California Division of Workers' Compensation Medical Billing and Payment Guide 2007

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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-200X. 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.

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 does 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, 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 Format" means the ASC X12 N standard format developed by the Accredited Standards Committee X12 Insurance Subcommittee of the American National Standards Institute and the retail pharmacy specifications developed by the National Council for Prescription Drug Programs ("NCPDP"). See the Companion Guide for specific format information.

(j) "Employer" as defined in this manual means any of the following: an Employer as defined in Labor Code section § 3300, an Insurer as defined in Labor Code section § 3211, and any person performing the duties of an employer under Division 4, Part 2, Chapter 2, Article 2 of the Labor Code.

(k) "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.

(l) "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.

(m) "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.

(n) "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.

(o) "Medical Treatment" means the treatment, goods and services as defined by Labor Code Section 4600.

(p) "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.

(q) "NCPDP" means the National Council for Prescription Drug Programs.

(r) 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.

(s) "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.

(t) "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.

(u) "Supporting Documentation" means those documents, other than a 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.

(v) "Third Party Biller/Assignee" means a person or entity who is either billing or collecting payment in place of, or on behalf of the rendering health care provider or health care facility.

(w) "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) "ASA Codes" means the codes contained in the ASA Relative Value Guide developed and maintained by the American Society of Anesthesiologists to describe anesthesia services and related modifiers. These codes are adopted by the Administrative Director for use in the Official Medical Fee Schedule (Title 8, California Code of Regulations §§ 9789.10-100).

(2) “California Codes” means those codes adopted by the Administrative Director for use in the Official Medical Fee Schedule (Title 8, California Code of Regulations §§ 9789.10-100). The California codes include those codes found in the 1999 OMFS book, as well as the CDT, CPT, HCPCS, DRG, ASA, and NDC codes.

(3) "CDT-4 Codes" means the current dental codes and nomenclature prescribed by the American Dental Association.

(4) "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.

(5) “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.

(6) "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.

(7) "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.

(8) "NDC" means the National Drug Codes of the Food and Drug Administration.

(9) “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.

(10) "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.

(2) The third Monday in January, known as "Dr. Martin Luther King, Jr. Day."

(3) February 12th, known as "Lincoln Day."

(4) The third Monday in February.

(5) March 31st known as "Cesar Chavez Day."

(6) The last Monday in May.

(7) July 4th.

(8) The first Monday in September.

(9) The second Monday in October, known as "Columbus Day."

(10) November 11th, known as "Veterans Day."

(11) December 25th.

(12) If January 1st, February 12th, 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.

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2.0 Standardized Medical Treatment Billing Format

(a) On and after XXXX, 2007, [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 for use by health facilties 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 for pharmacy bills.

(b) On and after XXXX, [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 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.

(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 must be provided when one is 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.

(d) For paper bills, if the required reports and supporthing documentation are not submitted in the same mailing envelope as the bill, then a header or attachement 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 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.

(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 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 on paper may not be also submitted as an electronic bill.

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 – 1.0. If the objection is based on the coding of a procedure, the explanation shall include both the code reported by the provider and the code believed reasonable by the claims administrator. In addition, the Explanation of Review should contain all the required elements spelled out in Appendix B – 2.0. There is no required format as long as all the elements are present.

(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.

(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) 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.

(e) This section does not prohibit a claims administrator from conducting a retrospective review as allowed by Labor Code section 4610 and Title 8, California Code of Regulations §§9792.6-9792.10.

(f) 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 and the Companion Guide.

(g) 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.

(h) Explanations of Review shall use the DWC Bill Adjustement Reason codes and descriptions listed in Appendix B Standard Explanation of Review – 1.0. The Explanations of Review shall contain all the required elements listed in Appendix B Standard Explanation of Review – 2.0.

7.0 Medical Treatment Billing and Payment Requirements for Electronically Submitted Bills

7.1 Timeframes

(a) Acknowledgements.

(1) Interchange Acknowledgement (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 (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) Detailed Acknowledgement (824) - within two working days of receipt of an electronically submitted bill, the claims administrator shall send electronic notice of whether or not the bill submission is complete. 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 824 transaction set as defined in Companion Guide Chapter 3 and must include specific information setting out the reason for rejection.

(A) Pending transactions

(i) A bill submitted, but missing an attachment or the injured worker's claim number shall be pended 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. All other timeframes are suspended during the time period the bill is pended. 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 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.

(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) Incomplete bill error messages shall include the following:

(i) Invalid form or format – indicate which form should be used and why

(ii) Missing fields- indicate specifically missing field number identifier or field name identifier

(iii) Invalid data – for each field of invalid data, indicate specifically the proper data type

(iv) Missing attachments – indicate specifically which attachment is 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.

(1) If the electronically submitted bill has been determined to be complete, payment for 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 will be sent using the (835) Healthcare Claim 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. 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:

(A) 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 – 1.0. If the objection is based upon appropriate coding of a procedure, the explanation shall include both the code reported by the submitter/provider and the code believed reasonable by the claims administrator.

(B) 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.

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

(D) 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.

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) All attachments accompanying an electronically submitted bill must either have a header or attached cover sheet that provides the following information:

(1) Claims Administrator

(2) Employer

(3) Attachment Control Number – unique for each bill (The Attachment Control Number populated on the document shall include the 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.) See the Companion Guide Chapter Chapter 4 for more information about the code sets.

(4) NPI

(5) Date of submission of original bill

(6) Bill Transaction Identification Number – The Provider, or their agent, assigns a unique identification number to the electronic bill transaction. This standard HIPAA implementation allows for a patient account number but “strongly recommends that submitters use completely unique number for this field for each individual claim.”

(7) Document type – use document codes as set forth in Chapter 11 of the Companion Guide.

(8) # of documents

(9) Page Number/Number of Pages

(b) All attachments accompanying 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) Attachment Control Number

(c) All attachment submissions shall comply with the rules set forth in Section One – 3.0. They shall be submitted according to the protocols specified in the Companion Guide Chapter 11 or other 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 11. 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) Requests for Authorization

(4) Misc. (other type of attachment)

7.4 Miscellaneous

(a) This section does not prohibit a claims administrator from conducting a retrospective review as allowed by Labor Code section 4610 and Title 8, California Code of Regulations §§9792.6-9792.10.

(b) Required reports and/or supporting documentation required with the bill shall be transmitted as set forth in the Section One – 7.3.

(c) This section does not prohibit a 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 and transmission format provides all the required information set forth in the Appendix A or the Companion Guide.

(d) Individually identifiable health information submitted on a uniform billing form shall not be disclosed by either the claims administrator or submitting health provider, health care facility or third party biller/assignee 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, ANSI X12 835 equivalent, field description, the field type (required, situational, optional or not applicable) and any comments.

Fields designated as "required" must be provided or the bill will be considered incomplete.

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

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

1.0 CMS 1500

The National Uniform Claim Committee (NUCC) has a Reference Manual for the CMS 1500 form. This manual is incorporated within this guide by reference. It is recommended that you review this manual carefully. Copies of the manual may be obtained directly from NUCC at: http://www.nucc.org/images/stories/PDF/claim_form_manual_v2-1_3-07.pdf

Billings must conform to the Reference Manual. Wherever the NUCC Reference 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 08/05

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLKLUNG ☐ (SSN) OTHER ☐ (ID)

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 ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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.

SIGNED _____ DATE

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

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

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 has 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 noncovered services. Coinsurance and the deductible are based 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 in "Insured", i.e., items 1a, 4, 6, 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 I (or any employee) who rendered services am not on 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 8126). 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: Any one 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 205(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 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq, and 30 USC 901 et seq, 38 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 payers 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. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Publication of Notices of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-31, as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received 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 litigations; 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.

DISCLOSURE: 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 1128B of the Social Security Act and 31 USC 3801-3812 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 1995, 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 0938-0999. The time required to complete this 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 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

1.1 Field Table CMS 1500

Paper Field	2007 CMS-1500 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	Comments
1	Coverage	Required	Mark an X in OTHER box
1a	Insured's ID Number (Employee SSN)	Required	Enter patient Social Security Number. If the patient does not have a Social Security Number then enter the following 9 digit number: 99999999
2	Patient's Last Name	Required	
	Patient's First Name	Required	
	Patient's Middle Name	Situational	
3	Patient's Birth Date	Required	Provide patient's date of birth in MMDDYY format
3b	Patient's Gender	Required	Mark an "X" in the box indicating patient gender
4	Insured Name (Employer)	Required	Employer Name
5	Patient's Address	Required	
	City		
	State		
	Zip Code		
	Telephone Number		Enter telephone number if known
6	Patient's Relationship to the Insured	Required	Place an "X" in the box "Self"
7	Insured's Address (Employer)	Required	Enter employer's address
	City		
	State		
	Zip Code		
	Telephone Number		Enter telephone number if known
8	Patient Status	N/A	
9	Other Insured	N/A	
10	Is the Patient's Condition Related to Employment	Required	Enter an X in the "Yes" box in field 10a indicating patient's condition is related to employment.10b Do not use 10c Do not use
10d	Rendering Provider Taxonomy Code	Situational	Required if Rendering Provider is a health care provider
11	Property and Casualty Number (Claim Number)	Situational	Enter claim number, if known in field 11 or if claim number is not known then enter a two digit numeric value 00 to indicate unknown claim number.
11b	Employer Name	Situational	Enter Employer Department Name /Division if applicable
11c	Insurance Plan Name or Program Name	Required	Payer Name
12	Patient's or Authorized Person's Signature on File	Optional	Enter "Signature on File" to indicate signature is on file. If there is no signature on file, leave the field blank or enter "No Signature on File"
13	Insured's or Authorized Person's Signature	NA	
14	Date of Current Illness, Injury or Pregnancy	Required	Date of Accident/ Illness
15	Date of Similar Illness	Optional	

Paper Field	2007 CMS-1500 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	Comments
16	Dates Patient Unable to Work	N/A	Do not fill in this field. This information should appear only on the medical report.
17	Name of Referring Physician or Other Source	Situational	Enter the name of the referring physician or other source(if different than field 31)
17a	ID Qualifier and State License Number of Referring Physician	Situational	Required if field 17 is populated. Enter the State License Number of referring physician or other source indicated in Field 17a in the shaded area. If other source has a certification number then enter certification number. Use the two digit ID Qualifier "OB" to indicate State License Number in the qualifier field to the immediate right of 17a.
17b	NPI Number of the Referring Provider or Ordering Provider	Situational	Enter the NPI Number of the referring provider, ordering provider, or source in field 17b
18	Hospitalization Dates Related to Current Services	Situational	Required if this bill includes charges for services rendered during an inpatient admission. Enter hospital admission date (MMDDYY) followed by the discharge date (If discharge has occurred) If not discharged, leave discharge date blank
19	Reserved for Local Use Workers' Compensation Attachment Control Number* See Instructions Below	Situational*	Attachment Report Type Code
			Attachment Deliver Method Code
			Attachment Control Indicator Code
			Unique ID number Related to Bill
20	Outside Lab/ Charges	Situational	Use when billing for diagnostic tests
21.1	Diagnosis or Nature of Illness or Injury	Required	
21.2		Situational	
21.3			
21.4			
22	Medicaid Resubmission Code/Original Reference Number - Workers' Compensation Code/ Bill Resubmission Indicator	Situational	Required field if resubmitting a bill. Enter the appropriate two digit resubmission code
			07=Duplicate
			15=Revised
			30=Appeal/Reconsideration
23	Prior Authorization Number	Situational	Enter prior authorization or certification number assigned by payer, if known

Paper Field	2007 CMS-1500 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	Comments
24	Supplemental Information	Optional	Supplemental information is to be entered in the shaded section of 24D through 24H as defined by each Item Number.
24A	Dates of Service	Required	Enter "From" and "To" dates of service in MMDDYY format. Line items can include no more than two dates of service for the same procedure code
24B	Place of Service	Required	Enter the appropriate CMS place of service code
24D	Procedures, Services or Supplies and Modifiers	Required	Enter Official Medical Fee Schedule code(s) and applicable modifier (s) for each service entered. If providing supplemental information use appropriate identification code followed by description in shaded area of this field.
		Situational	Modifier 1
			Modifier 2
			Modifier 3
			Modifier 4
24D RX	Pharmacy Supplies	RX Required	HCPCS code for RX
			Use second line to hold the NDC Number
24D DME	DME Supplies and Modifiers	DME Required	HCPCS code for DME
			Modifiers 1 thru 4. Use modifier to indicate if the DME is a purchase or a rental.
24E	Diagnosis Pointers	Required	Enter the diagnosis code reference pointer (1, 2, 3, and 4) of the entered diagnosis in Field 21 for which this service was rendered. Do not enter the ICD-9 or DSM diagnosis code
		Situational	
24F	Charges	Required	
24G	Days or Units	Required	Enter the appropriate number of units or days that correspond to the "From" and "To" dates indicated in Field 24a
24I	ID Qualifier	Situational	Required when rendering line provider is different than provider listed in box 31. Enter in the shaded area of 24I the ID qualifier "OB" indicating State License Number

Paper Field	2007 CMS-1500 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	Comments
24J_1	Rendering Line Provider State License	Situational	Required when rendering line provider is different than provider listed in box 31. Enter state license number or certification number in the shaded area of the field.
24J_2	Rendering Line Provider NPI	Situational	Required when rendering line provider is different than provider listed in box 31. Enter the NPI number in the unshaded area of the field
25	Federal Tax ID or Social Security Number and Type	Required	Billing Provider
26	Patient's Account Number	Required	Enter unique patient account number assigned by provider of services or suppliers account
27	Accept Assignment	Required	Enter an "X" in the YES box
28	Total Charge	Required	Enter the total charge for this bill. This is the total of all charges for each service noted in Field 24f, lines 1-6
29	Patient Amount Paid	N/A	
30	Balance Due	N/A	
31	Signature of Physician or Supplier Including Degrees or Credentials and Date	Required	
32	Service Facility Location Information	Required	Enter name and address of facility where services were rendered (if other than home or office)
32a	Service Facility Location NPI Number	Situational	Required if entity populated in Box 32 is a licensed health care provider eligible for a NPI number. Enter the NPI Number of the service facility location in field 32a
32b	Service Facility Location State License Number	Situational	Required if entity populated in Box 32 is a licensed health care provider. Enter service facility location state license number
33	Physician's/Supplier's Billing: Name	Required	Enter the provider's or supplier's billing name, address, zip code and phone number. The phone number is to be entered in the area to the right of the field title
	Address		
	City		
	State		
	Zip Code		
	Phone Number		
33a	NPI Number of Billing Provider	Situational	Required if Billing Provider is a health care entity. When Billing and Rendering Provider are the same, Billing Provider NPI is populated. When Rendering Provider is

Paper Field	2007 CMS-1500 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	Comments
			different than Billing Provider , populate Rendering Provider NPI number
33b	State License Number	Situational	Required if Billing Provider is a health care entity. When Billing and Rendering Provider are the same, Billing Provider state license number is populated. When Rendering Provider is different than Billing Provider, populate Rendering Provider state license number
*	*An attachment control number is required in box 19 and on supporting document (s) associated with this bill, if the document (s) is submitted separately from the bill. Refer to Section One – 7.3 and/or the Companion Guide Chapter 11 for Attachment Control Number Requirements. Enter the two digit codes for report type, method sent and attachment ID code" AC" followed by unique identification number of the attachment (s) related to this specific bill. Example Attachment Control Number : RR ELAC123456 (1) Report Type :Radiology=RR (2) Method Sent: Electronic=EL (3) Attachment Control Indicator =AC (4) Unique Attachment Control Number=123456		

2.0 UB 04

The National Uniform Billing Committee (NUBC) has a Data Specifications Manual for the UB 04 form. This manual is incorporated within this guide by reference. It is recommended that you review this manual. 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 Reference Manual. 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 THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a						a
b						b

38		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE 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	PAGE ____ OF ____	CREATION DATE		TOTALS			23

NOT TO SCALE
NOT FOR REPRODUCTION

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

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

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

66 DX										68

69 ADMIT DX	70 PATIENT REASON DX			71 PPS CODE	72 ECI				73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450

OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

2.1 Field Table UB 04

Paper Field	UB04 Medicare Field Description	Workers' Compensation Paper Fields R/S/O	Workers' Compensation Instructions
1	Name of provider submitting bill, complete mailing address to which the provider wishes payment sent and provider telephone number	Required	Enter facility name with complete billing address, including city state, zip code and telephone number
2	Name of provider receiving payment (pay to provider) if different than billing provider in box 1, pay to provider complete mailing address to which the provider wishes payment sent , and pay to provider telephone number	Situational	Required if entity receiving payment is different than the billing provider
3a	Patient Control Number	Required	Enter unique patient control number assigned by Facility
3b	Medical Record Number	Required	Enter the number assigned by the provider to the patient's medical or health record
4	Type of Bill	Required	Enter 3-digit National Uniform Billing Committee (NUBC) code for Type of Bill. If claims frequency type code indicates a resubmission then a bill resubmission code is required in box 7
5	Federal Tax Number	Required	Enter the 9-digit Employer Identification Number for the provider indicated in box 1 assigned by the Internal Revenue Services (IRS)
6	Statement Covers Period "From" and "Through"	Required	Enter the beginning and ending date of services for the period reflected on the claim in MMDDYY format
7	Workers' Compensation Bill Resubmission Code	Situational	Required field if bill type frequency code is 7 in box 4. Enter the appropriate 2 digit bill resubmission code
			07=Duplicate
			15=Revised
			30=Appeal/Consideration
8a-b	Patient's Name (last, first name, and middle initial if applicable)	Required	Enter the patient name (last, first name and middle initial)
9a-d	Patient Address including city, state and zip code	Required	Enter the complete mailing address of the patient. Include street number and name, PO box or rural route number, apartment number if applicable, city, state and zip code
9e	Patient County Code	Situational	Required if patient lives outside of the US
10	Birth Date	Required	Enter the patient's date of birth in MMDDYY format
11	Sex	Required	Enter the code for the gender of the patient
12	Admission Date	Required	Enter date admitted for inpatient care, first date of outpatient service or start of care (MMDDYY)

13	Admission Hour	Situational	Enter the admission hour in Military Standard Time (e.g. 00:00 to 24:00), if applicable
14	Admission Type	Situational	Required for Admissions. Enter the code for the admission type (NUBC)
15	Admission Source	Situational	Enter the appropriate admission source code, if applicable
16	Discharge Hour	Situational	Enter the hour at which the patient was discharged (applicable only if the patient was admitted as an inpatient, or was admitted for outpatient observation)
17	Patient Status (Discharge Status)	Situational	Enter the applicable code indicating the patient's disposition as of the ending date of service for the period care
18 – 28	Condition Codes	Situational	Enter a valid condition code if applicable
29	Accident State	N/A	
30	Unlabeled		
31a,b	Occurrence of Code and Date	Required	Enter a valid occurrence code (WC= O4 related to employment) and date (Date of Injury). Enter date in MMDDYY format
32a,b	Occurrence of Code and Date	Situational	Enter a valid occurrence code and date if applicable. Enter date in MMDDYY format
33a,b	Occurrence of Code and Date	Situational	Enter a valid occurrence code and date if applicable. Enter date in MMDDYY format
34a,b	Occurrence of Code and Date	Situational	Enter a valid occurrence code and date if applicable. Enter date in MMDDYY format
35a,b	Occurrence Span Code and " From and Through Date"	Situational	Required if an occurrence span code entered; enter the date in MMDDYY format
36a,b	Occurrence Span Code and " From and Through Date"	Situational	Enter occurrence code and date span (from MMDDYY through MMDDYY)
37	Unlabeled	N/A	
38	Workers' Compensation Insurance Carrier Name and Mailing Address city, state and zip code	Required	Enter the Payer's name and address including city, state, and zip code responsible for payment of the bill
39a - 41d	Value Code and Amount	Situational	Enter a valid value code and amount if applicable
42	Revenue Code	Required	Enter the applicable revenue code for the services rendered. Total Charged-0001 required as last entry of revenue code
43	Revenue Code Description	Situational	Enter narrative description of the related revenue categories included on this bill. RX description requires NDC number/DAW/Units

44	HCPCS/Rates/HIPPS Codes	Situational	Enter a valid HCPCS or CPT procedure code for the ancillary services for outpatient or the accommodation rate for inpatient claims if applicable
45	Service Date	Required	Enter the date the service was rendered in MMDDYY format
46	Units of Service	Required	Enter the service units for each service billed
47	Total Charges	Required	Enter the amount equal to the per unit charge to the related revenue codes gilled for the statement from and through dates. This amount includes both the covered and non-covered charges. The last revenue code entered in field 42 is "0001" which represents the grand total of all charges billed
48	Non Covered Charges	NA	
49	Unlabeled		
50a	Payer Name	Required	Payer Name
51a	Health Plan ID	NA	Payer Plan Identifier
52a	Release of Information Certification Indicator	Required	Enter the appropriate code denoting whether the provider has on file a signed statement form the beneficiary to release information.
53a	Assignment of Beneficiary	NA	
54a	Prior Payments	Situational	Enter amount of prior payment related to these services
55a	Estimated Amount Due from Patient	NA	
56	Billing Provider NPI Number	Situational	Required if billing provider is a health care entity. Enter billing provider NPI number
57a	Billing Provider State License Number	Situational	Required if billing provider is a health care entity. Enter billing provider state license number
58a	Insured Name	Optional	Employer Department/Division
59a	Patient Relationship to Insured	Required	
60a	Insured's Unique ID	Required	Patient Social Security Number
61a	Insured's Group Name	N/A	
62a	Insurance Group Number- Workers' Compensation Claim Number	Situational	Enter claim number, if known or if claim number is not known then enter a two digit numeric value 00 to indicate unknown claim number.
63a	Treatment Authorization Codes	Situational	Enter the authorization number assigned by the payer indicated in Field 50 if known
64a	Document Control Number (Original reference number-ICN/DCN)	Situational	Required if bill transaction is a resubmission. Payer's unique bill identification number.

64b	Attachment Control Number	Situational	Required if submitting documentation associated with a bill. Enter Report Type Code, Report Submission Code , Attachment Indicator and Attachment Control Number
65a	Employer Name	Required	Enter the name of primary employer that provides the coverage for the insured
65b	Employer Address (Street Address)	Required	Enter the employer address including city, state and zip code.
65c	Employer Address (City, State and Zip Code	Required	
66	Diagnosis Version Qualifier	Required	Indicates if ICD codes used are ICD9 or ICD10
67	Principal Diagnosis Code	Required	Enter a valid ICD-9 or DSM-IV diagnosis code (including fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered.
67a-q	Other Diagnosis Code	Situational	Required if there are other diagnoses other than the primary diagnosis. Enter a valid ICD-9 or DSM-IV diagnosis code (include fourth and fifth digits if applicable) for any other conditions that exist for the services rendered
68	Unlabeled		
69	Admitting Diagnosis Code	Situational	Required for Inpatient and optional for outpatient. Enter a valid ICD-9 or DSM-IV diagnosis code (include the fourth and fifth digits if applicable) that describes the diagnosis at the time of admission
70	Patient's Reason for Visit Code	Situational	Required for outpatient bills. Enter valid code value, if applicable
71	Prospective Payment System PPS Code	NA	
72	External Cause of Injury Code	Optional	Enter E code if applicable
73	Unlabeled (Workers' Compensation DRG Code)	Situational	Enter valid DRGs if Inpatient billing, not required for Outpatient
74	Principle Procedure Code and Date	Situational	Required on inpatient claims when a procedure was performed. Enter a valid ICD-9 code and date to identify the significant procedures performed during the statement from and through dates if applicable (MMDDYY)
74a,e	Other Procedure Code/Date	Situational	Required on inpatient claims when additional procedures were performed. Enter a valid ICD-9 code and date to identify the significant procedures performed during the statement from and through dates if applicable (MMDDYY)
75	Unlabeled		

76a	Attending Physician NPI Number	Required	Enter NPI Number for attending physician
b	2nd Provider ID Qualifier Code	Required	Enter ID Qualifier Code for State License
c	2nd Provider ID- State License Number	Required	Enter state license number of attending physician
d	Attending Physician Last Name and First Name	Required	Enter attending physician last and first name
77a	Operating Physician NPI Number	Situational	Required when surgical services are provided. Enter NPI Number for attending physician
b	2nd Provider ID Qualifier Code	Situational	Enter ID Qualifier Code for State License
c	2nd Provider ID- State License Number	Situational	Enter state license number of operating physician
d	Operating Physician Last Name and First Name	Required	Enter operating physician last name and first name
78a	Other Physician Block 1(Referring, Other Operating, Rendering Provider) NPI Number	Situational	Required when physician other than attending/operating provides services. Enter NPI Number
b	2nd Provider ID Qualifier Code	Situational	Enter ID Qualifier Code for State License
c	2nd Provider ID- State License Number	Situational	Enter state license number
d	Physician Last Name and First Name		Enter physician last name and first name
79a	Other Physician Block 2- NPI Number	Situational	Required when physician other than attending/operating or provider in box 78 provides service. Enter NPI Number
b	2nd Provider ID Qualifier Code	Situational	Enter ID Qualifier Code for State License
c	2nd Provider ID- State License Number	Situational	Enter state license number
d	Physician Last Name and First Name	Situational	Enter physician last name and first name
80	Remarks	Situational	
81	Code - Code Field		
	Qualifier Type Code B3 (Provider Taxonomy Code)	Required	Enter taxonomy code for attending physician
	Qualifier Type Code B3 (Provider Taxonomy Code)	Situational	Enter taxonomy code for operating physician
	Qualifier Type Code B3 (Provider Taxonomy Code)	Situational	Enter taxonomy code for other provider
	Qualifier Type Code B3 (Provider Taxonomy Code)	Situational	Enter taxonomy code for rendering physician

3.0 NCPDP

National Council of Prescription Drug Programs (NCPDP) has a Data Specifications Manual for the NCPCP form. This manual is incorporated within this guide by reference. It is recommended that you review this manual. Copies of the manual may be obtained directly from NCPCP at:

National Council of Prescription Drug Programs
www.**ncpdp**.org/

9240 E. Raintree Dr.
Scottsdale, Arizona 85260-7518

CARDHOLDER I.D. _____ GROUP I.D. _____

CARDHOLDER NAME L/F/MI _____ PLAN NAME _____

PATIENT NAME L/F/MI _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____

PATIENT DATE OF BIRTH ____ ____ ____ (MM DD CCYY) PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____

PHARMACY NAME _____

ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____

CITY _____ PHONE NO. ( ) _____

STATE & ZIP CODE _____ FAX NO. ( ) _____

FOR OFFICE USE ONLY	

WORKERS COMP. INFORMATION
EMPLOYER NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

CARRIER I.D. (6) _____ **EMPLOYER PHONE NO.** _____

DATE OF INJURY ____ ____ ____ (MM DD CCYY) **CLAIM (7) REFERENCE I.D.** _____

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT / AUTHORIZED REPRESENTATIVE _____

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1

PRESCRIPTION / SERV. REF. #	QUAL. (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL. (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL. (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL. (15)	DIAGNOSIS CODE	QUAL. (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL. (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2

PRESCRIPTION / SERV. REF. #	QUAL. (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL. (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL. (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL. (15)	DIAGNOSIS CODE	QUAL. (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL. (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

(PERF) 1A4

NCPDP UNIVERSAL CLAIM FORM (UCF)

(PERF) 1A4

TYPE OR PRINT ALL INFORMATION NEATLY AND COMPLETELY IN APPROPRIATE SPACES

1842-1108-9227

SCREENS: BOX 10%, TEXT 11%.

IMPORTANT I certify that the patient information entered on the front side of this form is correct, that the patient named is eligible for the benefits and that I have received the medication described. If this claim is for a workers compensation injury, the appropriate section on the front side has been completed. I hereby assign the provider pharmacy any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to this claim to the plan administrator, underwriter, sponsor, policyholder and the employer.

PLEASE SIGN CERTIFICATION ON FRONT SIDE FOR PRESCRIPTION(S) RECEIVED

INSTRUCTIONS

1. Fill in all applicable areas on the front of this form.
2. Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient, name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
3. Worker's Comp. Information is conditional. It should be completed only for a Workers Comp. Claim.
4. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
5. Limit 1 set of DUR/PPS codes per claim.

DEFINITIONS / VALUES

1. OTHER COVERAGE CODE

0=Not Specified
1=No other coverage identified
2=Other coverage exists-payment collected
3=Other coverage exists-this claim not covered
4=Other coverage exists-payment not collected
5=Managed care plan denial
6=Other coverage denied-not a participating provider
7=Other coverage exists-not in effect at time of service
8=Claim is billing for a copay

2. PERSON CODE: Code assigned to a specific person within a family.

3. PATIENT GENDER CODE

0=Not Specified
1=Male
2=Female

4. PATIENT RELATIONSHIP CODE

0=Not Specified
1=Cardholder
2=Spouse
3=Child
4=Other

5. SERVICE PROVIDER ID QUALIFIER

Blank=Not Specified
01=National Provider Identifier (NPI)
02=Blue Cross
03=Blue Shield
04=Medicare
05=Medicaid
06=UPIN
07=NCPDP Provider ID
08=State License
09=Champus
10=Health Industry Number (HIN)
11=Federal Tax ID
12=Drug Enforcement Administration (DEA)
13=State Issued
14=Plan Specific
99=Other

6. CARRIER ID: Carrier code assigned in Worker's Compensation Program.

7. CLAIM/REFERENCE ID: Identifies the claim number assigned by Worker's Compensation Program.

8. PRESCRIPTION/SERVICE REFERENCE # QUALIFIER

Blank=Not Specified
1=Rx billing
2=Service billing

9. QUANTITY DISPENSED: Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

10. PRODUCT/SERVICE ID QUALIFIER: Code qualifying the value in Product/Service ID (407-07)

Blank=Not Specified
00=Not Specified
01=Universal Product Code (UPC)
02=Health Related Item (HRI)
03=National Drug Code (NDC)
04=Universal Product Number (UPN)
05=Department of Defense (DOD)
06=Drug Use Review/Professional Pharm. Service (DUR/PPS)
07=Common Procedure Terminology (CPT4)
08=Common Procedure Terminology (CPT5)
09=HCFA Common Procedural Coding System (HCPCS)
10=Pharmacy Practice Activity Classification (PPAC)
11=National Pharmaceutical Product Interface Code (NAPPI)
12=International Article Numbering System (EAN)
13=Drug Identification Number (DIN)
99=Other

11. PRIOR AUTHORIZATION TYPE CODE

0=Not Specified
1=Prior authorization
2=Medical Certification
3=EPSDT (Early Periodic Screening Diagnosis Treatment)
4=Exemption from copay
5=Exemption from Rx limits
6=Family Planning Indicator
7=Aid to Families with Dependent Children (AFDC)
8=Payer Defined Exemption

12. PRESCRIBER ID QUALIFIER: Use service provider ID values.

13. DUR/PROFESSIONAL SERVICE CODES: Reason for Service, Professional Service Code, and Result of Service. For values refer to current NCPDP data dictionary.

A=Reason for Service
B=Professional Service Code
C=Result of Service

14. BASIS OF COST DETERMINATION

Blank=Not Specified
00=Not Specified
01=AWP (Average Wholesale Price)
02=Local Wholesaler
03=Direct
04=EAC (Estimated Acquisition Cost)
05=Acquisition
06=MAC (Maximum Allowable Cost)
07=Usual & Customary
09=Other

15. PROVIDER ID QUALIFIER

Blank=Not Specified
01=Drug Enforcement Administration (DEA)
02=State License
03=Social Security Number (SSN)
04=Name
05=National Provider Identifier (NPI)
06=Health Industry Number (HIN)
07=State Issued
99=Other

16. DIAGNOSIS CODE QUALIFIER

Blank=Not Specified
00=Not Specified
01=International Classification of Diseases (ICD9)
02=International Classification of Diseases (ICD10)
03=National Criteria Care Institute (NDCC)
04=Systemized Nomenclature of Human and Veterinary Medicine (SNOMED)
05=Common Dental Term (CDT)
06=Medi-Span Diagnosis Code
07=American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)
99=Other

17. OTHER PAYER ID QUALIFIER

Blank=Not Specified
01=National Payer ID
02=Health Industry Number (HIN)
03=Bank Information Number (BIN)
04=National Association of Insurance Commissioners (NAIC)
09=Coupon
99=Other

B-1A1

COMPOUND PRESCRIPTIONS - LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM.

Name	NDC	Quantity	Cost

1842-1108-9227

REGULAR BACKER, SCREEN 10%

3.1 Field Table NCPDP

California NCPDP Paper UCF Billing Form Instructions **For Workers' Compensation**				
UCF Paper Field #	**Paper UCF Field Label**	**Actual Field Data**	**DWC Data Type R/S/O**	**Workers' Compensation UCF Paper Form Instructions**
1	I.D.	Injured Worker SS #	Required	Enter the injured worker's social security number. If the injured worker does not have a social security number enter "999-99-9999".
2	Group I.D.	Billing Indicator	Required	Enter "Agent Billed" if claim is being processed by a third party billing service. If being billed by the provider enter "Provider Billed" For Agent Biled, the pharmacy information will need to be derived from the NCPDP or NPI number by using a cross-referencing table or system.
3	(White Space, upper right hand corner)	Billing Date	Required	Enter the date the form was created and sent to the carrier or payer.
4	Name	Provider ID Number	Required	Enter the Pharmacy NCPDP or NPI number. *This field will help payers identify who the dispensing provider is when form is being submitted by a third party agent or assignee.*
5	Plan Name	Provider ID Number Qualifier	Required	Enter 01 if the Provider ID provided in the "Plan Name" field is an NPI number. Enter "07" if the provider ID number provided in the "Plan Name" field is an NCPDP number. Payers would need to use a cross-reference tool to obtain complete provider information if form is being submitted by a third party agent or assignee. This information cannot be used to re-direct care.
6	Patient Name	Injured Worker Name	Required	Enter the injured worker's name - Last Name, First Name, Middle Initial
7	Other Coverage Code	*N/A*		*Leave Field Blank*
8	Person Code	*N/A*		*Leave Field Blank*
9	Patient Date of Birth	Injured Worker DOB	Required	Enter the injured worker's date of birth. Format=MM DD CCYY
10	Patient Gender Code	Injured Worker Gender	Required	Enter "1" for male or "2" for female
11	Patient Relationship Code	*N/A*		*Leave Field Blank*
12	Pharmacy Name	Payee Name	Required	Provider/Entity to whom payment should be made. (*If the UCF Paper Field #2 indicates "Agent Billed" then the dispensing pharmacy data will be derived from the ID number in Field #4.*)
13	Pharmacy Address	Payee Address	Required	Enter the address of the entity receiving payment.
14	Pharmacy City	Payee City	Required	Enter the city of the entity receiving payment.
15	Pharmacy State & Zip Code	Payee State & Zip	Required	Enter the state and zip code of the entity receiving payment.

UCF Paper Field #	Paper UCF Field Label	Actual Field Data	DWC Data Type R/S/O	Workers' Compensation UCF Paper Form Instructions
16	Service Provider I.D.	Payee Tax ID #	Required	Enter the Federal Tax ID # of the entity receiving payment.
17	Qual (5)	Provider Identifier	Required	Enter "F" for Federal Tax ID.
18	Pharmacy Phone Number	Payee Phone Number	Required	Enter the telephone number of the entity receiving payment.
19	Pharmacy Fax Number	Payee Fax Number	Optional	Enter the fax number for the payee.
20	Patient Signature	Overflow for Payer address	Optional	Use this field if more space is needed for carrier/payer mailing address information.
21	Employer Name	Employer Name	Required	Enter the name of the employer of the injured worker.
22	Employer Address	Employer Address	Required	Enter the address of the employer of the injured worker.
23	Employer City	Employer City	Required	Enter the city of the employer of the injured worker.
24	Employer State	Employer State	Required	Enter the state of the employer of the injured worker.
25	Employer Zip Code	Employer Zip Code	Required	Enter the zip code of the employer of the injured worker.
26	Carrier I.D.	Payer Name and Address	Required	Enter the name and address of the employer's workers' compensation insurance carrier, TPA, or designated payer. *(On the UCF Paper form, the text will need to be formatted to fit into the white space provided in this field area. You may only be able to fit in the carrier or payer name and City, St info. The patient signature line, field # 20, can be used for overflow.)*
27	Employer Phone No.	Employer Phone No.	Optional	Enter the telephone number of the employer of the injured worker.
28	Date of Injury	Date of Injury	Required	Enter the date the injury occurred - MM DD CCYY
29	Claim Reference I.D.	WC Claim Number	Required (if Known)	Enter the claim number assigned by the workers' compensation Payer, if known. Enter the value of "00" if claim number is unknown.
30	1 - Prescription/ Serv. Ref. #	Prescription Number	Required	Enter the pharmacy provided prescription number.
31	1 - Qual (8)	Qualifier Indicator	Required	Enter a "1" to indicate RX billing
32	1 - Date Written	Date script written	Required	Enter the date the prescription was written - MM DD CCYY.
33	1 - Date of Service	Date script filled	Required	Enter the date the prescription was filled - MM DD CCYY.
34	1 - Fill #	Number of times filled	Situational	Enter the number of times the prescription has been filled.
35	1 - Qty Dispensed	Quantity Dispensed	Required	Enter the quantity of the medication dispensed.

UCF Paper Field #	Paper UCF Field Label	Actual Field Data	DWC Data Type R/S/O	Workers' Compensation UCF Paper Form Instructions
36	1 - Days Supply	Days supply	Required	Enter the number of days supply.
37	1 - Product/Service I.D.	NDC number	Required	Enter the NDC number for the medication dispensed. For compounds enter "96371" as the NDC number. The payers will need to cross reference the NDC number to determine drug name and strength since the UCF does not have space designated for the drug description.
38	1 - Qual (10)	I.D. Qualifier		*Leave Field Blank - default is NDC number*
39	1 - DAW Code	DAW Code	Required	Enter the appropriate DAW Code: 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
40	1 - Prior Auth # Submitted	Prior Authorization #	Situational	Enter the Prior Authorization number when required.
41	1 - PA Type	Prior Auth # Qualifier	Situational	Enter the Qualifier Code for Prior Authorization number: Ø=Not Specified 1=Prior Authorization 8=Payer Defined Exemption
42	1 - Prescriber I.D.	Doctor's Identification #	Required	Enter the prescribing doctor's identification number - NPI, DEA or State License #. **California Requires prescribing doctor's DEA identification number** (*Payers will need to maintain a cross-referencing list to capture additional information needed on physician when a paper form is submitted.)*
43	1 - Qual (12)	Prescriber ID Qualifier	Required	Enter the Prescriber ID# Qualifier Code: Blank=Not Specified Ø1=National Provider Identifier (NPI) Ø7=NCPDP Provider ID Ø8=State License 12=Drug Enforcement Administration (DEA) Number
44	1 - DUR/PPS Codes	*N/A*		*Leave Field Blank*
45	1 - Cost Basis	Basis of Cost Determination	Required	Enter the Cost Determination Code 00=Not Specified 01=AWP (Average Wholesale Price) 02=Local Wholesaler 03=Direct 04=EAC (Estimated Acquisition Cost) 05=Acquisition 06=MAC (Maximum Allowable Cost) 07=Usual & Customary 09=Other

UCF Paper Field #	Paper UCF Field Label	Actual Field Data	DWC Data Type R/S/O	Workers' Compensation UCF Paper Form Instructions
46	1 - Provider I.D.	*N/A*		*Leave Field Blank*
47	1 - Qual (15)	*N/A*		*Leave Field Blank*
48	1 - Diagnosis Code	*N/A*		*Leave Field Blank*
49	1 - Qual (16)	*N/A*		*Leave Field Blank*
50	1 - Other Payer Date	*N/A*		*Leave Field Blank*
51	1 - Other Payer I.D.	*N/A*		*Leave Field Blank*
52	1 - Qual (17)	*N/A*		*Leave Field Blank*
53	1 - Other Payer Reject Codes	*N/A*		*Leave Field Blank*
54	1 - Usual & Cust. Charge	*N/A*	Situational	Enter the pharmacy's usual and customary charge as defined by statute or rule.
55	1 - Ingredient Cost Submitted	*N/A*		*Leave Field Blank*
56	1 - Dispensing Fee Submitted	*N/A*		*Leave Field Blank*
57	1 - Incentive Amount Submitted	*N/A*		*Leave Field Blank*
58	1 - Other Amount Submitted	*N/A*		*Leave Field Blank*
59	1 - Sales Tax Submitted	*N/A*		*Leave Field Blank*
60	1 - Gross Amt Due Submitted	Gross Amount Due	Required	Enter the gross amount due for this prescription.
61	1 - Patient Paid Amount	Patient Paid Amount	N/A	Not applicable for California
62	1 - Other Payer Amount Paid	*N/A*		*Leave Field Blank*
63	1 - Net Amount Due	*N/A*		*Leave Field Blank*
64	2 - Prescription/Serv. Ref. #	Prescription Number	Required	Enter the pharmacy provided prescription number.
65	2 - Qual (8)	Qualifier Indicator	Required	Enter a "1" to indicate RX billing
66	2 - Date Written	Date script written	Optional	Enter the date the prescription was written - MM DD CCYY.

UCF Paper Field #	Paper UCF Field Label	Actual Field Data	DWC Data Type R/S/O	Workers' Compensation UCF Paper Form Instructions
67	2 - Date of Service	Date script filled	Required	Enter the date the prescription was filled - MM DD CCYY.
68	2 - Fill #	Number of times filled	Situational	Enter the number of times the prescription has been filled.
69	2 - Qty Dispensed	Quantity Dispensed	Required	Enter the quantity of the medication dispensed.
70	2 - Days Supply	Days supply	Required	Enter the number of days supply.
71	2 - Product/Service I.D.	NDC number	Required	Enter the NDC number for the medication dispensed. For compounds enter "96371" as the NDC number. The payers will need to cross reference the NDC number to determine drug name and strength since the UCF does not have space designated for the drug description.
72	2 - Qual (10)	I.D. Qualifier		*Leave Field Blank - default is NDC number*
73	2 - DAW Code	DAW Code	Required	Enter the appropriate DAW Code: 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
74	2 - Prior Auth # Submitted	Prior Authorization #	Situational	Enter the Prior Authorization number when required.
75	2 - PA Type	Prior Auth # Qualifier	Situational	Enter the Qualifier Code for Prior Authorization number: Ø=Not Specified 1=Prior Authorization 8=Payer Defined Exemption
76	2 - Prescriber I.D.	Doctor's Identification #	Required	Enter the prescribing doctor's identification number - NPI, DEA or State License #. **California Requires prescribing doctor's DEA identification number** (*Payers will need to maintain a cross-referencing list to capture additional information needed on physician when a paper form is submitted.)*
77	2 - Qual (12)	Prescriber ID Qualifier	Required	Enter the Prescriber ID# Qualifier Code: Blank=Not Specified Ø1=National Provider Identifier (NPI) Ø7=NCPDP Provider ID Ø8=State License 12=Drug Enforcement Administration (DEA) Number

UCF Paper Field #	Paper UCF Field Label	Actual Field Data	DWC Data Type R/S/O	Workers' Compensation UCF Paper Form Instructions
78	2 - DUR/PPS Codes	*N/A*		*Leave Field Blank*
79	2 - Cost Basis	Basis of Cost Determination	Required	Enter the Cost Determination Code 00=Not Specified 01=AWP (Average Wholesale Price) 02=Local Wholesaler 03=Direct 04=EAC (Estimated Acquisition Cost) 05=Acquisition 06=MAC (Maximum Allowable Cost) 07=Usual & Customary 09=Other
80	2 - Provider I.D.	*N/A*		*Leave Field Blank*
81	2 - Qual (15)	*N/A*		*Leave Field Blank*
82	2 - Diagnosis Code	*N/A*		*Leave Field Blank*
83	2 - Qual (16)	*N/A*		*Leave Field Blank*
84	2 - Other Payer Date	*N/A*		*Leave Field Blank*
85	2 - Other Payer I.D.	*N/A*		*Leave Field Blank*
86	2 - Qual (17)	*N/A*		*Leave Field Blank*
87	2 - Other Payer Reject Codes	*N/A*		*Leave Field Blank*
88	2 - Usual & Cust. Charge	Usual & Customary	Required	Enter the pharmacy's usual and customary charge as defined by statute or rule. Required for California
89	2 - Ingredient Cost Submitted	*N/A*		*Leave Field Blank*
90	2 - Dispensing Fee Submitted	*N/A*		*Leave Field Blank*
91	2 - Incentive Amount Submitted	*N/A*		*Leave Field Blank*
92	2 - Other Amount Submitted	*N/A*		*Leave Field Blank*
93	2 - Sales Tax Submitted	*N/A*		*Leave Field Blank*
94	2 - Gross Amt Due Submitted	Gross Amount Due	Required	Enter the gross amount due for this prescription.
95	2 - Patient Paid Amount	Patient Paid Amount	N/A	Not applicable for California
96	2 - Other Payer Amount Paid	*N/A*		*Leave Field Blank*
97	2 - Net Amount Due	*N/A*		*Leave Field Blank*

4.0 ADA 2006

Unlike the other standard forms, the American Dental Association (ADA) doesn't publish a manual for the ADA 2006. Therefore, there is nothing for the Division to incorporate by reference. The ADA does publish various books which could be useful in providing guidance in the use of their form. These books may be obtained from the ADA at:

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

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

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 ☐M ☐F	8. Policyholder/Subscriber ID (SSN or ID#)
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

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 ☐M ☐F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

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

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

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									
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
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

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 ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

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

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

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.	Situational	Enter Certification or Authorization Number Provided By Payer
PRIMARY PAYER INFORMATION			
	Name		Workers' Compensation Payer Name & Address
	Address		
	City		
	State		
	Zip Code		
3	Phone Number	Required	
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)	Required	Employer Name and Address
	Address	Required	
	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	Situational	Workers' Compensation Claim Number, If Known
16	Plan / Group Number- Unique Patient Bill Identifier Number Assigned by Provider	Required	Unique Patient Bill Identifier Number
17	Employer Name	N/A	
PATIENT INFORMATION (Injured Worker)			
18	Relationship to Primary Subscriber	Optional	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	Required	
21	Patient Date of Birth	Required	
22	Gender	Required	
23	Patient ID Number (Social Security Number)	Required	Social Security Number
	RECORD OF SERVICES PROVIDED		
24	Date of Service	Required	
25	Area of oral Cavity	Situational	
26	Tooth System	Situational	
27	Tooth Number's) or Letter(s)	Situational	
28	Tooth Surface	Situational	
29	Procedure code	Required	
30	Description of service provided.	Required	
31	Fees	Required	
32	Other fees	N/A	
33	Total Fees	Required	
	MISSING TEETH INFORMATION		
34	Report missing teeth on each claim submission.	Situational	
35	Remarks (Attachment Control Number and or Notes)	Situational	
	AUTHORIZATIONS		
36	Authorization Signature 1	N/A	
37	Authorization Signature 2	N/A	
	ANCILLARY CLAIM/TREATMENT INFORMATION		
38	Place of Treatment	Required	Place of Service
39	Indicate the number of enclosures	Situational	
40	Is Treatment for Orthodontics	Required	
41	Date Appliance Placement	Situational	
42	Months of treatment remaining	Situational	
43	Replacement of Prosthesis?	Situational	
44	Date Prior Placement	Situational	
45	Treatment Resulting From	Required	
46	Date of Accident	Required	
47	Auto Accident State	Situational	

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

Appendix B. Standard Explanation of Review

The Division of Workers' Compensation has not developed a standard form for the paper EOR, but requires all of the elements indicated as required in the table below be included.

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 thirty working days after receipt of the bil ,any required reports and supporting documentation and shall pay any uncontested amount within 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 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) 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 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 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.

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.

How to use the tables.

There are two tables for use in creating the Standard Explanation of Review. A third table is provided as a quick reference.

The DWC ANSI Matrix Crosswalk includes the Bill Adjustment Reason Codes, the Adjustment Reason Code number, the DWC Bill Adjustment Reason Explanatory Message, a description of the billing problem the code is describing and any special instructions for the payor on additional information required when using that code. It crosswalks to the ANSI Claims Adjustment Group Codes, the ANSI Claims Adjustment Reason Codes and the ANSI Remittance Remark Codes. These 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.

A quick guide of the ANSI Matrix Code Set is provided for your reference.

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

1.0 California DWC ANSI Matrix Crosswalk

California DWC ANSI Matrix Crosswalk								
	I. General Explanations							
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
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.		MA	W1	Workers Compensation State Fee Schedule Adjustment	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
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.	OA	W13 *	The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service		
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.		PI	W14*	The Fee Schedule does not list this code. No payment is being made at this time. Please resubmit your claim with the fee schedule code(s) that best describe the service(s) provided and your supporting documentation.		

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
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.	CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
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.	PI	W15*	This charge was adjusted for the reasons set forth in correspondence to follow	M118	Alert: Letter to follow containing further information.
G6	No standard EOR message applies.	This charge was adjusted for the reasons set forth in the message below.	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.	PI	No mapping		Not Applicable for 835 Transaction	
G7	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.		MA	W16*	According to the Fee Schedule this service has a relative value of zero and therefore no payment is due.		

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G8	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.	MA	W24*	No separate payment was made because the value of the service is included within the value of another service performed on the same day.		
G9	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 OMFS General Instructions for Separate Procedures rule.		MA	97	Payment adjusted because 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.
G10	Provider submitted bill with no supporting documentation.	No documentation of unlisted or "by report" BR code was received with the billing for this service. Please resubmit your bill with the appropriate supporting documentation. See OMFS General Instructions for Procedures Without Unit Values.		MA	16	Claim/service lacks information which is needed for adjudication.	WC1*	No documentation of unlisted or "by report" BR code was received with the billing for this service. Please resubmit your bill with the appropriate supporting documentation. See Fee Schedule General Instructions for Procedures Without Unit Values.

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (Jurisdictional code)	ANSI Remittance Remark Code Description
G11	Provider's billing lacks sufficient identification or documentation for the unlisted or BR service reported.	The unlisted or BR service was not 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 you have need for a specific document, indicate it along with this EOR.	PI	16	Claim/service lacks information which is needed for adjudication.	WC2*	The unlisted or BR service was not sufficiently identified or documented. We are unable to make a payment without supplementary documentation giving a clearer description of the service. See Fee Schedule General Instructions for Procedures Without Unit Values.
							M29	Missing operative report.
							M30	Missing pathology report.
							M31	Missing radiology report.
G12	Provider's documentation 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.	PI	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	WC3*	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.
G13	Provider bills for service that is not related to the diagnosis.	This service appears to be unrelated to the patient's diagnosis.		OA	11	The diagnosis is inconsistent with the procedure.		

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G14	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.	OA	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.
G15	Service or procedure requires prior authorization and none was identified.	This service requires prior authorization and none was identified.		PI	197	Payment adjusted for absence of precertification/ authorization.	WC4*	This service requires prior authorization and none was identified.
G16	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 payer.	OA	W17*	Reimbursement for this report is included with other services provided on the same day; therefore a separate payment is not warranted.		
G17	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.	OA	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G18	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.		PI	191	Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation carrier.		
G19	Billed code is not supported by documentation provided.	The code billed does not accurately represent the service described in the documentation received with the bill. Reimbursement was made for a service that is supported by the documentation submitted with the billing.	Indicate alternative OMFS code that best describes the service or procedure used to adjust the bill.	PI	150	Payment adjusted because the payer 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.
G20	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.		PI	W18*	The charge was denied as the report/documentation does not indicate that the service was performed.		

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G21	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.	PI	40	Charges do not meet qualifications for emergent/urgent care.		
G22	Provider bills for services outside his/her scope of practice.	The billed service falls outside your scope of practice.		OA	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.
G23	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.	PI	16	Claim/service lacks information which is needed for adjudication.	WC43*	We cannot review this service without necessary documentation. Please resubmit with necessary documentation.
							M29	Missing operative report.
							M30	Missing pathology report.
							M31	Missing radiology report.

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G24	Provider charge of professional and/or technical component is submitted after global payment made to another provider.	The charge for both the technical and professional component of this service have already been paid to another provider.	Indicate name of other provider who received global payment.	OA	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	WC5*	The charge for both the technical and professional component of this service have already been paid to another provider.
G25	Timed code is billed without documentation.	Documentation of the time spent performing this service is needed for further review.		MA	16	Claim/service lacks information which is needed for adjudication.	WC6*	Documentation of the time spent performing this service is needed for further review.
G26	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. Use EOR G4 for comprehensive contractual agreements.	CO	131	Claim specific negotiated discount.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.
G27	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.		PI	198	Payment Adjusted for exceeding precertification/ authorization.	N188	The approved level of care does not match the procedure code submitted.

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G28	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 or when the service was preauthorized.	PI	38	Services not provided or authorized by designated (network/primary care) providers.		
G29	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.	PI	39	Services denied at the time authorization/pre-certification was requested.	N175	Missing Review Organization Approval.
G30	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.	PI	W9*	Unnecessary medical treatment based on peer review.	N175	Missing Review Organization Approval.
G31	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.		PI	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G32	Provider bills and does not provide requested documentation or the documentation was insufficient or incomplete	Payment adjusted because requested information was not provided or was insufficient/ incomplete.		PI	17	Payment adjusted because requested information was not provided or was insufficient/ incomplete.	WC7*	Missing/incomplete/insufficient requested documentation
G33	Provider bills payer/employer when there is no claim on file	Claim denied as patient cannot be identified as our insured.		PI	31	Claim denied as patient cannot be identified as our insured.		
G34	Provider bills for services that are not medically necessary	These are non-covered services because this is not deemed a `medical necessity' by the payer.		PI	50	These are non-covered services because this is not deemed a `medical necessity' by the payer.		
G35	Provider submits bill to incorrect payer/contactor	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		PI	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		
G36	Provider bills for multiple services with no or inadequate information to support this many services	Payment adjusted because the payer deems the information submitted does not support this many services.		MA	151	Payment adjusted because the payer deems the information submitted does not support this many services.		

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
G37	Bill exceeds or is received after $10,000 cap has been reached on a delayed claim..	Payment is being denied as 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.		MA	W26*	This claim has not been accepted and the mandatory medical reimbursements have been made. Should the claim be accepted, your bill will then be reconsidered. The determination must be made by 90 days from the date of injury.		
G38	Bill is submitted that is for a greater amount than remains in the $10,000 cap.	Your bill is being partially paid as this payment will complete the Labor Code 5402(c) mandatory $10,000 reimbursement. Should the claim be accepted, the remainder of your bill will then be reconsidered. Acceptance or denial of the claim must be made no later than 90 days from the date of injury but may be made sooner.		MA	W26*	Until the employee's claim is accepted or rejected, liability for medical treatment is limited according to jurisdictional guidelines. Your bill is being partially paid as this payment will complete the mandatory reimbursement limit per jurisdictional guidelines. Should the claim be accepted, the remainder of your bill will then be reconsidered. Acceptance or denial of the claim must be made no later than 90 days from the date of injury		

II. Physical Medicine and Rehabilitation Section Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
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.		MA	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	WC8*	This charge was denied as the Physical Therapy Assessment and Evaluation codes are billable by Registered Physical Therapists only.
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 l (h).		OA	16	Claim/service lacks information which is needed for adjudication.	WC9*	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 jurisdictional guidelines
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 l (b). Payment has been made in accordance with Physician Fee Schedule guidelines		MA	151	Payment adjusted because the payer deems the information submitted does not support this many services.	WC10*	When billing for modalities only, you are limited to two modalities in any single visit pursuant to jurisdictional physical medicine rule guidelines. Payment has been made in accordance with Physician Fee Schedule guidelines

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
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.		OA	152	Payment adjusted because the payer deems the information submitted does not support this length of service.	WC11*	This physical medicine extended time service was billed without the "initial 30 minutes" base code.
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 I (a).		MA	W19*	Payment adjusted because the payer deems the information submitted does not support the frequency of service.	WC12*	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.
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 I (c)		MA	152	Payment adjusted because the payer deems the information submitted does not support this length of service.	WC13*	Reimbursement for physical medicine procedures, modalities, including Chiropractic Manipulation and acupuncture codes are limited to 60 minutes per visit without prior authorization pursuant to jurisdictional guidelines

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
PM7	Provider bills for more than four physical medicine codes during a single visit	No more than four physical medicine procedures or modalities including, Chiropractic Manipulation and Acupuncture codes, are reimbursable during the same visit without prior authorization pursuant to physical medicine rule I (d).		MA	151	Payment adjusted because the payer deems the information submitted does not support this many services.	WC14*	No more than four physical medicine procedures including Chiropractic Manipulation and Acupuncture codes are reimbursable during the same visit without prior authorization pursuant to jurisdictional guidelines
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.		MA	59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	WC15*	Jurisdictional guidelines regarding multiple services (cascade) was applied to this service.
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).		MA	151	Payment adjusted because the payer deems the information submitted does not support this many services.	WC16*	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 jurisdictional guidelines

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
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).		MA	151	Payment adjusted because the payer deems the information submitted does not support this many services.	WC17*	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 jurisdictional guidelines
PM11	Physical Therapist /Occupationsal Therapists charged for E/M codes which are limited to physicians, nurse practitioners, and physician assistants.	Charge was denied as Physical Therapists/ Occupational Therapists may not bill Evaluation and Management services.		OA	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	WC18*	Charge was denied as Physical Therapists may not bill Evaluation and Management services.
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. If you object contact the claims administrator or its U.R. unit.	Optional: Provide Utilization Review phone number.	OA	198	Payment Adjusted for exceeding precertification/ authorization.		

III. Surgery Section Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
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.		MA	59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)		
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.		MA	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	WC19*	The value of the initial casting service is included within the value of a fracture or dislocation reduction service.
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.		OA	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	WC20*	The visit or service billed, occurred within the global surgical period and is not separately reimbursable.
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 ground rule 7 re: Arthroscopic Services.		MA	59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	WC21*	Additional arthroscopic services were reduced to 10 percent of scheduled values pursuant to jurisdictional surgery guidelines

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
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 surgical ground rule 10 (b) (1).		MA	W1	Workers Compensation State Fee Schedule Adjustment	WC22*	This initial visit was converted to code 99025 in accordance with the jurisdictional surgical guidelines
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 Surgical Section of the Physician's Fee Schedule).		MA	W1	Workers Compensation State Fee Schedule Adjustment	WC23*	Assistant Surgeon services have been reimbursed at 20% of the surgical procedure per jurisdictional surgical guidelines
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 Surgical Section of the Physician's Fee Schedule).		MA	W1	Workers Compensation State Fee Schedule Adjustment	WC24*	Non-physician assistant surgeon has been reimbursed at 10% of the surgical procedure per jurisdictional surgical guidelines
S8	Procedure does not normally require an Assistant Surgeon 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.	PI	54	Multiple physicians/assistants are not covered in this case.	WC25*	Assistant Surgeon services have been denied as not normally warranted for this procedure according to jurisdictional guidelines
S9	Procedure does not normally require two surgeons and no documentation was provided to substantiate a need in this case.	Two Surgeon service is not warranted for this procedure according to the listed citation. Please provide documentation that supports the need for two surgeons.	Identify the reference source listing of approved Two Surgeon services.	PI	54	Multiple physicians/assistants are not covered in this case.	WC26*	Two Surgeon service is not warranted for this procedure according to the listed citation. Please provide documentation that supports the need for two surgeons.

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
S10	Operative Report does not cite the billed procedure.	Incomplete/invalid operative report (billed service is not identified in the Operative Report)		OA	16	Claim/service lacks information which is needed for adjudication.	N233	Incomplete/invalid operative report.
S11	Surgeon's bill includes separate charge for delivery of local anesthetic.	Administration of Local Anesthetic is included in the Surgical Service per Surgical Section rule 16.		OA	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	WC27*	Administration of Local Anesthetic is included in the Surgical Service per jurisdictional surgical guidelines
IV. Anesthesia Section Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
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.		MA	152	Payment adjusted because the payer deems the information submitted does not support this length of service.	WC28*	Modifier -47 was used to indicate regional anesthesia by the surgeon. In accordance with the Fee Schedule, time units are not reimbursed.
A2	Insufficient information provided for payment determination.	Please submit anesthesia records and/or time units for further review.		OA	16	Claim/service lacks information which is needed for adjudication.	N203	Missing/incomplete/invalid anesthesia time/units
A3	Documentation does not describe emergency status.	Qualifying circumstances for emergency status not established.		PI	40	Charges do not meet qualifications for emergent/urgent care.		

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
A4	Documentation does not describe physical status/condition.	Patient's physical status/condition not identified. Please provide documentation using ASA Physical Status indicators.		OA	16	Claim/service lacks information which is needed for adjudication.	WC29*	Patient's physical status/condition not identified. Please provide documentation using ASA Physical Status indicators.
V. Evaluation and Management Section								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
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.	OA	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	WC30*	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.
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).		MA	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	WC31*	The billed service does not meet the requirements of a Consultation

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
EM3	Documentation does not support billing for Prolonged Services code.	Documentation provided does not justify payment for a Prolonged Evaluation and Management service.		PI	152	Payment adjusted because the payer deems the information submitted does not support this length of service.	WC32*	Documentation provided does not justify payment for a Prolonged Evaluation and Management service.
VI. Clinical Laboratory Section Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
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.		OA	W20*	This service is normally part of a panel and is reimbursed under the appropriate panel code.		
VII. Pharmacy								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
P1	Charge for Brand Name was submitted without "No Substitution" documentation.	Payment was made for a generic equivalent as "No Substitution" documentation was absent.		MA	W1	Workers Compensation State Fee Schedule Adjustment	WC33*	Payment was made for a generic equivalent as "No Substitution" documentation was absent.
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.		MA	91	Dispensing fee adjustment.	WC34*	A dispensing fee is not applicable for over-the-counter medication or medication administered at the time of a visit.

VIII. DMEPOS Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (Jurisdictional code)**	**ANSI Remittance Remark Code Description**
DME1	Billed amount exceeds formula using documented actual cost for DMEPOS	Payment for this item was based on the documented actual cost.		MA	108	Payment adjusted because rent/purchase guidelines were not met.	WC35*	Payment for this item was based on the documented actual cost.
DME2	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.		MA	108	Payment adjusted because rent/purchase guidelines were not met.	M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
IX. Special Services Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
SS1	A physician, other than the Primary Treating Physician or designee submits a progress report for reimbursement.	The Progress report charge was disallowed as you are not the Primary Treating Physician or his/her designee.		MA	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	WC36*	The Progress report charge was disallowed as you are not the Primary Treating Physician or his/her designee.
SS2	A physician, other than the Primary Treating Physician or designee submits a Permanent and Stationary report for reimbursement.	The Permanent and Stationary Report charge was disallowed as you are not the Primary Treating Physician or his/her designee.		MA	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	WC37*	The Permanent and Stationary Report charge was disallowed as you are not the Primary Treating Physician or his/her designee.

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
SS3	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.		MA	W21*	This report does not fall under the jurisdictional guidelines for a Separately Reimbursable Report		
SS4	No request was made for Chart Notes or Duplicate Report.	Chart Notes /Duplicate Reports were not requested		MA	96	Non-covered charge(s).	WC38*	Chart Notes /Duplicate Reports were not requested
SS5	Missed appointment is billed.	No payment is being made, as none is necessarily owed		OA	96	Non-covered charge(s).	WC39*	No payment is being made for missed appointment, as none is necessarily owed
X. Facility Explanations								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
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.		OA	197	Payment adjusted for absence of precertification/ authorization.	WC40*	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.

DWC Bill Adjustment Reason Codes	Problem	DWC Bill Adjustment Reason Explanatory Message	Special Payer Instructions	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Claim Adjustment Reason Code Description	ANSI Remittance Remark Codes (*Jurisdictional code)	ANSI Remittance Remark Code Description
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.		MA	40	Charges do not meet qualifications for emergent/urgent care.		
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.	MA	W22*	Service not reimbursable under Outpatient Facility Fee Schedule. Charges are being paid under a different fee schedule.		
F4	No payment required under Outpatient Facility Fee Schedule	Service not paid under Outpatient Facility Fee Schedule.		MA	96	Non-covered charge(s).	WC41*	Service not paid under Outpatient Facility Fee Schedule.
F5	Billing submitted without HCPCS codes	In accordance with OPPS guidelines billing requires HCPCS coding.		MA	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.		MA	W1	Workers Compensation State Fee Schedule Adjustment	WC42*	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.

X1 Miscellaneous DWC Bill Adjustment Reason Codes and ANSI Claim Adjustment Reason Codes								
DWC Bill Adjustment Reason Codes	**Problem**	**DWC Bill Adjustment Reason Explanatory Message**	**Special Payer Instructions**	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Claim Adjustment Reason Code Description**	**ANSI Remittance Remark Codes (*Jurisdictional code)**	**ANSI Remittance Remark Code Description**
M1	Bill submitted for non compensable claim	Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.		MA	W2*	Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.		
M2	Appeal /Reconsideration	Additional payment made on appeal/reconsideration.		MA	W3 *	Additional payment made on appeal/reconsideration.		
M3	Appeal /Reconsideration	No additional reimbursement allowed after review of appeal/reconsideration.		MA	W4 *	No additional reimbursement allowed after review of appeal/reconsideration.		
M4	Overpayment to health provider	Request of recoupment for an overpayment made to a health care provider.		MA	W5 *	Request of recoupment for an overpayment made to a health care provider.		
M5	Third Party Subrogation	Reduction/denial based on subrogation of a third party settlement.		MA	W6 *	Reduction/denial based on subrogation of a third party settlement.		
M6	Payment of interest /penalty to provider	Payment of interest/penalty to provider.		MA	W7 *	Payment of interest/penalty to provider.		
M7	Claim is under investigation	Extent of injury not finally adjudicated. Claim is under investigation.		MA	W23*	Extent of injury not finally adjudicated. Claim is under investigation		

2.0 DWC ANSI Matrix Code Set

DWC ANSI MATRIX CODE SET			
I. General Explanations			
DWC Bill Adjustment Reason Codes	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Remittance Remark Codes (*Jurisdictional code)**
G1	MA	W1	N14
G2	OA	W13 *	
G3	PI	W14*	
G4	CO	45	N14
G5	PI	W15*	M118
G6	PI	No mapping	Not Applicable for 835 Transaction
G7	MA	W16*	
G8	MA	W24*	
G9	MA	97	M15
G10	MA	16	WC1*
G11	PI	16	WC2*
			M29
			M30
			M31
G12	PI	150	WC3*
G13	OA	11	
G14	OA	18	M86
G15	PI	197	WC4*
G16	OA	W17*	
G17	OA	4	
G18	PI	191	
G19	PI	150	N22
G20	PI	W18*	
G21	PI	40	
G22	OA	8	N95
G23	PI	16	WC43*
			M29
			M30
			M31

DWC Bill Adjustment Reason Codes	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Remittance Remark Codes (*Jurisdictional code)
G24	OA	B20	WC5*
G25	MA	16	WC6*
G26	CO	131	N381
G27	PI	198	N188
G28	PI	38	
G29	PI	39	N175
G30	PI	W9*	N175
G31	PI	15	M62
G32	PI	17	WC7*
G33	PI	31	
G34	PI	50	
G35	PI	109	
G36	MA	151	
G37	MA	W25*	
G38	MA	W26*	

II. Physical Medicine and Rehabilitation Section Explanations

DWC Bill Adjustment Reason Codes	ANSI Claim Adjustment Group Code (CO, MA, OA, PI)	ANSI Claim Adjustment Reason Code (*Jurisdictional Code)	ANSI Remittance Remark Codes (*Jurisdictional code)
PM1	MA	8	WC8*
PM2	OA	16	WC9*
PM3	MA	151	WC10*
PM4	OA	152	WC11*
PM5	MA	W19*	WC12*
PM6	MA	152	WC13*
PM7	MA	151	WC14*
PM8	MA	59	WC15*
PM9	MA	151	WC16*
PM10	MA	151	WC17*
PM11	OA	8	WC18*
PM12	OA	198	

III. Surgery Section Explanations			
DWC Bill Adjustment Reason Codes	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Remittance Remark Codes (*Jurisdictional code)**
S1	MA	59	
S2	MA	97	WC19*
S3	OA	97	WC20*
S4	MA	59	WC21*
S5	MA	W1	WC22*
S6	MA	W1	WC23*
S7	MA	W1	WC24*
S8	PI	54	WC25*
S9	PI	54	WC26*
S10	OA	16	N233
S11	OA	97	WC27*
IV. Anesthesia Section Explanations			
DWC Bill Adjustment Reason Codes	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Remittance Remark Codes (*Jurisdictional code)**
A1	MA	152	WC28*
A2	OA	16	N203
A3	PI	40	
A4	OA	16	WC29*
V. Evaluation and Management Section			
DWC Bill Adjustment Reason Codes	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Remittance Remark Codes (*Jurisdictional code)**
EM1	OA	97	WC30*
EM2	MA	150	WC31*
EM3	PI	152	WC32*
EM4	OA	150	M13

VI. Clinical Laboratory Section Explanations			
DWC Bill Adjustment Reason Codes	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Remittance Remark Codes (*Jurisdictional code)**
CL1	OA	W20*	
VII. Pharmacy			
DWC Bill Adjustment Reason Codes	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Remittance Remark Codes (*Jurisdictional code)**
P1	MA	W1	WC33*
P2	MA	91	WC34*
VIII. DMEPOS Explanations			
DWC Bill Adjustment Reason Codes	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Remittance Remark Codes (*Jurisdictional code)**
DME1	MA	108	WC35*
DME2	MA	108	M7
IX. Special Services Explanations			
DWC Bill Adjustment Reason Codes	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Remittance Remark Codes (*Jurisdictional code)**
SS1	MA	B7	WC36*
SS2	MA	B7	WC37*
SS3	MA	W21*	
SS4	MA	96	WC38*
SS5	OA	96	WC39*

X. Facility Explanations			
DWC Bill Adjustment Reason Codes	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Remittance Remark Codes (*Jurisdictional code)**
F1	OA	197	WC40*
F2	MA	40	
F3	MA	W22*	
F4	MA	96	WC41*
F5	MA	W1	M20
F6	MA	W1	WC42*
XI. Miscellaneous Explanations			
DWC Bill Adjustment Reason Codes	**ANSI Claim Adjustment Group Code (CO, MA, OA, PI)**	**ANSI Claim Adjustment Reason Code (*Jurisdictional Code)**	**ANSI Remittance Remark Codes (*Jurisdictional code)**
M1	MA	W2*	
M2	MA	W3 *	
M3	MA	W4 *	
M4	MA	W5 *	
M5	MA	W6 *	
M6	MA	W7 *	
M7	MA	W23*	

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

Paper Field	Field Description	Workers' Compensation Paper Fields R/S/O/NA	Comments
35	Claim Filing Indicator Code	Optional	Claim Filing Indicator Code WC represents the type of Claim coverage (Workers' Compensation = WC). This is a required field for the ANSI 835
36	Payer Bill ID Number	Required	The tracking number assigned by payer/bill review entity
37	Bill Frequency Type	Situational	Required if Institutional bill
38	Diagnostic Related Group Code	Situational	Required if payment is based on DRG
39	Service Dates	Required	
40	Date Bill Received	Required	
Bill Level Adjustment Information- Situational			
Payer 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	Bill Adjustment Group Codes	Situational	Refer to Section One Appendix B for Bill Adjustment Group Codes
42	DWC Bill Adjustment Reason Code and Description	Situational	Refer to Section One Appendix B for Bill Adjustment Reason Codes and Descriptions
43	Adjustment Amount	Situational	
44	Adjustment Quantity	Situational	
Service Payment Information			
45	Composite Medical Procedure Code Identifier	N/A	Not Applicable for California Paper EOR forms. Situational field for ANSI 835
46	Charge Amount	Situational	
47	Paid Amount	Situational	
47a	Revenue Code	Situational	
48	Paid Units	Situational	
49	Billed Procedure Code	Situational	The service code used for the actual review, revenue, CPT, or NDC. Includes modifiers if applicable
50	Billed Units	Situational	
51	Date of Service	Required	
52	Prescription Number	Situational	Required for Retail Pharmacy and DME only
Service Level Adjustment			
53	Bill Adjustment Reason Group Codes	Situational	Refer to Section One Appendix B for Bill Adjustment Group Codes
54	DWC Bill Adjustment Reason Code and Descriptor	Situational	Refer to Section One Appendix B for Bill Adjustment Reason Codes and Descriptors.
55	Adjustment Amount	Situational	
56	Adjustment Quantity	Situational	
57	Remittance Code	N/A	Not applicable for California Paper EOR forms. Situational field for ANSI 835.
58	Revenue Code	Situational	Required when supplied on an Institutional bill in addition to the CPT procedure code

Section Two – Transmission Standards

(a) **"Electronic Standard Format"** means the ANSI X12 standard format developed by the Accredited Standards Committee X12 Insurance Subcommittee of the American National Standards Institute and the retail pharmacy specifications developed by the National Council for Prescription Drug Programs ("NCPDP").

(b) **IAIABC**

The International Association of Industrial Accident Boards and Commissions (IAIABC) is the organization that sets the national standards for the transmission of workers' compensation medical data via Electronic Data Interchange (EDI). The IAIABC published the standards in the *EDI Implementation Guides for Medical Bill Payment Records, July 2004*.

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

(c) **Supported transactions**

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

(1) **Health care billing transaction sets (837, 824, 835, and 997)**

The X12 transaction set contains the format and establishes the data contents of the health care billing transaction set (837), the bill payment acknowledgment set (824), the remittance advice set (835) and the functional acknowledgement (997) for use within the context of an EDI environment. All transactions must be submitted using these formats or, upon written agreement between the parties, their equivalent.

The 837 transaction set can be used to submit health care billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediaries and claims clearinghouses. It can also be used to transmit health care bills and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing and/or payment of health care services within a specific health care/insurance industry segment.

The 824 acknowledgment set is to inform the sender of the status of the health care billing transaction set (837). Each health care billing transaction set (837) is edited for required data elements and against the edit matrix, element requirement table and the event table. Out of those edit processes, each transaction will be determined to be either accepted or rejected. A bill payment acknowledgment set (824) will be sent to each trading partner after each health care billing transaction set (837) is evaluated for errors. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, pharmacies, and other entities providing medical information to meet regulatory requirements. The payor refers to a third party entity that pays bills or administers the insurance product or benefit or both. This is the same standard that is used to report institutional claim adjudication information for payment to private and public payers.

The 835 is intended to meet the particular needs of the health care industry for the payment of billing and transfer of remittance information. The 835 can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice from a health care payer to a health care provider, either directly or through an Electronic Funds Transfer (EFT).

The 997 is intended to be returned to the sender to report syntax file errors for each health care billing transaction set (837).

837 Professional, May 2000 Final Version
837 Institutional, May 2000, Final Version
837 Professional, Addenda, October 2002
837 Institutional, Addenda, October 2002
835 Professional, May 2000 Final Version
835 Institutional, May 2000, Final Version
835 Professional, Addenda, October 2002
835 Institutional, Addenda, October 2002
824 Detailed Acknowledgement
997 Functional Acknowledgements

(2) **275 Additional Information to Support a Health Care Claim or Encounter (Attachments)**
The ANSI 275 Additional Information to Support a Health Care Claim or Encounter is an optional format that is the recommended electronic standard for submitting electronic documentation. Providers and Claims Administrators may agree to exchange documentation in an alternative format by mutual agreement. The components required to identify information associated with documentation must be present in alternative formats.

(3) **270-271 Health Care Eligibility Benefit Inquiry and Response**
The 270 and 271 transaction set is used in the group health industry to inquire about eligibility benefit status of a subscriber. The 270 transaction is the inquiry and the 271 transaction is the reply. The 270/271 transaction set described in the companion guide has been adapted for use in workers' compensation as a mechanism to perform claim indexing. The 270/271 Health Eligibility Inquiry and Response formats are not mandated for California workers' compensation process. They are offered as a tool to facilitate effective communication between Health Care Providers and Claims Administrators.

(4) **276/277 Claim Status Request and Response**
The 276 and 277 transaction set is used in the group health industry to inquire about the current status of a specified healthcare bill or bills. The 276 transaction is the inquiry and the 277 transaction is the reply. It is possible use these transaction set unchanged in workers' compensation bill processing. The 276/277 Claim (Bill) Status formats are not mandated for California workers' compensation process. They are offered as a tool to facilitate effective communication between Health Care Providers and Claims Administrators.

Transaction sets can be obtained 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

(d) **California Electronic Medical Billing and Payment Companion Guide**
This guide is a separate document which gives detailed information for electronic billing and payment.

(e) **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 §§ 2200 – 2203, or if it conforms to other provisions of law. (See Section Two – Appendix A.)

Appendix for Section Two

Appendix A – Electronic and Digital Signature

Statute and Secretary of State Rules

California Government Code

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.

California Code of Regulations, Title 2

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.

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.

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.

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 tha t 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 s16.5 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 s16.5 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.

Section Three – Security Rules

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 HIPAA numbering is 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 standards 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.

Appendix for Section Three

Appendix A – Security Rule

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)

Standards	Sections	Implementation Specifications
		(R)=Required,
		(A)=Addressable
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)
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)

Standards	Sections	Implementation Specifications
		(R)=Required, (A)=Addressable
Person or Entity Authentication	164.312(d)	(R)
Transmission Security	164.312(e)(1)	Integrity Controls (A) Encryption (A)