~s~~Sent in the BHT segments of the 837 Transmission~~: 837~~ must be identical to the ~~time~~ date in the ISA09 interchange date and GS04 date in the 837 headers where the standard format is CCYYMMDD. The DN101 – Time Transmission Sent in the BHT segment(s) of the 837, must be identical to the item in the ISA10 interchange time and GS05 Time in the 837 headers where the standard format is HHMM.
ISA Information:	For test files use "T." For production files use "P."

Section III: The SFTP transmission mode

Data transmission with secure file transfer protocol (SFTP)

Trading partners will send all data files to an SFTP (SSH [Secure Shell] File Transfer Protocol) server hosted by the WCIS. An SFTP transfer establishes an encrypted transmission tunnel, which ensures data security. Trading partner login will be authenticated through username, password, SSH key exchange and source IP address verification. Acknowledgments will be retrieved from the same server.

Trading partners must coordinate certain processes and procedures with WCIS to ensure the efficient and secure transmission of data and acknowledgment files via SFTP.

Follow the following steps to set up SFTP connectivity:

Step 1. Trading Partner Profile

Complete and submit the Trading Partner Profile form in Section II. The WCIS requires the Trading Partner Profile form be submitted to the DWC at least 30 days before testing begins. Within five (5) days of receiving the completed trading partner profile, the WCIS will provide the WCIS host Address to the technical contact named in the Trading Partner Profile form. Within seven (7) days of receiving the completed trading partner form, the WCIS will create a user account, grant network access and ask the trading partner to send a test file to establish secure connectivity between the WCIS and the trading partner. Trading partners are responsible for keeping all information on their profile up to date.

Step 2. SFTP user account and password

The trading partner will be provided a user account and password by the WCIS ~~creates a user account and password for access in section C2 of the Trading Partner Profile form.~~ They must change the password every 90 days. User accounts will be locked out after three unsuccessful logon attempts. Password resets must be coordinated with the WCIS trading partner contact person.

Step 3. SFTP communication port

The WCIS SFTP server opens communication port 22 for SFTP transmissions.

Trading partner source IP address

Access to the WCIS SFTP server will be restricted to static source IP addresses that are entered on the Trading Partner Profile form. Trading partners may provide up to five source IP addresses. The source IP addresses must be public addresses. Although some network systems use private addresses for internal networks (e.g. 10.0.0.0, 172.16.0.1 and 192.168.1.1), WCIS will require the public IP address to where the private addresses translate. Trading partners must notify the WCIS when source IP addresses change.

Testing SFTP connectivity

The WCIS trading partner contact and the trading partner shall coordinate testing SFTP connectivity. Trading partners shall be asked to send a test file that contains data, but this

file will not be processed in the production database. A test acknowledgment file will then be left in the trading partner's 999 and 824 folder. After connectivity testing is completed, 837 files submission for structural and detailed testing may begin.

Sending data through SFTP

For testing connectivity, trading partners will send data files to the WCIS SFTP server by placing them in a directory named "Suspense." Production data files are placed in the 'inbound directory'. The contents of these directories are not visible to the trading partner. Once a file has been uploaded, the trading partner cannot edit it. If a transmission error occurs, the trading partner's SFTP program or process will generate a message. An error will occur when a file with the same name as one that already exists in the directory of the WCIS server is submitted.

File names must be unique and follow the file naming conventions prescribed below.

Naming convention:

The files must start with three character file layout File Layout of the 837, 999, or 824 file followed by an underscore "_."

The 5th through 13th characters are the Trading Partner/Sender FEIN followed by an underscore "_."

The 15th through 23rd characters are the Trading Partner's 9 digit zip code followed by an underscore "_". When the 4 digit extension for a zip code is not available, use "0000".

The ~~15th~~ 25th through ~~22nd~~-32nd characters are the Date Stamp of the 837, 999, or 824 file (8-digit date, CCYYMMDD) followed by an underscore "_."

The ~~24rd~~ 34th through ~~29th~~ 39th characters are the Time Stamp of 837, 999, or 824 file (6-digit time, HHMMSS) followed by an underscore "_."

The ~~31st~~ 41st character is the test/ production indicator: a "T" for Test or a "P" for Production followed by an underscore "_."

The ~~33rd~~ 43rd through ~~35th~~ 45th character are the unique three digit~~s~~ counters (001-999)

~~An error will occur when a file of the same name is submitted while a file of the same name still exists in the directory of the WCIS.~~

837 file example, 837_123456789_946125698_20140113_135012_T_001

999 file example, 999_123456789_946125698_20140113_135012_T_001

824 file example, 824_123456789_946125698_20140113_135012_T_001

An error will occur when a file of the same name is submitted while a file of the same name still exists in the directory of the WCIS.

Receiving acknowledgment files through SFTP

The WCIS will place Implementation and Detailed Acknowledgment files (999 and 824) on the WCIS SFTP server in the trading partner's 999 and 824 folders. Trading partners may delete acknowledgment files after the files have been retrieved. The WCIS will periodically review the contents of the trading partner's directory and may delete unauthorized user folders or files older than 14 days.

Section IV: EDI medical testing

The EDI medical testing process is designed to help trading partners comply with the WCIS electronic data reporting regulations. The Title 8 CCR § 9702(a) states "*Each claims administrator shall, at a minimum, provide complete, valid, accurate data for the data elements set forth in this section*."

- **Complete data** – In order to evaluate the effectiveness and efficiency of the California workers' compensation system, trading partners must submit all required medical bill payment data elements.

- **Valid data** — "Valid" means the data are consistent with the values assigned by the IAIABC and adopted by the California DWC. Review the usage, purpose, and notes for each required data element in section 2 of the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 to assure your use of the data element matches that assigned by the IAIABC and adopted by the California DWC.

- **Accurate data** — "Accurate" means free from errors.

Overview of the EDI medical testing process

The EDI medical testing process consists of several phases designed to help each new trading partner become a successful medical bill reporter in the California Workers' Compensation Information System. The EDI medical testing process begins by completing a Trading Partner Profile and establishing SFTP connectivity with the WCIS, followed by functional transmission testing and transaction level bill testing. More detailed information on each component of the process is provided below. An Information Systems contact person and the WCIS Research Unit are available to work with each trading partner during this process to ensure the transition to production is successful

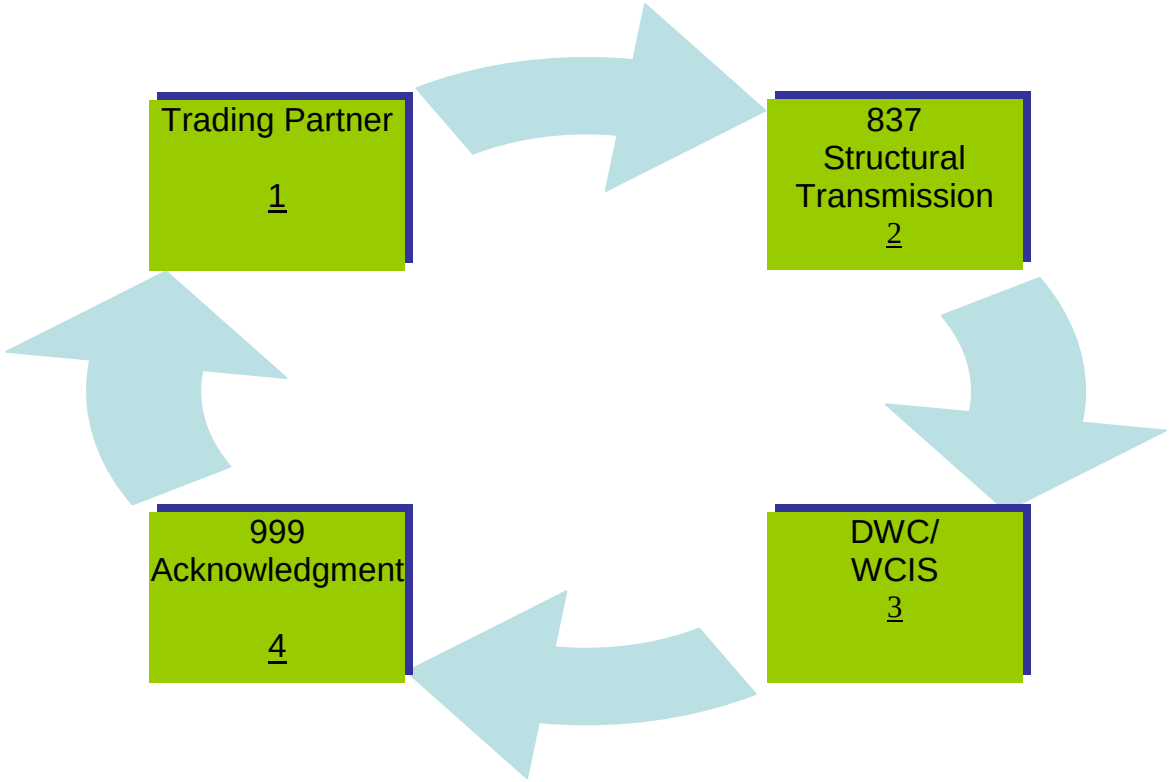
Testing connectivity

The first phase of testing is testing for connectivity. Within seven (7) days of receiving the completed SFTP information form, the WCIS will create a user account, and grant network access and ask the trading partner to send a sample of test file to establish secure connectivity between the WCIS and the Trading Partner. The goal for this testing is to get a successful secure connection using SFTP and ensure the ability to exchange files securely.

Transmission/functional EDI medical testing

During this next phase, trading partners test the ability to transmit 837 files to WCIS and receive 999 Implementation acknowledgment files from WCIS. The trading partner compiles and sends small ANSI 837 files with the required loops, segments, and California-adopted data elements. Examples of sample 837 ST-SE transaction sets are available in the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2013 Section 4 Health Care Claims (837) scenarios. After the 837 test file has been received and processed by the DWC/WCIS, an ASC X12 999 acknowledgment will be transmitted to the trading partner by WCIS.

Functional EDI medical testing communication loop



The 999 Implementation Acknowledgment EDI medical testing error messages

The WCIS adopts the ASC X12 Implementation Acknowledgment for Health Care Insurance (999). The 999 Implementation Acknowledgment communications acknowledge

the acceptance or rejection status of each functional group and the associated transaction sets received in an 837 Interchange.

The Interchange Control Structure of the 837 file has multiple parts. The 999 acknowledgment has specific segments for reporting errors detected in different parts of the 837 transmission. Errors found in syntax editing of a segment are shown in the IK3 segment of the 999. While those errors found in data element editing are shown in the IK4 segment, errors found in syntax editing at the transaction set level appear in the IK501 segment, and functional group errors appear in the AK9 segment of the 999 acknowledgment.

The WCIS 999 acknowledgments can report one of three possible outcomes: Accepted (A), Partially Accepted (P), and Rejected (R). If a 999 acknowledgment has a P in the AK901 position, at least one transaction set in the functional group was rejected and that transaction set needs to be corrected and resubmitted. An R in the AK 901 position means, there is an error in the functional group and all the transactions in the functional group need to be corrected and resubmitted.

Implementation Segment Syntax Error Code shown in IK3 segment

Code	Definition
1	Unrecognized segment ID
2	Unexpected segment
3	Required segment missing
4	Loop occurs over maximum times
5	Segment exceeds maximum use
6	Segment not in defined transaction set
7	Segment not in proper sequence
8	Segment has data element errors
I6	Implementation dependent segment missing
I7	Implementation loop occurs under minimum times
I8	Implementation segment below minimum Use

This table information is intended for reference and convenience use only
Source: ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, ASC X12C/005010X231, Version 5, Release 1 – Page 28

Implementation Data Element Syntax Error Code IK4 segment

Code	Definition
1	Required data element missing
2	Conditional required data element missing
3	Too many data elements
4	Data element too short
5	Data element too long
6	Invalid character in data element

7	Invalid code value
8	Invalid date
9	Invalid time
10	Exclusion condition violated
12	Too many repetitions
13	Too many components
I10	Implementation “Not Used” data element present
I11	Implementation too few repetitions
I12	Implementation pattern match failure
I13	Implementation dependent “Not Used” data element present
I6	Code value not used in implementation
I9	Implementation dependent data element missing

This table information is intended for reference and convenience use only
Source: ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, ASC X12C/005010X231, Version 5, Release 1 – Page 35

The table below shows the California-adopted IK4 error codes by data elements.

IK4 Error Codes for 999 Acknowledgments

DN	IAIABC Data Element Name	Required data element missing 1	Conditional required data element missing 2	Too many data elements 3	Data element too short 4	Data element too long 5	Invalid character in data element 6	Invalid code value 7	Invalid date 8	Invalid time 9	Exclusion condition violated 10	Too many repetitions 12	Too many components 13	Implementation “Not Used” value previously reported data element present I10
0005	JURISDICTION CLAIM NUMBER	X												
0006	INSURER FEIN	X			X	X	X							
0007	INSURER NAME	X												
0014	CLAIM ADMINISTRATOR MAILING POSTAL CODE	X			X	X								
0015	CLAIM ADMINISTRATOR CLAIM NUMBER	X					X							
0016	EMPLOYER FEIN	X			X	X	X							
0018	EMPLOYER NAME	X												
0031	DATE OF INJURY	X			X	X			X					
0042	EMPLOYEE SSN	X			X	X	X							
0043	EMPLOYEE LAST NAME	X												
0044	EMPLOYEE FIRST NAME	X												
0045	EMPLOYEE MIDDLE NAME/INITIAL													
0098	SENDER ID	X												
0099	RECEIVER ID	X												
0100	DATE TRANSMISSION SENT	X							X					
0101	TIME TRANSMISSION SENT	X								X				

IK4 Error Codes for 999 Acknowledgments

DN	IAIABC Data Element Name	Required data element missing 1	Conditional required data element missing 2	Too many data elements 3	Data element too short 4	Data element too long 5	Invalid character in data element 6	Invalid code value 7	Invalid date 8	Invalid time 9	Exclusion condition violated 10	Too many repetitions 12	Too many components 13	Implementation " Not Used" value previously reported data element present 10
0187	CLAIM ADMINISTRATOR FEIN	X			X	X	X							
0188	CLAIM ADMINISTRATOR NAME	X												
0208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	X												
0209	MANAGED CARE ORGANIZATION NAME	X												
0266	TRANSACTION TRACKING NUMBER	X					X							
0293	LUMP SUM PAYMENT/ SETTLEMENT CODE	X						X						
0500	UNIQUE BILL ID NUMBER	X					X							
0501	TOTAL CHARGE PER BILL	X					X							
0502	BILLING TYPE CODE					X		X						
0503	BILLING FORMAT CODE	X				X		X						
0504	FACILITY CODE	X				X								
0505	BILL FREQUENCY TYPE CODE	X				X		X						
0507	PROVIDER AGREEMENT CODE	X				X		X						
0508	BILL SUBMISSION REASON CODE	X			X	X		X						
0509	SERVICE BILL DATE(S) RANGE	X			X	X			X					
0510	DATE OF BILL	X				X			X					
0511	DATE INSURER RECEIVED BILL	X				X			X					
0512	DATE INSURER PAID BILL	X				X			X					
0513	ADMISSION DATE	X							X					
0514	DISCHARGE DATE	X							X					
0515	CONTRACT TYPE CODE	X				X		X						
0516	TOTAL AMOUNT PAID PER BILL	X					X							
0520	OUTPATIENT REASON FOR VISIT CODE	X												
0521	PRINCIPAL DIAGNOSIS CODE	X												
0522	DIAGNOSIS CODE	X												
0523	BILLING PROVIDER UNIQUE BILL IDENTIFICA-TION NUMBER	X					X							
0524	PROCEDURE DATE	X				X			X					
0525	PRINCIPAL PROCEDURE CODE	X												
0527	PRESCRIPTION BILL DATE	X			X	X			X					
0528	BILLING PROVIDER LAST/GROUP NAME	X												
0529	BILLING PROVIDER FIRST NAME													
0532	ORIGINATOR TRANSACTION IDENTIFICA-TION NUMBER	X												
0533	PRESENT ON ADMISSION INDICATOR	X				X		X						
0535	ADMITTING DIAGNOSIS CODE	X												

IK4 Error Codes for 999 Acknowledgments

DN	IAIABC Data Element Name	Required data element missing 1	Conditional required data element missing 2	Too many data elements 3	Data element too short 4	Data element too long 5	Invalid character in data element 6	Invalid code value 7	Invalid date 8	Invalid time 9	Exclusion condition violated 10	Too many repetitions 12	Too many components 13	Implementation " Not Used" ~~value previously reported~~ data element present 10
0537	BILLING PROVIDER PRIMARY SPECIALTY CODE	X												
0538	BILLING PROVIDER PRIMARY ADDRESS	X												
0539	BILLING PROVIDER SECONDARY ADDRESS													
0540	BILLING PROVIDER CITY	X												
0541	BILLING PROVIDER STATE CODE					X								
0542	BILLING PROVIDER POSTAL CODE					X								
0543	BILL ADJUSTMENT GROUP CODE	X	X			X		X						
0544	BILL ADJUSTMENT REASON CODE	X	X			X								
0545	BILL ADJUSTMENT AMOUNT	X	X				X							
0546	BILL ADJUSTMENT UNITS		X				X							
0547	LINE NUMBER	X					X							
0548	BILLED DRG CODE	X												
0549	PAID DRG CODE	X												
0550	PRINCIPAL PROCEDURE DATE	X				X			X					
0551	PROCEDURE DESCRIPTION													
0552	TOTAL CHARGE PER LINE	X					X							
0553	DAY(S)/UNIT(S) CODE	X				X		X						
0554	DAY(S) /UNIT(S) BILLED	X					X							
0555	PLACE OF SERVICE BILL CODE	X				X								
0556	CONDITION CODE	X												
0557	DIAGNOSIS POINTER	X				X		~~X~~						
0559	REVENUE BILLED CODE	X												
0561	PRESCRIPTION LINE NUMBER	X												
0562	DISPENSE AS WRITTEN CODE	X				X		X						
0563	DRUG NAME													
0569	BILLING PROVIDER COUNTRY CODE					X								
0570	DRUGS/SUP-PLIES QUANTITY DISPENSED	X					X							
0571	DRUGS/SUP-PLIES NUMBER OF DAYS	X					X							
0572	DRUGS/SUP-PLIES BILLED AMOUNT	X					X							
0574	TOTAL AMOUNT PAID PER LINE	X					X							
0576	REVENUE PAID CODE													
0577	ADMISSION TYPE CODE	~~X~~				X		X						
0579	DRUGS/SUP-PLIES DISPENSING FEE	X					X							
0580	DAY(S)/UNIT(S) PAID						X							

IK4 Error Codes for 999 Acknowledgments

DN	IAIABC Data Element Name	1 Required data element missing	2 Conditional required data element missing	3 Too many data elements	4 Data element too short	5 Data element too long	6 Invalid character in data element	7 Invalid code value	8 Invalid date	9 Invalid time	10 Exclusion condition violated	12 Too many repetitions	13 Too many components	I10 Implementation " Not Used" value previously reported data element present
0587	RENDERING LINE PROVIDER FIRST NAME													
0589	RENDERING LINE PROVIDER LAST/GROUP NAME	X												
0592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID		X											
0595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	X												
0599	RENDERING LINE PROVIDER STATE LICENSE NUMBER	X												
0600	PLACE OF SERVICE LINE CODE					X								
0604	PRESCRIPTION LINE DATE	X				X			X					
0605	SERVICE LINE DATE(S) RANGE	X			X	X			X					
0615	REPORTING PERIOD	X			X	X			X					
0616	INSURER POSTAL CODE	X			X	X								
0622	ADMISSION HOUR	X								X				
0623	DISCHARGE HOUR	X								X				
0625	HIPPS RATE CODE	X												
0629	BILLING PROVIDER FEIN	X			X	X	X							
0630	BILLING PROVIDER STATE LICENSE NUMBER	X												
0634	BILLING PROVIDER NATIONAL PROVIDER ID		X											
0638	RENDERING BILL PROVIDER LAST/GROUP NAME	X												
0639	RENDERING BILL PROVIDER FIRST NAME													
0643	RENDERING BILL PROVIDER STATE LICENSE NUMBER	X												
0647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID		X											
0651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	X												
0658	SUPERVISING PROVIDER LAST/GROUP NAME	X												
0659	SUPERVISING PROVIDER FIRST NAME													
0667	SUPERVISING PROVIDER NATIONAL PROVIDER ID		X											
0671	SUPERVISING PROVIDER PRIMARY SPECIALTY CODE	X												
0678	FACILITY NAME	X												
0680	FACILITY STATE LICENSE NUMBER	X												
0682	FACILITY NATIONAL PROVIDER ID		X											
0684	FACILITY PRIMARY ADDRESS	X												
0685	FACILITY SECONDARY ADDRESS													
0686	FACILITY CITY													
0687	FACILITY STATE CODE													
0688	FACILITY POSTAL CODE													
0689	FACILITY COUNTRY CODE					X								

IK4 Error Codes for 999 Acknowledgments

DN	IAIABC Data Element Name	1 Required data element missing	2 Conditional required data element missing	3 Too many data elements	4 Data element too short	5 Data element too long	6 Invalid character in data element	7 Invalid code value	8 Invalid date	9 Invalid time	10 Exclusion condition violated	12 Too many repetitions	13 Too many components	I10 Implementation " Not Used" ~~value previously reported~~ data element present
0690	REFERRING PROVIDER LAST/GROUP NAME	X												
0691	REFERRING PROVIDER FIRST NAME													
0699	REFERRING PROVIDER NATIONAL PROVIDER ID		X											
0704	MANAGED CARE ORGANIZATION FEIN	X			X	X	X							
0714	HCPCS LINE PROCEDURE BILLED CODE	X												
0715	JURISDICTION PROCEDURE BILLED CODE	X												
0717	HCPCS MODIFIER BILLED CODE					X								
0718	JURISDICTION MODIFIER BILLED CODE					X								
0719	ADA PROCEDURE BILLED CODE	X												
0721	NDC BILLED CODE	X												
0722	ADA PROCEDURE PAID CODE	X												
0726	HCPCS LINE PROCEDURE PAID CODE	X												
0727	HCPCS MODIFIER PAID CODE					X								
0728	NDC PAID CODE	X												
0729	JURISDICTION PROCEDURE PAID CODE	X												
0730	JURISDICTION MODIFIER PAID CODE					X								
0731	SERVICE ADJUSTMENT GROUP CODE	X				X		X						
0732	SERVICE ADJUSTMENT REASON CODE	X				X								
0733	SERVICE ADJUSTMENT AMOUNT	X					X							
0734	SERVICE ADJUSTMENT UNITS						X							
0736	OTHER PROCEDURE CODE	X												
0741	CONTRACT LINE TYPE CODE	X				X		X						
0742	PROVIDER AGREEMENT LINE CODE					X		X						
0760	PRIOR ACTUAL AMOUNT PAID	X					X							
0761	LINE ITEM PRIOR ACTUAL AMOUNT PAID	X					X							
0762	COMPOUND INDICATOR					X		X						

WCIS adopted Functional Group Acknowledgment code transmitted in IK501

Code	Definition
A	Accepted
R	Rejected

This table information is intended for reference and convenience use only
Source: ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, ASC X12C/005010X231, Version 5, Release 1 – Page 39

IK502 Implementation Transaction Set Syntax Error Codes

Code	**Definition**
1	Transaction set not supported
2	Transaction set trailer missing
3	Transaction set control number in header and trailer Do not match
4	Number of included segments does not match actual count
5	One or more segments in error
6	Missing or invalid transaction set identifier
7	Missing or invalid transaction set control number
18	Transaction set not in functional group
19	Invalid transaction set implementation convention reference
23	Transaction set control number not unique within the functional group

This table information is intended for reference and convenience use only
Source: ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, ASC X12C/005010X231, Version 5, Release 1 – Page 40

WCIS adopted ~~Functional Group~~ Transaction Set Acknowledgment code transmitted in AK901

Code	Definition
A	Accepted
P	Partially accepted, at least one transaction set was rejected
R	Rejected

This table information is intended for reference and convenience use only
Source: ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, ASC X12C/005010X231, Version 5, Release 1 – Page 42

AK905 Functional Group Syntax Error Code

CODE	DEFINITION
1	Functional group not supported
2	Functional group version not supported
3	Functional group trailer missing
4	Group control number in the functional group header and trailer do not agree
5	Number of included transaction sets does not match actual count
6	Group control number violates syntax
19	Functional group control number not unique within interchange

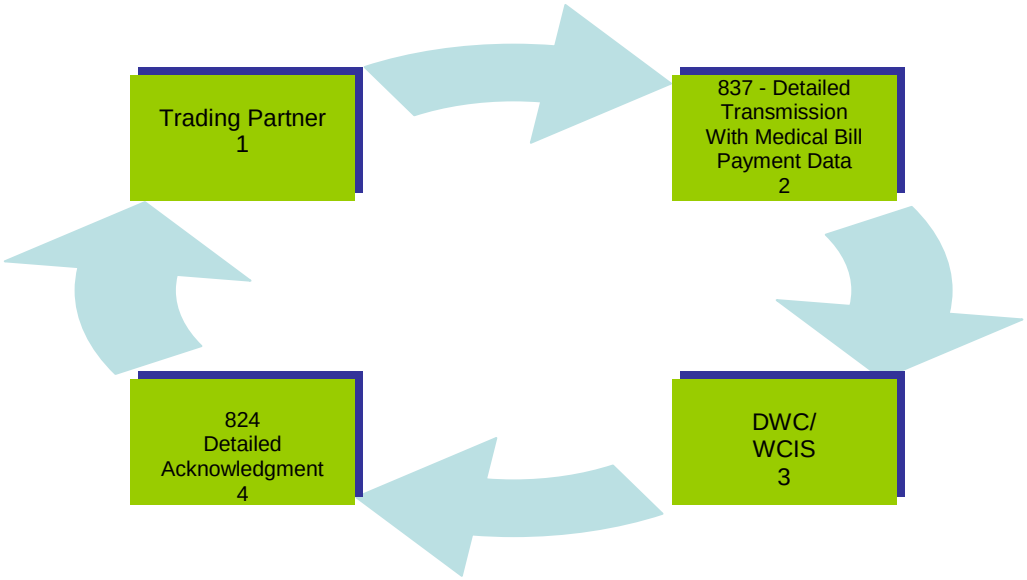
This table information is intended for reference and convenience use only
Source: ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, ASC X12C/005010X231, Version 5, Release 1 – Page 43

Transaction/bill level EDI testing

After successfully completing the transmission/functional tests, the trading partner transmits sample detailed medical bill payment data to the WCIS. During this phase of the test, the trading partner's ability to report complete, valid, and accurate data will be verified. The test file for this phase will include several bills from each bill type with a 00 Original Bill Submission Reason Code.

For examples of standard billing types refer to the IAIABC Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2014 Section 4, medical billing scenarios. Not all trading partners are required to test all of the IAIABC billing scenarios. If a trading partner will only report a certain bill type, then the trading partner only needs to test that billing scenario. If only certain types of bills are to be tested, please contact the WCIS to indicate which medical billing scenarios will be included in the transaction level testing.

Transaction level EDI testing communication loop



All data sent to the WCIS is subjected to California specific and California adopted IAIABC data edits. If a data element fails to pass a data edit, an error message will be generated for that data element. The 824 detailed acknowledgment will contain information about all detected errors for each ST-SE transaction set and all individual bills contained in the transaction sets accepted with an "A"' in the 999 acknowledgments. For more detailed information see the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2014 Section 5, Application Advice (824) scenarios.

If the 824 detailed acknowledgment indicates correctable errors, ~~transaction~~ item (bill) rejected (IR), the sender will need to make corrections and resend the ~~837 transmission~~ rejected bill to

the WCIS within 30 calendar days. When making corrections, all data elements in the affected bill originally submitted must be submitted again.

824 application acknowledgment error messages

Error Code	Message
001	Mandatory field not present
028	~~Must be numeric~~ All digits must be (0-9)
029	Must be a valid date (CCYYMMDD)
030	Must be A-Z, 0-9, or spaces
031	Must be a valid time ~~(HHMM)~~
033	Must be <= date of injury
034	Must be >= date of injury
039	No match on database
040	All digits cannot be the same
041	Must be <= current date
057	Duplicate ~~transaction set~~ Batch/ transaction
058	Code/ID invalid
059	Non-match data value inconsistent with value previously reported
063	Invalid event sequence~~/relationship~~
064	Invalid data relationship
070	Must be > date of bill <=Service Date
072	Must be > date of bill
073	Must be >= date payer received bill
074	Must be >= from date of service
075	Must be <= through service date
111	Must be valid content
117	Match value inconsistent with value previously reported
118	Trading partner not approved to submit data

Medical bill cancellation, bill correction, bill replacement testing

Once WCIS accepts the original bills, the trading partner transmits files with bill submission reason code of 01 (Cancellation), 02 (Correction) and 05 (Replace) for the accepted bills. The cancelled, corrected, and replaced medical bills are matched to the original bills previously sent during the detailed medical bill testing phase. For examples of standard cancellations, corrections, and replaced bills, refer to the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2014 Section 4, scenarios 10, 11, and 12. All trading partners, regardless of bill type being tested, are required to test bill submission reason code of 01 (Cancellation), 02 (Correction) and 05 (Replace).

Testing balancing rules

The bill-level and line-level amounts reported in an 837 must balance according to the balancing rule of the IAIABC balancing rules. Specifically, it is necessary to report billed, paid, and adjusted amounts at both the bill and line level balance. The following balancing rules are required to complete the testing process.

- ⇒ The charged amount(s) reported at the line level must add up to the total charged amount reported at the bill level.
- ⇒ The paid amount(s) reported at the line level must add up to the total paid amount reported at the bill level.
- ⇒ The reported total amount paid per bill plus the sum of all the reported bill adjustment amounts must equal the total charge per bill reported for each bill.
- ⇒ For each service line reported in a bill~~,~~ that was not adjusted at the bill level, the sum of reported total amount paid per line plus the sum of all the reported service adjustment amounts ~~for the line~~ must equal the total charge at bill level.

For numerical examples of the balancing rules, refer to the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2014 Section 1.3.

Production Status

After successful completion of the EDI medical testing, the trading partner will receive official notification requesting it to change the status of the 837 to production and to begin sending the required medical data. During production, data transmissions will be monitored for completeness, validity, and accuracy. Annual data quality reports tabulating the number and kind of errors will be sent to each trading partner. Claims administrators are responsible for assuring the accuracy of data they transmit.

Section V: Supported transactions and ANSI file structure

Supported transactions

The IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, which California adopted for reporting medical bill and payment information to workers' compensation jurisdictions, are based on the ASC X12 837 Health Care Claims (837) and the ASC X12 824 Application Advice (824) 005010 standards. California also adopted the ASC X12 999 Implementation Acknowledgment ~~F~~for Health Care Insurance. All three ASC X12 files are enveloped in the ISA-IEA interchange control header/trailer, the GS-GE functional group header(s)/trailer(s), and the ST-SE transaction sets, which must contain the correctly formatted mandatory segments and fields required by the WCIS medical data elements.

Health care claim transaction sets

The X12 837 health care claim transaction set is used in California to submit health care claim billing information from providers of health care services to payers (http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling_Regulations.htm). The IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2 is based on the ASC X12 837 Health Care Claims standards (IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2014). The IAIABC Release 2 837 for reporting to jurisdictions is consistent with the ANSI X12 health care claim transaction set(s) used for billing between medical providers and payers.

The IAIABC 824 Detailed Acknowledgment is used to inform the sender of the detailed status of the 837. Each 837 is edited against the edit matrix, and any errors in content get reported back to the sender in the 824 detailed acknowledgment. An 824 Detailed Acknowledgment will be sent to each trading partner after each 837 is evaluated for errors in content.

ANSI definitions

Loop:	A group of segments that may be repeated. The hierarchy of the looping structure is insurer, employer, patient, bill level, and bill service line level. The California-adopted loops are defined in the ANSI loop and segment summary that follows these definitions.
Segment ID:	Each segment begins with a two- or three-character segment identifier. The identifier serves as a label for a data segment.
Data Segment:	Each segment consists of a segment identifier, i.e., one or more composite data structures, or simple data elements, each proceeded by a data element separator and succeeded by a segment terminator. The California-adopted data segments are summarized in the ANSI loop and segment summary that follows these definitions.
Data Element Name:	The California-adopted IAIABC data element names are cross walked to the ASC X12 data element names in section 6 of the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0 February 1, 2014.
Format:	Type of data element as described below:
AN	A string data element containing a sequence of any character from the basic or extended character sets (with the exception of the delimiters at the bottom of this list). Example: Claim Administrator Claim Number LM&TZ-908
ID	Specific code taken from a pre-defined list of codes maintained by the Accredited Standards Committee (ASC) X12 or some other body recognized by the DWC/WCIS. Example: ~~Place of service code~~ Billing Format Code ~~11~~A
R	Numeric value containing an explicit decimal point. The decimal point must appear as part of the data stream anywhere other than the rightmost end of the number. Leading zeroes should be suppressed, as should trailing zeroes following the decimal point. If a decimal point is not included in the number, none will be assumed. Do not use commas in place of a period to indicate a decimal point (avoid using the European convention). Example: Bill Adjustment Amount 19.21
Delimiters:	***** Data element separator **:** Component element separator **~** Segment terminator

Note**:** The delimiters cannot be used as part of any data value or string. More detailed information can be found in ASC X12 Secretariat, the Data Interchange Standards Association (DISA): Data Interchange Standards Association (DISA) at http://store.x12.org/store/.

California-adopted ANSI 999 loops, segments, and errors summary

ST Transaction Set Header

Segment	ST	Transaction Set Header
Segment	AK1	Functional Group Response Header
LOOP ID	2000	TRANSACTION SET
Segment	AK2	Transaction Set Response Header
LOOP ID	2100	ERROR IDENTIFICATION
Segment	IK3	Error Identification
Segment	CTX	Segment Context
Segment	CTX	Business Unit Identifier
LOOP ID	2110	IMPLEMENTATION DATA ELEMENT NOTE
Segment	IK4	Implementation Data Element Note
Segment	CTX	Element Context
Segment	IK5	Transaction Set Response Trailer
Segment	AK9	Functional Group Response Trailer
Segment	SE	Transaction Set Trailer

California-adopted ANSI 837 loops, segments, and data elements summary

ST TRANSACTION SET HEADER

Segment	ST	Transaction Set Control Number
Segment	BHT	Beginning of Hierarchy Transaction
Data Element	0532	Originator Transaction ID Number
Data Element	0100	Date Transmission Sent
Data Element	0101	Time Transmission Sent
LOOP ID	1000A	SUBMITTER INFORMATION
Segment	NM1	Submitter Information
Data Element	0098	Sender ID
LOOP ID	1000B	RECEIVER INFORMATION
Segment	NM1	Receiver Information
Data Element	0099	Receiver ID

LOOP ID	2000A	INSURER HIERARCHICAL LEVEL INFORMATION
Segment	HL	Insurer Hierarchical Level
Segment	DTP	Reporting Period
Data Element	0615	Reporting Period
LOOP ID	2010AA	INSURER/SELF-INSURED INFORMATION
Segment	NM1	Insurer/Self-Insured Name
Data Element	0007	Insurer Name
Data Element	0006	Insurer FEIN
Segment	N4	Insurer/Self-Insured Postal Code
Data Element	0616	Insurer Postal Code
LOOP ID	2010AB	CLAIM ADMINISTRATOR INFORMATION
Segment	NM1	Claim Administrator Name
Data Element	0188	Claim Administrator Name
Data Element	0187	Claim Administrator FEIN
Segment	N4	Claim Administrator Postal Code
Data Element	0014	Claim Administrator Mailing Postal Code
LOOP ID	2000B	EMPLOYER HIERARCHICAL INFORMATION
Segment	HL	Employer Hierarchical Level
LOOP ID	2010BA	EMPLOYER INFORMATION
Segment	NM1	Employer Name
Data Element	0018	Employer name
Data Element	0016	Employer FEIN
LOOP ID	2000C	CLAIMANT HIERARCHICAL INFORMATION
Segment	HL	Claimant Hierarchical Level
Segment	DTP	Date of Injury
Data Element	0031	Date of Injury
LOOP ID	2010CA	CLAIMANT INFORMATION
Segment	NM1	Claimant Name
Data Element	0043	Employee Last Name
Data Element	0044	Employee First Name
Data Element	0045	Employee Middle Name/Initial
Data Element	0042	Employee Social Security Number
Segment	REF	Claim Administrator Claim Number
Data Element	0015	Claim Administrator Claim Number
Segment	REF	Replacement Claim Administrator Claim Number
Data Element	0015	Claim Administrator Claim Number
~~Data Element~~	~~0042~~	~~Employee Social Security Number~~
~~Segment~~	~~REF~~	~~Claimant Claim Number~~
~~Data Element~~	~~0015~~	~~Claim Administrator Claim Number~~

Segment	REF	Jurisdiction Assigned Claim Number
Data Element	0005	Jurisdiction Claim Number
LOOP ID	2300	BILLING INFORMATION
Segment	CLM	Bill Record Information
Data Element	0523	Billing Provider Unique Bill ID Number
Data Element	0501	Total Charge per Bill
Data Element	0502	Billing Type Code
Data Element	0504	Facility Code
Data Element	0555	Place of Service Bill Code
Data Element	0503	Billing Format Code
Data Element	0505	Bill Frequency Type Code
Data Element	0507	Provider Agreement Code
Data Element	0508	Bill Submission Reason Code
Segment	DTP	Date Insurer Received Bill
Data Element	0511	Date Insurer Received Bill
Segment	DTP	Date and Time of Admission
Data Element	0513	Admission Date
Data Element	0622	Admission Hour
Segment	DTP	Date and Time of Discharge
Data Element	0514	Discharge Date
Data Element	0623	Discharge Hour
Segment	DTP	Service Date(s) Range
Data Element	0509	Service Bill Date(s) Range
Segment	DTP	Date of Prescription
Data Element	0527	Prescription Date(s) Range
Segment	DTP	Date of Bill
Data Element	0510	Date of Bill
Segment	DTP	Date Insurer Paid Bill
Data Element	0512	Date Insurer Paid Bill
Segment	CL1	Admission Type
Data Element	0577	Admission Type Code
Segment	CN1	Contract Information
Data Element	0515	Contract Type Code
Segment	AMT	Total Amount Paid per Bill
Data Element	0516	Total Amount Paid per Bill
Segment	REF	Unique Bill Identification Number
Data Element	0500	Unique Bill ID Number
Segment	REF	Record Transmission Tracking Number
Data Element	0266	Transaction Tracking Number
Segment	REF	Settlement or Award Identifier
Data Element	0293	Lump Sum Payment Settlement Code
Segment	HI	Institutional Bill Principal Diagnosis
Data Element	0521	Principal Diagnosis Code
Data Element	0533	Present on Admission Indicator
Segment	HI	Institutional Bill Admitting Diagnosis

Data Element	0535	Admitting Diagnosis Code
Segment	HI	Institutional Bill Other Diagnosis
Data Element	0522	Diagnosis Code
Data Element	0533	Present on Admission Indicator
Segment	HI	Outpatient Reason for Visit
Data Element	0520	Outpatient Reason for Visit Code
Segment	HI	Non-Institutional Diagnosis Codes
Data Element	0521	Principal Diagnosis Code
Data Element	0522	Diagnosis Code
Segment	HI	Institutional Bill Principal Procedure
Data Element	0525	Principal Procedure Code
Data Element	0550	Principal Procedure Date
Segment	HI	Institutional Bill Other Procedure Codes
Data Element	0736	Other Procedure Code
Data Element	0524	Procedure Date
Segment	HI	Condition Codes
Data Element	0556	Condition Code
Segment	HI	Diagnosis Related Group Information
Data Element	0549	Paid DRG Code
Data Element	0548	Billed DRG Code
LOOP ID	2310A	BILLING PROVIDER INFORMATION
Segment	NM1	Billing Provider Name
Data Element	0528	Billing Provider Last/Group Name
Data Element	0529	Billing Provider First Name
Data Element	0634	Billing Provider National Provider ID
Segment	PRV	Billing Provider Specialty Information
Data Element	0537	Billing Provider Primary Specialty Code
Segment	N3	Billing Provider Address
~~Billing Provider Primary Address~~		
Data Element	0538	Billing Provider Primary Address
Data Element	0539	Billing Provider Secondary Address
Segment	N4	Billing Provider City, State, and Postal Code
Data Element	0540	Billing Provider City
Data Element	0541	Billing Provider State Code
Data Element	0542	Billing Provider Postal Code
Data Element	0569	Billing Provider Country Code
Segment	REF	Billing Provider Tax Identification Number
Data Element	0629	Billing Provider FEIN
Segment	REF	Billing Provider State License Number
Data Element	0630	Billing Provider State License Number
LOOP ID	2310B	RENDERING BILL PROVIDER INFORMATION
Segment	NM1	Rendering Bill Provider Name
Data Element	0638	Rendering Bill Provider Last/Group Name

Data Element	0639	Rendering Bill Provider First Name
Data Element	0647	Rendering Bill Provider National Provider ID
Segment	PRV	Rendering Bill Provider Specialty Information
Data Element	0651	Rendering Bill Provider Primary Specialty Code
Segment	REF	Rendering Bill Provider Secondary ID
Data Element	0643	Rendering Bill Provider State License Number
LOOP ID	2310C	SUPERVISING PROVIDER INFORMATION
Segment	NM1	Supervising Provider Name
Data Element	0658	Supervising Provider Last/Group Name
Data Element	0659	Supervising Provider First Name
Data Element	0667	Supervising Provider National Provider ID
Segment	PRV	Supervising Provider Specialty Information
Data Element	0671	Supervising Provider Primary Specialty Code
LOOP ID	2310D	SERVICE FACILITY LOCATION INFORMATION
Segment	NM1	Service Facility Location Name
Data Element	0678	Facility Name
Data Element	0682	Facility National Provider ID
Segment	N3	Service Facility Location Address
Data Element	0684	Facility Primary Address
Data Element	0685	Facility Secondary Address
Segment	N4	Service Facility Location City, State, and Postal Code
Data Element	0686	Facility City
Data Element	0687	Facility State Code
Data Element	0688	Facility Postal Code
Data Element	0689	Facility Country Code
Segment	REF	Service Facility Location Secondary Identification Number
Data Element	0680	Facility State License Number
LOOP ID	2310E	REFERRING PROVIDER INFORMATION
Segment	NM1	Referring Provider Name
Data Element	0690	Referring Provider Last/Group Name
Data Element	0691	Referring Provider First Name
Data Element	0699	Referring Provider National Provider ID
LOOP ID	2310F	MANAGED CARE ORGANIZATION INFORMATION
Segment	NM1	Managed Care Organization Information
Data Element	0209	Managed Care Organization Name
Data Element	0208	Managed Care Organization Identification Number
Segment	REF	Managed Care Organization Secondary ID Number
Data Element	0704	Managed Care Organization FEIN
LOOP ID	2320	BILL LEVEL ADJUSTMENTS AND AMOUNTS
Segment	SBR	Subscriber Information

Segment	CAS	Bill Level Adjustment Reasons and Amounts
Data Element	0543	Bill Adjustment Group Code
Data Element	0544	Bill Adjustment Reason Code
Data Element	0545	Bill Adjustment Amount
Data Element	0546	Bill Adjustment Unit(s)
Segment	AMT	Prior Payment Amount
Data Element	0760	Prior Actual Amount Paid
LOOP ID:	2400	SERVICE LINE INFORMATION
Segment	LX	Service Line Information
Data Element	0547	Line Number
Segment	SV1	Professional Service Information
Data Element	0721	NDC Billed Code
Data Element	0714	HCPCS Line Procedure Billed Code
Data Element	0717	HCPCS Modifier Billed Code
Data Element	0715	Jurisdiction Procedure Billed Code
Data Element	0718	Jurisdiction Modifier Billed Code
Data Element	0551	Procedure Description
Data Element	0552	Total Charge per Line
Data Element	0553	Day(s)/Unit(s) Code
Data Element	0554	Day(s)/Unit(s) Billed
Data Element	0600	Place of Service Line Code
Data Element	0557	Diagnosis Pointer
Data Element	0742	Provider Agreement Line Code
Segment	SV2	Institutional Service Information
Data Element	0559	Revenue Billed Code
Data Element	0625	HIPPS Rate Code
Data Element	0714	HCPCS Line Procedure Billed Code
Data Element	0717	HCPCS Modifier Billed Code
Data Element	0715	Jurisdiction Procedure Billed Code
Data Element	0718	Jurisdiction Modifier Billed Code
Data Element	0551	Procedure Description
Data Element	0552	Total Charge per Line
Data Element	0553	Day(s)/Unit(s) Code
Data Element	0554	Day(s)/Unit(s) Billed
Segment	SV3	Dental Service
Data Element	0714	HCPCS Line Procedure Billed Code
Data Element	0719	ADA Procedure Billed Code
Data Element	0717	HCPCS Modifier Billed Code
Data Element	0551	Procedure Description
Data Element	0552	Total Charge per Line
Data Element	0600	Place of Service Line Code
Data Element	0742	Provider Agreement Line Code
Segment	SV4	Prescription Drug Service
Data Element	0561	Prescription Line Number

Data Element	0721	NDC Billed Code
Data Element	0563	Drug Name
Data Element	0562	Dispense as Written Code
Data Element	0762	Compound Drug Indicator
Segment	DTP	Service Date(s)
Data Element	0605	Service Line Date(s) Range
Segment	DTP	Prescription Date
Data Element	0604	Prescription Line Date
Segment	QTY	Prescription Quantity
Data Element	0570	Drugs/Supplies Quantity Dispensed
Data Element	0571	Drugs/Supplies Number of Days
Segment	CN1	Contract Information
Data Element	0741	Contract Line Type Code
Segment	AMT	Pharmacy Dispensing Fee Paid Amount
Data Element	0579	Drugs/Supplies Dispensing Fee
Segment	AMT	Pharmacy Billed Amount
Data Element	0572	Drug/Supplies Billed Amount
LOOP ID	2420	RENDERING LINE PROVIDER INFORMATION
Segment	NM1	Rendering Line Provider Name
Data Element	0589	Rendering Line Provider Last/Group Name
Data Element	0587	Rendering Line Provider First Name
Data Element	0592	Rendering Line Provider National Provider ID
Segment	PRV	Rendering Line Provider Specialty Information
Data Element	0595	Rendering Line Provider Primary Specialty Code
Segment	REF	Rendering Line Provider Secondary Identification
Data Element	0599	Rendering Line Provider State License Number
LOOP ID	2430	SERVICE LINE ADJUSTMENTS AND AMOUNTS
Segment	SVD	Service Line Adjudication
Data Element	0574	Total Amount Paid per Line
Data Element	0722	ADA Procedure Paid Code
Data Element	0726	HCPCS Line Procedure Paid Code
Data Element	0727	HCPCS Modifier Paid Code
Data Element	0728	NDC Paid Code
Data Element	0729	Jurisdiction Procedure Paid Code
Data Element	0730	Jurisdiction Modifier Paid Code
Data Element	0576	Revenue Paid Code
Data Element	0580	Day(s)/Unit(s) Paid
Data Element	0547	Line Number
Segment	CAS	Service Line Adjustment
Data Element	0731	Service Adjustment Group Code
Data Element	0732	Service Adjustment Reason Code
Data Element	0733	Service Adjustment Amount
Data Element	0734	Service Adjustment Units
Segment	AMT	Line Item Prior Payment Amount
Data Element	0761	Line Item Prior Actual Amount Paid

SE Transaction Set Trailer

Segment	SE	Transaction Set Trailer

California-adopted ANSI 824 loops, segments, and data elements summary

The medical bill payment detailed acknowledgment (824) reports back to the trading partner at both the ST-SE transaction-set level and the bill level. At the transaction-set level, each ST-SE will either be accepted (TA) or rejected (TR). Within each accepted ST-SE transaction set, each medical bill will either be accepted (IA) or rejected (IR). The following outline summarizes the loop, segment, and data element structure of the medical bill payment detailed acknowledgment (824). More detailed information can be found in Section 3 of the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide for Medical Bill Payment Records, Release 2, February 1, 2014.

ST Transaction Set Header

Segment	ST	Transaction Set Control Number
Segment	BGN	Beginning Segment
Data Element	0743	Jurisdiction Tracking Number
Data Element	0100	Date Transmission Sent
Data Element	0101	Time Transmission Sent
Data Element	0532	Originator Transaction Identification Number
LOOP ID:	N1	SENDER INFORMATION
Segment	N1	Sender ID
Data Element	0098	Sender ID
LOOP ID:	N1	RECEIVER INFORMATION
Segment	N1	Receiver ID
Data Element	0099	Receiver ID
LOOP ID:	OTI	ORIGINAL TRANSACTION IDENTIFICATION ~~TRANSACTION~~
Segment	OTI	Original Transaction Identifier
Data Element	0111	Application Acknowledgment Code
Data Element	0500	Unique Bill ID Number
Data Element	0532	Originator Transaction Identification Number
Data Element	0102	Original Transmission Date
Data Element	0103	Original Transmission Time
Data Element	0110	Acknowledgment Transaction Set ID
Segment	REF	Line Number
Data Element	0547	Line Number
Segment	DTM	Processing Date
Data Element	0108	Date Processed
Data Element	0109	Time Processed
LOOP ID	LM	CODE SOURCE INFORMATION
Segment	LM	Code Source Information
LOOP ID:	LQ	INDUSTRY CODE

Segment	LQ	Industry Code
Data Element	0116	Element Error Number
Segment	RED	Related Data
TRANSACTION SET TRAILER		
Data Element	0115	Element Number
Segment	SE	Transaction Set Trailer

Section VI: Required medical data elements

Medical data elements by name and source

The Medical Data Elements by Source table below numerically lists the California-adopted IAIABC data elements that are to be included in the EDI transmission of the medical bills reported to the DWC WCIS. The table includes the IAIABC Data Element Number (DN), the IAIABC data element name and the data source in the workers' compensation system. In the case of the CMS 1500, UB04, Universal Claim Form (NCPDP), and the Dental Claim Form, the fields on the medical paper forms are identified. The table also includes information on which entity in the system has access to selected data elements. The entities include: Payers, Jurisdictional Licensing Boards (JLB), and Senders (SNDR).

California Medical Data Elements by Source								
DN	**DATA ELEMENT NAME**	**CMS 1500**	**UB 04**	**NCPDP**	**ADA**	**Payer**	**JLB**	**SNDR**
0005	JURISDICTION CLAIM NUMBER					x		
0006	INSURER FEIN					x		
0007	INSURER NAME	11c	50	18	3			
0014	CLAIM ADMINISTRATOR MAILING POSTAL CODE					x		
0015	CLAIM ADMINISTRATOR CLAIM NUMBER	11		17		x		
0016	EMPLOYER FEIN					x		
0018	EMPLOYER NAME	4	58a,65	23	12			
0031	DATE OF INJURY	14	31	11	46			
0042	EMPLOYEE SOCIAL SECURITY NUMBER	1a	60	12	23	x		
0043	EMPLOYEE LAST NAME	2	8a	3				
0044	EMPLOYEE FIRST NAME	2	8a	4				
0045	EMPLOYEE MIDDLE NAME/INITIAL	2	8a					
0098	SENDER ID							x
0099	RECEIVER ID							x
0100	DATE TRANSMISSION SENT							x
0101	TIME TRANSMISSION SENT							x
0102	ORIGINAL TRANSMISSION DATE							x
0103	ORIGINAL TRANSMISSION TIME							x
0104	TEST/PRODUCTION INDICATOR							x
0108	DATE PROCESSED							x
0109	TIME PROCESSED							x
0110	ACKNOWLEDGMENT TRANSACTION SET ID							x

California Medical Data Elements by Source								
DN	**DATA ELEMENT NAME**	**CMS 1500**	**UB 04**	**NCPDP**	**ADA**	**Payer**	**JLB**	**SNDR**
0111	APPLICATION ACKNOWLEDGMENT CODE							x
0115	ELEMENT NUMBER							x
0116	ELEMENT ERROR NUMBER							x
0187	CLAIM ADMINISTRATOR FEIN					x		
0188	CLAIM ADMINISTRATOR NAME					x		
0208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER						x	
0209	MANAGED CARE ORGANIZATION NAME					x		
0266	TRANSACTION TRACKING NUMBER							x
0293	LUMP SUM PAYMENT/SETTLEMENT CODE					x		
0500	UNIQUE BILL ID NUMBER					x		
0501	TOTAL CHARGE PER BILL	28	47	106	33			
0502	BILLING TYPE CODE					x		
0503	BILLING FORMAT CODE					x		
0504	FACILITY CODE	22	4					
0505	BILL FREQUENCY TYPE CODE	~~22~~	4					
0507	PROVIDER AGREEMENT CODE					x		
0508	BILL SUBMISSION REASON CODE					x		
0509	SERVICE BILL DATE(S) RANGE		~~45~~ 6					
0510	DATE OF BILL	31	~~6~~	2				
0511	DATE INSURER RECEIVED BILL					x		
0512	DATE INSURER PAID BILL					x		
0513	ADMISSION DATE		12					
0514	DISCHARGE DATE							
0515	CONTRACT TYPE CODE					x		
0516	TOTAL AMOUNT PAID PER BILL					x		
0520	OUTPATIENT REASON FOR VISIT CODE		70a-c					
0521	PRINCIPAL DIAGNOSIS CODE	21a	67					
0522	~~ICD-9 CM~~ DIAGNOSIS CODE	21 b-l	67(a-q)					
0523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER					x		
0524	PROCEDURE DATE		74					
0525	~~ICD-9 CM~~ PRINCIPAL PROCEDURE CODE		74a-e					
0527	PRESCRIPTION DATE(S) RANGE			~~66~~65				

California Medical Data Elements by Source								
DN	**DATA ELEMENT NAME**	**CMS 1500**	**UB 04**	**NCPDP**	**ADA**	**Payer**	**JLB**	**SNDR**
0528	BILLING PROVIDER LAST/GROUP NAME	33	1	~~34~~51	48			
0529	BILLING PROVIDER FIRST NAME	33			48			
0532	ORIGINATOR TRANSACTION IDENTIFICATION NUMBER							x
0533	PRESENT ON ADMISSION INDICATOR		67					
0535	ADMITTING DIAGNOSIS CODE		69					
0537	BILLING PROVIDER PRIMARY SPECIALTY CODE	33b	81b					
0538	BILLING PROVIDER PRIMARY ADDRESS	33	1	~~35~~ 52	48			
0539	BILLING PROVIDER SECONDARY ADDRESS	33				x		
0540	BILLING PROVIDER CITY	33	1	~~36~~ 53	48			
0541	BILLING PROVIDER STATE CODE		1	~~37~~54	48			
0542	BILLING PROVIDER POSTAL CODE	33	1	~~38~~ 55	48			
0543	BILL ADJUSTMENT GROUP CODE					x		
0544	BILL ADJUSTMENT REASON CODE					x		
0545	BILL ADJUSTMENT AMOUNT					x		
0546	BILL ADJUSTMENT UNITS					x		
0547	LINE NUMBER							x
0548	BILLED DRG CODE					x		
0549	PAID DRG CODE					x		
0550	PRINCIPAL PROCEDURE DATE		74					
0551	PROCEDURE DESCRIPTION					x		
0552	TOTAL CHARGE PER LINE	24f	47		31			
0553	DAYS/UNIT(S) CODE					x		
0554	DAYS/UNIT(S) BILLED	24g	46					
0555	PLACE OF SERVICE BILL CODE				38			
0556	CONDITION CODE	10d	18-28					
0557	DIAGNOSIS POINTER	24 e						
0559	REVENUE BILLED CODE		42					
0561	PRESCRIPTION LINE NUMBER			62				
0562	DISPENSE AS WRITTEN CODE			73				
0563	DRUG NAME			76*, 94**				
0569	BILLING PROVIDER COUNTRY CODE	33				x		
0570	DRUGS/SUPPLIES QUANTITY DISPENSED			71				

California Medical Data Elements by Source								
DN	**DATA ELEMENT NAME**	**CMS 1500**	**UB 04**	**NCPDP**	**ADA**	**Payer**	**JLB**	**SNDR**
0571	DRUGS/SUPPLIES NUMBER OF DAYS			~~71~~72				
0572	DRUGS/SUPPLIES BILLED AMOUNT			98**, 102*				
0574	TOTAL AMOUNT PAID PER LINE					x		
0576	REVENUE PAID CODE					x		
0577	ADMISSION TYPE CODE		14					
0579	DRUGS/SUPPLIES DISPENSING FEE			103				
0580	DAY(S)/UNIT(S) PAID					x		
0587	RENDERING LINE PROVIDER FIRST NAME					x		
0589	RENDERING LINE PROVIDER LAST/ GROUP NAME					x		
0592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID	24j				x		
~~0593~~	~~RENDERING LINE PROVIDER POSTAL CODE~~					~~x~~		
0595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	~~24j~~				x		
0599	RENDERING LINE PROVIDER STATE LICENSE NUMBER						x	
0600	PLACE OF SERVICE LINE CODE	24b						
0604	PRESCRIPTION LINE DATE			~~66~~ 65				
0605	SERVICE LINE DATE(S) RANGE	24a	45	66				
0615	REPORTING PERIOD					x		
0616	INSURER POSTAL CODE			22		x		
0622	ADMISSION HOUR		13					
0623	DISCHARGE HOUR		16					
0625	HIPPS RATE CODE		44					
0629	BILLING PROVIDER FEIN	25	5	49				
0630	BILLING PROVIDER STATE LICENSE NUMBER			49	50		x	
0634	BILLING PROVIDER NATIONAL PROVIDER ID	33a	56	~~32~~ 49	49			
0638	RENDERING BILL PROVIDER LAST/GROUP NAME	33	76	34				
0639	RENDERING BILL PROVIDER FIRST NAME		76					
0643	RENDERING BILL PROVIDER STATE LICENSE NUMBER			32			x	
0647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	33a	76	32				
0651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	33b			56a			

California Medical Data Elements by Source								
DN	**DATA ELEMENT NAME**	**CMS 1500**	**UB 04**	**NCPDP**	**ADA**	**Payer**	**JLB**	**SNDR**
0658	SUPERVISING PROVIDER LAST/ GROUP NAME	17	~~78~~					
0659	SUPERVISING PROVIDER FIRST NAME	17	~~78~~					
0667	SUPERVISING PROVIDER NATIONAL PROVIDER ID	17b						
0671	SUPERVISING PROVIDER PRIMARY SPECIALTY CODE							
0678	FACILITY NAME	32	1					
0680	FACILITY STATE LICENSE NUMBER	32b	57					
0682	FACILITY NATIONAL PROVIDER ID	32a	51, 56			x		
0684	FACILITY PRIMARY ADDRESS	32	1					
0685	FACILITY SECONDARY ADDRESS	32	1					
0686	FACILITY CITY	32	1					
0687	FACILITY STATE CODE	32	1					
0688	FACILITY POSTAL CODE	32	1					
0689	FACILITY COUNTRY CODE							
0690	REFERRING PROVIDER LAST/ GROUP NAME	17	78, 79	42	42			
0691	REFERRING PROVIDER FIRST NAME	17		43	43			
0699	REFERRING PROVIDER NATIONAL PROVIDER ID	17b	78, 79	40		x		
0704	MANAGED CARE ORGANIZATION FEIN					x		
0714	HCPCS LINE PROCEDURE BILLED CODE	24d	44					
0715	JURISDICTION PROCEDURE BILLED CODE	24d	44			x		
0717	HCPCS MODIFIER BILLED CODE	24d	44					
0718	JURISDICTION MODIFIER BILLED CODE	24d	44					
0719	ADA PROCEDURE BILLED CODE				29			
0721	NDC BILLED CODE	24		69*, 95**				
0722	ADA PROCEDURE PAID CODE					x		
0726	HCPCS LINE PROCEDURE PAID CODE					x		
0727	HCPCS MODIFIER PAID CODE					x		
0728	NDC PAID CODE					x		
0729	JURISDICTION PROCEDURE PAID CODE					x		
0730	JURISDICTION MODIFIER PAID CODE					x		
0731	SERVICE ADJUSTMENT GROUP CODE					x		

California Medical Data Elements by Source								
DN	**DATA ELEMENT NAME**	**CMS 1500**	**UB 04**	**NCPDP**	**ADA**	**Payer**	**JLB**	**SNDR**
0732	SERVICE ADJUSTMENT REASON CODE					x		
0733	SERVICE ADJUSTMENT AMOUNT					x		
0734	SERVICE ADJUSTMENT UNITS					x		
0736	~~ICD-9 CM~~ OTHER PROCEDURE CODE		74(a-e)					
0741	CONTRACT LINE TYPE CODE					x		
0742	PROVIDER AGREEMENT LINE CODE					x		
0743	JURISDICTION TRACKING NUMBER							x
0760	PRIOR ACTUAL AMOUNT PAID					x		
0761	LINE ITEM PRIOR ACTUAL AMOUNT PAID					x		
0762	COMPOUND DRUG INDICATOR							

Note: * = single drug
** = compound drugs

Section VII: Medical data element requirements

The structure of the element requirement table allows for requirement codes to be defined at the data element level (DN) for each bill submission reason code (00, 01, 02, or 05). Further, it provides for data element requirements to differ based on report requirements criteria established in the event table. A requirement code is entered at each cell marked by the intersection of a bill submission reason code column and each data element row.

Bill submission reason code values

The bill submission reason code (BSRC) defines the specific purpose (event) for which the transaction is being sent (triggered). Below are the four BSRC adopted by the WCIS to report the purpose of each transaction reported in the 837. The WCIS does not accept BSRC 09.

00 = Original
The code is used to report the first medical EDI record payment action taken by the claim administrator or insurer. A payment action may represent a payment to the health care provider or a denial. Only one original transaction is submitted for any individual medical bill.

01 = Cancellation
The code is used when a “00” original has been submitted which should never have been submitted to the WCIS or when the original transaction contained errors in critical data elements (see the IAIABC Workers’ Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2012, section 1.4.2.1, page 1.10). It is recommended that the value in DN0500 Unique Bill ID Number contained in a cancelled medical EDI record not be reused. Only required data elements should be reported for 01 cancellation. If data that is not required is reported, it must be in a valid format and value or the transaction will be rejected.

02 = Corrected and verified Original Claim
The code is used when the trading partner must correct errors to non-critical data elements on a “00” original or “05,” replace transaction. This value is not used if the amount of payment changed due to a subsequent payment action by the claim administrator or insurer. The Unique Bill ID Number (DN0500) reported on a corrected bill must be the same as that reported on the original (BSRC=00) bill.

05 = Replace
The code is used when the trading partner must report a subsequent payment action or denial by the claim administrator or insurer. A “00” original transaction must have been submitted and accepted before a “05” replace transaction is reported. The Unique Bill ID Number (DN0500) reported on a Replace bill must be

the same as that reported on the original (BSRC=00) or a prior Replace bill (BSRC=05)

Standard requirement code values:

The standard requirement code values are utilized in the medical data element requirement table to indicate the reporting requirement for each data element for each of the bill submission reason code. Below are the six standard requirement code values adopted by the WCIS.

M Mandatory.
The data element must be present and must be a valid value and format or the transaction will be rejected.

AA Applicable/Available Item Accepted.
Data should be sent if applicable and/or available. The data may or may not be populated. If the data is applicable to the bill and data is available, data must be sent. If reported, data is accepted and will not be edited for valid value and/or format.

AR Applicable/Available Item Rejected.
Data should be sent if applicable and/or available. The data may or may not be populated. If the data is applicable to the bill and data is available, data must be sent. If reported, data will be edited for valid value and/or format.

MC Mandatory/Conditional.
The data element becomes mandatory under stated conditions. If the defined condition exists, the data element becomes mandatory and mandatory rules apply (the data element must be present and must be a valid format or the transaction will be rejected).

NA Not Applicable.
The data element is not applicable to the California WCIS requirements for the bill type and may or may not be sent.

F Fatal Technical.
Data elements is essential for a transmission/transaction to be accepted in California's WCIS database or for an acknowledgment to be sent back to the sender. If the data is missing or invalid, the transmission/transaction will be rejected.

Mandatory trigger:
The mandatory trigger states the condition which makes a data element mandatory.

Legend for bill type code

Bill Type	California Specific Bill Type Code	Line Segment
Professional	P	SV1
Institutional	I	SV2
Dental	D	SV3
Pharmaceutical	R~~X~~x	SV4
All bills	ALL	SV1, SV2, SV3, SV4

Medical Data Elements Requirement Table

(Does not apply to medical lien lump sum payments or settlements)

~~*Medical Data Elements Requirements Table*~~ ~~(Does not apply to medical lien lump sum payments or settlements)~~							
		Original	**Cancellation**	**Correction**	**Replace**		**Bill Type(s)**
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0005	JURISDICTION CLAIM NUMBER	M	M	M	M		All
0006	INSURER FEIN	M	M	M	M		All
0007	INSURER NAME	M	M	M	M		All
0014	CLAIM ADMINISTRATOR MAILING POSTAL CODE	M~~C~~	M~~C~~	M~~C~~	M~~C~~	~~Required when DN0188 (Claim Administrator Name) is reported.~~	All
0015	CLAIM ADMINISTRATOR CLAIM NUMBER	M	M	M	M		All
0016	EMPLOYER FEIN	M	M	M	M		All
0018	EMPLOYER NAME	M	M	M	M		All
0031	DATE OF INJURY	F	F	F	F		All
0042	EMPLOYEE SSN	MC	NA	MC	MC	Required when the employee has SSN. If the employee does not have a SSN, use the default value of "000000006".	All
0043	EMPLOYEE LAST NAME	M	M	M	M		All
0044	EMPLOYEE FIRST NAME	M	M	M	M		All
0045	EMPLOYEE MIDDLE NAME/INITIAL	AA	NA	AA	AA		All
0098	SENDER ID	F	F	F	F		All
0099	RECEIVER ID	F	F	F	F		All
0100	DATE TRANSMISSION SENT	F	F	F	F		All
0101	TIME TRANSMISSION SENT	F	F	F	F		All
0187	CLAIM ADMINISTRATOR FEIN	M	M	M	M		All

~~Medical Data Elements Requirements Table~~ ~~(Does not apply to medical lien lump sum payments or settlements)~~							
		Original	**Cancellation**	**Correction**	**Replace**		**Bill Type(s)**
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0188	CLAIM ADMINISTRATOR NAME	M	M	M	M		All
0208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	MC	NA	MC	MC	Required if DN0209 (Managed Care Organization Name) is present. Report the DWC-assigned MPN (Medical Provider Network) ~~approval~~ *ID* number.	All
0209	MANAGED CARE ORGANIZATION NAME	MC	NA	MC	MC	Required when the service provided was within an MPN approved by DWC and both the provider and the injured worker belong to the same MPN.	All
0266	TRANSACTION TRACKING NUMBER	M	M	M	M		All
~~0293~~	~~LUMP SUM PAYMENT/SETTLEMENT CODE~~	~~MC~~	~~NA~~	~~MC~~	~~MC~~	~~Required when a settlement is paid covering more than one bill.~~	~~All~~
0500	UNIQUE BILL ID NUMBER	F	F	F	F		All
0501	TOTAL CHARGE PER BILL	M	NA	M	M		All
~~0502~~	~~BILLING TYPE CODE~~	~~MC~~	~~NA~~	~~MC~~	~~MC~~	~~Required when reporting aggregate or summary records.~~	~~All~~
0503	BILLING FORMAT CODE	M	NA	M	M		All
0504	FACILITY CODE	F	NA	F	F		I
0505	BILL FREQUENCY TYPE CODE	M	NA	M	M		I
0507	PROVIDER AGREEMENT CODE	M	NA	M	M		All
0508	BILL SUBMISSION REASON CODE	F	F	F	F		All
0509	SERVICE BILL DATE(S) RANGE	M	NA	M	M		I
0510	DATE OF BILL	M	NA	M	M		All
0511	DATE INSURER RECEIVED BILL	M	NA	M	M		All
0512	DATE INSURER PAID BILL	M	NA	M	M		All
0513	ADMISSION DATE	MC	NA	MC	MC	Required when reporting institutional bills and an inpatient admission was involved.	I

~~*Medical Data Elements Requirements Table*~~

~~(Does not apply to medical lien lump sum payments or settlements)~~

		Original	**Cancellation**	**Correction**	**Replace**		**Bill Type(s)**
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0514	DISCHARGE DATE	MC	NA	MC	MC	Required when reporting institutional bills and an inpatient admission was involved and patient is discharged.	I
0515	CONTRACT TYPE CODE	MC	NA	MC	MC	Required when the medical services provided were paid under a contract term.	All
0516	TOTAL AMOUNT PAID PER BILL	M	NA	M	M		All
0520	OUTPATIENT REASON FOR VISIT CODE	MC	NA	MC	MC	Required when an outpatient visit is involved.	I
0521	PRINCIPAL DIAGNOSIS CODE	MC	NA	MC	MC	~~--Required when reporting institutional claims.~~ --Required when the SV2 Institutional Services segment is reported. --Required when the SV1 Professional Services segment is reported. --Required when the SV3 Dental Services segment is reported and the diagnosis code is contained on the dental medical bill received by the claims administrator or insurer.	I, P, D
0522	DIAGNOSIS CODE	MC	NA	MC	MC	--Required when an institutional service is reported and other diagnosis other than what is shown on DN0521 Principal Diagnosis and DN0535 Admitting Diagnosis ~~is present~~. --Required when the SV1 Professional Services segment is reported. --Required when the SV3 Dental Services segment is reported and the diagnosis code is contained on the dental medical bill received by the claims administrator or insurer.	I, P, D
0523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	F	F	F	F		All
0524	PROCEDURE DATE	MC	NA	MC	MC	Required when the corresponding DN0736 Other Procedure Code is present.	I
0525	PRINCIPAL PROCEDURE CODE	MC	NA	MC	MC	Required for institutional inpatient surgical bills.	I

~~*Medical Data Elements Requirements Table*~~

~~(Does not apply to medical lien lump sum payments or settlements)~~

		Original	**Cancellation**	**Correction**	**Replace**		**Bill Type(s)**
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0527	PRESCRIPTION DATE(S) RANGE	M	NA	M	M		Rx
0528	BILLING PROVIDER LAST/GROUP NAME	M	~~NA~~ M	M	M		All
0529	BILLING PROVIDER FIRST NAME	MC	NA	MC	MC	Required when the billing provider is an individual.	All
0532	ORIGINATOR TRANSACTION IDENTIFICATION NUMBER	F	F	F	F		All
0533	PRESENT ON ADMISSION INDICATOR	MC	NA	MC	MC	~~Required on inpatient hospital bills for exempt diagnosis.~~ Required on inpatient hospital bills and diagnosis is not listed as exempt.	I
0535	ADMITTING DIAGNOSIS CODE	MC	NA	MC	MC	Required when an inpatient admission is involved.	I
0537	BILLING PROVIDER PRIMARY SPECIALTY CODE	~~AA~~ AR	NA	~~AA~~ AR	~~AA~~ AR		All
0538	BILLING PROVIDER PRIMARY ADDRESS	M	NA	M	M		All
0539	BILLING PROVIDER SECONDARY ADDRESS	MC	NA	MC	MC	Required if provider is located in the U.S. and there is a secondary address.	All
0540	BILLING PROVIDER CITY	M	NA	M	M		All
0541	BILLING PROVIDER STATE CODE	MC	NA	MC	MC	Required if provider is located in the U.S. Do not send if outside of U.S.	All
0542	BILLING PROVIDER POSTAL CODE	MC	NA	MC	MC	Required if provider is located in the U.S. Do not send if outside of U.S.	All
0543	BILL ADJUSTMENT GROUP CODE	MC	NA	MC	MC	Required when adjustments apply to service lines on a medical bill. ~~containing more than one line. or when submitting aggregate or summary records.~~	All
0544	BILL ADJUSTMENT REASON CODE	MC	NA	MC	MC	Required when bill level adjustments, bill level amounts, or prior payment amounts are reported.	All
0545	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	Required when bill level adjustments, bill level amounts, or prior payment amounts are reported.	All
0546	BILL ADJUSTMENT UNITS	MC	NA	MC	MC	Required when the number of service units has been adjusted.	All
0547	LINE NUMBER	MC	~~MC~~ NA	MC	MC	Required when reporting service line information is present.	All
0548	BILLED DRG CODE	MC	NA	MC	MC	Required for inpatient bills when the DN0515 Contract Type Code is DRG.	I

~~*Medical Data Elements Requirements Table*~~

~~(Does not apply to medical lien lump sum payments or settlements)~~

		Original	**Cancellation**	**Correction**	**Replace**		**Bill Type(s)**
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0549	PAID DRG CODE	MC	NA	MC	MC	Required for inpatient bills when the DN0515 Contract Type Code is DRG	I
0550	PRINCIPAL PROCEDURE DATE	MC	NA	MC	MC	Required when DN0525 (Principal Procedure Code) is present.	I
0551	PROCEDURE DESCRIPTION	~~MC~~ AA	NA	~~MC~~ AA	~~MC~~ AA	Required when reporting unlisted procedures.	I, P, D
0552	TOTAL CHARGE PER LINE	M	NA	M	M		I, P, D
0553	DAYS(S)/UNIT(S) CODE	M	NA	M	M		I, P
0554	DAY(S) /UNIT(S) BILLED	M	NA	M	M		I, P
0555	PLACE OF SERVICE BILL CODE	F	NA	F	F		P, Rx, D
0556	CONDITION CODE	MC	NA	MC	MC	Required when condition codes impact the adjudication of the medical bill.	I,P, D
0557	DIAGNOSIS POINTER	M	NA	M	M		P
0559	REVENUE BILLED CODE	M	NA	M	M		I
0561	PRESCRIPTION LINE NUMBER	M	NA	M	M		Rx
0562	DISPENSE AS WRITTEN CODE	M	NA	M	M		Rx
0563	DRUG NAME	AA	NA	AA	AA		Rx
0569	BILLING PROVIDER COUNTRY CODE	MC	NA	MC	MC	Required if the billing provider address is outside the U.S.	All
0570	DRUGS/SUPPLIES QUANTITY DISPENSED	M	NA	M	M		Rx ~~P~~
0571	DRUGS/SUPPLIES NUMBER OF DAYS	M	NA	M	M		Rx ~~P~~
0572	DRUGS/SUPPLIES BILLED AMOUNT	M	NA	M	M		Rx ~~P~~
0574	TOTAL AMOUNT PAID PER LINE	M	NA	M	M		All
0576	REVENUE PAID CODE	MC	NA	MC	MC	Required for institutional bills and outpatient bills.	I
0577	ADMISSION TYPE CODE	MC	NA	MC	MC	Required when reporting institutional bills and an inpatient admission was involved.	I
0579	DRUGS/SUPPLIES DISPENSING FEE	AR	NA	AR	AR		Rx
0580	DAYS(S)/UNIT(S) PAID	MC	NA	MC	MC	Required for institutional and professional bills.	I, P

~~*Medical Data Elements Requirements Table*~~

~~(Does not apply to medical lien lump sum payments or settlements)~~

		Original	**Cancellation**	**Correction**	**Replace**		**Bill Type(s)**
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0587	RENDERING LINE PROVIDER FIRST NAME	MC	NA	MC	MC	Required if DN0589 (Rendering Line Provider Last/Group Name) is present and an individual.	~~All~~ I, P,D
0589	RENDERING LINE PROVIDER LAST/GROUP NAME	MC	NA	MC	MC	Required when identified on the medical bill received by the insurer and claims administrator and different from DN0528 Billing Provider Last/ Group Name.	~~All~~ I,P,D
0592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	Required when DN0589 (Rendering Line Provider Last/ Group Name) is present and the provider is eligible for NPI.	~~All~~ I,P,D
0595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	MC	NA	MC	MC	Required when DN0589 is present.	~~All~~ I,P,D
0599	RENDERING LINE PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	Required when DN0589 Rendering Line Provider Last/Group Name is present and DN0592 (Rendering Line Provider National Provider ID) is not reported.	~~All~~ I,P,D
0600	PLACE OF SERVICE LINE CODE	MC	NA	MC	MC	Required when line-level place of service is different from the bill-level Place of Service. DN0503 Billing format code must be 'B'.	P, ~~RX,~~ D
0604	PRESCRIPTION LINE DATE	M	NA	M	M		Rx
0605	SERVICE LINE DATE(S) RANGE	M	NA	M	M		~~I, P, Rx, D~~ ALL
0615	REPORTING PERIOD	M	M	M	M		All
0616	INSURER POSTAL CODE	M	NA	M	M		All
0622	ADMISSION HOUR	MC	NA	MC	MC	Required when reporting institutional bills and an inpatient admission was involved.	I
0623	DISCHARGE HOUR	MC	NA	MC	MC	Required when reporting institutional bills, an inpatient admission was involved, and patient was discharged.	I
0625	HIPPS RATE CODE	MC	NA	MC	MC	Required when the medical bill received by the insurer or claims administrator contained a Health Insurance Prospective Payment System Code for this service line item.	I
0629	BILLING PROVIDER FEIN	M	NA	M	M		All
0630	BILLING PROVIDER STATE LICENSE NUMBER	AA	NA	AA	AA		All

~~*Medical Data Elements Requirements Table*~~

~~(Does not apply to medical lien lump sum payments or settlements)~~

		Original	**Cancellation**	**Correction**	**Replace**		**Bill Type(s)**
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0634	BILLING PROVIDER NATIONAL PROVIDER ID (NPI)	MC	NA	MC	MC	Required when the provider is eligible to receive an NPI.	All
0638	RENDERING BILL PROVIDER LAST/GROUP NAME	MC	NA	MC	MC	Required when different from DN0528 Billing Provider Last/Group Name and DN0595 Rendering Line Provider not identified on the medical bill received by the insurer or claims administrator.	All
0639	RENDERING BILL PROVIDER FIRST NAME	MC	NA	MC	MC	Required when DN 0638 Rendering Bill Provider Last/Group Name is present and the rendering bill provider is a person.	All
0643	RENDERING BILL PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	Required when DN 0638 Rendering Bill Provider Last/Group Name is present and the provider is not eligible for an NPI. If provider is not eligible for state licensing, enter 999999999.	All
0647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	Required when DN0638 Rendering Bill Provider Last/Group Name is present, and the provider is eligible to receive an NPI.	All
0651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	MC	NA	MC	MC	Required when DN 0638 Rendering Bill Provider Last/Group Name is present and is a person.	~~All~~ I, P, D
0658	SUPERVISING PROVIDER LAST/GROUP NAME	MC	NA	MC	MC	Required when reporting professional medical bill records where the rendering provider is a non-licensed person supervised by a licensed health care provider.	~~All~~ ~~I,~~P~~,D~~
0659	SUPERVISING PROVIDER FIRST NAME	AA	NA	AA	AA		~~All~~ ~~I,~~P~~,D~~
0667	SUPERVISING PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	Required when DN0658 Supervising Provider Last/Group Name is present and the provider is eligible for an NPI.	~~All~~ ~~I,~~P~~,D~~
0671	SUPERVISING PROVIDER PRIMARY SPECIALTY CODE	~~AA~~ AR	NA	~~AA~~ AR	~~AA~~ AR		~~All~~ ~~I,~~P~~,D~~
0678	FACILITY NAME	MC	NA	MC	MC	Required when the service facility information is different from the billing provider information (when the services were not provided at the billing provider's address).	All
0680	FACILITY STATE LICENSE NUMBER	MC	NA	MC	MC	Required when the Service Facility Location is not eligible for NPI. If the Service Facility Location is not eligible for state licensing, use	All

~~Medical Data Elements Requirements Table~~ ~~(Does not apply to medical lien lump sum payments or settlements)~~							
		Original	**Cancellation**	**Correction**	**Replace**		**Bill Type(s)**
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
						999999999.	
0682	FACILITY NATIONAL PROVIDER ID	MC	NA	MC	MC	Required when the facility is eligible to receive an NPI and facility information is different from the billing provider information.	All
0684	FACILITY PRIMARY ADDRESS	MC	NA	MC	MC	Required when DN678 (Facility Name) is reported.	All
0685	FACILITY SECONDARY ADDRESS	AA	NA	AA	AA		All
0686	FACILITY CITY	MC	NA	MC	MC	Required when DN0678 (Facility Name) is reported.	All
0687	FACILITY STATE CODE	MC	NA	MC	MC	Required when DN0678 (Facility Name) is reported.	All
0688	FACILITY POSTAL CODE	MC	NA	MC	MC	Required when DN0678 (Facility Name) is reported.	All
0689	FACILITY COUNTRY CODE	MC	NA	MC	MC	Required when facility is located outside of the U.S.	All
0690	REFERRING PROVIDER LAST/GROUP NAME	MC	NA	MC	MC	Required when the service provided involves a referral.	All
0691	REFERRING PROVIDER FIRST NAME	MC	NA	MC	MC	Required when DN0690 (Referring Provider Last/Group Name) is present.	All
0699	REFERRING PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	Required when DN0690 (Referring Provider Last/Group Name) is present and the provider is eligible to receive an NPI.	All
0704	MANAGED CARE ORGANIZATION FEIN	MC	NA	MC	MC	Required if DN0209 (Managed Care Organization Name) is present.	All
0714	HCPCS LINE PROCEDURE BILLED CODE	MC	NA	MC	MC	-Required for professional bills when DN0715 (Jurisdiction Procedure Billed code) and DN0721 (NDC Billed code) are not present. Required for institutional bills when DN0715 (Jurisdiction Procedure Billed code) and DN0625 (HIPPS Rate Code) are not present. Required for dental bills when DN0719 ADA Procedure Billed Code is not present.	I, P, D
0715	JURISDICTION PROCEDURE BILLED CODE	MC	NA	MC	MC	-Required for professional bills when DN0714 (HCPCS Line Procedure	I, P

~~Medical Data Elements Requirements Table~~ ~~(Does not apply to medical lien lump sum payments or settlements)~~							
		Original	**Cancellation**	**Correction**	**Replace**		**Bill Type(s)**
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
						Billed Code) and DN0721 (NDC Billed Code) are not present. -Required for institutional bills when DN0714 (HCPCS Line Procedure Billed Code) and DN0625 (HIPPS Rate Code) are not present.	
0717	HCPCS MODIFIER BILLED CODE	AR	NA	AR	AR	Used when 0714 (HCPCS line procedure billed code) is reported and a modifier is included on the bill.	I, P,D
0718	JURISDICTION MODIFIER BILLED CODE	AR	NA	AR	AR	Used when 0715 Jurisdiction procedure billed code is reported and a modifier is included on the bill.	I, P
0719	ADA PROCEDURE BILLED CODE	MC	NA	MC	MC	Required for dental bills if DN0714 HCPCS Line Procedure Billed Code is not present.	D
0721	NDC BILLED CODE	MC	NA	MC	MC	-Required for pharmacy bills dispensed by a retail pharmacy or mail order pharmacy. -Required for professional bills when DME or other prescription are dispensed by the Rendering Provider.	P, Rx
0722	ADA PROCEDURE PAID CODE	MC	NA	MC	MC	Required for Dental Bills.	D
0726	HCPCS LINE PROCEDURE PAID CODE	MC	NA	MC	MC	Required for professional bills and for institutional outpatient bills.	I,P
0727	HCPCS MODIFIER PAID CODE	MC	NA	MC	MC	Required when the HCPCS procedure reported in DN0726 has been modified.	I,P
0728	NDC PAID CODE	MC	NA	MC	MC	-Required for pharmacy bills. -Required for professional bills when DME or other prescription are dispensed by the Rendering Provider.	P, Rx
0729	JURISDICTION PROCEDURE PAID CODE	MC	NA	MC	MC	-Required for professional bills when DN0726 HCPCS Line Procedure Paid Code is not present. -Required for institutional bills when DN0726 HCPCS Line Procedure Paid Code is not present and DN0625 HIPPS Rate Code is not present	P, I
0730	JURISDICTION MODIFIER PAID CODE	MC	NA	MC	MC	Required when DN0729 Jurisdiction Procedure Paid Code has been modified.	I, P
0731	SERVICE ADJUSTMENT GROUP CODE	MC	NA	MC	MC	Required when line-level adjustments are applied.	All

~~Medical Data Elements Requirements Table~~

~~(Does not apply to medical lien lump sum payments or settlements)~~

		Original	Cancellation	Correction	Replace		Bill Type(s)
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**	
0732	SERVICE ADJUSTMENT REASON CODE	MC	NA	MC	MC	Required when there is a line-level adjustment.	All
0733	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	Required when line-level adjustment are applied.	All
0734	SERVICE ADJUSTMENT UNITS	MC	NA	MC	MC	Required when the number of units paid is different from the number of units billed.	All
0736	OTHER PROCEDURE CODE	MC	NA	MC	MC	Required when procedure other than DN0525 Principal Procedure Code is present.	I
0741	CONTRACT LINE TYPE CODE	MC	NA	MC	MC	Required if there is a contract between the insurer and the service provider.	All
0742	PROVIDER AGREEMENT LINE CODE	MC	NA	MC	MC	Required when the provider agreement code at the line level is different from the provider agreement code at the bill level.	P, D
0760	PRIOR ACTUAL AMOUNT PAID	NA	NA	~~NA~~ MC	~~MC~~ AA	Required ~~for lien bills,~~ when reporting bill adjudication actions related to a medical bill ~~that has~~ previously paid (prior to receipt of the request for reconsideration or appeal) ~~been reported .~~	All
0761	LINE ITEM PRIOR ACTUAL AMOUNT PAID	NA	NA	NA	MC	Required when reporting line-level adjudication actions related to a previously paid medical bill (prior to receipt of the request for reconsideration or appeal) ~~reported.~~	All
0762	COMPOUND DRUG INDICATOR	MC	NA	MC	MC	Required when the drug reported in SV402-1 was billed as part of a compound drug.	Rx

Section VIII: California-adopted IAIABC data edits and California specific data edits and error messages

The Edit Matrix below provides the data edits and error codes the WCIS applies to the ANSI 837 EDI medical bill payment transmissions that are part of the IAIABC data edits and California-specific edits. The error codes will be transmitted back to each trading partner in the 824 acknowledgments.

California Edit Matrix

Legend for error codes
X = California-adopted IAIABC data elements and error messages.
C= California-specific data edits

Error codes for 824 acknowledgments

DN	IAIABC Data Element Name / ERROR MESSAGE	001 Mandatory field not present	028 All digits must be 0—9	029 Must be a valid date (CCYYMMDD)	030 Must be A—Z, 0—9, or spaces	031 Must be a valid time	033 Must be <= Date of Injury	034 Must be >= Date of Injury*	039 No match on database	040 All digits cannot be the same	041 Must be <= current date	057 Duplicate Batch/Transaction	058 Code/ID invalid	059 Non-match data value not consistent with value previously reported	063 Invalid event sequence	064 Invalid data relationship	070 Must be <= Service Date	072 Must be > Date of Bill	073 Must be >= Date Payer Received Bill	074 Must be >= From Service date	075 Must be <= To Service Date	111 Must be valid content	117 Match data value not consistent with value previously reported	118 Trading partner not approved to submit data
0005	JURISDICTION CLAIM NUMBER								X															
0006	INSURER FEIN								X	~~C~~ X														
0007	INSURER NAME	~~X~~																						
0014	CLAIM ADMINISTRA-TOR MAILING POSTAL CODE	X							~~X~~				X											
0015	CLAIM ADMINISTRA-TOR CLAIM								~~X~~ C					C	C									

Error codes for 824 acknowledgments

DN	IAIABC Data Element Name / ERROR MESSAGE	001 Mandatory field not present	028 All digits must be 0—9	029 Must be a valid date (CCYYMMDD)	030 Must be A–Z, 0—9, or spaces	031 Must be a valid time	033 Must be <= Date of Injury	034 Must be >= Date of Injury*	039 No match on database	040 All digits cannot be the same	041 Must be <= current date	057 Duplicate Batch/Transaction	058 Code/ID invalid	059 Non-match data value not consistent with value previously reported	063 Invalid event sequence	064 Invalid data relationship	070 Must be <= Service Date	072 Must be > Date of Bill	073 Must be >= Date Payer Received Bill	074 Must be >= From Service date	075 Must be <= To Service Date	111 Must be valid content	117 Match data value not consistent with value previously reported	118 Trading partner not approved to submit data
	NUMBER																							
0016	EMPLOYER FEIN	~~X~~								X													X	
0018	EMPLOYER NAME	~~X~~																						
0031	DATE OF INJURY										X												X	
0042	EMPLOYEE SSN	~~C~~								X														
0043	EMPLOYEE LAST NAME	~~X~~																						
0044	EMPLOYEE FIRST NAME	~~C~~																						
0045	EMPLOYEE MIDDLE NAME/INITIAL																							
0098	SENDER ID																							
0099	RECEIVER ID																							
0100	DATE TRANSMIS-SION SENT																							
0101	TIME TRANSMIS-SION SENT																							
0187	CLAIM ADMINISTRATO R FEIN									X													X	
0188	CLAIM ADMINISTRATO R NAME	X																						
0208	MANAGED CARE ORGANIZA-TION IDENTIFICA-TION NUMBER	~~C~~											C			C								
0209	MANAGED CARE ORGANIZA-TION NAME															C								
0266	TRANSACTION TRACKING											C												

Error codes for 824 acknowledgments

DN	IAIABC Data Element Name / ERROR MESSAGE	001 Mandatory field not present	028 All digits must be 0—9	029 Must be a valid date (CCYYMMDD)	030 Must be A–Z, 0—9, or spaces	031 Must be a valid time	033 Must be <= Date of Injury	034 Must be >= Date of Injury*	039 No match on database	040 All digits cannot be the same	041 Must be <= current date	057 Duplicate Batch/Transaction	058 Code/ID invalid	059 Non-match data value not consistent with value previously reported	063 Invalid event sequence	064 Invalid data relationship	070 Must be <= Service Date	072 Must be > Date of Bill	073 Must be >= Date Payer Received Bill	074 Must be >= From Service date	075 Must be <= To Service Date	111 Must be valid content	117 Match data value not consistent with value previously reported	118 Trading partner not approved to submit data
	NUMBER																							
0293	LUMP SUM PAYMENT/ SETTLEMENT CODE	X																						
0500	UNIQUE BILL ID NUMBER																						X	
0501	TOTAL CHARGE PER BILL	~~X~~												C		C						C		
0502	BILLING TYPE CODE	X																						
0503	BILLING FORMAT CODE	~~X~~																						
0504	FACILITY CODE	~~X~~											X											
0505	BILL FREQUENCY TYPE CODE	~~X~~																						
0507	PROVIDER AGREEMENT CODE	~~C~~																						
0508	BILL SUBMISSION REASON CODE											X			X									
0509	SERVICE BILL DATE(S) RANGE	X						X														C		
0510	DATE OF BILL	~~X~~						X												X				
0511	DATE INSURER RECEIVED BILL	~~X~~						X			C				?			X						
0512	DATE INSURER PAID BILL	~~X~~						X										~~C~~	X					
0513	ADMISSION DATE	C						X			C													
0514	DISCHARGE DATE							X			C									X				
0515	CONTRACT TYPE CODE															X								
0516	TOTAL AMOUNT PAID	~~X~~														C								

Error codes for 824 acknowledgments

DN	IAIABC Data Element Name / ERROR MESSAGE	001 Mandatory field not present	028 All digits must be 0—9	029 Must be a valid date (CCYYMMDD)	030 Must be A–Z, 0—9, or spaces	031 Must be a valid time	033 Must be <= Date of Injury	034 Must be >= Date of Injury*	039 No match on database	040 All digits cannot be the same	041 Must be <= current date	057 Duplicate Batch/Transaction	058 Code/ID invalid	059 Non-match data value not consistent with value previously reported	063 Invalid event sequence	064 Invalid data relationship	070 Must be <= Service Date	072 Must be > Date of Bill	073 Must be >= Date Payer Received Bill	074 Must be >= From Service date	075 Must be <= To Service Date	111 Must be valid content	117 Match data value not consistent with value previously reported	118 Trading partner not approved to submit data
	PER BILL																							
0520	OUTPATIENT REASON FOR VISIT CODE	X											~~C~~ X			C								
0521	PRINCIPAL DIAGNOSIS CODE	X											X											
0522	DIAGNOSIS CODE												X											
0523	BILLING PROVIDER UNIQUE BILL IDENTIFICA-TION NUMBER																							
0524	PROCEDURE DATE	X						C																
0525	PRINCIPAL PROCEDURE CODE	C											X											
0527	PRESCRIPTION BILL DATE	X						X			C						~~X~~	X						
0528	BILLING PROVIDER LAST/GROUP NAME	~~X~~																						
0529	BILLING PROVIDER FIRST NAME	C																						
0532	ORIGINATOR TRANSACTION IDENTIFICA-TION NUMBER											C												
0533	PRESENT ON ADMISSION INDICATOR	X																						
0535	ADMITTING DIAGNOSIS CODE	X											X			X								
0537	BILLING PROVIDER PRIMARY SPECIALTY CODE												~~C~~ X											
0538	BILLING PROVIDER	~~X~~																						

Error codes for 824 acknowledgments

DN	IAIABC Data Element Name / ERROR MESSAGE	001 Mandatory field not present	028 All digits must be 0—9	029 Must be a valid date (CCYYMMDD)	030 Must be A–Z, 0—9, or spaces	031 Must be a valid time	033 Must be <= Date of Injury	034 Must be >= Date of Injury*	039 No match on database	040 All digits cannot be the same	041 Must be <= current date	057 Duplicate Batch/Transaction	058 Code/ID invalid	059 Non-match data value not consistent with value previously reported	063 Invalid event sequence	064 Invalid data relationship	070 Must be <= Service Date	072 Must be > Date of Bill	073 Must be >= Date Payer Received Bill	074 Must be >= From Service date	075 Must be <= To Service Date	111 Must be valid content	117 Match data value not consistent with value previously reported	118 Trading partner not approved to submit data
	PRIMARY ADDRESS																							
0539	BILLING PROVIDER SECONDARY ADDRESS																							
0540	BILLING PROVIDER CITY	~~X~~																						
0541	BILLING PROVIDER STATE CODE												X											
0542	BILLING PROVIDER POSTAL CODE												X											
0543	BILL ADJUSTMENT GROUP CODE	~~X~~																						
0544	BILL ADJUSTMENT REASON CODE	X											X		C									
0545	BILL ADJUSTMENT AMOUNT	~~X~~														C								
0546	BILL ADJUSTMENT UNITS	~~C~~																						
0547	LINE NUMBER																							
0548	BILLED DRG CODE	C											X											
0549	PAID DRG CODE	C											X											
0550	PRINCIPAL PROCEDURE DATE	X		X				X																
0551	PROCEDURE DESCRIPTION																							
0552	TOTAL CHARGE PER LINE	X														C								
0553	DAY(S)/UNIT(S) CODE	X																						
0554	DAY(S) /UNIT(S) BILLED	X																						

Error codes for 824 acknowledgments

DN	IAIABC Data Element Name / ERROR MESSAGE	001 Mandatory field not present	028 All digits must be 0—9	029 Must be a valid date (CCYYMMDD)	030 Must be A–Z, 0—9, or spaces	031 Must be a valid time	033 Must be <= Date of Injury	034 Must be >= Date of Injury*	039 No match on database	040 All digits cannot be the same	041 Must be <= current date	057 Duplicate Batch/Transaction	058 Code/ID invalid	059 Non-match data value not consistent with value previously reported	063 Invalid event sequence	064 Invalid data relationship	070 Must be <= Service Date	072 Must be > Date of Bill	073 Must be >= Date Payer Received Bill	074 Must be >= From Service date	075 Must be <= To Service Date	111 Must be valid content	117 Match data value not consistent with value previously reported	118 Trading partner not approved to submit data
0555	PLACE OF SERVICE BILL CODE	~~X~~											~~C~~ X											
0556	CONDITION CODE												X											
0557	DIAGNOSIS POINTER															X								
0559	REVENUE BILLED CODE	~~X~~											~~C~~ X											
0561	PRESCRIPTION LINE NUMBER	~~X~~																						
0562	DISPENSE AS WRITTEN CODE	~~X~~											~~X~~											
0563	DRUG NAME																							
0569	BILLING PROVIDER COUNTRY CODE												X											
0570	DRUGS/SUP-PLIES QUANTITY DISPENSED	X																						
0571	DRUGS/SUP-PLIES NUMBER OF DAYS	X																						
0572	DRUGS/SUP-PLIES BILLED AMOUNT	X														C								
0574	TOTAL AMOUNT PAID PER LINE	X																						
0576	REVENUE PAID CODE	C											X											
0577	ADMISSION TYPE CODE												X											
0579	DRUGS/SUP-PLIES DISPENSING FEE																							
0580	DAY(S)/UNIT(S) PAID	C											~~C~~											
0587	RENDERING LINE PROVIDER FIRST NAME	C																						

Error codes for 824 acknowledgments

DN	IAIABC Data Element Name / ERROR MESSAGE	001 Mandatory field not present	028 All digits must be 0—9	029 Must be a valid date (CCYYMMDD)	030 Must be A–Z, 0—9, or spaces	031 Must be a valid time	033 Must be <= Date of Injury	034 Must be >= Date of Injury*	039 No match on database	040 All digits cannot be the same	041 Must be <= current date	057 Duplicate Batch/Transaction	058 Code/ID invalid	059 Non-match data value not consistent with value previously reported	063 Invalid event sequence	064 Invalid data relationship	070 Must be <= Service Date	072 Must be > Date of Bill	073 Must be >= Date Payer Received Bill	074 Must be >= From Service date	075 Must be <= To Service Date	111 Must be valid content	117 Match data value not consistent with value previously reported	118 Trading partner not approved to submit data
0589	RENDERING LINE PROVIDER LAST/GROUP NAME	~~C~~																						
0592	RENDERING LINE PROVIDER NATIONAL PROVIDER ID												X											
0595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	C											X											
0599	RENDERING LINE PROVIDER STATE LICENSE NUMBER	C																						
0600	PLACE OF SERVICE LINE CODE												X											
0604	PRESCRIPTION LINE DATE	X						X																
0605	SERVICE LINE DATE(S) RANGE	~~X~~						X													C			
0615	REPORTING PERIOD	~~C~~						X																
0616	INSURER POSTAL CODE	~~X~~											X											
0622	ADMISSION HOUR	C																						
0623	DISCHARGE HOUR	C																						
0625	HIPPS RATE CODE	~~C~~											X											
0629	BILLING PROVIDER FEIN	~~X~~								X														
0630	BILLING PROVIDER STATE LICENSE																							

Error codes for 824 acknowledgments

DN	IAIABC Data Element Name / ERROR MESSAGE	001 Mandatory field not present	028 All digits must be 0—9	029 Must be a valid date (CCYYMMDD)	030 Must be A–Z, 0—9, or spaces	031 Must be a valid time	033 Must be <= Date of Injury	034 Must be >= Date of Injury*	039 No match on database	040 All digits cannot be the same	041 Must be <= current date	057 Duplicate Batch/Transaction	058 Code/ID invalid	059 Non-match data value not consistent with value previously reported	063 Invalid event sequence	064 Invalid data relationship	070 Must be <= Service Date	072 Must be > Date of Bill	073 Must be >= Date Payer Received Bill	074 Must be >= From Service date	075 Must be <= To Service Date	111 Must be valid content	117 Match data value not consistent with value previously reported	118 Trading partner not approved to submit data
	NUMBER																							
0634	BILLING PROVIDER NATIONAL PROVIDER ID												X											
0638	RENDERING BILL PROVIDER LAST/GROUP NAME	~~C~~																						
0639	RENDERING BILL PROVIDER FIRST NAME	C																						
0643	RENDERING BILL PROVIDER STATE LICENSE NUMBER	C																						
0647	RENDERING BILL PROVIDER NATIONAL PROVIDER ID												X											
0651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	~~C~~											X											
0658	SUPERVISING PROVIDER LAST/GROUP NAME																							
0659	SUPERVISING PROVIDER FIRST NAME	C																						
~~0660~~	~~SUPERVISING PROVIDER MIDDLE NAME/INITIAL~~																							
0667	SUPERVISING PROVIDER NATIONAL PROVIDER ID												X											
0671	SUPERVISING PROVIDER PRIMARY SPECIALTY CODE	~~C~~											X											

Error codes for 824 acknowledgments

DN	IAIABC Data Element Name / ERROR MESSAGE	001 Mandatory field not present	028 All digits must be 0—9	029 Must be a valid date (CCYYMMDD)	030 Must be A–Z, 0—9, or spaces	031 Must be a valid time	033 Must be <= Date of Injury	034 Must be >= Date of Injury*	039 No match on database	040 All digits cannot be the same	041 Must be <= current date	057 Duplicate Batch/Transaction	058 Code/ID invalid	059 Non-match data value not consistent with value previously reported	063 Invalid event sequence	064 Invalid data relationship	070 Must be <= Service Date	072 Must be > Date of Bill	073 Must be >= Date Payer Received Bill	074 Must be >= From Service date	075 Must be <= To Service Date	111 Must be valid content	117 Match data value not consistent with value previously reported	118 Trading partner not approved to submit data
0678	FACILITY NAME																							
0680	FACILITY STATE LICENSE NUMBER	C																						
0682	FACILITY NATIONAL PROVIDER ID												X											
0684	FACILITY PRIMARY ADDRESS	X																						
0685	FACILITY SECONDARY ADDRESS																							
0686	FACILITY CITY	X																						
0687	FACILITY STATE CODE	C											X			~~C~~								
0688	FACILITY POSTAL CODE												X											
0689	FACILITY COUNTRY CODE	C											X											
0690	REFERRING PROVIDER LAST/GROUP NAME																							
0691	REFERRING PROVIDER FIRST NAME	C																						
0699	REFERRING PROVIDER NATIONAL PROVIDER ID												X											
0704	MANAGED CARE ORGANIZA-TION FEIN	C								X						C								
0714	HCPCS LINE PROCEDURE BILLED CODE	~~C~~											X											
0715	JURISDICTION PROCEDURE BILLED CODE	~~C~~											C											

Error codes for 824 acknowledgments

DN	IAIABC Data Element Name / ERROR MESSAGE	001 Mandatory field not present	028 All digits must be 0—9	029 Must be a valid date (CCYYMMDD)	030 Must be A—Z, 0—9, or spaces	031 Must be a valid time	033 Must be <= Date of Injury	034 Must be >= Date of Injury*	039 No match on database	040 All digits cannot be the same	041 Must be <= current date	057 Duplicate Batch/Transaction	058 Code/ID invalid	059 Non-match data value not consistent with value previously reported	063 Invalid event sequence	064 Invalid data relationship	070 Must be <= Service Date	072 Must be > Date of Bill	073 Must be >= Date Payer Received Bill	074 Must be >= From Service date	075 Must be <= To Service Date	111 Must be valid content	117 Match data value not consistent with value previously reported	118 Trading partner not approved to submit data
0717	HCPCS MODIFIER BILLED CODE												X											
0718	JURISDICTION MODIFIER BILLED CODE												C											
0719	ADA PROCEDURE BILLED CODE	~~C~~											X											
0721	NDC BILLED CODE	~~X~~											X											
0722	ADA PROCEDURE PAID CODE	~~C~~											X											
0726	HCPCS LINE PROCEDURE PAID CODE	~~C~~											X											
0727	HCPCS MODIFIER PAID CODE												X											
0728	NDC PAID CODE	~~C~~											X											
0729	JURISDICTION PROCEDURE PAID CODE	C											C											
0730	JURISDICTION MODIFIER PAID CODE												C											
0731	SERVICE ADJUSTMENT GROUP CODE	~~X~~																						
0732	SERVICE ADJUSTMENT REASON CODE	~~X~~											X		~~X~~									
0733	SERVICE ADJUSTMENT AMOUNT	~~X~~														C								
0734	SERVICE ADJUSTMENT UNITS	~~C~~																						
0736	OTHER PROCEDURE CODE												X											
0741	CONTRACT LINE TYPE												~~X~~			~~C~~								

Error codes for 824 acknowledgments

DN	IAIABC Data Element Name / ERROR MESSAGE	001 Mandatory field not present	028 All digits must be 0—9	029 Must be a valid date (CCYYMMDD)	030 Must be A—Z, 0—9, or spaces	031 Must be a valid time	033 Must be <= Date of Injury	034 Must be >= Date of Injury*	039 No match on database	040 All digits cannot be the same	041 Must be <= current date	057 Duplicate Batch/Transaction	058 Code/ID invalid	059 Non-match data value not consistent with value previously reported	063 Invalid event sequence	064 Invalid data relationship	070 Must be <= Service Date	072 Must be > Date of Bill	073 Must be >= Date Payer Received Bill	074 Must be >= From Service date	075 Must be <= To Service Date	111 Must be valid content	117 Match data value not consistent with value previously reported	118 Trading partner not approved to submit data
	CODE																							
0742	PROVIDER AGREEMENT LINE CODE																							
0760	PRIOR ACTUAL AMOUNT PAID	X	~~X~~													C								
0761	LINE ITEM PRIOR ACTUAL AMOUNT PAID																							
0762	COMPOUND INDICATOR	~~C~~																						

Note: *= Edit does not apply to cumulative injuries.

Section IX: System specifications

Electronic t~~T~~ransmission types

The DWC/WCIS receives from trading partners the 837 transmission specified in the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2014. The DWC/WCIS transmits back to trading partners the 999 Implementation Acknowledgment and the ASC X12 824 Application Advice (824). The 999 Implementation Acknowledgments reports syntactical/structural and functional errors and the 824 Application Advice reports any errors in the content of the data.

999 Functional processing and sequencing

When the IAIABC Workers' Compensation Medical Bill Data Reporting 837 file is fully accepted with no errors by the WCIS, AK901 = A is returned to the trading partner. If the 837 file is partially accepted due to error in some of the transactions sets submitted, ~~with~~ AK901 = P is returned to trading partners. The following two steps outline the accepted 837 transmission procedure for full acceptance and then for partial acceptance.

837 file is fully accepted (no error in any transaction set in the file):
1. Sender transmits original 837.
2. The DWC/WCIS sends an "A" in the AK901 in the 999 Implementation Acknowledgment to sender.

837 file is partially accepted (at least one transaction set in the file was rejected):
1. Sender transmits original 837.
2. The DWC/WCIS sends an "~~E~~P" in the AK901 in the 999 Implementation Acknowledgment to sender.
3. Sender corrects and resubmits the transaction sets that had errors.

If any functional errors are detected, the 837 file is rejected by the WCIS, AK901 = R. The following five steps outline the rejected 837 transmission procedure:
1. Sender transmits original 837, including all required segments and fields.
2. The DWC/WCIS sends an "R" in the AK901 in the 999 Implementation Acknowledgment to sender. 3. Sender corrects all errors in the original 837.
4. Sender transmits the corrected 837, including all required segments and fields.
5. If no errors are encountered, the DWC/WCIS sends an "A" in the AK901 position in the 999.

List of error codes and the 999 position they are reported in is shown in Section IV.

837 Detailed Transaction processing and sequencing

Bill submission reason codes (BSRC) are used to define the specific purpose of a transmission. The DWC/WCIS accepts four BSRC: 00, 01, 02, and 05. The codes are grouped in the following tables to clarify their purpose and to demonstrate a logical order for their use.

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

BSRC code	BSRC name
00	Original

After the initial medical bill payment report, BSRC=00, Original, has been filed for the bill, BSRC 01 (Cancellation), 02 (Correction), or 05 (Replace) can follow. The BSRC sequencing is important since if a BSRC 01, 02, or 05 is filled prior to a BSRC=00 for any medical bill payment record, error code 063-invalid sequencing event error will be returned in the 824 Detailed Acknowledgment.

The BSRC=01, Cancellation, is used when a “00” Original has been submitted which should never have been submitted to the jurisdiction or when the original transaction contained errors in critical data elements DN0006 (Insurer ~~Fein~~EIN) and DN0500 (Unique Bill ID Number) (see IAIABC Workers’ Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2014, Section 1.4.2.1). It is recommended that the value in DN0500 Unique Bill ID Number contained in a cancelled medical EDI record not be reused. Please report all Cancellation medical bill reports immediately after discovering such an error.

The BSRC=02, Corrected and Verified Original Claim, is used when the trading partner must correct errors to non-critical data elements on a “00” Original or “05” Replace transaction. This value is not used if the amount of payment changed due to a subsequent payment action by the claim administrator or insurer.

The BSRC=05, Replace**,** is used when the trading partner must report a subsequent payment action or denial by the claim administrator or insurer. A “00” original transaction must have been submitted and accepted before a “05” Replace transaction is reported. Please report all Replace medical bill reports immediately. Reconsidered/appealed bills will be reported using a BSRC=05. A bill reported with a BSRC=05 must have the same Unique Bill ID Number (DN0500) as the one used on the corresponding original bill (BSRC=00).

BSRC code	BSRC name
01	Cancellation
02	Corrected and Verified Original Claim
05	Replace

The DWC/WCIS utilizes Application Acknowledgment Code (AAC) (DN 0111), and Originator Transaction Identification number (DN0532) in the ANSI 824 to inform the trading partner of the accepted or rejected status of each transaction set and each individual transaction included in the 837 transmission to the DWC. The two levels of acknowledgement codes are the batch level (ST-SE transaction set) and the bill level (transaction). The table below summarizes the application acknowledgment codes returned to the sender in the ASC X12 824 Application Advice Acknowledgment for each transaction set contained in the 837 transmission to the DWC. A combination of DN0532 Originator Transaction Identification Number, DN0100 Date Transmission Sent, DN0101 Time Transmission Sent, DN0098 Sender ID, and ISA015 Test Indicator should be unique. If this combination is not unique, i.e. exists in the WCIS database the transaction will be rejected and a TR will be sent in OTI segment of the 824.

Codes returned to the sender (Transaction~~/~~ level)	
Application Acknowledgement Code	Application Acknowledgment Code Description
TA	ST-SE transaction set accepted
TR	ST-SE transaction set rejected

Correcting Transaction set (ST-SE) level errors (BSRC=00) (AAC=TR)

All errors occurring in the transaction set header, submitter information, or receiver information will be rejected with a TR**.** The WCIS also checks for duplicates in the ST-SE transaction sets. When resubmitting a corrected ST-SE transaction set (BSRC=00) in response to a batch rejected (TR), the sender must report all medical bill payment data elements, not just the data elements being corrected. The following five steps outline the procedure:

1. Sender transmits original ST-SE transaction set, including all bills/lines, utilizing a BSRC=00.
2. The DWC/WCIS sends an A or ~~E~~P in the AK901 in the 999 and a TR in the OTI01 in the 824 Acknowledgment.
3. Sender corrects the error(s) in the original ST-SE transaction set.
4. Sender transmits the corrected transaction set, including all bills/lines, as an original BSRC=00.
5. If no errors are encountered, the DWC/WCIS sends an A in the AK901 in the 999 and a TA in the OTI01 in the 824 acknowledgment to sender.

The table below summarizes the application acknowledgment codes returned to the sender in the ASC X12 824 application advice acknowledgment for each individual bill/item contained in the 837 transmission to the DWC.

Codes returned to the sender (bill level)	
Application Acknowledgment Code	Application Acknowledgment Code Description
IA	Item/bill accepted

IR	Item/bill rejected

Correcting data elements (BSRC=00) (AAC= TA and IR)

The WCIS regulations require each claims administrator to resubmit to the WCIS all rejected bills with all data elements corrected. When resubmitting a corrected transmission (BSRC=00) in response to an item rejected (IR), the sender must report all medical bill payment data elements, not just the data elements being corrected. The following five steps outline the procedure:

1. Sender transmits original bill, including all lines, utilizing a BSRC=00.
2. The DWC/WCIS sends an “A” in the AK901 in the 999 and a TA in the OTI01and an IR in a different OTI01 segment in the 824 Acknowledgment.
3. Sender corrects errors in the original bill.
4. Sender transmits the corrected bill, including all lines, as a BSRC=00, Original.
5. The DWC/WCIS sends an “A” in the AK901in the 999 and a TA in the OTI01 and an IA in a different OTI01 for each bill\transaction accepted in the 824 Acknowledgment to sender.

Cancelling critical data elements (BSRC=01) (AAC=TA and IA)

The WCIS regulations require each claims administrator to submit to the WCIS any changed critical data elements to maintain complete, accurate, and valid data. There are two critical data elements, the DN0006 (Insurer FEIN); and the DN0500 (Unique Bill ID Number). To update the value of critical data elements contained in transmission already accepted by the DWC/WCIS, the sender transmits a BSRC=01 to cancel the original transmission (BSRC=00). The following five steps outline the procedure:

1. Sender transmits original bill, including all lines, utilizing a BSRC=00.
2. The DWC/WCIS sends an “A” in the AK901 in the 999 and a TA in the OTI01 and an IA in the OTI01 in the 824 Acknowledgment to sender.
3. Sender changes the value of a critical data element on the original bill.
4. Sender cancels incorrect original bill by transmitting a BSRC=01 for the same Insurer FEIN and Unique Bill ID Number.
5. The DWC/WCIS sends an “A” in the AK901 in the 999 and a TA in the OTI01 and an IA in the OTI01in the 824 Acknowledgment to sender.

Updating non critical data elements (BSRC=02) (AAC=TA and IA)

The WCIS regulations require each claims administrator to submit to the WCIS any changed, noncritical data elements to maintain complete, accurate, and valid data. To update the value of noncritical data elements contained in transmission already accepted by the DWC/WCIS, the sender transmits a BSRC=02 containing the updated data. The updated transmission (BSRC=02) is not sent in response to an 824 Acknowledgement containing error messages (IR) from the DWC/WCIS. When submitting a transmission

(BSRC=02) to update the value of a data element, the sender must report all medical bill payment data elements, not just the data elements being updated. The following five steps outline the procedure:

1. Sender transmits original bill, including all lines, utilizing a BSRC=00 or BSRC=05.
2. The DWC/WCIS sends an “A” in the AK901 in the 999 and a “TA” in the OTI01 for each ST-SE transaction set accepted and an IA in a subsequent OTI01 for each bill\transaction accepted in the 824 Acknowledgment to sender.
3. Sender changes the value of a noncritical data element or elements on the original accepted bill.
4. Sender updates the noncritical data elements in the accepted original bill by transmitting a BSRC "02".
5. The DWC/WCIS sends an “A” in the AK901 in the 999 and a “TA” in the OTI01 and an IA in a different OTI01 in the 824 Acknowledgment to sender.

Subsequent Payment Action or Denial (BSRC=05) (AAC=TA and IA)

Replacement reports (BSRC=05) are sent to WCIS indicating a subsequent payment action or denial by the claim administrator or insurer. A “00” original transaction must have been submitted and accepted before a “05” replace transaction can be reported
The updated transmission (BSRC=05) is not sent in response to an 824 Acknowledgment containing error messages (IR) from the DWC/WCIS. When submitting a transmission (BSRC=05) to update the payment amounts, the sender must report all medical bill payment data elements, not just the data elements being updated. The following five steps outline the procedure.

1. Sender transmits original bill, including all lines, utilizing a BSRC=00.
2. The DWC/WCIS sends an “A” in the AK901 in the 999 and a “TA” in the OTI01 for each ST-SE transaction accepted and an IA in a subsequent OTI01 for each bill/item ~~transaction~~ accepted in the 824 Acknowledgment to sender.
3. Sender engages in a subsequent payment action or previously reported medical service or good is denied by the claim administrator or insurer on the original bill.
4. Sender updates the payment amounts in original bill by transmitting a BSRC=05. For the complete list of data elements required in a 05, Replace, see the IAIABC Workers’ Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2014, section 1.3.1, page 1.11.
5. The DWC/WCIS sends an “A” in the AK901 in the 999 and a “TA” in the OTI01 for each ST-SE transaction set accepted and an IA in a subsequent OTI01 bill/item ~~transaction~~ accepted in the 824 Acknowledgment to sender.

Matching transmissions, transactions, claims and medical bills

The California DWC/WCIS matches files and data elements at several levels. They match individual injured worker claims in the FROI and in medical databases, transaction sets within an 837, individual medical bills in two 837s, individual bills within a given transaction

set, and 837 to 824 transmissions. The paragraphs below explain each of the matching processes and the data elements utilized in the matching criteria.

Matching 837 Health Care Claim(s) to 824 Application Advice(s)

At the highest level of matching, the inbound 837 transmissions are matched to outbound 824 transmissions utilizing the Sender ID (DN0098), Date transmission sent (DN0100), and Time transmission sent (DN0101), Originator Transaction Identification Number (DN0532) from the inbound 837 to the Receiver ID (DN0099), Original date transmission sent (DN0102), and Original time transmission sent (DN0103), and DN532 (Originator Transaction Identification Number) in the outbound 824. The DWC/WCIS requires each sender to utilize a standard format of HHMM for Time transmission sent (DN0101) in the BHT segment of the 837. ~~The Time transmission sent (DN0101) in the BHT segment(s) of the 837 must be identical to the time in the ISA10 interchange time and the GS05 Time in the 837 headers where the standard format is HHMM.~~

Matching ST-SE Transaction Sets

Individual transaction sets within each 837 are matched to a corresponding transaction set in the 824 advice. Each ST-SE transaction set in each 837 is identified by matching the Originator Transaction Identification Number (DN0532), Date ~~t~~Transmission ~~s~~Sent (DN0100), and Time ~~t~~Transmission ~~s~~Sent (DN0101) in the 837 to the Originator Transaction Identification Number (DN0532), Original Date Transmission Sent (DN0100), and Original Time Transmission Sent (DN0101) in the 824. ~~Date Transmission Sent, and DN0101 (Original Time Transmission Sent) in the 824.~~

Matching injured worker claims between the FROI and medical bill

The FROI (first report of injury) Agency Claim Number (DN0005) is the Jurisdiction Claim Number (DN0005) in the medical reporting. A Jurisdiction Claim Number (JCN) is created by the WCIS to uniquely identify each claim. The JCN is provided to the claims administrator in the acknowledgment of the accepted FROI by the DWC/WCIS. The WCIS uses a combination of the Jurisdiction Claim Number (DN0005), Claim Administrator Claim Number (DN0015) and Insurer FEIN (DN0006) to match medical bills in the 837 to claims previously reported in the FROI. If the Jurisdiction Claim Number is not reported in the 837, the bill will be rejected.

Matching medical bill records

Bill-level matching within the WCIS database occurs when medical bills are cancelled (BSRC=01), corrected (BSCR=02), or replaced (BSRC=05). The matching requirements and possible errors associated with each of the process are outlined below.

The Insurer FEIN (DN0006), Employer FEIN (DN0016) and the Unique Bill ID Number (DN0500) are utilized to match the original report (BSRC=00) to the cancelled report (BSRC=01). The DWC/WCIS requires both the DN0006 and the DN0500 be identical in both items/bills, the original (00) and the cancellation (01). If either of the critical elements are not matched, the WCIS will return a "TA" for each ST-SE transaction set accepted in the OTI01 segment, an IR in the subsequent OTI01 for each bill/item ~~transaction~~ rejected, and an error code, 117-Match Data value not consistent with value previously reported, in the LQ02 and a copy of the unmatched DN0006 or DN0500 in the RED01 in the 824 Acknowledgment returned to the sender.

The Insurer FEIN (DN0006), Employer FEIN (DN0016), and Unique Bill ID Number (DN0500) are utilized to match the original or replacement report (BSRC=00 or 05) to the corrected report (BSRC=02). The DWC/WCIS requires the DN0500 be identical in both, the original (00) and the corrected (02) transactions. If the two DN0500s do not match, the WCIS will return a "TA" for each ST-SE transaction set accepted in the OTI01, an "IR" in a subsequent OTI01 for each bill/item ~~transaction~~ rejected, and ~~an~~ error code, ~~the~~ "117"-Match data value not consistent with value previously reported, will be reported in the LQ02 segment, and the unmatched DN0500 in the RED01 segment in the 824 Acknowledgment returned to the sender.

The Insurer FEIN (DN0006), Employer FEIN (DN0016), and Unique Bill ID Number (DN0500) are utilized to match the original (BSRC=00) to the replacement report (BSRC=05). The DWC/WCIS requires the DN0500 be identical in both the original (00) and the replacement (05) transactions. If the two DN0500s are not matched, the WCIS will return a "TA" for each ST-SE transaction set accepted in the OTI01, ~~an~~ IR in the subsequent OTI01 for each bill/item transaction rejected with an error code~~, the~~ 117-Match Data value not consistent with value previously reported, in the LQ02 segment, and a copy of the unmatched DN500 in the RED01 segment within the 824 Acknowledgment returned to the sender.

Duplicate Batch Check

To ensure that duplicate transmissions have not been sent, DWC will match five values within the ISA:

- ISA06 Interchange Sender ID
- ISA08 Interchange Receiver ID
- ISA09 Interchange Date
- ISA10 Interchange Time
- ISA13 Interchange Control Number

Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA104 response of "R" (Rejected) with a TA105 value of "025" (Duplicate Interchange Control Number).

To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, DWC checks the ST02 value (the Transaction Set Control Number), which should be a unique value within the Functional Group transmitted. Duplicate Transaction Sets (ST/SE) return a 999 Functional Acknowledgement with an IK501 value of “R” (Rejected) and IK502 value of “23” (Transaction Set Control Number not unique within the Functional Group).

Duplicate transaction sets and medical bills

Transaction-set duplicates occur when the Originator Transaction Identification Number (DN0532), sender ID (DN0098), date transmission sent (DN0100), and time transmission sent (DN0101) information in 837(s) are identical to that of a previously accepted DWC ST-SE transaction set. The DWC will reject the entire ST-SE transaction set when a duplicate transaction set is detected. The DWC will transmit a “TR” in the OTI01 in the 824 Acknowledgement, an error code 057-duplicate transmission in the LQ02, and a copy of the Originator Transaction Identification Number (DN0532) in the RED01 in the 824 Acknowledgment returned to the sender.

Bill-level duplicates occur when the information the Insurer FEIN (DN0006), Claim Administrator FEIN (DN0187), JCN (DN0005), Unique Bill ID number (DN0500) on a bill are repeated. The DWC will check for duplicate bills in all ST-SE transaction sets included in each X12 interchange envelope (ISA-IEA interchange). The DWC also checks each bill for duplicates against the entire WCIS database. Duplicate medical bills that are not correctly coded with the appropriate claim adjustment reason code (18, or B13) will cause an error. When a duplicate bill is detected, the DWC will transmit an “IR” in the OTI01 for each bill/transaction rejected in the 824 Acknowledgement with a 057 error in the LQ02, as well as the unique bill ID number in the bad data field of the matching 824 Acknowledgment.

Balancing processes

The WCIS reporting regulations require each claims administrator to “… at a minimum, provide complete, valid, and accurate data for the data elements set forth in Title 8, California Code of Regulations section 9702.” It is necessary to apply certain accounting rules to the billed, paid, and adjusted amounts to insure compliance with the reporting regulations. Specifically, it is necessary for billed, paid and adjusted amounts reported at both the bill and line level to balance.

Balancing charged amounts at the bill and service line level

The charged amount(s) reported at the line level in the 2400 loop in any of the four service information segments (SV1, SV2, SV3, or SV4) must add up to the total amount reported at the bill level in the DN501(Total Charge Per Bill). The data element containing the charged

amount in the service information segments SV1, SV2, and SV3 is DN552 (Total Charge Per Line). The data element containing the charged amount in the service information segment SV4 is DN572 (Drugs/Supplies Billed Amount). The DWC will reject the bill and return an error code 064-Invalid data relationship if the charged balancing is not valid. For a numeric example, see the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2014, section 1.3.1, page 1.7.

Balancing paid amounts at the bill- and service-line level

The paid amount(s) reported at the line level in the 2400 loop in all of the service-line adjudication segments (SVD) must add up to the total amount reported at the bill level in the Total Amount paid Per Bill (DN0516). The data element containing the paid amount in the service line adjudication segment, SVD, is Total Paid Per Line (DN0574). The DWC will reject the bill and return an error code 064-Invalid data relationship if the paid balancing is not valid. For a numeric example, see the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2014, section 1.3.1, page 1.7.

Balancing medical bill charges, payment and adjustment amounts

The reported Total Amount Paid Per Bill (DN0516) plus the sum of all the reported Bill Adjustment Amounts (DN0545) and Service Adjustment Amounts (DN 0733) must equal the Total Charge Per Bill (DN0501) reported for each bill. Furthermore, for bills with no adjustment at the bill level, the reported Total Amount Paid Per Bill (DN0516) plus the sum of all the reported Service Adjustment Amounts (DN0733) must equal the Total Charge Per Bill (DN0501) reported for each bill. In general, positive adjustment amounts decrease the Total Amount Paid Per Bill and negative adjustment amounts increase the Total Amount Paid Per Bill. For a numeric example, see the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2014, section 1.3.1, page 1.8.

Balancing at the line level

For transactions not adjusted at the bill level that do not contain Bill Adjustment Amount (DN0545), line-level balancing is required and occurs independently for each individual service line reported in the transaction. For each service line reported in a bill that is not adjusted at the bill level, the reported Total Amount Paid Per Line (DN0574) plus the sum of all the reported Service Adjustment Amounts (DN0733) for the line must equal the total charge at the line level (DN0552) and Drug Supplies Billed amount (DN0572) for each line in the bill. For a numeric example see the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2014, section 1.3.1, page 1.9.

Compound drug reporting

Compound drugs can be dispensed through a retail pharmacy or by a physician during an office visit. The DWC/WCIS requires compound drugs dispensed through a retail pharmacy to be reported following the general guidelines in the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2014, on page 4.101 and utilizing the DN0762 (Compound drug indicator). The DWC/WCIS requires compound drugs dispensed by a physician to be reported utilizing the SV1 Professional Service segment and the Health Care Financing Administration Common Procedural Coding System (HCPCS) Code, S9430 (Pharmacy compounding and dispensing fee) on the first line of the bill to report any professional fees (such as compounding fees) not associated with the ingredient costs of the compound. All individual ingredients in each compound must be reported at the line level for all compound drug bills, regardless of the type of dispenser.

Lump sum bundled lien bill payment

California law allows the filing of a lien against any sum to be paid as compensation for the "reasonable expense incurred by or on behalf of the injured employee~~"~~ as provided by Article 2 (commencing with Section 4600), except those disputes subject to independent medical review or independent bill review"~~.~~ for medical treatment (see Labor Code section 4903 and 4903.1). Reportable lump sum medical liens originat~~e~~ing from medical bills are filed on DWC ~~Workers'~~ -WCAB Form 6. Th~~e~~is medical lien form is located at http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCForm6.pdf.
For ~~the complete list of~~ data elements required in a reportable lump sum medical lien see the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, February 1, 2014, section 1.7~~3.1~~, page 1.13.

On DN 0512 (Date Insurer Paid Bill) use the date final payment was made.~~For medical lien lump sum payments or settlements, use the date final payment was made on DN 0512 Date Insurer Paid Bill.~~
~~For medical lien lump sum payments or settlements, use the date on the first medical bill received on DN0512 Date Insurer Paid Bill.~~

~~Use the following codes for reporting DN0729 Jurisdiction procedure paid code on a medical lien lump sum payment or settlement:~~

- ~~MDS10 – Lump sum payment or settlement for multiple bills where the amount of reimbursement is in dispute between the claims payer and the healthcare provider~~
- ~~MDO10 – Final order or award of the Workers' Compensation Appeals Board requires a lump sum payment for multiple bills for which the amount of reimbursement is in dispute between the claims payer and the healthcare provider~~

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

OnDN0509 (Service Bill Date(s) Range) ~~For a medical lien lump sum payment or settlement,~~ use the date of lien filing. ~~on DN 0509 Service Bill Date(s) Range.~~
On DN 0516 (Total Amount Paid) ~~Per Bill For a medical lien lump sum payment or settlement,~~ use the settled or ordered amount on ~~DN 0516 Total Amount Paid Per Bill~~.
On DN 0501 (Total Charge Per Bill) ~~For a medical lien lump sum payment or settlement, use the amount in dispute on DN 0501 Total Charge Per Bill.~~

Data elements required to be reported for ~~in~~ a Lump Sum payment or settlement or a lien ~~Lien bills~~ are listed below.

Lien Bills Data Element Requirement Table

~~Lien Bills Data Element Requirements Table~~						
		Original	**Cancellation**	**Correction**	**Replace**	
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**
0005	Jurisdictional Claim Number	M	M	M	M	
0006	Insurer FEIN	M	M	M	M	
0007	Insurer Name	M	M	M	M	
0014	Claim Administrator Mailing Postal Code	M	M	M	M	
0015	Claim Administrator Claim Number	M	M	M	M	
0016	Employer FEIN	M	M	M	M	
0018	Employer Name	M	M	M	M	
0031	Date of Injury	F	F	F	F	
0042	Employee SSN	MC	NA	MC	MC	Required when the employee has SSN.
0043	Employee Last Name	M	M	M	M	
0044	Employee First Name	M	M	M	M	
0098	Sender ID	F	F	F	F	
0099	Receiver ID	F	F	F	F	
0100	Date Transmission Sent	F	F	F	F	
0101	Time Transmission Sent	F	F	F	F	

~~Lien Bills Data Element Requirements Table~~						
		Original	Cancellation	Correction	Replace	
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**
0187	Claim Administrator FEIN	M	M	M	M	
0188	Claim Administrator Name	M	M	M	M	
0266	Transaction Tracking Number	M	M	M	M	
0293	Lump Sum Payment /Settlement Code	M	M	M	M	
0500	Unique Bill ID Number	F	F	F	F	
0501	Total Charge per Bill	M	NA	M	M	
0502	Billing Type Code	M	M	M	M	
0503	Billing Format Code	M	NA	M	M	
0504	Facility Code	F	NA	F	F	
0507	Provider Agreement Code	M	NA	M	M	
0508	Bill Submission Reason code	F	F	F	F	
0509	Service Bill Date(s) Range	M	NA	M	M	
0510	Date of Bill	M	NA	M	M	
0511	Date Insurer Received Bill	M	NA	M	M	
0512	Date Insurer Paid Bill	M	NA	M	M	
0516	Total Amount Paid per Bill	M	NA	M	M	
~~0522~~	~~Diagnosis Code~~					
0523	Billing Provider Unique Bill ID	F	F	F	F	
0528	Billing Provider Last/Group Name	M	NA	M	M	
0529	Billing Provider First Name	MC	NA	MC	MC	Required when the billing provider is an individual.
0532	Originator Transaction Identification Number	F	F	F	F	
0543	Bill Adjustment ~~Units~~ Group Code	MC	NA	MC	MC	-Required when adjustment were applied to the aggregate or summary records. -Required if the total settled amount is less than the total lien amount.
0544	Bill Adjustment Reason Code	MC	NA	MC	MC	-Required when adjustment were applied the aggregate or summary records. -Required if the total settled amount is less than the total lien amount.
0545	Bill Adjustment Amount	MC	NA	MC	MC	Required when bill level adjustments, bill level amounts, or prior payment amounts are reported.
0546	Bill Adjustment Units	MC	NA	MC	MC	Required when the number of service units has been adjusted.
~~0547~~	~~Line Number~~					
0555	Place of Service Bill Code	F	NA	F	F	
0615	Reporting Period	M	M	M	M	
0616	Insurer Postal Code	M	NA	M	M	
0629	Billing Provider FEIN	M	NA	M	M	
0634	Billing Provider NPI	MC	NA	MC	MC	Required when the provider is eligible to receive an NPI.
0638	Rendering Bill Provider Last/Group Name	MC	NA	MC	MC	Required when different from DN0528 Billing Provider Last/Group Name. ~~and DN0595 Rendering Line Provider not identified on the medical bill received by the insurer or claims administrator.~~
0639	Rendering Bill Provider First Name	MC	NA	MC	MC	Required when DN 0638 Rendering Bill Provider Last/Group Name is present and the rendering bill

~~Lien Bills Data Element Requirements Table~~						
		Original	**Cancellation**	**Correction**	**Replace**	
DN	**Data Element Name**	**00**	**01**	**02**	**05**	**Business Condition/Mandatory Trigger**
						provider is a person.
0643	Rendering Bill provider State License number	MC	NA	MC	MC	Required when DN 0638 Rendering Bill Provider Last/Group Name is present and the provider is not eligible for an NPI. If provider is not eligible for state licensing, enter 999999999.
0647	Rendering Bill Provider NPI	MC	NA	MC	MC	Required when DN0638 Rendering Bill Provider Last/Group Name is present, and the provider is eligible to receive an NPI.
0651	Rendering Bill Provider Primary Specialty Code	MC	NA	MC	MC	Required when DN 0638 Rendering Bill Provider Last/Group Name is present and is a person.
~~0729~~	~~Jurisdiction Procedure Paid code~~					
0760	Prior Actual Amount Paid	~~NA~~ MC	NA	~~NA~~ MC	MC	Required when reporting bill adjudication actions related to medical bill(s) previously paid

Section X: Code lists and state license numbers

Code source

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

Billing provider country code
Available on IAIABC website: http://www.iaiabc.org
Contact information:
IAIABC Headquarters
5610 Medical Circle, suite 24
Madison, WI 53719
Phone: 1-608-663-6355
Fax: 1-608-663-1546
Email: hlore@iaiabc.org

Claim adjustment group codes
Available for purchase:
Washington Publishing Company (WPC)
Contact information:
WPC website: http://www.wpc-edi.com

Claim adjustment reason codes
Available for purchase:
Washington Publishing Company (WPC)
Contact information:
WPC website: http://www.wpc-edi.com

California state medical license numbers
Available on the California Department of Consumer Affairs (DCA)
Website: http://www.dca.ca.gov/
Contact information:
Department of Consumer Affairs
Consumer Information Division
1625 North Market Blvd., Suite N 112
Sacramento, CA 95834

Condition Codes - National Uniform Billing Committee (NUBC)
Partial Availability on the National Uniform Billing Committee
Website: http://www.nucc.org
Contact Information:

Nancy Spector, NUCC Chair
American Medical Association
515 N. State St.
Chicago, IL 60654
Email: info@nucc.org

Current Procedural Terminology (CPT) codes
Available for purchase:
American Medical Association (AMA)
Contact information:
AMA website: https://catalog.ama-assn.org/Catalog/home.jsp

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

Facility / Place of service codes
Available on Centers for Medicare & Medicaid Services
Website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/downloads/Website_POS_database.pdf
Contact information:
Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244-1850

Healthcare financing administration Common Procedural Coding System (HCPCS)
Available on Centers for Medicare & Medicaid Services (CMS)
Website: http://www.cms.hhs.gov/
Contact information:
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore MD 21244-1850

Health Insurance Prospective Payment System (HIPPS)
Available on Centers for Medicare and Medicaid Services (CMS)
Website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html
Contact information:
Centers for Medicare & Medicaid Services
7500 Security Boulevard,
Baltimore, MD 21244
Phone: 1(800)633-4227

International Classification of Diseases Clinical Modification (ICD-9 CM)

Available on International Classification of Diseases, Ninth Revision, Clinical Modification
Website: http://www.cdc.gov/nchs/icd9.htm
Contact information:
National Center of Health Statistics
3311 Toledo Rd
Room 5419
Hyattsville, MD 20782
Phone: 1(800)232-4636

International Classification of Diseases Clinical Modification (ICD-10 CM)
Available on International Classification of Diseases, Tenth Revision, Clinical Modification
Website: http://www.cdc.gov/nchs/icd/icd10cm.htm
Contact information:
National Center of Health Statistics
3311 Toledo Rd
Room 5419
Hyattsville, MD 20782
Phone: 1(800)232-4636

National Drug Code (NDC)
Available on U.S. Food and Drug Administration (FDA)
Website: http://www.fda.gov/cder/ndc/
Wolters Kluwer Health – Medi-Span
Contact information:
8425 Woodfield Crossing Blvd., Ste. 490
Indianapolis, IN

National plan and provider enumeration system
Available on National Plan & Provider Enumeration System
Website:
https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistrySearch.do?subAction=reset&searchType=ind
Available for purchase:
National Plan & Provider Enumeration System (NPPES)
Contact information:
NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059
1-800-465-3203
NPPES Website: https://nppes.cms.hhs.gov/NPPES/Welcome.do

Postal code
Available for purchase:
National Zip Code and Post Office Directory, Publication 65
The USPS Domestic Mail Manual
Contact information:
U.S. Postal Service
Washington, DC 20260
New orders:
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
Look up a zip code online: http://zip4.usps.com/zip4/welcome.jsp

Provider taxonomy codes
Available for purchase:
Washington Publishing Company (WPC)
Contact information:
WPC website: http://www.wpc-edi.com

Revenue billed/paid code
Available for purchase:
National Uniform Billing Committee (NUBC)
Contact information:
NUBC website: http://www.nubc.org