NOTICE OF INTENT
Louisiana Workforce Commission
Office of Workers' Compensation
Electronic Medical Billing and Payment Companion Guide
(LAC 40:I:305,306)

Notice is hereby given, in accordance with R.S. 49:950, et seq., that the Louisiana Workforce Commission, Office of Workers' Compensation, pursuant to the authority vested in the Director of the Office of Workers' Compensation by R.S. 23:1310.1 and in accordance with applicable provisions of the Administrative provisions Act, proposes to amend LAC 40:I:305,306. The amendments include:

Title 40
LABOR AND EMPLOYMENT
Part I. Workers' Compensation Administration
Subpart 1. General Administration
Chapter 3. Electronic Billing

§305. Formats for Electronic Medical Bill Processing

A.-F. …

G. The OWCA shall develop the "Electronic Medical Billing and Payment Companion Guide" found in Section 306 of this chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1310.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:3543 (December 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 38:

§306. Electronic Medical Billing and Payment Companion Guide

A. Introduction and Overview

1. HIPAA

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

2. Louisiana Workforce Commission, Office of Workers' Compensation-Electronic Billing.

a. Louisiana Workforce Commission, Office of Workers' Compensation, LSA-R.S. 23:1203.2 mandates that carriers accept electronic bills for medical goods and services. Payers other than carriers (self-insured employers or self-insured funds) may participate in electronic medical billing but are not mandated as of this time. The rules also provide that the regulations which establish electronic billing rules be consistent with HIPAA to the extent possible. If participating in electronic medical billing, the health care provider, health care facility, or third-party biller/assignee shall use the HIPAA adopted electronic

transaction formats outlined in Title 40:I:Chapter 3 to submit medical or pharmacy bills to the appropriate payer associated with the employer of the injured employee to whom the services are provided.

b. In workers' compensation, the payer is the party responsible for providing benefits on behalf of the employer of the injured employee to whom the services are due. The payer, or its authorized agent, is to validate the Electronic Data Interchange (EDI) file according to the guidelines provided in the prescribed national standard format implementation guide, this companion guide, and the jurisdictional data requirements. Problems associated with the processing of the ASC X12 Health Care Claim (837) EDI file are to be reported using acknowledgment transactions described in this companion guide. Problems associated with the processing of the NCPDP Telecommunications D.0 bills are reported via the reject response transactions described in this companion guide. If mutually agreed upon, the payer will use the HIPAA-adopted electronic transaction formats to report explanations of payments, reductions, and denials to the health care provider, health care facility, or third-party biller/assignee. These electronic transaction formats include the ASC X12N/005010X221A1, Health Care Claim Payment/Advice (835), and the NCPDP Telecommunication D.0 Paid response transaction or other formats pursuant to Title 40:I:Chapter 3.

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

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

B. Louisiana Workforce Commission, Office of Workers' Compensation Requirements

1. Compliance. If a billing entity chooses to submit bills electronically, it must also be able to receive an electronic response from the payer pursuant to Title 40:I. Chapter 3 . The electronic responses include electronic acknowledgments (required) and electronic remittance advices (Explanation of Review) (where mutually agreed upon). Electronic billing rules allow for providers and payers to use agents to meet the requirement of electronic billing, but these rules do not mandate the method of connectivity, or the use of, or connectivity to, clearinghouses or similar types of vendors. Nothing in this document prevents the parties from utilizing Electronic Funds Transfer (EFT) to facilitate payment of electronically submitted bills. Use of EFT is governed by RS 23: 1203.2.B. (2) and is not a pre-condition for electronic billing. If covered by RS 23: 1203.2, health care providers, health care facilities, third-party biller/assignees, and payers must be able to exchange electronic bills in the prescribed standard formats and may exchange data in non-prescribed formats by mutual agreement. All jurisdictionally-required data content must be present in mutually agreed upon formats.

2. Agents. Electronic billing rules allow for health care providers and payers to use agents to accomplish the requirement of electronic billing. Payers and health care providers are responsible for the acts or omissions of their agents executed in the performance of services for their client's payer or health care provider.

3. Privacy, Confidentiality, and Security. Health care providers, health care facilities, third-party biller/assignees, payers, and their agents must comply with all applicable Federal and Louisiana Acts, Codes, or Rules related to the privacy, confidentiality, security or similar issues.

4. National Standard Formats.

a. The national standard formats for billing, remittance, and acknowledgments are those adopted by the Federal Department of Health and Human Services rules (45 CFR Parts 160 and 162). The formats adopted under Louisiana Workforce Commission, Office of Workers' Compensation, RS 23: 1203.2 that are aligned with the current Federal HIPAA implementation include:

i. ASC X12N/005010X222A1 Health Care Claim: Professional (837);
ii. ASC X12N/005010X223A2 Health Care Claim: Institutional (837);
iii. ASC X12N/005010X224A2 Health Care Claim: Dental (837);
iv. ASC X12N/005010X221A1 Health Care Claim Payment/Advice (835);
v. ASC X12N/005010X212 Health Care Claim Status Request and Response (276/277);
vi. ASCX12N005010TA1; Interchange Acknowledgement
vii. ASCX12C005010X231 Implementation Acknowledgment for Health Care Insurance (999);
viii. ASCX12N005010X214 Health Care Claim Acknowledgment (277);
ix. NCPDP Telecommunication Standard Implementation Guide Version D.0; and
x. NCPDP Batch Standard Implementation Guide 1.2.

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

i. The ASC X12N/005010X213 Request for Additional Information (277) is used to request additional attachments that were not originally submitted with the electronic medical bill.

ii. The ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) is used to transmit electronic documentation associated with an electronic medical bill. The 005010X210 can accompany the original electronic medical bill, or may be sent in response to a 005010X213 Request for Additional Information.

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

5. Louisiana Workforce Commission, Office of Workers' Compensation 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

6. ASC X12 Ancillary Formats

a. Other formats not adopted by Louisiana Workforce Commission, Office of Workers' Compensation rule are used in ancillary processes related to electronic billing and reimbursement. The use of these formats is voluntary, and the companion guide is presented as a tool to facilitate their use in workers' compensation.

Format	Corresponding Process	Function
005010X210	Documentation/Attachments	Documentation/Attachments
005010X213	Request for Additional Information	Request for Medical Documentation
005010X214	Health Claim Status Request and Response	Medical Bill Status Request and Response

7. Companion Guide Usage

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

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

Loop	Segment or Element	Value	Description	Louisiana Workforce Commission, Office of Workers' Compensation Instructions
2000 B	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.

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

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

8. Description of ASC X12 Transaction Identification Numbers. The ASC X12 Transaction Identification requirements are defined in the appropriate ASC X12 Type 3 Technical Reports (Implementation Guides), available through the Accredited Standards Committee (ASC) X12, http://store.x12.org. The Louisiana Workforce Commission, Office of Workers' Compensation has provided the following additional information regarding transaction identification number requirements.

a. 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.

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

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

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

d. Injured Employee Identification. The injured employee is identified by name, Social Security Number, date of birth, date of injury, and workers' compensation claim number (see below).

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

e. Claim Identification. The workers' compensation claim number assigned by the payer is the claim identification number. This claim identification number is reported in the REF segment of Loop 2010CA, Property and Casualty Claim Number.

i. 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.

f. Bill Identification. The ASC X12N Technical Report Type 3 (Implementation Guides) refers to a bill as a "claim" for electronic billing transactions. This Louisiana Workforce Commission, Office of Workers' Compensation companion guide refers to these transactions as "bill" because in workers' compensation, a "claim" refers to the full case for a unique injured employee and injury. The health care provider, health care facility, or third-party biller/assignee, assigns a unique identification number to the electronic bill transaction. For 005010X222A1, 005010X223A2, and 005010224A2 transactions, the bill transaction identification number is populated in Loop 2300 Claim Information CLM Health Claim Segment CLM01 Claim (Bill) Submitter's Identifier data element. This standard HIPAA implementation allows for a patient account number but strongly recommends that submitters use a completely unique number for this data element on each individual bill.

g. Document/Attachment Identification. The 005010X210 is the standard electronic format for submitting electronic documentation and is addressed in a later chapter of the Louisiana Workforce Commission, Office of Workers' Compensation Electronic Billing and Payment Companion Guide. Bills containing services that require supporting documentation as defined Louisiana Workforce Commission, Office of Workers' Compensation, LRS-R.S. 23:1203.2 must be properly annotated in the PWK Attachment Segment. Bill transactions that include services that require documentation and are submitted without the PWK annotation documentation will be rejected. 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 between providers and payers. Documentation related to the electronic bill must be submitted within five business (5) days of submission of the electronic medical bill and must identify the following elements:

i. Patient Name (Injured Employee);
ii. Employer Name (if available);
iii. Payer Name;
iv. Date of Service
v. Date of Injury
vi. Claim Number (if known);
vii. Unique Attachment Indicator Number

h. 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.

9. Payer Validation Edits. Payers may apply validation edits based on Louisiana Workforce Commission, Workers' Compensation Office of Workers' Compensation eBill Regulations, Louisiana Electronic Medical Billing and Payment Companion Guide and ASC X12N Technical Reports Type 3 (TR3s) requirements. Payers 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.

10. Description of Formatting Requirements. The ASC X12 formatting requirements are defined in the ASC X12 Type 3 Technical Reports (Implementation Guides), Appendices A.1, available through the Accredited Standards Committee (ASC) X12, http://store.x12.org. The Louisiana Workforce Commission, Office of Workers' Compensation has provided the following additional information regarding formatting requirements:

a. 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.

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

12. Description of ASC X12Transmission/Transaction Dates. The ASC X12 required Transmission/Transaction Dates are defined in the ASC X12 Type 3 Technical Reports (Implementation Guides) available through the Accredited Standards Committee (ASC) X12, http://store.x12.org. The Louisiana Workforce Commission, Office of Workers' Compensation has provided additional information regarding specific transmission/transaction identification requirements.

13. 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.

14. Date Received. For medical bill processing purposes, the Date Received is the date the payer or its agent received the complete medical bill transaction. The Date Received is used to track timely processing of electronic bills, electronic reconsideration/appeal transactions, acknowledgment transactions, and timeliness of payments.

15. 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.

16. Description of Code Sets. Code sets utilized in electronic billing and reimbursement and other ancillary processes are prescribed by the applicable ASC X12 Type 3 Technical Reports (Implementation Guides), NCPDP Implementation Guide, Louisiana Workforce Commission, Office of Workers' Compensation rule, and this companion guide. The code sets are maintained by multiple standard setting organizations. Participants are required to utilize current valid codes based on requirements contained in the applicable implementation guide. The validity of the various codes may be based on the date of service (e.g., procedure and diagnosis codes) or based on the date of the electronic transaction (e.g., claim adjustment reason codes).

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

a. 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).

b. 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 payer, or its agent, is the Sender in the 005010X214, 005010X231 or 005010X221A1 electronic acknowledgment or remittance transactions.

c. 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.

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

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

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

g. Injured Employee. In workers' compensation, the Injured Employee, as the person who has been injured on the job or has a work related illness, is always considered to be the patient. Thus, the relationship between the insured and the patient is always an employer/employee relationship, as opposed to group health, where there are many possible relationships a patient may have to the insured. For example, in a group health setting, the patient may be the insured, or may be the child or spouse of the insured, but the child or spouse of the injured employee will never be a covered patient in workers' compensation.

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

18. Health Care Provider Agent/Payer Agent Roles. Electronic billing and reimbursement rules include provisions that allow for providers and payers to utilize agents to comply with the electronic billing (eBill) requirements. Billing agents, third party administrators, bill review companies, software vendors, data collection agents, and clearinghouses are examples of companies that may have a role in eBill. Payers and health care providers are responsible for the acts or omissions of their agents executed in the performance of services for the payer or health care provider. Under the eBill rules, carriers must be able to receive medical billing from health care providers. Payers may establish direct electronic connections to health care providers or may use agents to perform eBill functions. The rules do not mandate the use of, or regulate the costs of, agents performing eBill functions. Providers and payers are not required by Louisiana Workforce Commission, Office of Workers' Compensation rule to establish connectivity with a clearinghouse or to utilize a specific media/method of connectivity (i.e. Secured File Transfer Protocol [SFTP]). By mutual agreement, use of non-standard formats between the health care provider, health care facility, or

third-party biller/assignee and the payer is permissible. The eBill rules do not regulate the formats utilized between providers and their agents, or payers and their agents, or the method of connectivity between those parties.

19. Duplicate, Appeal/Reconsideration, and Corrected Bill Resubmissions

a. Claim Resubmission Code - 837 Billing Formats. Health care providers will identify resubmissions of prior medical bills (not including duplicate original submissions) by using the Claim Frequency Type Code of 7 (Resubmission/Replacement). The value is populated in Loop 2300 Claim Information CLM Health Claim Segment CLM05-3 Claim Frequency Type Code of the 005010X222A1, 005010X223A2 and 005010X224A2 electronic billing transactions. When the payer has provided the Payer Claim Control Number it had assigned to the bill being replaced, the health care provider must also use this number in its 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.

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

ii. The Reconsideration Claim Frequency Type Code '7' is used in conjunction with the Payer Claim Control Number that the claim administrator had assigned to the bill 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 NUBC Instruction for the use of Claim Frequency Type Codes can be referenced on the NUBC website at http://www.nubc.org/FL4forWeb2_RO.pdf. The CMS-required bill processing documentation for adjustments can be referenced at http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf.

b. Duplicate Bill Transaction Prior To Payment

i. 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.

ii. A health care Duplicate bill transaction shall be submitted no earlier than thirty (30) calendar days after the payer has acknowledged receipt of a complete electronic bill transaction or prior to receipt of a 005010X221A1 transaction.

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

(a) the duplicate bill is received within thirty (30) calendar days after acknowledgment;

(b) the bill has been processed and the 005010X221A1 transaction has been generated; or

(c) the payer does not have a corresponding accepted original transaction with the same bill identification numbers.

iv. 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 or through a non-electronic EOR process.

c. Corrected Bill Transactions

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

ii. 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.

iii. Billers should 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, if assigned by the payer.
- A corrected bill shall include the original dates of service and the same itemized services rendered as the original bill.
- When identifying elements change, the correction is accomplished by a void and re-submission process. A bill with CLM05-3 = ‘8’ (Void) must be submitted to cancel the incorrect bill, followed by the submission of a new original bill with the correct information.

iv. The payer may reject a revised bill transaction if

(a) the payer does not have a corresponding adjudicated bill transaction with the same bill identification number; or

(b) there is incorrect billing documentation for an adjustment based on CMS guidelines (inappropriate changed data).

v. If the 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 or through a non-electronic EOR process.

d. Appeal/Reconsideration Bill Transactions. Appeal/reconsideration of disputed disbursements and denials are outlined and detailed in LAC 40 Chapter 51: §5149 and R.S. 23:1034.2(F). Additional information can also be found on the Louisiana Workforce Commission, Office of Workers’ Compensation website, www.laworks.net/WorkersComp/OWC_MainMenu.asp.

20. 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.

21. Louisiana Workforce Commission, Office of Workers’ Compensation and Workers’ Compensation Specific Requirements. The requirements in this section identify Louisiana Workforce Commission, Office of Workers’ Compensation 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.

a. 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.

b. 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 are required to 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.

c. Transaction Type Code. The Transaction Type Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction Segment field BHT06 in 005010X222A1, 005010X223A2, or 005010X224A2 transactions is designated as ‘CH’ Chargeable. Currently, health care providers are not required to report electronic billing data to the Louisiana Workforce Commission, Office of Workers’ Compensation. Therefore, code ‘RP’ (Reporting) is not appropriate for this implementation.

d. Louisiana Workers’ Compensation Specific Requirements that Relate to Multiple Electronic. The requirements in this section identify Louisiana 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.

e. 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.

Loop	Segment	Description	Louisiana Companion Guide Workers’ Compensation 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	Value must be the name of the Employer.

		ORGANIZATION NAME	
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 . Not Applicable to LA regulations
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Refer to the companion guide for instruction regarding Documentation/Medical Attachment Requirements.
2300	PWK01	REPORT TYPE CODE	Use appropriate 005010 Report Type Code.
2300	PWK06	ATTACHMENT CONTROL NUMBER	Enter the Attachment Control Number Example PWK*OB*BM***AC*DMN0012~
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, ‘LULA’ indicates the medical bill is being submitted under Louisiana medical billing requirements.
2300	HI	CONDITION INFORMATION	For workers’ compensation purposes, the National Uniform Billing Committee and the National Uniform Claims Committee has approved the following condition code (W2) for resubmission of a duplicate of the original bill. • W2 - Duplicate of the original bill Note: Do not use condition codes when submitting revised or corrected bills.

C. Companion Guide ASC X12N/005010X222A1 Health Care Claim: Professional (837)

1. Introduction and Overview. The information contained in this companion guide has been created for use in conjunction with the *ASC X12N/005010X222A1 Health Care Claim: Professional (837) Technical Report Type 3*. It is not to be considered a replacement for the *ASC X12N/005010X222A1 Health Care Claim: Professional (837) Technical Report Type 3*, but rather is to be used as an additional source of information. This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the Jurisdictions. The companion guide is intended to be used by Jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the *ASC X12 Type 3 Technical Reports*. The *ASC X12N/005010X222A1 Health Care Claim: Professional (837) Technical Report Type 3* is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

2. Purpose, Applicability, and Expected Implementation Date. The purpose of Electronic Billing (LAC40:IChapter 3) is to provide a framework for electronic billing, processing, and payment of medical services and products provided to an injured employee and data reporting subject to R.S. 23:1203.2, mandated for insurance carriers, beginning July 1, 2013 for electronic submissions.

3. Trading Partner Agreements. The components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide (such as transmission parameters) remain the same; this companion guide is not intended to replace any of those components. The data elements transmitted as part of a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the *ASC X12 Type 3 Technical Reports* and the Jurisdiction-specific companion guide. The Trading Partner Agreement must not change the workers' compensation field value designations as defined in the Jurisdiction-specific companion guide.

4. Workers' Compensation Health Care Claim: Professional Instructions. Instructions for Louisiana specific requirements are also provided in Louisiana Workers' Compensation Requirements. The following table identifies the application/ instructions for Louisiana workers' compensation that need clarification beyond the *ASC X12 Type 3 Technical Reports*:

ASC X12N/005010X222A1

Loop	Segment	Description	Louisiana Companion Guide Workers' Compensation 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.

Loop	Segment	Description	Louisiana Companion Guide Workers' Compensation Comments or Instructions
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 . Not Applicable to LA regulations
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Refer to the companion guide for instruction regarding Documentation/Medical Attachment Requirements.
2300	PWK01	REPORT TYPE CODE	Use appropriate 005010 Report Type Code.
2300	PWK06	ATTACHMENT CONTROL NUMBER	Enter the Attachment Control Number Example PWK*OB*BM***AC*DMN0012~
2300	K3	FILE INFORMATION	State Jurisdictional Code is expected here.
2300	K301	2300	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, 'LULA' indicates the medical bill is being submitted under Louisiana medical billing requirements.
	HI	CONDITION INFORMATION	For workers' compensation purposes, the National Uniform Billing Committee and the National Uniform Claims Committee has approved the following condition code (W2) for resubmission of a duplicate of the original bill. • W2 - Duplicate of the original bill Note: Do not use condition codes when submitting revised or corrected bills.

D. Companion Guide ASC X12N/005010X223A2 Health Care Claim: Institutional (837)

1. Introduction and Overview. The information contained in this companion guide has been created for use in conjunction with the *ASC X12N/005010X223A2 Health Care Claim: Institutional (837) Technical Report Type 3*. It is not a replacement for the *ASC X12N/005010X223A2 Health Care Claim: Institutional (837) Technical Report Type 3*, but rather is an additional source of information. This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the Jurisdictions. The companion guide is intended to be used by Jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the *ASC X12 Type 3 Technical Reports*. The *ASC X12N/005010X223A2 Health Care Claim: Institutional (837) Technical Report Type 3* is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

2. Purpose, Applicability and Expected Implementation Date. The purpose of Electronic Billing (LAC40:IChapter 3) is to provide a framework for electronic billing, processing, and payment of medical services and products provided to an injured employee and data reporting subject to R.S. 23:1203.2, mandated for insurance carriers, beginning July 1, 2013 for electronic submissions.

3. Trading Partner Agreements. The components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide (such as transmission parameters) remain the same; this companion guide is not intended to replace any of those components. The data elements transmitted as part of a Trading Partner Agreement must, at

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

4. Workers' Compensation Health Care Claim: Institutional Instructions. Instructions for Louisiana specific requirements are also provided in Louisiana Workers' Compensation Requirements. The following table identifies the application/instructions for Louisiana workers' compensation that need clarification beyond the *ASC X12 Type 3 Technical Reports*:

ASC X12N/005010X223A2

Loop	Segment	Description	Louisiana Companion Guide Workers' Compensation 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.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Refer to the Jurisdiction companion guide for instruction regarding Documentation/Medical Attachment Requirements.
2300	PWK01	REPORT TYPE CODE	Use appropriate 005010 Report Type Code.
2300	PWK06	ATTACHMENT CONTROL NUMBER	Enter the Attachment Control Number Example: PWK*OB*BM***AC*DMN0012~
2300	K3	FILE INFORMATION	State Jurisdictional Code is expected here.
2300	K301	FIXED FORMAT INFORMATION	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, 'LULA' indicates the medical bill is being submitted under Louisiana 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.
2300	HI	CONDITION INFORMATION	For workers' compensation purposes, the National Uniform Billing Committee and the National Uniform Claims Committee has approved the following condition code (W2) for resubmissions of a duplicate of the original bill. • W2 - Duplicate of the original bill Note: Do not use condition codes when submitting revised or corrected bills.

E. Companion Guide ASC X12N/005010X224A2 Health Care Claim: Dental (837)

1. Introduction and Overview. The information contained in this companion guide has been created for use in conjunction with the *ASC X12N/05010X224A2 Health Care Claim: Dental (837) Technical Report Type 3*. It is not a replacement for the *ASC X12N/05010X224A2 Health Care Claim: Dental (837) Technical Report Type 3*, but rather is an additional source of information. This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the Jurisdictions. The companion guide is intended to be used by Jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the *ASC X12 Type 3 Technical Reports*. The *ASC X12N/05010X224A2 Health Care Claim: Dental (837) Technical Report Type 3* is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

2. Purpose, Applicability and Expected Implementation Date. The purpose of Electronic Billing (LAC40:IChapter 3) is to provide a framework for electronic billing, processing, and payment of medical services and products provided to an injured employee and data reporting subject to R.S. 23:1203.2, mandated for insurance carriers, beginning July 1, 2013 for electronic submissions.

3. Trading Partner Agreements. The components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide (such as transmission parameters) remain the same; this companion guide is not intended to replace any of those components. The data elements transmitted as part of a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the *ASC X12 Type 3 Technical Reports* and the Jurisdiction-specific companion guide. The workers' compensation field value designations as defined in the Jurisdiction-specific companion guide must remain the same as part of any Trading Partner Agreement.

4. Workers' Compensation Health Care Claim: Dental Instructions. Instructions for Louisiana specific requirements are also provided in Louisiana Workers' Compensation Requirements. The following table identifies the application/instructions for Louisiana workers' compensation that need clarification beyond the *ASC X12 Type 3 Technical Reports:*

Loop	Segment	Description	Louisiana Companion Guide Workers' Compensation 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.

Loop	Segment	Description	Louisiana Companion Guide Workers' Compensation Comments or Instructions
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.
2300	DTP	DATE – ACCIDENT	Required when the condition reported is for an occupational accident/injury.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION	Refer to the Jurisdiction companion guide for instruction regarding Documentation/Medical Attachment Requirements.
2300	PWK01	REPORT TYPE CODE	Use appropriate 005010 Report Type Code.
2300	PWK06	ATTACHMENT CONTROL NUMBER	Enter Attachment Control Number Example: PWK*OB*BM***AC*DMN0012~
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, 'LULA' indicates the medical bill is being submitted under Louisiana medical billing requirements.

F. Companion Guide NCPDP D.0 Pharmacy

1. Introduction and Overview. The information contained in this companion guide has been created for use in conjunction with the *NCPDP Telecommunication Standard Implementation Guide Version D.0* for pharmacy claim transactions. It is not a replacement for the *NCPDP Telecommunication Standard Implementation Guide Version D.0*, but rather is an additional source of information. Pharmacy transactions are processed both in real-time and via batch. Every transmission request has a transmission response. To address the appropriate process for responding to request transactions and reversal processing, users are directed to utilize the *NCPDP Telecommunication Standard Implementation Guide Version D.0* and *Batch Standard Implementation Guide Version 1.2*. This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the Jurisdictions. The companion guide is intended to be used by Jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the NCPDP Implementation Guide. The implementation guide for electronic pharmacy claims and responses is available through the National Council for Prescription Drug Programs (NCPDP) at http://www.ncpdp.org.

2. Purpose, Applicability and Expected Implementation Date. The purpose of Electronic Billing (LAC40:IChapter 3) is to provide a framework for electronic billing, processing, and payment of medical services and products provided to an injured employee and data reporting subject to R.S. 23:1203.2, mandated for insurance carriers, beginning July 1, 2013 for electronic submissions.

3. Trading Partner Agreements. The components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide (such as transmission parameters) remain the same; this companion guide is not intended to replace any of those components. The data elements transmitted as part of a Trading Partner Agreement must, at a minimum, contain all the same required data elements found within the NCPDP Implementation Guide and the Jurisdiction-specific companion guide. The workers' compensation field value designations as defined in the Jurisdiction-specific companion guide must remain the same as part of any Trading Partner Agreement. Where a payer has a separate contract with a Pharmacy Benefits Manager (PBM), the data elements exchanged between the payer and PBM may be in a mutually agreed upon format.

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

Segment	Field	Description	Louisiana Companion Guide Workers' Compensation 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	This data element is optional.
PRICING	426-DQ	USUAL AND CUSTOMARY CHARGE	This data element is optional.
PHARMACY PROVIDER	465-EY	PROVIDER ID QUALIFIER	This data element is required. The value must be '05' – NPI Number.
PRESCRIBER	466-EZ	PRESCRIBER ID QUALIFIER	This data element is required. 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".
CLINICAL			This data element is optional.
ADDITIONAL DOCUMENTATION			The Additional Documentation segment can be utilized for any additional information that does not have a required field above.

G. Companion Guide ASC X12N/005010X221A1 Health Care Claim Payment/Advice (835)

1. Introduction and Overview. The information contained in this companion guide has been created for use in conjunction with the *ASC X12N/005010X221A1 Health Care Claim Payment Advice (835) Technical Report Type 3*. It is not a replacement for the *ASC X12N/005010X221A1 Health Care Claim Payment Advice (835) Technical Report Type 3*, but rather is an additional source of information. This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the Jurisdictions. The companion guide is intended to be used by Jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the *ASC X12 Type 3 Technical Reports*. The *ASC X12N/005010X221A1 Health Care Claim Payment Advice (835) Technical Report Type 3* is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org. The *NCPDP ASC X12N 835 (005010X221) Pharmacy Remittance Advice Template*, is available at http://www.ncpdp.org/public_documents.asp.

2. Purpose, Applicability and Expected Implementation Date. The purpose of Electronic Billing (LAC40:IChapter 3) is to provide a framework for electronic billing, processing, and payment of medical services and products provided to an injured employee and data reporting subject to R.S. 23:1203.2, mandated for insurance carriers, beginning July 1, 2013 for electronic submissions. Electronic remittance notification is not mandated at this time and may be used upon mutual agreement of the parties.

3. Trading Partner Agreements. The components of trading partner agreements that define other transaction parameters beyond the ones described in this companion guide (such as transmission parameters) remain the same; this companion guide is not intended to replace any of those components. The data elements transmitted as part of a Trading Partner Agreement must at a minimum contain all the same required data elements found within the *ASC X12 Type 3 Technical Reports* and the Jurisdiction-specific companion guide. The workers' compensation field value designations as defined in the Jurisdiction-specific companion guide must remain the same as part of any Trading Partner Agreement. 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, that identifies usage standards when providing payment, reduction, or denial information. The TR2 is available at http://store.x12.org.

4. Claim Adjustment Group Codes. The 005010X221A1 transaction requires the use of Claim Adjustment Group Codes. The most current valid codes must be used as appropriate for workers' compensation. The Claim Adjustment Group Code represents the general category of payment, reduction, or denial. For example, the Group Code 'CO' (Contractual Obligation) might be used in conjunction with a Claim Adjustment Reason Code for a network contract reduction. The Claim Adjustment Group Code transmitted in the 005010X221A1 transaction is the same code that is transmitted in the IAIABC 837 Medical State Reporting EDI reporting format. Louisiana Workforce Commission, Office of Workers Compensation accepts Claim Adjustment Group Codes that were valid on the date the payer paid or denied a bill.

5. Claim Adjustment Reason Codes. The 005010X221A1 transaction requires the use of Claim Adjustment Reason Codes (CARC) codes as the electronic means of providing specific payment, reduction, or denial information. As a result, use of the 005010X221A1 transaction eliminates the use of proprietary reduction codes, Jurisdiction specific claim adjustment reason codes, and free form text used on paper Explanation of Review (EOR) forms .Claim Adjustment Reason Codes are available through Washington Publishing Company at www.wpc-edi.com/codes. The ASC X12N Technical Report Type 2 (TR2) Code Value Usage in Health Care Claim Payments and Subsequent Claims Reference Model is the encyclopedia of Claim Adjustment Group Codes, Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) combinations. The most current TR2 specified CARC and/or CARC RARC code combinations are to be used when providing payment, reduction, or denial information. The TR2 is available at http://store.x12.org. There is a great amount of variability in the mapping and combinations of codes used in the industry today. This results in different interpretations by the providers for each payer. TheTR2 defines CARC/RARC combinations which will provide a concrete and predictable message allowing the providers to set up rules to automate actions based upon the combinations of codes. Consistent use of these codes across all payers will result in significant administrative simplification in the workers' compensation industry. Every three months codes are added, modified or deleted through the ASC X12 External Code Committee process. These changes are maintained by ASC X12 and are updated in the TR2. If it is determined that a code, or CARC/RARC combination, needs to be added, modified or deleted, contact the IAIABC EDI Medical Committee to submit your request at www.IAIABC.org/.

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

7. 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.

8. Workers' Compensation Health Care Claim Payment/Advice Instructions. Instructions for Louisiana specific requirements are also provided in Louisiana Workers' Compensation Requirements. The following table identifies the application/instructions for Louisiana workers' compensation requirements that need clarification beyond the *ASC X12 Type 3 Technical Reports*. Currently, the 005010X221A1 is an optional transaction to be used upon mutual agreement by the payer and healthcare provider.

ASC X12N/005010X221A1

Loop	Segment or Element	Value	Description	Louisiana Companion Guide Workers' Compensation Comments or Instructions
1000A	PER		Payer Technical Contact Information	
	PER03	TE	Communication Number Qualifier	Value must be 'TE' Telephone Number
	PER04		Communication Number	Value must be the Telephone Number of the submitter.
2100	CLP		Claim Level Data	
	CLP06	WC	Claim Filing Indicator Code	Value must be "WC" – Workers' Compensation
	CLP07		Payer Claim Control Number	The payer- assigned claim control number for workers' compensation use is the bill control number.

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

1. Introduction and Overview. The information contained in this companion guide has been created for use in conjunction with the *ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) Technical Report Type 3*. It is not a replacement for the *ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) Technical Report Type 3*, but rather is an additional source of information. This companion guide is not, nor was it ever intended to be, a comprehensive guide to the electronic transaction requirements for each of the Jurisdictions. The companion guide is intended to be used by Jurisdictions to develop and publish companion guides tailored to their regulatory environment that consistently apply the syntactical requirements of the *ASC X12N Type 3 Technical Reports*. The *ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) Technical Report Type 3* is available through the Accredited Standards Committee (ASC) X12, http://store.x12.org.

2. Purpose, Applicability, and Expected Implementation Date. The purpose of Electronic Billing (LAC40:IChapter 3) is to provide a framework for electronic billing, processing, and payment of medical services and products provided to an injured employee and data reporting subject to R.S. 23:1203.2, mandated for insurance carriers, beginning July 1, 2013 for electronic submissions.

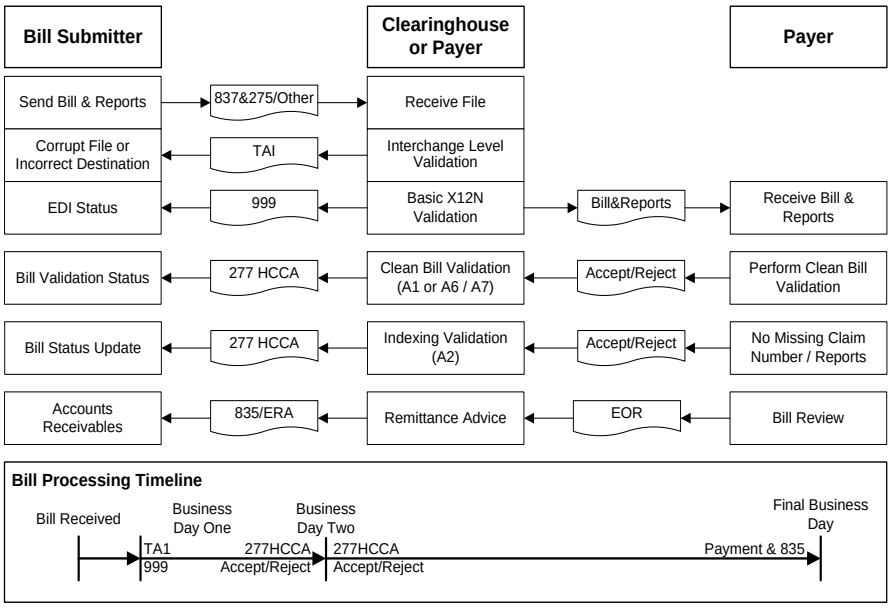
3. Method of Transmission. The 005010X210 transaction is the prescribed standard electronic format for submitting electronic documentation. Health care providers, health care facilities, or third party biller/assignees and payers may agree to exchange documentation in other non-prescribed electronic formats (such as uploading to a web-based system) by mutual agreement. If trading partners mutually agree to use non-prescribed formats for the documentation they exchange, they must include all components required to identify the information associated with the documentation. Health care providers, health care facilities, or third party biller/assignees and payers may also elect to submit documentation associated with electronic bill transactions through facsimile (fax) or electronic mail (email) in accordance Electronic Billing (LAC40:I. Chapter 3). Health care providers, health care facilities, or third party biller/assignees and payers must be able to electronically exchange medical documentation that is required to be submitted with the bill based on the regulatory requirements found in Electronic Billing (LAC 40.I.Chapter 3).

4. Documentation Requirements. "Medical documentation" includes, but is not limited to, medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records, and diagnostic test

results. Documentation requirements for Louisiana workers' compensation billing are defined in Electronic Billing (LAC 40.I.Chapter 3).

I. Companion Guide Acknowledgments

1. There are several different acknowledgments that a clearinghouse and/or payer may use to respond to the receipt of a bill. The purpose of these acknowledgments is to provide feedback on the following:
   a. Basic file structure and the trading partner information from the Interchange Header.
   b. Detailed structure and syntax of the actual bill data as specified by the X12 standard.
   c. The content of the bill against the Jurisdictional complete bill rules.
   d. Any delays caused by claim number indexing/validation.
   e. Any delays caused by attachment matching.
   f. The outcome of the final adjudication, including reassociation to any financial transaction.
2. 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.



3. Process Steps

a. 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.

b. 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.

c. Clean 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.

d. Clean Bill – Missing Claim Number and/or Missing Required Report: Refer to Section 9.2 Clean Claim - Missing Claim Number Pre-Adjudication Hold (Pending) Status and Section 9.3 Clean Claim - Missing Report Pre-Adjudication Hold (Pending) Status regarding bill acknowledgment flow and timeline diagrams.

e. 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. Currently, the 005010X221A1 is an optional transaction to be used upon mutual agreement by the payer and healthcare provider.

4. Clean Bill - Missing Claim Number Pre-Adjudication Hold (Pending) Status.

a. One of the processing steps that a bill goes through prior to adjudication is verification that the bill concerns an actual employment-related condition that has been reported to the employer and subsequently reported to the claims administrator. This

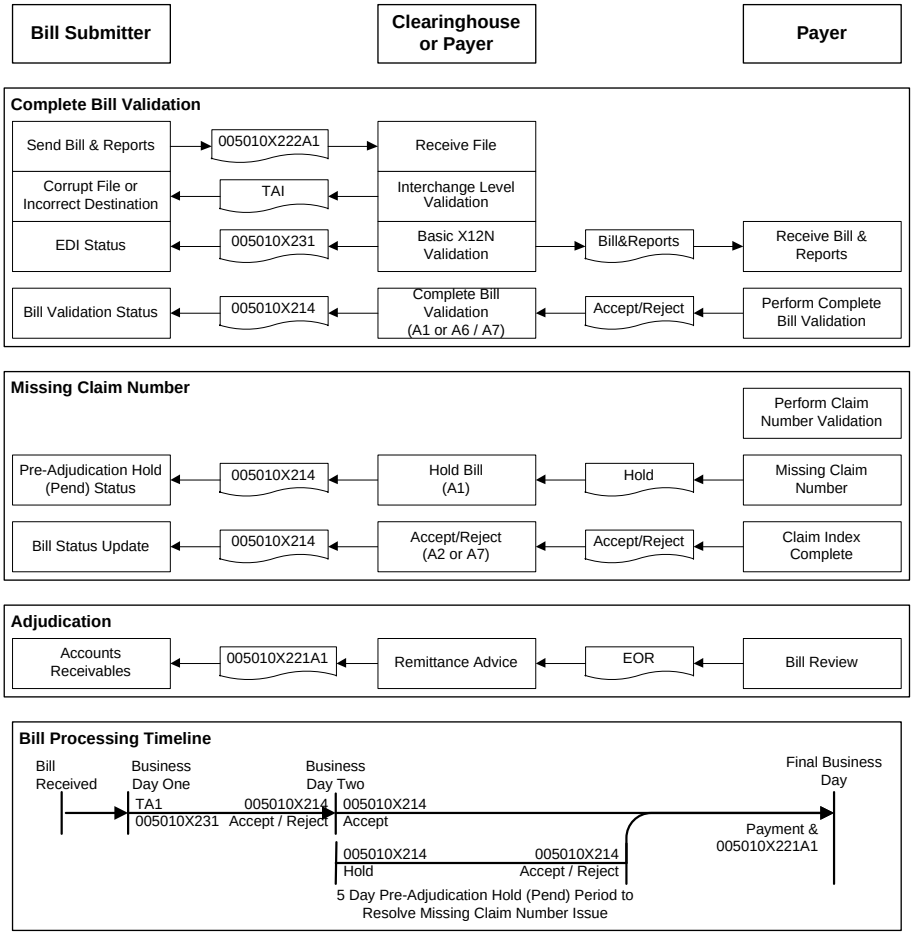
process, usually called "claim indexing/validation" can cause a delay in the processing of the bill. Once the validation process is complete, the claim administrator assigns a claim number to the injured worker's claim. This claim number is necessary for the proper processing of any bills associated with the claim. Until the claim number is provided to the bill submitter, it cannot be included on the 005010X222A1, 005010X223A2, and 005010X224A2 submission to the payer. In order to prevent medical bills from being rejected due to lack of a claim number, a pre-adjudication hold (pending) period of up to five business days is mandated to enable the payer to attempt to match the bill to an existing claim in its system. If the bill cannot be matched within the five 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 clean 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.

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

b. When a clean 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.

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

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



5. Missing Claim Number 005010X214 Acknowledgment Process Steps. When the 005010X222A1, 005010X223A2, or 005010X224A2 transaction has passed the clean 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.

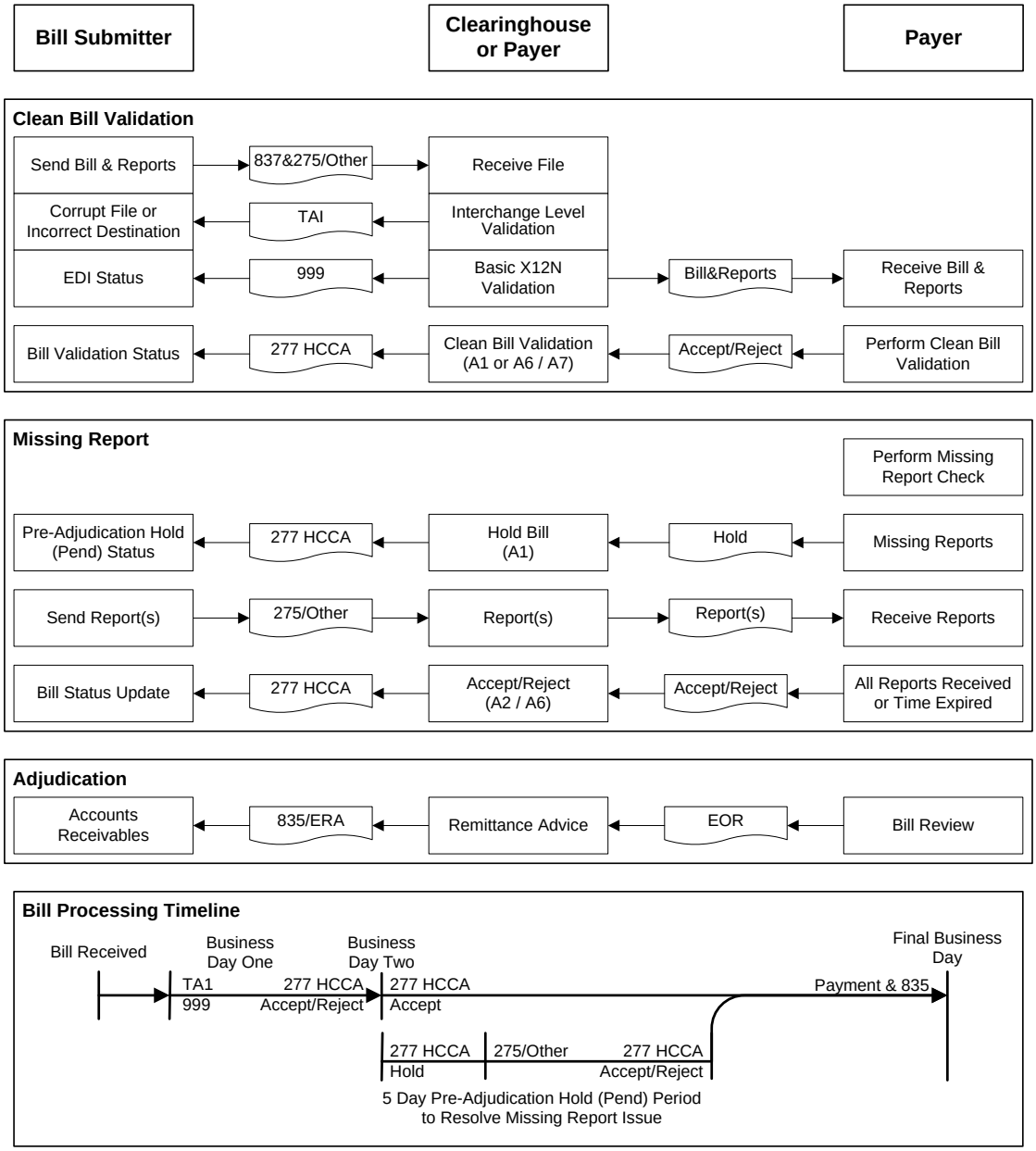
Claim Number Validation Status	005010X214
Clean Bill - Missing Claim Number	If the payer needs to pend an otherwise clean bill due to a missing claim number, it must use the following Claim Status Category Code and Claim Status Code: STC01-1 = A1 (The claim/encounter has been received. This does not

	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
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)

6. Clean 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 to enable the payer to receive and match the bill to the documentation. If the bill cannot be matched within the five business 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 business 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.



7. 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

Clean Bill - Missing Report	When a clean bill is missing a required report, the payer needs to place the bill in a pre-adjudication hold (pending) status during the specified waiting time period and return the following Claim Status Category Code and Claim Status Code: STC01-1 = A1 The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication. STC01-2 = 21 (Missing or Invalid Information) AND STC10-1 = A1 The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication. STC10-2 = Use the appropriate 277 Claim Status Code for missing report type. *Example: Claim Status Code* 294 Supporting documentation Example :STC*A1:21*20090830*WQ*70******A1:294~*:*
Report Received within the 5 day pre-adjudication hold (pending) period	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
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

8. Transmission Responses

a. Acknowledgments. The ASC X12 transaction sets include a variety of acknowledgments to inform the sender about the outcome of transaction processing. Acknowledgments are designed to provide information regarding whether or not a transmission can be processed, based on structural, functional, and/or application level requirements or edits. In other words, the acknowledgments inform the sender regarding whether or not the medical bill can be processed or if the transaction contains all the required data elements. Under Electronic Billing (LAC 40:I.Chapter 3) payers must return one of the following acknowledgments, as appropriate, according to the Bill Acknowledgment Flow and Timing Diagrams found in Section 9.1:

i. TA1 -- Implementation Acknowledgment

ii. 005010X231 -- Implementation Acknowledgment (999)

iii. 005010X214 -- Health Care Claim Acknowledgment (277)

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

b. 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:

i. Claim was pended; additional documentation required.

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

(b) STC01-2 = The LOINC code indicating the required documentation

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

c. 005010X221A1 - Health Care Claim Payment/Advice. Within thirty (30) calendar days of receipt of a complete electronic medical bill, the claims administrator is required to send the health care provider the 005010X221A1, if mutually agreed upon pursuant to LAC 40:I.Chapter 3, or Health Care Claim Payment/Advice or other form of paper EOR. This transaction set informs the health care provider about the payment action the claims administrator has taken. Additional information regarding this transaction

set may be found in Chapter 7 of this companion guide and the applicable ASC X12N Type 3 Technical Reports Implementation Guides.

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

J. Appendix A – Glossary of Terms

Acknowledgment	Electronic notification to original sender of an electronic transmission that the transactions within the transmission were accepted or rejected.
ADA	American Dental Association.
ADA-2006	American Dental Association (ADA) standard paper billing form.
AMA	American Medical Association
ANSI	American National Standards Institute, a private, non-profit organization that administers and coordinates the U.S. voluntary standardization and conformity assessment system.
ASC X12 275	A standard transaction developed by ASC X12 to transmit various types of patient information.
ASC X12 835	A standard transaction developed by ASC X12 to transmit various types of health care claim payment/advice information.
ASC X12 837	A standard transaction developed by ASC X12 to transmit various types of health care claim information.
CDT	Current Dental Terminology, coding system used to bill dental services.
Complete Bill	A complete electronic medical bill and its supporting transmissions must: • be submitted in the correct billing format, with the correct billing code sets, • be transmitted in compliance with all necessary format requirements • include in legible text all medical reports and records, including, but not limited to, evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results that are expressly required by law or can reasonably be expected by the payer or its agent under the Jurisdiction's law • include any other jurisdictional requirements found in its regulations or companion guide.
Clearinghouse	A public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that is an agent of either the payer or the provider and that may perform the following functions: 1) Processes or facilitates the processing of medical billing information received from a client in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction for further processing of a bill related transaction; or 2) Receives a standard transaction from another entity and processes or facilitates the processing of medical billing information into a nonstandard format or nonstandard data content for a client entity. An entity that processes information received in a nonstandard format or containing nonstandard data content into a standard transaction, or that receives a standard transaction and processes that information into a nonstandard transaction.
CMS	Centers for Medicare and Medicaid Services, the federal agency that administers these programs.
MS-1450	The paper hospital, institutional, or facility billing form, also referred to as a UB-04 or UB-92, formerly referred to as a HCFA-1450.
CMS-1500	The paper professional billing form formerly referred to as a HCFA or HCFA-1500.

Code Sets	Tables or lists of codes used for specific purposes. National standard formats may use code sets developed by the standard setting organization (i.e. X12 Provider Type qualifiers) or by other organizations (i.e. HCPCS codes).
CPT	Current Procedural Terminology, the coding system created and copyrighted by the American Medical Association that is used to bill professional services.
DEA	Drug Enforcement Administration
DEA Number	Prescriber DEA identifier used for pharmacy billing.
Detail Acknowledgment	Electronic notification to original sender that its electronic transmission or the transactions within the transmission were accepted or rejected.
Electronic Bill	A bill submitted electronically from the health care provider, health care facility, or third-party biller/assignee to the payer.
EFT	Electronic Funds Transfer.
Electronic Transmission	A collection of data stored in a defined electronic format. An electronic transmission may be a single electronic transaction or a set of transactions.
Electronic Format	The specifications defining the layout of data in an electronic transmission.
Electronic Record	A group of related data elements. A record may represent a line item, a health care provider, health care facility, or third party biller/assignee, or an employer. One or more records may form a transaction.
Electronic Transaction	A set of information or data stored electronically in a defined format that has a distinct and different meaning as a set. An electronic transaction is made up of one or more electronic records.
Electronic Transmission	Transmission of information by facsimile, electronic mail, electronic data interchange, or any other similar method that does not include telephonic communication. For the purposes of the electronic billing rules, electronic transmission generally does not include facsimile or electronic mail.
EOB/EOR	Explanation of Benefits (EOB) or Explanation of Review (EOR) is the paper form sent by the payer 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 payers to Jurisdictional workers' compensation agencies.
ICD-9	International Classification of Diseases, the code set administered by the World Health Organization used to identify diagnoses.
NABP	National Association of Boards of Pharmacy, the organization previously charged with administering pharmacy unique identification numbers. See NCPDP.
NABP Number	Identification number assigned to an individual pharmacy, administered by NCPDP. (Other term: NCPDP Provider ID)
NCPDP	National Council for Prescription Drug Programs, the organization administering pharmacy-unique identification numbers called NCPDP Provider IDs.
NCPDP Provider ID Number	Identification number assigned to an individual pharmacy, previously referred to as NABP number.

NCPDP WC/PC UCF	National Council for Prescription Drug Programs Workers' Compensation/Property and Casualty Universal Claim form, the pharmacy industry standard for pharmacy claims billing on paper forms.
NCPDP Telecommunication D.0	HIPAA compliant national standard billing format for pharmacy services.
NDC	National Drug Code, the code set used to identify medication dispensed by pharmacies.
Payer	The entity responsible, whether by law or contract, for the payment of the medical expenses incurred by a claimant as a result of a work related injury.
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.
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.

AUTHORITY NOTE:Promulgated in accordance with R.S. 23:1310.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR

Family Impact Statement

Implementation of this proposed Rule should not have any known or foreseeable impact on any family as defined by R.S. 49:972(D) or on any family formation, stability, and autonomy. This proposed Rule shall not have any impact on the six criteria set out in R.S. 49:972(D).

Small Business Statement

The impact of the proposed Rule on small business has been considered and it is estimated that the proposed action is not expected to have a significant adverse impact on small business as defined in the Regulatory Flexibility Act. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Public Comments

The proposed amendments create the Electronic Medical Billing and Payment Companion Guide. The proposed Electronic Medical Billing and Payment Companion Guide will give detailed information for electronic billing and payment. The guide outlines the workers' compensation industry national standards and Louisiana jurisdictional procedures necessary for engaging in electronic data interchange (EDI) and specifies clarifications where applicable.

Inquiries concerning the proposed amendments may be directed to Director, Office of Workers' Compensation Administration, Louisiana Workforce Commission, P.O. Box 94040, Baton Rouge, Louisiana 70804-9040.

Interested parties may submit data, views, arguments, information or comments on the proposed amendment in writing to the Louisiana Workforce Commission, Office of Workers' Compensation, P.O. Box 94040, Baton Rouge, Louisiana 70804-9040., Attention: Director, Office of Workers' Compensation Administration. Written comments must be submitted and received by the Department within 20 days from the publication of this notice. A request pursuant to R.S. 49:953(A)(2) for oral presentation, argument or public hearing must be made in writing and received by the Department within 20 days of the publication of this notice.

A public hearing will be held on November 27, 2012 at 9:30 AM at the LWC 4th Floor Auditorium, 1001 N. 23rd Street, Baton Rouge, LA 70802.

Curt Eysink
Executive Director
Louisiana Workforce Commission