Title 8, California Code of Regulations

Chapter 4.5 Division of Workers’ Compensation

Subchapter 1 Administrative Director – Administrative Rules

Article 1.1. Workers’ Compensation Information System

§9701. Definitions.

The following definitions apply in this article:

(a) Bona Fide Statistical Research. The analysis of existing workers' compensation data for the purpose of developing or contributing to basic knowledge regarding the California workers' compensation system.

(b) California EDI Implementation Guide for First and Subsequent Reports of Injury. Contains California-specific reporting requirements and information excerpted from the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, by the International Association of Industrial Accident Boards and Commissions. The California EDI Implementation Guide for First and Subsequent Reports of Injury is posted on the Division's Web site at <http://www.dir.ca.gov/dwc/WCIS.htm>, and is available from the Division of Workers' Compensation upon request.

(1) For reporting prior to November 15, 2011, use the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 2.1, dated February 2006, which is incorporated by reference.

(2) For reporting on or after November 15, 2011, but before the date of the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 3.1, dated March 27, 2018, use the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 3.0, dated November 15, 2011, which is incorporated by reference.

(3) For reporting on or after March 27, 2018, but before the date of the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 4.0, dated (Date inserted by OAL), use the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 3.1, dated March 27, 2018, which is incorporated by reference.

(4) For reporting on or after (six months after Date inserted by OAL), use the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 4.0, dated (date inserted by OAL), which is incorporated by reference.

(c) California EDI Implementation Guide for Medical Bill Payment Records. Contains the California-specific protocols and excerpts from the IAIABC EDI Implementation Guide for Medical Bill Payment Records, explains the technical design and functionality of the WCIS system, testing options for the trading partners, instructions regarding the medical billing data elements, and reporting standards and requirements. The California EDI Implementation Guide for Medical Bill Payment Records is posted on the Division's Web site at http://www.dir.ca.gov/dwc/WCIS.htm, and is available from the Division of Workers' Compensation upon request.

(1) For reporting prior to April 6, 2016, use the California EDI Implementation Guide for Medical Bill Payment Records, Version 1.1, dated November 15, 2011, which is incorporated by reference.

(2) For reporting prior to September 27, 2017, use the California EDI Implementation Guide for Medical Bill Payment Records, Version 2.0, dated April 6, 2016, which is incorporated by reference. For reporting on or after September 27, 2017, use the California EDI Implementation Guide for Medical Bill Payment Records, Version 2.0, dated September 27, 2017, which is incorporated by reference. This Guide adopts ASC (Accredited Standards Committee) X12 Implementation Acknowledgement for Health Care insurance (999) dated February 2011.

(d) California Jurisdiction Code. A California-specific code that identifies a medical procedure, service, or product that is not identified by a current HCPCS code. California Jurisdiction Codes are either set forth and/or incorporated by reference in California Code of Regulations, title 8, section 9795, regarding reasonable fees for medical-legal expenses, section 9789.11, regarding fees for physician services rendered on or after July 1, 2004, and before January 1, 2014, sections 9789.12.1-9789.19, regarding fees for physician services rendered on or after January 1, 2014, or in California EDI Implementation Guide for Medical Bill Payment, Release 1.1.

(e) Claim. An injury as defined in Division 4 of the Labor Code, occurring on or after March 1, 2000, that has resulted in the receipt of one or more of the following by a claims administrator:

(1) Employer's Report of Occupational Injury or Illness, as required by California Code of Regulations, title 8, sections 14004-14005.

(2) Doctor's First Report of Occupational Injury or Illness, as required by California Code of Regulations, title 8, sections 14006-14007.

(3) Application for Adjudication filed with the Workers' Compensation Appeals Board under Labor Code section 5500 and California Code of Regulations, title 8, section 10408.

(4) Any information indicating that the injury requires medical treatment by a physician as defined in Labor Code section 3209.3.

(f) Claims Administrator. 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, California Insurance Guarantee Association (CIGA), or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(g) Claims Administrator's Agents. Any entity contracted by the claims administrator to assist in adjusting the claim(s) including third party administrators, bill reviewers, utilization review vendors, and electronic data interchange vendors.

(h) Closed Claim. A claim in which future payment of indemnity benefits and/or provision of medical benefits cannot be reasonably expected to be due.

(i) Data Elements. Information identified by data number (DN) and defined in the dictionary of the IAIABC EDI Implementation Guide, Release 1. Data elements set forth in California Code of Regulations, title 8, section 9702 must be transmitted on all claims, where applicable, as indicated in section 9702. The data elements set forth in the IAIABC EDI Implementation Guide, Release 1 that are not enumerated in section 9702 are optional and may, but need not be, submitted on any or all claims.

(j) Electronic Data Interchange. ("EDI"). A computer to computer exchange of data or information in a standardized format acceptable to the Administrative Director.

(k) Health Care Organization ("HCO"). Any entity certified as a health care organization by the Administrative Director pursuant to Labor Code sections 4600.5 and 4600.6.

(*l*) HCPCS. Acronym for the Healthcare Common Procedure Coding System.

(m) IAIABC EDI Implementation Guide, Release 1. EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, by the International Association of Industrial Accident Boards and Commissions. The IAIABC EDI Implementation Guide, Release 1, can be obtained from the IAIABC at either the IAIABC website at http://www.iaiabc.org, or the IAIABC office located at 7780 Elmwood Avenue, Suite 207, Middleton, Wisconsin 53562; Telephone: (608) 663-6355.

(n) IAIABC Workers’ Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0, by the International Association of Industrial Accident Boards and Commissions. The IAIABC Workers’ Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0, February 1, 2015 Publication can be obtained from the IAIABC at either the IAIABC website at <http://www.iaiabc.org>, or the IAIABC office located at 7780 Elmwood Avenue, Suite 207, Middleton, Wisconsin 53562; Telephone: (608) 663-6355.

(1) For reporting prior to the designated effective date (see subdivision (c)(1)), use the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009, which is incorporated by reference.

(2) For reporting on or after the designated effective date (see subdivision(c)(2)), use the IAIABC Workers’ Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0, February 1, 2015 Publication, which is incorporated by reference.

(o) Indemnity Benefits. Payments conferred, including those made by settlement, for any of the following: temporary disability indemnity, permanent disability indemnity, death benefits, vocational rehabilitation maintenance allowance, and employer-paid salary in lieu of compensation.

(p) Individually Identifiable Information. Any data concerning an injury or claim that is linked to a uniquely identifiable employee, employer, claims administrator, or any other person or entity.

(q) International Association of Industrial Accident Boards and Commissions ("IAIABC"). A professional association of workers' compensation specialists, located at 7780 Elmwood Avenue, Suite 207, Middleton, Wisconsin 53562, which is, in addition to other activities, engaged in the production and publication of EDI standards for filing workers' compensation information. Note: IAIABC asserts ownership of such EDI standards which are published in various ways and include Implementation Guides with instructions on their use, technical and business specifications and coding information to permit the transfer of data between regulatory bodies and regulated entities in a uniform and consistent manner.

(r) WCIS. The Workers' Compensation Information System established pursuant to sections 138.6 and 138.7 of the Labor Code.

Authority: Sections 133, 138.6 and 138.7, Labor Code.

Reference: Sections 138.6 and 138.7, Labor Code.

§ 9702. Electronic Data Reporting.

(a) Each claims administrator shall transmit data elements, by electronic data interchange in the manner set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records, to the WCIS by the dates specified in this section. Each claims administrator shall, at a minimum, provide complete, valid, accurate data for the data elements set forth in this section. The data elements required in subdivisions (b), (c), (d) and (e) are taken from California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records. Claims administrators shall only transmit the data elements that are set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records. Each transmission of data elements shall include appropriate header and trailer records as set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records.

(b) Each claims administrator shall submit to the WCIS on each claim, within ten (10) business days of knowledge of the claim, each of the following data elements known to the claims administrator:

|  |  |
| --- | --- |
| DATA ELEMENT NAME | DN |
| ACCIDENT DESCRIPTION /CAUSE | 38 |
| CAUSE OF INJURY CODE | 37 |
| CLAIM ADMINISTRATOR ADDRESS LINE 1 | 10 |
| CLAIM ADMINISTRATOR ADDRESS LINE 2 | 11 |
| CLAIM ADMINISTRATOR CITY | 12 |
| CLAIM ADMINISTRATOR CLAIM NUMBER | 15 |
| CLAIM ADMINISTRATOR FEIN | 8 |
| CLAIM ADMINISTRATOR NAME | 9 |
| CLAIM ADMINISTRATOR POSTAL CODE | 14 |
| CLAIM ADMINISTRATOR STATE | 13 |
| CLASS CODE (3) | 59 |
| DATE DISABILITY BEGAN | 56 |
| DATE LAST DAY WORKED | 65 |
| DATE OF HIRE (1) | 61 |
| DATE OF INJURY | 31 |
| DATE OF RETURN TO WORK | 68 |
| DATE REPORTED TO CLAIM ADMINISTRATOR | 41 |
| DATE REPORTED TO EMPLOYER | 40 |
| EMPLOYEE ADDRESS LINE 1 (1) | 46 |
| EMPLOYEE ADDRESS LINE 2 (1) | 47 |
| EMPLOYEE CITY (1) | 48 |
| EMPLOYEE DATE OF BIRTH | 52 |
| EMPLOYEE DATE OF DEATH | 57 |
| EMPLOYEE FIRST NAME | 44 |
| EMPLOYEE LAST NAME | 43 |
| EMPLOYEE MIDDLE INITIAL (1) | 45 |
| EMPLOYEE PHONE (1) | 51 |
| EMPLOYEE POSTAL CODE (1) | 50 |
| EMPLOYEE STATE (1) | 49 |
| EMPLOYER ADDRESS LINE 1 | 19 |
| EMPLOYER ADDRESS LINE 2 | 20 |
| EMPLOYER CITY | 21 |
| EMPLOYER FEIN | 16 |
| EMPLOYER NAME | 18 |
| EMPLOYER POSTAL CODE | 23 |
| EMPLOYER STATE | 22 |
| EMPLOYMENT STATUS CODE (1) | 58 |
| GENDER CODE | 53 |
| INDUSTRY CODE | 25 |
| INITIAL TREATMENT CODE | 39 |
| INSURED REPORT NUMBER | 26 |
| INSURER FEIN | 6 |
| INSURER NAME | 7 |
| JURISDICTION | 4 |
| MAINTENANCE TYPE CODE | 2 |
| MAINTENANCE TYPE CODE DATE | 3 |
| MARITAL STATUS CODE (2) | 54 |
| NATURE OF INJURY CODE | 35 |
| NUMBER OF DEPENDENTS (2) | 55 |
| OCCUPATION DESCRIPTION | 60 |
| PART OF BODY INJURED CODE | 36 |
| POLICY EFFECTIVE DATE | 29 |
| POLICY EXPIRATION DATE | 30 |
| POLICY NUMBER | 28 |
| POSTAL CODE OF INJURY SITE | 33 |
| SALARY CONTINUED INDICATOR | 67 |
| SELF INSURED INDICATOR | 24 |
| SOCIAL SECURITY NUMBER (4) | 42 |
| TIME OF INJURY | 32 |
| WAGE (1) | 62 |
| WAGE PERIOD (1) | 63 |
| (1) Required only when provided to the claims administrator.  (2) Death Cases Only.  (3) Required for insured claims only; optional for self-insured claims.  (4) If the Social Security Number (DN 42) is not known, use a string of eight zeros followed by a six. | |

Data elements omitted under this subsection because they were not known by the claims administrator shall be submitted within sixty (60) days from the date of the first report under this subsection.

(c) Each transmission of data elements listed under subdivisions (b), (d), (e), (f), or (g) of this section shall also include the following elements for data linkage:

|  |  |
| --- | --- |
| DATA ELEMENT NAME | DN |
| AGENCY/Jurisdiction Claim Number (2) (3) | 5 |
| Claim Administrator Claim Number (4) | 15 |
| claim administrator fein (8) | 8 |
| Date of Injury (5) | 31 |
| EMPLOYEE DATE OF BIRTH (6) | 52 |
| eMPLOYEE FIRST NAME (7) | 44 |
| EMPLOYER FEIN (7) | 16 |
| INSURER FEIN (4) | 6 |
| jurisdiction (1) | 4 |
| Maintenance Type Code (1) | 2 |
| Maintenance Type CODE Date (1) | 3 |
| TIME OF INJURY (9) | 32 |
| TRANSACTION SET ID (1) | 1 |
| (1) Jurisdiction (DN 4), Maintenance Type Code (DN 2), Maintenance Type Code Date (DN 3), and Transaction Set ID (DN 1) are required for transmissions under subdivisions (b), (d), (f), and (g).  (2) The Agency/Jurisdiction Claim Number (DN 5) will be provided by WCIS upon acceptance of the first report under subdivision (b).  (3) The Agency/Jurisdiction Claim Number (DN 5) is required on all transmissions under subdivision (b), except for original, denied and acquired reports. The Agency/Jurisdiction Claim Number (DN 5) is required on all transmissions under subdivisions (d), (e), (f) and (g).  (4) The Insurer FEIN (DN 6) and Claim Administrator Claim Number (DN 15) are required on all transmissions under subdivisions (b), (d), (e), (f) and (g).  (5) The Date of Injury (DN 31) is required on all transmissions under subdivisions (b), (d) and (g), except acquired and cancel first report transmissions under subdivision (b).  (6) The Employee Date of Birth (DN 52) is required on all first report transmissions under subdivision (b), except cancel first report transmissions under subdivision (b).  (7) The Employer FEIN (DN 16) and Employee First Name (DN 44) are required on all first report transmissions under subdivision (b) except for transmissions to cancel a first report.  (8) The Claims Administrator FEIN (DN 8) is required on all transmissions under subdivisions (b), (d), (e), (f) and (g).  (9) The Time of Injury (DN 32) is required on all non-cumulative trauma first report transmissions except acquired transmissions and denied, changed and corrected transmissions for claims that have been previously submitted as acquired under subdivision (b) with a Date of Injury (DN 31) on or after the implementation date of the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 3.1. |  |

(d) Each claims administrator shall submit to the WCIS within fifteen (15) business days thirty (30) calendar days of the close of a quarter, the following data elements, whenever indemnity benefits of a particular type and amount are started, changed, suspended, restarted, stopped, delayed, or denied, or when a claim is closed, or when the claims administrator is notified of a change in employee representation. Submissions under this subsection are required only for claims with a date of injury on or after July 1, 2000, and shall not include data on routine payments made during the course of an uninterrupted period of indemnity benefits.

|  |  |
| --- | --- |
| DATA ELEMENT NAME | DN |
| BENEFIT ADJUSTMENT CODE | 92 |
| BENEFIT ADJUSTMENT START DATE | 94 |
| BENEFIT ADJUSTMENT WEEKLY AMOUNT | 93 |
| CLAIM ADMINISTRATOR POSTAL CODE | 14 |
| CLAIM STATUS | 73 |
| CLAIM TYPE | 74 |
| DATE DISABILITY BEGAN | 56 |
| DATE OF MAXIMUM MEDICAL IMPROVEMENT | 70 |
| DATE OF REPRESENTATION | 76 |
| DATE OF RETURN/ RELEASE TO WORK | 72 |
| EMPLOYEE DATE OF DEATH | 57 |
| INSURED REPORT NUMBER | 26 |
| LATE REASON CODE | 77 |
| NUMBER OF BENEFIT ADJUSTMENTS | 80 |
| NUMBER OF DEATH DEPENDENT/PAYEE RELATIONSHIPS | 82 |
| NUMBER OF DEPENDENTS | 55 |
| NUMBER OF PAID TO DATE/REDUCED EARNINGS/RECOVERIES | 81 |
| NUMBER OF PAYMENTS/ADJUSTMENTS | 79 |
| NUMBER OF PERMANENT IMPAIRMENTS | 78 |
| PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES AMOUNT | 96 |
| PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES CODE | 95 |
| PAYMENT/ADJUSTMENT CODE | 85 |
| PAYMENT/ADJUSTMENT DAYS PAID | 91 |
| PAYMENT/ADJUSTMENT END DATE | 89 |
| PAYMENT/ADJUSTMENT PAIDTO DATE | 86 |
| PAYMENT/ADJUSTMENT START DATE | 88 |
| PAYMENT/ADJUSTMENT WEEKLY AMOUNT | 87 |
| PAYMENT/ADJUSTMENT WEEKS PAID | 90 |
| PERMANENT IMPAIRMENT BODY PART CODE (1) (2) | 83 |
| PERMANENT IMPAIRMENT PERCENTAGE (2) | 84 |
| RETURN TO WORK QUALIFIER | 71 |
| SALARY CONTINUED INDICATOR | 67 |
| WAGE | 62 |
| WAGE PERIOD | 63 |
| (1) May use Code 90 (Multiple Body Parts) to reflect combined rating for any/all impairments.  (2) Use actual permanent disability rating at the time of initial payment of permanent disability benefits. For compromise and release cases and stipulated settlements, use permanent disability estimate as reported to the appropriate rating organization established under Insurance Code § 11750, et seq. | |

(e) Claims administrators handling one hundred and fifty (150) or more total claims per year shall submit to the WCIS on each claim the following data elements for all medical services for which the claims administrator has received a billing or other report of provided medical services. The California EDI Implementation Guide for Medical Bill Payment Records sets forth the specific California reporting.

|  |  |
| --- | --- |
| DATA ELEMENT NAME | DN |
| ACKNOWLEDGMENT TRANSACTION SET ID | 0110 |
| ADA PROCEDURE BILLED CODE | 0719 |
| ADA PROCEDURE PAID CODE | 0722 |
| ADMISSION DATE | 0513 |
| ADMISSION HOUR | 0622 |
| ADMISSION TYPE CODE | 0577 |
| ADMITTING DIAGNOSIS CODE | 0535 |
| APPLICATION ACKNOWLEDGMENT CODE | 0111 |
| BILL ADJUSTMENT AMOUNT | 0545 |
| BILL ADJUSTMENT GROUP CODE | 0543 |
| BILL ADJUSTMENT REASON CODE | 0544 |
| BILL ADJUSTMENT UNITS | 0546 |
| BILL FREQUENCY TYPE CODE | 0505 |
| BILL SUBMISSION REASON CODE | 0508 |
| BILLED DRG CODE | 0548 |
| BILLING FORMAT CODE | 0503 |
| BILLING PROVIDER CITY | 0540 |
| BILLING PROVIDER COUNTRY CODE | 0569 |
| BILLING PROVIDER FEIN | 0629 |
| BILLING PROVIDER FIRST NAME | 0529 |
| BILLING PROVIDER LAST/GROUP NAME | 0528 |
| BILLING PROVIDER NATIONAL PROVIDER ID | 0634 |
| BILLING PROVIDER POSTAL CODE | 0542 |
| BILLING PROVIDER PRIMARY ADDRESS | 0538 |
| BILLING PROVIDER PRIMARY SPECIALTY CODE | 0537 |
| BILLING PROVIDER SECONDARY ADDRESS | 0539 |
| BILLING PROVIDER STATE CODE | 0541 |
| BILLING PROVIDER STATE LICENSE NUMBER | 0630 |
| BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER | 0523 |
| BILLING TYPE CODE | 0502 |
| CLAIM ADMINISTRATOR CLAIM NUMBER | 0015 |
| CLAIM ADMINISTRATOR FEIN | 0187 |
| CLAIM ADMINISTRATOR MAILING POSTAL CODE | 0014 |
| CLAIM ADMINISTRATOR NAME | 0188 |
| COMPOUND DRUG INDICATOR | 0762 |
| CONDITION CODE | 0556 |
| CONTRACT LINE TYPE CODE | 0741 |
| CONTRACT TYPE CODE | 0515 |
| DATE INSURER PAID BILL | 0512 |
| DATE INSURER RECEIVED BILL | 0511 |
| DATE OF BILL | 0510 |
| DATE OF INJURY | 0031 |
| DATE PROCESSED | 0108 |
| DATE TRANSMISSION SENT | 0100 |
| DAYS/UNITS BILLED | 0554 |
| DAYS/UNITS CODE | 0553 |
| DAY(S)/UNIT(S) PAID | 0580 |
| DIAGNOSIS CODE | 0522 |
| DIAGNOSIS POINTER | 0557 |
| DISCHARGE DATE | 0514 |
| DISCHARGE HOUR | 0623 |
| DISPENSE AS WRITTEN CODE | 0562 |
| DRUG NAME | 0563 |
| DRUGS/SUPPLIES BILLED AMOUNT | 0572 |
| DRUGS/SUPPLIES DISPENSING FEE | 0579 |
| DRUGS/SUPPLIES NUMBER OF DAYS | 0571 |
| DRUGS/SUPPLIES QUANTITY DISPENSED | 0570 |
| ELEMENT ERROR NUMBER | 0116 |
| ELEMENT NUMBER | 0115 |
| EMPLOYEE FIRST NAME | 0044 |
| EMPLOYEE LAST NAME | 0043 |
| EMPLOYEE MAILING CITY | 0048 |
| EMPLOYEE MAILING POSTAL CODE | 0050 |
| EMPLOYEE MIDDLE NAME/INITIAL | 0045 |
| EMPLOYEE SOCIAL SECURITY NUMBER | 0042 |
| EMPLOYER FEIN | 0016 |
| EMPLOYER NAME | 0018 |
| FACILITY CITY | 0686 |
| FACILITY CODE | 0504 |
| FACILITY COUNTRY CODE | 0689 |
| FACILITY NAME | 0678 |
| FACILITY NATIONAL PROVIDER ID | 0682 |
| FACILITY POSTAL CODE | 0688 |
| FACILITY PRIMARY ADDRESS | 0684 |
| FACILITY SECONDARY ADDRESS | 0685 |
| FACILITY STATE CODE | 0687 |
| FACILITY STATE LICENSE NUMBER | 0680 |
| HCPCS LINE PROCEDURE BILLED CODE | 0714 |
| HCPCS LINE PROCEDURE PAID CODE | 0726 |
| HCPCS MODIFIER BILLED CODE | 0717 |
| HCPCS MODIFIER PAID CODE | 0727 |
| HIPPS RATE CODE | 0625 |
| INSURER FEIN | 0006 |
| INSURER NAME | 0007 |
| INSURER POSTAL CODE | 0616 |
| JURISDICTION CLAIM NUMBER | 0005 |
| JURISDICTION MODIFIER BILLED CODE | 0718 |
| JURISDICTION MODIFIER PAID CODE | 0730 |
| JURISDICTION PROCEDURE BILLED CODE | 0715 |
| JURISDICTION PROCEDURE PAID CODE | 0729 |
| JURISDICTION TRACKING NUMBER | 0743 |
| LINE ITEM PRIOR ACTUAL AMOUNT PAID | 0761 |
| LINE NUMBER | 0547 |
| LUMP SUM PAYMENT SETTLEMENT CODE | 0293 |
| MANAGED CARE ORGANIZATION FEIN | 0704 |
| MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER | 0208 |
| MANAGED CARE ORGANIZATION NAME | 0209 |
| NDC BILLED CODE | 0721 |
| NDC PAID CODE | 0728 |
| ORIGINATOR TRANSACTION IDENTIFICATION  BATCH CONTROL NUMBER | 0532 |
| ORIGINAL TRANSMISSION DATE | 0102 |
| ORIGINAL TRANSMISSION TIME | 0103 |
| OTHER PROCEDURE CODE | 0736 |
| OUTPATIENT REASON FOR VISIT CODE | 0520 |
| PAID DRG CODE | 0549 |
| PLACE OF SERVICE BILL CODE | 0555 |
| PLACE OF SERVICE LINE CODE | 0600 |
| PRESCRIPTION DATE(S) RANGE | 0527 |
| PRESCRIPTION LINE DATE | 0604 |
| PRESCRIPTION LINE NUMBER | 0561 |
| PRESENT ON ADMISSION INDICATOR | 0533 |
| PRINCIPAL DIAGNOSIS CODE | 0521 |
| PRINCIPAL PROCEDURE CODE | 0525 |
| PRINCIPAL PROCEDURE DATE | 0550 |
| PRIOR ACTUAL AMOUNT PAID | 0760 |
| PROCEDURE DATE | 0524 |
| PROCEDURE DESCRIPTION | 0551 |
| PROVIDER AGREEMENT CODE | 0507 |
| PROVIDER AGREEMENT LINE CODE | 0742 |
| RECEIVER ID | 0099 |
| REFERRING PROVIDER FIRST NAME | 0691 |
| REFERRING PROVIDER LAST/GROUP NAME | 0690 |
| REFERRING PROVIDER NATIONAL PROVIDER ID | 0699 |
| RENDERING BILL PROVIDER FIRST NAME | 0639 |
| RENDERING BILL PROVIDER LAST/GROUP NAME | 0638 |
| RENDERING BILL PROVIDER NATIONAL PROVIDER ID | 0647 |
| RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE | 0651 |
| RENDERING BILL PROVIDER STATE LICENSE NUMBER | 0643 |
| RENDERING LINE PROVIDER NATIONAL PROVIDER ID | 0592 |
| RENDERING LINE PROVIDER FIRST NAME | 0587 |
| RENDERING LINE PROVIDER LAST/GROUP NAME | 0589 |
| RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE | 0595 |
| RENDERING LINE PROVIDER STATE LICENSE NUMBER | 0599 |
| REPORTING PERIOD | 0615 |
| REVENUE BILLED CODE | 0559 |
| REVENUE PAID CODE | 0576 |
| SENDER ID | 0098 |
| SERVICE ADJUSTMENT AMOUNT | 0733 |
| SERVICE ADJUSTMENT GROUP CODE | 0731 |
| SERVICE ADJUSTMENT REASON CODE | 0732 |
| SERVICE ADJUSTMENT UNITS | 0734 |
| SERVICE BILL DATE(S) RANGE | 0509 |
| SERVICE LINE DATE(S) RANGE | 0605 |
| SUPERVISING PROVIDER FIRST NAME | 0659 |
| SUPERVISING PROVIDER LAST/GROUP NAME | 0658 |
| SUPERVISING PROVIDER NATIONAL PROVIDER ID | 0667 |
| SUPERVISING PROVIDER PRIMARY SPECIALTY CODE | 0671 |
| TEST/PRODUCTION INDICATOR | 0104 |
| TIME PROCESSED | 0109 |
| TIME TRANSMISSION SENT | 0101 |
| TOTAL AMOUNT PAID PER BILL | 0516 |
| TOTAL AMOUNT PAID PER LINE | 0574 |
| TOTAL CHARGE PER BILL | 0501 |
| TOTAL CHARGE PER LINE | 0552 |
| TRANSACTION TRACKING NUMBER | 0266 |
| UNIQUE BILL ID NUMBER | 0500 |

(1) Each claims administrator shall submit all medical bills data including interpreter bills within ninety (90) calendar days of the medical bill payment or the date of the final determination that payment for billed medical services will be denied.

(2) Each claims administrator shall submit all medical lien lump sum payments or settlements following the filing of a lien claim for the payment of such medical services pursuant to Labor Code sections 4903 and 4903.1 within ninety (90) calendar days of the medical lien lump sum payment or settlement.

(3) Data transmission shall follow the requirements set forth in IAIABC Workers’ Compensation Medical Bill Data Reporting Implementation Guide, Release 2.0, February 1, 2015 Publication. California Specific requirements are included in the California EDI Implementation Guide for Medical Bill payment Records Version 2.0, dated the designated effective date (see Section 9701(c)(2)).

(f)(1) Notwithstanding the requirement in Subsection (b) to submit data elements omitted from the first report within 60 days from the date of transmission of the first report, when a claims administrator becomes aware of an error, the claims administrator shall transmit the corrected data to WCIS within 60 calendar days from the date of transmission of the error acknowledgment.

(2)    Notwithstanding the requirement in Subsection (b) to submit data elements omitted from the first report within 60 days from the date of transmission of the first report, when a claims administrator becomes aware of a need to update data elements previously transmitted, or learns of information that was previously omitted, the claims administrator shall transmit the updated or omitted data to WCIS no later than the next submission of data for the affected claim.

(g) No later than January 31 of every year, Cclaims administrators shall report, for each claim open, denied, re-open, closed, or re-closed during the previous quarter, the total paid in any payment category in the previous calendar year by submitting the following data elements, within thirty (30) calendar days of the close of the quarter:

|  |  |
| --- | --- |
| DATA ELEMENT NAME | DN |
| PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES AMOUNT | 96 |
| PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES CODE | 95 |
| PAYMENT/ADJUSTMENT CODE | 85 |
| PAYMENT/ADJUSTMENT END DATE | 89 |
| PAYMENT/ADJUSTMENT DAYS PAID | 91 |
| PAYMENT/ADJUSTMENT PAID TO DATE | 86 |
| PAYMENT/ADJUSTMENT START DATE | 88 |
| PAYMENT/ADJUSTMENT WEEKLY AMOUNT | 87 |
| PAYMENT/ADJUSTMENT WEEKS PAID | 90 |

(h) Final reports (MTC = FN) are required only for claims where indemnity benefits are paid or claims where no benefits are paid. For medical-only claims or claims with only non-indemnity benefit payments, the final report may be reported under this section or on the annual report (MTC = AN) with Claim Status (DN0073) = “closed.”

(i) (h)(1) A claims administrator’s obligation to submit copies of benefit notices to the Administrative Director pursuant to Labor Code section 138.4 is satisfied upon written determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under subdivision (d) and continued compliance with that subsection.

(2) Reserved.

(3) On and after September 22, 2006, a claims administrator’s obligation to submit an Annual Report of Inventory pursuant to California Code of Regulations, title 8, section 10104 is satisfied upon determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under subdivisions (b), (d), (e), and (g), and continued compliance with those subsections.

(j)(i) The data submitted pursuant to this section shall not have any application to, nor be considered in, nor be admissible into, evidence in any personal injury or wrongful death action, except as between an employee and the employee’s employer. Nothing in this subdivision shall be construed to expand access to information held in the WCIS beyond that authorized in California Code of Regulations, title 8, section 9703 and Labor Code section 138.7.

(k)(j) Each claims administrator required to submit data under this section shall submit to the Administrative Director an EDI Trading Partner Profile at least thirty days prior to its first transmission of EDI data. Each claims administrator shall advise the Administrative Director of any subsequent changes and/or corrections made to the information provided in the EDI Trading Partner Profile by filing a corrected copy of the EDI Trading Partner Profile with the Administrative Director.

(*l*)(k)(1) The Administrative Director may grant a claims administrator either a partial or total variance in reporting all or part of the data elements required under this section upon a documented showing that compliance with the reporting deadlines would cause undue hardship to the claims administrator.

(2) “Undue hardship” shall be determined based upon a review of the documentation submitted by the claims administrator. The documentation shall include:

(A) A statement explaining why the claims administrator is unable to transmit required data elements to the WCIS.

(B) The claims administrator’s estimated expenses necessary to meet the reporting requirements of this section.

(C) The reporting cost per claim if transmitted directly by the claims administrator and the total cost per claim if reported by a vendor.

(D) Submission of a plan documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the date of the request.

(3) Any variance granted by the Administrative Director under this subdivision shall be set forth in writing and shall be for a period of six (6) months.

(4) The variance period for reporting data elements under this subdivision may be extended for additional six (6) month period if the claims administrator resubmits a written request for an extension of the variance.

(5) Upon expiration of the variance period, a claims administrator granted a variance shall submit to the WCIS all data elements that were required to be submitted under this section during the variance period except for data elements that were not known to the claims administrator, the claims administrator’s agents, or not captured on the claims administrator’s electronic data systems. The data shall be submitted in an electronic format acceptable to the Division.

Authority: Sections 133, 138.4, 138.6, and 138.7, Labor Code.

Reference: Sections 138.4, 138.6, and 138.7, Labor Code.