CHAPTER 436, DIVISION 008
OREGON ADMINISTRATIVE RULES

ELECTRONIC MEDICAL BILLING

Effective Jan. 1, 2015

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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

Electronic Billing and Payment Companion Guide {LINK}