# Electronic Data Interchange
# Oregon Administrative Rules
# Chapter 436, Division 160

## Effective July 1, 2008

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**Revisions are marked as follows:**

Deleted text has a "strike-through" style, as in ~~Deleted~~
Added text is bold and underlined, as in **Added**

**HISTORY LINES**: These rules include only the most recent "History" lines. The history line shows when the rule was last revised (or "filed" if the rule has never been revised) and its effective date. To obtain a comprehensive history for OAR chapter 436, please call the Workers' Compensation Division, (503) 947-7627, or visit the division's Web site: http://www.wcd.oregon.gov/policy/rules/full_set.html

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**
**WORKERS' COMPENSATION DIVISION**
**ELECTRONIC DATA INTERCHANGE**

# EXHIBIT "A"
# OREGON ADMINISTRATIVE RULES
# CHAPTER 436, DIVISION 160

## General Provisions

### 436-160-0001 Authority for Rules

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

**Stat. Authority:** ORS 656.264 and ORS 656.726(4)
**Stat. Implemented:** ORS 656.017, ORS 656.407, ORS 656.419, ORS 656.423, and ORS 656.427
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03

### 436-160-0002 Purpose

The director's purpose is to allow certain workers' compensation filing or reporting via electronic data interchange.

**Stat. Authority:** ORS 656.264 and ORS 656.726(4)
**Stat. Implemented:** ORS 656.017, ORS 656.407, ORS 656.419, ORS 656.423, and ORS 656.427
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03

### 436-160-0003 Applicability of Rules

(1) These rules apply to workers' compensation related transactions filed with the director via electronic data interchange on or after January 1, 2004.

(2) The director may, unless otherwise obligated by statute, waive any procedural rules in this rule division as justice so requires.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.726(4)
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03
Amended 12/3/03 as Admin. Order 03-064, eff. 1/1/04

### 436-160-0004 Adoption of Standards

(1) For proof of coverage, the director adopts, by reference, *IAIABC EDI Implementation Guide for Proof of Coverage*, Release 2, dated May 1, 2002 including the definition of standards and procedures, unless otherwise provided in these rules.

(2) For medical bill data, the director adopts, by reference, IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1, dated July 4, 2002, unless otherwise provided in these rules.

**Stat. Authority:** ORS 656.264
**Stat. Implemented:** ORS 656.017, ORS 656.407, ORS 656.419, ORS 656.423, and ORS 656.427
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff 4/1/03
Amended 11/1/07 as Admin. Order 07-068, eff. 1/1/08

### 436-160-0005 General Definitions

For the purpose of these rules, unless it conflicts with statute or rule:

(1) "ANSI" means the American National Standards Institute.

(2) "Conditional data element" means an element that becomes mandatory under certain conditions. Once mandatory, a conditional data element will cause a rejection of the transaction

if the data element is omitted or submitted in a format not capable of being processed by the division's information processing system.

(3) "Director" means the Director of the Department of Consumer and Business Services or the director's designee for the matter.

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

(5) "Electronic Data Interchange" or "EDI" means a computer to computer exchange of information in a standardized electronic format.

(6) "Electronic Record" means information created, generated, sent, communicated, received, or stored by electronic means.

(7) "FEIN" means the federal employer identification number or other federal reporting number used by the insurer, insured, or employer for federal tax reporting purposes.

(8) "Header record" means the record that precedes each transmission for the purpose of identifying a sender, the date and time of the transmission, and the transaction set within the transmission.

(9) "IAIABC" means the International Association of Industrial Accident Boards and Commissions, a professional trade association comprised of state workers' compensation regulators and insurance representatives (www.iaiabc.org).

(10) "Information" means data, text, images, sounds, codes, computer programs, software, databases, or the like.

(11) "Industry code" means the code which indicates the nature of the employer's business, which is contained in the Standard Industrial Classification (SIC) manual published by the Federal Office of Management and Budget, or in the North American Industrial Classification System (NAICS) published by the U.S. Census Bureau.

(12) "Insurer" means workers' compensation insurance carrier providing coverage to an employer, or a self-insured employer.

(13) "Mandatory data element" means an element that will cause a rejection of a transaction if the data element is omitted or submitted in a format not capable of being processed by the division's information processing system.

(14) "Optional data element" means an element that an insurer should report to the director if the information is available to the insurer. Optional data elements will not cause a rejection if missing or invalid.

(15) "Proof of coverage" means an electronic record or set of records identifying an insurer as providing workers' compensation coverage for a specific employer.

(16) "Record" means electronic record.

(17) "Sender" means the person or entity reporting electronic data interchange transactions to the division. Sender may include vendors or insurers.

(18) "Trading partner agreement" means the agreement entered into pursuant to OAR 436-160-0020 between the director and an insurer to conduct transactions via EDI.

(19) "Trailer record" means the record that designates the end of a transmission and provides a count of transactions contained within the transmission, not including the header and trailer records.

(20) "Transaction" means a set of EDI records, defined according to standards in OAR 436-160-0004.

(21) "Transmission" means a defined set of transactions, including both header and trailer records to be sent to the division or sender via EDI.

(22) "Vendor" means an agent identified in a trading partner agreement to submit transmissions to the division on behalf of an insurer. Vendors may include service companies, third party administrators, and managing general agents.

**Stat. Authority:** ORS 656.264 and ORS 656.726(4)
**Stat. Implemented:** ORS 84.004 and ORS 656.264
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03
Amended 11/1/07 as Admin. Order 07-068, eff. 1/1/08

### 436-160-0006 Administration of Rules

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

**Stat. Authority:** ORS 656.704 and ORS 656.726(4)
**Stat. Implemented:** ORS 656.704 and ORS 656.726(4)
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03

### 436-160-0010 Security

(1) The sender will verify that an electronic signature, record, or performance is that of a specific person.

(2) The sender will utilize anti-virus software to eliminate any viruses on all electronic transmissions. The sender will maintain the anti-virus software with the most recent anti-virus update files from the software provider. The sender will notify the director immediately if a virus is detected.

**Stat. Authority:** ORS 656.264 and ORS 656.726(4)
**Stat. Implemented:** ORS 656.264
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03

### 436-160-0020 Trading Partner Agreement

(1) **If the director so requires, a**~~A~~n insurer must enter into a trading partner agreement with the director before the division will begin testing with or accept production electronic transmissions from the insurer or from a vendor on behalf of that insurer.

(2) The trading partner agreement will include:

(a) A statement that the insurer will remain responsible and liable for all electronic records transmitted to the director;

(b) Transmission protocol between sender and director;

(c) A specific description of the form, format, and delivery of electronic transmissions pursuant to OAR 436-160-0004 and 436-160-0050;

(d) Specific identifying information for insurer, third party administrator, if any, and vendor, if any;

(e) Cost allocation of transactions, if any;

(f) The time frame for the director to submit acknowledgements of transmissions; and

(g) Any other necessary statements, conditions or requirements to facilitate EDI.

**Stat. Authority:** ORS 656.264 and ORS 656.726(4)
**Stat. Implemented:** ORS 84.013 and ORS 656.264
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03
**Amended 6/12/08 as Admin. Order 08-059, eff. 7/1/08**

### 436-160-0030 Retention of Electronic Records

Insurers and self-insured employers must retain workers' compensation records pursuant to OAR 436-050-0120, OAR 436-050-0220, and OAR 436-009-0030. Records may be retained in electronic format if the records can be reproduced.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.455 and ORS 731.475
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03
Amended 11/1/07 as Admin. Order 07-068, eff. 1/1/08

### 436-160-0040 Recognized Filing Date

(1) Unless otherwise stated in the trading partner agreement, an electronic record is sent when it:

(a) Is addressed or directed properly to an information processing system designated or used by the division to receive electronic records or information;

(b) Is in a form and format capable of being processed by that system; and

(c) Enters an information processing system outside the control of the sender or enters a region of the information processing system designated or used by the division and that is under control of the division.

(2) Unless otherwise stated in the trading partner agreement an electronic record is received when it:

(a) Enters an information processing system designated or used by the division to receive electronic records or information of the type sent and from which the division is able to retrieve the electronic record; and

(b) Is in a form and format capable of being processed by the division's information processing system.

(3) For the purpose of these rules, an electronic transaction is capable of being processed by the division's information processing system when all the required data elements are in the form and format specified in these rules, in the proper sequence, and in accordance with the terms of the trading partner agreement.

**Stat. Authority:** ORS 656.264 and ORS 656.726(4)
**Stat. Implemented:** ORS 84.043 and ORS 656.264
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03

**436-160-0050 Form, Format, and Delivery for Electronic Data Reporting**

The form, format, and delivery of data elements and definitions will conform to the standards specified in OAR 436-160-0004, or as otherwise identified in the trading partner agreement.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 84.013 and ORS 656.264
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03

**436-160-0060 Testing Procedures and Requirements**

(1) Proof of coverage testing:

(a) Each transmission for test purposes will conform to the standards specified in OAR 436-160-0004, or as otherwise identified in the trading partner agreement. Test files will be evaluated in terms of whether the data was sent in the correct, standardized format.

(b) To gain approval to send production transmissions, the sender must be able to:

(A) Transmit records via electronic data interchange; and

(B) Accomplish secure file transfer protocol uploads and downloads.

(c) To initiate a test for EDI, the sender must contact the director.

(d) The sender must demonstrate the ability to send transmissions to the director that are readable, in the correct format, and can be processed through the division's information processing system. A successful EDI test is determined by the resolution of any consistently recurring fatal technical errors identified by the division such that:

(A) Transmissions are sent to the director without errors in the header or trailer record;

(B) Transmissions are sent to the director without transaction level technical errors; and

(C) The sender can receive and process the automated EDI acknowledgement transaction.

(e) To move from test to production, the sender must achieve 90% accuracy for transactions sent for a minimum of three consecutive transmissions during the test (i.e. 90% of the transactions must have been accepted by the division and the sender has received a transaction accepted acknowledgement). The director will consider the sender's anticipated volume of production transactions to determine the number of transactions per test transmission required.

(f) Once approved, sender must maintain the accuracy as defined in subsections (d) and (e) of this section. Failure to meet technical requirements may result in the revocation of EDI transmission approval.

(g) The director will inform the sender and insurer (if different) if accuracy standards for technical requirements fall below standards prescribed in subsections (d) and (e) of this section during production.

(h) During the EDI test phase, insurer will continue to submit filings via paper. Once the sender becomes approved and moves into production, insurer will not submit same transaction filings via paper. If a problem occurs with EDI transmission during production, insurer may return to paper filing to meet statutory filing requirements until the problem is corrected.

(2) Medical bill data testing and transition to production:

(a) To initiate a test for EDI, the sender must contact the director.

(b) Each transmission for test purposes must conform to the standards specified in OAR 436-160-0004, or as otherwise identified in the trading partner agreement. Test files will be evaluated in terms of whether the data was sent in the correct, standardized format.

(c) To gain approval to send production transmissions, the sender must be able to:

(A) Transmit records via electronic data interchange; and

(B) Accomplish secure file transfer protocol uploads and downloads.

(d) The sender must demonstrate the ability to send transmissions to the director that are readable, in the correct format, and can be processed through the division's information processing system. A successful EDI FTP test is determined by the resolution of any consistently recurring fatal technical errors identified by the division such that:

(A) Transmissions are sent to the director without structural errors;

(B) Transmissions are sent to the director without transaction level technical errors; and

(C) The sender can receive and process the automated EDI acknowledgement transactions.

(e) To move from test to production, 80 percent of the sender's transactions must have been accepted by the division by the end of the testing period, allowing for corrected and resubmitted transactions. The director will consider the sender's anticipated volume of production transactions to determine the number of transactions per test transmission required.

(f) Once approved, sender must maintain the accuracy as defined in subsections (d) and (e) of this section. Failure to meet technical requirements may result in additional testing requirements.

(g) The director will inform the sender and insurer (if different) if accuracy standards for technical requirements fall below standards prescribed in subsections (d) and (e) of this section during production.

(h) During the EDI test phase, insurer will not be required to file the same medical bill data via Bulletin 220. If the test phase is not completed satisfactorily, as detailed in (e) above, the insurer may be required to submit data for the period covered by the unacceptable test via Bulletin 220 standard, and then complete a new EDI test.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 84.013 and ORS 656.264
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03
Amended 11/1/07 as Admin. Order 07-068, eff. 1/1/08

### 436-160-0070 Electronic signature

The sender's federal employer identification number (FEIN) plus its postal code as reported in the header record and stated in the trading partner agreement**, if such an agreement is required,** is the unique identifier that is the electronic signature for electronic data interchange.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 84.001-84.061 and ORS 656.264

**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03
**Amended 6/12/08 as Admin. Order 08-059, eff. 7/1/08**

### 436-160-0080 Acknowledgements

(1) Proof of Coverage:

(a) The director will respond to the sender with an electronic transaction accepted or transaction rejected acknowledgement of the insurer's transactions.

(b) The insurer must correct and resubmit any transactions rejected for which law or rule require filing, reporting, or notice to the director.

(2) Medical Bill Data:

(a) The sender will receive both functional and detailed electronic acknowledgements for each batch sent. The detailed acknowledgement will contain transaction accepted or transaction rejected acknowledgement of all of the insurer's transactions in the batch.

(b) The insurer must correct and resubmit any transactions rejected for which law or rule require filing, reporting, or notice to the director.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.264
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03
Amended 11/1/07 as Admin. Order 07-068, eff. 1/1/08

### 436-160-0090 Address Reporting

The sender will follow the standard United States Postal Service guidelines in reporting all addresses**.** ~~, as follows:~~

~~(1) The physical (street) address, or an attention line, must be in address line one. The attention line, if used, must be in line one.~~

~~(2) If the physical address is used in address line one, the mailing address may be used in address line two. If address line one was used as the attention line, then the physical (street) address must be in address line two.~~

~~(3) Physical (street) address and attention line must be on separate address lines.~~

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.264
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03
**Amended 6/12/08 as Admin. Order 08-059, eff. 7/1/08**

## Proof of Coverage

### 436-160-0300 Proof of Coverage Definitions

(1) Unless otherwise provided in these rules, the definitions and standards identified in OAR 436-160-0004 and OAR 436-160-0005 apply.

(2) For the purpose of OAR 436-160-0300 through OAR 436-160-0360 "establishing documents" is a term used in the *IAIABC EDI Implementation Guide for Proof of Coverage* to denote certain transaction types. The establishing document transaction types listed in OAR 436-160-0350(2)(c) can be used to file a guaranty contract under that rule. In Oregon, a reinstatement, an add location, and an add employer transaction type can also be an establishing document. A change policy number transaction type is not an establishing document.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.419, ORS 656.423 and ORS 656.427
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff 4/1/03

### 436-160-0310 Proof of Coverage Electronic Filing Requirements

(1) The chart in Appendix "A" shows all proof of coverage data elements accepted via EDI in Oregon, and whether the data element is mandatory (M), conditional (C), or optional (O) for each transaction type.

(2) Unless otherwise provided in these rules, the data elements shall have the meaning provided in the data dictionary pursuant to OAR 436-160-0004.

(3) Transactions will be rejected if mandatory or required conditional data elements are omitted or submitted in a format that is not capable of being processed by the division's information processing system designated for proof of coverage transactions.

(4) Optional data element(s) in a transaction will be ignored if the optional data element is either omitted, or submitted in a format that is not capable of being processed by the division's information processing system designated for proof of coverage transactions.

(5) Unless otherwise provided in these rules, an insurer approved for production transmissions will transmit proof of coverage via EDI, and will not submit like paper documents to the director except as provided in OAR 436-160-0340.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.264
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff 4/1/03
Amended 12/3/03 as Admin. Order 03-064, eff. 1/1/04

### 436-160-0320 Proof of Coverage Acknowledgement

(1) The division will respond to transmissions submitted with either a transaction accepted or a transaction rejected acknowledgement.

(2) A transaction rejected acknowledgement will be sent for all transactions incapable of being processed by the division's information processing system, including, but not limited to:

(a) An omitted mandatory data element;

(b) An improperly populated data element field, e.g. numeric data element field is populated with alpha or alphanumeric data, or is not a valid value;

(c) Transactions or electronic records within the transaction which require matching and cannot be matched to the division's database;

(d) Illogical data in mandatory or required conditional field, e.g. termination date is before coverage effective date;

(e) Duplicate transmission or duplicate transaction within the transmission;

(f) Invalid triplicate code; or

(g) Illogical event sequence relationship between transactions, e.g. endorsement transaction submitted before a policy transaction is submitted.

(3) A transaction accepted acknowledgement will be sent for all transactions that are in a format capable of being processed by the division's information processing system and are not rejected pursuant to section (2) of this rule.

(4) An insurer's obligation to file proof of coverage for the purposes of this rule is not satisfied unless the director acknowledges acceptance of the transaction.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.264
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff 4/1/03
Amended 12/3/03 as Admin. Order 03-064, eff. 1/1/04

### 436-160-0330 Proof of Coverage Effective Dates

(1) For all binder or new policy establishing document transactions submitted pursuant to OAR 436-160-0350, the coverage effective date will also be the guaranty contract effective date.

(2) For all other establishing document transactions that meet the guaranty contract filing requirements of OAR 436-160-0350, the transaction set type effective date will also be the guaranty contract effective date.

(3) For reinstatement transactions the transaction set type date will be a new guaranty contract effective date only if the transaction set type effective date is later than the expiration date of guaranty contract liability under ORS **656.423 or ORS** 656.427 as calculated by the division. If the transaction set type effective date is on or before the expiration date of guaranty contract liability, that guaranty contract will remain in effect as previously filed.

(4) For all other transactions, the effective date will be the transaction set type effective date.

(5) The policy expiration date submitted on a transaction does not terminate liability under a guaranty contract. Liability under a guaranty contract filed by an insurer continues until it is terminated pursuant to OAR 436-160-0360 ~~and~~ **or** ORS 656.427.

(6) For reissue, renewal, reinstatement, or endorsement transactions, the transaction effective date will be the transaction effective date submitted by the insurer.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.264, ORS 656.419, ORS 656.423 and ORS 656.427
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff 4/1/03
**Amended 6/12/08 as Admin. Order 08-059, eff. 7/1/08**

### 436-160-0340 Proof of Coverage Changes or Corrections

(1) Changes or corrections to proof of coverage information must be submitted pursuant to the standards referenced in OAR 436-160-0004.

(2) To report changes or corrections of an insured employer's name or address pursuant to ORS 656.419(4), or changes or corrections to other data elements, the insurer must transmit the appropriate transaction to specify what data is being changed or corrected.

(3) The insurer's policy number is used to assist in matching each transaction to the appropriate employer. When an insurer changes a policy number, the insurer must report that change with or prior to the next transaction submitted for that policy. Failure to report a change in the policy number will render future filings incapable of being processed by the division's information processing system and the insurer will receive a transaction rejected acknowledgement.

(4) If changing a partner name of an insured or employer does not change the entity, a new guaranty contract does not need to be filed.

(5) A transaction to change the effective date of coverage is capable of being processed by the division's information processing system only if the new date does not create a lapse in coverage. To report a change to the effective date of coverage which results in a lapse, the insurer must submit transactions to terminate the current guaranty contract and file a new guaranty contract.

(6) To add or delete coverage for corporate officers, members of a limited liability company, partners, sole proprietors or other non-subject workers, the insurer must file ~~written notice to the director listing the individual names as required by ORS 656.419~~ **the appropriate "include" or "exclude" endorsement transaction to the associated policy filing.**

(7) Transactions to change the wrap-up indicator, business market, assignment date, and professional employer organization (worker leasing company) indicator are not capable of being processed by the division's information processing system.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.264 and ORS 656.419
**Hist:** Amended 12/3/03 as Admin. Order 03-064, eff. 1/1/04
**Amended 6/12/08 as Admin. Order 08-059, eff. 7/1/08**

### 436-160-0350 Guaranty Contract Filing Requirements

(1) For the purpose of these rules, an electronic guaranty contract consists of an executed trading partner agreement containing the guaranty described in subsection (2)(a) of this rule, and an accepted proof of coverage insured and employer electronic record.

(2) To file a guaranty contract via EDI, an insurer must do all of the following:

(a) Enter into a trading partner agreement with the director pursuant to OAR 436-160-0020 that contains a statement of assumption of liability and guaranty of payment pursuant to ORS 656.419(1);

(b) Transmit an electronic record of the proof of coverage data elements identified as mandatory or required conditional pursuant to OAR 436-160-0310, including a unique FEIN for each legally distinct employer included in the establishing document transaction; and

(c) Transmit an establishing document transaction: binder, new policy, renew policy, rewrite/reissue policy, reinstatement, add location, add employer, or add jurisdiction. A renew policy, add location, or add employer transaction will only establish a guaranty contract if the data elements have not previously been transmitted, the employer FEIN is not a duplicate per section (3) below, and coverage for that unique employer FEIN has not been previously established by the reporting carrier. A reinstatement transaction will only establish a new guaranty contract if there is a lapse in coverage and the requirements of ORS 656.419 and OAR 436-160-0350 are otherwise met.

(3) A duplicate FEIN or a FEIN previously reported under the same policy will be recorded as an additional employer location and/or an assumed business name, but will not establish an additional guaranty contract.

(4) Reinstatement, rewrite, and reissue transaction types must follow a cancellation transaction.

(5) If an employer elects to include any non-subject worker(s) under coverage~~under ORS 656.419(2)(d)~~, or subsequently to exclude such workers from coverage, the insurer must submit a

transaction with a reason code for including or excluding a corporate officer, partner, member, sole proprietor, or any other person.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.264, ORS 656.419~~*~~, ORS 656.423~~*~~ and ORS 656.427~~* *(sections 3, 4, & 5, chapter 170, Oregon Laws 2003)~~
**Hist:** Amended 12/3/03 as Admin. Order 03-064, eff. 1/1/04
**Amended 6/12/08 as Admin. Order 08-059, eff. 7/1/08**

### 436-160-0360 Guaranty Contract Terminations

(1) For the purposes of EDI, to terminate a guaranty contract when an insurer receives written notice of cancellation of coverage from an employer pursuant to ORS 656.423, the insurer must:

(a) Provide notice to the director no more than ~~seven~~ **ten** calendar days after the effective date of termination by transmitting the transaction type for cancellation by insured or nonrenewal by insured. The "transaction effective date" will be used to report the effective date of termination pursuant to ORS **656.423 or ORS** 656.427;

(b) Retain the employer's written notice for inspection by the division; and

(c) Provide written notice to the employer ~~pursuant to~~**under ORS 656.423 or** ORS 656.427(1) and (3).

(2) For the purposes of EDI, to terminate a guaranty contract for any other reason, the insurer must:

(a) Provide notice to the director no more than ~~seven~~ **ten** calendar days after the effective date of termination by transmitting the transaction type for cancellation ~~or~~**,** nonrenewal**, or delete jurisdiction**~~pursuant to section (5) below~~; and

(b) Provide written notice to the employer ~~pursuant to~~ **under ORS 656.423 or** ORS 656.427(1) and (3).

(3) The date of termination must be included in the written notice to the employer to terminate a guaranty contract. For the purposes of notice to the director, the transaction effective date is the termination effective date.

(4) A delete location transaction can be used to notify the director that one or more locations for an employer are no longer workplaces of the employer. This transaction does not meet the requirements of **ORS 656.423 or** ORS 656.427 for notice of termination.

~~(5) If the intent of an insurer is to terminate guaranty contract liability for all insureds under a policy, the insurer must use a cancellation or nonrenewal transaction type and must report all covered employers.~~

~~(6) Delete jurisdiction transactions are not capable of being processed by the division's information processing system and will result in a transaction rejected acknowledgement being sent to the sender.~~

~~(7)~~ **(5)** Failure to provide timely notice to the director of termination of an insurer's guaranty contract may result in civil penalties pursuant to ORS 656.745.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.264, ORS 656.419~~*~~, ORS 656.423~~*~~ and ORS 656.427~~* *(sections 3, 4, & 5, chapter 170, Oregon Laws 2003)~~

**Hist:** Amended 12/3/03 as Admin. Order 03-064, eff. 1/1/04
**Amended 6/12/08 as Admin. Order 08-059, eff. 7/1/08**

# Insurers' Obligation to Report Medical Bill Data

## 436-160-0400 Medical Bill Definitions

Unless otherwise provided in these rules, the definitions and standards identified in OAR 436-160-0004 and OAR 436-160-0005 apply.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.264
**Hist:** Adopted 11/1/07 as Admin. Order 07-068, eff. 1/1/08

## 436-160-0410 Medical Bill Electronic Filing Requirements

(1) The chart in Appendix "B" shows all medical bill data elements accepted via EDI in Oregon, and whether the data element is mandatory (M), conditional (C), or optional (O) for each transaction type.

(2) Unless otherwise provided in these rules, the data elements must have the meaning provided in the data dictionary pursuant to OAR 436-160-0004.

(3) Transactions will be rejected if mandatory or required conditional data elements are omitted or submitted in a format that is not capable of being processed by the division's information processing system designated for medical bill transactions.

(4) Optional data element(s) in a transaction will be ignored if the optional data element is either omitted, or submitted in a format that is not capable of being processed by the division's information processing system designated for medical bill transactions.

(5) Unless otherwise provided in these rules, an insurer approved for production transmissions will transmit medical bill data via EDI, and will not submit the same medical bill data via Bulletin 220 proprietary format to the director.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.264
**Hist:** Adopted 11/1/07 as Admin. Order 07-068, eff. 1/1/08
**Amended 6/12/08 as WCD Admin. Order 08-059, eff. 7/1/08**

## 436-160-0420 Medical Bill Acknowledgement

(1) The sender will receive both a functional acknowledgement and a detailed acknowledgement for each medical bill batch submitted. The detailed acknowledgement will indicate either a transaction accepted (TA) or a transaction rejected (TR) acknowledgement for each individual transaction.

(2) A transaction rejected acknowledgement will be sent for all transactions incapable of being processed by the division's information processing system, including, but not limited to:

(a) An omitted mandatory data element;

(b) An improperly populated data element field, e.g. numeric data element field is populated with alpha or alphanumeric data, or is not a valid value according to the standards adopted in 436-160-0004;

(c) Transactions or electronic records within the transaction which require matching and cannot be matched to the division's database, e.g. cancellation of an original bill that does not match on Unique Bill ID;

(d) Illogical data in mandatory or required conditional field, e.g. service date is before date of injury;

(e) Duplicate transmission or duplicate transaction within the transmission;

(f) Invalid bill submission reason code; or

(g) Illogical event sequence relationship between transactions, e.g. cancellation transaction submitted before an original bill is submitted.

(3) A transaction accepted acknowledgement will be sent for all transactions that are in a format capable of being processed by the division's information processing system and are not rejected pursuant to section (2) of this rule.

(4) An insurer's obligation to file medical bill data for the purposes of this rule is not satisfied unless the director acknowledges acceptance of the transaction.

**Stat. Authority:** ORS 656.726(4)
**Stat. Implemented:** ORS 656.264
**Hist:** Adopted 11/1/07 as Admin. Order 07-068, eff. 1/1/08

### 436-160-0430 Medical Bill Data Changes or Corrections

(1) Changes or corrections to medical bill information must be submitted according to the standards referenced in OAR 436-160-0004.

~~(2) To report changes or corrections of an original bill, the insurer must first submit a cancellation of the original bill and then a replacement transaction with the corrected information.~~

~~(3)~~**(2)** The Unique Bill ID will be used to match cancellations and replacements to the original bill. Failure to match on this data element will result in a rejected transaction.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Adopted 11/1/07 as Admin. Order 07-068, eff. 1/1/08
**Amended 6/12/08 as Admin. Order 08-059, eff. 7/1/08**

| Data element | Data Element Number | Establishing document transactions | Endorsement | Cancellation or Nonrenewal by Insurer | Cancellation or Nonrenewal by Insured | Reinstatement |
|---|---|---|---|---|---|---|
| **INSURED RECORD** | | | | | | |
| Transaction Set ID | DN001 | M | M | M | M | M |
| Record Sequence Number | DN107 | M | M | M | M | M |
| Transaction Set Purpose Code | DN300 | M | M | M | M | M |
| Jurisdiction Designee Received Date | DN302 | M | M | M | M | M |
| Transaction Set Type Code | DN002 | M | M | M | M | M |
| Transaction Reason Code | DN303 | M | M | M | M | M |
| Transaction Set Type Effective Date | DN304 | M | M | M | M | M |
| Insurer FEIN | DN006 | M | M | M | M | M |
| Insurer Name | DN007 | M | O | O | O | O |
| Issuing Office Name | DN305 | O | O | O | O | O |
| Issuing Office Address Line 1 | DN306 | O | O | O | O | O |
| Issuing Office Address Line 2 | DN307 | O | O | O | O | O |
| Issuing Office City | DN308 | O | O | O | O | O |
| Issuing Office State | DN309 | O | O | O | O | O |
| Issuing Office Postal Code | DN310 | O | O | O | O | O |
| Issuing Agency Name | DN311 | O | O | O | O | O |
| Issuing Agency City | DN312 | O | O | O | O | O |
| Issuing Agency State | DN313 | O | O | O | O | O |
| Insured FEIN | DN314 | M | M | M | M | M |
| Insured Name | DN017 | M | M | M | M | M |
| Insured Address Line 1 | DN315 | M | O | O | O | O |
| Insured Address Line 2 | DN316 | O | O | O | O | O |
| Insured City | DN317 | M | O | O | O | O |
| Insured State | DN318 | M | O | O | O | O |
| Insured Postal Code | DN319 | M | O | O | O | O |
| Insured Telephone Number | DN320 | O | O | O | O | O |
| Business Market | DN321 | O | O | O | O | O |
| Wrap-Up Indicator | DN322 | C | O | O | O | O |
| Insured Legal Status | DN323 | M | O | O | O | O |
| Employee Leasing Policy Identification | DN333 | M | O | O | O | O |
| Policy Number | DN028 | M | M | M | M | M |
| Policy Effective Date | DN029 | M | O | O | O | M |
| Policy Expiration Date | DN030 | O | O | O | O | O |
| Prior Policy Number | DN324 | C | O | O | O | O |
| Assignment Date | DN325 | O | O | O | O | O |
| Jurisdiction | DN004 | M | M | M | M | M |
| Governing Class | DN326 | M | O | O | O | O |
| Total Payroll | DN327 | O | O | O | O | O |
| Number of Employers | DN328 | M | M | M | M | M |
| **EMPLOYER RECORD** | | | | | | |
| Transaction Set ID | DN001 | M | M | M | N/A | N/A |
| Record Sequence Number | DN107 | M | M | M | | |
| Employer FEIN | DN016 | M | M | M | | |
| Employer UI Code | DN329 | O | O | O | | |
| Employer Name | DN018 | M | M | O | | |
| Employer Address Line 1 | DN019 | M | O | O | | |
| Employer Address Line 2 | DN020 | O | O | O | | |
| Employer City | DN021 | M | O | O | | |
| Employer State | DN022 | M | O | O | | |
| Employer Postal Code | DN023 | M | O | O | | |
| Industry Code | DN025 | O | O | O | | |
| Number of Employees | DN330 | O | O | O | | |
| Employer Notification Date | DN331 | O | O | O | | |

# IAIABC ANSI 837 Medical Bill Reporting Requirements

1) **Event reporting requirements:**

   **Original medical bills: Report within 90 days of date paid.**

   **Cancellations: Report immediately, as soon as payer knows that an original medical bill was previously sent in error. Report prior to replacement of an original bill with a revised bill (Replacement transaction).**

   **Replacement: Report within 30 days of:**

   **a) Payer knowledge of change in claim administrator, location of service, or provider type;**

   **b) Payer action of paying an additional amount on a previously-reported bill; or**

   **c) Payer receipt of an overpayment from a medical provider on a previously-reported bill.**

2) **Data reporting requirements: See "Medical Bill Data Element Requirement Table" below.**

3) **The data must include all payments made during the previous 90 days for medical services.**

4) **Technical Requirements: See the Oregon EDI Medical Bill Implementation Guide for specifications on the Secure File Transfer Protocol (SFTP) requirements.**

5) **Data Quality: The director will conduct electronic edits for blank or invalid data. Affected insurers are responsible for pre-screening the data they submit to check that all the required information is reported, and is formatted correctly. See 436-160-0090, Acknowledgements, for a description of the acceptance/rejection protocol for all reported medical bills. The insurer is responsible for correcting and resubmitting all rejected transactions for which law or rule require filing, reporting, or notice to the director.**

NOTE: M = mandatory; C = conditional element which becomes mandatory under the stated trigger; O = optional **(must be reported if available)**

**The following data must be reported to the department:**

| ~~Note: This table is repeated in OR 436-009~~<br>Medical Bill Data Element Requirement Table | | | | | |
|---|---|---|---|---|---|
| **Bill Submission Reason Codes** | | | | | |
| | | Original | Cancellation | Replace | |
| DN | Data Element Name | 00 | 01 | 05 | Mandatory Trigger or Implementation Note |
| 719 | ADA Procedure Billed Code | C | C | C | Required for dental bills only (SV3 segment) |
| 722 | ADA Procedure Paid Code | C | C | C | Required for dental bills only (SV3 segment) |

| Bill Submission Reason Codes | | | | | |
|---|---|---|---|---|---|
| | | Original | Cancellation | Replace | |
| **DN** | **Data Element Name** | **00** | **01** | **05** | **Mandatory Trigger or Implementation Note** |
| 513 | Admission Date | C | ~~O~~**C** | ~~O~~**C** | ~~If Billing Format Code equals "A" and patient has been admitted.~~ **If DN 504 Facility Code = 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89.** |
| 535 | Admitting Diagnosis Code | C | ~~O~~**C** | ~~O~~**C** | ~~If Billing Format Code equals "A" and patient has been admitted.~~ **If DN 504 Facility Code = 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89.** |
| 564 | Basis of Cost Determination Code | C | ~~O~~**C** | ~~O~~**C** | ~~If a pharmacy bill submitted on universal claim form/NCPDP format.~~ **Required for pharmacy bills.** |
| 545 | Bill Adjustment Amount | C | ~~O~~**C** | ~~O~~**C** | ~~If paid amount is not equal to billed amount.~~ **If DN516 Total Amount Paid Per Bill is not equal to DN501 Total Charge Per Bill** |
| 543 | Bill Adjustment Group Code | C | ~~O~~**C** | ~~O~~**C** | ~~If paid amount is not equal to billed amount.~~ **If DN516 Total Amount Paid Per Bill is not equal to DN501 Total Charge Per Bill** |
| 544 | Bill Adjustment Reason Code | C | ~~O~~**C** | ~~O~~**C** | ~~If paid amount is not equal to billed amount.~~ **If DN516 Total Amount Paid Per Bill is not equal to DN501 Total Charge Per Bill** |
| 546 | Bill Adjustment Units | C | ~~O~~**C** | ~~O~~**C** | ~~If paid amount is not equal to billed amount.~~ **If DN580 Days/Units Paid is different than DN554 Days/Units Billed.** |
| 508 | Bill Submission Reason Code | M | M | M | |
| 503 | Billing Format Code | M | M | ~~O~~**M** | |
| 629 | Billing Provider FEIN | ~~C~~**M** | ~~O~~**M** | ~~C~~**M** | ~~If provider has no NPI, report FEIN plus State License Number.~~ |
| 528 | Billing Provider Last/Group Name | ~~C~~**M** | ~~O~~**M** | ~~O~~**M** | ~~If different than Rend. Bill Prov. Last/Grp Name~~ |
| 537 | Billing Provider Primary Specialty Code | ~~C~~**O** | O | O | ~~If applicable.~~ |
| 630 | Billing Provider State License Number | C | ~~O~~**C** | ~~O~~**C** | ~~If provider has no NPI,~~ **If DN634 Billing Provider National Provider ID is blank**, report ~~FEIN plus~~ **DN630** State License Number. Use "999999~~9~~" if provider type not licensed by the state **(e.g. pharmacy, durable medical)**. |
| 523 | Billing Provider Unique Bill Identification Number | ~~O~~**M** | ~~O~~**M** | ~~O~~**M** | **If not available, use default of all 9s.** |
| 634 | Billing Provider National Provider ID | C | ~~O~~**C** | C | ~~If provider has an NPI, it must be reported; otherwise, report the provider FEIN.~~ **Must be reported if billing provider has an NPI.** |
| 502 | Billing Type Code | C | ~~O~~**C** | ~~O~~**C** | ~~If Billing Format Code equals "B" and prescriptions or durable medical equipment are billed.~~ **If DN 502 = "RX" "DM" or "MO", then SV4 or SV5 must be present. Office bills for pharmaceuticals (drugs dispensed by provider) must be reported in SV1; all other pharmacy must be reported in SV4.** |
| 015 | Claim Administrator Claim Number | M | M | M | |

| Bill Submission Reason Codes | | | | | |
|---|---|---|---|---|---|
| | | Original | Cancellation | Replace | |
| **DN** | **Data Element Name** | **00** | **01** | **05** | **Mandatory Trigger or Implementation Note** |
| 187 | Claim Administrator FEIN | C | ~~O~~**C** | ~~O~~**C** | ~~If the Claim Administrator FEIN is different than Insurer FEIN.~~ **If different than DN6 Insurer FEIN** |
| 188 | Claim Administrator Name | C | ~~O~~**C** | ~~O~~**C** | ~~If the Claim Administrator name is different than Insurer name.~~ **If different than DN7 Insurer name** |
| **515** | **Contract Type Code** | **M** | **M** | **M** | |
| 512 | Date Insurer Paid Bill | M | ~~O~~**M** | ~~O~~**M** | |
| 511 | Date Insurer Received Bill | M | ~~O~~**M** | ~~O~~**M** | |
| 31 | Date of Injury | M | ~~O~~**M** | ~~O~~**M** | |
| 554 | Days/Units Billed | C | ~~O~~**C** | ~~O~~**C** | ~~If Jur. Proc. Billed Code or HCPCS Line Proc. Billed Code are present or Billing Type Code = DM, or a drug is dispensed by a physician during an office visit.~~ **If DN559 Revenue Billed Code is present. Required when SV1, SV2 and SV5 segments are used.** |
| 553 | Days/Units Code | C | ~~O~~**C** | ~~O~~**C** | ~~If Jur. Proc. Billed Code or HCPCS Line Proc. Billed Code are present or Billing Type Code = DM, or a drug is dispensed by a physician during an office visit.~~ **If DN554 Days/Units Billed is present. Required when SV1, SV2 and SV5 segments are used.** |
| 557 | Diagnosis Pointer | C | ~~O~~**C** | ~~O~~**C** | ~~If Billing Format Code equals "B" and Jur. Proc. Billed Code or HCPCS Line Proc. Billed Code is present or a drug is dispensed by a physician during an office visit.~~ **If DN503 Billing Format Code equals "B" and DN 715 Jur. Proc. Billed Code or DN 714 HCPCS Line Proc. Billed Code is present or a drug is dispensed by a physician during an office visit.** |
| 514 | Discharge Date | C | ~~O~~**C** | ~~O~~**C** | If **DN503** Billing Format Code equals "A" and patient has been discharged |
| 562 | Dispense As Written Code | C | ~~O~~**C** | ~~O~~**C** | ~~If a pharmacy bill submitted on universal claim form/NCPDP format.~~ **Required for pharmacy bills (when SV4 segment is present.)** |
| 567 | DME Billing Frequency Code | C | ~~O~~**C** | ~~O~~**C** | If **DN502** Billing Type Code = DM and **DN565** Total Chg. per Line - Rental is present. **Use the SV5 segment for DME rental and purchase services billed.** |
| 518 | DRG Code | ~~C~~**O** | O | O | If Billing Format Code equals "A" |
| 563 | Drug Name | O | O | O | |
| 572 | Drugs/Supplies Billed Amount | C | ~~O~~**C** | ~~O~~**C** | If **DN502** Billing Type Code, value is "RX" or "MO". **DN572 is required in the SV4/AMT segment.** |
| 579 | Drugs/Supplies Dispensing Fee | C | ~~O~~**C** | ~~O~~**C** | ~~If a pharmacy bill submitted on universal claim form/NCPDP format.~~ **Required for pharmacy** |

| Bill Submission Reason Codes | | | | | |
|---|---|---|---|---|---|
| | | Original | Cancellation | Replace | |
| **DN** | **Data Element Name** | **00** | **01** | **05** | **Mandatory Trigger or Implementation Note** |
| | | | | | **bills.** |
| 571 | Drugs/Supplies Number of Days | C | ~~O~~**C** | ~~O~~**C** | If **DN502** Billing Type Code, value is "RX" or "MO". |
| 570 | Drugs/Supplies Quantity Dispensed | C | ~~O~~**C** | ~~O~~**C** | If **DN502** Billing Type Code, value is "RX" or "MO". |
| 152 | Employee Employment Visa | C | ~~O~~**C** | ~~O~~**C** | If **DN42** Employee Social Security number or **DN153** Employee Green Card number is not available. |
| 44 | Employee First Name | M | ~~O~~**M** | ~~O~~**M** | |
| 153 | Employee Green Card | C | ~~O~~**C** | ~~O~~**C** | If **DN42** Employee Social Security number is not available. |
| 154 | Employee ID Assigned by Jurisdiction | C | ~~O~~**C** | ~~O~~**C** | If **DN42** Employee Social Security, **DN153** Employee Green Card, **DN152** Employee Employment Visa or **DN \156** Employee Passport Number not available. |
| 43 | Employee Last Name | M | ~~O~~**M** | ~~O~~**M** | |
| 156 | Employee Passport Number | C | ~~O~~**C** | ~~O~~**C** | If **DN42** Employee Social Security, **DN153** Employee Green Card, or **DN152** Employee Employment Visa not available. |
| 42 | Employee Social Security Number | C | ~~O~~**C** | ~~O~~**C** | **DN42** Employee SSN is preferred ID number. If none, see **DN153** Employee Green Card. If injured worker is not a United States citizen and has no other identification, **use "999999999".** ~~call WCD to receive Jurisdiction Assigned ID Number for reporting purposes~~ |
| **18** | **Employer Name** | **M** | **M** | **M** | |
| 504 | Facility Code | C | C | ~~O~~**C** | If **DN503** Billing Format Code = "A" |
| 678 | Facility Name | C | ~~O~~**C** | ~~O~~**C** | If service performed in a licensed facility |
| 682 | Facility National Provider ID | C | ~~O~~**C** | ~~O~~**C** | If service performed in a licensed facility |
| 737 | HCPCS Bill Procedure Code | C | ~~O~~**C** | ~~O~~**C** | If **DN503 = "A" and if DN626** HCPCS Prin. Procedure Billed Code is present and more than one procedure is performed |
| 714 | HCPCS Line Procedure Billed Code | C | ~~O~~**C** | ~~O~~**C** | If **DN502** Billing Type Code does not equal RX, DM or MO, and if **DN715** Jurisdiction Procedure Billed Code or **DN721** NDC Billed Code **is** not present |
| 726 | HCPCS Line Procedure Paid Code | C | ~~O~~**C** | ~~O~~**C** | If different than **DN714** HCPCS Line Proc. Billed Code |
| 717 | HCPCS Modifier Billed Code | ~~C~~**O** | O | O | ~~If HCPCS Line Proc. Billed Code is modified.~~ **If present, must be a valid code.** |
| 727 | HCPCS Modifier Paid Code | C | ~~O~~**C** | ~~O~~**C** | ~~If HCPCS Line Proc. Paid Code is modified.~~ **If different than DN 717 HCPCS Modifier Billed Code** |
| 626 | HCPCS Principal Procedure Billed Code | ~~C~~**O** | O | O | ~~If Billing Format Code is "A" and the code value is not an ICD-9 code. For surgical bills only.~~ **Must be reported if included on provider's bill.** |

| Bill Submission Reason Codes | | | | | |
|---|---|---|---|---|---|
| | | Original | Cancellation | Replace | |
| **DN** | **Data Element Name** | **00** | **01** | **05** | **Mandatory Trigger or Implementation Note** |
| 736 | ICD-9 CM Procedure Code | C | ~~O~~**C** | ~~O~~**C** | ~~If ICD-9 CM Prin. Proc. Code is present and more than one procedure is performed~~ **If DN503 = "A" and if DN525 ICD-9 CM Prin. Proc. Code is present and more than one procedure is performed** |
| 522 | ICD-9 CM Diagnosis Code | C | ~~O~~**C** | ~~O~~**C** | If **DN521** Principle Diagnosis Code is present and more than one diagnosis occurs or if **DN503** Billing Format Code = B and **DN714** HCPCS Line Proc. Billed Code or **DN715** Jurisdiction Procedure Billed Code or a drug is dispensed by a physician during an office visit. |
| 525 | ICD-9 CM Principal Procedure Code | ~~C~~**O** | O | O | ~~If Billing Format Code is "A" and the code value is not a HCPCS code. For surgical bills only.~~ **Must be reported if included on provider's bill.** |
| 6 | Insurer FEIN | M | M | M | |
| **7** | **Insurer Name** | **M** | **M** | **M** | |
| 5 | Jurisdictional Claim Number | C | ~~O~~**C** | ~~O~~**C** | If the first report of injury has been filed and a jurisdictional claim number ~~is available~~ **has been returned to the insurer.** |
| 718 | Jurisdictional Modifier Billed Code | ~~C~~**O** | O | O | ~~If Jur. Proc. Billed Code is modified~~ **N/A; Oregon has no jurisdictional modifiers** |
| 730 | Jurisdictional Modifier Paid Code | ~~C~~**O** | O | O | ~~If different than Juris. Mod. Billed Code~~ **N/A; Oregon has no jurisdictional modifiers** |
| 715 | Jurisdictional Procedure Billed Code | C | ~~O~~**C** | ~~O~~**C** | If the procedure is included as an Oregon-specific code in the Oregon Medical Fee Schedule |
| 729 | Jurisdictional Procedure Paid Code | C | ~~O~~**C** | ~~O~~**C** | If different than **DN715** Jurisdiction Procedure Billed Code |
| 547 | Line Number | M | ~~O~~**M** | ~~O~~**M** | **Required in Loop 2400/LX segment.** |
| 208 | Managed Care Organization Identification Number | C | ~~O~~**C** | ~~O~~**C** | If worker enrolled at time of service. |
| 721 | NDC Billed Code | C | ~~O~~**C** | ~~O~~**C** | If a pharmaceutical bill or a drug is dispensed by a physician during an office visit. **For compound drugs, use "99999."** |
| 728 | NDC Paid Code | C | ~~O~~**C** | ~~O~~**C** | If different than **DN721** NDC Billed Code. **For compound drugs, use "99999."** |
| 555 | Place of Service Bill Code | C | C | ~~O~~**C** | If **DN503** Billing Format Code equals "B" |
| 600 | Place of Service Line Code | C | ~~O~~**C** | ~~O~~**C** | ~~If different than Place of Svc. Billed Code and not a pharmacy bill~~ **If DN 503 Billing Format Code equals "B" and if different than DN555 Place of Svc. Billed Code and not a pharmacy bil**l |
| 527 | Prescription Bill Date | O | O | O | |
| 604 | Prescription Line Date | C | ~~O~~**C** | ~~O~~**C** | ~~If a pharmacy bill submitted on universal claim form/NCPDP format~~ **Required if SV4 is present**. |
| 561 | Prescription Line Number | C | ~~O~~**C** | ~~O~~**C** | ~~If a pharmacy bill submitted on universal claim form/NCPDP format~~ **Required if SV4 is present**. |

| Bill Submission Reason Codes | | | | | |
|---|---|---|---|---|---|
| | | Original | Cancellation | Replace | |
| **DN** | **Data Element Name** | **00** | **01** | **05** | **Mandatory Trigger or Implementation Note** |
| 521 | Principal Diagnosis Code | C | ~~O~~**C** | ~~O~~**C** | If **DN503** Billing Format Code equals "A" |
| 550 | Principal Procedure Date | C | ~~O~~**C** | ~~O~~**C** | ~~If Billing Format Code equals "A" and if ICD-9-CM Prin. Proc. Code or HCPCS Prin. Proc. Billed Code is present~~ **Required if DN626 HCPCS Principal Procedure Code or DN525 ICD-9 CM Principal Procedure Code are present**. |
| 524 | Procedure Date | C | ~~O~~**C** | ~~O~~**C** | ~~If Billing Format Code equals "A" and more than one surgical procedure was performed~~ **Required if DN736 ICD-9 CM Principal Procedure Code or DN737 HCPCS Bill Procedure Code are present.** |
| 507 | Provider Agreement Code | ~~M~~**C** | ~~O~~**C** | ~~O~~**C** | Enter the value "P" if the injured worker is enrolled in a Managed Care Organization at time of service |
| 642 | Rendering Bill Provider FEIN | ~~C~~**O** | O | ~~C~~**O** | ~~If provider has no NPI, report FEIN plus State License Number~~ |
| **639** | **Rendering Bill Provider First Name** | **M** | **M** | **M** | |
| 638 | Rendering Bill Provider Last/Group Name | M | ~~O~~**M** | ~~O~~**M** | |
| 647 | Rendering Bill Provider National Provider ID | ~~C~~**O** | O | ~~C~~**O** | If provider has reported an NPI **to the payer**, it ~~must~~ **should** be reported **to the jurisdiction.**~~;~~ ~~otherwise, report the provider FEIN~~ |
| 651 | Rendering Bill Provider Primary Specialty Code | ~~M~~**O** | O | O | |
| 643 | Rendering Bill Provider State License Number | ~~C~~**0** | O | O | ~~If provider has no NPI, report FEIN plus State License Number~~ **If DN 647 Rendering Bill Provider National Provider ID is blank, DN643 Rendering Bill Provider State License Number should be reported. If provider type not licensed by the state (e.g. pharmacy, durable medical), use "99999."** |
| 586 | Rendering Line Provider FEIN | ~~C~~**O** | O | ~~C~~**O** | ~~If provider has no NPI, report FEIN plus State License Number~~ |
| 592 | Rendering Line Provider National ID | C | ~~O~~**C** | C | If provider has an NPI, it must be reported, ~~otherwise, report the provider FEIN.~~ |
| 595 | Rendering Line Provider Primary Specialty Code | ~~C~~**O** | O | O | ~~If different than Rend. Bill Prov. Prim. Spec. Code~~ |
| 599 | Rendering Line Provider State License Number | C | ~~O~~**C** | ~~O~~**C** | ~~If provider has no NPI, report FEIN plus State License Number~~ **If DN592 Rendering Line Provider National ID is blank, DN599 State License Number must be present. If provider type not licensed by the state (e.g. pharmacy, durable medical), use "99999."** |
| 615 | Reporting Period | M | M | M | |

| Bill Submission Reason Codes | | | | | |
|---|---|---|---|---|---|
| | | Original | Cancellation | Replace | |
| **DN** | **Data Element Name** | **00** | **01** | **05** | **Mandatory Trigger or Implementation Note** |
| 559 | Revenue Billed Code | C | ~~O~~**C** | ~~O~~**C** | If a value for **DN504** Facility Code with 1st digit equal to 1 |
| 576 | Revenue Paid Code | C | ~~O~~**C** | ~~O~~**C** | If different than **DN559** Revenue Billed Code |
| 733 | Service Adjustment Amount | C | ~~O~~**C** | ~~O~~**C** | ~~If applicable.~~ **Required if DN552 Total Charge per Line is different than DN574 Total Amount Paid per Line.** |
| 731 | Service Adjustment Group Code | C | ~~O~~**C** | ~~O~~**C** | ~~If applicable.~~ **Required if DN552 Total Charge per Line is different than DN574 Total Amount Paid per Line.** |
| 732 | Service Adjustment Reason Code | C | ~~O~~**C** | ~~O~~**C** | ~~If applicable.~~ **Required if DN552 Total Charge per Line is different than DN574 Total Amount Paid per Line.** |
| 509 | Service Bill Date(s) Range | C | ~~O~~**C** | ~~O~~**C** | If different than **DN605** Svc. Lines Date Range |
| 605 | Service Line Date(s) Range | C | ~~O~~**C** | ~~O~~**C** | ~~If not a pharmacy bill submitted on universal claim form/NCPDP format~~ **Required for all bill types except pharmacy. DN604 is used specifically for pharmacy**. |
| 516 | Total Amount Paid Per Bill | C | ~~O~~**C** | ~~O~~**C** | If different than **DN501** Total Charge per Bill |
| 574 | Total Amount Paid Per Line | C | ~~O~~**C** | ~~O~~**C** | If paid amount is not equal to ~~billed amount~~ **DN552 Total Charge per Line**. |
| 501 | Total Charge Per Bill | ~~M~~**C** | ~~M~~**C** | ~~M~~**C** | **Required for professional and institutional service lines only (SV1, SV2, SV3)** |
| 552 | Total Charge Per Line | ~~O~~**M** | ~~O~~**M** | ~~O~~**M** | |
| 566 | Total Charge Per Line – Purchase | C | ~~O~~**C** | ~~O~~**C** | If Durable Medical Equipment is purchased |
| 565 | Total Charge Per Line – Rental | C | ~~O~~**C** | ~~O~~**C** | If Durable Medical Equipment is rented |
| 266 | Transaction Tracking Number | M | M | M | |
| 500 | Unique Bill ID Number | M | M | M | Cancel & Replace transactions must match previously submitted Original **DN500** Unique Bill ID ~~No.~~ **Number** |