

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION



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

**Effective July 1, 2008**

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NOTE: Significant revisions are marked with vertical lines in the right margins.

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

**BEFORE THE DIRECTOR  
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION**

In the Matter of the Amendment of Oregon Administrative Rules (OAR):  
  
436-160, Electronic Data Interchange

**ORDER OF  
ADOPTION  
No. 08-059**

The Director of the Department of Consumer and Business Services, under the general rulemaking authority in ORS 656.726(4), and in accordance with the procedure provided by ORS 183.335, amends OAR chapter 436, division 160, "Electronic Data Interchange." On April 10, 2008, the Workers' Compensation Division filed with the Secretary of State a *Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact*. The division mailed copies of the *Notice* and *Statement* to interested persons and legislators in accordance with ORS 183.335 and OAR 436-001-0009, and posted copies to its Web site. The Secretary of State included notice of the public hearing in its May 2008 *Oregon Bulletin*.

On May 19, 2008, a public hearing was held as announced. In addition, the record was held open for written testimony through May 22, 2008. Public testimony is on file and available for public inspection upon request during regular business hours, 8:00 a.m. to 5:00 p.m., Monday through Friday, in the Administrator's Office, Workers' Compensation Division, Labor & Industries Building, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405.

**RULE SUMMARY**

Revised rules:

- Provide the director discretion to require a trading partner agreement for medical data reporting, but eliminate the mandate for trading partner agreements for all EDI (436-160-0020)
- Clarify and simplify address reporting requirements (436-160-0090)
- Eliminate the requirement to submit paper reports to add or delete coverage for non-subject workers; the insurer must file the appropriate "include" or "exclude" endorsement transaction to the associated policy filing (436-160-0340 & 0350)
- Require insurers to notify the director of guaranty contract terminations within ten days (not within seven days) consistent with requirements in OAR 436-050 (436-160-0360)
- Eliminate the requirement that the insurer submit a cancellation of a medical bill before resubmitting (436-160-0430)
- Revise electronic data interchange medical reporting requirements in Appendix B (436-160-0410)

**FINDINGS**

Having reviewed and considered the record and being fully informed, I make the following findings:

- a) The applicable rulemaking procedures have been followed.

- b) These rules are within the director's authority.
- c) The rules being adopted are a reasonable administrative interpretation of the statutes and are required to carry out statutory responsibilities.

**IT IS THEREFORE ORDERED THAT**

- 1) Amendments to OAR chapter 436, as set forth in Exhibit "A", are attached, incorporated by reference, and **adopted on this 12<sup>th</sup> day of June 2008, to be effective July 1, 2008.**
- 2) A certified copy of the adopted rules will be filed with the Secretary of State.
- 3) A copy of the amended rules with revision marks will be filed with the Legislative Counsel under ORS 183.715 within ten days after filing with the Secretary of State.

**DATED this 12<sup>th</sup> day of June 2008.**

DEPARTMENT OF CONSUMER  
AND BUSINESS SERVICES

*/s/ John L. Shilts*

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John L. Shilts, Administrator  
Workers' Compensation Division

**Under the Americans with Disabilities Act guidelines, alternative format copies of the rules will be made available to qualified individuals upon request.**

**If you have questions about these rules or need them in an alternate format, contact the Workers' Compensation Division at (503) 947-7810.**

**Distribution:** WCD-ID, S0, S1, S2, S3, S4, S5, S6, S7, S8, ML, ME

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

**General Provisions**

**436-160-0001 Authority for Rules**

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

**Stat. Authority:** ORS 656.264 and ORS 656.726(4)

**Stat. Implemented:** ORS 656.017, ORS 656.407, ORS 656.419, ORS 656.423, and ORS 656.427

**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03

**436-160-0002 Purpose**

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

**Stat. Authority:** ORS 656.264 and ORS 656.726(4)

**Stat. Implemented:** ORS 656.017, ORS 656.407, ORS 656.419, ORS 656.423, and ORS 656.427

**Hist:** Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03

**436-160-0003 Applicability of Rules**

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

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

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.726(4)

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

**436-160-0004 Adoption of Standards**

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

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

**Stat. Authority:** ORS 656.264

**Stat. Implemented:** ORS 656.017, ORS 656.407, ORS 656.419, ORS 656.423, and ORS 656.427

**Hist:** Amended 11/1/07 as Admin. Order 07-068, eff. 1/1/08

**436-160-0005 General Definitions**

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

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

(2) "Conditional data element" means an element that becomes mandatory under certain conditions. Once mandatory, a conditional data element will cause a rejection of the transaction if the data element is omitted or submitted in a format not capable of being processed by the division's information processing system.

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

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

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

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

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

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

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

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

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

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

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

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

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

(16) "Record" means electronic record.

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

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

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

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

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

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

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

#### **436-160-0006 Administration of Rules**

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

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

#### **436-160-0010 Security**

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

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

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

#### **436-160-0020 Trading Partner Agreement**

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

(2) The trading partner agreement will include:

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

(b) Transmission protocol between sender and director;

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

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

(e) Cost allocation of transactions, if any;

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

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

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

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

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

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

**436-160-0040 Recognized Filing Date**

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Proof of coverage testing:

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

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

(A) Transmit records via electronic data interchange; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Transmit records via electronic data interchange; and

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

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

- (A) Transmissions are sent to the director without structural errors;
- (B) Transmissions are sent to the director without transaction level technical errors; and
- (C) The sender can receive and process the automated EDI acknowledgement transactions.

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

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

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

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

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

#### **436-160-0070      Electronic signature**

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

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 84.001-84.061 and ORS 656.264  
**Hist:** Amended 6/12/08 as Admin. Order 08-059, eff. 7/1/08

#### **436-160-0080      Acknowledgements**

(1) Proof of Coverage:

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

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

(2) Medical Bill Data:

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

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

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

#### **436-160-0090 Address Reporting**

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

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

### **Proof of Coverage**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (a) An omitted mandatory data element;
- (b) An improperly populated data element field, e.g. numeric data element field is populated with alpha or alphanumeric data, or is not a valid value;
- (c) Transactions or electronic records within the transaction which require matching and cannot be matched to the division's database;
- (d) Illogical data in mandatory or required conditional field, e.g. termination date is before coverage effective date;
- (e) Duplicate transmission or duplicate transaction within the transmission;
- (f) Invalid triplicate code; or
- (g) Illogical event sequence relationship between transactions, e.g. endorsement transaction submitted before a policy transaction is submitted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) To add or delete coverage for corporate officers, members of a limited liability company, partners, sole proprietors or other non-subject workers, the insurer must file the appropriate "include" or "exclude" endorsement transaction to the associated policy filing.

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

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

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

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

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

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

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

(c) Transmit an establishing document transaction: binder, new policy, renew policy, rewrite/reissue policy, reinstatement, add location, add employer, or add jurisdiction. A renew policy, add location, or add employer transaction will only establish a guaranty contract if the

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data elements have not previously been transmitted, the employer FEIN is not a duplicate per section (3) below, and coverage for that unique employer FEIN has not been previously established by the reporting carrier. A reinstatement transaction will only establish a new guaranty contract if there is a lapse in coverage and the requirements of ORS 656.419 and OAR 436-160-0350 are otherwise met.

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

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

(5) If an employer elects to include any non-subject worker(s) under coverage, or subsequently to exclude such workers from coverage, the insurer must submit a transaction with a reason code for including or excluding a corporate officer, partner, member, sole proprietor, or any other person.

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

#### **436-160-0360 Guaranty Contract Terminations**

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

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

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

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

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

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

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

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

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

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

**Stat. Authority:** ORS 656.726(4)

**Stat. Implemented:** ORS 656.264, ORS 656.419, ORS 656.423 and ORS 656.427

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

### **Insurers' Obligation to Report Medical Bill Data**

#### **436-160-0400 Medical Bill Definitions**

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

**Stat. Authority:** ORS 656.726(4)

**Stat. Implemented:** ORS 656.264

**Hist:** Adopted 11/1/07 as Admin. Order 07-068, eff. 1/1/08

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

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

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

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

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

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

**Stat. Authority:** ORS 656.726(4)

**Stat. Implemented:** ORS 656.264

**Hist:** Amended 6/12/08 as WCD Admin. Order 08-059, eff. 7/1/08

#### **436-160-0420 Medical Bill Acknowledgement**

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

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

(a) An omitted mandatory data element;

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

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

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

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

(f) Invalid bill submission reason code; or

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

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

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

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.264

**Hist:** Adopted 11/1/07 as Admin. Order 07-068, eff. 1/1/08

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

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

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

**Stat. Authority:** ORS 656.726(4); **Stat. Implemented:** ORS 656.264

**Hist:** Adopted 11/1/07 as Admin. Order 07-068, eff. 1/1/08

Amended 6/12/08 as Admin. Order 08-059, eff. 7/1/08

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

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

**IAIABC ANSI 837 Medical Bill Reporting Requirements**

1) Event reporting requirements:

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

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

Replacement: Report within 30 days of:

- a) Payer knowledge of change in claim administrator, location of service, or provider type;
- b) Payer action of paying an additional amount on a previously-reported bill; or
- c) Payer receipt of an overpayment from a medical provider on a previously-reported bill.

2) Data reporting requirements: See “Medical Bill Data Element Requirement Table” below.

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

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

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

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

The following data must be reported to the department:

Medical Bill Data Element Requirement Table					
Bill Submission Reason Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger or Implementation Note
719	ADA Procedure Billed Code	C	C	C	Required for dental bills only (SV3 segment)
722	ADA Procedure Paid Code	C	C	C	Required for dental bills only (SV3 segment)
513	Admission Date	C	C	C	If DN 504 Facility Code = 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89.

Bill Submission Reason Codes					
DN	Data Element Name	00	01	05	Mandatory Trigger or Implementation Note

535	Admitting Diagnosis Code	C	C	C	If DN 504 Facility Code = 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89.
564	Basis of Cost Determination Code	C	C	C	Required for pharmacy bills.
545	Bill Adjustment Amount	C	C	C	If DN516 Total Amount Paid Per Bill is not equal to DN501 Total Charge Per Bill
543	Bill Adjustment Group Code	C	C	C	If DN516 Total Amount Paid Per Bill is not equal to DN501 Total Charge Per Bill
544	Bill Adjustment Reason Code	C	C	C	If DN516 Total Amount Paid Per Bill is not equal to DN501 Total Charge Per Bill
546	Bill Adjustment Units	C	C	C	If DN580 Days/Units Paid is different than DN554 Days/Units Billed.
508	Bill Submission Reason Code	M	M	M	
503	Billing Format Code	M	M	M	
629	Billing Provider FEIN	M	M	M	
528	Billing Provider Last/Group Name	M	M	M	
537	Billing Provider Primary Specialty Code	O	O	O	
630	Billing Provider State License Number	C	C	C	If DN634 Billing Provider National Provider ID is blank, report DN630 State License Number. Use "999999" if provider type not licensed by the state (e.g. pharmacy, durable medical).
523	Billing Provider Unique Bill Identification Number	M	M	M	If not available, use default of all 9s.
634	Billing Provider National Provider ID	C	C	C	Must be reported if billing provider has an NPI.
502	Billing Type Code	C	C	C	If DN 502 = "RX" "DM" or "MO", then SV4 or SV5 must be present. Office bills for pharmaceuticals (drugs dispensed by provider) must be reported in SV1; all other pharmacy must be reported in SV4.
015	Claim Administrator Claim Number	M	M	M	
187	Claim Administrator FEIN	C	C	C	If different than DN6 Insurer FEIN
188	Claim Administrator Name	C	C	C	If different than DN7 Insurer name
515	Contract Type Code	M	M	M	
512	Date Insurer Paid Bill	M	M	M	
511	Date Insurer Received Bill	M	M	M	
31	Date of Injury	M	M	M	
554	Days/Units Billed	C	C	C	If DN559 Revenue Billed Code is present. Required when SV1, SV2 and SV5 segments are used.
553	Days/Units Code	C	C	C	If DN554 Days/Units Billed is present. Required when SV1, SV2 and SV5 segments are used.
557	Diagnosis Pointer	C	C	C	If DN503 Billing Format Code equals "B" and DN 715 Jur. Proc. Billed Code or DN 714 HCPCS Line Proc. Billed Code is present or a drug is dispensed by a physician during an office visit.

**Bill Submission Reason Codes**

DN	Data Element Name	00	01	05	Mandatory Trigger or Implementation Note
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514	Discharge Date	C	C	C	If DN503 Billing Format Code equals "A" and patient has been discharged
562	Dispense As Written Code	C	C	C	Required for pharmacy bills (when SV4 segment is present.)
567	DME Billing Frequency Code	C	C	C	If DN502 Billing Type Code = DM and DN565 Total Chg. per Line - Rental is present. Use the SV5 segment for DME rental and purchase services billed.
518	DRG Code	O	O	O	If Billing Format Code equals "A"
563	Drug Name	O	O	O	
572	Drugs/Supplies Billed Amount	C	C	C	If DN502 Billing Type Code, value is "RX" or "MO". DN572 is required in the SV4/AMT segment.
579	Drugs/Supplies Dispensing Fee	C	C	C	Required for pharmacy bills.
571	Drugs/Supplies Number of Days	C	C	C	If DN502 Billing Type Code, value is "RX" or "MO".
570	Drugs/Supplies Quantity Dispensed	C	C	C	If DN502 Billing Type Code, value is "RX" or "MO".
152	Employee Employment Visa	C	C	C	If DN42 Employee Social Security number or DN153 Employee Green Card number is not available.
44	Employee First Name	M	M	M	
153	Employee Green Card	C	C	C	If DN42 Employee Social Security number is not available.
154	Employee ID Assigned by Jurisdiction	C	C	C	If DN42 Employee Social Security, DN153 Employee Green Card, DN152 Employee Employment Visa or DN \156 Employee Passport Number not available.
43	Employee Last Name	M	M	M	
156	Employee Passport Number	C	C	C	If DN42 Employee Social Security, DN153 Employee Green Card, or DN152 Employee Employment Visa not available.
42	Employee Social Security Number	C	C	C	DN42 Employee SSN is preferred ID number. If none, see DN153 Employee Green Card. If injured worker is not a United States citizen and has no other identification, use "999999999".
18	Employer Name	M	M	M	
504	Facility Code	C	C	C	If DN503 Billing Format Code = "A"
678	Facility Name	C	C	C	If service performed in a licensed facility
682	Facility National Provider ID	C	C	C	If service performed in a licensed facility
737	HCPCS Bill Procedure Code	C	C	C	If DN503 = "A" and if DN626 HCPCS Prin. Procedure Billed Code is present and more than one procedure is performed

**Bill Submission Reason Codes**

DN	Data Element Name	00	01	05	Mandatory Trigger or Implementation Note
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714	HCPCS Line Procedure Billed Code	C	C	C	If DN502 Billing Type Code does not equal RX, DM or MO, and if DN715 Jurisdiction Procedure Billed Code or DN721 NDC Billed Code is not present
726	HCPCS Line Procedure Paid Code	C	C	C	If different than DN714 HCPCS Line Proc. Billed Code
717	HCPCS Modifier Billed Code	O	O	O	If present, must be a valid code.
727	HCPCS Modifier Paid Code	C	C	C	If different than DN 717 HCPCS Modifier Billed Code
626	HCPCS Principal Procedure Billed Code	O	O	O	Must be reported if included on provider's bill.
736	ICD-9 CM Procedure Code	C	C	C	If DN503 = "A" and if DN525 ICD-9 CM Prin. Proc. Code is present and more than one procedure is performed
522	ICD-9 CM Diagnosis Code	C	C	C	If DN521 Principle Diagnosis Code is present and more than one diagnosis occurs or if DN503 Billing Format Code = B and DN714 HCPCS Line Proc. Billed Code or DN715 Jurisdiction Procedure Billed Code or a drug is dispensed by a physician during an office visit.
525	ICD-9 CM Principal Procedure Code	O	O	O	Must be reported if included on provider's bill.
6	Insurer FEIN	M	M	M	
7	Insurer Name	M	M	M	
5	Jurisdictional Claim Number	C	C	C	If the first report of injury has been filed and a jurisdictional claim number has been returned to the insurer.
718	Jurisdictional Modifier Billed Code	O	O	O	N/A; Oregon has no jurisdictional modifiers
730	Jurisdictional Modifier Paid Code	O	O	O	N/A; Oregon has no jurisdictional modifiers
715	Jurisdictional Procedure Billed Code	C	C	C	If the procedure is included as an Oregon-specific code in the Oregon Medical Fee Schedule
729	Jurisdictional Procedure Paid Code	C	C	C	If different than DN715 Jurisdiction Procedure Billed Code
547	Line Number	M	M	M	Required in Loop 2400/LX segment.
208	Managed Care Organization Identification Number	C	C	C	If worker enrolled at time of service.
721	NDC Billed Code	C	C	C	If a pharmaceutical bill or a drug is dispensed by a physician during an office visit. For compound drugs, use "99999."
728	NDC Paid Code	C	C	C	If different than DN721 NDC Billed Code. For compound drugs, use "99999."
555	Place of Service Bill Code	C	C	C	If DN503 Billing Format Code equals "B"
600	Place of Service Line Code	C	C	C	If DN 503 Billing Format Code equals "B" and if different than DN555 Place of Svc. Billed Code and not a pharmacy bill

Bill Submission Reason Codes					
DN	Data Element Name	00	01	05	Mandatory Trigger or Implementation Note

527	Prescription Bill Date	O	O	O	
604	Prescription Line Date	C	C	C	Required if SV4 is present.
561	Prescription Line Number	C	C	C	Required if SV4 is present.
521	Principal Diagnosis Code	C	C	C	If DN503 Billing Format Code equals "A"
550	Principal Procedure Date	C	C	C	Required if DN626 HCPCS Principal Procedure Code or DN525 ICD-9 CM Principal Procedure Code are present.
524	Procedure Date	C	C	C	Required if DN736 ICD-9 CM Principal Procedure Code or DN737 HCPCS Bill Procedure Code are present.
507	Provider Agreement Code	C	C	C	Enter the value "P" if the injured worker is enrolled in a Managed Care Organization at time of service
642	Rendering Bill Provider FEIN	O	O	O	
639	Rendering Bill Provider First Name	M	M	M	
638	Rendering Bill Provider Last/Group Name	M	M	M	
647	Rendering Bill Provider National Provider ID	O	O	O	If provider has reported an NPI to the payer, it should be reported to the jurisdiction.
651	Rendering Bill Provider Primary Specialty Code	O	O	O	
643	Rendering Bill Provider State License Number	O	O	O	If DN 647 Rendering Bill Provider National Provider ID is blank, DN643 Rendering Bill Provider State License Number should be reported. If provider type not licensed by the state (e.g. pharmacy, durable medical), use "99999."
586	Rendering Line Provider FEIN	O	O	O	
592	Rendering Line Provider National ID	C	C	C	If provider has an NPI, it must be reported,
595	Rendering Line Provider Primary Specialty Code	O	O	O	
599	Rendering Line Provider State License Number	C	C	C	If DN592 Rendering Line Provider National ID is blank, DN599 State License Number must be present. If provider type not licensed by the state (e.g. pharmacy, durable medical), use "99999."
615	Reporting Period	M	M	M	
559	Revenue Billed Code	C	C	C	If a value for DN504 Facility Code with 1st digit equal to 1
576	Revenue Paid Code	C	C	C	If different than DN559 Revenue Billed Code
733	Service Adjustment Amount	C	C	C	Required if DN552 Total Charge per Line is different than DN574 Total Amount Paid per Line.

**Bill Submission Reason Codes**

DN	Data Element Name	00 Original	01 Cancellation	05 Replace	Mandatory Trigger or Implementation Note
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731	Service Adjustment Group Code	C	C	C	Required if DN552 Total Charge per Line is different than DN574 Total Amount Paid per Line.
732	Service Adjustment Reason Code	C	C	C	Required if DN552 Total Charge per Line is different than DN574 Total Amount Paid per Line.
509	Service Bill Date(s) Range	C	C	C	If different than DN605 Svc. Lines Date Range
605	Service Line Date(s) Range	C	C	C	Required for all bill types except pharmacy. DN604 is used specifically for pharmacy.
516	Total Amount Paid Per Bill	C	C	C	If different than DN501 Total Charge per Bill
574	Total Amount Paid Per Line	C	C	C	If paid amount is not equal to DN552 Total Charge per Line.
501	Total Charge Per Bill	C	C	C	Required for professional and institutional service lines only (SV1, SV2, SV3)
552	Total Charge Per Line	M	M	M	
566	Total Charge Per Line – Purchase	C	C	C	If Durable Medical Equipment is purchased
565	Total Charge Per Line – Rental	C	C	C	If Durable Medical Equipment is rented
266	Transaction Tracking Number	M	M	M	
500	Unique Bill ID Number	M	M	M	Cancel & Replace transactions must match previously submitted Original DN500 Unique Bill ID Number

**Secretary of State  
Certificate and Order for Filing  
PERMANENT ADMINISTRATIVE RULES**

I certify that the attached copies\* are true, full and correct copies of the PERMANENT Rule(s) adopted on

June 12, 2008 by the  
Date prior to or same as filing date

Department of Consumer and Business Services  
Workers' Compensation Division  
Agency and Division

OAR chapter 436  
Administrative Rules Chapter No.

Fred Bruyns 503-947-7717  
Rules Coordinator Telephone

350 Winter Street NE; Salem OR 97301-3879, PO Box 14480, Salem OR 97309-0405  
Address

to become effective July 1, 2008 Rulemaking Notice was published in the May 2008 *Oregon Bulletin*.\*\*  
Date upon filing or later Month and Year

**Rules affecting workers' compensation insurance, claims processing, medical billing, and return-to-work assistance.**

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

**RULEMAKING ACTION**

List each rule number separately, 000-000-0000.

**ADOPT:** OAR 436-050-0025

**AMEND:** OAR:

436-001-0003	436-001-0252	436-009-0070	436-045-0003	436-050-0175	436-160-0330
436-001-0004	436-001-0265	436-009-0090	436-050-0002	436-050-0190	436-160-0340
436-001-0005	436-001-0296	436-015-0005	436-050-0003	436-050-0200	436-160-0350
436-001-0009	436-001-0300	436-015-0009	436-050-0005	436-050-0210	436-160-0360
436-001-0019	436-009-0004	436-015-0010	436-050-0008	436-050-0220	436-160-0410
436-001-0023	436-009-0008	436-015-0020	436-050-0045	436-110-0240	436-160-0430
436-001-0027	436-009-0010	436-015-0030	436-050-0050	436-110-0320	
436-001-0030	436-009-0015	436-015-0040	436-050-0100	436-110-0330	
436-001-0170	436-009-0020	436-015-0110	436-050-0110	436-160-0020	
436-001-0240	436-009-0030	436-030-0003	436-050-0120	436-160-0070	
436-001-0246	436-009-0040	436-040-0003	436-050-0170	436-160-0090	

**REPEAL:** OAR 436-040-0100

ORS 656.726(4) Statutory Authority \_\_\_\_\_ Other Authority \_\_\_\_\_

ORS chapter 656 Statutes being Implemented \_\_\_\_\_

**RULE SUMMARY**

**Amendments to OAR 436-001, "Procedural Rules for Rulemaking and Hearings":**

- Clarify the applicability of the rules (436-001-0003)
- Carry out ORS 183.335 by requiring notice to legislators about proposed rulemaking (436-001-0009)
- Clarify the requirements for and methods of requesting a hearing (436-001-0019)

## **Certificate and Order for Filing Permanent Administrative Rules**

- Clarify that parties only need to provide supplemental exhibits to the director's representative if the director has filed an entry of appearance; clarify that all exhibits offered will be included in the hearing file whether or not they are admitted into the evidentiary record (436-001-0240)
- Clarify that written exceptions to a proposed and final order should include argument (436-001-0246)
- Provide that a party may request that director review be stayed if there is a pending matter concerning a claim that may make the matter within the director's jurisdiction moot (436-001-0252)
- Change the time frame for submitting a statement of services from seven days of the hearing date to any time before an order is issued (436-001-0265)
- Allow the ALJ to issue a proposed and final order dismissing the request for hearing if the parties resolve all issues within the director's jurisdiction via a settlement or agreement (436-001-0170 & 0296)

### **Amendments to OAR 436-009, "Oregon Medical Fee and Payment Rules":**

- Adopt by reference updated medical fee schedules and resources for the payment of health care providers, except as otherwise provided in these rules (436-009-0004)
- Extend the time for an insurer to request that a health care provider refund an overpayment for a compensable medical service from 90 to 180 days from the payment date; if the provider fails to respond or disagrees that an overpayment occurred, the insurer may request review by the director within 90 days of requesting the refund (436-009-0008)
- Exclude lumbar artificial disc replacement from compensability except under specified conditions (436-009-0015)
- Remove electronic data interchange medical reporting requirements in Appendix B, because OAR 436-160 includes the "Medical Bill Data Element Requirement Table" (436-009-0030)
- Raise the evaluation/management conversion factor from \$59.79 to \$64.79; lower the surgery conversion factor from \$93.66 to \$86.44 (436-009-0040)
- Reduce the maximum allowable fee for medications from 88% of the average wholesale price (AWP) to 83.5% of AWP and reduce the dispensing fee from \$8.70 to \$2.00 (436-009-0090)

### **Amendments to OAR 436-015, "Managed Care Organizations":**

- Clarify MCO certification requirements by defining the terms "group" (of medical service providers) and "non-qualifying employer." (436-015-0005 & 0009)
- Require that if an MCO has not obtained contracts with more than one insurer within one year from the effective date of its first contract, the MCO must provide the director with a report documenting its efforts to obtain additional contracts (436-015-0009)
- Eliminate the requirement that a prospective MCO submit certain documentation within 120 days of the filing of the "Notice of Intent to Form" (436-015-0010 & 0030)
- Reduce the number of copies of MCO applications or plans that must be submitted to the director from four copies to one copy (436-015-0020 & 0030)
- Eliminate the requirement that a prospective MCO submit a certification of incorporation and a copy of the MCO by-laws with its application (436-015-0030)
- For the purpose of quarterly data reporting, require that MCOs submit National Provider Identification (NPI) numbers rather than Oregon license numbers for their member providers (436-015-0040)
- Update the wording of appeal rights notices that MCOs must provide to a worker and all other parties that may appeal an MCO's decision, to include updated department contact information, and that appeal time frames begin with the mailing date of the notice, not from the date notice is received by the party; simplify the process for making complaints about rule violations (436-015-0110)

### **Amendments to OAR 436-030, "Claim Closure and Reconsideration," 436-040, "Workers with Disabilities Program," and 436-045, "Reopened Claims Program":**

- Correct the applicability provisions in rules 030-0003, 040-0003, and 045-0003

## **Certificate and Order for Filing Permanent Administrative Rules**

- Repeal OAR 436-040-0100, “Suspension and Revocation of Authorization to Issue Guaranty Contracts,” because this rule duplicates OAR 436-050-0015

### **Amendments to OAR 436-050, “Employer/Insurer Coverage Responsibility”:**

- Abbreviate the definition of “complete records” and adequately describe the term in the context of several rules in division 050 (436-050-0005, 0110, & 0210)
- Clarify rights of parties to appeal department orders by deleting an unnecessary and potentially misleading provision, which implies that if an order is final it cannot be appealed (436-050-0008(5)(d))
- Adopt a rule to explain how the Workers’ Compensation Division will serve penalty orders (436-050-0025)
- To implement House Bill 2007, expand the definition of “owner of the private home” to include any person related by an Oregon registered domestic partnership (436-050-0045)
- Eliminate the provision that an employer’s cancellation of coverage with an insurer does not terminate a guaranty contract; relocate a provision regarding overlapping self-insurance certification and guaranty contract coverage to rule 0200 (436-050-0100 & 0200)
- Supplement and clarify the description of record-keeping requirements (436-050-0110)
- Eliminate the requirement to include workers’ social security numbers on lists of claims provided to the director when an insurer or self-insured employer transfers claims to a new processor/location (436-050-0110 & 0210)
- Require insurers and self-insured employers to keep written records as to whether supplemental disability benefits were approved or denied (436-050-0120 & 0220)
- Provide that excess insurance coverage may include a deductible endorsement acceptable to the director (436-050-0170)
- Increase the time for a self-insured municipality to provide its annual report to the director (436-050-0175)
- Require that self insured employers notify the director within 30 days when the employer changes its operation in any manner that affects its workers’ compensation claims liability (436-050-0190)
- Require that self-insured employers conduct certain claim processing activities and record-keeping, and accommodate periodic audits, at in-state locations (436-050-0210)
- Require that self-insured employers provide contact information to the director for the location where records are or will be kept and where claims are or will be processed in Oregon; require that self-insured employers provide the director contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director (436-050-0220)

### **Amendments to OAR 436-110, “Preferred Worker Program”:**

- Allow issuance of a Preferred Worker card to a worker determined eligible before claim closure, even if the worker does not have available, immediate employment (436-110-0320)
- Provide additional time for insurers to request claim cost reimbursement (from the Workers’ Benefit Fund) if an employer informs an insurer about an injury to a preferred worker after the existing reimbursement deadlines have passed (436-110-0330)

### **Amendments to OAR 436-160, “Electronic Data Interchange”:**

- Provide the director discretion to require a trading partner agreement for medical data reporting, but eliminate the mandate for trading partner agreements for all EDI (436-160-0020)
- Clarify and simplify address reporting requirements (436-160-0090)
- Eliminate the requirement to submit paper reports to add or delete coverage for non-subject workers; the insurer must file the appropriate “include” or “exclude” endorsement transaction to the associated policy filing (436-160-0340 & 0350)
- Require insurers to notify the director of guaranty contract terminations within ten days (not within seven days) consistent with requirements in OAR 436-050 (436-160-0360)

**Certificate and Order for Filing Permanent Administrative Rules**

- Eliminate the requirement that the insurer submit a cancellation of a medical bill before resubmitting (436-160-0430)
- Revise electronic data interchange medical reporting requirements in Appendix B (436-160-0410)

Direct questions to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; or e-mail [fred.h.bruyns@state.or.us](mailto:fred.h.bruyns@state.or.us). Rules are available on the Internet: <http://www.wcd.oregon.gov/policy/rules/rules.html>

For a copy of the rules, contact Publications at 503-947-7627, Fax 503-947-7630.

/s/ John L. Shilts

Authorized Signer

6/12/08

Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

\*With this original, file one photocopy of certificate, one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules.

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