DRAFT

Ver. 1

Oregon Workers' Compensation Division
Electronic Billing and Payment Companion Guide

Release 1.0

Date: First External Review, Feb. 2012

The highlighted items in this draft are portions that need focused review, or items that we were unsure of because the TR3s are not yet available to us.

We appreciate your time in reviewing this draft implementation guide.

Purpose of the Electronic Billing and Payment Companion Guides

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

Documentation Change Control

The companion guide content is subject to change; however changes will only be made in conjunction with the Oregon rules revision process.

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

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

Oregon WCD Companion Guide Contact Information

Address: TBD
Attn: Electronic Billing
Telephone Number: TBD
FAX Number: TBD
Email Address: TBD

Methodology for Updating Companion Guide Document

Please contact the Oregon WCD regarding instructions for submitting change requests, recommendations, and document updates.

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Chapter 1 Introduction and Overview

1.1 HIPAA

The Administrative Simplification Act provisions of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) include requirements that national standards for electronic health care transactions and national identifiers for Health Care Providers (Provider), Health Plans, and Employers be established. These standards were adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. Additional information regarding the formats adopted under HIPAA is included in Chapter 2.

1.2 Oregon Administrative Rule (OAR) 436-xxx-xxxx (rule number to be determined)

OAR 436-xxx-xxxx mandates *(or allows)* that claims administrators accept electronic bills for medical goods and services. The health care provider, health care facility, or third-party biller/assignee shall use the HIPAA-adopted electronic transaction formats to submit medical or pharmacy bills to the appropriate workers' compensation claims administrator associated with the employer of the injured or ill patient for whom services are provided.

The claims administrator, or its authorized representative, is to validate the Electronic Data Interchange (EDI) file according to the guidelines provided in the prescribed national standard format implementation guide, this companion guide, and the jurisdictional data requirements. Problems associated with the processing of the ASC X12 Health Care Claim (837) EDI file are to be reported using acknowledgment transactions described in this companion guide. Problems associated with the processing of the NCPDP Telecommunications D.0 bills are reported via the reject response transactions described in this companion guide. The claims administrator will use the HIPAA-adopted electronic transaction formats to report explanations of payments, reductions, and denials to the health care provider, health care facility, or third-party biller/assignee. These electronic transaction formats include the ASC X12N/005010X221A1, Health Care Claim Payment/Advice (835), and the NCPDP Telecommunication D.0 Paid response transaction.

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

This guide outlines Oregon-specific procedures necessary for engaging in Electronic Data Interchange (EDI) and specifies clarifications where applicable. When coordination of a solution is required, the Oregon WCD will work with the IAIABC EDI Medical Committee and Provider to Payer Subcommittee to coordinate with national standard setting organizations and committees to address workers' compensation needs.

Chapter 2 Oregon Workers' Compensation Division Requirements

2.1 Compliance

If a billing entity chooses to submit bills electronically, it must be able to receive an electronic response from the claims administrator. The electronic responses include electronic acknowledgments and electronic remittance advices (referred to as either an Explanation of Review or an Explanation of Benefits).

Electronic billing rules allow for providers and claims administrators to use agents to meet the requirement of electronic billing, but these rules do not mandate the method of connectivity, or the use of, or connectivity to, clearinghouses or similar types of vendors.

Nothing in this document prevents the parties from utilizing Electronic Funds Transfer (EFT) to facilitate payment of electronically submitted bills. Use of EFT is optional, and is not a pre-condition for electronic billing.

Health care providers, health care facilities, third-party biller/assignees, and claims administrators must be able to exchange electronic bills in the prescribed standard formats and may exchange data in non-prescribed formats by mutual agreement. *(Oregon has not made a decision about whether or not to allow non-prescribed formats.)*

2.1.2 Agents

Electronic billing rules allow use of agents to accomplish electronic billing requirements.

Entities are responsible for the acts or omissions of their agents executed in the performance of services for those entities.

2.1.3 Privacy, Confidentiality, and Security

Health care providers, health care facilities, third-party biller/assignees, claims administrators, and their agents must comply with all applicable Federal and Oregon WCD's Statutes or Rules related to the privacy, confidentiality, security or similar issues.

2.2 National Standard Formats

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

- ASC X12N/005010X222A1 Health Care Claim: Professional (837);
- ASC X12N/005010X223A2 Health Care Claim: Institutional (837);
- ASC X12N/005010X224A2 Health Care Claim: Dental (837);
- ASC X12N/005010X221A1 Health Care Claim Payment/Advice (835);
- ASC X12N/005010X212 Health Care Claim Status Request and Response (276/277);
- NCPDP Telecommunication Standard Implementation Guide D.0; and
- NCPDP Batch Standard Implementation Guide 1.2.

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

- The ASC X12 TA1 is used to communicate the syntactical analysis of the interchange header and trailer.
- The ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance (999) is used to communicate acceptance or rejection of a functional group within an interchange (file).
- The ASC X12N/005010X214 Health Care Claim Acknowledgment (277) is used to communicate acceptance or rejection of an ASC X12 837 transaction.
- The ASC X12N/005010X213 Request for Additional Information (277) is used to request additional attachments that were not originally submitted with the electronic medical bill.
- The ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) is used to transmit electronic documentation associated with an electronic medical bill. The 005010X210 can accompany the original electronic medical bill, or may be sent in response to a 005010X213 Request for Additional Information.

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

2.2.1 Oregon WCD Prescribed Formats

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

2.2.2 ASC X12 Ancillary Formats

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

Format	Corresponding Process	Function
005010X210	Documentation/Attachments	Documentation/Attachments
005010X213	Request for Additional Information	Request for Medical Documentation
005010X214	Health Claim Status Request and Response	Medical Bill Status Request and Response

2.3 Oregon WCD Companion Guide Usage

Oregon WCD's implementation of the national standard formats aligns with HIPAA usage and requirements in most circumstances. This Oregon WCD Companion Guide is intended to convey information that is within the framework of the *ASC X12 Type 3 Technical Reports (Implementation Guides)* and *NCPDP Telecommunication Standard Version D.0 Implementation Guide* adopted for use. The Oregon WCD Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the *ASC X12 Type 3 Technical Reports (Implementation Guides)* or *NCPDP Telecommunication Standard Version D.0 Implementation Guide*. The Oregon WCD Companion Guide, where applicable, provides additional instruction on situational implementation factors that are different in workers' compensation than in the HIPAA implementation.

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

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

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

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

2.4 Description of ASC X12 Transaction Identification Numbers

The ASC X12 Transaction Identification requirements are defined in the appropriate *ASC X12 Type 3 Technical Reports (Implementation Guides)*, available through the Accredited Standards Committee (ASC) X12, http://store.x12.org. The Oregon WCD provides the following additional information regarding transaction identification number requirements.

2.4.1. Sender/Receiver Trading Partner Identification

Workers' compensation standards require the use of the Federal Employer Identification Number (FEIN) or other mutually agreed upon identification numbers to identify Trading Partners (sender/receiver) in electronic billing and reimbursement transmissions. Trading Partners will exchange the appropriate and necessary identification numbers to be reported based on the applicable transaction format requirements.

2.4.2 Claims Administrator Identification

In Oregon, a claims administrator is an insurer, self-insured employer, or an authorized agent, e.g., bill-review entity, third party administrator, etc. as defined in OAR 436-XXX-XXXX. A claims administrator is also identified through the use of the FEIN or other mutually agreed upon identification number. Claims administrator information is available through direct contact with the insurer. The Claims Administrator Identification information is populated in Loop 2010BB for 005010X222A1, 005010X223A2, and 005010X224A2 transactions.

Health care providers will need to obtain payer identification information from their connectivity trading partner agent (i.e., clearinghouses, practice management system, billing agent and/or other third party vendor) if they are not directly connecting to a claims administrator.

2.4.3 Health Care Provider Identification

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

2.4.4 Injured Employee Identification (Ill or Injured Worker)

The injured or ill employee is identified by social security number, date of birth, date of injury, and workers' compensation claim number (see below).

The injured or ill employee's (patient's) Identification Number is submitted using the Property and Casualty Patient Identifier REF segment in Loop 2010CA.

2.4.5 Claim Identification

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

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

2.4.6 Bill Identification

The *ASC X12N Technical Report Type 3 (Implementation Guides)* refers to a bill as a "claim" for electronic billing transactions. This Oregon WCD Companion Guide refers to these transactions as "bill" because in workers' compensation, "claim" refers to the full case for an ill or injured employee.

The health care provider, health care facility, or third-party biller/assignee, assigns a unique identification number to the electronic bill transaction. For 005010X222A1, 005010X223A2, and 005010224A2 transactions, the bill transaction identification number is populated in Loop 2300 Claim Information CLM Health Claim Segment CLM01 Claim (Bill) Submitter's Identifier data element. This standard HIPAA implementation allows for a patient account number but strongly recommends that submitters use a completely unique number for this data element on each individual bill.

2.4.7 Document/Attachment Identification

The ASC X12N/ 005010X210 is the standard electronic format for submitting electronic documentation and is addressed in a later chapter of this companion guide.

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

- Patient name (ill or injured employee);
- Claims administrator name;
- Date of service;
- Social security number (if available);
- Claim number (if available);
- Unique attachment indicator number

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

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

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

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

2.5 Claims Administrator Validation Edits

The Oregon WCD EDI Medical Bill Reporting Implementation Guide, used in conjunction with the IAIABC 837 Implementation Guide for Medical Bill/Payment Records, provides validation edits that the Oregon WCD applies to transactions the claims administrator reports to it. The claims administrator may also apply validation edits that are found in OAR 436-160 Electronic Data Interchange Medical Bill Data rules which may also reasonably apply to provider billing transactions. However, the claims administrator must tailor these edits to ensure accurate payment processing, as opposed to the jurisdictional data reporting requirements for which the edits were created. It is not appropriate to apply the data reporting edits without researching or investigating their potential impact on processing clean claims.

Claims administrators may refer to various sources for the validation edits they apply to electronic bills they receive from providers. Sources for validation edits may include:

- Jurisdictionally-required edits found in the Oregon Electronic Data Interchange Medical Bill Data rules,
- The IAIABC Medical Bill/Payment Records Implementation Guides,
- ASC X12N Type 3 Technical Reports (Implementation Guides) requirements.

Claims administrators use the 005010X214 transaction, referred to in this companion guide as an Acknowledgment, to communicate transaction (individual bill) rejections for ASC X12-based electronic medical bills. Error rejection codes are used to indicate the reason for the transaction rejection.

2.6 Description of Formatting Requirements

The ASC X12 formatting requirements are defined in the *ASC X12 Type 3 Technical Reports (Implementation Guides)*, Appendices A.1, available through the Accredited Standards Committee (ASC) X12, http://store.x12.org. The Oregon WCD has provided the following additional information regarding formatting requirements:

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

2.6.1 ASC X12 Hierarchical Structure

For information on how the ASC X12 Hierarchical Structure works, refer to Section 2.3.2.1 HL Segment of the *ASC X12 Type 3 Technical Reports (Implementation Guides),* available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

2.7 Description of ASC X12Transmission/Transaction Dates

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

2.7.1 Date Sent/Invoice Date

In the manual paper medical bill processing model, the paper bill includes a date the bill was generated, to verify timely filing. The Invoice Date is the Date Sent for electronic billing; it is reflected in the Interchange Control Header ISA Segment Interchange Date. The date in the Control Header ISA Segment must be the actual date the transmission is sent.

2.7.2 Date Received

The Date Sent, the Interchange Control Header ISA Segment Interchange Date, is considered the Date Received for the purposes of electronic billing and reimbursement transactions. The Date Received is used to track timely processing of electronic bills, electronic reconsideration/appeal transactions, acknowledgment transactions, and timeliness of payments.

2.7.3 Paid Date

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

2.8 Description of Code Sets

Code sets utilized in electronic billing and reimbursement and other ancillary processes are prescribed by the applicable *ASC X12 Type 3 Technical Reports (Implementation Guides)*, NCPDP Implementation Guide, Oregon WCD's rules, and this companion guide. The code sets are maintained by multiple standard setting organizations.

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

2.9 Participant Roles

Roles in the HIPAA implementation guides are generally the same in workers' compensation. The Employer, Insured, Injured Employee, and Patient are the roles that are used differently in workers' compensation and are addressed later in this section.

2.9.1 Trading Partner

Trading Partners are entities that have established EDI relationships and that exchange information electronically in standard or mutually agreed-upon formats. Trading Partners are both Senders and Receivers, depending on the electronic process (i.e., Billing v. Acknowledgment).

2.9.2 Sender

A Sender is the entity submitting a transmission to the receiver, or the Trading Partner. The health care provider, health care facility, or third-party biller/assignee, is the Sender in the 005010X222A1, 005010X223A2 and 005010X224A2 electronic billing transactions. The claims administrator, or its agent, is the Sender in the 005010X214, 005010X231 or 005010X221A1 electronic acknowledgment or remittance transactions.

2.9.3 Receiver

A Receiver is the entity that accepts a transmission submitted by a Sender. The health care provider, health care facility, or third-party biller/assignee, is the Receiver in the 005010X214, 005010X231 or 005010X221A1 electronic acknowledgment or remittance transactions. The claims administrator, or its agent, is the Receiver in the 005010X222A1, 005010X223A2, and 005010X224A2 electronic billing transactions.

2.9.4 Employer

The employer, as the policyholder of the workers' compensation coverage, is the subscriber in the workers' compensation implementation of the HIPAA electronic billing and reimbursement formats.

2.9.5 Subscriber

The subscriber or insured is the individual or entity that purchases or is covered by a policy. In this implementation, the workers' compensation policy is obtained by the employer, who is considered the subscriber.

2.9.6 Insured

The insured or subscriber is the individual or entity that purchases or is covered by a policy. In group health, the insured may be the patient, or the spouse or parent of the patient. In this implementation, the employer is considered the insured entity.

2.9.7 Injured or Ill Employee

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

2.9.8 Patient

The patient is the person receiving medical services due to a work related illness or injury.

2.10 Health Care Provider Agent/Claims Administrator Agent Roles

Electronic billing and reimbursement rules include provisions that allow for providers, facilities, and claims administrators to utilize agents to comply with the electronic billing requirements. Agents can be any of the following: billing companies, third party administrators, bill review companies, software vendors, data collection companies, and clearinghouses, and all may have a role in electronic billing. Entities or persons using agents are responsible for the acts or omissions of their agents executed in the performance of services for the entity or person.

The electronic billing rules require that the claims administrators have the ability to exchange medical billing and reimbursement information electronically with health care providers. The rules do not mandate the use of, or regulate the costs of, agents performing electronic billing functions. Providers and claims administrators are not required by the Oregon WCD's rules to establish connectivity with a clearinghouse or to utilize a specific media/method of connectivity (e.g., Secured File Transfer Protocol [(SFTP]).

Use of non-standard formats by mutual agreement between the health care provider, health care facility, or third-party biller/assignee and the claims administrator is permissible up to and until Oregon WCD adopts rules requiring exclusive use of X12 transaction sets. (Oregon has not made a decision on this as yet.)

The electronic billing rules do not regulate the formats utilized between providers and their agents, or claims administrators and their agents, or the method of connectivity between those parties.

2.11 Duplicate, Appeal/Reconsideration, and Corrected Bill Resubmissions

2.11.1 Claim Resubmission Code - 837 Billing Formats

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

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

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

2.11.2 Duplicate Bill Transaction Prior To Payment

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

Duplicate Bill Transaction
• CLM05-3 = Identical value as original. Cannot be '7'. • Condition codes in HI/K3 are populated with a condition code qualifier 'BG' and code value: 'W2' = Duplicate • NTE Example: NTE*ADD*BGW2 • Payer Claim Control Number does not apply • The resubmitted bill must be identical to the original bill, except for the 'W2' condition code. No new dates of service or itemized services may be included on the duplicate bill.

Duplicate bill transactions shall be submitted no earlier than thirty (30) working days after the claims administrator has acknowledged receipt of a complete electronic bill transaction and prior to receipt of a 005010X221A1 Health Care Claim Payment/Advice (835) transaction. (Is this a reasonable time frame for claims administrators and providers?)

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

1) the duplicate bill is received within thirty (30) working days after acknowledgment,
2) the bill has been processed and the 005010X221A1 transaction has been generated, or
3) the claims administrator does not have a corresponding accepted original transaction with the same bill identification numbers.

If the claims administrator does not reject the duplicate bill transaction within two business days, the duplicate bill transaction may be denied for the reasons listed above through the use of the 005010X221A1 transaction. (Is this a reasonable time frame for claims administrators and providers?)

2.11.3 Corrected Bill Transactions

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

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

Replacement or void of a prior bill should not be done until the prior submitted bill has reached final adjudication status. Final adjudication can be determined from remittance advice, web application or when showing a finalized code in a 005010X214 (277) transaction in response to a 005010X212 (276) transaction or non-electronic means.

Corrected Bill Transaction
• CLM05-3 = '7' indicates a replacement bill. • Condition codes of 'W2' to 'W5' in HI/K3 are not used. • REF*F8 includes the Payer Claim Control Number, if assigned by the payer. • A corrected bill shall include the original dates of service and the same itemized services rendered as the original bill. • When identifying elements change, the correction is accomplished by a void and re-submission process. • A bill with CLM05-3 = '8' (Void) must be submitted to cancel the incorrect bill, followed by the submission of a new original bill with the correct information.

The claims administrator may reject a revised bill transaction if:

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

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

2.11.4 Appeal/Reconsideration Bill Transactions

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

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

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

- 'W3' – 1st Level Appeal - Request for reconsideration or appeal with the claims administrator.
- 'W4' – 2nd Level Appeal - Resubmitted after receipt of a jurisdiction decision/order, typically from the WCD Medical Fee Dispute resolution process.
- 'W5' – 3rd Level Appeal - Resubmitted after receipt of a hearing or other judicial decision and order.

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

Reconsideration bill transactions may only be submitted after receipt of the 005010X221A1 transaction for the corresponding accepted original bill. The same bill identification number is used on both the original and the Reconsideration bill transaction to associate the transactions. All elements, fields, and values in the Reconsideration bill transaction, except the Reconsideration specific qualifiers and Claim

Supplemental Information PWK segment, must be the same as on the original bill transaction. Subsequent Reconsideration bill transactions related to the same original bill transaction may be submitted after receipt of the 005010X221A1 transaction corresponding to the initial Reconsideration bill transaction. Subsequent Reconsideration bill transactions shall not be submitted prior to the date the original request for reconsideration was sent or after the claims administrator has taken final action on the reconsideration request.

Corresponding documentation related to appeals/reconsideration is required in accordance with the Oregon WCD's rules for initial bill submission. The PWK Segment (Claim Supplemental Information) is required to be properly annotated when submitting an attachment related to an appeal/reconsideration.(Is it reasonable to require the provider to resend all documentation from the original transaction?)

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

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

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

The claims administrator may reject an appeal/reconsideration bill transaction if:

(1) the bill information does not match the corresponding original bill transaction,
(2) the claims administrator does not have a corresponding accepted original transaction,
(3) the original bill transaction has not been completed (no corresponding 005010X221A1 transaction or the Remittance submission Jurisdiction allowed time period has not been exceeded),or
(4) the bill is submitted without the PWK annotation.

Corresponding documentation related to appeals/reconsideration is required in accordance with the Oregon WCD rules for initial bill submission.

The claims administrator may deny appeal/reconsideration bill transactions for missing documentation. The claims administrator may deny the appeal/reconsideration bill transaction through the use of the 005010X221A1 transaction.

2.12 Balance Forward Billing

Balance forward billing is not permissible. Balance forward bills are bills that are either for a balance carried over from a previous bill or are for a balance carried over from a previous bill along with charges for additional services.

2.13 Oregon WCD Specific Requirements

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

2.13.1 Claim Filing Indicator

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

2.13.2 Transaction Set Purpose Code

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

2.13.3 Transaction Type Code

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

2.13.4 NCPDP Telecommunication Standard D.0 Pharmacy Formats

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

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

3.1 Introduction and Overview

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

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

3.2 Trading Partner Agreements

This companion guide does not replace the components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide.

The data elements transmitted as part of a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the *ASC X12 Type 3 Technical Reports* and Oregon WCD's companion guide. The Trading Partner Agreement must not change the workers' compensation field value designations as defined in Oregon WCD's companion guide.

3.3 Workers' Compensation Health Care Claim: Professional Instructions

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

ASC X12N/005010X222A1

Loop	Segment	Description	Oregon WCD Companion Guide Comments or Instructions
1000A	PER	SUBMITTER EDI CONTACT INFORMATION	When applicable, the Jurisdiction Companion Guide should specify any required communication number qualifiers and numbers. For example, if a telephone number is required, a comment may state: “One occurrence of the Communication Number Qualifier must be ‘TE’ – Telephone Number.”
2000B	SBR	SUBSCRIBER INFORMATION	In workers' compensation, the Subscriber is the Employer.
2000B	SBR04	NAME	In workers’ compensation, the group name is the employer of the patient/employee.
2000B	SBR09	CLAIM FILING INDICATOR CODE	Value must be 'WC' for workers’ compensation.
2010BA		SUBSCRIBER NAME	In workers' compensation, the Subscriber is the Employer.
2010BA	NM102	ENTITY TYPE QUALIFIER	Value must be '2' non-person.
2010BA	NM103	NAME LAST OR ORGANIZATION NAME	Value must be the name of the Employer.
2010BA	N3	SUBSCRIBER ADDRESS	In workers’ compensation, the Subscriber Address is the address of the Employer.
2010BA	N4	SUBSCRIBER CITY/STATE/ZIP CODE	In workers’ compensation, the Subscriber Address is the address of the Employer. (check specific – city/state/zip)
2010BA	REF	PROPERTY AND CASUALTY CLAIM NUMBER	When the workers’ compensation claim number is not assigned or is not available, use “UNKNOWN” as the default value. The claim number is required when assigned by the claims administrator.
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.
2010CA	REF	PROPERTY AND CASUALTY CLAIM NUMBER	When the workers’ compensation claim number is not assigned or is not available, use “UNKNOWN” as the default value. The claim number is required when assigned by the claims administrator.
2010CA	REF	PROPERTY AND CASUALTY PATIENT IDENTIFIER	The patient’s Social Security number is required.
2010CA	REF01	REFERENCE IDENTIFICATION QUALIFIER	Value must be ‘SY’.
2010CA	REF02	REFERENCE IDENTIFICATION	Enter the patient’s Social Security number. If the patient does not have a Social Security number then enter the following 9-digit number “999999999”
2300	CLM11	RELATED CAUSES INFORMATION	One of the occurrences in CLM11 must have a value of ‘EM’ -- Employment Related.
2300	DTP	DATE -- ACCIDENT	Required when the condition reported is for an occupational accident/injury.
2300	DTP	DATE – DISABILITY DATES	Do not use this segment.
2300	DTP	DATE – PROPERTY AND CASUALTY DATE OF FIRST CONTACT	Do not use this segment.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Required when submitting attachments related to a medical bill.

Loop	Segment	Description	Oregon WCD Companion Guide Comments or Instructions
2300	PWK01	REPORT TYPE CODE	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports, use appropriate 005010 Report Type Code.
2300	PWK02	Report Transmission Code	Use appropriate Report Transmission Codes specified in the 5010 Type 3 Technical Report.
2300	PWK06	ATTACHMENT CONTROL NUMBER	When the Report Type Code is 'OZ' and a jurisdiction report is sent, the first two characters of the attachment control number must be the Jurisdictional Report Type Code. Examples: Standard Report: PWK*OB*BM***AC*DMN0012~ Jurisdictional Report: PWK*OZ*BM***AC*J1DMN0012~
2300	K3	FILE INFORMATION	State Jurisdictional Code is expected here.
2300	K301	FIXED FORMAT INFORMATION	Jurisdiction State Code (State of Compliance Code) Required when the provider knows the state of jurisdiction is different than the billing provider's state (2010AA/N4/N402). Enter the state code qualifier 'LU' followed by the state code. For example, 'LUOR' indicates the medical bill is being submitted under Oregon medical billing requirements.
2300	HI	CONDITION INFORMATION	For workers' compensation purposes, the National Uniform Billing Committee and the National Uniform Claims Committee have approved the following condition codes for resubmissions: • W2 - Duplicate of the original bill • W3 - Level 1 Appeal • W4 - Level 2 Appeal • W5 - Level 3 Appeal Note: Do not use condition codes when submitting revised or corrected bills, (See Section 2.11 in this guide).
2310B	PRV	RENDERING PROVIDER SPECIALTY INFORMATION	Not required if an NPI is reported.
2420A	PRV	RENDERING PROVIDER SPECIALTY INFORMATION	Not required if an NPI is reported.

Chapter 4 Companion Guide ASC X12N/005010X223A2 Health Care Claim: Institutional (837)

4.1 Introduction and Overview

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

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

4.2 Trading Partner Agreements

This companion guide does not replace the components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide.

The data elements transmitted as part of a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the *ASC X12 Type 3 Technical Reports* and Oregon WCD's companion guide. The Trading Partner Agreement must not change the workers' compensation field value designations as defined in Oregon WCD's companion guide.

4.3 Workers' Compensation Health Care Claim: Institutional Instructions

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

ASC X12N/005010X223A2

Loop	Segment	Description	Oregon WCD Companion Guide Comments or Instructions
1000A	PER	SUBMITTER EDI CONTACT INFORMATION	If PER segment is used, then one occurrence of the Communication Number Qualifier must be 'TE' – Telephone Number.
2000B	SBR	SUBSCRIBER INFORMATION	In workers' compensation, the Subscriber is the Employer.
2000B	SBR04	NAME	In workers' compensation, the group name is the employer of the patient/employee.
2000B	SBR09	CLAIM FILING INDICATOR CODE	Value must be 'WC' for workers' compensation.
2010BA		SUBSCRIBER NAME	In workers' compensation, the Subscriber is the Employer.
2010BA	NM102	ENTITY TYPE QUALIFIER	Value must be '2' non-person.
2010BA	NM103	NAME LAST OR ORGANIZATION NAME	Value must be the name of the Employer.
2010BA	N3	SUBSCRIBER ADDRESS	In workers' compensation, the Subscriber Address is the address of the Employer.
2010BA	N4	SUBSCRIBER CITY/STATE/ZIP CODE	In workers' compensation, the Subscriber Address is the address of the Employer. (check specific – city/state/zip)
2010BA	REF	PROPERTY AND CASUALTY CLAIM NUMBER	When the workers' compensation claim number is not assigned or is not available, use "UNKNOWN" as the default value. The claim number is required when assigned by the claims administrator.
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.
2010CA	REF02	PROPERTY CASUALTY CLAIM NUMBER	When the workers' compensation claim number is not assigned or is not available, use "UNKNOWN" as the default value. The claim number is required when assigned by the claims administrator.
2010CA	REF	PROPERTY AND CASUALTY PATIENT IDENTIFIER	The patient's Social Security number is required.
2010CA	REF01	REFERENCE IDENTIFICATION QUALIFIER	Value must be 'SY'
2010CA	REF02	REFERENCE IDENTIFICATION	Value must be the patient's Social Security Number. Enter the patient's Social Security number. If the patient does not have a Social Security number then enter the following 9-digit number "999999999"
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Required when submitting attachments related to a medical bill.
2300	PWK01	REPORT TYPE CODE	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports, use appropriate 005010 Report Type Code.

Loop	Segment	Description	Oregon WCD Companion Guide Comments or Instructions
2300	PWK06	ATTACHMENT CONTROL NUMBER	When the Report Type Code is 'OZ' and a jurisdiction report is sent, the first two characters of the attachment control number must be the Jurisdictional Report Type Code. Examples: Standard Report: PWK*OB*BM***AC*DMN0012~ Jurisdictional Report: PWK*OZ*BM***AC*J1DMN0012~
2300	K3	FILE INFORMATION	State Jurisdictional Code is expected here.
2300	K301	FIXED FORMAT INFORMATION	Jurisdiction State Code (State of Compliance Code) Required when the provider knows the state of jurisdiction is different than the billing provider's state (2010AA/N4/N402). Enter the state code qualifier 'LU' followed by the state code. For example, 'LUOR' indicates the medical bill is being submitted under Oregon medical billing requirements.
2300	HI01	OCCURRENCE INFORMATION	At least one Occurrence Code must be entered with value of '04' - Accident/Employment Related or '11' -- illness. The Occurrence Date must be the Date of Occupational Injury or Illness.
2300	HI	CONDITION INFORMATION	For workers' compensation purposes, the National Uniform Billing Committee and the National Uniform Claims Committee have approved the following condition codes for resubmissions: • W2 - Duplicate of the original bill • W3 - Level 1 Appeal • W4 - Level 2 Appeal • W5 - Level 3 Appeal Note: Do not use condition codes when submitting revised or corrected bills.
2310A	PRV	ATTENDING PHYSICIAN SPECIALTY INFORMATION	If the attending physician's NPI is reported, the specialty information is not required.

Chapter 5 Companion Guide ASC X12N/005010X224A2 Health Care Claim: Dental (837)

5.1 Introduction and Overview

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

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

5.2 Trading Partner Agreements

This companion guide does not replace the components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide.

The data elements transmitted as part of a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the *ASC X12 Type 3 Technical Reports* and Oregon WCD's companion guide. The Trading Partner Agreement must not change the workers' compensation field value designations as defined in Oregon WCD's companion guide.

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

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

ASC X12N/005010X224A2

Loop	Segment	Description	Oregon WCD Companion Guide Comments or Instructions
1000A	PER	SUBMITTER EDI CONTACT INFORMATION	When applicable, the Jurisdiction Companion Guide should specify any required communication number qualifiers and numbers. For example, if a telephone number is required, a comment may state: “One occurrence of the Communication Number Qualifier must be ‘TE’ – Telephone Number.”
2000B	SBR	SUBSCRIBER INFORMATION	In workers' compensation, the Subscriber is the Employer.
2000B	SBR04	NAME	In workers’ compensation, the group name is the employer of the patient/employee.
2000B	SBR09	CLAIM FILING INDICATOR CODE	Value must be 'WC' for workers’ compensation.
2010BA		SUBSCRIBER NAME	In workers' compensation, the Subscriber is the Employer.
2010BA	NM102	ENTITY TYPE QUALIFIER	Value must be '2' non-person.
2010BA	NM103	NAME LAST OR ORGANIZATION NAME	Value must be the name of the Employer.
2010BA	N3	SUBSCRIBER ADDRESS	In workers’ compensation, the Subscriber Address is the address of the Employer.
2010BA	REF	PROPERTY AND CASUALTY CLAIM NUMBER	When the workers’ compensation claim number is not assigned or is not available, use “UNKNOWN” as the default value. The claim number is required when assigned by the claims administrator.
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.
2010CA	REF02	PROPERTY CASUALTY CLAIM NUMBER	When the workers’ compensation claim number is not assigned or is not available, use “UNKNOWN” as the default value. The claim number is required when assigned by the claims administrator.
2300	CLM11	RELATED CAUSES INFORMATION	One of the occurrences in CLM11 must have a value of ‘EM’ -- Employment Related.
2010CA	REF	PROPERTY AND CASUALTY PATIENT IDENTIFIER	The patient’s Social Security number is required.
2010CA	REF01	REFERENCE IDENTIFICATION QUALIFIER	Value must be ‘SY’.
2010CA	REF02	REFERENCE IDENTIFICATION	Value must be the patient’s Social Security Number. If the patient does not have a Social Security number then enter the following 9-digit number, “999999999”
2300	DTP	DATE -- ACCIDENT	Required when the condition reported is for an occupational accident/injury.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Required when submitting attachments related to a medical bill.
2300	PWK01	REPORT TYPE CODE	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports use appropriate 005010 Report Type Code.

Loop	Segment	Description	Oregon WCD Companion Guide Comments or Instructions
2300	PWK06	ATTACHMENT CONTROL NUMBER	When the Report Type Code is 'OZ' and a jurisdiction report is sent, the first two characters of the attachment control number must be the Jurisdictional Report Type Code. Examples: Standard Report: PWK*OB*BM***AC*DMN0012~ Jurisdictional Report: PWK*OZ*BM***AC*J1DMN0012~
2300	K3	FILE INFORMATION	State Jurisdictional Code is expected here.
2300	K301	FIXED FORMAT INFORMATION	Jurisdiction State Code (State of Compliance Code) Required when the provider knows the state of jurisdiction is different than the billing provider's state (2010AA/N4/N402). Enter the state code qualifier 'LU' followed by the state code. For example, 'LUOR' indicates the medical bill is being submitted under Oregon medical billing requirements.
2310A	PRV	REFERRING PROVIDER SPECIALTY INFORMATION	Not required.
2310B	PRV	RENDERING PROVIDER SPECIALTY INFORMATION	Not required.
2420A	PRV	RENDERING PROVIDER SPECIALTY INFORMATION	Not required.

Chapter 6 Companion Guide NCPDP D.0 Pharmacy

6.1 Introduction and Overview

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

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

This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the jurisdictions. The companion guide is intended to be used by jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the NCPDP Implementation Guides.

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

6.2 Trading Partner Agreements

This companion guide does not replace the components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide.

The data elements transmitted as part of a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the *NCPDP Implementation Guide* and Oregon WCD's companion guide. The workers' compensation field value designations as defined in Oregon WCD's companion guide must remain the same as part of any Trading Partner Agreement.

6.3 Workers' Compensation Health Care Claim: Pharmacy Instructions

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

Pharmacy NCPDP Version D.0

Segment	Field	Description	Oregon WCD Companion Guide Comments or Instructions
INSURANCE	3Ø2-C2	CARDHOLDER ID	If the Cardholder ID is not available or not applicable, the value must be 'NA'.
CLAIM	415-DF	NUMBER OF REFILLS AUTHORIZED	This field is optional.
PRICING	426-DQ	USUAL AND CUSTOMARY CHARGE	This field is optional.
PHARMACY PROVIDER	465-EY	PROVIDER ID QUALIFIER	The value must be '05' – NPI Number.
PRESCRIBER	466-EZ	PRESCRIBER ID QUALIFIER	This field is optional.
WORKERS' COMPENSATION			The Workers' Compensation Segment is required for workers' compensation claims.
WORKERS' COMPENSATION	435-DZ	CLAIM/REFERENCE ID	When the workers' compensation claim number is not assigned or is not available, use "UNKNOWN" as the default value. The claim number is required when assigned by the claims administrator.
CLINICAL			Oregon needs to know what this field is used for.
ADDITIONAL DOCUMENTATION			Not required.

Chapter 7 Companion Guide ASC X12N/005010X221A1 Health Care Claim Payment/Advice (835)

7.1 Introduction and Overview

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

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

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

7.2 Purpose

The ASCX12N/005010221 Health Care Claim Payment/Advice (835) Technical Report Type 3 is used by the payer to advise the provider of payment remittance and is also used to convey objections to the bill.

7.3 Trading Partner Agreements

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

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

7.4 Claim Adjustment Group Codes

The 005010X221A1 transaction requires the use of Claim Adjustment Group Codes. The most current valid codes should be used as appropriate for workers' compensation. The Claim Adjustment Group Code represents the general category of payment, reduction, or denial. For example, the Group Code 'CO' (Contractual Obligation) might be used in conjunction with a Claim Adjustment Reason Code for a network contract reduction.

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

7.5 Claim Adjustment Reason Codes

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

7.6 Remittance Advice Remark Codes

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

7.7 Claim Level Oregon Jurisdictional Explanation of Review (EOR) or Explanation of Benefit (EOB) Statement ID Qualifier

The Oregon WCD's paper Explanation of Review/Benefit (EOR/EOB) process includes a statement that is required on a paper EOR/EOB to provide health care providers, health care facilities, or third party biller/assignees with specific information regarding jurisdiction direction or limitations.

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

The Reference Identification value in REF02 is the jurisdictional code OR that represents Oregon WCD's EOR/EOB statement. The state jurisdictional REF02 OR value equates to the following EOR/EOB statement contained in Oregon Administrative Rules 436-009-0030(5)(a) through (f), 436-009-0180(1) through (4), and 436-009-0290(1) through (4). For Oregon, all EORs/EOBs must be in accordance with the following:

The explanation of benefits must include:

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

The specific reason for non-payment, reduced payment, or discounted payment for each service billed;

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

The following notice, web link, and phone number:

"To access information about Oregon's Medical Fee and Payment Rules, visit www.oregonwcdoc.info or call 503-947-7606.";

Space for a signature and date; and

A notice of right to administrative review as follows: "**If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the**

mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Section, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

7.8 Product/Service ID Qualifier

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

7.9 Workers' Compensation Health Care Claim Payment/Advice Instructions

Instructions for the Oregon WCD's specific requirements are also provided in *Chapter X* WCD Workers' Compensation Requirements. The following table identifies the application/instructions for the Oregon WCD that need clarification beyond the HIPAA implementation.

7.9.1 - ASC X12N/005010X221Health Care Claim Payment/Advice (835)

Loop	Segment or Element	Description	Oregon WCD Companion Guide Comments or Instructions
1000A	**PER**	**Payer Technical Contact Information**	
	PER03	Communication Number Qualifier	Value must be 'TE' Telephone Number.
	PER04	Communication Number	Value must be the Telephone Number of the submitter.
1000A	PER	Payer Web Site	If using the 2110 Loop REF Segment Health Care Policy Identification to communicate the Jurisdictional Statutory/Citation Reason Code, the PER Payer Web Site segment is required to communicate the Oregon Administrative Rule URL (OAR 436-009 Medical Fee and Payment Rules).
	PER01	Contact Function Code	Value must be 'IC'
	PER03	Communication Number Qualifier	Value must be 'UR' to indicate URL
	PER04	Communication Number	Enter the Oregon URL to the OAR 436-009 Medical Fee and Payment Rules
2100	**CLP**	**Claim Level Data**	
	CLP06	Claim Filing Indicator Code	Value must be "WC" – Workers' Compensation
	CLP07	Payer Claim Control Number	The payer assigned claim control number for workers' compensation use is the bill control number.
2100	**REF**	**Other Claim Related Identification**	Claim Level Jurisdictional EOR/EOB Code Statement; see Oregon Administrative Rules 436-009 Oregon Medical Fee and Payment Rules.
	REF01	Reference Identification Qualifier	Value must be "CE" Class of Contract Code
	REF02	Reference Identification	Oregon's Jurisdictional "OR" code value equates to the EOB/EOR statement (OAR 436-009) as defined in Chapter 7 section 7.7 of this companion guide.

Loop	Segment or Element	Description	Oregon WCD Companion Guide Comments or Instructions
2110	**REF**	**Healthcare Policy Identification**	
	REF01	Reference Identification Qualifier	Value must be "0K"
	REF02	Reference Identification	Enter Healthcare Policy, including any Jurisdictional Statutory/Citation Adjustment, Reference Identification Number Oregon is unsure if this is needed; more information required.

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

8.1 Introduction and Overview

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

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

8.2 Purpose

While Oregon allows the 275 transaction to transmit additional documentation for a medical bill, Oregon also allows other transmission types, e.g. fax, web upload, secure e-mail, etc.

8.3 Method of Transmission

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

8.4 Documentation

“Medical documentation” includes, but is not limited to, medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records, and diagnostic test results.

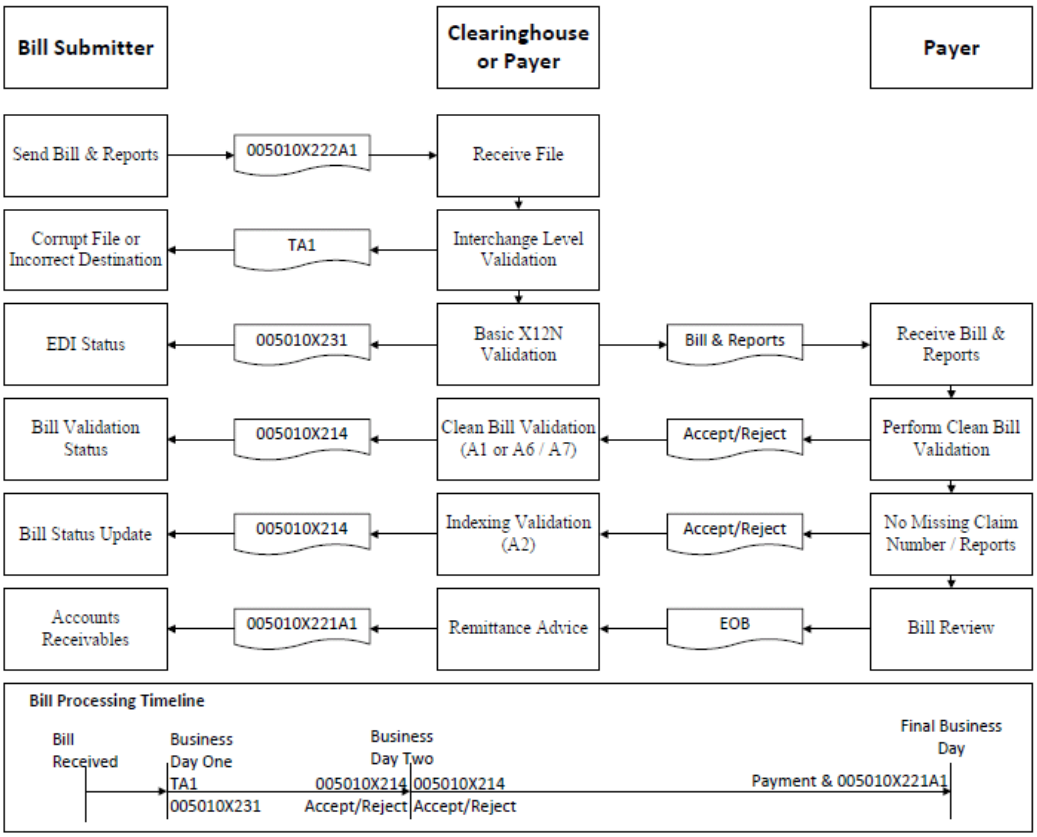
Chapter 9 Companion Guide Acknowledgments

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

1) Basic file structure and the trading partner information from the Interchange Header.
2) Detailed structure and syntax of the actual bill data as specified by the X12 standard.
3) The content of the bill against the jurisdictional clean bill rules.
4) Any delays caused by claim number indexing/validation.
5) Any delays caused by attachment matching.
6) The outcome of the final adjudication, including reassociation to any financial transaction.

9.2 Bill Acknowledgment Flow and Timing Diagrams

The process chart below illustrates how an incoming 005010X222A1, 005010X223A2, or 005010X224A2 transaction is validated and processed by the receiver. The diagram shows the basic acknowledgments that are generated by the receiver, including acknowledgments for validation and final adjudication for those bills that pass validation. **For more detailed information, see the Oregon flow diagram in Appendix XXX to this guide (see separate PDF document for this draft).**



9.2.1 Process Steps

1. **Interchange Level Validation**: Basic file format and the trading partner information from the Interchange Header are validated. If the file is corrupt or is not the expected type, the file is rejected. If the trading partner information is invalid or unknown, the file is rejected. A TA1 (Interchange Acknowledgment) is returned to indicate the outcome of the validation. A rejected EDI file is not passed on to the next step.
2. **Basic X12 Validation**: A determination will be made as to whether the transaction set contains a valid 005010X222A1. A 005010X231 (Functional Acknowledgment) will be returned to the submitter. The 005010X231 contains ACCEPT or REJECT information. If the file contains syntactical errors, the locations of the errors are reported. Bills that are part of a rejected transaction set are not passed on to the next step.
3. **Clean Bill Validation**: The jurisdictional and payer specific edits are run against each bill within the transaction set. The 005010X214 (Health Care Claim Acknowledgment) is returned to the submitter to acknowledge that the bill was accepted or rejected. Bills that are rejected are not passed on to the next step and are not clean bills. Accepted bills are considered clean bills.
4. **Clean Bill – Missing Claim Number and/or Missing Required Report:** Refer to Section 9.2 Clean Bill - Missing Claim Number Pre Adjudication Holding (Pending) Status and Section 9.2 Clean Bill - Missing Report Pre-Adjudication Holding (Pending) Status regarding bill acknowledgment flow and timeline diagrams.
5. **Bill Review**: The bills that pass through bill review and any post-bill review approval process will be reported in the 005010X221A1 (Remittance Payment/Advice). The 005010X221A1 contains the adjudication information from each bill, as well as any paper check or EFT payment information.

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

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

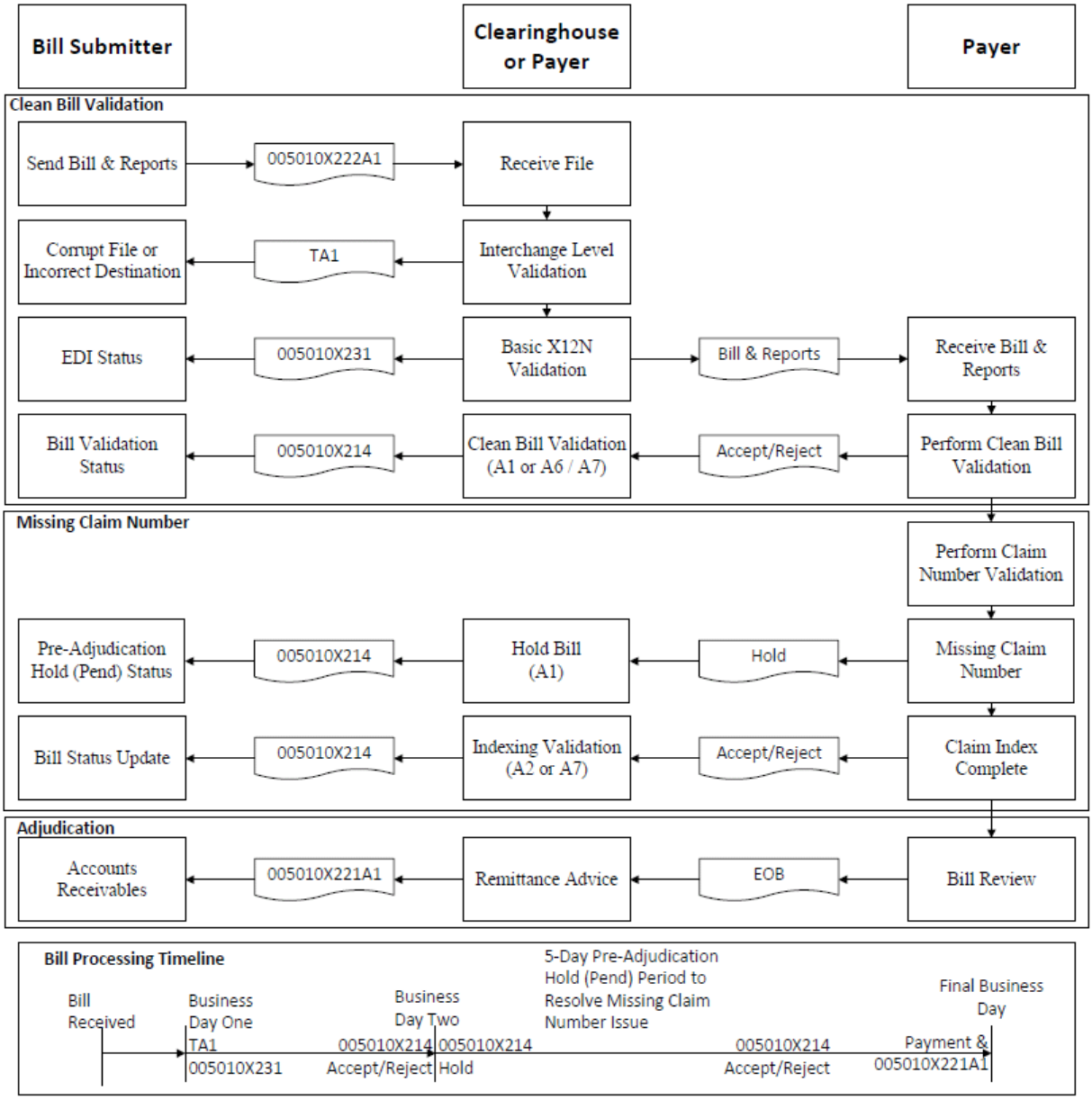
Due to the pre-adjudication hold (pend) status, a payer may send one STC segment with up to three claim status composites (STC01, STC10, and STC11) in the 005010X214. When a clean bill has a missing claim number and a missing report, the one STC segment in the 005010X214 would have the following three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

An example: STC*A1:21*20090830*U*70******A1:629*A1:294~

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

An example: STC*A1:21*20090830*U*70******A1:629~

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



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

Process Steps

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

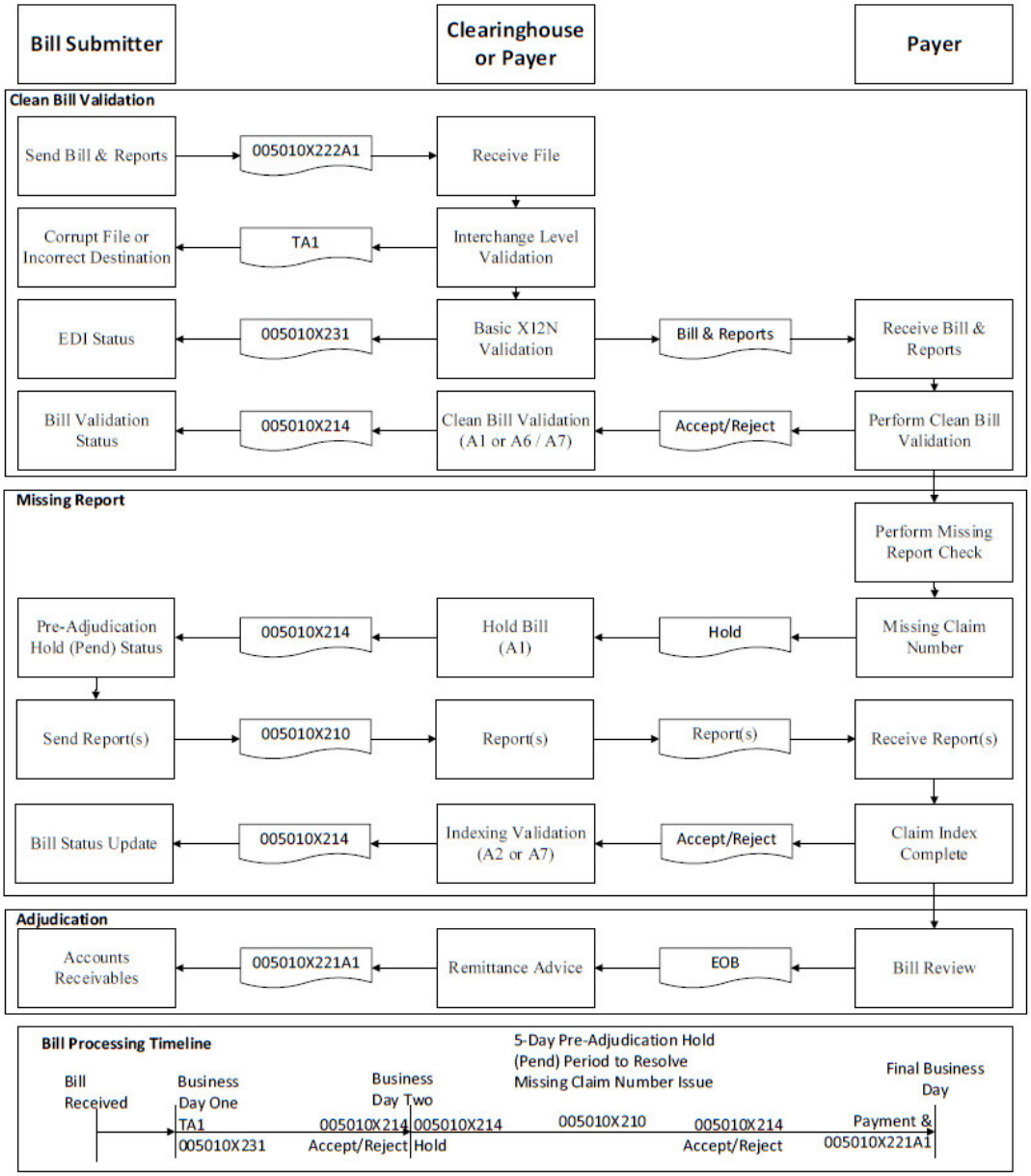
Claim Number Validation Status	005010X214
Clean Bill - Missing Claim Number	If the payer needs to pend an otherwise clean bill due to a missing claim number, it should use the following Claim Status Category Code and Claim Status Code: STC01-1 = A1 The claim/encounter has been received. This does not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

Claim Index/Validation Complete	005010X214
Claim Was Found	Once the Claim Indexing/Validation process has been completed and there is a bill/claim number match, then use the following Claim Status Category Code with the appropriate Claim Status Code: STC01-1 = A2 Acknowledgment/Acceptance into adjudication system. The claim/encounter has been accepted into the adjudication system. STC01-2 = 20 Accepted for processing
No Claim Found	After the Claim Indexing/ Validation process has been completed and there is no bill/ claim number match, use the following Claim Status Category Code with the appropriate Claim Status Code: STC01-1 = A6 Acknowledgment/Rejected for Missing Information. The claim/encounter is missing the information specified in the Status details and has been rejected. STC01-2 = 629 Property Casualty Claim Number (No Bill/Claim Number Match)

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

One of the processing steps that a bill goes through prior to adjudication is to verify if all required documentation has been provided. The bill submitter can send the reports using the 005010X210 or other mechanisms such as fax or e-mail. In order to prevent medical bill rejections due to lack of required documentation coming separately from the bill itself, a pre-adjudication holding (pending) period of up to five business days is mandated to enable the payer to receive and match the bill to the documentation. If the bill cannot be matched within the five days, or the documentation is not received, the bill may be rejected as incomplete. If the payer is able to match the bill to the documentation within the five days, it should put the bill through the adjudication process. The 005010X213 is used to inform the bill submitter

of the delay and the ultimate resolution of the issue. (Is this a reasonable time frame for claims administrators and providers?)



9.4.1 Missing Report - 277 Health Care Claim Acknowledgment Process Steps

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

Bill Status Findings	**277 HCCA Acknowledgment Options+**
Clean Bill - Missing Report	When a clean bill is missing a required report, the payer needs to place the bill in a pre-adjudication hold (pend) status during the specified waiting time period and return the following Claim Status Category Code and Claim Status Code: STC01-1 = A1 The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication. STC01-2 = 21 (Missing or Invalid Information) AND STC10-1 = A1 The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication. STC10-2 = Use the appropriate 277 Claim Status Code for missing report type. *Example: Claim Status Code* 294 Supporting documentation Example :STC*A1:21*20090830*U*70******A1:294~*:*
Report Received within the 5 day pre-adjudication hold (pend) period	Use the following Claim Status Category Code and Claim Status Code: STC01-1= A2 Acknowledgment/Acceptance into adjudication system. The claim/encounter has been accepted into the adjudication system. STC01-2=20 Accepted for processing
No Report Received within the 5 day pre-adjudication hold (pend) period	Use the following Claim Status Category Code and Claim Status Code. STC01-1= A6 Acknowledgment/Rejected for Missing Information. The claim/encounter is missing the information specified in the Status details and has been rejected. STC01-2=294 Supporting documentation

9.5 Transmission Responses

9.5.1 Acknowledgments - ASCX12N TA1 005010 – Interchange Acknowledgment

The ASC X12 transaction sets include a variety of acknowledgments to inform the sender about the outcome of transaction processing. Acknowledgments are designed to provide information regarding whether or not a transmission can be processed, based on structural, functional, and/or application level requirements or edits. In other words, the acknowledgments inform the sender regarding whether or not the medical bill can be processed or if the transaction contains all the required data elements.

Claims administrators must return one of the following acknowledgments within two working days of rejecting an electronic medical bill transmission or transaction:

- TA1 -- Implementation Acknowledgment
- 005010X231 -- Implementation Acknowledgment (999)

- 005010X214 -- Health Care Claim Acknowledgment (277)

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

9.5.2 ASC X12N/005010X213 - Request for Additional Information (277)

The 005010X213, or Request for Additional Information, is used to request missing required reports from the submitter. The following are the STC01 values:

Claim was pended; additional documentation required.

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

STC01-2 = The LOINC code indicating the required documentation

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

9.5.3 ASC X12N/005010X221A1 - Health Care Claim Payment/Advice (835)

The 005010X221A1, or Health Care Claim Payment/Advice, is required to be sent by the claims administrator within 15 days of receipt of a complete electronic medical bill. This transaction set informs the health care provider about the payment action taken by the insurance carrier. Additional information regarding this transaction set may be found in Chapter 7 of this companion guide and the applicable *ASC X12N Type 3 Technical Reports (Implementation Guides).*

9.5.4 ASC X12N/005010X212 Health Care Claim Status Request and Response (276 and 277)

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

Appendix A – Glossary of Terms

Acknowledgment	Electronic notification to original sender of an electronic transmission that the transactions within the transmission were accepted or rejected.
ADA	American Dental Association.
ADA-2006	American Dental Association (ADA) standard paper billing form.
AMA	American Medical Association
ANSI	American National Standards Institute is a private, non-profit organization that administers and coordinates the U.S. voluntary standardization and conformity assessment system.
ASC X12 275	A standard transaction developed by ASC X12 to transmit various types of patient information.
ASC X12 835	A standard transaction developed by ASC X12 to transmit various types of health care claim payment/advice information.
ASC X12 837	A standard transaction developed by ASC X12 to transmit various types of health care claim information.
CDT	Current Dental Terminology coding system used to bill dental services.
Claims Administrator	In Oregon, the claims administrator is the same as the insurer, i.e., an Oregon insurance carrier, State Accident Insurance Fund (SAIF), or an Oregon self-insured employer.
Clearinghouse	An entity that processes information received in a nonstandard format or containing nonstandard data content into a standard transaction, or that receives a standard transaction and processes that information into a nonstandard transaction.
CMS	Centers for Medicare and Medicaid Services, of the Dept. of Health and Human Services.
CMS-1450	The paper hospital, institutional, or facility billing form, also referred to as a UB-04 or UB-92, formerly referred to as a HCFA-1450.
CMS-1500	The paper professional billing form formerly referred to as a HCFA or HCFA-1500.
Code Sets	Tables or lists of codes used for specific purposes. National standard formats may use code sets developed by the standard setting organization (i.e. X12 Provider Type qualifiers) or by other organizations (i.e. HCPCS codes).
CPT	Current Procedural Terminology is the coding system created and copyrighted by the American Medical Association used to bill professional services.
DEA	Drug Enforcement Administration
DEA Number	Prescriber DEA identifier used for pharmacy billing [note, not required for Oregon pharmacy billing].
Detail Acknowledgment	Electronic notification to original sender that its electronic transmission or the transactions within the transmission were accepted or rejected.
Electronic Bill	A bill submitted from the health care provider, health care facility, or third-party biller/assignee to the payer electronically.
EFT	Electronic Funds Transfer.
Electronic Transmission	A collection of data stored in a defined electronic format. An electronic transmission may be a single electronic transaction or a set of transactions.
Electronic Format	The specifications defining the layout of data in an electronic transmission.

Electronic Record	A group of related data elements. A record may represent a line item, a health care provider, health care facility, or third party biller/assignee, or an employer. One or more records may form a transaction.
Electronic Transaction	A set of information or data stored electronically in a defined format that has a distinct and different meaning as a set. An electronic transaction is made up of one or more electronic records.
Electronic Transmission	Transmission of information by facsimile, electronic mail, electronic data interchange, or any other similar method that does not include telephonic communication. For the purposes of the electronic billing rules, electronic transmission generally does not include facsimile or electronic mail.
EOB/EOR	Explanation of Benefits (EOB) or Explanation of Review (EOR) is the paper form sent by the claims administrator to the health care provider, health care facility, or third party biller/assignee to explain payment or denial of a medical bill. The EOB/EOR might also be used to request recoupment of an overpayment or to acknowledge receipt of a refund.
Functional Acknowledgment	Electronic notification to the original sender of an electronic transmission that the functional group within the transaction was accepted or rejected.
HCPCS	Healthcare Common Procedure Coding System is the HIPAA code set used to bill durable medical equipment, prosthetics, orthotics, supplies, and biologics (Level II) as well as professional services (Level 1), Level 1 HCPCS codes are CPT codes.
HIPAA	Health Insurance Portability and Accountability Act, federal legislation that includes provisions that mandate electronic billing in the Medicare system and establishes national standard electronic file formats and code sets.
IAIABC	International Association of Industrial Accident Boards and Commissions
IAIABC 837	An implementation guide developed by the IAIABC based on the ASC X12 standard to transmit various types of health care medical bill and payment information from claims administrators to jurisdictions.
ICD-9	International Classification of Diseases, the code set administered by the World Health Organization used to identify diagnoses.
ICD-10	International Classification of Diseases, the code set administered by the World Health Organization used to identify diagnoses (replaces ICD-9).
NABP	National Association of Boards of Pharmacy, the organization previously charged with administering pharmacy unique identification numbers. (See NCPDP.)
NABP Numbers	Identification number assigned to individual pharmacy, administered by NCPDP. (Other term: NCPDP Provider ID, see NCPDP below.)
NCPDP	National Council for Prescription Drug Programs, the organization administering pharmacy unique identification numbers called NCPDP Provider Ids.
NPCPD Provider ID Number	Identification number assigned to individual pharmacy, previously referred to as NABP number.
NCPDP WC/PC UCF	National Council for Prescription Drug Program Workers Compensation/Property and casualty Universal Claim form which is the pharmacy industry standard for pharmacy claims billing on paper forms.
NCPDP Telecommunication D.0	HIPAA compliant national standard billing format for pharmacy services.
NDC	National Drug Code, the code set used to identify medication dispensed by pharmacies.
Receiver	The entity receiving/accepting an electronic transmission.

Remittance	Remittance is used in the electronic environment to refer to reimbursement or denial of medical bills.
Sender	The entity submitting an electronic transmission.
TPA	Third Party Administrator.
Trading Partner	An entity that has entered into an agreement with another entity to exchange data electronically.
UB-04	Universal billing form used for hospital billing. Replaces the UB-92 as the CMS-1450 billing form effective May 23, 2007.
UB-92	Universal billing form used for hospital billing, also referred to as a CMS-1450 billing form. Discontinued use as of May 23, 2007
Version	Electronic formats may be modified in subsequent releases. Version naming conventions indicate the release or version of the standard being referenced. Naming conventions are administered by the standard setting organization. Some ASC X12 versions, for example, are 3050, 4010, and 4050.

Appendix B - Jurisdiction Report Type Codes and Oregon WCD Descriptions

This Appendix is designed to provide stakeholders with the list of "jurisdictional codes" that will be used to identify documents for which an available ASC X12 code is not available**.**

Jurisdiction Report Type Codes	Oregon WCD Description as Applicable
J1 Doctor First Report of Injury	Oregon Form 827.
J2 Supplemental Medical Report	TBD
J3 Medical Permanent Impairment	TBD
J4 Medical Legal Report	TBD
J5 Vocational Report	TBD
J6 Work Status Report	TBD
J7 Consultation Report	TBD
J8 Permanent Disability Report	TBD
J9 Itemized Statement	Hospital Itemized Statement, or other itemized statement