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

Effective Oct. 1, 2014

TABLE OF CONTENTS

Rule **Page**

436-160-0001 Authority, Applicability, Purpose, and Administration of these Rules 1
436-160-0004 Adoption of Standards 1
436-160-0005 General Definitions 1
436-160-0040 Recognized Received Date 3
436-160-0060 Testing Procedures and Requirements 3
436-160-0405 Insurers' Reporting Responsibilities 4
436-160-0410 Electronic Medical Bill Data Transmission and Format Requirements 4
436-160-0415 Oregon ASC X12 837 Medical Bill Data Reporting Requirements 5
436-160-0420 Medical Bill Acknowledgement 6
436-160-0430 Medical Bill Data Changes 7
436-160-0440 Monitoring and Auditing Insurers 7
436-160-0445 Assessment of Civil Penalties 7
Appendix A and Appendix B (OAR 436-160-0410) 8
ORDER OF ADOPTION 38

Blank page for two-sided printing

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 160

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

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

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

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

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

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

Stat. Authority: ORS 656.264 and 656.726(4)
Stat. Implemented: ORS ch. 84, 656.264
Hist: Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temporary rule - repealed 7/10/14)
Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14

436-160-0004 Adoption of Standards

(1)(a) The director adopts, by reference, IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2.0, dated Feb 1, 2014.

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

(2) The form, format, and delivery of data elements reported and definitions will conform to the standards adopted under section (1), unless otherwise provided in these rules.

(3) Copies of the guides in section (1) are available for review during regular business hours at the Workers' Compensation Division, Operations Section, 350 Winter Street NE, Salem OR 97301, 503-947-7717.

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

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

Stat. Authority: ORS 656.264; Stat. Implemented: ORS 656.264
Hist: Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temporary rule - repealed 7/10/14)
Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14

436-160-0005 General Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

(17) "Mandatory data element" means an element that will cause a rejection of a transaction if the data element is omitted or submitted in an invalid format, or with an improper value.

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

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

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

(21) "Record" means electronic record.

(22) "Trading partner" means the entity sending electronic data interchange (EDI) transactions to the division. Trading partners may include vendors or insurers.

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

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

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

Stat. Authority: ORS 656.264 and ORS 656.726(4);
Stat. Implemented: ORS 84.004 and ORS 656.264
Hist: Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temporary rule - repealed 7/10/14)

436-160-0040 Recognized Received Date

An electronic record is received when:

(1) The record enters the division's designated information processing system;

(2) All the required data elements and electronic records are in the form and format specified in these rules in the proper sequence; and

(3) The record can be fully processed by the division's information processing system.

Stat. Authority: ORS 656.264 and ORS 656.726(4)
Stat. Implemented: ORS 84.043 and ORS 656.264
Hist: Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temporary rule - repealed 7/10/14)

436-160-0060 Testing Procedures and Requirements

Testing and transition to production:

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

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

(3) Test files will be evaluated in terms of whether the data sent was received in the correct standardized format and fully processed by the division's information processing system.

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

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

(a) Accomplish secure file transfer protocol (SFTP) uploads and downloads;

(b) Demonstrate the ability to send transmissions to the division that are in the correct format and can be processed through the division's information processing system;

(c) Resolve any consistently recurring errors, and demonstrate the ability to correct and resubmit corrections to errors identified by the division;

(d) Send transmissions to the division that do not result in a 999 acknowledgment indicating a rejection;

(e) Send transmissions to the division without transaction level technical errors;

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

(g) Achieve an acceptance rate of at least 90 percent.

Stat. Authority: ORS 656.726(4);
Stat. Implemented: ORS 84.013 and ORS 656.264
Hist: Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temporary rule - repealed 7/10/14)

436-160-0405 Insurers' Reporting Responsibilities

(1) Insurers with an average of at least 100 accepted disabling claims per year, based on the average accepted disabling claim volume for the previous three calendar years, are required to electronically submit detailed medical bill payment data to the Department of Consumer and Business Services under OAR 436-160-0415.

(2) The director will notify an insurer when the insurer has reached a three-year average accepted disabling claim count of at least 100. The insurer is required to report medical bill payment data beginning with the date specified in the notice and must continue to report in subsequent years.

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

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

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

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Adopted 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temporary rule - repealed 7/10/14)

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

(1) The transmission data and format requirements are included in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2.0 (Feb 1, 2014), and Appendices A and B of these rules. Oregon-specific information can be found on the division's Electronic Data EDI webpage: http://www.cbs.state.or.us/wcd/operations/edi/ediindex.html.

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

(a) Appendix A shows all medical bill data elements accepted by EDI in Oregon, and whether the data element is "Fatal Technical" (F), "Mandatory" (M), "Mandatory Conditional" (MC), "If

Applicable/Available with Item Reject if Invalid" (AR), or "If Applicable/Available with Item Accept if Invalid" (AA) for each transaction type.

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

(3) Unless otherwise provided in these rules, the data elements must have the meaning provided in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2.0, dated Feb. 1, 2014, Section 2; Health Care Claim (837).

(4) Transactions will be rejected if "Fatal Technical," "Mandatory," or "Mandatory Conditional" data elements are omitted, or include invalid values.

(5) Transactions will be rejected if "If Applicable/Available with Item Reject if Invalid" data elements include invalid values.

(6) Invalid "If Applicable/Available with Item Accept if Invalid" data elements will be ignored if they are included in a transaction.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 2/13/14 as WCD Admin. Order 14-050, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temporary rule - repealed 7/10/14)
Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14

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

(1) Event reporting requirements:

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

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

(c) Transactions must be received and accepted by the division within 60 days of either the date paid or the date denied to be considered timely reported. If a transaction is initially rejected it must be corrected, resubmitted, and accepted within the original 60 day time period to be considered timely reported.

(d) Cancellations must be reported as soon as the payer knows that a medical bill was sent in error.

(e) Corrections/Replacements must be reported within 60 days of changes to any of the "Fatal Technical," "Mandatory," or "Mandatory Conditional" data elements in Appendices A and B.

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

(2) Data reporting requirements are described in Appendices A and B.

(3) Technical requirements are described on the division's Electronic Data EDI webpage for specifications on the Secure File Transfer Protocol (SFTP) requirements.

(4) Data Quality: The director will conduct electronic edits for blank or invalid data. Affected insurers are responsible for pre-screening the data they submit to check that all the required information is reported and is formatted correctly. OAR 436-160-0420 describes the acceptance or rejection protocol

for all reported medical bills. The insurer is responsible for timely correcting and resubmitting all rejected transactions for which law or rule require filing, reporting, or notice to the director.

(5) An insurer must request and receive authorization from the director to stop submitting a previously rejected transaction when the division determines the transaction is uncorrectable.

(6) The director will periodically review reported bill data to monitor insurer performance. If the director finds repeated or egregious violations of the reporting requirements of these rules the director may issue civil penalties under OAR 436-160-0445 and ORS 656.745.

(a) Medical bills must be reported timely. "Timely" means that an insurer reports medical bills as required by OAR 436-160-0415(1).

(b) Medical bills must be reported accurately. "Accurately" means that the reported medical bill data accepted by the division conforms to the reporting requirements of the Appendices A and B.

(c) The insurer may be subject to penalties for any reported medical bills that have not been accepted by the division or designated as uncorrectable under OAR 436-160-0415(5) within 180 days of the date of bill payment or denial.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Adopted 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temporary rule - repealed 7/10/14)
Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14

436-160-0420 Medical Bill Acknowledgement

(1)(a) The sender is expected to retrieve both TA1 and 999 interchange and functional acknowledgements (as defined by ASC X12) for each medical bill file submitted, unless technical errors in the file prevent 999 processing. In addition, the sender is expected to retrieve the 824 detailed acknowledgement, as defined by IAIABC Release 2.0 (Feb.1, 2014) for each medical bill file submitted, if at least one transaction has successfully passed the 999 edits.

(b) The detailed acknowledgement will indicate either an item accepted (IA) or an item rejected (IR) acknowledgement for each individual transaction.

(2) A TA1, 999 or 824 acknowledgement will be available for all transactions the division is unable to process, including but not limited to:

(a) An omitted mandatory data element;

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

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

(d) Illogical data in mandatory or required conditional field, e.g., payment date is after reporting date;

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

(f) Invalid bill submission reason code; or

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

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

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

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Amended 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temporary rule - repealed 7/10/14)
Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14

436-160-0430 Medical Bill Data Changes

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

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

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

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Amended 6/12/08 as Admin. Order 08-059, eff. 7/1/08
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temporary rule - repealed 7/10/14)

436-160-0440 Monitoring and Auditing Insurers

(1) The director may monitor and conduct periodic audits of medical bill data to ensure compliance with ORS chapter 656 and these rules.

(2) All records maintained or required to be maintained must be disclosed upon request by the director.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.254, 656.264, 656.455, 656.726
Hist: Adopted 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temporary rule - repealed 7/10/14)

436-160-0445 Assessment of Civil Penalties

(1) Under ORS 656.745, the director may assess a civil penalty against an insurer that fails to comply with ORS chapter 656 or the director's rules and orders.

(2) The insurer is responsible for its own actions as well as the actions of others acting on the insurer's behalf. If an insurer or someone acting on the insurer's behalf violates any provisions of these rules, the director may impose a civil penalty against the insurer.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.254, 656.745
Hist: Adopted 10/1/10 as WCD Admin. Order 10-057, eff. 1/1/11
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temporary rule - repealed 7/10/14)

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

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

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Transaction Set Header - Required Loop																		
0532	BHT03	ORIGINATOR TRANSACTION IDENTIFICATION NUMBER	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0100	BHT04	DATE TRANSMISSION SENT	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0101	BHT05	TIME TRANSMISSION SENT	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 1000A - Submitter Information - Required Loop																		
0098	NM109	SENDER ID	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 1000B - Receiver Information - Required Loop																		
0099	NM109	RECEIVER ID	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 2000A - Insurer Hierarchical Level Information - Required Loop																		
0615	DTP03	REPORTING PERIOD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Loop ID 2010AA - Insurer/Self Insured Information - Required Loop																		
0007	NM103	INSURER NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0006	NM109	INSURER FEIN	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0616	N403	INSURER POSTAL CODE	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Loop ID 2010AB - Claim Administrator Information - Situational Loop																		
0188	NM103	CLAIM ADMINISTRATOR NAME	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0187	NM109	CLAIM ADMINISTRATOR FEIN	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0014	N403	CLAIM ADMINISTRATOR MAILING POSTAL CODE	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
Loop ID 2010BA - Employer Information - Required Loop																		
0018	NM103	EMPLOYER NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0016	NM109	EMPLOYER FEIN	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0019	N301	EMPLOYER PHYSICAL PRIMARY ADDRESS	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0020	N302	EMPLOYER PHYSICAL SECONDARY ADDRESS	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0021	N401	EMPLOYER PHYSICAL CITY	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0022	N402	EMPLOYER PHYSICAL STATE CODE	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0023	N403	EMPLOYER PHYSICAL POSTAL CODE	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0164	N404	EMPLOYER PHYSICAL COUNTRY CODE	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
Loop ID 2000C - Claimant Hierarchical Information - Required Loop																		
0031	DTP03	DATE OF INJURY	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2010CA - Claimant Information - Required Loop																		
0043	NM103	EMPLOYEE LAST NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0044	NM104	EMPLOYEE FIRST NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0045	NM105	EMPLOYEE MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0255	NM107	EMPLOYEE LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0042	NM109	EMPLOYEE SSN	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0153	NM109	EMPLOYEE GREEN CARD	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0154	NM109	EMPLOYEE ID ASSIGNED BY JURISDICTION	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0156	NM109	EMPLOYEE PASSPORT NUMBER	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0152	NM109	EMPLOYEE EMPLOYMENT VISA	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0046	N301	EMPLOYEE MAILING PRIMARY ADDRESS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0047	N302	EMPLOYEE MAILING SECONDARY ADDRESS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0048	N401	EMPLOYEE MAILING CITY	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0049	N402	EMPLOYEE MAILING STATE CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0050	N403	EMPLOYEE MAILING POSTAL CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0155	N404	EMPLOYEE MAILING COUNTRY CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0052	DMG02	EMPLOYEE DATE OF BIRTH	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0053	DMG03	EMPLOYEE GENDER CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0015	REF02	CLAIM ADMINISTRATOR CLAIM NUMBER	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0015	REF02	REPLACEMENT CLAIM ADMINISTRATOR CLAIM NUMBER	NA	NA	AA	AA	NA	NA	AA	AA	NA	NA	AA	AA	NA	NA	AA	AA
0005	REF02	JURISDICTION CLAIM NUMBER	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0051	PER04	EMPLOYEE PHONE NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2300 - Bill Information - Required Loop																		
0523	CLM01	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0501	CLM02	TOTAL CHARGE PER BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0502	CLM04	BILLING TYPE CODE	X	NA	X	X	X	NA	X	X	X	NA	X	X	X	NA	X	X
0504	CLM05-1	FACILITY CODE	X	NA	X	X	F	F	F	F	X	NA	X	X	X	NA	X	X
0555	CLM05-1	PLACE OF SERVICE BILL CODE	F	F	F	F	X	X	X	X	F	F	F	F	F	F	F	F
0503	CLM05-2	BILLING FORMAT CODE	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0505	CLM05-3	BILL FREQUENCY TYPE CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0507	CLM16	PROVIDER AGREEMENT CODE*	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0508	CLM19	BILL SUBMISSION REASON CODE	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0511	DTP03	DATE INSURER RECEIVED BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0513	DTP03	ADMISSION DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0622	DTP03	ADMISSION HOUR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0514	DTP03	DISCHARGE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0623	DTP03	DISCHARGE HOUR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0509	DTP03	SERVICE BILL DATE(S) RANGE	NA	NA	NA	NA	M	NA	M	M	NA	NA	NA	NA	NA	NA	NA	NA
0527	DTP03	PRESCRIPTION DATE(s)	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0510	DTP03	DATE OF BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0512	DTP03	DATE INSURER PAID BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0577	CL101	ADMISSION TYPE CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0515	CN101	CONTRACT TYPE CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0516	AMT02	TOTAL AMOUNT PAID PER BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0500	REF02	UNIQUE BILL ID NUMBER	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0266	REF02	TRANSACTION TRACKING NUMBER	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0581	REF02	TREATMENT AUTHORIZATION NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0293	REF02	LUMP SUM PAYMENT/SETTLEMENT CODE	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

*** Enter "P" if worker is enrolled in a WCD-certified managed care organization (MCO) at time of service or if provider participates in a WCD-registered fee discount agreement. Enter "H" if care was provided through a health maintenance organization (HMO). Enter "Y" for any other agreement. Enter "N" for none.**

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Institutional Bill Principal Diagnosis - Situational Segment																		
0521	HI01-2	PRINCIPAL DIAGNOSIS CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0533	HI01-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Admitting Diagnosis - Situational Segment																		
0535	HI01-2	ADMITTING DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Other Diagnosis - Situational Segment																		
0522	HI01-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI01-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI02-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI02-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI03-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI03-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI04-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI04-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI05-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI05-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI06-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI06-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI07-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI07-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI08-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI08-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI09-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI09-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI10-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI10-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI11-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI11-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI12-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI12-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Outpatient Reason For Visit - Situational Segment																		
0520	HI01-2	OUTPATIENT REASON FOR VISIT CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0520	HI02-2	OUTPATIENT REASON FOR VISIT CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0520	HI03-2	OUTPATIENT REASON FOR VISIT CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment																		
0521	HI01-2	PRINCIPAL DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI02-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI03-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI04-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment																		
0522	HI05-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI06-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI07-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI08-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI09-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI10-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI11-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI12-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
HI Segment - Institutional Bill Principal Procedure - Situational Segment																		
0525	HI01-2	PRINCIPAL PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0550	HI01-4	PRINCIPAL PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment																		
0736	HI01-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI01-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI02-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI02-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI03-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI03-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI04-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI04-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI05-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI05-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI06-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI06-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI07-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI07-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI08-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI08-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI09-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment																		
0524	HI09-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI10-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI10-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI11-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI11-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI12-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI12-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X

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

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2310A - Billing Provider Information - Required Loop																		
0537	PRV03	BILLING PROVIDER PRIMARY SPECIALTY CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0538	N301	BILLING PROVIDER PRIMARY ADDRESS	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0539	N302	BILLING PROVIDER SECONDARY ADDRESS	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0540	N401	BILLING PROVIDER CITY	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0541	N402	BILLING PROVIDER STATE CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0542	N403	BILLING PROVIDER POSTAL CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0569	N404	BILLING PROVIDER COUNTRY CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0629	REF02	BILLING PROVIDER FEIN	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0630	REF02	BILLING PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2310B - Rendering Bill Provider Information - Situational Loop																		
0638	NM103	RENDERING BILL PROVIDER LAST/GROUP NAME	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0639	NM104	RENDERING BILL PROVIDER FIRST NAME	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0640	NM105	RENDERING BILL PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0641	NM107	RENDERING BILL PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0647	NM109	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	M	NA	M	M	MC	NA	MC	MC	MC	NA	MC	MC
0651	PRV03	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0643	REF02	RENDERING BILL PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2310C - Supervising Provider Information - Situational Loop																		
0658	NM103	SUPERVISING PROVIDER LAST/GROUP NAME	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0659	NM104	SUPERVISING PROVIDER FIRST NAME	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0660	NM105	SUPERVISING PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0661	NM107	SUPERVISING PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0667	NM109	SUPERVISING PROVIDER NATIONAL PROVIDER ID	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0671	PRV03	SUPERVISING PROVIDER PRIMARY SPECIALTY CODE	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0663	REF02	SUPERVISING PROVIDER STATE LICENSE NUMBER	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2310D - Service Facility Location Information - Situational Loop																		
0678	NM103	FACILITY NAME	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0682	NM109	FACILITY NATIONAL PROVIDER ID	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0684	N301	FACILITY PRIMARY ADDRESS	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0685	N302	FACILITY SECONDARY ADDRESS	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0686	N401	FACILITY CITY	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0687	N402	FACILITY STATE CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0688	N403	FACILITY POSTAL CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0689	N404	FACILITY COUNTRY CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0680	REF02	FACILITY STATE LICENSE NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0683	REF02	FACILITY SERVICE LOCATION ID	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
Loop ID 2310E - Referring Provider Information - Situational Loop																		
0690	NM103	REFERRING PROVIDER LAST/GROUP NAME	NA	NA	NA	NA	NA	NA	NA	NA	M	NA	M	M	NA	NA	NA	NA
0691	NM104	REFERRING PROVIDER FIRST NAME	NA	NA	NA	NA	NA	NA	NA	NA	MC	NA	MC	MC	NA	NA	NA	NA
0692	NM105	REFERRING PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0693	NM107	REFERRING PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0699	NM109	REFERRING PROVIDER NATIONAL PROVIDER ID	NA	NA	NA	NA	NA	NA	NA	NA	MC	NA	MC	MC	NA	NA	NA	NA
0695	REF02	REFERRING PROVIDER STATE LICENSE NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	MC	NA	MC	MC	NA	NA	NA	NA
Loop ID 2310F - Managed Care Organization Information - Situational Loop																		
0209	NM103	MANAGED CARE ORGANIZATION NAME	~~NA~~ MC	NA	~~NA~~ MC	~~NA~~ MC	~~NA~~ MC	NA	~~NA~~ MC	~~NA~~ MC	~~NA~~ MC	NA	~~NA~~ MC	~~NA~~ MC	~~NA~~ MC	NA	~~NA~~ MC	~~NA~~ MC
0208	NM109	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0704	REF02	MANAGED CARE ORGANIZATION FEIN	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2320 - Bill Level Adjustments and Amounts - Situational Loop																		
0543	CAS01	BILL ADJUSTMENT GROUP CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0544	CAS02	BILL ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0545	CAS03	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0546	CAS04	BILL ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0544	CAS05	BILL ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0545	CAS06	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0546	CAS07	BILL ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0544	CAS08	BILL ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0545	CAS09	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0546	CAS10	BILL ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0760	AMT02	PRIOR ACTUAL AMOUNT PAID	X	X	X	NA	X	X	X	NA	X	X	X	NA	X	X	X	NA
Loop ID 2400 - Service Line Information - Situational Loop																		
0547	LX01	LINE NUMBER	F	NA	F	F	F	NA	F	F	F	NA	F	F	F	NA	F	F
0714	SV101-2	HCPCS LINE PROCEDURE BILLED CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0715	SV101-2	JURISDICTION PROCEDURE BILLED CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0721	SV101-2	NDC BILLED CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-3	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-3	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-4	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-4	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-5	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-5	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-6	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-6	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0551	SV101-7	PROCEDURE DESCRIPTION	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0552	SV102	TOTAL CHARGE PER LINE	M	NA	M	M	X	X	X	X	X	X	X	X	X	X	X	X

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2400 - Service Line Information - Situational Loop																		
0553	SV103	DAYS(S)/UNIT(S) CODE	M	NA	M	M	X	X	X	X	X	X	X	X	X	X	X	X
0554	SV104	DAY(S) /UNIT(S) BILLED	M	NA	M	M	X	X	X	X	X	X	X	X	X	X	X	X
0600	SV105	PLACE OF SERVICE LINE CODE	AR	NA	AR	AR	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-1	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-2	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-3	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-4	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0742	SV121	PROVIDER AGREEMENT LINE CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0559	SV201	REVENUE BILLED CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0714	SV202-2	HCPCS LINE PROCEDURE BILLED CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0625	SV202-2	HIPPS RATE CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0715	SV202-2	JURISDICTION PROCEDURE BILLED CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0717	SV202-3	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-3	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0717	SV202-4	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-4	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0717	SV202-5	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-5	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0717	SV202-6	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-6	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0551	SV202-7	PROCEDURE DESCRIPTION	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0552	SV203	TOTAL CHARGE PER LINE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0553	SV204	DAYS(S)/UNIT(S) CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0554	SV205	DAY(S) /UNIT(S) BILLED	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0719	SV301-2	ADA PROCEDURE BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0714	SV301-2	HCPCS LINE PROCEDURE BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2400 - Service Line Information - Situational Loop																		
0717	SV301-3	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0717	SV301-4	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0717	SV301-5	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0717	SV301-6	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0551	SV301-7	PROCEDURE DESCRIPTION	X	X	X	X	X	X	X	X	X	X	X	X	NA	NA	NA	NA
0552	SV302	TOTAL CHARGE PER LINE	X	X	X	X	X	X	X	X	X	X	X	X	M	NA	M	M
0600	SV303	PLACE OF SERVICE LINE CODE	X	X	X	X	X	X	X	X	X	X	X	X	AR	NA	AR	AR
0742	SV309	PROVIDER AGREEMENT LINE CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0561	SV401	PRESCRIPTION LINE NUMBER	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0721	SV402-2	NDC BILLED CODE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0562	SV405	DISPENSE AS WRITTEN CODE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0563	SV408	DRUG NAME	X	X	X	X	X	X	X	X	NA	NA	NA	NA	X	X	X	X
0762	SV410	COMPOUND DRUG INDICATOR	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0605	DTP03	SERVICE LINE DATE(S) RANGE	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0604	DTP03	PRESCRIPTION LINE DATE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0570	QTY02	DRUGS/SUPPLIES QUANTITY DISPENSED	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0571	QTY02	DRUGS/SUPPLIES NUMBER OF DAYS	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0741	CN101	CONTRACT LINE TYPE CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0738	REF02	TREATMENT LINE AUTHORIZATION NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0579	AMT02	DRUGS/SUPPLIES DISPENSING FEE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0572	AMT02	DRUGS/SUPPLIES BILLED AMOUNT	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0627	AMT02	LINE ITEM TAX CHARGE AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2420 - Rendering Line Provider Information - Situational Loop																		
0589	NM103	RENDERING LINE PROVIDER LAST/GROUP NAME	AA	NA	AA	AA	NA	NA	NA	NA	AA	NA	AA	AA	AA	NA	AA	AA
0587	NM104	RENDERING LINE PROVIDER FIRST NAME	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0591	NM105	RENDERING LINE PROVIDER MIDDLE NAME/INITIAL	AA	NA	AA	AA	NA	NA	NA	NA	AA	NA	AA	AA	AA	NA	AA	AA
0588	NM107	RENDERING LINE PROVIDER LAST NAME SUFFIX	AA	NA	AA	AA	NA	NA	NA	NA	AA	NA	AA	AA	AA	NA	AA	AA
0592	NM109	RENDERING LINE PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2420 - Rendering Line Provider Information - Situational Loop																		
0595	PRV03	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0599	REF02	RENDERING LINE PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop																		
0574	SVD02	TOTAL AMOUNT PAID PER LINE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0722	SVD03-2	ADA PROCEDURE PAID CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0726	SVD03-2	HCPCS LINE PROCEDURE PAID CODE	MC	NA	MC	MC	MC	NA	MC	MC	X	X	X	X	MC	NA	MC	MC
0728	SVD03-2	NDC PAID CODE	MC	NA	MC	MC	X	X	X	X	MC	NA	MC	MC	X	X	X	X
0729	SVD03-2	JURISDICTION PROCEDURE PAID CODE	MC	NA	MC	MC	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0727	SVD03-3	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-3	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0727	SVD03-4	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-4	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0727	SVD03-5	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-5	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0727	SVD03-6	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-6	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0576	SVD04	REVENUE PAID CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0580	SVD05	DAYS(S)/UNIT(S) PAID	AA	NA	AA	AA	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0547	SVD06	LINE NUMBER	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0731	CAS01	SERVICE ADJUSTMENT GROUP CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0732	CAS02	SERVICE ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0733	CAS03	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS04	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0732	CAS05	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS06	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC

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

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

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

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2300 - Bill Information - Required Loop					
MC	0513	DTP03	ADMISSION DATE	Required when DN0504 Facility Code is an inpatient type, and either DN0516 Total Amount Paid Per Bill is not equal to 0; or DN0513 is on the bill.	Required when DN0504 Facility Code is one of the following: 11, 12, 18, 21, 22, 28, 41, 65, 66, 86, and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0513 is known.
MC	0514	DTP03	DISCHARGE DATE	Required on final inpatient medical bills.	Required when DN0505 Bill Frequency Type Code equals 1 or 4.
MC	0577	CL101	ADMISSION TYPE CODE	Required when DN0504 Facility Code is an inpatient type, and either DN0516 Total Amount Paid Per Bill is not equal to 0; or DN0577 is on the bill.	Required when DN0504 Facility Code is one of the following: 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89 and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0577 is known.
MC	0515	CN101	CONTRACT TYPE CODE	When DN0549 Paid DRG Code is present, this value must be 01 (DRG). Otherwise, this data element must be reported when the medical services are subject to contractual adjustments and the post-adjudication reimbursement was impacted by the contract, but not be 01.	When DN0549 (Paid DRG Code) is present, this value must be 01 (DRG). Otherwise, this data element must be reported when a contract impacts payment of the bill, but must not have a value of 01.
HI Segment - Institutional Bill Admitting Diagnosis - Situational Segment					
MC	0535	HI01-2	ADMITTING DIAGNOSIS CODE	Required when DN0504 Facility Code is an inpatient type, and either DN0516 Total Amount Paid Per Bill is not equal to 0; or DN0535 is on the bill.	Required when DN0504 Facility Code is one of the following: 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89 and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0535 is known.

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
HI Segment - Institutional Bill Other Diagnosis					
MC	0522	HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI09-2, HI10-2, HI11-2, HI12-2	DIAGNOSIS CODE	Required when this element is on the bill.	Required when the value of DN0522 is known.
HI Segment - Outpatient Reason For Visit - Situational Segment					
MC	0520	HI01-2	OUTPATIENT REASON FOR VISIT CODE	Required when DN0516 Total Amount Paid Per Bill is not equal to 0, and DN0504 Facility Code is either hospital outpatient, critical access hospital or licensed freestanding emergency medical facility type and DN0577 Admission Type Code describes the admission type as emergency, urgent or trauma and a reported DN0559 Revenue Billed Code equals one of the following values with or without a leading 0: 450, 451, 452, 456, 459, 516, 526, 762.	Required when DN0516 Total Amount Paid Per Bill is not equal to 0, and DN0504 Facility Code equals 13, 85, or 78 and DN0577 Admission Type Code equals 1, 2, or 5 and a reported DN0559 Revenue Billed Code equals one of the following values with or without a leading 0: 450, 451, 452, 456, 459, 516, 526, 762.
MC	0520	HI02-2	OUTPATIENT REASON FOR VISIT CODE	Required when DN0520 (HI01-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.	Required when DN0520 (HI01-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.
MC	0520	HI03-2	OUTPATIENT REASON FOR VISIT CODE	Required when DN0520 (HI02-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.	Required when DN0520 (HI02-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

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

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

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

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

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

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

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

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2310B - Rendering Bill Provider Information - Situational Loop					
MC	0639	NM104	RENDERING BILL PROVIDER FIRST NAME	Required when NM102 = 1 (person) and the person has a first name.	Required when NM102 = 1 (person) and the person has a first name.
MC	0647	NM109	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	Required when the rendering bill provider has a National Provider ID.	Required when the rendering bill provider has a National Provider ID.
MC	0651	PRV03	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	Required when the rendering bill provider does not have a National Provider ID.	Required when loop 2310B is used and DN0647 Rendering Bill Provider National Provider ID (NM109) is not reported.
MC	0643	REF02	RENDERING BILL PROVIDER STATE LICENSE NUMBER	Required when the rendering bill provider does not have a National Provider ID. Use "99999" if the billing provider's type is not licensed by the state (e.g., ambulance or, durable medical equipment).	Required when loop 2310B is used and DN0647 Rendering Bill Provider National Provider ID (NM109) is not reported.
Loop ID 2310D - Service Facility Location Information - Situational Loop					
MC	0678	NM103	FACILITY NAME	Required when service was performed at an address different from the billing provider's address and either 1) the bill was paid; or 2) the facility name is known.	Required when service was performed at an address different from DN0538 Billing Provider Primary Address and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0678 is known.
MC	0682	NM109	FACILITY NATIONAL PROVIDER ID	Required when service was performed in a facility within the US.	Required when DN0678 Facility Name is present and DN0689 Facility Country Code is not reported, or has a value of US or USA.
MC	0684	N301	FACILITY PRIMARY ADDRESS	Required when service was performed in a facility, (e.g., hospital, ambulatory surgical center, etc.).	Required when DN0678 Facility Name is present.
MC	0686	N401	FACILITY CITY	Required when service was performed in a facility, (e.g., hospital, ambulatory surgical center, etc.).	Required when DN0678 Facility Name is present.
MC	0689	N404	FACILITY COUNTRY CODE	Required when service was performed in a facility outside the US.	Required when DN0678 Facility Name is present and DN0682 Facility National Provider ID is not present.

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2310E - Referring Provider Information - Situational Loop					
MC	0691	NM104	REFERRING PROVIDER FIRST NAME	Required when NM102 = 1 (person) and the person has a first name.	Required when NM102 = 1 (person) and the person has a first name.
MC	0699	NM109	REFERRING PROVIDER NATIONAL PROVIDER ID	Required when the referring provider has a National Provider ID.	Required when the referring provider has a National Provider ID.
MC	0695	REF02	REFERRING PROVIDER STATE LICENSE NUMBER	Required when the referring provider does not have a National Provider ID. Use "99999" if the referring provider's type is not licensed by the state (e.g., ambulance or, durable medical equipment).	Required when DN0699 Referring Provider National Provider ID (NM109) is not reported.
Loop ID 2310F - Managed Care Organization Information - Situational Loop					
MC	0209	NM103	MANAGED CARE ORGANIZATION NAME	Required when service was provided under the direction or control of a managed care organization.	Required when service was provided under the direction or control of a managed care organization.
MC	0208	NM109	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	Required when DN507 Provider Agreement Code equals 'P' and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0208 is known.	Required when DN507 Provider Agreement Code equals 'P' and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0208 is known.
Loop ID 2320 - Bill Level Adjustments and Amounts - Situational Loop					
MC	0543	CAS01	BILL ADJUSTMENT GROUP CODE	Required when adjustments apply to all service lines on a medical bill containing more than one line.	Required when DN0501 Total Charge Per Bill is not equal to DN0516 Total Amount Paid Per Bill and DN0501 Total Charge Per Bill minus DN0516 Total Amount Paid Per Bill minus the sum of all DN0733 Service Adjustment Amount values is not equal to zero.
MC	0544	CAS02	BILL ADJUSTMENT REASON CODE	Required when adjustments apply to all service lines on a medical bill containing more than one line.	Required when DN0543 Bill Adjustment Group Code is present.
MC	0545	CAS03	BILL ADJUSTMENT AMOUNT	Required when adjustments apply to all service lines on a medical bill containing more than one line.	Required when DN0544 Bill Adjustment Reason Code in CAS02 is present.
MC	0545	CAS06	BILL ADJUSTMENT AMOUNT	Required when a second Bill Adjustment Reason Code applies and is associated with the same group code.	Required when DN0544 Bill Adjustment Reason Code in CAS05 is present.

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2320 - Bill Level Adjustments and Amounts - Situational Loop					
MC	0545	CAS09	BILL ADJUSTMENT AMOUNT	Required when a third Bill Adjustment Reason Code applies and is associated with the same group code.	Required when DN0544 Bill Adjustment Reason Code in CAS08 is present.
Loop ID 2400 - Service Line Information - Situational Loop					
MC	0714	SV101-2	HCPCS LINE PROCEDURE BILLED CODE	Required when the bill type is non-pharmaceutical and the service is not billed as any of the following: Oregon-specific service, pharmaceutical product, ADA procedure. The value must be valid when the service was paid using the same code that was billed.	Required when DN0715 Jurisdiction Procedure Billed Code, DN0721 NDC Billed Code, and DN0719 ADA Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0715	SV101-2	JURISDICTION PROCEDURE BILLED CODE	Required when the bill type is non-pharmaceutical and the service is not billed as any of the following: HCPCS service, pharmaceutical product, ADA procedure. The value must be valid when the service was paid using the same code that was billed.	Required when DN0714 HCPCS Line Procedure Billed Code, DN0721 NDC Billed Code, and DN0719 ADA Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0721	SV101-2	NDC BILLED CODE	Required when a drug is dispensed by a physician during an office visit. The value must be valid when the service was paid using the same code that was billed.	Required when DN0714 HCPCS Line Procedure Billed Code, DN0715 Jurisdictional Procedure billed Code, and DN0719 ADA Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 Total Amount Paid Per Line is greater than 0 or DN0574 is not reported.
MC	0557	SV107-1	DIAGNOSIS POINTER	Required when there is a reported diagnosis code and the payment for the service line is greater than 0.	Required when DN0521 Principal Diagnosis Code is reported and either DN0574 Total Amount Paid Per Line is greater than 0 or DN0574 is not reported.

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2400 - Service Line Information - Situational Loop					
MC	0557	SV107-2	DIAGNOSIS POINTER	Required when SV107-1 is required and there are two diagnosis pointers for this service line on the bill.	Required when SV107-1 is reported and the value of the second diagnosis pointer is known.
MC	0557	SV107-3	DIAGNOSIS POINTER	Required when SV107-2 is required and there are three diagnosis pointers for this service line on the bill.	Required when SV107-2 is reported and the value of the third diagnosis pointer is known.
MC	0557	SV107-4	DIAGNOSIS POINTER	Required when SV107-3 is required and there are four diagnosis pointers for this service line on the bill.	Required when SV107-3 is reported and the value of the fourth diagnosis pointer is known.
MC	0742	SV121	PROVIDER AGREEMENT LINE CODE	Required when the provider agreement code at the line level is different than the bill level.	Required when the provider agreement code at the line level is different than the bill level.
MC	0714	SV202-2	HCPCS LINE PROCEDURE BILLED CODE	Required when a HCPCS code is used to bill for the service. The value must be valid when the service was paid using the same code that was billed.	The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0625	SV202-2	HIPPS RATE CODE	Required when a HIPPS rate code is used to bill for the service.The value must be valid when the service was paid using the same code that was billed.	The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0715	SV202-2	JURISDICTION PROCEDURE BILLED CODE	Required when an Oregon specific code is used to bill for the service.The value must be valid when the service was paid using the same code that was billed.	The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0719	SV301-2	ADA PROCEDURE BILLED CODE	Required when some amount of the bill is paid, the bill type is dental and the service is not billed as an HCPCS service. The value must be valid when the service was paid using the same code that was billed.	Required when DN0714 HCPCS Line Procedure Billed Code is not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2400 - Service Line Information - Situational Loop					
MC	0714	SV301-2	HCPCS LINE PROCEDURE BILLED CODE	Required when the bill type is dental and the service is not billed as an ADA service. The value must be valid when the service was paid using the same code that was billed.	Required when DN0719 ADA Procedure Billed Code is not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0742	SV309	PROVIDER AGREEMENT LINE CODE	Required when the provider agreement code at the line level is different than the bill level.	Required when the provider agreement code at the line level is different than the bill level.
MC	0741	CN101	CONTRACT LINE TYPE CODE	Required when a contract exists between the payer and the health care provider and the information at the line level is different than the information at the bill level.	Required when a contract exists between the payer and the health care provider and the information at the line level is different than the information at the bill level.
MC	0627	AMT02	LINE ITEM TAX CHARGE AMOUNT	Required when part of the amount charged for this service line includes a tax and the amount of tax is specified on the bill.	Required when part of either DN0552 Total Charge per Line or DN0572 Drugs/Supplies Billed Amount includes a tax and the amount of tax is specified on the bill.
Loop ID 2420 - Rendering Line Provider Information - Situational Loop					
MC	0587	NM104	RENDERING LINE PROVIDER FIRST NAME	Required when NM102 = 1 (person) and reported on the medical bill.	Required when NM102 = 1 (person) and reported on the medical bill.
MC	0592	NM109	RENDERING LINE PROVIDER NATIONAL PROVIDER ID	Required when the rendering line provider has a National Provider ID.	Required when the rendering line provider has a National Provider ID.
MC	0595	PRV03	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	Required when the rendering line provider does not have a National Provider ID.	Required when NM109 DN0592 Rendering Line Provider National Provider ID is not present.
MC	0599	REF02	RENDERING LINE PROVIDER STATE LICENSE NUMBER	Required when the rendering line provider does not have a National Provider ID. Use "99999" if the billing provider's type is not licensed by the state (e.g., ambulance or interpreter).	Required when NM109 DN0592 Rendering Line Provider National Provider ID is not present.

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop					
MC	0574	SVD02	TOTAL AMOUNT PAID PER LINE	Required when the amount paid for this service line is not equal to the amount charged.	Required when the amount paid is not equal to which of the following data elements is reported: DN0552 Total Charge per Line or DN0572 Drugs/Supplies Billed Amount.
MC	0722	SVD03-2	ADA PROCEDURE PAID CODE	Required when the service was paid more than $0.00 using a different code from the billed code and no other paid service code was used.	Required when • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.
MC	0726	SVD03-2	HCPCS LINE PROCEDURE PAID CODE	Required when the service was paid more than $0.00 using a different code from the billed code and no other paid service code was used.	Required when • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.
MC	0728	SVD03-2	NDC PAID CODE	Required when the service was paid more than $0.00 using a different code from the billed code and no other paid service code was used.	Required when • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop					
MC	0729	SVD03-2	JURISDICTION PROCEDURE PAID CODE	Required when the service was paid more than $0.00 using a different code from the billed code and no other paid service code was used.	Required when • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.
MC	0547	SVD06	LINE NUMBER	Required when the payment is bundled with a different service line.	Required when the payment is bundled with a different service line.
MC	0731	CAS01	SERVICE ADJUSTMENT GROUP CODE	Required when line-level adjustments were applied during the adjudication of the medical bill.	For non-pharmaceutical bills (SV4 segment is not used to report the service line), this element is required when DN0545 Bill Adjustment Amount is not reported and DN0552 Total Charge Per Line does not equal DN0574 Total Amount Paid Per Line.For pharmaceutical bills (SV4 segment is used to report the service line), this element is required when DN0545 is not reported and DN0572 Drugs/Supplies Billed Amount does not equal DN0574.
MC	0732	CAS02	SERVICE ADJUSTMENT REASON CODE	Required when line level adjustments were applied during the adjudication of the medical bill.	Required when DN0543 Bill Adjustment Group Code is present.
MC	0733	CAS03	SERVICE ADJUSTMENT AMOUNT	Required when line level adjustments were applied during the adjudication of the medical bill.	Required when DN0544 Bill Adjustment Reason Code in CAS02 is present.
MC	0733	CAS06	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS05 is present.

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

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

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; Medical Bill Data	))))	**ORDER OF ADOPTION No. 14-056**

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 procedures in ORS 183.335, amends OAR chapter 436, division 160.

On April 15, 2014, 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 website. The Secretary of State included notice of the public hearing in its May 2014 *Oregon Bulletin*. On May 22, 2014, a public hearing was held as announced. The record remained open for written testimony through May 27, 2014.

SUMMARY OF RULE AMENDMENTS

Revised OAR 436-160, Electronic Data Interchange (EDI); Medical Bill Data:

- Adopts, by reference, the updated IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2.0, dated Feb 1, 2014 (to supersede the Guide, also Release 2.0, dated Feb. 1, 2013);
- Includes technical corrections to Appendix "A," and related changes to Appendix "B," including:
  - Deletion of DN0586, RENDERING LINE PROVIDER FEIN;
  - Amendment of DN0522 (HI02-2 through HI12-2 in the HI Segment - Institutional Bill Other Diagnosis - Situational Segment) from Applicable/Available (AR) to MC; addition of DN0522 to Appendix B;
  - Amendment of DN0539 (N302 in the Loop ID 2310A – Billing Provider Information – Required Loop) from Not Applicable (NA) to If Applicable /Available (AA);
  - Amendment of DN0544 (CAS05 through CAS08 in the Loop ID 2320 - Bill Level Adjustments and Amounts - Situational Loop) from AR to MC;
  - Amendment of DN0557 (SV107-2 through SV107-4 in Loop ID 2400 - Service Line Information - Situational Loop) from AR to MC; amendment of two duplicate listings of DN0557 in Appendix B from SV107-1 to SV107-2 and -3, and addition of SV107-4;
  - Amendment of DN0592 (NM109 in Loop ID 2420 - Rendering Line Provider Information - Situational Loop) from AR to MC;

- Amendment of DN0647 (NM109 in Loop ID 2310B - Rendering Bill Provider Information - Situational Loop) from AR to MC;
- Amendment of DN0685 (N302 in Loop ID 2310D – Service Facility Location Information – Situational Loop) from NA to AA; and

- Includes correction or clarification of identifiers, business conditions, and technical conditions in Appendix B, affecting DN0209, DN0513, DN0514, DN0515, DN0592, DN0595, DN0599, DN0625, DN0643, DN0651, DN0695, DN0742, DN0714, and DN0715.

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, division 160 are adopted as administrative order No. 14-056 on this **10th day of July, 2014, to be effective Oct. 1, 2014.**

2) A certified copy of the adopted rules will be filed with the Secretary of State.

3) A copy of the adopted 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 10th day of July, 2014.

/s/ John L. Shilts
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, 503-947-7810.

Distribution: Workers' Compensation Division e-mail distribution lists, including advisory committee members and testifiers