

## **Oregon Workers' Compensation Division**



# **Oregon Medical State Reporting Electronic Data Interchange (EDI) Implementation Guide**

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**Release 1.2**

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## **Section 1 – Electronic Data Interchange Overview**

### ***Background***

The goal for Electronic Data Interchange (EDI) for workers' compensation data is improved transmission of information from its source, such as the health care provider to insurers and self-insured employers, and from the insurers and self-insured employers to state and federal workers' compensation regulatory agencies. EDI standards contribute to reduced administrative paperwork, improved accuracy, faster turnaround for payment of benefits, uniform reporting, and better overall monitoring of safety factors and payment data.

The International Association of Industrial Accident Boards and Commissions (IAIABC) includes in its membership numerous state regulatory agencies responsible for administering workers' compensation systems. The IAIABC EDI Implementation Guide for Medical Bill Payment Records (an adaptation of ANSI 837), details the processes and data elements for health care claims reporting in the workers' compensation environment. This IAIABC documentation is the primary resource for EDI medical 837 information.

The American National Standards Institute (ANSI) coordinates the formal development and use of voluntary standards in a wide range of business areas. Its Accredited Standards Committee, Property and Casualty Task Group, has published EDI standards (ANSI X12N 837 004010) that address the submission of medical billing and payment transactions to regulatory agencies. In addition, the Health Care Task Group has published implementation guides for the submission, acknowledgements, and other transactions related to health care billing and payment processes.

Effective Jan. 1, 2011, all insurers with 100 or more disabling claims per year in Oregon, as determined by the director based on an average accepted disabling claim volume for the previous three calendar years, are required to report paid medical bills to the division. The division uses Secure File Transfer Protocol (SFTP) for trading partners to submit medical EDI files.

### ***Division Rules***

Electronic Data Interchange medical bill data transactions are governed by Oregon Administrative Rules chapter 436, division 160, which can be found at:

<http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html>

### ***Transaction Types***

All actions by an insurer or self-insured employer that result in the payment or denial of payment for workers' compensation-related health care on an accepted claim are required to be reported to the division. In addition, refunds from a health care provider must also be reported to the division. Insurers and self-insured employers and their trading partners are required to report original bills within 60 days of making or denying the payment. Cancellations and replacement transactions should be reported with the next EDI filing after date of knowledge of the cancellation or change of key fields.

The transaction types accepted by the division on these actions include original, cancel, and replace (00, 01, and 05). Within each transaction type there are data elements that are mandatory, conditional, or optional. The data elements are located in Appendix A of Oregon Administrative Rules Chapter 436, Division 160. The Medical Bill Data Element Requirement Table contains

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the required data element for each transaction type and indicates if the field is mandatory, conditional, or optional. For information go to:

[http://www.cbs.state.or.us/wcd/policy/rules/docconv\\_21365/160\\_10057.pdf](http://www.cbs.state.or.us/wcd/policy/rules/docconv_21365/160_10057.pdf)

Insurers and self-insured employers are required to report medical billing and payment information for situations where the health care is rendered outside the United States of America. Country codes for foreign countries have been included in the division's database so that these transactions can be processed, and requirements for Federal Employer Identification Number (FEIN), National Provider Identification (NPI), and state license number will be bypassed.

Insurers and self-insured employers required to report are found on the list of required reporters in Bulletin 359. To view the list, go to:

[http://www.cbs.state.or.us/wcd/policy/bulletins/docconv\\_12819/bul\\_359.pdf](http://www.cbs.state.or.us/wcd/policy/bulletins/docconv_12819/bul_359.pdf)

### ***Excluded Transaction Types***

Insurers and self-insured employers are not required to report correction or encounter transactions (02 or 09). The division will return only TA (transaction accepted) or TR (transaction rejected) acknowledgements in the detail acknowledgement file; TE (transaction accepted with error) will not be used.

### ***Division Processing Actions***

For a new trading partner to actively submit medical bill data EDI into production, it will need to obtain a copy of the IAIABC standards and the State of Oregon Medical Billing Data Reporting EDI Implementation Guide.

Next, the trading partner will need to submit the EDI transmission profile to the division EDI coordinator, [dcbs.edimedical@state.or.us](mailto:dcbs.edimedical@state.or.us), 503-947-7742. The EDI coordinator will set up and assist in the testing process. Once testing is complete and the trading partner is approved for production, the trading partner will be able to electronically submit required paid medical bill data to the division. Both a 997 (functional) Acknowledgement and an 824 (detail) Acknowledgment will be sent back to the trading partner, if the file passes structural edits. The acknowledgments will identify any errors that need to be corrected and resubmitted. Files with structural or detail (data) errors must be corrected and resubmitted within 60 days of the date of payment or denial.

The Oregon Medical EDI ANSI 837 application processes SFTP transmissions sent by trading partners who have been approved by the division to submit medical bill data via ANSI 837 format. The Oregon Medical EDI ANSI 837 application follows the ANSI Implementation Guides issued by the IAIABC (IAIABC 837) to interpret transactions received in this format.

For more information, see the IAIABC website:

<http://www.iaiabc.org/>.

A trading partner may transmit either test or production data to the division and the trading partner must set the test/production indicator in the ISA envelope appropriately for each transmission.

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A Medical EDI ANSI 837 transaction set (batch) consists of an ST header segment, one or more detail records (transactions; medical bills), and an SE trailer segment. If the batch does not contain all three components, the batch is rejected. A transaction set may contain multiple transactions (a batch may contain multiple bills).

The Medical EDI ANSI 837 application first checks every inbound file for structural validation. Any error outside of a functional group, or in the GS segment, will cause a rejection and a TA1 reject will be sent and no further processing of the file will occur. If invalid syntax is found below the interchange level, the 997 file will indicate a rejection for the transaction set containing the error. The data in those transactions will not be edited and those transactions will not be acknowledged in the 824 file. At least one transaction set must pass the 997 edits in order for an 824 file to be created. A trading partner must monitor its SFTP directories and error reports, and immediately correct any TA1 or 997 errors and resubmit the file for processing.

If the Medical EDI ANSI 837 application has passed the structural validity of at least one transaction set in an inbound file, the application then checks the batches and individual transactions (bills) in the accepted transaction sets by validating each field (“data element”) in each batch and transaction using the edit rules. Each data element must meet the defined edits and validation rules included in the Event Table and Element Requirements Table found on the EDI webpage at

<http://www.cbs.state.or.us/external/wcd/operations/edi/ediindex.html>.

After processing, the application sends the trading partner an 824 Detail Acknowledgment with information about the results of the processing. If a data element fails to pass any edit validation, then the medical EDI application will produce the appropriate error message in the 824 Detail Acknowledgment. All data element errors will be included in the 824 acknowledgement.

### Division Production Schedule

The division will process incoming 837 files after 5 p.m. Pacific time, seven days a week. Files dropped off after the 5 p.m. deadline may not be processed until the next business day. Acknowledgements will be available for pickup on the next business day after files are dropped off. In case of any required maintenance that causes a delay to this schedule, incoming files will be credited with their receipt date to determine timeliness of filing.

In order to ensure adequate space on the SFTP server, the division recommends that insurers and self-insured employers delete transaction files that have already been processed. Insurers and self-insured employers are encouraged to actively monitor production operations and schedules, identify any issues or defects, and quickly notify the division if any unexpected problems occur with picking up their acknowledgement files.

### ***Monitoring***

The division will be developing various reports related to timeliness of reporting and the accuracy of reporting. These reports will be used to monitor both trading partner and insurer or self-insured employer performance on the data reporting requirements. The responsibility of accurate reporting resides with the insurer or self-insured employer. These entities must be familiar with billing, payment, and coding standards to ensure accuracy and should not rely simply on the edits implemented by the division to determine whether or not they are accurately reporting their data.

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If potential problems are identified, the division will provide this information to the trading partner and insurer or self-insured employer to help resolve potential issues or seek clarification. In addition, certain findings may be referred to our Compliance Section staff to determine if further investigative or audit actions are necessary.

### ***Where to Get Help:***

Oregon Workers' Compensation Division

Home page: <http://www.cbs.state.or.us/external/wcd/index.html>

EDI guide: <http://www.cbs.state.or.us/external/wcd/operations/edi/ediindex.html>

E-mail: [dcbs.edimedical@state.or.us](mailto:dcbs.edimedical@state.or.us)

Phone: 503-947-7742

Fax: 503-947-7514

### IAIABC

International Association of Industrial Accident Boards and Commissions

<http://www.iaabc.org>

5610 Medical Circle, Suite 24

Madison, WI 53719-1295

Phone: 608-663-6355

Fax: 608-663-1546

### ANSI

American National Standards Institute

<http://www.ansi.org/>

E-mail: [info@ansi.org](mailto:info@ansi.org)

Phone: 212-642-4980

Fax: 212-302-1286

Mailing Address:

ANSI Attn: Customer Service Department

25 W. 43rd Street, 4th Floor

New York, NY 10036

## **Section 2 – Submitter Profile Information**

### ***EDI Trading Partner Profile***

The trading partner profile information is submitted to the Workers' Compensation Division on the EDI Trading Partner Profile and Transmission Profile. These profiles are required to be completed by entities intending to send medical bill data to the division using the EDI process.

Information contained on the profile defines the trading partner's type of business, contact information, sender specifications, and receiver specifications. Trading partners are responsible for keeping their profiles up-to-date, including technical and business contact names and contact information.

The division will notify trading partners that they are approved for production submissions after successful completion of EDI data testing.

### ***Transmissions Method***

The division will accept transmissions through an SFTP (Secure File Transfer Protocol). The data within the file request may contain confidential or sensitive information that must be safeguarded during transmission to or from the trading partner. For this reason, all file transfers will be exchanged using SFTP.

The initial EDI profile form submitted by a trading partner is used to set up the trading partner SFTP access, directory profile, and points of contact. The trading partner will use SFTP client software that is appropriate for their operating system environment and can successfully interface with the division environment. Inbound and outbound naming conventions can be found in Appendix B.

Files are expected to be placed on the SFTP server by trading partners no later than 5 p.m. Pacific time each business day to ensure they are deemed received by the division that business day. The division will place acknowledgements for completely processed batches on the SFTP server the following business day.

### ***Previously Rejected Transactions***

All rejected transactions are tracked but not loaded to the division's reporting database. Therefore, to satisfy filing requirements, all rejected transactions must be corrected and re-transmitted, using the same unique bill ID (DN500) and insurer FEIN (DN006), and be accepted by the division.

The division recognizes that the adjudication processes for compensability and extent of injury occasionally takes a significant period of time before final resolution. As such, certain code values (HCPCS, NDC, etc.) may no longer be valid at the time the medical billing and payment transactions are submitted to the division. In order to accommodate this exception, the division will retain code value lists for previous years for use in validating transactions. The insurer or self-insured employer must ensure that the paid codes were valid codes for the date of service prior to submitting the transaction.

## **Section 3 – ANSI File Structure**

### ***Overview***

Trading partners are required to use the IAIABC standards to transmit EDI medical bill data to meet mandatory and conditional requirements in accordance with Oregon Workers' Compensation Division EDI data elements and validation rules. These requirements supplement the IAIABC EDI Implementation Guide Release 1.1 for the transmission of medical payment data.

All EDI files use a defined American National Standards Institute (ANSI) file structure. The guide provides additional specific information on Oregon requirements and processing of the 837, TA1, 997, and 824 information from the IAIABC EDI instructions.

Each text file contains at least three defined, nested components: one interchange control statement (ISA) defined by a header segment and a trailer segment, one functional group (GS) defined by a header segment and a trailer segment, and one or more transaction sets (ST/SE) within the functional group defined by a header segment and a trailer segment.

The division allows multiple insurers or self-insured employers to be reported within a single file. We do not have limitations on file size.

When the division receives an EDI ANSI 837 file that the division's system can read, the division performs initial processing of the file and sends a 997 Functional Acknowledgment to the original sender. (A file with an error at the Interchange level will receive a TA1 Acknowledgment rather than a 997.)

For each transaction set that passes the initial checks, the division sends a 997 Accept message. The division will process those accepted transaction sets and will send an 824 Detail Acknowledgment identifying the transactions that were processed. If any transaction set fails, the trading partner must correct the failed transaction sets and resubmit them.

For each transaction set that does not pass the initial checks, the division sends a 997 Reject message. The division will not process the transaction set any further and will send no additional messages. The trading partner must review and interpret the 997 Reject messages, correct the errors, and resubmit the corrected transactions.

When the division receives an EDI ANSI 837 file that the division's system cannot read, the division will attempt to identify the trading partner and work with the trading partner to correct and resubmit the file.

### ***File Structure Overview***

An ANSI file is made up of sets of data in a structured text file.

The smallest piece of data is the data element, which represents a single field or value. As an example, the data element that represents the employer last name is assigned a specific data element number (DN 43).

The data elements are arranged in a defined structure to represent a segment. As an example, the geographical location segment includes the data elements for city, state code, postal code, and country code.

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Sets of segments make up loops. As an example, Loop ID Employer Named Insured Information includes: name, address, geographical location, identification number, and contact number segments.

Every 837 file must contain at least one transaction set. The set of loops in a transaction set may provide information for a single medical bill or many bills. The data elements, segments, and loops required depend on the types of bills that the file contains.

A file is the entire submission (ISA, GS, ST/SE, GE, IEA). Every 837 file must contain a defined set of data elements, segments, and loops required in the file. The file includes one ISA header and trailer (ISA/IEA), one functional group header and trailer (GS/GE), and the transaction sets (ST/SE) (pairs of headers and trailers and the medical billing data included between them).

### ***ISA Envelope***

Every ANSI EDI file is identified by elements that define an ISA envelope. The ISA envelope provides information that identifies the sender, the receiver, and critical identifying information on the file (the type of data contained in the file, time sent, date sent, and tracking number).

The ISA envelope includes the ISA and IEA segments shown below.

ISA Envelope:

ISA (Interchange Control header segment)

GS (Functional Group header segment)

Transaction Set or Sets: ST/SE pairs (header segment and trailer segment and the medical billing data content between those segments). An 837 transaction set also is called a batch.

Optional Transaction Set 2: ST/SE

Optional Transaction Set 3

GE (trailer segment; end of the functional group)

GS

ST/SE

GE

IEA (trailer segment, end of the ISA envelope; end of the file)

The ISA envelope for an inbound EDI ANSI 837 file being sent to the division provides information that identifies the following:

The sender: the trading partner submitting the file

The receiver: the division

Identifying information that defines the file as a specific EDI ANSI 837 file

The division uses the FEIN (Federal Employer ID Number) as the identifier for the sender and the receiver of an EDI file. The trading partner FEIN for the Oregon EDI system is the FEIN that was filed when the trading partner submitted the EDI Trading Partner Application and Profile, and which matches the FEIN on file with the Oregon Insurance Division. The division's FEIN is 930952020. Each number is formatted as nine continuous digits.

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The ISA envelope for the outbound 997 and 824 acknowledgment files from the division to the trading partner includes the same data elements, but the information in the transaction sets tells whether the data in each transaction set in the 837 was read. For the 997 and the 824, the ISA envelope identifies the following:

The sender (the division)

The receiver (the original trading partner/sender of the 837)

Identifying information relating the response to the original inbound 837 file

### ***Required Delimiters***

For Oregon medical EDI transactions, insurer or self-insured employer trading partners are required to use the following delimiters:

Data element separator -- \* (asterisk). Separates the data elements in a segment

Example: ST\*837\*82341

For an 837 file, header for the transaction set with control number 82341.

If an optional field is blank, do not insert an asterisk. The data element is not included.

Sub element separator –: (colon). Separates sub elements in the same data element, such as code modifiers.

Example: HI\*BK:820\*BF:873.9

Principal diagnosis code is 820, admitting diagnosis code is 873.9.

(Modifiers associate the use of the diagnosis codes).

Segment Terminator -- ~ (tilde); indicates the end of a segment. In an EDI file, do not follow a tilde by a line space (space-bar space) or line break character.

Example: SE\*56\*82341~

Transaction Set trailer; Transaction Set 82341 contains 56 segments including the ST and SE segments.

### ***Functional Errors***

The two basic types of file failure are functional and structural. EDI ANSI 837 files that fail interchange-level structural validation will not generate a 997 Acknowledgment; a TA1 Acknowledgment will be generated instead.

A trading partner must monitor its SFTP mailboxes to determine whether an expected 997 was not received and a TA1 received in its stead. Files that fail functional validation, or the resulting error logs, must be reviewed against the ISA envelope segments to determine the error for each file.

A trading partner may find it beneficial to view these files with a hex editor to locate hidden or missing characters in the envelope segments.

Common functional problems include:

Missing segment terminators (~)

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Line breaks (carriage returns) or line spaces (space-bar spaces) between segments.

Not enough characters in the ISA06 and ISA08 segments. The Interchange Sender ID (trading partner ZIP) and Receiver ID (the division's ZIP) segments specify that the field length is exactly 15 characters, although the data required (ZIP) is only nine digits. For fixed-length fields found in the ANSI X12 envelope, use spaces to fill the remainder of the data element field.

Inappropriate ISA15: Usage Indicator should be 'T' for Test, 'P' for Production.

ANSI X12 v4010 Envelope Segments With Oregon Comments ANSI Version 1.0, 04/19/05

### Section 4 -- Set-up

#### *Interchange Control Header*

**Purpose:** To start and identify an interchange of zero or more functional groups and interchange-related control segments

**Notes:** 1. The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. The character immediately before the segment terminator is the sub-element separator.

2. Spaces in the example are represented by "." for clarity.

**Example:** ISA\* 00\* .....\*00\*.....\* ZZ\*76533224.....\*  
ZZ\*746000119.....\*030923\*1901\*U\* 00401\*123456789\* 0\* T\* :~

ELEMENT SUMMARY				
USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
<b>MUST USE</b>	<b>ISA01</b>	<b>I01</b>	<b>Authorization Information Qualifier</b>	<b>M ID 2/2</b>
Code to identify the type of information in the Authorization Information.				
<b>CODE DEFINITION</b>				
<b>00 NO AUTHORIZATION INFORMATION PRESENT</b>				
<b>MUST USE</b>	<b>ISA02</b>	<b>I02</b>	<b>Authorization Information</b>	<b>M AN 10/10</b>
Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)				
<b>INSERT SPACES</b>				
<b>MUST USE</b>	<b>ISA03</b>	<b>I03</b>	<b>Security Information Qualifier</b>	<b>M ID 2/2</b>
Code to identify the type of information in the Security Information. Since EDI837 transactions are sent through SFTP, Security Information is not necessary.				
<b>CODE DEFINITION</b>				
<b>00 NO SECURITY INFORMATION PRESENT</b>				
<b>MUST USE</b>	<b>ISA04</b>	<b>I04</b>	<b>Security Information</b>	<b>M AN 10/10</b>
This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03).				
<b>INSERT SPACES</b>				

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ELEMENT SUMMARY				
USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
MUST USE	ISA05	I05	<b>Interchange ID Qualifier</b> Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified <b>THIS ID QUALIFIES THE SENDER IN ISA06.</b> <hr/> CODE      DEFINITION <hr/> <b>ZZ      MUTUALLY DEFINED</b>	M   ID   2/2
MUST USE	ISA06	I06	<b>Interchange Sender ID</b> Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element. <hr/> CODE      DEFINITION <hr/> <b>9 DIGIT TRADING PARTNER FEIN AS FILED IN THE TRADING PARTNER PROFILE FORM PLUS SPACES; OR WCD FEIN (930952020) PLUS SPACES</b>	M   AN   15/15
MUST USE	ISA07	I05	<b>Interchange ID Qualifier</b> Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified. <b>THIS ID QUALIFIES THE RECEIVER IN ISA08.</b> <hr/> CODE      DEFINITION <hr/> <b>ZZ      MUTUALLY DEFINED</b>	M   ID   2/2
MUST USE	ISA08	I07	<b>Interchange Receiver ID</b> Identification code published by the receiver of the data. When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them. <hr/> CODE      DEFINITION <hr/> <b>WCD FEIN (930952020) PLUS SPACES; OR 9 DIGIT TRADING PARTNER FEIN AS FILED IN THE TRADING PARTNER PROFILE FORM PLUS SPACES</b>	M   AN   15/15
MUST USE	ISA09	I08	<b>Interchange Date</b> Date of the interchange. <b>The date format is YYMMDD and is provided by the sender.</b>	M   DT   6/6
MUST USE	ISA10	I09	<b>Interchange Time</b> Time of the interchange. <b>The time format is HHMM and is provided by the sender.</b>	M   TM   4/4
MUST USE	ISA11	I10	<b>Interchange Control Standards Identifier</b> Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer. <hr/> CODE      DEFINITION <hr/> <b>U      U.S. EDI COMMUNITY OF ASC X12</b>	M   ID   1/1

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ELEMENT SUMMARY				
USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
<b>MUST USE</b>	<b>ISA12</b>	<b>I11</b>	<b>Interchange Control Version Number</b>	<b>M ID 5/5</b>
This version number covers the interchange control segments.				
<b>CODE      DEFINITION</b>				
<b>00401    APPROVED VERSION</b>				
<b>MUST USE</b>	<b>ISA13</b>	<b>I12</b>	<b>Interchange Control Number</b>	<b>M N0 9/9</b>
A control number assigned by the interchange sender.				
<b>The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.</b>				
<b>MUST USE</b>	<b>ISA14</b>	<b>I13</b>	<b>Acknowledgment Requested</b>	<b>M ID 1/1</b>
Code sent by the sender to request an interchange acknowledgment (TA1).				
<b>CODE      DEFINITION</b>				
<b>0            NO ACKNOWLEDGMENT REQUESTED</b>				
<b>NOTE: A FILE THAT IS SENT TO WCD THAT PASSES INTERCHANGE-LEVEL VALIDATION WILL AUTOMATICALLY RECEIVE A 997 ACKNOWLEDGEMENT.</b>				
<b>MUST USE</b>	<b>ISA15</b>	<b>I14</b>	<b>Usage Indicator</b>	<b>M ID 1/1</b>
Code to indicate whether data enclosed by this interchange envelope is test, production or information.				
<b>CODE      DEFINITION</b>				
<b>P            PRODUCTION DATA</b>				
<b>T            TEST DATA</b>				
<b>MUST USE</b>	<b>ISA16</b>	<b>I15</b>	<b>Component Element Separator</b>	<b>M      1/1</b>
Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator.				
<b>: - COLON</b>				

### *Interchange Control Trailer*

**Purpose:** To define the end of an interchange of zero or more functional groups and interchange-related control segments

**Example:** IEA\*1\*123456789~ End of ISA Envelope; indicates one functional group processed

ELEMENT SUMMARY				
USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
<b>MUST USE</b>	<b>IEA01</b>	<b>I16</b>	<b>Number of Included Functional Groups</b>	<b>M N0 1/5</b>
A count of the number of functional groups included in an interchange				
<b>MUST USE</b>	<b>IEA02</b>	<b>I12</b>	<b>Interchange Control Number</b>	<b>M N0 9/9</b>
A control number assigned by the interchange sender				
<b>NUMBER MUST MATCH NUMBER IN ISA13</b>				

# Oregon EDI Medical Bill Reporting Implementation Guide

## ***Functional Group Header***

**Purpose:** To indicate the beginning of a functional group and to provide control information

**Example:** GS\*HC\*765332244.....\*746000119.....\* 20030923\* 1901\*  
000000001\*X\*004010~

### Beginning segment, Functional Group

ELEMENT SUMMARY				
USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
<b>MUST USE</b>	<b>GS01</b>	<b>479</b>	<b>Functional Identifier Code</b>	<b>M ID 2/2</b>
Code identifying a group of application related transaction sets.				
<b>CODE      DEFINITION</b>				
<b>HC      HEALTH CARE CLAIM (837)</b>				
<b>AG      APPLICATION ADVICE (824)</b>				
<b>FA      FUNCTIONAL ACKNOWLEDGMENT (997)</b>				
<b>MUST USE</b>	<b>GS02</b>	<b>142</b>	<b>Application Sender's Code</b>	<b>M AN 2/15</b>
Code identifying party sending transmission; codes agreed to by trading partners.				
<b>CODE      DEFINITION</b>				
<b>9 DIGIT TRADING PARTNER FEIN PLUS SPACES; OR 9 DIGIT WCD FEIN E (930952020) PLUS SPACES</b>				
<b>This is the same ID as in ISA06.</b>				

### **I.**

ELEMENT SUMMARY				
USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
<b>MUST USE</b>	<b>GS03</b>	<b>124</b>	<b>Application Receiver's Code</b>	<b>M AN 2/15</b>
Code identifying party receiving transmission. Codes agreed to by trading partners.				
<b>CODE      DEFINITION</b>				
<b>9 DIGIT WCD FEIN (930952020) PLUS SPACES; OR 9 DIGIT TRADING PARTNER FEIN PLUS SPACES</b>				

### **II.**

<b>MUST USE</b>	<b>GS04</b>	<b>373</b>	<b>Date</b>	<b>M DT 8/8</b>
Date expressed as CCYYMMDD				
SEMANTIC: GS04 is the group date.				
<b>Use this date for the functional group creation date.</b>				
<b>MUST USE</b>	<b>GS05</b>	<b>337</b>	<b>Time</b>	<b>M TM 4/8</b>
Time expressed in 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59).				
SEMANTIC: GS05 is the group time.				
<b>Use this time for the creation time.</b>				

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ELEMENT SUMMARY				
USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES

**MUST USE            GS06            28            Group Control Number            M N0 1/9**

Assigned number originated and maintained by the sender.

**SEMANTIC:** The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

**MUST USE            GS07            455            Responsible Agency Code            M ID 1/2**

Code used in conjunction with Data Element 480 to identify the issuer of the standard.

CODE	DEFINITION
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<b>X</b>	<b>ACCREDITED STANDARDS COMMITTEE X12</b>
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### III.

**MUST USE            GS08            480            Version / Release / Industry Identifier Code            M AN 1/12**

Code indicating the version, release, sub release, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and sub release, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed.

CODE	DEFINITION
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<b>004010</b>	<b>ANSI RELEASE 004010</b>
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### *Functional Group Trailer*

**Purpose:**            To indicate the end of a functional group and to provide control information

**Example:**        GE\*1\*000000001~    End of Functional Group; indicates one transaction set in Functional Group 000000001

ELEMENT SUMMARY				
USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES

**MUST USE            GE01            97            Number of Transaction Sets Included            M N0 1/6**

Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.

<b>A</b>	<b>TRANSACTION SET IS DEFINED BY ONE ST/SE PAIR</b>
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**MUST USE            GE02            28            Group Control Number            M N0 1/9**

Assigned number originated and maintained by the sender.

**SEMANTIC:** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.

<b>MUST MATCH THE NUMBER IN GS06</b>	
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### ***EDI ANSI 837 Transaction Set***

The EDI ANSI 837 file structure of a transaction set tracks information under the insurance carrier (“20”), the employer (EM), and the claimant (CL

A hierarchical level (HL) statement identifies the category of participant: ‘20’, ‘EM’, or ‘CL’ in a relationship comparable to a three-level outline.

A higher level is a ‘Parent.’

A lower level is a ‘Child’ of the last prior Parent.

The 837 submission always must contain at least one 20, one EM, and one CL hierarchical level.

The hierarchical levels are numbered consecutively in one continuous sequence. The level number itself does not identify the category of participant.

Like an outline, each hierarchical level controls the content that follows it until there is another hierarchical level introduction at the same level or a parent level.

An IC hierarchical level ‘parent’ controls the content that follows it until there is another ‘20’ hierarchical level statement. (Any EM or CL statement introduced refers to that insurance carrier.)

An EM hierarchical level ‘parent’ controls all CL level statements until there is another EM or 20 statement. An EM is the ‘child’ of the last prior 20.

A CL hierarchical level is the ‘child’ of the last prior EM and also belongs to the last ‘20’;

The last hierarchical level must be a CL.

Each hierarchical level must have content following it. Each parent must have at least one child; if not, the transaction is invalid and should not be sent.

For each claimant (CL) there are one or more transactions (medical bills). Each transaction includes detailed information about the services being billed; and there can be multiple transactions submitted for a claimant.

The 837 hierarchical structure enables trading partners to report medical bills for multiple insurers, employers, and claimants in a single file; each file must contain at least one insurer, one employer, one claimant, one bill, and one line item.

If there is no claimant, there is no way to associate the medical bill with the workers’ compensation claim.

If there is no billing information (CLM segment), the transaction is invalid and should not be sent.

Once a claimant hierarchical level is included in the 837 submission, all bills are treated as belonging to that claimant until another claimant, employer, or insurer is included.

#### **Transaction Set Examples**

An example of the transaction set structure contains loops such as the following.

Transaction Set Header segment (ST)

Sender Information for the trading partner

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Receiver Information for the division

Carrier 1 – Hierarchical Level 1 (parent)

Employer 1 for this insurance Carrier - Hierarchical Level 2

(employer is a child to the last carrier listed and a parent to the claimant or claimants that follow)

Claimant 1 for this employer - Hierarchical Level 3 (claimant is a child to the last employer listed)

Billing (Claim, 'CLM' A claim is attached to a claimant, and thus to the employer and the insurance carrier. Each CLM contains one or more line items, 'LX,' to define the charges that are requested to be paid.)

Bill Data

Provider Data

Network Data

Line Item Data, 'LX'

Service Adjustment Line Data

Billing (repeat for each bill for this claimant)

Next claimant (claimant 2 for this employer) - Hierarchical Level 4 (claimant is a child to the last employer listed)

Billing for this claimant

Next claimant (claimant 3 for this employer) - Hierarchical Level 5 (claimant is a child to the last employer listed)

Billing for this claimant

Next employer (employer 2 for this insurance carrier) - Hierarchical Level 6 (employer is a child to the last carrier listed and a parent to the claimant or claimants that follow)

Next claimant (claimant 1 for this employer) - Hierarchical Level 7 (claimant is a child to the last employer listed)

Billing for this claimant

Insurance Carrier 2 - Hierarchical Level 8 (parent). There must be at least one employer (HL\*9\*) and one claimant (HL\*10\*) for this insurance carrier. NOTE: The division can accept files containing submissions for multiple insurers and self-insured employers.

***Transaction Set Trailer (ST)***

The following is a different representation of the same hierarchical looping within a transaction set (everything from one ST statement through its following SE statement). Remember, hierarchical levels are numbered continuously, and the IC, EM, or CL designation identifies the information contained in the hierarchical level.

HL ID #	Parent ID #	Description	Child Code
1	NA	1st Carrier	1 = Yes
2	1	1st Employer of 1stCarrier	1 = Yes
3	2	Claimant 1 of 1st Employer under 1st Carrier	0 = No
4	2	Claimant 2 of 1st Employer under 1st Carrier	0 = No
5	1	2nd Employer of 1st Carrier	1 = Yes
6	5	Claimant 1 of 2nd Employer under 1st Carrier	0 = No
7	5	Claimant 2	0 = No
8	NA	2nd Carrier	1 = Yes
9	8	1st Employer of 2nd Carrier	1 = Yes
10	9	Claimant 1 of 1st Employer under 2nd Carrier	0 = No

***Sample EDI ANSI 837 File***

The following is an example of a complete EDI ANSI 837 file containing the minimum required structure – ISA Envelope (header and trailer), functional group (header and trailer), transaction set (header and trailer), one carrier, one employer, one claimant, one bill, and one line item. To enhance readability, line breaks have been added after the segment terminators (~) to show the structure of the file. A file submitted in this manner would fail structural validation.

```

ISA*00*      *00*      *ZZ*765332244  *ZZ*746000119
*030923*1901*U*00401*123456789*0*T*:~ BEGINNING SEGMENT, ISA ENVELOPE

GS*HC*765332244*930952020*20030923*1901*000000001*X*004010~      BEGINNING
SEGMENT, FUNCTIONAL GROUP HEADER

ST*837*82341~      BEGINNING SEGMENT, TRANSACTION SET (BATCH)

BHT*0080*00*54321*20030923*1900~

NM1*10*2*****FI*765332244~

SENDER LOOP

N4***752341234~

NM1*40*2*****FI*746000119~  RECEIVER LOOP

N4***787441609~

HL*1**20*1~

BEGINNING SEGMENT, CARRIER LOOP – Hierarchical Level 1

DTP*582*RD8*20030802-20030915~

NM1*CA*2*Oregon Insurance Company*****FI*765332244~

N4***752341234~
    
```

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NM1\*CX\*2\*Oregon Insurance Company\*\*\*\*\*FI\*765332244~

N4\*\*\*752341234~

HL\*2\*1\*EM\*1~

BEGINNING SEGMENT, EMPLOYER LOOP - Hierarchical Level 2

NM1\*36\*2\*Bagels Etc.~

HL\*3\*2\*CL\*0~

BEGINNING SEGMENT, CLAIMANT LOOP - Hierarchical Level 3

DTP\*558\*D8\*20020918~

NM1\*CC\*1\*Davidson\*Darlene\*\*\*\*\*34\*224173272~

REF\*Y1\*14000714D~

CLM\*99999\*575.02\*\*DM\*12:B\*\*\*\*\*00~

BEGINNING SEGMENT, CLAIM (BILLING DATA)

DTP\*050\*D8\*20030906~

DTP\*434\*D8\*20030903~

DTP\*666\*D8\*20030910~

AMT\*TP\*572~

REF\*DD\*4564656~

REF\*2I\*10000001~

HI\*BK:820\*BF:873.9~

NM1\*85\*2\*Austin Billing Co.\*\*\*\*\*FI\*345678912~

BEGINNING SEGMENT, PROVIDER DATA

NM1\*82\*2\*Medical Supplies, Inc.~

REF\*0B\*99999~

NM1\*61\*2\*Medical Supplies, Inc.~

N3\*2700 Medical Drive~

N4\*Dallas\*TX\*72311\*USA~

SBR\*P~

CAS\*CO\*131\*3.02\*0~

LX\*1~

BEGINNING SEGMENT, LINE ITEM DATA

SV5\*HC:E1160\*25.02\*UN\*6\*12\*\*2~

DTP\*472\*RD8\*20030824-20030824~

SVD\*XX\*22~

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CAS\*CO\*131\*3.02\*0\*45\*0\*0~ SERVICE ADJUSTMENT LINE DATA

HL\*4\* Another hierarchical level would start here. See Note below.

SE\*56\*82341~ END OF TRANSACTION SET (BATCH)

GE\*1\*000000001~ END OF FUNCTIONAL GROUP; indicates 1 Transaction Set

IEA\*1\*123456789~ END OF ISA ENVELOPE; indicates 1 Functional Group processed

NOTE: HL\*4 could introduce a new claimant (still the child of the last employer at HL 2); a new employer (still the child of the last insurance carrier at HL 1); or a new insurance carrier. Each new parent hierarchical level must have appropriate children levels.

### ***Acknowledgment Files***

The three possible acknowledgments generated in response to an 837 transmission are:

TA1 Functional Acknowledgment;

997 Functional Acknowledgment, and

824 Detail Acknowledgment, also identified by ANSI as the application advice.

The TA1 response to an 837 is an acknowledgment by the division to the trading partner indicating:

The 837 file has been received by the division's system,

The division's system was able to identify the sender and intended receiver, and

The division's system accepted or rejected the file based on the results of the structural evaluation. (NOTE: If the TA1 indicates a rejection, no 997 or 824 will be sent.)

The 997 response to an 837 is an acknowledgment by the division to the trading partner indicating:

The 837 file has been received by the division's system,

The division's system was able to identify the sender and intended receiver,

The division's system validated the file structure to be an 837 file, and

The division's system accepted or rejected the transaction sets based on results of the structural validation.

The 824 is an acknowledgment to the trading partner indicating the results of the data-content edits specific to the Oregon Medical EDI ANSI 837 application. The transactions inside the file are accepted or rejected based on the results of the data-content edits.

837 files that fail functional or structural validation will not generate an 824 Detail Acknowledgment.

837 files that contain multiple transaction sets (ST/SE) within one file will generate an 824 if one of the transaction sets (ST/SE) passes syntax validation.

### ***997 Acknowledgment File Format***

The examples below include ISA and GS header and trailer segments for a 997 Acknowledgment.

Within the ISA envelope (ISA and GS segments), the following segments are included in the current Oregon implementation of the 997:

**ST - Transaction Set Header:** Contains the acknowledgment type (997) and a unique number assigned by the division, the originator of the acknowledgment file.

Example: ST\*997\*1234

**AK1 - Functional Group Response Header:** Contains the functional ID and group control number cited in the GS segment of the originating 837 file.

Example: AK1\*000000001

**AK2 - Transaction Set Response Header:** Contains the transaction set ID and transaction set control number cited in the ST segment of the originating 837 file.

Example: AK2\*837\*82341

**AK5 - Transaction Set Response Trailer:** Contains the status of the transaction set (whether the corresponding AK2 segment was accepted or rejected). If the transaction set was rejected, the AK5 identifies up to five syntax errors at the transaction level.

Example: AK5\*A~

**AK9 - Functional Group Response Trailer:** Contains the status of the entire file (accepted or rejected), the total number of transaction sets included (from the GE segment in the originating 837 file).

Examples: AK9\*A\*1\*1\*1

AK9\*R\*15\*14\*1

**SE - Transaction Set Trailer:** Contains the number of segments in the transaction set and a unique number assigned by the originator of the acknowledgment file.

Example: SE\*27\*1234

### ***997 Examples***

The 997 examples below indicate whether an 837 will or will not generate an 824. The actual 997 file contains no line breaks, and there is no spacebar space that follows a segment terminator (tilde).

Example 1: 997-Accept

File with Single ST/SE Transaction Set: 837 Passed Structural Validation –824 Will Be Generated

```
ISA*00*      *00*      *ZZ*746000119  *ZZ*765332244
*060405*0859*U*00401*000000639*0*T*::~~GS*FA*746000119*765332244*20060405*0859
03*6390001*X*004010~ST*997*0001~AK1*HC*1~AK2*837*82341~AK5*A~AK9*A*1*1*
1~SE*6*0001~GE*1*6390001~IEA*1*000000639~
```

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### Example 2: 997-Reject

File with Single ST/SE Transaction Set: 837 Failed Structural Validation – No 824 Will Be Generated

```
ISA*00*      *00*      *ZZ*746000119   *ZZ*765332244
*060405*0909*U*00401*000000641*0*T*:~GS*FA*746000119*765332244*20060405*0909
33*6410001*X*004010~ST*997*0001~AK1*HC*1~AK2*837*62341~AK5*R*4*4~AK9*R*1
*1*0~SE*6*0001~GE*1*6410001~IEA*1*000000641~
```

### Example 3: 997-Reject

File with Multiple ST/SE Transaction Sets: 1 Structural Failure – No 824 Will Be Generated

```
ISA*00*      *00*      *ZZ*746000119   *ZZ*765332244
*060405*0909*U*00401*000000641*0*T*:~GS*FA*746000119*765332244*20060405*0909
33*6410001*X*004010~ST*997*0001~AK1*HC*1~AK2*837*000000001~AK5*R*5*5~AK2
*837*000000002~AK5*A~AK2*837*000000003~AK5*A~AK2*837*000000004~AK5*A~AK
9*R*4*4*3~SE*12*0001~GE*1*6410001~IEA*1*000000641~
```

## ***824 Acknowledgment File Format***

The examples below include ISA and GS header and trailer segments for an 824 Detail Acknowledgment.

Within the ISA envelope (ISA and GS segments), and for each transaction set, the following segments are included in the current Oregon implementation of the 824:

ST – Transaction Set Header: Identifies this transaction as an 824 and provides a unique control number.

BGN – Beginning statement: Provides the purpose of the transaction, version of the IAIABC medical bill payment records EDI guide used, and date/time of transmission.

N1 – Sender information

N4 – Sender postal code

N1 – Receiver information

N4 – Receiver postal code

OTI - Original Transaction Identification: Used to identify the edited transaction set, and the level at which the results of the edit are reported – Batch or transaction level. Within each file, there will be 1 OTI segment for each batch/transaction set (ST/SE), and 1 OTI segment for each transaction (Bill) within the batch. Valid acknowledgment codes for Oregon are:

BA – Batch Accepted

BR – Batch Rejected

TA – Transaction Accepted

TR – Transaction Rejected

NOTE: The Workers' Compensation Division does not use the ANSI option TE, transaction accepted with errors.

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For Oregon medical bill file processing, any errors at the batch level (except 039 on DN6) will cause a TR for the constituent transactions. All detected errors will be reported in the 824 regardless of batch acceptance/rejection.

Oregon tracks medical bills/invoices to ensure corrections are sent using the following data elements:

DN6 (insurer FEIN) and DN500 (unique bill ID number). Transactions for the same bill/invoice are distinguished using DN266 (transaction tracking number). When a transaction is sent for the same bill/invoice, as a replacement, cancellation, or correction of a rejected original transaction, you must use the same DN6 and DN500 values. After an accepted cancellation, that DN6 + DN500 combination can be used for a different medical bill/invoice.

Examples:

OTI\*BA\*55\*54321\*\*\*20030923\*1900\*\*\*837~ BATCH ID-Batch Accepted

DTM\*009\*20060307\*0752~ 824 PROCESSED DATE/TIME STAMP

OTI\*TR\*55\*R2005\*\*\*20030923\*1900\*\*\*837~ BILL ID-Bill Rejected

DTM - Processed date

LM – Code source information: Oregon only uses the IAIABC agency qualifier code.

Example: LM\*IB~

LQ - Industry Code: Contains element error code. The full lists of error codes are contained in Section 8 of this Guide. Some of the most common codes include:

001 – Mandatory field not present

028 – Must be numeric

030 – Must be A-Z, 0-9, or spaces

039 – No match on database

058 – Code/ID invalid

RED - Related Data: Contains a copy of the bad data and number (DN) of the element in error. Contains supplemental information such as the billing line number where the error occurs. The following Code List Qualifier Codes are used to indicate either invalid data or supplemental information:

GJ – Reject Indicator Code: Used in this segment to indicate bad data and the DN of the element in error.

A9 – Supplemental Data: Used to indicate the DN associated with supplemental information.

Example 1 – Invalid code occurred in DN 522:

LQ\*FZ\*058~ “058 – Code/ID invalid”

RED\*820\*\*IB\*\*GJ\*522~ BAD DATA = 820; DN #522

Example 2:

LQ\*FZ\*001~ “001 – Mandatory field not present”

RED\*1\*\*IB\*\*A9\*547~ DN 547 = Line Number; error occurred in billing line number 1

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RED\*BLANK DATA SENT\*\*IB\*\*GJ\*552~ Nothing between asterisk 2 and 3 indicates no data in DN 552

For cases such as this (where blank data was sent), Oregon will return the value “BLANK DATA SENT” in RED01.

Any transactions rejected in an 824 acknowledgment must be corrected and resubmitted with the following two exceptions:

A transaction rejected as a duplicate (a transaction where DN508 = 00 after one with the same DN6 and DN500 values was accepted) should not be resubmitted.

A transaction rejected for an insurer or self-insured employer not required to report medical billing data does not have to be corrected and resubmitted. Acknowledgements for these bills will also include the error 039 “No match on database” for DN006 Insurer FEIN only at the batch level.

### **824 Examples**

Following are examples of 824 files indicating the status of the system edits. An actual 824 file contains no line breaks, and there is no line space that follows a segment terminator (tilde).

#### Example 1 – One Transaction Rejected With Reject Indicator Code

```
ISA*00*      *00*      *ZZ*746000119  *ZZ*765332244
*060601*1105*U*00401*000000681*0*T*::~~GS*AG*746000119*765332244*20060601*1105
07*6810001*X*004010~ST*824*0001~BGN*11*MED01*20030923*1900~N1*10**FI*74600
0119~N4***787441609~N1*40**FI*765332244~N4***752341234~OTI*BA*55*54321***20
030923*1900***837~DTM*009*20060601*110437~
OTI*TR*55*4564656***20030923*1900***837~DTM*009*20060601*110437~LM*IB~LQ*
FZ*039~RED*765332244**IB**GJ*6~SE*14*0001~GE*1*6810001~IEA*1*000000681~
```

#### Example 2 – Multiple Transactions Rejected But Batch Accepted

```
ISA*00*      *00*      *ZZ*746000119  *ZZ*202036689
*060523*1056*U*00401*000000139*0*T*::~~GS*AG*746000119*202036689*20060523*1056
52*1390001*X*004010~ST*824*0001~BGN*11*MED01*20060309*1652~N1*10**FI*74600
0119~N4***787047491~N1*40**FI*202036689~N4***606613600~OTI*BA*55*2***200603
09*1652***837~DTM*009*20060523*105639~OTI*TA*55*0088766860***20060309*1652*
**837~DTM*009*20060523*105639~OTI*TA*55*0090466521***20060309*1652***837~D
TM*009*20060523*105639~OTI*TR*55*0090726341***20060309*1652***837~DTM*009*
20060523*105639~LM*IB~LQ*FZ*001~RED*BLANK DATA
SENT**IB**GJ*516~LQ*FZ*058~RED*836.20**IB**GJ*522~OTI*TA*55*0090596462***2
0060309*1652***837~DTM*009*20060523*105639~OTI*TA*55*0090577423***20060309*
1652***837~DTM*009*20060523*105639~OTI*TR*55*0083943162***20060309*1652***8
37~DTM*009*20060523*105639~LM*IB~LQ*FZ*001~RED*BLANK DATA
SENT**IB**GJ*516~LQ*FZ*001~RED*1**IB**A9*547~RED*BLANK DATA
SENT**IB**GJ*557~LQ*FZ*001~RED*1**IB**A9*547~RED*BLANK DATA
SENT**IB**GJ*731~LQ*FZ*001~RED*1**IB**A9*547~RED*BLANK DATA
SENT**IB**GJ*732~SE*38*0001~GE*1*1390001~IEA*1*000000139~
```

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### Example 3 – Bad Batch Containing Good and Bad Bills; All Bills Rejected Due to Batch Rejection

```
ISA*00*      *00*      *ZZ*746000119  *ZZ*202036689
*060523*1056*U*00401*000000139*0*T*:~GS*AG*746000119*202036689*20060523*1056
52*1390001*X*004010~ST*824*0001~BGN*11*MED01*20060309*1652~N1*10**FI*74600
0119~N4***787047491~N1*40**FI*202036689~N4***606613600~OTI*BR*55*2***200603
09*1652***837~DTM*009*20060523*105639~LM*IB~LQ*FZ*044~RED*123456**IB**A9*
6~RED*123456**IB**GJ*6~OTI*TR*55*0088766860***20060309*1652***837~DTM*009*
20060523*105639~OTI*TR*55*0090466521***20060309*1652***837~DTM*009*20060523
*105639~OTI*TR*55*0090726341***20060309*1652***837~DTM*009*20060523*105639~
LM*IB~LQ*FZ*001~RED*BLANK DATA
SENT**IB**GJ*516~LQ*FZ*058~RED*836.20**IB**GJ*522~OTI*TR*55*0090596462***2
0060309*1652***837~DTM*009*20060523*105639~OTI*TR*55*0090577423***20060309*
1652***837~DTM*009*20060523*105639~OTI*TR*55*0083943162***20060309*1652***8
37~DTM*009*20060523*105639~LM*IB~LQ*FZ*001~RED*BLANK DATA
SENT**IB**GJ*516~LQ*FZ*001~RED*1**IB**A9*547~RED*BLANK DATA
SENT**IB**GJ*557~LQ*FZ*001~RED*1**IB**A9*547~RED*BLANK DATA
SENT**IB**GJ*731~LQ*FZ*001~RED*1**IB**A9*547~RED*BLANK DATA
SENT**IB**GJ*732~SE*38*0001~GE*1*1390001~IEA*1*000000139~
```

## SECTION 5 – Test Transmission Guidelines

Trading partners are required to use the IAIABC standards to transmit EDI medical bill data to meet mandatory and conditional requirements in accordance with Oregon Workers' Compensation Division EDI data elements and validation rules. These requirements supplement the IAIABC EDI Implementation Guide Release 1.1 for the transmission of medical billing and payment data (EDI837).

Note: Refer to the Reference Tables section of the guide for current events, code lists, elements, and edits from the IAIABC standard used by the division to eliminate the need for re-transmissions because of the additional Oregon validation edits and requirements.

### ***STEP 1 Complete EDI Trading Partner Application and Profile***

An EDI Trading Partner Application and Profile is required to be completed and submitted to the division EDI coordinator, [dcbs.edimedical@state.or.us](mailto:dcbs.edimedical@state.or.us), 503-947-7742. The profile is needed to initiate and begin the testing process. The profile may be obtained from the division's website at <http://www.cbs.state.or.us/external/wcd/operations/edi/ediindex.html>. The EDI coordinator can provide a copy of the form, and answer questions regarding completion of the form.

The division must be notified of any changes to the trading partner's profile. The trading partner is responsible for keeping profiles up-to-date. If the transmission mode or specifications are changed, retesting of some or all types of transactions may be required.

Note: A trading partner may serve more than one insurer or self-insured employer or group.

### ***STEP 2 Transmission Mode Set Up***

The division will accept ANSI X12 transmissions through a Secure File Transfer Protocol (SFTP). The trading partner will use SFTP client software that is appropriate for their operating system environment and can successfully interface with the division environment.

The initial profile form submitted by a trading partner is used set up the trading partner SFTP access, directory profile, and points of contact. An e-mail will be sent to the contact person, notifying the trading partner of their SFTP identification number, password, and directory information.

### ***STEP 3 Test Criteria***

The trading partner may submit a portion or all of its projected weekly bill volume; by the end of the 12-week testing period, the anticipated total weekly claim volume should be reported.

The trading partner must include all bill types (professional, institutional, dental, pharmacy, and DME) and transaction types (original, cancellation, replacement) during the testing phase. These test files will be analyzed for format and data quality for each bill type.

### ***STEP 4 Prepare Initial Test File***

Select files containing live data that meet the test criteria, and create a batch to submit for testing. It is recommended that the trading partner contact the division prior to submitting test data at 503-947-7742.

The batch format includes: interchange header, one or more functional groups, one or more transaction segments, and appropriate ending records (transaction end, functional group end, and interchange end).

The division recommends you submit current medical bill payments in the EDI 837 record with the appropriate header and trailer records, rather than using “dummy data” for testing.

Note: Test data will not be loaded into the production database. Live data will need to be transmitted when approved for production.

### ***STEP 5 Submit Test Data to the Division***

After completing your SFTP mailbox set up (Steps 1 and 2), you may submit a test file. Make sure that your file is named correctly according to the file naming convention standards (see Appendix B). Do NOT send zipped files; they will not be processed.

### ***STEP 6 Acknowledgments***

After the file is received and processed by the division, a TA1, 997 Functional Acknowledgment, or both, will be transmitted to the trading partner. If the batch was not successful, error codes in the acknowledgment will identify the elements within the transaction with errors or the reason for rejected transactions.

### ***STEP 7 Correct Errors/Submit Remaining Test Files***

Any bills rejected in an 824 acknowledgment must be corrected and resubmitted to the division with the following exceptions:

A transaction rejected as a duplicate (a transaction where DN508 = 00 after one with the same DN6 and DN500 values are accepted) should not be resubmitted.

A transaction rejected from an insurer or self-insured employer not required to report medical bill data does not have to be corrected and resubmitted.

Acknowledgements for these transactions will also include the error 039 “No match on database” for DN006 Insurer FEIN.

Note: The trading partner is responsible for ensuring the appropriate sequencing of transactions based on the Bill Submission Reason Code (DN508).

A rejected transaction must be resubmitted using the same unique bill ID and insurer FEIN as the rejected transaction. This is necessary for the division to match the transactions, which will remove the rejected transaction from the division’s aging report once it is corrected and accepted.

If some errors are deemed by the reporter to be “uncorrectable” due to internal processing issues, the reporter must contact the division so that the rejected transactions can be flagged and removed from the aging transaction report. Failure to contact the division will result in the rejected transactions continuing to appear on the aging transaction report as late for correction, and may result in penalties against the associated insurer or self-insured.

### ***STEP 8 Production Approvals***

Upon completion of successful transmissions of all required maintenance type codes, the division will then complete the evaluation of test data received. After the evaluation is complete, an electronic notice by e-mail will be sent informing the trading partner of test completion and approval to transmit data into production.

The trading partner is now ready for the production environment, and will need to note the following information:

The header record in the ISA 15 segment of the envelope should be changed to show “P” for the test/production indicator.

The insurers and self-insured employers and trading partners are responsible for timely resubmissions of errors identified in the acknowledgment for all insurers or self-insured employers required to report medical bills (see Acknowledgement section above for more information).

During the testing period, each reporter will send transactions of actual medical bill data once each week. If transactions are rejected due to errors submitted by the reporter, we expect the reporter to resubmit corrected transactions within 30 days, using the same unique bill ID (DN500) and insurer FEIN (DN6).

At the end of the testing period, the percentage of total transactions that were accepted will be calculated for each reporter (accepted transactions divided by total transactions). This percentage will include rejected transactions that were resubmitted and accepted.

If 80 percent of a reporter’s initial and resubmitted transactions were accepted, that reporter will

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be approved for production. The reporter will be required to resubmit in ANSI 837 format all medical bill payments made from the start of testing through the date of approval for production. The reporter will submit all future medical bill transactions in the ANSI 837 format per the weekly or monthly schedule agreed upon with the division.

If the percentage of accepted transactions for a reporter is below 80 percent, that reporter will continue to submit transactions under an extended testing period.

At the end of each month of the extended testing period, the percentage of total transactions that were accepted will be recalculated. If the percentage meets or exceeds the 80 percent threshold for acceptance, that reporter will be approved for production with the ANSI 837 format for medical bill reporting. The data submitted during the extended test period will be removed from the DCBS database and the reporter will be required to submit all medical payments in ANSI 837, including those bills previously reported as test data.

If you have questions please contact the division EDI coordinator at 503-947-7742 or [dcbs.edimedical@state.or.us](mailto:dcbs.edimedical@state.or.us).

## SECTION 6 – Medical EDI Terminology

Note: These glossary terms are for your convenience when working with Oregon EDI files. Some terms and some usages are specific to the IAIABC Implementation Guide <http://www.iaiaabc.org/>.

824 See ANSI X12 824.

837 See ANSI X12 837, IAIABC 837.

997 See ANSI X12 997.

4010 See ASC X12 Version implementation (Date TBD).

5010 See ASC X12 Version implementation (Date TBD).

Acknowledgment	An electronic notification to the original sender of an electronic file that the file or the transactions within the file were received and were either accepted or rejected. For medical EDI transactions sent by a trading partner, the three types of acknowledgment from the division are the TA1, the 997, and the 824 (ANSI formats). See also ANSI X12 824, ANSI X12 997, and ANSI X12 TA1.
ADA	See American Dental Association
ADA-J515	American Dental Association (ADA) standard paper billing form.
AK1, AK2, AK5, AK9	Acknowledgment segments in a 997 Functional Acknowledgment. AK1 states which Functional Group is being reviewed; AK2 states which Transaction Set is being reviewed. AK5 and AK9 declare whether particular information in an inbound transmission was accepted or rejected. If an AK5 segment indicates that the batch was rejected, then the entire inbound transmission is rejected; it must be corrected and resubmitted. The AK9 segment is a synopsis for the entire transmission.  See also Acknowledgment.
Alphanumeric Data	Formatting that includes the characters on a standard English-language keyboard: the letters A – Z and a - z, numeric digits 0 - 9, the space character, and selected special characters: , < . > / ? ; : ' " [ { ] } \   ` ~ ! @ # \$ % ^ & * ( ) - _ = + . The Oregon EDI documentation defines certain special characters as delimiters (tilde, colon). Generally, any of the alphanumeric characters can be used in data elements with the alphanumeric data type. See also Non-Alphanumeric, Numeric.

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AMA/American Medical Association	A national physicians' group that provides various standards of conduct and practice for medical doctors. The AMA maintains various code lists used in medical EDI transmissions, including the CPT codes.
American Dental Association	(ADA) A national dentists' organization that provides various standards of conduct and practice in the field of dentistry. The ADA maintains the Current Dental Terminology (CDT) codes used in medical EDI transmissions.
ANSI	American National Standards Institute: A private, nonprofit organization that reviews, administers, and coordinates U.S. voluntary standardization efforts in many areas of business.
ANSI ASC X12	ANSI Accredited Standards Committee X12: A national organization that develops and maintains standards for electronic transactions and the exchange of business data.
ANSI Envelope	Same as ISA Envelope: The parts of an ANSI electronic file that contain information about the sender, the expected receiver, file creation date and time, ANSI version, transaction type (such as 148, 837, HIPAA), and amount of data included. The envelope includes both header and trailer control segments (ISA, GS, GE, IEA).
ANSI X12 824	Bill Payment Acknowledgment or Detail Acknowledgement: A HIPAA-compliant national electronic file format for responding to bills submitted electronically. For Oregon medical EDI processes, it is the final acknowledgement of data accepted and rejected for each transaction (bill) received. For Oregon medical EDI processes, an 824 represents successful completion of all workflow processes that translate the medical bill data, edit for quality and completeness, and load the data. If the 824 states that any transaction (bill) was rejected, the division will perform no system updates based on that particular bill; the trading partner must correct the bill and resubmit it in a new medical EDI transaction using the same unique bill ID and insurer FEIN. In the production environment, any bill that is accepted is deemed a proper filing with the division and is stored in the database.
ANSI X12 837	Medical EDI (Health Care Claim): A HIPAA-compliant national standard electronic file format for transmitting provider billing data for medical services: professional services (837P), institutional services (hospital/ facility; 837I), dental services (837D), and pharmacy services (837RX, NCPDP Telecommunications Standard 5.1).

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ANSI X12 997	<p>Functional Acknowledgment: A HIPAA-compliant national standard electronic file format that provides a confirmation from the receiver that a transmitted file was received and accepted, or was rejected. If the 997 indicates that the medical EDI file was rejected (see the AK9 segment), the division will perform no further processing on that particular file. The 997 reject message details which specific transaction sets are accepted or rejected (see the AK5 segments); the trading partner must correct structural issues and resubmit the entire contents of the file. NOTE: If the sender includes multiple batches in a file and one of those batches fails structural validation, the entire file will be rejected.</p>
ANSI X12 TA1	<p>Structural Acknowledgement: A HIPAA-compliant national standard electronic file format that provides a confirmation from the receiver that a transmitted file was received, and passed basic structural edits. A file that fails to pass the TA1 edits will not be processed further, so no 997 or 824 will be returned to the sender.</p>
Authorization Process	<p>The steps a trading partner must follow to become approved for transmitting EDI information to the division for an insurer or self-insured employer. See also Trading Partner.</p>
Batch	<p>An electronic transmission (file) or a specified part of the file, depending on the context. For medical EDI, the term is not the entire file but is a specific component of the file, a transaction set, that contains a transaction set header and trailer control segment (ST/SE segments) plus information about a group of medical bills. A medical EDI file can contain multiple batches; each batch may report information from multiple insurers and self-insured employers, at the sender's discretion.</p>
Batch Accept	<p>If all elements in a batch are correct, the 824 Acknowledgment contains a single batch accept statement for the batch. In the production environment for medical EDI, any bill that is accepted is processed and is stored in the Oregon workers' compensation database, so if the batch is accepted, all bills in the batch are accepted and stored.</p>

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Batch Reject	For a medical EDI transmission, if any element in a batch (transaction set) is not correct, the 997 Functional Acknowledgment contains a single batch reject statement (AK5 segment) for the batch and the entire transmission must be corrected and resubmitted. In an 824 Detail Acknowledgment, the EDI system can accept a batch but does not reject a batch. If there is an error in a batch, the 824 details each transaction (bill) in the batch as being accepted or rejected. In the production environment, any bill that is accepted is processed and is stored in the Oregon workers' compensation database. If any bill is rejected, the division will perform no system updates based on that particular bill; the trading partner must correct the bill and resubmit it in a new medical EDI transaction. See also AK1.
Bill	A transaction representing all billing lines included on a single provider billing form for medical services provided to an injured worker. A bill must contain at least one line item.
Bill Payment Acknowledgment	Also called detail acknowledgment: The ANSI 824 electronic notification to the original sender of an electronic file stating that the transactions within a file were received and were either accepted or rejected. See also Batch Accept, Batch Reject
Bill Type	Professional, institutional, dental, pharmacy, or durable medical equipment (DME) bills. Professional services are billed on a CMS-1500 form and reported in the SV1 segment of a medical EDI transmission. Institutional (hospital, skilled nursing facility, hospice, or other institutional claim filer) services are billed on a UB-04 form and reported in the SV2 segment. Dental services are billed on an ADA-J515 form and reported in the SV3 segment. Pharmacy services are billed on the NCPDP form and reported in the SV4 segment. DME services are reported in the SV5 segment.
Billing Line	The individual line item within a bill transaction reported in a medical EDI SV (service) segment (e.g., SV1, SV2). The lines within an EDI transaction represent each distinct line billed on a billing form.
Billing Provider	The individual or organization that provides a service and receives a payment (or notice that a payment has been received).

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CARC	Claim Adjustment Reason Codes: An ANSI code set used in remittance advice transactions to indicate the reasons for any differences between the original amount billed for a service and the current payment for the service; also used in some coordination of benefits transactions. In remittance advice transactions, both Claim Adjustment Reason Codes and Remittance Advice Remark Codes must be used to report payment adjustments. See also Remittance Advice Remark Codes.
Carrier Claim Number	See Claim Administrator Claim Number.
CDT	Current Dental Terminology: Codes for dental procedures and nomenclature published by the American Dental Association and used to bill dental services.
Centers for Medicare and Medicaid Services (CMS)	The Centers for Medicare and Medicaid Services (formerly HCFA); the federal agency that administers the Medicare and Medicaid programs under the Department of Health and Human Services.
Certified Self-Insurer	A private employer that has been granted a certificate of authority from the division to self-insure for the payment of workers' compensation claims. A government agency also may self-insure. See also Self-Insured Government Entity.
Child	A lower hierarchical level in a transaction set; groups of data are identified as belonging to an insurance carrier, an employer, or a claimant. The three terms convey information ranging from most general to most specific. See also Hierarchical Level, Parent.
Claim Adjustment Reason Codes (CARC)	An ANSI code set used in remittance advice transactions to indicate the reasons for any differences between the original amounts billed for a service and the current payment for the service; also used in some coordination of benefits transactions. In remittance advice transactions, both Claim Adjustment Reason Codes and Remittance Advice Remark Codes must be used to report payment adjustments. See also Remittance Advice Remark Codes.
Claim Administrator Claim No.	The workers' compensation claim number established by an insurer, third-party administrator, or self-insured employer for a workers' compensation claim.
CMS-1450	The standard medical billing form used for hospital, skilled nursing facility, hospice, or other institutional claim filer, and some outpatient hospital charges; also called Universal Billing form (UB-04).

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CMS-1500	The standard medical billing form used for professional charges; previously called HCFA-1500.
Code Sets	Tables or lists of codes used for specific purposes. National standard formats may use code sets developed by a standards-setting organization (such as ANSI Provider Type qualifiers) or by other organizations (such as HCPCS codes).
Control Segments	See Envelope.
CPT (CPT-4)	See Current Procedural Terminology:
Current Dental Terminology (CDT)	Codes for dental procedures and nomenclature published by the American Dental Association, and used to identify and bill dental services.
Current Procedural Terminology (CPT, CPT-4)	Provider procedure codes published by the American Medical Association and used to identify and bill professional medical services. See also ICD-9.
Data Dictionary	A file that lists tables of codes and definitions for the data used in EDI processes, including information specific to the jurisdiction (Oregon). A data dictionary includes data element requirements for length and formatting, as well as whether elements are mandatory (required), conditional (situational), or optional. See also Jurisdictional, Situational.
Data Elements	Individual defined types of data in an EDI transmission, expressed as DN 1, DN 2, . . . . IAIABC 837 is the standard that the division uses for Oregon medical EDI data elements, modified as needed for Oregon requirements (jurisdictional edits). The Oregon EDI Data Element Requirements Table includes whether elements are mandatory (required), conditional (situational), or optional. See also Jurisdictional, Situational.
Date of Service (DOS)	The date on which medical or pharmacy services were provided, or a data range representing the first and last dates that medical or pharmacy services were provided. Hospital services report DOS at the bill level and/or the line level. All other bill types report DOS at the line level.
DEA	See Drug Enforcement Agency

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DEA Number	A prescriber identifier used for pharmacy billing given by the DEA.
Default Values	Data values that are provided automatically if no other value is supplied. An example for medical bills is DN 154, Employee ID Assigned by Jurisdiction, Default Value = 999999999 to indicate claimant has no other identification number.
Detail Acknowledgment	The 824 Bill Payment Acknowledgment: An electronic notification to the original sender of an electronic file (such as medical EDI) stating that the file was received and accepted and that transactions within the file were either accepted or rejected.
Division (WCD)	A division within the Oregon Department of Consumer and Business Services (DCBS), a state agency. The division regulates the provision of workers' compensation services in Oregon: it administers workers' compensation laws, resolves disputes over workers' compensation benefits, and provides information and assistance to injured workers and others about the Oregon workers' compensation system.
Division Rules	Requirements and guidelines to supplement the provisions of laws that govern the Oregon workers' compensation system, incorporated in Chapter 436 of the Oregon Administrative Rules, and can be found at <a href="http://www.cbs.state.or.us/external/wcd/policy/rules/oarors.html">http://www.cbs.state.or.us/external/wcd/policy/rules/oarors.html</a> .
DN 1, DN 2, ...	Data Element Names: Individual defined types of data in an EDI transmission, expressed as DN 1, DN 2, . . . Each type of EDI process specifies the data elements that it uses. For example, IAIABC 837 is the standard that the division uses for Oregon medical EDI data elements, modified as needed for Oregon requirements (jurisdictional edits).
Doctor	A doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.
DOS	Date of Service: The date on which medical or pharmacy services were provided, or a data range representing the first and last dates that medical or pharmacy services were provided. Hospital services report DOS at the bill level. All other bill types report DOS at the line level.
Drug Enforcement Agency (DEA)	A U.S. federal agency that monitors pharmacy operations as a part of its responsibility for enforcing controlled substances regulations.

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Electronic Data Interchange (EDI)	The transfer of data between different entities using computer networks, in particular, the capacity for an insurer or self-insured employer to exchange information electronically with the division, either directly or through a trading partner.
Electronic File	A collection of data stored in a defined electronic format. An electronic file may be a single electronic record or a set or series of transactions.
Electronic Format	The specifications that define the layout of data in an electronic file. ANSI is an organization that defines electronic formats for a wide variety of business uses.
Electronic Record	A group of related data elements. In a medical EDI file, a record might represent a line item, a provider, or an employer. One or more records form a transaction.
Electronic Transaction	A grouping of information or data stored electronically in a defined format that has a distinct meaning as a set. An electronic transaction is made up of one or more electronic records.
Electronic Transmission	A single electronic file sent from a sender to a receiver. Basically, the sending of information by facsimile, electronic mail, electronic data interchange, or any other similar method, not including telephone communication. In this glossary, an inbound transmission is an EDI file sent by means of SFTP from the sender to the receiver, and an outbound transmission is sent from the original receiver to the original sender. For medical EDI, the sender of an inbound transmission is a trading partner and the receiver is the division.
Envelope	ANSI Envelope or ISA Envelope: The parts (control segments) of an ANSI electronic file that contain information about the sender, the expected receiver, file creation date and time, ANSI version, transaction type (such as 997, 824, 837), and amount of data included. The envelope includes both header and trailer control segments (ISA, GS, GE, IEA).
Environment	The computer context, either test or production, into which data is sent. For medical EDI, trading partners initially send data files to the test environment to assure that the files are formatted appropriately for processing. After completion of the SFTP structural test, data sent to the test environment updates the division's medical database and is tracked for submission success rates for trading partner status approvals.

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Federal Employer ID Number (FEIN)	Federal Employer ID Number (Federal Taxpayer ID): The business equivalent of an individual’s Social Security number as a unique nine-digit ID. A FEIN is issued to anyone, including individuals, who must pay withholding taxes on employees. In Oregon EDI transmissions, the FEIN is used as the Sender ID or Receiver ID. See also SSN, Tax ID.
File	A single EDI transmission. A medical EDI file sent to the division must contain: one ISA statement including its header/trailer control segments; one functional group including its header/trailer control segments; and at least one transaction set (batch) that includes detail records.
Functional Acknowledgment	An electronic notification to the original sender of an electronic file that the file was received and accepted, or was rejected and will not undergo further processing. Oregon uses the ANSI 997 file format for this transmission.
Functional Group	The second part of an ANSI file in which the sender specifies the type of EDI transmission included in the file. The Oregon implementation allows only a single functional group in a medical EDI file. The functional group includes both a header control segment (GS) and a trailer control segment (GE) and the transaction sets between those segments.
HCFA	Health Care Finance Administration. In 1977, the agency was established to administer the Medicare and Medicaid programs. This agency has been replaced by the Centers for Medicare and Medicaid Services (CMS), under the Department of Health and Human Services.
HCFA-1450	The standard medical billing form, now called CMS-1450, used for hospital, skilled nursing facility, hospice, or other institutional claim filer, and some outpatient hospital charges. Also called Universal Billing form (UB-04).
HCP Health Care Provider:	An all-inclusive term for the individual or organization that delivers health care services: e.g., a healthcare facility (institution), health care practitioner, or pharmacy.
HCPCS	Healthcare Common Procedure Coding System: HIPAA categories of medical procedure codes. Level II codes, commonly referred to as HCPCS codes, include ambulance, durable medical equipment, prosthetics, orthotics, and supply codes (DMEPOS). Level I HCPCS codes are the CPT (CPT-4) professional services codes.

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Header	Part of an EDI file; a header must have a corresponding trailer. Headers and trailers define a file's ISA information, functional group, and transaction sets.
Health Insurance Portability and Accountability Act (HIPAA)	Federal legislation passed in 1996 that requires covered entities (including health plans, health care clearinghouses, and most health care providers) to comply with three primary sets of federal rules: privacy; transactions and code sets (EDI provisions); and security. HIPAA includes provisions that mandate electronic billing in the Medicare system and establishes national standard electronic file formats and code sets. See also ANSI.
Hierarchical Level (HL)	A statement in the transaction set of a medical EDI file that identifies groups of data as belonging to an insurance carrier, an employer, or a claimant. The HL statements are numbered consecutively, and each new hierarchical level identifies a new participant, always beginning with an insurance carrier and always ending with a claimant. Each claimant record also contains billing information for medical services. See also Child, Parent.
IAIABC	International Association of Industrial Accident Boards and Commissions: An association of government agencies that administer and regulate their jurisdictions' workers' compensation acts, as well as private organizations involved in the delivery of workers' compensation coverage and benefits.
IAIABC 837	A version of ANSI X12 837 guidelines that specifically address workers' compensation data reporting and billing. Oregon has adopted the IAIABC 837 electronic file format as its primary standard.
ICD-9	International Classification of Diseases Codes, Clinical Modification (ICD-9-CM): The code set administered by the World Health Organization and used by hospitals to describe diagnoses and procedures in a hospital setting. Similar to CPT-4 codes used to describe provider procedures.
IEA	See ISA Envelope.
Inbound	EDI files, such as medical EDI transmissions, that are sent from a trading partner to the division, or EDI files sent by the owner of data to a trading partner.
Inpatient	Medical care that is administered to a patient who has been admitted to an institutional facility for an overnight stay.

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Institution; Institutional Facility	A hospital, skilled nursing facility, hospice, or similar facility.
Insurance Carrier; Insurer	An insurance company, a certified self-insurer for workers' compensation insurance, or a governmental entity that self-insures. The insurance carrier has the responsibility of paying for claims that meet the criteria of loss under an insurance policy. See also Insured, Insurer.
Insurance Group	A group of insurance companies under common ownership and, often, common management.
Insured	The holder of an insurance policy that provides workers' compensation coverage; the covered employer. One policy may cover a number of employers associated with the policyholder.
Insurer	The insurance carrier that assumes an employer's financial responsibility for workers' compensation claims. In Oregon, an employer may self-insure (act as its own insurance carrier) if approved by the division.
Interchange Control Structures (Control segments)	The headers and trailers that define components of an electronic file.
ISA Envelope Same as ANSI Envelope	The parts of an ANSI electronic file that contain information about the sender, the expected receiver, file creation date and time, ANSI version, transaction type (such as 997, 824, and 837), and amount of data included. The envelope includes two header control segments (ISA, GS) at the beginning of the file and two trailer control segments (GE, IEA) at the end of the file.
ISA Header	The Interchange Control Header segment that begins and identifies the EDI file. See also Interchange Control Structures.
Jurisdictional Information	Code sets or requirements that are specific to a jurisdiction such as Oregon; exceptions to general EDI usage.

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Loop	A defined, named series of data segments and data elements; a Loop ID is a quick way to refer to a related cluster of information. Examples are Loop ID 1000A, Sender Information; or Loop ID 2310D, Facility Information. See also Segment.
Medical EDI	An IAIABC interpretation of the ANSI 4010 standard for transmitting medical billing data. Oregon has adopted the IAIABC 837 standard.
National Provider Identifier(NPI)	A single standardized national ID number for individual and corporate health care providers; mandated by HIPAA for use in most electronic transactions by May 23, 2007. Oregon requires reporting of the NPI when the provider has an NPI. (See the Data Element Requirement Table in Appendix A Bill Data Element Requirement Table, go to: <a href="http://www.cbs.state.or.us/wcd/policy/rules/docconv_21365/160_10057.pdf">http://www.cbs.state.or.us/wcd/policy/rules/docconv_21365/160_10057.pdf</a> for how to report if the provider does not have an NPI.)
NCPDP	National Council for Prescription Drug Programs: An ANSI-accredited standards development organization for the transfer of data to and from the pharmacy services sector of the health care industry.
NCPDP Number	A unique identifier for a pharmacy location.
NDC	National Drug Code: A code set that identifies the manufacturer, type, and strength of medication dispensed by a pharmacy.
Non-Alphanumeric	Data formatting that includes non-standard ASCII characters (characters not included on a standard English-language keyboard), such as non-English letters, or symbols other than punctuation (® ⊕ Δ ™ ñ é ü). See also Alphanumeric, Numeric.
NPI	See National Provider Identifier.
NUBC - National Uniform Billing Committee	The National Uniform Billing Committee (NUBC) was brought together by the American Hospital Association (AHA) in 1975 and it includes the participation of all the major national provider and payer organizations. The NUBC was formed to develop a single billing form and standard data set that could be used nationwide by institutional providers and payers for handling health care claims.

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NUCC	National Uniform Claim Committee. The National Uniform Claim Committee (NUCC) is a voluntary organization that replaced the Uniform Claim Form Task Force in 1995. The committee was created to develop a standardized data set for use by the non-institutional health care community to transmit claim and encounter information to and from all third-party payers. It is chaired by the American Medical Association (AMA), with the Centers for Medicare and Medicaid Services (CMS) as a critical partner. The committee includes representation from key provider and payer organizations, as well as designated standards maintenance organizations, public health organizations, and a vendor association.
Numeric	Data formatting that includes only numeric digits 0 – 9. Generally, data elements with the numeric data type do not include separators such as slash or hyphen; for instance, a date is formatted as CCYYMMDD rather than as 2007/02/01 or 2/1/2007, and a Social Security Number or FEIN is formatted as nine continuous digits. See also Alphanumeric, Non-Alphanumeric.
Original Transaction ID - (OTI)	An identifier segment in an 824 Acknowledgment that refers to a batch number in the medical EDI transmission to which the 824 is the response.
Outbound	Electronic files transmitted from the division to an EDI trading partner, or any response from a receiver to the original sender of electronic data.
Outpatient	Medical care that is administered to a patient who has not been admitted to an institutional facility for an overnight stay.
Parent	A higher hierarchical level in a transaction set; groups of data are identified as belonging to an insurance carrier, an employer, or a claimant. The three terms convey information ranging from most general to most specific. See also Child, Hierarchical Level.
Payor (Payer)	The insurer or self-insured employer or third-party administrator that is processing and paying medical bills; the entity that reimburses for services delivered under a workers' compensation claim. See also Fiscal Intermediary.
PBM;	See Pharmacy Benefits Manager (or Management)
PDF; Portable Document	A means of displaying computerized information in a form that can be utilized by many software

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Format	Applications.
Pharmacist	A person licensed to provide drugs, especially drugs prescribed by a doctor and dispensed by the pharmacist when working at a pharmacy.
Pharmacy	A licensed facility that provides drugs, especially drugs prescribed by a doctor and dispensed by a licensed pharmacist.
Pharmacy Benefits Manager (or Management) (PBM)	A company that provides support services to a pharmacy, such as drug information reviews, billing, education, risk management, and benefit plan administration.
Place of Service (POS)	The location where a health care service was provided.
POS; Place of Service	See above. Also, Point of Sale for medical equipment.
Production	The computer context into which data is sent; the options are test and production. See also Environment.
Provider (Health Care Provider, HCP)	An all-inclusive term for the individual or organization that delivers health care services: e.g., a health care facility (institution), health care practitioner, or pharmacy.
Reason Codes	See Claim Adjustment Reason Codes.
Receiver	The entity receiving an electronic transmission. In response to an original inbound transaction such as a medical EDI transmission, the receiver (such as the division submits an electronic notification (acknowledgment such as 997) to the original sender that the file or the transactions in the file were received and accepted, or were rejected.
Receiver ID	An identifier that designates the entity intended to receive an electronic transmission. Oregon EDI transmissions use an entity's FEIN as its sender ID or receiver ID.
Reject	An insurer or self-insured employer's (payer's) refusal to pay a medical bill based on inadequate or incorrect documentation. In a medical EDI file, a trading partner must correct and resubmit a rejected bill. See also Deny.

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Remark Codes	See Remittance Advice Remark Codes.
Remittance	In the electronic environment, the term refers to reimbursement or denial of medical bills.
Remittance Advice Remark Codes (RARC)	A national code set maintained by the Centers for Medicare and Medicaid Services (CMS), and used by all payers to indicate the reasons for any differences between the original amount billed for a service and the current payment for the service. Both Claim Adjustment Reason Codes and Remittance Advice Remark Codes must be used to report payment adjustments in remittance advice transactions. See also Claim Adjustment Reason Codes.
Rendering Provider	The health care provider that delivered medical care or services. The CMS 1500 form captures the rendering provider's identity numbers (NPI or state license number at the line level). The UB-04 form doesn't capture rendering provider identity information, but rather the "attending," "operating", and "other" provider information. The ADA form captures the "treating" provider, and not the rendering provider. The new NCPDP form allows for both the "pharmacy" and "provider" identity numbers to be used. The division views all of these collectively as rendering providers. See also Billing Provider, Pay to Provider.
Revenue Code	A hospital code used to describe the procedure or procedure category of medical care provided.
Secure File Transfer Protocol (SFTP)	An interactive file transfer program that encrypts both commands and data, preventing passwords and sensitive information from being transmitted in the clear. All division-approved medical EDI trading partners must be able to transmit data using SFTP.
Segment	A defined sequence of data elements that identifies a specific part of an EDI file, such as a header. At the end of a segment is a segment terminator character, a tilde (~). Examples: an ISA header segment contains 16 data elements; an N4 segment contains city, state, and postal code data elements for a particular defined address. See also Loop.
Self-Insurer	A private employer that is granted a certificate of authority from the division to self-insure for the payment of workers' compensation claims (certified self-insurer). A government agency also may self-insure (Self-Insured Governmental Entity).

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Sender	The entity that has submitted an electronic transmission to the receiver. For a medical EDI transmission, the sender is the external trading partner and the receiver is the division. For an acknowledgment to that transmission (for a 997 or 824), the sender is the division and the receiver is the original sender.
Sender ID	An identifier that designates the entity that initiates an electronic transmission. Oregon EDI transmissions use an entity's FEIN as its sender ID or receiver ID.
Separator	A character placed between items to separate them. In medical EDI transmissions, an asterisk (*) is the separator between data elements in a segment and a colon (:) is the separator between subelements in a segment.
SFTP	Secure File Transfer Protocol: An interactive file transfer program that encrypts both commands and data, preventing passwords and sensitive information from being transmitted in the clear. All division approved medical bill payment trading partners must be able to transmit data using SFTP.
Situational	A data edit condition under which a data element may become required in some circumstances, based on the data provided in a different data element. Example: If a last name is provided, a first name then becomes required. See also Data Elements, Jurisdictional.
SSN	Social Security number: A unique nine-digit ID that is assigned to an individual at the U.S. federal level. A SSN frequently is used as a tracking number or identifier for an individual. See also FEIN, Tax ID.
SV1, SV2, SV3, SV4, SV5	Services segments for reporting different types of bill information. Professional services are billed on a CMS-1500 form and reported in the SV1 segment. Institutional (hospital, skilled nursing facility, hospice or other institutional claim filer) services are billed on a CMS-1450 form (UB-04) and reported in the SV2 segment. Dental services are billed on an ADA-J515 form and reported in the SV3 segment. Pharmacy services are billed on CMS 1500 or NCPDP form and reported in the SV4 segment. DME services are reported in the SV5 segment.
Tax ID	Either a Social Security number (SSN) or a Federal Employer Identification Number (FEIN). All these terms refer to a unique nine-digit ID that is assigned at the U.S. federal level.
Test	The computer context into which data is sent; the options are test and production. See also Environment.

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TPA	Third-Party Administrator: Any of several types of business entity that handle claims for an insurer or self-insured employer. For processing medical EDI transactions, this business entity may act as the insurer or self-insured employer’s trading partner with the division.
Trading Partner	A business entity that has entered into an agreement with the division to exchange information electronically. An insurer or self-insured employer is the owner of most EDI information. The trading partner that transmits the information to the division can be the insurance carrier, or a certified self-insured, a governmental entity, a third-party administrator (TPA), a servicing agent, or a vendor representing one or more insurers and self-insured employers.
Traffic Reports	Electronic summaries that provide information about the overall processing of medical EDI files that were submitted by trading partners to the division. The reports track every file from the moment it enters the division’s EDI system for processing to the point where 997 and 824 acknowledgment files are delivered to the SFTP server utilities for delivery to the various trading partners. The traffic reports provide summary details on acknowledgments generated. For more information, see Section 8 of this guide.
Trailer	Part of an EDI file; a header must have a corresponding trailer. Headers and trailers define a file’s ISA information, functional group, and transaction sets.
Transaction	The information for one medical bill, including provider information and services information. See also Transaction Set.
Transaction Set	(ST/SE). The data segments from the ST transaction set header segment through the SE transaction set trailer segment. In a medical EDI file, a transaction set contains all the information for numerous medical bills, including claimant (injured worker) information, provider information, and services information. As an example: <ul style="list-style-type: none"> <li>• In the 997 Functional Acknowledgment to a medical EDI file, each incoming transaction set is acknowledged as being accepted or rejected, and the entire file is rejected if any transaction set is rejected.</li> <li>• In the 824 Detail Acknowledgment to a medical EDI file, an entire transaction set can be accepted (batch accept). If there is any error in a transaction set, each individual line item of a medical bill is acknowledged as being accepted or rejected, and any transaction (bill) that is rejected must be corrected and then resubmitted in a subsequent medical EDI transmission.</li> </ul>

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Transaction Type	Information that identifies the data within the EDI transaction, such as identifying the transaction as containing 837 medical billing data or being a 997 acknowledgment.
Translator	Conversion software, such as software that converts a flat file (table structure) to an EDI compatible text file.
Transmission	A single electronic file that is sent from a sender to a receiver. A medical EDI transmission that is sent from a trading partner and received satisfactorily by the division will trigger a 997 Acknowledgment from the division.
UB-04	Universal billing form used for hospital (institutional) billing, also referred to as a CMS-1450 billing form. It replaced the UB-92 form in 2007.
Unique bill ID	Unique number assigned by the insurer to individual bills/invoices. All transactions related to the same medical bill/invoice contain the same unique bill ID number. The insurer and/or reporter use the same unique bill ID number until such time as a cancellation transaction is accepted by the jurisdiction.
Units	The quantity of a drug dispensed, such as a number of pills or a volume of a solid or liquid (## cc, mg, ml). Also, the number of hours or days during which a service was provided.
Version	The release number for an electronic format. Later releases contain changes from earlier versions, so an EDI file indicates which version's requirements should apply. Version naming conventions are administered by the organization that defined the format; for example, ANSI has released format versions 3050, 4010, and 4050, and Oregon Medical EDI uses ANSI Version 4010.
Waiver	An exception to electronic reporting requirements for insurers and self-insured employers. Contact the division to request a waiver if your company needs more time to prepare for EDI filing of electronic medical bills.
WCD	See Division/Workers' Compensation Division.
X12 ANSI Accredited Standards Committee X12	A national organization that develops and maintains standards for electronic transactions and the exchange of business data, including medical data. See also ANSI.

## SECTION 7 – Oregon Reporting Criteria

The Oregon Administrative Rules, chapter 436, division 160 define specific criteria trading partners are required to electronically file with the division. The following tables include the actions and events that can trigger the requirement to submit information electronically and the timeframe in which the data should be submitted for medical billing and payment actions:

### Medical Billing/Payment Actions or Events

MTC	ACTION or EVENT	EDI SUBMISSION DUE
00 (Original)	Original transactions must be submitted when the insurer or self-insured employer issues or denies payment for a medical bill received on an accepted workers' compensation claim. Rejected transactions must be corrected, re-submitted, and accepted to meet reporting requirements. (Except duplicate transactions and bills for non-required Oregon reporters, which are not required to be re-submitted.)	No later than the 60th day after payment is made or denied for both original transactions and corrected transactions.
01 (Cancel)	Cancellations are submitted when the insurer or self-insured employer previously reported an incorrect file. A common situation is when the insurer or self-insured employer submits a bill paid to an Oregon provider, but the claim is actually handled under another jurisdiction's coverage. Cancellations are notifications that the bill should never have been reported to the division.	Immediately, no later than the next scheduled EDI filing after the reporter knows an original medical bill was previously sent in error.
05 (Replace)	Replacements are corrections or changes to previously accepted original submissions: Claim Admin. Claim #; Prov. Type; Location of Service; Total Amt. Pd. Per Bill; Total Amt. Pd. Per Line.	No later than the 60th day after: 1) Payer knowledge of a change in information; 2) Payer paying an additional amount on a previously reported bill; or 3) Payer receipt of an overpayment from a provider on a previously reported bill.

## SECTION 8 – Reference Tables

### *Functional Tables*

ISA: Interchange Control Header

The ISA segment is fixed length; a total of 106 characters from ISA through the segment terminator. The IEA segment ends the interchange envelope started by the previous ISA segment.

Example for an 837:

ISA\*00\*0000000000\*00\*0000000000\*ZZ\*123456789 \*ZZ\*930952020 \*080814\*1602\*U\*00401\*000000001\*1\*T\*:~

IEA\*06\*000000001~

Element	Element Name	Length	ISA Error code indicating this element in error	Comment	Example
ISA01	Authorization Information Qualifier	2	010	Currently not restricted to a set of valid values.	00
ISA02	Authorization Information	10	011	Currently not restricted to a set of valid values.	0000000000
ISA03	Security Information Qualifier	2	012	Currently not restricted to a set of valid values.	00
ISA04	Security Information	10	013	Currently not restricted to a set of valid values.	0000000000
ISA05	Interchange ID Qualifier (sender)	2	005	Currently not restricted to a set of valid values.	ZZ
ISA06	Interchange Sender ID	15	006	Sender FEIN submitted on trading partner documentation and listed in file name, followed by 6 spaces.	123456789
ISA07	Interchange ID Qualifier (receiver)	2	007	Currently not restricted to a set of valid values.	ZZ

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ISA08	Interchange Receiver ID	15	008 or 009	The division's FEIN followed by 6 spaces.	930952020
ISA09	Interchange Date	6	014	YYMMDD	080814 for August 14, 2008
ISA10	Interchange Time	4	015	HHMM	1602 for 4:02 pm
ISA11	Interchange Control Standards Identifier	1	016	Only U is valid	U
ISA12	Interchange Control Version Number	5	017	Only 00401 is valid	00401
ISA13	Interchange Control Number	9	018 or 025	Must be unique among all files sent by the reporter to the division for medical bill reporting.	000000001
ISA14	Acknowledgment Requested	1	019	Must be 0 or 1. When ISA14 = 1, then a TA1 will always be sent to the reporter. When ISA14 = 0, a TA1 will be sent only if there is a structural error.	1
ISA15	Test Indicator	1	020	T for Test or P for production.	T
ISA16	Component Element Separator	1	027	Must be :	:
	Element Separator	1	026	Must be *	*
	Segment Terminator	1	004	Must be ~	~
IEA01	Number of Included Functional Groups	1/3	024	Must be a number between 1 and 999	6
IEA02	Interchange Control Number	9	001	Must match ISA13	000000001

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### ***Functional Groups***

The GS segment indicates the beginning of a functional group. If there is an error in the GS segment, then an error 024 will be reported in the TA1 file. The GE segment ends the functional group. Errors in the GE will be reported in the AK9 segment of the 997 file.

The following segment is an example for an 837. For the 997 and 824, the GS02 and GS03 would be switched.

GS\*HC\*123456789\*930952020\*20080814\*160201\*6\*X\*004010~

GE\*400\*6~

	Element Name	Length min/max	Comment	Example
GS01	Functional Identifier Code	2/2	HC in 837 FA in 997 AG in 824	HC
GS02	Application Sender's Code	9/9	Reporter's FEIN	123456789
GS03	Application Receiver's Code	9/9	The division's FEIN	930952020
GS04	Date	8/8	YYYYMMDD	20080814 for August 14, 2008
GS05	Time	4/6	HHMM(SS)	160201 for 4:02:01 pm
GS06	Group Control Number	1/9	Must be unique within the ISA/IEA envelope.	3
GS07	Responsible Agency Code	1	Only X is valid.	X
GS08	Version/Release/Industry Identifier code	6/6	Only 004010 is valid.	004010
GE01	Number of Transaction Sets Included	1/6	The number of ST/SE segment pairs.	400
GE02	Group Control Number	1/9	Must match GS06	3

**997 Functional Acknowledgment**

Note: This 997 section is copied from the Ohio Department of Mental Retardation and Developmental Disabilities October 15, 2003. There have been some formatting adjustments to make it readable in Word.

**Functional Group ID=FA**

Introduction:

This Draft Standard for Trial Use contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat
ISA	Interchange Control Header	M	1	
GS	Functional Group Header	M	1	
ST	Transaction Set Header	M	1	
AK1	Functional Group Response Header	M	1	
	LOOP ID - AK2			999999
AK2	Transaction Set Response Header	O	1	
	LOOP ID - AK3			999999
AK3	Data Segment Note	O	1	
AK4	Data Element Note	O	99	
AK5	Transaction Set Response Trailer	M	1	
AK9	Functional Group Response Trailer	M	1	
SE	Transaction Set Trailer	M	1	
GE	Functional Group Trailer	M	1	
IEA	Interchange Control Trailer	M	1	

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### ***Transaction Set Notes***

1. These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.

The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.

There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

2. AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

3. AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

### ***Segments: ISA/IEA Interchange Control Header/Trailer***

Usage: Mandatory

Max Use: 1

Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments.

Reference Designation	Data Element	Name	Comment	Example	Attributes
ISA01	101	Authorization Information Qualifier	Code to identify the type of information in ISA02.	00	M ID 2/2
ISA02	102	Authorization Information	Information used for additional identification or authorization of the interchange sender or the data in the interchange	0000000000	M AN 10/10
ISA03	103	Security Information Qualifier	Code to identify the type of information in ISA04.	00	M ID 2/2
ISA04	104	Security Information	This is used for identifying the	0000000000	M AN 10/10

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			security information about the interchange sender or the data in the interchange.		
ISA05	105	Interchange ID Qualifier	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified. Set by Trading Partner Agreement.	ZZ (mutually defined)	M ID 2/2
ISA06	106	Interchange Sender ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element. Set by Trading Partner Agreement.	930952020 (the division's FEIN followed by 6 spaces)	M AN 15/15
ISA07	105	Interchange ID Qualifier	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified. Set by Trading Partner Agreement.	ZZ (mutually defined)	M ID 2/2
ISA08	107	Interchange Receiver ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element. Set by Trading Partner Agreement.	123456789 (Reporter's FEIN followed by 6 spaces)	M AN 15/15
ISA09	108	Interchange Date	Date of the interchange formatted as YYMMDD.	081224 (December 24, 2008)	M DT 6/6
ISA10	109	Interchange Time	Time of the interchange formatted as HHMM.	1643 (4:43 pm)	M TM 4/4
ISA11	110	Interchange Control Standards Identifier	Code to identify the agency responsible for the control standard used by the message that is enclosed	U (U.S. EDI Community of	M ID 1/1

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			by the interchange header and trailer.	ASC X12, TDCC, and UCS)	
ISA12	111	Interchange Control Version Number	This version number covers the interchange control segments.	00401	M ID 5/5
ISA13	112	Interchange Control Number	A control number assigned by the interchange sender. Identical to the associated Interchange Trailer, IEA02.	000000001	M N0 9/9
ISA14	113	Acknowledgment Requested	Code sent by the sender to request an interchange acknowledgment (TA1). Always 0 for 997.	0	M ID 1/1
ISA15	114	Usage Indicator	Code to indicate whether data enclosed by this interchange envelope is test, production or information	T for Test or P for Production.	M ID 1/1
ISA16	115	Component Element Separator	This value must be different than the data element separator and the segment terminator.	:	M AN 1/1
		Segment Terminator	This is the delimiter used between segments.	~	M AN 1/1
IEA01	116	Number of Included Functional Groups	A count of the number of functional groups included in an interchange.	23	M N0 1/5
IE	112	Interchange Control Number	A control number assigned by the interchange sender. Identical to the associated Interchange Trailer, ISA13.	000000001	M N0 9/9

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**Segment: GS/GE Functional Group Header/Trailer**

Usage: Mandatory

Max Use: 1

Purpose: To indicate the beginning of a functional group and to provide control information.

Reference Designation	Data Element	Name	Comment	Example	Attributes
GS01	479	Functional Identifier Code	Code identifying a group of application related transaction sets.	FA (Functional Acknowledgment)	M ID 2/2
GS02	142	Application Sender's Code	Code identifying party sending transmission; codes agreed to by trading partners. Set by Trading Partner Agreement.	930952020 (the division's FEIN)	M AN 2/15
GS03	124	Application Receiver's Code	Code identifying party receiving transmission; codes agreed to by trading partners. Set by Trading Partner Agreement.	123456789 (reporter's FEIN)	M AN 2/15
GS04	373	Date	Date expressed as CCYYMMDD	20081008 (October 8, 2008)	M DT 8/8
GS05	337	Time	Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99).	16435899 (4:43:58.99 pm)	M TM 4/8
GS06	28	Group Control Number	Assigned number originated and maintained by the sender.	345	M N0 1/9
GS07	455	Responsible Agency Code	Code used in conjunction with GS08 to identify the issuer of the	X (Accredited Standards Committee	M ID 1/2

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			standard.	X12)	
GS08	480	Version / Release / Industry Identifier Code	Code indicating the version, release, sub-release, and industry identifier of the EDI standard being used, including the GS and GE segments.	004010	M A/N 1/12
GE01	97	Number of Transaction Sets Included	Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.	1	M N0 1/6
GE02	28	Group Control Number	Assigned number originated and maintained by the sender. Matches the associated GS06.	345	M N0 1/9

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### ***Segment: ST/SE Transaction Set Header/Trailer***

Usage: Mandatory

Max Use: 1

Purpose: To indicate the start of a transaction set and to assign a control number.

Reference Designation	Data Element	Name	Comment	Example	Attributes
ST01	143	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	997 (Functional Acknowledgment)	M ID 3/3
ST02	329	Transaction Set Control Number	Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set.	1234	M A/N 4/9
SE01	96	Number of Included Segments	Total number of segments included in a transaction set including ST and SE segments.	654	M N0 1/10
SE02	329	Transaction Set Control Number	Matches associated ST02.	1234	M A/N 4/9

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### ***Segment: AK1 Functional Group Response Header***

Usage: Mandatory

Max Use: 1

Purpose: To start acknowledgment of a functional group.

Reference Designation	Data Element	Name	Comment	Example	Attributes
AK101	479	Functional Identifier Code	Code identifying a group of application related transaction sets.	HC (from GS01 in the 837)	M ID 2/2
AK102	28	Group Control Number	Assigned number originated and maintained by the sender.	1234 (from GS06 in the 837)	M N0 1/9

### ***Segment: AK2 Transaction Set Response Header***

Usage: Optional

Max Use: 1

Purpose: To start acknowledgment of a single transaction set

Reference Designation	Data Element	Name	Comment	Example	Attributes
AK201	143	Transaction Set Identifier Code	Code uniquely identifying a transaction set.	837 (from ST01 in the 837)	M ID 2/2
AK202	329	Transaction Set Control Number	Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set.	0001 (from ST02 in the 837)	M AN 4/9

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**Segment: AK3 Data Segment Note**

Usage: Optional

Max Use: 1

Purpose: To report errors in a data segment and identify the location of the data segment

Reference Designation	Data Element	Name	Comment	Example	Attributes										
AK301	721	Segment ID code	Code defining the segment ID of the data segment in error.	NM1	M IS 2/3										
AK302	719	Segment Position in Transaction Set	The numerical count position of this data segment from the start of the transaction set: the transaction set header is count position 1.	65	M N0 1/6										
AK303	447	Loop Identifier Code	The loop id from the IAIABC guide where this segment occurs.	2310A	O AN 1/6										
AK304	720	Segment Syntax Error Code	Code indicating error found based on the syntax editing of a segment.	<table border="1"> <tr> <td>1</td> <td>Unrecognized segment ID</td> </tr> <tr> <td>2</td> <td>Unexpected segment</td> </tr> <tr> <td>3</td> <td>Mandatory segment missing</td> </tr> <tr> <td>4</td> <td>Loop Occurs Over Maximum Times</td> </tr> <tr> <td>5</td> <td>Segment Exceeds</td> </tr> </table>	1	Unrecognized segment ID	2	Unexpected segment	3	Mandatory segment missing	4	Loop Occurs Over Maximum Times	5	Segment Exceeds	O ID 1/3
1	Unrecognized segment ID														
2	Unexpected segment														
3	Mandatory segment missing														
4	Loop Occurs Over Maximum Times														
5	Segment Exceeds														

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					Maximum Use		
				6	Segment Not in Defined Transaction Set		
				7	Segment Not in Proper Sequence		
				8	Segment Has Data Element Errors		

***Segment: AK4 Data Element Note***

Usage: Optional

Max Use: 99

Purpose: To report errors in a data element or composite data structure and identify the location of the data element.

Reference Designation	Data Element	Name	Comment	Example	Attributes
AK401	C030	Position in segment	Code indicating the relative position of a simple data element, or the relative position of a composite data structure combined with the relative position of the component data element within the composite data structure, in error; the count starts with 1 for the simple data element or composite data structure immediately		M

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			following the segment ID.			
C0301	722	Element Position in Segment.	Identifies the data element/composite element position within the segment that is in error.	1	M N0 1/2	
C0302	1528	Component Data Element Position in Composite.	Identifies the component data element position within the composite that is in error.	2	O N0 1/2	
AK402	725	Data Element Reference Number	Reference number used to locate the data element in the Data Element Dictionary. The DN in error.	509	O N0 1/2	
AK403	723	Data Element Syntax Error Code	Code indicating the error found after syntax edits of a data element.	1	Mandatory data element missing	M ID 1/3
				2	Conditional required data element missing.	
				3	Too many data elements.	
				4	Data element too short.	
				5	Data element too long.	
				6	Invalid character in data	

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					element.	
				7	Invalid code value.	
				8	Invalid Date	
				9	Invalid Time	
				10	Exclusion Condition Violated	
AK404	724	Copy of Bad Data Element	This is a copy of the data element in error.	D1999		O AN 1/99

**Segment: AK5 Transaction Set Response Trailer**

Usage: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection and report errors in a transaction set

AK5\*R\*1\*3\*4\*5~

Reference Designation	Data Element	Name	Comment	Example	Attributes	
AK501	717	Transaction Set Acknowledgment Code	A = Accepted R = Rejected	R	M ID 1/1	
AK502	718	Transaction Set Syntax Error Code	Code indicating error found based on the syntax editing of a transaction set.	1	Transaction Set Not Supported	O ID 1/3
				2	Transaction Set Trailer Missing	
				3	Transaction Set Control Number in Header and Trailer Do Not	

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					Match	
				4	Number of Included Segments Does Not Match Actual Count	
				5	One or More Segments in Error	
				6	Missing or Invalid Transaction Set Identifier	
				7	Missing or Invalid Transaction Set Control Number	
				8	Authentication Key Name Unknown	
AK503	718	Transaction Set Syntax Error Code	See AK502	See AK502		O ID 1/3
AK504	718	Transaction Set Syntax Error Code	See AK502	See AK502		O ID 1/3
AK505	718	Transaction Set Syntax Error Code	See AK502	See AK502		O ID 1/3
AK506	718	Transaction Set Syntax Error Code	See AK502	See AK502		O ID 1/3

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**Segment: AK9 Functional Group Response Trailer**

Usage: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group.

Reference Designation	Data Element	Name	Comment	Example	Attributes						
AK901	715	Functional Group Acknowledge Code	Code indicating accept or reject condition based on the syntax editing of the functional group.	A = Accepted R = Rejected P = Partially Accepted, At Least One Transaction Set Was Rejected	M ID 1/1						
AK902	97	Number of Transaction Sets Included	Total number of transaction sets included in the functional group.		M N0 1/6						
AK903	123	Number of Received Transaction Sets	Number of Transaction Sets received		M N0 1/6						
AK904	2	Number of Accepted Transaction Sets	Number of accepted Transaction Sets in a Functional Group.		M N0 1/6						
AK905	716	Functional Group Syntax Error Code	Code indicating error found based on the syntax editing of the functional group header and/or trailer.	<table border="1"> <tr> <td>1</td> <td>Functional Group Not Supported</td> </tr> <tr> <td>2</td> <td>Functional Group Version Not Supported</td> </tr> <tr> <td>3</td> <td>Functional Group Trailer</td> </tr> </table>	1	Functional Group Not Supported	2	Functional Group Version Not Supported	3	Functional Group Trailer	O ID 1/3
1	Functional Group Not Supported										
2	Functional Group Version Not Supported										
3	Functional Group Trailer										

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				Missing	
				4 Group Control Number in the Functional Group Header and Trailer Do Not Agree	
				5 Number of Included Transaction Sets Does Not Match Actual Count	
				6 Group Control Number Violates Syntax	
AK906	716	See AK905	See AK905	See AK905	O ID 1/3
AK907	716	See AK905	See AK905	See AK905	O ID 1/3
AK908	716	See AK905	See AK905	See AK905	O ID 1/3
AK909	716	See AK905	See AK905	See AK905	O ID 1/3

## **SECTION 9 – Acknowledgments/Traffic Reports**

Trading partners are responsible for monitoring the status of their files and the errors or status indicators included in the Interchange, Functional, and Detail Acknowledgements. Trading partners need to respond to these acknowledgements by correcting the errors and submit those corrections as appropriate.

### ***TA1 Interchange Acknowledgements***

The IAIABC 837 electronic file format supports reporting multiple functional groups or “groups” in a single 837 file. A functional group is defined as the segments beginning with, and including, the GS Functional Group Header Segment and ending with, and including, the GE Functional Group Trailer Segment.

The TA1 Interchange Acknowledgment file is intended to communicate the file status of the inbound 837 file. The TA1 file is generated by the receiver of the inbound 837 file and transmitted to the sender of the inbound 837 file. The Oregon implementation allows for TA1 Interchange Acknowledgements to be generated at the interchange level of the 837 file. A TA1 file will be sent only when either the inbound 837’s ISA14 element is “1” or there is an error at the interchange level (above the functional group or within the GS segment), which warrants rejection. Within each TA1, the TA104 element provides the status of the file and the TA105 element notes the reason. If an interchange is rejected, the division rejects the entire file; there will be neither a 997 Functional Acknowledgment nor an 824 acknowledgment sent for that file.

### ***997 Functional Acknowledgements***

The IAIABC 837 electronic file format supports reporting multiple transaction sets or “batches” in a single 837 file. A transaction set is defined as the segments beginning with, and including, the ST Transaction Set Header Segment and ending with, and including, the SE Transaction Set Trailer Segment.

The 997 Functional Acknowledgment file is intended to communicate the file status of the inbound 837 file. The 997 file is generated by the receiver of the inbound 837 file and transmitted to the sender of the inbound 837 file. The Oregon implementation allows for 997 Functional Acknowledgements to be generated at the group level of the 837 file. Each batch will be acknowledged in the AK5 segment of the 997 Functional Acknowledgement, with the AK9 segment providing the status of the functional group. When one or more batches are rejected in a multiple-batch-functional group, the AK9 segment will indicate the group was rejected or partially accepted. If a Transaction Set (batch) is rejected, the division rejects only that batch and its bills will not appear in the 824 acknowledgment.

Trading partners are responsible for monitoring the status of their files and the errors or status indicators included in the Functional and Detail Acknowledgements. Trading partners need to respond to these acknowledgements by correcting the errors and submit those corrections as appropriate.

## ***824 Detail Acknowledgements***

When the division accepts an EDI ANSI 837 file and sends a response, 997-Accept, the division will process the incoming file and send an 824 Detail Acknowledgment that provides information about the internal edits applied to the data. The acknowledgment messages are

**BA Batch Accepted** -- all items at the Transaction-Set (batch) level were accepted. The loops between the Transaction Set Header and 2010CA (every element before the CLM segment) make up the batch level..

**BR Batch Rejected** -- within a Transaction Set (batch), the division identified at least one problem. If any batch is rejected, the division rejects the entire batch and all of its transactions. The 824 will detail the results of the errors in the batch.

**TA Transaction Accepted** -- the associated individual bill within a Transaction Set (batch) was accepted by the division. The loops between 2300 and 2430 make up the transaction level.

**TR Transaction Rejected** – the associated individual bill within a Transaction Set (batch) was rejected and the 824 Detail Acknowledgement provides information on the rejection reason.

If every Transaction Set (batch) is accepted, that means that all data elements above the CLM segment were accepted. The entire inbound EDI ANSI 837 file is processed and the trading partner needs to perform no further action on the data unless there are bill-level errors.

If any Transaction Set (batch) is rejected, the division EDI ANSI 837 application will indicate whether individual transactions (medical bills) were accepted or rejected, and will detail the results of the edits applied to every line item of every bill. The trading partner must decide the appropriate business approach to submit the corrected transactions (medical bills). In any event, it is the responsibility of the trading partner and insurer or self-insured employer to ensure all records are successfully transmitted and accepted.

## ***Traffic Report***

### Overview

The traffic report is a tool that provides information about the overall processing of accepted EDI ANSI 837 files submitted by trading partners to the Oregon WCD. The tool tracks a file from the moment it starts to be processed to the point where the file is delivered to the SFTP server utilities to be appropriately sorted into the various trading partners file structures. The traffic report indicates when acknowledgement files are created, however the tool may not reflect any delivery problems encountered on the SFTP server.

The traffic report is available on the DCBS Report Catalog Web site at:

<http://www4.cbs.state.or.us/ex/imd/reports/rpt/index.cfm?ProgID=MED8004>

The traffic report provides summary details on

Processed Date/Time

Acknowledgements generated for each file

Accepted EDI files have proper naming conventions as defined in [Appendix B](#). Allowed deviations on the naming conventions through the use of other unique identification numbers will be reviewed on a case-by-case basis.

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### Traffic Report Details

**Processed Date/Time:** Provides the date and time when an accepted file begins the medical EDI processing workflow. A delay between the date a file is submitted to the SFTP box for processing and the date processing begins may reflect a processing problem on the state system.

**File Name:** The name of the inbound file as submitted by the trading partner without file extensions.

**Acknowledgment Sent:** Indicator showing if the acknowledgment was created. For example, “Y” displayed for a TA1 and “N” shown for the subsequent 997 and 824 means that the file failed structural validation. No 997 or 824 will be created for that file. “N” displayed for a TA1 and “Y” shown for the subsequent 997 and 824 means that the file passed structural validation, and only a 997 and 824 were created for that file. No TA1 will be created.

The following is a list of potential values for the error codes included in a TA1, 997 or 824 acknowledgments.

### TA1 Error Codes

TA1 ERROR CODE	DESCRIPTION
000	No error
001	The Interchange Control Number in the header and trailer do not match
002	This Standard as noted in the Control Standards Identifier is not supported
003	This Version of the controls is not supported
004	The Segment Terminator is invalid
005	Invalid Interchange ID Qualifier for sender
006	Invalid Interchange Sender ID (FEIN mismatch between Interchange Sender FEIN and File Name Sender FEIN)
007	Invalid Interchange ID Qualifier for receiver
008	Invalid Interchange Receiver ID
009	Unknown Interchange Receiver ID
010	Invalid Authorization Information Qualifier value
011	Invalid Authorization Information value
012	Invalid Security Information Qualifier value
013	Invalid Security Information value
014	Invalid Interchange Date value
015	Invalid Interchange Time value
016	Invalid Interchange Standards Identifier value
017	Invalid Interchange Version ID value
018	Invalid Interchange Control Number
019	Invalid Acknowledgment Requested value
020	Invalid Test Indicator value
021	Invalid Number of Included Group value
022	Invalid control structure
023	Improper (Premature) end-of-file (Transmission)
024	Invalid Interchange Content

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TA1 ERROR CODE	DESCRIPTION
025	Duplicate Interchange Control Number
026	Invalid Data Element Separator
027	Invalid Component Element Separator
028	Invalid delivery date in Deferred Delivery Request
029	Invalid delivery time in Deferred Delivery Request
030	Invalid delivery time Code in Deferred Delivery Request
031	Invalid grade of Service Code

997 Error Codes

997 ERROR CODE	DESCRIPTION
	<b>SEGMENT ERRORS (AK3)</b>
1	Unrecognized Segment ID
2	Unexpected Segment
3	Mandatory Segment Missing
4	Loop Occurs Over Maximum Times
5	Segment Exceeds Maximum Use
6	Segment Not in Defined Transaction
7	Segment Not in Proper Sequence
8	Segment has Data Element Errors
	<b>ELEMENT ERROR CODES (AK4)</b>
1	Mandatory Data Element Missing
2	Conditional Required Data Element
3	Too Many Data Elements
4	Data Element Too Short
5	Data Element Too Long
6	Invalid Character in Data Element
7	Invalid Code Value
8	Invalid Date
9	Invalid Time
10	Exclusion Condition Violated
	<b>TRANSACTION SET RESPONSE TRAILER (AK5); AK501</b>
A	Accepted
R	Rejected
	<b>AK502</b>
1	Transaction Set Not Supported
2	Transaction Set Trailer Missing
3	Transaction Set Control Number In Header and Trailer Do Not Match
4	Number of Included Segments Does Not Match Actual Count

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997 ERROR CODE	DESCRIPTION
5	One or More Segments In Error
6	Missing or Invalid Transaction Set Identifier
7	Missing or Invalid Transaction Set Control Number
8	Authentication Key Name Unknown
	<b>FUNCTIONAL GROUP ERRORS (AK9)</b>
	Functional Group Acknowledge Code (AK901)
A	Accepted
R	Rejected
P	Partially Accepted; At Least One Transaction Set Was Rejected
	<b>FUNCTIONAL GROUP SYNTAX ERROR CODE (AK905)</b>
1	Functional Group Not Supported
2	Functional Group Version Not Supported
3	Functional Group Trailer Missing
4	Header and Trailer Do Not Agree
5	Number of Included Transaction Sets Does Not Match Actual Count
6	Group Control Number Violates Syntax

824 Error Codes

824 ERROR CODE	DESCRIPTION
001	Mandatory Field Not Present
028	Must be numeric (0-9)
029	Must be a valid date (CCYYMMDD)
030	Must be A-Z, 0-9, or spaces
033	Must be <= Date of Injury
034	Must be >= Date of Injury
039	No Match on Database
040	All Digits Cannot Be the Same
041	Must be <= Current Date
042	Not Statutorily Valid
044	Value is > Than Required By Jurisdiction
045	Value is < Than Required By Jurisdiction
050	No Matching Subsequent Report (A49)
053	No Matching FROI (148)
054	Must be Valid Occurrence for Segment
057	Duplicate Transmission/Transaction
058	Code/ID Invalid
059	Value Not Consistent with Value Previously Reported
061	Event Criteria Not Met

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824 ERROR CODE	DESCRIPTION
062	Required Segment Not Present
063	Invalid Event Sequence/Relationship
064	Invalid Data Sequence/Relationship
065	Corresponding Report/Data Not Found
066	Invalid Record Count
070	Must be <= 'From' Service Date
071	Must be >= 'Through' Service Date
072	Must be > Date of Bill
073	Must be >= Date Payer Received Bill
074	Must be >= 'From' Service Date
075	Must be <= 'Through' Service Date

## SECTION 10 – FAQs

### *Setup / Modes / Formats / Testing issues*

#### **Does each insurer or self-insured employer need to fill out a Trading Partner Agreement?**

No, we only require a Trading Partner Agreement and Profile from reporters.

#### **Where should questions about file processing, acknowledgments, and errors returned be directed?**

If a trading partner has questions about their testing or production files, contact the division EDI coordinator at 503-947-7742, or email [dcbs.edimedical@state.or.us](mailto:dcbs.edimedical@state.or.us)

#### **How many bills should be submitted for testing?**

The trading partner may submit a percentage of their expected volume for the first phase of testing (1 – 4 weekly files), but should increase their percentage reported volume throughout the testing period so that at the end of the 12-week test, they are transmitting their expected production volume of bills. For example, if a trading partner will be submitting high volumes of claims, they might submit 200 bills of all types in their first file; by their 12th file, they might be submitting 2,000 bills.

#### **Are you expecting one file per TPA or one file per insurer or self-insured employer? We report on behalf of the TPA and not the insurer or self-insured employer.**

Each trading partner may include multiple insurer or self-insured employers' medical bill data in one file. The insurer or self-insured employer is responsible for all aspects of a claim, even if they have outsourced certain aspects to a TPA. The insurer or self-insured employer is responsible to ensure that all of their entities or associated companies submit the data to the division as required by the rules. It is possible that more than one trading partner will submit data for an individual insurer or self-insured employer, not only for TPA relationships but also for bill types (some insurers and self-insured employers have pharmacy benefit management companies transmitting their pharmacy data).

**Does a trading partner have to zip an EDI transmission file when sending data over to the SFTP server?**

No. Oregon currently expects no limitations on file size submitted. Do not send zipped files; they cannot be processed.

**What kinds of structural errors have you seen in submitted files?**

We are finding quite a few loop segment problems. Even if the division has not specified required data fields in a segment which begins the loop containing the required data, the (loop-starting) segment itself must be present, or else a structural error will be triggered. For example, NM1 indicates that a new loop is starting and should be used, with asterisks showing the presence of the fields/absence of data, before the group of REF segments indicating a provider's license number, NPI, etc.

**If only replacing one line in a previously-submitted bill, is the trading partner required to send all lines as replacements?**

Yes. The "05" replacement is a complete replacement of the bill and the insurer or self-insured employer is required to submit all the information related to the replacement.

**If a data element is required on the medical billing form, but is listed as optional for state reporting; can the trading partner omit that data from the EDI 837 transaction?**

Yes. However, if the data is included in the transmission, it should meet all associated edits. The division encourages the insurers and self-insured employers to report data that is used to determine reimbursement to ensure the accuracy of analysis during fee guideline development or other research activities which use the EDI ANSI 837 data.

**I dropped off some files on your SFTP server that have not been picked up yet. What's wrong?**

Please check your file name; that has been the most frequent error to date. See below in this document for our File Naming Convention. Files that are misnamed will not be recognized by our file retrieval program, and can't be processed. Also, please do not send zipped files; they can't be processed.

**I got a "TA1" file back from you; what does that mean?**

A TA1 acknowledgment means there was an Interchange-Level error that prevented us from creating a 997 acknowledgment. There's a structural error with your file that must be corrected before resubmission. The TA1 file name will be formatted just like all our other file names, but ending in "TA1" instead of "997."

**How often can we submit medical bill files during the testing period? Do we have to submit them only on the day of the week we indicated in our Transmission Profile?**

You can submit files daily during testing, if you like. Or you may submit them on a different day than you indicated. Once we move to production, we'd like to be able to predict and balance processing load, so we'd like our submitters to send files on the day of the week we've agreed to.

**What is Oregon's Receiver ID? ID Code Qualifier = FI (FEIN) Receiver FEIN = 930952020 Receiver Postal Code = 97301-3879 Whom do we contact to set up a Secure FTP mailbox to report ANSI 837 medical bill data?**

Please contact the EDI coordinator at 503-947-7742 or email [dcbs.edimedical@state.or.us](mailto:dcbs.edimedical@state.or.us) to provide your company's technical contact for setting up SFTP filing. The division will then email or call your technical contact person to get the process started.

**How soon can we expect to receive the 997 and 824 acknowledgements after we submit an 837 file to Oregon?**

We will process files daily, after 5:00 p.m. Pacific time (8:00 pm on weekends). Any files that you drop off before the cut-off time will be processed that evening, and TA1 (if sent), 997 and 824 acknowledgements will be dropped off to your SFTP mailbox overnight. Files submitted after the cut-off time will be processed the next day and the acknowledgements will be returned the evening of the file processing day.

**For the 837 Filename, the FEIN is required as part of the name. Our business supports two different lines and we have two different FEINS. Do you want separate files for each LOB, or can we just use one of the FEINS for all of our transactions?**

You can pick one of your FEINs and use it for all your reporting. Just make sure to let us know that (as part of the Reporter Profile information we're working on) so that we can set up our Reporter FEIN table for matching purposes. Also, please make sure that the FEIN listed on the Trading Partner Agreement matches the FEIN in the file name and the Sender FEIN in the ISA of your file; otherwise, your file will be rejected for Invalid Sender ID.

**What rules govern EDI filing of medical bills for Oregon?**

Medical reporting is governed by the division 009 Rules, and EDI medical data reporting, the division 160 rules. These rules can be found on our main rules page at: <http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html>

**Do you have a File Naming Convention that you are using for inbound EDI files?**

Yes; see Appendix B of this implementation guide.

**I was comparing data elements for the 837 between California and Oregon. There are some data elements that California requires, but Oregon does not. If those CA fields are written to the 837, will you ignore those elements, or must we leave that information out completely?**

If we do not require it, then we will skip it. An optional field will not cause a transaction to reject.

**The structural fields (such as the ISA header fields) are not listed in your data requirements. Are they mandatory?**

Yes, these structural fields are required to build the file, and are mandatory. We did not list them on our business data requirements because we assumed that all reporters building the ANSI 837 file would automatically include them. Your file cannot be processed without all structural components present and in the correct order.

**Batch Control Number is listed as ‘optional’. Do we have to include a Batch Control Number in our submissions?**

Although this is listed as optional, we strongly suggest that reporters include a unique Batch Control Number to help them match acknowledgements to submissions. We will return the reported Batch Control Number in our 824 acknowledgement, even if it is all zeroes.

**For California reporting, if we sent an IAIABC expectable segment when there were no elements in that segment that California had identified as reportable, they indicated that we could expect a structural error. How does your translator handle valid but unexpected segments?**

We do not consider it a structural error if a segment that we do not utilize is reported. However, those unutilized segments must be structurally correct--including proper codes--as defined in the IAIABC manual.

**Will we be able to submit for multiple parties in a single interchange (as opposed to having to do a separate run for each)?**

Yes, you will be able to send information for multiple insurers or self-insured employers in a single file. We don't anticipate a limit on file size.

**If we have both the Rendering NPI and State License Number, do you want the REF segment twice, one with the NPI and the second REF with the State License Number, or will reporting just one REF with the NPI be enough?**

Yes, just one REF segment with the NPI is all we require. Note: the only time a state license number should be reported is when the provider or facility has no NPI.

***Data-Related Questions***

**Why did I get an error on a diagnosis code?**

Oregon requires the ICD-9 diagnosis code to be sufficient to identify a diagnosis. Please make sure that it has the appropriate number of digits after the decimal, where applicable. ICD-9-CM instructs providers to “assign three-digit codes if there are no four-digit codes within the code category. Assign four-digit codes if there are no five-digit codes for that category. Assign five-digit codes for those categories where they are available.” Provider bills that do not contain a valid diagnosis code according to these instructions may be returned for completion.

**Why did I get a 001 error on a paid code?**

The billed code was invalid and no paid code was given. Instead of placing an error code on what a provider billed an insurer, Oregon will allow that billed code as long as either there is a valid paid code or the service line is not paid.

**For DN507 Provider Agreement Code, the element requirements matrix states ‘enter the value “P” if the injured worker is enrolled in a Managed Care Organization at time of service’. However, there can be a range of dates represented in the bill. The worker may have been in an MCO during only a part of this period. How should we treat this situation?**

In this case, please treat as though the worker was enrolled in an MCO for the entire billing period. If the worker changes MCOs during the billing period, report the one that is in force at the end of the billing period.

**What are your expectations for MCO enrollment data? Does it only matter if the MCO enrollment affects the amount paid?**

If a worker is enrolled in an MCO, we want the MCO ID number to be reported to us, whether the MCO enrollment affects the amount paid or not.

**DN682 Facility National Provider ID is currently listed as Conditional, with the condition: “If service performed in a licensed facility.” There are no data elements that we can use to base an edit upon/to tell if the facility is licensed or not. Will you be changing this to Optional?**

We have changed the Condition to, “if service performed in a facility within the United States.” That condition can be used to base an edit for inclusion of the Facility NPI.

**Will the division accept a dental transaction (SV3) which contains HCPCS Level 1 codes (professional medical services)?**

No. HCPCS codes that begin with “D” are the same as ADA codes and if submitted on a CMS-1500 form, the HCPCS codes should be reported in the SV1 (professional) segment. The SV3 (dental) segment should contain the ADA codes. SV1 and SV3 segments cannot be sent together on the same line; two separate lines (can be on the same bill) must be submitted if both ADA and HCPCS codes are included on the original provider’s bill. The only valid segment combination on a single line is SV1 and SV5.

**Which bills are required to be reported to Oregon?**

Insurers and self-insured employers are required to report all paid and denied medical bills on accepted claims within 60 days of the date of bill payment or denial. Per OAR 436-010-0005: "Medical Service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

**How does an insurer or self-insured employer report pharmacy compound medication billing?**

Compound medications should be reported as a single drug with an NDC code of “99999.” You do not need to separate the individual components of the compound medication. Report the total amount paid under the “99999” NDC.

**How does an insurer or self-insured employer report shipping charges for pharmacy services?**

Shipping charges are not considered medical expenses and are not reported in the EDI837 transaction.

**Where can I find the list of insurers or self-insured employers that are required to report medical bill data to Oregon?**

You can find the list on our website at:

[http://www.cbs.state.or.us/external/wcd/policy/bulletins/ab\\_index.html](http://www.cbs.state.or.us/external/wcd/policy/bulletins/ab_index.html) Scroll down this page to “Bulletin 359” a .pdf list of insurers required to report this data.

**We report ANSI 837 medical data for Oregon insurers and self-insured employers that are not required to report Medical Billing Data. Should we report their medical bills along with the rest of our ANSI 837 required reporters?**

We hope that you will report all Oregon medical bill data to us. In order to encourage reporting for non-required insurers, we will send an additional error message: “DN0006 Insurer FEIN: Error Code 039, No Match on Database” for any bill transactions from non-required insurers that reject for other data errors. That way, the submitter can segregate those errors if they do not wish to correct and resubmit them.

**What do you expect to get when a Pharmacy Benefit Manager (PBM) reports pharmacy payments? Which amount and which received date do you want?**

We think there may be two scenarios: 1) PBM pays the pharmacy and then submits that bill payment to us. Insurer or self-insured employer pays PBM and that bill is also submitted to us (2 bills); OR 2) PBM pays the pharmacy and does not submit that bill payment to us. Insurer or self-insured employer pays PBM and that bill is submitted to us (1 bill).

In the first case, PBM will send us a Replacement Bill (same Unique Bill ID as the one they originally submitted to us) when the insurer or self-insured employer pays them. Each bill will have its own received and paid dates.

In the second case, PBM sends us an Original Bill telling us how much the insurer or self-insured employer paid them, along with the received and paid date. We will not know how much the PBM paid the pharmacy, or when that payment was made.

**Is there a generic NDC code for over-the-counter drugs?**

No, there is no generic NDC code. All over-the-counter drugs have their own NDC code associated with them. If you pay for OTC drugs, please indicate their correct NDC code on the line.

**Will a pharmacy or pharmacist have a state license number?**

We want the pharmacy information, not the individual pharmacist’s NPI, and license number. Pharmacies are licensed in Oregon; their license numbers begin with “IP” for institutional pharmacies and “RP” for retail pharmacies. If you do not report the pharmacy’s NPI, you must report their state license number. We believe all pharmacies have NPIs, though, and we would prefer that identifier.

**Does Oregon require reporting of denied bills?**

We have just changed our requirements to require reporting of denied bills for accepted claims. We have reduced edit requirements for these bills to the minimum necessary to process the data (see Data Element Requirements table in Appendix A - Medical Bill Data Element Requirement Table, go to:

[http://www.cbs.state.or.us/wcd/policy/rules/docconv\\_21365/160\\_10057.pdf](http://www.cbs.state.or.us/wcd/policy/rules/docconv_21365/160_10057.pdf).)

**Could you clarify how reconsiderations must be submitted?**

You may send reconsiderations one of two ways. For example, if the original provider bill was for \$100, and you paid \$50 and then reconsidered and paid an additional \$25, you could:

Send a replacement (05) transaction, to replace it with the total reconsidered amount (\$75); or

Send a cancellation (01) transaction, to remove the original payment (\$50), and send another original (00) transaction with the total reconsidered amount (\$75).

**Will Oregon perform validation of the provider license prefix?**

No, Oregon will not be validating provider license prefixes. You only need to report the provider license number if or when the provider does not have an NPI.

**Regarding the Insurer FEIN (DN6): The data edit matrix indicates that it is a required field and it must “match on database” (code 039). What database is this and how does it get populated? Will you be sending back a reject code in the 824 response file for invalid FEINs?**

We will not reject a batch or bill for an insurer FEIN that we do not recognize. If a transaction is rejected for some other data error and the insurer FEIN is not one that is required to report to the division, then an “error” will be reported (at the batch level) on DN6 with code 039. That will not cause a rejection of the batch, or any other transactions. That is a note to let the reporter know that transactions from that insurer do not need to be corrected and resubmitted to the division.

**Many jurisdictions require validation of the provider license prefix. Am I correct in stating that Oregon will not be validating provider license prefixes?**

Oregon will not be validating provider license prefixes.

**Do you want us to report short paid or only fully paid transactions? If short paid, do you need some type of denial code?**

If by "short paid" you mean invoices where you paid less than billed, then yes, we want those reported. There are Bill Adjustment Reason Codes to indicate why you paid less than billed. You would report a Bill Adjustment Reason Code along with your billed amount and paid amount.

**Can you confirm the latest edit requirements for DN515, Contract Type Code? One document we have says that it is conditional for original, canceled, and replacement transactions, while another document states that it should be mandatory.**

DN515, Contract Type Code, is Mandatory. Please make sure you're working with the latest version of our Data Element Requirements table in Appendix A - Medical Bill Data Element Requirement Table, go to:

[http://www.cbs.state.or.us/wcd/policy/rules/docconv\\_21365/160\\_10057.pdf](http://www.cbs.state.or.us/wcd/policy/rules/docconv_21365/160_10057.pdf).) These are the requirements contained in the applicable Division 160 Rules.

***Form-Related Questions***

**We have questions on the form fields for some of your data requirements; where can we find out more information?**

We have completed a Data Elements by Source Table, which is on our main EDI Web page at: <http://www.cbs.state.or.us/wcd/operations/edi/elesource.pdf>. This table gives information on the various source field(s) for our required data elements. Please note that the national NCPDP form is still under review and has not been finalized.

**How will the state control number (transaction number) be derived? Is this field number 226 (transaction tracking number) or 500 (Unique bill ID Number)? Will each transaction/Rx have a unique bill ID number? Also, how should we group the transactions when assigning a transaction number, by date of service, by invoice, one transaction per number?**

DN226 will track the individual transmission of the bill and DN500 will track that bill throughout the life of the bill. So we will match on DN500 to determine if the transmitted bill

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was already sent to us, but DN226 will reference one particular transmission of that bill. So for a bill submission reason of 00, then 05 and then 01, they would all have the same DN500, but each would have a different transaction tracking number. We will store each in our database with our own key as well.

## Required Data Elements [Appendix A]

Appendix A Medical Bill Data Element Requirement Table, go to:

[http://www.cbs.state.or.us/wcd/policy/rules/docconv\\_21365/160\\_10057.pdf](http://www.cbs.state.or.us/wcd/policy/rules/docconv_21365/160_10057.pdf)

## Appendix B – SFTP Naming Convention

The file name convention for inbound and outbound EDI files consists of a composite of multiple values that are expected to facilitate the proper transfers of files placed on to, or picked up from the SFTP server by trading partners.

Oregon requires the following standards for file names:

The State/Jurisdiction (2 Alpha) (OR)

The Trading Partner/Sender FEIN (9 numeric)

(NOTE: This must match the Sender FEIN in the Sender Information Loop of the ISA, and the Sender FEIN on the Trading Partner Agreement)

Test/Production Indicator (1 Alpha) (T or P)

Date Stamp of 837 File (8 Date CCYYMMDD)

Time Stamp of 837 File (6 Time HHMMSS)

File Sequential Counter (3 Numeric)

File Layout (837, 997, TA1, or 824) (3 Alphanumeric)

An example of the 837 File name is as follows:

OR\_123456789\_T\_20080101\_120100\_001\_837

The corresponding acknowledgement files would be named:

OR\_123456789\_T\_20080101\_120100\_001\_TA1

OR\_123456789\_T\_20080101\_120100\_001\_997

OR\_123456789\_T\_20080101\_120100\_001\_824

The Date and Time stamp as well as the sequential counter match those of the original 837, not the date/time the acknowledgement files were created. This is done to assist with file pairing.

Note: The date and time stamp of the creation of the 997 and 824 are provided in the file; therefore, there is no need to include the 997 and 824 File creation date and time in the file name.

The 997 and 824 File Date/Time Stamps are located in the GS segment of the outer envelope (ISA/GS/GE/IEA)

## **Appendix C – 837/824 Loop/Segment/Data Element Summary**

Oregon ANSI 837 loop, segment, data element summary

ST Transaction Set Header

Segment ST Transaction Set Control Number

Data Element 143 Transaction Set Identifier Code (837)

Data Element 329 Transaction Set Control Number

Segment BHT Beginning of Hierarchy Transaction

Data Element 532 Batch Control Number

Data Element 100 Date Transmission Sent

Data Element 101 Time Transmission Sent

LOOP ID 1000A Sender Information

Segment NM1 Identification code

Data Element 98 Sender Identification (FEIN only)

Segment N4 Identification code

Data Element 98 Sender Identification (Postal Code only)

LOOP ID 1000B Receiver Information

Segment NM1 Identification code

Data Element 99 Receiver Identification (FEIN only)

Segment N4 Geographical code

Data Element 99 Receiver Identification (Postal Code only)

LOOP ID 2000A Source of Hierarchical Information

Segment HL

Segment DTP Date/Time Period

Data Element 615 Reporting Period

LOOP ID 2010AA Insurer/Self Insured/Claim Admin. Info.

Segment NM1 Insurer/Self Insured/Claim Admin. Info.

Data Element 7 Insurers Name

Data Element 6 Insurers FEIN

Data Element 188 Claim Administrators Name

Data Element 187 Claim Administrators FEIN

## Oregon EDI Medical Bill Reporting Implementation Guide

### LOOP ID 2000B Employer Hierarchical Information

Segment HL

### LOOP ID 2010BA Employer Named Insurer Information

Segment NM1 Employer Name

Data Element 18 Employer Name

### LOOP ID 2000C Claimant Hierarchical Information

Segment HL

Segment DTP Date/Time Period

Data Element 31 Date of Injury

### LOOP ID 2010CA Claimant Information

Segment NM1 Claimant Information

Data Element 43 Employee Last Name

Data Element 44 Employee First Name

Data Element 42 Employee Social Security Number

Data Element 153 Employee Green Card

Data Element 156 Employee Passport Number

Data Element 152 Employee Employment Visa

Data Element 154 Employee ID Assigned by Jurisdiction

Segment REF Claimant Claim Number

Data Element 15 Claim Administrators Claim Number

Data Element 5 Jurisdiction Claim Number

### LOOP ID 2300 Billing Information (Repeat > 100)

Segment CLM Billing Information

Data Element 523 Billing Provider Unique Bill ID Number

Data Element 501 Total Charge per Bill

Data Element 502 Billing Type Code

Data Element 504 Facility Code

Data Element 555 Place of Service Bill Code

Data Element 503 Billing Format Code

Data Element 507 Provider Agreement Code

## Oregon EDI Medical Bill Reporting Implementation Guide

Data Element 508 Bill Submission Reason Code

Segment DTP Date/Time Period

Data Element 511 Date Insurer Received Bill

Data Element 513 Admission Date

Data Element 514 Discharge Date

Data Element 509 Service Bill Date Ranges

Data Element 527 Prescription Bill Date

Data Element 512 Date Insurer Paid Bill

Segment CN1 Contract Information

Data Element 515 Contract Type Code

Data Element 518 DRG Code

Segment AMT Total Amount Paid

Data Element 516 Total Amount Paid Per Bill

Segment REF Unique Bill ID

Data Element 500 Unique Bill Identification

Segment REF Transaction Tracking Number

Data Element 266 Transaction Tracking Number

Segment HI Diagnosis

Data Element 522 ICD\_9 Diagnosis Code

Data Element 521 Principal Diagnosis Code

Data Element 535 Admitting Diagnosis Code

Segment HI Institutional Procedure Codes

Data Element 525 ICD\_9 CM Principal Procedure Code

Data Element 626 HCPCS Principal Procedure Billed Code

Data Element 550 Principal Procedure Date

Data Element 736 ICD\_9 CM Procedure Code

Data Element 737 HCPCS Bill Procedure Code

Data Element 524 Procedure Date

LOOP ID 2310A Billing Provider Information

Segment NM1 Billing Provider Information

Data Element 528 Billing Provider Last/Group Name

Data Element 629 Billing Provider FEIN

Segment PRV Billing Provider Specialty Information

## Oregon EDI Medical Bill Reporting Implementation Guide

Data Element 537 Billing Provider Primary Specialty Code

Segment N4 Billing Provider City, State, and Postal Code, Country Code

Data Element 569 Billing Provider Country Code

Segment REF Billing Provider Secondary ID Number

Data Element 630 Billing Provider State License Number

Data Element 634 Billing Provider National Provider ID

LOOP ID 2310B Rendering Bill Provider Information

Segment NM1 Rendering Bill Provider Information

Data Element 638 Rendering Bill Provider Last/Group Name

Data Element 639 Rendering Bill Provider First Name

Data Element 642 Rendering Bill Provider FEIN

Segment PRV Rendering Bill Provider Specialty Info.

Data Element 651 Rendering Bill Provider Primary Specialty Code

Segment N4 Rendering Bill Provider City, State, Postal Code, Country Code

Data Element 657 Rendering Bill Provider Country Code

Segment REF Rendering Bill Provider Secondary ID Number

Data Element 643 Rendering Bill Provider State License Number.

Data Element 647 Rendering Bill Provider National Provider ID

LOOP ID 2310D Facility Information

Segment NM1 Facility Information

Data Element 678 Facility Name

Segment N4 Facility City, State, Postal Code, Country Code

Data Element 689 Facility Country Code

Segment REF Facility Secondary ID Number

Data Element 682 Facility National Provider ID

LOOP ID 2310F Managed Care Organization Information

Segment NM1 Managed Care Organization Information

Segment REF Managed Care Organization Identification Number

Data Element 208 Managed Care Organization Identification Number

## Oregon EDI Medical Bill Reporting Implementation Guide

LOOP ID 2320 Subscriber Insurance

Segment SBR Subscriber Information

Data Element 1138 Payer Responsibility Sequence Number Code (must = P)

Segment CAS Bill Level Adjustment Reasons Amount

Data Element 543 Bill Adjustment Group Code

Data Element 544 Bill Adjustment Reason Code

Data Element 545 Bill Adjustment Amount

Data Element 546 Bill Adjustment Units

LOOP ID: 2400 Service Line Information

Segment LX Service Line Information

Data Element 547 Line Number

Segment SV1 Procedure Code Billed

Data Element 721 NDC Billed Code

Data Element 714 HCPCS Line Procedure Billed Code

Data Element 717 HCPCS Modifier Billed Code

Data Element 715 Jurisdictional Procedure Billed Code

Data Element 718 Jurisdictional Modifier Billed Code

Data Element 552 Total Charge per Line

Data Element 553 Days/Units Code

Data Element 554 Days/Units Billed

Data Element 600 Place of Service Line Code

Data Element 557 Diagnosis Pointer

Segment SV2 Institutional Service Revenue Procedure Code

Data Element 559 Revenue Billed Code

Data Element 714 HCPCS Line Procedure Billed Code

Data Element 717 HCPCS Modifier Billed Code

Data Element 715 Jurisdictional Procedure Billed Code

Data Element 718 Jurisdictional Modifier Billed Code

Data Element 552 Total Charge per Line

Data Element 553 Days/Units Code

Data Element 554 Days/Units Billed

Segment SV3 Dental Service

Data Element 714 HCPCS Line Procedure Billed Code

NOTE: Only 1 SV  
segment per 2400  
loop allowed except  
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## Oregon EDI Medical Bill Reporting Implementation Guide

Data Element 719 ADA Procedure Billed Code

Data Element 717 HCPCS Modifier Billed Code

Data Element 552 Total Charge per Line

Data Element 600 Place of Service Line Code

Segment SV4 Prescription Drug Information

Data Element 561 Prescription Line Number

Data Element 721 NDC Billed Code

Data Element 562 Dispense as Written Code

Data Element 563 Drug Name

Data Element 564 Basis of Cost Determination

Segment SV5 Durable Medical Equipment

Data Element 714 HCPCS Line Procedure Billed Code

Data Element 717 HCPCS Modifier Billed Code

Data Element 553 Days/Units Code

Data Element 554 Days/Units Billed

Data Element 565 Total Charge per Line Rental

Data Element 566 Total Charge per Line Purchase

Data Element 567 DME Billing Frequency Code

Segment DTP Service Date(s)

Data Element 605 Service Line Dates

Segment DTP Prescription Date

Data Element 604 Prescription Line Date

Segment QTY Quantity

Data Element 570 Drugs Supplied Quantity

Data Element 571 Drugs/Supplied Number of Days

Segment AMT Dispensing Fee Amount

Data Element 579 Drugs/Supplied Dispensing Fee

Segment AMT Drug/Supply Billed Amount

Data Element 572 Drug/Supply Billed Amount

LOOP ID 2420 Rendering Line Provider Name

Segment NM1 Rendering Line Provider Information

Data Element 586 Rendering Line Provider FEIN

Segment PRV Rendering Line Provider Specialty Information

## Oregon EDI Medical Bill Reporting Implementation Guide

Data Element 595 Rendering Line Provider Primary Specialty Code

Segment N4 Geographic Location

Data Element 585 Rendering Line Provider Country Code

Segment REF Rendering Line Provider Secondary ID Number

Data Element 592 Rendering Line Provider National ID Number

LOOP ID 2430 Service Line Adjustment

Segment SVD Service Line Adjudication

Data Element 574 Total Amount Paid per Line

Data Element 722 ADA Procedure Paid Code

Data Element 726 HCPCS Line Procedure Paid Code

Data Element 727 HCPCS Modifier Paid Code

Data Element 728 NDC Paid Code

Data Element 729 Jurisdiction Procedure Paid Code

Data Element 730 Jurisdiction Modifier Paid Code

Data Element 576 Revenue Paid Code

Data Element 580 Days/Units Paid

Data Element 547 Line Number

Segment CAS Service Line Adjustment

Data Element 731 Service Adjustment Group Code

Data Element 732 Service Adjustment Reason Code

Data Element 733 Service Adjustment Amount

Data Element 734 Service Adjustment Units

SE Transaction Set Trailer

Segment Transaction Set Trailer

Data Element 96 Number of Included Segments

Data Element 329 Transaction Set Control Number

Oregon ANSI 824 loop, segment, data element summary

ST Transaction Set Header

Segment ST Transaction Set Control Number

Data Element 143 Transaction Set Identifier Code (837)

Data Element 329 Transaction Set Control Number

Segment BGN Beginning Segment

Data Element 105 Interchange Version Identification

## Oregon EDI Medical Bill Reporting Implementation Guide

Data Element 100 Date Transmission Sent

Data Element 101 Time Transmission Sent

LOOP ID: N1A Sender Information

Segment N1 Sender Identification

Data Element 98 Sender Identification (FEIN)

Segment N4 Geographic Location

Data Element 98 Sender Identification (Postal Code)

LOOP ID: N1B Receiver Information

Segment N1 Receiver Identification

Data Element 99 Receiver Identification (FEIN)

Segment N4 Geographic Location

Data Element 99 Receiver Identification (Postal Code)

## Oregon EDI Medical Bill Reporting Implementation Guide

LOOP ID: OTI Original Identification Transaction

Segment OTI Original Transaction Identifier

Data Element 111 Application Acknowledgment Code

Data Element 500 Unique Bill Identification Number

Data Element 532 Batch Control Number

Data Element 102 Original Transmission Date

Data Element 103 Original Transmission Time

Data Element 110 Acknowledgment Transaction Set Identifier

Segment DTM Processing Date

Data Element 108 Date Processed

Data Element 109 Time Processed

Segment LM Code Source Information

LOOP ID: LQ Industry Code

Segment LQ Industry Code

Data Element 116 Element Error Number

Segment RED Related Data

One of the following (batch level):

Data Element 532 Batch Control Number

Data Element 6 Insurer FEIN

Data Element 188 Claim Administrator Name

Data Element 15 Claim Administrator Claim Number (bill level):

Data Element 500 Unique Bill Identification Number

Data Element 266 Transaction Tracking Number

Data Element 508 Bill Submission Reason Code

Data Element 528 Billing Provider Last/Group Name

Data Element 638 Rendering Bill Provider Last/Group Name

Data Element 658 Supervising Provider Last/Group Name

Data Element 678 Facility Name

Data Element 690 Referring Provider Last/Group Name

Data Element 209 Managed Care Organization Name

Data Element 543 Bill Adjustment Group Code

Data Element 544 Bill Adjustment Reason Code

Data Element 545 Bill Adjustment Amount

## Oregon EDI Medical Bill Reporting Implementation Guide

Data Element 546 Bill Adjustment Units

Data Element 547 Line Number

Data Element 731 Service Adjustment Group Code

Data Element 732 Service Adjustment Reason Code

Data Element 733 Service Adjustment Amount

Data Element 734 Service Adjustment Units

Data Element 722 ADA Procedure Paid Code

Data Element 726 HCPCS Line Procedure Paid Code

Data Element 728 NDC Paid Code

Data Element 729 Jurisdiction Procedure Paid Code

Data Element 576 Revenue Paid Code;

➤ One of the following:

A9 (Supplemental Data)

GJ (Reject Indicator Code)

Data Element 115 Element Number

SE Transaction Set Trailer

Segment Transaction Set Trailer

Data Element 96 Number of Included Segments

Data Element 329 Transaction Set Control Number

**Appendix D – Code List Sources and Update Schedule**

| Code Type    | Code Name                         | Update Frequency | Update timeframe  | Source                           |
|--------------|-----------------------------------|------------------|-------------------|----------------------------------|
| Fee Schedule | RVU                               | Annual           | November          | CMS                              |
| Fee Schedule | CF                                | Annual           | WCD dependent     | OR WCD                           |
| Medical      | CPT (AMA)                         | Annual           | November          | CMS                              |
| Medical      | CPT (ASA)                         | Annual           | January           | ASA                              |
| Medical      | HCPCS                             | Annual           | November          | CMS                              |
| Medical      | Revenue Code                      | Annual           | July              | NUBC (also CMS)                  |
| Medical      | OSC                               | Annual           | WCD dependent     | OR WCD                           |
| Medical      | ICD-9-CM -<br>Procedural          | Annual           | October           | CMS                              |
| Medical      | ICD-9-CM -<br>Diagnostic          | Annual           | October           | CMS                              |
| Medical      | DRG                               | Annual           | October           | CMS                              |
| Modifier     | Modifier                          | Annual           | CMS dependent     | CMS                              |
| Pharmacy     | NDC                               | Weekly           | Weekly            | Medispan                         |
| Provider     | NPI                               | Quarterly        | Quarterly         | CMS                              |
| Provider     | Provider Taxonomy<br>Code         | Annual           | Upon notification | Washington Publishing<br>Company |
| Provider     | Facility/Place of<br>Service Code | Annual           | CMS dependent     | CMS                              |
| Insurer      | Claims Adjustment<br>Reason Code  | Annual           | Upon notification | Washington Publishing<br>Company |
| Other        | NUCC membership                   | Annual           | Upon notification | NUCC                             |
| Other        | NUBC membership                   | Annual           | Upon notification | NUBC                             |