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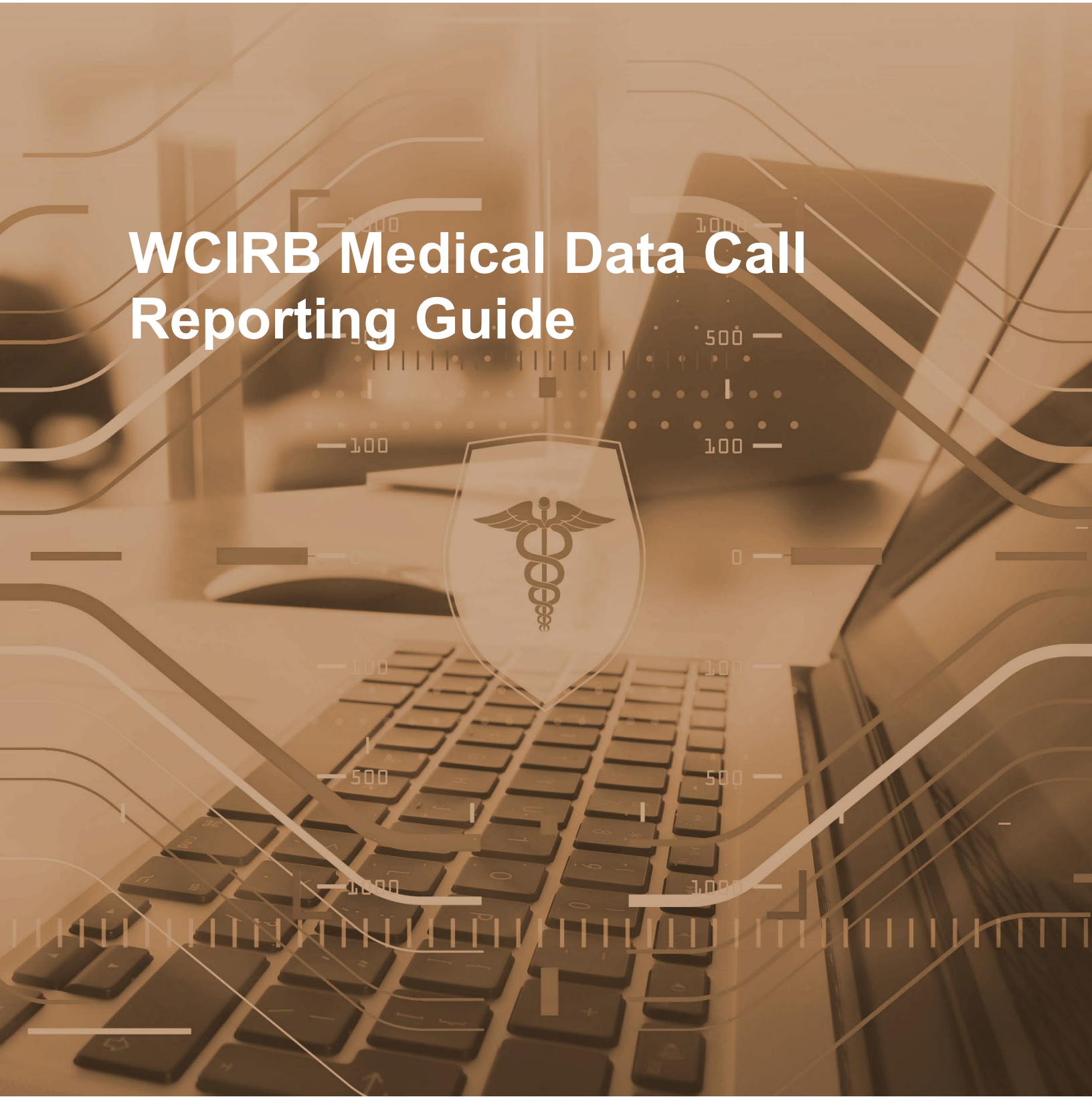
WCIRB Medical Data Call Reporting Guide



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Notice
This *Medical Data Call Reporting Guide* was developed by the Workers' Compensation Insurance Rating Bureau of California for the convenience and guidance of its members. It does not bear the official approval of the Insurance Commissioner and is not a regulation.

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Section 1 — Introduction

A. Overview

The *WCIRB Medical Data Call Reporting Guide* outlines the general rules, medical data call structure, record layouts, data dictionary, reporting rules, editing, and other validation procedures pertaining to the reporting of California medical transaction data to the Workers' Compensation Insurance Rating Bureau of California (WCIRB).

B. Medical Data Call Background

At the December 9, 2009 meeting, the WCIRB's Governing Committee adopted a plan to facilitate the collection of medical transaction data in California. The plan was adopted in order to meet the WCIRB's ratemaking needs and to respond to California Department of Insurance directives. Medical transaction data on California workers' compensation claims will be collected in accordance with the Workers Compensation Insurance Organizations' (WCIO) WCMED data specifications.

C. WCIRB Medical Data Call Contacts

If you have any questions about the Medical Data Call, please contact the WCIRB Medical Data Call team at transactiondata@wcirb.com.

Section 2 — General Rules

A. Scope and Effective Date

The Medical Data Call (Call) began with medical transactions occurring in the third quarter of 2012 required to be reported to the WCIRB by December 31, 2012.

B. Participation / Eligibility

Beginning with transactions occurring January 1, 2022, NAIC Groups that write at least 0.5% of the California workers' compensation market, as determined by written pure premium in the most recent calendar year, are required to submit medical transaction data to the WCIRB. Once an NAIC Group is required to submit medical transaction data, it will continue to be required to report data even if its California market share declines to less than 0.5%.

Annually, the WCIRB evaluates market share and notifies all newly eligible NAIC Groups of their participation requirement. The eligibility notification letter includes details regarding data certification and production data reporting timeline requirements.

Insurers who are submitting medical transaction data to the NCCI are encouraged to submit California medical transaction data to the WCIRB even if their share of the California workers' compensation market is less than 0.5%.

1. Insurer Participation

When an NAIC Group is required to submit the Call, all Insurers within that Group are required to report under the Call.

Insurers within the NAIC Group may elect to submit the medical data as one or more separate business subset groupings instead of reporting the entire NAIC Group's data in a single file.

2. Participation Timeline

Once notified of their eligibility to report, Insurer Groups must complete testing, receive certification approval, and begin to submit production data no later than one year from the date of notification of eligibility.

3. Reporting Responsibility

Participants in the Call will have the flexibility of meeting their reporting obligation in several ways, including:

(a) Submitting all of their Call data directly to the WCIRB; and
(b) Authorizing their vendor business partners (Third Party Administrators (TPAs), medical bill review vendors, etc.) to report the data directly to the WCIRB. To authorize a business partner to report data directly to the WCIRB, each Insurer must first complete WCIRB Form 902, *Third Party Entity Registration* for each third party (TPE) authorized to report on its behalf. This form will be provided along with the eligibility notification letter or participants may contact WCIRB's Medical Data Call Unit to obtain a copy.

The Data Submitter must report the standard WCMED record layout in its entirety with all data elements populated. Refer to *Section 4 — Record Layouts* of this Guide.

The Insurer Group is responsible for data quality, regardless of which entity is designated as the Data Submitter. Although data may be provided by an authorized vendor on behalf of an Insurer, quality, completeness and timeliness of the data is the responsibility of the Insurer.

C. Reporting Frequency

Data Submitters are to report medical transactions at a frequency of no less than monthly. The Due Date for monthly Medical Data Call submissions is the last calendar day two months from the end of the month the transactions occured as per the following schedule:

Data Call Calendar Month	Due Date
January	March 31
February	April 30
March	May 31
April	June 30
May	July 31
June	August 31
July	September 30
August	October 31
September	November 30
October	December 31
November	January 31
December	February 28/29*

* Due Date will be February 29th for leap years

1. Duration of Reporting

Medical Data Call transactions are required to be reported until transactions no longer occur for the claim or 30 years after the claim (Accident Date), whichever comes first.

Example 1

Reporting Duration for Claim with an Accident Date Prior to July 2023

A medical transaction occurs in June 2023 for a claim with an Accident Date of July 1993. The medical transaction would be reported with the June 2023 submission. No further reporting of medical transactions for this claim is expected since the Accident Date is more than thirty years prior. However, data reporters may elect to continue to report data on claims with accident dates beyond 30 years.

Example 2

Reporting Duration for Claim with an Accident Date on or After June 2023

A medical transaction occurs in June 2023 for a claim with an Accident Date of June 2023. Any medical transactions occurring on this claim through June 2053 are required to be reported.

D. Submission of Medical Transactions

Medical Data Call transactions are to be reported to the WCIRB using Compensation Data Exchange (CDX) or File Transfer Protocol.

Regardless of the file upload method utilized, all files be must in Windows format (CRLF) and cannot be in Unix. Files submitted in Unix are considered ‘Invalid’ and will not be processed by the WCIRB medical data submission module.

1. **Compensation Data Exchange, LLC (CDX).**

   CDX is a self-administered, secure internet application service offered to Insurers that are submitting data to the WCIRB or to any other American Cooperative Council on Compensation Technology (ACCCT) member. The use of CDX for the submission or retrieval of data and to provide access to other services or products is subject to availability and the terms and conditions of use established by the ACCCT, CDX or individual Data Collection Organizations. These guidelines may be accessed through the ACCCT website at cdxworkcomp.org. The ACCCT disclaims all liability, direct or implied, and all damages, whether direct, incidental, or punitive, arising from the use or misuse of the CDX site or services by any person or entity.

a) CDX usage requirements

Before Data Submitters can send Medical Data Call production files using CDX, a completed Insurance Group Administrator (IGA) application for each Data Submitter must be on file, and each Data Submitter's electronic data submissions must pass Certification Testing.

If an Insurer Group has already established an IGA and currently submits policy data or unit statistical data to the WCIRB via CDX, an Insurer does not need to submit an additional IGA application to submit Medical Data Call information.

b) File Format

Submitted files must be in Windows format (CRLF) and cannot be in Unix. Files submitted in Unix are considered 'Invalid' and will not be able to be processed by the WCIRB medical data submission module.

2. **File Transfer Protocol (FTP)**

FTP is a standard network protocol used for the transfer of files from one host to another over a TCP-based network.

Transactions are to be submitted electronically to the WCIRB via secure transfer to the WCIRB's File Transfer Protocol (FTP) server using the file layout in accordance with the Workers Compensation Insurance Organization's (WCIO) WCMED data specifications and strict file naming convention rules.

Before Data Submitters can send Call production files using FTP, an Insurer Group location must be established and each Data Submitter's electronic data submissions must pass Certification Testing

a) FTP File Naming Convention

Data Submitters must adhere to the specified format below when naming their file for the FTP file submission method to ensure its acceptance and successful processing:

- Files must begin with MCD where "MC" denotes the file is for medical data and the "D" denotes that the file is an FTP submission
- The 4th character is the test/production indicator: a "T" for Test or a "P" for Production followed by an underscore
- The 6th through 10th characters are the Insurer Group code for which the data is submitted
- The 11th character indicates the Submitter Type: a "C" for Carrier and "T" for a Third Party Submitter followed by an underscore
- The 13th through 17th characters are to be populated with "00004" followed by an underscore which denotes the file is for California
- The 19th through 30th characters are the Date and Time Stamp for the submission formatted as "YYYYMMDDHHMM" followed by an underscore
- There is an optional additional 12 characters available. If the submitter wishes to use this field to add additional useful information to the file name denoting something such as data source, character 31 must be an underscore followed by up to 11 additional characters
- Files must be text files with the .txt extension
- Test file name example where the submitter is a *Carrier* and a portion of the additional optional characters is used:
- MCDT_12345C_00004_202306150122_GRP_05_2023.txt
- Production file name example where the submitter is a *Third Party* and a portion of the additional optional characters is used:
- MCDP_12345T_00004_202306140123_GRP_05_2023.txt
- File names must be unique and cannot contain spaces.

b) File Format
Submitted files must be in Windows format (CRLF) and cannot be in Unix. Files submitted in Unix are considered 'Invalid' and will not be able to be processed by the WCIRB medical data submission module.

c) File Upload Location and Foldering
Data Submitters utilizing FTP upload will have a unique location for Certification to upload Test files and for Production to upload Production files. Within the Certification or Production location, there will be a separate folder location for the Data Submitter's various Insurer Group clients in which the file is to be uploaded. File Acceptance edits will compare the File Name to the upload location and may reject the file if the File Name does not comport with the upload location.

Electronic Transmittal Record and File Control Record

All Medical Data Call transactions submitted through CDX or FTP must contain an Electronic Transmittal Record (ETR) at the beginning of the file and a File Control Record (FCR) at the end of the file. For more details regarding these records, refer to *Section 4 — Record Layouts* of this Guide.

E. Business Exclusions Options

It is expected that 100% of medical transactions from workers' compensation claims incurred by a participating NAIC Group in the state of California will be reported in the Medical Data Call. The WCIRB recognizes that in certain limited circumstances it may be an extreme hardship for Insurers to comply with reporting 100% of the expected medical transactions.

Accordingly, an Insurer participating in the Call may request permission to exclude data for the state of California from its reporting requirement.This option may be utilized for small subsidiaries and/or business segments (e.g., Coverage Providers, branches, TPAs) where the WCIRB has determined that it would be an extreme hardship for these entities to establish the required reporting infrastructure and where the exclusion would not impact the overall integrity of the medical transaction data. The exclusion option must be based on a business segment and may not be based on the claim type or claim characteristics. All requests for such exclusions must be presented to the WCIRB for approval, and will be subject to periodic re-evaluation. Refer to *Requests for Business Exclusion* section below.

The request for exclusion does **not** apply to selection by any of the following:

- Medical services provided (pharmacy, hospital fees, negotiated fees, etc.)
- Claim characteristics such as claim status (e.g., open, closed, etc.)
- Claim types such as specific injury types (medical only, death, permanent total disability, etc.)

Once a claim has been reported under the Call, all related medical transactions must be reported according to the reporting requirements for the Call.

Example 1

Business Exclusion Option – Extreme Hardship

An Insurer Group uses a TPA that does not have the established infrastructure to report the data to the WCIRB. The claims associated with this TPA would not impact the overall integrity of the medical transaction data. The Insurer Group may request exclusion of the TPA's transactions from the Call.

Example 2

Business Exclusion Option – Insurer in Runoff

An Insurer Group includes an insurer which is currently in runoff and is not writing any new business or a book of claims where the business is in runoff, and the Insurer Group has determined that it would be an extreme hardship to report the data to the WCIRB. The claims associated with the

insurer in runoff would not impact the overall integrity of the medical transaction data. The Insurer Group may request exclusion of the runoff insurer's transactions from the Call.

Example 3

Business Exclusion Option – No Written Premium

An Insurer Group includes an insurer which is currently not writing any business. To avoid having to notify the WCIRB each quarter that there is no data to report for the insurer, the Insurer Group may request exclusion for this insurer's transactions from the Call.

To the extent the insurer begins to write workers' compensation business, this business exclusion option will be rescinded and the insurer will be required to submit their medical transaction data.

1. Requests for Business Exclusion

Insurers participating in the Call are required to submit their request for exclusion to the WCIRB for review using WCIRB Form 102, *California Medical Data Call – Business Exclusion Request Form*. This form outlines the method for estimating the proportion of business excluded in addition to an option to request to exclude run-off business.

All exclusion requests must include the following documentation:

(a) The nature of the data to be excluded (e.g., any vendors or entities)
(b) An explanation as to why reporting the data would result in extreme hardship (e.g., business is in run-off, reporting is by hard copy)
(c) A unique policy numbering schema, claim numbering schema or list of policy and claim information, including claim and loss information used to identify the business segment
(d) (d) Output used to demonstrate that the excluded segment(s) will be less than the maximum exclusion. Refer to WCIRB Form 102 for calculation method and;
(e) Contact information for the individual responsible for the request

Section 3 — Medical Data Call Structure

A. General

Medical Data Call data is not aggregated at the bill level. Instead, each line of a bill is reported as a separate record. While certain data elements will be repeated on each line, others are distinct per line. These two classifications of data elements are called Bill Header and Bill Detail.

B. Bill Header Data Elements

Bill Header data elements identify the information that is common to all lines of a bill. Therefore, the data in these elements is the same for all records from the same bill.

A bill is identified by the combination of Claim Number Identifier and Bill Identification Number.

Bill Header data elements include:

- Carrier Code
- Policy Number Identifier
- Policy Effective Date
- Claim Number Identifier
- Jurisdiction State Code (04 for California)
- Claimant Gender Code
- Birth Year
- Accident Date
- Bill Identification Number
- Service From Date
- Service To Date
- Provider Taxonomy Code
- Provider Identification Number
- Provider Postal (ZIP) Code
- Network Service Code
- Place of Service Code

These elements are typically located on the header (top) section of standard bill forms such as CMS-1500, UB-04, NCPDP Pharmacy billing form or ADA Dental Claim Form. For specific locations of the data information on these standard forms (if applicable), refer to the *Source* column of the *Medical Data Call Record Layout* table in *Section 4 — Record Layouts* of this Guide or California Code of Regulations Title 8 Section 9792.5.1.

C. Bill Detail Data Elements

Bill Detail data elements provide the line level information and, therefore, can differ among the individual records of a bill.

Bill Detail data elements include:

- Transaction Code
- Transaction Date
- Line Identification Number
- Service Date
- Paid Procedure Code
- Paid Procedure Code Modifier
- Amount Charged by Provider
- Paid Amount
- Primary ICD Diagnostic Code
- Secondary ICD Diagnostic Code
- Quantity/Number of Units per Procedure Code
- Secondary Procedure Code

Some detail data elements, such as ICD Diagnostic Codes, can act like Bill Header data elements because they may be the same for all lines. However, it is possible for these codes to vary per line.

These elements are typically located on the detail (lower) section of standard bill forms, such as CMS-1500, UB-04, NCPDP Pharmacy billing form or ADA Dental Claim Form. For specific locations of the data information on these standard forms (if applicable), refer to the *Source* column of the *Medical Data Call Record Layout* table in the *Section 4 — Record Layouts* of this Guide or California Code of Regulations Title 8, Section 9792.5.1.

D. Key Fields

The following data elements are considered key fields. They must be reported the same as on the original record for any replacement or cancellation record related to a medical transaction (line):

- Carrier Code
- Policy Number Identifier
- Policy Effective Date
- Claim Number Identifier
- Bill Identification Number
- Line Identification Number

Correctly reporting the key fields ensures the accurate linking and unique identification of the cancellation or replacement record to the original record. To change a key field, refer to *Record Replacements and Cancellations* in *Section 6 — Reporting Rules* of this Guide.

Section 4 — Record Layouts

A. Overview

In order for the WCIRB to properly receive data submissions, data providers are required to comply with specific requirements regarding record layouts, data elements and link data when reporting Medical Data Call data. Data files are transmitted in specific record layouts to allow for quick processing. This allows the data contained within the record layouts to be formatted, sorted and customized according to the user's specifications.

The record layouts that comprise the Medical Data Call are provided in this section of the Guide.

B. Medical Data Call Record

Report one Medical Data Call Record for each medical transaction (line) of a bill. For specific data element reporting instructions, refer to *Section 5 — Data Dictionary* of this Guide.

Medical Data Call Record Layout						
Field No.	**Field Title / Description**	**Class**	**Position**	**Bytes**	**Header / Detail**	**Source**
1	**Carrier Code***	N	1-5	5	H	Payer
2	**Policy Number Identifier***	AN	6-23	18	H	CMS 11
3	**Policy Effective Date***	N	24–31	8	H	
4	**Claim Number Identifier***	AN	32–43	12	H	Payer
5	**Transaction Code**	N	44–45	2	D	Payer
6	**Jurisdiction State Code**	N	46–47	2	H	Payer
7	**Claimant Gender Code**	AN	48	1	H	CMS 3 UB 11
8	**Birth Year**	N	49–52	4	H	CMS 3 UB 10
9	**Accident Date**	N	53–60	8	H	CMS 14
10	**Transaction Date**	N	61–68	8	D	Payer
11	**Bill Identification Number***	AN	69–98	30	H	Payer
12	**Line Identification Number***	AN	99–128	30	D	Payer
13	**Service Date**	N	129–136	8	D	CMS 24A UB 45
14	**Service From Date**	N	137–144	8	H	CMS 18 UB 6
15	**Service To Date**	N	145–152	8	H	CMS 18 UB 6
16	**Paid Procedure Code**	AN	153–177	25	D	CMS 24D UB 42 UB 44 or Payer
17	**Paid Procedure Code Modifier**	AN	178–185	8	D	CMS 24D UB 44 or Payer
	First Paid Procedure Code Modifier		(178-181)	(4)		
	Second Paid Procedure Code Modifier		(182-185)	(4)		
18	**Amount Charged by Provider**	N	186–196	11	D	CMS 24F UB 47
19	**Paid Amount**	N	197–207	11	D	Payer
20	**Primary ICD Diagnostic Code**	AN	208–221	14	H/D	CMS 21-1 (D) UB 67 (H)
21	**Secondary ICD Diagnostic Code**	AN	222–235	14	H/D	CMS 21-2 (D) UB 67 A (H)
22	**Provider Taxonomy Code**	AN	236-255	20	H	Provider or Payer

Medical Data Call Record Layout						
23	**Provider Identification Number**	AN	256–270	15	H	CMS 33A UB 56
24	**Provider Postal (ZIP) Code**	AN	271–273	3	H	CMS 32 UB 1
25	**Network Service Code**	A	274	1	H	Provider or Payer
26	**Quantity/Number of Units per Procedure Code**	N	275–281	7	D	CMS 24G UB 46
27	**Place of Service Code**	AN	282–289	8	H	CMS 24B UB-4**
28	**Secondary Procedure Code**	AN	290–314	25	D	UB 42
29	**Reserved for Future Use**		315–350	36		

* This data element is considered a key field and must be reported the same as on the original record for all records related to a medical transaction (line). Refer to *Key Fields* in *Section 3 — Medical Data Call Structure* of this Guide.

** Refer to Place of Service Crosswalk in Section 9.

Source Notes

CMS: Data is located on form CMS-1500. The field number on the form where the data is located is also provided.

Payer: Data is not on a form; it is provided by the entity that pays the bill.

Provider: Data is not on a form; it is provided by the healthcare provider.

UB: Data is located on form UB-04. The field number on the form where the data is located also is provided.

C. Electronic Transmittal Record

An Electronic Transmittal Record (ETR) is required for each file submitted. The ETR should be placed at the beginning of the file. The Universal Electronic Transmittal Record Specifications are located in Section 4 of the *WCIO Workers' Compensation Data Specifications Manual – General* and can be accessed on the WCIO's website at wcio.org.

D. File Control Record

A File Control Record is required for each file submitted. The File Control Record should be placed at the end of the file.

File Control Record Layout				
Field No.	**Field Title / Description**	**Class**	**Position**	**Bytes**
1	**Record Type Code** Report "SUBCTRLREC" One File Control Record is required for each submission. Format: A 10	A	1-10	10
2	**Submission File Type Code** Report the code that identifies the type of file being submitted. O=Original R=Replacement Format: A, this field cannot be blank.	A	11	1
3	**Carrier Group Code *** Report the Carrier Group Code that corresponds to the Reporting Group for which the data provider has been certified to report on its behalf. Format: N 5	N	12-16	5
4	**Reporting Quarter Code *** Report the code that corresponds to the quarter when the medical transactions being reported occurred. 1 = First Quarter 2 = Second Quarter 3 = Third Quarter 4 = Fourth Quarter Format: N	N	17	1
5	**Reporting Year *** Report the year that corresponds to the year when the medical transactions being reported occurred. Format: YYYY	N	18-21	4
6	**Submission File Identifier*** Report the unique identifier created by the data provider to distinguish the file being submitted from previously submitted files. Format: A/N 30, this field must be left justified and contain blanks in all spaces to the right of the last character if the Submission File Identifier is less than 30 bytes.	AN	22-51	30
7	**Submission Date**** Report the date the file was generated. Format: YYYYMMDD	N	52-59	8
8	**Submission Time**** Report the time the file was generated in military time. Format: HHMMSS (HH = Hours, MM = Minutes, SS = Seconds)	N	60-65	6
9	**Record Total** Report the total number of records in the file, **excluding** the File Control Record. **Note** Blank rows will be removed during processing and not counted. If blank rows are included in the Record Total, the file will appear out of balance and reject. Format: N 11, this field must be right justified and left zero-filled	N	66-76	11
10	**Reserved for Future Use**		77-350	274

* If this is a replacement submission (Submission File Type Code, Position 11 is R-Replacement), then this field must be reported the same as the submission being replaced. For details, refer to *File Replacements* in *Section 6 — Reporting Rules* of this Guide.

** For replacements (Submission File Type Code R), the combination of Submission Date and Submission Time must be after that of the file being replaced.

For Key Field Change records, refer to *Key Field Changes* in *Section 6B* of this Guide.

Section 5 — Data Dictionary

A. Overview

To assist medical data providers in automating their medical data call reporting systems, the alphabetized Data Dictionary in this section provides metadata such as data element descriptions and reporting format associated with the data elements in the Medical Data Call Record Layout. Refer to *Section 4 — Record Layouts* of this Guide.

B. Data Dictionary

Accident Date

Field No.:	9
Position(s):	53-60
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD

Definition

The date the Claimant was injured.

Reporting Requirement

Report the date the Claimant was injured.

The Accident Date must be the same as or after Policy Effective Date (Positions 24-31), and before or the same as Service Date (Positions 129-136) or Service From Date (Positions 137-144) and Service to Date (145-152).

The Accident Date should match the Accident Date reported on Unit Statistical data as required by the *California Workers' Compensation Uniform Statistical Reporting Plan—1995.*

Amount Charged by Provider

Field No.:	18
Position(s):	186-196
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	11
Format:	N 11, this field must be right justified and left zero-filled. There is an implied decimal between positions 194 and 195. If the reported amount does not include digits after the decimal, add 00 to the right of the reported amount. **For example:** • $123.45 is reported as 00000012345 • $123.00 is reported as 00000012300

Definition

The total amount per line billed for the medical service by the Service Provider.

Reporting Requirement

Report the total amount per line that was billed by the Service Provider for the applicable line. This is the amount prior to any adjustments but includes revisions/corrections. If a change to the Amount Charged by Provider occurs to a previously reported record, submit a replacement transaction, Transaction Code 03 (Positions 44-45), and report the current cumulative amount (original amount plus or minus changes) for the applicable line. This field should never be a negative value since the total amount charged rather than the change in charged dollars is to be reported. For medical lien transactions, the disputed amount should be reported as the Amount Charged by Provider and should not equal the Paid Amount.

For information on changes to an amount field, such as when reporting a re-evaluated bill, refer to *Record Replacements and Cancellations* in *Section 6 — Reporting Rules* of this Guide.

Bill Identification Number

Field No.:	11
Position(s):	69-98
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	30
Format:	A/N 30, exclude non-ASCII characters. This field must be left justified and contain blanks in all spaces to the right of the last character if the Bill Identification Number is less than 30 bytes.

Definition

A unique number assigned to each bill by the administering entity.

Reporting Requirement

Report the unique number assigned to the bill that corresponds to this transaction.

Birth Year

Field No.:	8
Position(s):	49-52
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	4
Format:	YYYY

Definition

The actual or estimated (accident year minus Claimant age) year the Claimant was born.

Reporting Requirement

Report the year the Claimant was born. The Birth Year must be before Accident Date (Positions 53-60). Leave blank if unknown. The Birth Year should match the current Birth Date Year reported in FROI transactions for the Indemnity Data Call.

Carrier Code

Field No.:	1
Position(s):	1-5
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	5
Format:	N 5

Definition

The code assigned to the insurer/carrier by the NCCI.

Reporting Requirement

Report the 5-digit NCCI assigned Carrier Code. Do not report the NCCI Group ID, NAIC Carrier Code or California Insurer Code. This field may not be left blank or filled with a default value.

Claim Number Identifier

Field No.:	4
Position(s):	32-43
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	12
Format:	A/N 12, letters A–Z and numbers 0–9 only (if the Claim Number Identifier is less than 12 bytes, this field must be left justified, and blanks in all spaces to the right of the last character).

Definition

A set of alphanumeric characters that uniquely identify the claim (letters A–Z and numbers 0–9 only).

Reporting Requirement

Report the unique set of numbers and/or letters that identify the specific claim that the bill applies to. For the purpose of this requirement, unique means that each time a medical service is provided and billed for a specific claim, the same claim number is reflected on each bill.

The Claim Number Identifier reported must match the Unit Statistical data claim number. For older claims for which the final Unit Statistical valuation has been submitted, report the Claim Number Identifier that identifies the claim in your system today. The Claim Number Identifier must be consistent for all future reporting.

Claimant Gender Code

Field No.:	7
Position(s):	48
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	1
Format:	N 1

Definition

A code that corresponds to the Claimant’s gender.

Reporting Requirement

Report the code that corresponds to the Claimant's gender. Leave blank if unknown.

Code	Description
1	Male
2	Female
3	Other

Jurisdiction State Code

Field No.:	6
Position(s):	46-47
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	2
Format:	N 2, Data field is to be right-justified and left zero-filled.

Definition

The 2-digit state code of the governing jurisdiction that will administer the claim and whose statutes will apply to the claim adjustment process. The Jurisdiction State as used in this Guide means the state's Workers' Compensation Act under which the Claimant's benefits are being paid. All medical transactions (Transaction Codes 01, 02, and 03) incurred by participating Insurers with a Jurisdiction State of California are reportable to the WCIRB. This includes all workers' compensation claims, including but not limited to medical-only claims. *Note: It is understood that the State Code under which the Claimant's benefits are being paid may not equate to the exposure state.*

Reporting Requirement

Report the code that corresponds to the state under whose Workers' Compensation Act or Employers' Liability Act the Claimant's benefits are being paid.

Jurisdiction	State Code
California	04

Line Identification Number

Field No.:	12
Position(s):	99-128
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	30
Format:	A/N 30, exclude non-ASCII characters. This field must be left justified and contain blanks in all spaces to the right of the last character if the Line Identification Number is less than 30 bytes.

Definition

A unique number that the administering entity assigns to each line associated with the Bill Identification Number (Positions 69-98).

Reporting Requirement

Report the unique number assigned to the line associated with the Bill Identification Number (Positions 69-98) and for which this record applies.

Network Service Code

Field No.:	25
Position(s):	274
Class:	Alphanumeric (AN) – Field contains only alphabetic characters
Bytes:	1
Format:	A 1

Definition

A code that indicates whether the medical service is provided through a provider network.

Reporting Requirement

Report the code that indicates whether the service is provided through a provider network regardless of whether a network discount was applied. This field should not be left blank.

Code	Description
B	Pharmacy Benefit Manager
H	HMO – the medical Service Provider belongs to a Health Maintenance Organization.
N	No Agreement – the medical Service Provider does not belong to a provider network.
P	Participation Agreement – the medical Service Provider is part of an agreement that is not an HMO or PPO. For California, this includes Health Care Organizations (HCOs).
Y	PPO Agreement – the medical Service Provider belongs to a Preferred Provider Organization agreement. For California, this includes Medical Provider Networks (MPNs).

Paid Amount

Field No.:	19
Position(s):	197-207
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	11
Format:	N 11, this field must be right justified and left zero-filled. There is an implied decimal between positions 205 and 206. If the reported amount does not include digits after the decimal, add 00 to the right of the reported amount. For example: • $123.45 is reported as 00000012345 • $123.00 is reported as 00000012300

Definition

The amount on the bill (line) paid by the Coverage Provider for the medical service.

Reporting Requirement

Report the total amount that was paid by the Coverage Provider for the applicable line.

If a change to the Paid Amount occurs to a previously reported record, submit a replacement transaction, Transaction Code 03 (Positions 44-45), and report the current cumulative amount (original amount plus or minus changes) for the applicable line.

This field should never be a negative value since the total amount paid rather than the change in paid dollars is to be reported.

This field should also not exceed the amount charged for the bill line. In the event that a global reimbursement fee is paid, the amount paid should be parsed out across all bill lines of the billing and not reported in one single bill line.

For information on changes to an amount field, such as when reporting a re-evaluated bill, refer to *Record Replacements and Cancellations* in *Section 6 — Reporting Rules* of this Guide.

Paid Procedure Code

Field No.:	16
Position(s):	153-177
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	25
Format:	A/N Varies, format according to the requirements for the code list used. Refer to the *Procedure Code List Type* table in the *Reporting Requirement* for this field.

Definition

A code from the jurisdiction-approved code table that identifies the procedure associated with the reimbursement.

Reporting Requirement

Report the Paid Procedure Code from the jurisdiction-approved code table (refer to the Procedure Code List Type table within this description) that corresponds to the Line Identification Number (Positions 99-128) as it relates to the reimbursement reported in Paid Amount (Positions 197-207).

If the bill reflects a procedure code other than the procedure code associated with the reimbursement, report the Paid Procedure Code associated with the reimbursement, also known as the 'Best Described As' code, in this field.

The Paid Procedure Code must be populated with correct code values, including leading zeros. When a procedure code is reported without leading zeros, that code may be edited as invalid or may match values from other code sets. For example, if the leading zero is not reported on Revenue Code 0490 – Ambulatory Surgery Center, the resulting value appears to be a 3-digit DRG Code 490 Back and Neck Procedures Except Spinal Fusion with CC/MCC or Disc Device/Neurostimulator, inappropriately identifying the service.

California State-Specific Codes

California Specific Codes, as defined in California Code of Regulations, Title 8, Section 9789.12.14, are to be reported in the Paid Procedure Code field as follows:

CA Code	Procedure
WC001	Doctor's First Report of Occupational Illness or Injury (Form 5021) (Section 9789.14(a)(1))
WC002	Treating Physician's Progress Report (PR-2 or narrative equivalent in accordance with § 9785) (Section 9789.14(b)(1))
WC003	Primary Treating Physician's Permanent and Stationary Report (Form PR-3) (Section 9789.14(b)(2))
WC004	Primary Treating Physician's Permanent and Stationary Report (Form PR-4) (Section 9789.14(b)(3))
WC005	Psychiatric Report requested by the WCAB or the Administrative Director, other than medical-legal report. Use modifier -32 (Section 9789.14(b)(4))
WC006	[Reserved]
WC007	Consultation Reports Requested by the Workers' Compensation Appeals Board or the Administrative Director (Use modifier -32) Consultation Reports requested by the QME or AME in the context of a medical-legal evaluation (Section 9789.14(b)(5)). (Use modifier -30)
WC008	Chart Notes (Section 9789.14(c))
WC009	Duplicate Reports (Section 9789.14(d))
WC010	Duplication of X-Ray

CA Code	Procedure
WC011	Duplication of Scan
WC012	Missed Appointments. This code is designated for communication only. It does not imply that compensation is owed.

Copy Service

The Copy Service Fee Schedule pursuant to California Code of Regulations, Title 8, Section 9983 applies to any services provided on or after July 15, 2022 regardless of the date of injury.

CA Code	Description	Fee
WC019	Copy Service Flat Rate	$230.00
WC021	Copy Service Cancelled Service	$75.00
WC022	Copy Service Certificate of No Records	$75.00
WC023	Copy Service Per Page Fee	$0.10 per page
WC028	Copy Service Duplication of X-Ray or scan	$10.26 each
WC029	Copy Service Electronic Storage Media	$3.00
WC030	Copy Service Requested Services	(Indicate amount)
WC031	Copy Service Contracted Rate for Additional Sets	(Indicate amount)
WC032	Copy Service Contracted Services	(Indicate amount)
WC033	Copy Services Additional Set	$10.00
WC034	Copy Service Surcharge for Late Payment	(Indicate amount)

DWC regulations set forth specific data elements to be included in each Copy Service transaction. The following example illustrates how to properly report a Copy Service transaction.

Paid Procedure Code	Taxonomy Code	Service Date	Place of Service Code	Amount Charged	Amount Paid	Quantity # of Units
WC023	174400000X	20220731	22	00000024300	00000023000	32

- The date of service should be reported as a single Service Date and reflect the date the subpoena or authorization to release documents was served.
- Taxonomy should be reported as 174400000X (Other Medical Provider) since no other taxonomy would be applicable.
- The Place of Service should reflect the location from which the medical records originated. Place of Service 99 should only be used when records are obtained from another insurance company or from the WCAB and not be used as a default value when reporting copy service transactions.
- The Quantity Number of Units field should be populated with either the number of pages produced or with any other applicable quantity from which reimbursement is derived for Paid Procedure Codes WC023, WC028, WC031 and WC033.
- An ICD Diagnosis code is not expected to be reported with copy service transactions as it is not a required billing element pursuant to the California Code of Regulations.

Pursuant to the regulations, the Copy Service Fee Schedule reimbursement is not inclusive of sales tax. Sales tax, if billed and/or reimbursed, should appear as a separate transaction and be reported with Paid Procedure Code S9999.

Medical Legal

For a Medical Legal billing, the Paid Procedure Code must be reported with a California state-specific code based on the California fee schedule. Medical Legal Codes are paid pursuant to procedural codes included in the California fee schedule. These codes are contained in California Code of Regulations, Title 8, Section 9795.

Modifiers indicating the Medical Legal examiner type (-92 for examination performed by the Primary Treating Physician, -94 for examination performed by an Agreed Medical Examiner and -95 for examination performed by a Panel Qualified Medical Evaluator) are expected to be reported with the Medical Legal billing code reported in the Paid Procedure Code field.

Modifiers indicating the Medical Legal examination type (-96 evaluation performed by a Psychiatrist or Psychologist when a psychiatric or psychological evaluation is the primary focus of the medical-legal evaluation; -97 evaluation performed by a physician who is board certified in Toxicology, a physician who is certified as a Qualified Medical Evaluator in the specialty of Internal Medicine or a physician who is board certified in Internal Medicine, when a Toxicology evaluation is the primary focus of the medical-legal evaluation and -98 evaluation performed by a physician who is board certified in Medical Oncology, a physician who is certified as a Qualified Medical Evaluator in the specialty of Internal Medicine or a physician who is board certified in Internal Medicine, when an Oncology evaluation is the primary focus of the medical-legal evaluation) are expected to be reported with the Medical Legal billing code reported in the Paid Procedure Code field.

Taxonomy reporting for Medical Legal services is expected to be a taxonomy which meets the definition of a physician pursuant to Labor Code Section 3209.3.

Taxonomy reporting for Medical Legal examinations for psychiatric or psychological evaluations, toxicology evaluations, or oncology evaluations is expected to be a taxonomy appropriate to that physician's Classification and Specialization as per NUCC standards.

The ICD Diagnostic Code is not expected or required to be reported for Medical Legal transactions.

Medical Lien

In California, the following state-specific Paid Procedure codes must be used to report medical lien payments:

MDO10	Final order or award of the Workers' Compensation Appeals Board requires a lump sum payment for multiple bills where the amount of reimbursement is in dispute between the claims Payer and the healthcare provider.
MDO11	Final order or award of the Workers' Compensation Appeals Board requires a lump sum payment for multiple bills where claims Payer is found to be liable for a claim which it had denied liability.
MDO21	Final order or award of the Workers' Compensation Appeals Board requires a lump sum payment for a single bill where the amount of reimbursement is in dispute between the claims Payer and the healthcare provider.
MDS10	Lump sum settlement for multiple bills where the amount of reimbursement is in dispute between the claims Payer and the healthcare provider.
MDS11	Lump sum settlement for multiple bills where liability for a claim was denied but finally accepted by the claims Payer.
MDS21	Lump sum settlement for a single bill where the amount of reimbursement is in dispute between the claims Payer and the healthcare provider.

Other data element reporting for lien settlements follows the rules set forth for WCIS EDI reporting as specified in the California Medical EDI Implementation Guide for Medical Bill Payment Records and should correspond to the underlying billing for which the lien settlement is being paid.

For medical lien transactions, report the disputed amount as the Amount Charged by Provider and report the settlement amount as the Paid Amount. The Amount Charged should not equal the Paid Amount.

Transaction Date and Service Date must not be equal or the record will reject. Report the Service Date for lien settlements as the date the lien was filed in accordance with the WCIS EDI reporting rules.

Medical Marijuana

MM001	Reimbursement to Injured Worker (Claimant)
MM002	Reimbursement to Dispensary

- The date of service should be reported as a single Service Date.
- Taxonomy should be reported as 175F00000X (Naturopath).
- The Place of Service should be reported as DS (Dispensary). Place of Service 99 should not be used when reporting Medical Marijuana services.
- The Quantity Number of Units field should be populated with the number of grams dispensed.
- An ICD Diagnosis code is not expected to be reported with medical marijuana transactions as it is not a required billing element pursuant to the California Labor Code.

Reporting Services Paid Utilizing the Ambulatory Payment Classification

For medical treatment performed in a hospital outpatient setting which may be payable utilizing the APC under the Hospital Outpatient Prospective Payment System (HOPPS), report the HCPCS/CPT code in the Paid Procedure Code field. An example would be radiology services performed at a hospital where the technical component of the study is billed by the hospital or physical medicine services where the treatment is performed by a therapist who is the employee of the hospital. Other examples of services to be reported with the HCPCS/CPT code include clinic visits, hospital-based home health care or laboratory services.

For facility services, the Revenue Code should be used as the Paid Procedure Code data element with the CPT/HCPCS code reported as the Secondary Procedure Code (Positions 290-314), if available. This includes all facility services including Ambulatory Surgery Center, Hospital Emergency Room, Hospital Outpatient Surgery and Skilled Nursing/Custodial Care which pay or may not be payable under the Facility Fee Schedules pursuant to California Code of Regulations, Title 8, Section 9789.33.

The example below represents the reporting of a five line facility bill for an emergency room transaction with Place of Service Code 23.

Facility Bill Reported with Revenue Code as Paid Procedure Code					
Revenue Code as Paid Procedure Code	Revenue Code Description	Secondary Procedure Code	Secondary Procedure Code Description	Billed (Amount Charged by Provider)	Paid Amount
0250	Pharmacy			50.00	0.00
0251	Pharmacy: Generic			100.00	0.00
0320	Radiology – Diagnostic	73140	X-Ray Exam of Finger(s)	175.00	16.39
0450	Emergency Room	99283	Emergency Dept Visit	350.00	215.99
0450	Emergency Room	12001	RPR S/N/AX/GEN/TR NK 2.5CM/<	250.00	136.98

Inpatient Hospital Transactions

Inpatient Hospital services are to be reported with the Diagnosis Related Group (DRG), which is used to calculate the global fee populated in the Paid Procedure Code field for each bill line and the HCPCS/CPT Revenue Code for the line in the Secondary Procedure Code field regardless of whether or not the hospitalization is payable under the Inpatient Hospital Fee Schedule pursuant to California Code of Regulations, Title 8, Section 9789.22. The Place of Service is expected to be populated with either 21 (Acute Hospital), 51 (Psychiatric Hospital) or 61 (Rehabilitation Hospital or Long Term Care Hospital). The Taxonomy is to be reported as that for the hospital and not that for the attending physician or other providers associated with the services rendered during the hospital stay. Service From and Service To dates should reflect the dates of admission and discharge. Single service dates should not be reported except in the rare case of a patient transfer to another hospital or patient death.

An example of how to report an inpatient hospital payment is outlined below:

Bill Reported with DRG as Paid Procedure Code					
DRG Code as Paid Procedure Code	DRG Code Description	Secondary Procedure Code	Secondary Procedure Code Description	Billed (Amount Charged by Provider)	Paid Amount
025	Craniotomy	0201	Room & Board (Semi-Private 2 beds)	10,000.00	5,000.00
025	Craniotomy	0250	Pharmacy	3,000.00	1,000.00
025	Craniotomy	0301	Laboratory – Clinical Diagnostic: Chemistry	4,000.00	2,325.46
025	Craniotomy	0424	Physical Therapy: Evaluation/re-evaluation	800.00	0.00
025	Surgery	0632	Drugs Require Specific ID: Multiple source drug	25,000.00	7,171.42

Interpreting Services

Interpreting services rendered at a medical treatment appointment or a Medical Legal evaluation are to be reported with either Paid Procedure Code T1013 as required for WCIS reporting or a carrier specific non-medical code. Interpreting services may not be reported with CPT Code 99199. Further, interpreting services must be reported with Taxonomy Code 171R00000X in all circumstances so as to identify the service as interpreting. An ICD Diagnosis Code is not expected to be reported with Interpreting Services and is not a required billing element pursuant to the California Billing and Payment Regulations.

Non-Emergency Transportation

Non-emergency transportation services rendered to an injured worker to attend a medical treatment appointment or a Medical Legal evaluation are to be reported with HCPCS codes A0080 through A0170 in lieu of State Medicaid Agency T-Codes T2001 through T2005. Place of Service for non-emergency transportation services is to be reported as ‘99’ (Other); Place of Service 41 (Ambulance) should not be reported. The ICD Diagnostic Code is not expected or required to be reported for Non-emergency transportation transactions.

Paid Procedure Codes

Procedure Code List Type		
Code List Type	**Code Length (Bytes)**	**Description / Formatting**
CPT-Current Procedural Terminology	5	• Codes are either 5 numbers or 4 numbers followed by a single alpha character • Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code**
OMFS-Official Medical Fee Schedule for Physician and Non-Physician Services	5	• Codes are either 5 numbers or 2 alpha characters followed by 3 numbers • Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes • Must include leading zeros when part of the code**
CDT-Current Dental Terminology	5	• Codes are a single alpha character followed by 4 numbers (e.g. D1234) • Left justify and blank-fill all spaces to the right of the last number
HCPCS-Healthcare Common Procedure Coding System	5	• Codes are a single alpha character followed by 4 numbers • Level 1 uses the CPT codes while level 2 adds alphanumeric codes for other services such as ambulance or prosthetics • Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes • Must include leading zeros when part of the code**
NDC-National Drug Codes	11	• 11-byte FDA (Food and Drug Administration) codes • Left justify and blank-fill all spaces to the right of the last number • Do not include dashes • Must include leading zeros when part of the code**
DRG-Diagnostic Related Group	3	• Numeric codes classify procedures into related groups for inpatient services • Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code** • Transactions with a DRG in the Paid Procedure Code field must report a Revenue Code in the Secondary Procedure Code field

Procedure Code List Type		
Code List Type	**Code Length (Bytes)**	**Description / Formatting**
Revenue Codes	4	• Numeric codes classify procedures into related groups for outpatient facility transactions • Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code** • Transactions with a Revenue Code in the Paid Procedure Code field must report the corresponding CPT or HCPCS code in the Secondary Procedure Code field, when applicable, for outpatient facility transactions

State-Specific	5	• Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes
		• California State-Specific Codes and modifiers include but are not limited to:
		  • California Specific Codes
		  • Medical Legal
		  • Medical Lien
		  • Copy Service

Compound Drugs	11	• Report as S9430 in the Paid Procedure Code field with:
		  • The total billed amount in the Amount Charged by Provider field
		  • The total paid amount in the Paid Amount field
		  • The total number of ingredients in the Quantity / Number of Units per Procedure Code field
		AND
		• Report the NDC code in the Paid Procedure Code field on subsequent records with:
		  • Zero dollars in the Amount Charged by Provider field
		  • Zero dollars in the Paid Amount field
		  • The quantity of the ingredient used in the Quantity / Number of Units per Procedure Code field
		• Left justify and blank-fill Positions 164-177

** If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if the system stores 59 for a code that is listed as 0059 on the code list, then insert two zeros to the left of the 5 when reporting to the WCIRB.

Paid Procedure Code Modifier(s)

Field No.:	17
Position(s):	178-185
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	8 – First Paid Procedure Code Modifier (4), Second Paid Procedure Code Modifier (4)
Format:	First Paid Procedure Code Modifier – A/N 4 (Positions 178-181), left justified and blank-filled to the right of the last number or character when the First Paid Procedure Code Modifier(s) is less than 4 bytes.

	Second Paid Procedure Code Modifier – A/N 4 (Positions 182-185), left justified and blank-filled to the right of the last number or character when the Second Paid Procedure Code Modifier(s) is less than 4 bytes.
	If only one Paid Procedure Code Modifier applies, report in Positions 178-181 and leave Positions 182-185 blank.

Definition

A code from the jurisdiction-approved code table that identifies the unique circumstances related to the Paid Procedure Code (Positions 153-177) when the circumstance alters a procedure or service but does not change the Paid Procedure Code or its definition.

Reporting Requirement

Report the Paid Procedure Code Modifier(s) related to the Paid Procedure Code (Positions 153-177). If there are more than two modifiers, report only the modifier(s) that impacts the reimbursement.

For Medical Legal services, report the Modifier indicating the examiner type (-92) Primary Treating Physician, (-94) Agreed Medical Examiner, (-95) Panel Qualified Medical Evaluator and then the Modifier for psych (-96), toxicology (-97), oncology (-98) in lieu of Modifier -93 (Interpreter) when all are applicable.

If there is no Paid Procedure Code Modifier, leave blank.

California State-Specific Modifiers

California Code of Regulations, Title 8, Section 9789.12.15, California Specific Modifier

The following modifier is to be appended to the applicable CPT Code or California Specific code in addition to any applicable CPT modifier.

-30	Consultation Service During Medical-Legal Evaluation: Services or procedures performed by a consultant at the request of a QME or AME in the context of a medical-legal evaluation where those services are paid under the Physician Fee Schedule.

Medical Legal Modifiers

Modifiers indicating the Medical Legal examiner type (-92 for examination performed by the Primary Treating Physician, -94 for examination performed by an Agreed Medical Examiner and -95 for examination performed by a Panel Qualified Medical Evaluator) are expected to be reported when a Medical Legal billing code is reported in the Paid Procedure Code field. Any other applicable modifiers which affect reimbursement of the medical legal service are also to be reported. *See Medical Legal subsection of Paid Procedure Code Section.*

Place of Service Code

Field No.:	27
Position(s):	282-289
Class:	Alphanumeric (AN) – Field contains numeric characters
Bytes:	8
Format:	N 8, this field must be left justified and blank-filled to right of the last number or character when the Place of Service Code is less than 8 bytes. Include leading zeros when part of the code. If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if the system stores 1 for a code that is listed as 01 on the code list, insert a zero to the left of the 1 when reporting to the WCIRB.

Definition

A code that indicates where the medical service was performed.

Reporting Requirement

Report the Place of Service Code from the Place of Service list that indicates where the medical service was performed. Do not report Place of Service Code 99 (Other Place of Service) when the place of service is unavailable. Instead, leave this field blank. For instructions on reporting Place of Service appropriately for Copy Services and Non-Emergency Transportation, see applicable subsections in the Paid Procedure Code section.

For facility and hospital services, the Place of Service Crosswalk was developed to provide a mapping of the Type of Bill code to the Place of Service code. Refer to the Place of Service Crosswalk in Section 9.

Place of Service*			
Code	**Description**	**Code**	**Description**
01	Pharmacy	33	Custodial Care Facility
02	Telemedicine	34	Hospice
03	School	35-40	Unassigned – Not valid for CA
04	Homeless Shelter	41	Ambulance – Land
05	Indian Health Service – Free -Standing Facility	42	Ambulance – Air or Water
06	Indian Health Service – Provider-Based Facility	43-48	Unassigned – Not valid for CA
07	Tribal 638 Freestanding Facility	49	Independent Clinic
08	Tribal 638 Provider-Based Facility	50	Federally Qualified Health Center
09	Prison-Correctional Facility	51	Inpatient Psychiatric Facility
10	Unassigned – Not valid for CA	52	Psychiatric Facility – Partial Hospitalization
11	Office	53	Community Mental Health Center
12	Home	54	Intermediate Care Facility/Individuals with Intellectual Disabilities
13	Assisted Living Facility	55	Residential Substance Abuse Treatment Facility
14	Group Home	56	Psychiatric Residential Treatment Center
15	Mobile Unit	57	Non-Residential Substance Abuse Treatment Facility
16	Temporary Lodging	58-59	Unassigned – Not valid for CA
17	Walk-in Retail Health Clinic	60	Mass Immunization Center
18	Place of Employment – Worksite	61	Comprehensive Inpatient Rehabilitation Facility
19	Off Campus – Outpatient Hospital	62	Comprehensive Outpatient Rehabilitation Facility
20	Urgent Care Facility	63-64	Unassigned – Not valid for CA
21	Inpatient Hospital	65	End-Stage Renal Disease Treatment Facility
22	Outpatient Hospital	66-70	Unassigned – Not valid for CA
23	Emergency Room-Hospital	71	Public Health Clinic
24	Ambulatory Surgical Center	72	Rural Health Clinic
25	Birthing Center	73-80	Unassigned – Not valid for CA
26	Military Treatment Facility	81	Independent Laboratory
27-30	Unassigned – Not valid for CA	82-98	Unassigned – Not valid for CA
31	Skilled Nursing Facility	99	Other Place of Service
32	Nursing Facility	DS	Medical Marijuana Dispensary [1]

* Source: Centers for Medicare & Medicaid Services (www.cms.gov)

[1] This is an NCCI-assigned value. CMS does not currently have a code for Dispensary.

Policy Effective Date

Field No.:	3
Position(s):	24-31
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD

Definition

The date the policy under which the claim occurred became effective.

Reporting Requirement

Report the effective date that corresponds to the date shown on the policy Information Page or to endorsements attached. The Policy Effective Date should match the Policy Effective Date reported in unit statistical data. The Policy Effective Date reported must be before or the same as Accident Date (Positions 53-60).

Policy Number Identifier

Field No.:	2
Position(s):	6-23
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	18
Format:	A/N 18, letters A-Z and numbers 0-9 only (if the Policy Number Identifier is less than 18 bytes, this field must be left justified, and blanks in all spaces to the right of the last character).

Definition

The unique set of numbers and/or letters that identify the policy under which the claim occurred (letters A-Z and numbers 0-9 only).

Reporting Requirement

Report the unique set of numbers and/or letters that identify the policy under which the claim occurred.

Policy Number Identifier must match the Unit Statistical data policy number including any prefixes or suffixes. The Policy Number Identifier must be consistently reported for all medical transactions.

Primary ICD Diagnostic Code

Field No.:	20
Position(s):	208-221
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	14

Format:	A/N 14, this field must be left justified and contain blanks in all spaces to the right of the last character if the Primary ICD Diagnostic Code is less than 14 bytes. Additional formatting rules include (see example): • Report zeros only when part of the code • Capitalize alphabetic characters • Report the decimal only if the code contains characters (including zero) to the right of the decimal

If ICD Diagnostic Code is:	Then valid format is ("_" indicates a space)
S42.2	S42 2_ _ _ _ _ _ _ _ _ _
S42.01	S42.01 _ _ _ _ _ _ _ _ _
S42.001D	S42.001D _ _ _ _ _ _

- If converting codes from a system that does not store a decimal, ensure that the decimal is inserted correctly (always in the 4th position). For example, S42012 should be S42.012.

Definition

A code that identifies the primary diagnosis associated with the medical service rendered.

Reporting Requirement

Report the CMS (Centers for Medicare & Medicaid Services) ICD-CM code that identifies the primary diagnosis associated with the medical service rendered. Refer to CMS https://www.cms.gov/medicare/coding-billing/icd-10-codes for the ICD Diagnostic Code listing.

The WCIRB does **not** recognize Codes T07.XXXA, T07XXXD, T07.XXXS, T14.8XXA, T14.8XXD, T14.8XXS, T14.90, T14.90XA, T14.90XD, or T14.90XS (unspecified injury) as valid codes.

Leave blank if a primary diagnosis has not been identified or if the service type does not require a diagnosis code for the billing to be considered complete as defined under the Billing regulations such as in the case of Copy Services, Medical Legal, Interpreter, Non-Emergency Transportation, Pharmacy or other similar services.

Provider Identification Number

Field No.:	23
Position(s):	256-270
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	15
Format:	A/N 15, this field must be left justified and contain blanks in all spaces to the right of the last character if the Provider Identification Number is less than 15 bytes.

Definition

A number that uniquely identifies the Medical/Service Provider.

Reporting Requirement

Report the number that uniquely identifies the Medical/Service Provider (i.e., National Provider Identification, state-required number, Federal Employer Identification Number or unique Insurer coding scheme) that performed the service. For hospitals billing from a centralized location, report the National Provider Identification Number of the service facility. For example, if a line item of a hospital bill indicates that a Registered Physical Therapist provided therapy to a Claimant as an employee of the hospital, report the hospital's Provider Identification Number.

For transactions reported by a Pharmacy Benefit Management (PBM) company, report the Provider Identification Number of the medical service provider for whom the billing house/PBM is submitting the bill.

A unique Insurer coding scheme may be used in lieu of a state-required number when reporting to the WCIRB. However, the unique Insurer coding scheme must be used consistently.

Provider Postal (ZIP) Code

Field No.:	24
Position(s):	271-273
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	3
Format:	A/N 3

Definition

The code assigned by the postal service (USPS or other) to the Medical/Service Provider address where the service was performed.

Reporting Requirement

Report only the first three digits/characters of the postal (ZIP) code for the Medical/Service Provider address where the service was performed. In instances where the postal (ZIP) code impacts the reimbursement, report the postal (ZIP) code associated with the reimbursement.

If unavailable, report only the first three digits of the postal (ZIP) code of the provider's billing address unless it is a billing house. When the billing address is a billing house and no other postal (ZIP) code is unavailable, leave this field blank.

Provider Taxonomy Code

Field No.:	22
Position(s):	236-255
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	20
Format:	A/N 20, this field must be left justified and contain blanks in all spaces to the right of the last character if the Provider Taxonomy Code is less than 20 bytes.

Definition

A taxonomy code that identifies the type of provider that billed for and is being paid for the medical service.

Reporting Requirement

Report the taxonomy code that identifies the type of provider that billed for and is being paid for the medical service. For example, if a line item of a hospital bill indicates that a Registered Physical Therapist provided therapy to a Claimant as an employee of the hospital, report the Provider Taxonomy Code associated with the hospital.

In cases where a PBM or billing house bills the Payer, report the Provider Taxonomy Code associated with the Medical/Service Provider for whom the billing house/PBM is submitting the bill.

Taxonomy Code 174400000X (Medical provider not otherwise specified) should only be reported for Copy Services. For all other medical treatment, goods and services, the rendering provider's NPI per the medical billing should have an applicable Taxonomy Code for reporting purposes. If it is

determined that the medical provider has registered with the non-specific taxonomy, the data source should take steps to communicate this data issue to the provider and explain the impact it can have on their reimbursement. In the event that there is no NPI available, the reviewer is expected to map the service to a more appropriate and expected Taxonomy Code.

Taxonomy reporting for Medical Legal services is expected to be a taxonomy which meets the definition of a physician pursuant to Labor Code Section 3209.3. Use the Provider Taxonomy list of standard codes maintained by the National Uniform Claim Committee—Code Subcommittee (available at taxonomy.nucc.org) *See Medical Legal subsection of Paid Procedure Code Section.*

Quantity / Number of Units per Procedure Code

Field No.:	26
Position(s):	275-281
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	7
Format:	N 7, rounded up to the nearest whole number. Do not report a decimal. This field must be right justified and left zero-filled.

Definition

The number of units of service performed or the quantity of drugs dispensed.

Reporting Requirement

Report the number of units of service performed or the quantity of drugs dispensed that are related to the Paid Procedure Code (Positions 153-177). Use the base quantity specified by the applicable procedure code to determine the quantity or number to report.

Example

Base Size / Amount as Specified by Applicable Procedure Code

- Supplies – The Paid Procedure Code reported is for surgical gloves. The code specifies that the base quantity is a pair of gloves. For this example, if one pair was used, 0000001 would be reported in this field.

Drugs / Medication

For Paid Procedure Codes related to medications, the quantity/units depend on the type of drug.

- For tablets, capsules, suppositories, non-filled syringes, etc., report the actual number of the drug provided. For example, a bottle of 30 pills would be reported as 0000030.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., dispensed in standard packages, report the units as specified by the Procedure Code. For example, a cream is dispensed in a standard tube, which is defined as a unit by the Procedure Code. Report 0000001 (one tube).
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., that are not dispensed in standard packages, report the amount provided in its standard unit of measurement (e.g., microcuries, milliliters, grams, ounces). For example, codeine cough syrup dispensed by a pharmacist into a four-ounce bottle would be reported as 0000004.
- For compounded medications report the quantity/units decimal units used in the recipe. For example, bulk chemical is 1000 grams and the recipe calls for 0.1 grams, report the quantity number of units as 0.0001. Note that for a decimal value to be accepted in this field, the billing must be reported with S9430 in the first line of the bill followed by the ingredients (see Paid Procedure Code – Compound Drug).

Physical Medicine Services

For Paid Procedure Codes related to physical medicine services, the quantity/units is reported as billed for the service. For example, two units of 97110 is reported as 0000002.

Anesthesia

For Paid Procedure Codes related to anesthesia, the quantity/units is reported in minutes. For example, if 220 minutes of anesthesia was provided, report 0000220 in this field.

Medical Legal

For Medical Legal evaluations in California, the quantity/units are reported in minutes for the time-based medical legal codes, ML204 and ML205. For non-time-based medical legal codes ML200, ML201, ML202 and ML203, report 0000001 in this field. For Medical Legal record review beyond the initial 200 pages included in the medical legal evaluation code using medical legal code MLPRR, report the number of additional pages reviewed in the quantity/units field.

Secondary ICD Diagnostic Code

Field No.:	21
Position(s):	222-235
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	14
Format:	A/N 14, this field must be left justified and contain blanks in all spaces to the right of the last character if the Secondary ICD Diagnostic Code is less than 14 bytes. Additional formatting rules include (see example): • Report zeros only when part of the code • Capitalize alphabetic characters • Report the decimal only if the code contains characters (including zero) to the right of the decimal

If ICD Diagnostic Code is:	Then valid format is ("_" indicates a space)
S42.2	S42 2_ _ _ _ _ _ _ _ _ _
S42.01	S42.01 _ _ _ _ _ _ _ _ _
S42.001D	S42.001D _ _ _ _ _ _

- If converting codes from a system that does not store a decimal, ensure that the decimal is inserted correctly (always in the 4th position). For example, S42001D should be S42.001D.

Definition

A code that identifies the secondary diagnosis associated with the medical service rendered.

Reporting Requirement

Report the CMS (Centers for Medicare & Medicaid Services) ICD code that identifies the secondary diagnosis associated with the medical service rendered. Refer to CMS (cms.gov/ICD-10) for the ICD Diagnostic Code listing.

Leave blank if a secondary diagnosis has not been identified.

Secondary Procedure Code

Field No.:	28
Position(s):	290-314
Class:	Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes:	25
Format:	A/N 25, format according to the requirements for the code list used. Refer to the *Procedure Code List Type* table in the *Reporting Requirement* for this field.

Definition

A code from the jurisdiction-approved code table that identifies the billed procedure.

Reporting Requirement

Report the Secondary Procedure Code from the jurisdiction-approved code table (refer to the Procedure Code List Type table within this description) if the bill reflects a procedure code other than the procedure code associated with the reimbursement.

Secondary Procedure Codes are required to be reported for inpatient hospital service transactions and outpatient facility service transactions. See the Paid Procedure Code section for details about proper reporting.

Leave blank if the Secondary Procedure Code is the same as the Paid Procedure Code (Positions 153-177).

Procedure Code List Type		
Code List Type	**Code Length (Bytes)**	**Description / Formatting**
CPT – Current Procedural Terminology	5	• Codes are either 5 numbers or 4 numbers followed by a single alpha character • Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code** • Transactions with a Revenue Code in the Paid Procedure Code field must report the corresponding CPT or HCPCS code in the Secondary Procedure Code field, when applicable, for outpatient facility transactions
OMFS – Official Medical Fee Schedule for Physician and Non-Physician Services	5	• Codes are either 5 numbers or 2 alpha characters followed by 3 numbers • Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes • Must include leading zeros when part of the code**
CDT – Current Dental Terminology	5	• Codes are a single alpha character followed by 4 numbers • Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code**

Procedure Code List Type		
Code List Type	**Code Length (Bytes)**	**Description / Formatting**
HCPCS – Healthcare Common Procedure Coding System	5	• Codes are a single alpha character followed by 4 numbers • Level 1 uses the CPT codes while level 2 adds alphanumeric codes for other services such as ambulance or prosthetics • Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes • Must include leading zeros when part of the code** • Transactions with a Revenue Code in the Paid Procedure Code field must report the corresponding CPT or HCPCS code in the Secondary Procedure Code field, when applicable, for outpatient facility transactions
NDC – National Drug Codes	11	• 11-byte FDA (Food and Drug Administration) codes • Left justify and blank-fill all spaces to the right of the last number • Do not include dashes • Must include leading zeros when part of the code**
DRG – Diagnostic Related Group	3	• DRG codes are applicable to inpatient hospital transactions and should only be reported in the Paid Procedure Code field
Revenue Codes	4	• Left justify and blank-fill all spaces to the right of the last number • Must include leading zeros when part of the code** • Transactions with a DRG in the Paid Procedure Code field must have a Revenue Code in the Secondary Procedure Code field
State-Specific	5	• Left justify and blank-fill all spaces to the right of the last number or character when less than 25 bytes • State-Specific codes are to be reported in the Paid Procedure Code field

** If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if the system stores 5.9 for a code that is listed as 005.9 on the code list, then insert two zeros to the left of the 5 when reporting to the WCIRB.

Service Date

Field No.:	13
Position(s):	129-136
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD

Definition

The date when the medical provider performed the service.

Reporting Requirement

Report the date the service related to Line Identification Number (Positions 99-129) was performed. If an inpatient hospital payment spanning multiple days was made, zero-fill this field and report in Service From Date (Positions 137-144) and Service To Date (Positions 145-152).

Except for cumulative injury claims, Service Date is expected to be the same as or after Accident Date (Positions 53-60).

Example

Bill Spans Multiple Days — Line Item Detail Is Available

A Claimant receives 30 minutes* of physical therapy on January 8, 10, 15 and 17, 2021. The four services are listed as separate lines (Line Identification Number 1 through 4). Report four records, one for each line. For each record, report the individual date the service was performed in the Service Date field (Positions 129-136). There will only be one date reported for each record. In this example, the Service From Date and Service To Date fields will be zero-filled.

Bill ID (69-98)	Line ID (99-128)	Paid Procedure Code (153-177)	Service Date (129-136)	Quantity / # of Units (275-281)
1001	1	97110	20210108	0000002
1001	2	97110	20210110	0000002
1001	3	97110	20210115	0000002
1001	4	97110	20210117	0000002

* For this example, Paid Procedure Code 97110-Therapeutic Procedure specifies each >8 minute segment as 1 unit. Therefore, 20 minutes of physical therapy is reported as 2 units.

Service From Date

Field No.:	14
Position(s):	137-144
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD

Definition

The date when services were initiated.

Reporting Requirement

Use this field for the starting date of service if an inpatient hospital payment spanning multiple days was made. In all other cases, zero-fill this field and report the date of service in Service Date (Positions 129-136).

This field is the first date of a date range and must be accompanied by a Service To Date (Positions 145-152).

Service From Date must be before the Service To Date (Positions 145-152).

Service From Date must be the same as or after Accident Date (Positions 53-60).

Service To Date

Field No.:	15
Position(s):	145-152
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD

Definition

The date when services were terminated and patient was discharged.

Reporting Requirement

Use this field for the ending date of service if an inpatient hospital payment spanning multiple days was made. In all other cases, zero-fill this field and report the date of service in Service Date (Positions 129-136).

This field is the last date of a date range and must be accompanied by a Service From Date (Positions 137-144).

Service To Date must be after Service From Date (Positions 137-144).

Transaction Code

Field No.:	5
Position(s):	44-45
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	2
Format:	N 2, Data field is to be right justified and left zero-filled

Definition

A code that identifies the type of transaction being submitted to the WCIRB.

Reporting Requirement

Report the code that identifies the type of transaction of the record being submitted.

Code	Description
01	Original – the initial report of the record to the WCIRB. Only one original (Transaction Code 01) may be submitted for a given transaction.
02	Cancellation – cancels (deletes) a previously submitted (Transaction Code 01 or 03) transaction.
03	Replacement – replaces (changes) a previously submitted (Transaction Code 01 or 03) transaction.
04*	Key Field Change – replaces (changes) one or more key fields of a previously submitted transaction.*

**For Key Field Change record layout and reporting details, see Key Field Change Section 6B.*

An Original (01) must be in the same submission or in the WCIRB's database before a Cancellation (02) or a Replacement (03) can be submitted.

Transaction Date

Field No.:	10
Position(s):	61-68
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	8
Format:	YYYYMMDD

Definition

The date the information in the medical transaction was processed as established by the original source of the data. Original source of the data is defined as the entity initially responsible for administering the medical bill(s). This may be an Insurer, TPA bill review vendor, pharmacy benefit manager, or other entity that is responsible for medical claim management.

Reporting Requirement

Report the date corresponding to the Transaction Code (Positions 44-45) of the record being submitted. Transaction Date and Service Date must not be equal or the record will reject.

If Transaction Code is:	Then report:
01- Original	The date the information was originally processed by the administering entity. For example: A medical service was performed on 01/15/2021. The medical Service Provider submitted the bill to a third party administrator, which processed and paid the bill on 01/21/2021. The medical data provider reports the original transaction to the WCIRB with its January submission on 03/01/2021. The Transaction Date for this original record is 01/21/2021 (reported as 20210121).
02- Cancellation	The date the cancellation was performed in the system of the administering entity.
03- Replacement	The date that the information was changed or corrected in the system of the administering entity. For example: Using the same scenario as described in the example for 01-Original, the administering entity discovers an error on the bill and corrects it in its system on 05/01/2021. The medical data provider reports the replacement transaction to the WCIRB with its May submission on 07/01/2021. The Transaction Date for this replacement record is 05/01/2021 (reported as 20210501).

Section 6 — Reporting Rules

A. Original Reports

Medical Data Call data is the detailed line information of a bill, also referred to as a medical transaction, reported to the WCIRB as an individual record. The Original report is the first reporting of the medical transaction, identified by Transaction Code 01 – Original in the record layout (Positions 44-45). For record reporting details, refer to *Section 3 — Medical Data Call Structure* and *Section 5 — Data Dictionary* of this Guide.

All medical transactions (existing claims and new claims) that occur within a specific reporting period, based on Transaction Date (Positions 61-68), must be reported in that quarter or month's submission. Historical data for existing claims is not to be reported. For details about timely reporting, refer to *Reporting Frequency* in *Section 2 — General Rules* of this Guide.

B. Record Replacements and Cancellations

Medical data providers may delete or change previously reported records (whether the records were reported in earlier submissions or as a prior record in the current submission). Since Medical Data Call reporting is done at the individual line level of a bill, it is not necessary to resubmit every line of a bill if only one line must be deleted or changed.

Transaction Code (Positions 44-45) is used to identify these changes as follows:

- Transaction Code 02 – Cancellation – Deletes a record.
- Transaction Code 03 – Replacement – Changes a record.

An Original (01) must be in the same submission or on the WCIRB's database before a Cancellation (02) or a Replacement (03) can be submitted.

For additional information, refer to *Transaction Code* in *Section 5 — Data Dictionary* of this Guide.

1. Record Deletions

A record or multiple records that have been previously reported can be deleted from the WCIRB's database via a cancellation record. The Cancellation transaction (Transaction Code 02) deletes **all** records, whether one or multiple, for a given key field combination (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number and Line Identification Number).

To delete a previously submitted record, submit a cancellation record with the following:

(a) All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number and Line Identification Number) populated. The key fields must match those reported on the previous record to which the cancellation applies.
(b) Transaction Code 02 – Cancellation (Positions 44-45).
(c) Transaction Date (Positions 61-68) reported as the date the cancellation is performed. This date must be after the Transaction Date on the previous record to which the cancellation applies.

Example

Deleting a Single Record

Carrier 99990 submits an erroneous record (A). To delete it from the database, the Carrier submits a cancellation record (B) with the same key fields and Transaction Code 02. The Transaction Date of the cancellation record is the date when the cancellation is performed.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/ # of Units
A	99990	0006	01	20121210	1001	1	20121203	00000010000	00000010000	0000001
B	99990	0006	02	20121217	1001	1	20121203	00000010000	00000010000	0000001

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

2. Key Field Changes

Changing Key Fields can be done in two ways:

Key Field Change Using Cancellation Record

Key Field Change Using Key Field Change Record

i) To make a Key Field change using a cancellation record, a cancellation record must first be submitted to remove the record from the database. For details, refer to *Record Deletions* above.

After deleting the previously reported record, submit a new record with the following:

(a) All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number and Line Identification Number) populated with the corrected information and the previously reported information for any key fields that are not being changed.
(b) Transaction Code 01 – Original (Positions 44-45).
(c) Transaction Date (Positions 61-68) reported as the date the key field change was made.

Example

Carrier 99990 submits an original record (A) with an erroneous Claim Number Identifier of 1000. To change the Claim Number Identifier, the Carrier first submits a cancellation record (B) with all the key fields as previously reported (including Claim Number Identifier 1000), Transaction Code 02, and Transaction Date as the date the key field change was made. After submitting the cancellation, the Carrier submits a new record (C) with the corrected Claim Number Identifier and all the other key fields as previously reported, Transaction Code 01, and Transaction Date as the date the change was performed.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/ # of Units
A	99990	1000	01	20121210	1001	1	20121203	00000010000	00000010000	0000001
B	99990	1000	02	20121217	1001	1	20121203	00000010000	00000010000	0000001
C	99990	0001	01	20121217	1001	1	20121203	00000010000	00000010000	0000001

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

ii) Key Field Change Using Key Field Change Record

Key Field changes using the Key Field Change record must be submitted in a file containing only Key Field Change Records. The previous key fields on the Key Rield Change record must match those reported on any existing records to which the Key Field Change record applies. It is possible to change one or more Key Fields in a single Key Field Change record.

When a Key Field Change record is submitted, it changes only the Key Field(s) of historical data available in the database and does not change the Key Field(s) for any future transactions that may be submitted. New Key Field(s) should be used consistently in future transactions.

The record layout for a Key Field Change record is as follows:

Field No.	Field Title	Class	Position	Bytes
1	Previous Carrier Code	(N)	1-5	5
2	Previous Policy Number Identifier	(AN)	6-23	18
3	Previous Policy Effective Date	(N)	24-31	8
4	Previous Claim Number Identifier	(AN)	32-43	12
5	Transaction Code	04	44-45	2
6	Carrier Code	(N)	46-50	5
7	Policy Number Identifier	(AN)	51-68	18
8	Policy Effective Date	(N)	69-76	8
9	Claim Number Identifier	(AN)	77-88	12
10	Reserved for Future Use		89-350	262

Refer to WCMED Data Specifications Manual at www.wcio.org

If changing the Carrier Code using a Key Field Change record, the Carrier Code must be in the same data reporting group as the Previous Carrier Code. If the new Carrier Code is not part of the same reporting group, the Key Field Change Using Cancellation Record process must be followed.

1. Record Changes

A record or multiple records that have been previously reported can be changed via a replacement record. The replacement record shows the current cumulative values for all data elements rather than the change in value.

Changes via a replacement record can only be made to non-key fields. To change key fields, refer to *Key Field Changes via Cancellation* above.

To change a non-key field for a previously reported record (original or replacement), submit a replacement record with the following:

(a) All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number and Line Identification Number) populated. The key fields must match those reported on the previous record to which the change applies.
(b) Transaction Code 03 – Replacement (Positions 44-45).
(c) Transaction Date (Positions 61-68) reported as the date the information was changed in the system of the administering entity.
(d) The current cumulative values for all non-key fields (not the change in value).

The replacement record must include all data elements even if they do not change.

Example

Changing an Amount Field Due to an Additional Reimbursement

Carrier 99990 submits a record (A) for a medical transaction. One week later, the Carrier makes an additional reimbursement of $1,000. To change the transaction, the Carrier submits a replacement record (B) with the same key fields as the record being changed, Transaction Code 03, and the current cumulative value (not the change in value) for all non-key fields including the

Paid Amount, which reflects the total after reimbursement. The Transaction Date of the replacement record is the date the additional reimbursement was made in the system of the administering entity.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity / # of Units
A	99990	0001	01	20121210	1001	1	20121203	00000009999	00000008999	0000001
B	99990	0001	03	20121217	1001	1	20121203	00000009999	00000009999	0000001

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

Example

Changing a Quantity Field Due to a Previously Reported Error

Carrier 99990 submits a record with an error in the Quantity/Number of Units field (A). To correct the error, the Carrier submits a replacement record (B) with the same key fields as the record being corrected, Transaction Code 03 and the current cumulative value (not the change in value) for all non-key fields including Quantity/# of Units, which reflects the corrected value. The Transaction Date of the replacement record is the date the change was made in the system of the administering entity.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/ # of Units
A	99990	0001	01	20121210	1001	1	20121203	00000010000	00000010000	0000001
B	99990	0001	03	20121217	1001	1	20121203	00000010000	00000010000	0000002

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

2. Multiple Field Changes

Changes may be made to multiple fields in a record by submitting a single replacement record that includes the following:

(a) All key fields (Carrier Code, Policy Number, Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number and Line Identification Number) populated. The key fields must match those reported on the previously reported original or replacement record to which the changes apply.
(b) Transaction Code 03 – Replacement (Positions 44-45).
(c) Transaction Date (Positions 61-68) reported as the date the information was changed in the system of the administering entity.
(d) The current cumulative values for all non-key fields (not the change in value).

The replacement record must include all data elements even if they do not change.

Example

Changing Multiple Fields

Carrier 99990 must change the Service Date, Amount Charged by Provider, and Paid Amount (A). The Carrier submits a replacement record (B) with the same key fields as the record being changed, Transaction Code 03, and the current cumulative value (not the change in values) for all

non-key fields including Service Date, Amount Charged by Provider, Paid Amount, and Quantity/# of Units. The Transaction Date of the replacement record is the date the change was made in the system of the administering entity.

Scenario	(1) Carrier Code	(4) Claim Number Identifier	(5) Trans Code	(10) Trans Date	(11) Bill ID#	(12) Line ID#	(13) Service Date	(18) Amount Charged by Provider	(19) Paid Amount	(20) Quantity/ # of Units
A	99990	0001	01	20121210	1001	1	20121203	00000010000	00000000000	0000001
B	99990	0001	03	20130115	1001	1	20121215	00000020000	00000020000	0000002

Not all data elements are shown. For each record of this example, the corresponding data for the elements not shown is identical.

C. File Replacements

The Replacing Files option used to replace an entire file that was submitted in error is not applicable to California Medical Data Call submissions.

Medical data providers may delete an entire file that was previously submitted by using Submission File Type Code “R” (Replacement) on the File Control Record (Record Type Code – SUBCTRLREC). For record layout and data element details, refer to *File Control Record* in *Section 4 — Record Layouts* of this Guide.

A Replacement (R) file received by the WCIRB more than two years after the first day of the reporting quarter will be rejected.

Example

A data submitter wants to delete a file reported in 1st quarter 2022. The first day of the quarter is 01/01/2022. The WCIRB will not accept a replacement file submitted on or after 01/01/2024.

To delete an entire file from the WCIRB’s database, submit a File Control Record with no other records in the file. The File Control Record for the file is completed as follows:

Field No.	Field Title / Description	Reported as
1	Record Type Code	SUBCTRLREC
2	Submission File Type Code	R (Replacement)
3	Carrier Group Code	Same as file being deleted
4	Reporting Quarter Code	Same as file being deleted
5	Reporting Year	Same as file being deleted
6	Submission File Identifier	Same as file being deleted
7	Submission Date	Date this file was generated
8	Submission Time	Time this file was generated
9	Record Total	0 (Do not include the File Control Record in the count)
10	Reserved for Future Use	

Please note: a File Replacement cannot be used to delete a Key Field Change File. A new Key Field Change record must be submitted.

D. Duplicate Records

Duplicate records are two or more records that refer to a single service performed by a medical provider. Duplicates can affect medical analysis by overstating utilization. Therefore, submitters are responsible for filtering out duplicates before sending data to the WCIRB.

The WCIRB will review the file for records with the same key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number and Line Identification Number) and the same Transaction Code. If the key fields and Transaction Code are the same, the WCIRB will keep the record with the latest Transaction Date. If the Transaction Date is also the same, the WCIRB will keep the latest record submitted.

1. True Duplicates (Repeating a Single Bill or Line)

It is possible to have records that are truly duplicates but do not share all key fields. This can occur if a Service Provider sends a second bill (notice) for a service that was not paid. The Payer's system might create two records with different Bill Identification Numbers although they are for a single service. In this situation, the medical data provider must filter out the duplicate records. Do not submit both records since it will overstate utilization.

There are three options to accomplish this:

Option #1

Do not submit the second record to the WCIRB. The original record will be considered the current record on the database.

Option #2

If both records are created in the same quarter and the first has not yet been reported, do not submit the first record to the WCIRB. The second record, once submitted, will be considered the current record on the database.

Option #3

Cancel the original record and submit a new original record. The second record will be considered the current record on the database. For details, refer to *Record Replacements and Cancellations* above.

It is possible that the duplicate bill includes additional lines (e.g., follow-up visits, prescriptions). Report the additional lines in accordance with standard reporting procedures.

Example

Reporting Options for True Duplicates

A Claimant visits a doctor's office. The Service Provider bills Payer (Bill ID 101) but does not get paid immediately. The following month, the Service Provider sends another bill to the Payer with the charge for the original office visit, and the Payer's system assigns Bill ID 201 to the second notice.

Incorrect Reporting

If both records are submitted, the WCIRB's database will show two office visits for a total charge of $150, double the amount of what actually occurred:

Claim Number	Transaction Code	Bill ID	Line ID	Paid Procedure Code	Amount Charged	Quantity / # of Units
12345	01	101	1	99201	00000007500	0000001
12345	01	201	1	99201	00000007500	0000001

Correct Reporting (3 Options)

Option #1

Submitting only the first record provides an accurate picture of what occurred and minimizes the number of records stored on the database:

Claim Number	Transaction Code	Bill ID	Line ID	Paid Procedure Code	Amount Charged	Quantity / # of Units
12345	01	101	1	99201	00000007500	0000001

Option #2

Submitting only the second record provides an accurate picture of what occurred and minimizes the number of records stored on the database (this option may not be used if the first record is already in the WCIRB's database):

Claim Number	Transaction Code	Bill ID	Line ID	Paid Procedure Code	Amount Charged	Quantity / # of Units
12345	01	201	1	99201	00000007500	0000001

Option #3

Submitting a cancellation record (Transaction Code 02) cancels the first record. Submitting a new record (Transaction Code 01) then provides an accurate picture of what occurred.

Claim Number	Transaction Code	Bill ID	Line ID	Paid Procedure Code	Amount Charged	Quantity / # of Units
12345	01	101	1	99201	00000007500	0000001
12345	02	101	1	99201	00000007500	0000001
12345	01	201	1	99201	00000007500	0000001

If Bill 201 includes additional lines (e.g., follow-up visits, prescriptions), report the additional lines in accordance with standard reporting procedures.

2. Multiples of a Procedure Code

It is possible to have a situation where a Service Provider performs the same service multiple times. These instances are not considered true duplicates (single service billed multiple times) and must be reported to the WCIRB. For example, a Claimant receives an X-ray, and the Service Provider requests a second X-ray that repeats the first. Both procedures would be reported.

E. Dispensing Fees

Dispensing fees are charges assessed when providers issue drugs or supplies to Claimants. These dispensing fees include overhead, supplies, and labor, etc., to fill a prescription. The majority of California's fee schedules include dispensing fees. When reporting any separately reimbursable dispensing fees to the WCIRB, include these fees along with the cost of the medication or supply.

Add the dispensing fee to the Amount Charged and Paid Amount in the record for the item dispensed. For example, if a pharmacy charges $50 for a medication, with an additional $1 dispensing fee, report one record with an Amount Charged of $51.

F. Capitated Payment Arrangements

Following are examples of two types of capitated payment arrangements that may exist for Insurers in California, as well as reporting instructions for each scenario.

1. Capitated Medical Case Management

For large or catastrophic claims, an Insurer may negotiate with a medical case management vendor to pay a flat fee or lump sum for complete medical care of a Claimant for a specified time frame. The vendor manages the care and issues all payments for medical costs directly to the medical providers. In this situation, the Insurer or authorized data submitter *must* report the medical bill detail as a separate Medical Data Call record as outlined in this Guide.

2. Capitated Physical Medicine Treatment

For long term physical medicine treatment, an Insurer may negotiate with a physical medicine provider to pay a flat fee/lump sum for all physical medicine treatments of a Claimant for a specified time frame. If the physical medicine provider does not provide the medical bill detail for each individual treatment, the Insurer or authorized data submitter may report the lump sum payment as a single medical transaction data record. The Service Dates should define the entire length of treatment for the Claimant and should use CPT Code ‘97799’ (“unlisted physical medicine service or procedure”) as the Paid Procedure Code. However, if the physical medicine provider does provide the treatment detail, the detail of each treatment *must* be submitted as a separate Medical Data Call record.

Section 7 — Editing and Other Validation Procedures

A. Editing Process

The WCIRB's editing process is performed to ensure that the medical data provider's data is consistent with reporting requirements and that it meets quality standards. The edit process for the Medical Data Call is based on two quality components:

- Proper File Name
- Completeness test (e.g., are the data elements appropriately populated?)
- Validation test (e.g., are the data elements populated with valid values?)

These tests will be performed within each data element and across Call elements where needed.

B. Validating a Submission

Each Medical Data Call edit is classified into one of two edit types—File Acceptance or File Processing.

- File Acceptance edits ensure that the following items are correct:
    - File Name (when submission methodology is FTP)
    - File record length
    - Data provider information
    - File Control Record exists
    - Record count balances.
    - FTP folder location (when applicable)
    - FTP Insurer Group permissions (when applicable)

- File Processing edits ensure that the data contained in each data field is acceptable and usable for research. There are two types of File Processing edits:
    - Reject Record – transaction is not consumed into the database
    - Informational – transaction is consumed into the database

1. File Acceptance

Every Medical Data Call file received by the WCIRB goes through three stages of editing; (1) File Acceptance, (2) File Processing and (3) Quarterly Data Quality Program Administration.

File Acceptance, the first stage of the editing process, includes submission, field and relational level edits to determine whether the WCIRB can process the file. Refer to *Edit Types* in this section for edit type descriptions.

File Acceptance edits determine whether the file can be accepted or rejected. File Acceptance edits can include:

- Permissions edits
- File formatting edits
- Record formatting edits

In the File Acceptance stage, the entire file is either accepted or rejected. Files that fail File Acceptance edits are rejected and not processed. The Insurer and/or the Medical Data Call Submitter are notified that the file was rejected, so that it can be repaired, renamed and resubmitted.

To ensure the completeness and validity of the required fields, field and relational level edits are also performed during this stage on any field that is identified as "Required for File Acceptance." Refer to *Validating a Submission* in this section for data element tolerance descriptions. The required fields include the key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number and Line Identification Number) plus Transaction Code and Transaction Date.

- Field edits ensure the completeness and validity of each data element. For example, Carrier Code cannot be missing and must be a valid NCCI Carrier Code.
- Relational edits check for acceptable relationships between elements on different records, either within the submission or in the WCIRB's database. For example, the Submitter must be authorized to submit on behalf of an Insurer Group on the date the file is submitted.

Once a file passes File Acceptance, it proceeds to the File Processing stage of editing.

2. File Processing

File Processing is the second stage of the editing process. It is at this stage that the WCIRB assesses the data in order to determine whether reported transactions can be consumed into the WCIRB's database.

In this stage, the editing verifies that fields are populated and valid. During the File Processing stage, transactions may be rejected and not consumed into the database, may fire an informational edit and be accepted, or may be accepted without any edit firing. Rejected transactions are not consumed into the WCIRB database and will be provided to the Insurer and their Data Submitter in a monthly detail report documenting the edit reason. It is expected that rejected transactions are then researched to determine whether or not further action is required. Since rejected transactions are not consumed into the database, there is potential for an Insurer Group's data to be incomplete if the transactions are not repaired and resubmitted.

- Field edits ensure the completeness and validity of each data element. For example, Paid Procedure Code cannot be missing.
- Logical edits check the relationship between elements within the same transaction. For example, Policy Effective Date must be on or before Accident Date.
- Relational edits check for acceptable relationships between fields in different transactions, either within the submission or on the WCIRB's database. For example, if an Original record (Transaction Code 01) already resides in the WCIRB's database, a new Original with the same key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, Bill Identification Number and Line Identification Number) and the same Transaction Code and Transaction Date will fire an edit.

Once a month, the results of the File Acceptance and File Processing edits are communicated to the Insurer Group and Data Submitter in a monthly Data Submission Summary report.

For details on all Medical Data Call edits, refer to the *Edit Matrix* in this section of the Guide.

3. Data Quality Program Administration

Data Quality Program Administration is the third and final stage of the editing process. This stage begins in the quarter for which the Data Quality Program is being administrated. The entire quarter's data is considered to be all of the reporting insurer's or Insurer Group's data that has been submitted for the quarter, whether submitted by the Insurer or by multiple Data Submitters.

During the Data Quality Program administration stage, edits for all the medical data providers reporting for the Insurer Group are summarized for the entire quarter's data, developing data completeness and quality measurements across all submissions. Additional relational edits are performed in this stage to check the entire submission for completeness, accuracy and reasonability. For example, an office visit is the most common Place of Service; therefore, the WCIRB would expect to see the Place of Service Code reported, and reported more frequently than other Place of Service Codes.

Aggregate validation distributions based on the additional relational edits are provided as anticipated values (including the corresponding data elements) and as distribution graphs.

The WCIRB will contact an Insurer Group if a potential data quality issue is identified that may have a significant impact on the WCIRB's ability to conduct research using the medical transaction data submitted.

For details on all Medical Data Call edits, refer to the *Medical Data Call Edit Matrix* in this section of the Guide.

C. Medical Data Call Edit Matrix

1. Medical Data Call Edit Matrix

The Medical Data Call Edit Matrix contains details on the enhanced editing process that currently takes place in the WCIRB's database. This online edit matrix is the most comprehensive resource for information on the WCIRB's Medical Data Call editing and can be used when researching rejected files and/or transactions. It is updated, as necessary, to ensure the most current editing information.

The Medical Data Call Edit Matrix can be found on the WCIRB's website, www.wcirb.com and is incorporated by reference.

2. Online Edit Matrix Updates

When changes are made to the Medical Data Call Edit Matrix, Medical Data Call contacts that have been provided to the WCIRB by each Insurer will be notified, and the updated edit matrix will be posted on the WCIRB website.

Section 8 — WCIRB Transaction Data Quality Program

A. Definition

The *WCIRB Medical Transaction Data Quality Program* (Progam) is intended to promote the timely, complete and accurate submission of California medical transaction data information to the WCIRB inasmuch this data will be used for research and medical cost trend analysis and to enhance pure premium ratemaking. Analogous to other WCIRB data quality programs, Insurer Groups are subject to monetary fines and other administrative action for failure to submit data, or for failure to address documented data quality reporting issues, in a timely manner.

The *WCIRB Transaction Data Quality Program* includes both medical and indemnity transaction data. Administration of the Program applies to Insurer Groups that are eligible to report the Medical Data Call. The Program is administered on a calendar quarter basis, applies to production Medical Data Call submissions made in accordance with the rules contained in this Guide and is effective January 1, 2022.

Section 9 — Glossary

A. Definitions of Terms

Adjustment	A change to the paid amount on a previously reported *record*. Adjustments do not include changes due to data reporting errors.
Administering Entity	The *Insurer*, *Third Party Administrator*, bill review vendor or other entity that receives the *Bill* from a medical *Service Provider* and that pays for the medical transaction.
Ambulatory Payment Classification (APC)	A grouping used in the determination of facility fee payments. Ambulatory payment classifications categorize outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.
Ambulatory Surgical Center (ASC)	A state-licensed facility that is used mainly to perform outpatient surgery, has a staff of physicians, has continuous physician and nursing care and does not provide for overnight stays. An ambulatory surgical center can bill for facility fees much like a hospital, but generally has a separate fee schedule.
APC	See *Ambulatory Payment Classification*.
ASC	See *Ambulatory Surgical Center*.
ASCII	American Standard Code for Information Interchange – The standard code for representing characters as binary numbers. In addition to printable characters, the ASCII code includes control characters to indicate carriage return, backspace and the like.
Bill	A listing (lines) of charges for medical services. A Bill may consist of multiple lines.
Calendar Year Premium	Associated with premium within a given calendar year period. Calendar Year Premium is final at the end of the period and does not change from valuation to valuation.
Cancellation	A Medical Data Call *transaction* that allows the *medical data provider* to completely remove a previously submitted record or multiple records from the WCIRB's database.
Carrier	See *Insurer*.
Carrier Group	See *Insurer Group*.
CDT	Current Dental Terminology.
CDX	See *Compensation Data Exchange.*
Claim	A demand to recover from a loss or damage covered by a policy of insurance. A Medical Data Call claim (identified by claim number) includes one or more *Bills* for medical services. The Claim Number Identifier must match the Unit Statistical data claim number.
Claimant	The person who makes a *claim*. The Claimant receives the medical services listed on the *Bill*(s) for the associated claim.

CMS-1500 Form	The standard claim form of the Centers for Medicare and Medicaid Services used by non-institutional providers or suppliers to bill Medicare Carriers and durable medical equipment regional Carriers (DMERCs) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. It is also used for billing of some Medicaid State Agencies.
Compensation Data Exchange (CDX)	A self-administered, secure internet application used to electronically exchange data submitted using WCIO standards.
Copy Service	All services and expenses related to the retrieval and copying of documents that are responsive to a duly issued subpoena or authorization to release documents for a workers' compensation claim.
Count Occurrences	A mechanism for tracking record level edits that pass or fail. During File Acceptance processing, all edits with an outcome of *Count Occurrences* that fail will cause the record to be rejected and returned to the data submitter. Quality Tracking edits with an outcome of *Count Occurrences* that fail will always be displayed as a percentage of the total records. Quarter End Validation edits with an outcome of *Count Occurrences* that fail will be displayed as a percentage of total records.
Coverage Provider	See *Insurer*.
CPT	Current Procedural Terminology
Data Element	The smallest unit of physical data for which attributes are defined.
Deductible	A clause in an insurance policy that relieves the *Insurer* of responsibility in dollars, percentage of the total, or percentage of the loss before paying the loss.
Electronic Transmittal Record (ETR)	Required to appear as the first record in a data submission through CDX. The specifications for the record are located in the WCIO Data Specifications Manual.
Field	An area designated for a particular category of data.
File	An organized, named collection of related records packaged collectively and reported electronically to the WCIRB. For Medical Data Call data, a file may only include the data from one *reporting entity*, but data for multiple Carrier Codes within the reporting entity is acceptable.
File Control Record (FCR)	The last record in a data submission through CDX.
Gross Premium	The direct California workers' compensation premium prior to reinsurance or application of deductible credits.
HCO	See *Health Care Organization*.
HCPCS	Healthcare Common Procedure Coding System
Health Care Organization (HCO)	An organization certified by the California Department of Industrial Relations to provide managed medical care within the workers' compensation system.
Health Maintenance Organization (HMO)	An organization of medical care providers that offers a specified range of medical care in return for a set fee. See also *Preferred Provider Organization*.

HMO	See *Health Maintenance Organization*.
ICD	International Standard Classification of Diseases
Insured	The policyholder. In *workers' compensation insurance*, the Insured is the person or organization (employer) that is protected (covered) by the insurance *policy* and is entitled to recover benefits under its terms. The Insured is designated in Item 1 of the policy Information Page.
Insurer	All WCIRB member insurance companies, individually or as a group, providing workers' compensation insurance policies in California.
Insurer Group	One or more *Insurers* within the same NAIC Group.
Lien	In California, a right or claim for payment against a workers' compensation claim. A lien claimant, such as a medical provider, can file a form with the local California Workers' Compensation Appeals Board (WCAB) to identify themselves as a party to the claim so that the cost of their services paid on behalf of or to the Claimant must be addressed by the Employer or the Employer's representative.
Line	A single charge for a medical service or services listed on a *Bill*. Also referred to as a line item detail.
Medical Data Submitter	Any unique data reporting entity that is certified to send Medical Data Call data to the WCIRB. This includes, but may not be limited to, *Insurers*, *Third Party Administrators (TPAs)*, bill review vendors and pharmacy vendors. See also *Reporting Entity*.
Medical Legal Expense	Any costs and expenses incurred by or on behalf of any party, the administrative director, the board, or a referee for X-rays, laboratory fee, other diagnostic tests, medical examination, medical reports, medical records, medical testimony and, as needed, interpreter's fees, for the purpose of proving or disproving a contested workers' compensation insurance claim or disputed issue.
Medical Provider Network (MPN)	Any entity or group of providers approved as a Medical Provider Network by the California Department of Workers' Compensation Administrative Director pursuant to California Labor Code sections 4616 and 4616.7.
Medical / Service Provider	See *Service Provider.*
MPN	See *Medical Provider Network.*
NCCI	National Council on Compensation Insurance, Inc.
NDC	National Drug Codes
Patient	The person receiving medical services. For a workers' compensation *Claim*, the patient is also the *Claimant*.
Payer	The entity that ultimately pays for medical services.
Policy	The formal written contract of insurance between the employer (*Insured*) and the *Insurer*.

PPO	See *Preferred Provider Organization*.
Preferred Provider Organization (PPO)	A network of medical care providers contracted by the *Insurer* to provide various medical care services to covered employees for specified fees. The covered employees have the option to go to the network of medical care providers or to go outside of the network for medical care services for reasonable and customary fees after a set *Deductible* is met. See also *Health Maintenance Organization*.
Provider	See *Service Provider*.
Quarterly Submission	The data *File*, or files that represent the *Reporting Entities'* aggregate submission for a given three-month (quarter) period.
Record	A collection of related data elements that are treated as one unit.
Record Layout	Defines the parameters for each data *Field* contained in the *Record* that is submitted electronically, including the data field's starting and ending positions on the record and the field's specific type/class (i.e., alpha, numeric or alpha/numeric). The consistent parameters allow for efficient processing, so the data contained within can be sorted, formatted and customized.
Reporting Entity	An *Insurer Group or* the designated *Medical Data Submitter(s)* that report the Medical Data Call to the WCIRB on their behalf.
Service Provider	*Service Provider*, or Medical Service Provider, refers to the individual or group that furnishes a *Patient* with various medical services (e.g., physician, clinic, hospital, pharmacy). Refer to *Data Dictionary—Provider Taxonomy Code* for the source link to the accepted Provider Taxonomy Code list.
Special Characters	Refers to the additional characters other than letters A-Z and numbers 0-9.
Submission	A *File* transmitted to the WCIRB for a given *Reporting Entity*. Also referred to as a Transmission.
Third Party Administrator (TPA)	An entity who provides claims administration services on behalf of an Insurer.
Third Party Entity (TPE)	A Medical Data Submitter approved to reporti insurance data to the WCIRB on behalf of a Reporting Entity.
Transaction	Refers to either of the following: • The *Line* item of a medical *Bill*. Referred to as a medical transaction of this Guide. Use this definition for Transaction Date. • The general term given to data transmitted from one computer system to another for the purpose of accessing, querying or updating a record, file or database. Use this definition for Transaction Code.
Transmission	See *Submission*.
UB-04 Form	The basic form that Centers for Medicare and Medicaid Services prescribes for the Medicare program. It is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act (ASCA), Public Law 107105, and the implementing regulation at 42 CFR 424.32.

Unit Statistical Data	Data submitted by the Insurer to the WCIRB pursuant to the *California Workers' Compensation Uniform Statistical Reporting Plan—1995.*
Utilization	The frequency that a particular medical procedure is performed.
WCIO	Workers Compensation Insurance Organizations
WCMED	Name of the WCIO Standard layout for the Medical Data Call.
Workers' Compensation Insurance	Statutory coverage for employers subject to the workers' compensation law. It provides benefits to employees who are injured during the course of their employment.

Section 10 — Place of Service Crosswalk

The Place of Service Crosswalk was developed to provide a mapping of the Type of Bill code on Form CMS-1450 to the Place of Service Code, for reporting the Place of Service Code on the Medical Data Call. This Place of Service Crosswalk is intended for reporting facility and hospital services that are using Form CMS-1450, because that form **does not** contain a Place of Service Code field. Therefore, the Type of Bill code (positions 1 and 2 without leading 0) can be mapped to the Place of Service Code as displayed in the following chart.

The Type of Bill code is a three-digit code with each digit defining a different aspect of the medical bill—Type of Facility, Bill Classification, and Frequency of the Bill. This three-digit code is located in field 4 of the National Uniform Billing Committee (NUBC) approved UB-04 Claim Form CMS-1450.

While the Type of Bill is a three-digit code, some providers report it as a four-digit code, with the first digit being a leading zero. Take that into consideration for accurate mapping to the Place of Service Code.

Refer to the Key that is located after the Place of Service Crosswalk chart.

Place of Service Crosswalk

Type of Bill	Type of Bill Position 1 (Type of Facility)	Type of Bill Position 2 (Bill Classification)	Place of Service*	Place of Service Description
11X	Hospital	Inpatient	21	Inpatient Hospital
12X	Hospital	Inpatient	21	Inpatient Hospital
13X	Hospital	Outpatient	22	Outpatient Hospital
14X	Hospital	Other	22	Outpatient Hospital
18X	Hospital	Swing Bed	21	Inpatient Hospital
21X	Skilled Nursing	Inpatient	31	Skilled Nursing Facility
22X	Skilled Nursing	Inpatient	31	Skilled Nursing Facility
23X	Skilled Nursing	Outpatient	32	Nursing Facility
28X	Skilled Nursing	Swing Bed	32	Nursing Facility
32X	Home Health	Inpatient	12	Home
33X	Home Health	Outpatient	12	Home
34X	Home Health	Other	12	Home
41X	Religious Nonmedical	Inpatient	21	Inpatient Hospital
42X	Religious Nonmedical	Inpatient	21	Inpatient Hospital
43X	Religious Nonmedical	Outpatient	22	Outpatient Hospital
65X	Intermediate Care	Intermediate Care—Level I	54	Intermediate Care Facility/Individuals with Intellectual Disabilities
66X	Intermediate Care	Intermediate Care—Level II	54	Intermediate Care Facility/Individuals with Intellectual Disabilities
71X	Clinic or Hospital Based Renal Dialysis Facility	Rural Health Clinic (RHC)	72	Rural Health Clinic
72X	Clinic or Hospital Based Renal Dialysis Facility	Hospital Based or Independent Renal Dialysis Facility	65	End-Stage Renal Disease Treatment Facility
73X	Clinic or Hospital Based Renal Dialysis Facility	Free Standing Provider-Based Federally Qualified Health Center (FQHC)	49	Independent Clinic
74X	Clinic or Hospital Based Renal Dialysis Facility	Outpatient Rehabilitation Facility (ORF)	49	Independent Clinic
75X	Clinic or Hospital Based Renal Dialysis Facility	Comprehensive Outpatient Rehabilitation Facility (CORF)	62	Comprehensive Outpatient Rehabilitation Facility

76X	Clinic or Hospital Based Renal Dialysis Facility	Community Mental Health Center (CMHC)	53	Community Mental Health Center
79X	Clinic or Hospital Based Renal Dialysis Facility	OTHER	49	Independent Clinic
81X	Special facility or hospital ASC surgery	Hospice (Nonhospital Based)	34	Hospice
82X	Special facility or hospital ASC surgery	Hospice (Hospital Based)	34	Hospice
83X	Special facility or hospital ASC surgery	Ambulatory Surgical Center Services to Hospital Outpatients	24	Ambulatory Surgical Center
84X	Special facility or hospital ASC surgery	Free Standing Birthing Center	25	Birthing Center
85X	Special facility or hospital ASC surgery	Critical Access Hospital	22	Outpatient Hospital
* Source: Centers for Medicare & Medicaid Services/Department of Health Services 2010 reference table				

Chart Key—Place of Service Crosswalk

Type of Bill	Located on the National Uniform Billing Committee (NUBC) approved UB-04 Claim Form, also known as CMS-1450, in field 4.
Type of Bill Code (1st position)	Identifies the **Type of Facility** that provided the medical services. The following are two examples: Type of Bill 11X, the 1 in position 1 represents services provided at a Hospital Type of Bill 21X, the 2 in position 1 represents services provided at a Skilled Nursing facility
Type of Bill Code (2nd position)	Identifies the **Bill Classification**. Two examples are as follows: Type of Bill 11X, the 1 in position 2 represents Inpatient Services Type of Bill 13X, the 3 in position 2 represents Outpatient Services
Type of Bill Code (3rd position)	Identifies the Frequency of the Bill. This position is **not** needed for the crosswalk mapping.
Place of Service Code	The two-digit code that identifies where the medical service was performed. The Place of Service Code is reported in field 27 on the NCCI Medical Data Call.
Place of Service Description	Provides a description of where the medical service was performed.

Section 11 — Appendix

A. California WCMED Reporting Requirements

The following list highlights the principal differences between reporting California medical transaction data and reporting requirements in other jurisdictions.

1. CDX Electronic Transmittal Record

All Medical Data Call transactions submitted through CDX must contain an Electronic Transmittal Record (ETR) at the beginning of the file and a File Control Record (FCR) at the end of the file.

See *Section 4 – Record Layouts.*

2. Medical Liens

In California, the Paid Procedure Code for a lien must be reported with a California state-specific code. The Amount Charged by Provider must be the disputed amount of the medical lien. The codes to be used are consistent with the codes used to report liens to the Division of Workers' Compensation (DWC) via the Workers' Compensation Information System (WCIS).

See *Section 5 – Data Dictionary, Paid Procedure Code.*

3. Medical Legal

For a medical legal bill, the Paid Procedure Code must be reported with a California state-specific code based on the California fee schedule.

See *Section 5 – Data Dictionary, Paid Procedure Code.*

4. California Specific Codes

For services as defined in CCR 9789.12.14, the codes WC001 through WC012 must be reported in the Paid Procedure Code field.

See *Section 5 – Data Dictionary, Paid Procedure Code.*

5. Ambulatory Payment Classification (APC) Reimbursements

If the APC is used as the basis of reimbursement in California for outpatient facility charges, the Revenue Code should be used as the Paid Procedure Code data element with the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code reported as the Secondary Procedure Code, if available.

See *Section 5 – Data Dictionary, Paid Procedure Code.*

6. File Replacements/Replacing Files

The Replacing Files processing reporting rule is not valid in California. This reporting rule allowed data submitters to collectively replace all of the individual records in a single data submission.

See *Section 6C – File Replacements.*

7. Capitated Payment Arrangements

Capitated payment arrangements for medical case management and physical medicine treatment may exist in California. The Guide explains the reporting instructions for both types of arrangements.

See *Section 6F – Reporting Rules, Capitated Payment Arrangements.*

8. Key Field Changes

If transactions need to have link data changed in any of the Key Fields, the Data Submitter has the option of two different methods to do so.

See Section 6B – Record Replacements and Cancellations (Key Field Changes)

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