

Florida

Medical EDI Implementation Guide (MEIG)

2006

for

Electronic Medical Report Submission



**Department of Financial Services
Division of Workers' Compensation
Office of Data Quality and Collection
Medical Data Management Section**

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Definitions

Accepted Claim: Any medical claim that is acknowledged by the division as complete and accurate, passing all edits, and successfully loaded into the division's database

Claim Detail Record(s): Record or records that contain specific information: services, charges, quantities, etc., reported on the claim, and associating the specific information to the claim header record

Claim Header Record: A record that contains unique identifying information about a submitted medical claim

Data Element: A single field within a physical record, e.g., date of accident, procedure code, etc.

Defective Transmission: A transmission that could not be processed by the division due to structural failures, e.g., empty file, invalid file name, etc.

Division Forms: Includes the following for medical data reporting forms.

Form DFS-F5-DWC-9, (CMS-1500) Health Insurance Claim Form

Form DFS-F5-DWC-10, Statement of Charges for Drugs and Medical Supplies Form

Form DFS-F5-DWC-11, American Dental Association Dental Claim Form (Rev. 2002)

Form DFS-F5-DWC-90, (UB-92 HCFA-1450), Uniform Bill (Hospital Billing Claim Form)

Electronic Data Interchange (EDI): Computer to computer exchange of business transactions in a standardized format

File Layout: A file description specifying the data elements by name, field type, field size, field position, location within a record, and other applicable requirements, establishing the order in which data for each record must be transmitted

Medical Claim Processing Report (ASCII Data File): A computer-readable report containing the results of the processing of all the claims submitted in a transmission that is electronically placed in a submitter's SSL/FTP account for retrieval

Medical Claim Processing Report (PDF Report): A human-readable report containing the results of the processing of all the claims submitted in a transmission that is electronically placed in a submitter's SSL/FTP account for retrieval

Medical Submitter Specifications: The document required by the division prior to the first submission of electronic data that contains submitter contact information and other specifications

Production Transmission: An electronic file containing required data elements from designated forms sent to the division after the submitter has received division approval to transmit data electronically

Definitions

Rejected Claim: Any medical claim that is acknowledged by the division as incomplete and/or inaccurate, failing system or business edits, not successfully loaded into the division's database, and returned to the submitter for correction and re-filing

Report: An accurately completed form containing required medical data that is sent by the insurer to the division

Report Reason Code: An indicator in the claim header record specifying that the submitted claim is an original report, a withdrawal of a previously submitted report, a correction to a previously rejected report, or a replacement of a previously accepted report

SSL/FTP: An internet-based file transfer protocol with a Secure Socket Layer (SSL) that provides data encryption, client and/or server authentication, and message integrity, using a Public Key Infrastructure (PKI) system based on digital certificates

Submitter: An approved insurer, service co/TPA, or vendor acting as an agent on behalf of an insurer or service co/TPA, who has been approved to electronically transmit required division data

Submitter ID: A unique number assigned by the division to identify a submitter

Test Transmission: A sample electronic file containing the required data elements from designated division forms for the purpose of evaluation by the division to ensure the submitter's accuracy and program compatibility with division standards and edits, prior to the transmission of production data

Transmission Header Record (HD1): A single record at the beginning of each transmission that has information regarding the transmission, e.g., submitter ID, form type, revision code, etc.

Transmission ID: A sequentially assigned number for each transmission (formerly called VolSer Number)

Transmission Receipt Confirmation: An e-mail notice sent to the submitter to verify that the transmission has been received by the division

Transmission Trailer Record (TR1): A single record at the end of each transmission that contains the total claim count for the transmission

Submitter Responsibilities

Obtaining a Submitter ID

A submitter must complete and submit to the division the Medical Submitter Specifications document for assignment of a Submitter ID prior to transmittal of the first electronic submission. This document is found on page 68 of this guide.

Each submitter will receive only one Submitter ID. All transmissions received by the division must contain claims with the same Submitter ID in the control numbers as reported in the transmission header.

Submitting a Submitter Client List

A submitter must provide the division with an accurate and complete list of insurers and/or service co/TPAs for whom they will be transmitting electronic data. This list must include the insurer's code number and, if applicable, the service co/TPA's code number (both assigned by the division), full name, federal employer identification number (FEIN), and office location zip code. It is the responsibility of the submitter to notify the division when any insurer or service co/TPA is added to or deleted from the client list, to avoid claim rejection when transmissions are processed. The Submitter Client Listing Update Request Form on page 69 is used for this notification.

Establishing an SSL/FTP Account

An SSL/FTP account shall be established for transmitting electronic medical transactions to the division. Instructions for setting up an SSL/FTP account can be downloaded from the division's website at www.fldfs.com/wc or can be obtained by contacting the Medical Data Management Section in the Office of Data Quality and Collection at 850.413.1607.

Submitting Test Transmissions

Prior to submission of production data to the division, each submitter must provide a test transmission for each form type (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, DFS-F5-DWC-90). The division will review and analyze the test transmission to ensure the accuracy of the data being transmitted and program compatibility with division standards outlined in the section entitled "DWC Form File Layouts" beginning on page 9 of this guide. Instructions for the test transmission are found in the "Test Transmission Guidelines" section on page 5 of this guide.

Test Transmission Guidelines

Before a submitter can be approved to submit production data to the division, the submitter must send a test transmission to the division for each form type being filed. This test transmission is reviewed and analyzed to ensure the data are formatted in accordance with the standards detailed in the “DWC Form File Layouts” section beginning on page 9 of this guide and in accordance with s. 440.13(4) and s. 440.185(5), Florida Statutes. (See Appendix J for proper file naming formats.)

Test Transmission Content

For each of the four form types (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, or DFS-F5-DWC-90), data in the test transmission must match the data shown on 25 original paper claim forms received from the health care providers. Test transmissions must be sent via SSL/FTP.

Requirements for Test Transmission of Paper Claim Forms

A copy of the paper claim forms matching the 25 electronically transmitted reports must accompany the test transmission and be sorted in the order they appear on the transmission. Failure to properly sort paper claim forms could result in a delay in processing the test transmission.

Test Transmission Processing Address

The test transmission paper claim forms may be sent to the division at the following address:

**Florida Department of Financial Services
Division of Workers' Compensation
Office of Data Quality and Collection
Attn: Medical Data Management Section
200 E. Gaines Street
Tallahassee, Florida 32399-4226**

The test transmission paper claim forms may also be faxed to (850) 921-0305.

Test Transmission Approval

If the test transmission meets division requirements for approval, the submitter will be notified in writing, by e-mail, of the date electronic submission of production data may begin.

Test Transmission Rejection

If the test transmission fails to meet requirements for approval, the submitter will be notified in writing, by e-mail, as to the reasons for the rejection. The division will retain the copies of the submitted paper claim forms for use when the submitter resubmits the test transmission for review.

NOTE: Data used in a test transmission are NOT considered “filed with the division”. The filing requirement of the originally received claim form from the provider must be met pursuant to Rule 69L-7.602 (5)(e), F.A.C., by submitting the data again in production.

Production Transmission Guidelines

Types of Transmissions Effective November 1, 2004

Beginning November 1, 2004, all submitters shall submit data using only the SSL/FTP transmission method.

The submitter will be notified via e-mail if the data transmission cannot be processed, and the transmission will be placed in “badfiles” on their SSL/FTP account. Data are not considered “filed with the division” until the submitter submits a replacement transmission that is successfully accepted into the division’s database. (Refer to Appendix J for proper file naming formats.)

Sequencing of Records in Transmissions:

All transmissions must be submitted with records in the following order:

Transmission Header Record (HD1)
Claim #1 Header Record
Claim #1 Detail Record #1
Claim #1 Detail Record #2
Claim #1 Detail Record #3 (actual number of detail records for each claim varies)
Claim #2 Header Record
Claim #2 Detail Record #1
Claim #2 Detail Record #2
Claim #3 Header Record
Claim #3 Detail Record #1
Claim #3 Detail Record #2
Claim #3 Detail Record #3
Claim #3 Detail Record #4
Transmission Trailer Record (TR1)

NOTE: Only one set of HD1/TR1 records is allowed for each transmission file. When transmitting all four form types on a monthly basis, it will be necessary to transmit four separate transmission files each month (one for each form type).

Submitting a Previously Reported Disallowed or Denied Line Item

If one or more line item(s) are disallowed or denied for a claim, these line items must be submitted to the division with the entire claim using the appropriate EOBR codes found in Appendix E and reporting the disallowed or denied charges as \$0.00. If and when the disallowed or denied line item(s) are resubmitted by the provider and paid or adjusted and paid, they must be reported to the division as a new claim with new control numbers.

Division Processing of Data Transmissions

Each data transmission received is processed through a data quality program specific to the claim form type. Each claim is validated and analyzed. Once the transmission has been processed through the data quality programs, Medical Claim Processing Reports are generated. These reports will be placed in the outgoing folder on the division's SSL/FTP account for the submitter to retrieve as notification of the division's acceptance or rejection of the medical report data submitted. The layout for this division-generated report can be found beginning on page 50 of this guide.

Division's Acceptance / Rejection of Claims

Submitted claims containing no errors in any data elements will be accepted by the Medical Data Management System. Submitted claims containing errors in any data element will be rejected by the system. Upon completion of processing the submitted file, a Medical Claim Processing Report will be sent in two formats (PDF and flat text file) via e-mail to the submitter. The PDF version summarizes the number of claims submitted, accepted, and rejected in the transmission. This report also lists each claim submitted, its status as accepted or rejected, and the reason(s) for rejection. After receiving this report, the submitter shall verify that all of the data in the transmission have been accurately accounted for on the report and investigate any errors. All rejected claims must then be re-submitted with necessary corrections, using the same control number as the original rejected claim(s) to the division. The original submission and the re-submission of rejected claims must be in compliance with Rule 69L-7.602 (5)(e), F.A.C. Data are not considered "filed with the division" until they have been submitted with no errors and accepted into the medical database.

Division's Outstanding Rejection Reports

Twice each month, the division will generate an Outstanding Rejection Report, which will be placed in the "outgoing" folder on the SSL/FTP server for pick up by batch submitters. This report is comprised of cumulative unresolved rejection issues and serves as a reminder of the corrections that need to be made. Rejections that have not been corrected and successfully accepted into the division's database are not considered "filed with the division" and are subject to penalty pursuant to Rule 69L-7.602 (7)(b)2., F.A.C.

NOTE: When submitting a correction for a rejected claim, a replacement claim, or a withdrawal claim, use the same control number that was used in the original submission of the claim.

Annual Data Closeout

The division has established a policy for closing out medical claims data for a given calendar year. On June 30 of each year, beginning in 2005, medical claims with the previous calendar year's dates of service will be "frozen" to create a stable, final version of the data set for the previous calendar year. This final version will be used for analysis in creating new fee schedule information, resolving medical disputes, and conducting research into medical trends in workers' compensation. Submitters need to keep this annual deadline in mind and make sure that as many submissions, corrections, replacements, and withdrawals as possible that are related to the previous calendar year are processed by June 30.

After June 30 of each year, medical claims submitted with dates of service during the previous calendar year will continue to be processed by the system; however, they will be internally flagged to indicate they were received after the official cut-off deadline for closeout, and they will not be included in the formal baseline data set for the previous calendar year. This process will be transparent to the submitter, but the important concept is for submitters to strive to get all claims related to the previous calendar year into the Medical Data Management System database by June 30, so that the data will be included in the closeout.

Please note that this closeout requirement does not negate the timely filing requirement as established in Rule 69L-7.602, F.A.C.

NOTE: For an individual claim with multiple dates of service, the claim's earliest date of service is used to establish the date of service for the entire claim.

DFS-F5-DWC

FORM FILE

LAYOUTS

FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)

FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 300

TRANSMISSION HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER FORMAT: AAN	REQUIRED Valid Value = HD1
2H			4-6	3 Num	SUBMITTER ID FORMAT: NNN	REQUIRED Must be numeric Right justify and zero pad on the left to complete field (ex: 034)
3H			7-15	9 Num	SUBMITTER ZIP CODE FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space)	REQUIRED Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
4H			16-24	9 Num	SUBMITTER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric
5H			25-26	2 Num	FORM ID FORMAT: NN	REQUIRED Valid Value = 09
6H			27-28	2 A/N	REVISION INDICATOR FORMAT: A_ (‘_’ indicates 1 space)	REQUIRED Valid Value = C_ Left justify and enter a space in the second position
7H			29	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	REQUIRED Valid Values: T = Test Transmission P = Production Transmission
8H			30-37	8 Date	DATE OF SUBMISSION FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill
9H			38-300	263	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	REQUIRED Space fill Must not include any alpha or numeric

FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)

FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 300

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1A			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS= SUBMITTER ID YY=Year submitted JJJ= Julian date of day submitted NNNN = Sequence number	<u>REQUIRED</u> Must be numeric NNNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2A			14	1 Num	RECORD FLAG FORMAT: N	<u>REQUIRED</u> Valid Value = 1
3A			15-16	2 Num	FORM ID FORMAT: NN	<u>REQUIRED</u> Valid Value = 09
4A			17-18	2	RESERVED FOR INTERNAL USE SPACE FILLER FORMAT: __	<u>REQUIRED</u> Space fill
5A			19-23	5 Num	INSURER CODE NUMBER FORMAT: NNNNN	<u>REQUIRED</u> Must be numeric Right justify and zero pad on the left to complete field Must not be in the range of 05000 - 06999
6A			24-32	9 Num	INSURER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be numeric
7A			33-41	9 Num	INSURER LOCATION ZIP CODE* FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space) *Location is the insurer’s office responsible for report.	<u>REQUIRED</u> Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code

FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)

FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 300

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
8A			42-46	5 Num	SERVICE CO/TPA CODE NUMBER FORMAT: NNNNN	<u>SITUATIONAL</u> Must be numeric Right justify and zero pad on the left to complete field Must be in the range of 05000 - 06999 If not applicable, space fill
9A			47-55	9 Num	SERVICE CO/TPA FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>SITUATIONAL</u> Must be numeric If not applicable, space fill (Must be provided if Service Co/TPA Code Number is present.)
10A			56-64	9 Num	SERVICE CO/TPA LOCATION ZIP CODE* FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘ _ ’ indicates 1 space) *Location is the Service Co/TPA’s office responsible for report.	<u>SITUATIONAL</u> Must be numeric Left justify and leave unused spaces blank 1 st four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code If not applicable, space fill (Must be provided if Service Co/TPA Code Number is present.)
11A	1a	INSURED’S ID NUMBER	65-74	10 Num	EMPLOYEE IDENTIFICATION NUMBER (For a division-assigned number go to the division’s web site at http://www.fldfs.com/wc/organization/odqc.html) FORMAT: NNNNNNNNN_ (‘ _ ’ indicates 1 space)	<u>REQUIRED</u> Left justify and space fill to end of field Must be SSN or Division-Assigned Number Division-Assigned Number must begin with ‘0000’
12A	14	DATE OF CURRENT ILLNESS/ INJURY/ PREGNANCY	75-82	8 Date	DATE OF ACCIDENT, ILLNESS OR INJURY FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<u>REQUIRED</u> Must be valid date in the correct format Must be less than or equal to “Date of Service – From” and “Date of Service - To”

FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)

FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 300

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
13A	33	PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	83-95	13 A/N	PROVIDER'S FLORIDA LICENSE NUMBER FORMAT: AANNNNNNNNNN (OR) AAANNNNNNNNNN (OR) AAAANNNNNNNNNN (See Appendix F for valid formats)	REQUIRED Left justify and space fill to end of field Key alpha prefix and numeric digits of license number Must be valid value DO NOT zero pad numeric portion
14A	25	FEDERAL TAX ID NUMBER	96-104	9 Num	PROVIDER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric
15A	32	NAME & ADDR. OF FACILITY WHERE SERVICES WERE RENDERED	105-113	9 Num	ZIP CODE WHERE SERVICES WERE RENDERED FORMAT: NNNNN_ _ _ _ OR NNNNNNNNNN (‘_’ indicates 1 space)	REQUIRED Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
16A	2	PATIENT'S NAME	114-143	30 A/N	INJURED EMPLOYEE'S LAST NAME	REQUIRED Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
17A	2	PATIENT'S NAME	144-158	15 A/N	INJURED EMPLOYEE'S FIRST NAME	REQUIRED Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
18A	2	PATIENT'S NAME	159	1 Alpha	INJURED EMPLOYEE'S MIDDLE INITIAL FORMAT: A OR _ (‘_’ indicates 1 space)	SITUATIONAL Must be uppercase A-Z If not applicable, space fill
19A			160-167	8 Date	DATE INSURER RECEIVED BILL FROM PROVIDER (OR INJURED EMPLOYEE) FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Date of Service - To”

FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)

FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 300

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
20A			168–175	8 Date	DATE INSURER PAID, ADJUSTED AND PAID, DISALLOWED OR DENIED BILL FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date Insurer Received Bill From Provider”
21A	29	AMOUNT PAID	176–186	11 Num	TOTAL PAID TO PROVIDER OR REIMBURSED TO INJURED EMPLOYEE BY INSURER FORMAT: NNNNNNNNNNN	REQUIRED Must be numeric Zero is valid value Decimal point implied at two places Right justify and zero pad on the left to complete field
22A			187–188	2 Num	REPORT REASON CODE FORMAT: NN (See Appendix C for Valid Codes)	REQUIRED Must be numeric Must be a valid value
23A			189–190	2 A/N	PAYMENT CODE FORMAT: AN (See Appendix D for Valid Codes)	SITUATIONAL 1 st position must be alpha 2 nd position must be numeric If field 30A equals “E” then space fill
24A	21 ₁	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	191-196	6 A/N	ICD-9 DIAGNOSTIC CODE 1 FORMAT: See Appendix A for Valid Diagnosis Code Formats	REQUIRED Must be a valid ICD-9 code Left justify and space fill to end of field
25A	21 ₂	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	197-202	6 A/N	ICD-9 DIAGNOSTIC CODE 2 FORMAT: See Appendix A for Valid Diagnosis Code Formats	SITUATIONAL Must be a valid ICD-9 code, if applicable Left justify and space fill to end of field If not applicable, space fill
26A	21 ₃	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	203-208	6 A/N	ICD-9 DIAGNOSTIC CODE 3 FORMAT: See Appendix A for Valid Diagnosis Code Formats	SITUATIONAL Must be a valid ICD-9 code, if applicable Left justify and space fill to end of field If not applicable, space fill
27A	21 ₄	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	209–214	6 A/N	ICD-9 DIAGNOSTIC CODE 4 FORMAT: See Appendix A for Valid Diagnosis Code Formats	SITUATIONAL Must be a valid ICD-9 code, if applicable Left justify and space fill to end of field If not applicable, space fill

FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)

FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 300

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
28A			215-244	30A/N	CLAIMS HANDLING ENTITY INTERNAL FILE NUMBER (From the Insurer/TPA’s office file)	<u>REQUIRED</u> Left justify and space fill to end of field
29A			245-264	20A/N	SUBMITTER LOCATION	<u>SITUATIONAL</u> Left justify and space fill to end of field If not applicable, space fill
30A			265	1 Alpha	PRE-PAYMENT/EMPLOYEE PAYMENT INDICATOR FORMAT: A OR _ (‘_’ indicates 1 space)	<u>SITUATIONAL</u> If the “Date Insurer Received Bill from Provider” or the “Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill” is before the “Date of Service – From” due to an agreement between the provider and the insurer, place a "P" in this field. If the Employee has been directly reimbursed by the insurer, place an “E” in this field. If neither is applicable, space fill.
31A			266	1 Alpha	DUPLICATE OVERRIDE INDICATOR FORMAT: A OR _ (‘_’ indicates 1 space)	<u>SITUATIONAL</u> Enter “Y” to resubmit a claim that has been rejected as a duplicate claim to bypass the duplicate check. By marking this indicator, you are confirming that you have researched and verified that the claim is not a duplicate. If not applicable, space fill.
32A			267-300	34	SPACE FILLER FORMAT: _____ (‘____’ indicates space fill to end)	<u>REQUIRED</u> Space fill

FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)

FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 300

CLAIM DETAIL RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
1B			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNN = Sequence number	REQUIRED Must be numeric NNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2B			14	1 Num	RECORD FLAG FORMAT: N	REQUIRED Valid Value = 2
3B			15-17	3 Num	DETAIL SEQUENCE NUMBER FORMAT: NNN	REQUIRED NNN Valid Values = 001-999 Must be numeric Left pad with zeros to fill all 3 digits (ex: 001) Each detail record presented with a claim must be assigned a unique detail sequence number for that claim
4B	24B	PLACE OF SERVICE	18-19	2 Num	PLACE OF SERVICE FORMAT: NN (See the AMA’s CPT manual for valid values)	REQUIRED Must be numeric Must be a valid code
5B	24E	DIAGNOSIS CODE	20-23	4 Num	ICD-9 DIAGNOSTIC CODE REFERENCE NUMBER (S) FORMAT: N_ _ _ OR NN_ _ OR NNN_ OR NNNN (‘_’ indicates space)	REQUIRED. Must be numeric Left justify and space fill to end of field Must correlate with appropriate ICD-9 Code shown in header fields 24A, 25A, 26A, 27A Valid Values: 1, 2, 3, 4, or any combination of these must be keyed in place of the corresponding diagnosis(es) in Form Fields ID 21 ₁ , 21 ₂ , 21 ₃ , 21 ₄
6B	24D	PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	24-28	5 A/N	PROCEDURE, SERVICE OR SUPPLY CODE (AS BILLED BY PROVIDER) FORMAT: NNNNN, OR ANNNN	REQUIRED Must be a valid CPT, HCPCS or Unique Florida WC code

FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)

FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 300

CLAIM DETAIL RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
7B	24D	PROCEDURES, SERVICES, OR SUPPLIES MODIFIER	29-30	2A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER (AS BILLED BY PROVIDER) FORMAT: NN, OR AN, OR AA	<u>SITUATIONAL</u> Must be valid modifier code If not applicable, space fill
8B			31-35	5 A/N	PROCEDURE, SERVICE OR SUPPLY CODE (AS PAID BY INSURER) FORMAT: NNNNN, OR ANNNN	<u>REQUIRED</u> Must be a valid CPT, HCPCS or Unique Florida WC code If an NDC number is present, submit code 96370 and report the NDC number in Field 18B
9B			36-37	2 A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER (AS PAID BY INSURER) FORMAT: NN, OR AN, OR AA	<u>SITUATIONAL</u> Must be valid modifier code If not applicable, space fill
10B	24F	\$ CHARGES	38-48	11 Num	PROVIDER CHARGE PER LINE FORMAT: NNNNNNNNNNN	<u>REQUIRED</u> Must be numeric Decimal point implied at two places Right justify and zero pad on the left to complete field
11B	24G	DAYS OR UNITS	49-51	3 Num	NUMBER OF DAYS, HOURS, MINUTES OR UNITS* FORMAT: NNN *Anesthesia units must be reported in total minutes	<u>REQUIRED</u> Must be numeric Right justify and zero pad on the left to complete field Must be whole number Must not equal all zeros
12B			52-62	11 Num	INSURER PAYMENT TO PROVIDER OR REIMBURSED TO INJURED EMPLOYEE PER LINE* FORMAT: NNNNNNNNNNN *After all adjustments have been applied	<u>REQUIRED</u> Must be numeric Decimal point implied at 2 places Right justify and zero pad on the left to complete field

FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)

FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 300

CLAIM DETAIL RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
13B	24A	DATE(S) OF SERVICE FROM	63-70	8 Date	DATE OF SERVICE – FROM FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be less than or equal to “Date of Service – To” Must be less than or equal to “Date Insurer Received Bill From Provider” and “Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill”, unless the Pre-Pay indicator = P
14B	24A	DATE(S) OF SERVICE TO	71-78	8 Date	DATE OF SERVICE – TO FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Date of Service – From”
15B			79-80	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	REQUIRED Must be valid code
16B			81-82	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	SITUATIONAL Must be valid code If not applicable, space fill
17B			83-84	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	SITUATIONAL Must be valid code If not applicable, space fill
18B			85-95	11 Num	NATIONAL DRUG CODE NUMBER FORMAT: NNNNNNNNNNN	SITUATIONAL Must be a valid NDC number Must be numeric Right justify and zero pad on the left to complete field If not applicable, or if field 8B = 99070, space fill
19B			96-300	205	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	REQUIRED Space fill

FORM DFS-F5-DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 300
TRANSMISSION TRAILER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1T			1-3	3 A/N	TRANSMISSION TRAILER MARKER FORMAT: AAN	<u>REQUIRED</u> Valid Value = TR1
2T			4-9	6 Num	NUMBER OF CLAIMS IN TRANSMISSION FORMAT: NNNNNN	<u>REQUIRED</u> Must be numeric Right justify and zero pad on the left to complete field
3T			10-300	291	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 250

TRANSMISSION HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER FORMAT: AAN	REQUIRED Valid Value = HD1
2H			4-6	3 Num	SUBMITTER ID FORMAT: NNN	REQUIRED Must be numeric Right justify and zero pad on the left to complete field (ex: 034)
3H			7-15	9 Num	SUBMITTER ZIP CODE FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space)	REQUIRED Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
4H			16-24	9 Num	SUBMITTER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric
5H			25-26	2 Num	FORM ID FORMAT: NN	REQUIRED Valid Value = 10
6H			27-28	2 A/N	REVISION INDICATOR FORMAT: A_ (‘_’ indicates 1 space)	REQUIRED Valid Value = C_ Left justify and enter a space in the second position
7H			29	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	REQUIRED Valid Values: T = Test Transmission P = Production Transmission
8H			30-37	8 Date	DATE OF SUBMISSION FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill”
9H			38-250	213	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	REQUIRED Space fill

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 250

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1A			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNN = Sequence number	REQUIRED Must be numeric NNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2A			14	1 Num	RECORD FLAG FORMAT: N	REQUIRED Valid Value = 1
3A			15-16	2 Num	FORM ID FORMAT: NN	REQUIRED Valid Value = 10
4A			17-18	2	RESERVED FOR INTERNAL USE SPACE FILLER FORMAT: _ _	REQUIRED Space fill
5A			19-23	5 Num	INSURER CODE NUMBER FORMAT: NNNNN	REQUIRED Must be numeric Right justify and zero pad on the left to complete field Must not be in the range of 05000 - 06999
6A			24-32	9 Num	INSURER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric
7A			33-41	9 Num	INSURER LOCATION ZIP CODE* FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space) *Location is the insurer’s office responsible for report.	REQUIRED Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
8A			42-46	5 Num	SERVICE CO/TPA CODE NUMBER FORMAT: NNNNN	SITUATIONAL Must be numeric Right justify and zero pad on the left to complete field Must be in the range of 05000 - 06999 If not applicable, space fill

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 250

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
9A			47-55	9 Num	SERVICE CO/TPA FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>SITUATIONAL</u> Must be numeric If not applicable, space fill (Must be provided if Service Co/TPA Code Number is present.)
10A			56-64	9 Num	SERVICE CO/TPA LOCATION ZIP CODE* FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘ _ ’ indicates 1 space) *Location is the Service Co/TPA ’s office responsible for report.	<u>SITUATIONAL</u> Must be numeric Left justify and leave unused spaces blank 1 st four digits must be greater than zero If not applicable, space fill Must be a valid 5 or 9 digit Zip Code (Must be provided if Service Co/TPA Code Number is present.)
11A	2	SOC. SEC. OR DIVISION-ASSIGNED NUMBER	65-74	10 Num	EMPLOYEE IDENTIFICATION NUMBER (For a division-assigned number go to the division’s web site at http://www.fldfs.com/wc/organization/odqc.html) FORMAT: NNNNNNNNN_ (‘ _ ’ indicates 1 space)	<u>REQUIRED</u> Left justify and space fill to end of field Must be SSN or Division-Assigned Number Division-Assigned Number must begin with ‘0000’
12A	3	DATE OF ACCIDENT	75-82	8 Date	DATE OF ACCIDENT, INJURY OR ILLNESS FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<u>REQUIRED</u> Must be valid date in the correct format Must be less than or equal to “Statement Date”
13A	1	EMPLOYEE’S NAME	83-112	30 A/N	INJURED EMPLOYEE’S LAST NAME	<u>REQUIRED</u> Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 250

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
14A	1	EMPLOYEE'S NAME	113-127	15 A/N	INJURED EMPLOYEE'S FIRST NAME	REQUIRED Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
15A	1	EMPLOYEE'S NAME	128	1 Alpha	INJURED EMPLOYEE'S MIDDLE INITIAL	SITUATIONAL Must be uppercase A-Z If not applicable, space fill
16A			129-136	8 Date	DATE INSURER RECEIVED BILL FROM PROVIDER (OR INJURED EMPLOYEE) FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Statement Date”
17A			137-144	8 Date	DATE INSURER PAID, ADJUSTED AND PAID, DISALLOWED OR DENIED BILL FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Date Insurer Received Bill From Provider”
18A	26	TOTAL REIMBURSED FROM SECTION 2	145-155	11 Num	TOTAL PHARMACY CHARGES PAID BY INSURER FORMAT: NNNNNNNNNN	REQUIRED Must be numeric Zero is valid value Decimal point implied at two places Right justify and zero pad on the left to complete field
19A	27	TOTAL REIMBURSED FROM SECTION 3	156-166	11 Num	TOTAL MEDICAL SUPPLY CHARGES PAID BY INSURER FORMAT: NNNNNNNNNN	REQUIRED Must be numeric Zero is valid value Decimal point implied at two places Right justify and zero pad on the left to complete field

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 250

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
20A			167-168	2 Num	REPORT REASON CODE FORMAT: NN (See Appendix C for Valid Codes)	<u>REQUIRED</u> Must be numeric Must be a valid value
21A	22	DATE OF THIS STATEMENT	169-176	8 Date	STATEMENT DATE FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<u>REQUIRED</u> Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be less than or equal to “Date Insurer Received Bill”
22A			177-206	30A/N	CLAIMS HANDLING ENTITY INTERNAL FILE NUMBER (From the Insurer/TPA’s office file)	<u>REQUIRED</u> Left justify and space fill to end of field
23A			207-226	20A/N	SUBMITTER LOCATION	<u>SITUATIONAL</u> Left justify and space fill to end of field If not applicable, space fill
24A			227-228	2 A/N	PAYMENT CODE FORMAT: AN (See Appendix D for Valid Codes)	<u>SITUATIONAL</u> 1 st position must be alpha 2 nd position must be numeric If field 25A equals “E” then space fill
25A			229	1 Alpha	PRE-PAYMENT/EMPLOYEE PAYMENT INDICATOR FORMAT: A OR _ (‘ _ ’ indicates 1 space)	<u>SITUATIONAL</u> If the “Date Insurer Received Bill from Provider” or the “Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill” is before the “Date Filled” due to an agreement between the provider and the insurer, place a “P” in this field. If the Employee has been directly reimbursed by the insurer, place an “E” in this field. If neither is applicable, space fill
26A			230	1 Alpha	DUPLICATE OVERRIDE INDICATOR FORMAT: A OR _ (‘ _ ’ indicates 1 space)	<u>SITUATIONAL</u> Enter “Y” to resubmit a claim that has been rejected as a duplicate claim to bypass the duplicate check. By marking this indicator, you are confirming that you have researched and verified that the claim is not a duplicate. If not applicable, space fill

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 250

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
27A			231 -250	20	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill Must not include any alpha or numeric

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 250

CLAIM DETAIL RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1B			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNN = Sequence number	REQUIRED Must be numeric NNNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2B			14	1 Num	RECORD FLAG FORMAT: N	REQUIRED Valid Value = 2
3B			15-17	3 Num	DETAIL SEQUENCE NUMBER FORMAT: NNN	REQUIRED NNN Valid Values = 001-999 Must be numeric Right justify and zero pad on the left to complete field (ex: 001) Each detail record presented with a claim must be assigned a unique detail sequence number for that claim
4B	7	QUANTITY	18-22	5 Num	QUANTITY OF MEDICATION FORMAT: NNNNN	REQUIRED Must be numeric Right justify and zero pad on the left to complete field
5B	8	DAYS SUPPLY	23-25	3 Num	DAYS SUPPLY OF MEDICATION FORMAT: NNN	REQUIRED Must be numeric Right justify and zero pad on the left to complete field
6B	9	NDC	26-36	11 Num	NATIONAL DRUG CODE NUMBER FORMAT: NNNNNNNNNNN	REQUIRED Must be a valid NDC number Must be numeric Right justify and zero pad on the left to complete field For compounded drugs, use 96371, right justify and zero pad on the left to complete field

NOTE: Do not report Claim Detail Records for Medical Supplies!

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 250

CLAIM DETAIL RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
7B	10	RX #	37-46	10 A/N	PHARMACY'S INTERNAL NUMBER ASSIGNED TO THE PRESCRIPTION	REQUIRED Alpha characters must be uppercase A-Z Left justify and space fill to complete field
8B	11	NEW OR REFILL	47	1 Alpha	PRESCRIPTION – NEW OR REFILL FORMAT: N for New R for Refill	REQUIRED Must be alpha
9B	12	DATE FILLED	48-55	8 Date	DATE FILLED FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be less than or equal to “Date Insurer Received Bill” and “Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill”, unless Pre-Payment Indicator = P
10B	13	CERTIFICATION	56	1 Num	CERTIFICATION FORMAT: N	REQUIRED Valid Values = 1, 2, 3 or 4
11B	14	PRESCRIBER'S FL. DEPT. OF HEALTH (DOH) LICENSE #	57-69	13 A/N	PRESCRIBER'S FL LICENSE NUMBER FORMAT: AANNNNNNNNNN (OR) AAANNNNNNNNNN (OR) AAANNNNNNNNNN (See Appendix F for valid formats)	REQUIRED Left justify and space fill to end of field Key alpha prefix and numeric digits of license number – Must be valid value DO NOT zero pad numeric portion
12B	15	USUAL CHARGE	70-80	11 Num	PHARMACY'S USUAL CHARGE FORMAT: NNNNNNNNNNN	REQUIRED Must be numeric Decimal point implied at two places Right justify and zero pad on the left to complete field

NOTE: Do not report Claim Detail Records for Medical Supplies!

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 250

CLAIM DETAIL RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
13B			81-82	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	<u>REQUIRED</u> Must be valid code
14B			83-84	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	<u>SITUATIONAL</u> Must be valid code If not applicable, space fill
15B			85-86	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	<u>SITUATIONAL</u> Must be valid code If not applicable, space fill
16B			87-97	11 Num	AMOUNT PAID BY INSURER FORMAT: NNNNNNNNNNN	<u>REQUIRED</u> Must be numeric Decimal point implied at two places Right justify and zero pad on the left to complete field
17B			98-250	153	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill Must not include any alpha or numeric

NOTE: Do not report Claim Detail Records for Medical Supplies!

**FORM DFS-F5-DWC-10 STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 250

TRANSMISSION TRAILER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1T			1-3	3 A/N	TRANSMISSION TRAILER MARKER FORMAT: AAN	<u>REQUIRED</u> Valid Value = TR1
2T			4-9	6 Num	NUMBER OF CLAIMS IN TRANSMISSION FORMAT: NNNNNN	<u>REQUIRED</u> Must be numeric Right justify and zero pad on the left to complete field
3T			10-250	241	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM (Rev. 2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 300

TRANSMISSION HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER FORMAT: AAN	REQUIRED Valid Value = HD1
2H			4-6	3 Num	SUBMITTER ID FORMAT: NNN	REQUIRED Must be numeric Right justify and zero pad on the left to complete field (ex: 034)
3H			7-15	9 Num	SUBMITTER ZIP CODE FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space)	REQUIRED Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
4H			16-24	9 Num	SUBMITTER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric
5H			25-26	2 Num	FORM ID FORMAT: NN	REQUIRED Valid Value = 11
6H			27-28	2 A/N	REVISION INDICATOR FORMAT: A_ (‘_’ indicates 1 space)	REQUIRED Valid Value = C_ Left justify and enter a space in the second position
7H			29	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	REQUIRED Valid Values: T = Test Transmission P = Production Transmission
8H			30-37	8 Date	DATE OF SUBMISSION FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill”
9H			38-300	263	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	REQUIRED Space fill

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM (Rev. 2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 300

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1A			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	<u>REQUIRED</u> Must be numeric NNNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2A			14	1 Num	RECORD FLAG FORMAT: N	<u>REQUIRED</u> Valid Value = 1
3A			15-16	2 Num	FORM ID FORMAT: NN	<u>REQUIRED</u> Valid Value = 11
4A			17-18	2	RESERVED FOR INTERNAL USE SPACE FILLER FORMAT: __	<u>REQUIRED</u> Space fill
5A			19-23	5 Num	INSURER CODE NUMBER FORMAT: NNNNN	<u>REQUIRED</u> Must be numeric Right justify and zero pad on the left to complete field Must not be in the range of 05000 – 06999
6A			24-32	9 Num	INSURER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be numeric
7A			33-41	9 Num	INSURER LOCATION ZIP CODE* FORMAT: NNNNN_ OR NNNNNNNNN (‘_’ indicates 1 space) *Location is the insurer’s office responsible for report.	<u>REQUIRED</u> Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code

FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM (Rev. 2002)

FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 300

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
8A			42-46	5 Num	SERVICE CO/TPA CODE NUMBER FORMAT: NNNNN	<u>SITUATIONAL</u> Must be numeric Right justify and zero pad on the left to complete field Must be in the range of 05000 - 06999 If not applicable, space fill
9A			47-55	9 Num	SERVICE CO/TPA FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>SITUATIONAL</u> Must be numeric If not applicable, space fill (Must be provided if Service Co/TPA Code Number is present.)
10A			56-64	9 Num	SERVICE CO/TPA LOCATION ZIP CODE* FORMAT: NNNNN_ ___ OR NNNNNNNNN (‘_’ indicates 1 space) *Location is the Service Co/TPA ’s office responsible for report.	<u>SITUATIONAL</u> Must be numeric Left justify and leave unused spaces blank 1 st four digits must be greater than Zero If not applicable, space fill Must be a valid 5 or 9 digit Zip Code (Must be provided if Service Co/TPA Code Number is present.)
11A	8	SUBSCRIBER IDENTIFIER (SSN OR ID#)	65-74	10 Num	EMPLOYEE IDENTIFICATION NUMBER (For a division-assigned number go to the division’s web site at http://www.fldfs.com/wc/organization/odqc.html) FORMAT: NNNNNNNNN_ (‘_’ indicates 1 space)	<u>REQUIRED</u> Left justify and space fill to end of field Must be SSN or Division-Assigned Number Division-Assigned Number must begin with ‘0000’
12A	46	DATE OF ACCIDENT	75-82	8 Date	DATE OF ACCIDENT, INJURY OR ILLNESS FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	<u>REQUIRED</u> Must be valid date in the correct format Must be less than or equal to “Date of Service”

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM (Rev. 2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 300

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
13A	55	LICENSE NUMBER	83-95	13 A/N	PROVIDER’S FLORIDA LICENSE NUMBER FORMAT: AANNNNNNNNNN (See Appendix F for valid formats)	REQUIRED Key alpha prefix and numeric digits of license number Left justify and space fill to end of field Must be valid value DO NOT zero pad numeric portion
14A	51	SSN or TIN	96-104	9 Num	PROVIDER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric
15A	56	ADDRESS, CITY, STATE, ZIP CODE	105-113	9 Num	PROVIDER LOCATION ZIP CODE FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space)	REQUIRED Must be numeric Left justify and leave unused spaces blank 1 st four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
16A	20	NAME, ADDRESS, CITY, STATE, ZIP CODE	114-143	30 A/N	INJURED EMPLOYEE’S LAST NAME	REQUIRED Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
17A	20	NAME, ADDRESS, CITY, STATE, ZIP CODE	144-158	15 A/N	INJURED EMPLOYEE’S FIRST NAME	REQUIRED Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
18A	20	NAME, ADDRESS, CITY, STATE, ZIP CODE	159	1 Alpha	INJURED EMPLOYEE’S MIDDLE INITIAL	SITUATIONAL If applicable, must be uppercase A-Z If not applicable, leave unused space blank
19A	38	PLACE OF TREATMENT	160-161	2 Num	PLACE OF TREATMENT FORMAT: NN (See Appendix B For Valid Codes)	REQUIRED Must be numeric Must be valid code
20A			162-169	8 Date	DATE INSURER RECEIVED BILL FROM PROVIDER (OR INJURED EMPLOYEE) FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Date of Service”

FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM (Rev. 2002)

FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 300

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
21A			170-177	8 Date	DATE INSURER PAID, ADJUSTED AND PAID, DISALLOWED OR DENIED BILL FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date Insurer Received Bill From Provider”
22A			178-188	11 Num	TOTAL PAID BY INSURER FORMAT: NNNNNNNNNN	REQUIRED Must be numeric Decimal point implied at two places Right justify and zero pad on the left to complete field
23A			189-190	2 Num	REPORT REASON CODE FORMAT: NN (See Appendix C for Valid Codes)	REQUIRED Must be numeric Must be a valid value
24A			191-192	2 A/N	PAYMENT CODE FORMAT: AN (See Appendix D for Valid Codes)	SITUATIONAL 1 st position must be alpha 2 nd position must be numeric If field 27A equals “E” then space fill
25A			193-222	30A/N	CLAIMS HANDLING ENTITY INTERNAL FILE NUMBER (From the Insurer/TPA’s office file)	REQUIRED Left justify and space fill to end of field
26A			223-242	20A/N	SUBMITTER LOCATION	SITUATIONAL Left justify and space fill to end of field If not applicable, space fill
27A			243	1 Alpha	PRE-PAYMENT/EMPLOYEE PAYMENT INDICATOR FORMAT: A OR _ (‘ _ ’ indicates 1 space)	SITUATIONAL If the “Date Insurer Received Bill from Provider” or the “Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill” is before the “Date of Service/Treatment” due to an agreement between the provider and the insurer, place a "P" in this field. If the Employee has been directly reimbursed by the insurer, place an “E” in this field. If neither is applicable, space fill

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM (Rev. 2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 300

CLAIM HEADER RECORD LAYOUT- REVISION "C"

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
28A			244	1 Alpha	<p>DUPLICATE OVERRIDE INDICATOR FORMAT: A OR _ ('_' indicates 1 space)</p>	<p><u>SITUATIONAL</u> Enter "Y" to resubmit a claim that has been rejected as a duplicate claim to bypass the duplicate check. By marking this indicator, you are confirming that you have researched and verified that the claim is not a duplicate. If not applicable, space fill</p>
29A			245-300	56	<p>SPACE FILLER FORMAT: _____ ('___' indicates space fill to end)</p>	<p><u>REQUIRED</u> Space fill</p>

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM (Rev. 2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 300

CLAIM DETAIL RECORD LAYOUT- REVISION "C"

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
1B			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNN = Sequence number	REQUIRED Must be numeric NNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2B			14	1 Num	RECORD FLAG FORMAT: N	REQUIRED Must be numeric Valid Value = 2
3B			15-17	3 Num	DETAIL SEQUENCE NUMBER FORMAT: NNN	REQUIRED Must be numeric NNN Valid Values = 001-999 Left pad with zeros to fill all 3 digits (ex: 001) Each detail record presented with a claim must be assigned a unique detail sequence number for that claim
4B	24	PROCEDURE DATE	18-25	8 Date	DATE OF SERVICE/TREATMENT FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be a valid date in the correct format Must be greater than or equal to "Date of Accident" Must be less than or equal to "Date Insurer Received Bill from Provider" and "Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill", unless Pre-Pay Indicator = P
5B	29	PROCEDURE CODE	26-30	5 A/N	PROCEDURE, SERVICE OR SUPPLY CODE (AS BILLED BY PROVIDER) FORMAT: NNNNN, OR ANNNN	REQUIRED Must be a valid CPT, CDT-4, HCPCS 'D' or Unique Florida WC code
6B			31-35	5 A/N	PAID CPT, CDT-4 OR HCPCS CODE FORMAT: NNNNN, OR ANNNN	REQUIRED Must be a valid CPT, CDT-4, HCPCS 'D' or Unique Florida WC code

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM (Rev. 2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 300

CLAIM DETAIL RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
7B	31	FEE	36-46	11 Num	PROVIDER CHARGE PER LINE FORMAT: NNNNNNNNNN	<u>REQUIRED</u> Must be numeric Decimal point is implied at 2 places Right justify and zero pad on the left to complete field
8B			47-57	11 Num	INSURER PAYMENT PER LINE* FORMAT: NNNNNNNNNN *After all adjustments have been applied.	<u>REQUIRED</u> Must be numeric Decimal point is implied at 2 places Right justify and zero pad on the left to complete field
9B			58-59	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	<u>REQUIRED</u> Must be valid code
10B			60-61	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	<u>SITUATIONAL</u> Must be valid code If not applicable, space fill
11B			62-63	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	<u>SITUATIONAL</u> Must be valid code If not applicable, space fill
12B			64-300	237	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

**FORM DFS-F5-DWC-11 AMERICAN DENTAL ASSOCIATION DENTAL CLAIM FORM (Rev. 2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 300

TRANSMISSION TRAILER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1T			1-3	3 A/N	TRANSMISSION TRAILER MARKER FORMAT: AAN	<u>REQUIRED</u> Valid Value = TR1
2T			4-9	6 Num	NUMBER OF CLAIMS IN TRANSMISSION. FORMAT: NNNNNN	<u>REQUIRED</u> Must be numeric Right justify and zero pad on the left to complete field
3T			10-300	291	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

**FORM DFS-F5-DWC-90 (UB-92 HCFA-1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 350

TRANSMISSION HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER FORMAT: AAN	REQUIRED Valid Value = HD1
2H			4-6	3 Num	SUBMITTER ID FORMAT: NNN	REQUIRED Must be numeric Right justify and zero pad on the left to complete field (ex: 034)
3H			7-15	9 Num	SUBMITTER ZIP CODE FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space)	REQUIRED Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code
4H			16-24	9 Num	SUBMITTER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric
5H			25-26	2 Num	FORM ID FORMAT: NN	REQUIRED Valid Value = 90
6H			27-28	2 A/N	REVISION INDICATOR FORMAT: A_ (‘_’ indicates 1 space)	REQUIRED Valid Value = C_ Left justify and enter a space in the second position
7H			29	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	REQUIRED Valid Values: T = Test Transmission P = Production Transmission
8H			30-37	8 Date	DATE OF SUBMISSION FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill”
9H			38-350	313	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	REQUIRED Space fill

**FORM DFS-F5-DWC-90 (UB-92 HCFA-1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 350

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1A			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	REQUIRED Must be numeric NNNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2A			14	1 Num	RECORD FLAG FORMAT: N	REQUIRED Valid Value = 1
3A			15-16	2 Num	FORM IDENTIFIER FORMAT: NN	REQUIRED Valid Value = 90
4A			17-18	2	RESERVED FOR INTERNAL USE SPACE FILLER FORMAT: _ _	REQUIRED Space fill
5A			19-23	5 Num	INSURER CODE NUMBER FORMAT: NNNNN	REQUIRED Must be numeric Right justify and zero pad on the left to complete field Must not be in the range of 05000 - 06999
6A			24-32	9 Num	INSURER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric
7A	50	PAYER	33-41	9 Num	INSURER LOCATION ZIP CODE* FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space) *Location is the insurer’s office responsible for report.	REQUIRED Must be numeric Left justify and space fill to end of field 1 st four digits must not = ‘0000’ Must be a valid 5 or 9 digit Zip Code

**FORM DFS-F5-DWC-90 (UB-92 HCFA-1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 350

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
8A			42-46	5 Num	SERVICE CO/TPA CODE NUMBER FORMAT: NNNNN	<u>SITUATIONAL</u> Must be numeric Right justify and zero pad on the left to complete field Must be in the range of 05000 - 06999 If not applicable, space fill
9A			47-55	9 Num	SERVICE CO/TPA FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>SITUATIONAL</u> Must be numeric If not applicable, space fill (Must be provided if Service Co/TPA Code Number is present)
10A			56-64	9 Num	SERVICE CO/TPA LOCATION ZIP CODE* FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space) *Location is the Service Co/TPA’s office responsible for report.	<u>SITUATIONAL</u> Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’ If not applicable, space fill Must be a valid 5 or 9 digit Zip Code (Must be provided if Service Co/TPA Code Number is present)
11A	4	TYPE OF BILL	65-67	3 A/N	TYPE OF REPORT FORMAT: NNN, OR NNA (See UB-92 Manual for valid codes for form locator 4)	<u>REQUIRED</u> Must be valid code
12A	60A	CERT. - SSN – HIC. – ID NO.	68-77	10 Num	EMPLOYEE IDENTIFICATION NUMBER (For a division-assigned number go to the division’s web site at http://www.fldfs.com/wc/organization/odqc.html) FORMAT: NNNNNNNNN_ (‘_’ indicates 1 space)	<u>REQUIRED</u> Left justify and space fill to end of field Must be SSN or Division-Assigned Number Division-Assigned Number must begin with ‘0000’

**FORM DFS-F5-DWC-90 (UB-92 HCFA-1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 350

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
13A	32	OCCURRENCE DATE	78-85	8 Date	DATE OF ACCIDENT, ILLNESS OR INJURY FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be less than or equal to date of “Statement Covers Period From and Through” Must be less than or equal to “Admission Date”
14A	82	ATTENDING PHYSICIAN ID	86-98	13 A/N	PROVIDER FLORIDA LICENSE NUMBER FORMAT: AANNNNNNNNNN (OR) AAANNNNNNNNNN (OR) AAAANNNNNNNNNN (See Appendix F for valid formats)	REQUIRED Left justify and space fill to end of field Key alpha prefix and numeric digits of license number Must be valid value DO NOT zero pad numeric portion
15A	12	PATIENT NAME	99-128	30 A/N	INJURED EMPLOYEE’S LAST NAME	REQUIRED Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
16A	12	PATIENT NAME	129-143	15 A/N	INJURED EMPLOYEE’S FIRST NAME	REQUIRED Must be uppercase A-Z Can include space, comma, apostrophe, period or hyphen Left justify and space fill to end of field
17A	12	PATIENT NAME	144	1 Alpha	INJURED EMPLOYEE’S MIDDLE INITIAL	SITUATIONAL If applicable, must be uppercase A-Z If not applicable, space fill
18A	17	ADMISSION DATE	145-152	8 Date	ADMISSION DATE FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be less than or equal to the “Date Insurer Received Bill From Provider” and “Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill”

**FORM DFS-F5-DWC-90 (UB-92 HCFA-1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 350

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
19A	18	ADMISSION HR	153-154	2 Num	ADMISSION HOUR FORMAT: NN (See UB-92 manual for valid codes)	REQUIRED Must be numeric Must be valid code
20A	6	STATEMENT COVERS PERIOD: FROM	155-162	8 Date	DATE STATEMENT COVERS FROM FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be less than or equal to “Date Statement Covers Through” date Must be less than or equal to the “Date Insurer Received Bill From Provider” and “Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill”, unless Pre-Pay Indicator = P.
21A	6	STATEMENT COVERS PERIOD: THROUGH	163-170	8 Date	DATE STATEMENT COVERS THROUGH FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Date Statement Covers From”
22A	21	D HR	171-172	2 Num	DISCHARGE HOUR FORMAT: NN (See UB-92 manual for valid codes)	SITUATIONAL Must be numeric Must be valid code If first digit in form locator 4 (field 11A) equals 1 and second digit equals 1, 2, 7 or 8, then field must be filled. All other situations, space fill
23A	5	FEDERAL TAX NO.	173-181	9 Num	FACILITY FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric
24A	84	REMARKS	182-190	9 Num	FACILITY LOCATION ZIP CODE FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space)	REQUIRED Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’ Must be a valid 5 or 9 digit Zip Code

**FORM DFS-F5-DWC-90 (UB-92 HCFA-1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 350

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH / TYPE	DESCRIPTION	REQUIREMENTS
25A			191-198	8 Date	DATE INSURER RECEIVED BILL FROM PROVIDER (OR INJURED EMPLOYEE) FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date of Accident” Must be greater than or equal to “Admission Date” Must be greater than or equal to “Date Statement Covers From and Through”
26A			199-206	8 Date	DATE INSURER PAID, ADJUSTED AND PAID, DISALLOWED OR DENIED BILL FORMAT: CCYYMMDD CC = Century YY = Year MM = Month DD = Day	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date Insurer Received Bill From Provider” Must be greater than or equal to “Admission Date” Must be greater than or equal to “Date Statement Covers From and Through”
27A			207-217	11 Num	TOTAL PAID BY INSURER FORMAT: NNNNNNNNNNN	REQUIRED Must be numeric Decimal point implied at two places Right justify and zero pad on the left to complete field
28A	67	PRIN. DIAG. CD.	218-223	6 A/N	ICD-9 DIAGNOSTIC CODE 1 FORMAT: See Appendix A for Valid Diagnosis Code Formats	REQUIRED Must be a valid ICD-9 code Left justify and space fill to end of field
29A	68	CODE	224-229	6 A/N	ICD-9 DIAGNOSTIC CODE 2 FORMAT: See Appendix A for Valid Diagnosis Code Formats	SITUATIONAL Must be a valid ICD-9 code Left justify and space fill to end of field If not applicable, space fill
30A	69	CODE	230-235	6 A/N	ICD-9 DIAGNOSTIC CODE 3 FORMAT: See Appendix A for Valid Diagnosis Code Formats	SITUATIONAL Must be a valid ICD-9 code Left justify and space fill to end of field If not applicable, space fill
31A	70	CODE	236-241	6 A/N	ICD-9 DIAGNOSTIC CODE 4 FORMAT: See Appendix A for Valid Diagnosis Code Formats	SITUATIONAL Must be a valid ICD-9 code Left justify and space fill to end of field If not applicable, space fill
32A			242	1	RESERVED FOR INTERNAL USE SPACE FILLER FORMAT: _	REQUIRED Space fill

**FORM DFS-F5-DWC-90 (UB-92 HCFA-1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 350

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
33A	80	PRINCIPAL PROCEDURE CODE	243-247	5 A/N	PRINCIPAL PROCEDURE CODE FORMAT: NNNNN, ANNNN OR NN.NN (See Appendix A for valid ICD-9 Procedure Code Formats)	<u>SITUATIONAL</u> Must be a valid CPT, HCPCS, or ICD-9 Procedure Code Left justify and space fill to end of field If not applicable, space fill
34A	81	OTHER PROCEDURE CODE	248-252	5 A/N	OTHER PROCEDURE CODE FORMAT: NNNNN, ANNNN OR NN.NN (See Appendix A for valid ICD-9 Procedure Code Formats)	<u>SITUATIONAL</u> If applicable, must be a valid CPT, HCPCS, or ICD-9 Procedure Code Left justify and space fill to end of field If not applicable, space fill
35A			253-254	2 Num	REPORT REASON CODE FORMAT: NN (See Appendix C for Valid Codes)	<u>REQUIRED</u> Must be numeric Must be a valid value
36A			255-256	2 A/N	PAYMENT CODE FORMAT: AN (See Appendix D for Valid Codes)	<u>SITUATIONAL</u> 1 st position must be alpha 2 nd position must be numeric If field 40A equals “E” then space fill
37A	19	ADMISSION TYPE	257	1 Num	TYPE OF ADMISSION/VISIT FORMAT: N (See UB-92 Manual for Valid Codes)	<u>REQUIRED</u> Must be numeric Must be a valid code
38A			258-287	30A/N	CLAIMS HANDLING ENTITY INTERNAL FILE NUMBER (From the Insurer/TPA’s office file)	<u>REQUIRED</u> Left justify and space fill to end of field
39A			288-307	20A/N	SUBMITTER LOCATION	<u>SITUATIONAL</u> Left justify and space fill to end of field If not applicable, space fill
40A			308	1 Alpha	PRE-PAYMENT/EMPLOYEE PAYMENT INDICATOR FORMAT: A OR _ (‘_’ indicates 1 space)	<u>SITUATIONAL</u> If the “Date Insurer Received Bill from Provider” or the “Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill” is before the “Date Statement Covers From” due to an agreement between the provider and the insurer, place a “P” in this field. If the Employee has been directly reimbursed by the insurer, place an “E” in this field. If neither is applicable, space fill

**FORM DFS-F5-DWC-90 (UB-92 HCFA-1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 350

CLAIM HEADER RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
41A			309	1 Alpha	DUPLICATE OVERRIDE INDICATOR FORMAT: A OR _ (‘_’ indicates 1 space)	<u>SITUATIONAL</u> Enter “Y” to resubmit a claim that has been rejected as a duplicate claim to bypass the duplicate check. By marking this indicator, you are confirming that you have researched and verified that the claim is not a duplicate. If not applicable, space fill
42A			310-350	41	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

**FORM DFS-F5-DWC-90 (UB-92 HCFA-1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 350

CLAIM DETAIL RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
1B			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Submitter ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	REQUIRED Must be numeric NNNNN Valid Values = 00001-99999 Each claim must be assigned a unique control number within the transmission
2B			14	1 Num	RECORD FLAG FORMAT: N	REQUIRED Valid Value = 2
3B			15-17	3 Num	DETAIL SEQUENCE NUMBER FORMAT: NNN	REQUIRED NNN Valid Values = 001-999 Must be numeric Right justify and zero pad on the left to complete field Each detail record presented with a claim must be assigned a unique detail sequence number for that claim
4B	42	REVENUE CODE	18-21	4 Num	REVENUE CODE FORMAT: NNNN (See UB-92 Manual for Valid Codes)	REQUIRED Must be numeric Must be a valid code Right justify and zero pad on the left to complete field
5B	44	HCPCS/RATES	22-26	5 A/N	PROCEDURE, SERVICE OR SUPPLY CODE (AS BILLED BY THE PROVIDER) FORMAT: NNNNN or ANNNN	SITUATIONAL Must be valid CPT, HCPCS or Unique WC code Left justify and space fill to end of field If not applicable, space fill
6B	44	HCPCS/RATES	27-28	2 A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER (AS BILLED BY THE PROVIDER) FORMAT: NN OR, AN OR, AA	SITUATIONAL Must be valid CPT or HCPCS modifier code If not applicable, space fill
7B	46	SERVICE UNITS	29-35	7 Num	UNITS OF SERVICE FORMAT: NNNNNNN	REQUIRED Must be numeric Right justify and zero pad on the left to complete field

**FORM DFS-F5-DWC-90 (UB-92 HCFA-1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 350

CLAIM DETAIL RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
8B	47	TOTAL CHARGES	36-46	11 Num	CHARGE PER REVENUE CODE FORMAT: NNNNNNNNNNN (Do not enter credits in this field)	REQUIRED Must be numeric Decimal point implied at 2 places Right justify and zero pad on the left to complete field
9B			47-48	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	REQUIRED Must be valid code
10B			49-50	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	SITUATIONAL Must be valid code If not applicable, space fill
11B			51-52	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	SITUATIONAL Must be valid code If not applicable, space fill
12B	45	SERVICE DATE	53-60	8 Date	DATE OF OUTPATIENT SERVICE	SITUATIONAL Must be valid date in the correct format Must be present if first digit in field 11A = ‘1’ AND the second digit = ‘3’ If not applicable, space fill
13B			61-350	290	SPACE FILLER FORMAT: _____ ('___' indicates space fill to end)	REQUIRED Space fill

**FORM DFS-F5-DWC-90 (UB-92 HCFA-1450), UNIFORM BILL (HOSPITAL BILLING CLAIM FORM)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 350
TRANSMISSION TRAILER LAYOUT – REVISION “C”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
1T			1-3	3 A/N	TRANSMISSION TRAILER MARKER FORMAT: AAN	<u>REQUIRED</u> Valid Value = TR1
2T			4-9	6 Num	NUMBER OF REPORTS IN TRANSMISSION FORMAT: NNNNNN	<u>REQUIRED</u> Must be numeric Right justify and zero pad on the left to complete field
3T			10-350	341	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

**MEDICAL CLAIM PROCESSING REPORT TRANSMISSION
FILE LAYOUT
RECORD LENGTH: 250
TRANSMISSION HEADER RECORD LAYOUT – REVISION “C”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	NOTES
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER FORMAT: AAN	Hard coded as HD1
2H			4-6	3 Num	SUBMITTER ID FORMAT: NNN	Will be numeric and right justified with zero padding on the left to complete field (ex: 034)
3H			7-15	9 Num	SUBMITTER ZIP CODE FORMAT: NNNNN_ _ _ _ OR NNNNNNNNN (‘_’ indicates 1 space)	Will be numeric Will be left justified and space filled to end of field
4H			16-23	8 Num	TRANSMISSION ID NUMBER ASSIGNED FORMAT: NNNNNNNN	Will contain division assigned Transmission ID Will be numeric and left justified (Current Transmission ID numbers are only 7 digits long, but we are reserving 8 digits for future expansion.)
5H			24-25	2 Num	FORM ID FORMAT: NN	Will be numeric Values = 09, 10, 11, or 90
6H			26	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	Values : T = Test Transmission P = Production Transmission
7H			27 - 29	3 Alpha	FILE LAYOUT REVISION	Hard coded as “C” for this release of the Medical Claim Processing Report file
8H			30-250	221	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	Space filled to end of record length

**MEDICAL CLAIM PROCESSING REPORT TRANSMISSION
FILE LAYOUT**

RECORD LENGTH: 250

CLAIM PROCESSING RESPONSE RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	NOTES
1K			1-3	3 A/N	RECORD TYPE INDICATOR	Hard coded as CP1
2K			4-16	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS= SUBMITTER ID YY= Year submitted JJJ= Julian date of day submitted NNNN = Sequence number	Will be numeric, matching control number submitted
3K			17-18	2 Num	FORM ID FORMAT: NN	Values = 09, 10, 11, or 90
4K			19-20	2 Alpha	SUBMISSION REASON CODE	Will repeat the submission reason code submitted in the data file
5K			21-30	10 Alpha	PROCESSING RESULT CODE See Appendix G for Values.	Code will indicate the result of processing of the claim
6K			31-40	10 Alpha	BYPASS REASON CODE See Appendix H for Values.	If the Processing Result Code = BYPASSED, this will contain a reason code why it could not be processed
7K			41-70	30 A/N	INSURER/SERVICE CO/TPA FILE NUMBER	Will contain the file number submitted in the data file
8K			71-90	20 A/N	SUBMITTER LOCATION	<u>SITUATIONAL</u> Will contain the SUBMITTER LOCATION submitted in the data file.
9K			91-98	8 Date	DATE DIVISION ACCEPTED, REJECTED, WITHDREW OR BYPASSED.	FORMAT: YYYYMMDD
10K			99-250	152 A/N	NARRATIVE TEXT	Will contain an explanation of why the claim could not be processed (if it was bypassed)

**MEDICAL CLAIM PROCESSING REPORT TRANSMISSION
FILE LAYOUT
RECORD LENGTH: 250
CLAIM VALIDATION ERROR RECORD LAYOUT – REVISION “C”**

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	NOTES
1E			1-3	3 A/N	RECORD TYPE INDICATOR	Hard coded as ER1
2E			4-16	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJJNNNNN SSS= SUBMITTER ID YY= Year submitted JJJ= Julian date of day submitted NNNN = Sequence number	Will be numeric, matching control number submitted
3E			17-19	3 Num	ERROR SEQUENCE NUMBER FORMAT: NNN Examples: 001, 002, 003...	Uniquely identifies each error associated with a claim Will be right justified and zero padded to complete field
4E			20-22	3 Num	DETAIL SEQUENCE NUMBER FORMAT: NNN Examples: 000, 001, 002...	Will contain the Detail Sequence Number that this error corresponds to. It will contain 000 if the error is associated with the claim's header record
5E			23-25	3 Num	ERROR CODE FORMAT: NNN Examples: 058, 028 See Appendix I for Values.	Code will indicate the type of error encountered
6E			26-29	4 A/N	MEIG FIELD ID NUMBER Examples: 4A, 12B	Contains the MEIG field number that is being rejected
7E			30-33	4 A/N	PAPER FORM FIELD NUMBER Examples: 1, 6D, 24F	Contains the corresponding paper form field number
8E			34-37	4 A/N	COMPARISON MEIG FIELD ID NUMBER Examples: 4A, 12B	When the validation rule is comparing to values in the supplied claim, this will contain the 2 nd MEIG field number being compared

**MEDICAL CLAIM PROCESSING REPORT TRANSMISSION
FILE LAYOUT**

RECORD LENGTH: 250

CLAIM VALIDATION ERROR RECORD LAYOUT – REVISION “C”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	NOTES
9E			38–41	4 A/N	COMPARISON PAPER FORM FIELD NUMBER Examples: 1, 6D, 24F	When the validation rule is comparing to values in the supplied claim, this will contain the 2 nd paper form field number being compared
10E			42–66	25 A/N	RAW REJECTED VALUE	Contains the actual rejected value supplied The value will be truncated to 25 characters for rejected fields longer than 25 characters
11E			67–91	25 A/N	COMPARISON RAW VALUE	When the validation rule is comparing two values in the supplied claim, this will contain the 2 nd raw value that was compared
12E			92–171	80 A/N	NARRATIVE ERROR MESSAGE	Error message corresponding to the Error Code given in field 5E
13E			172–250	79	SPACE FILLER	Space filled to end of record length

**MEDICAL CLAIM PROCESSING REPORT TRANSMISSION
FILE LAYOUT FOR ELECTRONIC SUBMISSION**

RECORD LENGTH: 250

TRANSMISSION TRAILER RECORD LAYOUT- REVISION "C"

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1T			1-3	3 A/N	TRANSMISSION TRAILER MARKER FORMAT: AAN	Will be hard coded as TR1
2T			4-9	6 Num	NUMBER OF CLAIM PROCESSING RESULTS IN TRANSMISSION FORMAT: NNNNNN	Will be numeric and right justified and space filled to complete field
3T			10-250	241	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	Space filled to end of the record length

APPENDICES

APPENDIX A

ICD-9 Diagnosis Code and ICD-9 Procedure Code Formats

(Forms DFS-F5-DWC-9 and DFS-F5-DWC-90)

If ICD-9 Diagnosis Code Is:

Valid Format Is:

942	942_ _ _
942.	942_ _ _
942.0	942.0_
372.61	372.61
043.9	043.9_
005.9	005.9_
V03	V03_ _ _
V03.	V03_ _ _
V03.0	V03.0_
V03.7	V03.7_
E111	E111_ _
E111.	E111_ _
E111.0	E111.0
E111.9	E111.9

(Form DFS-F5-DWC-90)

If ICD-9 Procedure Code Is:

Valid Format Is:

01.0	01.0_
01.01	01.01

(' _ ' indicates a space)

NOTE: Be sure to key in the decimal point. If a letter is used, make sure it is capitalized.

EXCEPTIONS: Do NOT key the decimal for diagnosis codes containing no digits to the right of the decimal; instead, left justify and space fill to the end of the field. For HOSPITAL BILLING, key diagnosis according to the UB-92 Manual.

APPENDIX B

Place of Treatment Codes

(Form DFS-F5-DWC-11)

<u>Place of Treatment (Location)</u>	<u>Valid Codes</u>
Office	11
Hospital	23
Extended Care Facility (ECF)	31
Other Unlisted	99

APPENDIX C

Report Reason Codes

(Forms DFS-F5-DWC-9, DFS-F5-DWC-10,
DFS-F5-DWC-11 and DFS-F5-DWC-90)

<u>Reason Description</u>	<u>Valid Codes</u>
Original Submission to the division	00
Cancel/ Withdraw – report sent to the division in error (Claim must be submitted with original control number)	01
Correction of report previously rejected by the division (Claim must be submitted with original control number)	02
Replacement report for claims previously accepted by the division (Claim must be submitted with original control number)	03
Automatically Select Report Reason Code 00 or 02*	99

*System will automatically select Report Reason Code 00 or 02, according to the following rules:

If the claim control number is not currently in our database, it will automatically select Report Reason Code 00.

If the claim is in our database and is currently **Rejected**, it will automatically select Report Reason Code 02.

If the claim is in our database and is currently **Accepted** or **Withdrawn**, it will automatically select Report Reason Code 00 and bypass the processing.

Using Report Reason Code 99 allows for the entire original transmission file to be re-submitted using the same control numbers as many times as necessary until all of the claims have been corrected and accepted. The claims that have already been accepted will be bypassed and not processed by our system.

APPENDIX D

Payment Codes

(Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, and DFS-F5-DWC-90)

Payment Code is a two-position field. Each of the two positions has a distinct meaning.

The left position designates the payment plan, as described below:

<u>Payment Plan</u>	<u>Valid Codes</u>
Reimbursement Manual (Services are reimbursed according to the appropriate reimbursement manual)	R
Managed Care (Services are reimbursed according to the language of the WC Managed Care Arrangement contract)	M
Contracted Amount (Services are reimbursed according to a contract not associated with a WC Managed Care Arrangement)	C

The right position indicates the insurer’s documented business arrangement that identifies the “date insurer received” and “date insurer paid” as they relate to medical bill processing.

The medical bill claims-handling arrangements and corresponding values for the right position are described below:

<u>Receipt and Payment Arrangement</u>	<u>Valid Codes</u>
“Date insurer received” and “date insurer paid, adjusted and paid, disallowed or denied” are based on payment and receipt by the insurer.	1
“Date insurer received” and “date insurer paid, adjusted and paid, disallowed or denied” are based on payment and receipt by the entity.	2
“Date insurer received” is based on the date received by the insurer and “date insurer paid, adjusted and paid, disallowed or denied” is based on payment by the entity.	3
“Date insurer received” is based on the date received by the entity and “date insurer paid, adjusted and paid, disallowed or denied” is based on insurer payment.	4

APPENDIX E

Explanation of Bill Review (EOBR) Codes

(Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11
and DFS-F5-DWC-90)

<u>EOBR Description</u>	<u>Valid Codes</u>
Services not authorized, as required.	01
Services denied as not related to the compensable work injury.	02
Services related to a denied work injury: DFS-F2-DWC-12 on file with the division.	03
Services billed are listed as not covered or non-covered (“NC”) in applicable reimbursement manual.	04
Documentation does not support the level, intensity, frequency, duration or provision of service(s) billed. (Insurer must specify to the health care provider.)	05
Location of service(s) is not consistent with level of service(s) billed.	06
Reimbursement equals the amount billed.	07
Reimbursement is based on the applicable reimbursement fee schedule.	08
Reimbursement is based on any contract.	09
Reimbursement is based on charges exceeding the stop-loss point.	10
Reimbursement is based on insurer re-coding. (Insurer must specify to the health care provider.)	11
Charge(s) are included in the per diem reimbursement.	12
Reimbursement is included in the allowance of another service. (Insurer must specify procedure to the health care provider.)	13
Hospital itemized statement not submitted with billing form.	14
Invalid code. (Use only when other valid codes are present.)	15
Documentation does not support that services rendered were medically necessary.	16
Required supplemental documentation not filed with the bill. (Insurer must specify required documentation to the health care provider.)	17
Duplicate Billing: Service previously paid, adjusted and paid, disallowed, or denied on prior claim form or multiple billing of service(s) billed on same date of service.	18
Required DFS-F5-DWC-25 form not submitted within three business days of the first treatment pursuant to s. 440.13(4)(a), F.S.	19
Other: Unique EOBR code description. (Insurer must provide specific explanation to health care provider.)	20

APPENDIX F

Proper Provider Number Formats

(Forms DFS-F5-DWC-9, DFS-F5-DWC-10,
DFS-F5-DWC-11 and DFS-F5-DWC-90)

Advanced Registered Nurse Practitioners: Enter “ARNP” followed by their Florida medical license number (ARNP#####).

Ambulatory Surgical Centers: Enter “ASC” followed by the Agency for Health Care Administration assigned license number (ASC#####).

Independent Laboratories: Enter “IL”, for required alpha characters, followed by the Agency for Health Care Administration assigned license number (IL8#####).

Individual Health Care Providers, Physicians, and Therapists: Enter the Florida health care provider’s or rehabilitation facility’s prefix and license number assigned by the professional regulatory board, licensing authority, or state regulatory agency.

Out-of-state Providers: Code “ZZ9999999999” for the provider license number.

Radiology or Other Facilities (providing ONLY the technical component): Code “XX9999999999” for the license number.

Work Hardening/Pain Programs: Enter the Division of Vocational Rehabilitation assigned facility number.
WC1##### = Individual Qualified Rehabilitation Provider
WC2##### = Rehabilitation Facility
WC3##### = Rehabilitation Company (Individual QRP's sometimes are employed by and bill through these Rehabilitation Companies.)

APPENDIX G

Claim Processing Result Codes

The following is a list of claim processing result codes from the division's Medical Data Management System:

<u>CODE</u>	<u>MEANING</u>
ACCEPTED	The claim was accepted into the division's database.
REJECTED	The claim was processed, but failed one or more of the validation tests. This claim must be corrected and resubmitted to the division.
WITHDRAWN	The Cancel/Withdraw claim (01) was successfully withdrawn from the division's database.
REPLACED	The Replacement claim (03) was accepted as a replacement in the division's database.
BYPASSED	The claim could not be processed. Refer to the Bypass Reason Codes on page 63.

APPENDIX H

Bypass Reason Codes

The following is a list of bypass reason codes that are possible when a submitted claim could not be processed by the division's Medical Data Management System:

<u>CODE</u>	<u>MEANING</u>
ALRDYACCP	The claim is being submitted as a Correction claim (02) or Automatic Reason (99), but the claim was found to be currently accepted in the division's database.
NOTFOUND	The claim is being submitted as a Correction (02), Replacement (03), or Cancel/Withdraw (01), but the claim could not be located in the database.
NOTORIG	The claim is being submitted as an Original submission (00), but the claim is already present in our database.
ALRDYWITH	The claim is being submitted as a Cancel/Withdraw (01), but the claim is already coded as Cancelled/Withdrawn in the division's database.
NOTREJCTD	The claim is being submitted as a Correction claim (02), but the claim is not currently rejected in the division's database.
INSIDDIF	The INSURER ID NUMBER on the submitted claim is different from ID number on the current copy of this claim in our database.
NOREPWITH	No Replacement (03) submissions allowed against a withdrawn claim.
NOREPREJ	No Replacement (03) submissions allowed against a rejected claim (use Correction (02) submission instead).

APPENDIX I

Validation Error Codes

The following is a list of Validation Error Codes reported by the division's Medical Data Management System:

<u>CODE</u>	<u>MEANING</u>
028	Must be numeric
029	Must be a valid date (CCYYMMDD)
034	Must be greater than or equal to the date of accident
039	No matching code value found in database
041	Cannot be a future date
057	Comparison of 10 key fields indicates duplicate claim
058	Invalid Code, ID, or value specified
060	Date comparison validation failure
062	Claim detail record(s) missing
066	Insurer/TPA not authorized for submitter
069	Total paid in header does not equal sum of detail paid amounts
070	Blank or zero value not allowed
071	FEIN does not match division records
072	License number not found in our database
073	Diagnosis reference number given does not have a corresponding header diagnosis
074	EOBR code present indicates non-payment, but item was paid
075	CPT code paid different than billed, but EOBR code 11 not reported
076	Modifier code paid different than billed, but EOBR code 11 not reported
077	Amount paid different than billed, but EOBR code 08, 09, 11, or 20 not reported
078	Amount paid is zero, but appropriate EOBR code not reported
079	Service Co./TPA FEIN or zip supplied, but ID number not supplied
080	Date of accident is after insurer cancellation date
081	NDC Drug Code supplied, but Procedure Code Paid not equal to 96370
083	If EOBR 01-04, 06, 13, or 15-19 are reported, line item payment must equal zero

Validation Error Codes (continued)

<u>CODE</u>	<u>MEANING</u>
085	If EOBR 08 or 11 are reported, line item payment must be greater than zero
086	EOBR Codes 10, 12, and 14 are for Hospital (DWC-90) use only
088	If EOBR Code 07 is reported, line item payment must equal charged
089	If EOBR Code 10 or 12 are reported, total paid on header record must be > \$0.00
091	Procedure Code Paid 99070 reported, but NDC Code not space filled
092	Procedure Code Paid 96370 reported, but NDC Code space filled

APPENDIX J

Electronic File Naming Conventions

Please use the following file naming convention for files uploaded to the division:

STTTTTDWCXX_YYMMDD_HHMMSSZ.TXT

Example: **SMTP123DWC09_20020929_090500T.TXT**

Where

“**S**” is hard coded. (all files submitted must start with the letter “S”)

“**TTTTTT**” is your 6 digit Submitter ID (i.e. – MTP123)

“**DWC**” is hard coded and must always be present in the filename.

“**XX**” is the Form Type. Current valid Form Type values are as follows:

“**09**” = DWC-9 Medical Claim Form

“**10**” = DWC-10 Pharmacy Billing Form

“**11**” = DWC-11 Dental Claim Form

“**90**” = DWC-90 Hospital Claim Form

“**_**” There must be an underscore immediately following the Form Type in the filename.

“**YYMMDD**” = The Year, Month, and Day of the file submission.

“**_**” **There must be an underscore immediately following the submission date in the filename.**

“**HHMMSS**” = **The Hour, Minute, and Seconds of the file submission, making the filename unique, just in case you have multiple files being transmitted in quick succession.**

“**Z**” = Test / Production indicator. Use “T” for a Test file, and “P” for a Production file.

“**.TXT**” = All files must end with a .TXT extension.

DOCUMENTS

MEDICAL Submitter Specifications

Submitter Name: _____ **FEIN:** _____

The insurer or service co/TPA shall complete and send this form to the division at least two weeks prior to sending the initial test transmission.

1. **Purpose.** For purposes of this document, a submitter is an insurer or service co/TPA that is using Electronic Data Interchange (EDI) to exchange workers' compensation medical data with the Florida Division of Workers' Compensation (DWC). The submitter shall refer to the Florida Medical EDI Implementation Guide, 2006 (MEIG) when sending electronic form equivalents of division medical forms.
2. **Format.** Data shall be submitted using the DWC form file layouts contained in the MEIG.
3. **Transmission Costs.** The submitter shall pay all transmission costs related to sending medical EDI data to the division. The division shall bear the cost of sending medical EDI transmission acknowledgments to the submitter.
4. **Filing Volume and Frequency.**

Estimated volume of EDI DFS-F5-DWC-9 filings: _____ per Week/Month (circle one)
Estimated volume of EDI DFS-F5-DWC-10 filings: _____ per Week/Month (circle one)
Estimated volume of EDI DFS-F5-DWC-11 filings: _____ per Week/Month (circle one)
Estimated volume of EDI DFS-F5-DWC-90 filings: _____ per Week/Month (circle one)

5. **Test Start Date.** Specify the target date for sending test transmissions: _____
6. **Contact Person(s) for EDI Test and Production Phases.** Provide the name, phone number, and e-mail address for all persons to whom EDI test and production communications should be sent (i.e., Transmission Receipt Confirmations and Medical Claim Processing Reports).

Contact: _____
Contact Type: Business Technical
Phone: _____
Email: _____

Contact: _____
Contact Type: Business Technical
Phone: _____
Email: _____

Contact: _____
Contact Type: Business Technical
Phone: _____
Email: _____

Contact: _____
Contact Type: Business Technical
Phone: _____
Email: _____

Mailing Address: _____

7. **Virus Software Used (Required)** _____

