

California Division of Workers' Compensation Medical Billing and Payment Guide 2010



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Introduction

This manual is adopted by the Administrative Director of the Division of Workers' Compensation pursuant to the authority of Labor Code sections §§ 4603.4, 4603.5 and 5307.3. It specifies the billing, payment and coding rules for paper and electronic medical treatment bill submissions in the California workers' compensation system. Such bills may be submitted either on paper or through electronic means. Entities that need to adhere to these rules include, but are not limited to, Health Care Providers, Health Care Facilities, Claims Administrators, Third Party Billers/Assignees and Clearinghouses.

Labor Code §4603.4 (a)(2) requires claims administrators to accept electronic submission of medical bills. The effective date is XX-XX-2011 [approximately 18 months after adoption]. The entity submitting the bill has the option of submitting bills on paper or electronically.

If an entity chooses to submit bills electronically it must be able to receive an electronic response from the claims administrator. This includes electronic acknowledgements, notices and electronic Explanations of Review.

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

For electronic billing, parties must also consult the Division of Workers' Compensation Medical Billing and Payment Companion Guide which sets forth rules on the technical aspects of electronic billing.

Health Care Providers, Health Care Facilities, Claims Administrators, Third Party Billers/Assignees and Clearinghouses that submit bills on paper must adhere to the rules relating to use of the standardized billing forms for bills submitted on or after XX-XX-2011 [approximately 90 days after adoption].

The Division would like to thank all those who participated in the development of this guide. Many members of the workers' compensation, medical, and EDI communities attended meetings and assisted in putting this together. Without them, this process would have been much more difficult.

Section One – Business Rules

1.0 Standardized Billing / Electronic Billing Definitions

- (a) “Authorized medical treatment” means medical treatment in accordance with Labor Code section 4600 that was authorized pursuant to Labor Code section 4610 and which has been provided or authorized by the treating physician.
- (b) “Bill” means the uniform billing form setting forth the itemization of services provided found in Appendix A along with the required reports and/or supporting documentation as described in Section One – 3.0.
- (c) “California Electronic Medical Billing and Payment Companion Guide” is a separate document which gives detailed information for electronic billing and payment. The guide outlines the workers’ compensation industry national standards and California jurisdictional procedures necessary for engaging in Electronic Data Interchange (EDI) and specifies clarifications where applicable. It will be referred to throughout this document as the “Companion Guide”.
- (d) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.
- (e) “Clearinghouse” means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that provides either of the following functions:
 - (1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
 - (2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.
- (f) “Complete Bill” means a bill submitted on the correct uniform billing form/format, with the correct uniform billing code sets, filled out in compliance with the form/format requirements of Appendix A and/or the Companion Guide with the required reports, written authorization, if any and/or supporting documentation as set forth in Section One – 3.0.
- (g) “CMS” means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.
- (h) “Electronic signature” means a signature that conforms to the requirements for digital signatures adopted by the Secretary of State in Title 2, California Code of Regulations §§ 22000 – 22003 pursuant to Government Code § 16.5 or a signature that conforms to other applicable provisions of law.
- (i) "Electronic Standard Formats" means the ASC X12N standard formats developed by the Accredited Standards Committee X12N Insurance Subcommittee of the American National Standards Institute and the retail pharmacy specifications developed by the National Council for Prescription Drug Programs (“NCPDP”) identified in Section Two - Transmission Standards, which have been and adopted by the Secretary of Health and Human Services under HIPAA.. See the Companion Guide for specific format information.
- (j) “Explanation of Review” (EOR) means the explanation of payment or the denial of the payment using the standard code set found in Appendix B – 1.0. EOR’s use the following standard codes:
 - (1) DWC Bill Adjustment Reason Codes provide California specific workers’ compensation explanations of a payment, reduction or denial. They are found in Appendix B – 1.0 DWC ANSI Matrix Crosswalk.

- (2) ANSI Claims Adjustment Group Codes represent the general category of payment, reduction, or denial. The most current, valid codes should be used as appropriate for workers' compensation. These codes are obtained from the Washington Publishing Company <http://www.wpc-edi.com>.
- (3) ANSI Claims Adjustment Reason Codes (CARC) represent the national standard explanation of payment, reduction or denial information. These codes are obtained from the Washington Publishing Company <http://www.wpc-edi.com>.
- (4) ANSI Remittance Advice Remark Codes (RARC) represent supplemental explanation for a payment, reduction or denial. These are always used in conjunction with a ANSI Claims Adjustment Reason Code. These codes are obtained from the Washington Publishing Company <http://www.wpc-edi.com>.
- (k) "Health Care Provider" means a provider of medical treatment, goods and services, including but not limited to a physician, a non-physician or any other person or entity who furnishes medical treatment, goods or services in the normal course of business.
- (l) "Health Care Facility" means any facility as defined in Section 1250 of the Health and Safety Code, any surgical facility which is licensed under subdivision (b) of Section 1204 of the Health and Safety Code, any outpatient setting as defined in Section 1248 of the Health and Safety Code, any surgical facility accredited by an accrediting agency approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, or any ambulatory surgical center or hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act.
- (m) "Itemization" means the list of medical treatment, goods or services provided using the codes required by Section One – 3.0 to be included on the uniform billing form.
- (n) "Medical Treatment" means the treatment, goods and services as defined by Labor Code Section 4600.
- (o) "National Provider Identification Number" or "NPI" means the unique identifier assigned to a health care provider or health care facility by the Secretary of the United States Department of Health and Human Services.
- (p) "NCPDP" means the National Council for Prescription Drug Programs.
- (q) Official Medical Fee Schedule (OMFS) means all of the fee schedules found in Article 5.3 of Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations (Sections 9789.10 - 9789.111), adopted pursuant to Section 5307.1 of the Labor Code for all medical services, goods, and treatment provided pursuant to Labor Code Section 4600. These include the following schedules: Physician's services; Inpatient Facility; Outpatient Facility; Clinical Laboratory; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); Ambulance; and Pharmaceutical.
- (r) "Physician" has the same meaning specified in Labor Code Section 3209.3: physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.
- (1) "Psychologist" means a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.
- (2) "Acupuncturist" means a person who holds an acupuncturist's certificate issued pursuant to Chapter 12 (commencing with Section 4925) of Division 2 of the Business and Professions Code.
- (s) "Required report" means a report which must be submitted pursuant to Section 9785 or pursuant to the OMFS. These reports include the Doctor's First Report of Injury, PR-2, PR-3, PR-4 and their narrative equivalents, as well as any report accompanying a "By Report" code billing.

- (t) “Supporting Documentation” means those documents, other than a required report, necessary to support a bill. These include, but are not limited to: any written authorization received from the claims administrator or an invoice required for payment of the DME item being billed.
- (u) “Third Party Biller/Assignee” means a person or entity authorized by law and acting under contract as the agent or assignee of a rendering physician, health care provider or healthcare facility to bill and/or collect payment from the responsible payor.
- (v) “Treating Physician” means the primary treating physician or secondary physician as defined by section 9785(a)(1), (2).
- (x) “Uniform Billing Forms” are the CMS 1500, UB 04, NCPDP Universal Claim Form and the ADA 2006 set forth in Appendix A.
- (y) “Uniform Billing Codes” are defined as:
 - (1) “California Codes” means those codes adopted by the Administrative Director for use in the Physician’s Services section of the Official Medical Fee Schedule (Title 8, California Code of Regulations §§ 9789.10-11).
 - (2) “CDT-4 Codes” means the current dental codes, nomenclature, and descriptors prescribed by the American Dental Association in “Current Dental Terminology, Fourth Edition.”
 - (3) “CPT-4 Codes” means the procedural terminology and codes contained in the “Current Procedural Terminology, Fourth Edition,” as published by the American Medical Association and as adopted in the appropriate fee schedule contained in sections 9789.10-9789.100.
 - (4) “Diagnosis Related Group (DRG)” means the inpatient classification scheme used by CMS for hospital inpatient reimbursement. The DRG system classifies patients based on principal diagnosis, surgical procedure, age, presence of co morbidities and complications and other pertinent data.
 - (5) “HCPCS” means CMS’ Healthcare Common Procedure Coding System, a coding system which describes products, supplies, procedures and health professional services and includes, the American Medical Association’s (AMA’s) Physician “Current Procedural Terminology, Fourth Edition,” (CPT-4) codes, alphanumeric codes, and related modifiers.
 - (6) “ICD-9-CM Codes” means the diagnosis and procedure codes in the International Classification of Diseases, Ninth Revision, Clinical Modification published by the U.S. Department of Health and Human Services.
 - (7) “NDC” means the National Drug Codes of the Food and Drug Administration.
 - (8) “Revenue Codes” means the 4-digit coding system developed and maintained by the National Uniform Billing Committee for billing inpatient and outpatient hospital services, home health services and hospice services.
 - (9) “UB 04 Codes” means the code structure and instructions established for use by the National Uniform Billing Committee (NUBC).
- (z) “Working days” means Mondays through Fridays but shall not include Saturdays, Sundays or the following State Holidays.
 - (1) January 1st (“New Year’s Day”.)
 - (2) The third Monday in January (“Dr. Martin Luther King, Jr. Day.”)
 - (3) The third Monday in February (“Washington Day” or “President’s Day.”)
 - (4) .March 31st (“Cesar Chavez Day.”)
 - (5) The last Monday in May (“Memorial Day.”)

- (6) July 4th (“Independence Day.”)
 - (7) The first Monday in September (“Labor Day.”)
 - (8) November 11th (“Veterans Day.”)
 - (9) The third Thursday in November (“Thanksgiving Day.”)
 - (10) The Friday After Thanksgiving Day
 - (11) December 25th (“Christmas Day.”)
- (12) If January 1st, March 31st, July 4th, November 11th, or December 25th falls upon a Sunday, the Monday following is a holiday. If November 11th falls upon a Saturday, the preceding Friday is a holiday.

2.0 Standardized Medical Treatment Billing Format

- (a) On and after XXXX, 2010, [90 days after the effective date of this regulation] all, health care providers, health care facilities and third party billers/assignees shall submit medical bills for payment on the uniform billing forms or utilizing the format prescribed in this section, completed as set forth in Appendix A. All information on the paper version of the uniform billing forms shall be typewritten when submitted. Format means a document containing all the same information using the same data elements in the same order as the equivalent uniform billing form.
 - (1) “Form CMS-1500” means the health insurance claim form maintained by CMS, revised August 2005, for use by health care providers.
 - (2) “CMS Form 1450” or “UB04” means the health insurance claim form maintained by CMS, revised 2005, for use by health facilities and institutional care providers as well as home health providers.
 - (3) “American Dental Association, Version 2006” means the uniform dental claim form approved by the American Dental Association for use by dentists.
 - (4) “NCPDP Universal Claim Form” means the NCPDP claim form, revised 2008, for pharmacy bills.
- (b) On and after XXXX, 2011, [18 months after the effective date of this regulation], all health care providers, health care facilities and third party billers/assignees providing medical treatment may electronically submit medical bills to the claims administrator for payment. All claims administrators must accept bills submitted in this manner. The bills shall conform to the electronic billing standards and rules set forth in this Medical Billing and Payment Guide and the Companion Guide.

3.0 Complete Bills

- (a) All bills being submitted for payment, whether electronically or on paper must be complete before payment time frames begin.
- (b) To be complete a submission must consist of the following:
 - (1) The correct uniform billing form/format for the type of health care provider.
 - (2) The correct uniform billing codes for the applicable portion of the OMFS under which the services are being billed.
 - (3) The uniform billing form/format must be filled out according to the requirements specified for each format in Appendix A and/or the Companion Guide.

- (c) All required reports and supporting documentation must be submitted as follows:
- (1) A Doctor's First Report of Occupational Injury (DLSR 5021), must be submitted when the bill includes Evaluation and Management services and a Doctor's First Report of Occupational Injury is required under Title 8, California Code of Regulations § 9785.
 - (2) A PR-2 report or its narrative equivalent must be submitted when the bill is for Evaluation and Management services and a PR-2 report is required under Title 8, California Code of Regulations § 9785.
 - (3) A PR-3, PR-4 or their narrative equivalent must be submitted when the bill is for Evaluation and Management services and the injured worker's condition has been declared permanent and stationary with permanent disability or a need for future medical care. (Use of Modifier – 17)
 - (4) A narrative report must be submitted when the bill is for Evaluation and Management services for a consultation.
 - (5) A report must be submitted when the provider uses the following Modifiers – 19, – 21, – 22, – 23 and – 25.
 - (6) A descriptive report of the procedure, drug, DME or other item must be submitted when the provider uses any code that is payable "By Report".
 - (7) A descriptive report must be submitted when the Official Medical Fee Schedule indicates that a report is required.
 - (8) An operative report is required when the bill is for Surgery Services.
 - (9) An invoice or other proof of documented paid costs must be provided when required for reimbursement.
 - (10) Appropriate additional information reasonably requested by the claims administrator or its agent to support a billed code when the request was made prior to submission of the billing. Supporting documentation should be sufficient to support the level of service or code that has been billed.
 - (11) Written authorization for services shall be provided where one was given.
- (d) For paper bills, if the required reports and supporting documentation are not submitted in the same mailing envelope as the bill, then a header or attachment cover sheet as defined in Section One – 7.3 for electronic attachments must be submitted.

4.0 Third Party Billers/Assignees

- (a) Third party billers and assignees shall submit bills in the same manner as the original rendering provider would be required to do had the bills been submitted by the provider directly.
- (b) The original rendering provider information will be provided in the fields where that information is required along with identifying information about the third party biller/assignee submitting the bill.

5.0 Duplicate Bills, Bill Revisions and Balance Forward Billing

- (a) The resubmission of a duplicate bill shall clearly be marked as a duplicate using the appropriate NUBC Bill Frequency Code in the field designated for that information. Duplicate bills shall contain all the same information as the original bill. No new dates of service or itemized services may be included. Duplicate bills shall not be submitted prior to expiration of the time allowed for payment unless requested by the claims administrator or its agent. For the time frame for payment of paper submissions see 6.0 (b) and for time frame for payment of electronic submission see 7.1(b).

- (b) When there is an error or a need to make a coding correction, a revised bill may be submitted to replace a previously submitted bill. Revised bills shall be marked as revised using the appropriate NUBC Condition Code in the field designated for that information. Revised bills shall include the original dates of service and the same itemized services rendered as the original bill. No new dates of service may be included.
- (c) Balance forward billing is not permissible. "Balance forward bills" are bills that include a balance carried over from a previous bill along with additional services.
- (d) A bill which has been previously submitted in one manner (paper or electronic) may not subsequently be submitted in the other manner.

6.0 Medical Treatment Billing and Payment Requirements for Non-Electronically Submitted Medical Treatment Bills.

- (a) Any complete bill submitted in other than electronic form or format not paid within 45 working days of receipt, or within 60 working days if the employer is a governmental entity, shall be increased 15%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill unless the health care provider, health care facility or third party biller/assignee is notified within 30 working days of receipt that the bill is contested, denied or considered incomplete. The increase and interest are self-executing and shall apply to the portion of the bill that is neither timely paid nor objected to.
- (b) A claims administrator who objects to all or any part of a bill for medical treatment shall notify the health care provider, health care facility or third party biller/assignee of the objection within 30 working days after receipt of the bill and any required report or supporting documentation necessary to support the bill and shall pay any uncontested amount within 45 working days after receipt of the bill, or within 60 working days if the employer is a governmental entity. If the required report or supporting documentation necessary to support the bill is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill, report, and/or supporting documentation whichever is received later. If the claims administrator receives a bill and believes that it has not received a required report and/or supporting documentation to support the bill, the claims administrator shall so inform the health care provider, health care facility or third party biller/assignee within 30 working days of receipt of the bill. An objection will be deemed timely if sent by first class mail and postmarked on or before the thirtieth working day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth working day after receipt. Any notice of objection shall include or be accompanied by all of the following:
 - (1) A clear and concise explanation of the basis for the objection to each contested procedure and charge using the DWC Bill Adjustment Reason codes contained in Appendix B Standard Explanation of Review along with the appropriate ANSI Claims Adjustment Group Codes.
 - (2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the information required.
 - (3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection.
 - (4) A statement that the health care provider, health care facility, or third party biller/assignee may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board.
 - (5) To adjudicate contested charges before the Workers' Compensation Appeals Board, the health care provider, health care facility or third party biller/assignee must file a lien. Liens are subject to the statute of limitations spelled out in Labor Code § 4903.5.

4903.5. (a) No lien claim for expenses as provided in subdivision (b) of Section 4903 may be filed after six months from the date on which the appeals board or a workers' compensation administrative law judge issues a final decision, findings, order, including an order approving compromise and release, or award, on the merits of the claim, after five years from the date of the injury for which the services were provided, or after one year from the date the services were provided, whichever is later.

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

- (c) An objection to charges from a hospital, outpatient surgery center, or independent diagnostic facility shall be deemed sufficient if the provider is advised, within the thirty working day period specified in subdivision (b), that a request has been made for an audit of the billing, when the results of the audit are expected, and contains the name, address, and telephone number of the person or office to contact for additional information concerning the audit.
- (d) This section does not prohibit a claims administrator from conducting a retrospective utilization review as allowed by Labor Code section 4610 and Title 8, California Code of Regulations §§9792.6 – 9792.10.
- (e) This section does not prohibit the claims administrator or health care provider, health care facility or third party biller/assignee from using alternative forms or procedures provided such forms or procedures are specified in a written agreement between the claims administrator and the health care provider, health care facility or third party biller/assignee, as long as the alternative billing format provides all the required information set forth in this Medical Billing and Payment Guide.
- (f) All individually identifiable health information contained on a uniform billing form shall not be disclosed by either the claims administrator or submitting health provider or health care facility except where disclosure is permitted by law or necessary to confer compensation benefits as defined in Labor Code Section 3207.
- (g) Explanations of Review shall use the DWC Bill Adjustment Reason codes and descriptions listed in Appendix B Standard Explanation of Review – 1.0 California DWC ANSI Matrix Crosswalk along with the appropriate ANSI Claims Adjustment Group Codes. The Explanations of Review shall contain all the required elements listed in Appendix B Standard Explanation of Review – 2.0 Field Table Standard Explanation of Review.

7.0 Medical Treatment Billing and Payment Requirements for Electronically Submitted Bills

7.1 Timeframes

- (a) Acknowledgements.
- (1) Interchange Acknowledgement (ASC X12 TA1) – within one working day of the receipt of an electronically submitted bill, the claims administrator shall send an Interchange Acknowledgement using the TA 1 transaction set, as defined in Companion Guide Chapter 10, indicating that a trading partner agreement has been put in place by the parties.
- (2) Functional Acknowledgement (ASC X12 997) – within one working day of the receipt of an electronically submitted bill, the claims administrator shall send an electronic functional acknowledgment using the 997 transaction set as defined in Companion Guide Chapter 10.

- (3) Health Care Claim Acknowledgement (ASC X12 N 277) – within two working days of receipt of an electronically submitted bill, the claims administrator shall send a Health Care Claim Acknowledgement ASC X12N 277 electronic notice of whether or not the bill submission is complete. The ASC X12 N 277 details what errors are present, and if necessary, what action the submitter should take. A bill may be rejected if it is not submitted in the required electronic standard format or if it is not complete as set forth in Section One – 3.0. Such notice must use the ASC X12N 277 transaction set as defined in Companion Guide Chapter 9 and must include specific information setting out the reason for rejection.

(A) ASC X12N 277 Claim Pending Status Information

- (i) A bill submitted, but missing an attachment or the injured worker's claim number shall be held as pending for up to five working days while the attachment and/or claim number is provided, prior to being rejected as incomplete. If the issue is a missing claim number, during the five working day timeframe the claims administrator shall, if possible, promptly locate and affix the claim number to the bill for processing and payment. If the claims administrator has already provided the claim number to the billing entity, the bill may be rejected as incomplete without placing the bill in pending status. All other timeframes are suspended during the time period the bill is pending. The payment timeframe begins when the missing information is provided. An extension of the five day pending period may be mutually agreed upon.
- (ii) A Health Care Claim Acknowledgement ASC X12 N 277 Pending notice shall be sent to the submitter/provider indicating that the bill has been put into pending status and indicating the specific reason for doing so using the appropriate ASC X12N 277 code values.
- (iii) If the required information is not received by the claims administrator within the five working days, the bill may be rejected as being incomplete.

(B) Bill rejection error messages shall include the following:

- (i) Invalid form or format – indicate which form should be used.
- (ii) Missing. Information- indicate specifically which information is missing by using the appropriate 277 Claim Status Category Code with the appropriate Claim Status Code..
- (iii) Invalid data – Indicate specifically which information is invalid by using the appropriate Claim Status Category Code with the appropriate Claim Status Code
- (iv) Missing attachments – indicate specifically which attachment(s) are missing.
- (v) Missing required documentation – indicate specifically what documentation is missing.
- (vi) Injured worker's claim of injury is denied.
- (vii) There is no coverage by the claims administrator.

(C) The submitted bill is complete and has moved into bill review.

(b) Payment and Remittance Advice.

Healthcare Claim Payment/Advice (ASC X12 N 835) – If the electronically submitted bill has been determined to be complete, payment for uncontested medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made by the employer within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Section §5307.1. Nothing prevents the parties from agreeing to submit bills electronically that are being paid per contract rates under Labor Code § 5307.11. Remittance advice shall be sent using the Healthcare Claim

Payment Advice (ASC X12 N (835) Payment transaction set as defined in Companion Guide Chapter 9. Explanations of Review shall use the codes listed in Appendix B – 1.0.

A claims administrator who objects to all or any part of an electronically submitted bill for medical treatment shall notify the health care provider, health care facility or third party biller/assignee of the objection within 15 working days after receipt of the bill and any required report and/or supporting documentation and shall pay any uncontested amount within 15 working days after receipt of the bill and required report and /or supporting documentation. If the claims administrator receives a bill and believes that it has not received a required report and/or supporting documentation to support the bill, the claims administrator shall so inform the health care provider within 15 working days of receipt of the bill. An objection will be deemed timely if sent electronically on or before the 15th working day after receipt. Any notice of objection shall include or be accompanied by all of the following:

- (1) A specific explanation of the basis for the objection to each contested procedure and charge. The notice shall use the DWC Bill Adjustment Reason codes contained in Appendix B Standard Explanation of Review along with the ANSI Claims Adjustment Group Codes
- (2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the specific information required shall be included.
- (3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection.
- (4) A statement that the health care provider, health care facility or third party biller/assignee may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board.
- (5) To adjudicate contested charges before the Workers' Compensation Appeals Board, the health care provider, health care facility or third party biller/assignee must file a lien. Liens are subject to the statute of limitations spelled out in Labor Code § 4903.5.

4903.5. (a) No lien claim for expenses as provided in subdivision (b) of Section 4903 may be filed after six months from the date on which the appeals board or a workers' compensation administrative law judge issues a final decision, findings, order, including an order approving compromise and release, or award, on the merits of the claim, after five years from the date of the injury for which the services were provided, or after one year from the date the services were provided, whichever is later.

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

7.2 Penalty

- (a) Any electronically submitted bill determined to be complete, not paid or objected to within the 15 working day period, shall be subject to audit penalties per Title 8, California Code of Regulations section 10111.2 (b) (10), (11).
- (b) In addition, any electronically submitted complete bill that is not paid within 45 working days of receipt, or within 60 working days if the employer is a governmental entity, shall be increased 15%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill unless the health care provider, health care facility or third party biller/assignee is notified within 30 working days of receipt that the bill is contested, denied or considered incomplete. The increase and interest are self-executing and shall apply to the portion of the bill that is neither timely paid nor objected to.

7.3 Electronic Bill Attachments

- (a) Required reports and/or supporting documentation to support a bill as defined in Complete Bill Section 3.0 shall be submitted in accordance with this section. All attachments to support an electronically submitted bill must either have a header or attached cover sheet that provides the following information:
- (1) Claims Administrator - the name shall be the same as populated in the ASC X12N 837 Loop 2010BB, NM103
 - (2) Employer - the name shall be the same as populated in the ASC X12N 837 Loop 2010BA, NM103
 - (3) Unique Attachment Indicator Number- -the Unique Attachment Indicator Number shall be the same as populated in the ASC X12 837 Loop 2300,PWK Segment : Report Type Code, the Report Transmission Code, Attachment Control Qualifier (AC) and the unique Attachment Control Number, It is the combination of these data elements that will allow a claims administrator to appropriately match the incoming attachment to the electronic medical bill. Refer to the Companion Guide Chapter 2 for information regarding the Unique Attachment Indicator Number Code Sets.
 - (4) Billing Provider NPI Number – the number must be the same as populated in Loop 2010AA, NM109. If you are ineligible for an NPI, then this number is your atypical billing provider ID . This number must be the same as populated in Loop 2010AA, REF02.
 - (5) Billing Provider Name
 - (6) Bill Transaction Identification Number – The shall be the same number as populated in the ASC X12N 837 transactions, Loop 2300 Claim Information, CLM01.
 - (7) Document type – use Report Type codes as set forth in Appendix C of the Companion Guides.
 - (8) Page Number/Number of Pages the page numbers reported should include the cover sheet.
 - (9) Contact Name/Phone Number including area code
- (b) All attachments to support an electronically submitted bill shall contain the following information in the body of the attachment or on an attached cover sheet:
- (1) Patient's name
 - (2) Claims Administrator's name
 - (3) Date of Service
 - (4) Date of Injury
 - (5) Social Security number (if available)
 - (6) Claim number (if available)
 - (7) Unique Attachment Indicator Number

- (c) All attachment submissions shall comply with the rules set forth in Section One – 3.0 Complete Bills and Section Three – Security Rules. They shall be submitted according to the protocols specified in the Companion Guide Chapter 8 or other mutually agreed upon methods.
- (d) Attachment submission methods:
 - (1) FAX
 - (2) Electronic submission – if submitting electronically, the Division strongly recommends using the Claims Attachment (275) transaction set. Specifications for this transaction set are found in the Companion Guide Chapter 8. The Division is not mandating the use of this transaction set. Other methods of transmission may be mutually agreed upon by the parties.
 - (3) E-mail
- (e) Attachment types
 - (1) Reports
 - (2) Supporting Documentation
 - (3) Written Authorization
 - (4) Misc. (other type of attachment)

7.4 Miscellaneous

- (a) This Medical Billing and Payment Guide does not prohibit a claims administrator from conducting a retrospective utilization review as allowed by Labor Code section 4610 and Title 8, California Code of Regulations §§9792.6 et seq .
- (b) This Medical Billing and Payment Guide does not prohibit a claims administrator or health care provider, health care facility or third party biller/assignee from using alternative forms/format or procedures provided such forms/format or procedures are specified in a written agreement between the claims administrator and the health care provider, health care facility, third party biller/assignee or clearinghouse, as long as the alternative billing and transmission format provides all the required information set forth in Section One - Appendix A or the Companion Guide.
- (c) Individually identifiable health information submitted on an electronic bill and attachments shall not be disclosed by either the claims administrator or submitting health provider, health care facility, third party biller/assignee or clearinghouse except where disclosure is permitted by law or necessary to confer compensation benefits as defined in Labor Code Section 3207.

7.5 Trading Partner Agreements

- (a) Health care providers, health care facilities and third party billers/assignees choosing to submit their bills electronically must enter into a Trading Partner agreement either directly with the claims administrator or with the clearinghouse that will handle the claims administrator’s electronic transactions.

Trading partner agreement means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)
- (b) The purpose of a Trading Partner Agreement is to memorialize the rights, duties and responsibilities of the parties when utilizing electronic transactions for medical billing.
- (c) Business Associate - any entity which is not covered under paragraph (a) that is handling electronic transactions on behalf of another.

Appendices for Section One

Appendix A. Standard Paper Forms

How to use the following forms

The following forms are the only forms to be used for paper billing of California workers' compensation medical treatment services and goods unless there is a written contract agreed to by the parties specifying something different. Following each form is a table indicating the fields to be filled out on the form. The table is in field order and indicates the field number, field description, the field type (required, situational, optional or not applicable) and any comments.

Fields designated as "required," notated by "R", must be provided or the bill will be considered incomplete.

Fields designated as "situational," notated by "S" are only required if the circumstances warrant it. The bill will be considered incomplete if the situation requires a field to be filled and it hasn't been.

Fields designated as "optional," notated by "O," do not need to be filled in, but if they are, the bill is still considered to be complete.

Fields designated as "not applicable," notated by "N," should be left blank. If they are not left blank, the bill will still be considered complete.

1.0 CMS 1500

The CMS 1500 form (version 08/05) may be obtained from the U.S. Government Bookstore at <http://bookstore.gpo.gov/collections/cms1500-form.jsp> or from a variety of private vendors.

The National Uniform Claim Committee (NUCC) has a reference manual for the CMS 1500 form. The manual is incorporated within this guide by reference: 1500 Health Insurance Claim Form Reference Instruction Manual For Form Version 08/05, Version 5.0 07/09. It is recommended that you review this manual carefully. Copies of the manual may be obtained directly from NUCC at: http://www.nucc.org/index.php?option=com_content&task=view&id=33&Itemid=42 .

Billings must conform to the Reference Instruction Manual and this guide. Wherever the NUCC Reference Instruction Manual differs from the instructions in this guide, the rules in this guide prevail.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/06

CARRIER

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLACK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY					STATE					CITY					STATE				
ZIP CODE					TELEPHONE (Include Area Code) ()					ZIP CODE					TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME				
b. OTHER INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)					c. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete Item 9 a.d.				
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED _____										SIGNED _____									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM/DD/YY) TO (MM/DD/YY)									
17a. _____										16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM/DD/YY) TO (MM/DD/YY)									
17b. NPI _____										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES									
19. RESERVED FOR LOCAL USE										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Reference Items 1, 2, 3 or 4 to Item 24 E by Line)										23. PRIOR AUTHORIZATION NUMBER									
1. _____										24. A. DATE(S) OF SERVICE From (MM/DD/YY) To (MM/DD/YY)									
2. _____										B. PLACE OF SERVICE EMG									
3. _____										C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)									
4. _____										E. DIAGNOSIS POINTER									
5. _____										F. \$ CHARGES									
6. _____										G. DAYS OR UNITS									
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$									
29. AMOUNT PAID \$										30. BALANCE DUE \$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH # ()										a. b.									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person had employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown in Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are passed upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services Information on the patient's sponsor should be provided in those items captioned as "Insured", i.e., items 1a, 4, 5, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 6536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 206(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101, 41 CFR 101 of sec and 10 USC 1076 and 1089; 5 USC 9101 of sec. and 39 USC 901 of sec. 3B USC 613, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 89-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed, Sept. 12, 1980, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Publication of Notice of Systems of Records," Federal Register, Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-6, ESA-A, ESA-12, ESA-13, ESA-19, ESA-20, as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSES: To evaluate eligibility for medical care provided by certain sources and to issue payment upon establishment of eligibility and determination that the services/supplies required are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in proceedings, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 11295 of the Social Security Act and 31 USC 9801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1985, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0499. The time required to complete the information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1859. This address is for comments and/or suggestions only. **DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.**

1.1 Field Table CMS 1500

CMS 1500 Box #	CMS 1500 Field Description	Workers' Compensation Requirements (Required/ Situational/ Not Applicable)	California Workers' Compensation Instructions
0	CARRIER NAME AND ADDRESS	R	Enter the Name and Address of the Payer to whom this bill is being sent.
1	MEDICARE, MEDICAID, TRICARE CHAMPUS, CHAMPVA, GROUP HEALTH PLAN, FECA, BLACK LUNG, OTHER	R	Enter 'X' in Box Other.
1a	INSURED'S I.D. NUMBER	R	Enter the patient's Social Security Number. If the patient does not have a Social Security Number, enter the following 9 digit number: '999999999'.
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	R	
3	PATIENT'S BIRTH DATE, SEX	R	
4	INSURED'S NAME (Last Name, First Name, Middle Initial)	R	Enter the name of the Employer.
5	PATIENT'S ADDRESS (No., Street), CITY, STATE, ZIP CODE, TELEPHONE	R	
6	PATIENT RELATIONSHIP TO INSURED	R	Enter 'X' in Box 'Other'.
7	INSURED'S ADDRESS (No., Street), CITY, STATE, ZIP CODE, TELEPHONE	S	Required when the bill is the first indication of the work related incident and the claim number is not entered in Box 11. Enter the physical address where the employee works.
8	PATIENT STATUS	N	
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	S	Required if applicable.
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	S	Required if applicable.
9b	OTHER INSURED'S DATE OF BIRTH, SEX	S	Required if applicable.
9c	EMPLOYER'S NAME OR SCHOOL NAME	S	Required if applicable.
9d	INSURANCE PLAN NAME OR PROGRAM NAME	S	Required if applicable.
10a	IS PATIENT'S CONDITION RELATED TO: EMPLOYMENT	R	Enter 'X' in Box 'YES'.
10b	IS PATIENT'S CONDITION RELATED TO: AUTO ACCIDENT _ PLACE (State)	N	
10c	IS PATIENT'S CONDITION RELATED TO: OTHER ACCIDENT	N	
10d	RESERVED FOR LOCAL USE	S	Required when submitting a bill that is a duplicate or an appeal. (Original Reference Number must be entered in Box 22 for these conditions). Enter the NUBC Condition Code Qualifier 'BG' followed by the appropriate NUBC Condition Code for resubmission. W2 - Duplicate of the original bill W3 - Level 1 Appeal W4 - Level 2 Appeal W5 - Level 3 Appeal Example: BGW3 Note: Do not use condition codes when submitting revised or corrected bill.
11	INSURED'S POLICY GROUP OR FECA NUMBER	S	Enter claim number, if known, or if claim number is not known then enter the value of 'Unknown' to indicate unknown claim number. This box requires one of the above values and cannot be left blank or may result in the bill being rejected.
11a	INSURED'S DATE OF BIRTH, SEX	N	
11b	EMPLOYER'S NAME OR SCHOOL NAME	N	
11c	INSURANCE PLAN NAME OR PROGRAM NAME	S	Required when the Employer Department Name/Division is applicable and is different than Box 4.

CMS 1500 Box #	CMS 1500 Field Description	Workers' Compensation Requirements	California Workers' Compensation Instructions
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	S	Required if applicable.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	R	
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	N	
14	DATE OF CURRENT ILLNESS, OR INJURY OR PREGNANCY	R	Enter the Date of Accident/ Illness.
15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	S	
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	N	This information is not used by CA Workers' Compensation and should not be included on the Bill. Inclusion of this data may cause the payer to reject the bill.
17	NAME OF REFERRING PROVIDER OR OTHER SOURCE	S	Required when other providers are associated with the bill.
17a	OTHER ID #	S	Required when other providers are associated with the bill and do not have an NPI# Enter 'OB' qualifier followed by the State License Number of the provider.
17b	NPI #	S	If known.
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	S	
19	RESERVED FOR LOCAL USE	S	<p>Box 19 is also to be used to communicate the Attachment Information, if applicable. Attachment Information is required in Box 19 and on supporting document(s) associated with this bill, when the document (s) is submitted separately from the bill.</p> <p>Refer to California Workers' Compensation Companion Guide regarding Attachment Information data requirements. Enter the three digit ID qualifier PWK, the appropriate two digits Report Type Code, e.g. Radiology Report Code = RR, the appropriate two digit Transmission Type Code, e.g. FAX =FX, followed by the unique Attachment Control identification number. Do not enter spaces between qualifiers and data. Example: PWKRRFX1234567.</p> <p>When the documentation represents a Jurisdictional Report, then use the Report Type Code 'OZ', and enter the Jurisdictional Report Type Code in front of the Attachment Control Number. Example: PWKOZFXJ1999234567</p> <p>Summary: Enter the first qualifier and number/code/information in Box 19. After the first item, enter three blank spaces and then the next qualifier and number/code/information.</p>
20	OUTSIDE LAB?	S	Use when billing for diagnostic tests (refer to CMS instructions).
21.1	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	R	
21.2	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	S	
21.3	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	S	
21.4	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	S	

CMS 1500 Box #	CMS 1500 Field Description	Workers' Compensation Requirements	California Workers' Compensation Instructions
22	MEDICAID RESUBMISSION CODE ORIGINAL REF. NUMBER	S	<p>Required when the bill is a resubmission. Enter the Original Reference Number assigned to the bill by the Workers' Compensation Carrier.</p> <p>When the Original Reference Number is entered and a Condition Code is not present in 10d the Bill is considered a Revised Bill for reconsideration.</p> <p>When resubmitting a bill, enter the appropriate NUBC Bill Frequency Code left justified in the left-hand side of the field. The values will be: 7 – Replacement of prior claim 8 – Void/cancel of prior claim The Resubmission Code is not intended for use for original bill submissions.</p>
23	PRIOR AUTHORIZATION NUMBER	S	Required when a prior authorization, referral, concurrent review, or voluntary certification was received. Enter the number/name as assigned by the payer for the current service. Do not enter hyphens or spaces within the number.
24A	DATE(S) OF SERVICE	R	
24B	PLACE OF SERVICE	R	
24C	EMG	N	
24D	PROCEDURES, SERVICES, OR SUPPLIES	R	
24E	DIAGNOSIS CODE POINTER	R	
24F	\$ CHARGES	R	
24G	DAYS OR UNITS	R	
24H	EPSDT/FAMILY PLAN	N	
24I Grey	ID QUAL	S	Required when the Rendering Provider is a health care provider. Enter 'ZZ' Qualifier for Taxonomy Code of the Rendering Provider.
24J Grey	RENDERING PROVIDER ID. #	S	Required when the Rendering Provider is a health care provider. Enter the Taxonomy Code of the Rendering Provider.
24J	NPI#	S	Required when the Rendering Provider is different from the provider reported in Box 33 and the provider is eligible for an NPI.
24 Grey	GREY AREA SUPPLEMENTAL DATA	S	Required when supplemental data is being submitted.
25	FEDERAL TAX ID. NUMBER	R	
26	PATIENT'S ACCOUNT NO.	R	
27	ACCEPT ASSIGNMENT?	N	
28	TOTAL CHARGE	R	
29	AMOUNT PAID	N	
30	BALANCE DUE	N	
31	SIGNATURE OF PHYSICIAN OR SUPPLIER	R	
32	SERVICE FACILITY LOCATION INFORMATION	S	
32a	NPI #	S	Required if entity populated in Box 32 is a licensed health care provider eligible for an NPI #. Enter the NPI # of the service facility location in field 32A
32b	OTHER ID #	S	
33	BILLING PROVIDER INFO & PH #	R	
33a	NPI #	S	
33b	OTHER ID #	S	

2.0 UB 04

The National Uniform Billing Committee Official UB-04 Data Specifications Manual 2010, Version 4.0, July 2009, including the UB 04 form, is incorporated within this guide by reference. Copies of the manual may be obtained directly from NUBC at:

<http://www.nubc.org/become.html>

You must become a subscriber in order to obtain this manual.

Billings must conform to the Specification Manual. However, wherever the NUBC Data Specifications Manual differs from the instructions in this guide, the rules in this guide prevail.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM
			7 THROUGH
8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		c	d
10 BIRTHDATE	11 SEX	12 DATE	13 HR
			14 TYPE
			15 SRC
			16 DHR
			17 STAT
			18
			19
			20
			21
			22
			23
			24
			25
			26
			27
			28
			29 ACDT STATE
			30
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE
35 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN FROM	37	
a			
b			
38	39 VALUE CODES AMOUNT	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT
a			
b			
c			
d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23

SAMPLE

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A						57 OTHER PRV ID
B						
C						

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A				
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX	67	A	B	C	D	E	F	G	H	68

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73	
74 PRINCIPAL PROCEDURE CODE	a. OTHER PROCEDURE CODE	b. OTHER PROCEDURE CODE	75	76 ATTENDING NPI	QUAL	LAST	FIRST	77 OPERATING NPI	QUAL	LAST	FIRST
c. OTHER PROCEDURE CODE	d. OTHER PROCEDURE CODE	e. OTHER PROCEDURE CODE		78 OTHER NPI	QUAL	LAST	FIRST	79 OTHER NPI	QUAL	LAST	FIRST

80 REMARKS	81CC a	b	c	d

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
 - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
 - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
 - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
 - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
 - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
 - (f) If a hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
 - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
 - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

2.1 Field Table UB 04

UB-04 Form Loc	UB-04 Field Description	Workers' Compensation Requirements (Required/Situational/ Not Applicable)	California Workers' Compensation Instructions
01	Billing Provider Name, Address and Telephone Number	R	
02	Pay-to Name and Address	S	
03a	Patient Control Number	R	
03b	Medical/Health Record Number	S	
04	Type of Bill	R	When reporting a corrected bill use Type of Bill 7 - Replacement of a Prior Claim. When submitting a bill for an appeal or as a duplicate enter the appropriate NUBC Condition Code in Form Locator 18-28 to indicate bill resubmission type.
05	Federal Tax Number	R	
06	Statement Covers Period	R	
07	Reserved for Assignment by the NUBC	N	
08a	Patient Identifier	R	Enter the patient's Social Security Number. If the patient does not have a Social Security Number, enter the following 9 digit number: '999999999'.
08b	Patient Name	R	
09	Patient Address	R	
10	Patient Birth Date	R	
11	Patient Sex	R	
12	Admission/Start of Care Date	R	
13	Admission Hour	S	
14	Priority (Type) of Visit	S	Required when patient is being admitted to hospital for inpatient services.
15	Point of Origin for Admission or Visit	S	Required for all inpatient admissions and outpatient registration for diagnostic testing services
16	Discharge Hour	S	Required on all final inpatient claims/encounters.
17	Patient Status	S	Required for all inpatient admissions and outpatient registration for diagnostic testing services.
18-28	Condition Codes	S	Required when Condition information applies to the bill. Required when submitting a bill that is a duplicate or an appeal (Original Reference Number must be entered in Form Locator 64 for these conditions). Appropriate resubmission codes are: W2 - Duplicate of the original bill W3 - Level 1 Appeal W4 - Level 2 Appeal W5 - Level 3 Appeal Note: Do not use condition codes when submitting revised or corrected bill.
29	Accident State	N	
30	Reserved for Assignment by the NUBC	N	

UB-04 Form Loc	UB-04 Field Description	Workers' Compensation Requirements	California Workers' Compensation Instructions
31-34a,b	Occurrence Codes and Dates	R	At least one Occurrence Code must be entered with value of '04' Accident/Employment Related. The Occurrence Date must be the Date of Occupational Injury/Illness.
35-36a,b	Occurrence Span Codes and Dates	S	
37	Reserved for Assignment by the NUBC	N	
38	Responsible Party Name and Address	R	Enter the Workers' Compensation Payer responsible for payment of the bill including name address, city, state, and zip code.
39-41a-d	Value Codes and Amounts	S	
42	Revenue Codes	R	
43	Revenue Description	R	Enter the standard abbreviated description of the related revenue code categories included on this bill. When REV Code is for RX, the description requires NDC Number/ Dispense As Written Code/Units.
44	HCPCS/Accommodation Rates/HIPPS Rate Codes	S	
45	Service Date	S	
46	Service Units	R	
47	Total Charges	R	
48	Non-covered Charges	N	
49	Reserved for Assignment by the NUBC	N	
50a	Payer Name	R	
51a	Health Plan Identification Number	N	Not Used.
52a	Release of Information Certification Indicator	R	
53a	Assignment of Benefits Certification Indicator	R	Enter a value of 'Y' - Yes.
54a	Prior Payments - Payer	N	
55a	Estimated Amount Due-Payer	N	
56	National Provider identifier -Billing Provider	S	
57	Other (Billing) Provider Identifier	S	
58a	Insured's Name	R	Enter the name of the Employer.
59a	Patient's Relationship to Insured	R	Enter a value of '20' Employee.
60a	Insured's Unique Identifier	R	Enter the patient's Social Security Number. If the patient does not have a Social Security Number, enter the following 9 digit number: '999999999'.
61a	Insured's Group Name	S	Required when the Employer Department Name/Division is different than Form Locator 58a.

UB-04 Form Loc	UB-04 Field Description	Workers' Compensation Requirements	California Workers' Compensation Instructions
62a	Insured's' Group Number	S	Enter claim number, if known, or if claim number is not known then enter the value of 'Unknown' to indicate unknown claim number. This box requires one of the above values and cannot be left blank or may result in the bill being rejected.
63a	Treatment Authorization Code	S	Enter the authorization number assigned by the payer indicated in Form Locator 50, if known.
64a	Document Control Number	S	
65a	Employer Name (of the Insured)	R	Enter the name of the Employer.
50-65b,c	Other Insured Information	S	Required if applicable.
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	R	
67	Principal Diagnosis Code and Present on Admission Indicator	R	
68	Reserved for Assignment by the NUBC	N	
69	Admitting Diagnosis Code	S	
70a-c	Patient's Reason for Visit	S	
71	Prospective Payment System (PPS) Code	S	Required when the bill is for inpatient admissions.
72a-c	External Cause of Injury (ECI) Code	S	
73	Reserved for Assignment by the NUBC	N	
74a-e	Other Procedure Codes and Dates	S	
75	Reserved for Assignment by the NUBC	N	
76	Attending Provider Name and Identifiers (NPI)	S	
76	Attending Provider Name and Identifiers (QUAL)	S	
76	Attending Provider Name and Identifiers (ID)	S	
76	Attending Provider Name and Identifiers (LAST/FIRST)	S	
77	Operating Physician Name and Identifiers (NPI)	S	
77	Operating Physician Name and Identifiers (QUAL)	S	
77	Operating Physician Name and Identifiers (ID)	S	
77	Operating Physician Name and Identifiers (LAST/FIRST)	S	
78-79	Other Provider Name and Identifiers (NPI)	S	
78-79	Other Provider Name and Identifiers (QUAL)	S	
78-79	Other Provider Name and Identifiers (ID)	S	
78-79	Other Provider Name and Identifiers (LAST/FIRST)	S	

UB-04 Form Loc	UB-04 Field Description	Workers' Compensation Requirements	California Workers' Compensation Instructions
81	Code-Code Field	R	<p>Enter the Taxonomy Code of the Billing Provider. Use the 'B3' qualifier followed by the 10 digit taxonomy code of the Billing Provider.</p> <p>Refer to California Workers' Compensation Companion Guide regarding Attachment Information data requirements. Attachment Information is required in Box 81 with a Code-Code of 'AC' when there is supporting documentation associated with this bill, and the documentation is submitted separately from the bill.</p> <p>Enter 'AC' in the Code Field followed by the appropriate two digit Report Type Code, e.g. Radiology Report Code = RR, the appropriate two digit Transmission Type Code, e.g. FAX =FX, followed by the unique Attachment Control Identification Number. Do not enter spaces between codes and data. Example: ACRRFX1234567.</p> <p>When the documentation represents a Jurisdictional Report, then use the Report Type Code 'OZ', followed by the Jurisdictional Report Type Code in front of the Attachment Control Number. Example: ACOZFXJ1999234567</p>
80	Remark Field	S	<p>Required when the bill is the first indication of the work related incident and the claim number is not submitted. Enter the physical address where the employee works.</p>

3.0 National Council for Prescription Drug Programs “NCPDP” Workers’ Compensation/Property & Casualty Universal Claim Form (“WC/PC UCF”)

The Division adopts and incorporates by reference the NCPDP Workers’ Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Version 1.0, 05/2008 as the prescribed paper billing form for pharmacy services.

The Division adopts and incorporates by reference the NCPDP *Manual Claims Form Reference Implementation Guide Version 1.0, October 2008*, except for pages 13-36 relating to the Universal Claim Form, which must be used in the completion of the WC/PC UCF.

The NCPDP WC/PC UCF and *Manual Claims Form Reference Implementation Guide* are available for purchase through the NCPDP approved vendor, CommuniForm, at:

<http://www.communiform.com/ncdp/>.

Telephone number: (800) 869-6508.

Contact information will also be posted on the NCPDP website <http://www.ncdp.org>.

The Division is providing additional instruction for the following data elements:

- 17 - Claim Reference Number
- 32 - Pharmacy ID Number
- 40 - Prescriber ID Number
- 99 - Usual & Customary Charge
- 106 - Patient Paid Amount

The California workers’ compensation NCPDP WC/PC UCF Additional Instruction Requirements are defined in Table 3.1 of this section.



WORKERS' COMPENSATION / PROPERTY & CASUALTY CLAIM FORM
Version 1.0 - 05/2008

FOR OFFICE USE ONLY
15 (Document Control Number)

SIGNATURE OF PROVIDER
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

30-(Signed) _____ 31-(Date) _____

ATTENTION PROVIDER!
PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE

1-WC/P&C Indicator: 2-Date of Billing: MM DD CCYY

3-Last: _____ 4-First: _____
5-Address: _____ 6-City: _____
7-State: _____ 8-ZIP: _____ 9-Phone No.: () _____
10-D.O.B.: MM DD CCYY 11-D.O.I.: MM DD CCYY
12-ID: _____ 13-Qualifier: 14-Gender:

16-Jurisdictional State: 17-Claim Ref #: _____
18-Name: _____ 19-Address: _____
20-City: _____ 21-State: _____ 22-ZIP: _____

23-Name: _____ 24-Address: _____
25-City: _____ 26-State: _____ 27-ZIP: _____
28-Phone No.: () _____ 29-Contact Name: _____

32-ID: _____ 33-Qual:
34-Name: _____
35-Address: _____
36-City: _____ 37-State: _____
38-ZIP: _____ 39-Tel #: () _____

40-ID: _____ 41-Qualifier:
42-Last: _____ 43-First: _____
44-Address: _____
45-City: _____ 46-State: _____
47-ZIP: _____ 48-Tel #: () _____

49-ID: _____ 50-Qual:
51-Name: _____
52-Address: _____
53-City: _____ 54-State: _____
55-ZIP: _____ 56-Tel #: () _____

57 - Jurisdiction # 1: _____
58 - Jurisdiction # 2: _____
59 - Jurisdiction # 3: _____
60 - Jurisdiction # 4: _____
61 - Jurisdiction # 5: _____

Claim	62 - Prescription/Service Ref. #		63-Qual	64-Fill #	65-Date Written MM DD CCYY			66-Date Of Service MM DD CCYY			67-Submission Clarification
	68-Product/Service ID		69-Qual	70-Quantity Dispensed	71-Days Supply	72-DAW Code	73-Prior Auth. # Submitted		74-PA Type		
	75-Description				76-Strength	77-Unit of Measure	78-Other Coverage		79-Delay Reason		
Compound	80-Other Payer ID	81-Qual	82-Other Payer Date MM DD CCYY		83-Other Payer Rejects		DUR / PPS CODES 84Reason/85Service/86Result		87-Level of Effort	88-Procedure Modifier	
	89-Dosage Form Description Code		90-Dispensing Unit Form Indicator:		91-Route of Administration			92-Ingredient Component Count			
93-Product Name		94-Product ID		95-Qual	96-Ingredient Qty		97-Ingredient Drug Cost		98-Basis Cost		
1											
2											
3											
4											
5											
6											
7											

----- Pricing ----- (Format 1,234.56)	
	99-Usual & Customary Charge
	100-Basis of Cost Det.
	101-Ingredient Cost Submitted
	102-Dispensing Fee Submitted
	103-Other Amount Submitted
	104-Sales Tax Submitted
	105-Gross Amount Due (Submitted)
	106-Patient Paid Amount
	107-Other Payer Amount Paid
	108-Other Payer Patient Resp. Amnt.
	109-Net Amount Due

The provider agrees to the following:

- Certifies that required beneficiary signatures, or legally authorized signatures of beneficiaries, are on file;
- That the submitted claim is accurate, complete, and truthful; and
- That it will research and correct claim discrepancies.

Hawaii – “Charges are in accordance with Chapter 286, HRS, and any related rules.”

New Hampshire: - “I certify that the narrative descriptions of the principal and secondary diagnosis and the major procedures performed are accurate and complete to the best of my knowledge.

For more instructions on this form, see the NCPDP *Manual Claim Forms Reference Implementation Guide* available at www.ncdp.org.

Code List

For fields not listed below, or more values which may be available, see the NCPDP *Manual Claim Forms Reference Implementation Guide* or the NCPDP *External Code List*.

01 - Workers' Compensation / Property & Casualty Indicator
“WC” - Workers' Compensation
“PC” - Property & Casualty

14 - Patient Gender Code
“0” - Not Specified
“1” - Male
“2” - Female

32 - Service Provider ID Qualifier
“blank” - Not Specified
“01” - NPI
“05” - Medicaid
“07” - NCPDP
“99” - Other

40 - Prescriber ID Qualifier
“01” - NPI
“08” - State License
“12” - DEA
“99” - Other

62 - Prescription/Service Reference # Qualifier
“1” - Rx Billing
“2” - Service Billing

67 - Submission Clarification Code
“1” - No Override
“2” - Other Override
“3” - Vacation Supply
“4” - Lost Prescription
“5” - Therapy Change
“6” - Starter Dose
“7” - Medically Necessary
“8” - Process Compound for Approved Ingredients
“9” - Encounters
“10” - Meets Plan Limitations
“11” - Certification on File
“12” - DME Replacement Indicator
“13” - Payer-Recognized Emergency/Disaster Assistance Request
“14” - Long Term Care Leave of Absence
“15” - Long Term Care Replacement Medication
“16” - Long Term Care Emergency Box or Automated Dispensing Machine
“17” - Long Term Care Emergency Supply Remainder
“18” - Long Term Care Patient Admit / Readmit Indicator
“19” - Split Billing
“99” - Other

68 - Product/Service ID Qualifier
“00” - Not Specified
“01” - UPC
“02” - HRI
“03” - NDC
“04” - HIBCC
“06” - DUR/PPS
“07” - CPT4
“08” - CPT5
“09” - HCPCS
“10” - PPAC
“11” - NAPPI
“12” - GTIN
“15” - GCN
“28” - FDB Med Name ID
“29” - FDB Routed Med ID
“30” - FDB Routed Doage Form Med ID

72 - Dispense as Written (DAW) / Product Selection
“0” - No Product Selection Indicated
“1” - Substitution Not Allowed by Prescriber
“2” - Substitution Allowed – Patient Requested Product Dispensed
“3” - Substitution Allowed – Pharmacist Selected Product Dispensed
“4” - Substitution Allowed – Generic Drug Not in Stock
“5” - Substitution Allowed – Brand Drug Dispensed as a Generic
“6” - Override
“7” - Substitution Not Allowed – Brand Drug Mandated by Law
“8” - Substitution Allowed – Generic Drug not Available in Marketplace
“9” - Substitution Allowed by Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product to be Dispensed

74 - Prior Authorization Type Code
“0” - Not Specified
“1” - Prior Authorization
“2” - Medical Certification
“3” - EPSDT
“4” - Exemption from Copay and/or Coinsurance
“5” - Exemption from Rx
“6” - Family Planning Indicator
“7” - TANF (Temporary Assistance for Needy Families)
“8” - Payer Defined Exemption
“9” - Emergency Preparedness

78 - Other Coverage Code
“0” - Not Specified by patient
“1” - No Other Coverage
“2” - Other Coverage Exists – Payment Collected
“3” - Other Coverage Billed – Claim Not Covered
“4” - Other Coverage Exists – Payment Not Collected
“8” - Claim is billing for patient financial responsibility only

79 - Delay Reason Code
“1” - Proof of eligibility unknown or unavailable
“2” - Litigation
“3” - Authorization delays
“4” - Delay in certifying provider
“5” - Delay in supplying billing forms
“6” - Delay in delivery of custom-made appliances
“7” - Third party processing delay
“8” - Delay in eligibility determination
“9” - Original claims rejected or denied due to a reason unrelated to the billing limitation rules
“10” - Administration delay in the prior approval process
“11” - Other
“12” - Received late with no exceptions
“13” - Substantial damage by fire, etc to provider records
“14” - Theft, sabotage/other willful acts by employee

81 - Other Payer ID Qualifier
“01” - National Payer ID
“02” - HIN
“03” - BIN
“04” - NAIC
“05” - Medicare Carrier Number
“99” - Other

82 - Other Payer Reject Codes
(For values refer to current External Code List)

84 - Reason for Service &
85 - Professional Service Code &
86 - Result of Service Code
(For values refer to current NCPDP External Code List)

87 - DUR/PPS Level of Effort
“0” - Not Specified
“11” - Level 1 (Lowest)
“12” - Level 2
“13” - Level 3
“14” - Level 4
“15” - Level 5 (Highest)

91 - Route of Administration
(Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) terminology which is available from the College of American Pathologists, Northfield, Illinois
<http://www.snomed.org/>)

99 - Basis of Cost Determination &
97 - Compound Ingredient Basis of Cost Determination (For values refer to current NCPDP External Code List)

3.1 Field Table NCPDP

NCPDP WORKERS' COMPENSATION/PROPERTY AND CASUALTY UCF USAGE INSTRUCTIONS

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields (Required/Situational/Optional/Not Applicable)	NCPDP 5.1 Data Element	Comments	California Workers' Compensation Instructions
1	WC/P&C Indicator	R	N/A	Code qualifying whether the claim submitted is for Workers' Compensation or Property & Casualty	
2	Date of Billing	R	N/A	Date the invoice was created. Used only by those entities creating the paper invoice and submitting for payment Format: MMDDCCYY	
3	Patient Last Name	R	311-CB	Individual Last Name	
4	Patient First Name	R	310-CA	Individual First Name	
5	Patient Street Address	R	322-CM	Free-form text for address information	
6	Patient City	R	323-CN	Free-form text for city name	
7	Patient State	R	324-CO	Standard State/Province Code as defined by appropriate government agency	
8	Patient Zip	R	325-CP	Code defining international postal zone excluding punctuation and blanks (zip code for US)	
9	Patient Phone Number	S	326-CQ	Ten-digit phone number of patient	
10	Patient Date of Birth	R	304-C4	Date of birth of patient Format: MMDDCCYY	
11	Date of Injury	R	434-DY	Date on which the injury occurred Format: MMDDCCYY	
12	Patient ID	R	332-CY	Patient ID	
13	Patient ID Qualifier	R	331-CX	Code qualifying the Patient ID (332-CY) Valid values for WC/PC UCF are blank, Ø1, Ø2, Ø3, Ø4 and Ø5 99	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields R/S/O/N	NCPDP 5.1 Data Element	Comments	California Workers' Compensation Instructions
14	Patient Gender	R	305-C5	Code indicating the gender of the individual	
15	Document Control Number	O	N/A	Internal number used by the payer or processor to further identify the claim for imaging purposes – Document archival, retrieval and storage. Not to be used by the pharmacy	
16	Jurisdictional State	S	N/A	Postal State Abbreviation identifying the state which has jurisdiction over the payment of benefits and medical claims. Typically, the Jurisdictional State is the state where the worker was injured.	
17	Claim Reference Number	S	435-DZ	Identifies the claim number assigned by the Workers' Compensation program	Enter the claim number assigned by the workers' compensation Payer, if known. If claim number is not known, then enter the value of 'Unknown'
18	Carrier Name	R	811-1H	Name of the carrier	
19	Carrier Street Address	R	807-1D	Address of the carrier	
20	Carrier City	R	809-1F	This field identifies the name of the city in which the carrier is located	
21	Carrier State	R	810-1G	State of the carrier	
22	Carrier Zip	R	813-1J	Zip code of the carrier, expanded. Note: Excludes punctuation and blanks	
23	Employer Name	R	315-CF	Complete name of employer	
24	Employer Street Address	R	316-CG	Free-form text for address information	
25	Employer City	R	317-CH	Free-form text for city name	
26	Employer State	R	318-CI	Standard State/Province Code as defined by appropriate government agency	
27	Employer Zip	R	319-CJ	Code defining	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields (Required/Situational/Optional/Not Applicable)	NCPDP 5.1 Data Element	Comments	California Workers' Compensation Instructions
				international postal zone excluding punctuation and blanks (zip code for US)	
28	Employer Phone Number	O	320-CK	Ten-digit phone number of employer	
29	Employer Contact Name	S	321-CL	Employer primary contact	
30	Signature of Provider	S	N/A	Enter the legal signature of the pharmacy or service representative. "Signature on File" or "SOF" acceptable	
31	Date of Provider Signature	S	N/A	Enter either the 6-digit date (MMDDYY), 8-digit date (MMDDCCYY) or alphanumeric date (e.g. January 1, 2008) the form was signed	
32	Pharmacy ID	R	201-B1	ID assigned to a pharmacy or provider	Enter the Pharmacy NPI number.
33	Pharmacy ID Qualifier	R	202-B2	Code qualifying the "Service Provider ID" (201-B1)	
34	Pharmacy Name	R	833-5P	Name of pharmacy	
35	Pharmacy Address	R	829-5L	The street address for a pharmacy	
36	Pharmacy City	R	831-5N	City of pharmacy	
37	Pharmacy State	R	832-6F	State abbreviation of pharmacy	
38	Pharmacy Zip	R	835-5R	This field identifies the expanded zip code of the pharmacy. Note: excludes punctuation and blanks. This left-justified field contains the five-digit zip code and may include the four-digit expanded zip code where the pharmacy is located.	
39	Pharmacy Telephone	R	834-5Q	Telephone number of the pharmacy	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields R/S/O/N	NCPDP 5.1 Data Element	Comments	California Workers' Compensation Instructions
40	Prescriber ID	R	411-DB	ID assigned to the prescriber	Enter Prescribing Doctor NPI, if none available; Enter Prescribing Doctor State License number, if none available; Enter other value as qualified by NCPDP 5.1
41	Prescriber ID Qualifier	R	466-EZ	Code qualifying the Prescriber ID (411-DB)	
42	Prescriber Last Name	R	427-DR	Individual last name	
43	Prescriber First Name	R	364-2J	Individual first name	
44	Prescriber Street Address	R	365-2K	Free-form text for prescriber address information	
45	Prescriber City	R	366-2M	Free-form text for prescriber city name	
46	Prescriber State	R	367-2N	Standard state/province code as defined by appropriate government agency.	
47	Prescriber Zip	R	368-2P	Code defining international postal zone excluding punctuation and blanks	
48	Prescriber Telephone	O	498-PM	Ten-digit phone number of the prescriber	
49	Payee ID	R	119-TT V D.0	Identifying number of the entity to receive payment for claim	
50	Payee ID Qualifier	R	118-TS V D.0	Code qualifying the Pay-To ID (119-TT)	
51	Payee Name	R	120-TU V D.0	Name of the entity to receive payment for claim	
52	Payee Street Address	R	121-TV V D.0	Street address of the entity to receive payment for claim	
53	Payee City	R	122-TW V D.0	City of the entity to receive payment for claim	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields R/S/O/N	NCPDP 5.1 Data Element	Comments	California Workers' Compensation Instructions
54	Payee State	R	123-TX V D.0	Standard state/province code as defined by appropriate government agency	
55	Payee Zip	R	124-TY V D.0	Code defining international postal zone excluding punctuation and blanks (zip code for US)	
56	Payee Telephone	R	N/A	Telephone number of the payee	
57	Jurisdiction Field #1	S	N/A	Text-field with constraints Used to support state specific requirements in a specified format as approved and defined by NCPDP see IG for specific criteria.	
58	Jurisdiction Field #2	S	N/A	Text-field with constraints	
59	Jurisdiction Field #3	S	N/A	Text-field with constraints	
60	Jurisdiction Field #4	S	N/A	Text-field with constraints	
61	Jurisdiction Field #5	S	N/A	Text-field with constraints	
62	Prescription Service Reference #	R	402-D2	Reference number assigned by the provider for the dispensed drug/product and/or service provided	
63	Prescription Service Reference # Qualifier	R	455-EM	Indicates the type of billing submitted	
64	Fill #	R	403-D3	The code indicating whether the prescription is original or refill	
65	Date Written	R	414-DE	Date prescription was written Format: CCYYMMDD	
66	Date of Service	R	401-D1	Identifies date the prescription was filled or professional service rendered Format: CCYYMMDD	
67	Submission Clarification	S	420-DK	Code indicating that the pharmacist is clarifying the submission	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields R/S/O/N	NCPDP 5.1 Data Element	Comments	California Workers' Compensation Instructions
68	Product/Service ID	R	407-D7	ID of the product dispensed or service provided. When the claim is for a compound where individual ingredients are submitted, this field must not be populated.	
69	Product/Service ID Qualifier	R	436-E1	Code qualifying the value in Product/Service ID (407-D7)	
70	Quantity Dispensed	R	442-E7	Quantity dispensed expressed in metric decimal units Format: 9999999.999	
71	Days Supply	R	405-D5	Estimated number of days the prescription will last	
72	DAW Code	R	408-D8	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed	
73	Prior Authorization # Submitted	S	462-EV	Number submitted by the provider to identify the prior authorization	
74	Prior Authorization Type	S	461-EU	Code clarifying the Prior Authorization Number Submitted (462-EV) or benefit/plan exemption	
75	Description	R	601-20	Description of product being submitted	
76	Strength	R	601-24	The strength of the product	
77	Unit of Measure	R	600-28	NCPDP standard product billing codes	
78	Other Coverage	S	308-C8	Code indicating whether or not the patient has other insurance coverage	
79	Delay Reason	S	357-NV	Code to specify the reason that submission of the transaction has been delayed	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields R/S/O/N	NCPDP 5.1 Data Element	Comments	California Workers' Compensation Instructions
80	Other Payer ID	S	340-7C	Coordination of Benefits Segment ID assigned to the payer	
81	Other Payer ID Qualifier	S	339-6C	Coordination of Benefits Segment Code qualifying the Other Payer ID (340-7C)	
82	Other Payer Date	S	443-E8	Coordination of Benefits Segment	
83	Other Payer Rejects	S	472-6E	The error encountered by the previous Other Payer in Reject Code (511-FB)	
84	DUR/PPS Codes Reason	S	439-E4	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service	
85	DUR/PPS Codes Service	S	440-E5	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered	
86	DUR/PPS Codes Result	S	441-E6	Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.	
87	Level of Effort	S	474-8E	Code identifying the level of effort as determined by the complexity of decision-making or resources	
88	Procedure Modifier	S	459-ER	Identifies special circumstances related to the performance of the service	
89	Compound Dosage Form Description Code	S	450-EF	Dosage form of the complete compound mixture	
90	Compound Dispensing Unit Form Indicator	S	451-EG	NCPDP standard product billing code	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields R/S/O/N	NCPDP 5.1 Data Element	Comments	California Workers' Compensation Instructions
91	Compound Route of Administration	S	995-E2	This is an override to the default route referenced for the product. For a multi-ingredient compound, it is the route of the complete mixture	
92	Compound Ingredient Compound Count	S	447-EC	Count of compound product IDs (both active and inactive) in the compound mixture submitted	
93	Compound Product Name	S	N/A	Description of product being submitted	
94	Compound Product ID	S	489-TE	Product identification of an ingredient being used in a compound	
95	Compound Product ID Qualifier	S	488-RE	Code qualifying the type of product dispensed	
96	Compound Ingredient Quantity	S	448-ED	Amount expressed in metric decimal units of the product included in the compound mixture Format: 9999999.999	
97	Compound Ingredient Drug Cost	S	449-EE	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in Compound Ingredient Quantity (Field 448-ED) Format: 9999999.999	
98	Compound Basis Cost	S	490-UE	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	
99	Usual & Customary Charge	O	426-DQ	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed Format: 9999999.99	Required for California: Enter the pharmacy's usual and customary charge as defined by California Statute 5307.1 (a)

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields R/S/O/N	NCPDP 5.1 Data Element	Comments	California Workers' Compensation Instructions
100	Basis of Cost Determination	R	423-DN	Code indicating the method by which Ingredient Cost Submitted (Field 409-D9) was calculated	
101	Ingredient Cost Submitted	S	409-D9	Submitted product component cost of the dispensed prescription. This amount is included in the Gross Amount Due (430-DU) Format: 9999999.99	
102	Dispensing Fee Submitted	R	412-DC	Dispensing fee submitted by the pharmacy. This amount is included in the Gross Amount Due (430-DU) Format: 9999999.99	
103	Other Amount Submitted	S	480-H9	Amount representing the additional incurred costs for a dispensed prescription or service. Format: 9999999.99	
104	Sales Tax Submitted	S	481-HA & 482-GE	Flat sales tax submitted for prescription. This amount is included in the Gross Amount Due (430-DU) Or Percentage sales tax submitted Format: 9999999.99	
105	Gross Amount Due (Submitted)	R	430-DU	Total price claimed from all sources. Format: 9999999.99	
106	Patient Paid Amount	S	433-DX	Amount the pharmacy received from the patient for the prescription dispensed. Format: 9999999.99	Not Applicable for California
107	Other Payer Amount Paid	S	431-DV	Amount of any payment known by the pharmacy from other sources Format: 9999999.99	

Paper Form Item #	2008 WC/PC NCPDP Field Description	Workers' Compensation Paper Fields R/S/O/N	NCPDP 5.1 Data Element	Comments	California Workers' Compensation Instructions
108	Other Payer Patient Responsibility Amount	S	352-NQ	The patient's cost share from a previous payer. Format: 9999999.99	
109	Net Amount Due	R	N/A	Total of all pharmacy services amount due less any other paid amounts. Format: 99999999.99	

4.0 ADA 2006

The Division adopts and incorporates by reference the ADA 2006 Dental Claim Form (including instructions on reverse of form) as the mandatory standard billing form for dental bills submitted in a paper format. The Division adopts and incorporates by reference the *Current Dental Terminology, Fourth Edition (CDT-4) 2009/2010*. Health Care providers billing for dental procedures shall use the CDT-4 and codes in effect on the date of service. The ADA 2006 Dental Claim Form and the *Current Dental Terminology, Fourth Edition* may be obtained from the ADA at:

American Dental Association

<http://www.ada.org/>

211 East Chicago Ave.

Chicago, IL 60611-2678

Or on the web at:

<http://www.ada.org/>

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

Statement of Actual Services Request for Predetermination/Preauthorization

EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)

M F

16. Plan/Group Number 17. Employer Name

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)

M F

9. Plan/Group Number 10. Patient's Relationship to Person Named in #5

Self Spouse Dependent Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status

Self Spouse Dependent Child Other FTS PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)

M F

RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)	Permanent																Primary										32. Other Fee(s)	33. Total Fee
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
																	T	S	R	Q	P	O	N	M	L	K		

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 39. Number of Enclosures (00 to 99)

Provider's Office Hospital ECF Other Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY)

No (Skip 41-42) Yes (Complete 41-42)

42. Months of Treatment Remaining 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY)

No Yes (Complete 44)

45. Treatment Resulting from

Occupational illness/injury Auto accident Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number () - 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI 55. License Number

56. Address, City, State, Zip Code 56A. Provider Specialty Code

57. Phone Number () - 58. Additional Provider ID

4.1 Field Table ADA 2006

American Dental Association 2006 Paper Claim Form			
Paper Field	2006 ADA Claim Form Field Description	Workers' Compensation Paper Fields R/S/O/NA	Comments
1		N/A	
2	Predetermination/Preauthorization Number Enter the Claim Reference Number (CRN) of the original bill when resubmitting a bill.	S	Enter Certification or Authorization Number Provided By Payer
PRIMARY PAYER INFORMATION			
3	Name	R	Workers' Compensation Payer Name & Address
	Address		
	City		
	State		
	Zip Code		
	Phone Number		
OTHER COVERAGE (Not Applicable)			
4	Other Dental or Medical Coverage?	N/A	
5	Subscriber Name, Address	N/A	
6	Date of Birth	N/A	
7	Gender	N/A	
8	Subscriber Identifier	N/A	
9	Plan/Group Number	N/A	
10	Relationship to Primary Subscriber	N/A	
11	Other Carrier Name, Address	N/A	
PRIMARY SUBSCRIBER INFORMATION (Employer)			
12	Primary Subscriber Name (Employer)	R	Employer Name and Address
	Address	R	
	City		
	State		
	Zip Code		
	Telephone Number, If Known		
13	Date of Birth	N/A	
14	Gender	N/A	
15	Subscriber ID (SSN)- Workers' Compensation Claim Number	S	Workers' Compensation Claim Number, If Known
16	Plan / Group Number- Unique Patient Bill Identifier Number Assigned by Provider	R	Unique Patient Bill Identifier Number
17	Employer Name	N/A	
PATIENT INFORMATION (Injured Worker)			
18	Relationship to Primary Subscriber	O	Check "Other" Box
19	Student Status	N/A	

Paper Field	2006 ADA Claim Form Field Description	Workers' Compensation Paper Fields R/S/O/NA	Comments
	Patient's Last Name		
	Patient's First Name		
	Patient's Middle Name		
	Address		
	City		
	State		
	Zip Code		
20	Telephone Number, If Known	R	
21	Patient Date of Birth	R	
22	Gender	R	
23	Patient ID Number (Social Security Number)	R	Social Security Number
RECORD OF SERVICES PROVIDED			
24	Date of Service	R	
25	Area of oral Cavity	S	
26	Tooth System	S	
27	Tooth Number's) or Letter(s)	S	
28	Tooth Surface	S	
29	Procedure code	R	
30	Description of service provided.	R	
31	Fees	R	
32	Other fees	N/A	
33	Total Fees	R	
MISSING TEETH INFORMATION			
34	Report missing teeth on each claim submission.	S	
35	Remarks (Attachment Control Number and or Notes)	S	
AUTHORIZATIONS			
36	Authorization Signature 1	N/A	
37	Authorization Signature 2	N/A	
ANCILLARY CLAIM/TREATMENT INFORMATION			
38	Place of Treatment	R	Place of Service
39	Indicate the number of enclosures	S	
40	Is Treatment for Orthodontics	R	
41	Date Appliance Placement	S	
42	Months of treatment remaining	S	
43	Replacement of Prosthesis?	S	
44	Date Prior Placement	S	
45	Treatment Resulting From	R	
46	Date of Accident	R	
47	Auto Accident State	S	

Paper Field	2006 ADA Claim Form Field Description	Workers' Compensation Paper Fields R/S/O/NA	Comments
BILLING DENTIST OR DENTAL ENTITY			
48	Name	R	
	Address		
	City		
	State		
	Zip Code		
	Phone Number		
49	Provider ID -NPI Number	S	NPI Number Required if Billing Provider is a Health Care Entity
50	License Number (state license)	S	State License Number Required if Billing Provider is a Health Care Entity
51	SSN or TIN	R	
52	Phone number of the entity listed in box 48.	R	
TREATING DENTIST AND TREATMENT LOCATION INFORMATION			
53	Signed (Treating Dentist) and Date	R	If signed enter Y in CLMO6 Field or N if not signed
54	Provider ID -NPI Number	R	
55	License Number (state license)	S	
56	Address	R	
	City		
	State		
	Zip Code		
56a	Provider Specialty Code	R	Enter Provider Taxonomy Code
57	Phone number	S	
58	Additional Provider ID	S	

Appendix B. Standard Explanation of Review

Any Explanation of Review (EOR) must include all of the data elements indicated as required in Appendix B - 2.0 Field Table for Standard Explanation of Review. The Division of Workers' Compensation has not developed a standard paper form or format for the EOR. Payors providing paper EOR's may use any format as long as all required data elements are present. Electronic EOR's must comply with the ANSI X12 N 835 instructions found in the California Division of Workers' Compensation Electronic Billing and Payment Companion Guide

In addition, a claims administrator who objects to all or any part of a bill for medical treatment shall notify the physician or other authorized provider of the objection within 30 working days after receipt of the bill, any required reports and supporting documentation and shall pay any uncontested amount within forty-five working days after receipt of the bill, or, for governmental entities, within 60 working days. If a required report is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill or report, whichever is received later. If the claims administrator receives a bill and believes that it has not received required reports and supporting documentation to support the bill, the claims administrator shall so inform the medical provider within thirty working days of receipt of the bill. An objection will be deemed timely if sent by first class mail and postmarked on or before the thirtieth working day after receipt, or if personally delivered or sent by electronic facsimile or other electronic means on or before the thirtieth working day after receipt. Any notice of objection shall include or be accompanied by all of the following:

- (1) A clear and concise explanation of the basis for the objection to each contested procedure and charge using the DWC Bill Adjustment Reason codes contained in Appendix B Standard Explanation of Review and the ANSI Claims Adjustment Group Code.
- (2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the information required.
- (3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection.
- (4) A statement that the treating physician or authorized provider may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board.
- (5) To adjudicate contested charges before the Workers' Compensation Appeals Board, the health care provider, health care facility or third party biller/assignee must file a lien. Liens are subject to the statute of limitations spelled out in Labor Code § 4903.5.

4903.5. (a) No lien claim for expenses as provided in subdivision (b) of Section 4903 may be filed after six months from the date on which the appeals board or a workers' compensation administrative law judge issues a final decision, findings, order, including an order approving compromise and release, or award, on the merits of the claim, after five years from the date of the injury for which

the services were provided, or after one year from the date the services were provided, whichever is later.

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

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

How to use the tables.

The DWC ANSI Matrix Crosswalk includes the DWC Bill Adjustment Reason Codes, a description of the billing problem the code is describing, the Explanatory Message, and any special instructions for the payor on additional information required when using that code. It crosswalks the ANSI Claims Adjustment Reason Codes (CARC) and the ANSI Remittance Advice Remark Codes (RARC). This sub set of the CARC and RARC codes are the only acceptable codes for use on an EOR for California workers' compensation purposes unless there is a written contract agreed to by the parties specifying something different. The table is divided into sections that correspond with the different fee schedules or sections of fee schedules being used for medical billing. General explanations may be used for any section, but the section specific codes should only be used for bills being submitted under that section.

When receiving an electronic EOR via ANSI X12 N 835, medical providers can determine the DWC Bill Adjustment Reason Code from the combination of CARC and RARC. In most cases, each CARC/RARC combination only maps to one DWC Bill Adjustment Reason Code. The DWC ANSI Matrix Crosswalk is presented in two different orders for the convenience of both paper and electronic EOR receivers. The first is presented in DWC Bill Adjustment Reason Code order. The second is in CARC order.

The Field Table for Standard Explanation of Review provides the required elements for a paper EOR.

1.0 California DWC ANSI Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
G1	Provider's charge exceeds fee schedule allowance.	The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.		W1	Workers' Compensation State Fee Schedule Adjustment		
G2	The OMFS does not include a code for the billed service.	The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service.	Indicate code for comparable service.	W1	Workers' Compensation State Fee Schedule Adjustment	N448	This drug/service/ supply is not included in the fee schedule or contracted/legislated fee arrangement.
G3	The OMFS does not list the code for the billed service	The Official Medical Fee Schedule does not list this code. No payment is being made at this time. Please resubmit your claim with the OMFS code(s) that best describe the service(s) provided and your supporting documentation.		220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G4	Billed charges exceed amount identified in your contract.	This charge was adjusted to comply with the rate and rules of the contract indicated.	Requires name of specific Contractual agreement from which the reimbursement rate and/or payment rules were derived.	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).		
G5	No standard EOR message applies.	This charge was adjusted for the reasons set forth in the attached letter.	Message to be used when no standard EOR message applies and additional communication is required to provide clear and concise reason(s) for adjustment/denial.	162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.	M118	Alert: Letter to follow containing further information
G6	Provider charges for service that has no value.	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.		W1	Workers' Compensation State Fee Schedule Adjustment	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G7	Provider bills for a service included within the value of another.	No separate payment was made because the value of the service is included within the value of another service performed on the same day.	Requires identification of the specific payment policy or rules applied. For example: CPT coding guidelines, CCI Edits, fee schedule ground rules.	97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.		
G8	Provider billed for a separate procedure that is included in the total service rendered.	A charge was made for a "separate procedure" that does not meet the criteria for separate payment. See Physician's Fee Schedule General Instructions for Separate Procedures rule.		97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G9	Provider submitted bill with no supporting or lack of sufficient identification or documentation for the unlisted or BR Service reported.	The unlisted or BR service was not received or sufficiently identified or documented. We are unable to make a payment without supplementary documentation giving a clearer description of the service. See OMFS General Instructions for Procedures Without Unit Values	If specific documentation is needed, use the specific RARC for the report needed.	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.
G10	Bill is submitted without necessary documentation needed for bill processing.	We cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible.	Identify documentation or report necessary for bill processing. Only RARC N29 if none of the more specific RARC report type codes below do not apply. (G11 – G52)	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N29	Missing documentation/orders/notes/summary/report/chart.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G11				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M30	Missing pathology report.
G12				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N236	Incomplete/invalid pathology report.
G13				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N240	Incomplete/invalid radiology report.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G14				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M31	Missing radiology report.
G15				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N451	Missing Admission Summary Report.
G16				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N452	Incomplete/Invalid Admission Summary Report.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G17			If the payor needs documentation supporting a prescription that was Dispensed As Written, a request for additional information should be sent to the prescribing physician.	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M118	Alert: Letter to follow containing further information
G18				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N456	Incomplete/Invalid Physician Order.
G19				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N455	Missing Physician Order.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G20				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N497	Missing Medical Permanent Impairment or Disability Report
G21				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N498	Incomplete/Invalid Medical Permanent Impairment or Disability Report
G22				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N499	Missing Medical Legal Report

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G23				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N500	Incomplete/Invalid Medical Legal Report
G24				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N501	Missing Vocational Report
G25				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N502	Incomplete/Invalid Vocational Report

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G26				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N503	Missing Work Status Report
G27				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N504	Incomplete/Invalid Work Status Report
G28				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N453	Missing Consultation Report

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G29				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N454	Incomplete/Invalid Consultation Report
G30				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N26	Missing Itemized Bill/ Statement
G31				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N455	Missing Physician's Report- Delete Comments

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G32				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N456	Incomplete/Invalid Physician Report
G33				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N394	Incomplete/invalid progress notes/report.
G34				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N393	Missing progress notes/report.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G35				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N396	Incomplete/invalid laboratory report.
G36				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N395	Missing laboratory report.
G37				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N458	Incomplete/Invalid Diagnostic Report.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G38				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N457	Missing Diagnostic Report.
G39				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N460	Incomplete/Invalid Discharge Summary.
G40				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N459	Missing Discharge Summary.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G41				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N462	Incomplete/Invalid Nursing Notes.
G42				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N461	Missing Nursing Notes.
G43				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N464	Incomplete/Invalid support data for claim.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G44				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N463	Missing support data for claim.
G45				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N466	Incomplete/Invalid Physical Therapy Notes.
G46				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N465	Missing Physical Therapy Notes.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G47				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N468	Incomplete/Invalid Report of Tests and Analysis Report.
G48				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N467	Missing Report of Tests and Analysis Report.
G49				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N493	Missing Doctor First Report of Injury

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G50				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N494	Incomplete/invalid Doctor First Report of Injury.
G51				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N495	Missing Supplemental Medical Report
G52				16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N496	Incomplete/invalid Supplemental Medical Report.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G53				175 176	Prescription is incomplete Prescription is not current CARC 175 and 176 may be used with any of the listed RARC Codes	N378 N388 N349 N389 M123	Missing/incomplete/invalid prescription quantity Missing/incomplete/invalid prescription number The administration method and drug must be reported to adjudicate this service. Duplicate prescription number submitted. Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
G54	Provider's documentation and/or code does not support level service billed	The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.	Indicate alternate OMFS code on which payment amount is based.	150	Payor deems the information submitted does not support this level of service.	N22	This procedure code was added/changed because it more accurately describes the services rendered.
G55	Provider bills for service that is not related to the diagnosis.	This service appears to be unrelated to the patient's diagnosis.		11	The diagnosis is inconsistent with the procedure.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G56	Provider bills a duplicate charge.	This appears to be a duplicate charge. This charge has been previously reviewed.	Indicate date original charge was reviewed for payment.	18	Duplicate claim/service.		
G57	Service or procedure requires prior authorization and none was identified.	This service requires prior authorization and none was identified.		197	Precertification/ authorization/ notification absent.		
G58	Provider bills separately for report included as part of another service.	Reimbursement for this report is included with other services provided on the same day; therefore a separate payment is not warranted.	Message shall not be used to deny separately reimbursable special and/or duplicate reports requested by the payor.	97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.	N390	This service/report cannot be billed separately.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G59	Provider bills inappropriate modifier code.	The appended modifier code is not appropriate with the service billed.	If modifier is incorrect, billed OMFS code should still be considered for payment either without use of the modifier or with adjustment by the reviewer to the correct modifier, when the service is otherwise payable. Indicate alternative modifier if assigned	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
G60	Billing is for a service unrelated to the work illness or injury.	Payment for this service has been denied because it appears to be unrelated to the claimed work illness or injury.		191	Not a work related injury/illness and thus not the liability of the workers' compensation		
G61	Provider did not document the service that was performed.	The charge was denied as the report/documentation does not indicate that the service was performed.		112	Service not furnished directly to the patient and/or not documented.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G62	Provider inappropriately billed for emergency services.	Reimbursement was made for a follow-up visit, as the documentation did not reflect an emergency.	For use in cases where the emergency physician directs the patient to return to the emergency department for non-emergent follow-up medical treatment.	40	Charges do not meet qualifications for emergent/urgent care.		
G63	Provider bills for services outside his/her scope of practice.	The billed service falls outside your scope of practice.		8	The procedure code is inconsistent with the provider type/specialty (taxonomy).		
G64	Provider charge of professional and/or technical component is submitted after global payment made to another provider.	Provider charge of professional and/or technical component is submitted after global payment made to another provider.	Indicate name of other provider who received global payment.	134	Technical fees removed from charges.		
G65	Provider charge of professional and/or technical component is submitted after global payment made to another provider.	Provider charge of professional and/or technical component is submitted after global payment made to another provider.	Indicate name of other provider who received global payment.	89	Professional fees removed from charges.	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G66	Timed code is billed without documentation.	Documentation of the time spent performing this service is needed for further review.		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N443	Missing/incomplete/invalid total time or begin/end time.
G67	Charge is for a different amount than what was pre-negotiated.	Payment based on individual pre-negotiated agreement for this specific service.	Identify name of specific contracting entity, authorization # if provided, and pre-negotiated fee or terms. This EOR is for individually negotiated items/ services.	131	Claim specific negotiated discount.		
G68	Charge submitted for service in excess of pre-authorization.	Service exceeds pre-authorized approval. Please provide documentation and/or additional authorization for the service not included in the original authorization.		198	Precertification/ authorization exceeded.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G69	Charge is made by provider outside of HCO or MPN.	Payment is denied as the service was provided outside the designated Network.	Indicate name of HCO or MPN designated network. This message is not to be used to deny payment to out-of-network providers when the employee is legally allowed to treat out of network. For example: when the employer refers the injured worker to the provider.	38	Services not provided or authorized by designated (network/primary care) providers.		
G70	Charge denied during Prospective or Concurrent Utilization Review	This charge is denied as the service was not authorized during the Utilization Review process. If you disagree, please contact our Utilization Review Unit.	Optional: Provide Utilization Review phone number.	39	Services denied at the time authorization/ pre-certification was requested.	N175	Missing review organization approval.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G71	Charge denied during a Retrospective Utilization Review.	This charge was denied as part of a Retrospective Review. If you disagree, please contact our Utilization Review Unit.	Optional: Provide Utilization Review phone number.	216	Based on the findings of a review organization		
G72	Provider bills with missing, invalid or inappropriate authorization number	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.		15	The authorization number is missing, invalid, or does not apply to the billed service.		
G73	Provider bills and does not provide requested documentation or the documentation was insufficient or incomplete	Provider bills and does not provide requested documentation or the documentation was insufficient or incomplete.		17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N66	Missing/incomplete/invalid documentation.
G73	Provider bills payor/employer when there is no claim on file	Claim denied as patient cannot be identified as our insured.		31	Patient cannot be identified as our insured.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G74	Provider bills for services that are not medically necessary	These are non-covered services because this is not deemed a 'medical necessity' by the payor.		50	These are non-covered services because this is not deemed a 'medical necessity' by the payor.		
G75	Provider submits bill to incorrect payor/contactor	Claim not covered by this payor/contractor. You must send the claim to the correct payor/contractor.		109	Claim not covered by this payor/contractor. You must send the claim to the correct payor/contractor. (CARC) 109 is to be used with qualifier PR in NM1 to indicate the employer entity.		
G76	Provider bills for multiple services with no or inadequate information to support this many services.	Payment adjusted because the payor deems the information submitted does not support this many services.		151	Payment adjusted because the payor deems the information submitted does not support this many/frequency of services.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G77	Bill exceeds or is received after \$10,000 cap has been reached on a delayed claim	This claim has not been accepted and the mandatory \$10,000 medical reimbursements have been made. Should the claim be accepted, your bill will then be reconsidered. This determination must be made by 90 days from the date of injury but may be made sooner.	For additional clarification to the provider, use additional Remark Code N437 - Alert: If the injury claim is accepted, these charges will be reconsidered.	119	Benefit maximum for this time period or occurrence has been reached.	N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made.
G78	Bill is submitted that is for a greater amount than remains in the \$10,000 cap.	Until the employee's claim is accepted or rejected, liability for medical treatment is limited to \$10,000 (LC 5402(c)). Your bill is being partially paid as this payment will complete the Labor Code 5402(c) mandatory \$10,000 reimbursement. Should the claim	For additional clarification to the provider, use additional Remark Code N437 - Alert: If the injury claim is accepted, these charges will be reconsidered.	119	Benefit maximum for this time period or occurrence has been reached.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
PHYSICAL MEDICINE							
PM1	Non-RPT provider bills Physical Therapy Assessment and Evaluation code.	This charge was denied as the Physical Therapy Assessment and Evaluation codes are billable by Registered Physical Therapists only.		8	The procedure code is inconsistent with the provider type/specialty (taxonomy).		
PM2	Provider bills both E/M or A/E, and test and measurement codes on the same day.	Documentation justifying charges for both test and measurements and evaluation and management or assessment and evaluation on the same day is required in accordance with Physical Medicine rule 1 (h).		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N435	Exceeds number/frequency approved/allowed within time period without support documentation.
PM3	Provider bills three or more modalities only, in same visit.	When billing for modalities only, you are limited to two modalities in any single visit pursuant to Physical Medicine rule 1 (b). Payment has been made in accordance with Physician Fee Schedule guidelines		119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
PM4	Provider bills "additional 15 minute" code without billing the "initial 30 minute" base code.	This physical medicine extended time service was billed without the "initial 30 minutes" base code.		107	The related or qualifying claim/ service was not identified on this claim.	N122	Add-on code cannot be billed by itself.
PM5	Provider bills a second physical therapy A/E within 30 days of the last evaluation.	Only one assessment and evaluation is reimbursable within a 30 day period. The provider has already billed for a physical therapy evaluation within the last 30 days. See Physical Medicine rule 1 (a).		119	Benefit maximum for this time period or occurrence has been reached.	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
PM6	Provider billing exceeds 60 minutes of physical medicine or acupuncture services.	Reimbursement for physical medicine procedures, modalities, including Chiropractic Manipulation and acupuncture codes are limited to 60 minutes per visit without prior authorization pursuant to Physical Medicine rule 1 (c)		119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
PM7	No more than four physical medicine procedures including Chiropractic Manipulation and Acupuncture codes are reimbursable during the same visit without prior authorization pursuant to Physical Medicine rule 1 (d).	No more than four physical medicine procedures including Chiropractic Manipulation and Acupuncture codes are reimbursable during the same visit without prior authorization pursuant to Physical Medicine rule 1 (d).		151	Payment adjusted because the payor deems the information submitted does not support this many/frequency of services.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
PM8	Provider bills full value for services subject to the multiple service cascade.	Physical Medicine rule 1 (e) regarding multiple services (cascade) was applied to this service.		59	Processed based on multiple or concurrent procedure rules.		
PM9	Provider bills office visit in addition to physical medicine/ acupuncture code or OMT/CMT code at same visit. Specified special circumstances not applicable.	Billing for evaluation and management service in addition to physical medicine/acupuncture code or OMT/CMT code resulted in a 2.4 unit value deduction from the treatment codes in accordance with Physical Medicine rule 1 (g).		59	Processed based on multiple or concurrent procedure rules.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
PM10	Provider fails to note justification for follow-up E/M charge during treatment.	Payment for this service was denied because documentation of the circumstances justifying both a follow-up evaluation and management visit and physical medicine treatment has not been provided as required by physical medicine rule 1 (f).		W1	Workers' Compensation State Fee Schedule Adjustment	N435	Exceeds number/frequency approved /allowed within time period without support documentation.
PM11	Physical Therapist charged for E/M codes which are limited to physicians, nurse practitioners, and physician assistants.	Charge was denied as Physical Therapists may not bill Evaluation and Management services.		170	Payment is denied when performed/ billed by this type of provider.		
PM12	Visits in excess of 24 are charged without prior authorization for additional visits.	Charge is denied as there is a 24 visit limitation on Physical Therapy, Chiropractic and Occupational Therapy encounters for injuries on/after January 1, 2004 without prior authorization for additional visits.	Optional: Provide Utilization Review phone number.	198	Precertification/ authorization exceeded.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
SURGERY							
S1	Physician billing exceeds fee schedule guidelines for multiple surgical services.	Recommended payment reflects Physician Fee Schedule Surgery Section, rule 7 guidelines for multiple or bi-lateral surgical services.		59	Processed based on multiple or concurrent procedure rules.		
S2	Physician billed for initial casting service included in value of fracture or dislocation reduction allowed on the same day.	The value of the initial casting service is included within the value of a fracture or dislocation reduction service.		97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.		
S3	Physician bills office visit or service which is not separately reimbursable as it is within the global surgical period.	The visit or service billed, occurred within the global surgical period and is not separately reimbursable.		97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
S4	Multiple arthroscopic services to same joint same session are billed at full value.	Additional arthroscopic services were reduced to 10 percent of scheduled values pursuant to Surgery Section, rule 7 re: Arthroscopic Services.		59	Processed based on multiple or concurrent procedure rules.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
S5	Physician bills initial visit in addition to starred service, which constituted the major service.	This initial visit was converted to code 99025 in accordance with the starred service Surgery Section, rule 10 (b) (1).		W1	Workers' Compensation State Fee Schedule Adjustment	N22	This procedure code was added/changed because it more accurately describes the services rendered.
S6	Assistant Surgeon charged greater than 20% of the surgical procedure.	Assistant Surgeon services have been reimbursed at 20% of the surgical procedure. (See Modifier 80 in the Surgery Section of the Physician's Fee Schedule).		W1	Workers' Compensation State Fee Schedule Adjustment	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
S7	Non-physician assistant charged greater than 10% of the surgical procedure.	Non-physician assistant surgeon has been reimbursed at 10% of the surgical procedure. (See Modifier 83 in the Surgery Section of the Physician's Fee Schedule).		W1	Workers' Compensation State Fee Schedule Adjustment	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
S8	Surgeon's bill does not include operative report			16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M29	Missing operative note/report.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
S9	Operative Report does not cite the billed procedure.	Incomplete/invalid operative report (billed service is not identified in the Operative Report)		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N233	Incomplete/invalid operative report.
S10	Surgeon's bill includes separate charge for delivery of local anesthetic.	Administration of Local Anesthetic is included in the Surgical Service per Surgery Section, rule 16.		W1	Workers' Compensation State Fee Schedule Adjustment	N514	Consult plan benefit documents/guidelines for information about restrictions for this service.
S11	Procedure does not normally require an Assistant Surgeon or multiple surgeons and no documentation was provided to substantiate a need in this case.	Assistant Surgeon services have been denied as not normally warranted for this procedure according to the listed citation.	Identify the reference source listing of approved Assistant Surgeon services.	54	Multiple physicians/assistants are not covered in this case.	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
ANESTHESIA							
A1	Physician bills for additional anesthesia time units not allowed by schedule	Modifier -47 was used to indicate regional anesthesia by the surgeon. In accordance with the Physician Fee Schedule, time units are not reimbursed.		97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
A2	No anesthesia records provided for payment determination.	Please submit anesthesia records for further review.		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N463	Missing support data for claim.
A3	Insufficient information provided for payment determination.	Please submit complete/valid anesthesia records for further review.		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N464	Incomplete/invalid support data for claim.
A4	Insufficient information provided for payment determination.	Please submit anesthesia records time units for further review.		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N203	Missing/incomplete/invalid anesthesia time/units

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
A5	Documentation does not describe emergency status.	Qualifying circumstances for emergency status not established.		40	Charges do not meet qualifications for emergent/urgent care.		
A6	Documentation does not describe physical status/condition.	Patient's physical status/condition not identified. Please provide documentation using ASA Physical Status indicators.		16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N439 N440	Missing anesthesia physical status report/indicators. Incomplete/invalid anesthesia physical status report/indicators
E/M							
EM1	Physician bills for office visit which is already included in a service performed on the same day.	No reimbursement was made for the E/M service as the documentation does not support a separate significant, identifiable E&M service performed with other services provided on the same day.	This EOR should only be used if documentation does not support the use of modifier 25, 57, or 59.	95	Plan procedures not followed.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
EM2	Documentation does not support Consultation code.	The billed service does not meet the requirements of a Consultation (See the General Information and Instructions Section of the Physician's Fee Schedule).		150	Payor deems the information submitted does not support this level of service.	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
EM3	Documentation does not support billing for Prolonged Services code.	Documentation provided does not justify payment for a Prolonged Evaluation and Management service.		152	Payor deems the information submitted does not support this length of service.		
CLINICAL LAB							
CL1	Physician bills for individual service normally part of a panel.	This service is normally part of a panel and is reimbursed under the appropriate panel code.		97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
PHARMACY							
P1	Charge for Brand Name was submitted without "No Substitution" documentation.	Payment was made for a generic equivalent as "No Substitution" documentation was absent.		W1	Workers' Compensation State Fee Schedule Adjustment	N447	Payment is based on a generic equivalent as required documentation was not provided.
P2	Provider charges a dispensing fee for over-the-counter medication or medication administered at the time of the visit.	A dispensing fee is not applicable for over-the-counter medication or medication administered at the time of a visit.		91	Dispensing fee adjustment.		
DME							
DME1	Billed amount exceeds formula using documented actual cost for DMEPOS	Payment for this item was based on the documented actual cost.		108	Rent/purchase guidelines were not met.	N446	Incomplete/invalid document for actual cost or paid amount.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
DME2	Billed amount exceeds formula using documented actual cost for DMEPOS	Payment for this item was based on the documented actual cost.		108	Rent/purchase guidelines were not met.	N445	Missing document for actual cost or paid amount.
DME3	Billing for purchase is received after cost of unit was paid through rental charges.	Charge is denied as total rental cost of DME has met or exceeded the purchase price of the unit.		108	Rent/purchase guidelines were not met.		
DME4	Billed amount exceeds formula using documented actual cost for DMEPOS	Payment for this item was based on the documented actual cost.		W1	Workers' Compensation State Fee Schedule Adjustment		
SPECIAL SERVICES							
SS1	A physician, other than the Primary Treating Physician or designee submits a Progress and or Permanent and Stationary Report for reimbursement.	The Progress report and or Permanent and Stationary Report were disallowed as you are not the Primary Treating Physician or his/her designee.		B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N450	Covered only when performed by the primary treating physician or the designee.
SS2	Non-reimbursable report is billed.	This report does not fall under the guidelines for a Separately Reimbursable Report found in the General Instructions Section of the Physician's Fee Schedule.		W1	Workers' Compensation State Fee Schedule Adjustment	N390	This service/report cannot be billed separately.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
SS3	No request was made for Chart Notes or Duplicate Report.	Chart Notes/ Duplicate Reports were not requested		96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N390	This service/report cannot be billed separately.
SS4	Missed appointment is billed.	No payment is being made, as none is necessarily owed		W1	Workers' Compensation State Fee Schedule Adjustment	N441	This missed appointment is not covered.
FACILITY							
F1	Procedure is on the Inpatient Only list. Needs advanced authorization in order to be performed on an outpatient basis.	No reimbursement is being made as this procedure is not usually performed in an outpatient surgical facility. Prior authorization is required but was not submitted.		197	Precertification/ authorization/ notification absent.		
F2	Charge submitted for facility treatment room for non-emergent service.	Treatment rooms used by the physician and/or hospital treatment rooms for non-emergency services are not reimbursable per the Physician's Fee Schedule Guidelines.		40	Charges do not meet qualifications for emergent/urgent care.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
F3	Paid under a different fee schedule.	Service not reimbursable under Outpatient Facility Fee Schedule. Charges are being paid under a different fee schedule.	Specify which other fee schedule.	W1	Workers' Compensation State Fee Schedule Adjustment	N442	Payment based on an alternate fee schedule.
F4	No payment required under Outpatient Facility Fee Schedule	Service not paid under Outpatient Facility Fee Schedule.		W1	Workers' Compensation State Fee Schedule Adjustment	130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
F5	Billing submitted without HCPCS codes	In accordance with OPPS guidelines billing requires HCPCS coding.		W1	Workers' Compensation State Fee Schedule Adjustment	M20	Missing/incomplete/invalid HCPCS.
F6	Facility has not filed for High Cost Outlier reimbursement formula.	This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation. The bill will be reimbursed using the regular reimbursement methodology.		W1	Workers' Compensation State Fee Schedule Adjustment	N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation.

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
MISC.							
M1	Bill submitted for non compensable claim	Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.		214	Workers' Compensation claim adjudicated as non-compensable. This Payor not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only)		
M2	Appeal /Reconsideration	No additional reimbursement allowed after review of appeal/reconsideration.		193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.		
M3	Third Party Subrogation	Reduction/denial based on subrogation of a third party settlement.		215	Based on subrogation of a third party settlement		
M4	Claim is under investigation	Extent of injury not finally adjudicated. Claim is under investigation.		221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution		
M5	Medical Necessity Denial. You may submit a request for an appeal/reconsideration.	Medical Necessity Denial. You may submit a request for an appeal/reconsideration.		50	These are non-covered services because this is not deemed a 'medical necessity' by the payor.		

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
M6	Appeal/ Reconsideration denied based on medical necessity.			50	These are non-covered services because this is not deemed a 'medical necessity' by the payor.	N10	Payment based on the findings of a review organization/ professional consult/manual adjudication/ medical or dental advisor.
M7	This claim is the responsibility of the employer. Please submit directly to employer.			109	Claim not covered by this payor/ contractor. You must send the claim to the correct payor/ contractor. (CARC) 109 is to be used with qualifier PR in NM1 to indicate the employer entity.		

2.0 Matrix List in CARC Order

DWC Bill Adjustment Reason Code	CARC	RARC
G59	4	
G63	8	
PM1	8	
G55	11	
G72	15	
G9	16	N350
G10	16	N29
G11	16	M30
G12	16	N236
G13	16	N240
G14	16	M31
G15	16	N451
G16	16	N452
G17	16	M118
G18	16	N456
G19	16	N455
G20	16	N497
G21	16	N498
G22	16	N499
G23	16	N500
G24	16	N501
G25	16	N502
G26	16	N503
G27	16	N504
G28	16	N453
G29	16	N454
G30	16	N26
G31	16	N455
G32	16	N456
G33	16	N394
G34	16	N393
G35	16	N396

DWC Bill Adjustment Reason Code	CARC	RARC
G36	16	N395
G37	16	N458
G38	16	N457
G39	16	N460
G40	16	N459
G41	16	N462
G42	16	N461
G43	16	N464
G44	16	N463
G45	16	N466
G46	16	N465
G47	16	N468
G48	16	N467
G49	16	N493
G50	16	N494
G51	16	N495
G52	16	N496
G66	16	N443
PM2	16	N435
S8	16	M29
S9	16	N233
A2	16	N463
A3	16	N464
A4	16	N203
A6	16	N439
		N440
G73	17	N66
G56	18	
G73	31	
G69	38	
G70	39	N175
G62	40	
A5	40	
F2	40	
G4	45	
G74	50	

DWC Bill Adjustment Reason Code	CARC	RARC
M5	50	
M6	50	N10
S11	54	N130
PM8	59	
PM9	59	N130
S1	59	
S4	59	N130
G65	89	N130
P2	91	
EM1	95	M15
SS3	96	N390
G7	97	
G8	97	M15
G58	97	N390
S2	97	
S3	97	M144
A1	97	N130
CL1	97	M15
PM4	107	N122
DME1	108	N446
DME2	108	N445
DME3	108	
G75	109	
M7	109	
G61	112	
G77	119	N436
G78	119	
PM3	119	N362
PM5	119	N130
PM6	119	N362
G67	131	
G64	134	
G54	150	N22
EM2	150	N130
G76	151	
PM7	151	N362

DWC Bill Adjustment Reason Code	CARC	RARC
EM3	152	
G5	162	M118
PM11	170	
G53	175	N378
		N388
	176	N349
		N389
		M123
G60	191	
M2	193	
G57	197	
F1	197	
G68	198	N435
PM12	198	
M1	214	
M3	215	
G71	216	
G3	220	
M4	221	
SS1	B7	N450
G1	W1	
G2	W1	N448
G6	W1	N130
PM10	W1	N435
S5	W1	N22
S6	W1	N130
S7	W1	N130
S10	W1	N514
P1	W1	N447
DME4	W1	
SS2	W1	N390
SS4	W1	N441
F3	W1	N442
F4	W1	130

DWC Bill Adjustment Reason Code	CARC	RARC
F5	W1	M20
F6	W1	N444

3.0 Field Table Standard Explanation of Review

California DWC EOR Requirements			
Paper Field	Field Description	Workers' Compensation Paper Fields R/S/O/NA	Comments
1	Date of Review	R	Date of Review
2	Purpose	N/A	Not Applicable for California Paper EOR forms.
3	Method of Payment	R	Paper Check or EFT
4	Payment ID Number	R	Paper Check Number or EFT Tracer Number
5	Payment Date	R	
6	Payor Name	R	
7	Payor Address	R	
8	Payor Identification Number	O	Payor Identification Number (FEIN).
9	Payor Contact Name	S	Additional claim administration contact information e.g., Adjustor ID reference for appeal contact
10	Payor Contact Phone Number	S I	Additional claim administration contact information e.g., Adjustor ID reference for appeal contact
11	Jurisdiction	O	The state that has jurisdictional authority over the claim
12	Pay-To Provider Name	R	
13	Pay-To Provider Address	R	
14	Pay-To Provider TIN	R	
14a	Pay- To Provider State License Number	S	If additional payee ID information is required. This applies only to billing provider health entities
15	Patient Name	R	Patient Name
16	Patient Social Security Number	R	
17	Patient Address	O	
18	Patient Date of Birth	O	
19	Employer Name	R	Employer Name
20	Employer ID	R	Employer ID assigned by Payor
20a	Employer Address	O	
21	Rendering Provider Name	R	
22	Rendering Provider ID	R	Rendering Provider NPI Number
23	PPO/MPN Name	S	Required if a PPO / MPN reduction is used
24	PPO/MPN ID Number	S	State License Number or Certification Number
25	Not Applicable	N/A	
26	Not Applicable	NA	
27	Claim Number	R	Workers' Compensation Claim Number assigned by payor
28	Date of Accident	R	
29	Payor Bill Review Contact Name	R	
30	Payor Bill Review Phone Number	R	
Bill Payment Information			
31	Bill Submitter's Identifier	R	Patient Control /Unique Bill Identification Number assigned by provider
32	Payment Status Code	R	Payment Status Code Indicates if the bill is being Paid, Denied, or a Reversal of Previous Payment. Payment Status Codes: Paid = (1) Denied = (4) Reversal of Previous Payment = (22)

Paper Field	Field Description	Workers' Compensation Paper Fields R/S/O/NA	Comments
33	Total Charges	R	
34	Total Paid	R	
35	Claim Filing Indicator Code	O	Claim Filing Indicator Code WC represents the type of Claim coverage (Workers' Compensation = WC)
36	Payor Bill ID Number	R	The tracking number assigned by payor/bill review entity
37	Bill Frequency Type	S	Required if Institutional bill
38	Diagnostic Related Group Code	S	Required if payment is based on DRG
39	Service Dates	R	
40	Date Bill Received	R	
Bill Level Adjustment Information- Situational			
Payor may use the bill level adjustment codes if an adjustment causes the amount paid to differ from the amount originally charged. The Bill Level Adjustment is used when an adjustment cannot be made to a single service line. The bill level adjustment is not a roll up of the line adjustments. The total adjustment is the sum of the bill and line level adjustment			
41	DWC Bill Adjustment Reason Code and Description	S	Refer to Section One Appendix B for Bill Adjustment Reason Codes and Descriptions
42	Adjustment Amount	S	
43	Adjustment Quantity	S	
Service Payment Information			
44	Paid Procedure Code	R	The service code used for the actual review, revenue, HCPCS/CPT, or NDC. Includes modifiers if applicable
45	Charge Amount	R	
46	Paid Amount	R	A zero amount is acceptable
46a	Revenue Code	S	Required when used in the review in addition to the HCPCS/CPT procedure code
47	Paid Units	R	
48	Billed Procedure Code	S	Required if different from the procedure code used for the review
49	Billed Units	S	Required if different from the units used for the review
50	Date of Service	R	
51	Prescription Number	S	Required for Retail Pharmacy and DME only
Service Level Adjustment			
52	DWC Bill Adjustment Reason Code and Descriptor	S	Refer to Section One Appendix B for Bill Adjustment Reason Codes and Descriptors.
53	Adjustment Amount	S	
54	Adjustment Quantity	S	

Section Two – Transmission Standards

For electronic transactions on or after XXXX, 2011 [18 months after effective date of regulation], the Division adopts the electronic standard formats and related implementation guides set forth below, as the mandatory transaction standards for electronic billing, acknowledgment, remittance and documentation, except for standards identified as optional.

The Division has adopted HIPAA – compliant standards wherever feasible.

1.0 California Electronic Medical Billing and Payment Companion Guide

The Companion Guide is a separate document which contains detailed information for electronic billing and payment. Compliance with the Companion Guide is mandatory as it has been adopted as a regulation. The Companion Guide may be downloaded from the Division's website: http://www.dir.ca.gov/dwc/dwc_home_page.htm.

2.0 Electronic Standard Formats

2.1 Billing:

(a) Dental Billing: The ASC X12N 837 -- Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097 and Addenda to Health Care Claim: Dental, Version 4010, October 2002, Washington Publishing Company, 004010X097A1.

(b) Professional Billing: The ASC X12N 837 -- Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098 and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1.

(c) Institutional/Hospital Billing: The ASC X12N 837 -- Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096 and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X096A1.

(d) Retail Pharmacy Billing:

(i) The Telecommunication Standard Implementation Guide Version 5, Release 1 (Version 5.1), September 1999, National Council for Prescription Drug Programs.

(ii) The Batch Standard Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000, supporting Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record, National Council for Prescription Drug Programs.

2.2 Acknowledgment:

(a) Electronic responses to ASC X12N 837 transactions:

(i) The TA1 Interchange Acknowledgment contained in the adopted ASC X12N 837 standards.

(ii) The 997 Functional Acknowledgment contained in the adopted ASC X12N 837 standards.

(b) Electronic responses to NCPDP Pharmacy transactions:

The Responses contained in the adopted NCPDP Telecommunication Standard Implementation Guide Version 5.1 and the Standard Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000.

(c) The ASC X12N 277: Health Care Claim Acknowledgement Version 4040, February 2004, Washington Publishing Company, 004040X167.

2.3 Remittance:

The ASC X12N 835 -- Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, Washington Publishing Company, 004010X091A1.

2.4 Documentation / Attachments to Support a Claim:

(a) The ASC X12N 275 -- Additional Information to Support a Health Care Claim or Encounter, Version 4050, June 2004, Washington Publishing Company, 00450X151. [Optional.]

(b) The ASC X12N 277 Health Care Claim Request for Additional Information, Version 4050, June 2004, Washington Publishing Company, 004050X150 [Optional.]

3.0 Obtaining Transaction Standards/Implementation Guides

All transaction standards / implementation guides (except NCPDP retail pharmacy) can be purchased from:

Washington Publishing Company (425) 831-4999 or <http://www.wpc-edi.com>
301 West North Bend Way, Suite 107
P.O. Box 15388, North Bend, WA 98045

NCPDP Telecommunication Standard Implementation Guide can be purchased from:

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

4.0 Electronic Signature

An electronic or digital signature shall be recognized as valid if it conforms to the requirements for digital signatures under Government Code § 16.5 and the Secretary of State's implementing regulations at Title 2, California Code of Regulations §§ 22000 – 22003, or if it conforms to other provisions of law. (See Electronic Medical Billing and Payment Companion Guide, Appendix E.)

The Secretary of State's "Approved List of Digital Signature Certification Authorities" can be accessed on the web at: <http://www.sos.ca.gov/digsig/>.

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

Version 1.0
2010



California Electronic Medical Billing and Payment Companion Guide

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

This guide has been adopted in Title 8, California Code of Regulations section 9792.5.1 as part of the Division of Workers' Compensation billing regulations. It has been created for use in conjunction with national standard implementation guides of the Accredited Standards Committee (ASC X12), and the National Council for Prescription Drug Programs (NCPDP) which have been adopted by the U.S. Secretary of Health and Human Services for use pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specified ASC X12 and NCPDP electronic standards have been incorporated by reference into this guide.

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

Other Important Billing Rules

Other important billing rules are contained in:

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

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

California Companion Guide Contact Information

Division of Workers' Compensation, Medical Unit

P.O. Box 71010

Oakland, CA 94612

Attn: Electronic Billing

(510) 286- 3700 phone (510) 286-0693 FAX

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

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Chapter 1 Introduction and Overview

1.1 HIPAA

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

1.2 California Labor Code § 4603.4

California Labor Code § 4603.4 mandates that California employers accept electronic bills for medical goods and services. Electronic billing is optional for medical providers and health facilities. The statute provides that the regulations which establish electronic billing rules be consistent with HIPAA to the extent feasible. The health care provider, health care facility, or third-party biller/assignee shall use the HIPAA adopted ASC X12N 837 Professional, Institutional or Dental transaction formats to submit medical bill transactions or the NCPDP Telecommunication 5.1 and NCPDP Batch Standard 1.1 to submit pharmacy bill transactions to the appropriate claims administrator associated with the employer of the injured employee to whom the services are provided.

In workers' compensation, the payor is the Claims Administrator providing coverage for the employer of the injured employee to whom the services are provided. The Claims Administrator, or its authorized agent, is to validate the Electronic Data Interchange (EDI) file according to the guidelines provided in the prescribed national standard format implementation guide, this companion guide, and the jurisdiction data requirements. Problems associated with the processing of the EDI file are to be reported using acknowledgment transactions specified in this companion guide. The Claims Administrator will use the HIPAA adopted ASC X12N 835 Remittance Advice to report an explanation of payments, reductions, and denial to the health care provider, health care facility, or third-party biller/assignee.

Health care providers, health care facilities, or third-party biller/assignees, claims administrators, clearinghouses, or other electronic data submission entities shall use this guideline in conjunction with HIPAA adopted ASC X12N national implementation guides, the NCPDP Telecommunication 5.1, the NCPDP Batch Standard 1.1 and other specified national implementation guides. The ASC X12N implementation guides can be accessed by contacting the Washington Publishing Company at <http://www.wpc-edi.com>. The NCPDP Telecommunication 5.1 and Batch Standard 1.1 are available from NCPDP at www.ncpdp.org.

This guide supplements the national standard implementation guides and specifies clarifications where necessary to adapt the national standards for use in the California workers' compensation system. Wherever there is a difference between the national standard and this guide, the rules from this guide prevail.

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

Chapter 2 California Workers' Compensation Requirements

2.1 Compliance

California Labor Code § 4603.4 (a) (2) requires claims administrators to accept electronic submission of medical bills. Claims administrators must be able to accept electronic medical bills and adhere to the requirements of this guide by XXXX, 2011 [approximately 18 months after adoption]. The entity submitting the bill has the option of submitting bills on paper or electronically.

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

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

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

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

2.1.2 Agents

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

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

2.1.3 Confidentiality of Medical Information Submitted on Electronic Claims/ Security

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

2. 2 National Standard Formats

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

- Health Care Claim: Professional ASC X12N 837 (004010X098A1);
- Health Care Claim: Institutional ASC X12N 837 (004010X096A1);
- Health Care Claim: Dental ASC X12N 837 (004010X097A1);
- Health Care Claim Payment/Advice ASC X12N 835 (004010X091A1);

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- NCPDP Telecommunication Standard Implementation Guide 5.1; and
- NCPDP Batch Standard Implementation Guide 1.1

The TA 1 Acknowledgment and the 997 Functional Acknowledgment are contained within the ASC X12N 835 (004010X091A1) implementation guide adopted in the HIPAA rules. The ASC X12N TA1 is used to communicate the syntactical analysis of the interchange header and trailer. The ASC X12 997 Functional Acknowledgment, version 4010, is used to communicate acceptance or rejection of a transmission (file).

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

- Health Care Claim Acknowledgement ASC X12N 277 (used to communicate acceptance or rejection of a bill transaction, and to communicate that the bill has been put into pending status)
- Health Care Claim Request for Additional Information ASC X12N 277 (may be used to request additional attachments that were not originally submitted with the electronic medical bill and that are needed to process the payment)
- Additional Information to Support a Health Care Claim or Encounter, ASC X12N 275 version 4050 (may be used to transmit electronic documentation associated with an electronic medical bill; may accompany the original electronic medical bill, or be in response to a 277 Request for Additional Information)

The NCPDP Telecommunication Standard Version 5.1 and the NCPDP Batch Standard Implementation Guide 1.1 contain the corresponding acknowledgement and error messages to be used for NCPDP transactions.

2.2.1 California Prescribed Formats

For electronic transactions on or after XXXX, 2011 [18 months after effective date of regulation], the Division incorporates by reference and adopts the electronic standard formats and related implementation guides set forth below, as the mandatory transaction standards for electronic billing, acknowledgment, remittance and documentation, except that standards identified as optional are recommended rather than mandatory.

The Division has adopted HIPAA – compliant standards wherever feasible.

(1) Billing:

(a) Dental Billing: The ASC X12N 837 -- Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097 and Addenda to Health Care Claim: Dental, Version 4010, October 2002, Washington Publishing Company, 004010X097A1.

(b) Professional Billing: The ASC X12N 837 -- Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098 and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1.

(c) Institutional/Hospital Billing: The ASC X12N 837 -- Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096 and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X096A1.

(d) Retail Pharmacy Billing:

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(i) The Telecommunication Standard Implementation Guide Version 5, Release 1 (Version 5.1), September 1999, National Council for Prescription Drug Programs.

(ii) The Batch Standard Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000, supporting Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record, National Council for Prescription Drug Programs.

(2) Acknowledgment:

(a) Electronic responses to ASC X12N 837 transactions:

(i) The TA1 Interchange Acknowledgment contained in the adopted ASC X12N 837 standards.

(ii) The 997 Functional Acknowledgment contained in the adopted ASC X12N 837 standards.

(b) Electronic responses to NCPDP Pharmacy transactions:

The Responses contained in the adopted NCPDP Telecommunication Standard Implementation Guide Version 5.1 and the Batch Standard Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000.

(c) The ASC X12N 277: Health Care Claim Acknowledgement Version 4040, February 2004, Washington Publishing Company, 004040X167.

(3) Remittance:

The ASC X12N 835 -- Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, Washington Publishing Company, 004010X091A1.

(4) Documentation / Attachments to Support a Claim:

(a) The ASC X12N 275 -- Additional Information to Support a Health Care Claim or Encounter, Version 4050, June 2004, Washington Publishing Company, 004050X151. [Optional.]

(b) The ASC X12N 277 Health Care Claim Request for Additional Information, Version 4050, June 2004, Washington Publishing Company, 004050X150 [Optional.]

2.2.2 Summary of Adopted Formats and Correlation to Paper Form

Format	Corresponding Paper Form	Function
837P 004010X098A1	CMS-1500	Professional Billing
837I 004010X096A1	UB-04	Institutional/Hospital Billing
837D 004010X97A1	ADA-2006	Dental Billing
NCPDP 5.1	NCPDP UCF	Pharmacy Billing
NCPDP Batch 1.1	None	Pharmacy Billing
835 004010X091A1	None	Explanation of Review (EOR)
TA1 004010	None	Interchange Acknowledgement
997 004010	None	Transmission Level Acknowledgment
277 004040X167	None	Health Care Claim [Bill]Acknowledgment

2.2.3 Optional Formats

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

Format	Corresponding Process	Function
275 004050X151	Documentation/Attachments	Documentation/Attachments
277 004050X150	Documentation/Attachments	Request for Additional Information

2.4 Companion Guide Usage

California workers' compensation implementation of the national standard formats aligns with HIPAA usage and requirements in most circumstances. This Companion Guide is intended to convey information that is within the framework of the *ASC X12N Implementation Guides* and *NCPDP Telecommunication Standard Version 5.1 Implementation Guide* and *NCPDP Batch Standard 1.1* adopted for use. The Companion Guide supplements the implementation guides by providing additional instruction on situational implementation factors that are different in workers' compensation than the HIPAA implementation.

When the workers' compensation application situation needs additional clarification or a specific code value is expected, the Companion Guide includes this information in a table format. Shaded rows represent "segments" in the *ASC X12N Implementation Guide*. Non-shaded rows represent "data elements" in the *ASC X12N Implementation Guide*. An example is provided in the following table:

Loop	Segment or Element	Value	Description	California Workers' Compensation Instructions
2000B	SBR		Subscriber Information	In Workers' Compensation, the Subscriber is the Employer
	SBR04		Group or Plan Name	Required when the Employer Department Name/Division is applicable and is different than the Employer reported in Loop 2010BA NM103.
	SBR09	WC	Claim Filing Indicator Code	Value must be 'WC' to indicate Workers' Compensation bill.

Detailed information explaining the various components of the use of loops, segments, data elements, and conditions can be found in the appropriate *ASC X12N Implementation Guide*.

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

2.5 Description of ASC X12 Transaction Identification Numbers

The ASC X12 Transaction Identification requirements are defined in the appropriate *ASC X12N Implementation Guides*, available through the Washington Publishing Company at <http://www.wpc-edi.com>. The Division provides the following additional information regarding transaction identification number requirements:

2.5.1. Sender/Receiver Trading Partner Identification

Workers' compensation standards require the use of the Federal Employer Identification Number (FEIN) or other mutually agreed upon identification numbers to identify Trading Partners (sender/receiver) in electronic billing and reimbursement transmissions. Trading Partners will exchange the appropriate and necessary identification numbers to be reported in Loops 1000A and 1000B (Sender and Receiver).

2.5.2 Claims Administrator Identification

Claims Administrators, and their agents, are also identified through the use of the FEIN or other mutually agreed upon identification number. Claims administrator information is available through direct contact with the claims administrator. For ASC X12N 837 Professional and Dental transactions, the Claim Administrator Identification information is populated in Loop 2010BB and in the 837 Institutional, Loop 2010BC (Payor Information).

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

2.5.3 Health Care Provider Identification

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

2.5.4 Injured Employee Identification (Member ID Number)

The injured employee is identified by Social Security Number, date of birth, date of injury and workers' compensation claim number (see below). Social Security Number (SSN) fields are required in electronic billing and reimbursement formats. When a SSN is not available, the health care provider, health care facility, or third-party biller/assignee must report a default 9- digit code of 999999999 in the SSN data element.

The Social Security Identification Number is populated in NM109 segment of Loop 2010BA.

2.5.5 Claim Identification

The workers' compensation claim number assigned by the claim administrator is the claim identification number. This claim identification number is reported in the REF segment of Loop 2010CA, Property and Casualty Claim Number.

The California companion guide instructions for the claim identification REF02 segment of Loop 2010CA differ from the ASC X12N 837 Implementation Guide.

The California Instructions for the claim identification REF02 segment requires the health care provider, health care facility, or third-party biller/assignee to submit the claim identification number, if known. If the claim identification number is not known, then the required value must be "Unknown" and be reported in the REF02 segment.

2.5.6 Bill Identification

The *ASC X12N Implementation Guides* refer to a bill as a "claim" for electronic billing transactions. This companion guide refers to these transactions as "bill" in order to avoid confusion, because in workers' compensation, the term "claim" is generally used to refer to a unique injured employee and injury.

The health care provider, health care facility, or third-party biller/assignee, assigns a unique identification number to the electronic bill transaction. For ASC X12N 837 transactions, the bill transaction identification number is populated in Loop 2300 Claim Information CLM Health Claim Segment CLM01 Claim (Bill) Submitter's Identifier data element. This standard HIPAA implementation allows for a patient account number but strongly recommends that submitters use completely unique number for this data element on each individual bill.

2.5.7 Document/ Attachment Identification

The ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter is the standard electronic format for submitting electronic documentation and is addressed in a later chapter of this companion guide.

Documentation, or the attachment, is identified in the ASC X12N 837 format in PWK Claim Supplemental Information (Attachment) Segment in Loop 2300. The PWK Claim Supplemental Information (Attachment) Segment indicates that an attachment is expected, the type of attachment, delivery method (i.e. electronic, email or fax) and an attachment control number. It is the combination of these attachment identification data elements that will allow a claims administrator to appropriately match the incoming attachment to the electronic medical bill.

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

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

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

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

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

It is recognized that the code sets currently available for version 4010A1 do not include some of the workers' compensation specific codes to identify the type of medical report. The ASC X12N 5010 Standard Report Type Codes do include specific workers' compensation report type codes. In an effort to enhance the communication between the health care provider and claims administrator, the use of specific ASC X12N 5010 Report Type Codes, defined as Jurisdictional Report Type Codes may be used in this implementation.

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

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

2.6 Claims Administrator Validation Edits

Claims Administrators may apply validation edits based on California DWC Workers’ Compensation Billing and Payment Guide rules, *ASC X12N Implementation Guide* requirements, and, to the extent that they have been adopted by the DWC for workers’ compensation, Medicare policies or rules. Claims administrators may not apply Medicare policies or rules that have not been adopted by the DWC.

Claims Administrators use the ASC X12N 277 Health Care Claim Acknowledgement, referred to in this companion guide to communicate acceptance or rejection of a bill transaction. The 277 details what errors are present, and if necessary, what action the submitter should take. ASC X12N 277 Error rejection codes are used to indicate the reason for the transaction rejection.

2.7 Description of Formatting Requirements

The ASC X12 Formatting requirements are defined in the *ASC X12N Implementation Guides*, Appendices A.1, available through the Washington Publishing Company at <http://www.wpc-edi.com>. The Division has provided additional information regarding the ASC X12N 837 Hierarchical structure for workers’ compensation billing.

2.7.1 Hierarchical Structure

For California workers’ compensation, it is assumed that these formats are used to communicate information at the transaction level, with the exception of the ASC X12 997 Acknowledgment. To that end, the parent/child hierarchical structure requires each transaction to contain the necessary hierarchical levels, parent/child qualifiers, and parent/child relationships.

Each transmission must contain at least one Billing Provider loop containing at least one Subscriber child loop, where the Subscriber is the Workers’ Compensation Employer. Each Subscriber loop must contain at least one Patient child loop, where the Patient is the Workers’ Compensation Injured Employee.

Beneath the hierarchical levels, the same logic applies to Injured Employees, bills, and service lines. Each Injured Employee record must contain at least one bill transaction; each bill transaction must contain at least one service line. The maximum number of bills and lines is determined by format standard.

For more information on how the HL Structure works refer to Section 2.3.2.1 HL Segment of the *ASC X12N Implementation Guides* available through the Washington Publishing Company at <http://www.wpc-edi.com>.

2.8 Description of Transmission/Transaction Dates

The ASC X12 required Transmission/Transaction Dates are defined in the *ASC X12N Implementation Guides* available through the Washington Publishing Company at <http://www.wpc-edi.com>.

2.9 Description of Code Sets

Code sets utilized in electronic billing and reimbursement and other ancillary processes are prescribed by the applicable workers’ compensation medical fee schedule, *ASC X12N Implementation Guides*, NCPDP Implementation Guide, Division rule, this companion guide and the California Division of Workers’

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Compensation Medical Billing and Payment Guide. The code sets are maintained by multiple standard setting organizations.

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

Information regarding Code Sets (Internal Transaction Codes and External Codes) utilized in ASC X12N electronic transactions are available through the Washington Publishing Company at <http://www.wpc-edi.com>.

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

There is currently no dental fee schedule. Dental Codes have been adopted by incorporation by reference of *Current Dental Terminology, Fourth Edition* (CDT-4) of the American Dental Association into the California Division of Workers' Compensation Medical Billing and Payment Guide.

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

2.10 Participant Roles

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

2.10.1 Trading Partner

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

2.10.2 Sender

A Sender is the entity submitting a transmission to the receiver, or the Trading Partner. The health care provider, health care facility, or third-party biller/assignee, is the Sender in the ASC X12N 837 electronic billing process. The Claims Administrator, or its agent, is the Sender in the ASC X12 997 or ASC X12N 277 Health Care Claim Acknowledgement or ASC X12N 835 remittance processes.

2.10.3 Receiver

A Receiver is the entity that accepts a transmission submitted by a Sender. The health care provider, health care facility, or third-party biller/assignee, is the Receiver in the ASC X12 997 or ASC X12N 277 Health Care Claim Acknowledgement or ASC X12N 835 remittance processes. The Claims Administrator, or its agent, is the Receiver in the ASC X12N 837 electronic billing processes.

2.10.4 Employer

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

2.10.5 Subscriber

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

2.10.6 Insured

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

2.10.7 Injured Employee

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

2.10.8 Patient

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

2.11 Health Care Provider Agent/Claims Administrator Agent Roles

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

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

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

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

2.12 Duplicate, Appeal/Reconsideration and Corrected Bill Resubmissions

2.12.1 Claim Resubmission Code - ASC X12N 837 Billing Formats

Health care providers will use the Claim Frequency Type Code of 7 (Resubmission/Replacement) to identify resubmissions of prior medical bills (not including duplicate original submissions). (The NUBC Instruction for the use of Claim Frequency Type Codes can be referenced on the NUBC website at http://www.nubc.org/FL4forWeb2_RO.pdf) The value is populated in Loop 2300 Claim Information CLM Health Claim Segment CLM05-3 Claim Frequency Type Code of ASC X12 837 billing formats. The health care provider must also populate the Document Control Number/Internal Control Number assigned to the bill by the insurance carrier for the bill being replaced, when the payor has provided this number in response to the previous bill submission. This information is populated in Loop 2300 Claim Information REF Original Reference Number (ICN/DCN) of ASC X12N 837 billing formats.

Health care providers must also populate the appropriate NUBC Condition Code to identify the type of resubmission on electronically submitted medical bills. The Condition Code is submitted based on the instructions for each bill type, in the Institutional (HI Segment), Professional (K3 Segment) or Dental (NTE

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Segment). Condition codes provide additional information to the claims administrator when the resubmitted bill is a request for reconsideration.

2.12.2 Duplicate Bill Transaction Prior To Payment

A Condition Code “W2” (Duplicate of the original bill) is required when submitting a bill that is a duplicate. The Condition Code is submitted based on the instructions for each bill type, in the Institutional (HI Segment), Professional (K3 Segment) or Dental (NTE Segment). The duplicate bill must be identical to the original bill, with the exception of the added Condition Code. No new dates of service or itemized services may be included.

Duplicate Bill Transaction
<ul style="list-style-type: none">• CLM05-3 = Identical value as original. Cannot be “7”;• Condition codes in HI/K3//NTE are populated with a condition code qualifier ‘BG’ and code value:W2=Duplicate• Example: K3*BGW2• Original Reference Number does not apply• The resubmitted bill must be identical to the original bill, except for the W2 condition code. No new dates of service or itemized services may be included

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

The Claims Administrator may reject a bill transaction with a Condition Code W2 indicator if (1) the duplicate bill is received within fifteen (15) working days after transmission of the 997 acknowledgment, (2) the bill has been processed and an ASC X12N 835 transaction has been generated, or (3) the Claims Administrator does not have a corresponding accepted original transaction with the same bill identification numbers. The duplicate bill transaction may be denied through the use of an ASC X12N 835 Healthcare Claim Remittance Advice transaction.

2.12.3 Corrected Bill Transactions

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

The replacement bill should be identical to the original except for the corrections. Its identifying information should be changed to reflect its status as a corrected bill. The provider must populate the Original Document Control Number/Internal Control Number assigned to the bill by the claims administrator when the payor has provided this number in response to the previous bill submission. This information is populated in Loop 2300 Claim Information REF*F8 Segment: Original Reference Number (ICN/DCN) of ASC X12N 837 billing formats.

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

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

Corrected Bill Transaction

- CLM05-3 = 7 indicates a Replacement Bill
- Condition codes of W2 to W5 in HI/K3/NTE are not used;
- REF*F8 includes the claims administrator's Original Reference Number, if assigned by the payor.
- A corrected bill shall include the original dates of service and the same itemized services rendered as the original bill.
- When identifying elements change, the "correction" is accomplished by a "void" and re-submission process
- A bill with CLM05-3 = 8 (Void) must be submitted to cancel the incorrect bill, followed by the submission of a new original bill with the correct information.

The Claims Administrator may reject a revised bill transaction if (1) the Claims Administrator does not have a corresponding adjudicated bill transaction with the same bill identification number or (2) inadequate documentation supporting the request for correction. The revised bill transaction may be denied through the use of an ASCX12N 835 Healthcare Claim Remittance Advice transaction.

2.12.4 Appeal/Reconsideration Bill Transactions

Electronic submission of Reconsideration transactions is accomplished in the ASC X12N 837 billing format through the use of Claim Frequency Type Code 7 in Loop 2300 Claim Information CLM Health Claim Segment CLM05-3 Claim Frequency Type Code. The value '7' Replacement of a Prior Claim represents Resubmission transactions.

The Reconsideration Claim Frequency Type Code '7' is used in conjunction with the Original Internal Control Number/Document Control Number assigned to the bill by the claim administrator when the payor has provided this number in response to the previous bill submission. This information is populated in Loop 2300 Claim Information REF Original Reference Number (ICN/DCN) of ASC X12N 837 billing formats.

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

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

These codes are included in the 2300/K3 segment on professional claims, 2300/HI segment on institutional claims, and 2300/NTE segment on dental claims.

Reconsideration bill transactions may only be submitted after receipt of an ASC X12N 835 Remittance transaction for the corresponding accepted original bill. The same bill identification number is used on both the original and the Reconsideration bill transaction to associate the transactions. All elements, fields, and values in the Reconsideration bill transaction, except the Reconsideration specific qualifiers and PWK Attachment Segment, must be the same as the original bill transaction. Subsequent Reconsideration bill transactions related to the same original bill transaction may be submitted after receipt of an ASC X12N

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835 transaction corresponding to the initial Reconsideration bill transaction. Subsequent Reconsideration bill transactions shall not be submitted prior to the claims administrator taking final action on the original reconsideration request.

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

The *ASC X12 Implementation Guides* and the California Division of Workers' Compensation indicate that the value passed in CLM01 represents a unique identification number specific to the bill transaction, the Provider Unique Bill Identification Number. The California Division of Workers' Compensation implementation links the original bill (parent) to the subsequent bill transaction through the use of the Provider Unique Bill Identification Number (CLM01). The intent is to link an appeal, or multiple subsequent appeals, to a single original parent bill transaction.

The *ASC X12 Implementation Guides* includes a REF Reference Identification Number Segment in Loop 2300 Claim Information that represents an Original Reference Number (ICN/DCN), which is the claims administrator generated unique transaction identification number. This number needs to be included on resubmitted bills to ensure that the payor can match the resubmission request with its original processing action.

Appeal/ Reconsideration Bill Transaction

- CLM05-3 = 7;
- Condition codes in HI/K3/NTE are populated with a condition code qualifier 'BG' and one of the following codes values must be present:
 - W3 = 1st Level Appeal (Request for reconsideration or appeal with the claim administrator)
 - W4 = 2nd Level Appeal (Resubmitted after receipt of a judicial decision and order, typically from Medical Fee Dispute resolution)
 - W5 = 3rd Level Appeal (Resubmitted after receipt of a hearing or other judicial decision and order)
- REF*F8 includes the claim administrators Original Reference Number, if assigned by the payor.
- The appeal/reconsideration bill must be identical to the original bill, with the exception of the added Condition Code, Original Reference Identifier Number (ICN/DCN) and the Claim Frequency Type Code. No new dates of service or itemized services may be included.
- Supporting Documentation is required.
- Loop 2300, PWK Segment must be properly annotated.

The Claims Administrator may reject an appeal/reconsideration bill transaction if (1) the bill information does not match the corresponding original bill transaction, (2) the Claims Administrator does not have a corresponding accepted original transaction, (3) the original bill transaction has not been completed (no corresponding ASC X12N 835 Remittance transaction or the Remittance submission has been sent.), (4) the bill is submitted without the PWK annotation. Corresponding documentation related to appeals/reconsideration is required in accordance with the Division's rules for initial bill submission.

The Claims Administrator may deny appeal/reconsideration bill transactions for missing documentation. The bill transaction may be denied through the use of an ASC X12N 835 Healthcare Claim Remittance Advice transaction.

2.13 Balance Forward Billing

Balance forward billing is not permissible. Balance forward bills are bills that include a balance carried over from a previous bill along with additional services.

2.14 California-Specific Requirements that Relate to Multiple Electronic Formats

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

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

2.14.1 Claim Filing Indicator

The ASC X12 N 837 Claim Filing Indicator code for workers compensation is 'WC' populated in Loop 2000B Subscriber Information, SBR Subscriber Information Segment field SBR09.

2.14.2 Transaction Set Purpose Code

The Transaction Set Purpose Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction Segment field BHT02 in ASC X12 837 formats is designated as '00' Original. Insurance Carriers are required to acknowledge acceptance or rejection of transmissions (files) and transactions (bills). Transmissions that are rejected by the insurance carrier are corrected by the provider and are submitted, after correction, as '00' Original transmissions.

2.14.3 Transaction Type Code

The Transaction Type Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction Segment field BHT06 in ASC X12 837 formats is designated as 'CH' Chargeable. Currently, there is not a requirement for health care providers to report electronic medical billing data to the Division. Therefore, code 'RP' (Reporting) is not appropriate for this implementation.

2.14.4 FEIN/NPI

The FEIN is populated in the NM1 Individual or Organizational Name Segment; field NM109, with the appropriate qualifier in field NM108 when required. When the entity is a health care provider, the NPI is populated in the NM1 Segment and the FEIN is populated in the associate REF Reference Identification Segment with the appropriate qualifier.

2.14.5 NCPDP Telecommunication Standard 5.1 Pharmacy Format and NCPDP Batch Standard 1.1

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

2.14.6 Jurisdictional State Code: Compliance State Identification

Anyone exchanging transactions that apply to the California Workers' Compensation State of Jurisdiction must be submitted using the California companion guides, regardless of where the submitter, receiver, provider, or payor are located.

A Jurisdiction State Code (two byte postal state abbreviation) is required for California workers' compensation medical bills when the state of jurisdiction is different than the Billing Provider or Service Facility address state code. The Jurisdictional State Code assists the receiver, in identifying which jurisdictional specific edits should be applied to a workers' compensation bill.

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The 837 Professional and Institutional Jurisdictional State Code is populated in Loop 2300, K301 and in the Dental NTE Segment. The Jurisdiction State Qualifier is 'LU' followed by the state jurisdiction code (CA= California). Example: California Jurisdictional State Code = LUCA

Chapter 3 Companion Guide 837 Professional

The information contained in this companion guide has been created for use in conjunction with the ASC X12N 837 004010A1 Professional Healthcare Claim Implementation Guide. It should not be considered a replacement for the ASC X12N 837 004010A1 Professional Healthcare Claim Implementation Guide, but rather used as a supplement to the ASC X12N implementation guide. Wherever the national standard differs from the California rules, the California rules prevail.

3.1 Reference Information

The implementation guide for the ASC X12N 837 004010A1 Health Care Claim: Professional is available through the Washington Publishing Company at <http://www.wpc-edi.com>.

3.2 Trading Partner Agreements

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

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

3.3 Workers' Compensation Health Care Claim: Professional ASC X12N 837 Instructions

Instructions for California specific requirements are also provided in Chapter 2 California Workers' Compensation Requirements. The following table identifies the application/instructions for California workers' compensation that are different than the HIPAA implementation:

3.3.1 Health Care Claim: Professional ASC X12N 837 Version 004010X98A1

Loop	Segment or Element	Value	Description	California Workers' Compensation Instructions
1000A	PER		Submitter Contact Information	
1000A	PER03	TE	Communication Number Qualifier	One occurrence of PER Segment must have a value 'TE' -Telephone Number.
1000A	PER04		Communication Number	One value must be the Telephone Number of the submitter.
2000B	HL		Subscriber Hierarchical Level	In Workers' Compensation, the Subscriber is the Employer
2000B	SBR		Subscriber Information	In Workers' Compensation, the Subscriber is the Employer
2000B	SBR04		Group or Plan Name	Required when the Employer Department Name/Division is applicable and is different than the Employer reported in Loop 2010BA, Segment NM103.
2000B	SBR09	WC	Claim Filing Indicator Code	Value must be 'WC' for Workers' Compensation.
2010BA			Subscriber Name	In Workers' Compensation, the Subscriber is the Employer. (i.e., an organization, sole proprietor or company name).
2010BA	NM102	2	Entity Type Qualifier	Value must be '2' non-person.
2010BA	NM103		Last or Organization Name	Value must be the name of the Employer
2010BA	NM108	MI	Identification Code Qualifier	Value must be 'MI' – Member Identification Number
2010BA	NM109		Primary Identifier	Member Identification Number. Enter the patient's Social Security Number. If the patient does not have a Social Security Number then enter the following 9 digit

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Loop	Segment or Element	Value	Description	California Workers' Compensation Instructions
				number: '99999999'.
2010BA	N3		Subscriber Address	Enter Employer Address
2010BA	N4		Subscriber City/State/ Zip Code	Enter Employer City/ State/Zip Code
2000C	PAT01	20	Patient's Relationship to Subscriber	Value must be '20' - Employee
2010CA	REF		Property & Casualty Claim Number	Workers' compensation claim number assigned by the claims administrator. This Segment is Required for California Workers' Compensation.
2010CA	REF02		Workers' Compensation Claim Number	Enter the claim number if known. If not known, then enter the default value ' UNKNOWN'
2300	CLM11		Related Cause Codes	If more than one code applies to the bill, one of the occurrences in CLM11 must have a value of 'EM' for Employment Related.
2300	DTP		Onset of Current Symptom or Illness date	Required when the condition reported is for an occupational illness.
2300	DTP		Accident Date	Required when the condition reported is for an occupational accident/injury.
2300	DTP		Disability Begin Date	Do not use Segment. Leave Blank
2300	DTP		Disability End Date	Do not use Segment. Leave blank
2300	PWK		Claim Supplemental Information	Required when submitting attachments related to the medical bill.
2300	PWK01		Report Type Code	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports use appropriate 004010 Report Type Code.
2300	PWK02		Report Transmission Code	Use the Report Transmission Code 'EL' for file transfers For all other report transmission's use appropriate 004010.Report Transmission Codes with the exception of the 'BM'-By Mail Code which is not allowed under the California Rules.
2300	PWK06		Attachment Control Number	In formatting the attachment control number, always include the Jurisdictional Report Type Code as the first two characters of the attachment control number. Example: J1=Doctor's First Report of Injury: J13456789
2300	K3		File Information	Resubmission Condition Code is required for submitting a bill that is a duplicate or an appeal/reconsideration. Jurisdiction State Code Qualifier is required for California workers' compensation medical bills. , when the Billing Provider or Service Facility State Code is different than the Jurisdiction State Code (compliance state).
2300	K301		State Data Requirement	<u>Resubmission Condition Code</u> Enter the Condition Code Qualifier 'BG' followed by the appropriate resubmission code. 'W2' - Duplicate of Original 'W3' - 1 st Level appeal (request for reconsideration or appeal with claims administrator) 'W4' - 2 nd Level appeal (resubmitted after receipt of judicial decision) 'W5' - 3 rd Level appeal (resubmitted after receipt of hearing or judicial decision) <i>Example: BGW3</i> Note: Do not use condition codes when submitting revised or corrected bill.

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Loop	Segment or Element	Value	Description	California Workers' Compensation Instructions
				<p><u>Jurisdiction State Code Qualifier</u> Enter the Jurisdiction State Code Qualifier 'LU' followed by the state jurisdiction code 'CA' to indicate that California is the Jurisdictional State: Example: LUCA</p>
2300	NTE		Claim Note	When applicable, identify any additional information that needs to be conveyed in the Claim Note Segment. For example, a comment may require additional information to assist in the proper adjudication of the workers' compensation medical bill that is not identified elsewhere within the transaction data set.
2310B			Rendering Provider	Required when loop 2310B is used
2310B	PRV	ZZ	Provider Specialty Code	The Rendering Provider Specialty Information is required for California workers' compensation medical bills.
2410			Drug Identification	Only one repeat of this loop is permitted for workers' compensation medical bills
2420A			Rendering Line Provider	Required when loop 2420A is used.
2420A	PRV	ZZ	Provider Specialty Code	The Rendering Provider Specialty Information is required for California workers' compensation medical bills.

Chapter 4 Companion Guide 837 Institutional

The information contained in this companion guide has been created for use in conjunction with the ASC X12N 837 004010X096 Institutional Healthcare Claim Implementation Guide. It should not be considered a replacement for the ASC X12N 837 004010X096 Institutional Health Care Claim Implementation Guide, but rather used as a supplement to the ASC X12N implementation guide. Wherever the national standard differs from the California rules, the California rules prevail.

4.1 Reference Information

The implementation guide for the ASC X12N 837 004010X096 Health Care Claim Institutional is available through the Washington Publishing Company at <http://www.wpc-edi.com>.

4.2 Trading Partner Agreements

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

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

4.3 Workers' Compensation Health Care Claim: Institutional ASC X12N 837 Instructions

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

4.3.1 Health Care Claim: Institutional ASC X12N 837 Version 00410X096A1

Loop	Segment or Element	Value	Description	California Workers' Compensation Instructions
1000A	PER		Submitter Contact Information	
1000A	PER03	TE	Communication Number Qualifier	One occurrence of PER Segment must have a value 'TE' -Telephone Number.
1000A	PER04		Communication Number	One value must be the Telephone Number of the submitter.
2000B	HL		Subscriber Hierarchical Level	In Workers' Compensation, the Subscriber is the Employer
2000B	SBR		Subscriber Information	In Workers' Compensation, the Subscriber is the Employer
2000B	SBR04		Group or Plan Name	Required when the Employer Department Name/Division is applicable and is different than the Employer reported in Loop 2010BA, Segment NM103.
2000B	SBR09	WC	Claim Filing Indicator Code	Value must be 'WC' – Workers' Compensation.
2010BA	NM1		Subscriber Name	In Workers' Compensation, the Subscriber is the Employer. (i.e., an organization, sole proprietor or company name).
2010BA	NM102	2	Entity Type Qualifier	Value must be '2' non-person.
2010BA	NM103		Last or Organization Name	Value must be the name of the Employer.
2010BA	NM108	MI	Identification Code Qualifier	Value must be 'MI' – Member Identification Number
2010BA	NM109		Primary Identifier	Member Identification Number. Enter the patient's Social Security Number. If the patient does not have a Social Security Number then enter the following 9 digit number: '99999999'.

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Loop	Segment or Element	Value	Description	California Workers' Compensation Instructions
2010BA	N3		Subscriber Address	Enter Employer Address
2010BA	N4		Subscriber City/State/ Zip Code	Specify City/ State/Zip Code
2000C	PAT01	20	Patient's Relationship to Subscriber	Value must be '20' - Employee
2010CA	REF		Property & Casualty Claim Number	Workers' compensation claim number assigned by the insurance carrier This Segment is Required for workers' compensation medical bills submitted electronically.
2010CA	REF02		Workers' Compensation Claim Number	Enter the claim number if known. If not known, then enter the default value ' UNKNOWN'
2300	PWK		Claim Supplemental Information	Required when submitting attachments related to the medical bill.
2300	PWK01		Report Type Code	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports use appropriate 004010 Report Type Code.
2300	PWK02		Report Transmission Code	Use the Report Transmission Code 'EL' for file transfers For all other report transmission's use appropriate 004010.Report Transmission Codes with the exception of the 'BM'-By Mail Code which is not allowed under the California Rules.
2300	PWK06		Attachment Control Number	In formatting the attachment control number, always include the Jurisdictional Report Type Code as the first two characters of the attachment control number. Example: J1=Doctor's First Report of Injury: J13456789
2300	K3		File Information	Jurisdiction State Code Qualifier is required for California workers' compensation medical bills. , when the Billing Provider or Service Facility State Code is different than the Jurisdiction State Code (compliance state).
2300	K301		State Data Requirement	<u>Jurisdiction State Code Qualifier</u> Enter the Jurisdiction State Code Qualifier 'LU' followed by the state jurisdiction code 'CA' to indicate that California is the Jurisdictional State: Example: LUCA.
2300	NTE		Billing Note	When applicable, identify any additional information that needs to be conveyed in the Billing Note Segment. For example, a comment may require additional information to assist in the proper adjudication of the workers' compensation medical bill that is not identified elsewhere within the transaction data set.
2300	HI01		Occurrence Information	At least one Occurrence Code must be entered with value of '04' -Accident/Employment Related or '11' -- illness. The Occurrence Date must be the Date of Occupational Injury or Illness.
2300	HI		Condition Information	Required when a condition code applies. Required when submitting a bill that is a duplicate or an appeal. W2' - Duplicate of Original 'W3' - 1 st Level appeal (request for reconsideration or appeal with claims administrator) 'W4' - 2 nd Level appeal (resubmitted after receipt of judicial decision) 'W5' - 3 rd Level appeal (resubmitted after receipt of hearing or judicial decision) Note: Do not use condition codes when submitting revised or corrected bill

Chapter 5 Companion Guide 837 Dental

This companion guide for the ASC X12N 837 004010X097 Dental Health Care Claim transaction has been created for use in conjunction with the *ASC X12N 837 004010X097 Dental Claim Implementation Guide*. It should not be considered a replacement for the *ASC X12N 837 004010X097 Dental Claim Implementation Guide*, but rather used as a supplement to the ASC X12N implementation guide. Wherever the national standard differs from the California rules, the California rules prevail.

5.1 Reference Information

The implementation guide for the ASC X12 837 004010X097 Health Care Claim: Dental is available through the Washington Publishing Company at <http://www.wpc-edi.com>

5.2 Trading Partner Agreements

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

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

5.3 Workers Compensation Health Care Claim: Dental ASC X12N 837 Instructions

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

5.3.1 Health Care Claim: Dental ASC X12N 837 (004010X097A1)

Loop	Segment or Element	Value	Description	California Workers' Compensation Instructions
1000A	PER		Submitter Contact Information	
1000A	PER03	TE	Communication Number Qualifier	One occurrence of PER Segment must have a value 'TE' -Telephone Number.
1000A	PER04		Communication Number	One value must be the Telephone Number of the submitter.
2000B	HL		Subscriber Hierarchical Level	In Workers' Compensation, the Subscriber is the Employer
2000B	SBR		Subscriber Information	In Workers' Compensation, the Subscriber is the Employer
2000B	SBR04		Group of Plan Name	Required when the Employer Department Name/Division is applicable and is different than the Employer reported in Loop 2010BA, Segment NM103.
2000B	SBR09	WC	Claim Filing Indicator Code	Value must be 'WC' – Workers' Compensation.
2010BA	NM1		Subscriber Name	In Workers' Compensation, the Subscriber is the Employer. (i.e., an organization, sole proprietor or company name).
2010BA	NM102	2	Entity Type Qualifier	Value must be '2' non-person.
2010BA	NM103		Last or Organization Name	Value must be the name of the Employer
2010BA	NM108	MI	Identification Code Qualifier	Value must be 'MI' – Member Identification Number
2010BA	NM109		Primary Identifier	Member Identification Number. Enter the patient's Social Security Number. If the patient does not have a Social Security Number then enter the following 9 digit number: '99999999'.
2010BA	N3		Subscriber Address	In Workers' Compensation, the Subscriber Address is

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Loop	Segment or Element	Value	Description	California Workers' Compensation Instructions
				the address of the Employer.
2010BA	N4		Subscriber City/State/Zip Code	Enter Employer City/State/Zip Code
2000C	PAT01	20	Patient's Relationship to Subscriber	Value must be '20' - Employee
2010CA	REF02		Workers' Compensation Claim Number	Enter the claim number if known. If not known, then enter the default value of 'UNKNOWN'.
2300	CLM11		Related Cause Code	One of the occurrences in CLM11 must have a value of 'EM' -- Employment Related
2300	DTP		Onset of Current Symptom or Illness date	Required when the condition reported is for an occupational illness.
2300	DTP		Accident Date	Required when the condition reported is for an occupational accident/injury.
2300	DTP		Disability Begin Date	Do not use Segment. Leave Blank
2300	DTP		Disability End Date	Do not use Segment. Leave blank
2300	PWK		Claim Supplemental Information	Required when submitting attachments related to the medical bill.
2300	PWK01		Report Type Code	Use appropriate code value or 'OZ' when report is a jurisdictional report.
2300	PWK02		Report Transmission Code	One of the occurrences in CLM11 must have a value of 'EM' -- Employment Related
2300	PWK05	AC	Identification Code Qualifier	Value must be 'AC' Attachment Control Number
2300	PWK06		Attachment Control Number	In formatting the attachment control number, always include the Jurisdictional Report Type Code as the first two characters of the attachment control number. Example: J1=Doctor's First Report of Injury: J13456789
2300	NTE		Remarks	Resubmission Condition Code required for submitting a bill that is a duplicate or an appeal/reconsideration. Jurisdiction State Code Qualifier is required for California workers' compensation medical bills when the Billing Provider or Service Facility State Code is different than the Jurisdiction State Code (compliance state).
2300	NTE01	ADD	Note Reference Code	Value must be 'ADD' – Additional Information
2300	NTE02		Claim Note Text	<u>Resubmission Condition Code</u> – Required when submitting a bill that is a duplicate or an appeal. Enter the Condition Code Qualifier 'BG' followed by the appropriate resubmission code. 'W2' - Duplicate of Original 'W3' - 1 st Level appeal (request for reconsideration or appeal with insurance carrier) 'W4' - 2 nd Level appeal (resubmitted after receipt of judicial decision) 'W5' - 3 rd Level appeal (resubmitted after receipt of hearing or judicial decision) <i>Example: BGW3</i> Note: Do not use condition codes when submitting revised or corrected bill. <u>Jurisdiction State Code Qualifier</u> Enter the Jurisdiction State Code Qualifier 'LU' followed by the state jurisdiction code 'CA' to indicate that California is the Jurisdictional State: Example: LUCA
2310B			Rendering Provider	Required when loop 2310B is used

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

Chapter 6 Companion Guide Pharmacy NCPDP 5.1

This companion guide has been created for use in conjunction with the *NCPDP Telecommunication Standard Implementation Guide Version 5.1* and the *NCPDP Batch Standard Implementation Guide Version 1.1*. It should not be considered a replacement for the NCPDP guides, but rather used as a supplement to the guides. Wherever the NCPDP national standards differ from the California rules, the California rules prevail. The text below includes cross-references to the data fields of the paper NCPDP Universal Claim Form.

6.1 NCPDP Reference

The NCPDP Telecommunication Standard Implementation Guide Version 5.1 that supports the electronic pharmacy billing transaction, along with the NCPDP Data Dictionary (September 1999) and the NCPDP Batch Standard Implementation Guide Version 1.1 are available through the National Council for Prescription Drug Programs (NCPDP), www.ncdp.org.

6.2 Trading Partner Agreements

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

Trading Partners may utilize non-prescribed electronic formats by mutual agreement. The data elements transmitted pursuant to such a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the *NCPDP Telecommunication Standard Implementation Guide Version 5.1* and the *NCPDP Batch Standard Implementation Guide Version 1.1* and the California companion guide.

6.3 Pharmacy Invoice Number

The Prescription/Service Reference Number (4Ø2-D2) (Field #62 on WC/PC UCF) is the reference number assigned by the provider for the dispensed drug/product and/or service provided and will be used to identify the invoice number for electronic billing. Real time and batch electronic pharmacy bill processing uses the specific prescription number to identify an individual, unique pharmacy transaction. Other fields, such as the Service Provider ID (2Ø1-B1) (Field #32 on WC/PC UCF) can be used for uniqueness.

6.4 Billing Date

For electronically submitted claims, the date of service is considered the Billing Date, unless other transactional verification information is provided to the claims administrator to confirm the date the bill was transmitted. This date is communicated in the Claim Segment of the NCPDP Telecommunication Standard Implementation Guide Version 5.1 Date of Service field (4Ø1-D1) (Field #66 on WC/PC UCF), which is included in the Transaction Header Segment.

6.5 Dispensing Pharmacy Billing and Pharmacy Billing Agents

When the dispensing pharmacy is the billing entity, the Federal Employer Identification Number (FEIN) is reported in the Service Provider ID field (2Ø1-B1) at the header level and the NPI Number in the Provider ID field (444-E9) in the Pharmacy Provider Segment.

The current version of the NCPDP Telecommunication Standard Implementation Guide Version 5.1 does not support the use of third party billing agents or pharmacy benefit managers (PBM) when they are acting as pharmacy billing agents. The format does not currently support a designated field, an identifier, or a qualifier to flag an entity as a pharmacy billing agent.

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When a third party biller or PBM are the billing and payee of the claim(s), the FEIN of the third party biller or PBM will be reported in the Service Provider ID field (2Ø1-B1) at the header level and the dispensing pharmacy information will be identified by their NPI number in the Provider ID field (444-E9) in the Pharmacy Provider Segment. It is important that these issues be addressed in the trading partner agreements between the claims administrator, their electronic billing agent, and pharmacy claim submitters.

6.6 Fill Number v. Number of Fills Remaining

The NCPDP Telecommunication Standard Implementation Guide Version 5.1 supports the Fill Number (Field 4Ø3-D3) (Field #64 on WC/PC UCF) and the Number of Refills Authorized (Field 415-DF), which taken together, provide the number of refills remaining.

6.7 Compound Medications

Division rules require components of compound medications be identified. Compound medications in the NCPDP Telecommunication Standard Implementation Guide Version 5.1 are identified through the use of the Compound Code (Field 4Ø6-D6) (Fields 89 – 98 on WC/PC UCF) value 2(Compound). If the transaction includes a compound medication, the Compound Segment is required.

6.8 Brand v. Generic

The NCPDP Telecommunication Standard Implementation Guide Version 5.1 contains a code set to indicate dispensed as written status, Dispense As Written (DAW)/ Product Selection Code (Field 4Ø8-D8) (Field #72 on WC/PC UCF). Some dispensed as written codes do indicate the generic availability status. However, the name of the medication, and the brand/generic status of the NDC code, is not communicated for each medication. Claims Administrators may obtain this information from purchased NDC code sets or from their agents/vendor partners.

6.9 Prescribing Physician

For California workers' compensation claims, the Prescribing Physician Identification Number will be the NPI. This data is supported in the NCPDP Telecommunication Standard Implementation Guide Version 5.1 in Fields 411-DB (Prescriber ID) (Field # 40 on WC/PC UCF) and 466-EZ (Field # 41 on WC/PC UCF) (Qualifier (12) DEA Number). If the prescribing physician does not have an NPI, the prescribing physician's state license number should be populated. The NCPDP Telecommunication Standard Version 5.1 contains qualifiers for all the identifiers detailed.

6.10 California Pharmacy Workers' Compensation Instructions

With the exception of the specific instructions below, for electronic transactions the *NCPDP Telecommunication Standard Implementation Guide Version 5* should be used to complete the electronic transaction.

6.10.1 NCPDP 5.1

NCPDP Field Description	NCPDP Paper Field Number	NCPDP Workers' Compensation Requirements	NCPDP 5.1 Data Element	California Workers' Compensation Instructions
Claim Reference Number	Field 17	R	435-DZ	Enter the claim number assigned by the workers' compensation claims administrator, if known. If not known, enter default value 'CA00'
Pharmacy ID	Field 32	R	2Ø1--B1	Enter the Pharmacy NPI number.
Prescriber ID	Field 40	R	411-DB	Enter Prescribing Doctor NPI. If none available, enter Prescribing Doctor State License number. If none available; enter other value as qualified by

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NCPDP Field Description	NCPDP Paper Field Number	NCPDP Workers' Compensation Requirements	NCPDP 5.1 Data Element	California Workers' Compensation Instructions
				NCPDP Telecommunication Standard Implementation Guide Version 5.1
Prescriber ID Qualifier	Field 41	R	466-EZ	Code qualifying the Prescriber ID (411-DB)
Usual & Customary Charge	Field 99	O	426-DQ	Optional
Patient Paid Amount	Field 106	S	433-DX	Not applicable for California workers' compensation

6.11 Optional Transaction Set Based on ASC X12N 837 004010A1 Implementation Guide.

The companion guide for the ASC X12N 837 004010A1 Professional is also referred to as the Alternate Pharmacy Billing Format. The use of this optional transaction set requires mutual agreement of the health care provider and the Claims Administrator and is not a substitute for the *NCPDP Telecommunication Standard Version 5.1 Implementation Guide*. The Claims Administrator, their eBill agents, and pharmacy claim submitters must document any agreement to use this format in their trading partner agreements. Due to the differences between NCPDP 5.1 and ANSI X12 code sets and formats, the parties must understand the programming changes that may be needed to map and process transactions using any mutually agreed upon format.

Chapter 7 Companion Guide 835 Payment & Remittance Advice

The ASC X12N 835 004010A1 Health Claim Payment/Advice is used by the payor to advise the provider of payment remittance and is also used to convey objections to the bill. Labor Code §4603.2 (b)(1)(B) requires the payor to “advise in the manner prescribed by the administrative director”, the physician, or another provider, of the “items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees.” In order to provide detailed information to the provider, the Division directs the claims administrator to use the Explanation of Review (EOR) standards set forth in the Medical Billing and Payment Guide, Appendix B Standard Explanation of Review. For electronic billing purposes, this is accomplished by use of the ASC X12N 835 004010A1 Health Claim Payment/Advice. The Claim Adjustment Group Codes, the Claim Adjustment Reason Codes and Remittance Advice Remark Codes are the standard code sets required. The Division of Workers’ Compensation has developed jurisdictional Bill Adjustment Reason Codes for use on paper EOR’s which do not have an exact equivalent for use in the ASC X12N 835 Healthcare Claim Payment/Advice format. A crosswalk table has been developed showing the relationship between the DWC Bill Adjustment Reason Codes and the CARC/RARC codes for use in electronic EOR’s. This table is found in the Medical Billing and Payment Guide, Appendix B – 1.0.

This companion guide for the ASC X12N 835 Healthcare Claim Payment/Advice transaction has been created for use in conjunction with the *ASC X12N 835 004010A1 Healthcare Claim Payment and Remittance Advice Implementation Guide*. It should not be considered a replacement for the *ASC X12N 835 004010A1 Healthcare Claim Payment and Remittance Advice Implementation Guide*, but rather used as a supplement to the ASC X12N implementation guide. Wherever the national standard differs from the California rules, the California rules prevail.

7.1 Reference Information

The Implementation Guide for the ASC X12N 835 *004010A1* Healthcare Claim Payment and Remittance Advice transaction is available through the Washington Publishing Company at <http://www.wpc-edi.com>.

7.2 Trading Partner Agreements

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

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

7.3 Claim Adjustment Group Code

The Division prescribes the use of ANSI Claim Adjustment Group Codes in the ASC X12N 835 format. The most current, valid codes should be used as appropriate for workers’ compensation. The ANSI Group Code represents the general category of payment, reduction, or denial. For example, the ANSI Group Code CO Contractual Obligation might be used in conjunction with an ANSI Reason Code for a network contract reduction.

The ANSI Group Code transmitted in the ASC X12N 835 is the same code that is transmitted in the IAIABC 837 Medical State Reporting EDI reporting format for reporting to the Workers’ Compensation Information System pursuant to Labor Code section 138.6. The Division accepts ANSI Group Codes that

were valid on the date the insurance carrier paid or denied a bill. The Division does validate for ANSI Group Code/ANSI Reason Code agreement in Medical State Reporting EDI processing.

7.4 Claim Adjustment Reason Code

The ASC X12N 835 uses the ANSI Claim Adjustment Reason Codes, as the electronic means of providing specific payment, reduction, or denial information. The Division prescribes a specific subset of the ANSI Claim Adjustment Reason Codes to be used in the ASC X12N 835 format. These codes are set forth in the Medical Billing and Payment Guide, Appendix B – 1.0 California DWC ANSI Matrix Crosswalk. As a result, use of the ASC X12N 835 eliminates the use of proprietary reduction codes and free form text.

7.5 Remittance Advice Remark Codes

The ASC X12N 835 format supports the use of ANSI Remittance Advice Remark Codes to provide supplemental explanation for a payment, reduction or denial already described by an ANSI Claims Adjustment Reason Code. The Division prescribes a specific subset of the ANSI RARC to be used in the ASC X12N 835 format. These codes are set forth in the Medical Billing and Payment Guide, Appendix B – 1.0 California DWC ANSI Matrix Crosswalk. Claims administrators should use the appropriate remittance remark codes to provide additional information to the health care provider regarding why a bill was adjusted or denied. Please note that RARC codes are required for certain Claim Adjustment Reason Codes.

7.6 California Jurisdictional EOR Statement ID Qualifier

The California paper Explanation of Review (EOR) process includes a requirement to provide health care providers, health care facilities, or third party biller/assignees with notice of “remedies,” i.e. specific information regarding how to seek Workers’ Compensation Appeals Board review of contested charges. For electronic billing/remittance, the California required EOR remedies statement is reflected as a jurisdictional code in the ASC X12N 835. The jurisdictional code is populated in Other Claim Related Identification REF Segment in Loop 2100. The existing Reference Identification Qualifier “CE” Class of Contract Code is to be used as the qualifier in REF01 Segment for workers’ compensation to indicate the value in REF02. The Reference Identification value in REF02 is the 2 byte postal state abbreviation “CA” that represents the California EOR statement. California’s Jurisdictional REF02 “CA” code value equates to the following EOR statement (Labor Code § 4903.5):

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

4903.5. (a) No lien claim for expenses as provided in subdivision (b) of Section 4903 may be filed after six months from the date on which the appeals board or a workers' compensation administrative law judge issues a final decision, findings, order, including an order approving compromise and release, or award, on the merits of the claim, after five years from the date of the injury for which the services were provided, or after one year from the date the services were provided, whichever is later.

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

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

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

7.7 Product/Service ID Qualifier

The Product/Service Identification Number transmitted in the inbound electronic billing format is returned in the ASC X12N 835 SVC Service Payment Information Segment with the appropriate qualifier. For

example, a Revenue Code billed with a HCPCS on a UB-04 is transmitted to the Claims Administrator. The Revenue Code qualifier and Revenue Code are returned in the ASC X12N 835, not the HCPCS Code.

7.8 California 835 Workers' Compensation Instructions

Instructions for California specific requirements are also provided in Chapter 2 California Workers' Compensation Requirements. When the application/instructions for California 835 workers' compensation are different than the HIPAA implementation, it is identified in the following table:

7.8.1 ASC X12N 835 004010A1 Healthcare Claim Payment and Remittance Advice

Loop	Segment or Element	Value	Description	California Workers' Compensation Instructions
1000A	PER		Submitter Contact Information	
1000A	PER03	TE	Communication Number Qualifier	One occurrence of the PER Segment must have a value 'TE' Telephone Number.
1000A	PER04		Communication Number	One value must be the Telephone Number of the submitter.
2100	CLP		Claim Level Data	
2100	CLP06	WC	Claim Filing Indicator Code	Value must be 'WC' – Workers' Compensation
2100	CLP07		Payor Claim Control Number	Value must be payor assigned claim control number (bill control number)
2100	REF		Other Claim Related Identification	California Jurisdictional EOR Code Statement Required ((Labor Code § 4903.5)
2100	REF01	CE	Reference Identification Qualifier	Value must be 'CE' Class of Contract Code
2100	REF02		Reference Identification	Reference Identification must be 'CA'. California's Jurisdictional 2 byte postal state code 'CA' value equates to the EOR statement (Labor Code § 4903.5) as defined in this companion guide.
2100	REF		Other Claim Related Identification	Corrected Workers' Compensation Claim Number
2100	REF01	1L	Reference Identification Qualifier	Value must be '1L' Group or Policy Number assigned by the payor.
2100	REF02		Reference Identification	Enter Corrected Workers' Compensation Claim Number assigned by the payor.
2100	DTM		Claim Date	Corrected Workers' Compensation Date of Accident / Injury / Illness
2100	DTM01	036	Date/Time Qualifier	Value must be '036' to indicate Corrected Workers' Compensation Date of Accident / Injury / Illness
2100	DTM02		Date	Enter Corrected Date of Accident / Injury / Illness

Chapter 8 Companion Guide 275 Additional Information to Support a Health Care Claim or Encounter (Documentation/Medical Attachment)

The *ASC X12N 275 004050 Additional Information to Support a Health Care Claim or Encounter Implementation Guide* contains the recommended (but not required) standard electronic format for submitting documentation to support a bill. Health care providers, health care facilities, or third party biller/assignees and claims administrators may also elect to submit documentation associated with electronic bill transactions through facsimile (fax) or electronic mail (email) in accordance with Chapter 2, section 2.5.7 *Document/ Attachment Identification* and the Medical Billing and Payment Guide. Health care providers, health care facilities, or third party biller/assignees that engage in electronic billing and all claims administrators must be able to electronically exchange medical and other documentation that is required to be submitted with the bill based on the regulatory requirements.

8.1 Reference Information

The implementation guide for the *ASC X12N 275 004050 Additional Information to Support a Health Care Claim or Encounter Implementation Guide* is available through the Washington Publishing Company at <http://www.wpc-edi.com>.

8.2 Documentation Requirements

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

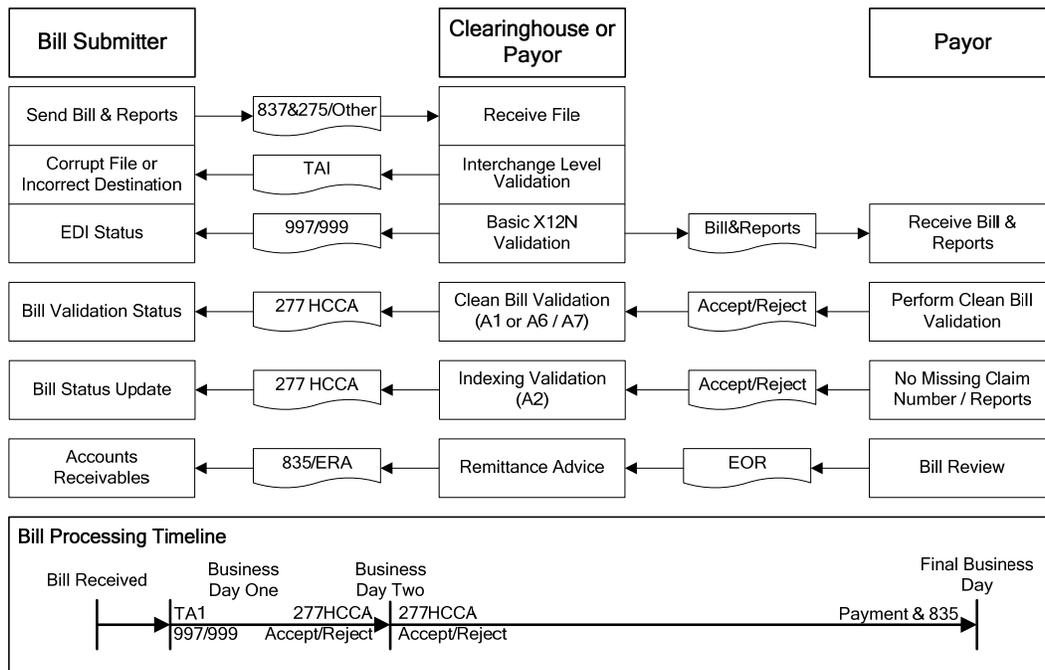
Chapter 9 Companion Guide Acknowledgements

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

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

9.1 Clean Bill Acknowledgement Flow and Timing Diagrams

The process chart below shows how an incoming ASC X12N 837 Professional, Institutional and Dental transaction is validated and processed by the receiver. The diagram shows the basic acknowledgements that are generated by the receiver, including those for validation and final adjudication for those bills that pass validation.



9.1.2 Process Steps

1. **Interchange Level Validation:** Basic file format and the trading partner information from the Interchange Header are validated. If the file is corrupt or is not the expected type the file is rejected. If the trading partner information is invalid or unknown, the file is rejected. A TA1 (Interchange Acknowledgement) is returned to indicate the outcome of the validation. A rejected EDI file is not passed on to the next step.
2. **Basic X12 Validation:** A determination will be made as to whether the transaction set contains a valid 837. A 997 (Functional Acknowledgement) or 999 will be returned to the submitter. For 5010 837 a 999 should be returned and a 997 should be used with the 4010A1 837. The 997 or 999 contains ACCEPT or REJECT of the Functional Acknowledgement information. If the file contains syntactical errors, the locations of the errors are reported. Bills that are part of a rejected transaction set are not passed on to the next step. Note: A trading partner under mutual agreement may also send the 999 with the same level of X12 validation as the 997. Only one, either a 997 or 999 may be sent for this validation layer.
3. **Clean Bill Validation:** The jurisdictional and payor specific edits are run against each bill within the transaction set. A 277 HCCA (Health Care Claim Acknowledgement) is returned to accept or reject the bills. Bills that are rejected are not passed on to the next step.
4. **Clean Bill – Missing Claim Number and or Missing Required Report:** Refer to Section 9.2 Clean Claim- Missing Claim Number Pre Adjudication Holding (Pending) Status and Section 9.2 Clean Claim- Missing Report Pre-Adjudication Hold (Pending) Status regarding bill acknowledgment flow and timeline diagrams.
5. **Bill Review:** The bills that pass through bill review and any post-bill review approval process will be reported in the 835 Remittance Advice. The 835 contains the adjudication information from each bill, plus any paper check or EFT payment information.

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

One of the processing steps that a bill goes through prior to adjudication is to verify that the bill concerns an actual employment-related condition that has been reported to the employer and subsequently reported to the claims administrator. This process, usually called “claim indexing/validation” can cause a delay in the processing of the bill. Once the validation process is complete, a claim number is assigned to the injured worker’s claim. This claim number is necessary for the proper processing of the bill. Until the claim number is provided to the bill submitter, it cannot be included on the ANSI ASC X12N 837 for submission to the payor. In order to prevent medical bills from being rejected due to lack of a claim number, a pre-adjudication hold (pending) period of up to five business days is mandated to enable the payor to attempt to match the bill to an existing claim in their system. If the bill cannot be matched within the five days, the bill may be rejected as incomplete. If the payor is able to match the bill to an existing claim, it should attach the claim number to the transaction and put it through the adjudication process. The claim number should then be provided to the bill submitter using the ASCX12N 277 HCCA for use in future billing. The ASCX12N 277 HCCA is also used to inform the bill submitter of the delay and the ultimate resolution of the issue.

Due to the pre adjudication hold (pending) status a payor may send one STC segment with up to three claim status composites (STC01, STC10, and STC11) in a 277 HCCA. When a clean claim has a missing claim number and a missing report, the one STC segment in the 277 HCCA would have the following three claim status composites: STC01, STC10 and STC11.

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

When a clean bill is only missing a claim number or missing a report the one STC segment in the 277 HCCA would have the following two claim status composites: STC01 and STC10:

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

A bill submitter could potentially receive two 277 HCCA as a result of the pre adjudication hold (pending) status.

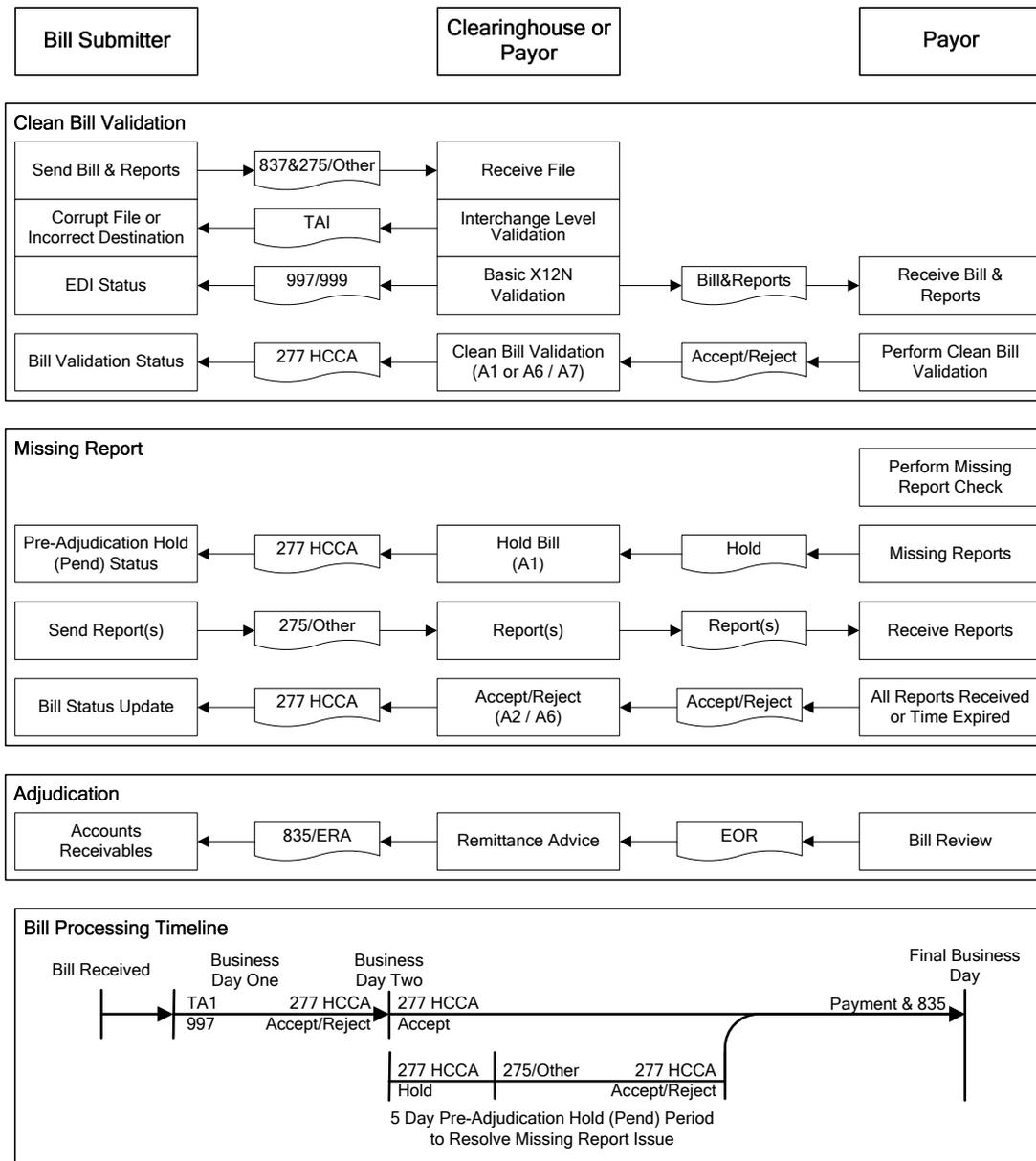
9.2.1 Missing Claim Number-277 Health Care Claim Acknowledgement Process Steps

When the ASC X12N 837 transaction has passed the clean bill validation process and Loop 2010 CA REF02 indicates that the workers' compensation claim number is "unknown" the payor will need to respond with the appropriate ASC X12N 277 HCCA response (s) as applicable:

Claim Number Validation Status	277 HCCA Acknowledgement
Clean Bill - Missing Claim Number	<p>If the payor needs to pend an otherwise clean bill due to a missing claim number, then use the following Claim Status Category Code and Claim Status Code:</p> <p>STC01-1 = A1 The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.</p> <p>STC01-2= 21 (Missing or Invalid Information)</p> <p>AND `</p> <p>STC10 -1 = ` A1 The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.</p> <p>STC10-2 = 629 Property Casualty Claim Number</p> <p>Example: STC*A1:21*20090830*U*70*****A1:629~</p>
Claim Index/Validation Complete	277 HCCA Acknowledgement
Claim was Found	<p>Once the Claim Indexing/ Validation process has been completed and there is a bill/ claim number match, then use the following Claim Status Category Code with the appropriate Claim Status Code:</p> <p>STC01-1 = A2 Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system.</p> <p>STC01-2 = 20 Accepted for processing</p> <p>Payor Claim Control Number: Use Loop 2200D REF segment "Payor Claim Control Number with qualifier 1K Identification Number to return the workers' compensation claim number and or the payor bill control number in the REF02:</p> <ol style="list-style-type: none"> a. Always preface the workers' compensation claim number with the two digit qualifier "Y4" followed by the property casualty claim number. Example: Y412345678 b. If there are two numbers (payor claim control number and the workers' compensation claim number) returned in the REF02, then use a blank space to separate the numbers. <ul style="list-style-type: none"> - The first number will be the payor claim control number- assigned by the payor (bill control number). - The second number will be the workers' compensation property and casualty claim number assigned by the payor with a "Y4" qualifier followed by the claim number. <p>-Example: REF*1K*3456832 Y43333445556~</p>
No Claim Found	<p>After the Claim Indexing/ Validation process has been completed and there is no bill/ claim number match, then use the following Claim Status Category Code with the appropriate Claim Status Code:</p> <p>STC01-1 = A6 Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected.</p> <p>STC01-2 = 629 Property Casualty Claim Number (No Bill/Claim Number Match)</p>

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

One of the processing steps that a bill goes through prior to adjudication is to verify if all required documentation has been provided. The bill submitter can send the reports using the ASCX12N 275 or other mechanisms such as fax or e-mail. In order to prevent medical bills from being rejected due to lack of a required piece of documentation coming separately from the bill itself, a pre-adjudication holding (pending) period of up to five business days is mandated to enable the payor to receive and match the bill to the documentation. If the bill cannot be matched within the five days, or the documentation is not received, the bill may be rejected as incomplete. If the payor is able to match the bill to the documentation within the five days, it should put the bill through the adjudication process. The ASCX12N 277 HCCA is used to inform the bill submitter of the delay and the ultimate resolution of the issue.



9.3.1 Missing Report - ASC X12N 277 Health Care Claim Acknowledgement Process Steps

When a bill submitter sends an ASC X12N 837 that requires an attachment and Loop 2300 PWK Segment indicates there is a report that will be following , the payor will need to respond with the appropriate ASC X12N 277 HCCA response (s) as applicable:

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

9.4 Transmission Responses

9.4.1 ASC X12N TA1 - Interchange Acknowledgement

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

9.4.2 ASC X12N 997 - Functional Acknowledgement

If the trading partners are using version 4010 of ASC X12N standard, the ASC X12N 997, or Functional Acknowledgement, is used to provide the submitter a positive or negative confirmation of the structure of

the 837 EDI file. If the 837 file contained syntactical errors, the segment(s) and element(s) where the error(s) occurred will be reported.

9.4.3 ASC X12N 277 – Health Care Claim Acknowledgement

The ASC X12N 277 Health Care Claim Acknowledgement is used to provide the bill submitter with a positive or negative confirmation of each bill within the EDI file. The 277 details what errors are present, and if necessary, what action the submitter should take. The ASC X12N 004040X167 277 should be used. Payors need to use the most current claim status category and claims status codes as they are subject to change as maintenance on these codes is done three times a year.

Most of the segments in the 277 are used to identify which claim or service line is being acknowledged. The STC segment in the 277 relays the status of the claim.

The STC segment is primarily made up of four fields:

- STC01 the claim status code composite
- STC02 the effective date of the status
- STC03 the action code; accept or reject
- STC04 original claim charge amount

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

The STC01 field is made up of four sub fields:

- STC01-1 the status category code. Used to show if the status indicates a reject, accept, etc
- STC01-2 the status code. Usually indicates the bill field that has a problem.
- STC01-3 an optional entity type. Used when STC01-2 is an entity, to further refine the definition of the entity.
- STC01-4 the status code list qualifier code. Always 65 for the 4040X167 277 HCCA.

The following are the most common scenarios and STC01 values:

- 1) Claim was accepted and forwarded to another clearing house.
 - STC01-1 = A0 (acknowledgement/forwarded)
 - STC01-2 = 16 (claim has been forwarded to entity)
 - STC01-3 = List the entity
- 2) Claim was accepted for further processing (pre- adjudication hold pend status).
 - STC01-1 = A1 (acknowledgement/received but does not mean the bill was accepted into the payor's adjudication system)
 - STC01-2 = 21 (Missing or Invalid Information)
 - STC10-1= A1 (acknowledgement/received but does not mean the bill was accepted into the payor's adjudication system)
 - STC10-2=629 Property Casualty Claim Number
- 3) Claim was accepted by the payor for adjudication. An optional response based on level of feedback from the payor.
 - STC01-1 = A2 (acknowledgement/accepted into adjudication system)
 - STC01-2 = 20 (accepted for processing)
- 4) Claim was accepted and split into multiple claims.
 - STC01-1 = A5 (acknowledgement/split)
 - STC01-2 = 20 (accepted for processing)
- 5) Claim was rejected for missing information.

STC01-1 = A6 (acknowledgement/rejected for missing information)

STC01-2 = code indicating the missing data

STC01-3 = optional code indicating the entity type

6) Claim was rejected for invalid information.

STC01-1 = A7 (acknowledgement/rejected for invalid information)

STC01-2 = code indicating the invalid data

STC01-3 = optional code indicating the entity type

9.4.4 ASC X12N 835 - Remittance Advice

The ASC X12N 835 Remittance Advice is used as a replacement for a paper remittance advice. The ASC X12N 835 Remittance Advice will be delivered to the bill submitter. It is used to communicate claims processing decisions relating to payment, adjustment, or denial of the bill. See Chapter 7 for further detail regarding the 835 Remittance Advice.

Appendix A – Glossary of Terms

Acknowledgment	Electronic notification to original sender of an electronic transmission or the transactions within the transmission were accepted or rejected.
ADA	American Dental Association.
ADA-2006	American Dental Association (ADA) standard paper billing form.
AMA	American Medical Association
ANSI	American National Standards Institute is a private, non-profit organization that administers and coordinates the U.S. voluntary standardization and conformity assessment system.
ANSI X12 275	National standard format for attachments/documentation. The 275 format is being reviewed for possible adoption as a HIPAA standard format.
ANSI X12 835	HIPAA compliant national standard remittance/reimbursement format.
ANSI X12 837	HIPAA compliant national standard billing format for professional services (837P), hospital/facility services (837I), and dental services (837D).
ANSI X12 997	HIPAA compliant national standard functional acknowledgment format.
CDT	Current Dental Terminology coding system used to bill dental services.
Clearinghouse	An entity that processes information received in a nonstandard format or containing nonstandard data content into a standard transaction, or that receives a standard transaction and processes that information into a nonstandard transaction
CMS	Centers for Medicare and Medicaid Services, of U.S. Dept. of Health and Human Services.
CMS-1450	The paper hospital, institutional or facility billing form also referred to as a UB-04.
CMS-1500	The paper professional billing form formerly referred to as a HCFA or HCFA-1500.
Code Sets	Tables or lists of codes used for specific purposes. National standard formats may use code sets developed by the standard setting organization (i.e. ANSI Provider Type qualifiers) or by other organizations (i.e. HCPCS codes).
CPT	Current Procedural Terminology is the coding system created and copyrighted by the American Medical Association used to bill professional services.
DEA	Drug Enforcement Agency
DEA Number	Prescriber DEA identifier used for pharmacy billing.

Detail Acknowledgment	Electronic notification to original sender of an electronic transmission or the transactions within the transmission were accepted or rejected.
DWC	Division of Workers' Compensation of the California Dept. of Industrial Relations.
Electronic Bill	A bill submitted from the health care provider, health care facility, or third-party biller/assignee to the payor electronically.
EFT	Electronic Funds Transfer.
Electronic Format	The specifications defining the layout of data in an electronic transmission.
Electronic Record	A group of related data elements. A record may represent a line item, a health care provider, health care facility, or third party biller/assignee, or an employer. One or more records may form a transaction.
Electronic Transaction	A set of information or data stored electronically in a defined format that has a distinct and different meaning as a set. An electronic transaction is made up of one or more electronic records.
Electronic Transmission	Transmission of information by electronic data interchange.
EOB/EOR	Explanation of Benefits (EOB) or Explanation of Review (EOR) is paper form sent by the Claims Administrator to the health care provider, health care facility, or third party biller/assignee to explain payment or denial of a medical bill. The EOB/EOR might also be used to request a recoupment of an overpayment or acknowledge receipt of a refund.
Functional Acknowledgment	Electronic notification to original sender of an electronic transmission that the functional group within the transaction was accepted or rejected.
HCPCS	Health Care Common Procedure Coding System is the HIPAA code set used to bill durable medical equipment, prosthetics, Orthotics, supplies, and biologics (Level II) as well as professional services (Level I). Level I HCPCS codes are CPT codes.
HIPAA	Health Insurance Portability and Accountability Act, federal legislation that includes provisions that mandate electronic billing in the Medicare system and establishes national standard electronic file formats and code sets.
IAIABC	International Association of Industrial Accident Boards and Commissions.
IAIABC 837	A version of the ANSI 837 electronic file format adopted by IAIABC for Claims Administrator-to-jurisdiction reporting of medical bill payment data.
ICD-9	International Classification of Diseases, the code set administered by the World Health Organization used to identify diagnoses.
MPN	Medical Provider Network as defined by California Labor Code § 4614.
NCPDP	National Council on Prescription Drug Programs.

NCPDP Telecommunication 5.1	HIPAA compliant national standard billing format for pharmacy services.
NDC	National Drug Code, code set used to identify medication dispensed by pharmacies.
NPI	National Provider Identification Number, obtained from CMS.
OMFS	California Official Medical Fee Schedule, established pursuant to Labor Code § 5307.1.
PBM	Pharmacy Benefit Manager.
PPO	Preferred Provider Organization
Receiver	The entity receiving/accepting an electronic transmission.
Remittance	Remittance is used in the electronic environment to refer to reimbursement or denial of medical bills.
Sender	The entity submitting an electronic transmission.
TPA	Third Party Administrator.
Trading Partner	Parties to an electronic transaction.
UB-04	Universal billing form used for hospital billing.
UCF	Universal Claim Form, NCPDP proprietary pharmacy billing form.
Version	Electronic formats may be modified in subsequent releases. Version naming conventions indicate the release or version for a format. Naming conventions are administered by the standard setting organization. Some ANSI formats, for example, are 3050, 4010, and 4050.

Appendix B – Code Set References

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

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

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

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

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

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

Appendix C – Jurisdictional Report Type Codes and DWC Descriptions

OZ -Jurisdictional List of Report Type Codes	California DWC Description
J1 Doctor First Report of Injury	A Doctor's First Report of Occupational Injury (DLSR 5021), must be submitted when the bill is for Evaluation and Management services and a Doctor's First Report of Occupational Injury is required under Title 8, California Code of Regulations § 9785.
J2 Supplemental Medical Report	This is to be used when billing for a "By Report" code or any other additional type of supplemental report.
J3 Medical Permanent Impairment Report	Do not use
J4 Medical Legal Report	A Medical-Legal report is a report submitted by a QME, AME or the Primary Treating Physician when addressing a disputed medical issue.
J5 Vocational Report	
J6 Work Status Report	
J7 Consultation Report	A narrative report must be submitted when the bill is for Evaluation and Management services for a consultation.
J8 Permanent Disability Report	A PR-3, PR-4 or their narrative equivalent must be submitted when the bill is for Evaluation and Management services and the injured worker's condition has been declared permanent and stationary with permanent disability or a need for future medical care. (Use of Modifier – 17)
J9	Itemized Statement
09 Progress Report	A PR-2 report or its narrative equivalent must be submitted when the bill is for Evaluation and Management services and a PR-2 report is required under Title 8, California Code of Regulations § 9785.
10 Continued Treatment	To be used when submitting a Functional Improvement Report.
11 Chemical Analysis	
13 Certified Test Report	
06 Initial Assessment	Physical Therapy or Occupational Therapy initial assessment report
21 Recovery Plan	
A3 Allergies/Sensitivities Document	
A4 Autopsy Report	
AM Ambulance	

Certification	
DB Durable Medical Equipment Prescription	
DJ Discharge Monitoring Report	
LA Laboratory Results	
M1 Medical Record Attachment	
OD Orders and Treatments Document	
P4 Pathology Report	
PY Physician's Report	
V5 Death Notification	
XP Photographs	

Appendix D – Security Rule

SECURITY RULE TO PROTECT THE CONFIDENTIALITY OF MEDICAL INFORMATION SUBMITTED ELECTRONICALLY

1.0 Introduction

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

2.0 § 164.302 Applicability.

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

3.0 § 164.304 Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

User means a person or entity with authorized access.

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

4.0 § 164.306 Security standards: General rules.

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

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

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

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

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

(b) Flexibility of approach.

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

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

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

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

(iii) The costs of security measures.

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

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

(d) Implementation specifications.

In this security rule:

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

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

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

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

(ii) As applicable to the entity --

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

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

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

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

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

5.0 § 164.308 Administrative safeguards.

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

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

(ii) Implementation specifications:

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

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

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

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

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

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

(ii) Implementation specifications:

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

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

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

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

(ii) Implementation specifications:

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

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

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

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

(ii) Implementation specifications. Implement:

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

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

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

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

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

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

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

(ii) Implementation specifications:

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

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

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

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

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

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

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

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

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

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

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

6.0 § 164.310 Physical safeguards.

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

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

(2) Implementation specifications:

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

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

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

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

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

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

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

(2) Implementation specifications:

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

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

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

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

7.0 § 164.312 Technical safeguards.

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

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

(2) Implementation specifications:

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

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

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

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

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

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

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

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

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

(2) Implementation specifications:

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

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

8.0 § 164.314 Organizational requirements.

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

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

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

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

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

(2) Implementation specifications (Required).

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

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

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

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

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

(ii) Other arrangements.

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

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

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

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

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

9.0 § 164.316 Policies and procedures and documentation requirements.

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

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

(b)(1) Standard: Documentation.

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

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

(2) Implementation specifications:

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

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

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

Attachment A to Security Rule

1.0 Security Standards: Matrix

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

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

Appendix E – Electronic and Digital Signature

An electronic or digital signature shall be recognized as valid if it conforms to the requirements for digital signatures under Government Code § 16.5 and the Secretary of State's implementing regulations at Title 2, California Code of Regulations §§ 22000 – 22003, or if it conforms to other provisions of law. The Secretary of State's "Approved List of Digital Signature Certification Authorities" can be accessed on the web at: <http://www.sos.ca.gov/digsig/>.

Statute and Secretary of State Rules

1.0 California Government Code

1.1 Section § 16.5. Digital signatures

(a) In any written communication with a public entity, as defined in Section 811.2, in which a signature is required or used, any party to the communication may affix a signature by use of a digital signature that complies with the requirements of this section. The use of a digital signature shall have the same force and effect as the use of a manual signature if and only if it embodies all of the following attributes:

- (1) It is unique to the person using it.
 - (2) It is capable of verification.
 - (3) It is under the sole control of the person using it.
 - (4) It is linked to data in such a manner that if the data are changed, the digital signature is invalidated.
 - (5) It conforms to regulations adopted by the Secretary of State. Initial regulations shall be adopted no later than January 1, 1997. In developing these regulations, the secretary shall seek the advice of public and private entities, including, but not limited to, the Department of Information Technology, the California Environmental Protection Agency, and the Department of General Services. Before the secretary adopts the regulations, he or she shall hold at least one public hearing to receive comments.
- (b) The use or acceptance of a digital signature shall be at the option of the parties. Nothing in this section shall require a public entity to use or permit the use of a digital signature.
- (c) Digital signatures employed pursuant to Section 71066 of the Public Resources Code are exempted from this section.
- (d) "Digital signature" means an electronic identifier, created by computer, intended by the party using it to have the same force and effect as the use of a manual signature.

2.0 California Code of Regulations, Title 2

2.1 Section § 22000. Definitions.

- (a) For purposes of this chapter, and unless the context expressly indicates otherwise:
- (1) "Digitally-signed communication" is a message that has been processed by a computer in such a manner that ties the message to the individual that signed the message.

(2) "Message" means a digital representation of information intended to serve as a written communication with a public entity.

(3) "Person" means a human being or any organization capable of signing a document, either legally or as a matter of fact.

(4) "Public entity" means the public entity as defined by California Government Code Section 811.2.

(5) "Signer" means the person who signs a digitally signed communication with the use of an acceptable technology to uniquely link the message with the person sending it.

(6) "Technology" means the computer hardware and/or software-based method or process used to create digital signatures.

Note: Authority cited: Section 16.5, Government Code. Reference: Section 16.5, Government Code.

Section 22001. Digital Signatures Must Be Created by an Acceptable Technology.

(a) For a digital signature to be valid for use by a public entity, it must be created by a technology that is acceptable for use by the State of California.

Note: Authority cited: Section 16.5, Government Code. Reference: Section 16.5, Government Code.

2.2 Section § 22002. Criteria for State to Determine if a Digital Signature Technology Is Acceptable for Use by Public Entities.

(a) An acceptable technology must be capable of creating signatures that conform to requirements set forth in California Government Code Section 16.5, specifically,

(1) It is unique to the person using it;

(2) It is capable of verification;

(3) It is under the sole control of the person using it;

(4) It is linked to data in such a manner that if the data are changed, the digital signature is invalidated;

(5) It conforms to Title 2, Division 7, Chapter 10 of the California Code of Regulations.

Note: Authority cited: Section 16.5, Government Code. Reference: Section 16.5, Government Code.

2.3 Section § 22003. List of Acceptable Technologies.

(a) The technology known as Public Key Cryptography is an acceptable technology for use by public entities in California, provided that the digital signature is created consistent with the provisions in Section 22003(a)1-5.

(1) Definitions - For purposes of Section 22003(a), and unless the context expressly indicates otherwise:

(A) "Acceptable Certification Authorities" means a certification authority that meets the requirements of either Section 22003(a)6(C) or Section 22003(a)6(D).

(B) "Approved List of Certification Authorities" means the list of Certification Authorities approved by the Secretary of State to issue certification for digital signature transactions involving public entities in California.

(C) "Asymmetric cryptosystem" means a computer algorithm or series of algorithms which utilize two different keys with the following characteristics:

(i) one key signs a given message;

(ii) one key verifies a given message; and,

(iii) the keys have the property that, knowing one key, it is computationally infeasible to discover the other key.

(D) "Certificate" means a computer-based record which:

(i) identifies the certification authority issuing it;

(ii) names or identifies its subscriber;

(iii) contains the subscriber's public key; and

(iv) is digitally signed by the certification authority issuing or amending it, and

(v) conforms to widely-used industry standards, including, but not limited to ISO x.509 and PGP certificate standards.

(E) "Certification Authority" means a person or entity that issues a certificate, or in the case of certain certification processes, certifies amendments to an existing certificate.

(F) "Key pair" means a private key and its corresponding public key in an asymmetric cryptosystem. The keys have the property that the public key can verify a digital signature that the private key creates.

(G) "Practice statement" means documentation of the practices, procedures and controls employed by a Certification Authority.

(H) "Private key" means the key of a key pair used to create a digital signature.

(I) "Proof of Identification" means the document or documents presented to a Certification Authority to establish the identity of a subscriber.

(J) "Public key" means the key of a key pair used to verify a digital signature.

(K) "Subscriber" means a person who:

(i) is the subject listed in a certificate;

(ii) accepts the certificate; and

(iii) holds a private key which corresponds to a public key listed in that certificate.

(2) California Government Code s16.5 requires that a digital signature be 'unique to the person using it'. A public key-based digital signature may be considered unique to the person using it, if:

(A) The private key used to create the signature on the document is known only to the signer, and

(B) the digital signature is created when a person runs a message through a one-way function, creating a message digest, then encrypting the resulting message digest using an asymmetrical cryptosystem and the signer's private key, and,

(C) although not all digitally signed communications will require the signer to obtain a certificate, the signer is capable of being issued a certificate to certify that he or she controls the key pair used to create the signature, and

(D) it is computationally infeasible to derive the private key from knowledge of the public key.

(3) California Government Code s16.5 requires that a digital signature be 'capable of verification'. A public-key based digital signature is capable of verification if:

(A) the acceptor of the digitally signed document can verify the document was digitally signed by using the signer's public key to decrypt the message; and

(B) if a certificate is a required component of a transaction with a public agency, the issuing Certification Authority, either through a certification practice statement or through the content of the certificate itself, must identify which, if any, form(s) of identification it required of the signer prior to issuing the certificate.

(4) California Government Code s16.5 requires that the digital signature remain 'under the sole control of the person using it'. Whether a signature is accompanied by a certificate or not, the person who holds the key pair, or the subscriber identified in the certificate, assumes a duty to exercise reasonable care to retain control of the private key and prevent its disclosure to any person not authorized to create the subscriber's digital signature pursuant to Evidence Code Section 669.

(5) The digital signature must be linked to the message of the document in such a way that if the data are changed, the digital signature is invalidated.

(6) Acceptable Certification Authorities

(A) The California Secretary of State shall maintain an "Approved List of Certificate Authorities" authorized to issue certificates for digitally signed communication with public entities in California.

(B) Public entities shall only accept certificates from Certification Authorities that appear on the "Approved List of Certification Authorities" authorized to issue certificates by the California Secretary of State.

(C) The Secretary of State shall place Certification Authorities on the "Approved List of Certification Authorities" after the Certification Authority provides the Secretary of State with a copy of an unqualified performance audit performed in accordance with standards set in the American Institute of Certified Public Accountants (AICPA) Statement on Auditing Standards No. 70 (S.A.S. 70) "Reports on the Processing of Service Transactions by Service Organizations" (1992) to ensure that the Certification Authorities' practices

and policies are consistent with the Certifications Authority's stated control objectives. The AICPA Statement on Auditing Standards No. 70 (1992) is hereby incorporated by reference.

(i) Certification Authorities that have been in operation for one year or less shall undergo a SAS 70 Type One audit - A Report of Policies and Procedures Placed in Operation, receiving an unqualified opinion.

(ii) Certification Authorities that have been in operation for longer than one year shall undergo a SAS 70 Type Two audit - A Report Of Policies And Procedures Placed In Operation And Test Of Operating Effectiveness, receiving an unqualified opinion.

(iii) To remain on the "Approved List of Certification Authorities" a Certification Authority must provide proof of compliance with Section 20003(a)(6)(C)(ii) to the Secretary of State every two years after initially being placed on the list.

(D) In lieu of completing the auditing requirement in Section 22003(a)(6)(C), Certification Authorities may be placed on the "Approved List of Certification Authorities" upon providing the Secretary of State with proof of accreditation that has been conferred by a national or international accreditation body that the Secretary of State has determined utilizes accreditation criteria that are consistent with the requirements of Section 22003(a)(1)-(5).

(i) Certification Authorities shall be removed from the "Approved List of Acceptable Certifications Authorities" unless they provide current proof of accreditation to the Secretary of State at least once per year.

(ii) If the Secretary of State is informed that a Certification Authority has had its accreditation revoked, the Certification Authority shall be removed from the "Approved List of Certification Authorities" immediately.

(b) The technology known as "Signature Dynamics" is an acceptable technology for use by public entities in California, provided that the signature is created consistent with the provisions in Section 22003(b)(1)-(5).

(1) Definitions - For the purposes of Section 22003(b), and unless the context expressly indicates otherwise:

(A) "Handwriting Measurements" means the metrics of the shapes, speeds and/or other distinguishing features of a signature as the person writes it by hand with a pen or stylus on a flat surface.

(B) "Signature Digest" is the resulting bit-string produced when a signature is tied to a document using Signature Dynamics.

(C) "Expert" means a person with demonstrable skill and knowledge based on training and experience who would qualify as an expert pursuant to California Evidence Code s720.

(D) "Signature Dynamics" means measuring the way a person writes his or her signature by hand on a flat surface and binding the measurements to a message through the use of cryptographic techniques.

(2) California Government Code s16.5 requires that a digital signatures be 'unique to the person using it.' A signature digest produced by Signature Dynamics technology may be considered unique to the person using it, if:

(A) the signature digest records the handwriting measurements of the person signing the document using signature dynamics technology, and

(B) the signature digest is cryptographically bound to the handwriting measurements, and

(C) after the signature digest has been bound to the handwriting measurements, it is computationally infeasible to separate the handwriting measurements and bind them to a different signature digest.

(3) California Government Code §16.5 requires that a digital signature be capable of verification. A signature digest produced by signature dynamics technology is capable of verification if:

(A) the acceptor of the digitally signed message obtains the handwriting measurements for purposes of comparison, and

(B) if signature verification is a required component of a transaction with a public entity, the handwriting measurements can allow an expert handwriting and document examiner to assess the authenticity of a signature.

(4) California Government Code §16.5 requires that a digital signature remain 'under the sole control of the person using it'. A signature digest is under the sole control of the person using it if:

(A) the signature digest captures the handwriting measurements and cryptographically binds them to the message directed by the signer and to no other message, and

(B) the signature digest makes it computationally infeasible for the handwriting measurements to be bound to any other message.

(5) The signature digest produced by signature dynamics technology must be linked to the message in such a way that if the data in the message are changed, the signature digest is invalidated.

2.4 Section § 22004. Provisions for Adding New Technologies to the List of Acceptable Technologies.

(a) Any individual or company can, by providing a written request that includes a full explanation of a proposed technology which meets the requirements of Section 22002, petition the California Secretary of State to review the technology. If the Secretary of State determines that the technology is acceptable for use with the state, the Secretary of State shall adopt regulation(s), pursuant to the Administrative Procedure Act, which would add the proposed technology to the list of acceptable technologies in Section 22003.

(b) The Secretary of State has 180 calendar days from the date the request is received to review the petition and inform the petitioner, in writing, whether the technology is accepted or rejected. If the petition is rejected, the Secretary of State shall provide the petitioner with the reasons for the rejection.

(1) If the proposed technology is rejected, the petitioner can appeal the decision through the Administrative Procedures Act ([Government Code Section 11500 et seq](#)).

Note: Authority cited: [Section 16.5, Government Code](#). Reference: [Section 16.5, Government Code](#).

Proposed Electronic and Standardized Billing Regulations

Title 8, California Code of Regulations Chapter 4.5 Division of Workers' Compensation Subchapter 1 Administrative Director – Administrative Rules

Text proposed to be added is displayed in underscore type.

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Article 5.5. Application of the Official Medical Fee Schedule (Treatment)

§9792.5. Payment for Medical Treatment.

This section is applicable to medical treatment rendered before XXXX, 2010 [approximately 90 days after the effective date of this regulation].

(a) As used in this section:

(1) "Claims Administrator" has the same meaning specified in Section 9785(a)(3).

(2) "Medical treatment" means the treatment to which an employee is entitled under Labor Code Section 4600.

(3) "Physician" has the same meaning specified in Labor Code Section 3209.3.

(4) "Required report" means a report which must be submitted pursuant to Section 9785.

(5) "Treating physician" means the "primary treating physician" as that term is defined by Section 9785(a)(1).

(b) Any properly documented bill for medical treatment within the planned course, scope and duration of treatment reported under Section 9785 which is provided or authorized by the treating physician shall be paid by the claims administrator within ~~sixty~~ forty five working days from receipt of each separate itemized bill and any required reports, unless the bill is contested, as specified in subdivisions (d), and (e), within thirty working days of receipt of the bill. Any amount not contested within the thirty working days or not paid within the ~~sixty day~~ forty five working day period shall be increased ~~40%~~ 15%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill.

For purposes of this Section, treatment which is provided or authorized by the treating physician includes but is not limited to treatment provided by a "secondary physician" as that term is defined by Section 9785(a)(2).

~~(c) To be properly documented, a bill for medical treatment which exceeds the amount presumed reasonable in the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1, must be accompanied by an itemization and explanation for the excess charge.~~

(d) A claims administrator who objects to all or any part of a bill for medical treatment shall notify the physician or other authorized provider of the objection within thirty working days after receipt of the bill and any required report and shall pay any uncontested amount within ~~sixty days~~ forty five working days after receipt of the bill. If a required report is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill or report, whichever is received later. If the claims administrator receives a bill and believes that it has not received a required report to support the bill, the claims administrator shall so inform the medical provider within thirty working days of receipt of the bill. An objection will be deemed timely if sent by first class mail and postmarked on or before the thirtieth working day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth working day after receipt. Any notice of objection shall include or be accompanied by all of the following:

(1) An explanation of the basis for the objection to each contested procedure and charge. The original procedure codes used by the physician or authorized provider shall not be altered. If the objection is based on appropriate coding of a procedure, the explanation shall include both the code reported by the provider and the code believed reasonable by the claims administrator.

(2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the information required.

(3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection.

(4) A statement that the treating physician or authorized provider may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board.

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

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

Authority: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4603.2 and 5307.1, Labor Code.

**Article 5.5.0 Rules for Medical Treatment Billing and Payment on or after XXXX,
2010 [approximately 90 days after the effective date of this regulation]**

Section 9792.5.0 Definitions.

As used in this article:

(a) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(b) "Health Care Facility" means any facility as defined in Section 1250 of the Health and Safety Code, any surgical facility which is licensed under subdivision (b) of Section 1204 of the Health and Safety Code, any outpatient setting as defined in Section 1248 of the Health and Safety Code, any surgical facility accredited by an accrediting agency approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, or any ambulatory surgical center or hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act.

(c) "Health Care Provider" means a provider of medical treatment, goods and services, including but not limited to a physician, a non-physician or any other person or entity who furnishes medical treatment, goods or services in the normal course of business.

(d) "Physician" includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.

(1) "Psychologist" means a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

(2) "Acupuncturist" means a person who holds an acupuncturist's certificate issued pursuant to Chapter 12 (commencing with Section 4925) of Division 2 of the Business and Professions Code.

(e) "Third Party Biller/Assignee" means a person or entity authorized by law and acting under contract as the agent or assignee of a rendering physician, health care provider or healthcare facility to bill and/or collect payment from the responsible payor.

Authority: Sections 133, 4603.4, 4603.5 and 5307.3, Labor Code.

Reference: Sections 3209.3, 4603.2, 4603.4 and 5307.1, Labor Code.

Section 9792.5.1. Medical Billing and Payment Guide; Medical Billing and Payment Companion Guide; Various Implementation Guides.

(a) The California Division of Workers' Compensation Medical Billing and Payment Guide, dated XXXX, 2010, which sets forth billing, payment and coding rules for paper and electronic medical treatment bill submissions, is incorporated by reference. It may be downloaded from the Division of Workers' Compensation website at www.XXXX.ca.gov or may be obtained by writing to:

Division of Workers' Compensation
Medical Unit
Attn: Medical Billing and Payment Guide
P.O. Box 71010
Oakland, CA 94612

(b) The California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, dated XXXX, 2010, which sets forth billing, payment and coding rules and technical information for electronic medical treatment bill submissions, is incorporated by reference. It may be downloaded from the Division of Workers' Compensation website at www.XXXX.ca.gov or may be obtained by writing to:

Division of Workers' Compensation
Medical Unit
Attn: Medical Billing and Payment Companion Guide
P.O. Box 71010
Oakland, CA 94612

(c) The HIPAA-approved billing implementation guides listed in subdivision (c)(1) through (3) are incorporated by reference. They may be obtained for a fee from the Washington Publishing Company, PMB 161, 5284 Randolph Road, Rockville, MD, 20852-2116; Telephone (301) 949-9740; and FAX: (301) 949-9742. They are also available through the Washington Publishing Company on the Internet at <http://www.wpc-edi.com/>.

(1) ASC X12N 837—Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097 and Addenda to Health Care Claim: Dental, Version 4010, October 2002, Washington Publishing Company, 004010X097A1.

(2) ASC X12N 837—Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098 and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1.

(3) ASC X12N 837—Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096 and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X096A1.

(d) The HIPAA-approved implementation guides for pharmacy billing listed in subdivision (d)(1) through (3) are incorporated by reference. They may be obtained for a fee from the National Council for Prescription Drug Programs (NCPDP), 9240 E. Raintree Drive, Scottsdale, AZ 85260; Telephone (480) 477-1000; and FAX (480) 767-1042. They may also be obtained through the Internet at <http://www.ncdp.org>.

(1) Telecommunication Standard Implementation Guide Version 5, Release 1 (Version 5.1), September 1999, National Council for Prescription Drug Programs.

(2) The Batch Standard Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000, supporting Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record, National Council for Prescription Drug Programs.

(e) The HIPAA-approved implementation guide for remittance, the ASC X12N 835 -- Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, Washington Publishing Company, 004010X091A are incorporated by reference. They may be obtained for a fee from the Washington Publishing Company, PMB 161, 5284 Randolph Road, Rockville, MD, 20852-2116; Telephone (301) 949-9740; and FAX: (301) 949-9742. They are also available through the Washington Publishing Company on the Internet at <http://www.wpc-ed.com/>.

(f) The *National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version*, Version 5.0 07/09, and the 1500 Form (revised 08-05) are incorporated by reference. The manual can be obtained directly from the National Uniform Claim Committee at: http://www.nucc.org/index.php?option=com_content&task=view&id=33&Itemid=42 .

(g) The *National Uniform Billing Committee Official UB-04 Data Specifications Manual 2010, Version 4.0, July 2009*, including the UB 04 form, is incorporated by reference. The manual can be obtained from the National Uniform Billing Committee at <http://www.nubc.org/become.html> by becoming a UB 04 committee paid subscriber.

(h) The *Manual Claim Forms Reference Implementation Guide Version 1.0*, October 2008, National Council of Prescription Drug Programs (NCPDP) *Data Specifications Manual* including the NCPDP paper WC/PC Universal Claim Form Version 1.0 05/2008, except pages 13-36, is incorporated by reference. The manual can be obtained from the NCPDP's vendor at: www.communiform.com/ncdpd.

(i) The *Current Dental Terminology, Fourth Edition (CDT-4) 2009/2010*, including the ADA 2006 Dental Claim Form, is incorporated by reference. The manual can be obtained from the American Dental Association at:

American Dental Association
<http://www.ada.org/>
211 East Chicago Ave.
Chicago, IL 60611-2678

Or on the web at:

<http://www.ada.org/>

Authority: Sections 133, 4603.4, 4603.5 and 5307.3, Labor Code.

Reference: Section 4600, 4603.2 and 4603.4, Labor Code.

Section 9792.5.2 – Standardized Medical Treatment Billing Forms/Formats, Billing Rules, Requirements for Completing and Submitting Form CMS 1500, Form CMS 1450 (or UB 04), American Dental Association Form, Version 2006, NCPDP Workers’ Compensation / Property & Casualty Universal Claim Form, Payment Requirements.

(a) On and after XXXX, 2010, [approximately 90 days after the effective date of this regulation] all paper bills for medical treatment provided by physicians, health care providers, and health care facilities shall be submitted on claim forms set forth in the *California Division of Workers’ Compensation Medical Billing and Payment Guide*.

(b) On and after XXXX, 2010, [approximately 90 days after the effective date of this regulation] all medical bills shall conform to the provisions of the *California Division of Workers’ Compensation Medical Billing and Payment Guide* which includes coding, billing standards, timeframes and other rules.

(c) On and after XXXX, 2011 [approximately 18 months after the effective date of regulation], all bills for medical treatment provided by physicians, health care providers, and health care facilities may be electronically submitted to the claims administrator for payment. Electronic bills submitted on or after that date shall conform to the applicable provisions of the *California Division of Workers’ Compensation Medical Billing and Payment Guide* and the *California Division of Workers’ Compensation Electronic Medical Billing and Payment Companion Guide*.

(d) Except as otherwise specifically provided, legally authorized third party billers and assignees shall submit bills in the same manner as the original rendering provider or facility would be required to do had the bills been submitted by the provider or facility directly and shall conform to applicable provisions of the *California Division of Workers’ Compensation Medical Billing*

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

Authority: Sections 133, 4603.4, 4603.5 and 5307.3, Labor Code.

Reference: Section 4600, 4603.2 and 4603.4, Labor Code.

Section 9792.5.3 – Medical Treatment Bill Payment Rules.

(a) On and after XXXX, 2010, [approximately 90 days after the effective date of this regulation] claims administrators shall conform to the payment, communication, penalty, and other provisions contained in the California Division of Workers' Compensation Medical Billing and Payment Guide, except that the provisions relating to the payment of electronic medical bills shall become effective on XXXX, 2011 [18 months after the effective date of this regulation].

(b) On and after XXXX, 2011 [approximately 18 months after the effective date of this regulation] claims administrators shall conform to the payment, communication, penalty, and other provisions contained in the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide.

Authority: Sections 133, 4603.4, 4603.5 and 5307.3, Labor Code.

Reference: Section 4600, 4603.2 and 4603.4, Labor Code.