North Carolina Workers' Compensation Electronic Billing and Payment Companion Guide

Based on ASC X12 005010 and NCPDP D.0

Release 2.0

February 21, 2014

Important Note

The International Association of Industrial Accident Boards and Commissions (IAIABC) Workers' Compensation Electronic Billing and Payment National Companion Guide serves as a template for jurisdictions to use in producing their own guides.

The *IAIABC Companion Guide* was reviewed and approved by the ASC X12 Intellectual Property Committee prior to publication. ASC X12 has granted IAIABC the authority to review companion guides that are based on the IAIABC template and to extend their permission to reproduce materials to those documents. When a jurisdiction customizes the *IAIABC Companion Guide* to reflect its specific requirements, a draft of the customized version must be submitted to the IAIABC for review and approval.

The *North Carolina Workers' Compensation Electronic Billing and Payment Companion Guide* is based on Version 2.0 of the *IAIABC Companion Guide*, and has been reviewed and approved by the IAIABC.

Purpose of the NC Workers' Compensation Electronic Billing and Payment Companion Guide

This companion guide has been created for use in conjunction with the Accredited Standards Committee X12 (ASC X12) Technical Reports Type 3 implementation guides and the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide Version D.0 adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These national standard implementation guides are incorporated by reference. This 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 North Carolina 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**

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Methodology for Updating Companion Guide Document

Please contact the Industrial Commission's Medical Fees Section above regarding instructions for submitting change requests, recommendations, and document updates.

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Chapter 1 Introduction and Overview

1.1 HIPAA

Title II of HIPAA, entitled "Administrative Simplification", requires "covered entities" – healthcare providers, health insurers, clearinghouses, and others – to use established national standards for electronic health care transactions, identifiers, and code sets. These standards were adopted by the U.S. Secretary of Health and Human Services to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread, consistent use of electronic data interchange. Additional information regarding the formats adopted under HIPAA is included in Chapter 2.

HIPAA's Administrative Simplification provisions do not apply to state workers' compensation systems, however. In North Carolina this has meant (1) reluctance by many workers' compensation stakeholders to transition away from paper-based systems, and (2) no consistency in electronic billing, payment, and coding processes for those stakeholders who have individually attempted to streamline their systems with electronic processes.

1.2 Administrative Simplification and the North Carolina Workers' Compensation Act

In 2011, the North Carolina General Assembly addressed the lack of standards by amending the Workers' Compensation Act. With N.C.G.S. § 97-26(g1), the General Assembly explicitly imported HIPAA regulations into our workers' compensation system as a way to streamline administrative processes for workers' compensation stakeholders. The provision states:

> **Administrative Simplification. –** The applicable administrative standards for code sets, identifiers, formats, and electronic transactions to be used in processing electronic medical bills under this Article shall comply with 45 C.F.R. § 162. The Commission shall adopt rules to require electronic medical billing and payment processes, to standardize the necessary medical documentation for billing adjudication, to provide for effective dates and compliance, and for further implementation of this subsection.

In 2012, the Industrial Commission adopted rules in compliance with and to carry out the mandate contained in the statute. The "Electronic Billing Rules" have been codified at Title 4, Chapter 10, Subchapter F of the North Carolina Administrative Code.

1.3 The North Carolina Workers' Compensation Electronic Billing and Payment Companion Guide

In accordance with the Electronic Billing Rules, the Industrial Commission has created and published this Guide.

As a starting point, the Guide incorporates by reference national electronic standards of the Accredited Standards Committee (ASC X12), Technical Reports Type 3 (and all related errata), and the National Council for Prescription Drug Programs (NCPDP). These standards are copyrighted by the Data Interchange Standards Association (DISA) on behalf of ASC X12 and the NCPDP, respectively, and may be purchased for use via http://store.x12.org, and www.ncpdp.org.

The North Carolina Workers' Compensation Electronic Medical Billing and Payment Companion Guide is to be used in conjunction with and as a supplement to the national technical reports and guides. The

Guide provides clarifications and specialized instructions derived from specific business rules that apply to processing bills and payments electronically in North Carolina's workers' compensation system.

Chapter 2 North Carolina Workers' Compensation Requirements

2.1 Compliance

According to state law and the Commission's rules, health care providers, provider agents, payers, payer agents, and clearinghouses must utilize electronic billing and payment for workers' compensation medical bills. These entities must develop and implement electronic billing processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before July 1, 2014. These entities must develop and implement electronic payment processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before January 1, 2015.

Payers and providers may use a direct data entry methodology for complying with these requirements by mutual agreement, provided the methodology complies with the data content requirements of the adopted formats, the Commission's rules, and this Guide.

2.1.1 Agents

The Commission's Electronic Billing Rules allow providers and payers to use agents to meet electronic billing and electronic payment requirements. The rules do not mandate the method of connectivity, the use of, or connectivity to, clearinghouses or similar types of vendors. Providers and payers are responsible for the acts or omissions of their agents.

2.1.2 Privacy, Confidentiality, and Security

Providers, payers, and agents must comply with all applicable federal and state requirements related to privacy, confidentiality, security, and similar issues.

2.2 Standard Formats

The standard formats incorporated by reference into this Guide 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 Acknowledgement;
- ASCX12C005010X231 Implementation Acknowledgment for Health Care Insurance (999);
- ASCX12N005010X214 Health Care Claim Acknowledgment (277);
- ASC X12N/005010X213 Request for Additional Information (277) (for requesting attachments not originally submitted with the electronic medical bill);
- The ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) (for transmitting 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.

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

2.2.1 North Carolina 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

The following formats are used in ancillary processes related to electronic billing and payment. The use of these formats is voluntary, and the Guide is presented as a tool to facilitate their use in workers' compensation.

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

2.3 Companion Guide Usage

Implementation of electronic billing and payment in North Carolina's workers' compensation system aligns with HIPAA usage and requirements in most circumstances. This Companion Guide is intended to convey information that is within the framework of the ASC X12 Technical Reports Type 3 (Implementation Guides) and NCPDP Telecommunication Standard Implementation Guide Version D.0 adopted for use. The Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the ASC X12 Technical Reports Type 3 (Implementation Guides) or NCPDP Telecommunication Standard Implementation Guide Version D.0. Where applicable, this Guide 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 Technical Reports Type 3 (Implementation Guides). Non-shaded rows represent "data elements" in the ASC X12 Technical Reports Type 3 (Implementation Guides). An example is provided in the following table:

Loop	Segment or Element	Value	Description	North Carolina 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 Technical Reports Type 3.

The ASC X12 Technical Reports Type 3 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 Technical Reports Type 3. The Guide provides 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 may 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 the payer or its claims administrator.

2.4.3 Health Care Provider Identification

Provider roles and identification numbers are addressed extensively in the ASC X12 Technical Reports Type 3. However, it is noted that in the national transaction sets most health care providers are identified by their National Provider Identification numbers (NPIs), and secondary identification numbers are generally not transmitted.

2.4.4 Injured Employee Identification

The employee is identified by Social Security Number, date of birth, date of injury, and workers' compensation claim number (see 2.4.5 below).

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

2.4.5 Claim Identification

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 refers to a bill as a "claim" for electronic billing transactions. In an effort to avoid confusion, this Guide refers to these transactions as "bills," since in workers' compensation the term "claim" generally refers to the employee's legal action to have the employer cover lost wages and medical expenses resulting from the employee's workplace illness or 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 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:

- 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.

- **Note for Preauthorization:** When sending supporting documentation for treatment authorization, use PWK 01 Report Type Qualifier CT = certification.

2.5 Claim Administrator Validation Edits

The North Carolina Medical State Reporting Guide, used in conjunction with the IAIABC Workers' Compensation Medical Bill Data Reporting Implementation Guide (Release 2.0), provides validation edits that the North Carolina Industrial Commission applies to transactions reported by the claim administrator. The claim administrator may also apply the state reporting validation edits (in the Commission's *Medical Implementation Guide and Requirements*, available at http://www.ncicedi.info/med-guide) where appropriate 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 North Carolina Industrial Commission's *Medical Implementation Guide and Requirements*;
- The IAIABC Medical Bill/Payment Records Implementation Guide; and
- ASC X12N Technical Reports Type 3 (Implementation Guides) requirements

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 Technical Reports Type 3 (Implementation Guides), Appendices A.1, available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

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 2.3.2.1 HL Segment of the ASC X12 Technical Reports Type 3 (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 Technical Reports Type 3 (Implementation Guides) available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

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 Control Header ISA Segment must be the actual date the transmission is sent.

2.7.2 Date Received

For medical bill processing purposes, the Date Received is the date the claim administrator or its agent physically 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 physically 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 BPR 16, “Check Issue or EFT Effective Date,” in the 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 Technical Reports Type 3 (Implementation Guides), NCPDP Implementation Guide, Industrial Commission rule, and this Guide. The code sets are maintained by multiple standard setting organizations.

Providers, payers, and agents are required to utilize current valid codes based on requirements contained in the applicable implementation guide. **This means, for example, that payers, providers, and their agents will be required to utilize the ICD-10-CM diagnosis and ICD-10-PCS procedure code sets starting October 1, 2014.** 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, 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 payer 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 this workers' compensation implementation, the Employer is considered the insured entity.

2.9.7 Employee

In this Guide, the Employee is the individual patient that has been injured on the job or has a work-related illness.

2.9.8 Patient

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

2.10 Health Care Provider, Payer, and Agent Roles

The Industrial Commission's Electronic Billing Rules allow providers and payers to utilize agents to comply with the requirements. Billing agents, third party administrators, bill review companies, software vendors, data collection agents, and clearinghouses are examples of companies that may serve as agents. Providers and payers are responsible for ensuring that electronic transactions transmitted via agents reach the intended recipient..

Under the rules, payers must exchange medical billing information and payments electronically with providers and provider agents that request the exchange of data. Payers may establish direct electronic connections to providers or may use agents.

A provider that cannot send standard transactions shall use an internet-based direct data entry system offered by a payer if the payer does not charge a transaction fee. A provider using an internet-based direct data entry system offered by a payer shall use the appropriate data content and data condition requirements of the standard transaction.

2.11 Duplicate, Appeal/Reconsideration, and Corrected Bill Resubmissions

2.11.1 Claim Resubmission Code - 837 Billing Formats

Providers or provider agents 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 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, providers must also populate the appropriate NUBC Condition Code to identify the type of resubmission. Condition codes provide additional information to the payer when the resubmitted bill is a request for reconsideration or a new submission after receipt of a decision from the Industrial Commission or other administrative or judicial proceeding. 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.)

Guidance on the use of Bill Type Frequency Codes can be referenced on the National niform Billing Committee's (NUBC's) website at http://www.nubc.org/resources/PDFs/BillTypeFrequencyCodes837.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.

A provider or provider agent may not submit a duplicate electronic medical bill earlier than sixty (60) calendar days from the date originally submitted if the payer has acknowledged acceptance of the original complete electronic medical bill.

The payer may reject a bill transaction with a Condition Code W2 indicator if:

(1) the duplicate bill is received within sixty (60) calendar days after acknowledgment;
(2) the bill has been processed and the 005010X221A1 transaction has been generated; or
(3) the payer does not have a corresponding accepted original transaction with the same bill identification numbers.

If the payer 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 provider or provider agent may submit a corrected medical bill electronically to the payer after receiving notification of a rejection. This includes scenarios 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.

A provider or provider agent 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 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. • 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.

The payer may reject a revised bill transaction if:

(1) the payer does not have a corresponding adjudicated bill transaction with the same Payer Claim Control number; or
(2) there is incorrect billing documentation for an adjustment based on CMS guidelines (inappropriate changed data).

If payer 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 payer 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 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: Request for reconsideration or appeal with the payer

- 'W4' – 2nd Level Appeal: 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 thirty (30) calendar 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 payer.

If possible, the provider may use the same bill identification number on both the original bill and Reconsideration bill transactions to increase the opportunity for matching the transactions in the payer's system. The Payer Claim Control Number can also be used to associate the Reconsideration bill transaction with the original bill transaction. 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 thirty (30) calendar 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 appeals/reconsideration is required in accordance with the 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 Technical Reports Type 3 (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 payer. 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: Request for reconsideration or appeal with the payer
  o 'W4' = 2nd Level Appeal: Resubmitted after receipt of a hearing or other judicial decision and order.
• REF*F8 includes the Payer Claim Control Number.
• The appeal/reconsideration bill must be identical to the original bill, with the exception of the added Condition Code, Payer Claim Control Number, Bill Submitter's Identifier (Patient Control Number – CLM01), 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.

The payer may reject an appeal/reconsideration bill transaction if:

(1) the bill information does not match the corresponding original bill transaction (excluding the specific fields listed above);
(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 rules for initial bill submission.

The payer may deny appeal/reconsideration bill transactions for missing documentation. If the payer does not reject the appeal/reconsideration bill transaction within two (2) 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 payer may also deny the appeal/reconsideration bill transaction through the use of the 005010X221A1 transaction, if the documentation is not submitted within the required time frame.

NOTE: Currently there is no official appeal or reconsideration process for NCPDP Version D.0.

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 Requirements Specific to North Carolina Workers' Compensation

The requirements in this section identify North Carolina 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. Payers must acknowledge acceptance or rejection of transmissions (files) and transactions (bills). Transmissions that are rejected by the payer 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, providers are not required to report electronic billing data to the Industrial Commission. Therefore, code 'RP' (Reporting) is not appropriate for provider use.

2.13.4 Other State Data Requirements

Reserved.

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 Chapter of the 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 Guide is not, nor was intended to be, a comprehensive guide to the electronic transaction requirements for North Carolina or other jurisdictions. The Guide is intended to be used to develop and publish information tailored to the regulatory environment for consistent application the syntactical requirements of the *ASC X12 Technical Reports Type 3*.

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

The purpose of the Commission's Electronic Billing Rules and this Guide is to provide a framework for electronic billing, processing, and payment of medical services and products. Health care providers, provider agents, payers, payer agents, and clearinghouses must develop and implement electronic billing processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before July 1, 2014. These entities must develop and implement electronic payment processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before January 1, 2015.

3.2 Trading Partner Agreements

The components of trading partner agreements that define other transaction parameters beyond the ones described in this Guide (such as transmission parameters) remain the same; this 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 Technical Reports Type 3* and this Guide. The Trading Partner Agreement must not change the workers' compensation field value designations as defined herein.

3.3 Workers' Compensation Health Care Claim: Professional Instructions

The following table identifies the application/ instructions for North Carolina workers' compensation that need clarification beyond the *ASC X12 Technical Reports Type 3*.

Refer to Chapter 9 for additional information regarding an electronic bill that is sent without a claim number or is sent without a report.

ASC X12N/005010X222A1

Loop	Segment	Description	North Carolina Workers' Compensation Companion Guide Comments or Instructions
1000A	PER	SUBMITTER EDI CONTACT INFORMATION	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	Enter the claim number if known, If not known, then enter the default value of "UNKNOWN".
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.
2010CA	REF	PROPERTY AND CASUALTY CLAIM NUMBER	Enter the claim number if known, If not known, then enter the default value of "UNKNOWN".
2010CA	REF	PROPERTY AND CASUALTY PATIENT IDENTIFIER	Required
2010CA	REF01	REFERENCE IDENTIFICATION QUALIFIER	Value must be 'SY'. (Social Security Number)
2010CA	REF02	REFERENCE IDENTIFICATION	Value must be the patient's Social Security Number. When applicable, utilize '999999999' as a default value where the social security number is not known.
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.
2300	DTP	DATE – DISABILITY DATES	Do not use Segment. Leave blank.
2300	DTP	DATE – PROPERTY AND CASUALTY DATE OF FIRST CONTACT	Do not use Segment. Leave blank.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Refer to the Companion Guide for instruction regarding Documentation/Medical Attachment Requirements.
2300	PWK01	REPORT TYPE CODE	For all 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.
2300	K3	FILE INFORMATION	State Jurisdictional Code.

Loop	Segment	Description	North Carolina Workers' Compensation Companion Guide Comments or Instructions
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, 'LUNC' indicates the medical bill is being submitted under North Carolina 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: Request for reconsideration or appeal • W4 – Level 2 Appeal: Resubmitted after receipt of a hearing or other judicial decision and order. Note: Do not use condition codes when submitting revised or corrected bills.

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

Introduction and Overview

The information contained in this Chapter of the 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 to be considered a replacement for the *ASC X12N/005010X223A2 Health Care Claim: Institutional (837) Technical Report Type 3*, but rather is to be used as an additional source of information.

This Guide is not, nor was intended to be, a comprehensive guide to the electronic transaction requirements for North Carolina or other jurisdictions. The Guide is intended to be used to develop and publish information tailored to the regulatory environment for consistent application the syntactical requirements of the *ASC X12 Technical Reports Type 3*.

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

The purpose of the Commission's Electronic Billing Rules and this Guide is to provide a framework for electronic billing, processing, and payment of medical services and products. Health care providers, provider agents, payers, payer agents, and clearinghouses must develop and implement electronic billing processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before July 1, 2014. These entities must develop and implement electronic payment processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before January 1, 2015.

4.2 Trading Partner Agreements

The components of trading partner agreements that define other transaction parameters beyond the ones described in this Guide (such as transmission parameters) remain the same; this 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 Technical Reports Type 3* and this Guide. The Trading Partner Agreement must not change the workers' compensation field value designations as defined herein.

4.3 Workers' Compensation Health Care Claim: Institutional Instructions

The following table identifies the application/ instructions for North Carolina workers' compensation that need clarification beyond the *ASC X12 Technical Reports Type 3*.

Refer to Chapter 9 for additional information regarding an electronic bill that is sent without a claim number or is sent without a report.

ASC X12N/005010X223A2

Loop	Segment	Description	North Carolina Workers' Compensation Companion Guide Comments or Instructions
1000A	PER	SUBMITTER EDI CONTACT INFORMATION	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	Enter the claim number if known. If not known, then enter the default value of "UNKNOWN".
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.
2010CA	REF02	PROPERTY CASUALTY CLAIM NUMBER	Enter the claim number if known. If not known, then enter the default value of "UNKNOWN".
2010CA	REF	PROPERTY AND CASUALTY PATIENT IDENTIFIER	Required.
2010CA	REF01	REFERENCE IDENTIFICATION QUALIFIER	Value must be 'SY'. (Social Security Number)
2010CA	REF02	REFERENCE IDENTIFICATION	Value must be the patient's Social Security Number. When applicable, utilize '999999999' as a default value where the social security number is not known.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Refer to the Companion Guide for instruction regarding Documentation/Medical Attachment Requirements.
2300	PWK01	REPORT TYPE CODE	For all 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.
2300	K3	FILE INFORMATION	State Jurisdictional Code is expected here.
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, 'LUNC' indicates the medical bill is being submitted under North Carolina medical billing requirements.
2300	HI01	OCCURRENCE INFORMATION	At least one Occurrence Code must be entered with value of '04' - Accident/Employment Related or '11' - - illness. The Occurrence Date must be the Date of Occupational Injury or Illness.

ASC X12N/005010X223A2

Loop	Segment	Description	North Carolina Workers' Compensation Companion Guide Comments or Instructions
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: Request for reconsideration or appeal • W4 – Level 2 Appeal: Resubmitted after receipt of a hearing or other judicial decision and order. Note: Do not use condition codes when submitting revised or corrected bills.

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

Introduction and Overview

The information contained in this Chapter of the 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 to be considered 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 Guide is not, nor was intended to be, a comprehensive guide to the electronic transaction requirements for North Carolina or other jurisdictions. The Guide is intended to be used to develop and publish information tailored to the regulatory environment for consistent application the syntactical requirements of the *ASC X12 Technical Reports Type 3*.

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

The purpose of the Commission's Electronic Billing Rules and this Guide is to provide a framework for electronic billing, processing, and payment of medical services and products. Health care providers, provider agents, payers, payer agents, and clearinghouses must develop and implement electronic billing processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before July 1, 2014. These entities must develop and implement electronic payment processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before January 1, 2015.

5.2 Trading Partner Agreements

The components of trading partner agreements that define other transaction parameters beyond the ones described in this Guide (such as transmission parameters) remain the same; this 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 Technical Reports Type 3* and this Guide. The Trading Partner Agreement must not change the workers' compensation field value designations as defined herein.

5.3 Workers' Compensation Health Care Claim: Dental Instructions

The following table identifies the application/ instructions for North Carolina workers' compensation that need clarification beyond the *ASC X12 Technical Reports Type 3*.

Refer to Chapter 9 for additional information regarding an electronic bill that is sent without a claim number or is sent without a report.

X12N/005010X224A2

Loop	Segment	Description	North Carolina Workers' Compensation Companion Guide Comments or Instructions
1000A	PER	SUBMITTER EDI CONTACT INFORMATION	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	Enter the claim number if known. If not known, then enter the default value of "UNKNOWN".
2000C	PAT01	INDIVIDUAL RELATIONSHIP CODE	Value must be '20' Employee.
2010CA	REF02	PROPERTY CASUALTY CLAIM NUMBER	Enter the claim number if known. If not known, then enter the default value of "UNKNOWN".
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	Required.
2010CA	REF01	REFERENCE IDENTIFICATION QUALIFIER	Value must be 'SY'. (Social Security Number)
2010CA	REF02	REFERENCE IDENTIFICATION	Value must be the patient's Social Security Number. When applicable, utilize '999999999' as a default value where the social security number is not known.
2300	DTP	DATE -- ACCIDENT	Required when the condition reported is for an occupational accident/injury.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Refer to the Companion Guide for instruction regarding Documentation/Medical Attachment Requirements.
2300	PWK01	REPORT TYPE CODE	For all 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.
2300	K3	FILE INFORMATION	State Jurisdictional Code is expected here.
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, 'LUNC' indicates the medical bill is being submitted under North Carolina medical billing requirements.

Chapter 6 Companion Guide NCPDP D.0 Pharmacy

Introduction and Overview

The information contained in this Chapter of the 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 Guide is not, nor was intended to be, a comprehensive guide to the electronic transaction requirements for North Carolina or other jurisdictions. The Guide is intended to be used to develop and publish information tailored to the regulatory environment for consistent application of 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. Specific guidance for workers' compensation is available in the "Resources/Guidance" area of the NCPDP website.

6.1 Purpose, Applicability, and Expected Implementation Date

The purpose of the Commission's Electronic Billing Rules and this Guide is to provide a framework for electronic billing, processing, and payment of medical services and products.Health care providers, provider agents, payers, payer agents, and clearinghouses must develop and implement electronic billing processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before July 1, 2014. These entities must develop and implement electronic payment processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before January 1, 2015.

6.2 Trading Partner Agreements

The components of trading partner agreements that define other transaction parameters beyond the ones described in this Guide (such as transmission parameters) remain the same; this 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 this Guide. The Trading Partner Agreement must not change the workers' compensation field value designations as defined herein.

6.3 Workers' Compensation Health Care Claim: Pharmacy Instructions

The following table identifies the application/ instructions for North Carolina workers' compensation that need clarification beyond the NCPDP Telecommunication Standard Implementation Guide Version D.0.

NCPDP D.0 Pharmacy

Segment	Field	Description	North Carolina Workers' Compensation Companion Guide Comments or Instructions
INSURANCE	3Ø2-C2	CARDHOLDER ID	If the Cardholder ID is not available or not applicable, the value must be 'NA'."
CLAIM	415-DF	NUMBER OF REFILLS AUTHORIZED	Required, if no refill is authorized enter "0."
PRICING	426-DQ	USUAL AND CUSTOMARY CHARGE	Not Required.
PHARMACY PROVIDER	465-EY	PROVIDER ID QUALIFIER	The value must be '05' – NPI Number
PRESCRIBER	466-EZ	PRESCRIBER ID QUALIFIER	The value must be '01' – NPI Number, however, if prescriber NPI is not available, enter applicable prescriber ID qualifier
WORKERS' COMPENSATION			The Workers' Compensation Segment is required for workers' compensation claims.
WORKERS' COMPENSATION	435-DZ	CLAIM/REFERENCE ID	Enter the claim number if known. If not known, then enter the default value of "UNKNOWN."

Chapter 7 Companion Guide ASC X12N/005010X221A1 Health Care Claim Payment/Advice (835) and Electronic Funds Transfer (EFT)

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 North Carolina or other jurisdictions. The companion guide is intended to be used to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the *ASC X12 Technical Reports Type 3*.

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

The purpose of the Commission's Electronic Billing Rules and this Guide is to provide a framework for electronic billing, processing, and payment of medical services and products. Health care providers, provider agents, payers, payer agents, and clearinghouses must develop and implement electronic billing processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before July 1, 2014. These entities must develop and implement electronic payment processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before January 1, 2015.

7.2 Trading Partner Agreements

The components of trading partner agreements that define other transaction parameters beyond the ones described in this Guide (such as transmission parameters) remain the same; this 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 this Guide. The Trading Partner Agreement must not change the workers' compensation field value designations as defined herein.

Trading Partner Agreements pertaining to Claims Adjustment Group Codes and Claim Adjustment Reason Code/Remittance Advice Remark Code combinations must follow the current ASC X12N Technical Report Type 2 (TR2) Code Value Usage in Health Care Claim Payments and Subsequent Claims Reference Model, which identifies usage standards when providing payment, reduction, or denial information. The TR2 is available at http://store.x12.org.

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 formal. North Carolina accepts Claims 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 Claim Adjustment Reason Codes (CARCs) 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, payers that provide the required 005010X221A1 transaction information in the transmission are compliant with applicable rules. CARCs are available through Washington Publishing Company at www.wpc-edi.com/codes.

7.5 Remittance Advice Remark Codes

The 005010X221A1 transaction supports the use of Remittance Advice Remark Codes (RARCs) 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. Payers must use the Remittance Advice Remark Codes where appropriate 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. RARCs are not associated with a Group or Reason Code in the same manner that a CARC is associated with a Group Code. RARCs are available through Washington Publishing Company at http://www.wpc-edi.com/codes.

7.6 ASCX12 Technical Report Type 2 Health Care Claim Payment/Advice Code Usage Rules (TR2)

The ASC X12 Technical Report Type 2 Health Care Claim Payment/Advice Code Usage Rules is the encyclopedia of Group Codes, specific CARC and RARC combinations for payers to use when providing payment, reduction, or denial information. These codes and their combinations are defined, maintained, modified, and/or deleted by the ASC X12 External Code Committees and CMS Remittance Advice Remark Committee, which meets every three months. The TR2 has a specific Workers' Compensation CARC and RARC defined usage section that shall be used to explain a claim denial or adjustment in the 005010x221A1 transaction. The TR2 is available at http://store.x12.org.

The great amount of variability in the mapping and combinations of codes used in both the health care and property and casualty industries today results in different interpretations by the providers for each payer. The TR2 workers' compensation section defines CARC-RARC combinations that provide a concrete and predictable message, thereby allowing providers to set up rules to automate actions based upon the combinations of codes. Consistent use of these codes by all payers will result in significant administrative simplification in the workers' compensation industry.

7.7 Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rules

In furtherance of the directive that the Commission must require electronic payment processes, see N.C.G.S. 97-26(g1), the Industrial Commission adopts into this Guide the following operating rules established by the CAQH Committee on Operating Rules for Information Exchange (CORE):

Phase III CORE 370 EFT & ERA (CCD+/835) Reassociation Rule

One of the major barriers to widespread EFT adoption in health care has been transmission of EFT payment information to the provider independent of the remittance advice. Previously, no mechanism allowed these two transactions to be paired electronically. This operating rule resolves that problem by establishing consistent and uniform rules that enable providers to match the payment received via EFT with a specific ERA. The rule requires a unique Reassociation Trace Number be reported in the ASCX12N 835 (TRN02) as well as in the EFT CCD+ Addenda Record Payment Related Information field.

Complete information regarding this rule may be referenced via http://www.caqh.org/Host/CORE/EFT-ERA/EFTERA_Reassociation_Rule.pdf.

Phase III CORE 380 EFT Enrollment Data Rule

Another industry barrier to widespread EFT adoption has been the lack of consistent enrollment standards across payers. The CAQH CORE 380 Operating Rule resolves this issue by mandating the use of a standard EFT enrollment form and maximum enrollment data set requirements.

Complete information regarding this rule may be referenced via http://www.caqh.org/Host/CORE/EFT-ERA/EFT_Enrollment_Data_Rule.pdf.

Phase III CORE 382 ERA Enrollment Data Rule

This operating rule mandates the use of a standard ERA enrollment form and maximum enrollment data set requirements. The rule creates a consistent and uniform approach that enables providers to quickly and efficiently enroll in ERA transactions.

The standardization of the ERA enrollment process will help to facilitate stakeholder EDI adoption as well as promote a single automated workflow process across all lines of health care business.

Complete information regarding this rule may be referenced via http://www.caqh.org/Host/CORE/EFT-ERA/EFT_Enrollment_Data_Rule.pdf.

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

Reserved. This section is not applicable in North Carolina.

7.9 Line Level Jurisdictional Statutory/Citation Reason Code ID Qualifier and URL Reference

Reserved. This section is not applicable in North Carolina.

7.10 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.

7.11 Workers' Compensation Health Care Claim Payment/Advice Instructions

The following table identifies the application/instructions for North Carolina workers' compensation requirements that need clarification beyond the *ASC X12 Technical Reports Type 3*.

ASC X12N/005010X221A1

Loop	Segment or Element	Value	Description	North Carolina Workers' Compensation Companion Guide 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**	Not applicable in NC
	REF01	CE	Reference Identification Qualifier	
	REF02		Reference Identification	
2110	**REF**		**Healthcare Policy Identification**	This section not applicable in NC
	REF01	OK	Reference Identification Qualifier	
	REF02		Reference Identification	

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 to be considered 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 Guide is not, nor was intended to be, a comprehensive guide to the electronic transaction requirements for North Carolina or other jurisdictions. The Guide is intended to be used to develop and publish information tailored to the regulatory environment for consistent application the syntactical requirements of the *ASC X12 Technical Reports Type 3*.

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

The purpose of the Commission's Electronic Billing Rules and this Guide is to provide a framework for electronic billing, processing, and payment of medical services and products. Health care providers, provider agents, payers, payer agents, and clearinghouses must develop and implement electronic billing processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before July 1, 2014. These entities must develop and implement electronic payment processes consistent with 45 C.F.R. § 162, including all subsequent amendments and editions, on or before January 1, 2015.

8.2 Method of Transmission

The 005010X210 transaction is the standard electronic format for submitting electronic documentation. Providers, payers, and agents should be able to electronically exchange medical documentation that is required to be submitted with the bill.

Simultaneous submission of electronic documentation using this transaction is the preference of the Industrial Commission, but is not required by the Electronic Billing Rules. However, providers, payers, and agents may agree to exchange documentation in other formats 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. Non-prescribed formats may include uploading to a web-based system, facsimile (fax), or electronic mail (email).

Refer to Chapter 9 for additional information regarding an electronic bill that is sent without documentation.

8.3 Documentation Requirements

“Electronic documentation” includes, but is not limited to, medical reports, records, evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records, and diagnostic test results.

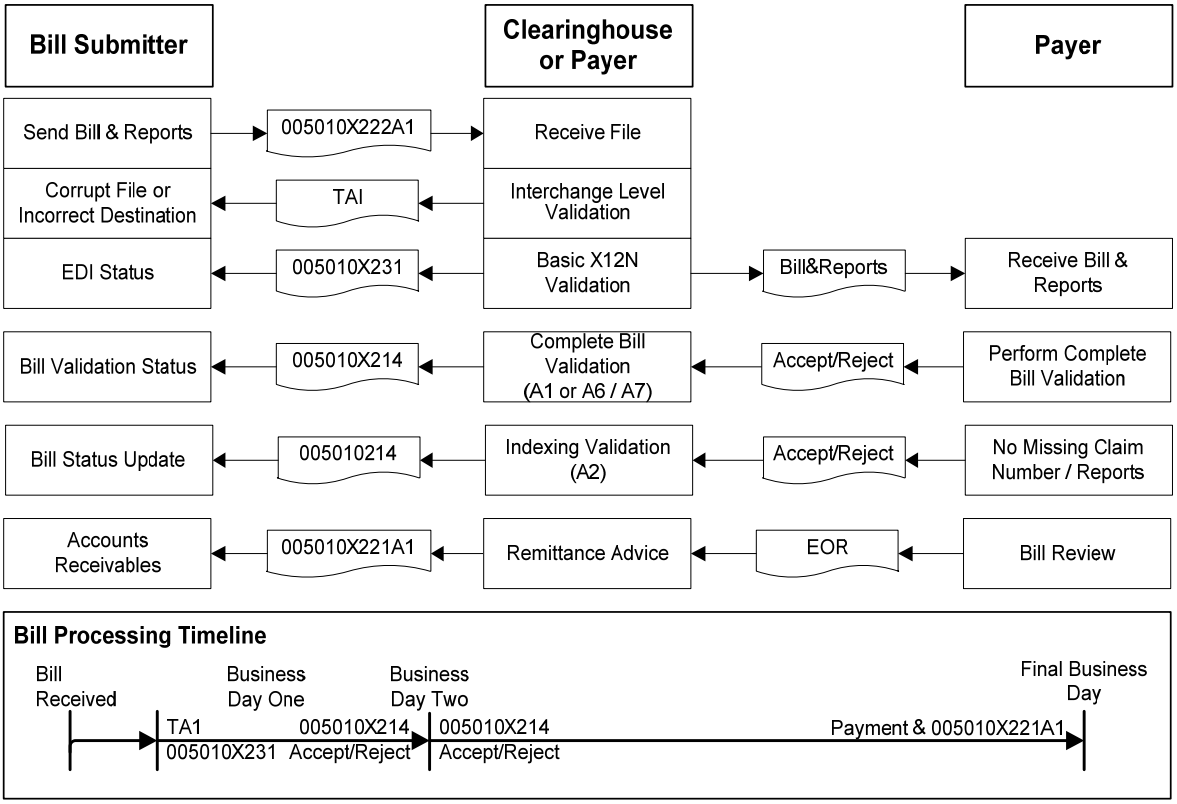
Chapter 9 Companion Guide Acknowledgments

There are several different acknowledgments that a payer or payer agent 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 jurisdiction's 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. A 005010X231 (Functional 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

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 during which the payer shall attempt to match the bill to an existing claim in its system. If the bill cannot be matched within the five business 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.

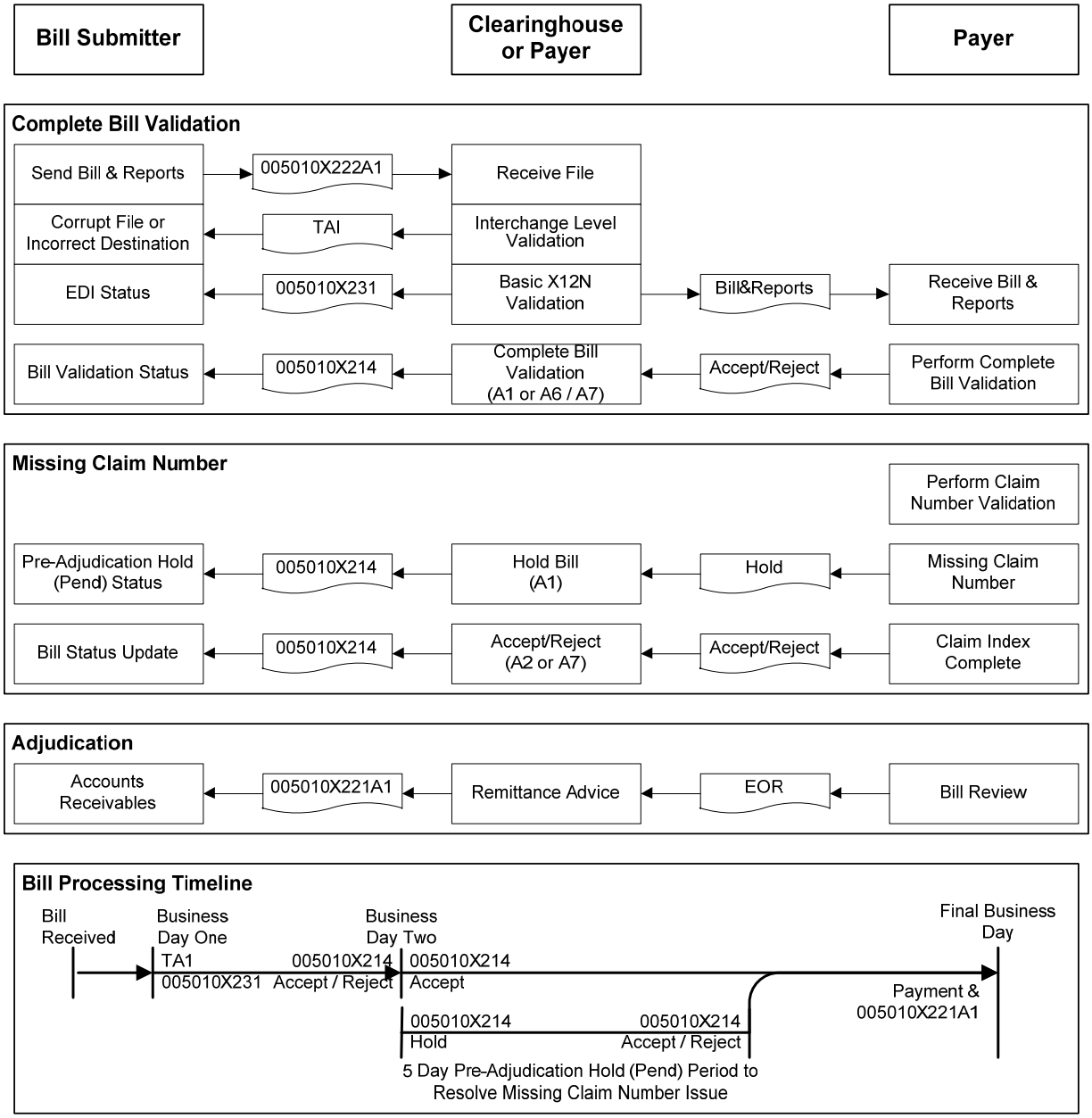
Due to the pre-adjudication hold (pend) status, a payer may send one STC segment with up to three claim status composites (STC01, STC10, and STC11) in the 005010X214. When a complete claim has a missing claim number and a missing report, the one STC segment in the 005010X214 would have the following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


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 Claim Number
Perform Claim Number Validation
Pre-Adjudication Hold (Pend) Status
005010X214
Hold Bill (A1)
Hold
Missing Claim Number
Bill Status Update
005010X214
Accept/Reject (A2 or A7)
Accept/Reject
Claim Index Complete
Adjudication
Accounts Receivables
005010X221A1
Remittance Advice
EOR
Bill Review
Bill Processing Timeline
Bill Received
Business Day One
TA1
005010X231
005010X214
Accept / Reject
Business Day Two
005010X214
Accept
Final Business Day
Payment &
005010X221A1
005010X214
Hold
005010X214
Accept / Reject
5 Day Pre-Adjudication Hold (Pend) Period to Resolve Missing Claim Number Issue

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.

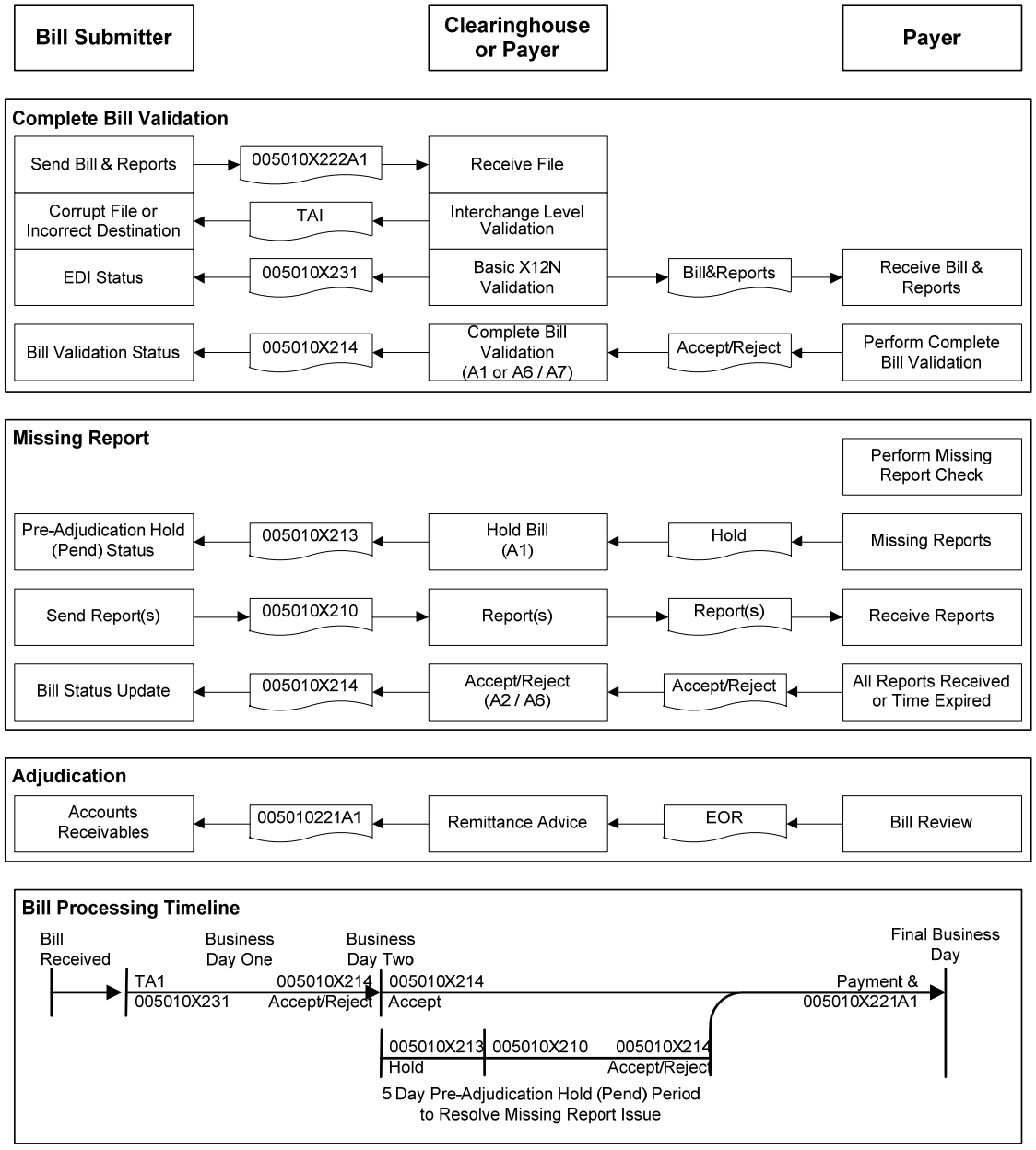
Claim Number Validation Status	**005010X214**
Complete Bill - Missing Claim Number	If the payer needs to pend an otherwise complete bill due to a missing claim number, it must use the following Claim Status Category Code and Claim Status Code: STC01-1 = A1 (The claim/encounter has been received. This 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 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~

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

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 during which the payer shall 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 HCCA Acknowledgment 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~*:*
Claim Index/Validation Complete	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 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~

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~
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

Reserved.

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 a transmission can be processed based on structural, functional, and/or application level requirements or edits. In other words, the acknowledgments inform the sender if the medical bill can be processed or if the transaction contains all the required data elements.

Under Industrial Commission Rule 04 N.C.A.C. 10F .0105, claim administrators must return one or more of the following acknowledgments, as appropriate, according to the Bill Acknowledgment Flow and Timing Diagrams found in Section 9.1:

- TA1 – Interchange Acknowledgment, upon receipt of an incoming transaction
- 005010X231 – Implementation Acknowledgment (999), within one (1) business day of receipt of an electronic medical bill
- 005010X214 – Health Care Claim (Detail) Acknowledgment (277), within two (2) business days of receipt of the electronic submission.

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

9.4.3 005010X221A1 - Health Care Claim Payment/Advice

Within thirty (30) 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 Technical Reports Type 3 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 Technical Reports Type 3 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.
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.
CMS	Centers for Medicare and Medicaid Services
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).

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 necessary for adjudication.
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, ICD-10	International Classification of Diseases code sets 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 Descriptions

Reserved. The North Carolina Industrial Commission has not adopted specific report types to be used by providers and submitted to payers.

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.

Jurisdiction Report Type Codes	Description as Applicable