



Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services
Workers' Compensation Division
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April 17, 2008

Proposed Changes to Workers' Compensation Rules

The Department of Consumer and Business Services, Workers' Compensation Division proposes changes to OAR chapter 436, affecting hearings before the director, medical services and fee schedules, managed care organizations, workers' compensation insurance coverage, insurers' record keeping and reporting, the Preferred Worker Program, and electronic data interchange of medical bill payment records.

Please review the attached documents for more information about proposed changes and possible fiscal impacts.

The department welcomes public comment on proposed changes and has scheduled a public hearing.

- When is the hearing?** May 19, 2008, 9:00 a.m.
- Where is the hearing?** Labor & Industries Building
350 Winter Street NE, Room 260 (2nd Floor),
Salem, Oregon 97301
- How can I make a comment?** Come to the hearing and speak, send written comments, or do both. Send written comments to:
Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Email - fred.h.bruyns@state.or.us
Phone - (503) 947-7717; Fax - (503) 947-7581

The closing date for written comments is May 22, 2008.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –

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

Or call (503) 947-7627 to get free paper copies

Questions?

Contact Fred Bruyns, (503) 947-7717.

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING
A Statement of Need and Fiscal Impact accompanies this form.

Department of Consumer and Business Services,
Workers' Compensation Division

OAR CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

Fred Bruyns^{FB}
Rules Coordinator

PO Box 14480, Salem, OR 97309-0405;
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RULE CAPTION

Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.

Hearing date	Time	Location	Hearings Officer
May 19, 2008	9:00 a.m.*	Room 260 (2 nd Floor, Labor & Industries Building) 350 Winter Street NE, Salem, Oregon	Fred Bruyns

***NOTE: The hearing will begin at 9:00 a.m. and end when all present who wish to testify have done so. Written testimony will be accepted through May 22, 2008.**

The site of the hearing is accessible for individuals with mobility impairments. Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

ADOPT: OAR 436-050-0025

AMEND: OAR 436-001, 436-009, 436-010, 436-015, 436-050, 436-160 and 436-030-0003, 436-040-0003, 436-045-0003, 436-110-0320, 436-110-0330, 436-110-0240^{FB}

REPEAL: OAR 436-040-0100

ORS 656.726(4)

Stat. Auth.

Other Authority

ORS chapter 656

Stats. Implemented

RULE SUMMARY

General changes to OAR chapter 436: The agency proposes to correct typographical and citation errors, delete duplicate requirements, clarify or relocate some provisions, and streamline processes. To the extent that these changes may substantially affect the meaning of the rules, they are described below.

The agency proposes to amend OAR chapter 436, division 001, "Procedural Rules Governing Rulemaking and Hearings." These proposed rules address: The applicability of the rules; notice of rulemaking; distribution of exhibits; content of exceptions; stay of director review; time limits for attorneys to submit statements of services; and administrative law judge authority to approve settlements and dismiss cases.

The agency proposes to amend OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules." These proposed rules address: Adoption of updated medical fee schedules and resources for the payment of health care providers; time frames for refunds of overpaid medical bills and related appeal rights; compensability of lumbar artificial disc replacements; electronic data interchange medical reporting requirements; adjustment of the conversion factors for evaluation/management (increase) and surgery (decrease); reduction of the maximum allowable fee for brand and generic drugs from 88% to 83.5% of the average wholesale price; and reduction of the dispensing fee from \$8.70 to \$2.00.

The agency proposes to amend OAR chapter 436, division 010, "Medical Services." These proposed rules address: Treatment and time-loss authority time limits applicable to several health care provider types; how the enrollment of a nonsubject worker in an MCO affects the worker's maximum number of choices of attending physician; contraindications to lumbar artificial disc replacement; and requirements for the worker's social security number on Form 827.

Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Department of Consumer and Business Services,
Workers' Compensation Division

OAR CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

In the Matter of)
The Amendment of OAR:)
436-001, Procedural Rules Governing Rulemaking and Hearings)
436-009, Oregon Medical Fee and Payment Rules)
436-010, Medical Services)
436-015, Managed Care Organizations)
436-030, Claim Closure and Reconsideration)
436-040, Workers with Disabilities Program)
436-045, Reopened Claims Program)
436-050, Employer/Insurer Coverage Responsibility)
436-110, Preferred Worker Program)
436-160, Electronic Data Interchange)

Rule Caption:

Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.

Statutory Authority: ORS 656.726(4)

Other Authority:

Statutes Implemented: ORS chapter 656

Need for the Rule(s): The agency is proposing changes: to update the medical fee schedules as required by ORS 656.248; to implement House Bill 2007 affecting domestic partners; to begin to implement Senate Bill 559 affecting how insurers report proof of workers' compensation insurance coverage to the agency; to establish standards for electronic data interchange of medical and coverage data; to ensure insurers and self-insured employers keep sufficient records in Oregon for agency audits; to streamline certain procedures affecting the Preferred Worker Program; and to make other changes consistent with the director's responsibilities under ORS 656.726(4).

Documents Relied Upon, and where they are available: "Issues" documents presented to stakeholder advisory committees; advisory committee meeting minutes; written advice from advisory committee members and other interested parties. These records are available for public inspection in the Administrator's Office, Workers' Compensation Division of the Department of Consumer and Business Services, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Please call (503) 947-7717 to request copies.

Fiscal and Economic Impact, including Statement of Cost of Compliance: Unless stated otherwise, references to "insurers" (below) include "self-insured employers." The following is a list of significant estimated fiscal/economic impacts on persons and organizations affected by OAR chapter 436:

OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules"

- Adoption by reference of Centers for Medicare & Medicaid Services (CMS) 2008 Medicare Resource-Based Relative Value Scale (RBRVS), Addendum B and Addendum C, 72 Federal Register No. 227, Nov. 27, 2007, as the fee schedule for payment of medical service providers, except as otherwise provided in the rules

The agency projects, due to some changes in the CMS relative value units for 2008, that adoption of the RBRVS would decrease overall medical payments that are subject to the RBRVS by approximately \$350,000, or -0.18%.

- Increasing the conversion factor for the service category "Evaluation/Management" (E&M) from \$59.79 to \$64.79 and decreasing the conversion factor for Surgery from \$93.66 to \$86.44

The agency projects an annual increase in E&M reimbursements of approximately \$2 million and a decrease in Surgery reimbursements of approximately \$2 million. Data available to the agency shows payments for E&M services average 9% above the maximums allowed during calendar year 2007, while payments for surgery average 26% below the maximums allowed. The purpose of these changes is to better align these components of the fee schedule with reimbursement generally received for the services provided, as required under ORS 656.248(1); in addition, access to high quality E&M services is critical in promoting early, effective treatment, improving long-term outcomes, and promoting early return to work.

- Maintaining the other conversion factors at 2007 levels

Overall, the agency projects that keeping the conversion factors at 2007 levels will result in reduced net income for some medical providers, because providers' business costs are rising. Between 2006 and 2007, the Physicians' Services Component of the Consumer Price Index increased by 4.04%. Relative to increasing the conversion factors by the 2006-2007 CPI increase, 4.04% is the approximate, potential, maximum effect on Oregon medical providers as a whole; effects on individual providers may be more or less depending on the types of services provided. However, available medical billing data shows that average payments in the following service categories are below the maximums allowed during calendar year 2007: Surgery, Radiology, Lab & Pathology, Medicine, Physical Medicine and Rehabilitation, and Multidisciplinary/Other Oregon-Specific Codes. For those medical providers that bill below the maximums, maintaining the 2007 levels will have no direct fiscal impact.

- Reducing the maximum allowable fee for brand and generic drugs from 88% to 83.5% of the average wholesale price (AWP); reducing the dispensing fee from \$8.70 to \$2.00

Under ORS 656.248(1), the director must adopt fee schedules that “* * * represent reimbursement generally received for the services provided.” The proposed rates are more consistent with rates paid for brand name drugs in other parts of the health care system, while generic drug fees would remain above fees under some widely accepted benefit plans. The agency projects that proposed rule changes would reduce annual drug payments by approximately \$3.6 million, or 21.8% of total pharmacy payments.

- Restricting compensability of lumbar artificial disc replacements

Under ORS 656.245(3), the director may exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded, or experimental. Based on the advice of the Medical Advisory Committee, the director proposes to exclude artificial disc replacements from compensability unless the devices and the patients meet specific conditions – with the goal to improve patient outcomes. Improved patient outcomes should lower overall medical costs paid by insurers. Restrictions affecting artificial disc replacement could have a slight negative fiscal impact on surgeons who perform disc replacements, though surgeons may perform other procedures on patients that do not meet the criteria for disc replacement. Artificial disc replacement is not a commonly used procedure, so the overall fiscal impact should be small.

OAR chapter 436, division 010, “Medical Services”

- Contraindications to lumbar artificial disc replacement

See analysis under OAR 436-009 regarding “Restricting compensability of lumbar artificial disc replacements”

OAR chapter 436, division 015, “Managed Care Organizations” (MCOs)

- Reduced documentation requirements for prospective MCOs (applicants)

The agency projects a small savings for applicant MCOs.

OAR chapter 436, division 050, “Employer/Insurer Coverage Responsibility”

- Required record-keeping for supplemental disability benefits (SDB)

The agency projects that insurers that have elected to process SDB will incur small initial costs to establish record-keeping procedures, plus some on-going costs to track eligibility and payments. The

majority of insurers have elected to refer affected claims to the agency's contracted agent for processing; for these companies there would be no fiscal impact. The few companies that process their own SDB claims are reimbursed by the agency for SDB claims costs from the Workers' Benefit Fund. Included in these reimbursements is an administrative cost factor, most recently 17.15%, which is intended to cover the costs to process claims, including associated record-keeping.

OAR chapter 436-110, "Preferred Worker Program"

- Issuance of Preferred Worker cards to workers determined eligible before claim closure
The agency projects a small positive fiscal impact on affected workers - those who can receive Preferred Worker cards earlier and use them to obtain employment.
 - Expanded time frames for insurers to request claim cost reimbursement from the Workers' Benefit Fund
The agency projects a small positive fiscal impact on employers whose insurers can obtain reimbursement of claims costs even if the insurer is informed about eligibility late – after existing deadlines for requesting reimbursement would have expired. Affected insurers would reimburse their insured employers for any premiums and premium assessments paid during the premium exemption period.
-

Regarding additional proposed changes to chapter 436, including amendments to OAR 436-001, 030, 040, 045, and 160

The agency estimates that additional changes will not have a significant economic impact on any persons or businesses, including small businesses.

How were small businesses involved in the development of this rule?

Representatives of small businesses participated in the stakeholder advisory committee. Small businesses affected by these rules are primarily medical providers and pharmacies.

Cost of compliance effect on small businesses:

Estimated number of small businesses subject to the proposed rule:

Based on available data, we estimate approximately 12,000 medical providers and 110 pharmacies are small businesses, as defined in ORS 183.310(10).

Identify the types of businesses and industries with small businesses subject to the proposed rule:

Oregon medical providers
Oregon pharmacies

Describe the projected reporting, record-keeping and other administrative activities required for compliance with the proposed rule, including costs of professional services:

Reporting: The proposed changes do not require increased reporting for small businesses.

Record-keeping: The proposed changes do not require increased record-keeping for small businesses.

Other administrative activities and costs of professional services:

The agency projects that, due to some changes in the Centers for Medicare & Medicaid Services (CMS) relative value units for 2008, adoption of the CMS schedule would decrease overall medical payments that are subject to the schedule by approximately \$350,000, or -0.18%.

The agency projects that increasing the conversion factor for the service category Evaluation/Management (E&M) from \$59.79 to \$64.79 will increase reimbursements for E&M services by approximately \$2 million.

The agency projects that decreasing the conversion factor for Surgery from \$93.66 to \$86.44 will decrease reimbursements for surgical services by approximately \$2 million.

Overall, the agency projects that keeping the remaining conversion factors at 2007 levels will result in reduced net income for some medical providers, because providers' business costs are rising. Between 2006 and 2007, the Physicians' Services Component of the Consumer Price Index increased by 4.04%. Relative to increasing the conversion factors by the 2006-2007 CPI increase, 4.04% is the approximate, potential, maximum effect on Oregon medical providers as a whole; effects on individual providers may be more or less depending on the

Statement of Need and Fiscal Impact
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types of services provided. However, available medical billing data shows that average payments in the following service categories are below the maximums allowed during calendar year 2007: Surgery, Radiology, Lab & Pathology, Medicine, Physical Medicine and Rehabilitation, and Multidisciplinary/Other Oregon-Specific Codes. For those medical providers that bill below the maximums, maintaining the 2007 levels will have no direct fiscal impact.

The agency projects that reducing the maximum allowable fee for drugs from 88% to 83.5% of the average wholesale price, and reducing the dispensing fee from \$8.70 to \$2.00 would reduce annual drug payments by approximately \$3.6 million, or 21.8% of total pharmacy payments.

Extent of economic impact: The proposed changes to the conversion factors and pharmacy fees for brand name drugs would better align the medical fee schedules with reimbursement generally received for the services provided, as required under ORS 656.248(1). The proposed changes to pharmacy fees for generic drugs continue to provide a significantly higher reimbursement than some widely accepted pharmacy benefit plans. There is no basis to say that economic impacts would be “significantly adverse” (under ORS 183.540), but we invite public testimony on the probable extent of the impact.

Identify equipment, supplies, labor and increased administration required for compliance with the proposed rule:

Equipment: The proposed changes do not require the purchase of equipment to achieve compliance.

Supplies: The proposed changes do not require the purchase of supplies to achieve compliance.

Labor: The proposed changes do not require that small businesses hire additional staff to achieve compliance.

Administration: The proposed changes do not require increased administration to achieve compliance.

Extent of economic impact: There is no basis to say that any impacts would be “significantly adverse” (under ORS 183.540), but we invite public testimony on the probable extent of the impact.

Administrative Rule Advisory Committee consulted:

Yes, advisory committees met on Jan. 25, Feb 11, and Feb. 25, 2008.

The agency asked the committees for advice on the economic impacts of the discussed changes, including impacts on small businesses.

/s/ John L. Shilts

4/10/08

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION



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

Proposed Rules

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Revisions are marked as follows:

Deleted text has a "strike-through" style, as in	Deleted
Added text is bold and underlined, as in	<u>Added</u>

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

ORDER NO. XX-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed **ELECTRONIC DATA INTERCHANGE Rules**

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

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

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

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***Proposed* ELECTRONIC DATA INTERCHANGE Rules**

if the data element is omitted or submitted in a format not capable of being processed by the division's information processing system.

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

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

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

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

(7) "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.iaaiabc.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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***Proposed* ELECTRONIC DATA INTERCHANGE Rules**

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

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WORKERS' COMPENSATION DIVISION
Proposed ELECTRONIC DATA INTERCHANGE Rules

- (d) Specific identifying information for insurer, third party administrator, if any, and vendor, if any;
- (e) Cost allocation of transactions, if any;
- (f) The time frame for the director to submit acknowledgements of transmissions; and
- (g) Any other necessary statements, conditions or requirements to facilitate EDI.

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

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

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* ELECTRONIC DATA INTERCHANGE Rules**

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

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

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 84.013 and ORS 656.264

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

436-160-0060 Testing Procedures and Requirements

(1) Proof of coverage testing:

(a) 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.

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(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.

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

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Stat. Implemented: ORS 84.001-84.061 and ORS 656.264
Hist: Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx

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.

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

~~(1) The physical (street) address, or an attention line, must be in address line one. The attention line, if used, must be in line one.~~

~~(2) If the physical address is used in address line one, the mailing address may be used in address line two. If address line one was used as the attention line, then the physical (street) address must be in address line two.~~

~~(3) Physical (street) address and attention line must be on separate address lines.~~

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Adopted 3/17/03 as Admin. Order 03-052, eff. 4/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx

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

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

(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.

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

Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx

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

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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 ~~written notice to the director listing the individual names as required by ORS 656.419~~ **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 12/3/03 as Admin. Order 03-064, eff. 1/1/04

Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx

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 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.

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(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 ~~under ORS 656.419(2)(d)~~, 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* ~~*(sections 3, 4, & 5, chapter 170, Oregon Laws 2003)~~

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

Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx

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 ~~seven~~ **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 ~~pursuant to~~ **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 ~~seven~~ **ten** calendar days after the effective date of termination by transmitting the transaction type for cancellation ~~or~~, nonrenewal, **or delete jurisdiction** pursuant to section (5) below; and

(b) Provide written notice to the employer ~~pursuant to~~ **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.

~~(5) If the intent of an insurer is to terminate guaranty contract liability for all insureds under a policy, the insurer must use a cancellation or nonrenewal transaction type and must report all covered employers.~~

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~~(6) Delete jurisdiction transactions are not capable of being processed by the division's information processing system and will result in a transaction rejected acknowledgement being sent to the sender.~~

~~(7)~~ **(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*~~*(sections 3, 4, & 5, chapter 170, Oregon Laws 2003)~~

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

Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx

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

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.

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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 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) To report changes or corrections of an original bill, the insurer must first submit a cancellation of the original bill and then a replacement transaction with the corrected information.~~

~~(3)~~**(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 xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx

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

Data element	Data Element Number	Establishing document transactions	Endorsement	Cancellation or Nonrenewal by Insurer	Cancellation or Nonrenewal by Insured	Reinstatement
INSURED RECORD						
Transaction Set ID	DN001	M	M	M	M	M
Record Sequence Number	DN107	M	M	M	M	M
Transaction Set Purpose Code	DN300	M	M	M	M	M
Jurisdiction Designee Received Date	DN302	M	M	M	M	M
Transaction Set Type Code	DN002	M	M	M	M	M
Transaction Reason Code	DN303	M	M	M	M	M
Transaction Set Type Effective Date	DN304	M	M	M	M	M
Insurer FEIN	DN006	M	M	M	M	M
Insurer Name	DN007	M	O	O	O	O
Issuing Office Name	DN305	O	O	O	O	O
Issuing Office Address Line 1	DN306	O	O	O	O	O
Issuing Office Address Line 2	DN307	O	O	O	O	O
Issuing Office City	DN308	O	O	O	O	O
Issuing Office State	DN309	O	O	O	O	O
Issuing Office Postal Code	DN310	O	O	O	O	O
Issuing Agency Name	DN311	O	O	O	O	O
Issuing Agency City	DN312	O	O	O	O	O
Issuing Agency State	DN313	O	O	O	O	O
Insured FEIN	DN314	M	M	M	M	M
Insured Name	DN017	M	M	M	M	M
Insured Address Line 1	DN315	M	O	O	O	O
Insured Address Line 2	DN316	O	O	O	O	O
Insured City	DN317	M	O	O	O	O
Insured State	DN318	M	O	O	O	O
Insured Postal Code	DN319	M	O	O	O	O
Insured Telephone Number	DN320	O	O	O	O	O
Business Market	DN321	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
EMPLOYER RECORD						
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:

Note: This table is repeated in OR 436-009 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
513	Admission Date	C	OC	OC	If Billing Format Code equals "A" and patient has been admitted. 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	0C	0C	If Billing Format Code equals "A" and patient has been admitted. If DN 504 Facility Code = 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89.
564	Basis of Cost Determination Code	C	0C	0C	If a pharmacy bill submitted on universal claim form/NCPDP format. Required for pharmacy bills.
545	Bill Adjustment Amount	C	0C	0C	If paid amount is not equal to billed amount. If DN516 Total Amount Paid Per Bill is not equal to DN501 Total Charge Per Bill
543	Bill Adjustment Group Code	C	0C	0C	If paid amount is not equal to billed amount. If DN516 Total Amount Paid Per Bill is not equal to DN501 Total Charge Per Bill
544	Bill Adjustment Reason Code	C	0C	0C	If paid amount is not equal to billed amount. If DN516 Total Amount Paid Per Bill is not equal to DN501 Total Charge Per Bill
546	Bill Adjustment Units	C	0C	0C	If paid amount is not equal to billed amount. 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	0M	
629	Billing Provider FEIN	0M	0M	0M	If provider has no NPI, report FEIN plus State License Number.
528	Billing Provider Last/Group Name	0M	0M	0M	If different than Rend. Bill Prov. Last/Grp Name
537	Billing Provider Primary Specialty Code	0O	O	O	If applicable.
630	Billing Provider State License Number	C	0C	0C	If provider has no NPI, If DN634 Billing Provider National Provider ID is blank , report FEIN plus 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	0M	0M	0M	If not available, use default of all 9s.
634	Billing Provider National Provider ID	C	0C	C	If provider has an NPI, it must be reported; otherwise, report the provider FEIN. Must be reported if billing provider has an NPI.
502	Billing Type Code	C	0C	0C	If Billing Format Code equals "B" and prescriptions or durable medical equipment are billed. 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	
					If the Claim Administrator FEIN is different than Insurer FEIN. If different than DN6 Insurer

Bill Submission Reason Codes

DN	Data Element Name	00	01	05	Mandatory Trigger or Implementation Note
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					FEIN
188	Claim Administrator Name	C	ΘC	ΘC	If the Claim Administrator name is different than Insurer name: <u>If different than DN7 Insurer name</u>
515	Contract Type Code	M	M	M	
512	Date Insurer Paid Bill	M	ΘM	ΘM	
511	Date Insurer Received Bill	M	ΘM	ΘM	
31	Date of Injury	M	ΘM	ΘM	
554	Days/Units Billed	C	ΘC	ΘC	If Jur. Proc. Billed Code or HCPCS Line Proc. Billed Code are present or Billing Type Code = DM, or a drug is dispensed by a physician during an office visit. <u>If DN559 Revenue Billed Code is present. Required when SV1, SV2 and SV5 segments are used.</u>
553	Days/Units Code	C	ΘC	ΘC	If Jur. Proc. Billed Code or HCPCS Line Proc. Billed Code are present or Billing Type Code = DM, or a drug is dispensed by a physician during an office visit. <u>If DN554 Days/Units Billed is present. Required when SV1, SV2 and SV5 segments are used.</u>
557	Diagnosis Pointer	C	ΘC	ΘC	If Billing Format Code equals "B" and Jur. Proc. Billed Code or HCPCS Line Proc. Billed Code is present or a drug is dispensed by a physician during an office visit. <u>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.</u>
514	Discharge Date	C	ΘC	ΘC	If <u>DN503</u> Billing Format Code equals "A" and patient has been discharged
562	Dispense As Written Code	C	ΘC	ΘC	If a pharmacy bill submitted on universal claim form/NCPDP format. <u>Required for pharmacy bills (when SV4 segment is present.)</u>
567	DME Billing Frequency Code	C	ΘC	ΘC	If <u>DN502</u> Billing Type Code = DM and <u>DN565</u> Total Chg. per Line - Rental is present. <u>Use the SV5 segment for DME rental and purchase services billed.</u>
518	DRG Code	ΘO	O	O	If Billing Format Code equals "A"
563	Drug Name	O	O	O	
572	Drugs/Supplies Billed Amount	C	ΘC	ΘC	If <u>DN502</u> Billing Type Code, value is "RX" or "MO". <u>DN572 is required in the SV4/AMT segment.</u>
579	Drugs/Supplies Dispensing Fee	C	ΘC	ΘC	If a pharmacy bill submitted on universal claim form/NCPDP format. <u>Required for pharmacy bills.</u>

Bill Submission Reason Codes

DN	Data Element Name	00	01	05	Mandatory Trigger or Implementation Note
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571	Drugs/Supplies Number of Days	C	0C	0C	If DN502 Billing Type Code, value is "RX" or "MO".
570	Drugs/Supplies Quantity Dispensed	C	0C	0C	If DN502 Billing Type Code, value is "RX" or "MO".
152	Employee Employment Visa	C	0C	0C	If DN42 Employee Social Security number or DN153 Employee Green Card number is not available.
44	Employee First Name	M	0M	0M	
153	Employee Green Card	C	0C	0C	If DN42 Employee Social Security number is not available.
154	Employee ID Assigned by Jurisdiction	C	0C	0C	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	0M	0M	
156	Employee Passport Number	C	0C	0C	If DN42 Employee Social Security, DN153 Employee Green Card, or DN152 Employee Employment Visa not available.
42	Employee Social Security Number	C	0C	0C	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" . call WCD to receive Jurisdiction Assigned ID Number for reporting purposes
18	Employer Name	M	M	M	
504	Facility Code	C	C	0C	If DN503 Billing Format Code = "A"
678	Facility Name	C	0C	0C	If service performed in a licensed facility
682	Facility National Provider ID	C	0C	0C	If service performed in a licensed facility
737	HCPCS Bill Procedure Code	C	0C	0C	If DN503 = "A" and if DN626 HCPCS Prin. Procedure Billed Code is present and more than one procedure is performed
714	HCPCS Line Procedure Billed Code	C	0C	0C	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	0C	0C	If different than DN714 HCPCS Line Proc. Billed Code
717	HCPCS Modifier Billed Code	0C	O	O	If HCPCS Line Proc. Billed Code is modified. If present, must be a valid code.
727	HCPCS Modifier Paid Code	C	0C	0C	If HCPCS Line Proc. Paid Code is modified. If different than DN 717 HCPCS Modifier Billed Code
626	HCPCS Principal Procedure Billed Code	0C	O	O	If Billing Format Code is "A" and the code value is not an ICD-9 code. For surgical bills only. Must be reported if included on provider's bill.

Bill Submission Reason Codes

DN	Data Element Name	00	01	05	Mandatory Trigger or Implementation Note
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736	ICD-9 CM Procedure Code	C	0C	0C	If ICD-9 CM Prin. Proc. Code is present and more than one procedure is performed 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	0C	0C	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	0C	O	O	If Billing Format Code is "A" and the code value is not a HCPCS code. For surgical bills only. 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	0C	0C	If the first report of injury has been filed and a jurisdictional claim number is available has been returned to the insurer.
718	Jurisdictional Modifier Billed Code	0C	O	O	If Jur. Proc. Billed Code is modified N/A; Oregon has no jurisdictional modifiers
730	Jurisdictional Modifier Paid Code	0C	O	O	If different than Juris. Mod. Billed Code N/A; Oregon has no jurisdictional modifiers
715	Jurisdictional Procedure Billed Code	C	0C	0C	If the procedure is included as an Oregon-specific code in the Oregon Medical Fee Schedule
729	Jurisdictional Procedure Paid Code	C	0C	0C	If different than DN715 Jurisdiction Procedure Billed Code
547	Line Number	M	0M	0M	Required in Loop 2400/LX segment.
208	Managed Care Organization Identification Number	C	0C	0C	If worker enrolled at time of service.
721	NDC Billed Code	C	0C	0C	If a pharmaceutical bill or a drug is dispensed by a physician during an office visit.
728	NDC Paid Code	C	0C	0C	If different than DN721 NDC Billed Code
555	Place of Service Bill Code	C	C	0C	If DN503 Billing Format Code equals "B"
600	Place of Service Line Code	C	0C	0C	If different than Place of Svc. Billed Code and not a pharmacy bill If DN 503 Billing Format Code equals "B" and if different than DN555 Place of Svc. Billed Code and not a pharmacy bill
527	Prescription Bill Date	O	O	O	
604	Prescription Line Date	C	0C	0C	If a pharmacy bill submitted on universal claim form/NCPDP format Required if SV4 is present.
561	Prescription Line Number	C	0C	0C	If a pharmacy bill submitted on universal claim form/NCPDP format Required if SV4 is present.
521	Principal Diagnosis Code	C	0C	0C	If DN503 Billing Format Code equals "A"

Bill Submission Reason Codes

DN	Data Element Name	00	01	05	Mandatory Trigger or Implementation Note
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550	Principal Procedure Date	C	0C	0C	If Billing Format Code equals "A" and if ICD-9 CM Prin. Proc. Code or HCPCS Prin. Proc. Billed Code is present Required if DN626 HCPCS Principal Procedure Code or DN525 ICD-9 CM Principal Procedure Code are present.
524	Procedure Date	C	0C	0C	If Billing Format Code equals "A" and more than one surgical procedure was performed Required if DN736 ICD-9 CM Principal Procedure Code or DN737 HCPCS Bill Procedure Code are present.
507	Provider Agreement Code	MC	0C	0C	Enter the value "P" if the injured worker is enrolled in a Managed Care Organization at time of service
642	Rendering Bill Provider FEIN	00	O	00	If provider has no NPI, report FEIN plus State License Number
638	Rendering Bill Provider Last/Group Name	M	0M	0M	
647	Rendering Bill Provider National Provider ID	C	0C	C	If provider has an NPI, it must be reported; otherwise, report the provider FEIN
651	Rendering Bill Provider Primary Specialty Code	MO	O	O	
643	Rendering Bill Provider State License Number	C	0C	0C	If provider has no NPI, report FEIN plus State License Number If DN 647 Rendering Bill Provider National Provider ID is blank, DN643 Rendering Bill Provider State License Number must be reported. If provider type not licensed by the state (e.g. pharmacy, durable medical), use "99999."
586	Rendering Line Provider FEIN	00	O	00	If provider has no NPI, report FEIN plus State License Number
592	Rendering Line Provider National ID	C	0C	C	If provider has an NPI, it must be reported, otherwise, report the provider FEIN.
595	Rendering Line Provider Primary Specialty Code	00	O	O	If different than Rend. Bill Prov. Prim. Spec. Code
599	Rendering Line Provider State License Number	C	0C	0C	If provider has no NPI, report FEIN plus State License Number 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	0C	0C	If a value for DN504 Facility Code with 1st digit equal to 1
576	Revenue Paid Code	C	0C	0C	If different than DN559 Revenue Billed Code
					If applicable. Required if DN552 Total Charge per Line is different than DN574 Total

Bill Submission Reason Codes

DN	Data Element Name	00	01	05	Mandatory Trigger or Implementation Note
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		Original	Cancellation	Replace	
					Amount Paid per Line.
731	Service Adjustment Group Code	C	⊖C	⊖C	If applicable. Required if DN552 Total Charge per Line is different than DN574 Total Amount Paid per Line.
732	Service Adjustment Reason Code	C	⊖C	⊖C	If applicable. 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	If not a pharmacy bill submitted on universal claim form/NCPDP format 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 billed amount DN552 Total Charge per Line.
501	Total Charge Per Bill	M	M	M	
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 No. Number