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

Effective July 1, 2014

TABLE OF CONTENTS

NOTE: Revisions are marked as follows:

Deleted text has a "strike-through" style, as in	~~Deleted~~
Added text is 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 visit the division's website: http://wcd.oregon.gov/policy/rules/history.html

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
ELECTRONIC DATA INTERCHANGE; MEDICAL BILL DATA

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 160

436-160-0001 Authority~~-~~, Applicability, Purpose, and Administration of these~~for~~ Rules

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

(2) These rules apply to workers' compensation related transactions filed with the director by electronic data interchange (EDI) on or after July 1, 2014.

(3) The purpose of these rules is to require workers' compensation medical bill data reporting by electronic data interchange.

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

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

Stat. Authority: ORS 656.264 and 656.726(4)
Stat. Implemented: ORS ch. 84, 656.264
Hist: Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0002 Purpose (Moved to OAR 436-160-0001)

~~The director's purpose is to require workers' compensation medical data reporting via electronic data interchange.~~

Stat. Authority: ORS 656.264 and 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Repealed 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0003 Applicability of Rules (Moved to OAR 436-160-0001)

~~(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 10/5/09 as WCD Admin. Order 09-052, eff. 1/1/2010
Repealed 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0004 Adoption of Standards

(1)(a) The director adopts, by reference, IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release ~~1.1~~2.0, dated ~~July~~ Feb 1, ~~2009~~2013. ~~,~~

(b) The director adopts, by reference, the ASC X12 Implementation Acknowledgment for Health Care Insurance (999), dated February 2011.

(2) The form, format, and delivery of data elements reported and definitions will conform to the standards adopted under section (1), unless otherwise provided in these rules. ~~Copies of the guide are available from the IAIABC website: http://www.iaiabc.org/i4a/pages/index.cfm?pageid=3339.~~

(3) Copies of the guides in section (1) are available for review during regular business hours at the Workers' Compensation Division, Operations Section, 350 Winter Street NE, Salem OR 97301, 503-947-7742.

(a) IAIABC members may view a copy of the Release 2.0 guide, or non-members may purchase a copy at the IAIABC website: http://www.iaiabc.org.

(b) The ASC X12 999 guide is available for purchase at the X12 online store: http://store.x12.org/store/healthcare-5010-consolidated-guides.

Stat. Authority: ORS 656.264
Stat. Implemented: ORS 656.264
Hist: Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

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) "ASC X12" means the Accredited Standards Committee chartered by the American National Standards Institute (http://www.x12.org/x12org/index.cfm).

~~(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 d~~D~~ata i~~I~~nterchange" or "EDI" means a computer to computer exchange of information in a standardized electronic format.

(6) "Electronic r~~R~~ecord" means information created, generated, sent, communicated, received, or stored by electronic means.

(7) "Exclude (not applicable to the transaction)" means the data element must not be sent or cannot be sent.

(8) "Fatal Technical" means the transaction set or item structurally requires the data element.

~~(7)~~(9) "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~~10) "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.

(11) "Health Care Provider" has the same meaning as "medical provider," under OAR 436-010-0005(28).

(~~9~~12) "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)~~www.iaiabc.org).

(13) "If Applicable/Available with Item Accept if Invalid" means the data element must be sent if appropriate for the item record. Even if the item record has an invalid value, the transaction set or item record will not be rejected.

(14) "If Applicable/Available with Item Reject if Invalid" means the data element must be sent if appropriate for the item record. If the item record has an invalid value, then the transaction set or item record will be rejected.

(~~10~~15) "Information" means data, text, images, sounds, codes, computer programs, software, databases, or the like.

(~~11~~16) "Insurer" means the State Accident Insurance Fund Corporation, an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon, an assigned claims agent selected by the director under ORS 656.054, or a self-insured employer.

(~~12~~17) "Mandatory data element" means an element that will cause a rejection of a transaction if the data element is omitted or submitted in an invalid format, or with an improper value.~~not capable of being processed by the division's information processing system.~~

(18) "Mandatory Conditional" means the data element is required when certain conditions are present.

(19) "Medical Bill" means a statement of charges for medical services, specified as "compensable medical services," under ORS 656.245.

(20) "Not Applicable" means the data element is not relevant, appropriate, or doesn't apply, although if present with an improper value will not cause a rejection of a transaction.

(~~13~~21) ~~"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.~~

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

(~~15~~22) ~~"Reprocessed transaction" means a rejected transaction that, at the discretion of the director, has been reprocessed and accepted by the division.~~

~~(16)~~ "~~Sender~~Trading partner" means the ~~person or~~ entity ~~reporting~~ sending electronic data interchange (EDI) transactions to the division. ~~Senders~~ Trading partners may include vendors or insurers.

~~(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.~~

(~~18~~23) "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.

(~~19~~24) "Transaction" means a set of EDI records, defined according to standards in OAR 436-160-0004.

(~~20~~25) "Transmission" means a defined set of transactions, including both header and trailer records to be sent to the division or sender ~~via~~ by EDI.

~~(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 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0006 Administration of Rules (Moved to OAR 436-160-0001)

~~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
Repealed 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0010 Security (Repealed)

~~(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
Repealed 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0020 Trading Partner Agreement (Repealed)

~~(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
Repealed 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0030 Retention of Electronic Records (Repealed)

~~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
Repealed 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0040 Recognized ~~Filing~~ Received 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 a~~An electronic record is received when ~~it~~:

~~(a)~~ (1) The record enters the division's designated information processing system;~~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)~~ (2) All the required data elements and electronic records are in the form and format specified in these rules in the proper sequence; and~~Is in a form and format capable of being processed by the division's information processing system.~~

(3) The record can be fully processed by the division's information processing system.~~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: Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0050 Form, Format, and Delivery for Electronic Data Reporting (Repealed)

~~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
Repealed 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0060 Testing Procedures and Requirements

Testing and transition to production:

(1) Before testing can begin, or the division can accept medical billing data, the trading partner must submit a completed Medical Billing Data EDI Trading Partner Profile (Form 4015) to the division's EDI Coordinator. Form 4015 is available on the division's website: http://wcd.oregon.gov/operations/edi/ediindex.html#bill.

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

(2) ~~Each transmission for~~ For test purposes each transmission must conform to the standards specified in OAR 436-160-0004.

(3) ~~, or as otherwise identified in the trading partner agreement.~~ Test files will be evaluated in terms of whether the data sent was ~~sent~~ received in the correct~~,~~ standardized format and fully processed by the division's information processing system.

(4) The EDI Coordinator will determine the number of required transactions per test submission based on the anticipated volume of production transactions.~~.~~

(~~3~~5) To be approved to send production transmissions, the sender must:

(a) ~~Transmit records via EDI; and~~

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

(b) ~~4) The sender must~~ D~~d~~emonstrate the ability to send transmissions to the ~~director~~ division that are ~~readable,~~ in the correct format~~,~~ and can be processed through the division's information processing system;~~.~~

(c) ~~An EDI FTP test is successful if the sender is able to~~R ~~r~~esolve any consistently recurring ~~fatal technical~~ errors, and demonstrate the ability to correct and resubmit corrections to errors identified by the division ~~so that~~;~~:~~

(~~a~~d) Send t~~T~~ransmissions ~~are sent~~ to the ~~director~~ division that~~without~~ do not result in a 999 acknowledgment indicating a rejection~~structural errors~~;

(~~b~~e) Send ~~T~~transmissions ~~are sent~~ to the ~~director~~ division without transaction level technical errors; ~~and~~

(f~~c~~) Demonstrate the ability to receive and process acknowledgement transactions; and

(g) Achieve an acceptance rate of at least 90 percent.~~The sender can receive and process the automated EDI acknowledgement transactions.~~

~~(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, 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.~~

Stat. Authority: ORS 656.726(4);
Stat. Implemented: ORS 84.013 and ORS 656.264
Hist: Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0070 Electronic signature (Repealed)

~~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
Repealed 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0090 Address Reporting (Repealed)

~~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
Repealed 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0405 Insurers' Reporting Responsibilities

(1) Insurers with an average of at least 100 accepted disabling claims per year, based on the average accepted disabling claim volume for the previous three calendar years, 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) The director will notify an insurer when the insurer has reached a three-year average accepted disabling claim count of at least 100. The insurer is required to report medical bill payment data beginning with the date specified in the notice and must continue to report in subsequent years. ~~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.~~

(3) If the insurer's claim count drops below an average of 50 accepted disabling claims, based on the average accepted disabling claim volume for the previous three calendar years, ~~the insurer~~ insurers may apply to the director for an exemption from the reporting requirement.

(4) The list of insurers required to report medical bill data is published in Bulletin 359.

(5) Insurers that do not meet the requirement to submit medical data under (1) of this rule may voluntarily submit medical billing data.

~~(3) The director will publish the 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
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0410 Electronic Medical Bill Data ~~Electronic Filing~~ Transmission and Format Requirements

(1) The transmission data and format requirements are included in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release ~~1.1~~2.0, dated ~~July~~ Feb 1, ~~2009~~2013~~,~~ , and ~~Appendix~~ Appendices A and B of these rules. ~~Additional~~ Oregon-specific information can be found o~~i~~n the ~~Oregon Medical State Reporting Electronic Data Interchange (EDI) Implementation~~division's Electronic Data EDI ~~Guide~~webpage~~, available from the division's website~~: http://www.cbs.state.or.us/wcd/operations/edi/ediindex.html~~http://www.cbs.state.or.us/wcd/operations/edi/ediindex.html#bill~~.

(2) Data elements are listed in Appendices A and B:

(a) ~~The chart in~~ Appendix ~~"~~A~~"~~ shows all medical bill data elements accepted ~~via~~ by EDI in Oregon, and whether the data element is "Fatal Technical" (F), "M~~m~~andatory" (M), "Mandatory C~~c~~onditional" (MC), ~~or~~ "If Applicable/Available with Item Reject if Invalid" (AR), or "If Applicable/Available with Item Accept if Invalid" (AA)~~optional (O)~~ for each transaction type.

(b) Appendix B lists mandatory conditional data elements that are mandatory under specific conditions.

(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~~2.0, dated ~~July~~ Feb. 1, ~~2009~~2013, Section 2; Health Care Claim (837)~~Section 6,. Medical Bill Payment Records Dictionaries, available from the IAIABC website: http://www.iaiabc.org/i4a/pages/index.cfm?pageid=3339.~~

(4) Transactions will be rejected if "Fatal Technical," "M~~m~~andatory," or "Mandatory Conditional" ~~or required conditional~~ data elements are omitted, or include invalid values~~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) Transactions will be rejected if "If Applicable/Available with Item Reject if Invalid" data elements include invalid values.

(~~5~~6) Invalid "If Applicable/Available with Item Accept if Invalid"~~Optional~~ data element~~(~~s will be ignored~~)~~ if they are included 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~~.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

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

(1) Event reporting requirements:

(a) ~~Original m~~Medical bills, including interpreter bills under OAR 436-009, must be reported within 60 days of the date paid.

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

(c) Transactions must be received and 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 : Rmust be reported immediately, as soon as the payer knows that an originala medical bill was previously sent in error.

(e) Corrections/Replacements : Reportmust be reported via a Replacement transaction or a Cancel/Original combination transaction within 60 days of changes to any of the "Fatal Technical," "Mandatory," or "Mandatory Conditional" following data elements in Appendices A and B.

(f) Bills received by the insurer before July 1, 2014, may be reported to the Division using the IAIABC reporting standard version 1.1.

(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 are described in "Medical Bill Data Element Requirement Table" AppendixAppendices A and B.

(3) Technical Requirementsrequirements : Seeare described on the division's Electronic Data EDI webpage 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 ofdescribes the acceptance/ or 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~~ director to stop submitting a previously rejected transaction when the ~~department~~ division 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~~ bills ~~data within 60 days of the date the bill is paid or denied as outlined in~~as required by OAR 436-160-0415(1).

(b) Medical bills must be reported accurately. "Accurately" means that the reported medical bill data ~~on bills~~ accepted by the division conforms to the reporting requirements of the Appendices A and B. ~~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
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0420 Medical Bill Acknowledgement

(1)(a) The sender ~~will receive~~ is expected to retrieve both TA1 and ~~997~~ 999 interchange and functional acknowledgements (as defined by ~~ANSI~~ ASC X12~~N~~) for each medical bill batch submitted, unless technical errors in the file prevent 999~~7~~ processing. In addition, the sender is expected to retrieve ~~will receive an~~the 824 detailed acknowledgement (as defined by ~~ANSI X12N~~IAIABC Release 2.0) for each medical bill batch submitted, if the batch has successfully passed the 999~~7~~ edits.

(b) The detailed acknowledgement will indicate either an ~~transaction~~ item accepted (~~TA~~IA) or an ~~transaction~~ item rejected (I~~T~~R) acknowledgement for each individual transaction.

(2) A TA1, 999~~7,~~ or 824 ~~error~~ acknowledgement will be ~~sent~~ available for all transactions ~~incapable of being processed by~~ the ~~division's~~ division is ~~information processing system~~unable to process, 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~~ that require matching, and cannot be matched to the division's database, e.g., cancellation of an original bill that does not match ~~on~~ the 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.~~

(~~4~~3) A transaction accepted acknowledgement will be ~~sent~~ available for all transactions that are in a format capable of being processed by the division's information processing system and that are not rejected ~~pursuant to~~under section (2) of this rule.

(~~5~~4) An insurer's obligation to ~~file~~ report medical bill data for the purposes of this rule is not satisfied unless the ~~director~~ division acknowledges acceptance of the transaction.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

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, corrections, and replacements to the original bill. Failure to match on this data element will result in a rejected transaction.

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

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
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0440 Monitoring and Auditing Insurers

(1) The ~~department~~ director 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
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

436-160-0445 Assessment of Civil Penalties

(1) Under ORS 656.745, the director may assess a civil penalty against an insurer ~~who~~ that 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
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

~~OAR 436-160-0410~~ Appendix A and Appendix B (OAR 436-160-0410)

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

Requirement Codes (for Appendix A)	
F	Fatal Technical
M	Mandatory
MC	Mandatory Conditional: Conditions are defined on the Medical Conditions Table, Appendix B
AA	If Applicable/Available with Item Accept if Invalid
AR	If Applicable/Available with Item Reject if Invalid
NA	Not Applicable
X	Exclude (not applicable to the transaction)

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

Oregon Medical EDI Element Requirement Table – Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Transaction Set Header - Required Loop																		
0532	BHT03	ORIGINATOR TRANSACTION IDENTIFICATION NUMBER	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0100	BHT04	DATE TRANSMISSION SENT	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0101	BHT05	TIME TRANSMISSION SENT	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 1000A - Submitter Information - Required Loop																		
0098	NM109	SENDER ID	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 1000B - Receiver Information - Required Loop																		
0099	NM109	RECEIVER ID	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 2000A - Insurer Hierarchical Level Information - Required Loop																		
0615	DTP03	REPORTING PERIOD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Loop ID 2010AA - Insurer/Self Insured Information - Required Loop																		
0007	NM103	INSURER NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0006	NM109	INSURER FEIN	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0616	N403	INSURER POSTAL CODE	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Loop ID 2010AB - Claim Administrator Information - Situational Loop																		
0188	NM103	CLAIM ADMINISTRATOR NAME	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0187	NM109	CLAIM ADMINISTRATOR FEIN	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0014	N403	CLAIM ADMINISTRATOR MAILING POSTAL CODE	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
Loop ID 2010BA - Employer Information - Required Loop																		
0018	NM103	EMPLOYER NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0016	NM109	EMPLOYER FEIN	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
Loop ID 2000C - Claimant Hierarchical Information - Required Loop																		
0031	DTP03	DATE OF INJURY	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 2010CA - Claimant Information - Required Loop																		
0043	NM103	EMPLOYEE LAST NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0044	NM104	EMPLOYEE FIRST NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0045	NM105	EMPLOYEE MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0255	NM107	EMPLOYEE LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0042	NM109	EMPLOYEE SSN	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC

Oregon Medical EDI Element Requirement Table – Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2010CA - Claimant Information - Required Loop																		
0153	NM109	EMPLOYEE GREEN CARD	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0154	NM109	EMPLOYEE ID ASSIGNED BY JURISDICTION	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0156	NM109	EMPLOYEE PASSPORT NUMBER	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0152	NM109	EMPLOYEE EMPLOYMENT VISA	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0046	N301	EMPLOYEE MAILING PRIMARY ADDRESS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0047	N302	EMPLOYEE MAILING SECONDARY ADDRESS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0048	N401	EMPLOYEE MAILING CITY	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0049	N402	EMPLOYEE MAILING STATE CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0050	N403	EMPLOYEE MAILING POSTAL CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0155	N404	EMPLOYEE MAILING COUNTRY CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0052	DMG02	EMPLOYEE DATE OF BIRTH	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0053	DMG03	EMPLOYEE GENDER CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0015	REF02	CLAIM ADMINISTRATOR CLAIM NUMBER	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0005	REF02	JURISDICTION CLAIM NUMBER	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0051	PER04	EMPLOYEE PHONE NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Loop ID 2300 - Bill Information - Required Loop																		
0523	CLM01	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0501	CLM02	TOTAL CHARGE PER BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0502	CLM04	BILLING TYPE CODE	X	NA	X	X	X	NA	X	X	X	NA	X	X	X	NA	X	X
0504	CLM05-1	FACILITY CODE	X	NA	X	X	F	NA	F	F	X	NA	X	X	X	NA	X	X
0555	CLM05-1	PLACE OF SERVICE BILL CODE	F	F	F	F	X	X	X	X	F	F	F	F	F	F	F	F
0503	CLM05-2	BILLING FORMAT CODE	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0505	CLM05-3	BILL FREQUENCY TYPE CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0507	CLM16	PROVIDER AGREEMENT CODE	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0508	CLM19	BILL SUBMISSION REASON CODE	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0511	DTP03	DATE INSURER RECEIVED BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0513	DTP03	ADMISSION DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0622	DTP03	ADMISSION HOUR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0514	DTP03	DISCHARGE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X

Oregon Medical EDI Element Requirement Table – Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2300 - Bill Information - Required Loop																		
0623	DTP03	DISCHARGE HOUR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0509	DTP03	SERVICE BILL DATE(S) RANGE	NA	NA	NA	NA	M	NA	M	M	NA	NA	NA	NA	NA	NA	NA	NA
0527	DTP03	PRESCRIPTION DATE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0510	DTP03	DATE OF BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0512	DTP03	DATE INSURER PAID BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0577	CL101	ADMISSION TYPE CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0515	CN101	CONTRACT TYPE CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0516	AMT02	TOTAL AMOUNT PAID PER BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0500	REF02	UNIQUE BILL ID NUMBER	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0266	REF02	TRANSACTION TRACKING NUMBER	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0581	REF02	TREATMENT AUTHORIZATION NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0293	REF02	LUMP SUM PAYMENT/SETTLEMENT CODE	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Principal Diagnosis - Situational Segment																		
0521	HI01-2	PRINCIPAL DIAGNOSIS CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0533	HI01-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Admitting Diagnosis - Situational Segment																		
0535	HI01-2	ADMITTING DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Other Diagnosis - Situational Segment																		
0522	HI01-2	DIAGNOSIS CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0533	HI01-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI02-2	DIAGNOSIS CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0533	HI02-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI03-2	DIAGNOSIS CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0533	HI03-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI04-2	DIAGNOSIS CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0533	HI04-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI05-2	DIAGNOSIS CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0533	HI05-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI06-2	DIAGNOSIS CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X

Oregon Medical EDI Element Requirement Table – Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Institutional Bill Other Diagnosis - Situational Segment																		
0533	HI06-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI07-2	DIAGNOSIS CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0533	HI07-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI08-2	DIAGNOSIS CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0533	HI08-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI09-2	DIAGNOSIS CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0533	HI09-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI10-2	DIAGNOSIS CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0533	HI10-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI11-2	DIAGNOSIS CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0533	HI11-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI12-2	DIAGNOSIS CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0533	HI12-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
HI Segment - Outpatient Reason For Visit - Situational Segment																		
0520	HI01-2	OUTPATIENT REASON FOR VISIT CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0520	HI02-2	OUTPATIENT REASON FOR VISIT CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0520	HI03-2	OUTPATIENT REASON FOR VISIT CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment																		
0521	HI01-2	PRINCIPAL DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI02-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI03-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI04-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI05-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI06-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI07-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI08-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI09-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI10-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI11-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC

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Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment																		
0522	HI12-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
HI Segment - Institutional Bill Principal Procedure - Situational Segment																		
0525	HI01-2	PRINCIPAL PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0550	HI01-4	PRINCIPAL PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment																		
0736	HI01-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI01-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI02-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI02-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI03-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI03-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI04-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI04-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI05-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI05-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI06-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI06-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI07-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI07-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI08-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI08-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI09-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI09-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI10-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI10-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI11-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI11-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI12-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI12-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X

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		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Condition Codes - Situational Segment																		
0556	HI01-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI02-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI03-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI04-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI05-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI06-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI07-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI08-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI09-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI10-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI11-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI12-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
HI Segment - Diagnosis Related Group (DRG) Information - Situational Segment																		
0549	HI01-2	PAID DRG CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0548	HI01-8	BILLED DRG CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
Loop ID 2310A - Billing Provider Information - Required Loop																		
0528	NM103	BILLING PROVIDER LAST/GROUP NAME	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0529	NM104	BILLING PROVIDER FIRST NAME	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0530	NM105	BILLING PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0531	NM107	BILLING PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0634	NM109	BILLING PROVIDER NATIONAL PROVIDER ID	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0537	PRV03	BILLING PROVIDER PRIMARY SPECIALTY CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0538	N301	BILLING PROVIDER PRIMARY ADDRESS	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0539	N302	BILLING PROVIDER SECONDARY ADDRESS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0540	N401	BILLING PROVIDER CITY	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0541	N402	BILLING PROVIDER STATE CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0542	N403	BILLING PROVIDER POSTAL CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0569	N404	BILLING PROVIDER COUNTRY CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0629	REF02	BILLING PROVIDER FEIN	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M

Oregon Medical EDI Element Requirement Table – Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2310A - Billing Provider Information - Required Loop																		
0630	REF02	BILLING PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2310B - Rendering Bill Provider Information - Situational Loop																		
0638	NM103	RENDERING BILL PROVIDER LAST/GROUP NAME	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0639	NM104	RENDERING BILL PROVIDER FIRST NAME	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0640	NM105	RENDERING BILL PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0641	NM107	RENDERING BILL PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0647	NM109	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	AR	NA	AR	AR	M	NA	M	M	AR	NA	AR	AR	AR	NA	AR	AR
0651	PRV03	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0643	REF02	RENDERING BILL PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2310C - Supervising Provider Information - Situational Loop																		
0658	NM103	SUPERVISING PROVIDER LAST/GROUP NAME	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0659	NM104	SUPERVISING PROVIDER FIRST NAME	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0660	NM105	SUPERVISING PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0661	NM107	SUPERVISING PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0667	NM109	SUPERVISING PROVIDER NATIONAL PROVIDER ID	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0671	PRV03	SUPERVISING PROVIDER PRIMARY SPECIALTY CODE	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0663	REF02	SUPERVISING PROVIDER STATE LICENSE NUMBER	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
Loop ID 2310D - Service Facility Location Information - Situational Loop																		
0678	NM103	FACILITY NAME	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0682	NM109	FACILITY NATIONAL PROVIDER ID	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0684	N301	FACILITY PRIMARY ADDRESS	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0685	N302	FACILITY SECONDARY ADDRESS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0686	N401	FACILITY CITY	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0687	N402	FACILITY STATE CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0688	N403	FACILITY POSTAL CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0689	N404	FACILITY COUNTRY CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0680	REF02	FACILITY STATE LICENSE NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0683	REF02	FACILITY SERVICE LOCATION ID	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA

Oregon Medical EDI Element Requirement Table – Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2310E - Referring Provider Information - Situational Loop																		
0690	NM103	REFERRING PROVIDER LAST/GROUP NAME	NA	NA	NA	NA	NA	NA	NA	NA	M	NA	M	M	NA	NA	NA	NA
0691	NM104	REFERRING PROVIDER FIRST NAME	NA	NA	NA	NA	NA	NA	NA	NA	MC	NA	MC	MC	NA	NA	NA	NA
0692	NM105	REFERRING PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0693	NM107	REFERRING PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0699	NM109	REFERRING PROVIDER NATIONAL PROVIDER ID	NA	NA	NA	NA	NA	NA	NA	NA	MC	NA	MC	MC	NA	NA	NA	NA
0695	REF02	REFERRING PROVIDER STATE LICENSE NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	MC	NA	MC	MC	NA	NA	NA	NA
Loop ID 2310F - Managed Care Organization Information - Situational Loop																		
0209	NM103	MANAGED CARE ORGANIZATION NAME	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0208	NM109	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0704	REF02	MANAGED CARE ORGANIZATION FEIN	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Loop ID 2320 - Bill Level Adjustments and Amounts - Situational Loop																		
0543	CAS01	BILL ADJUSTMENT GROUP CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0544	CAS02	BILL ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0545	CAS03	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0546	CAS04	BILL ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0544	CAS05	BILL ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0545	CAS06	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0546	CAS07	BILL ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0544	CAS08	BILL ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0545	CAS09	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0546	CAS10	BILL ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0760	AMT02	PRIOR ACTUAL AMOUNT PAID	X	X	X	NA	X	X	X	NA	X	X	X	NA	X	X	X	NA
Loop ID 2400 - Service Line Information - Situational Loop																		
0547	LX01	LINE NUMBER	F	NA	F	F	F	NA	F	F	F	NA	F	F	F	NA	F	F
0714	SV101-2	HCPCS LINE PROCEDURE BILLED CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0715	SV101-2	JURISDICTION PROCEDURE BILLED CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0721	SV101-2	NDC BILLED CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X

0717	SV101-3	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2400 - Service Line Information - Situational Loop																		
0718	SV101-3	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-4	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-4	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-5	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-5	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-6	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-6	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0551	SV101-7	PROCEDURE DESCRIPTION	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0552	SV102	TOTAL CHARGE PER LINE	M	NA	M	M	X	X	X	X	X	X	X	X	X	X	X	X
0553	SV103	DAYS(S)/UNIT(S) CODE	M	NA	M	M	X	X	X	X	X	X	X	X	X	X	X	X
0554	SV104	DAY(S) /UNIT(S) BILLED	M	NA	M	M	X	X	X	X	X	X	X	X	X	X	X	X
0600	SV105	PLACE OF SERVICE LINE CODE	AR	NA	AR	AR	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-1	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-2	DIAGNOSIS POINTER	AR	NA	AR	AR	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-3	DIAGNOSIS POINTER	AR	NA	AR	AR	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-4	DIAGNOSIS POINTER	AR	NA	AR	AR	X	X	X	X	X	X	X	X	X	X	X	X
0742	SV121	PROVIDER AGREEMENT LINE CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0559	SV201	REVENUE BILLED CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0714	SV202-2	HCPCS LINE PROCEDURE BILLED CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0625	SV202-2	HIPPS RATE CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0715	SV202-2	JURISDICTION PROCEDURE BILLED CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0717	SV202-3	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-3	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0717	SV202-4	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-4	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0717	SV202-5	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-5	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0717	SV202-6	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X

DN #	Ref. Des.	Data Element Name	Professional 00	Professional 01	Professional 02	Professional 05	Institutional 00	Institutional 01	Institutional 02	Institutional 05	Pharmaceutical 00	Pharmaceutical 01	Pharmaceutical 02	Pharmaceutical 05	Dental 00	Dental 01	Dental 02	Dental 05
0718	SV202-6	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
		Loop ID 2400 - Service Line Information - Situational Loop																
0551	SV202-7	PROCEDURE DESCRIPTION	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0552	SV203	TOTAL CHARGE PER LINE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0553	SV204	DAYS(S)/UNIT(S) CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0554	SV205	DAY(S) /UNIT(S) BILLED	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0719	SV301-2	ADA PROCEDURE BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0714	SV301-2	HCPCS LINE PROCEDURE BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0717	SV301-3	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0717	SV301-4	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0717	SV301-5	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0717	SV301-6	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0551	SV301-7	PROCEDURE DESCRIPTION	X	X	X	X	X	X	X	X	X	X	X	X	NA	NA	NA	NA
0552	SV302	TOTAL CHARGE PER LINE	X	X	X	X	X	X	X	X	X	X	X	X	M	NA	M	M
0600	SV303	PLACE OF SERVICE LINE CODE	X	X	X	X	X	X	X	X	X	X	X	X	AR	NA	AR	AR
0742	SV309	PROVIDER AGREEMENT LINE CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0561	SV401	PRESCRIPTION LINE NUMBER	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0721	SV402-2	NDC BILLED CODE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0562	SV405	DISPENSE AS WRITTEN CODE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0563	SV408	DRUG NAME	X	X	X	X	X	X	X	X	NA	NA	NA	NA	X	X	X	X
0762	SV410	COMPOUND DRUG INDICATOR	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0605	DTP03	SERVICE LINE DATE(S) RANGE	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0604	DTP03	PRESCRIPTION LINE DATE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0570	QTY02	DRUGS/SUPPLIES QUANTITY DISPENSED	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0571	QTY02	DRUGS/SUPPLIES NUMBER OF DAYS	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0741	CN101	CONTRACT LINE TYPE CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0738	REF02	TREATMENT LINE AUTHORIZATION NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0579	AMT02	DRUGS/SUPPLIES DISPENSING FEE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0572	AMT02	DRUGS/SUPPLIES BILLED AMOUNT	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0627	AMT02	LINE ITEM TAX CHARGE AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2420 - Rendering Line Provider Information - Situational Loop																		
0589	NM103	RENDERING LINE PROVIDER LAST/GROUP NAME	AA	NA	AA	AA	NA	NA	NA	NA	AA	NA	AA	AA	AA	NA	AA	AA
0587	NM104	RENDERING LINE PROVIDER FIRST NAME	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0591	NM105	RENDERING LINE PROVIDER MIDDLE NAME/INITIAL	AA	NA	AA	AA	NA	NA	NA	NA	AA	NA	AA	AA	AA	NA	AA	AA
0588	NM107	RENDERING LINE PROVIDER LAST NAME SUFFIX	AA	NA	AA	AA	NA	NA	NA	NA	AA	NA	AA	AA	AA	NA	AA	AA
0592	NM109	RENDERING LINE PROVIDER NATIONAL PROVIDER ID	AR	NA	AR	AR	NA	NA	NA	NA	AR	NA	AR	AR	AR	NA	AR	AR
0595	PRV03	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0586	REF02	RENDERING LINE PROVIDER FEIN	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0599	REF02	RENDERING LINE PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop																		
0574	SVD02	TOTAL AMOUNT PAID PER LINE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0722	SVD03-2	ADA PROCEDURE PAID CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0726	SVD03-2	HCPCS LINE PROCEDURE PAID CODE	MC	NA	MC	MC	MC	NA	MC	MC	X	X	X	X	MC	NA	MC	MC
0728	SVD03-2	NDC PAID CODE	MC	NA	MC	MC	X	X	X	X	MC	NA	MC	MC	X	X	X	X
0729	SVD03-2	JURISDICTION PROCEDURE PAID CODE	MC	NA	MC	MC	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0727	SVD03-3	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-3	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0727	SVD03-4	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-4	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0727	SVD03-5	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-5	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0727	SVD03-6	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-6	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0576	SVD04	REVENUE PAID CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0580	SVD05	DAYS(S)/UNIT(S) PAID	AA	NA	AA	AA	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0547	SVD06	LINE NUMBER	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0731	CAS01	SERVICE ADJUSTMENT GROUP CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0732	CAS02	SERVICE ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC

0733	CAS03	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS04	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop																		
0732	CAS05	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS06	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS07	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0732	CAS08	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS09	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS10	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0732	CAS11	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS12	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS13	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0732	CAS14	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS15	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS16	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0761	AMT02	LINE ITEM PRIOR ACTUAL AMOUNT PAID	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0628	AMT02	LINE ITEM TAX PAID AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
Loop ID 2010AB - Claim Administrator Information - Situational Loop					
MC	0188	NM103	CLAIM ADMINISTRATOR NAME	Required when the Claim Administrator is a different entity than the insurer or self-insured reported in Loop 2010AA/NM103/DN0007.	Required when NM101 equals "CX".
MC	0187	NM109	CLAIM ADMINISTRATOR FEIN	Required when the Claim Administrator is a different entity than the insurer or self-insured reported in Loop 2010AA/NM103/DN0007.	Required when DN0188 Claim Administrator Name is reported.
MC	0014	N403	CLAIM ADMINISTRATOR MAILING POSTAL CODE	Required when Claim Administrator information is reported in Loop 2010AB	Required when DN0188 Claim Administrator Name is reported.
Loop ID 2010CA - Claimant Information - Required Loop					
MC	0042	NM109	EMPLOYEE SSN	DN0042 Employee SSN is the preferred ID number. If none, see DN153 Employee Green Card. If injured worker has no other identification, use “999999999.”	Required when DN0153, DN0154, DN0156 and DN0152 are not reported.
MC	0153	NM109	EMPLOYEE GREEN CARD	Required when DN0042 Employee Social Security number is not available.	Required when DN0042, DN0154, DN0156 and DN0152 are not reported.
MC	0154	NM109	EMPLOYEE ID ASSIGNED BY JURISDICTION	Required when DN0042 Employee Social Security, DN0153 Employee Green Card, DN0152 Employee Employment Visa and DN0156 Employee Passport Number are not available.	Required when DN0042, DN0153, DN0156 and DN0152 are not reported.
MC	0156	NM109	EMPLOYEE PASSPORT NUMBER	Required when DN0042 Employee Social Security, DN0153 Employee Green Card, and DN0152 Employee Employment Visa are not available.	Required when DN0042, DN0153, DN0154 and DN0152 are not reported.
MC	0152	NM109	EMPLOYEE EMPLOYMENT VISA	Required when DN0042 Employee Social Security number and DN0153 Employee Green Card number are not available.	Required when DN0042, DN0153, DN0154 and DN0156 are not reported.
MC	0005	REF02	JURISDICTION CLAIM NUMBER	Required when the insurance carrier, claim administrator, or reporting entity has received the jurisdiction's assigned claim number.	Required when segment is used by jurisdiction and REF01 = Y4.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
Loop ID 2300 - Bill Information - Required Loop					
MC	0513	DTP03	ADMISSION DATE	Required when DN0504 Facility Code is an inpatient type, and either DN0516 Total Amount Paid Per Bill is not equal to 0; or DN0513 is on the bill.	Required when DN0504 Facility Code is one of the following: 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89 and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0513 is known.
MC	0514	DTP03	DISCHARGE DATE	Required on final inpatient medical bills.	Required when DN0505 Bill Frequency Type Code equals 4.
MC	0577	CL101	ADMISSION TYPE CODE	Required when DN0504 Facility Code is an inpatient type, and either DN0516 Total Amount Paid Per Bill is not equal to 0; or DN0577 is on the bill.	Required when DN0504 Facility Code is one of the following: 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89 and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0577 is known.
MC	0515	CN101	CONTRACT TYPE CODE	When DN0549 Paid DRG Code is present, this value must be 01 (DRG). Otherwise, this data element must be reported, but not be 01.	When DN0549 (Paid DRG Code) is present, this value must be 01 (DRG). Otherwise, this data element must be reported, but must not have a value of 01.
HI Segment - Institutional Bill Admitting Diagnosis - Situational Segment					
MC	0535	HI01-2	ADMITTING DIAGNOSIS CODE	Required when DN0504 Facility Code is an inpatient type, and either DN0516 Total Amount Paid Per Bill is not equal to 0; or DN0535 is on the bill.	Required when DN0504 Facility Code is one of the following: 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89 and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0535 is known.
HI Segment - Outpatient Reason For Visit - Situational Segment					
MC	0520	HI01-2	OUTPATIENT REASON FOR VISIT CODE	Required when DN0516 Total Amount Paid Per Bill is not equal to 0, and DN0504 Facility Code is either hospital outpatient, critical access hospital or licensed freestanding emergency medical facility type and DN0577 Admission Type Code describes the admission type as emergency, urgent or trauma and a reported DN0559 Revenue Billed Code equals one of the following values with or without a leading 0: 450, 451, 452, 456, 459, 516, 526, 762.	Required when DN0516 Total Amount Paid Per Bill is not equal to 0, and DN0504 Facility Code equals 13, 85, or 78 and DN0577 Admission Type Code equals 1, 2, or 5 and a reported DN0559 Revenue Billed Code equals one of the following values with or without a leading 0: 450, 451, 452, 456, 459, 516, 526, 762.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
HI Segment - Outpatient Reason For Visit - Situational Segment					
MC	0520	HI02-2	OUTPATIENT REASON FOR VISIT CODE	Required when DN0520 (HI01-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.	Required when DN0520 (HI01-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.
MC	0520	HI03-2	OUTPATIENT REASON FOR VISIT CODE	Required when DN0520 (HI02-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.	Required when DN0520 (HI02-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment					
MC	0521	HI01-2	PRINICPAL DIAGNOSIS CODE	Required when both DN0537 Billing Provider Primary Specialty Code and DN0651 Rendering Bill Provider Primary Specialty Code are not values excluded from diagnosing an injury or illness, any DN0721 NDC Billed Code or DN0714 HCPCS Line Procedure Billed Code not beginning with A0 is paid as billed, or any DN0728 NDC Paid Code is paid, or any DN0726 HCPCS Line Procedure Paid Code not beginning with A0 is paid; and DN0516 Total Amount Paid Per Bill is not equal to 0.	Required when both DN0537 Billing Provider Primary Specialty Code and DN0651 Rendering Bill Provider Primary Specialty Code are 1) not of the following types (Type Level 1 Provider Type) as defined by Washington Publishing Company: "Respiratory, Developmental, Rehabilitative and Restorative Service Providers," "Technologists, Technicians & Other Technical Service Providers," "Other Service Providers," "Transportation Services" and 2) not any of the classifications (Type Level II Classification) as defined by Washington Publishing Company are named "Ambulance," "Pharmacist," and "Pharmacy;" and any DN0721 NDC Billed Code or DN0714 HCPCS Line Procedure Billed Code not beginning with A0 is paid as billed, or any DN0728 NDC Paid Code is paid, or any DN0726 HCPCS Line Procedure Paid Code is paid; and DN0516 Total Amount Paid Per Bill is not equal to 0.
MC	0522	HI02-2	DIAGNOSIS CODE	Required when DN0521 Principal Diagnosis Code is required and there is another diagnosis.	Required when DN0521 Principal Diagnosis Code is required and there is another diagnosis.
MC	0522	HI03-2	DIAGNOSIS CODE	Required when DN0522 (HI02-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI02-2) Diagnosis Code is required and there is another diagnosis.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment					
MC	0522	HI04-2	DIAGNOSIS CODE	Required when DN0522 (HI03-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI03-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI05-2	DIAGNOSIS CODE	Required when DN0522 (HI04-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI04-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI06-2	DIAGNOSIS CODE	Required when DN0522 (HI05-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI05-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI07-2	DIAGNOSIS CODE	Required when DN0522 (HI06-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI06-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI08-2	DIAGNOSIS CODE	Required when DN0522 (HI07-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI07-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI09-2	DIAGNOSIS CODE	Required when DN0522 (HI08-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI08-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI10-2	DIAGNOSIS CODE	Required when DN0522 (HI09-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI09-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI11-2	DIAGNOSIS CODE	Required when DN0522 (HI10-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI10-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI12-2	DIAGNOSIS CODE	Required when DN0522 (HI11-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI11-2) Diagnosis Code is required and there is another diagnosis.
HI Segment - Institutional Bill Principal Procedure - Situational Segment					
MC	0550	HI01-4	PRINCIPAL PROCEDURE DATE	Required when DN0525 Principal Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0550 is known.	Required when DN0525 Principal Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0550 is known.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment					
MC	0524	HI01-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI01-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI02-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI02-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI03-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI03-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI04-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI04-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI05-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI05-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI06-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI06-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI07-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI07-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment					
MC	0524	HI08-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI08-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI09-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI09-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI10-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI10-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI11-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI11-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI12-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI12-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
Loop ID 2310A - Billing Provider Information - Required Loop					
MC	0529	NM104	BILLING PROVIDER FIRST NAME	Required when NM102 = 1 (person) and the person has a first name.	Required when NM102 = 1 (person) and the person has a first name.
MC	0569	N404	BILLING PROVIDER COUNTRY CODE	Required when provider address is outside the US.	Required when provider address is outside the US.
MC	0630	REF02	BILLING PROVIDER STATE LICENSE NUMBER	Required when the billing provider does not have a National Provider ID. Use "99999" if the billing provider's type is not licensed by the state (e.g., ambulance or, durable medical equipment).	Required when DN0634 Billing Provider National Provider ID (NM109) is not reported and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0630 is known.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
Loop ID 2310B - Rendering Bill Provider Information - Situational Loop					
MC	0639	NM104	RENDERING BILL PROVIDER FIRST NAME	Required when NM102 = 1 (person) and the person has a first name.	Required when NM102 = 1 (person) and the person has a first name.
MC	0647	NM109	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	Required when the rendering bill provider has a National Provider ID.	Required when the rendering bill provider has a National Provider ID.
MC	0651	PRV03	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	Required when the rendering bill provider does not have a National Provider ID.	Required when DN0647 Rendering Bill Provider National Provider ID (NM109) is not reported.
MC	0643	REF02	RENDERING BILL PROVIDER STATE LICENSE NUMBER	Required when the rendering bill provider does not have a National Provider ID. Use "99999" if the billing provider's type is not licensed by the state (e.g., ambulance or, durable medical equipment).	Required when DN0647 Rendering Bill Provider National Provider ID (NM109) is not reported.
Loop ID 2310D - Service Facility Location Information - Situational Loop					
MC	0678	NM103	FACILITY NAME	Required when service was performed at an address different from the billing provider's address and either 1) the bill was paid; or 2) the facility name is known.	Required when service was performed at an address different from DN0538 Billing Provider Primary Address and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0678 is known.
MC	0682	NM109	FACILITY NATIONAL PROVIDER ID	Required when service was performed in a facility within the US.	Required when DN0678 Facility Name is present and DN0689 Facility Country Code is not reported, or has a value of US or USA.
MC	0684	N301	FACILITY PRIMARY ADDRESS	Required when service was performed in a facility, (e.g., hospital, ambulatory surgical center, etc.).	Required when DN0678 Facility Name is present.
MC	0686	N401	FACILITY CITY	Required when service was performed in a facility, (e.g., hospital, ambulatory surgical center, etc.).	Required when DN0678 Facility Name is present.
MC	0689	N401	FACILITY COUNTRY CODE	Required when service was performed in a facility outside the US.	Required when DN0678 Facility Name is present and DN0682 Facility National Provider ID is not present.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
Loop ID 2310E - Referring Provider Information - Situational Loop					
MC	0691	NM104	REFERRING PROVIDER FIRST NAME	Required when NM102 = 1 (person) and the person has a first name.	Required when NM102 = 1 (person) and the person has a first name.
MC	0699	NM109	REFERRING PROVIDER NATIONAL PROVIDER ID	Required when the referring provider has a National Provider ID.	Required when the referring provider has a National Provider ID.
MC	0695	REF02	REFERRING PROVIDER STATE LICENSE NUMBER	Required when the referring provider does not have a National Provider ID. Use "99999" if the referring provider's type is not licensed by the state (e.g., ambulance or, durable medical equipment).	Required when DN0690 Referring Provider National Provider ID (NM109) is not reported.
Loop ID 2310F - Managed Care Organization Information - Situational Loop					
MC	0208	NM109	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	Required when DN507 Provider Agreement Code equals 'P' and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0208 is known.	Required when DN507 Provider Agreement Code equals 'P' and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0208 is known.
Loop ID 2320 - Bill Level Adjustments and Amounts - Situational Loop					
MC	0543	CAS01	BILL ADJUSTMENT GROUP CODE	Required when adjustments apply to all service lines on a medical bill containing more than one line.	Required when DN0501 Total Charge Per Bill is not equal to DN0516 Total Amount Paid Per Bill and DN0501 Total Charge Per Bill minus DN0516 Total Amount Paid Per Bill minus the sum of all DN0733 Service Adjustment Amount values is not equal to zero.
MC	0544	CAS02	BILL ADJUSTMENT REASON CODE	Required when adjustments apply to all service lines on a medical bill containing more than one line.	Required when DN0543 Bill Adjustment Group Code is present.
MC	0545	CAS03	BILL ADJUSTMENT AMOUNT	Required when adjustments apply to all service lines on a medical bill containing more than one line.	Required when DN0544 Bill Adjustment Reason Code in CAS02 is present.
MC	0545	CAS06	BILL ADJUSTMENT AMOUNT	Required when a second Bill Adjustment Reason Code applies and is associated with the same group code.	Required when DN0544 Bill Adjustment Reason Code in CAS05 is present.
MC	0545	CAS09	BILL ADJUSTMENT AMOUNT	Required when a third Bill Adjustment Reason Code applies and is associated with the same group code.	Required when DN0544 Bill Adjustment Reason Code in CAS08 is present.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
Loop ID 2400 - Service Line Information - Situational Loop					
MC	0714	SV101-2	HCPCS LINE PROCEDURE BILLED CODE	Required when the bill type is non-pharmaceutical and the service is not billed as any of the following: Oregon-specific service, pharmaceutical product, ADA procedure. The value must be valid when the service was paid using the same code that was billed.	Required when DN0715 Jurisdiction Procedure Billed Code, DN0721 NDC Billed Code, and DN0719 ADA Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0715	SV101-2	JURISDICTION PROCEDURE BILLED CODE	Required when the bill type is non-pharmaceutical and the service is not billed as any of the following: HCPCS service, pharmaceutical product, ADA procedure. The value must be valid when the service was paid using the same code that was billed.	Required when DN0714 HCPCS Line Procedure Billed Code, DN0721 NDC Billed Code, and DN0719 ADA Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0721	SV101-2	NDC BILLED CODE	Required when a drug is dispensed by a physician during an office visit. The value must be valid when the service was paid using the same code that was billed.	Required when DN0714 HCPCS Line Procedure Billed Code, DN0715 Jurisdictional Procedure billed Code, and DN0719 ADA Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 Total Amount Paid Per Line is greater than 0 or DN0574 is not reported.
MC	0557	SV107-1	DIAGNOSIS POINTER	Required when there is a reported diagnosis code and the payment for the service line is greater than 0.	Required when DN0521 Principal Diagnosis Code is reported and either DN0574 Total Amount Paid Per Line is greater than 0 or DN0574 is not reported.
MC	0742	SV121	PROVIDER AGREEMENT LINE CODE	Required when the provider agreement code at the line level is different than the bill level.	Required when the provider agreement code at the line level is different than the bill level.
MC	0557	SV107-1	DIAGNOSIS POINTER	Required when there is a reported diagnosis code and the payment for the service line is greater than 0.	Required when DN0521 Principal Diagnosis Code is reported and either DN0574 Total Amount Paid Per Line is greater than 0 or DN0574 is not reported.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
Loop ID 2400 - Service Line Information - Situational Loop					
MC	0742	SV121	PROVIDER AGREEMENT LINE CODE	Required when the provider agreement code at the line level is different than the bill level.	Required when the provider agreement code at the line level is different than the bill level.
MC	0557	SV107-1	DIAGNOSIS POINTER	Required when there is a reported diagnosis code and the payment for the service line is greater than 0.	Required when DN0521 Principal Diagnosis Code is reported and either DN0574 Total Amount Paid Per Line is greater than 0 or DN0574 is not reported.
MC	0742	SV121	PROVIDER AGREEMENT LINE CODE	Required when the provider agreement code at the line level is different than the bill level.	Required when the provider agreement code at the line level is different than the bill level.
MC	0714	SV201-2	HCPCS LINE PROCEDURE BILLED CODE	Required when the service is billed as neither an Oregon-specific service nor an HIPPS Rate Code. The value must be valid when the service was paid using the same code that was billed.	Required when DN0715 Jurisdiction Procedure Billed Code and DN0625 HIPPS Rate Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0625	SV201-2	HIPPS RATE CODE	Required when the service is billed as neither an Oregon-specific service nor an HCPCS service. The value must be valid when the service was paid using the same code that was billed.	Required when DN0715 Jurisdiction Procedure Billed Code and DN0714 HCPCS Line Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0715	SV201-2	JURISDICTION PROCEDURE BILLED CODE	Required when the service is billed as neither an HIPPS Rate Code nor an HCPCS service. The value must be valid when the service was paid using the same code that was billed.	Required when DN0625 HIPPS Rate Code and DN0714 HCPCS Line Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
Loop ID 2400 - Service Line Information - Situational Loop					
MC	0719	SV301-2	ADA PROCEDURE BILLED CODE	Required when some amount of the bill is paid, the bill type is dental and the service is not billed as an HCPCS service. The value must be valid when the service was paid using the same code that was billed.	Required when DN0714 HCPCS Line Procedure Billed Code is not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0714	SV301-2	HCPCS LINE PROCEDURE BILLED CODE	Required when the bill type is dental and the service is not billed as an ADA service. The value must be valid when the service was paid using the same code that was billed.	Required when DN0719 ADA Procedure Billed Code is not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0742	SV309	PROVIDER AGREEMENT LINE CODE	Required when the provider agreement code at the line level is different than the bill level.	Required when the provider agreement code at the line level is different than the bill level.
MC	0741	CN101	CONTRACT LINE TYPE CODE	Required when a contract exists between the payer and the health care provider and the information at the line level is different than the information at the bill level.	Required when a contract exists between the payer and the health care provider and the information at the line level is different than the information at the bill level.
MC	0627	AMT02	LINE ITEM TAX CHARGE AMOUNT	Required when part of the amount charged for this service line includes a tax and the amount of tax is specified on the bill.	Required when part of either DN0552 Total Charge per Line or DN0572 Drugs/Supplies Billed Amount includes a tax and the amount of tax is specified on the bill.
Loop ID 2420 - Rendering Line Provider Information - Situational Loop					
MC	0586	REF02	RENDERING LINE PROVIDER FEIN	Required when the rendering line provider does not have a National Provider ID (e.g., ambulance or interpreter).	Required when NM109 DN0592 Rendering Line Provider National Provider ID is not present.
MC	0587	NM104	RENDERING LINE PROVIDER FIRST NAME	Required when NM102 = 1 (person) and reported on the medical bill.	Required when NM102 = 1 (person) and reported on the medical bill.
MC	0592	NM109	RENDERING LINE PROVIDER NATIONAL PROVIDER ID	Required when the rendering bill provider has a National Provider ID.	Required when the rendering bill provider has a National Provider ID.
MC	0595	PRV03	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	Required when the rendering bill provider does not have a National Provider ID.	Required when NM109 DN0592 Rendering Line Provider National Provider ID is not present.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
Loop ID 2420 - Rendering Line Provider Information - Situational Loop					
MC	0599	REF02	RENDERING LINE PROVIDER STATE LICENSE NUMBER	Required when the rendering bill provider does not have a National Provider ID. Use "99999" if the billing provider's type is not licensed by the state (e.g., ambulance or interpreter).	Required when NM109 DN0592 Rendering Line Provider National Provider ID is not present.
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop					
MC	0574	SVD02	TOTAL AMOUNT PAID PER LINE	Required when the amount paid for this service line is not equal to the amount charged.	Required when the amount paid is not equal to which of the following data elements is reported: DN0552 Total Charge per Line or DN0572 Drugs/Supplies Billed Amount.
MC	0722	SVD03-2	ADA PROCEDURE PAID CODE	Required when the service was paid more than $0.00 using a different code from the billed code and no other paid service code was used.	Required when • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.
MC	0726	SVD03-2	HCPCS LINE PROCEDURE PAID CODE	Required when the service was paid more than $0.00 using a different code from the billed code and no other paid service code was used.	Required when • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop					
MC	0728	SVD03-2	NDC PAID CODE	Required when the service was paid more than $0.00 using a different code from the billed code and no other paid service code was used.	Required when • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.
MC	0729	SVD03-2	JURISDICTION PROCEDURE PAID CODE	Required when the service was paid more than $0.00 using a different code from the billed code and no other paid service code was used.	Required when • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.
MC	0547	SVD06	LINE NUMBER	Required when the payment is bundled with a different service line.	Required when the payment is bundled with a different service line.
MC	0731	CAS01	SERVICE ADJUSTMENT GROUP CODE	Required when line-level adjustments were applied during the adjudication of the medical bill.	For non-pharmaceutical bills (SV4 segment is not used to report the service line), this element is required when DN0545 Bill Adjustment Amount is not reported and DN0552 Total Charge Per Line does not equal DN0574 Total Amount Paid Per Line.For pharmaceutical bills (SV4 segment is used to report the service line), this element is required when DN0545 is not reported and DN0572 Drugs/Supplies Billed Amount does not equal DN0574.
MC	0732	CAS02	SERVICE ADJUSTMENT REASON CODE	Required when line level adjustments were applied during the adjudication of the medical bill.	Required when DN0543 Bill Adjustment Group Code is present.

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Req Code	**DN**	**Ref. Des.**	**Data Element Name**	**Business Condition**	**Technical Condition**
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop					
MC	0733	CAS03	SERVICE ADJUSTMENT AMOUNT	Required when line level adjustments were applied during the adjudication of the medical bill.	Required when DN0544 Bill Adjustment Reason Code in CAS02 is present.
MC	0733	CAS06	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS05 is present.
MC	0733	CAS09	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS08 is present.
MC	0733	CAS12	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS11 is present.
MC	0733	CAS15	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS14 is present.
MC	0628	AMT02	LINE ITEM TAX PAID	Required when part of the amount paid for this service line includes a billed tax.	Required when DN0574 Total Amount Paid Per Line is present and DN0627 Line Item Tax Charge Amount is present.

	Medical Bill Data Element Requirement Table				
	Bill Submission Reason Codes				
		Accepted Original/Replace	Denied Original/Replace	Cancellation	[This table is to be replaced in its entirety. Please refer to the preceding appendices A and B.]
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 be used in the SV3 segment.
722	ADA Procedure Paid Code	C	O	O	If different from DN719, DN721, DN715, or DN714 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' (i.e., required for pharmacy bills).
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	If 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 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	
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	O	O	If DN518 DRG Code is present.
512	Date Insurer Paid Bill	M	M	O	

	Medical Bill Data Element Requirement Table				
	Bill Submission Reason Codes				
		Accepted Original/Replace	Denied Original/Replace	Cancellation	[This table is to be replaced in its entirety. Please refer to the preceding appendices A and B.]
DN	Data Element Name	00/ 05	00/ 05	01	Mandatory Trigger or Implementation Note
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	If Professional (SV1 segment used), Institutional (SV2 segment used), or 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	If 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, 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	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	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	If DN502 Billing Type Code value is 'RX' or 'MO' (i.e., for pharmacy bills).
571	Drugs/Supplies Number of Days	C	O	O	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	
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.

	Medical Bill Data Element Requirement Table				
	Bill Submission Reason Codes				
		Accepted Original/Replace	Denied Original/Replace	Cancellation	[This table is to be replaced in its entirety. Please refer to the preceding appendices A and B.]
DN	Data Element Name	00/05	00/05	01	Mandatory Trigger or Implementation Note
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 US 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	If 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 if service performed in a facility within the US.
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).
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.
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.
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	

	Medical Bill Data Element Requirement Table				
	Bill Submission Reason Codes				
		Accepted Original/Replace	Denied Original/Replace	Cancellation	[This table is to be replaced in its entirety. Please refer to the preceding appendices A and B.]
DN	Data Element Name	00/05	00/05	01	Mandatory Trigger or Implementation Note
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).
547	Line Number	M	M	O	Required in Loop 2400/LX segment.
208	Managed Care Organization Identification Number	C	O	O	If DN507 Provider Agreement Code equals 'P.'
721	NDC Billed Code	C	O	O	If DN502 Billing Type Code is 'RX' or 'MO', or if 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).
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).
561	Prescription Line Number	C	O	O	If DN502 Billing Type Code value is 'RX' or 'MO' (i.e., required for pharmacy bills).
521	Principal Diagnosis Code	C	O	O	If DN503 Billing Format Code equals "A."
550	Principal Procedure Date	C	O	O	If DN626 HCPCS Principal Procedure Code or DN525 ICD-9 CM Principal Procedure Code is present.
524	Procedure Date	C	O	O	If DN736 ICD-9 CM Procedure Code or DN737 HCPCS Bill Procedure Code is present.

	Medical Bill Data Element Requirement Table				
	Bill Submission Reason Codes				
		Accepted Original/Replace	Denied Original/Replace	Cancellation	[This table is to be replaced in its entirety. Please refer to the preceding appendices A and B.]
DN	Data Element Name	00/05	00/05	01	Mandatory Trigger or Implementation Note
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	If provider address is outside the US.
642	Rendering Bill Provider FEIN	O	O	O	
639	Rendering Bill Provider First Name	C	C	O	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 if 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" if provider type not licensed by the state (e.g., ambulance or durable medical equipment).
585	Rendering Line Provider Country Code	C	O	O	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 provider has a National Provider ID.
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).
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	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	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	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	If DN580 Days/Units Paid is not equal to DN554 Days/Units Billed.

	Medical Bill Data Element Requirement Table				
	Bill Submission Reason Codes				
		Accepted Original/Replace	Denied Original/Replace	Cancellation	[This table is to be replaced in its entirety. Please refer to the preceding appendices A and B.]
DN	Data Element Name	00/05	00/05	01	Mandatory Trigger or Implementation Note
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	If bill type 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	If professional and institutional service lines (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	
500	Unique Bill ID Number	M	M	M	Cancel & Replace transactions must match previously accepted Original DN500 Unique Bill ID Number. Resubmitted Original transactions must match previously submitted DN500 Unique Bill ID Number.