Electronic Medical Billing
Oregon Administrative Rules
Chapter 436, Division 008

Effective Jan. 1, 2015

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Note: OAR chapter 436, division 008, is an all-new division.

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OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 008

436-008-0001 Authority, Applicability, Purpose, and Administration of these Rules

(1) These rules are promulgated under the director's authority contained in ORS 656.726(4) and specific authority under ORS 656.252.

(2) These rules apply to all electronic medical billing transactions generated on or after the effective date of these rules.

(3) The purpose of these rules is to establish uniform guidelines for the exchange of electronic medical billing transactions within the workers' compensation system.

(4) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(5) Orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 are considered orders of the director.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254, 656.726(4)
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0004 Adoption of Standards

(1) The director adopts, by reference, the following electronic medical bill processing standards:

(a) Professional Billing:

(A) The Accredited Standards Committee X12 (ASC X12) Standards for Electronic Data Interchange (EDI) Type 3 Technical Reports (TR3);

(B) Health Care Claim: Professional (837), May 2006, ASC X12, 005010X222; and

(C) Type 3 Errata to Health Care Claim: Professional (837), June 2010, ASC X12, 005010X222A1.

(b) Institutional/Hospital Billing:

(A) The ASC X12 Standards for EDI TR3;

(B) Health Care Claim: Institutional (837), May 2006, ASC X12, 005010X223;

(C) Type 1 Errata to Health Care Claim: Institutional (837);

(D) ASC X12 Standards for EDI TR3, October 2007, ASC X12, 005010X223A1; and

(E) Type 3 Errata to Health Care Claim: Institutional (837), June 2010, ASC X12, 005010X223A2.

(c) Dental Billing:

(A) The ASC X12 Standards for EDI TR3;

(B) Health Care Claim: Dental (837), May 2006, ASC X12, 005010X224;

(C) Type 1 Errata to Health Care Claim: Dental (837);

(D) ASC X12 Standards for EDI Technical Report Type 3, October 2007, ASC X12, 005010X224A1; and

(E) Type 3 Errata to Health Care Claim: Dental (837), June 2010, ASC X12, 005010X224A2.

(d) Retail Pharmacy Billing:

(A) The Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, National Council for Prescription Drug Programs (NCPDP); and

(B) The Batch Standard Batch Implementation Guide, Version 1, Release 2 (Version 1.2), January 2006, NCPDP.

(e) Remittance:

(A) The ASC X12 Standards for EDI TR3, Health Care Claim Payment/Advice (835), April 2006, ASC X12, 005010X221; and

(B) Type 3 Errata to Health Care Claim Payment/Advice (835), June 2010, ASC X12, 005010X221A1.

(2) The director adopts, by reference, the following electronic standards for medical bill acknowledgments:

(a) The ASC X12 Standards for EDI TA1 Interchange Acknowledgment contained in the standards adopted under section (1) of this rule;

(b) The ASC X12 Standards for EDI TR3, Implementation Acknowledgment for Health Care Insurance (999), June 2010, ASC X12, 005010X231A1;

(c) The ASC X12 Standards for EDI TR3, Health Care Claim Acknowledgment (277CA), January 2007, ASC X12, 005010X214; and

(d) Electronic responses to NCPDP transactions, and the response contained in the standards adopted under subsection (1)(d).

(3) The director adopts, by reference, the ASC X12N 275 - Additional Information to Support a Health Claim or Encounter, Version 005010, February 2008, 005010X210, for attachments to medical bills.

(4) The director adopts, by reference, the ASC X12N/2013-57, effective Dec. 2013, Code Value Usage in Health Care Claim Payments and Subsequent Claims Technical Report Type 2.

(5) ASC X12N and the ASC X12 standards for EDI may be purchased from the ASC X12, 7600 Leesburg Pike, Suite 430, Falls Church, VA 22043; telephone 703-970-4480; and fax 703-970-4488. They are also available for purchase through the internet at http://www.X12.org.

(6) Retail pharmacy standards may be purchased from the NCPDP, 9240 East Raintree Drive, Scottsdale, AZ 85260, telephone 480-477-1000; fax 480- 767-1042. They are also available, for purchase, through the Internet at http://www.ncpdp.org.

(7) The director adopts the Oregon Workers' Compensation Division Electronic Billing and Payment Companion Guide Release 1.0, Jan. 1, 2015. A copy of the guide is available at the following website: http://wcd.oregon.gov/insurer/edi/Pages/ebilling.aspx.

(8) Copies of the standards referenced in this rule are available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301, 503-947-7717.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0005 Definitions

For the purpose of these rules and the Oregon Electronic Billing and Payment Companion Guide:

(1) "Clearinghouse" means an entity that is an authorized agent of the insurer or health care provider, including billing services, re-pricing companies, community health management information systems or community health information systems, and "value-added" networks and switches that does either of the following functions:

(a) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(b) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

(2) "Companion guide" means the Oregon Workers' Compensation Division Electronic Billing and Payment Companion Guide adopted by the division in these rules that provides standards for workers' compensation electronic billing transactions.

(3) "Complete electronic bill submission" means an electronic medical billing transaction that is populated with current and valid values defined in the applicable standard set forth in OAR 436-008-0004 that:

(a) Includes the correct billing format, with the correct billing code sets;

(b) Is transmitted in compliance with all necessary format requirements; and

(c) Contains, in legible text, all supporting documentation that is expressly required by law or can reasonably be expected by the payer or its agent under the jurisdiction's law.

(4) "Days" means calendar days. For calendar days, the first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

(5) "Director" means the director of the Department of Consumer and Business Services.

(6) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(7) "Electronic" refers to a communication between computerized data exchange systems that complies with the standards set forth in these rules.

(8) "Explanation of benefits (EOB)" means an electronic remittance advice (ERA) or notification, sent or made available electronically by the insurer or an authorized agent of the insurer, to the health care provider, health care facility, or third-party biller or assignee regarding payment or denial of a bill, reduction of a bill, or refund.

(9) "Insurer" means:

(a) The State Accident Insurance Fund Corporation;

(b) An insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon;

(c) An insurer-authorized agent or payer;

(d) An assigned claims agent selected by the director under ORS 656.054; or

(e) An employer or employer group that has been certified under ORS 656.430 meeting the qualifications of a self-insured employer under ORS 656.407.

(10) "Medical Bill" means a statement of charges for medical services.

(11) "Payer" means the insurer or an entity authorized to make payments on behalf of the insurer.

(12) "Supporting documentation" means those documents necessary for the insurer to process a bill, including but not limited to medical reports and records, evaluation reports, narrative reports, assessment reports, progress report/notes, chart notes, hospital records, and diagnostic test results.

(13) "Trading partner" means any entity that exchanges information electronically with another entity.

Stat. Auth.: ORS 656 252, 656.726(4)
Stats. Implemented: ORS 656.726(4)
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0010 Electronic Medical Bills

(1) Beginning Jan. 1, 2015, insurers must accept and process all electronically transmitted medical bills in accordance with these rules, the standards adopted under OAR 436-008-0004, and the companion guide.

(2) An insurer is exempt from the requirement to accept medical bills electronically from health care providers on or after Jan. 1, 2015, if a written notice is sent to the division, and approved by the director, on or before close of business on Dec. 31, 2014. The notice must explain in detail that the cost of electronic medical bill implementation will create an unreasonable financial hardship.

(3) Health care providers that elect to submit electronic medical bills to insurers must do so in accordance with these rules, the standards adopted under OAR 436-008-0004, and companion guide.

(4) All electronic medical billing transactions must be populated with current and valid values defined in the applicable standard set forth in OAR 436-008-0004.

(5) The health care provider, health care facility, third-party biller or assignee and the insurer may mutually agree to use nonstandard formats, but those formats must include all data elements required under the applicable standard, as set forth in OAR 436-008-0004.

(6) Health care providers and insurers may contract with other entities for electronic medical bill processing.

(7) Insurers and health care providers are responsible for the acts or omissions of their agents executed in the performance of electronic medical billing services.

(8) The data elements transmitted as part of a Trading Partner Agreement must at a minimum contain all the same required data elements found within the ASC X12 Type 3 Technical Reports and the jurisdiction-specific companion guide.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0015 Electronic Medical Bill Attachments or Documentation

(1) A unique attachment indicator number must be assigned to all documentation. The attachment indicator number populated on the document must include the report type code, the report transmission code, the attachment control qualifier, and the attachment control number.

(2) Documentation in support of electronic medical bills may be submitted by fax, secure email, regular mail, electronic transmission using the prescribed format, or by a mutually agreed upon format.

(3) Documentation in support of electronic medical bills must be submitted within five days of submission of the bill and include the following elements:

(a) Patient name (ill or injured worker);

(b) Date of birth (if available);

(c) Employer name;

(d) Insurer name;

(e) Date of service;

(f) Claim number (if no claim number then use "UNKNOWN"); and

(g) Unique attachment indicator number.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0020 Electronic Medical Bill Acknowledgements

(1) If the electronic submission does not conform to the standards adopted under OAR 436-008-0004(1), then the insurer must send an acknowledgment adopted under OAR 436-008-0004(2)(a) or OAR 436-008-0004(2)(b) to the health care provider. This acknowledgement must be sent within one day of receipt of the electronic bill unless the electronic submission lacks sufficient identifiers to create an acknowledgment.

(2) If the electronic submission does conform to a standard adopted under OAR 436-008-0004(1), then the insurer must send an acknowledgment adopted under OAR 436-008-0004(2)(c) to the health care provider within two days.

(3) Any acknowledgment of a medical bill, as provided in (1) or (2) of this rule is not an admission of liability by the insurer.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0025 Electronic Medical Bill Payments

(1) Insurers that accept and process a complete electronic bill for services, under OAR 436-008-0010(1) (a) or (b), must pay for treatment related to the injury or disease, provided or authorized by the treating health care provider, on accepted claims within 14 days of any action causing the service to be payable, or within 45 days of receipt of the electronic bill, whichever is later.

(2) If an insurer requires additional information before a payment decision can be made, a request for this information must be made to the medical provider within 20 days of receipt of the bill.

(3) The insurer must provide an explanation (EOB) of services being paid or denied.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0030 Electronic Remittance Advice; Explanation of Benefits

(1) An electronic remittance advice (ERA) or notification is an explanation of benefits (EOB) that the insurer submits electronically regarding payment or denial of a bill, reduction of a bill, or refund. An insurer must submit an EOB no later than five days after generating a payment.

(2) The EOB must include:

(a) The amount of payment for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

(b) The specific reason for non-payment, reduced payment, or discounted payment for each service billed; and

(c) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a health care provider's payment question within 48 hours, excluding weekends and legal holidays.

(3) The insurer must make available, to health care providers, the applicable information specified under OAR 436-009-0030(3)(c)(A) through (F), including:

"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the director of the Department of Consumer and Business Services. Your request for review must be made within 90 calendar days of the send/receive date of this explanation. To request a review, provide information that shows what you believe is incorrect about the payment, and send this information and required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, P.O. Box 14480, Salem, OR 97309-0405. You may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this information for your records."

(4) Any information required under sections (1) through (3) of this rule that cannot be submitted on the electronic EOB must be made available on the insurer's website or by any other means reasonably convenient for the EOB recipient.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0040 Assessment of Civil Penalties

Under ORS 656.745, the director may assess a civil penalty against an insurer that fails to comply with ORS chapter 656, the director's rules, or orders of the director.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.254, 656.745
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

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Oregon Workers' Compensation Division

Electronic Billing and Payment

Companion Guide

Release 1.0
January 1, 2015

Purpose of the Electronic Billing and Remittance Advice Guide

This guide has been created for use in conjunction with the Accredited Standards Committee X12 (ASC X12) Type 3 Technical Reports and the National Council for Prescription Drug Programs (NCPDP) national standard implementation guides adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These national standard implementation guides are incorporated by reference. The Oregon Workers' Compensation Division (WCD) Companion Guide is not a replacement for those national standard implementation guides, but should be used as an additional source of information. This companion guide contains data clarifications that apply to processing bills and remittance advice within Oregon's workers' compensation system**.**

Documentation Change Control

The companion guide content is subject to change. Changes will only be made in conjunction with the Oregon administrative rule revision process.

Documentation change control is listed in the Change Control Table shown below. Each change made to this companion guide after the creation date is noted along with the date and reason for the change.

Change Control Table			
Date	**Page(s)**	**Change**	**Reason**

Oregon WCD Companion Guide Contact Information

Address: 350 Winter Street NE, Salem OR 97301-3878

Attn: Electronic Billing

Telephone Number: 503-947-7742

FAX Number: 503-947-7514

Email Address: dcbs.edimedical@state.or.us

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Chapter 1 Introduction and Overview

1.1 HIPAA

The Administrative Simplification Act provisions of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) establishes national standards for electronic health care transactions and national identifiers for health care providers (provider), health plans, and employers. Although workers' compensation is exempt, these standards were adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. Information regarding the formats adopted under HIPAA is included in Chapter 2.

1.2 Electronic Medical Billing Oregon Administrative Rule (OAR) 436-008

Insurers must accept electronic bills from health care providers and must process bills in accordance with these rules, the standards adopted under OAR 436-008-0004, and this guide, on or after Jan.1, 2015.

Insurers that accept electronic billing from health care providers before Jan. 1, 2015, may process bills in accordance with these rules, the standards adopted under OAR 436-008-0004, and this companion guide.

An insurer is exempt from the requirement to accept electronic bills from health care providers if the insurer sends written notice to the director that the cost of electronic billing implementation will create an undue financial hardship.

The insurer must validate the Electronic Data Interchange (EDI) file according to the guidelines provided in the national standard format implementation guides, this guide, and Oregon Administrative Rules OAR 436-008. Problems associated with the processing of the ASC X12 Health Care Claim (837) EDI file must be reported using transmission responses described in this guide. Problems associated with the processing of the NCPDP Telecommunications D.0 bills must use the reject response transactions described in this guide. The insurer must use the HIPAA-adopted electronic transaction formats to report explanations of payments, reductions, and denials to the health care provider, health care facility, third-party biller or assignee. These electronic transaction formats include the ASC X12N/005010X221A1, Health Care Claim Remittance Advice (835), and the NCPDP Telecommunication D.0 Paid response transaction.

Health care providers, health care facilities, third-party billers or assignees, clearinghouses, or other electronic data submission entities, submitting medical bills electronically, must use this guide in conjunction with the HIPAA-adopted ASC X12 Technical Reports Type 3 (implementation guides) and the NCPDP Telecommunication Standard Implementation Guide Version D.0. The ASC X12 Technical Reports Type 3 (implementation guides) can be accessed by contacting the Accredited Standards Committee (ASC) X12, at http://store.x12.org. The NCPDP Telecommunication Standard Implementation Guide Version D.O implementation guides are available from NCPDP at http://www.ncpdp.org.

This guide outlines Oregon-specific procedures necessary for engaging in electronic billing and specifies clarifications where applicable. When coordination of a solution is required, Oregon WCD will work with the IAIABC EDI Medical Committee and Provider to Payer Subcommittee to address Oregon's workers' compensation needs.

Chapter 2
Oregon Workers' Compensation Division Requirements

2.1 Compliance

Health care providers who submit medical bills electronically must be able to receive electronic responses from the insurer. The electronic responses include electronic acknowledgments and electronic remittance advice, referred to as an Explanation of Benefits. (**See Flowchart Appendix C**)

OAR 436-008 allows health care providers and insurers to use agents to meet the requirements of electronic billing. These rules do not mandate the method of connectivity, or the use of, or connectivity to, clearinghouses or similar types of vendors.

Nothing in this guide prevents the parties from using Electronic Funds Transfer (EFT) to pay submitted bills. Use of EFT is optional, and is not a prerequisite for electronic billing.

Health care providers, health care facilities, third-party billers or assignees, and insurers must be able to exchange electronic medical bills in either the prescribed standard formats, or may exchange electronic medical bill data in non-prescribed formats by mutual agreement. However, all required data elements, set forth in OAR 436-008, must be present in the mutually agreed upon format.

2.1.2 Agents

OAR 436-008 allows the use of agents to accomplish electronic billing requirements.

Health care providers and insurers are responsible for the acts or omissions of their agents executed in the performance of electronic billing and payment transactions.

2.1.3 Privacy, Confidentiality, and Security

Health care providers, health care facilities, third-party billers or assignees, insurers, and their agents must comply with all applicable Federal and Oregon statutes and rules related to privacy, confidentiality, security, or similar issues.

2.2 National Standard Formats

The national standard formats for billing and remittance advice are those adopted by the US Department of Health and Human Services rules (45 CFR Parts 160 and 162). The formats adopted under OAR 436-008-0004 that are aligned with the current Federal HIPAA implementation include:

- ASC X12N/005010X222A1 Health Care Claim – Professional (837);
- ASC X12N/005010X223A2 Health Care Claim – Institutional (837);
- ASC X12N/005010X224A2 Health Care Claim – Dental (837);

- ASC X12N/005010X221A1 Health Care Claim – Remittance Advice (835)
- ASC X12N/005010X212 Health Care Claim – Status Request and Response (276/277);
- ASCX12N005010TA1 Interchange Acknowledgement;
- ASCX12N005010X231 Implementation Acknowledgement for Healthcare Insurance (999);
- ASCX12N005010X214 Health Care Claim Acknowledgement (277);
- NCPDP Telecommunication Standard Implementation Guide D.0; and
- NCPDP Batch Standard Implementation Guide 1.2.

The following acknowledgment formats and the attachment format have not been adopted in the current HIPAA rules but are based on ASC X12 standards.

- The ASC X12N/005010X213 Request for Additional Information (277) is used to request additional attachments that were not originally submitted with the electronic bill.
- The ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) is used to transmit electronic documentation associated with an electronic bill. The 005010X210 can accompany the original electronic bill, or may be sent in response to a 005010X213 Request for Additional Information.

The NCPDP Telecommunication Standard D.0 contains the corresponding request and response messages to be used for pharmacy transactions.

2.2.1 Oregon Prescribed Formats

Format	**Corresponding Paper Form**	**Function**
005010X222A1	CMS-1500	Professional Billing
005010X223A2	UB-04	Institutional/Hospital Billing
005010X224A2	ADA-2006	Dental Billing
NCPDP D.0 and Batch 1.2	NCPDP WC/PC UCF	Pharmacy Billing
005010X221A1	None	Explanation of Benefits (EOB)
TA1 005010	None	Interchange Acknowledgment
005010X231	None	Transmission Level Acknowledgment
005010X214	None	Bill Acknowledgment

2.2.2 ASC X12 Ancillary Formats – Voluntary, not Adopted by Oregon

Other formats not adopted by Oregon, are used in ancillary processes related to electronic billing. The use of these formats is voluntary, and this companion guide is presented as a tool to facilitate their use in workers' compensation.

Format	Corresponding Process	Function
005010X210	Documentation/Attachments	Documentation/Attachments
005010X213	Request for Additional Information	Request for Medical Documentation
005010X212	Health Claim Status Request and Response	Medical Bill Status Request and Response

2.3 Oregon WCD Electronic Billing and Payment Companion Guide Usage

Oregon WCD's companion guide implementation of the national standard formats aligns with HIPAA usage and requirements in most circumstances. This guide is intended to convey information that is within the framework of the ASC X12 Technical Reports Type 3 (Implementation Guides) and NCPDP Telecommunication Standard Version D.0 Implementation Guide adopted for use. This guide is not intended to convey information that exceeds the requirements or usages of data expressed in those guides. This guide provides additional instruction on situations that are different in Oregon workers' compensation.

When a workers' compensation application situation needs additional clarification or a specific code value is expected, the guide includes this information in a table format. Shaded rows represent "segments" in the ASC X12 Technical Reports Type 3 (Implementation Guides). Non-shaded rows represent "data elements" in the ASC X12 Technical Reports Type 3 (Implementation Guides). For example:

Loop	Segment or Element	Value	Description	Oregon WCD Instructions
2000B	**SBR**		**Subscriber Information**	In workers' compensation, the Subscriber is the Employer.
	SBR04		**Group or Plan Name**	Required when the Employer Department Name/Division is applicable and is different than the Employer reported in Loop 2010BA NM103.
	SBR09	WC	**Claim Filing Indicator Code**	Value must be 'WC' to indicate workers' compensation bill.

Detailed information explaining the various components of the use of loops, segments, data elements, and conditions can be found in the appropriate ASC X12 Technical Reports Type 3 (Implementation Guides).

The ASC X12 Technical Reports Type 3 (Implementation Guides) include elements that do not relate directly to workers' compensation, for example, coordination of benefits. If necessary, the identification of these loops, segments, and data elements can be described in the trading partner agreements to help ensure efficient processing of standard transaction sets.

2.4 Description of ASC X12 Transaction Identification Numbers

The ASC X12 Transaction Identification Number requirements are defined in the appropriate ASC X12 Technical Reports Type 3 (Implementation Guides), available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

2.4.1. Sender/Receiver Trading Partner Identification

Most workers' compensation systems throughout the United States use the Federal Employer Identification Number (FEIN) to identify trading partners. However, other mutually agreed upon identifiers may be used. Trading partners must exchange appropriate and necessary identifiers to be reported based on the applicable transaction format requirements.

2.4.2 Insurer Identification

In Oregon, an insurer is identified through the use of the FEIN or other mutually agreed upon identifier. This information is available through direct contact with the insurer. The insurer identification information is populated in Loop 2010BB for 005010X222A1, 005010X223A2, and 005010X224A2 transactions.

Health care providers will need to obtain insurer identification information from their trading partner agent (e.g., clearinghouses, practice management system, billing agent, or other third party vendor) if they are not directly connecting to the insurer.

2.4.3 Health Care Provider Identification

Health care provider identification numbers are addressed extensively in the ASC X12 Technical Reports Type 3 (Implementation Guides). However, in the national transaction sets, most health care providers are identified by the National Provider Identification (NPI) number, and secondary identification numbers are generally not transmitted.

2.4.4 Ill or Injured Worker

The worker is identified by name, date of birth, date of injury, and workers' compensation claim number.

The worker's identification number is submitted using the Property and Casualty Patient Identifier REF segment in Loop 2010CA.

2.4.5 Claim Identification

The workers' compensation claim number, assigned by the insurer, is the claim identification number. This claim identification number is reported in the REF segment of Loop 2010CA, Property and Casualty Claim Number.

The ASC X12N Technical Report Type 3 (Implementation Guides) instructions for the Property and Casualty Claim Number REF segments require the health care provider, health care facility, third-party biller or assignee to submit the claim identification number in the 005010X222A1, 005010X223A2 and 005010X224A2 transactions. When the claim number is not assigned by the insurer, the bill submitter must use the value of "UNKNOWN."

2.4.6 Bill Identification

The ASC X12N Technical Report Type 3 (Implementation Guides) refers to a bill as a "claim" for electronic billing transactions. This guide refers to these transactions as "bills" because in workers' compensation, "claim" refers to the full case for a worker.

The health care provider, health care facility, third-party biller or assignee, assigns a unique identification number to the electronic bill transaction. For 005010X222A1, 005010X223A2, and 005010X224A2 transactions, the bill transaction identification number is populated in Loop 2300 Claim Information CLM Health Claim Segment CLM01 Claim (Bill) Submitter's Identifier data element. This standard HIPAA implementation allows for a patient account number but strongly recommends that submitters use a completely unique number for this data element on each individual bill.

2.4.7 Document/Attachment Identification

The 005010X210 is the standard electronic format for submitting electronic documentation and is addressed in a later chapter of this guide.

Documentation to support electronic bills may be submitted by facsimile (fax), electronic mail (e-mail), regular mail, electronic transmission using the prescribed format, or by a mutually agreed upon format. Documentation related to an electronic bill must be submitted within five business days of submission of the electronic bill and include the following elements:

- Patient name (ill or injured worker)
- Date of birth (if available)
- Employer name
- Insurer name
- Date of service
- Claim number (if no claim number, use "UNKNOWN")
- Unique attachment indicator number

The PWK Segment and the associated documentation identify the type of documentation through the use of ASC X12 standard Report Type Codes. The PWK Segment and the associated documentation also identify the method of submission of the documentation through the use of ASC X12 Report Transmission Codes.

A unique Attachment Indicator Number must be assigned to all documentation. The Attachment Indicator Number populated on the document must include the Report Type Code, the Report Transmission Code, the Attachment Control Qualifier (AC) and the Attachment Control Number. For example, operative note (report type code OB) sent by fax (FX) is identified as OBFXAC12345. The combination of these data elements will allow the insurer to appropriately match the incoming attachment to the electronic medical bill.

In situations when the documentation represents a Jurisdictional Report, the provider should use code value 'OZ' (Support Data for Claim) as the Report Type Code in PWK01 and enter the Jurisdictional Report Type Code (e.g. J1=Doctor First Report) in front of the Attachment Control Number. Example: OZFXACJ199923 in PWK06.

Please refer to Appendix B for a list of Jurisdictional Report Type Codes and associated Oregon WCD report type code descriptions.

2.5 Validation Edits (Functional or Structural Validation)

This guide, when used in conjunction with the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide Release 2.0, provides validation edits that Oregon WCD applies to transactions reported by the insurer.

The insurer must apply validation edits to electronic billing transactions. The insurer must tailor these edits to ensure accurate payment processing, as opposed to jurisdictional data reporting requirements. It is not appropriate to apply the data reporting edits without researching or investigating their potential impact on processing complete claims.

There are various sources for validation edits that apply to electronic bills submitted by health care providers. Sources for validation edits include:

- ASC X12N Technical Reports Type 3 (Implementation Guides) requirements
- The IAIABC Medical Bill/Payment Records Implementation Guide
- The Oregon WCD EDI Medical Bill Reporting Guide, which provides detailed information on functional or structural validation edits
- Oregon required edits are found in the Oregon Electronic Data Interchange Medical Bill Data rules, OAR 436-160.

The insurer must use the 005010X214 transaction, referred to in this guide as an acknowledgment, to communicate transaction (individual bill) rejections for ASC X12-based electronic bills. Error rejection codes are used to indicate the reason for the transaction rejection.

2.6 Description of Formatting Requirements

The ASC X12 formatting requirements are defined in the ASC X12 Technical Reports Type 3 (Implementation Guides), Appendices B.1, available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

The NCPDP Telecommunication D.0 formatting requirements are defined in the NCPDP Telecommunication Standard Implementation Guide Version D.0, available at http://www.ncpdp.org.

2.6.1 ASC X12 Hierarchical Structure

For information on the ASC X12 Hierarchical Structure, refer to Section 2.3.2.1 HL Segment of the ASC X12 Technical Reports Type 3 (Implementation Guides), available through the Accredited Standards Committee (ASC) X12, http://www.ncpdp.org.

2.7 Description of ASC X12Transmission/Transaction Dates

The ASC X12 required Transmission/Transaction Dates are defined in the ASC X12 Technical Reports Type 3 (Implementation Guides) available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

2.7.1 Date Sent/Invoice Date

With manual paper billing, the paper bill includes a date the bill was generated, to verify timely filing. In Oregon, the "transaction set creation date" is the invoice-date for electronic billing, and is reflected in the BHT04 data element. The date in the BHT04 must be the actual date the electronic billing transaction was created.

2.7.2 Received Dates

Complete Electronic Bill Received Date

For electronic bill processing purposes, the date received is the date the complete bill and related documentation are under the ownership and control of the insurer or its agent. This date is used to track the timely processing of electronic bills, electronic reconsideration or appeal transactions, acknowledgement transactions, and payments.

Electronic Transaction Received Date

For electronic transaction tracking, the date received is the date the insurer or its agent receives the transaction. This date is used to track the timeliness of an acknowledgment transaction and delivery of additional documentation needed to compose a complete electronic medical bill.

Note: The date included in the electronic transaction or outer envelope (e.g., Interchange Control Header ISA segment Interchange Date, Business Application Creation Date) is not considered the received date.

2.7.3 Paid Date

When the 005010X221A1 transaction set is used to electronically provide the remittance advice, the paid date is the date contained in BPR 16, "Check Issue or EFT Effective Date," in the financial information segment.

2.8 Description of Code Sets

Code sets used in electronic billing, and other ancillary processes are prescribed by the applicable ASC X12 Technical Reports Type 3 (Implementation Guides), NCPDP Implementation Guide, Oregon Administrative Rules (OAR 436-008), and guide. The code sets are maintained by multiple standard setting organizations.

Participants are required to use current valid codes based on requirements contained in the applicable implementation guide. The validity of the various codes may be based on the date of service (e.g., procedure and diagnosis codes) or the date of the electronic transaction (e.g., claim adjustment reason codes).

2.9 Participants

In general, entities described in the HIPAA implementation guides are similar to those in workers' compensation. However, terms such as employer, insured, ill or injured employee, and patient may have different meanings in workers' compensation and are addressed later in this section.

2.9.1 Trading Partner

Trading partners are entities that have established EDI relationships and that exchange information electronically in standard or mutually agreed-upon formats. Trading partners are both senders and receivers, depending on the electronic process (i.e., billing or acknowledgment).

2.9.2 Sender

A sender is the entity submitting a transmission to the receiver, or the trading partner. The health care provider, health care facility, third-party biller or assignee, is the sender in the 005010X222A1, 005010X223A2, and 005010X224A2 electronic billing transactions. The insurer is the sender in the 005010X214, 005010X231, or 005010X221A1 electronic acknowledgment or remittance advice.

2.9.3 Receiver

A receiver is the entity that accepts a transmission submitted by a sender. The health care provider, health care facility, third-party biller or assignee, is the receiver in the 005010X214, 005010X231, or 005010X221A1electronic acknowledgment or remittance advice. The insurer is the receiver in the 005010X222A1, 005010X223A2, and 005010X224A2 electronic billing transactions.

2.9.4 Employer/Subscriber/Insured

In group health, the insured or subscriber can be the patient, or the spouse or parent of the patient. In workers' compensation the employer, subscriber, or insured is always the policyholder or the insured entity.

2.9.5 Ill or Injured Worker/ Patient

In group health, there can be many relationships a patient may have to the insured. For example, the patient may be the insured or may be the child or spouse of the insured. In workers' compensation the injured or ill worker is the person who has been injured on the job or who has a work-related illness and is always considered to be the patient.

2.10 Health Care Provider Agent/Insurer Agent Roles

OAR 436-008 includes provisions that allow health care providers, facilities, and insurers to use agents to comply with the electronic billing requirements. Agents can be any of the following: billing companies, third party administrators, bill review companies, software vendors, data collection companies, or clearinghouses. Entities using agents are responsible for the acts or omissions of their agents executed in the performance of services for the entity.

Oregon's rules do not mandate the use of, or regulate the costs of, agents performing electronic billing functions. Health care providers and insurers are not required to establish connectivity with a clearinghouse or to use a specific media/method of connectivity (e.g., Secured File Transfer Protocol [SFTP]).

The health care provider, health care facility, third-party biller or assignee and the insurer may mutually agree to use non-standard formats, but those formats must include all data elements required in the format prescribed in OAR 436-008-0004(1).

2.11 Duplicate, Appeal/Reconsideration, and Corrected Bill Resubmissions

2.11.1 Claim Resubmission Code - 837 Billing Formats

Health care providers must use the Claim Frequency Type Code of 7 (Resubmission/Replacement) to identify resubmissions of prior medical bills (not including duplicate original submissions). The value is populated in Loop 2300 Claim Information CLM Health Claim Segment CLM05-3 Claim Frequency Type Code of the 005010X222A1, 005010X223A2, and 005010X224A2 electronic billing transactions. The health care provider must also populate the Payer Claim Control Number assigned to the bill by the insurer for the bill being replaced, when the payer has provided this number in response to the previous bill submission. This information is populated in Loop 2300 Claim Information REF Payer Claim Control Number of the 005010X222A1, 005010X223A2, and 005010X224A2 electronic billing transactions.

For electronically submitted bills, health care providers must also populate the appropriate National Uniform Billing Committee (NUBC) Condition Code to identify the type of resubmission. The Condition Code is submitted, based on the instructions for each bill type, in the HI Segment for 005010X222A1 and 005010X223A2 transactions and in the NTE Segment for the 005010X224A2 transaction. (The use of the NTE segment is at the discretion of the sender.) Condition codes provide additional information to the insurer when the resubmitted bill is a request for reconsideration or a new submission after receipt of a decision from the Oregon Workers' Compensation Board or other compensability decision.

The NUBC Instruction for the use of Claim Frequency Type Codes can be referenced on the NUBC website at http://www.nubc.org/FL4forWeb2_RO.pdf.

2.11.2 Duplicate Bill Transaction Prior To Payment

A Condition Code 'W2' (duplicate of the original bill) is required when submitting a bill that is a duplicate. The condition code is submitted based on the instructions for each bill type. It is submitted in the HI segment for professional and institutional transactions and in the NTE segment for dental transactions. (The use of the NTE segment is at the discretion of the sender.) The duplicate bill must be identical to the original bill, with the exception of the added condition code. No new dates of service or itemized services may be included on the duplicate bill.

Duplicate Bill Transaction
• CLM05-3 = Identical value as original. Cannot be '7'. • Condition codes in HI/NTE are populated with a condition code qualifier 'BG' and code value: 'W2' = Duplicate • NTE Example: NTE*ADD*BGW2 • Payer Claim Control Number does not apply • The resubmitted bill must be identical to the original bill, except for the 'W2' condition code. No new dates of service or itemized services may be included on the duplicate bill.

Duplicate bill transactions must be submitted prior to receipt of a 005010X221A1 Health Care Claim Remittance Advice (835) transaction no earlier than 30 days after the insurer has acknowledged receipt of a complete electronic bill transaction.

The insurer may reject a bill transaction with a Condition Code W2 indicator if:

1) the duplicate bill is received within 30 days after acknowledgment
2) the bill has been processed and the 005010X221A1 transaction has been generated
3) the insurer does not have a corresponding accepted original transaction with the same bill identification numbers

If the insurer does not reject the duplicate bill transaction within two days, the duplicate bill transaction may be denied for the reasons listed above through the use of the 005010X221A1 transaction.

2.11.3 Corrected Bill Transactions

A replacement bill is sent when a data element on the bill was either not previously sent or needs to be corrected.

When identifying elements change, the correction is accomplished by a void and re-submission process: a bill with CLM05-3 = '8' (Void) must be submitted to cancel the incorrect bill, followed by the submission of a new ***original*** bill with the correct information.

Replacement or void of a prior bill should not be done until the prior submitted bill has reached final adjudication status. Final adjudication can be determined from remittance advice, web application or

when showing a finalized code in a 005010X212 (277) transaction in response to a 005010X212 (276) transaction or non-electronic means.

Corrected Bill Transaction
• CLM05-3 = '7' indicates a replacement bill. • Condition codes of 'W2' to 'W5' in HI/NTE are not used. • REF*F8 includes the Payer Claim Control Number, if assigned by the payer. • A corrected bill shall include the original dates of service and the same itemized services rendered as the original bill. • When identifying elements change, the correction is accomplished by a void and re-submission process. • A bill with CLM05-3 = '8' (Void) must be submitted to cancel the incorrect bill, followed by the submission of a new ***original*** bill with the correct information.

The insurer may reject a revised bill transaction if:

(1) The insurer does not have a corresponding adjudicated bill transaction with the same bill identification number
(2) There is inadequate billing documentation supporting the request for correction.

If the insurer does not reject the revised bill transaction within two days, the revised bill may be denied for the reasons listed above through the use of the 005010X221A1 transaction.

2.11.4 Appeal/Reconsideration Bill Transactions

Electronic submission of Reconsideration Bill Transactions is accomplished in the 005010X222A1, 005010X223A2, and 005010X224A2 electronic billing transactions through the use of Claim Frequency Type Code 7 in Loop 2300 Claim Information CLM Health Claim Segment CLM05-3 Claim Frequency Type Code. The value '7' Replacement of a Prior Claim represents Resubmission Bill Transactions.

The Reconsideration Claim Frequency Type Code '7' is used in conjunction with the Payer Claim Control Number assigned to the bill by the insurer when the insurer has provided this number in response to the previous bill submission. This information is populated in Loop 2300 Claim Information REF Payer Claim Control Number of the 005010X222A1, 005010X223A2, and 005010X224A2 electronic billing transactions.

The health care provider must also populate the appropriate condition code to identify the type of resubmission on electronically submitted bills. The NUBC Condition Codes which apply to reconsiderations and appeals include:

- 'W3' – 1st Level Appeal - Request for reconsideration or appeal with the insurer
- 'W4' – 2nd Level Appeal - Resubmitted after receipt of a decision or order following WCD's administrative review process for disputes over medical fees or services
- 'W5' – 3rd Level Appeal - Resubmitted after receipt of a hearing or other judicial decision and order

These codes are included in the 2300/HI segment on professional and institutional claims, and in the 2300/NTE segment on dental claims. (Note – the use of the NTE segment is at the discretion of the sender.)

Reconsideration bill transactions may only be submitted after receipt of the 005010X221A1 transaction for the corresponding accepted original bill. The same bill identification number must be used on both the original and the reconsideration bill transaction. All elements, fields, and values in the reconsideration bill transaction, except the reconsideration specific qualifiers and Claim Supplemental Information PWK segment, must be the same as on the original bill transaction.

Subsequent reconsideration bill transactions related to the same original bill transaction may be submitted after receipt of the 005010X221A1 transaction that corresponds to the initial reconsideration bill transaction.

The PWK Segment (Claim Supplemental Information) is required to be properly annotated when submitting an attachment related to an appeal or reconsideration.

The ASC X12 Technical Reports Type 3 (Implementation Guides) and the Oregon WCD strongly recommend that the value passed in CLM01 is a unique identification number specific to the bill, i.e., the Provider Unique Bill Identification Number. This method links the original bill transaction to the subsequent bill transaction using the Provider Unique Bill Identification Number (CLM01). The intent is to link an appeal, or multiple appeals, to the original bill transaction.

The ASC X12 Technical Reports Type 3 (Implementation Guides) includes a Reference Identification Number REF segment in Loop 2300 Claim Information that represents the Payer Claim Control Number, which is the unique bill identification number generated by the insurer. This number must be included on resubmitted bills to ensure that the insurer can match the resubmission request with its original processing action.

Appeal/Reconsideration Bill Transaction
• CLM05-3 = ‘7’; • Condition codes in HI/NTE are populated with a condition code qualifier ‘BG’ and one of the following codes values must be present: o ‘W3’ – 1st Level Appeal - Request for reconsideration or appeal with the insurer. o ‘W4’ – 2nd Level Appeal - Resubmitted after receipt of a decision or order from the WCD medical fee dispute resolution process. o ‘W5’ – 3rd Level Appeal - Resubmitted after receipt of a hearing or other judicial decision and order. • REF*F8 includes the Payer Claim Control Number, if assigned by the insurer. • The appeal/reconsideration bill must be identical to the original bill, with the exception of the added Condition Code, Payer Claim Control Number, and the Claim Frequency Type Code. No new dates of service or itemized services may be included. • Supporting documentation is required. • Loop 2300, PWK Segment must be properly annotated.

The insurer may reject an appeal or reconsideration bill transaction using a 005010X214 transaction if:

(1) the bill information does not match the corresponding original bill transaction
(2) the insurer does not have a corresponding accepted original transaction
(3) the original bill transaction has not been completed (no corresponding 005010X221A1 transaction or the remittance advice submission time period in accordance with Oregon's rules has not been exceeded)
(4) the bill is submitted without the PWK annotation

The insurer may deny appeal or reconsideration bill transactions for missing documentation. The insurer may deny the appeal or reconsideration bill transaction through the use of the 005010X221A1 transaction for reasons of missing documentation as well as other data content problems with the 837.

2.12 Oregon WCD Specific Requirements

The requirements in this section identify Oregon WCD specific requirements that apply to more than one electronic format. Requirements that are related to a specific format are identified in the chapter related to that format.

2.12.1 Claim Filing Indicator

The Claim Filing Indicator code for workers' compensation is 'WC' populated in Loop 2000B Subscriber Information, SBR Subscriber Information Segment field SBR09 for the 005010X222A1, 005010X223A2, or 005010X224A2 transactions.

2.12.2 Transaction Set Purpose Code

The Transaction Set Purpose Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction Segment field BHT02 in 005010X222A1, 005010X223A2, or 005010X224A2 transactions is designated as '00' Original. Insurers are required to acknowledge acceptance or rejection of transmissions (files) and transactions (bills). Transmissions that are rejected by the insurer and then corrected by the health care provider are submitted, after correction, as '00' original transmissions.

2.12.3 Transaction Type Code

The Transaction Type Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction Segment field BHT06 in 005010X222A1, 005010X223A2, or 005010X224A2 transactions is designated as 'CH' Chargeable. Health care providers are not required to report electronic billing data to Oregon WCD. Therefore, code 'RP' (Reporting) is not appropriate.

2.12.4 NCPDP Telecommunication Standard D.0 Pharmacy Formats

Issues related to electronic pharmacy billing transactions are addressed in this guide, Chapter 6, Pharmacy.

Chapter 3 ASC X12N/005010X222A1 Health Care Claim: Professional (837)

3.1 Introduction and Overview

The information contained in this guide has been created for use in conjunction with the ASC X12N/005010X222A1 Health Care Claim: Professional (837) Technical Reports Type 3. It should not be considered a replacement for the ASC X12N/005010X222A1 Health Care Claim: Professional (837) Technical Reports Type 3, but rather should be used as an additional source of information.

The ASC X12N/005010X222A1 Health Care Claim: Professional (837) Technical Reports Type 3 is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

3.2 Trading Partner Agreements

The data elements transmitted as part of a trading partner agreement for the purpose of electronic billing must contain all the same required data elements found within the ASC X12 Technical Reports Type 3 and this guide. The trading partner agreement must not change the workers' compensation field value designations defined in this guide.

3.3 Workers' Compensation Health Care Claim: Professional Instructions

The following table identifies the application and instructions for Oregon WCD that need clarification beyond the ASC X12 Type 3 Technical Reports.

ASC X12N/005010X222A1

Loop	Segment	Description	Oregon Guide Comments/Instructions
1000A	PER	SUBMITTER EDI CONTACT INFORMATION	One occurrence of the Communication Number Qualifier must be 'TE' – Telephone Number.
2000B	SBR	SUBSCRIBER INFORMATION	In workers' compensation, the Subscriber is the Employer.
2000B	SBR04	NAME	In workers' compensation, the group name is the employer of the patient or employee.
2000B	SBR09	CLAIM FILING INDICATOR CODE	Value must be 'WC' for workers' compensation.
2010BA		SUBSCRIBER NAME	In workers' compensation, the Subscriber is the Employer.
2010BA	NM102	ENTITY TYPE QUALIFIER	Value must be '2' non-person.
2010BA	NM103	NAME LAST OR ORGANIZATION NAME	Value must be the name of the Employer.
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.

Loop	Segment	Description	Oregon Guide Comments/Instructions
2010CA	REF	PROPERTY AND CASUALTY CLAIM NUMBER	The workers' compensation claim number is required when assigned by the insurer. When the workers' compensation claim number is not assigned or is not available, use "UNKNOWN" as the default value. This is in accordance with ANSI X12 RFI #974 and can be found at http://x12n.org/portal.
2300	CLM11	RELATED CAUSES INFORMATION	One of the occurrences in CLM11 must have a value of 'EM' -- Employment Related.
2300	DTP	DATE -- ACCIDENT	Required when the condition reported is for an occupational accident/injury.
2300	DTP	DATE – DISABILITY DATES	Do not use this segment.
2300	DTP	DATE – PROPERTY AND CASUALTY DATE OF FIRST CONTACT	Do not use this segment.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Required when submitting attachments related to a medical bill.
2300	PWK01	REPORT TYPE CODE	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports, use appropriate 005010 Report Type Code.
2300	PWK06	ATTACHMENT CONTROL NUMBER	When the Report Type Code is 'OZ' and an Oregon report is sent, the first two characters of the attachment control number must be the Jurisdictional Report Type Code. Examples: Standard Report: PWK*OB*BM***AC*DMN0012~ (Operative Note) Jurisdictional Report: PWK*OZ*BM***AC*J1DMN0012~ (Form 827)
2300	K3	FILE INFORMATION	State Jurisdictional Code

Loop	Segment	Description	Oregon Guide Comments/Instructions
2300	K301	FIXED FORMAT INFORMATION	Jurisdiction State Code (State of Compliance Code) Required. Enter the state code qualifier 'LU' followed by the state code. For example - 'LUOR' indicates the medical bill is being submitted under Oregon medical billing requirements.
2300	HI	CONDITION INFORMATION	For workers' compensation purposes, the National Uniform Billing Committee and the National Uniform Claims Committee have approved the following condition codes for resubmissions: • W2 - Duplicate of the original bill • W3 - Level 1 Appeal • W4 - Level 2 Appeal • W5 - Level 3 Appeal Note: Do not use condition codes when submitting revised or corrected bills, (See Section 2.11 in this guide).

Chapter 4
ASC X12N/005010X223A2
Health Care Claim – Institutional (837)

4.1 Introduction and Overview

The information contained in this guide has been created for use in conjunction with the ASC X12N/005010X223A2 Health Care Claim: Institutional (837) Technical Reports Type 3. It should not be considered a replacement for the ASC X12N/005010X223A2 Health Care Claim: Institutional (837) Technical Reports Type 3, but rather should be used as an additional source of information.

The ASC X12N/005010X223A2 Health Care Claim: Institutional (837) Technical Reports Type 3 is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

4.2 Trading Partner Agreements

The data elements transmitted as part of a trading partner agreement for the purpose of electronic billing must contain all the same required data elements found within the ASC X12 Technical Reports Type 3

and this guide. The trading partner agreement must not change the workers' compensation field value designations as defined in this guide.

4.3 Workers' Compensation Health Care Claim – Institutional Instructions

The following table identifies the application and instructions for Oregon WCD that need clarification beyond the ASC X12 Technical Reports Type 3.

ASC X12N/005010X223A2

Loop	Segment	Description	Oregon Guide Comments/Instructions
1000A	PER	SUBMITTER EDI CONTACT INFORMATION	One occurrence of the Communication Number Qualifier must be 'TE' – Telephone Number.
2000B	SBR	SUBSCRIBER INFORMATION	In workers' compensation, the Subscriber is the Employer.
2000B	SBR04	NAME	In workers' compensation, the group name is the employer of the patient or employee.
2000B	SBR09	CLAIM FILING INDICATOR CODE	Value must be 'WC' for workers' compensation.
2010BA		SUBSCRIBER NAME	In workers' compensation, the Subscriber is the Employer.
2010BA	NM102	ENTITY TYPE QUALIFIER	Value must be '2' non-person.
2010BA	NM103	NAME LAST OR ORGANIZATION NAME	Value must be the name of the Employer.
2010BA	N3	SUBSCRIBER ADDRESS	In workers' compensation, the Subscriber Address is the address of the Employer.
2010BA	N4	SUBSCRIBER CITY/STATE/ZIP CODE	In workers' compensation, the Subscriber Address is the address of the Employer. (check specific – city/state/zip)
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.
2010CA	REF	PROPERTY CASUALTY CLAIM NUMBER	The workers' compensation claim number is required when assigned by the insurer. When the workers' compensation claim number is not assigned or is not available, use "UNKNOWN" as the default value. This is in accordance with ANSI X12 RFI #974 and can be found at http://x12n.org/portal.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Required when submitting attachments related to a bill.

Loop	Segment	Description	Oregon Guide Comments/Instructions
2300	PWK01	REPORT TYPE CODE	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports, use appropriate 005010 Report Type Code.
2300	PWK06	ATTACHMENT CONTROL NUMBER	When the Report Type Code is ‘OZ’ and an Oregon report is sent, the first two characters of the attachment control number must be the Jurisdictional Report Type Code. Examples: Standard Report: PWK*OB*BM***AC*DMN0012~ (Operative Note) Jurisdictional Report: PWK*OZ*BM***AC*J1DMN0012~ (Form 827)
2300	K3	FILE INFORMATION	State Jurisdictional Code is expected here.
2300	K301	FIXED FORMAT INFORMATION	Jurisdiction State Code (State of Compliance Code) Required. Enter the state code qualifier ‘LU’ followed by the state code. For example - ‘LUOR’ indicates the medical bill is being submitted under Oregon medical billing requirements.
2300	HI01	OCCURRENCE INFORMATION	At least one Occurrence Code must be entered with value of '04' - Accident/Employment Related or ‘11’ -- illness. The Occurrence Date must be the Date of Occupational Injury or Illness.

Loop	Segment	Description	Oregon Guide Comments/Instructions
2300	HI	CONDITION INFORMATION	For workers' compensation purposes, the National Uniform Billing Committee and the National Uniform Claims Committee have approved the following condition codes for resubmissions: • W2 - Duplicate of the original bill • W3 - Level 1 Appeal • W4 - Level 2 Appeal • W5 - Level 3 Appeal Note: Do not use condition codes when submitting revised or corrected bills.

Chapter 5
ASC X12N/005010X224A2
Health Care Claim – Dental (837)

5.1 Introduction and Overview

The information contained in this guide has been created for use in conjunction with the ASC X12N/05010X224A2 Health Care Claim: Dental (837) Technical Reports Type 3. It should not be considered a replacement for the ASC X12N/05010X224A2 Health Care Claim: Dental (837) Technical Reports Type 3, but rather should be used as an additional source of information.

The ASC X12N/05010X224A2 Health Care Claim: Dental (837) Technical Reports Type 3 is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

5.2 Trading Partner Agreements

The data elements transmitted as part of a trading partner agreement for the purpose of electronic billing must contain all the same required data elements found within the ASC X12 Technical Reports Type 3 and this guide. The trading partner agreement must not change the workers' compensation field value designations as defined in this guide.

5.3 Workers' Compensation Instructions for ASCX12N/005010X224 Health Care Claim: Dental (837)

The following table identifies the application and instructions for Oregon WCD's workers' compensation electronic billing that needs clarification beyond the ASC X12 Technical Reports Type 3.

ASC X12N/005010X224A2

Loop	Segment	Description	Oregon Guide Comments/Instructions
1000A	PER	SUBMITTER EDI CONTACT INFORMATION	One occurrence of the Communication Number Qualifier must be 'TE' – Telephone Number.
2000B	SBR	SUBSCRIBER INFORMATION	In workers' compensation, the Subscriber is the Employer.
2000B	SBR04	NAME	In workers' compensation, the group name is the employer of the patient or employee.
2000B	SBR09	CLAIM FILING INDICATOR CODE	Value must be 'WC' for workers' compensation.
2010BA		SUBSCRIBER NAME	In workers' compensation, the Subscriber is the Employer.
2010BA	NM102	ENTITY TYPE QUALIFIER	Value must be '2' non-person.
2010BA	NM103	NAME LAST OR ORGANIZATION NAME	Value must be the name of the Employer.
2010BA	N3	SUBSCRIBER ADDRESS	In workers' compensation, the Subscriber Address is the address of the Employer.
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.
2010CA	REF	PROPERTY CASUALTY CLAIM NUMBER	The workers' compensation claim number is required when assigned by the insurer. When the workers' compensation claim number is not assigned or is not available, use "UNKNOWN" as the default value. This is in accordance with ANSI X12 RFI #974 and can be found at http://x12n.org/portal.
2300	CLM11	RELATED CAUSES INFORMATION	One of the occurrences in CLM11 must have a value of 'EM' -- Employment Related.
2300	DTP	DATE -- ACCIDENT	Required when the condition reported is for an occupational accident/injury.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Required when submitting attachments related to a medical bill.

Loop	Segment	Description	Oregon Guide Comments/Instructions
2300	PWK01	REPORT TYPE CODE	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports use appropriate 005010 Report Type Code.
2300	PWK06	ATTACHMENT CONTROL NUMBER	When the Report Type Code is 'OZ' and an Oregon report is sent, the first two characters of the attachment control number must be the Jurisdictional Report Type Code. Examples: Standard Report: PWK*OB*BM***AC*DMN0012~ (Operative Note) Jurisdictional Report: PWK*OZ*BM***AC*J1DMN0012~ (Form 827)
2300	K3	FILE INFORMATION	State Jurisdictional Code is expected here.
2300	K301	FIXED FORMAT INFORMATION	Jurisdiction State Code (State of Compliance Code) Required. Enter the state code qualifier 'LU' followed by the state code. For example - 'LUOR' indicates the medical bill is being submitted under Oregon medical billing requirements.

Chapter 6 NCPDP D.0 Pharmacy

6.1 Introduction and Overview

The information contained in this guide has been created for use in conjunction with the NCPDP Telecommunication Standard Implementation Guide Version D.0 for pharmacy claim transactions. It should not be considered a replacement for the NCPDP Telecommunication Standard Implementation Guide Version D.0, but rather should be used as an additional source of information.

Pharmacy transactions are processed both in real-time and in batches. Every transmission request has a transmission response. To address the appropriate process for responding to request transactions and reversal processing, users should use the NCPDP Telecommunication Standard Implementation Guide Version D.0 and Batch Standard Implementation Guide Version 1.2.

The implementation guides for electronic pharmacy claims and responses are available through the National Council for Prescription Drug Programs (NCPDP) at http://www.ncpdp.org.

6.2 Trading Partner Agreements

The data elements transmitted as part of a trading partner agreement for the purpose of electronic billing must contain all the same required data elements found within the NCPDP Implementation Guide and this guide. The workers' compensation field value designations as defined in this guide must remain the same as part of any trading partner agreement.

6.3 Workers' Compensation Health Care Claim – Pharmacy Instructions

The following table identifies the application and instructions for Oregon WCD's workers' compensation electronic billing that needs clarification beyond the NCPDP Implementation Guide.

Pharmacy NCPDP Version D.0

Segment	Field	Description	Oregon Guide Comments/Instructions
INSURANCE	3Ø2-C2	CARDHOLDER ID	If the Cardholder ID is not available or not applicable, the value must be 'NA'.
CLAIM	415-DF	NUMBER OF REFILLS AUTHORIZED	Required. If no refills this value must be '0'.
PRICING	426-DQ	USUAL AND CUSTOMARY CHARGE	This field is optional. In Oregon, this is the provider's usual fee.
PHARMACY PROVIDER	465-EY	PROVIDER ID QUALIFIER	The value must be '05' – NPI Number.
PRESCRIBER	466-EZ	PRESCRIBER ID QUALIFIER	The value must be '01' – NPI Number.
WORKERS' COMPENSATION			The Workers' Compensation Segment is required for workers' compensation claims.
WORKERS' COMPENSATION	435-DZ	CLAIM/ REFERENCE ID	The workers' compensation claim number is required when assigned by the insurer. When the workers' compensation claim number is not assigned or is not available, use "UNKNOWN" as the default value.

Chapter 7
ASC X12N/005010X221A1 Health Care Claim – Remittance Advice (835)

7.1 Introduction and Overview

The information contained in this guide has been created for use in conjunction with the ASC X12N/05010X221 Health Care Claim Remittance Advice (835) Technical Reports Type 3. It should not be considered a replacement for the ASC X12N/05010X221, but rather should be used as an additional source of information.

The ASC X12N/05010X221 Health Care Claim Remittance Advice (835) Technical Reports Type 3 is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

The NCPDP ASC X12N 835 (005010X221) Pharmacy Remittance Advice Template, is available at http://www.ncpdp.org/public_documents.asp

7.2 Trading Partner Agreements

The components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide (such as transmission parameters) remain the same; this companion guide is not intended to replace any of those components.

The data elements transmitted as part of a Trading Partner Agreement must at a minimum contain all the same required data elements found within the ASC X12 Technical Reports Type 3 and this companion guide. The workers' compensation field value designations as defined in this companion guide must remain the same as part of any Trading Partner Agreement.

Trading partner agreements must follow the Code Value Usage in Health Care Claim Payments and Subsequent Claims Technical Report Type 2 (TR2) that specify the specific Group Code. Claim Adjustment Reason Code and Remittance Advice Remark Code combinations that are to be used when providing payment, reduction, or denial information. The TR2 is available at www.wpc-edi.com.

7.3 Claim Adjustment Group Codes

The 005010X221A1 transaction requires the use of Claim Adjustment Group Codes. Valid codes adopted under OAR 436-008 must be used. The Claim Adjustment Group Code represents the general category of payment, reduction, or denial. For example, the Group Code 'CO' (Contractual Obligation) might be used in conjunction with a Claim Adjustment Reason Code for a network contract reduction.

The Claim Adjustment Group Code transmitted in the 005010X221A1 transaction is the same code that is transmitted in the IAIABC 837 Medical State Reporting EDI reporting format. Oregon WCD will accept Claim Adjustment Group Codes that were valid on the date the insurer paid, reduced, or denied a bill.

7.4 Claim Adjustment Reason Codes

The 005010X221A1 transaction requires the use of codes as the electronic means of providing specific payment, reduction, or denial information. As a result, use of the 005010X221A1 transaction replaces all use of proprietary reduction codes, jurisdiction specific claim adjustment reason codes, and free form text used on a paper Explanation of Benefits (EOB) form. Claim Adjustment Reason Codes are available through Washington Publishing Company at http://www.wpc-edi.com/reference/.

The ASC X12 TR2 Health Care Claim Payment/Advice Code Usage Rules (TR2) is the encyclopedia of Group Codes, specific Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) combinations, that payers are to use when providing payment, reduction, or denial information. The TR2 is available at www.wpc-edi.com.

7.5 Remittance Advice Remark Codes

The 005010X221A1 transaction supports the use of Remittance Advice Remark Codes to provide supplemental explanations for a payment, reduction, or denial already described by a Claim Adjustment Reason Code. NCPDP Reject Codes are allowed for NCPDP transactions. Insurers should use the remittance advice remark codes to provide additional information to the health care provider regarding why a bill was adjusted or denied. The 005010X221A1 transaction replaces all use of proprietary reduction codes, jurisdiction specific claim adjustment reason codes, and free form text used on a paper Explanation of Benefits (EOB) forms. Remittance Advice Remark Codes are not associated with a Group or Reason Code in the same manner that a Claim Adjustment Reason Code is associated with a Group Code. Remittance Advice Remark Codes are available through Washington Publishing Company at http://www.wpc-edi.com/reference/.

7.6 Claim Level Oregon WCD's Explanation of Benefit (EOB) Statement ID Qualifier

Oregon WCD requires paper EOBs to include a statement to give health care providers, health care facilities, third-party billers or assignees specific information regarding jurisdiction direction or limitations.

Oregon WCD's required EOB Claim Level statement is reflected as a state jurisdictional postal code in the 005010X221A1 transaction. The jurisdictional postal code is populated in the REF Segment in Loop 2100 'Other Claim Related Identification'. The Reference Identification Qualifier "CE" Class of Contract Code is to be used as the qualifier in REF01 Segment for workers' compensation to indicate the value in REF02.

The Reference Identification value in REF02 is the jurisdictional code for Oregon and equates to Oregon WCD's EOB requirements in OAR 436-008-0030:

> The amount of payment for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;
>
> The specific reason for non-payment, reduced payment, or discounted payment for each service billed;
>
> An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a medical provider's payment question within 48 hours, excluding weekends and legal holidays;
>
> The following notice, web link, and phone number:
>
> "To access information about Oregon's Medical Fee and Payment Rules, visit www.oregonwcdoc.info or call 503-947-7606.";
>
> A notice of right to administrative review as follows: "**If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the director of the Department of Consumer and Business Services. Your request for review must be made within 90 calendar days of receipt date of this explanation. To request review, provide information to indicate what you believe is incorrect about the payment, and send this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this information for your records.**"

7.7 Product/Service ID Qualifier

The Product/Service Identification Number transmitted in the inbound electronic billing format is returned in the 005010X221A1 transaction SVC Service Payment Information Segment with the appropriate qualifier.

7.8 Workers' Compensation Health Care Claim Remittance Advice Instructions

The following table identifies the application and instructions for Oregon WCD's workers' compensation electronic billing that needs clarification beyond the ASC X12 Technical Reports Type 3. In addition to the PER segment in loop 1000A shown in the table below, a second PER segment is highly recommended to be included in loop 1000A. The second PER segment must include the URL for the technical contact.

ASC X12N/005010X221Health Care Claim Remittance Advice (835)

Loop	Segment or Element	Value	Description	Oregon Guide Comments/Instructions
1000 A	**PER**		**Payer Technical Contact Information**	**Required to be sent at least once.**
	PER03	TE	Communication Number Qualifier	Value must be 'TE' (Telephone Number) for at least one instance in this loop.
	PER04		Communication Number	Value must be the Telephone Number of the submitter when PER03 = 'TE'.
2100	**CLP**		**Claim Level Data**	
	CLP06	WC	Claim Filing Indicator Code	Value must be "WC" – Workers' Compensation
	CLP07		Payer Claim Control Number	The payer assigned claim control number for workers' compensation use is the bill control number.
2100	**REF**		**Other Claim Related Identification**	Claim Level Jurisdictional EOB Code Statement; see Oregon Administrative Rules 436-008 Oregon Electronic Medical Billing Rules.
	REF01	CE	Reference Identification Qualifier	Value must be "CE" Class of Contract Code
	REF02	OR	Reference Identification	Oregon's Jurisdictional "OR" code value equates to the EOB statement (OAR 436-008-0030) as defined in Chapter 7 section 7.6 of this companion guide.

Chapter 8
ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275)

8.1 Introduction and Overview

The information contained in this guide has been created for use in conjunction with the ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) Technical Reports Type 3. It should not be considered a replacement for the ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) Technical Reports Type 3, but rather should be used as an additional source of information.

The ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) Technical Reports Type 3 is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

8.2 Purpose

While Oregon WCD allows the 275 transaction to transmit additional electronic bill documentation, Oregon WCD also allows this information be provided in other ways, e.g., secure fax, secure Web upload, regular mail, or secure e-mail.

8.3 Method of Transmission

The 005010X210 transaction is the prescribed standard electronic format for submitting electronic bill documentation. Health care providers, health care facilities, third-party billers or assignees and insurers may agree to exchange documentation in other non-prescribed formats (such as uploading to a secure web-based system, secure e-mail, regular mail, and fax) by mutual agreement. The components required to identify the bill associated with the documentation must be present in non-prescribed formats. (See Chapter 2, section 2.4.7 Document/Attachment Identification).

8.4 Documentation Requirements

Electronic bill documentation includes, but is not limited to, chart notes, medical reports and records, evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records, and diagnostic test results.

Chapter 9 Acknowledgments

9.1 Introduction/Overview

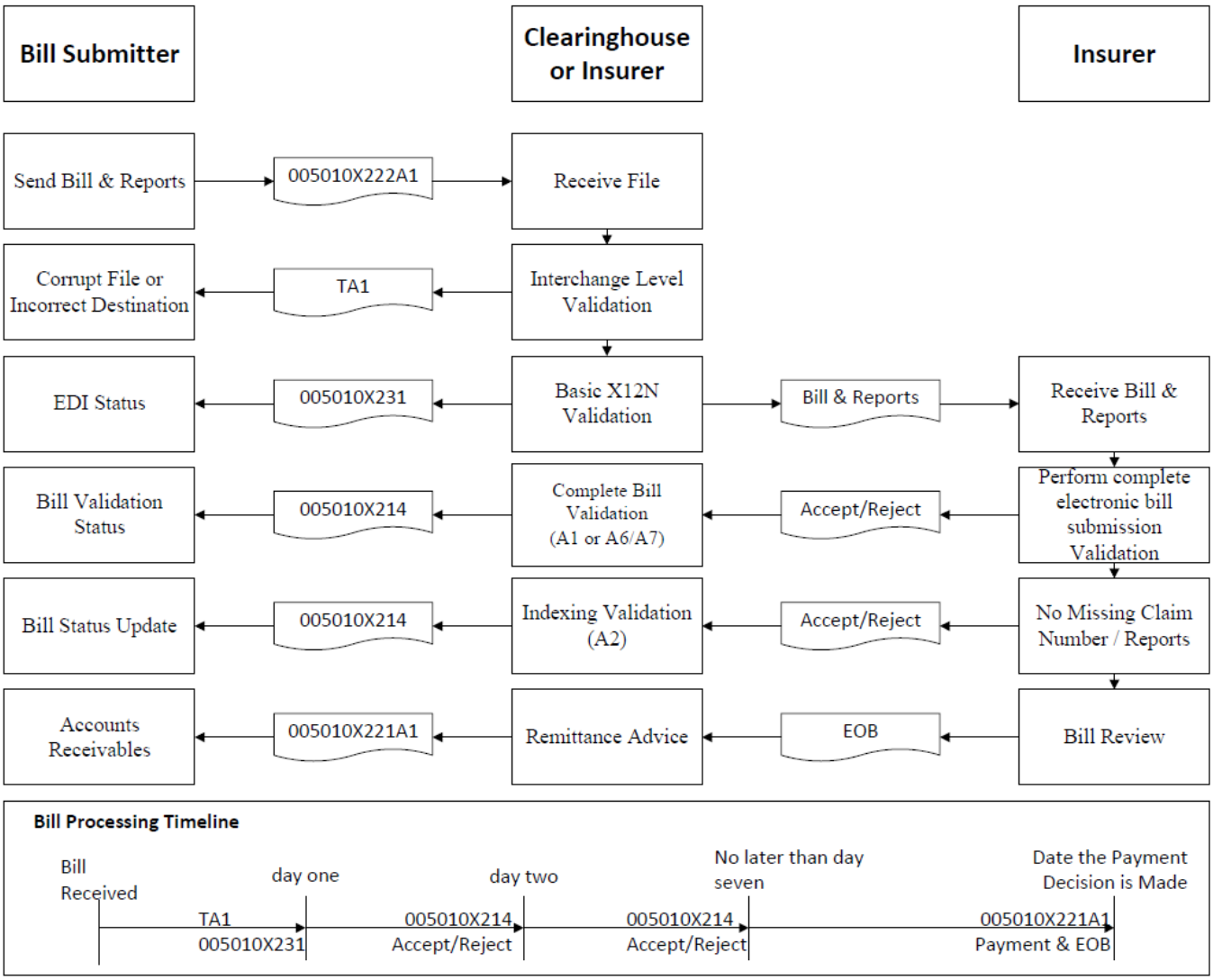
There are several different acknowledgments that are used to respond to the receipt of a bill by a clearinghouse or insurer. The purpose of these acknowledgments is to provide the following feedback:

1) Basic file structure and the trading partner information from the Interchange Header.

2) Detailed structure and syntax of the actual bill data as specified by the X12 standard.
3) The content of the bill against the jurisdictional complete bill rules.
4) Any delays caused by claim number indexing/validation.
5) Any delays caused by attachment matching.
6) The outcome of the final adjudication, including the association to any financial transaction.

9.2 Bill Acknowledgment Flow and Timing Diagrams

The process chart below illustrates how a receiver validates and processes an incoming 005010X222A1, 005010X223A2, or 005010X224A2 transaction. The diagram shows the basic acknowledgments that the receiver generates, including acknowledgments for validation and final adjudication for those bills that pass validation. For more detailed information, see the Oregon E-Billing Workflow in Appendix C.



9.2.1 Process Steps

1. **Interchange Level Validation:** Basic file format and the trading partner information from the Interchange Header are validated. If the file is corrupt or is not the expected type, the file is rejected. If the trading partner information is invalid or unknown, the file is rejected. A TA1 (Interchange Acknowledgment) is returned to indicate the outcome of the validation. A rejected EDI file is not passed on to the next step.
2. **Basic X12 Validation:** A determination will be made as to whether the transaction set contains a valid 005010X222A1 (Remittance Advice). A 005010X231 (Functional Acknowledgment) will be returned to the submitter. The 005010X231 contains ACCEPT or REJECT information. If the file contains syntactical errors, the locations of the errors are reported. Bills that are part of a rejected transaction set are not passed on to the next step.
3. **Complete Bill Validation:** The Oregon WCD and insurer-specific edits are run against each bill within the transaction set. The 005010X214 (Health Care Claim Acknowledgment) is returned to the submitter to acknowledge that the bill was accepted or rejected. Bills that are rejected are not passed on to the next step and are not complete bills. Accepted bills are considered complete bills.
4. **Bill - Missing Claim Number/Missing Required Report:** Refer to Section 9.3Bill - Missing Claim Number Pre-Adjudication Hold (Pending) Status and Section 9.4 Bill - Missing Report Pre-Adjudication Hold (Pending) Status regarding bill acknowledgment flow and timeline diagrams.
5. **Bill Review**: The bills that pass through bill review and any post-bill review approval process will be reported in the 005010X221A1 (Remittance Advice). The 005010X221A1 contains the adjudication information from each bill, as well as any paper check or EFT payment information.

9.3 Bill - Missing Claim Number Pre-Adjudication Hold (Pending) Status

One of the processing steps that a bill goes through prior to adjudication is verification that the bill concerns an actual employment-related condition that has been reported to the employer and subsequently reported to the insurer. This process, usually called “claim indexing/validation” can cause a delay in the processing of the bill. Once the validation process is complete, the insurer assigns a claim number to the worker’s claim. This claim number is necessary for the proper processing of the bill. Until the claim number is provided to the bill submitter, it cannot be included on the 005010X222A1, 005010X223A2, and 005010X224A2 submission to the insurer. In order to prevent bills from being rejected due to lack of a claim number, a pre-adjudication hold (pending) period of up to seven days is required to enable the insurer to attempt to match the bill to an existing claim in its system. If the bill cannot be matched within the seven days, the insurer may reject the bill as incomplete. If the insurer is able to match the bill to an existing claim, it should attach the claim number to the transaction and follow through with the adjudication process. The insurer provides the claim number to the bill submitter using the 005010X214 for use in future billing. The 005010X214 is also used to inform the bill submitter of the delay and the ultimate resolution of the issue.

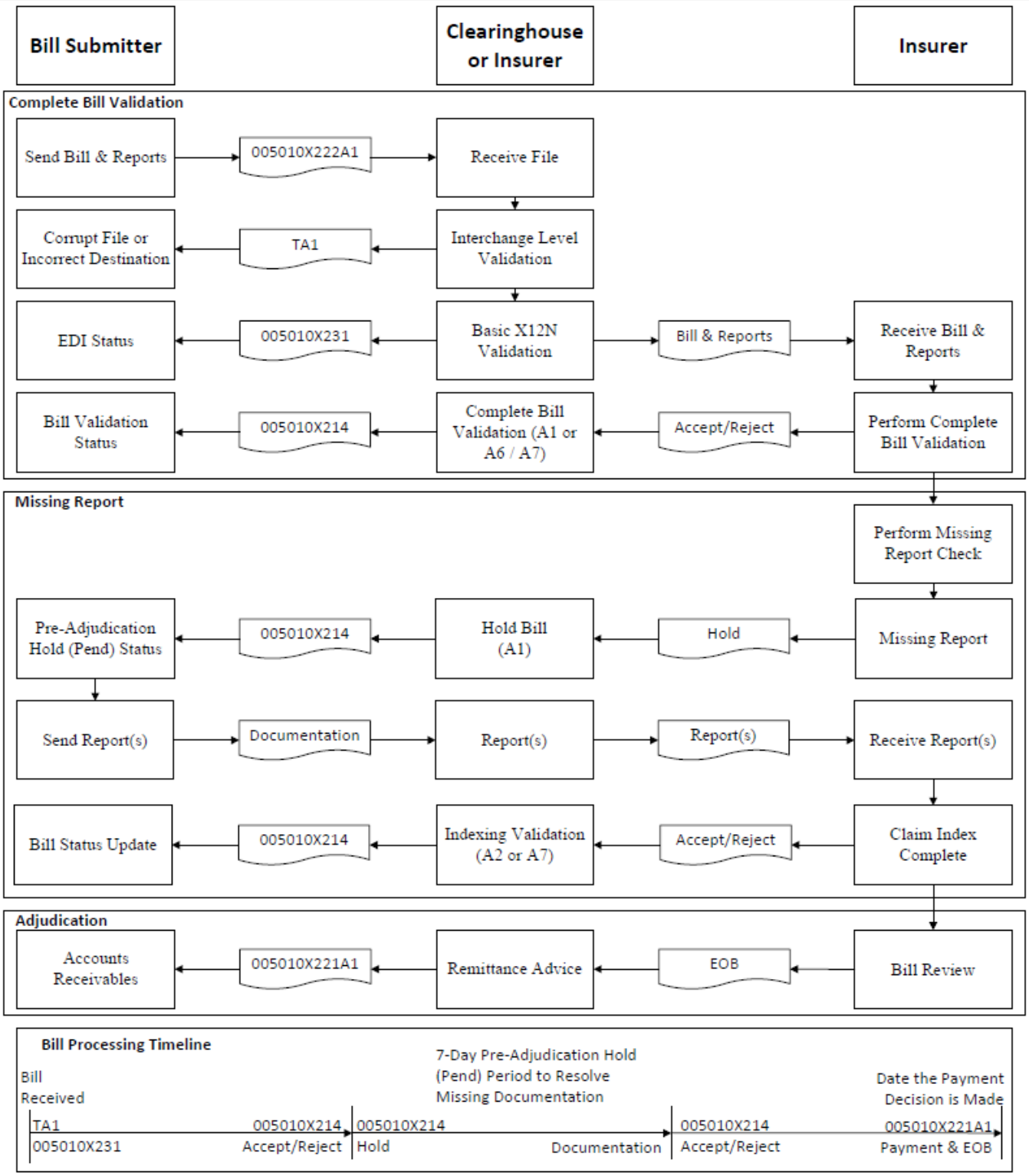
Due to the pre-adjudication hold (pending) status, a payer may send one STC segment with up to three claim status composites (STC01, STC10, and STC11) in the 005010X214. When a complete bill has a missing claim number and a missing report, the one STC segment in the 005010X214 would have the following three claim status composites: STC01, STC10 and STC11.

For example: STC*A1:21*20090830*WQ*70******A1:629*A1:294~

When an otherwise complete bill is only missing a claim number or missing documentation, the one STC segment in the 005010X214 would have the following two claim status composites: STC01 and STC10:

For example: STC*A1:21*20090830*WQ*70******A1:629~

A bill submitter could potentially receive two 005010X214 transactions as a result of the pre-adjudication hold (pending) status.


Bill Submitter
Clearinghouse or Insurer
Insurer
Complete Bill Validation
Send Bill & Reports
005010X222A1
Receive File
Corrupt File or Incorrect Destination
TA1
Interchange Level Validation
EDI Status
005010X231
Basic X12N Validation
Bill & Reports
Receive Bill & Reports
Bill Validation Status
005010X214
Complete Bill Validation (A1 or A6 / A7)
Accept/Reject
Perform Complete Bill Validation
Missing Report
Perform Missing Report Check
Pre-Adjudication Hold (Pend) Status
005010X214
Hold Bill (A1)
Hold
Missing Report
Send Report(s)
Documentation
Report(s)
Report(s)
Receive Report(s)
Bill Status Update
005010X214
Indexing Validation (A2 or A7)
Accept/Reject
Claim Index Complete
Adjudication
Accounts Receivables
005010X221A1
Remittance Advice
EOB
Bill Review
Bill Processing Timeline
Bill Received
7-Day Pre-Adjudication Hold (Pend) Period to Resolve Missing Documentation
Date the Payment Decision is Made
TA1
005010X231
005010X214
Accept/Reject
005010X214
Hold
Documentation
005010X214
Accept/Reject
005010X221A1
Payment & EOB

9.3.1 Missing Claim Number – ASC X12N/005010X214 Health Care Claim Acknowledgment (277CA) - Process Steps

When the 005010X222A1, 005010X223A2, or 005010X224A2 transaction has passed the complete bill validation process and Loop 2010 CA REF02 indicates that the workers' compensation claim number is "UNKNOWN," the insurer will need to respond with the appropriate 005010X214.

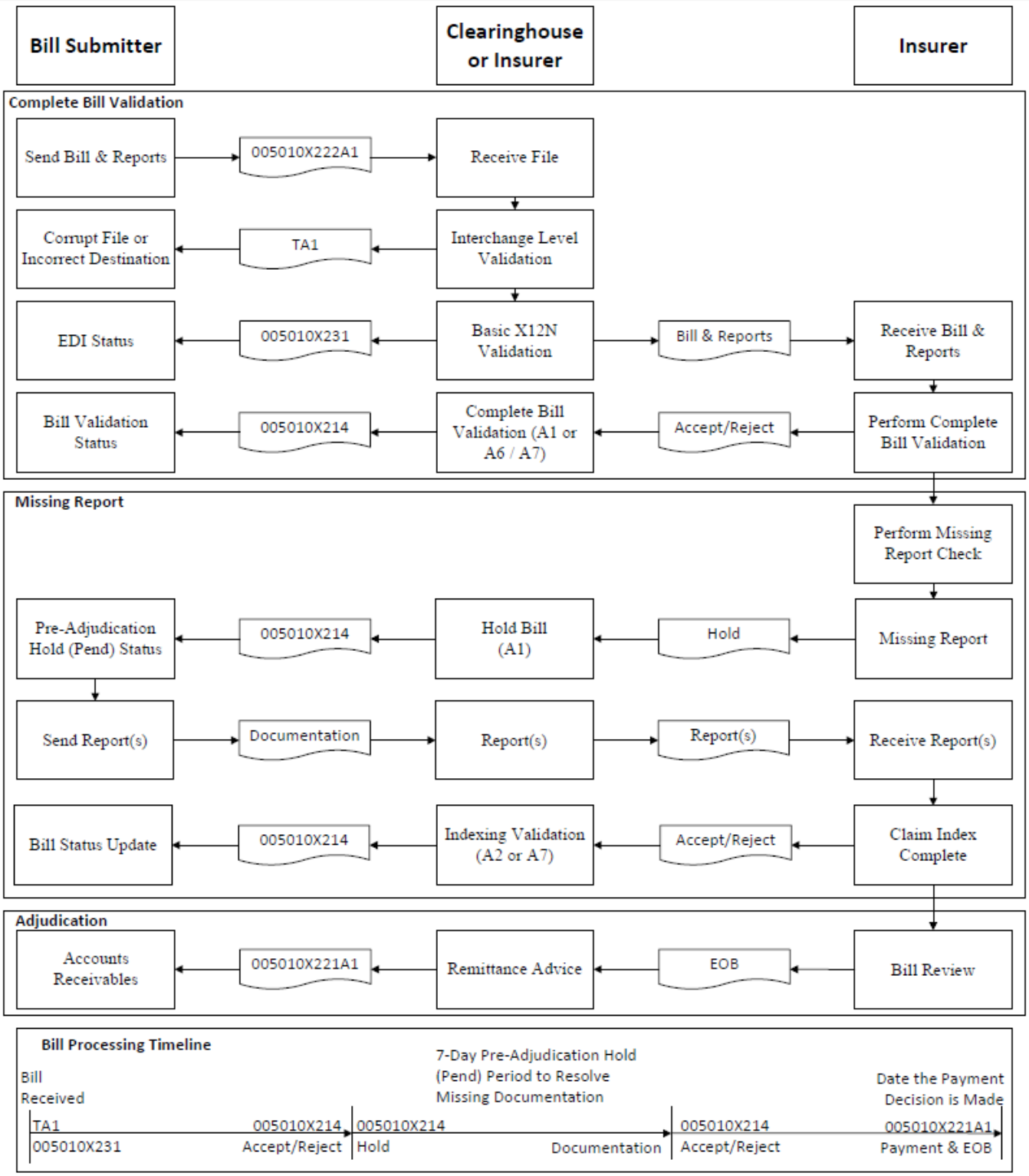
Claim Number Validation Status	005010X214
Complete Bill - Missing Claim Number	If the insurer needs to pend an otherwise complete bill due to a missing claim number, it should use the following Claim Status Category Code and Claim Status Code: STC01-1 = A1 (The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.) STC01-2= 21 (Missing or Invalid Information) <u>AND</u> STC10 -1 = A1 (The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.) STC10-2 = 629 (Property Casualty Claim Number) Example: STC*A1:21*20090830*WQ*70******A1:629~

Claim Index/Validation Complete	005010X214
Complete Bill - Claim was Found	Once the Claim Indexing/Validation process has been completed and there is a bill/claim number match, then use the following Claim Status Category Code with the appropriate Claim Status Code: STC01-1 = A2 (Acknowledgment/Acceptance into adjudication system. The claim/encounter has been accepted into the adjudication system.) STC01-2 = 20 (Accepted for processing) Insurer Claim Control Number: Use Loop 2200D REF Insurer Payer Claim Control Number segment with qualifier 1K Identification Number to return the workers' compensation claim number or the insurer control number in the REF 02: a. Always preface the workers' compensation claim number with the two digit qualifier 'Y4' followed by the workers' compensation claim number. Example: Y4123456778 b. If there are two numbers (insurer claim control number and workers'

	compensation claim number) returned in the REF 02, a blank space should be used to separate the numbers. • The first number will be the insurer claim control number assigned by the insurer (bill control number). • The second number will be the workers' compensation claim number assigned by the insurer with a 'Y4' qualifier followed by the workers' compensation claim number. Example: REF*1K*3456832 Y43333445556~
Complete Bill - No Claim Found	After the Claim Indexing/ Validation process has been completed and there is no bill/ claim number match, use the following Claim Status Category Code with the appropriate Claim Status Code: STC01-1 = A6 (Acknowledgment/Rejected for Missing Information. The claim/encounter is missing the information specified in the Status details and has been rejected.) STC01-2 = 629 (Workers' Compensation Claim Number - No Bill/Claim Number Match)

9.4 Complete Bill - Missing Report Pre-Adjudication Hold (Pending) Status

One of the processing steps that a bill goes through prior to adjudication is to verify if all required documentation has been provided. The bill submitter can send the documentation using the 005010X210 or other mechanisms such as fax, regular mail, or e-mail. In order to prevent bill rejections because required documentation was submitted separately from the bill itself, a pre-adjudication holding (pending) period of up to seven days is required to enable the insurer to receive and match the bill to the documentation. If the bill cannot be matched within the seven days, or the documentation is not received, the bill may be rejected as incomplete. If the insurer is able to match the bill to the documentation within the seven days, the adjudication process continues. The 005010X213 is used to inform the bill submitter of the delay and the ultimate resolution of the issue.


Bill Submitter
Clearinghouse or Insurer
Insurer
Complete Bill Validation
Send Bill & Reports
005010X222A1
Receive File
Corrupt File or Incorrect Destination
TA1
Interchange Level Validation
EDI Status
005010X231
Basic X12N Validation
Bill & Reports
Receive Bill & Reports
Bill Validation Status
005010X214
Complete Bill Validation (A1 or A6 / A7)
Accept/Reject
Perform Complete Bill Validation
Missing Report
Perform Missing Report Check
Pre-Adjudication Hold (Pend) Status
005010X214
Hold Bill (A1)
Hold
Missing Report
Send Report(s)
Documentation
Report(s)
Report(s)
Receive Report(s)
Bill Status Update
005010X214
Indexing Validation (A2 or A7)
Accept/Reject
Claim Index Complete
Adjudication
Accounts Receivables
005010X221A1
Remittance Advice
EOB
Bill Review
Bill Processing Timeline
Bill Received
7-Day Pre-Adjudication Hold (Pend) Period to Resolve Missing Documentation
Date the Payment Decision is Made
TA1
005010X231
005010X214
Accept/Reject
005010X214
Hold
Documentation
005010X214
Accept/Reject
005010X221A1
Payment & EOB

9.4.1 Missing Report – 277CA Health Care Claim Acknowledgment Process Steps

When a bill submitter sends an 837 that requires an attachment and Loop 2300 PWK Segment indicates that documentation will be following, the insurer will need to respond with the appropriate 277CA response(s) as applicable:

Bill Status Findings	277CA Health Care Claim Acknowledgment Options+
Complete Bill - Missing Report	When a complete bill is missing documentation, the insurer needs to place the bill in a pre-adjudication hold (pending) status during the specified waiting time period and return the following Claim Status Category Code and Claim Status Code: STC01-1 = A1 (The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.) STC01-2 = 21 (Missing or Invalid Information) <u>AND</u> STC10-1 = A1 (The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.) STC10-2 = Use the appropriate 277 Claim Status Code for missing report type. Example: Claim Status Code 294 supporting documentation Example :STC*A1:21*20090830*WQ*70******A1:294~:
Report Received within the 7 day pre-adjudication hold (pending) period	Once the Claim Indexing/Validation process has been completed and there is a bill/claim number match, then the insurer should use the following Claims Status Category Code with the appropriate Claim Status Code: STC01-1= A2 **(**Acknowledgment/Acceptance into adjudication system. The claim/encounter has been accepted into the adjudication system.) STC01-2=20 (Accepted for processing) Insurer Claim Control Number: Use Loop 2200D REF segment "Insurer Claim Control Number with qualifier 1K Identification Number to return the workers' compensation claim number or the insurer control number in the REF 02: a. Always preface the workers' compensation claim number with the two-digit qualifier 'Y4' followed by the workers' compensation claim number.

	Example: Y412345678 b. If there are two numbers (insurer claim control number and the workers' compensation claim number) returned in the REF 02, the insurer should use a black space to separate the numbers. • The first number will be the insurer claim control number assigned by the insurer (bill control number). • The second number shall be the workers' compensation claim number assigned by the insurer with a 'Y4' qualifier followed by the claim number. Example: REF*1K3456832 Y43333445556~
No Report Received within the 7 day pre-adjudication hold (pending) period	Use the following Claim Status Category Code and Claim Status Code. STC01-1= **(**A6 Acknowledgment/Rejected for Missing Information. The claim/encounter is missing the information specified in the Status details and has been rejected.) STC01-2=294 (Supporting documentation)

9.5 Acknowledgments

The ASC X12 transaction sets include a variety of acknowledgments to inform the sender about the outcome of transaction processing. Acknowledgments are designed to provide information regarding whether a transmission can be processed, based on structural, functional, or application level requirements or edits. For example, the acknowledgments inform the sender whether the bill can be processed or if the transaction contains all the required data elements.

Insurers must return one of the following acknowledgments, as appropriate, within two days of rejecting an electronic bill transmission or transaction:

- TA1 -- Implementation Acknowledgment
- 005010X231 -- Implementation Acknowledgment (999)
- 005010X214 -- Health Care Claim Acknowledgment (277CA)

Detailed information regarding the content and use of the various acknowledgments can be found in the applicable ASC X12N Technical Reports Type 3 (Implementation Guides).

9.5.1 005010X213 - Request for Additional Information

The 005010X213, or Request for Additional Information, is one method that can be used to request missing documentation from the submitter. The following are the STC01 values:

Claim was pended; additional documentation required.

STC01-1 = R4 (pended/request for additional supporting documentation)

STC01-2 = LOINC (code indicating the required documentation)

Additional information regarding this transaction set may be found in the applicable ASC X12N Technical Reports Type 3 (Implementation Guides).

9.5.2 005010X221A1 - Health Care Claim Remittance Advice

The 005010X221A1, or Health Care Claim Remittance Advice, is required to be sent by the insurer as specified under 436-009-0030. This transaction set informs the health care provider about the payment action taken by the insurer. Additional information regarding this transaction set may be found in Chapter 7 of this guide and the applicable ASC X12N Technical Reports Type 3 (Implementation Guides).

9.5.3 005010X212 Health Care Claim Status Request and Response

The 005010X212 transaction set is used in the group health industry to inquire about the current status of a specified bill or bills. The 276 transaction set identifier code is used for the inquiry and the 277 transaction set identifier code is used for the reply. By mutual agreement, it is possible to use these transaction sets unchanged in workers' compensation bill processing. Additional information regarding this transaction set may be found in the applicable ASC X12N Technical Reports Type 3 (Implementation Guides).

Appendix A – Glossary of Terms

Note: These glossary terms are for your convenience when working with electronic billing. Some terms and some usages are specific to this guide. A copy of this guide is available at the following website: http://wcd.oregon.gov/insurer/edi/Pages/ebilling.aspx.

Acknowledgment	Electronic notification to original sender of an electronic transmission that the transactions within the transmission were accepted or rejected.
ADA	American Dental Association.
ADA-2006	American Dental Association (ADA) standard paper billing form.
AMA	American Medical Association
ANSI	American National Standards Institute is a private, non-profit organization that administers and coordinates the U.S. voluntary standardization and conformity assessment system.
ASC X12 275	A standard transaction developed by ASC X12 to transmit various types of patient information.
ASC X12 835	A standard transaction developed by ASC X12 to transmit various types of health care claim remittance advice information.
ASC X12 837	A standard transaction developed by ASC X12 to transmit various types of health care claim information.
CDT	Current Dental Terminology coding system used to bill dental services.
Clearinghouse	An public or private entity, including billing services, repricing companies, community health management information systems or community health information systems, and "value-added" networks and switches that, as an agent of the insurer or provider, may perform the following functions: (a) Process or facilitate the processing of medical billing information received from a client in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction for further processing of a bill related transaction; or, (b) Receive a standard transaction from another entity and process or facilitate the processing of medical billing information into nonstandard format or nonstandard data content for a client entity. An entity that processes information received in a nonstandard format or containing nonstandard data content into a standard transaction, or that receives a standard transaction and processes that information into a nonstandard transaction.
CMS	Centers for Medicare and Medicaid Services of the US Dept. of Health and Human Services (HHS), the federal agency that administers these programs.

CMS-1450	The paper hospital, institutional, or facility billing form, also referred to as a UB-04 or UB-92, formerly referred to as a HCFA-1450.
CMS-1500	The paper professional billing form formerly referred to as a HCFA or HCFA-1500.
Code Sets	Tables or lists of codes used for specific purposes. National standard formats may use code sets developed by the standard setting organization (i.e. X12 Provider Type qualifiers) or by other organizations (i.e. HCPCS codes).
Complete Bill (Clean Claim)	A complete electronic medical bill is: • submitted in the correct billing format, with the correct billing code sets, • transmitted in compliance with all necessary format requirements, • includes in legible text all medical reports and records, including, but not limited to, evaluation reports, narrative reports, assessment reports, progress report/notes, chart notes, hospital records and diagnostic test results that are expressly required by law or can reasonably be expected by the insurer under the jurisdiction's law, and • includes any other jurisdictional requirements found in its regulations or companion guide.
CPT	Current Procedural Terminology is the coding system created and copyrighted by the American Medical Association used to bill professional services.
Days	Means calendar days. For calendar days, the first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.
DEA	Drug Enforcement Administration
Detail Acknowledgment	Electronic notification to original sender that its electronic transmission or the transactions within the transmission were accepted or rejected.
Electronic Bill	An electronic medical bill submitted from the health care provider, health care facility, third-party biller or assignee to the insurer.
EFT	Electronic Funds Transfer.
Electronic Format	The specifications defining the layout of data in an electronic transmission.
Electronic Record	A group of related data elements. A record may represent a line item, a health care provider, health care facility, third party biller or assignee, or an employer. One or more records may form a transaction.
Electronic Transaction	A set of information in a defined format that is made up of one or more electronic records.

Electronic Transmission	Transmission of information by facsimile, electronic mail, electronic data interchange, or any other similar method that does not include telephonic communication. For the purposes of electronic billing, electronic transmission does not include facsimile or electronic mail.
EOB/EOR	An explanation of benefits (EOB) or explanation of review (EOR) is the electronic remittance advice or notification, sent by the insurer, to the health care provider, health care facility, or third party biller or assignee regarding payment or denial of a bill, reduction of a bill, or refund request.
Functional Acknowledgment	Electronic notification to the original sender of an electronic transmission that the functional group within the transaction was accepted or rejected.
HCPCS	Health Care Common Procedure Coding System, the HIPAA code set used to bill durable medical equipment, prosthetics, orthotics, supplies, and biologics (Level II) as well as professional services (Level 1). Level 1 HCPCS codes are CPT codes.
HIPAA	Health Insurance Portability and Accountability Act, federal legislation that includes provisions that mandate electronic billing in the Medicare system and establishes national standard electronic file formats and code sets.
IAIABC	International Association of Industrial Accident Boards and Commissions.
IAIABC 837	An implementation guide developed by the IAIABC based on the ASC X12 standards to transmit various types of health care medical bill and payment information from insurers to jurisdictions.
ICD-9 and ICD-10	International Classification of Diseases code sets administered by the World Health Organization used to identify diagnoses.
Insurer	In Oregon, insurer means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon; an insurer-authorized agent, or payer; an assigned claims agent selected by the director under ORS 656.054; or an employer or employer group that has been certified under ORS 656.430 meeting the qualifications of a self-insured employer under ORS 656.407.
NCPDP	National Council for Prescription Drug Programs, the organization administering pharmacy unique identification numbers called NCPDP Provider IDs.
NCPDP Provider ID Number	Identification number assigned to an individual pharmacy
NCPDP WC/PC UCF	National Council for Prescription Drug Programs, Workers' Compensation/Property and Casualty Universal Claim form, the industry standard for paper billing of pharmacy claims.

NCPDP Telecommunication D.0	HIPAA compliant national standard billing format for pharmacy services.
NDC	National Drug Code, the code set used to identify medication dispensed by pharmacies.
Receiver	The entity receiving/accepting an electronic transmission.
Remittance Advice	See EOB/EOR
Sender	The entity submitting an electronic transmission.
TPA	Third Party Administrator.
Trading Partner	An entity that has entered into an agreement with another entity to exchange data electronically.
UB-04	Universal billing form used for hospital billing. Replaced the UB-92 as the CMS-1450 billing form effective May 23, 2007.
UB-92	Universal billing form used for hospital billing, also referred to as a CMS-1450 billing form. Discontinued use as of May 23, 2007
Version	Electronic formats may be modified in subsequent releases. Version naming conventions indicate the release or version of the standard being referenced. Naming conventions are administered by the standard setting organization. Some ASC X12 versions, for example, are 3050, 4010, 4050, and 5010.

Appendix B - Jurisdiction Report Type Codes and Oregon WCD Descriptions

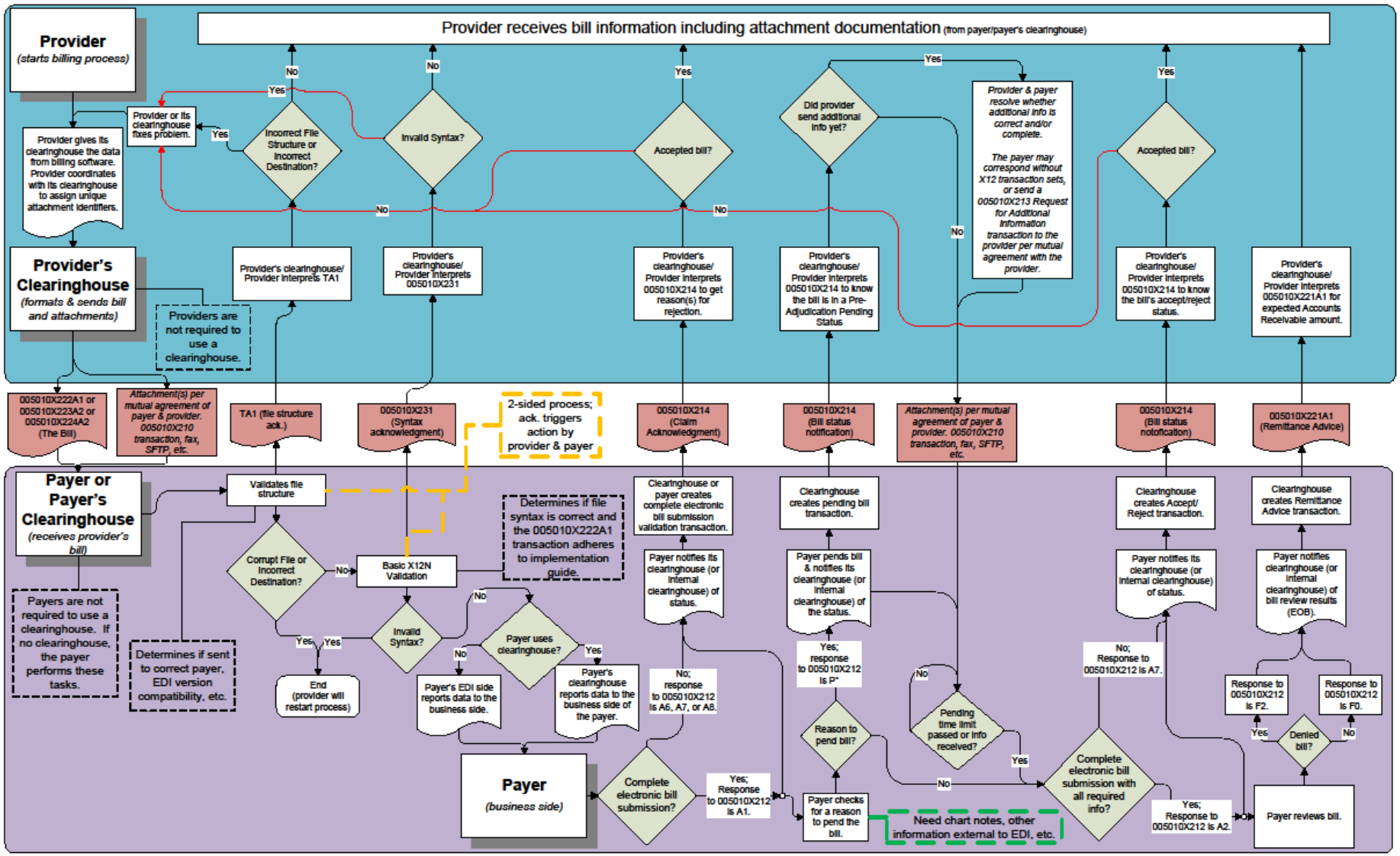
This Appendix is designed to provide the list of Oregon WCD codes that are used to identify documents for which an ASC X12 code is not available.

Jurisdiction Report Type Codes	Oregon WCD Description as Applicable
J1 Doctor First Report of Injury	Oregon Form 827
J2 Supplemental Medical Report	Oregon Form 827
J3 Medical Permanent Impairment	Oregon Forms: • 2278C-Spinal/Cervical ROM • 2278L-Spinal/Lumbar ROM • 2278T-Spinal/Thoracic ROM • 2279T-Upper Extremity ROM (Deformity/Deviation, Amputation and Sensation); • 2312-Visual Impairment • 4841-Lower Extremity ROM • 4842-Shoulder ROM
J4 Medical Legal Report	N/A
J5 Vocational Report	N/A
J6 Work Status Report	Oregon Form 3245
J7 Consultation Report	N/A
J8 Permanent Disability Report	N/A
J9 Itemized Statement	Hospital Itemized Statement, or other itemized statement

A

Appendix C - Oregon E-Billing Workflow

January 1, 2015



BEFORE THE DIRECTOR
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

In the Matter of the Amendment of Oregon Administrative Rules (OAR):	)	**ORDER OF ADOPTION**
436-008, Electronic Medical Billing	)	**No. 14-058**
	)	

The Director of the Department of Consumer and Business Services, under the general rulemaking authority in ORS 656.726(4), and in accordance with the procedures in ORS 183.335, amends OAR chapter 436, division 008.

On May 15, 2014, the Workers' Compensation Division filed with the Secretary of State a *Notice of Proposed Rulemaking Hearing* and *Statement of Need and Fiscal Impact*. The division mailed copies of the *Notice* and *Statement* to interested persons and legislators in accordance with ORS 183.335 and OAR 436-001-0009, and posted copies to its website. The Secretary of State included notice of the public hearing in its June, 2014 *Oregon Bulletin*. On June 23, 2014, a public hearing was held as announced. The record remained open for written testimony through June 27, 2014.

SUMMARY OF RULE AMENDMENTS

The agency adopts OAR 436-008, Electronic Medical Billing, to establish uniform standards for electronic medical billing in the workers' compensation system, including:

- Adoption of national-level electronic medical billing standards for use in Oregon;
- Definition of terms used to explain electronic medical billing standards;
- Provision of an option for an insurer to become exempt from the requirement to accept electronic medical bills;
- Allowance for use of alternative billing formats if those formats include all of the data elements required under the standard;
- Description of how to track and submit related documentation (attachments);
- Prescription of standards for electronic medical bill acknowledgements, remittance advice, and explanations of benefits; and
- Explanation of the potential for application of civil penalties.

FINDINGS

Having reviewed and considered the record and being fully informed, I make the following findings:

a) The applicable rulemaking procedures have been followed.

b) These rules are within the director's authority.

c) The rules being adopted are a reasonable administrative interpretation of the statutes and are required to carry out statutory responsibilities.

Order of Adoption
OAR chapter 436, division 008

IT IS THEREFORE ORDERED THAT

1) Amendments to OAR chapter 436, division 008 are adopted as administrative order No. 14-058 on this **14th day of July, 2014, to be effective Jan. 1, 2015.**
2) A certified copy of the adopted rules will be filed with the Secretary of State.
3) A copy of the adopted rules with revision marks will be filed with the Legislative Counsel under ORS 183.715 within ten days after filing with the Secretary of State.

DATED this 14th day of July, 2014.

/s/ John L. Shilts
John L. Shilts, Administrator
Workers' Compensation Division

Under the Americans with Disabilities Act guidelines, alternative format copies of the rules will be made available to qualified individuals upon request.

If you have questions about these rules or need them in an alternate format, contact the Workers' Compensation Division, 503-947-7810.

Distribution: Workers' Compensation Division e-mail distribution lists, including advisory committee members and testifiers