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Florida Workers' Compensation

**Medical EDI
Implementation
Guide (MEIG)**

**for
Medical Report Submission**

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***Florida Department of Financial Services
Division of Workers' Compensation***

Effective March 1, 2004

Medical EDI Implementation Guide

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Definitions

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

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

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

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 placed in a trading partner's SSL/FTP account for retrieval

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

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 -

DWC-9 (CMS-1500)	Health Insurance Claim Form
DWC-10 (2003)	Statement of Charges for Drugs and Medical Supplies Form
DWC-11 (ADA2002)	American Dental Association Dental Claim Form
DWC-90 (UB-92 HFCA 1450)	Hospital Uniform Bill

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 Trading Partner Specifications: The document required by the division prior to the first submission of electronic data that contains trading partner contact information and other specifications

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

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

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

Reporting Reason Code: Indicator placed in the required field to show the submitted document is either an original report or a replacement report (DWC-9, DWC-10, DWC-11, or DWC-90) that has been previously filed with the division

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

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 trading partner's accuracy and program compatibility with division standards, prior to the transmission of production data

Trading Partner: An approved insurer, claims handling entity, or vendor acting as an agent on behalf of an insurer or claims handling entity, who has been approved to electronically transmit required division data

Trading Partner ID: A unique number assigned by the division to identify a trading partner

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

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

Transmission Receipt Confirmation: An E-mail notice sent to the trading partner to verify that the transmission has been received by the division

Trading Partner Responsibilities

Obtaining a Trading Partner ID

A trading partner must complete and submit to the division the Medical Trading Partner Specifications document for assignment of a Trading Partner ID prior to transmittal of the first electronic submission. This document is found on page 61 of this guide.

Submitting a Trading Partner Client List

A trading partner must provide the division with an accurate and complete list of insurers and/or claims handling entities for whom they will be transmitting electronic data. This list must include the insurer's code number and, if applicable, the claims handling entity's code number (both assigned by the division), full name, and office location zip code. It is the responsibility of the trading partner to notify the division when any insurers or claims handling entities are added to or deleted from the client list to avoid claim rejection when transmissions are processed. The Trading Partner Client Listing Update Request Form on page 62 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 found on the division's website or can be obtained by contacting the Medical Data Management Section with the Office of Data Quality and Collection at 850.413.1607.

Submitting Test Transmissions

Prior to submission of production data to the division, each trading partner must provide a test transmission for each form type (DWC-9, DWC-10, DWC-11, DWC-90). The division will review and analyze 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 trading partner can be approved to submit production data to the division, the trading partner 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.

Test Transmission Content

The test transmission must contain claim form data for 25 electronically-transmitted reports for each claim form type (DWC-9, DWC-10, DWC-11, DWC-90). Test transmissions must be sent via Diskette-3.5, CD-ROM, or SSL/FTP.

Requirements for Paper Claims Forms

A copy of the paper claim forms for 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 (and diskettes or CD-ROM, if applicable) must 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**

Test Transmission Approval

If the test transmission meets division requirements for approval, the trading partner will be notified of the date that electronic submission of production data may begin.

Test Transmission Rejection

If the test transmission fails to meet requirements for approval, the trading partner will be notified as to the reasons for the rejection. The division will retain copies of the submitted paper claim forms for use when the trading partner resubmits the test transmission for review.

NOTE: Data used in a test transmission is NOT considered “Filed with the Division” and must be transmitted as production data following division approval.

Production Transmission Guidelines

Types of Transmissions Accepted through July 30, 2004

The trading partner may submit data via any of the following transmission methods through Friday, July 30, 2004:

1. Diskette (3.5" 1.44 MB) Files on diskette must be ASCII format and may be compressed.
2. CD-ROM Compact disks must be ASCII format.
3. SSL/FTP This is the file transfer protocol used to transmit medical claims data to the division via the Internet using SSL technology.

Transmittal Requirements for Diskettes and CD-ROMS

1. External Label for Diskettes or CD-ROMS

When a trading partner transmits data to the division via diskette or CD-ROM, the trading partner must include an external label containing the following information:

Trading Partner Name
Trading Partner ID
Contact Person Name
Trading Partner Address
DWC Form Type

2. Receipt of Production Transmissions

All production transmissions mailed to the division must be received 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

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Types of Transmissions Effective August 2, 2004

Beginning Monday, August 2, 2004, all trading partners shall submit data using only the SSL/FTP transmission method.

The trading partner will be notified via their SSL/FTP account if a data transmission cannot be processed and is rejected by the division's edit program. The trading partner must send a replacement transmission.

Sequencing of Records in Transmissions:

All of the transmissions submitted (except for the DWC-10, which has no claim detail records) must be submitted with records in the following general 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. This means that if you are transmitting all four form types to the division on a monthly basis, you will need to transmit four separate transmissions each month (one for each form type).

Division Processing of Data Transmissions

Each data transmission received is processed through a data quality program specific to the claim form type of data received. Each claim is validated and analyzed. Once the transmission has been processed through the data quality programs, Claim Processing Reports are generated. These reports are sent to the trading partner for notification of the division's acceptance or rejection of data submitted. The layout for this division-generated report can be found beginning on page 44 of this guide.

Division Acceptance of Data

If the claims submitted contain no errors in any data elements, the claims are accepted by the division. A Claim Processing Report will be sent to the trading partner detailing the number of claims submitted for the insurers and, if applicable, the claims handling entities. After receiving this report, the trading partner shall verify that all of the data on the transmission has been accurately accounted for on the report.

Division Rejection of Data

Submitted claims that contain errors in any data element will be rejected by the division. A Claim Processing Report identifying the claims and specific data elements causing the rejection will be sent to the trading partner. The trading partner shall resubmit the claims with the necessary corrections to the division.

NOTE: Each corrected claim must be resubmitted with the original control number assigned at the time of the initial transmission.

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DWC FORM FILE LAYOUTS

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DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)
FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 250

TRANSMISSION HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER FORMAT: AAN	<u>REQUIRED</u> Valid Value = HD1
2H			4-6	3 Num	TRADING PARTNER ID FORMAT: NNN	<u>REQUIRED</u> Must be numeric Left pad with zeros to fill all three digits (ex: 034)
3H			7-15	9 Num	TRADING PARTNER ZIP CODE FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’
4H			16-24	9 Num	TRADING PARTNER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be numeric Must not be the same digit repeated nine times
5H			25-26	2 Num	FORM ID FORMAT: NN	<u>REQUIRED</u> Must be numeric Valid Value = 09
6H			27-28	2 A/N	REVISION INDICATOR FORMAT: A_ (‘ ’ indicates 1 space)	<u>REQUIRED</u> Left justify and space fill to end of field Valid Value = B_
7H			29	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	<u>REQUIRED</u> Valid Values : T = Test Transmission P = Production Transmission
8H			30-37	8 Num	DATE OF SUBMISSION FORMAT: CCYYMMDD	<u>REQUIRED</u> Must be valid date in the correct format Must be greater than or equal to Date Insurer Paid Provider
9H			38-250	213	SPACE FILLER FORMAT: _____ (‘ ’ indicates space fill to end)	<u>REQUIRED</u> Space fill Must not include any alpha or numeric

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DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 250
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1A			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS= TRADING PARTNER ID YY= Year submitted JJJ= Julian date of day submitted NNNNN = Sequence number	<u>REQUIRED</u> Must be numeric NNNNN Valid Values = 00001-99999
2A			14	1 Num	RECORD FLAG FORMAT: N	<u>REQUIRED</u> Must be numeric Valid Value = 1
3A			15-16	2 Num	FORM ID FORMAT: NN	<u>REQUIRED</u> Must be numeric 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 fill
6A			24-32	9 Num	INSURER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be numeric Must not be the same digit repeated nine times

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DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 250
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
7A			33-41	9 Num	INSURER LOCATION ZIP CODE* FORMAT: NNNNNNNNN *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”
8A			42-46	5 Num	CLAIMS HANDLING ENTITY CODE NUMBER FORMAT: NNNNN	SITUATIONAL Must be numeric Right justify and zero fill 1 st digit of 4 digit audit number must = “6” If not present, zero fill
9A			47-55	9 Num	CLAIMS HANDLING ENTITY FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	SITUATIONAL Must be numeric Must not be the same digit repeated nine times If not present, zero fill (Must be provided if Claims Handling ENTITY CODE Number is present.)
10A			56-64	9 Num	CLAIMS HANDLING ENTITY LOCATION ZIP CODE* FORMAT: NNNNNNNNN *Location is the Claims Handling Entity’s office responsible for report.	SITUATIONAL Must be numeric Left justify and leave unused spaces blank 1 st four digits must not equal ‘ 0000’ If not present, zero fill (Must be provided if Claims Handling ENTITY CODE Number is present.)
11A	1a	INSURER’S ID NUMBER	65-74	10 A/N	EMPLOYEE IDENTIFICATION NUMBER	REQUIRED Left justify and space fill to end of field If numeric, must not be the same digit repeated 10 times Must be SSN or Division-Assigned Number

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DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 250
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
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	REQUIRED Must be valid date in the correct format Must be less than or equal to “Date of Service- From” and “Date of Service - To”
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 G for valid values)	REQUIRED Left justify and space fill to end of field Key alpha prefix and numeric digits of license number – DO NOT zero pad numeric portion Must be valid values
14A	25	FEDERAL TAX ID NUMBER	96-104	9 Num	PROVIDER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric Must not be the same digit repeated nine times
15A	32	NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED	105-113	9 Num	ZIP CODE WHERE SERVICES WERE RENDERED FORMAT: NNNNNNNNN	REQUIRED Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’
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 Alpha	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 present, space fill

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DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 250
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
19A			160-167	8 Date	DATE INSURER RECEIVED BILL FROM PROVIDER 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”
20A			168-175	8 Date	DATE INSURER PAID, ADJUSTED AND PAID OR DISALLOWED 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 BY INSURER FORMAT: NNNNNNNNNN	REQUIRED Must be numeric Zero is valid value Decimal point implied at two places Right justify and zero fill
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 1 st digit must equal zero
23A			189-190	2 Alpha	PAYMENT PLAN FORMAT: AA (See Appendix D for Valid Codes)	REQUIRED Must be alpha Must be a valid value
24A	21 ₁	DIAGNOSIS CODE	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 CODE	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 Left justify and space fill to end of field If not present, space fill to end of field

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DWC-9 HEALTH INSURANCE CLAIM FORM (CMS-1500)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 250
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
26A	21 ₃	DIAGNOSIS CODE	203-208	6 A/N	ICD-9 DIAGNOSTIC CODE 3 FORMAT: (See Appendix A for Valid Diagnosis Code Formats)	<u>SITUATIONAL</u> Must be a valid ICD-9 code Left justify and space fill to end of field If not present, space fill to end of field
27A	21 ₄	DIAGNOSIS CODE	209-214	6 A/N	ICD-9 DIAGNOSTIC CODE 4 FORMAT: (See Appendix A for Valid Diagnosis Code Formats)	<u>SITUATIONAL</u> Must be a valid ICD-9 code Left justify and space fill to end of field If not present, space fill to end of field
28A			215-250	36	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

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DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 250
CLAIM DETAIL RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
1B			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Trading Partner ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	REQUIRED Must be numeric NNNNN Valid Values = 00001-99999
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)
4B	24B	PLACE OF SERVICE	18-19	2 Num	PLACE OF SERVICE FORMAT: NN (see appropriate CPT 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 fields 24, 25, 26, 27 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

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DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 250
CLAIM DETAIL RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
6B	24D ₁	PROCEDURES, SERVICE, 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
7B	24D ₂	PROCEDURES, SERVICE, OR SUPPLIES MODIFIER	29-30	2A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER (AS BILLED BY PROVIDER) FORMAT: NN, OR AN, OR AA	SITUATIONAL Must be valid modifier code If not present, zero fill
8B			31-35	5 A/N	PROCEDURE, SERVICE OR SUPPLY CODE (AS PAID BY INSURER) FORMAT: NNNNN, OR ANNNN	SITUATIONAL If different from billed code Must be a valid CPT, HCPCS or Unique Florida WC code If not present, zero fill
9B			36-37	2 A/N	PROCEDURE, SERVICE OR SUPPLY CODE MODIFIER (AS PAID BY INSURER) FORMAT: NN, OR AN, OR AA	SITUATIONAL If different from billed code Must be valid modifier code If not present, zero fill
10B	24F	\$ CHARGES	38-48	11 Num	PROVIDER CHARGE PER LINE FORMAT: NNNNNNNNNN	REQUIRED Must be numeric Decimal point implied at 2 places Right justify and zero fill
11B	24G	DAYS OR UNITS	49-51	3 Num	NUMBER OF DAYS, HOURS, MINUTES OR UNITS* FORMAT: NNN *Anesthesia units must have total minutes reported	REQUIRED Must be numeric Right justify and zero fill Must be whole number

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DWC-9 HEALTH INSURANCE CLAIM FORM (CMS1500)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 250
CLAIM DETAIL RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH TYPE	DESCRIPTION	REQUIREMENTS
12B			52-62	11 Num	INSURER PAYMENT PER LINE* FORMAT: NNNNNNNNNN *After all adjustments have been applied	REQUIRED Must be numeric Decimal point implied at 2 places Right justify and zero fill If disallowed, zero fill
13B	24A	DATES 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”
14B	24A	DATES 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 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 present, zero 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 present, zero fill
18B			85-250	166	SPACE FILLER FORMAT: _____ (‘ ’ indicates space fill to end)	REQUIRED Space fill

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DWC-9 HEALTH INSURANCE CLAIM FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 250

TRANSMISSION TRAILER RECORD LAYOUT – REVISION “B”

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 fill
3T			10-250	241	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

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DWC-10 PHARMACY AND MEDICAL SUPPLY CLAIM FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION

RECORD LENGTH: 200

TRANSMISSION HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER FORMAT: AAN	<u>REQUIRED</u> Valid Value = HD1
2H			4-6	3 Num	TRADING PARTNER ID FORMAT: NNN	<u>REQUIRED</u> Must be numeric Left pad with zeros to fill all three digits (ex: 034)
3H			7-15	9 Num	TRADING PARTNER ZIP CODE FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’
4H			16-24	9 Num	TRADING PARTNER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be numeric Must not be the same digit repeated nine times
5H			25-26	2 Num	FORM ID FORMAT: NN	<u>REQUIRED</u> Must be numeric Valid Value = 10
6H			27-28	2 A/N	REVISION INDICATOR FORMAT: A_ (‘ ’ indicates 1 space)	<u>REQUIRED</u> Left justify and space fill to end of field Valid Value = B_
7H			29	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	<u>REQUIRED</u> Valid Values: T = Test Transmission P = Production Transmission
8H			30-37	8 Num	DATE OF SUBMISSION FORMAT: CCYYMMDD	<u>REQUIRED</u> Must be valid date in the correct format Must be greater than or equal to “Date Insurer Paid Provider”
9H			38-200	163	SPACE FILLER FORMAT: _____ (‘ ’ indicates space fill to end)	<u>REQUIRED</u> Space fill

DRAFT
DWC-10 PHARMACY AND MEDICAL SUPPLY CLAIM FORM (2003)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 200
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1A			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Trading Partner ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	REQUIRED Must be numeric NNNNN Valid Values = 00001-99999
2A			14	1 Num	RECORD FLAG FORMAT: N	REQUIRED Must be numeric Valid Value = 1
3A			15-16	2 Num	FORM ID FORMAT: NN	REQUIRED Must be numeric Valid Value = 10
4A			17-18	2	RESERVED FOR INTERNAL USE SPACE FILLER FORMAT: __	REQUIRED Space fill
5A			19-23	5 Num	INSURER ID NUMBER FORMAT: NNNNN	REQUIRED Must be numeric Right justify and zero fill 1 st digit of 4 digit audit number must not = “6”
6A			24-32	9 Num	INSURER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric Must not be the same digit repeated nine times
7A			33-41	9 Num	INSURER LOCATION ZIP CODE* FORMAT: NNNNNNNNN *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’
8A			42-46	5 Num	CLAIMS HANDLING ENTITY CODE NUMBER FORMAT: NNNNN	SITUATIONAL Must be numeric Right justify and zero fill 1 st digit of 4 digit audit number must = “6” If not present, zero fill

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DWC-10 PHARMACY AND MEDICAL SUPPLY CLAIM FORM (2003)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 200
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
9A			47-55	9 Num	CLAIMS HANDLING ENTITY FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>SITUATIONAL</u> Must be numeric Must not be the same digit repeated nine times If not present, zero fill (Must be provided if Claims Handling ENTITY CODE Number is present.)
10A			56-64	9 Num	CLAIMS HANDLING ENTITY LOCATION ZIP CODE* FORMAT: NNNNNNNNN *Location is the Claims Handling Entity '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 present, zero fill (Must be provided if Claims Handling ENTITY CODE Number is present.)
11A	2	SOCIAL SECURITY NUMBER	65-74	10 A/N	EMPLOYEE IDENTIFICATION NUMBER	<u>REQUIRED</u> Left justify and space fill to end of field If numeric, must not be the same digit repeated 10 times Must be SSN or Division-Assigned Number
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 “Date of Service”
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

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DWC-10 PHARMACY AND MEDICAL SUPPLY CLAIM FORM (2003)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 200
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
14A	1	EMPLOYEE'S NAME	113-127	15 Alpha	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 present, space fill to end of field
16A			129-136	8 Date	DATE INSURER RECEIVED BILL FROM PROVIDER 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”
17A			137-144	8 Date	DATE INSURER PAID, ADJUSTED AND PAID OR DISALLOWED 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”
18A	26	TOTAL REIMBURSED FROM THIS SECTION (PHARMACY)	145-155	11 Num	TOTAL PHARMACY CHARGES PAID BY INSURER FORMAT: NNNNNNNNNN	SITUATIONAL Must be numeric Decimal point implied at two places Right justify and zero fill Zero fill if not applicable
19A	27	TOTAL REIMBURSED FROM THIS SECTION (MEDICAL SUPPLIES)	156-166	11 Num	TOTAL MEDICAL SUPPLY CHARGES PAID BY INSURER FORMAT: NNNNNNNNNN	SITUATIONAL Must be numeric Decimal point implied at two places Right justify and zero fill Zero fill if not applicable

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DWC-10 PHARMACY AND MEDICAL SUPPLY CLAIM FORM (2003)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 200
CLAIM HEADER RECORD LAYOUT – REVISION “B”

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 1 st digit must equal zero, “0”
21A			169-200	32	SPACE FILLER FORMAT: _____ (‘ ’ indicates space fill to end)	<u>REQUIRED</u> Space fill Must not include any alpha or numeric

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DWC-10 PHARMACY AND MEDICAL SUPPLY CLAIM FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 200
TRANSMISSION TRAILER RECORD LAYOUT – REVISION “B”

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 fill
3T			10-200	191	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

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DWC-11 DENTAL CLAIM FORM (ADA2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 225

TRANSMISSION HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1H			1-3	3 A/N	TRANSMISSION HEADER MARKER FORMAT: AAN	<u>REQUIRED</u> Valid Value = HD1
2H			4-6	3 Num	TRADING PARTNER ID FORMAT: NNN	<u>REQUIRED</u> Must be numeric Left pad with zeros to fill all three digits (ex: 034)
3H			7-15	9 Num	TRADING PARTNER ZIP CODE FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’
4H			16-24	9 Num	TRADING PARTNER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>REQUIRED</u> Must be numeric Must not be the same digit repeated nine times
5H			25-26	2 Num	FORM ID FORMAT: NN	<u>REQUIRED</u> Must be numeric Valid Value = 11
6H			27-28	2 A/N	REVISION INDICATOR FORMAT: A_ (‘ ’ indicates 1 space)	<u>REQUIRED</u> Left justify and space fill to end of field Valid Value = B_
7H			29	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	<u>REQUIRED</u> Valid Values: T = Test Transmission P = Production Transmission
8H			30-37	8 Num	DATE OF SUBMISSION FORMAT: CCYYMMDD	<u>REQUIRED</u> Must be valid date in the correct format Must be greater than or equal to “Date Insurer Paid Provider”
9H			38-225	188	SPACE FILLER FORMAT: _____ (‘ ’ indicates space fill to end)	<u>REQUIRED</u> Space fill

DRAFT
DWC-11 DENTAL CLAIM FORM (ADA2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 225
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1A			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Trading Partner ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	REQUIRED Must be numeric NNNNN Valid Values = 00001-99999
2A			14	1 Num	RECORD FLAG FORMAT: N	REQUIRED Must be numeric Valid Value = 1
3A			15-16	2 Num	FORM ID FORMAT: NN	REQUIRED Must be numeric Valid Value = 11
4A			17-18	2	RESERVED FOR INTERNAL USE SPACE FILLER FORMAT: _ _	REQUIRED Space fill
5A			19-23	5 Num	INSURER ID NUMBER FORMAT: NNNNN	REQUIRED Must be numeric Right justify and zero fill 1 st digit of 4 digit audit number must not = “6”
6A			24-32	9 Num	INSURER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric Must not be the same digit repeated nine times
7A			33-41	9 Num	INSURER LOCATION ZIP CODE* FORMAT: NNNNNNNNN *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’

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DWC-11 DENTAL CLAIM FORM (ADA2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 225
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
8A			42-46	5 Num	CLAIMS HANDLING ENTITY CODE NUMBER FORMAT: NNNNN	SITUATIONAL Must be numeric Right justify and zero fill 1 st digit of 4 digit audit number must = “6” If not present, zero fill
9A			47-55	9 Num	CLAIMS HANDLING ENTITY FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	SITUATIONAL Must be numeric Must not be the same number repeated nine times If not present, zero fill (Must be provided if Claims Handling ENTITY CODE Number is present.)
10A			56-64	9 Num	CLAIMS HANDLING ENTITY LOCATION ZIP CODE* FORMAT: NNNNNNNNN *Location is the Claims Handling Entity 's Office responsible for report	SITUATIONAL Must be numeric Left justify and leave unused spaces blank 1 st four digits must be greater than Zero If not present, zero fill (Must be provided if Claims Handling ENTITY CODE Number is present.)
11A	8	SOCIAL SECURITY NUMBER	65-74	10 A/N	EMPLOYEE IDENTIFICATION NUMBER	REQUIRED Left justify and space fill to end of field If numeric, must not be the same digit repeated 10 times Must be SSN or Division-Assigned Number

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DWC-11 DENTAL CLAIM FORM (ADA2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 225
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
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	REQUIRED Must be valid date in the correct format Must be less than or equal to “Date of Service”
13A	55	LICENSE NUMBER	83-95	13 A/N	PROVIDER’S FLORIDA LICENSE NUMBER FORMAT: AANNNNNNNNNN (See Appendix G for valid value)	REQUIRED Key alpha prefix and numeric digits of license number Left justify and space fill to end of field Must be valid value
14A	54	PROVIDER ID	96-104	9 Num	PROVIDER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric Must not be the same digit repeated nine times
15A	58	ADDRESS, CITY, STATE, ZIP CODE	105-113	9 Num	PROVIDER LOCATION ZIP CODE FORMAT: NNNNNNNNN	REQUIRED Must be numeric Left justify and leave unused spaces blank 1 st four digits must not equal ‘0000’
16A	20	PATIENT 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	20	PATIENT NAME	144-158	15 Alpha	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	PATIENT NAME	159	1 Alpha	INJURED EMPLOYEE’S MIDDLE INITIAL	SITUATIONAL If present, must be uppercase A-Z If not present, 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

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DWC-11 DENTAL CLAIM FORM (ADA2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 225
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
20A			162-169	8 Date	DATE INSURER RECEIVED BILL FROM PROVIDER 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”
21A			170-177	8 Date	DATE INSURER PAID, ADJUSTED AND PAID OR DISALLOWED 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 fill
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 1 st digit must equal zero, “0”
24A			191-192	2 Alpha	PAYMENT PLAN FORMAT: AA (See Appendix D for Valid Codes)	REQUIRED Must be alpha Must be a valid value
25A			193-225	33	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	REQUIRED Space fill

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DWC-11 DENTAL CLAIM FORM (ADA2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 225
CLAIM DETAIL RECORD LAYOUT- REVISION "B"

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1B			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Trading Partner ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	REQUIRED Must be numeric NNNNN Valid Values = 00001-99999
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)
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"
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, HCPCS 'D' or Unique Florida WC code
6B			31-35	5 A/N	PAID CPT, CDT OR HCPCS CODE IF DIFFERENT FROM BILLED CODE FORMAT: NNNNN, OR ANNNN	SITUATIONAL If different from billed code Must be a valid CPT, CDT, HCPCS or Unique Florida WC code If not present, zero fill

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DWC-11 DENTAL CLAIM FORM (ADA2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 225

CLAIM DETAIL RECORD LAYOUT – REVISION “B”

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	REQUIRED Must be numeric Decimal point is implied at 2 places Right justify and zero fill
8B			47-57	11 Num	INSURER PAYMENT PER LINE** FORMAT: NNNNNNNNNN **After all adjustments have been applied.	REQUIRED Must be numeric Decimal point is implied at 2 places Right justify and zero fill If disallowed, zero fill
9B			58-59	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	REQUIRED Must be valid code Must be present
10B			60-61	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	SITUATIONAL Must be valid code If not present, zero fill
11B			62-63	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	SITUATIONAL Must be valid code If not present, zero fill
12B			64-225	162	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	REQUIRED Space fill

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DWC-11 DENTAL CLAIM FORM (ADA2002)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 225

TRANSMISSION TRAILER RECORD LAYOUT – REVISION “B”

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 fill
3T			10-225	216	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

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DWC-90 HOSPITAL CLAIM FORM (UB92)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 300

TRANSMISSION HEADER RECORD LAYOUT – REVISION “B”

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 Left justify Valid Value = HD1
2H			4-6	3 Num	TRADING PARTNER ID FORMAT: NNN	REQUIRED Must be numeric Left pad with zeros to fill all three digits (ex: 034)
3H			7-15	9 Num	TRADING PARTNER ZIP CODE FORMAT: NNNNNNNNN	REQUIRED Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’
4H			16-24	9 Num	TRADING PARTNER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric Must not be the same digit repeated nine times
5H			25-26	2 Num	FORM ID FORMAT: NN	REQUIRED Must be numeric Valid Value = 90
6H			27-28	2 A/N	REVISION INDICATOR FORMAT: A_ (‘_’ indicates 1 space)	REQUIRED Left justify and space fill to end of field Valid Value = B_
7H			29	1 Alpha	TEST / PRODUCTION INDICATOR FORMAT: A	REQUIRED Valid Values : T = Test Transmission P = Production Transmission
8H			30-37	8 Num	DATE OF SUBMISSION FORMAT: CCYYMMDD	REQUIRED Must be valid date in the correct format Must be greater than or equal to “Date Insurer Paid Provider”
9H			38-300	263	SPACE FILLER FORMAT: _____ (‘_’ indicates space fill to end)	REQUIRED Space fill

DRAFT
DWC-90 HOSPITAL CLAIM FORM (UB92)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 300
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1A			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Trading Partner ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	REQUIRED Must be numeric NNNNN Valid Values = 00001-99999
2A			14	1 Num	RECORD FLAG FORMAT: N	REQUIRED Must be numeric Valid Value = 1
3A			15-16	2 Num	FORM IDENTIFIER FORMAT: NN	REQUIRED Must be numeric 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 fill 1 st digit of 4 digit audit number must not = “6”
6A			24-32	9 Num	INSURER FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric Must not be the same digit repeated nine times
7A			33-41	9 Num	INSURER LOCATION ZIP CODE* FORMAT: NNNNNNNNN *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’

DRAFT
DWC-90 HOSPITAL CLAIM FORM (UB92)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 300
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/TYPE	DESCRIPTION	REQUIREMENTS
8A			42-46	5 Num	CLAIMS HANDLING ENTITY CODE NUMBER FORMAT: NNNNN	<u>SITUATIONAL</u> Must be numeric Right justify and zero fill 1 st digit of 4 digit audit number must equal “6” If not present, zero fill
9A			47-55	9 Num	CLAIMS HANDLING ENTITY FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	<u>SITUATIONAL</u> Must be numeric Must not be the same digit repeated nine times If not present, zero fill (Must be provided if Claims Handling ENTITY CODE number is present)
10A			56-64	9 Num	CLAIMS HANDLING ENTITY LOCATION ZIP CODE* FORMAT: NNNNNNNNN *Location is the Claims Handling Entity’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 present, zero fill (Must be provided if Claims Handling ENTITY 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 numeric Must be valid code
12A	60	SOCIAL SECURITY NUMBER	68-77	10 A/N	EMPLOYEE IDENTIFICATION NUMBER	<u>REQUIRED</u> Left justify and space fill to end of field If numeric, must not be the same digit repeated 10 times Must be SSN or Division-Assigned Number

DRAFT
DWC-90 HOSPITAL CLAIM FORM (UB92)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 300
CLAIM HEADER RECORD LAYOUT – REVISION “B”

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 G for valid values)	REQUIRED Left justify and space fill to end of field Key alpha prefix and numeric digits of license number Must be valid value
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 Alpha	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 present, must be uppercase A-Z If not present, leave unused space blank
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 Provider”

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DWC-90 HOSPITAL CLAIM FORM (UB92)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 300
CLAIM HEADER RECORD LAYOUT – REVISION “B”

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 Period Through” date
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 Period From” Must be less than or equal to the “Date Insurer Received Bill From Provider”
22A	21	D HR	171-172	2 Num	DISCHARGE HOUR FORMAT: NN (See UB-92 manual for valid codes)	REQUIRED Must be numeric Must be valid code
23A	5	FEDERAL TAX NO.	173-181	9 Num	FACILITY FEDERAL TAX ID NUMBER FORMAT: NNNNNNNNN	REQUIRED Must be numeric Must not be the same digit repeated nine times
24A	1	PROVIDER NAME, ADDRESS AND TELEPHONE NUMBER	182-190	9 Num	FACILITY LOCATION ZIP CODE FORMAT: NNNNNNNNN	REQUIRED Must be numeric Left justify and space fill to end of field 1 st four digits must not equal ‘0000’

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DWC-90 HOSPITAL CLAIM FORM (UB92)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 300
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
25A			191-198	8 Date	DATE INSURER RECEIVED BILL FROM PROVIDER 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 “Admission Date” Must be greater than or equal to “Date Statement Covers From and Through”
26A			199-206	8 Date	DATE INSURER PAID PROVIDER 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: NNNNNNNNNN	REQUIRED Must be numeric Decimal point implied at two places Right justify and zero fill
28A	67	PRIN DIAG CODE	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	OTHER DIAG CODES	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 present, zero fill (Do not key decimal)
30A	69	OTHER DIAG CODES	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 present, zero fill (Do not key decimal)
31A	70	OTHER DIAG CODES	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 present, zero fill (Do not key decimal)

DRAFT
DWC-90 HOSPITAL CLAIM FORM (UB92)
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 300
CLAIM HEADER RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
32A	79	PROCEDURE CODING METHOD USED	242	1 Num	PROCEDURE CODING METHOD FORMAT: N (See UB-92 Manual and Appendix F for valid codes)	<u>SITUATIONAL</u> If Principal Procedure is present, PCM code must be present Must be numeric Must be valid code If not present, zero fill
33A	80	PRINCIPAL PROCEDURE	243-247	5 Num	PRINCIPAL PROCEDURE CODE FORMAT NNNNN OR ANNNN	<u>SITUATIONAL</u> If Procedure Coding Method is present, Principal Procedure Code must be present Must be a valid ICD-9 Code If not present, zero fill
34A	81	OTHER PROCEDURE	248-252	5 Num	OTHER PROCEDURE CODE FORMAT: NNNNN OR ANNNN	<u>SITUATIONAL</u> If present, must be a valid ICD-9 code If not present, zero 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 1 st digit must equal zero, “0”
36A			255-256	2 Alpha	PAYMENT PLAN FORMAT: AA (See Appendix D for Valid Codes)	<u>REQUIRED</u> Must be alpha Must be valid value
37A	19	TYPE OF ADMISSION/ VISIT	257	1 Num	ADMISSION TYPE (See UB-92 for Valid Codes)	<u>REQUIRED</u> Must be numeric Must a valid code
38A			258-300	43	SPACE FILLER FORMAT: _____ (‘ ’ indicates space fill to end)	<u>REQUIRED</u> Space fill

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DWC-90 HOSPITAL CLAIM FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 300
CLAIM DETAIL RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
1B			1-13	13 Num	CLAIM CONTROL NUMBER FORMAT: SSSYYJJNNNNN SSS=Trading Partner ID YY= Year submitted JJJ=Julian date of day submitted NNNNN = Sequence number	<u>REQUIRED</u> Must be numeric NNNNN Valid Values = 00001-99999
2B			14	1 Num	RECORD FLAG FORMAT: N	<u>REQUIRED</u> Must be numeric Valid Value = 2
3B			15-17	3 Num	DETAIL SEQUENCE NUMBER FORMAT: NNN	<u>REQUIRED</u> Must be numeric NNN Valid Values = 001-999 Left pad with zeros to fill all 3 digits (ex: 001)
4B	42	REVENUE CODE	18-21	4 Num	REVENUE CODE FORMAT: NNNN (See UB-92 Manual for Valid Codes)	<u>REQUIRED</u> Must be numeric Must be a valid code Right justify and zero fill
5B	44	HCPCS/RATES	22-26	5 Num	CPT PROCEDURE CODE FORMAT: NNNNN	<u>SITUATIONAL</u> Must be valid CPT procedure code Left justify and space fill to end of field If not present, zero fill
6B	44	HCPCS/RATES	27-28	2 A/N	CPT MODIFIER FORMAT: NN OR, AN OR, AA	<u>SITUATIONAL</u> Must be valid CPT modifier code If not present, zero fill

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DWC-90 HOSPITAL CLAIM FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 300
CLAIM DETAIL RECORD LAYOUT – REVISION “B”

FIELD NO.	FORM FIELD ID	FORM FIELD NAME	LOCATION	LENGTH/ TYPE	DESCRIPTION	REQUIREMENTS
7B	46	SERVICE UNITS	29-35	7 Num	UNITS OF SERVICE FORMAT: NNNNNNN	<u>REQUIRED</u> Must be numeric Right justify and zero fill
8B	47	TOTAL CHARGES (BY REVENUE CODE CATEGORY)	36-46	11 Num	CHARGE PER REVENUE CODE FORMAT: NNNNNNNNNNN *Do not enter credits in this field.	<u>REQUIRED</u> Must be numeric Decimal point implied at 2 places Right justify and zero fill
9B			47-48	2 Num	EXPLANATION OF BILL REVIEW CODE FORMAT: NN (See Appendix E for valid EOBR Codes)	<u>REQUIRED</u> Must be valid code Must be present
10B			49-50	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 present, zero fill
11B			51-52	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 present, zero fill
12B			53-300	248	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

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DWC-90 HOSPITAL CLAIM FORM
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 300
TRANSMISSION TRAILER LAYOUT – REVISION “B”

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 fill
3T			10-300	291	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	<u>REQUIRED</u> Space fill

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**CLAIM PROCESSING REPORT TRANSMISSION
FILE LAYOUT**

RECORD LENGTH: 200

TRANSMISSION HEADER RECORD LAYOUT – REVISION “NEW”

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	TRADING PARTNER ID FORMAT: NNN	Will be numeric Will be left padded with zeros to fill all three digits (ex: 034)
3H			7-15	9 Num	TRADING PARTNER ZIP CODE FORMAT: NNNNNNNNN	Will be numeric Will be left justified and space filled to end of field
4H			16-23	8 Num	TRANSMISSION ID NUMBER ASSIGNED FORMAT: NNNNNNNNN	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 “NEW” for this release of the Claim Processing Report file
8H			30-200	171	SPACE FILLER FORMAT: _____ (‘___’ indicates space fill to end)	Space filled to end of record length

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CLAIM PROCESSING REPORT TRANSMISSION
FILE LAYOUT

RECORD LENGTH: 200

CLAIM PROCESSING RESPONSE RECORD LAYOUT – REVISION “NEW”

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: SSSYYJJJNNNNN SSS= TRADING PARTNER ID YY= Year submitted JJJ= Julian date of day submitted NNNNN = 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 I for Values.	Code will indicate the result of processing of the claim
6K			31-40	10 Alpha	BYPASS REASON CODE See Appendix J for Values.	If the Processing Result Code = BYPASSED, this will contain a reason code why it could not be processed
7K			41-200	160 A/N	NARRATIVE TEXT	Will contain an explanation of why the claim could not be processed (if it was bypassed)

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CLAIM PROCESSING REPORT TRANSMISSION
FILE LAYOUT

RECORD LENGTH: 200

CLAIM VALIDATION ERROR RECORD LAYOUT – REVISION “NEW”

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= TRADING PARTNER ID YY= Year submitted JJJ= Julian date of day submitted NNNNN = 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, zero padded
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 K 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 <u>MEIG</u> field number that is being rejected.
7E			30-33	4 A/N	PAPER FORM FIELD NUMBER Examples: 1, 6D, 24F	Contains the corresponding <u>paper form</u> 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 <u>MEIG</u> field number being compared

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CLAIM PROCESSING REPORT TRANSMISSION
FILE LAYOUT

RECORD LENGTH: 200

CLAIM VALIDATION ERROR RECORD LAYOUT – REVISION “NEW”

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 <u>paper form</u> 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 2 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			172–200	29 Alpha	SPACE FILLER	Space filled to end of record length

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CLAIM PROCESSING REPORT TRANSMISSION
FILE LAYOUT FOR ELECTRONIC SUBMISSION
RECORD LENGTH: 200
TRANSMISSION TRAILER RECORD LAYOUT

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, right justified and zero filled
3T			10-200	191	SPACE FILLER FORMAT: _____ (‘__’ indicates space fill to end)	Space filled to end of the record length

APPENDICES

APPENDIX A

ICD-9 Diagnosis Code Formats

(DWC-9 & DWC-90)

If Diagnosis Code Is:

Valid Format Is:

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

(‘ _ ’ indicates a space)

NOTE: Be sure to key in the decimal point. EXCEPTION: 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.

APPENDIX B

Place of Treatment Codes

(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

(DWC-9, DWC-10, DWC-11 and 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	01
Correction of report previously rejected by the division	02
Replacement report for claims previously accepted by the division	03

APPENDIX D

Payment Plan Codes

(DWC-9, DWC-11 and DWC-90)

Payment Plan

Valid Codes

Reimbursement Manual (Services Rendered Outside MCA)

RM

Managed Care (Services Rendered within a WC Managed Care Arrangement)

MC

Contracted Amount (Services Rendered, but not Associated With a Workers' Compensation Managed Care Arrangement)

CA

APPENDIX E

Explanation of Bill Review Codes (EOBR)

(DWC-9, DWC-11, & DWC-90)

<u>EOBR Description</u>	<u>Valid Codes</u>
Services are not authorized, as required. (Insurer must specify reason.)	01
Services are not related to the compensable injury and are denied.	02
Services are related to a denied case: DWC-12 is 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 or duration of service(s) billed. (Insurer must specify.)	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 applicable reimbursement schedule.	08
Reimbursement is based on contracted amount.	09
Reimbursement is based on charges exceeding the stop-loss point.	10
Charge(s) are included in the per diem reimbursement.	11
Reimbursement is included in allowance of another service. (Insurer must specify procedure.)	12
Incorrect billing form was filed. (Insurer must specify correct form.)	13
Hospital itemized statement not submitted with billing form.	14
Illegible or incomplete bill (Insurer must specify.)	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.)	17
Other: Unique EOBR code description.	18
Required supplemental documentation not filed with the bill.	19
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.	20
Other: Unique EOBR code description.	21

APPENDIX F

UB-92 Procedure Coding Method

If Field 32A = 4 Then Field 33A and 34A must be valid CPT codes

If Field 32A = 5 Then Field 33A and 34A must be valid HCPCS codes

If Field 32A = 9 Then Field 33A and 34A must be valid ICD-9 codes

APPENDIX G

Proper Provider Number Formats

(DWC-9, DWC-11 and DWC-90)

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

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

Independent Laboratories: Enter “IL” followed by the Agency for Health Care assigned license number (i.e. IL8000##### or IL80000##### or IL800000####)

Individual Health Care Providers, Physicians and Therapists: Enter the Florida health care provider’s license or rehabilitation facility number assigned by the professional regulatory board, licensing authority or state regulatory agency. Do not zero pad the numeric portion of the license number. Right pad the license number with spaces to fill to the field length. (i.e. ME#####_____)

Out-of-state Providers: Code “ZZ999999999999” for the provider license number.

Radiology Facilities (providing ONLY the technical component): Enter “XX” for required alpha characters and 99999 for required numeric characters (i.e. XX#####)

Work Hardening/Pain Programs: Enter the Division of Vocational Rehabilitation assigned facility number (i.e. WC3#####).

APPENDIX H

Claim Processing Result Codes

The following is a list of claim processing result codes from the division's Medical Data 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/Withdrawal 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 Code.

APPENDIX I

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 System:

<u>CODE</u>	<u>MEANING</u>
ALRDYACCP	The claim is being submitted as a Correction claim (02), but the claim was found to currently be accepted in the division's database.
NOTFOUND	The claim is being submitted as a Correction (02), Replacement (03), or Cancel/Withdrawal (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/Withdrawal (01), but the claim is already coded as Cancelled/Withdrawn in the division's database.

APPENDIX J

Validation Error Codes

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

<u>CODE</u>	<u>MEANING</u>
028	Must be numeric
029	Must be a valid date (CCYYMMDD)
033	Must be less than or equal to the Date of Accident
034	Must be greater than or equal to the Date of Accident
039	No matching code value found in database
041	Can not be a future date
057	Duplicate claim submission
058	Invalid Code, ID, or Value specified
060	Date Comparison Validation Failure
062	Claim Detail Record(s) missing
066	Carrier/TPA not authorized for Trading Partner
069	Payment Comparison Validation Failure
070	Can not be blank or zero filled
071	FEIN does not match division records
072	Entity indicated has an invalid status in our database

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DOCUMENTS

MEDICAL Trading Partner Specifications

Trading Partner Name: _____

The insurer or claims handling entity 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 trading partner is an insurer or claims handling entity that is using Electronic Data Interchange (EDI) to exchange workers' compensation medical data with the Florida Division of Workers' Compensation (DWC). The trading partner shall refer to the Medical EDI Implementation Guide (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 trading partner 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 trading partner.

4. **Filing Volume and Frequency.**

Estimated volume of EDI DWC-9 filings: _____ per Week/Month (circle one)
 Estimated volume of EDI DWC-10 filings: _____ per Week/Month (circle one)
 Estimated volume of EDI DWC-11 filings: _____ per Week/Month (circle one)
 Estimated volume of EDI 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 Claim Processing Reports).

Contact: _____
Phone: _____
Email: _____

Contact: _____
Phone: _____
Email: _____

Contact: _____
Phone: _____
Email: _____

Contact: _____
Phone: _____
Email: _____

Mailing Address: _____

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

