IAIABC Workers' Compensation Electronic Billing and Payment National Companion Guide

Based on ASC X12 005010 and NCPDP D.0

Release 2.0

July 2, 2012

Important Notes

1. Assistance requests and documentation error reporting should be made to the IAIABC at 608-663-6355 or contact us at www.iaiabc.org.
2. The IAIABC companion guide is a template for jurisdictions to use to create their own guide. The use of this product requires the jurisdiction to tailor requirements to match its regulatory environment. This companion guide includes instructions and notes to help guide jurisdictions in identifying those areas that need specific jurisdictional language.
3. The IAIABC companion guide was reviewed and approved by the ASC X12 Intellectual Property (IP) Committee prior to publication. ASC X12 has granted the IAIABC authority to review jurisdictions' eBill companion guides that are based on this IAIABC template and to extend their permission to reproduce materials to those documents. Jurisdictions that customize this eBill companion guide to reflect their jurisdictional eBill requirements must submit their draft companion guide to the IAIABC for review and approval.
4. This companion guide is the product of consensus. The IAIABC makes no warranties regarding the fitness for any purpose of any resource, product or service that is mentioned within the guide and assumes no responsibility for consequential damages resulting from the use or reliance thereupon.

Jurisdictions should remove paragraph 2 above when developing their jurisdiction-specific companion guides.

Attestation of approval from IAIABC and X12 (for each jurisdiction-specific companion guide)

About the IAIABC eBill Companion Guide

Congratulations on adopting eBilling for workers' compensation in your jurisdiction! This document, the IAIABC Workers' Compensation Electronic Billing and Payment National Companion Guide based on ASC X12 005010 and NCPDP D.0 (Release 2.0) has been prepared to assist medical practice management providers and payers in your jurisdiction to efficiently bill and pay for professional, institutional, dental, and pharmacy services provided to your workers' compensation patients.

The IAIABC recognizes that electronic transmission of medical bills and payments using a national standard is the most efficient and effective processing method, and has worked diligently with ASC X12 to develop this companion guide for medical billers and payers in the workers' compensation community. This guide was developed with the support and approval of ASC X12, using their copyright-protected work as the foundation and is intended to be used in conjunction with the ASC X12 005010 TR3s and the NCPDP D.0 (Release 2.0). This companion guide is supplemental to the ASC X12 005010 TR3s and NCPDP D.0 (Release 2.0) and cannot be used independently of those standards. The purpose of the companion guide is to show the exceptions to normal group health medical bill processing that workers' compensation billing will require.

To assist jurisdictions in preparing the companion guide to fit their jurisdictional-specific requirements, the IAIABC drafting team has highlighted in red the areas that the jurisdiction must customize to align with their regulations. These highly-visible decision points will greatly speed the completion of this task. Jurisdictions must submit their completed draft product to the IAIABC for review and registration with ASC X12, to stay in compliance both with ASC X12's intellectual property policies and with the memorandum of understanding between the IAIABC and ASC X12, as well as to assure that the jurisdiction's eBilling implementation will be as smooth as possible.

The IAIABC Medical and ProPay Committees are developing toolkits to walk jurisdictions through the customization process, and will also use those toolkits as they carefully review each draft. Additionally, the IAIABC eBill Model Rule will help you to be sure that your eBill implementation is complete.

Because the companion guide cannot be used independently of the established ASCX12 and NCPDP electronic billing standards, you will need the following resources to fully implement eBilling in your jurisdiction:

- The Accredited Standards Committee X12 (ASC X12) Type 3 Technical Reports (available through the ASC X12, http://store.x12.org)
- The National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide Version D.0 (available from NCPDP at www.ncpdp.org)

As your jurisdiction prepares for eBilling, it will also be very important to create a knowledgeable team to review and customize your eBilling companion guide. Personnel should include, at a minimum, subject matter experts from the jurisdiction's workers' compensation agency's medical billing, medical reporting, technical, and legal areas. The IAIABC Medical and ProPay Committee members are also available to assist with questions that may come up; you may access them by contacting Faith Howe, IAIABC EDI Manager, at fhowe@iaiabc.org.

Purpose of the Electronic Billing and Payment Companion Guide

This guide has been created for use in conjunction with the Accredited Standards Committee X12 (ASC X12) Type 3 Technical Reports and the National Council for Prescription Drug Programs (NCPDP) national standard implementation guides adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These national standard implementation guides are incorporated by reference. The *(Insert Jurisdiction)* Companion Guide is not to be a replacement for those national standard implementation guides but rather is to be used as an additional source of information. This companion guide contains data clarifications derived from specific business rules that apply to processing bills and payments electronically within the *(Insert Jurisdiction)* workers' compensation system**.**

Documentation Change Control

The companion guide content is subject to change.

Documentation change control is maintained in this document through the use of the Change Control Table shown below. Each change made to this companion guide after the creation date is noted, along with the date and reason for the change.

Change Control Table			
Date	**Page(s)**	**Change**	**Reason**

(Insert Jurisdiction) Companion Guide Contact Information

(Insert Jurisdiction Workers' Compensation Organization Name)
Address:
Attn: Electronic Billing
Telephone Number:
FAX Number:
Email Address:

Methodology for Updating Companion Guide Document

Please contact the *(Insert Jurisdiction Workers' Compensation Organization)* above regarding instructions for submitting change requests, recommendations, and document updates.

(Insert any additional jurisdictional instructions)

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Chapter 1 Introduction and Overview

1.1 HIPAA

The Administrative Simplification Act provisions of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) include requirements that national standards for electronic health care transactions and national identifiers for Health Care Provider (Providers), Health Plans, and Employers be established. These standards were adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. Additional information regarding the formats adopted under HIPAA is included in Chapter 2.

1.2 *(Insert Jurisdiction's Regulatory Reference)*

(Insert Regulatory Reference, such as the Labor Code provisions) mandates that payers accept electronic bills for medical goods and services. This companion guide attempts to establish electronic billing rules that are as consistent with HIPAA as possible. The health care provider, health care facility, or third-party biller/assignee shall use the HIPAA-adopted electronic transaction formats to submit medical or pharmacy bills to the appropriate claim administrator associated with the employer of the injured employee to whom the services are provided.

(Jurisdictions must tailor this language to align with their definitions and processes) In workers' compensation, the payer is the claim administrator providing coverage for the employer of the injured employee to whom the services are provided. The claim administrator, or its authorized agent, is to validate the Electronic Data Interchange (EDI) file according to the guidelines provided in the prescribed national standard format implementation guide, this companion guide, and the jurisdictional data requirements. Problems associated with the processing of the ASC X12 Health Care Claim (837) EDI file are to be reported using acknowledgment transactions described in this companion guide. Problems associated with the processing of the NCPDP Telecommunications D.0 bills are reported via the reject response transactions described in this companion guide. The claim administrator will use the HIPAA-adopted electronic transaction formats to report explanations of payments, reductions, and denials to the health care provider, health care facility, or third-party biller/assignee. These electronic transaction formats include the ASC X12N/005010X221A1, Health Care Claim Payment/Advice (835), and the NCPDP Telecommunication D.0 Paid response transaction.

Health care providers, health care facilities, or third-party biller/assignees, claim administrators, clearinghouses, or other electronic data submission entities shall use this guideline in conjunction with the HIPAA-adopted ASC X12 Type 3 Technical Reports (implementation guides) and the NCPDP Telecommunication Standard Implementation Guide Version D.0. The ASC X12 Type 3 Technical Reports (implementation guides) can be accessed by contacting the Accredited Standards Committee (ASC) X12, http://store.x12.org. The NCPDP Telecommunication Standard Implementation Guide Version D.0 is available from NCPDP at www.ncpdp.org.

This guide outlines jurisdictional procedures necessary for engaging in Electronic Data Interchange (EDI) and specifies clarifications where applicable. When coordination of a solution is required, *(Insert Jurisdiction Workers' Compensation Organization Name)* will work with the IAIABC EDI Medical Committee and Provider to Payer Subcommittee to coordinate with national standard setting organizations and committees to address workers' compensation needs.

Chapter 2 *(Insert Jurisdiction Workers' Compensation Organization Name)* Workers' Compensation Requirements

2.1 Compliance

If a billing entity chooses to submit bills electronically, it must also be able to receive an electronic response from the claim administrator. The electronic responses include electronic acknowledgments and electronic remittance advices (Explanation of Review).

Electronic billing rules allow for providers and claim administrators to use agents to meet the requirement of electronic billing, but these rules do not mandate the method of connectivity, or the use of, or connectivity to, clearinghouses or similar types of vendors.

Nothing in this document prevents the parties from utilizing Electronic Funds Transfer (EFT) to facilitate payment of electronically submitted bills. Use of EFT is optional, and is not a pre-condition for electronic billing.

Health care providers, health care facilities, third-party biller/assignees, and claim administrators must be able to exchange electronic bills in the prescribed standard formats and may exchange data in non-prescribed formats by mutual agreement. All jurisdictionally-required data content must be present in mutually agreed upon formats. *(Exclude this paragraph if the Jurisdiction does not allow mutually agreed upon formats.)*

2.1.2 Agents

Electronic billing rules allow for health care providers and claim administrators to use agents to accomplish the requirement of electronic billing.

Claim administrators and health care providers are responsible for the acts or omissions of their agents.

2.1.3 Privacy, Confidentiality, and Security

Health care providers, health care facilities, third-party biller/assignees, claim administrators, and their agents must comply with all applicable Federal and *(Insert Jurisdiction)* Acts, Codes, or Rules related to privacy, confidentiality, security or similar issues.

2.2 National Standard Formats

The national standard formats for billing, remittance, and acknowledgments are those adopted by the Federal Department of Health and Human Services rules (45 CFR Parts 160 and 162). The formats adopted under *(Insert Jurisdiction's Regulatory Reference)* that are aligned with the current Federal HIPAA implementation include:

- ASC X12N/005010X222A1 Health Care Claim: Professional (837);
- ASC X12N/005010X223A2 Health Care Claim: Institutional (837);
- ASC X12N/005010X224A2 Health Care Claim: Dental (837);
- ASC X12N/005010X221A1 Health Care Claim Payment/Advice (835);
- ASC X12N/005010X212 Health Care Claim Status Request and Response (276/277);
- ASCX12N005010TA1 Interchange Acknowledgment;
- ASCX12C005010X231 Implementation Acknowledgment for Health Care Insurance (999);
- ASCX12N005010X214 Health Care Claim Acknowledgment (277);

- NCPDP Telecommunication Standard Implementation Guide Version D.0; and
- NCPDP Batch Standard Implementation Guide 1.2.

The following acknowledgment formats and the attachment format have not been adopted in the current HIPAA rules but are also based on ASC X12 standards.

- The ASC X12N/005010X213 Request for Additional Information (277) is used to request additional attachments that were not originally submitted with the electronic medical bill.
- The ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) is used to transmit electronic documentation associated with an electronic medical bill. The 005010X210 can accompany the original electronic medical bill, or may be sent in response to a 005010X213 Request for Additional Information.

The NCPDP Telecommunication Standard Implementation Guide Version D.0 contains the corresponding request and response messages to be used for pharmacy transactions.

2.2.1 *(Insert Jurisdiction Workers' Compensation Organization Name)* Prescribed Formats

Format	Corresponding Paper Form	Function
005010X222A1	CMS-1500	Professional Billing
005010X223A2	UB-04	Institutional/Hospital Billing
005010X224A2	ADA-2006	Dental Billing
NCPDP D.0 and Batch 1.2	NCPDP WC/PC UCF	Pharmacy Billing
005010X221A1	None	Explanation of Review (EOR)
TA1 005010	None	Interchange Acknowledgment
005010X231	None	Transmission Level Acknowledgment
005010X214	None	Bill Acknowledgment

2.2.2 ASC X12 Ancillary Formats

Other formats not adopted by (*Insert Jurisdiction Workers' Compensation Organization Name*) rule are used in ancillary processes related to electronic billing and reimbursement. The use of these formats is voluntary, and the companion guide is presented as a tool to facilitate their use in workers' compensation.

Format	Corresponding Process	Function
005010X210	Documentation/Attachments	Documentation/Attachments
005010X213	Request for Additional Information	Request for Medical Documentation
005010X212	Health Claim Status Request and Response	Medical Bill Status Request and Response

2.3 Companion Guide Usage

(Insert Jurisdiction Workers' Compensation Organization Name) workers' compensation implementation of the national standard formats aligns with HIPAA usage and requirements in most circumstances. This jurisdictional companion guide is intended to convey information that is within the framework of the ASC X12 Type 3 Technical Reports (Implementation Guides) and NCPDP Telecommunication Standard Implementation Guide Version D.0 adopted for use. The jurisdictional companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the ASC X12 Type 3 Technical Reports (Implementation Guides) or NCPDP Telecommunication Standard Implementation Guide Version D.0. The jurisdictional companion guide, where applicable, provides additional instruction on situational implementation factors that are different in workers' compensation than in the HIPAA implementation.

When the workers' compensation application situation needs additional clarification or a specific code value is expected, the companion guide includes this information in a table format. Shaded rows represent "segments" in the ASC X12 Type 3 Technical Reports (Implementation Guides). Non-shaded rows represent "data elements" in the ASC X12 Type 3 Technical Reports (Implementation Guides). An example is provided in the following table:

Loop	Segment or Element	Value	Description	*(Insert Jurisdiction Workers' Compensation Organization Name)* Workers' Compensation Instructions
2000B	**SBR**		**Subscriber Information**	In workers' compensation, the Subscriber is the Employer.
	SBR04		**Group or Plan Name**	Required when the Employer Department Name/Division is applicable and is different than the Employer reported in Loop 2010BA NM103.
	SBR09	WC	**Claim Filing Indicator Code**	Value must be 'WC' to indicate workers' compensation bill.

Detailed information explaining the various components of the use of loops, segments, data elements, and conditions can be found in the appropriate ASC X12 Type 3 Technical Reports (Implementation Guides).

The ASC X12 Type 3 Technical Reports (Implementation Guides) also include elements that do not relate directly to workers' compensation processes, for example, coordination of benefits. If necessary, the identification of these loops, segments, and data elements can be described in the trading partner agreements to help ensure efficient processing of standard transaction sets.

2.4 Description of ASC X12 Transaction Identification Numbers

The ASC X12 Transaction Identification requirements are defined in the appropriate ASC X12 Type 3 Technical Reports (Implementation Guides), available through the Accredited Standards Committee (ASC) X12, http://store.x12.org. The *(Insert Jurisdiction Workers' Compensation Organization Name)* has provided the following additional information regarding transaction identification number requirements.

2.4.1. Sender/Receiver Trading Partner Identification

Workers' compensation standards require the use of the Federal Employer Identification Number (FEIN) or other mutually agreed upon identification numbers to identify Trading Partners (sender/receiver) in electronic billing and reimbursement transmissions. Trading Partners will exchange the appropriate and necessary identification numbers to be reported based on the applicable transaction format requirements.

2.4.2 Claim Administrator Identification

Claim administrators and their agents are also identified through the use of the FEIN or other mutually agreed upon identification number. Claim administrator information is available through direct contact with the claim administrator. The Claim Administrator Identification information is populated in Loop 2010BB for 005010X222A1, 005010X223A2, and 005010X224A2 transactions.

Health care providers will need to obtain payer identification information from their connectivity trading partner agent (i.e. clearinghouses, practice management system, billing agent and/or other third party vendor) if they are not directly connecting to a claim administrator.

2.4.3 Health Care Provider Identification

(Note: The Jurisdiction must not require secondary identification numbers for health care providers that would conflict with the national transaction standards.) Health Care Provider roles and identification numbers are addressed extensively in the ASC X12 Type 3 Technical Reports (Implementation Guides). However, it is noted that in the national transaction sets most health care providers are identified by the National Provider Identification number, and secondary identification numbers are generally not transmitted.

2.4.4 Injured Employee Identification

(Note: The Jurisdiction needs to verify the data requirements associated with identifying the injured employee and tailor this subsection according to its requirements. The language contained in this section is for illustration purposes only. The ASC X12 Type 3 Technical Reports contain a situational rule regarding when the Property and Casualty Patient Identifier is required. Jurisdictions that mandate the reporting of the Social Security Number must clearly identify that requirement in their regulatory framework.) The injured employee is identified by (Social Security Number), date of birth, date of injury, and workers' compensation claim number (see below).

The injured employee's (patient's) Identification Number is submitted using the Property and Casualty Patient Identifier REF segment in Loop 2010CA.

2.4.5 Claim Identification

(Note: The Jurisdiction needs to verify the data requirements associated with claim identification and tailor this subsection according to its requirements. The language contained in this section is for illustration purposes only.) The workers' compensation claim number assigned by the claim administrator is the claim identification number. This claim identification number is reported in the REF segment of Loop 2010CA, Property and Casualty Claim Number.

The ASC X12N Technical Report Type 3 (Implementation Guides) instructions for the Property and Casualty Claim Number REF segments require the health care provider, health care facility, or third-party biller/assignee to submit the claim identification number in the 005010X222A1, 005010X223A2 and 005010X224A2 transactions.

2.4.6 Bill Identification

The ASC X12N Technical Report Type 3 (Implementation Guides) refers to a bill as a "claim" for electronic billing transactions. This *(Insert Jurisdiction Workers' Compensation Organization Name)* companion guide refers to these transactions as "bill" because in workers' compensation, a "claim" refers to the full case for a unique injured employee and injury.

The health care provider, health care facility, or third-party biller/assignee, assigns a unique identification number to the electronic bill transaction. For 005010X222A1, 005010X223A2, and 005010224A2 transactions, the bill transaction identification number is populated in Loop 2300 Claim Information CLM Health Claim segment CLM01 Claim (Bill) Submitter's Identifier data element. This standard HIPAA implementation allows for a patient account number but strongly recommends that submitters use a completely unique number for this data element on each individual bill.

2.4.7 Document/Attachment Identification

The 005010X210 is the standard electronic format for submitting electronic documentation and is addressed in a later chapter of this *(Insert Jurisdiction Workers' Compensation Organization Name)* companion guide.

Documentation to support electronic medical bills may be submitted by facsimile (fax), electronic mail (email), electronic transmission using the prescribed format, or by a mutually agreed upon format. Documentation related to an electronic bill must identify the following elements: (*insert Jurisdiction required data elements).*

- The PWK segment and the associated documentation identify the type of documentation through the use of ASC X12 standard Report Type Codes. The PWK segment and the associated documentation also identify the method of submission of the documentation through the use of ASC X12 Report Transmission Codes.
- A unique Attachment Indicator Number shall be assigned to all documentation. The Attachment Indicator Number populated on the document shall include the Report Type Code, the Report Transmission Code, the Attachment Control Qualifier (AC) and the Attachment Control Number. For example, operative note (report type code OB) sent by fax is identified as OBFXAC12345. The combination of these data elements will allow a claim administrator to appropriately match the incoming attachment to the electronic medical bill.
- In situations when the documentation represents a Jurisdictional Report, the provider uses code value 'OZ' (Support Data for Claim) as the Report Type Code in PWK01 and enters the Jurisdictional Report Type Code (e.g. J1=Doctor First Report) in front of the Attachment Control Number. Example: OZFXACJ199923 in PWK06.

Please refer to Appendix B for a list of Jurisdictional Report Type Codes and associated *(Insert Jurisdiction Workers' Compensation Organization Name)* report type code descriptions.

2.5 Claim Administrator Validation Edits

Note: if your Jurisdiction uses the IAIABC Medical State Reporting, paragraph 1 applies. If your Jurisdiction does not use the IAIABC EDI Medical State Reporting standard, please remove paragraph 1 from your jurisdictional companion guide.

The *(Insert Jurisdiction Workers' Compensation Organization Name)* Medical State Reporting EDI Guide, used in conjunction with the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide (Release 2.0), provides validation edits that the *(Insert Jurisdiction Workers' Compensation Organization Name)* applies to transactions reported by the claim administrator. The claim administrator may also apply *(Insert Jurisdiction Workers' Compensation Organization Name)* Medical State Reporting EDI validation edits that might also reasonably apply to provider billing transactions. However, the claim administrator must use appropriate edits to ensure accurate payment processing, as opposed to using edits that were created for the different requirements of jurisdictional data reporting. It is not appropriate to apply the data reporting edits without researching or investigating their potential impact on processing complete claims.

Claim administrators may refer to various sources for the validation edits they apply to electronic bills received from providers. Sources for validation edits may include:

- Jurisdictionally-required edits found in the (*Insert Jurisdiction Workers' Compensation Organization Name*) Medical Bill State Reporting Implementation Guide,
- The IAIABC Medical Bill/Payment Records Implementation Guide,
- ASC X12N Type 3 Technical Reports (Implementation Guides) requirements, or
- Medicare coding and billing policies when applicable.

Claim administrators use the 005010X214 transaction, referred to in this companion guide as an Acknowledgment, to communicate transaction (individual bill) rejections for ASC X12-based electronic medical bills. Error rejection codes are used to indicate the reason for the transaction rejection.

2.6 Description of Formatting Requirements

The ASC X12 formatting requirements are defined in the ASC X12 Type 3 Technical Reports (Implementation Guides), Appendices A.1, available through the Accredited Standards Committee (ASC) X12, http://store.x12.org. The *(Insert Jurisdiction Workers' Compensation Organization Name)* has provided the following additional information regarding formatting requirements: (*Insert Jurisdiction formatting requirements, if any*).

The NCPDP Telecommunication D.0 formatting requirements are defined in the NCPDP Telecommunication Standard Implementation Guide Version D.0, available at http://www.ncpdp.org.

2.6.1 ASC X12 Hierarchical Structure

For information on how the ASC X12 Hierarchical Structure works, refer to Section 2.3.2 HL segment of the ASC X12 Type 3 Technical Reports (Implementation Guides), available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

2.7 Description of ASC X12 Transmission/Transaction Dates

The ASC X12 required Transmission/Transaction Dates are defined in the ASC X12 Type 3 Technical Reports (Implementation Guides) available through the Accredited Standards Committee (ASC) X12, http://store.x12.org. The *(Insert Jurisdiction Workers' Compensation Organization Name)* has provided additional information regarding specific transmission/transaction identification requirements.

2.7.1 Date Sent/Invoice Date

In the manual paper medical bill processing model, the paper bill includes a date the bill was generated, to verify timely filing. For electronic billing, the Invoice Date is the Date Sent, which is reflected in the Interchange Control Header ISA segment Interchange Date. The date in the Interchange Control Header ISA segment must be the actual date the transmission is sent.

2.7.2 Date Received

(This subsection needs to reflect the Jurisdiction's requirements for electronic medical bill processing. The language contained in this subsection is for illustration purposes only and must be modified to reflect the Jurisdiction's specific requirements.)

For medical bill processing purposes, the Date Received is the date the claim administrator or its agent systematically received the transaction. Other dates included in the electronic transaction or outer envelope (e.g. Interchange Control Header ISA segment Interchange Date, Business Application Creation Date) are often the same as the actual date systematically received, but based on processing delays,

intermediary connections, or other automated handling by the submitter or the submitter agent, those dates are not considered as the Date Received because they may not be current. The Date Received is used to track timely processing of electronic bills, electronic reconsideration/appeal transactions, acknowledgment transactions, and timeliness of payments.

2.7.3 Paid Date

When the 005010X221A1 transaction set is used to electronically provide the remittance advice, the Paid Date is the date contained in BPR16, "Check Issue or EFT Effective Date," in the BPR Financial Information segment.

2.8 Description of Code Sets

Code sets utilized in electronic billing and reimbursement and other ancillary processes are prescribed by the applicable ASC X12 Type 3 Technical Reports (Implementation Guides), NCPDP Implementation Guide, *(Insert Jurisdiction Workers' Compensation Organization Name)* rule, and this companion guide. The code sets are maintained by multiple standard setting organizations.

Participants are required to utilize current valid codes based on requirements contained in the applicable implementation guide. The validity of the various codes may be based on the date of service (e.g., procedure and diagnosis codes) or based on the date of the electronic transaction (e.g., claim adjustment reason codes).

2.9 Participant Roles

Roles in the HIPAA implementation guides are generally the same as in workers' compensation. The Employer, Insured, Injured Employee, and Patient are roles that are used differently in workers' compensation and are addressed later in this section.

2.9.1 Trading Partner

Trading Partners are entities that have established EDI relationships and that exchange information electronically either in standard or mutually agreed-upon formats. Trading Partners can be both Senders and Receivers, depending on the electronic process involved (i.e. Billing or Acknowledgment).

2.9.2 Sender

A Sender is the entity submitting a transmission to the Receiver, or its Trading Partner. The health care provider, health care facility, or third-party biller/assignee, is the Sender in the 005010X222A1, 005010X223A2 and 005010X224A2 electronic billing transactions. The claim administrator, or its agent, is the Sender in the 005010X214, 005010X231 or 005010X221A1 electronic acknowledgment or remittance transactions.

2.9.3 Receiver

A Receiver is the entity that accepts a transmission submitted by a Sender. The health care provider, health care facility, or third-party biller/assignee, is the Receiver in the 005010X214, 005010X231, or 005010X221A1 electronic acknowledgment or remittance transactions. The claim administrator, or its agent, is the Receiver in the 005010X222A1, 005010X223A2, and 005010X224A2 electronic billing transactions.

2.9.4 Employer

The Employer, as the policyholder of the workers' compensation insurance coverage, is considered the Subscriber in the workers' compensation implementation of the HIPAA electronic billing and reimbursement formats.

2.9.5 Subscriber

The subscriber or insured is the individual or entity that purchases or is covered by an insurance policy. In this implementation, the workers' compensation insurance policy is obtained by the Employer, who is considered the Subscriber.

2.9.6 Insured

The insured or subscriber is the individual or entity that purchases or is covered by an insurance policy. In group health, the insured may be the patient, the spouse or the parent of the patient. In this workers' compensation implementation, the Employer is considered the insured entity.

2.9.7 Injured Employee

In workers' compensation, the Injured Employee, as the person who has been injured on the job or has a work related illness, is always considered to be the patient. In group health, there are many relationships a patient may have to the insured. For example, the patient may be the insured, or may be the child or spouse of the insured.

2.9.8 Patient

The patient is the person receiving medical services. In the workers' compensation implementation of electronic billing and reimbursement processes, the patient is considered the Injured Employee.

2.10 Health Care Provider Agent/Claim Administrator Agent Roles

(This section needs to reflect the Jurisdiction's requirements for electronic medical bill processing. The language contained in this section is for illustration purposes only.)

Electronic billing and reimbursement rules include provisions that allow for providers and claim administrators to utilize agents to comply with the electronic billing (eBill) requirements. Billing agents, third party administrators, bill review companies, software vendors, data collection agents, and clearinghouses are examples of companies that may have a role in eBill. Claim administrators and health care providers are responsible for the acts or omissions of their agents executed in the performance of services for the claim administrator or health care provider.

Under the eBill rules, claim administrators must be able to exchange medical billing and reimbursement information electronically with health care providers. Claim administrators may establish direct electronic connections to health care providers or may use agents to perform eBill functions. The rules do not mandate the use of, or regulate the costs of, agents performing eBill functions. Providers and claim administrators are not required by *(Insert Jurisdiction Workers' Compensation Organization Name)* rule to establish connectivity with a clearinghouse or to utilize a specific media/method of connectivity (i.e. Secured File Transfer Protocol [SFTP]).

By mutual agreement, use of non-standard formats between the health care provider, health care facility, or third-party biller/assignee and the claim administrator is permissible.

The eBill rules do not regulate the formats utilized between providers and their agents, or claim administrators and their agents, or the method of connectivity between those parties.

2.11 Duplicate, Appeal/Reconsideration, and Corrected Bill Resubmissions

2.11.1 Claim Resubmission Code - 837 Billing Formats

Health care providers will identify resubmissions of prior medical bills (not including duplicate original submissions) by using the Claim Frequency Type Code of 7 (Resubmission/Replacement). The value is populated in Loop 2300 Claim Information CLM Health Claim segment CLM05-3 Claim Frequency Type Code of the 005010X222A1, 005010X223A2, and 005010X224A2 electronic billing transactions. When the payer has provided the Payer Claim Control Number it had assigned to the previous bill, the health care provider must use this number when the bill is replaced. This information is populated in Loop 2300 Claim Information REF Payer Claim Control Number of the 005010X222A1, 005010X223A2 and 005010X224A2 electronic billing transactions.

On electronically submitted medical bills, health care providers must also populate the appropriate NUBC Condition Code to identify the type of resubmission. Condition codes provide additional information to the claim administrator when the resubmitted bill is a request for reconsideration or a new submission after receipt of a decision from the *(Insert Jurisdiction's Workers' Compensation Organization Name Administrative or Appeal Board)* or other administrative proceeding, such as a judicial review. Based on the instructions for each bill type, the Condition Code is submitted in the HI segment for 005010X222A1 and 005010X223A2 transactions and in the NTE segment for the 005010X224A2 transaction. (The use of the NTE segment is at the discretion of the sender.)

The NUBC Instruction for the use of Claim Frequency Type Codes can be referenced on the NUBC website at http://www.nubc.org/FL4forWeb2_RO.pdf. The CMS-required bill processing documentation for adjustments can be referenced at http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf.

2.11.2 Duplicate Bill Transaction Prior To Payment

A Condition Code 'W2' (Duplicate of the original bill) is required when a provider submits a bill that is a duplicate. The Condition Code is submitted based on the instructions for each bill type. It is submitted in the HI segment for professional and institutional transactions and in the NTE segment for dental transactions. (The use of the NTE segment is at the discretion of the sender.) The duplicate bill must be identical to the original bill, with the exception of the added Condition Code. No new dates of service or itemized services may be included on the duplicate bill.

Duplicate Bill Transaction
• CLM05-3 = Identical value as original. Cannot be '7'. • Condition codes in HI/K3 are populated with a condition code qualifier 'BG' and code value: 'W2' = Duplicate. • NTE Example: NTE*ADD*BGW2 • Payer Claim Control Number does not apply. • The resubmitted bill must be identical to the original bill, except for the 'W2' condition code. No new dates of service or itemized services may be included on the duplicate bill.

(Insert Jurisdiction Workers' Compensation Organization Name Duplicate Bill Rules: The following is an example of a Jurisdiction Duplicate Bill Rule.)

Duplicate bill transactions shall be submitted no earlier than thirty (30) working days after the claim administrator has acknowledged receipt of a complete electronic bill transaction and prior to receipt of a 005010X221A1 transaction.

The claim administrator may reject a bill transaction with a Condition Code 'W2' indicator if

1) *the duplicate bill is received within thirty (30) working days after acknowledgment,*
2) *the bill has been processed and the 005010X221A1 transaction has been generated, or*
3) *the claim administrator does not have a corresponding accepted original transaction with the same bill identification numbers.*

If the claim administrator does not reject the duplicate bill transaction within two business days, the duplicate bill transaction may be denied for the reasons listed above through the use of the 005010X221A1 transaction.

2.11.3 Corrected Bill Transactions

A replacement bill is sent when a data element on the original bill was either not previously sent or needs to be corrected.

When identifying elements change, the correction is accomplished by a void and re-submission process: a bill with CLM05-3 = '8' (Void) must be submitted to cancel the incorrect bill, followed by the submission of a new original bill with the correct information.

Billers must not replace or void a prior bill until that prior submitted bill has reached final adjudication status, which can be determined from the remittance advice, a web application, when showing a finalized code under Claim Status Category in the 277, or by non-electronic means.

Corrected Bill Transaction
• CLM05-3 = '7' indicates a replacement bill. • Condition codes of 'W2' to 'W5' in HI/K3 are not used. • REF*F8 includes the Payer Claim Control Number, if assigned by the payer. • A corrected bill shall include the original dates of service and the same itemized services rendered as the original bill. • When identifying elements change, the correction is accomplished by a void and re-submission process. A bill with CLM05-3 = '8' (Void) must be submitted to cancel the incorrect bill, followed by the submission of a new original bill with the correct information.

(Insert Jurisdiction Workers' Compensation Organization Name Corrected Bill Rules; the following is an example of a Jurisdiction Corrected Bill Rule)

The claim administrator may reject a revised bill transaction if

1) *the claim administrator does not have a corresponding adjudicated bill transaction with the same bill identification number, or*
2) *there is incorrect billing documentation for an adjustment based on CMS guidelines (inappropriate changed data).*

If the claim administrator does not reject the revised bill transaction within two business days, the revised bill transaction may be denied for the reasons listed above through the use of the 005010X221A1 transaction.

2.11.4 Appeal/Reconsideration Bill Transactions

Electronic submission of Reconsideration transactions is accomplished in the 005010X222A1, 005010X223A2, and 005010X224A2 electronic billing transactions through the use of Claim Frequency Type Code '7' in Loop 2300 Claim Information CLM Health Claim segment CLM05-3 Claim Frequency Type Code. The value '7' Replacement of a Prior Claim represents Resubmission transactions.

The Reconsideration Claim Frequency Type Code '7' is used in conjunction with the Payer Claim Control Number assigned to the bill by the claim administrator when the payer has provided this number in response to the previous bill submission. This information is populated in Loop 2300 Claim Information REF Payer Claim Control Number of the 005010X222A1, 005010X223A2, and 005010X224A2 electronic billing transactions.

The health care provider must also populate the appropriate condition code to identify the type of resubmission on electronically submitted medical bills. The NUBC Condition Codes which apply to reconsiderations and appeals include:

- 'W3' – 1st Level Appeal *(Insert Jurisdiction definition)*
  Example: Request for reconsideration or appeal with the payer
- 'W4' – 2nd Level Appeal *(Insert Jurisdiction definition)*
  Example: Resubmitted after receipt of a Jurisdiction decision/order, typically from Medical Fee Dispute resolution.
- 'W5' – 3rd Level Appeal *(Insert Jurisdiction definition)*
  Example: Resubmitted after receipt of a hearing or other judicial decision and order.

These codes are included in the 2300/HI segment on professional and institutional claims, and in the 2300/NTE segment on dental claims. (Note: the use of the NTE segment is at the discretion of the sender.)

Reconsideration bill transactions may only be submitted after receipt of the 005010X221A1 transaction for the corresponding accepted original bill or *(Insert Jurisdiction-specified days)* (X) days after the claim administrator acknowledged receipt of a complete electronic medical bill when no 005010X221A1 transaction has been received. Reconsideration bill transactions shall be submitted by the provider, and processed by the claim administrator in accordance with *(Insert Jurisdiction Workers' Compensation Organization Name reference and citation title, i.e. Reconsideration for Payment of Medical Bills)*. The same bill identification number is used on both the original and the Reconsideration bill transaction to associate the transactions. All elements, fields, and values in the Reconsideration bill transaction, except the Reconsideration-specific qualifiers and the Claim Supplemental Information PWK segment, must be the same as on the original bill transaction. Subsequent Reconsideration bill transactions related to the same original bill transaction may be submitted after receipt of the 005010X221A1 transaction corresponding to the initial Reconsideration bill transaction. Subsequent Reconsideration bill transactions shall not be submitted prior to *(Insert Jurisdiction-specified days)* (X) days from the date the original request for reconsideration was sent or after the claim administrator has taken final action on the reconsideration request.

Corresponding documentation related to an appeal/reconsideration is required in accordance with the *(Insert Jurisdiction name)* rules for initial bill submission. The PWK segment (Claim Supplemental Information) is required to be properly annotated when submitting an attachment related to an appeal/reconsideration.

The *ASC X12 Type 3 Technical Reports (Implementation Guides)* and the *(Insert Jurisdiction Workers' Compensation Organization Name)* recommend that the value passed in CLM01 represent a unique identification number specific to the bill transaction, the Provider Unique Bill Identification Number. The *(Insert Jurisdiction Name)* eBilling implementation uses the Provider Unique Bill Identification Number

(CLM01) to link the original bill to the subsequent bill transaction. The intent is to link an appeal, or multiple subsequent appeals, to a single original bill transaction.

The *ASC X12 Type 3 Technical Reports (Implementation Guides)* include a Reference Identification Number REF segment in Loop 2300 Claim Information that represents the Payer Claim Control Number, which is the unique transaction identification number generated by the claim administrator. This number must be included on resubmitted bills to ensure that the payer can match the resubmission request with its original processing action.

Appeal/Reconsideration Bill Transaction
• CLM05-3 = '7'; • Condition codes in HI/NTE are populated with a condition code qualifier 'BG' and one of the following codes values must be present: o 'W3' =1st Level Appeal *(Insert Jurisdiction Workers' Compensation Organization Name definition)* Example: Request for reconsideration or appeal with the payer o 'W4'= 2nd Level Appeal *(Insert Jurisdiction Workers' Compensation Organization Name definition)* Example: Resubmitted after receipt of a Jurisdiction decision/order, typically from Medical Fee Dispute resolution. o 'W5'= 3rd Level Appeal *(Insert Jurisdiction Workers' Compensation Organization Name definition)* Example: Resubmitted after receipt of a hearing or other judicial decision and order. • REF*F8 includes the Payer Claim Control Number, if assigned by the payer. • The appeal/reconsideration bill must be identical to the original bill, with the exception of the added Condition Code, Payer Claim Control Number, and the Claim Frequency Type Code. No new dates of service or itemized services may be included on the appeal/reconsideration bill. • Supporting documentation is required. • Loop 2300, PWK segment must be properly annotated.

(Insert Jurisdiction Appeal/Reconsideration Rules; the following is an example of a Jurisdiction Appeal/Reconsideration Rule.)

The claim administrator may reject an appeal/reconsideration bill transaction if

(1) the bill information does not match the corresponding original bill transaction;
(2) the claim administrator does not have a corresponding accepted original transaction;
(3) the original bill transaction has not been completed (no corresponding 005010X221A1 transaction or the Remittance submission Jurisdiction-allowed time period has not been exceeded);or
(4) the bill is submitted without the PWK annotation.

Corresponding documentation related to appeals/reconsideration is required in accordance with the Jurisdiction rules for initial bill submission.

The claim administrator may deny appeal/reconsideration bill transactions for missing documentation. If the claim administrator does not reject the appeal/reconsideration bill transaction within two business days because it is incomplete, the bill transaction may be denied through the use of the 005010X221A1 transaction for the reasons listed above. The claim administrator may also deny the appeal/ reconsideration bill transaction through the use of the 005010X221A1 transaction, if the documentation is not submitted within the Jurisdiction-required time frame.

2.12 Balance Forward Billing

Balance forward bills are bills that are either for a balance carried over from a previous bill or are for a balance carried over from a previous bill along with charges for additional services. Balance forward billing is not permissible.

2.13 *(Insert Jurisdiction Workers' Compensation Organization Name)* and Workers' Compensation Specific Requirements

The requirements in this section identify (*Insert Jurisdiction Workers' Compensation Organization Name*) workers' compensation specific requirements that apply to more than one electronic format. Requirements that are related to a specific format are identified in the chapter related to that format.

2.13.1 Claim Filing Indicator

The Claim Filing Indicator code for workers' compensation is 'WC' populated in Loop 2000B Subscriber Information, SBR Subscriber Information segment field SBR09 for the 005010X222A1, 005010X223A2, or 005010X224A2 transactions.

2.13.2 Transaction Set Purpose Code

The Transaction Set Purpose Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction segment field BHT02 in 005010X222A1, 005010X223A2, or 005010X224A2 transactions is designated as '00' Original. Claim administrators are required to acknowledge acceptance or rejection of transmissions (files) and transactions (bills). Transmissions that are rejected by the claim administrator and then corrected by the provider are submitted, after correction, as '00' Original transmissions.

2.13.3 Transaction Type Code

The Transaction Type Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction segment field BHT06 in 005010X222A1, 005010X223A2, or 005010X224A2 transactions is designated as 'CH' Chargeable. Currently, health care providers are not required to report electronic billing data to the *(Insert Jurisdiction Workers' Compensation Organization Name)*. Therefore, code 'RP' (Reporting) is not appropriate for this implementation.

2.13.4 Other State Data Requirements

(Jurisdictions should specifically list any individual data elements required for their implementation, especially any data elements that may be contained in the K3 or NTE segments. This may include, depending on the jurisdictional requirements, the resubmission condition codes, or Jurisdiction state code (state of compliance code). Prior to including direction on the use of the K3 or NTE segments, it is recommended that the Jurisdiction submit a Request for Interpretation (RFI) to the IAIABC to submit to ASC X12 to validate direction and data usage.)

2.13.5 NCPDP Telecommunication Standard D.0 Pharmacy Formats

Issues related to electronic pharmacy billing transactions are addressed in Chapter 6 Companion Guide NCPDP D.0 Pharmacy.

Chapter 3 Companion Guide ASC X12N/005010X222A1 Health Care Claim: Professional (837)

Introduction and Overview

The information contained in this companion guide has been created for use in conjunction with the *ASC X12N/005010X222A1 Health Care Claim: Professional (837) Technical Report Type 3*. It is not to be considered a replacement for the *ASC X12N/005010X222A1 Health Care Claim: Professional (837) Technical Report Type 3*, but rather is to be used as an additional source of information.

This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the Jurisdictions. The companion guide is intended to be used by Jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the *ASC X12 Type 3 Technical Reports*.

The *ASC X12N/005010X222A1 Health Care Claim: Professional (837) Technical Report Type 3* is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

3.1 Purpose, Applicability and Expected Implementation Date

To be completed by the Jurisdiction with specific statute or regulatory references.

3.2 Trading Partner Agreements

The components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide (such as transmission parameters) remain the same; this companion guide is not intended to replace any of those components.

The data elements transmitted as part of a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the *ASC X12 Type 3 Technical Reports* and the Jurisdiction-specific companion guide. The Trading Partner Agreement must not change the workers' compensation field value designations as defined in the Jurisdiction-specific companion guide.

3.3 Workers' Compensation Health Care Claim: Professional Instructions

Instructions for *(Insert Jurisdiction)* specific requirements are also provided in *(Insert Jurisdiction)* Workers' Compensation Requirements. The following table identifies the application/instructions for *(Insert Jurisdiction)* workers' compensation that need clarification beyond the *ASC X12 Technical Report Type 3*.

Loop	Segment	Description	IAIABC Companion Guide Workers' Compensation Comments or Instructions
1000A	PER	SUBMITTER EDI CONTACT INFORMATION	When applicable, the Jurisdiction companion guide should specify any required communication number qualifiers and numbers. For example, if a telephone number is required, a comment may state: "One occurrence of the Communication Number Qualifier must be 'TE' – Telephone Number."
2000B	SBR	SUBSCRIBER INFORMATION	In workers' compensation, the Subscriber is the Employer.
2000B	SBR04	NAME	In workers' compensation, the group name is the employer of the patient/employee.
2000B	SBR09	CLAIM FILING INDICATOR CODE	Value must be 'WC' for workers' compensation.
2010BA		SUBSCRIBER NAME	In workers' compensation, the Subscriber is the Employer.
2010BA	NM102	ENTITY TYPE QUALIFIER	Value must be '2' non-person.
2010BA	NM103	NAME LAST OR ORGANIZATION NAME	Value must be the name of the Employer.
2010BA	REF	PROPERTY AND CASUALTY CLAIM NUMBER	When applicable, the Jurisdiction companion guide may reference Request For Interpretation number 974 (*see* http://x12n.org/portal) regarding the payer's ability to direct the use of a default value for situations where the workers' compensation claim number is not known.
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.
2010CA	REF	PROPERTY AND CASUALTY CLAIM NUMBER	When applicable, the Jurisdiction companion guide may reference Request For Interpretation number 974 (*see* http://x12n.org/portal) regarding the payer's ability to direct the use of a default value for situations where the workers' compensation claim number is not known.
2010CA	REF	PROPERTY AND CASUALTY PATIENT IDENTIFIER	When applicable, the Jurisdiction companion guide may include a usage statement to indicate whether or not the patient identifier must be used. For example, a comment may state: "Required."
2010CA	REF01	REFERENCE IDENTIFICATION QUALIFIER	When applicable, the Jurisdiction companion guide should identify any additional clarification which further explains the application of the ASC X12 situational usage notes. For example, if the patient's Social Security Number is required, a comment may state: "Value must be 'SY'."
2010CA	REF02	REFERENCE IDENTIFICATION	When applicable, the Jurisdiction companion guide should identify any additional clarification which further explains the application of the ASC X12 situational usage notes. For example, if the patient's Social Security Number is required as the Member Identification Number, a comment may state: "Value must be the patient's Social Security Number."
2300	CLM11	RELATED CAUSES INFORMATION	One of the occurrences in CLM11 must have a value of 'EM' -- Employment Related.
2300	DTP	DATE -- ACCIDENT	Required when the condition reported is for an occupational accident/injury.

Loop	Segment	Description	IAIABC Companion Guide Workers' Compensation Comments or Instructions
2300	DTP	DATE – DISABILITY DATES	Refer to the Jurisdiction companion guide for instruction regarding the submission of disability data. It is recommended that this segment be left blank and not be used by the health care provider.
2300	DTP	DATE – PROPERTY AND CASUALTY DATE OF FIRST CONTACT	Refer to the Jurisdiction companion guide for instruction regarding Date of First Contact.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Refer to the Jurisdiction companion guide for instruction regarding Documentation/Medical Attachment Requirements.
2300	PWK01	REPORT TYPE CODE	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports, use appropriate 005010 Report Type Code.
2300	PWK06	ATTACHMENT CONTROL NUMBER	When the Report Type Code is 'OZ' and a Jurisdiction report is sent, the first two characters of the attachment control number must be the Jurisdictional Report Type Code. When necessary, the Jurisdiction companion guide should provide examples of the expected reports in the Jurisdiction's billing and reimbursement processes and the identification of the appropriate Report Type Code to use as the first two digits of this data element. Examples: Standard Report: PWK*OB*BM***AC*DMN0012~ Jurisdictional Report: PWK*OZ*BM***AC*J1DMN0012~
2300	K3	FILE INFORMATION	It is recommended that the Jurisdiction companion guide include descriptions on the X12-approved usage of data transmitted in the K3 segment. Items listed below (K301) are for illustration purposes subject to the jurisdictional requirements.
2300	K301	FIXED FORMAT INFORMATION	Jurisdiction State Code (State of Compliance Code) Required when the provider knows the state of Jurisdiction is different than the billing provider's state (2010AA/N4/N402). Enter the state code qualifier 'LU' followed by the state code. For example, 'LUCA' indicates the medical bill is being submitted under California medical billing requirements.
2300	HI	CONDITION INFORMATION	For workers' compensation purposes, the National Uniform Billing Committee and the National Uniform Claims Committee have approved the following condition codes for resubmissions: • W2 - Duplicate of the original bill • W3 - Level 1 Appeal • W4 - Level 2 Appeal • W5 - Level 3 Appeal Note: Do not use condition codes when submitting revised or corrected bills.

Loop	Segment	Description	IAIABC Companion Guide Workers' Compensation Comments or Instructions
2310B	PRV	RENDERING PROVIDER SPECIALTY INFORMATION	When applicable, the Jurisdiction companion guide should identify any additional clarification which further explains the application of the ASC X12 situational usage notes. For example, if the taxonomy code at this level is required for a particular Jurisdiction, a comment may state: "The Rendering Provider Specialty Information is required for *(insert Jurisdiction)* workers' compensation medical bills."
2420A	PRV	RENDERING PROVIDER SPECIALTY INFORMATION	When applicable, the Jurisdiction companion guide should identify any additional clarification which further explains the application of the ASC X12 situational usage notes. For example, if the taxonomy code at this level is required for a particular Jurisdiction, a comment may state: "The Rendering Provider Specialty Information is required for *(insert Jurisdiction)* workers' compensation medical bills."

Chapter 4 Companion Guide ASC X12N/005010X223A2 Health Care Claim: Institutional (837)

Introduction and Overview

The information contained in this companion guide has been created for use in conjunction with the *ASC X12N/005010X223A2 Health Care Claim: Institutional (837) Technical Report Type 3*. It is not a replacement for the *ASC X12N/005010X223A2 Health Care Claim: Institutional (837) Technical Report Type 3*, but rather is an additional source of information.

This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the Jurisdictions. The companion guide is intended to be used by Jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the *ASC X12 Type 3 Technical Reports.*

The *ASC X12N/005010X223A2 Health Care Claim: Institutional (837) Technical Report Type 3* is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

4.1 Purpose, Applicability and Expected Implementation Date

To be completed by the jurisdiction with specific statute or regulatory references.

4.2 Trading Partner Agreements

The components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide (such as transmission parameters) remain the same; this companion guide is not intended to replace any of those components.

The data elements transmitted as part of a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the *ASC X12 Type 3 Technical Reports* and the jurisdiction-specific companion guide. The workers' compensation field value designations as defined in the jurisdiction-specific companion guide must remain the same as part of any Trading Partner Agreement.

4.3 Workers' Compensation Health Care Claim: Institutional Instructions

Instructions for *(Insert Jurisdiction)* specific requirements are also provided in *(Insert Jurisdiction)* Workers' Compensation Requirements. The following table identifies the application/instructions for *(Insert Jurisdiction)* workers' compensation that need clarification beyond the *ASC X12 Type 3 Technical Reports*.

Loop	Segment	Description	IAIABC Companion Guide Workers' Compensation Comments or Instructions
1000A	PER	SUBMITTER EDI CONTACT INFORMATION	When applicable, the Jurisdiction companion guide should specify any required communication number qualifiers and numbers. For example, if a telephone number is required, a comment may state: "One occurrence of the Communication Number Qualifier must be 'TE' – Telephone Number."
2000B	SBR	SUBSCRIBER INFORMATION	In workers' compensation, the Subscriber is the Employer.
2000B	SBR04	NAME	In workers' compensation, the group name is the employer of the patient/employee.
2000B	SBR09	CLAIM FILING INDICATOR CODE	Value must be 'WC' for workers' compensation.
2010BA		SUBSCRIBER NAME	In workers' compensation, the Subscriber is the Employer.
2010BA	NM102	ENTITY TYPE QUALIFIER	Value must be '2' non-person.
2010BA	NM103	NAME LAST OR ORGANIZATION NAME	Value must be the name of the Employer.
2010BA	REF	PROPERTY AND CASUALTY CLAIM NUMBER	When applicable, the Jurisdiction companion guide may reference Request For Interpretation number 974 (*see* http://x12n.org/portal) regarding the payer's ability to direct the use of a default value for situations where the workers' compensation claim number is not known.
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.
2010CA	REF02	PROPERTY CASUALTY CLAIM NUMBER	When applicable, the Jurisdiction companion guide may reference Request For Interpretation number 974 (*see* http://x12n.org/portal) regarding the payer's ability to direct the use of a default value for situations where the workers' compensation claim number is not known.
2010CA	REF	PROPERTY AND CASUALTY PATIENT IDENTIFIER	When applicable, the Jurisdiction companion guide may include a usage statement to indicate whether or not the patient identifier must be used. For example, a comment may state: "Required."
2010CA	REF01	REFERENCE IDENTIFICATION QUALIFIER	When applicable, the Jurisdiction companion guide should identify any additional clarification which further explains the application of the ASC X12 situational usage notes. For example, if the patient's Social Security Number is required, a comment may state: "Value must be 'SY'.
2010CA	REF02	REFERENCE IDENTIFICATION	When applicable, the Jurisdiction companion guide should identify any additional clarification which further explains the application of the ASC X12 situational usage notes. For example, if the patient's Social Security Number is required as the Member Identification Number, a comment may state: "Value must be the patient's Social Security Number."
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Refer to the Jurisdiction companion guide for instruction regarding Documentation/Medical Attachment Requirements.

Loop	Segment	Description	IAIABC Companion Guide Workers' Compensation Comments or Instructions
2300	PWK01	REPORT TYPE CODE	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports, use appropriate 005010 Report Type Code.
2300	PWK06	ATTACHMENT CONTROL NUMBER	When the Report Type Code is 'OZ' and a Jurisdiction report is sent, the first two characters of the attachment control number must be the Jurisdictional Report Type Code. When necessary, the Jurisdiction companion guide should provide examples of the expected reports in the Jurisdiction's billing and reimbursement processes and the identification of the appropriate Report Type Code to use as the first two digits of this data element. Examples: Standard Report: PWK*OB*BM***AC*DMN0012~ Jurisdictional Report: PWK*OZ*BM***AC*J1DMN0012~
2300	K3	FILE INFORMATION	It is recommended that the Jurisdiction companion guide include descriptions on the X12-approved usage of data transmitted in the K3 segment. Items listed below (K301) are for illustration purposes subject to the jurisdictional requirements.
2300	K301	FIXED FORMAT INFORMATION	Jurisdiction State Code (State of Compliance Code) Required when the provider knows the state of Jurisdiction is different than the billing provider's state (2010AA/N4/N402). Enter the state code qualifier 'LU' followed by the state code. For example, 'LUCA' indicates the medical bill is being submitted under California medical billing requirements.
2300	HI01	OCCURRENCE INFORMATION	At least one Occurrence Code must be entered with a value of '04' - Accident/Employment Related or '11' - Illness. The Occurrence Date must be the Date of Occupational Injury or Illness.
2300	HI	CONDITION INFORMATION	For workers' compensation purposes, the National Uniform Billing Committee and the National Uniform Claims Committee has approved the following condition codes for resubmissions: • W2 - Duplicate of the original bill • W3 - Level 1 Appeal • W4 - Level 2 Appeal • W5 - Level 3 Appeal Note: Do not use condition codes when submitting revised or corrected bills.
2310A	PRV	ATTENDING PHYSICIAN SPECIALTY INFORMATION	When applicable, the Jurisdiction companion guide should identify any additional clarification which further explains the application of the ASC X12 situational usage notes. For example, if the taxonomy code at this level is required for a particular Jurisdiction, a comment may state: "The Attending Physician Specialty Information is required for *(Insert Jurisdiction)* workers' compensation medical bills."

Chapter 5 Companion Guide ASC X12N/005010X224A2 Health Care Claim: Dental (837)

Introduction and Overview

The information contained in this companion guide has been created for use in conjunction with the *ASC X12N/05010X224A2 Health Care Claim: Dental (837) Technical Report Type 3*. It is not a replacement for the *ASC X12N/05010X224A2 Health Care Claim: Dental (837) Technical Report Type 3*, but rather is an additional source of information.

This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the Jurisdictions. The companion guide is intended to be used by Jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the *ASC X12 Type 3 Technical Reports*.

The *ASC X12N/05010X224A2 Health Care Claim: Dental (837) Technical Report Type 3* is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

5.1 Purpose, Applicability and Expected Implementation Date

To be completed by the Jurisdiction with specific statute or regulatory references.

5.2 Trading Partner Agreements

The components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide (such as transmission parameters) remain the same; this companion guide is not intended to replace any of those components.

The data elements transmitted as part of a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the *ASC X12 Type 3 Technical Reports* and the jurisdiction-specific companion guide. The workers' compensation field value designations as defined in the jurisdiction-specific companion guide must remain the same as part of any Trading Partner Agreement.

5.3 Workers' Compensation Health Care Claim: Dental Instructions

Instructions for *(Insert Jurisdiction)* specific requirements are also provided in *(Insert Jurisdiction)* Workers' Compensation Requirements. The following table identifies the application/instructions for *(Insert Jurisdiction)* workers' compensation that need clarification beyond the *ASC X12 Type 3 Technical Reports.*

Loop	Segment	Description	IAIABC Companion Guide Workers' Compensation Comments or Instructions
1000A	PER	SUBMITTER EDI CONTACT INFORMATION	When applicable, the Jurisdiction companion guide should specify any required communication number qualifiers and numbers. For example, if a telephone number is required, a comment may state: "One occurrence of the Communication Number Qualifier must be 'TE' – Telephone Number."
2000B	SBR	SUBSCRIBER INFORMATION	In workers' compensation, the Subscriber is the Employer.

X12N/005010X224A2

Loop	Segment	Description	IAIABC Companion Guide Workers' Compensation Comments or Instructions
2000B	SBR04	NAME	In workers' compensation, the group name is the employer of the patient/employee.
2000B	SBR09	CLAIM FILING INDICATOR CODE	Value must be 'WC' for workers' compensation.
2010BA		SUBSCRIBER NAME	In workers' compensation, the Subscriber is the Employer.
2010BA	NM102	ENTITY TYPE QUALIFIER	Value must be '2' non-person.
2010BA	NM103	NAME LAST OR ORGANIZATION NAME	Value must be the name of the Employer.
2010BA	REF	PROPERTY AND CASUALTY CLAIM NUMBER	When applicable, the Jurisdiction companion guide may reference HIPAA Interpretation Request number 974 (*see* http://x12n.org/portal) regarding the payer's ability to direct the use of a default value for situations where the workers' compensation claim number is not known.
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.
2010CA	REF02	PROPERTY CASUALTY CLAIM NUMBER	When applicable, the Jurisdiction companion guide may reference Request For Interpretation number 974 (*see* http://x12n.org/portal) regarding the payer's ability to direct the use of a default value for situations where the workers' compensation claim number is not known.
2300	CLM11	RELATED CAUSES INFORMATION	One of the occurrences in CLM11 must have a value of 'EM' -- Employment Related.
2010CA	REF	PROPERTY AND CASUALTY PATIENT IDENTIFIER	When applicable, the Jurisdiction companion guide may include a usage statement to indicate whether or not the patient identifier must be used. For example, a comment may state: "Required."
2010CA	REF01	REFERENCE IDENTIFICATION QUALIFIER	When applicable, the Jurisdiction companion guide should identify any additional clarification which further explains the application of the ASC X12 situational usage notes. For example, if the patient's Social Security Number is required, a comment may state: "Value must be 'SY'.
2010CA	REF02	REFERENCE IDENTIFICATION	When applicable, the Jurisdiction companion guide should identify any additional clarification which further explains the application of the ASC X12 situational usage notes. For example, if the patient's Social Security Number is required as the Member Identification Number, a comment may state: "Value must be the patient's Social Security Number."
2300	DTP	DATE -- ACCIDENT	Required when the condition reported is for an occupational accident/injury.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Refer to the Jurisdiction companion guide for instruction regarding Documentation/Medical Attachment Requirements.
2300	PWK01	REPORT TYPE CODE	Value must be 'OZ' when report is a Jurisdictional Report. For all other reports use appropriate 005010 Report Type Code.

X12N/005010X224A2

Loop	Segment	Description	IAIABC Companion Guide Workers' Compensation Comments or Instructions
2300	PWK06	ATTACHMENT CONTROL NUMBER	When the Report Type Code is 'OZ' and a Jurisdiction report is sent, the first two characters of the attachment control number must be the Jurisdictional Report Type Code. When necessary, the Jurisdiction companion guide should provide examples of the expected reports in the Jurisdiction's billing and reimbursement processes and the identification of the appropriate Report Type Code to use as the first two digits of this data element. Examples: Standard Report: PWK*OB*BM***AC*DMN0012~ Jurisdictional Report: PWK*OZ*BM***AC*J1DMN0012~
2300	K3	FILE INFORMATION	It is recommended that the Jurisdiction companion guide include descriptions on the X12-approved usage of data transmitted in the K3 segment. Items listed below (K301) are for illustration purposes subject to the jurisdictional requirements.
2300	K301	FIXED FORMAT INFORMATION	Jurisdiction State Code (State of Compliance Code) Required when the provider knows the state of Jurisdiction is different than the billing provider's state (2010AA/N4/N402). Enter the state code qualifier 'LU' followed by the state code. For example, 'LUCA' indicates the medical bill is being submitted under California medical billing requirements.
2310A	PRV	REFERRING PROVIDER SPECIALTY INFORMATION	When applicable, the Jurisdiction companion guide should identify any additional clarification which further explains the application of the ASC X12 situational usage notes. For example, if the taxonomy code at this level is required for a particular Jurisdiction, a comment may state: "The Referring Provider Specialty Information is required for *(Insert Jurisdiction)* workers' compensation medical bills."
2310B	PRV	RENDERING PROVIDER SPECIALTY INFORMATION	When applicable, the Jurisdiction companion guide should identify any additional clarification which further explains the application of the ASC X12 situational usage notes. For example, if the taxonomy code at this level is required for a particular Jurisdiction, a comment may state: "The Rendering Provider Specialty Information is required for *(Insert Jurisdiction)* workers' compensation medical bills."
2420A	PRV	RENDERING PROVIDER SPECIALTY INFORMATION	When applicable, the Jurisdiction companion guide should identify any additional clarification which further explains the application of the ASC X12 situational usage notes. For example, if the taxonomy code at this level is required for a particular Jurisdiction, a comment may state: "The Rendering Provider Specialty Information is required for *(Insert Jurisdiction)* workers' compensation medical bills."

Chapter 6 Companion Guide NCPDP D.0 Pharmacy

Introduction and Overview

The information contained in this companion guide has been created for use in conjunction with the *NCPDP Telecommunication Standard Implementation Guide Version D.0* for pharmacy claim transactions. It is not a replacement for the *NCPDP Telecommunication Standard Implementation Guide Version D.0*, but rather is an additional source of information.

Pharmacy transactions are processed both in real-time and via batch. Every transmission request has a transmission response. To address the appropriate process for responding to request transactions and reversal processing, users are directed to utilize the *NCPDP Telecommunication Standard Implementation Guide Version D.0* and *Batch Standard Implementation Guide Version 1.2.*

This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the Jurisdictions. The companion guide is intended to be used by Jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the NCPDP Implementation Guide.

The implementation guide for electronic pharmacy claims and responses is available through the National Council for Prescription Drug Programs (NCPDP) at http://www.ncpdp.org.

6.1 Purpose, Applicability and Expected Implementation Date

To be completed by the Jurisdiction with specific statute or regulatory references.

6.2 Trading Partner Agreements

The components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide (such as transmission parameters) remain the same; this companion guide is not intended to replace any of those components.

The data elements transmitted as part of a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the NCPDP Implementation Guide and the jurisdiction-specific companion guide. The workers' compensation field value designations as defined in the jurisdiction-specific companion guide must remain the same as part of any Trading Partner Agreement.

6.3 Workers' Compensation NCPDP Pharmacy Claim Instructions

Instructions for *(Insert Jurisdiction)* specific requirements are also provided in *(Insert Jurisdiction)* Workers' Compensation Requirements. The following table identifies the application/instructions for *(Insert Jurisdiction)* workers' compensation that need clarification beyond the *NCPDP Telecommunication Standard Implementation Guide Version D.0.*

Segment	Field	Description	IAIABC Companion Guide Workers' Compensation Comments or Instructions
INSURANCE	3Ø2-C2	CARDHOLDER ID	Refer to the Jurisdiction companion guide for instruction regarding the appropriate value to report in this field. For example, a comment allowing a default value may state: "If the Cardholder ID is not available or not applicable, the value must be 'NA'."

NCPDP D.0 Pharmacy

Segment	Field	Description	IAIABC Companion Guide Workers' Compensation Comments or Instructions
CLAIM	415-DF	NUMBER OF REFILLS AUTHORIZED	Refer to the Jurisdiction companion guide for instruction regarding the usage of this field. The Jurisdiction companion guide must indicate whether or not this field is required, conditional, or optional.
PRICING	426-DQ	USUAL AND CUSTOMARY CHARGE	Refer to the Jurisdiction companion guide for instruction regarding the usage of this field. The Jurisdiction companion guide must indicate whether or not this field is required, conditional, or optional.
PHARMACY PROVIDER	465-EY	PROVIDER ID QUALIFIER	When applicable, the Jurisdiction companion guide should identify any requirement for a specific qualifier. For example, if the NPI number for the dispensing pharmacy is required for a particular Jurisdiction, a comment may state: "The value must be '05' – NPI Number."
PRESCRIBER	466-EZ	PRESCRIBER ID QUALIFIER	When applicable, the Jurisdiction companion guide should identify any requirement for a specific qualifier. For example, if the NPI number for the prescribing doctor is required for a particular Jurisdiction, a comment may state: "The value must be '01' – NPI Number."
WORKERS' COMPENSATION			The Workers' Compensation segment is required for workers' compensation claims. If needed, the Jurisdiction companion guide should include additional instruction regarding the usage of the fields.
WORKERS' COMPENSATION	435-DZ	CLAIM/REFERENCE ID	When applicable, the Jurisdiction companion guide may include a default code to populate this field when the workers' compensation claim number is not known. For example, a comment allowing a default value may state: "If not known by the health care provider, the value must be 'UNKNOWN'."
CLINICAL			When applicable, the Jurisdiction companion guide should identify any requirement to submit this segment. For example, a comment may state: "The Clinical segment is required." If needed, the Jurisdiction companion guide should include additional instruction regarding the usage of the fields.
ADDITIONAL DOCUMENTATION			When applicable, the Jurisdiction companion guide should identify any requirement to submit this segment. For example, a comment may state: "The Additional Documentation segment is required when (insert condition)." If required, the Jurisdiction companion guide must include specific instruction regarding the situations when additional documentation is required and the identification of the required documentation.

Chapter 7 Companion Guide ASC X12N/005010X221A1 Health Care Claim Payment/Advice (835)

Introduction and Overview

The information contained in this companion guide has been created for use in conjunction with the *ASC X12N/005010X221A1 Health Care Claim Payment Advice (835) Technical Report Type 3*. It is not a replacement for the *ASC X12N/005010X221A1 Health Care Claim Payment Advice (835) Technical Report Type 3*, but rather is an additional source of information.

This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the Jurisdictions. The companion guide is intended to be used by Jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the *ASC X12 Type 3 Technical Reports*.

The *ASC X12N/005010X221A1 Health Care Claim Payment Advice (835) Technical Report Type 3* is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

The *NCPDP ASC X12N 835 (005010X221) Pharmacy Remittance Advice Template*, is available at http://www.ncpdp.org/public_documents.asp

7.1 Purpose, Applicability and Expected Implementation Date

To be completed by the Jurisdiction with specific statute or regulatory references.

7.2 Trading Partner Agreements

The components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide (such as transmission parameters) remain the same; this companion guide is not intended to replace any of those components.

The data elements transmitted as part of a Trading Partner Agreement must at a minimum contain all the same required data elements found within the *ASC X12 Type 3 Technical Reports* and the jurisdiction-specific companion guide. The workers' compensation field value designations as defined in the jurisdiction-specific companion guide must remain the same as part of any Trading Partner Agreement.

7.3 Claim Adjustment Group Codes

The 005010X221A1 transaction requires the use of Claim Adjustment Group Codes. The most current valid codes must be used as appropriate for workers' compensation. The Claim Adjustment Group Code represents the general category of payment, reduction, or denial. For example, the Group Code 'CO' (Contractual Obligation) might be used in conjunction with a Claim Adjustment Reason Code for a network contract reduction.

The Claim Adjustment Group Code transmitted in the 005010X221A1 transaction is the same code that is transmitted in the IAIABC 837 Medical State Reporting EDI reporting format. (*Insert Jurisdiction)* accepts Claim Adjustment Group Codes that were valid on the date the claim administrator paid or denied a bill.

7.4 Claim Adjustment Reason Codes

The 005010X221A1 transaction requires the use of codes as the electronic means of providing specific payment, reduction, or denial information. As a result, use of the 005010X221A1 transaction eliminates the use of proprietary reduction codes, Jurisdiction specific claim adjustment reason codes, and free form text used on paper Explanation of Review (EOR) forms. Accordingly, claim administrators that provide the required 005010X221A1 transaction information in the transmission are compliant with *(Insert Jurisdiction and rules statement if applicable)*. Claim Adjustment Reason Codes are available through Washington Publishing Company at http://www.wpc-edi.com/codes.

7.5 Remittance Advice Remark Codes

The 005010X221A1 transaction supports the use of Remittance Advice Remark Codes to provide supplemental explanations for a payment, reduction, or denial already described by a Claim Adjustment Reason Code. NCPDP Reject Codes are allowed for NCPDP transactions. Claim administrators must use the remittance remark codes to provide additional information to the health care provider regarding why a bill was adjusted or denied. The use of the 005010X221A1 transaction eliminates the use of proprietary reduction codes and free form text used on paper Explanation of Review (EOR) forms. Remittance Advice Remark Codes are not associated with a Group or Reason Code in the same manner that a Claim Adjustment Reason Code is associated with a Group Code. Remittance Advice Remark Codes are available through Washington Publishing Company at http://www.wpc-edi.com/codes.

7.6 Claim Level Jurisdictional Explanation of Review (EOR) or Explanation of Benefit (EOB) Statement ID Qualifier

The *(Insert Jurisdiction)* paper Explanation of Review/Benefit (EOR/EOB) process includes a Jurisdiction statement that is required on a paper EOR/EOB to provide health care providers, health care facilities, or third party biller/assignees with specific information regarding Jurisdiction direction or limitations.

The *(Insert Jurisdiction)*-required EOR/EOB Claim Level statement is reflected as a state jurisdictional postal code in the 005010X221A1 transaction. The state jurisdictional postal code is populated in the REF segment in Loop 2100 'Other Claim Related Identification'. The Reference Identification Qualifier "CE" Class of Contract Code is to be used as the qualifier in REF01 segment for workers' compensation to indicate the value in REF02.

The Reference Identification value in REF02 is the jurisdictional code *(Insert Jurisdiction 2 digit postal code)* that represents *(Insert Jurisdiction)* EOR/EOB statement. The state Jurisdictional REF02 *(Insert Jurisdiction 2 digit postal code)* value equates to the following EOR/EOB statement *(Insert Jurisdiction Labor Code Statement § XXXX)*: Example: California's Jurisdictional 'CA' code value equates to the EOR statement (Labor Code § 4903.5)

7.7 Line Level *(Insert Jurisdictional Statutory/Citation)* Reason Code ID Qualifier and URL Reference

To adjust a charge based on a *(Insert Jurisdiction)* statute or rule, use the 2110 Service Payment Information Loop (SVC) with the Healthcare Policy Identification REF segment. Supply the Policy Form Identifying Number identifier in REF01 and reference the statute or rule name in REF02. This associated Healthcare Policy explains the workers' compensation statute or rule used to process the claim which resulted in the adjusted payment. If this segment is used, the PER (Payer Web Site) segment is required to provide a non-secure website where the provider can access the Healthcare Policy, including the Jurisdiction's enumerated, published workers' compensation statute or rule.

7.8 Product/Service ID Qualifier

The Product/Service Identification Number transmitted in the inbound electronic billing format is returned in the 005010X221A1 transaction SVC Service Payment Information segment with the appropriate qualifier.

7.9 Workers' Compensation Health Care Claim Payment/Advice Instructions

Instructions for *(Insert Jurisdiction)* specific requirements are also provided in *(Insert Jurisdiction)* Workers' Compensation Requirements. The following table identifies the application/instructions for *(Insert Jurisdiction)* workers' compensation requirements that need clarification beyond the *ASC X12 Type 3 Technical Reports*.

ASC X12N/005010X221A1

Loop	Segment or Element	Value	Description	IAIABC Companion Guide Workers' Compensation Comments or Instructions
1000A	**PER**		**Payer Technical Contact Information**	
	PER03	TE	Communication Number Qualifier	Value must be 'TE' Telephone Number.
	PER04		Communication Number	Value must be the Telephone Number of the submitter.
2100	**CLP**		**Claim Level Data**	
	CLP06	WC	Claim Filing Indicator Code	Value must be "WC" – Workers' Compensation
	CLP07		Payer Claim Control Number	The payer- assigned claim control number for workers' compensation use is the bill control number.
2100	**REF**		**Other Claim Related Identification**	Claim Level Jurisdictional EOR/EOB Code Statement (Insert Jurisdiction Labor Code § XXXX)
	REF01	CE	Reference Identification Qualifier	Value must be "CE" Class of Contract Code
	REF02		Reference Identification	Reference Identification must be the State Jurisdiction 2 digit Postal Code. The State's Jurisdictional Postal code value equates to the EOR/EOB statement (Labor Code § XXXX) as defined in this companion guide. Example: *California's Jurisdictional "CA" code value equates to the EOR statement (Labor Code § 4903.5) as defined in this companion guide.*
2110	**REF**		**Healthcare Policy Identification**	
	REF01	0K	Reference Identification Qualifier	Value must be "0K"
	REF02		Reference Identification	Enter Healthcare Policy, including any Jurisdictional Statutory/Citation Adjustment, Reference Identification Number

Chapter 8 Companion Guide ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275)

Introduction and Overview

The information contained in this companion guide has been created for use in conjunction with the *ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) Technical Report Type 3*. It is not a replacement for the *ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) Technical Report Type 3*, but rather is an additional source of information.

This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the Jurisdictions. The companion guide is intended to be used by Jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the *ASC X12N Type 3 Technical Reports*.

The *ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) Technical Report Type 3* is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

8.1 Purpose, Applicability, and Expected Implementation Date

To be completed by the Jurisdiction with specific statute or regulatory references.

8.2 Method of Transmission

The 005010X210 transaction is the recommended standard electronic format for submitting electronic documentation in workers' compensation. Health care providers, health care facilities, or third party biller/assignees and claim administrators may agree to exchange documentation in other non-prescribed electronic formats (such as uploading to a web-based system) by mutual agreement. If trading partners mutually agree to use non-prescribed formats for the documentation they exchange, they must include all components required to identify the information associated with the documentation.

Health care providers, health care facilities, or third party biller/assignees and claim administrators may also elect to submit documentation associated with electronic bill transactions through facsimile (fax) or electronic mail (email) in accordance with (*Insert Jurisdiction regulatory reference.)* Health care providers, health care facilities, or third party biller/assignees and claim administrators must be able to electronically exchange medical documentation that is required to be submitted with the bill based on the regulatory requirements found in (*Insert Jurisdiction regulatory reference.)*

8.3 Documentation Requirements

"Medical documentation" includes, but is not limited to, medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records, and diagnostic test results. Documentation requirements for (*Insert Jurisdiction*) workers' compensation billing are defined in (*Insert Jurisdiction regulatory reference.).*

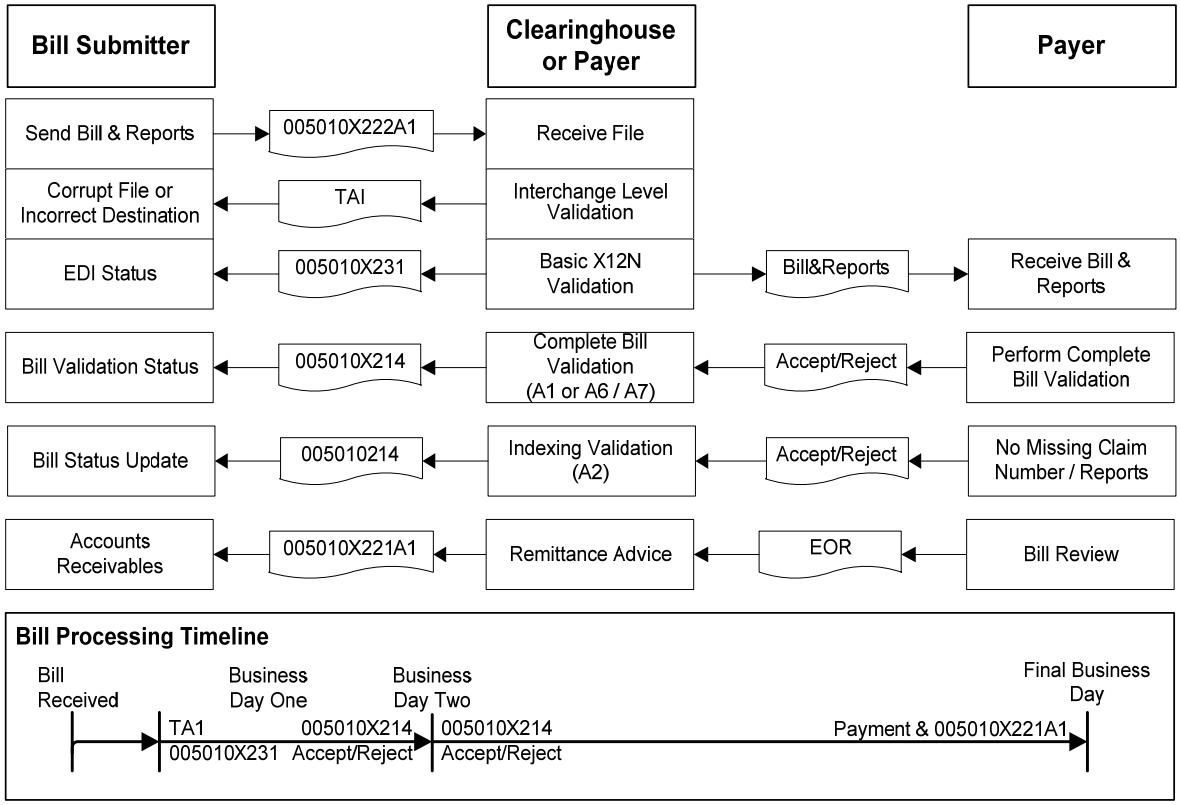
Chapter 9 Companion Guide Acknowledgments

(Information contained in this Chapter is for illustration purposes. Each Jurisdiction must tailor the time frames and processes to align with its regulatory framework.) There are several different acknowledgments that a clearinghouse and/or payer may use to respond to the receipt of a bill. The purpose of these acknowledgments is to provide feedback on the following:

1) Basic file structure and the trading partner information from the Interchange Header.
2) Detailed structure and syntax of the actual bill data as specified by the X12 standard.
3) The content of the bill against the Jurisdictional complete bill rules.
4) Any delays caused by claim number indexing/validation.
5) Any delays caused by attachment matching.
6) The outcome of the final adjudication, including reassociation to any financial transaction.

9.1 Bill Acknowledgment Flow and Timing Diagrams

The process chart below illustrates how a receiver validates and processes an incoming 005010X222A1, 005010X223A2, or 005010X224A2 transaction. The diagram shows the basic acknowledgments that the receiver generates, including acknowledgments for validation and final adjudication for those bills that pass validation.



9.1.2 Process Steps

1. **Interchange Level Validation**: Basic file format and the trading partner information from the Interchange Header are validated. If the file is corrupt or is not the expected type, the file is rejected. If the trading partner information is invalid or unknown, the file is rejected. A TA1 (Interchange Acknowledgment) is returned to indicate the outcome of the validation. A rejected EDI file is not passed on to the next step.
2. **Basic X12 Validation**: A determination will be made as to whether the transaction set contains a valid 005010X222A1, 005010X223A2, or 005010X224A2. A 005010X231 (Implementation Acknowledgment) will be returned to the submitter. The 005010X231 contains ACCEPT or REJECT information. If the file contains syntactical errors, the locations of the errors are reported. Bills that are part of a rejected transaction set are not passed on to the next step.
3. **Complete Bill Validation**: The jurisdictional and payer specific edits are run against each bill within the transaction set. The receiver returns a 005010X214 (Health Care Claim Acknowledgment) to the submitter to acknowledge that the bill was accepted or rejected. Bills that are rejected are not passed on to the next step.
4. **Complete Bill – Missing Claim Number and/or Missing Required Report:** Refer to Section 9.2 Complete Claim - Missing Claim Number Pre-Adjudication Hold (Pending) Status and Section 9.3 Complete Claim - Missing Report Pre-Adjudication Hold (Pending) Status regarding bill acknowledgment flow and timeline diagrams.
5. **Bill Review**: The bills that pass through bill review and any post-bill review approval process will be reported in the 005010X221A1 (Remittance Payment/Advice). The 005010X221A1 contains the adjudication information from each bill, as well as any paper check or EFT payment information.

9.2 Complete Bill - Missing Claim Number Pre-Adjudication Hold (Pending) Status

(This subsection applies to Jurisdictions that allow payers to hold medical bills for a defined period of time to allow for claims indexing and matching. Jurisdictions that allow the medical bill to constitute the first notice of injury and do not allow for electronic bills to be rejected for missing claim numbers should remove this subsection.)

One of the processing steps that a bill goes through prior to adjudication is verification that the bill concerns an actual employment-related condition that has been reported to the employer and subsequently reported to the claims administrator. This process, usually called “claim indexing/validation” can cause a delay in the processing of the bill. Once the validation process is complete, the claim administrator assigns a claim number to the injured worker’s claim. This claim number is necessary for the proper processing of any bills associated with the claim. Until the claim number is provided to the bill submitter, it cannot be included on the 005010X222A1, 005010X223A2, and 005010X224A2 submission to the payer. In order to prevent medical bills from being rejected due to lack of a claim number, a pre-adjudication hold (pending) period of up to five business days is mandated to enable the payer to attempt to match the bill to an existing claim in its system. If the bill cannot be matched within the five days, the bill may be rejected as incomplete. If the payer is able to match the bill to an existing claim, it must attach the claim number to the transaction and continue the adjudication process. The payer then provides the claim number to the bill submitter using the 005010X214 for use in future billing. The 005010X214 is also used to inform the bill submitter of the delay and the ultimate resolution of the issue.

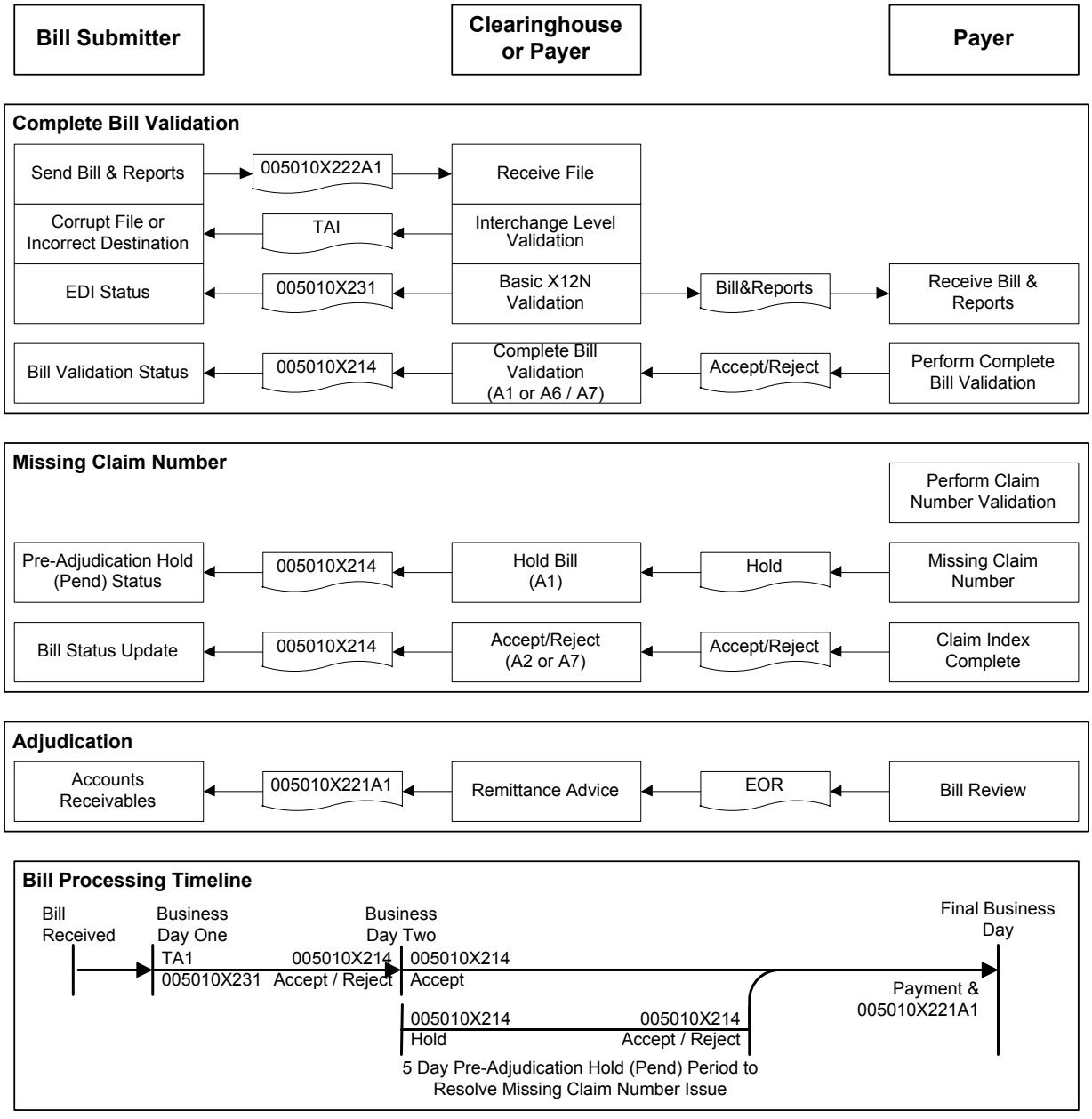
Due to the pre-adjudication hold (pend) status, a payer may send one STC (Status Information) segment with up to three claim status composites (STC01, STC10, and STC11) in the 005010X214. When a complete claim has a missing claim number and a missing report, the one STC segment in the 005010X214 would have the following three claim status composites: STC01, STC10, and STC11.

An example: STC*A1:21*20090830*WQ*70******A1:629*A1:294~

When a complete bill is only missing a claim number or missing a report, the one STC segment in the 005010X214 would have the following two claim status composites: STC01 and STC10.

An example: STC*A1:21*20090830*WQ*70******A1:629~

A bill submitter could potentially receive two 005010X214 transactions as a result of the pre-adjudication hold (pend) status.



9.2.1 Missing Claim Number 005010X214 Acknowledgment Process Steps

When the 005010X222A1, 005010X223A2, or 005010X224A2 transaction has passed the complete bill validation process and Loop 2010 CA REF02 indicates that the workers' compensation claim number is "unknown," the payer will need to respond with the appropriate 005010X214.

Claim Number Validation Status	**005010X214**
Complete Bill - Missing Claim Number	If the payer needs to pend an otherwise complete bill due to a missing claim number, it must use the following Claim Status Category Code and Claim Status Code: STC01-1 = A1 (The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.) STC01-2 = 21 (Missing or Invalid Information) AND STC10-1 = A1 (The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.) STC10-2 = 629 (Property Casualty Claim Number) Example: STC*A1:21*20090830*WQ*70******A1:629~

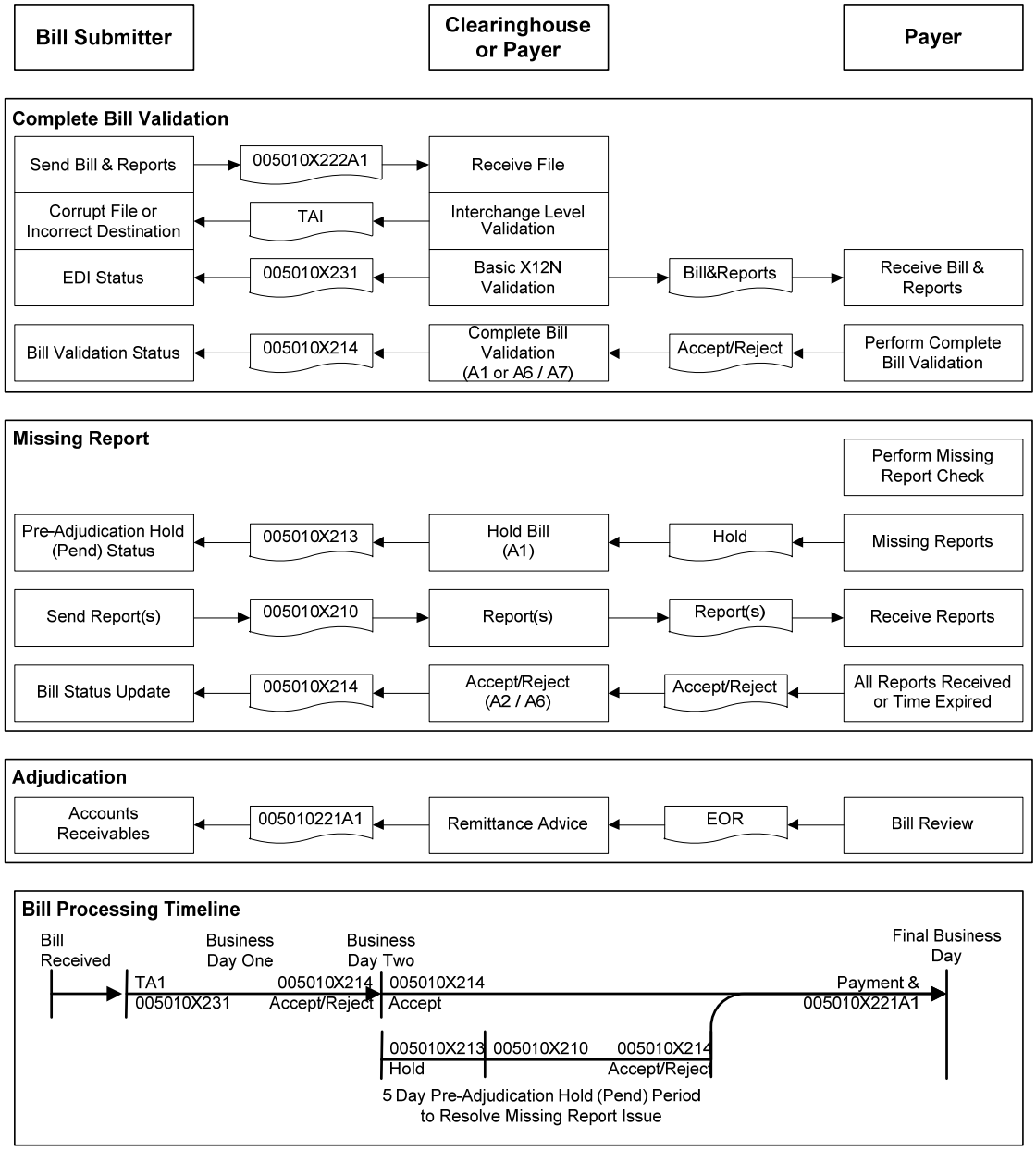
Claim Index/Validation Complete	**005010X214**
Complete Claim Was Found	Once the Claim Indexing/Validation process has been completed and there is a bill/claim number match, then use the following Claim Status Category Code with the appropriate Claim Status Code: STC01-1 = A2 (Acknowledgment/Acceptance into adjudication system. The claim/encounter has been accepted into the adjudication system.) STC01-2 = 20 (Accepted for processing) Payer Claim Control Number: Use Loop 2200D REF Payer Claim Control Number segment with qualifier 1K Identification Number to return the workers' compensation claim number and/or the payer bill control number in the REF02: a. Always preface the workers' compensation claim number with the two digit qualifier 'Y4' followed by the property/casualty claim number. Example: Y412345678 b. If there are two numbers (payer claim control number and property/casualty claim number) returned in the REF02, then use a blank space to separate the numbers. - The first number will be the payer claim control number assigned by the payer (bill control number). - The second number will be the workers' compensation property/ casualty claim number assigned by the payer with a 'Y4' qualifier followed by the claim number. - Example: REF*1K*3456832 Y43333445556~

Claim Index/Validation Complete	005010X214
No Claim Found	After the Claim Indexing/Validation process has been completed and there is no bill/claim number match, use the following Claim Status Category Code with the appropriate Claim Status Code: STC01-1 = A6 (Acknowledgment/Rejected for Missing Information - the claim/encounter is missing the information specified in the Status details and has been rejected.) STC01-2 = 629 (Property Casualty Claim Number - No Bill/Claim Number Match)

9.3 Complete Bill - Missing Report Pre-Adjudication Hold (Pending) Status

(This subsection applies to Jurisdictions that allow payers to hold medical bills for a defined period of time to allow for required medical documentation to be submitted. Jurisdictions that do not allow for "pending" status prior to a determination of bill acceptance would generally remove this subsection. However, those Jurisdictions may wish to allow for the use of the 005010X213 as an electronic means to request medical documentation.)

One of the processing steps that a bill goes through prior to adjudication is verification that all required documentation has been provided. The bill submitter can send the reports using the 005010X210 or other mechanisms such as fax or e-mail. In order to prevent medical bill rejections because required documentation was sent separately from the bill itself, a pre-adjudication hold (pending) period of up to five business days is mandated to enable the payer to receive and match the bill to the documentation. If the bill cannot be matched within the five days, or if the supporting documentation is not received, the bill may be rejected as incomplete. If the payer is able to match the bill to the documentation within the five day hold period, it continues the adjudication process. The 005010X213 is used to inform the bill submitter of the delay and the ultimate resolution of the issue.


Bill Submitter
Clearinghouse or Payer
Payer
Complete Bill Validation
Send Bill & Reports
005010X222A1
Receive File
Corrupt File or Incorrect Destination
TAI
Interchange Level Validation
EDI Status
005010X231
Basic X12N Validation
Bill&Reports
Receive Bill & Reports
Bill Validation Status
005010X214
Complete Bill Validation (A1 or A6 / A7)
Accept/Reject
Perform Complete Bill Validation
Missing Report
Perform Missing Report Check
Pre-Adjudication Hold (Pend) Status
005010X213
Hold Bill (A1)
Hold
Missing Reports
Send Report(s)
005010X210
Report(s)
Report(s)
Receive Reports
Bill Status Update
005010X214
Accept/Reject (A2 / A6)
Accept/Reject
All Reports Received or Time Expired
Adjudication
Accounts Receivables
005010221A1
Remittance Advice
EOR
Bill Review
Bill Processing Timeline
Bill Received
Business Day One
Business Day Two
Final Business Day
TA1
005010X231
005010X214
Accept/Reject
005010X214
Accept
Payment &
005010X221A1
005010X213
Hold
005010X210
005010X214
Accept/Reject
5 Day Pre-Adjudication Hold (Pend) Period
to Resolve Missing Report Issue

9.3.1 Missing Report - 277 Health Care Claim Acknowledgment Process Steps

When a bill submitter sends an 837 that requires an attachment and Loop 2300 PWK segment indicates that a report will be following, the payer will need to respond with the appropriate 277 HCCA response(s) as applicable:

Bill Status Findings	277 Health Care Claim Acknowledgment (HCCA) Options
Complete Bill - Missing Report	When a complete bill is missing a required report, the payer needs to place the bill in a pre-adjudication hold (pending) status during the specified waiting time period and return the following Claim Status Category Code and Claim Status Code: STC01-1 = A1 (The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.) STC01-2 = 21 (Missing or invalid information) AND STC10-1 = A1 (The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.) STC10-2 = Use the appropriate 277 Claim Status Code for missing report type. *Example: Claim Status Code* 294 Supporting documentation Example: STC*A1:21*20090830*WQ*70******A1:294~*:*
Report Received within the 5 day pre-adjudication hold (pending) period	Once the Claim Indexing/ Validation process has been completed and there is a bill/claim number match, then use the following Claim Status Category Code with the appropriate Claim Status Code: STC01-1= A2 Acknowledgment/Acceptance into adjudication system. The claim/encounter has been accepted into the adjudication system. STC01-2=20 Accepted for processing Use Loop 2200D REF segment "Payer Claim Control Number with qualifier 1K Identification Number to return the workers' compensation claim number and or the payer bill control number in the REF02: a. Always preface the workers' compensation claim number with the two digit qualifier "Y4" followed by the property casualty claim number. Example: Y412345678 b. If there are two numbers (payer claim control number and the workers' compensation claim number) returned in the REF02, then use a blank space to separate the numbers. - The first number will be the payer claim control number assigned by the payer (bill control number). - The second number will be the workers' compensation property and casualty claim number assigned by the payer with a "Y4" qualifier followed by the claim number. -Example: REF*1K*3456832 Y43333445556~

Bill Status Findings	277 Health Care Claim Acknowledgment (HCCA) Options
No Report Received within the 5 day pre-adjudication hold (pending) period	Use the following Claim Status Category Code and Claim Status Code. STC01-1= A6 Acknowledgment/Rejected for Missing Information. The claim/encounter is missing the information specified in the Status details and has been rejected. STC01-2=294 Supporting documentation

9.4 Transmission Responses

(This subsection applies to Jurisdictions that require system participants to use other transmission responses related to electronic medical bill processing. Jurisdictions must tailor this section to the acknowledgments and/or transmission responses required by their regulatory framework.)

9.4.1 Acknowledgments

The ASC X12 transaction sets include a variety of acknowledgments to inform the sender about the outcome of transaction processing. Acknowledgments are designed to provide information regarding whether or not a transmission can be processed, based on structural, functional, and/or application level requirements or edits. In other words, the acknowledgments inform the sender regarding whether or not the medical bill can be processed or if the transaction contains all the required data elements.

Under *(Insert Jurisdiction's Regulatory Reference)*, claim administrators must return one of the following acknowledgments, as appropriate, according to the Bill Acknowledgment Flow and Timing Diagrams found in Section 9.1:

- TA1 -- Implementation Acknowledgment
- 005010X231 -- Implementation Acknowledgment (999)
- 005010X214 -- Health Care Claim Acknowledgment (277)

Detailed information regarding the content and use of the various acknowledgments can be found in the applicable *ASC X12N Type 3 Technical Reports (Implementation Guides).*

9.4.2 005010X213 - Request for Additional Information

The 005010X213, or Request for Additional Information, is used to request missing required reports from the submitter. The following are the STC01 values:

Claim was pended; additional documentation required.

STC01-1 = R4 (pended/request for additional supporting documentation)

STC01-2 = The LOINC code indicating the required documentation

Additional information regarding this transaction set may be found in the applicable *ASC X12N Type 3 Technical Reports (Implementation Guides).*

9.4.3 005010X221A1 - Health Care Claim Payment/Advice

Within (*insert number of days*) of receipt of a complete electronic medical bill, the claims administrator is required to send the health care provider the 005010X221A1, or Health Care Claim Payment/Advice. This transaction set informs the health care provider about the payment action the claims administrator has taken. Additional information regarding this transaction set may be found in Chapter 7 of this companion guide and the applicable ASC X12N Type 3 Technical Reports Implementation Guides.

9.4.4 005010X212 Health Care Claim Status Request and Response

The 005010X212 transaction set is used in the group health industry to inquire about the current status of a specified healthcare bill or bills. The 276 transaction set identifier code is used for the inquiry and the 277 transaction set identifier code is used for the reply. It is possible to use these transaction sets unchanged in workers' compensation bill processing. Additional information regarding this transaction set may be found in the applicable ASC X12N Type 3 Technical Reports Implementation Guides.

Appendix A – Glossary of Terms

Acknowledgment	Electronic notification to original sender of an electronic transmission that the transactions within the transmission were accepted or rejected.
ADA	American Dental Association.
ADA-2006	American Dental Association (ADA) standard paper billing form.
AMA	American Medical Association
ANSI	American National Standards Institute, a private, non-profit organization that administers and coordinates the U.S. voluntary standardization and conformity assessment system.
ASC X12 275	A standard transaction developed by ASC X12 to transmit various types of patient information.
ASC X12 835	A standard transaction developed by ASC X12 to transmit various types of health care claim payment/advice information.
ASC X12 837	A standard transaction developed by ASC X12 to transmit various types of health care claim information.
CDT	Current Dental Terminology, coding system used to bill dental services.
Complete Bill (Clean Claim)	A complete electronic medical bill and its supporting transmissions must: • be submitted in the correct billing format, with the correct billing code sets, • be transmitted in compliance with all necessary format requirements • include in legible text all medical reports and records, including, but not limited to, evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results that are expressly required by law or can reasonably be expected by the payer or its agent under the Jurisdiction's law • include any other jurisdictional requirements found in its regulations or companion guide.
Clearinghouse	A public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that is an agent of either the payer or the provider and that may perform the following functions: 1) Processes or facilitates the processing of medical billing information received from a client in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction for further processing of a bill related transaction; or 2) Receives a standard transaction from another entity and processes or facilitates the processing of medical billing information into a nonstandard format or nonstandard data content for a client entity. An entity that processes information received in a nonstandard format or containing nonstandard data content into a standard transaction, or that receives a standard transaction and processes that information into a nonstandard transaction.

CMS	Centers for Medicare and Medicaid Services, the federal agency that administers these programs.
CMS-1450	The paper hospital, institutional, or facility billing form, also referred to as a UB-04 or UB-92, formerly referred to as a HCFA-1450.
CMS-1500	The paper professional billing form formerly referred to as a HCFA or HCFA-1500.
Code Sets	Tables or lists of codes used for specific purposes. National standard formats may use code sets developed by the standard setting organization (i.e. X12 Provider Type qualifiers) or by other organizations (i.e. HCPCS codes).
CPT	Current Procedural Terminology, the coding system created and copyrighted by the American Medical Association that is used to bill professional services.
DEA	Drug Enforcement Administration
DEA Number	Prescriber DEA identifier used for pharmacy billing.
Detail Acknowledgment	Electronic notification to original sender that its electronic transmission or the transactions within the transmission were accepted or rejected.
Electronic Bill	A bill submitted electronically from the health care provider, health care facility, or third-party biller/assignee to the payer.
EFT	Electronic Funds Transfer.
Electronic Transmission	A collection of data stored in a defined electronic format. An electronic transmission may be a single electronic transaction or a set of transactions.
Electronic Format	The specifications defining the layout of data in an electronic transmission.
Electronic Record	A group of related data elements. A record may represent a line item, a health care provider, health care facility, or third party biller/assignee, or an employer. One or more records may form a transaction.
Electronic Transaction	A set of information or data stored electronically in a defined format that has a distinct and different meaning as a set. An electronic transaction is made up of one or more electronic records.
Electronic Transmission	Transmission of information by facsimile, electronic mail, electronic data interchange, or any other similar method that does not include telephonic communication. For the purposes of the electronic billing rules, electronic transmission generally does not include facsimile or electronic mail.
EOB/EOR	Explanation of Benefits (EOB) or Explanation of Review (EOR) is the paper form sent by the claim administrator to the health care provider, health care facility, or third party biller/assignee to explain payment or denial of a medical bill. The EOB/EOR might also be used to request recoupment of an overpayment or to acknowledge receipt of a refund.
Functional Acknowledgment	Electronic notification to the original sender of an electronic transmission that the functional group within the transaction was accepted or rejected.
HCPCS	Healthcare Common Procedure Coding System, the HIPAA code set used to bill durable medical equipment, prosthetics, orthotics, supplies, and biologics (Level II) as well as professional services (Level I). Level I HCPCS codes are CPT codes

HIPAA	Health Insurance Portability and Accountability Act, federal legislation that includes provisions that mandate electronic billing in the Medicare system and establishes national standard electronic file formats and code sets.
IAIABC	International Association of Industrial Accident Boards and Commissions.
IAIABC 837	An implementation guide developed by the IAIABC based on the ASC X12 standard to transmit various types of health care medical bill and payment information from claim administrators to Jurisdictional workers' compensation agencies.
ICD-9	International Classification of Diseases, the code set administered by the World Health Organization used to identify diagnoses.
NABP	National Association of Boards of Pharmacy, the organization previously charged with administering pharmacy unique identification numbers. See NCPDP.
NABP Number	Identification number assigned to an individual pharmacy, administered by NCPDP. (Other term: NCPDP Provider ID)
NCPDP	National Council for Prescription Drug Programs, the organization administering pharmacy-unique identification numbers called NCPDP Provider IDs.
NCPDP Provider ID Number	Identification number assigned to an individual pharmacy, previously referred to as NABP number.
NCPDP WC/PC UCF	National Council for Prescription Drug Programs Workers' Compensation/Property and Casualty Universal Claim form, the pharmacy industry standard for pharmacy claims billing on paper forms.
NCPDP Telecommunication D.0	HIPAA compliant national standard billing format for pharmacy services.
NDC	National Drug Code, the code set used to identify medication dispensed by pharmacies.
Receiver	The entity receiving/accepting an electronic transmission.
Remittance	Remittance is used in the electronic environment to refer to reimbursement or denial of medical bills.
Sender	The entity submitting an electronic transmission.
TPA	Third Party Administrator.
Trading Partner	An entity that has entered into an agreement with another entity to exchange data electronically.
UB-04	Universal billing form used for hospital billing. Replaced the UB-92 as the CMS-1450 billing form effective May 23, 2007.
UB-92	Universal billing form used for hospital billing, also referred to as a CMS-1450 billing form. Discontinued use as of May 23, 2007
Version	Electronic formats may be modified in subsequent releases. Version naming conventions indicate the release or version of the standard being referenced. Naming conventions are administered by the standard setting organization. Some ASC X12 versions, for example, are 3050, 4010, and 4050.

Appendix B - Jurisdiction Report Type Codes and *(Insert Jurisdiction)* Descriptions

Note: This Appendix is designed to provide stakeholders with the list of "jurisdictional codes" that will be used to identify documents for which an ASC X12 code is not yet available. Jurisdictions should review the code list contained in the ASC X12 Type 3 Technical Reports and evaluate Jurisdiction-specific documentation requirements before completing this table. Any code values not used by a Jurisdiction must be removed from the table (for example, J3 Medical Permanent Impairment Report is not used in California and would be removed from the California companion guide). The code values listed below represent the first two characters of the attachment control number when a jurisdictional report is being submitted with the 837 transaction.

Jurisdiction Report Type Codes	**(Insert Jurisdiction) Description as Applicable**
J1 Doctor First Report of Injury	
J2 Supplemental Medical Report	
J3 Medical Permanent Impairment	
J4 Medical Legal Report	
J5 Vocational Report	
J6 Work Status Report	
J7 Consultation Report	
J8 Permanent Disability Report	
J9 Itemized Statement	

