



Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services
Workers' Compensation Division
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August 20, 2007

Proposed Changes to Workers' Compensation Rules

The 2007 Oregon Legislature passed a number of bills affecting workers' compensation laws. The Department of Consumer and Business Services, Workers' Compensation Division proposes changes to OAR chapter 436 to make these rules consistent with the revised laws. In addition, the department proposes changes to make the rules easier to understand, to streamline regulations, and to expand return-to-work incentives for the Employer-at-Injury Program and Preferred Worker Program.

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

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

- When is the hearing?** September 24, 2007, 2:00 p.m.
- Where is the hearing?** Labor & Industries Building
350 Winter Street NE, Room 260 (2nd Floor),
Salem, Oregon 97301
- How can I make a comment?** Come to the hearing and speak, send written comments, or do both. Send written comments to:
Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Email - fred.h.bruyns@state.or.us
Phone - (503) 947-7717; Fax - (503) 947-7581

The closing date for written comments is September 27, 2007.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –

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

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

Questions?

Contact Fred Bruyns, (503) 947-7717.

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services (DCBS),
Workers' Compensation Division
Agency and Division

OAR CHAPTER 436
Administrative Rules Chapter Number

Fred Bruyns
Rules Coordinator

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

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

Hearing date	Time	Location	Hearings Officer
September 24, 2007	2:00 p.m.*	Room 260 (2 nd Floor, Labor & Industries Building) 350 Winter Street NE, Salem, Oregon	Fred Bruyns

***NOTE: The hearing will begin at 2:00 p.m. and end when all present who wish to testify have done so. Written testimony will be accepted through September 27, 2007.**

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

RULEMAKING ACTION

ADOPT: OAR 436-105-0511; 436-105-0512; 436-160-0400; 436-160-0410; 436-160-0420; 436-160-0430

AMEND: OAR 436-040; 436-105; 436-110; 436-120; and

436-009-0005	436-015-0005	436-030-0175	436-050-0100	436-060-0008	436-160-0004
436-009-0010	436-015-0030	436-030-0185	436-050-0175	436-060-0010	436-160-0005
436-009-0020	436-015-0040	436-035-0005	436-050-0200	436-060-0015	436-160-0006
436-009-0030	436-015-0120	436-035-0110	436-050-0400	436-060-0018	436-160-0010
436-009-0040	436-030-0007	436-035-0350	436-050-0410	436-060-0055	436-160-0020
436-010-0005	436-030-0020	436-035-0390	436-050-0420	436-060-0060	436-160-0030
436-010-0210	436-030-0035	436-035-0420	436-050-0440	436-060-0140	436-160-0040
436-010-0220	436-030-0115	436-035-0500	436-050-0450	436-060-0147	436-160-0050
436-010-0230	436-030-0135	436-045-0008	436-050-0455	436-060-0150	436-160-0060
436-010-0240	436-030-0145	436-045-0030	436-050-0460	436-160-0001	436-160-0070
436-010-0265	436-030-0155	436-050-0003	436-050-0470	436-160-0002	436-160-0080
436-010-0280	436-030-0165	436-050-0005	436-050-0480	436-160-0003	436-160-0090

REPEAL: 436-030-0440; 436-030-0450; 436-030-0460; 436-030-0550; 436-030-0570;
436-110-0326; 436-110-0327; 436-110-0380; 436-120-0730

ORS 656.726(4)
Stat. Auth.

Other Authority

ORS chapter 656, as amended by enrolled: Senate Bill (SB) 83 – Oregon Laws (OL) 2007, ch. 70; SB 147 - OL 2007, ch. 86; SB 253 - OL 2007, ch. 491; SB 504 - OL 2007, ch. 505; SB 563 - OL 2007, ch. 423; SB 762 - OL 2007, ch. 518; House Bill (HB) 2218 - OL 270; HB 2756 - OL 2007, ch. 252; HB 2783 - OL 2007, ch. 656; HB 2943 - OL 2007, ch. 300

Stats. Implemented

RULE SUMMARY

Amendments to implement changes in the Workers' Compensation Law, including:

- Replacing the term "Handicapped Workers" with "Workers with Disabilities" (SB 83);
- Updating name of Board of Medical Examiners for the State of Oregon to "Oregon Medical Board" (SB 147);

- Including “administrative law judge” as a person who may approve or disapprove a claims disposition agreement (SB 253);
- Describing restrictions affecting emergency room physicians’ rights to be attending physicians and authorize temporary disability benefits (SB 504);
- Deleting requirement that managed care organizations send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director’s review and approval; deleting related definitions (SB 563);
- Explaining how DCBS will publish the maximum reimbursable amount for medical services for non-disabling claims (SB 762);
- Amending penalty provisions affecting managed care organizations; deleting procedures for temporary rule promulgation to address disability in individual claims (when medical conditions are not addressed by current standards), and addressing such conditions in the director’s order on reconsideration, and providing that penalties will not be assessed if an increase in compensation results from such an order; describing how insurers must process requests for a lump sum payments of permanent partial disability awards (HB 2218);
- Describing the authority and limitations for several types of providers - chiropractors, naturopaths, podiatrists, and physician assistants - when acting as attending physicians (HB 2756);
- Referring to ORS 656.427 regarding time frames for termination of guaranty contracts; defining “premium” (HB 2783);
- Adopting standards of professional conduct for health care providers who perform independent medical examinations, which apply if the provider’s professional regulatory board has not adopted standards for performing such examinations (HB 2943);

General amendments to OAR chapter 436, including:

- Using plain language to add clarity to a number of rules;
- Shortening some rules by removing unnecessary descriptions of DCBS procedures;

Amendments to OAR 436, 009, “Oregon Medical Fee and Payment Rules” and OAR 436-160, “Electronic Data Interchange” (EDI), to improve the quality of medical billing data for use by DCBS and its customers, including:

- Requiring hospitals and other health care providers to include sufficient data on their billings so insurers and DCBS can identify the providers;
- Requiring insurers to report medical billing data to DCBS using standards for electronic data interchange adopted by the International Association of Industrial Accident Boards and Commissions;
- Listing the data elements reportable to DCBS; testing procedures for EDI; phase-in dates for EDI and when insurers and self-insured employers are subject; procedures for requesting deferral of EDI reporting;

Amendment to OAR 436-010, “Medical Services,” to remove obsolete medical utilization guideline:

- Regarding frequency of treatment in OAR 436-010-0230;

Amendments to OAR 436-030, “Claim Closure and Reconsideration,” to eliminate conflicts between statute and rules, streamline processing, delete obsolete rules, and reduce litigation, including:

- Restricting reconsideration of claim closure to issues raised by the parties plus requirements under ORS 656.268(1);
- Requiring insurers to submit documents related to reconsideration of claim closure in chronological order;
- Removing the limitation on attorney fees from OAR 436-030-0175(4);
- Deleting obsolete rules OAR 436-030-0440, 0450; 0460, 0550, and 0570; the relevant subject matter from these rules has been addressed in other rules in OAR 436-030 and 436-035 (since approximately 1988), but the rules have remained in the Oregon Administrative Rules published by the Secretary of State;

Amendments to OAR 436-035, “Disability Rating Standards,” to clarify or correct certain provisions, and to provide for rating disability for a medical condition not currently addressed by the standards, including:

- Clarifying the definition of “direct medical sequela”;
- Correcting the description of impairment involving angulation or malalignment of the humerus;
- Clarifying how to rate impairment for surgery involving one or more discs or vertebrae;
- Eliminating provision that if a value of impairment is determined for damage to the brain, no additional value for speech or psychiatric impairment is allowed;

- Provide standards for rating impairment for vaginal prolapse;

Amendments to OAR 436-050, “Employer/Insurer Coverage Responsibility,” to clarify certain provisions and ensure appropriate oversight of worker leasing company licensing and practices, including:

- Clarifying time frames and process for cancellation of self-insurance;
- Revising regulations affecting worker leasing companies, including:
 - Relevant definitions;
 - The application and license renewal process;
 - Reporting and record-keeping;
 - Grounds for disqualification, suspension of license, and revocation of license by the director;
 - Appeal rights for persons refused approval or renewal of a worker leasing license;
 - Reapplication following disqualification for, or revocation of, license;
 - Continuation of a disqualification, suspension, or revocation of a worker leasing license applicable to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company’s assets to another person or controlling person;
 - Penalties under ORS 656.990;

Amendments to OAR 436-060, “Claims Administration,” to eliminate inconsistencies in DCBS rules and clarify or streamline certain provisions, including:

- Revising time frame for employers’ first aid record-keeping (to be consistent with Oregon OSHA requirements);
- Reducing the documentation a worker must submit when appealing an insurer’s refusal to reclassify a claim;
- Clarifying conditions under which the insurer must notify health care providers when a workers’ compensation claim is denied or partially denied;

Amendments to OAR 436-105, “Employer-at-Injury Program” (EAIP), to promote increased use of the EAIP and therefore earlier return to work of injured workers with their employers at injury, by streamlining program administration, setting an appropriate fee payable to insurers for administration of the program, and expanding some incentives, including:

- Providing that a medical release remains in effect until another medical release is issued by the worker’s medical service provider;
- Providing that a worker is eligible for EAIP services while the claim is “deferred” (prior to acceptance or denial);
- Providing insurers greater discretion to determine appropriate EAIP worksite modifications and EAIP purchases;
- Providing insurers greater discretion to determine what is appropriate training; eliminating the requirement that EAIP purchases for training are limited to “accredited” or “licensed” training or courses;
- Increasing maximum reimbursable amount for EAIP purchases for tools and equipment;
- Allowing insurers to submit more than one reimbursement request per EAIP;
- Stating the administrative fee payable to the insurer for its administration of EAIP services (formerly not prescribed by rule);

Amendments to OAR 436-110, “Preferred Worker Program” (PWP) to promote increased use of the PWP and therefore facilitate the return to work of injured workers and improve return-to-work outcomes (wages, tenure, etc.), by streamlining program administration, creating new PWP incentives, and expanding some existing incentives, including:

- Redefining and simplifying “date of hire” and “reimbursable wages”;
- Shortening and simplifying the wording that must appear on notices to workers about potential PWP benefits;
- Issuing PWP identification cards with no expiration date - workers could offer the initial and any subsequent employers three full years of premium exemption and claim cost reimbursement;
- Eliminating the requirement that a modification of regular work be “substantial” in order for a worker to be eligible for PWP benefits other than Worksite Modification;
- Removing the restriction that Wage Subsidies may not be combined with subsidies from other sources, with the exception of subsidies under OAR 436-120;
- Revising the name of “Obtained Employment Purchases” to “Employment Purchases”;
- Allowing Employment Purchases while a worker is receiving vocational assistance under OAR 436-120;

- Allowing replacement of Employment Purchases;
- Increasing the maximum expenditure for an Employment Purchase for tools and equipment;
- Providing Employment Purchases needed to create a new worksite;
- Creating a miscellaneous category of Employment Purchase that may be used to help a worker find, accept, or retain employment;
- Allowing a second use of Wage Subsidy and a second use of each category of Employment Purchase for a different job with the same employer (formerly two wage subsidies could not be used with the same employer);
- Eliminating forms currently required for Worksite Modifications costing \$2,500 or less;
- Eliminating the general requirement for competitive bids for Worksite Modification;

Amendments to OAR 436-120, “Vocational Assistance to Injured Workers,” to improve sufficiency of certain notices, clarify time frames for submitting information to DCBS, streamline return-to-work plan development process, clarify or define certain provisions, and delete obsolete provisions, including:

- Describing how the Workers’ Compensation Division will determine the timeliness of any document that must be sent to the division in vocational matters;
- Requiring that notices of eligibility for vocational assistance, training, or direct employment services explain the rights of the worker to request a return-to-work plan conference;
- Requiring that notice must be in writing when an insurer notifies a worker that an eligibility determination is postponed while awaiting information about permanent restrictions;
- Requiring that if an insurer ends a worker’s eligibility because lack of suitable employment is not due to the limitations caused by the injury, the insurer must have obtained new information that did not exist or that the insurer could not have discovered with reasonable effort at the time the insurer determined eligibility;
- Including among the reasons a worker would be ineligible for vocational assistance or for which eligibility would end, that the worker is unavailable for vocational assistance due to short-term incarceration;
- Eliminating all time frames related to return-to-work plan development except that a plan must be approved within 45 days (direct employment) or 90 days (training) under OAR 436-120-0500(1) & (2);
- Updating the vocational fee schedule (consistent with changes in state average weekly wage and Bulletin 124);
- Eliminating the requirement that insurers request administrative approval for vocational services when the insurer is entitled to claims cost reimbursement under OAR 436-110;
- Repealing the rule: “Reimbursement of Vocational Assistance Costs for Pre-1986 Injuries”; and
- Defining “show-cause hearing” for the purposes of OAR 436-120-0915(3).

Request for public comment: The Workers’ Compensation Division requests public comment on whether other options should be considered for achieving the rules’ substantive goals while reducing the negative economic impact of the rules on business.

Address questions to:

Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; e-mail fred.h.bruyns@state.or.us

Proposed rules are available on the Workers’ Compensation Division’s Web site:

<http://wcd.oregon.gov/policy/rules/rules.html#proprules>

or from WCD Publications, 503-947-7627 or fax 503-947-7630.

September 27, 2007
Last Day for Public Comment

John L. Shilts
Authorized Signer and Date

8-14-07

John L. Shilts, Administrator, Workers’ Compensation Division
Printed name

*The *Oregon Bulletin* is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation. Notice forms must be submitted to the Administrative Rules Unit, Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310 by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a Saturday, Sunday or legal holiday when Notice forms are accepted until 5:00 pm on the preceding workday.

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Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

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

Department of Consumer and Business Services,
Workers' Compensation Division

OAR CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

In the Matter of)
The Amendment of OAR:)
436-009, Oregon Medical Fee and Payment Rules)
436-010, Medical Services)
436-015, Managed Care Organizations)
436-030, Claim Closure and Reconsideration)
436-035, Disability Rating Standards)
436-040, Workers with Disabilities Program)
436-045, Reopened Claims Program)
436-050, Employer/Insurer Coverage Responsibility)
436-060, Claims Administration)
436-105, Employer-at-Injury Program)
436-110, Preferred Worker Program)
436-120, Vocational Assistance to Injured Workers)
436-160, Electronic Data Interchange)

Rule Caption:

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

Statutory Authority: ORS 656.726(4)

Other Authority:

Statutes Implemented: ORS chapter 656, as amended by enrolled: Senate Bill (SB) 83 – Oregon Laws (OL) 2007, ch. 70; SB 147 - OL 2007, ch. 86; SB 253 - OL 2007, ch. 491; SB 504 - OL 2007, ch. 505; SB 563 - OL 2007, ch. 423; SB 762 - OL 2007, ch. 518; House Bill (HB) 2218 - OL 270; HB 2756 - OL 2007, ch. 252; HB 2783 - OL 2007, ch. 656; HB 2943 - OL 2007, ch. 300

Need for the Rule(s): Chapter 436 must be amended to be consistent with the Workers' Compensation Law, as amended by legislation passed by the 2007 Oregon Legislature. Some of that legislation required the director to make rules to implement revised laws. The department is proposing additional changes to make the rules easier to understand, to streamline regulations affecting stakeholders, and to expand return-to-work incentives for the Employer-at-Injury Program and Preferred Worker Program.

Documents Relied Upon, and where they are available: "Issues" documents as presented to advisory committees; advisory committee meeting minutes; written advice from advisory committee members.

These records are available for public inspection in the Administrator's Office, Workers' Compensation Division of the Department of Consumer and Business Services, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Please call (503) 947-7717 to request copies.

Fiscal and Economic Impact, including Statement of Cost of Compliance: The following is a list of significant estimated fiscal/economic impacts on persons and organizations affected by proposed rule amendments:

Amendments to implement changes in the Workers' Compensation Law

- Senate Bill 504 restricts emergency room physicians' rights to be attending physicians and authorize temporary disability benefits. Overall emergency-room treatment charges can be substantially higher than charges for visits to primary care physicians. In addition, early referral to primary care physicians should improve insurers'

ability to keep track of authorization of temporary disability benefits and to promote return-to-work. The agency estimates that these changes should result in a small reduction in insurers' claims costs.

- Senate Bill 563 eliminates the requirement that managed care organizations (MCOs) send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director's review and approval. In the "Statement of Need and Fiscal Impact" filed with the Secretary of State on 8/14/06, DCBS estimated reporting costs for such reporting based on advice from MCOs. The low-high range of estimated reporting costs was then \$100 per year to \$50,000 per year per MCO, potentially \$400/year to \$200,000/year for the four active MCOs. The agency projects elimination of these reporting costs for MCOs.
- House Bill 2756 provides authority and limitations for several types of providers - chiropractors, naturopaths, podiatrists, and physician assistants - when acting as attending physicians. Because we cannot project how many injured workers will choose these providers as their attending physicians, we cannot now project the fiscal impacts. However, DCBS will monitor the effects of HB 2756 to identify impacts over time.
- House Bill 2783 requires insurers to notify the employer of termination of a guaranty contract 45 days in advance instead of the 30 days currently required. In addition, HB 2783 allows for a shorter notice requirement of only 10 days if the termination is based on nonpayment of premium. The agency projects some reductions in costs for insurers, because they can shorten their liability under the 10-day notice provision. The agency projects that these savings will be greater than any increased costs due to the 45-day notice provision, because insurers can adjust notice procedures in order to end liability, in most cases, by a date certain. The agency projects a small positive impact for employers subject to the 45-day notice, as it will give them more time to shop for cost-effective workers' compensation insurance coverage.

In addition to changes to implement changes in the Workers' Compensation Law:

Amendments to OAR 436, 009, "Oregon Medical Fee and Payment Rules" and OAR 436-160, "Electronic Data Interchange" (EDI)

- The agency projects that proposed rule changes will not have a significant fiscal impact on Oregon health care providers, as providers already send sufficient data to insurers on standard billing forms. The agency projects some fiscal impacts for insurers and self-insured employers, smaller for those companies already using EDI in other states and greater for Oregon-only reporters. The advisory committee did not express concerns about implementation costs. However, the agency projects significant costs for some insurers and self-insured employers in order to prepare for EDI, and also projects that these costs will eventually be exceeded by savings due to efficiencies inherent in electronic communication.

Amendments to OAR 436-035, "Disability Rating Standards"

- The agency projects that eliminating provision that if a value of impairment is determined for damage to the brain, no additional value for speech or psychiatric impairment is allowed, will have a positive economic impact on affected workers and an equal increased cost to affected insurers. However, this combination of medical conditions is very rare and the impact is not expected to be significant overall.

Amendments to OAR 436-050, "Employer/Insurer Coverage Responsibility"

- The agency projects that proposed rules affecting worker leasing companies will add a small cost to submit additional information with the application for initial license or renewal of license.
- Conversely, the purpose of these rule changes is to create a level playing field for leasing companies by preventing or removing unfair competition by companies that cannot or will not comply with worker leasing laws and rules. Successfully preventing unfair competition would have a positive economic effect on leasing companies that do comply with the laws and rules. Relative to taking no action, the agency projects a small positive economic impact on worker leasing companies.

Amendments to OAR 436-105, “Employer-at-Injury Program” (EAIP) and OAR 436-110, “Preferred Worker Program” (PWP)

- The agency projects that expanded benefits and administrative fees for the EAIP will cost the Workers’ Benefit Fund (maximum/annual):
 - Reimbursement of EAIP costs before the claim is accepted or denied (if ultimately denied)..... \$700,000.00
 - Increased reimbursable amount for EAIP purchases for tools and equipment \$300,000.00
 - Proposed fee payable to insurers for administration of the EAIP..... \$480,000.00
 - Total \$1,480,000.00

- The agency projects that expanded benefits for the PWP will cost the Workers’ Benefit Fund (maximum/annual):
 - Providing Employment Purchases needed to create a new worksite..... \$100,000.00
 - Creating a miscellaneous category of Employment Purchase that may be used to help a worker find, accept, or retain employment \$100,000.00
 - Total \$200,000.00

- The agency projects that issuing PWP identification cards with no expiration date will increase use of premium exemption and thus increase costs to the Workers’ Benefit Fund. However, the impact would be very minor in the near term and increase gradually over time. The agency does not have a basis to project how many workers will use their cards for future employment, but will monitor this closely.

- Additional proposed changes that expand access to reemployment incentives will have lesser impacts on the Workers’ Benefit Fund; however, the agency does not have a basis to project how extensively these incentives will be used.

- All moneys paid out of the Workers’ Benefit Fund would have a positive economic impact on Oregon employers and insurers. In addition to the direct dollar transfer, by promoting early return to work, the proposed rules may reduce claims costs. In addition, the proposed changes should positively affect injured workers by promoting early return to work, which produces better long-term employment outcomes.

- The Workers’ Benefit Fund has adequate reserves to cover any increased costs resulting from proposed rule changes.

Regarding: Additional proposed changes:

- The agency estimates that additional changes will not have any significant negative economic impacts on any persons or businesses, including small businesses. Because a number of the proposed rule changes streamline processes, the agency projects a small overall positive economic impact of proposed rule changes not otherwise described.

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

Representatives from small businesses participated in the stakeholder advisory committees.

Cost of compliance effect on small businesses:

Estimated number of small businesses subject to the proposed rule:

One managed care organization. (Of the four managed care organizations certified and active in the Oregon workers’ compensation system, one managed care organization meets the definition of a small business under ORS 183.310.)

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

The proposed rule amendments will affect managed care organizations.

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

Reporting: Proposed rule changes would require less reporting by managed care organizations, who will no longer have to send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director's review and approval.

Record-keeping: Proposed rule changes may substantially reduce record keeping by a managed care organization only if organization keeps a running record of updated treatment standards, protocols, and guidelines for the purpose of reporting the updates to the director.

Other administrative activities and costs of professional services: For managed care organizations that contract with companies that specialize in provision of guidelines and protocols, there is the potential for reduced professional services costs.

Extent of economic impact: The agency projects a substantial reduction in reporting costs for MCOs.

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

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

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

Labor: The proposed rule changes do not require increased labor costs to achieve compliance.

Administration: The proposed rule changes do not require increased administrative costs to achieve compliance.

Extent of economic impact: No increased costs for these categories.

Administrative Rule Advisory Committee consulted:

Yes. Advisory committees met on 6/21/07, 7/10/07, 7/16/07, 7/17/07, 7/19/07, 7/20/07, 7/23/07, 7/26/07, 7/31/07

The agency asked the advisory committee for advice on the impact of the discussed changes on costs, including any significant adverse impacts on small businesses.

John L. Shilts

8-14-07

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION



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

Summer/Fall 2007

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Revisions are marked as follows:

Deleted text has a "strike-through" style, as in

~~Deleted~~

Added text is bold and underlined, as in

Added

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

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

General Provisions

436-160-0001 Authority for Rules

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

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

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

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

436-160-0002 Purpose

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

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

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

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

436-160-0003 Applicability of Rules

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

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

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 656.726(4)

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

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

436-160-0004 Adoption of Standards

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

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

Stat. Authority: ORS 656.264

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

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

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.

~~(1)~~**(2)** "Conditional data element" means an element that becomes mandatory under certain conditions. Once mandatory, a conditional data element will cause a rejection of the

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

~~(2)~~**(3)** "Director" means the Director of the Department of Consumer and Business Services or the director's designee for the matter.

~~(3)~~**(4)** "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

~~(4)~~**(5)** "Electronic Data Interchange" or "EDI" means a computer to computer exchange of information in a standardized electronic format.

~~(5)~~**(6)** "Electronic Record" means information created, generated, sent, communicated, received, or stored by electronic means.

~~(6)~~**(7)** "FEIN" means the federal employer identification number or other federal reporting number used by the insurer, insured, or employer for federal tax reporting purposes.

~~(7)~~**(8)** "Header record" means the record that precedes each transmission for the purpose of identifying a sender, the date and time of the transmission, and the transaction set within the transmission.

~~(8)~~**(9)** "IAIABC" means the International Association of Industrial Accident Boards and Commissions, a professional trade association comprised of state workers' compensation regulators and insurance representatives (www.iaaiabc.org).

~~(9)~~**(10)** "Information" means data, text, images, sounds, codes, computer programs, software, databases, or the like.

~~(10)~~**(11)** "Industry code" means the code which indicates the nature of the employer's business, which is contained in the Standard Industrial Classification (SIC) manual published by the Federal Office of Management and Budget, or in the North American Industrial Classification System (NAICS) published by the U.S. Census Bureau.

~~(11)~~**(12)** "Insurer" means workers' compensation insurance carrier providing coverage to an employer, or a self-insured employer.

~~(12)~~**(13)** "Mandatory data element" means an element that will cause a rejection of a transaction if the data element is omitted or submitted in a format not capable of being processed by the division's information processing system.

~~(13)~~**(14)** "Optional data element" means an element that an insurer should report to the director if the information is available to the insurer. Optional data elements will not cause a rejection if missing or invalid.

~~(14)~~**(15)** "Proof of coverage" means an electronic record or set of records identifying an insurer as providing workers' compensation coverage for a specific employer.

~~(15)~~**(16)** "Record" means electronic record.

~~(16)~~**(17)** "Sender" means the person or entity reporting electronic data interchange transactions to the division. Sender may include vendors or insurers.

~~(17)~~**(18)** "Trading partner agreement" means the agreement entered into pursuant to OAR 436-160-0020 between the director and an insurer to conduct transactions via EDI.

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~~(18)~~**(19)** "Trailer record" means the record that designates the end of a transmission and provides a count of transactions contained within the transmission, not including the header and trailer records.

~~(19)~~**(20)** "Transaction" means a set of EDI records, defined according to standards in OAR 436-160-0004.

~~(20)~~**(21)** "Transmission" means a defined set of transactions, including both header and trailer records to be sent to the division or sender via EDI.

~~(21)~~**(22)** "Vendor" means an agent identified in a trading partner agreement to submit transmissions to the division on behalf of an insurer. Vendors may include service companies, third party administrators, and managing general agents.

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

Stat. Implemented: ORS 84.004 and ORS 656.264

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

436-160-0006 Administration of Rules

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

Stat. Authority: ORS 656.704 and ORS 656.726(4)

Stat. Implemented: ORS 656.704 and ORS 656.726(4)

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

436-160-0010 Security

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

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

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

Stat. Implemented: ORS 656.264

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

436-160-0020 Trading Partner Agreement

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

(2) The trading partner agreement will include:

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

(b) Transmission protocol between sender and director;

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

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

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- (e) Cost allocation of transactions, if any;
- (f) The time frame for the director to submit acknowledgements of transmissions; and
- (g) Any other necessary statements, conditions or requirements to facilitate EDI.

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

Stat. Implemented: ORS 84.013 and ORS 656.264

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

436-160-0030 Retention of Electronic Records

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

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 656.455 and ORS 731.475

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

436-160-0040 Recognized Filing Date

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

- (a) Is addressed or directed properly to an information processing system designated or used by the division to receive electronic records or information;
- (b) Is in a form and format capable of being processed by that system; and
- (c) Enters an information processing system outside the control of the sender or enters a region of the information processing system designated or used by the division and that is under control of the division.

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

- (a) Enters an information processing system designated or used by the division to receive electronic records or information of the type sent and from which the division is able to retrieve the electronic record; and
- (b) Is in a form and format capable of being processed by the division's information processing system.

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

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

Stat. Implemented: ORS 84.043 and ORS 656.264

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

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

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

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Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 84.013 and ORS 656.264

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

436-160-0060 Testing Procedures and Requirements

(1) Proof of Coverage Testing:

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

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

(a)(A) Transmit records via electronic data interchange; and

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

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

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

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

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

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

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

(6)(f) Once approved, sender must maintain the accuracy as defined in subsections (4)(d) and (5)(e) of this rule section. Failure to meet technical requirements may result in the revocation of EDI transmission approval.

(7)(g) The director will inform the sender and insurer (if different) if accuracy standards for technical requirements fall below standards prescribed in subsections (4)(d) and (5)(e) of this section during production.

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

(2) Medical Bill Data Testing and Transition to Production:

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

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

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

(A) Transmit records via electronic data interchange; and

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

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

(A) Transmissions are sent to the director without structural errors;

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

and

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

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

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

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

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

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 84.013 and ORS 656.264

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

436-160-0070 Electronic signature

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

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 84.001-84.061 and ORS 656.264

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

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436-160-0080 Acknowledgements**(1) Proof of Coverage:**

~~(1)~~**(a)** The director will respond to the sender with an electronic transaction accepted or transaction rejected acknowledgement of the insurer's transactions.

~~(2)~~**(b)** The insurer must correct and resubmit any transactions rejected for which law or rule require filing, reporting, or notice to the director.

(2) Medical Bill Data:

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

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

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 656.264

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

436-160-0090 Address Reporting

The sender will follow the standard United States Postal Service guidelines in reporting all addresses, as follows:

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

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

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

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 656.264

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

Insurers' Obligation to Report Medical Bill Data

436-160-0400 Medical Bill Definitions

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

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 656.264

Hist: Adopted xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

436-160-0410 Medical Bill Electronic Filing Requirements

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

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

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

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

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

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 656.264

Hist: Adopted xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

436-160-0420 Medical Bill Acknowledgement

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

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

(a) An omitted mandatory data element;

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

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

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

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

(f) Invalid bill submission reason code; or

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

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

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

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Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Adopted xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

436-160-0430 Medical Bill Data Changes or Corrections

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

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

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

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Adopted xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

OAR 436-160-0410, Appendix B

NOTE: M = mandatory; C = conditional element which becomes mandatory under the stated trigger; O = optional

OREGON MEDICAL DATA ELEMENT REQUIREMENT TABLE					
<i>NOTE: This table is also published in OAR 436-009.</i>					
Bill Reason Submission Codes					
		Original	Cancellation	Replace	
DN	Data Element Name	00	01	05	Mandatory Trigger
513	<u>Admission Date</u>	C	O	O	<u>If Billing Format Code equals "A" and patient has been admitted</u>
535	<u>Admitting Diagnosis Code</u>	C	O	O	<u>If Billing Format Code is "A" and patient has been admitted</u>
564	<u>Basis of Cost Determination Code</u>	C	O	O	<u>If a pharmacy bill submitted on universal claim form/NCPDP format</u>
545	<u>Bill Adjustment Amount</u>	C	O	O	<u>If paid amount is not equal to billed amount</u>
543	<u>Bill Adjustment Group Code</u>	C	O	O	<u>If paid amount is not equal to billed amount</u>
544	<u>Bill Adjustment Reason Code</u>	C	O	O	<u>If paid amount is not equal to billed amount</u>
546	<u>Bill Adjustment Units</u>	C	O	O	<u>If paid amount is not equal to billed amount</u>
508	<u>Bill Submission Reason Code</u>	M	M	M	
503	<u>Billing Format Code</u>	M	M	O	
629	<u>Billing Provider FEIN</u>	C	O	C	<u>If provider has no NPI, report FEIN plus State License Number</u>
528	<u>Billing Provider Last/Group Name</u>	C	O	O	<u>If different than Rend. Bill Prov. Last/Gp. Name</u>
537	<u>Billing Provider Primary Specialty Code</u>	C	O	O	<u>If applicable.</u>
630	<u>Billing Provider State License Number</u>	C	O	O	<u>If provider has no NPI, report FEIN plus State License Number</u>
523	<u>Billing Provider Unique Bill Identification Number</u>	O	O	O	
634	<u>Billing Provider National Provider ID</u>	C	O	C	<u>If provider has an NPI, it must be reported; otherwise, report the provider FEIN</u>
502	<u>Billing Type Code</u>	C	O	O	<u>If Billing Format Code equals "B" and prescriptions or durable medical equipment are billed</u>
015	<u>Claim Administrator Claim Number</u>	M	M	M	
187	<u>Claim Administrator FEIN</u>	C	O	O	<u>If the Claim Administrator FEIN is different than Insurer FEIN</u>
188	<u>Claim Administrator Name</u>	C	O	O	<u>If the Claim Administrator name is different than Insurer name</u>

512	<u>Date Insurer Paid Bill</u>	<u>M</u>	<u>O</u>	<u>O</u>	
511	<u>Date Insurer Received Bill</u>	<u>M</u>	<u>O</u>	<u>O</u>	
31	<u>Date of Injury</u>	<u>M</u>	<u>O</u>	<u>O</u>	
554	<u>Days/Units Billed</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Jur. Proc. Billed Code or HCPCS Line Proc. Billed Code are present or Billing Type Code = DM, or a drug is dispensed by a physician during an office visit.</u>
553	<u>Days/Units Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Jur. Proc. Billed Code or HCPCS Line Proc. Billed Code are present or Billing Type Code = DM or a drug is dispensed by a physician during an office visit.</u>
557	<u>Diagnosis Pointer</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "B" and Jur. Proc. Billed Code or HCPCS Line Proc. Billed Code is present or a drug is dispensed by a physician during an office visit.</u>
514	<u>Discharge Date</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "A" and patient has been discharged</u>
562	<u>Dispense As Written Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a pharmacy bill submitted on universal claim form/NCPDP format</u>
567	<u>DME Billing Frequency Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Type Code = DM and Total Chg. per Line - Rental is present</u>
518	<u>DRG Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "A"</u>
563	<u>Drug Name</u>	<u>O</u>	<u>O</u>	<u>O</u>	
572	<u>Drugs/Supplies Billed Amount</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Type Code, value is "RX" or "MO".</u>
579	<u>Drugs/Supplies Dispensing Fee</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a pharmacy bill submitted on universal claim form/NCPDP format</u>
571	<u>Drugs/Supplies Number of Days</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Type Code, value is "RX" or "MO".</u>
570	<u>Drugs/Supplies Quantity Dispensed</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Type Code, value is "RX" or "MO".</u>
152	<u>Employee Employment Visa</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Employee Social Security number or Employee Green Card number is not available.</u>
44	<u>Employee First Name</u>	<u>M</u>	<u>O</u>	<u>O</u>	
153	<u>Employee Green Card</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Employee Social Security number is not available.</u>
154	<u>Employee ID Assigned by Jurisdiction</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Employee Social Security, Employee Green Card, Employee Employment Visa or Employee Passport Number not available.</u>
43	<u>Employee Last Name</u>	<u>M</u>	<u>O</u>	<u>O</u>	
156	<u>Employee Passport Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Employee Social Security, Employee Green Card, or Employee Employment Visa not available.</u>
42	<u>Employee Social Security Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>Employee SSN is preferred ID number. If none, see Employee Green Card. If injured worker is not a United States citizen and has no other identification, call WCD to receive Jurisdiction Assigned ID Number for reporting purposes</u>
504	<u>Facility Code</u>	<u>C</u>	<u>C</u>	<u>O</u>	<u>If Billing Format Code equals "A"</u>
678	<u>Facility Name</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If service performed in a licensed facility</u>
682	<u>Facility National Provider ID</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If service performed in a licensed facility</u>

737	<u>HCPCS Bill Procedure Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If HCPCS Prin. Proc. Billed Code is present and more than one procedure is performed</u>
714	<u>HCPCS Line Procedure Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Type Code not equal RX or MO, and if Jur. Proc. Billed Code or NDC Billed Code not present</u>
726	<u>HCPCS Line Procedure Paid Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than HCPCS Line Proc. Billed Code</u>
717	<u>HCPCS Modifier Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If HCPCS Line Proc. Billed Code is modified</u>
727	<u>HCPCS Modifier Paid Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If HCPCS Line Proc. Paid Code is modified</u>
626	<u>HCPCS Principal Procedure Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code is "A" and the code value is not an ICD-9 code. For surgical bills only.</u>
736	<u>ICD-9 CM Procedure Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If ICD-9 CM Prin. Proc. Code is present and more than one procedure is performed</u>
522	<u>ICD-9 CM Diagnosis Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Prin. Diag. Code is present and more than one diagnosis occurs or if Billing Format Code = B and HCPCS Line Proc. Billed Code or Jur. Proc. Billed Code or a drug is dispensed by a physician during an office visit.</u>
525	<u>ICD-9 CM Principal Procedure Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code is "A" and the code value is not a HCPCS code. For surgical bills only.</u>
6	<u>Insurer FEIN</u>	<u>M</u>	<u>M</u>	<u>M</u>	
5	<u>Jurisdictional Claim Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If the first report of injury has been filed and a jurisdictional claim number is available</u>
718	<u>Jurisdictional Modifier Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Jur. Proc. Billed Code is modified</u>
730	<u>Jurisdictional Modifier Paid Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Juris. Mod. Billed Code</u>
715	<u>Jurisdictional Procedure Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If the procedure is included as an Oregon-specific code in the Oregon Medical Fee Schedule</u>
729	<u>Jurisdictional Procedure Paid Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Jur. Proc. Billed Code</u>
547	<u>Line Number</u>	<u>M</u>	<u>O</u>	<u>O</u>	
208	<u>Managed Care Organization Identification Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If worker enrolled at time of service.</u>
721	<u>NDC Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a pharmaceutical bill or a drug is dispensed by a physician during an office visit.</u>
728	<u>NDC Paid Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than NDC Billed Code</u>
555	<u>Place of Service Bill Code</u>	<u>C</u>	<u>C</u>	<u>O</u>	<u>If Billing Format Code equals "B"</u>
600	<u>Place of Service Line Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Place of Svc. Billed Code and not a pharmacy bill</u>
527	<u>Prescription Bill Date</u>	<u>O</u>	<u>O</u>	<u>O</u>	
604	<u>Prescription Line Date</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a pharmacy bill submitted on universal claim form/NCPDP format</u>
561	<u>Prescription Line Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a pharmacy bill submitted on universal claim form/NCPDP format</u>
521	<u>Principal Diagnosis Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "A"</u>
550	<u>Principal Procedure Date</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "A" and if ICD-9 CM Prin. Proc. Code or HCPCS Prin. Proc. Billed Code is present</u>

524	<u>Procedure Date</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "A" and more than one surgical procedure was performed</u>
507	<u>Provider Agreement Code</u>	<u>M</u>	<u>O</u>	<u>O</u>	<u>Enter the value "P" if the injured worker is enrolled in a Managed Care Organization at time of service</u>
642	<u>Rendering Bill Provider FEIN</u>	<u>C</u>	<u>O</u>	<u>C</u>	<u>If provider has no NPI, report FEIN plus State License Number</u>
638	<u>Rendering Bill Provider Last/Group Name</u>	<u>M</u>	<u>O</u>	<u>O</u>	
647	<u>Rendering Bill Provider National Provider ID</u>	<u>C</u>	<u>O</u>	<u>C</u>	<u>If provider has an NPI, it must be reported; otherwise, report the provider FEIN</u>
651	<u>Rendering Bill Provider Primary Specialty Code</u>	<u>M</u>	<u>O</u>	<u>O</u>	
643	<u>Rendering Bill Provider State License Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If provider has no NPI, report FEIN plus State License Number</u>
586	<u>Rendering Line Provider FEIN</u>	<u>C</u>	<u>O</u>	<u>C</u>	<u>If provider has no NPI, report FEIN plus State License Number</u>
592	<u>Rendering Line Provider National ID</u>	<u>C</u>	<u>O</u>	<u>C</u>	<u>If provider has an NPI, it must be reported; otherwise, report the provider FEIN</u>
595	<u>Rendering Line Provider Primary Specialty Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Rend. Bill Prov. Prim. Spec. Code</u>
599	<u>Rendering Line Provider State License Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If provider has no NPI, report FEIN plus State License Number</u>
615	<u>Reporting Period</u>	<u>M</u>	<u>M</u>	<u>M</u>	
559	<u>Revenue Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a value for Facility Code with 1st digit equal to 1</u>
576	<u>Revenue Paid Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Rev. Billed Code</u>
733	<u>Service Adjustment Amount</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If applicable.</u>
731	<u>Service Adjustment Group Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If applicable.</u>
732	<u>Service Adjustment Reason Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If applicable.</u>
509	<u>Service Bill Date(s) Range</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Svc. Lines Date Range</u>
605	<u>Service Line Date(s) Range</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If not a pharmacy bill submitted on universal claim form/NCPDP format</u>
516	<u>Total Amount Paid Per Bill</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Total Chg. per Bill</u>
574	<u>Total Amount Paid Per Line</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If paid amount is not equal to billed amount</u>
501	<u>Total Charge Per Bill</u>	<u>M</u>	<u>M</u>	<u>M</u>	
552	<u>Total Charge Per Line</u>	<u>O</u>	<u>O</u>	<u>O</u>	
566	<u>Total Charge Per Line – Purchase</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Durable Medical Equipment is purchased</u>
565	<u>Total Charge Per Line – Rental</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Durable Medical Equipment is rented</u>
266	<u>Transaction Tracking Number</u>	<u>M</u>	<u>M</u>	<u>M</u>	
500	<u>Unique Bill ID Number</u>	<u>M</u>	<u>M</u>	<u>M</u>	<u>Canc. & Replace. Transactions must match prev. submitted Original Unique Bill ID No.</u>