

**Workers' Compensation Companion Guide
837 Requirements and Attachment Options**

Revision History

Date	Version	Description	Author	SME
2/25/2010	1.0	Workers' Companion Guide	Scott Codon	Kouri Andrews Eric Bowen
3/12/2010	1.0	Updated terms Added sample fax cover page	Scott Codon	Kouri Andrews Eric Bowen
3/19/2010	1.0	Add screen shot. Revised formatting.	Scott Codon	Kouri Andrews Bob Robinson

Table of Contents

Overview	4
Terms and Definitions	4
Attachment Methods	5
Portal Access	5
Sample Fax Cover Sheet.....	6
Companion Guide – 837 Professional Requirements.....	7
Workflow	10
Sample Workflow.....	10
Response Levels	11
Capario Tilde Format - (CTF).....	11
Header Record	11
Detail Record.....	11
Trailer record	13

Overview

Capario's Workers' Compensation eBill and attachment processing allows for electronic claims to be sent with the necessary attachments to Payers who require supporting documentation for adjudication. Workers' Comp payers do not require enrollment to submit eBills, however, you must be contracted and approved through Capario to submit Workers' Comp eBills.

To Contract with Capario for Workers' Compensation

- Contact Capario Sales or your Account Manager
- Sales: (800) 586-6870 or Sales@capario.com

Terms and Definitions

Case: In Workers' Compensation a workplace injury or *incident* is referred to as a case.

Claim: In Workers' Compensation, a claim is a demand by an injured employee against the employer's Workers' compensation policy for statutory benefits allowed under that policy.

eBill: eBilling or eBill is used in Workers' Compensation to refer to an electronic Workers' compensation medical bill. The charge for each episode of care or encounter with an injured employee is considered a "bill".

eBill Agent: Much like group health clearinghouses, an eBill agent sometimes acts on the behalf of the provider and sometimes acts on behalf of the payer. The eBill agent will facilitate the processing of the eBill for the parties the same way a clearinghouse does. It can also establish electronic connectivity between the various parties to the transaction.

Subscriber: The employer is the subscriber and holds the Workers' Compensation insurance coverage on its employees. In electronic billing, the employer information must be sent in the Subscriber Loop of the ACS X12 837 claim and reflected as the Subscriber in the ASC X12 835 Electronic Remittance Advice.

Subscriber Identification Number: The eBill does not use this information since the Subscriber in Workers' compensation is the employer.

Date of Accident or Illness: In Workers' Compensation, the accident date may also be referred to as the date of injury. Month, day and year when the injury occurred.

.TIFF: Tagged image file format. The images associated in the PWK segment as TIFF images are transmitted as non human readable data file – base64 encoded TIFF. When opened as a TIFF image, via an image reader, it becomes a human readable document. These are not electronic forms, they are documents transmitted electronically.

.PDF: Portable Document Format or PDF is a file format created by Adobe Systems, Inc. PDF uses the PostScript printer description language and is highly portable across computer platforms. PDF documents have a .pdf file extension.

PWK: Claim Supplemental Information (Situational). The number of PWK segments indicates the number of attachments required for the eBill. The PWK segment is required if there is paper documentation supporting the eBill.

PWK06: Attachment Control Number

837W: Workers' Comp Professional

837IW: Workers' Comp Institutional

Attachment Methods

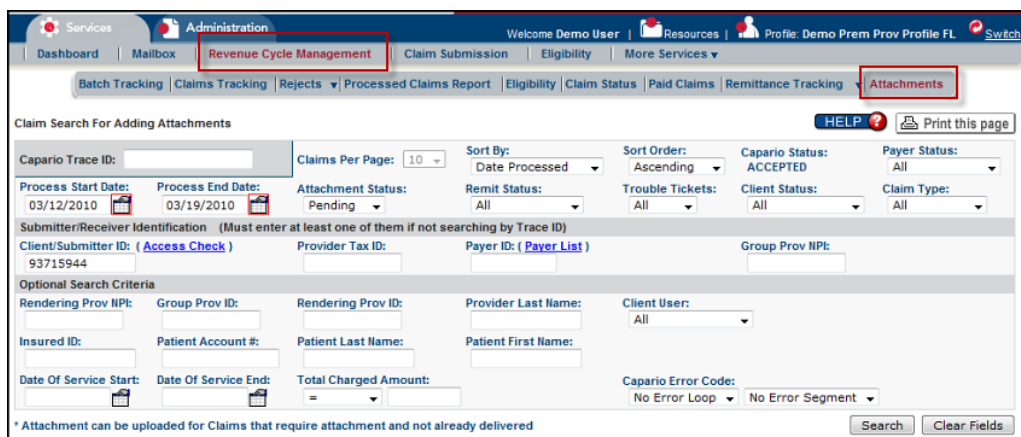
Capario offers the following attachment processing options:

- **275 - Attachment file:** This is the ASC X12 275 Patient Information Transaction Set - Embedded binary data. The binary data for Capario needs to be a TIFF image.
- **Portal Attachment Upload:** From the Capario Provider Portal the submitter can search for open eBills that require attachments and use the upload option to attach documents to the eBill.
- **Fax Cover Sheet:** For Workers' Comp. eBills we reply the next day with a zip file which contains a PDF fax cover sheet. The submitter uses the bar-coded fax cover sheet to fax their attachment(s) to Capario. We use the bar code to match the attachment to the eBill.
 - The FCS PDF files can be configured to include the Billing Provider NPI, the submitters clearinghouse trace number (carried in the 2300/REF*D9), or a combination of both in the naming convention.

Portal Access

Go to Revenue Cycle Management > Attachments.

- To access and search for Workers' Compensation eBills
- View the status of attachments
- Upload Attachments



Sample Fax Cover Sheet

Subject: **eBill Attachment**

Date: 12/04/2009
 To: **eBill Processing [Fax: (404) 877-3299]**
 From: Billing Provider Name
 Contact: First Lasto [Phone: (800) 999-9999]

Instructions: Print this page. This Fax Cover Sheet is for the attached Document Control Number only.
 Fax supporting eBill documentation using this bar coded Fax Cover Sheet as the first page. DO NOT include an additional Fax Cover Sheet, this will cause the process to fail.

Supporting eBill documentation must be sent with this Fax Cover Sheet to prevent processing delays to the payer. Upon receipt of all document(s), the eBill(s) with attachments will be released to the payers for further processing.

Thank you,
 Production Team

Attachment Details:

Trace Id:	xxxxxxxxxxxxxxxx		
Document Control Number:	xxxxxx-xxxxx		
Submitter:	Client Name (99999999)		
Payer:	Texas Mutual Insurance Co. (WK002)		
Patient Name:	John Patient		
Patient Control Number:	xxxxxxxx		
Billing Provider Name:	Billing Provider Name		
Billing NPI:	xxxxxxxx	Billing Tax Id:	xxxxxxxx
Rendering Provider Name:	Rendering Provider First Last MD		
Date(s) of Service:	11/03/2009	Total Charge Amount:	\$62.00

(Source: PRTL)

Confidentiality Statement: The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individuals or entities listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Companion Guide – 837 Professional Requirements

This companion guide for the ASC X12N 837 Professional Healthcare Claim transaction has been created for use in conjunction with the ASC X12N 837 004010A1 Professional Healthcare Claim Implementation Guide. It should not be considered a replacement for the ASC X12N 837 004010A1 Professional Healthcare Claim Implementation Guide, but rather used as an additional source of information.

Loop	Segment or Element	Value	Description	Workers' Compensation Instructions
	BHT		Beginning of Hierarchical Transaction	
	BHT06	CH	Claim or Encounter Identifier	Value must be 'CH' Chargeable.
1000A	PER		Submitter 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.
2010AA	REF		Billing Provider Secondary Identifiers	
	REF01	0B	Reference Identification Qualifier	One occurrence of this REF Segment must have a value '0B' – State License Number.
	REF02		Reference Identification	State License Number
2010AB	REF		Pay-to Provider Secondary Identifiers	
	REF01	0B	Reference Identification Qualifier	One occurrence of this REF Segment must have a value '0B' – State License Number.
	REF02		Reference Identification	State License Number
2000B	HL		Subscriber Hierarchical Level	
				In Workers' Compensation, the Subscriber is the Employer
2000B	SBR		Subscriber Information	
				In Workers' Compensation, the Subscriber is the Employer
	SBR01	P	Payer Responsibility Sequence Number Code	Value must be 'P' -Primary Payer.
	SBR04		Group of 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' – Workers' Compensation.
2010BA	NM1		Subscriber Name	
				In Workers' Compensation, the

Loop	Segment or Element	Value	Description	Workers' Compensation Instructions
				Subscriber is the Employer. The name will usually be a non-person entity (i.e., an organization or company name).
2000C	PAT		Patient Information	
	PAT01	20	Patient's Relationship to Insured	Value must be '20' - Employee
2010CA	NM1		Patient Name	
	NM108	MI	Identification Code Qualifier	Value must be 'MI' – Member Identification Number
	NM109		Primary Identifier	Member Identification Number. Enter patient's ID (if SSN is not available, use driver's license number + jurisdiction, green card number + ZY, visa number + TA, or passport number + ZZ).
2010CA	REF		Property & Casualty Claim Number	Workers' Compensation claim number assigned by the insurance carrier. Required for Workers' compensation medical bills submitted electronically.
2300	CLM		Claim Information	
	CLM11-1	EM	Related Cause Codes	Value must be 'EM' - Employment
	CLM11-2	AA OA	Related Cause Codes	Use appropriate code value of 'AA' Automobile Accident or 'OA' Other Accident when reporting that another related cause is present.
2300	PWK		Claim Supplemental Information	Required when submitting attachments related to the medical bill.
	PWK01		Report Type Code	Use appropriate code value or 'OZ' when report is a jurisdictional report.
	PWK02		Report Transmission Code	
	PWK05	AC	Identification Code Qualifier	Value must be 'AC' Attachment Control Number
	PWK06		Attachment Control Number	When report type code is a Jurisdictional Report, providers should enter the Jurisdictional Type Code followed by the Attachment Control Number.
2300	K3		File Information	Required after January 1, 2009

Loop	Segment or Element	Value	Description	Workers' Compensation Instructions
				when submitting a bill that is a duplicate or an appeal.
	K301		State Data Requirement	<p>Resubmission Condition Code – Enter the Condition Code Qualifier 'BG' followed by the appropriate resubmission code.</p> <p>'W2' - Duplicate of Original</p> <p>'W3' - 1st Level appeal (request for reconsideration or appeal with insurance carrier)</p> <p>'W4' - 2nd Level appeal (resubmitted after receipt of TDI decision)</p> <p>'W5' - 3rd Level appeal (resubmitted after receipt of hearing or judicial decision)</p> <p><i>Example: BGW3</i></p>
2310A	REF		Referring/PCP Provider Secondary Identifiers	Required when loop 2310A used.
	REF01	0B	Reference Identification Qualifier	One occurrence of this REF Segment must have a value '0B' – State License Number.
	REF02		Reference Identification	State License Number
2310B	REF		Rendering Provider Secondary Identifiers	Required when loop 2310B used.
	REF01	0B	Reference Identification Qualifier	One occurrence of this REF Segment must have a value '0B' – State License Number.
	REF02		Reference Identification	State License Number
2310D	REF		Service Facility Location Secondary Identifiers	Required when loop 2310D used and the Service Facility Location is a licensed health care facility.
	REF01	0B	Reference Identification Qualifier	One occurrence of this REF Segment must have a value '0B' – State License Number.
	REF02		Reference Identification	State License Number
2420A	REF		Rendering Provider Secondary Identifiers	Required when loop 2420A used.
	REF01	0B	Reference Identification Qualifier	One occurrence of this REF Segment must have a value '0B' – State License Number.
	REF02		Reference Identification	State License Number

Workflow

Here's a summary of how it works:

- eBills are typically held for 7 calendar days while waiting for the supporting documentation. The documentation is "attached" using one of the attachment options described above.
- If the required documentation is not delivered before the hold period expires, the eBills will reject and will not be delivered to the Payer/Trading Partner.**

The workflow for all WC payers includes:

- An "enhanced Workers' Comp. REC report". This report will let clients know about attachments expected and attachments received.
- For clients who send eBills and attachments in a single file, the REC entries about expected attachments and specific attachment details are on separate lines. This occurs because we process attachments after we split the file and process all eBills.

Sample Workflow

- In this example we are expecting 10 attachments within the 7 day period. We receive 7 and 3 are missing.
- We will deliver the 7 eBills, with their attachments
- For the 3 eBills that are missing attachments we will create an INS rejection for the payer to be sent to the submitter.
- We do not send the eBills with missing attachments to the payer.

This sample shows eBill History for an eBill where 1 attachment was expected but 0 received (0 of 1 Received).

Claim History				
Date	Time (EST)	Source	Type	Message
01/21/2010	12:13 PM	Capario	Ack	Received at Capario
01/21/2010	12:13 PM	Capario	Accept	Passed payer edits at Capario
02/12/2010	04:37 PM	Payer/Trading Partner	REJ Payer Response	EBILL REJECTED, FAILURE TO MEET REQUIRED NUMBER OF ATTACHMENTS. 0 OF 1 RECEIVED (JPI01) View Response Appeal

Response Levels

IPF Format	When eBill/Claim is received	When Attachment Received for a claim	When Claim is delivered successfully to Payer with attachment(s)	When claim hold period expired and claim is not delivered to payer due to missing attachments
Action 1	eBill/Claim runs thru validation. If validation fails, eBill/Claim is rejected and a detailed rejection messages is sent back to the submitter.	A status message is sent back with detailed information about the eBill/attachment for each attachment received.	eBill/Claim and attachments batched and forwarded to payer / trading partner.	ebill/Claim is rejected and a detailed rejection message is sent back to the submitter. The eBill is closed out from the hold status and is not delivered to the payer / trading partner.
Action 2	If eBills passes validation, the eBill is held pending receipt of attachments.			
Status Message	EBILL/CLAIM HAS BEEN RECEIVED PENDING RECEIPT OF X ATTACHMENT(S). HOLD PERIOD THRU (EXPERATION DATE)	ATTACHMENT RECEIVED	EBILL/CLAIM AND X ATTACHMENT(S) FORWARDED TO PAYER FOR FURTHER PROCESSING	EBILL/CLAIM REJECTED, FAILURE TO MEET REQUIRED NUMBER OF ATTACHMENTS X OF N RECEIVED
Notes	X = Number of attachments		X = Number of attachments	X = Number of attachments received N = Number of attachments expected
Transaction note:	Where EBILL/CLAIM is mentioned, for transaction type 837W and 837IW use EBILL. For transaction type 837, 837I and 837D use CLAIM.			

Capario Tilde Format - (CTF)

Header Record

Field	Field Name	Description
1	Record ID (Required)	The record ID is a hard coded value "HDR"
2	Capario ID (Required)	This is an ID representing the creator of this report. The Capario ID is "Capario"
3	Client Name (Required)	This is the name of the client as it appears on file at Capario
4	Capario File Name (Required)	This is the internal Capario file/batch name
5	Report Date (Required)	This represents the date the report was created - CCYYMMDD

Detail Record

Conditional fields will be empty if no data is present.

Field	Field Name	Descriptions
1	Record ID (Required)	The record ID is either "ACK", "CST" or "CCS" ACK indicates that this detail record represents a message generated by Capario CST indicates that this detail record represents a message from a payer CCS indicates that this detail record represents a message generated by a Clearinghouse (Gateway)

2	Capario Trace Number (Required)	This is a unique, 15 digit ID created by Capario and assigned to each claim
3	Transaction Type (Required)	This value represents the transaction type: 275 = Attachment 837 = Professional 837D = Dental 837I = Institutional 837W = Professional Workers' Comp 837IW = Institutional Workers' Comp
4	Submitter Trace Number (Conditional)	Trace number received from a submitter for a claim For ANSI must be sent in: 2300/REF*D9 For NSF must be sent in: CA0-30 (pos 234-248) for NSF
5	Patient Account Number (Required)	This is the patient account number / control number for a claim
6	Claim Attachments: Attachment Report Type Code/Attachment Control Number (Conditional)	This field is used for attachment processing and will return the Attachment Report Type sent in the 2300/PWK01 and the Attachment Control Number sent in the 2300/PWK06. This field will use sub delimiters. The colon (:) will be used to separate the Report Type and Control Number within the single tilde (~) delimited field. 10 PWK segments max. Example of 4 PWK segments: (~PWK01:PWK06:PWK01:PWK06:PWK01:PWK06:PWK01:PWK06~) ~B3:A001:B4:B002:RB:C003:RR:D004~
7	Payer Trace Number (Conditional)	This field can represent a trace number received from a payer for a claim. (returned only in CST or CCS record id's)
8	Payer ID (Required)	This field represents the Capario ID used to identify the receiving payer
9	Billing Provider Tax ID (Required)	This is the billing provider tax identification number for a claim
10	Billing Provider NPI (Conditional)	This is the billing provider NPI. (Conditional until NPI mandate, then this field will be set to required)
11	Patient Last Name (Required)	This is the patient last name for a claim
12	Patient First Name (Required)	This is the patient first name for a claim
13	Patient Middle Initial (Conditional)	This field can represent the patient middle initial
14	Start Date of Service (Required)	This field represents the start date of service for a client in the format - CCYYMMDD
15	Claim Charge (Required)	This field contains the total charges for a claim. (It contains the decimal point)
16	Message Classification (Required)	This field contains a value representing the type of message (REJ, ACK, or WRN) REJ = Rejected ACK = Acknowledgement WRN = Warning

17	Process Date (Required)	This field contains the claim process date in the format - CCYYMMDD
18	Message (Required)	This is the detail message for the claim

Special Messaging for Field 18			
When eBill/Claim is received	When an attachment is received for a eBill/Claim	When eBill/Claim is delivered successfully to Payer with all attachment(s)	When eBill/Claim hold period expires and required documentation is not delivered
Attachment Message			
EBILL/CLAIM RECEIVED PENDING RECEIPT OF X ATTACHMENT(S). HOLD PERIOD THRU (EXPERATION DATE) (PAYER ID)	ATTACHMENT RECEIVED (PAYER ID)	EBILL/CLAIM AND X ATTACHMENT(S) FORWARDED TO PAYER FOR FURTHER PROCESSING (PAYER ID)	EBILL/CLAIM REJECTED, FAILURE TO MEET REQUIRED NUMBER OF ATTACHMENTS X OF N RECEIVED (PAYER ID)
Message Notes			
X = Number of attachments		X = Number of attachments	X = Number of attachments received N = Number of attachments expected
Transaction note: Where EBILL/CLAIM is mentioned, EBILL is used for transaction types 837W and 837IW. CLAIM is used for transaction types 837, 837I and 837D.			

Trailer record

Field	Field Name (Required)	Descriptions
1	Record ID (Required)	The record ID is a hard coded value "TRL"
2	Capario ID (Required)	This is an ID representing the creator of this report. The Capario ID is "Capario"
3	Client Name (Required)	This is the name of the client as it appears on file at Capario
4	Report Date (Required)	This represents the date the report was created – CCYYMMDD
5	Total Detail Count (Required)	This is the total number of detail records (ACK/CST) in this file
6	Total Claim Charges (Required)	This field represents the total charges of all claims in this file (Only reported back on record type ACK)