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

**Effective Jan. 1, 2011**

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**NOTE**: 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 and its effective date. To obtain a comprehensive history for OAR chapter 436, please call the Workers' Compensation Division, (503) 947-7717, or visit the division's Web site: http://wcd.oregon.gov/policy/rules/history.html

# 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~~**ch. 84, 656.264**
**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03

## 436-160-0002 Purpose

The director's purpose is to require workers' compensation ~~proof of coverage and~~ medical data 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~~**656.264**
**Hist:** Amended 10/5/09 as WCD Admin. Order 09-052, eff. 1/1/2010
**Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11**

## 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 the effective date of these rules.

(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:** Amended 12/3/03 as Admin. Order 03-064, eff. 1/1/04
Amended 10/5/09 as WCD Admin. Order 09-052, eff. 1/1/2010

## 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 2.1, dated June 1, 2007, including the definition of standards and procedures, unless otherwise provided in these rules.~~

~~(2) For medical bill data, t~~**T**he director adopts, by reference, *IAIABC EDI Implementation Guide for Medical Bill Payment Records*, Release 1.1, dated July 1, 2009, unless otherwise provided in these rules. ~~(3)~~ Copies of the **guide** ~~standards described in sections (1) and (2)~~ are available from the IAIABC **website**~~Web site~~: http://www.iaiabc.org/i4a/pages/index.cfm?pageid=3339.

**Stat. Authority:** ORS 656.264; **Stat. Implemented:** ORS ~~656.017, ORS 656.407, ORS 656.419, ORS 656.423, and ORS 656.427~~**656.264**
**Hist:** Amended 10/5/09 as WCD Admin. Order 09-052, eff. 1/1/2010
**Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11**

## 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) "Establishing document" means an EDI transaction that reports coverage for one or more entities. Establishing document types may include binders, new policies, rewrite/reissue transactions, renewals, reinstatements, add jurisdiction endorsements, or add employer/location endorsements.~~

~~(8)~~**(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.

~~(9)~~**(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.

~~(10)~~**(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).

~~(11)~~**(10)** "Information" means data, text, images, sounds, codes, computer programs, software, databases, or the like.

~~(12) "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.~~

~~(13)~~**(11)** "Insurer" means the State Accident Insurance Fund Corporation, an insurer authorized under **ORS** chapter 731 to transact workers' compensation insurance in Oregon, or a self-insured employer.

~~(14)~~**(12)** "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.

~~(15)~~**(13)** "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.

~~(16) "Proof of coverage" means an electronic record or set of records identifying an insurer as providing workers' compensation coverage for a specific employer.~~

~~(17)~~**(14)** "Record" means electronic record.

~~(18)~~**(15)** "Reprocessed transaction" means a rejected transaction that, at the discretion of the director, has been reprocessed and accepted by the division.

~~(19)~~**(16)** "Sender" means the person or entity reporting electronic data interchange transactions to the division. Sender may include vendors or insurers.

~~(20)~~**(17)** "Trading partner agreement" means the agreement entered into under OAR 436-160-0020 between the director and an insurer to conduct transactions via EDI.

~~(21)~~**(18)** "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.

~~(22)~~**(19)** "Transaction" means a set of EDI records, defined according to standards in OAR 436-160-0004.

~~(23)~~**(20)** "Transmission" means a defined set of transactions, including both header and trailer records to be sent to the division or sender via EDI.

~~(24)~~**(21)** "Vendor" means an agent identified by the insurer 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:** Amended 11/1/07 as Admin. Order 07-068, eff. 1/1/08
Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09
**Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11**

### 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, an 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 under 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:** Amended 6/12/08 as Admin. Order 08-059, eff. 7/1/08
Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09

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

Insurers and self-insured employers must retain workers' compensation records under 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:** Amended 11/1/07 as Admin. Order 07-068, eff. 1/1/08
Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09

### 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.

(4) A reprocessed transaction retains the filing date of the original transaction.

**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
Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09

## 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) The director adopts the Oregon EDI Implementation Guide for Proof of Coverage as the standard for EDI testing procedures and requirements.~~

~~(b) Senders conducting EDI transactions as of January 1, 2009, do not have to complete EDI testing. Insurers using an approved EDI vendor to submit proof of coverage data to the department do not have to complete testing as provided by this rule.~~

~~(c) Senders must obtain director approval to submit proof of coverage data via EDI transactions. Each sender must successfully complete the Secure File Transfer Protocol (SFTP) test and the format and structure test(s) detailed in the Oregon EDI Implementation Guide for Proof of Coverage to demonstrate ability to successfully transmit coverage data in the format specified in OAR 436-160-0004. The director will notify senders once they have successfully completed testing. Insurers must either use an approved sender or be approved as a sender to report proof of coverage via EDI starting July 1, 2009. If an insurer is not an approved sender, it must report through an approved sender until approved by the director for direct reporting of proof of coverage via EDI.~~

~~(2) Medical bill data t~~**T**esting and transition to production:

~~(a)~~**(1)** To initiate a test for EDI, the sender must contact the director.

~~(b)~~**(2)** 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)~~**(3) To be approved** ~~To gain approval~~ to send production transmissions, the sender must ~~be able to~~:

~~(A)~~**(a)** Transmit records via **EDI** ~~electronic data interchange~~; and

~~(B)~~**(b)** Accomplish secure file transfer protocol **(SFTP)** uploads and downloads.

~~(d)~~**(4)** 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**n** ~~successful~~ EDI FTP test is **successful if the sender is able to resolve** ~~determined by the resolution of~~ any consistently recurring fatal technical errors identified by the division ~~such~~ **so** that:

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

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

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

~~(e)~~**(5)** 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~~ **including** 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.

**(6) Test periods will last a maximum of 120 days. Test periods begin the day the division processes the sender's first test file. If the sender has not met the minimum requirements to move from test to production within 120 days of the start of testing, the sender may request a testing extension period of 60 days.**

**(7) Senders that fail to successfully transition from test into production within 180 days must wait an additional 180 days before requesting a new test period of 120 days.**

~~(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:** Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09
**Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11**

### 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:** 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) Insurers are not required to resubmit reprocessed transactions.~~

~~(3) Medical Bill Data:~~

~~(a) The sender will receive both TA1 and 997 interchange and functional acknowledgements (as defined by ANSI X12N) for each medical bill batch submitted, unless technical errors in the file prevent 997 processing. In addition, the sender will receive an 824 detailed acknowledgement (as defined by ANSI X12N) for each medical bill batch submitted, if the batch has successfully passed the 997 edits. An 824 detailed acknowledgment will contain transaction accepted (TA) or transaction rejected (TR) 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:** Amended 10/5/09 as WCD Admin. Order 09-052, eff. 1/1/2010
**Repealed 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11**

## 436-160-0090 Address Reporting

The sender will follow the standard United States Postal Service guidelines in reporting all addresses.

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.264
**Hist:** 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 policies effective before July 1, 2009, the establishing document transaction types listed in OAR 436-160-0350(3)(c) can be used to file a guaranty contract under that rule. For policies effective on or after July 1, 2009, the establishing document transaction types listed in OAR 436-160-0355(2)(b) can be used to file proof of coverage. 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:** Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09
**Amended and renumbered to OAR 436-162-0300 10/1/10 as Admin. Order 10-057, eff. 1/1/11**

**~~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 under 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 must transmit proof of coverage via EDI. Insurers may not submit paper documents to the director without the director's express permission or as provided in OAR 436-160-0350(7).~~

~~(6) Changes or corrections to proof of coverage transactions must be filed within 30 days of insurer knowledge of the change to a required data field.~~

~~(7) Professional employee organization (PEO) policies will be accepted via EDI, subject to the same data and transaction editing standards as other policies. A policy filing for a PEO does not eliminate the PEO's requirement to file worker leasing notices under OAR 436-050-0410.~~

~~(8) Wrap-up policies will be accepted via EDI, subject to the same data and transaction editing standards as other policies.~~

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.264
**Hist:** Amended 12-1-2009 as WCD Admin. Order 09-063, eff. 1-1-2010
**Amended and renumbered 10/1/10 to OAR 436-162-0310 as Admin. Order 10-057, eff. 1/1/11**

**~~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. The division may, at its discretion, reprocess transactions.~~

~~(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:** Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09
**Amended and renumbered 10/1/10 to OAR 436-162-0320 as Admin. Order 10-057, eff. 1/1/11**

**~~436-160-0330 Proof of Coverage Effective Dates~~**

~~(1) For policies with effective dates before July 1, 2009:~~

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

~~(b) 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.~~

~~(c) 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 under OAR 436-160-0360 and ORS 656.423 or 656.427.~~

~~(2) For policies with effective dates on or after July 1, 2009:~~

~~(a) For binder or new policy establishing document transactions, the policy effective date will also be the effective date of the proof of coverage for the reported entity(ies).~~

~~(b) For all other establishing document transactions, the transaction set type effective date will also be the effective date of the proof of coverage for the reported entity(ies).~~

~~(3) For reinstatement transactions the transaction set type date will determine whether the transaction reinstates the guaranty contract or reinstates proof of coverage shown by the reinstated policy. Transaction effective dates before July 1, 2009, will reinstate the guaranty contract, which will remain in effect until renewed, replaced by new coverage, or terminated by the insurer. Transaction effective dates on or after July 1, 2009, will reinstate the director's required proof of coverage through the reinstated policy, which will remain in effect until the policy expiration date or the date of cancellation, whichever is earlier.~~

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

~~(5) For reissue, renewal, reinstatement, or endorsement transactions, the transaction effective date will be the transaction set type 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:** Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09

**Amended and renumbered 10/1/10 to OAR 436-162-0330 as Admin. Order 10-057, eff. 1/1/11**

**~~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, or 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 or policy proof of coverage does not need to be filed.~~

~~(5) 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 the appropriate "include" or "exclude" endorsement transaction to the associated policy filing.~~

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.264 and ORS 656.419
**Hist:** Amended 12-1-2009 as WCD Admin. Order 09-063, eff. 1-1-2010
**Amended and renumbered 10/1/10 to OAR 436-162-0340 as Admin. Order 10-057, eff. 1/1/11**

**~~436-160-0350 Guaranty Contract Filing Requirements~~**

~~(1) This rule applies to coverage effective before July 1, 2009.~~

~~(2) For the purpose of these rules, an electronic guaranty contract consists of an executed trading partner agreement containing the guaranty described in subsection (3)(a) of this rule, and an accepted proof of coverage insured and employer electronic record.~~

~~(3) An insurer may file a guaranty contract via EDI by:~~

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

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

~~(c) Transmitting 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 (4) 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.~~

~~(4) A duplicate FEIN or a FEIN previously reported under the same policy will be recorded as an additional employer location or an assumed business name, but will not establish an additional guaranty contract for effective dates of coverage before July 1, 2009.~~

~~(5) Reinstatement, rewrite, and reissue transaction types must follow a cancellation transaction.~~

~~(6) If an employer elects to include any non-subject worker(s) under coverage, 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.~~

~~(7) Insurers not approved to file guaranty contract information via EDI by December 31, 2008, must continue to file changes to existing guaranty contracts via paper on or after July 1, 2009.~~

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.264, ORS 656.419, ORS 656.423 and ORS 656.427
**Hist:** Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09
**Amended and renumbered 10/1/10 to OAR 436-162-0350 as Admin. Order 10-057, eff. 1/1/11**

**~~436-160-0355 Proof of Coverage Filing Requirements~~**

~~(1) This rule applies to coverage effective on or after July 1, 2009.~~

~~(2) An insurer may file proof of coverage via EDI by:~~

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

~~(b) Transmitting an establishing document transaction: binder, new policy, renew policy, rewrite/reissue policy, reinstatement, add location, add employer, or add jurisdiction.~~

~~(3) Reinstatement, rewrite, and reissue transaction types must follow a cancellation transaction.~~

~~(4) If an employer elects to include any non-subject worker(s) for coverage, 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
**Hist:** Adopted 9/17/08 as Admin. Order 08-062, eff. 7/1/09
**Renumbered 10/1/10 to OAR 436-162-0355 as Admin. Order 10-057, eff. 1/1/11**

**~~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 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 under 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 under ORS 656.423 or ORS 656.427(1) and (3), if required.~~

~~(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 ten calendar days after the effective date of termination by transmitting the transaction type for cancellation, nonrenewal, or delete jurisdiction; and~~

~~(b) Provide written notice to the employer under ORS 656.423 or ORS 656.427(1) and (3), if required.~~

~~(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.~~

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.264, ORS 656.419, ORS 656.423 and ORS 656.427
**Hist:** Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09
**Renumbered 10/1/10 to OAR 436-162-0360 as Admin. Order 10-057, eff. 1/1/11**

**~~436-160-0370 Proof of Coverage Terminations~~**

~~For policies effective on or after July 1, 2009, to report a cancellation of a policy before the expiration of the policy term, the insurer must:~~

~~(1) Provide notice to the director no more than ten calendar days after the effective date of cancellation by transmitting the transaction type for cancellation, delete jurisdiction, or delete location(s). The "transaction set type effective date" will be used to report the effective date of cancellation under ORS 656.423 or 656.427;~~

~~(2) Retain a record of the written notice sent to the employer under ORS 656.427 for inspection by the division; and~~

~~(3) Provide written notice to the employer under ORS 656.427(1) and (3).~~

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.264, ORS 656.419, ORS 656.423 and ORS 656.427
**Hist:** Adopted 9/17/08 as Admin. Order 08-062, eff. 7/1/09
**Renumbered 10/1/10 to OAR 436-162-0370 as Admin. Order 10-057, eff. 1/1/11**

## ~~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

**Repealed 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11**

**436-160-0405 Insurers' Reporting Responsibilities**

**(1) Insurers with an average of at least 100 accepted disabling claims per year are required to electronically submit detailed medical bill payment data to the Department of Consumer and Business Services under OAR 436-160-0415. The number of accepted disabling claims is determined by the director based on an average accepted disabling claim volume for the previous three calendar years.**

**(2) Once the director has determined that an insurer's average accepted disabling claim count is 100 or higher the insurer must report medical bill payment data in subsequent years. If the insurer's claim count drops below an average of 50 accepted disabling claims, the insurer may apply to the director for exemption from the reporting requirement.**

**(3) The director will publish the a list of insurers required to report medical bill data in Bulletin 359.**

**(4) Insurers that were required to report medical bill payment data under OAR 436-009-0030(12) before Jan. 1, 2011, must successfully complete EDI testing and begin reporting production data before Jan. 1, 2011.**

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.264
**Hist:** **Adopted 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11**

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

**(1) The transmission data and format requirements are included in the *IAIABC EDI Implementation Guide for Medical Bill Payment Records*, Release 1.1, dated July 1, 2009, and Appendix A of these rules. Additional Oregon-specific information can be found in the Oregon Medical State Reporting Electronic Data Interchange (EDI) Implementation Guide, available from the division's website: http://www.cbs.state.or.us/wcd/operations/edi/ediindex.html#bill.**

~~(1)~~**(2)** The chart in Appendix "~~B~~**A**" 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)~~**(3)** Unless otherwise provided in these rules, the data elements must have the meaning provided in the data dictionary **included in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, dated July 1, 2009, Section 6, Medical Bill Payment Records Dictionaries, available from the IAIABC website: http://www.iaiabc.org/i4a/pages/index.cfm?pageid=3339** ~~pursuant to OAR 436-160-0004~~.

~~(3)~~**(4)** 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)~~**(5)** 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:** Amended 6/12/08 as WCD Admin. Order 08-059, eff. 7/1/08
Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09
Amended 10/5/09 as WCD Admin. Order 09-052, eff. 1/1/2010
**Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11**

**436-160-0415 Oregon ASC X12 837 Medical Bill Reporting Requirements**

**(1) Event reporting requirements:**

**(a) Original medical bills, including interpreter bills under OAR 436-009, must be reported within 60 days of date paid.**

**(b) Denied bills for accepted claims must be reported within 60 days of date denied. Denied bills are defined as any bills in which there is a non-zero charge and a zero payment.**

**(c) Transactions must be accepted by the division within 60 days of either the date paid or the date denied to be considered timely reported. If a transaction is initially rejected it must be corrected, resubmitted, and accepted within the original 60 day time period to be considered timely reported.**

**(d) Cancellations: Report immediately, as soon as the payer knows that an original medical bill was previously sent in error.**

**(e) Corrections: Report via a Replacement transaction or a Cancel/Original combination transaction within 60 days of changes to any of the following data elements:**

**(A) DN15 – Claim Administrator Claim Number**

**(B) DN504 – Facility Code**

**(C) DN555 – Place of Service Bill Code**

**(D) DN518 – DRG Code**

**(E) DN682 – Facility NPI**

**(F) DN634 – Billing Provider NPI**

**(G) DN647 – Rendering Bill Provider NPI**

**(H) DN592 – Rendering Line Provider NPI**

**(I) DN726 – HCPCS Line Procedure Paid Code**

**(J) DN576 – Revenue Paid Code**

**(K) DN728 – NDC Paid Code**

**(L) DN580 – Days/Units Paid**

**(M) DN516 – Total Amount Paid per Bill**

**(N) DN501 – Total Charges per Bill**

**(2) Data reporting requirements: See "Medical Bill Data Element Requirement Table" Appendix A.**

**(3) Technical Requirements: See the Oregon Medical State Reporting Electronic Data Interchange (EDI) Implementation Guide for specifications on the Secure File Transfer Protocol (SFTP) requirements.**

**(4) 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 OAR 436-160-0420 for a description of the acceptance/rejection protocol for all reported medical bills. The insurer is responsible for timely correcting and resubmitting all rejected transactions for which law or rule require filing, reporting, or notice to the director.**

**(5) An insurer must request and receive authorization from the department to stop submitting a previously rejected transaction when the department determines the transaction is uncorrectable. The department may impose a civil penalty against the insurer when, within any six month period, the insurer's number of uncorrectable transactions exceeds one percent of the insurer's total accepted transactions.**

**(6) The director will periodically review reported bill data to monitor insurer performance. If the director finds repeated or egregious violations of the reporting requirements of these rules the director may issue civil penalties under OAR 436-160-0445 and ORS 656.745.**

**(a) Medical bills must be reported timely. "Timely" means that an insurer reports medical payment data within 60 days of the date the bill is paid or denied as outlined in OAR 436-160-0415(1).**

**(b) Medical bills must be reported accurately. "Accurate" means that the medical bill data on bills accepted by the division conforms to the reporting requirements of the Medical Bill Data Element Requirement Table in Appendix A of these rules.**

**(c) The insurer may be subject to penalties for any reported medical bills that have not been accepted by the division or designated as uncorrectable under OAR 436-160-0415(5) within 180 days of the date of bill payment or denial.**

**(d) If the insurer's volume of uncorrectable bills exceeds one percent of the insurer's total accepted transactions within any six month period, the insurer may be assessed a penalty.**

**(7) The director may conduct additional audits to monitor insurer reporting compliance.**

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.264
**Hist:** **Adopted 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11**

### 436-160-0420 Medical Bill Acknowledgement

(1) The sender will receive both TA1 and 997 interchange and functional acknowledgements (as defined by ANSI X12N) for each medical bill batch submitted, unless technical errors in the file prevent 997 processing. In addition, the sender will receive an 824 detailed acknowledgement (as defined by ANSI X12N) for each medical bill batch submitted, if

the batch has successfully passed the 997 edits. The detailed acknowledgement will indicate either a transaction accepted (TA) or a transaction rejected (TR) acknowledgement for each individual transaction.

(2) A TA1, 997, or 824 error 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., payment date is after reporting date;

(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 accepted.

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

~~(3)~~**(4)** 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)~~**(5)** 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:** Amended 10/5/09 as WCD Admin. Order 09-052, eff. 1/1/2010
**Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11**

### 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) 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

### 436-160-0440 Monitoring and Auditing Insurers

**(1) The department may monitor and conduct periodic audits of medical bill data to ensure compliance with ORS chapter 656 and these rules.**

**(2) All records maintained or required to be maintained must be disclosed upon request by the director.**

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.252, 656.254, 656.264, 656.455, 656.726
**Hist:** **Adopted 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11**

## 436-160-0445 Assessment of Civil Penalties

**(1) Under ORS 656.745, the director may assess a civil penalty against an insurer who fails to comply with ORS chapter 656 or the director's rules and orders.**

**(2) The insurer is responsible for its own actions as well as the actions of others acting on the insurer's behalf. If an insurer or someone acting on the insurer's behalf violates any provisions of these rules, the director may impose a civil penalty against the insurer.**

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.254, 656.745
**Hist:** **Adopted 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11**

## OAR 436-160-0310 Appendix A Proof of Coverage Data Element Requirement Table

| 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 | M | M | M | O | O |
| Wrap-Up Indicator | DN322 | M | M | M | 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 | M | M | M | M |
| Policy Expiration Date | DN030 | M | M | M | 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 | C | C | C | C | C |
| Number of Employers Expanded | DN336 | C | C | C | C | C |
| **EMPLOYER RECORD** | | | | | | |
| Transaction Set ID | DN001 | M | M | M | | |
| Record Sequence Number | DN107 | M | M | M | | |
| Employer FEIN | DN016 | M | M | O | | |
| 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 | | | M | | |

## ~~Oregon ASC X12 837 Medical Bill Reporting Requirements~~

~~1) Event reporting requirements:~~

~~a. Original medical bills must be reported within 60 days of date paid.~~

~~b. Denied bills for accepted claims must be reported within 60 days of date denied. Denied bills are defined as any bills in which there is a non-zero charge and a zero payment. The department will not reject denied bill transactions with invalid data values, such as invalid ICD-9 codes, if the Claim Adjustment Reason Code(s) indicate that the denial was due to invalid data values.~~

~~c. Cancellations: Report immediately, as soon as payer knows that an original medical bill was previously sent in error.~~

~~d. Replacement: Report within 60 days of:~~

~~i) Payer knowledge of change in claim administrator, location of service, or provider type;~~

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

~~iii) 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 or denied during the previous 60 days for medical services.~~

~~4) Technical Requirements: See the Oregon Medical State Reporting Electronic Data Interchange (EDI) 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.~~

~~6) An insurer must request and receive authorization from the department to stop submitting a previously rejected transaction when the department determines the transaction is uncorrectable. The department may impose a civil penalty against the insurer when the insurer's number of uncorrectable transactions exceeds one percent of the insurer's total accepted transactions.~~

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:

| | Medical Bill Data Element Requirement Table | | | | |
|---|---|---|---|---|---|
| | Bill Submission Reason Codes | | | | |
| | | Accepted Original/Replace | Denied Original/Replace | Cancellation | |
| DN | Data Element Name | 00/05 | 00/05 | 01 | Mandatory Trigger or Implementation Note |
| 719 | ADA Procedure Billed Code | C | O | O | **If DN715 Jurisdiction Procedure Billed Code, DN721 NDC Billed Code, and DN714 HCPCS Line Procedure Billed Code are not present. Must**~~May~~ be used ~~for dental bills~~ **in the** ~~(~~SV3 segment~~)~~. |
| 722 | ADA Procedure Paid Code | C | O | O | If different from DN719**, DN721, DN715, or DN714** ~~ADA Procedure Billed Code~~ **and paid with ADA code (i.e., if paid is different than billed)**. |
| 513 | Admission Date | C | O | O | If DN504 Facility Code **is one of the following:** 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89. |
| 535 | Admitting Diagnosis Code | C | O | O | If DN504 Facility Code **is one of the following:** 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89. |
| 564 | Basis of Cost Determination Code | C | O | O | **If DN502 Billing Type Code value is 'RX' or 'MO'**~~Required for pharmacy bills~~ (i.e., **required for pharmacy bills** ~~DN502 Billing Type Code value is 'RX' or 'MO'~~). |
| 545 | Bill Adjustment Amount | C | C | O | If DN516 Total Amount Paid Per Bill is not equal to DN501 Total Charge Per Bill. Total of all adjustments plus amount paid must equal amount billed. |
| 543 | Bill Adjustment Group Code | C | C | O | If DN516 Total Amount Paid Per Bill is not equal to DN501 Total Charge Per Bill. |
| 544 | Bill Adjustment Reason Code | C | C | O | If DN516 Total Amount Paid Per Bill is not equal to DN501 Total Charge Per Bill. |
| 546 | Bill Adjustment Units | C | O | O | If DN580 Days/Units Paid is different from DN554 Days/Units Billed. |
| 508 | Bill Submission Reason Code | M | M | M | |
| 503 | Billing Format Code | M | M | O | |
| 629 | Billing Provider FEIN | M | M | O | |
| 569 | Billing Provider Country Code | C | O | O | ~~Required if~~**I**f provider address is outside the US. |
| 528 | Billing Provider Last/Group Name | M | M | O | |
| 634 | Billing Provider National Provider ID | C | O | O | Must be reported if billing provider has a~~n NPI~~**National Provider ID**. |
| 537 | Billing Provider Primary Specialty Code | O | O | O | |
| 630 | Billing Provider State License Number | C | O | O | Report DN 630 State License Number only if DN634 Billing Provider does not have a National Provider ID. Use "99999" if provider type not licensed by the state (e.g., ambulance **or**~~,~~ durable medical **equipment**). |
| 523 | Billing Provider Unique Bill Identification Number | M | M | M | If not available, use default of all 9s. |
| 502 | Billing Type Code | C | C | O | If DN502 = "DD," there must be an SV3 segment. If DN502 = "RX" or "MO," there must be an SV4 segment. If DN502 = "DM," there must be an SV5 segment. A combination SV1 and SV5 is permitted on a single line. |
| 015 | Claim Administrator Claim Number | M | M | M | ~~Default to '99999' if not present for denied claim.~~ |

| | Medical Bill Data Element Requirement Table | | | | |
|---|---|---|---|---|---|
| | Bill Submission Reason Codes | | | | |
| | | Accepted Original/Replace | Denied Original/Replace | Cancellation | |
| DN | Data Element Name | 00/05 | 00/05 | 01 | Mandatory Trigger or Implementation Note |
| 187 | Claim Administrator FEIN | C | C | O | If different from DN6 Insurer FEIN. |
| 188 | Claim Administrator Name | C | O | O | If different from DN7 Insurer name. |
| 515 | Contract Type Code | C~~M~~ | O | O | **If DN518 DRG Code is present.** |
| 512 | Date Insurer Paid Bill | M | M~~O~~ | O | |
| 511 | Date Insurer Received Bill | M | M | O | |
| 31 | Date of Injury | M | M | M | |
| 100 | Date Transmission Sent | M | M | M | |
| 554 | Days/Units Billed | C | O | O | ~~Required for~~**If** Professional (SV1 segment used), Institutional (SV2 segment used), **or**~~and~~ DME (SV5 segment used) bills. |
| 553 | Days/Units Code | C | O | O | If DN554 Days/Units Billed is present. |
| 580 | Days/Units Paid | C | O | O | ~~Required i~~**I**f different from DN554 Days/Units Billed. |
| 557 | Diagnosis Pointer | C | O | O | 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. Diagnosis pointer not required for ambulance services ~~(billing or rendering provider's specialty codes 341600000X, 3416L0300X, 3416S0300X and 3416A0800X, or HCPCS codes beginning with A0)~~, DME or jurisdiction service codes. |
| 514 | Discharge Date | C | O | O | If DN503 Billing Format Code equals "A" and patient has been discharged. |
| 562 | Dispense As Written Code | C | O | O | ~~Required for pharmacy bills (i.e.,~~**If** DN502 Billing Type Code value is 'RX' or 'MO'~~).~~ **(i.e., for pharmacy bills).** |
| 567 | DME Billing Frequency Code | C | O | O | 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 DN503 Billing Format Code equals "A" and DN504 Facility Code is one of the following; 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89 and DN682 Facility National Provider ID identifies a required facility. Reported DRG Codes must be MS-DRG Codes; as referenced in OAR 436-009 Medical Billing and Payment Rules.** |
| 563 | Drug Name | O | O | O | |
| 572 | Drugs/Supplies Billed Amount | C | C | O | If DN502 Billing Type Code value is "RX" or "MO~~.~~" **(i.e., for pharmacy bills).** |
| 579 | Drugs/Supplies Dispensing Fee | C | O | O | ~~Required for pharmacy bills (i.e.,~~**If** DN502 Billing Type Code value is 'RX' or 'MO'~~)~~ **(i.e., for pharmacy bills).** |
| 571 | Drugs/Supplies Number of Days | C | O | O | ~~Required for pharmacy bills (i.e.,~~**If** DN502 Billing Type Code value is "RX" or "MO"~~)~~ **(i.e., for pharmacy bills).** |
| 570 | Drugs/Supplies Quantity Dispensed | C | O | O | If DN502 Billing Type Code value is "RX" or "MO" **(i.e., for pharmacy bills).** |
| 152 | Employee Employment Visa | C | C | C | If DN42 Employee Social Security number or DN153 Employee Green Card number is not available. |
| 44 | Employee First Name | M | M | M | |

| | Medical Bill Data Element Requirement Table | | | | |
|---|---|---|---|---|---|
| | Bill Submission Reason Codes | | | | |
| | | Accepted Original/Replace | Denied Original/Replace | Cancellation | |
| DN | Data Element Name | 00/05 | 00/05 | 01 | Mandatory Trigger or Implementation Note |
| 153 | Employee Green Card | C | C | C | If DN42 Employee Social Security number is not available. |
| 154 | Employee ID Assigned by Jurisdiction | C | C | C | If DN42 Employee Social Security, DN153 Employee Green Card, DN152 Employee Employment Visa or DN156 Employee Passport Number not available. |
| 43 | Employee Last Name | M | M | M | |
| 156 | Employee Passport Number | C | C | C | If DN42 Employee Social Security, DN153 Employee Green Card, or DN152 Employee Employment Visa not available. |
| 42 | Employee Social Security Number | C | C | C | DN42 Employee SSN is preferred ID number. If none, see DN153 Employee Green Card. If injured worker is not a U**S** ~~nited States~~ citizen and has no other identification, use "999999999." |
| 18 | Employer Name | M | M | M | |
| 504 | Facility Code | C | O | O | If DN503 Billing Format Code = "A." |
| 689 | Facility Country Code | C | O | O | ~~Required i~~**I**f facility address is outside the US. |
| 678 | Facility Name | C | O | O | If service performed in a facility, (e.g., hospital, ambulatory surgical center, etc.). |
| 682 | Facility National Provider ID | C | O | O | **Must be reported i**~~I~~f service performed in a facility within the U**S** ~~nited States~~. |
| 737 | HCPCS Bill Procedure Code | C | C | O | If DN503 Billing Format Code = "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 | C | O | If DN502 Billing Type Code does not equal RX or MO, and if DN715 Jurisdiction Procedure Billed Code, DN721 NDC Billed Code, and DN719 ADA Procedure Billed Code are not present. **Must be used in the SV1, SV2, SV3, or SV5 segment.** |
| 726 | HCPCS Line Procedure Paid Code | C | O | O | **If different from DN719ADA Procedure Billed Code, DN721 NDC Billed Code, DN715 Jurisdictional Procedure Billed Code, or DN714 HCPCS Line Procedure Billed Code, and paid with HCPCS code (i.e., if paid is different than billed).** ~~If different from DN714 HCPCS Line Proc. Billed Code.~~ |
| 717 | HCPCS Modifier Billed Code | O | O | O | If present, must be a valid code. |
| 727 | HCPCS Modifier Paid Code | C | O | O | If different from DN717 HCPCS Modifier Billed Code. |
| 626 | HCPCS Principal Procedure Billed Code | C | C | O | Must be reported if **DN503 Billing Format Code = "A" and** included on provider's bill. |
| 736 | ICD-9 CM Procedure Code | C | O | O | If DN503 = "A" and if DN525 ICD-9 CM Prin. Proc. Code is present and more than one procedure is performed. |

| | Medical Bill Data Element Requirement Table | | | | |
|---|---|---|---|---|---|
| | Bill Submission Reason Codes | | | | |
| | | Accepted Original/Replace | Denied Original/Replace | Cancellation | |
| DN | Data Element Name | 00/05 | 00/05 | 01 | Mandatory Trigger or Implementation Note |
| 522 | ICD-9 CM Diagnosis Code | C | O | O | If DN521 Principal 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 are present or a drug is dispensed by a physician during an office visit. Code must be specific enough to provide valid diagnosis, according to CMS definition. Summary codes that are specifically excluded from use as a diagnosis will be rejected. Diagnosis code not required for DME, jurisdiction service codes, or ambulance services ~~(billing or rendering provider's specialty codes 341600000X, 3416L0300X, 3416S0300X and 3416A0800X, or HCPCS codes beginning with A0)~~. |
| 525 | ICD-9 CM Principal Procedure Code | C | C | O | Must be reported if **DN503 Billing Format Code = "A" and** included on provider's bill. |
| 6 | Insurer FEIN | M | M | M | **Cancel and Replace transactions must match previously accepted Original DN6 Insurer FEIN. Resubmitted Original transactions must match previously submitted DN6 Insurer FEIN.** |
| 7 | Insurer Name | M | M | M | |
| 5 | Jurisdictional Claim Number | C | O | O | If the first report of injury has been filed and a jurisdictional claim number has been returned to the insurer. |
| 718 | Jurisdictional Modifier Billed Code | O | O | O | Use HCPCS modifier values in this field if billing based on jurisdiction code. |
| 730 | Jurisdictional Modifier Paid Code | C | O | O | If different than DN718 Jurisdictional Modifier Billed Code. Use HCPCS modifier values in this field if payment based on jurisdiction code. |
| 715 | Jurisdictional Procedure Billed Code | C | O | O | If the procedure is included as an Oregon-specific code in the Oregon Medical Fee Schedule**;** ~~.~~ **and if DN502 Billing Type Code does not equal RX or MO; and if DN714 HCPCS Line Procedure Billed Code, DN721 NDC Billed Code, and DN719 ADA Procedure Billed Code are not present. Must be used in the SV1 or SV2 segment.** |
| 729 | Jurisdictional Procedure Paid Code | C | O | O | **If different from DN719 ADA Procedure Billed Code , DN721 NDC Billed Code, DN715 Jurisdictional Procedure Billed Code, or DN714 HCPCS Line Procedure Billed Code and paid with Jurisdictional code (i.e., if paid is different than billed).** ~~If different from DN715 Jurisdiction Procedure Billed Code.~~ |
| 547 | Line Number | M | M | O | Required in Loop 2400/LX segment. |
| 208 | Managed Care Organization Identification Number | C | O | O | If ~~worker enrolled in an MCO at time of service.~~**DN507 Provider Agreement Code equals 'P.'** |

| | Medical Bill Data Element Requirement Table | | | | |
|---|---|---|---|---|---|
| | Bill Submission Reason Codes | | | | |
| | | Accepted Original/Replace | Denied Original/Replace | Cancellation | |
| DN | Data Element Name | 00/05 | 00/05 | 01 | Mandatory Trigger or Implementation Note |
| 721 | NDC Billed Code | C | O | O | ~~Required for pharmacy bills (i.e.,~~**If** DN502 Billing Type Code is 'RX' or 'MO'~~,)~~ or **if** ~~for professional bills when a drug is dispensed by a physician during an office visit.~~ **DN714 HCPCS Line Procedure Billed Code, DN715 Jurisdictional Procedure billed Code, and DN719 ADA Procedure Billed Code are not present. Must be used in the SV1 or SV4 segment.** For compound drugs, use "99999." |
| 728 | NDC Paid Code | C | O | O | **If different from DN719ADA Procedure Billed Code, DN721 NDC Billed Code, DN715 Jurisdictional Procedure Billed Code, or DN714 HCPCS Line Procedure Billed Code and paid with NDC code (i.e., if paid is different than billed).**~~If different from DN721 NDC Billed Code. For compound drugs, use "99999."~~ |
| 555 | Place of Service Bill Code | C | O | O | If DN503 Billing Format Code equals "B." |
| 600 | Place of Service Line Code | C | O | O | If different from DN555 Place of Svc. Billed Code. |
| 527 | Prescription Bill Date | O | O | O | |
| 604 | Prescription Line Date | C | O | O | **If DN502 Billing Type Code value is 'RX' or 'MO' (i.e., required for pharmacy bills).**~~Required for pharmacy bills (i.e., DN502 Billing Type Code value is 'RX' or 'MO').~~ |
| 561 | Prescription Line Number | C | O | O | **If DN502 Billing Type Code value is 'RX' or 'MO' (i.e., required for pharmacy bills).**~~Required for pharmacy bills (i.e., DN502 Billing Type Code value is 'RX' or 'MO').~~ |
| 521 | Principal Diagnosis Code | C | O | O | If DN503 Billing Format Code equals "A." |
| 550 | Principal Procedure Date | C | O | O | ~~Required i~~**I**f DN626 HCPCS Principal Procedure Code or DN525 ICD-9 CM Principal Procedure Code is present. |
| 524 | Procedure Date | C | O | O | ~~Required i~~**I**f DN736 ICD-9 CM Procedure Code or DN737 HCPCS Bill Procedure Code is present. |
| 507 | Provider Agreement Code | M | O | O | Enter "P" if worker is enrolled in a **WCD-certified** Managed Care Organization at time of service or if provider participates in a WCD-registered fee discount agreement. Enter "Y" for any other agreement. Enter "N" for none. |
| 657 | Rendering Bill Provider Country Code | C | O | O | ~~Required i~~**I**f provider address is outside the US. |
| 642 | Rendering Bill Provider FEIN | O | O | O | |
| 639 | Rendering Bill Provider First Name | C | C | O | ~~Required when~~**If** Rendering Bill Provider is a person. |
| 638 | Rendering Bill Provider Last/Group Name | M | M | O | |
| 647 | Rendering Bill Provider National Provider ID | C | O | O | **Must be reported i**~~I~~f DN503 Billing Format Code equals A, and if provider has a National Provider ID. |
| 651 | Rendering Bill Provider Primary Specialty Code | O | O | O | |
| 643 | Rendering Bill Provider State License Number | C | O | O | Report DN643 Rendering Bill Provider State License Number only if DN647 Rendering Bill Provider does not have a National Provider ID. **Use "99999"** ~~I~~**i**f provider type not licensed by the state (e.g., ambulance **or**~~,~~ durable medical **equipment**)~~,~~. ~~use "99999."~~ |

| | Medical Bill Data Element Requirement Table | | | | |
|---|---|---|---|---|---|
| | Bill Submission Reason Codes | | | | |
| | | Accepted Original/Replace | Denied Original/Replace | Cancellation | |
| DN | Data Element Name | 00/05 | 00/05 | 01 | Mandatory Trigger or Implementation Note |
| 585 | Rendering Line Provider Country Code | C | O | O | ~~Required if~~**If** provider address is outside the US. |
| 586 | Rendering Line Provider FEIN | O | O | O | |
| 592 | Rendering Line Provider National Provider ID | C | C | O | **Must be reported if**~~f~~ provider has a~~n~~ N**ational** P**rovider** I**D**~~, it must be reported~~. |
| 595 | Rendering Line Provider Primary Specialty Code | O | O | O | |
| 599 | Rendering Line Provider State License Number | C | O | O | If DN592 Rendering Line Provider does not have a National Provider ID, DN599 State License Number must be present. **Use "99999" if provider type not licensed by the state (e.g., ambulance or durable medical equipment).**~~If provider type not licensed by the state (e.g., ambulance, durable medical), use "99999."~~ |
| 615 | Reporting Period | M | M | M | |
| 559 | Revenue Billed Code | C | C | O | If a value for DN504 Facility Code with 1st digit equal to 1. |
| 576 | Revenue Paid Code | C | O | O | If different from DN559 Revenue Billed Code. |
| 733 | Service Adjustment Amount | C | C | O | ~~Required if~~**If** DN574 Total Amount Paid Per Line is different from DN552 Total Charge Per Line, DN566 Total Charge Per Line – Purchase, DN565 Total Charge Per Line – Rental, or DN572 Drugs/Supplies Billed amount. |
| 731 | Service Adjustment Group Code | C | C | O | ~~Required if~~**If** DN574 Total Amount Paid Per Line is different from DN552 Total Charge Per Line, DN566 Total Charge Per Line – Purchase, DN565 Total Charge Per Line – Rental, or DN572 Drugs/Supplies Billed amount. |
| 732 | Service Adjustment Reason Code | C | C | O | ~~Required if~~**If** DN574 Total Amount Paid Per Line is different from DN552 Total Charge Per Line, DN566 Total Charge Per Line – Purchase, DN565 Total Charge Per Line – Rental, or DN572 Drugs/Supplies Billed amount. |
| 734 | Service Adjustment Units | C | O | O | ~~Required when~~ **If** DN580 Days/Units Paid is not equal to DN554 Days/Units Billed. |
| 509 | Service Bill Date(s) Range | C | O | O | If different from DN605 Svc. Lines Date Range. |
| 605 | Service Line Date(s) Range | C | O | O | ~~Required for all~~**If** bill type~~s except~~**is not** pharmacy. **(**DN604 **Prescription Line Date** is used specifically for pharmacy.**)** |
| 101 | Time Transmission Sent | M | M | M | |
| 516 | Total Amount Paid Per Bill | C | C | O | If different from DN501 Total Charge per Bill~~.~~ **and must equal the sum of all the amounts paid at the line level.** |
| 574 | Total Amount Paid Per Line | C | O | O | If paid amount is not equal to DN552 Total Charge per Line**, DN572 Drugs/Supplies Billed Amount, or the sum of DN566 Total Charge Per Line–Purchase plus DN565 Total Charge Per Line–Rental**. |
| 501 | Total Charge Per Bill | M | M | O | |
| 552 | Total Charge Per Line | C | C | O | ~~Required for~~**If** professional and institutional service lines~~ only~~ (**i.e.**, SV1, SV2, **and** SV3). |
| 566 | Total Charge Per Line – Purchase | C | O | O | If Durable Medical Equipment is purchased. |
| 565 | Total Charge Per Line – Rental | C | O | O | If Durable Medical Equipment is rented. |
| 266 | Transaction Tracking Number | M | M | M | |

| | Medical Bill Data Element Requirement Table | | | | |
|---|---|---|---|---|---|
| | Bill Submission Reason Codes | | | | |
| | | Accepted Original/Replace | Denied Original/Replace | Cancellation | |
| DN | Data Element Name | 00/05 | 00/05 | 01 | Mandatory Trigger or Implementation Note |
| 500 | Unique Bill ID Number | M | M | M | Cancel & Replace transactions must match previously ~~submitted~~ **accepted** Original DN500 Unique Bill ID Number. **Resubmitted Original transactions must match previously submitted DN500 Unique Bill ID Number.** |