



Chapter 4 - Billing Instructions Table of Contents

A.	Applicable BWC Laws and Rules.....	4-1
B.	Instructions for CMS-1500.....	4-1
C.	Instructions for UB-92/UB-04.....	4-13
D.	Instructions for BWC Service Invoice C-19.....	4-19
E.	Instructions for BWC Pharmacy Invoice C-17.....	4-21
F.	Instructions for American Dental Association (ADA) Form.....	4-23
G.	EOB Quick Reference Guide.....	4-25
H.	National Provider Identifier (NPI) EOB.....	4-41

A. APPLICABLE BWC LAWS AND RULES

For applicable BWC laws and rules, refer to General Information, Chapter 1.

NOTE: Per O.A.C 4123-3-23 – Fee bills must be filed within two years from the date services were rendered or within six months from the date of mailing of a final order of allowance of a claim, whichever period is longer, or be forever barred.

B. INSTRUCTIONS FOR CMS-1500

To avoid delays in payment, as required by CMS, providers should use the most recent CMS-1500 form, printed in red and dated (08-05). Line by line instructions for completing the CMS-1500 form (08-05) are included in the following section B2. For a brief transition period, line by line instructions for completing the CMS-1500 form Dec (1990) will also be included in section B3.

Providers may experience delays if bills are not completed correctly. Improperly completed bills also may be returned for correction and re-submission. Attached is a sample of the form along with instructions for completion. It is imperative that these instructions are followed explicitly. **All providers should pay special attention to instructions for completing blocks 24, 25 and 33, which are used in determining provider eligibility in bill processing as well as financial reporting to the Internal Revenue Service (IRS).**

1. Processing Guidelines

Along with the instructions outlined, you can ensure that your bills are processed quickly and appropriately by following these guidelines:

- All information should be typed, not handwritten; if computer generated, use letter quality fonts.
- Enter all information completely within the lines of the appropriate block. Do not enter two lines of information in one block.
- The individual provider number must be typed in block 25.** This 11-digit number consists of nine numbers followed by a dash and a two-digit suffix (e.g., 123456789-00). If you do not know your individual provider number, call the MCO that is medically managing the claim or call 1-800-OHIOBWC
- Enter the group or individual provider name in the **lower right corner of block 33**. Do not use a business name and address stamp.
- In block 33B group providers must use the proper 11-digit BWC Provider number, including the two-digit suffix. Individual servicing providers must use their individual BWC assigned provider number, same as in block 25. **Remember to complete both blocks 25 and 33. See additional instructions regarding the use of Box 33a and Box 33b under “National Provider Identifier instructions” below.**
- Send the CMS-1500 billing form flat, not folded.
- To avoid tearing forms, use paper clips. Do not use staples.



- h) Do not attach documents unless requested or when billing unlisted procedures and modifiers.
- i) Do not use correction fluid, correction tape or markers.
- j) Tax information (1099s) will be reported to the IRS based on the tax identification number that is the first nine-digits of the provider number entered in block 33. If the provider has successfully enrolled the NPI, and is using the NPI as the identifier on the bill, the tax information will be reported to the IRS based on the first 9 digits of the BWC Provider Number to which the NPI is attached. See NPI information below. In order to ensure correct information on your 1099, please submit a current IRS form W-9 to Provider Enrollment.
- k) National Provider Identifier instructions for use in Ohio Workers' Compensation billing:
 - 1) The National Provider Identifier (NPI) is the 10-digit number assigned by Centers for Medicare and Medicaid (CMS) to identify health care provider persons and organizations.
 - 2) The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers. Ohio Workers' Comp, while exempted from the mandatory implementation of NPI has made changes to support the use of NPI by providers billing for treatment rendered to Ohio's injured workers.
 - 3) Effective 5/23/2007 BWC will accept the National Provider Identifier (NPI) as an alternate identifier on the CMS-1500.
 - 4) BWC does not require providers to use NPI in billing BWC, but has made changes to allow providers who wish to incorporate the NPI into their workers' compensation billing to do so. Providers may continue to use the BWC Provider Number (the 11 digit, tax id based number) as previously instructed.
 - 5) Successful billing using the NPI as an alternate identifier with BWC is dependant on the correct enrollment of the NPI with BWC Provider Relations Department.
 - a. A copy of the verification e-mail received from the Enumerator is required by BWC to attach the provider NPI to the BWC eligibility record.
 - b. The provider must document which BWC Provider Number (11 digit) the NPI is to be linked to in our provider database, so that we can successfully cross-match the NPI to the BWC Provider Number as we process invoices. In this way, providers can ensure that their bills continue to be processed, and payments are not interrupted.
 - 6) NPI for the individual "Servicing" (aka "Rendering") provider should be reported in box 24j, but may also be reported in box 32a.
 - a. If the individual servicing provider's NPI is reported both in box (es) 24j, and in box 32a, they must agree (they cannot be different NPIs). BWC only accepts one servicing provider per invoice. So if servicing provider NPI information is reported in box(s) 24j and in box 32a, they must agree.
 - b. Until the individual provider is sure that the NPI is being correctly cross-walked to their BWC Provider Number, and that their payments will not be interrupted, they should continue bill using their 11 digit BWC Provider Number in box 25.
 - c. If applicable, providers may include Taxonomy Code information in box (es) 24j or in box 32b.
 - i. Taxonomy codes are not required in BWC billing, but may be helpful in cross-walking the NPI to the BWC Provider Number.



- ii. If this information is included, it must be the same for all lines 24j.
 - iii. If this information is reported in box (es) 24j and/or box 32b, the taxonomy information must agree. Only one taxonomy code per bill per individual provider will be processed.
- 7) NPI for the provider being paid (aka “Pay to” provider) may be reported in Box 33a.
- a. Box 33b is dedicated for the 11 digit BWC Provider Number of the billing provider (aka “Pay to”).
 - b. Providers should continue to report the BWC 11 digit provider number until they are sure that the NPI in box 33b is being correctly cross-walked to their 11 digit tax id based BWC Provider number.
 - c. If applicable, providers may include Taxonomy Code information in box 33b ONLY after they have successfully transitioned to billing BWC with their NPI.
 - i. Taxonomy codes are not required in BWC billing, but may be helpful in cross-walking the NPI to the BWC Provider Number.
 - d. The identifiers in box 33 are the ones used to report payments to the IRS, whether it is by using the primary BWC 11 digit tax id based number, or the NPI cross-walked to the BWC 11 digit tax id based number.
- 8) Providers may continue to use the BWC Provider Number and not use the NPI at all, at their discretion. BWC will continue to process invoices with the individual servicing provider number in box 25, and the billing (pay to) provider in box 33.

2. Line-by-Line Instructions CMS-1500 Billing Form (08-05)

Line-by-line instructions for providers completing the CMS-1500 Billing Form have been revised to cross reference Provider 837 electronic transmission requirements. Complete requirements for the Provider 837 can be found on BWC’s Web site at <http://www.ohiobwc.com/p837>.

1. **Type of health-care coverage:** No entry required.
 - 1a. **Insured’s I.D. number:** Enter the BWC claim number.
2. **Patient’s name:** Enter the injured worker’s last name, first name and middle initial.
3. **Patient’s birth date and sex:** Enter the injured worker’s date of birth in month, day, and year format. Enter “X” in the appropriate box, indicating male or female.
4. **Insured’s name:** Enter the employer’s name. Required on self-insured bills only.
5. **Patient’s address:** Enter the injured worker’s full mailing address including street number, P.O. Box or rural route number, city, state and ZIP code on paper bills. No entry required for Provider 837.
6. **Patient relationship to insured:** No entry required.
7. **Insured’s address:** No entry required.
8. **Patient status:** No entry required.
9. **Other insured’s name:** No entry required.



- 9a. Other insured's policy or group number:** No entry required.
- 9b. Other insured's date of birth:** No entry required.
- 9c. Employer's name or school name:** No entry required.
- 9d. Insurance plan name or program name:** No entry required.
- 10. Is patient's condition related to:** No entry required.
- 11. Insured's policy group or FECA number:** Enter the Social Security number of the injured worker. Required on self-insured bills only.
- 11a. Insured's date of birth:** No entry required.
- 11b. Employer's name or school name:** No entry required.
- 11c. Insurance plan name or program name:** No entry required.
- 11d. Is there another health benefit plan?:** No entry required.
- 12. Patient's or authorized person's signature:** Patient medical release indicator required for Provider 837. No entry required on paper bills.
- 13. Insured's or authorized person's signature:** Benefits assigned indicator required for Provider 837. No entry required on paper bills.
- 14. Date of current injury:** Enter the date of injury on paper bills. No entry required for Provider 837.
- 15. If patient has had some similar illness. Give first date:** Enter the date of injury or illness on paper bills. No entry required for Provider 837.
- 16. Dates patient unable to work in current occupation:** No entry required. Use the *Request for Temporary Total Compensation (C-84)* to document patient's dates of disability.
- 17. Name of referring physician or other source:** Required ONLY for consultation codes 99241 through 99263. Enter the referring physician's full name or BWC provider number, (17a) on paper bills. If desired, the National Provider Identifier may be reported in 17b. NPI is not required for BWC billing, but will be accepted as an alternate identifier after 5/23/2007. See instructions under #1 "processing guidelines". No entry required for Provider 837.
- 18. Hospitalization dates related to current services:** No entry required.
- 19. Reserved for local use:** No entry required.
- 20. Outside lab:** No entry required.
- 21. Diagnosis or nature of illness or injury:** Enter the ICD-9-CM code that corresponds to the primary diagnosis. This is the primary condition you are **treating**. Services should be related to the diagnosis billed. To avoid delays in payment, enter only one ICD-9-CM code. NOTE: Enter the diagnosis code exactly as it appears in the ICD-9-CM codebook. Example: CORRECT: 014.0 for tuberculosis peritonitis. INCORRECT: 14.0 or 014.00. Use the most specific diagnosis code from the ICD-9-CM codebook. If there is a fourth and/or fifth digit, it is a **required** part of the code. BWC will accept V codes for the principal diagnosis on all bills. BWC will not accept E codes for the principal diagnosis. E and V codes can be accepted as the secondary diagnosis on both inpatient and outpatient bills.



22. **Medicaid resubmission:** No entry required.

23. **Prior authorization number:** No entry required.

24. Line detail

24A. Date(s) of service: Enter the beginning date of service in month, day, year format. **BWC will not accept any medical bill that contains more than one (1) date of service per line item.** Line items that contain a different “From” and “To” date will be denied with the following: *EOB 269 – Payment is denied as BWC allows only one date of service per line item.*

24B. Place of service: Enter the place of service code from the list below for each procedure performed:

- 03 – School
- 04 – Homeless Shelter
- 11 – Office
- 12 – Home
- 15 - Mobile Unit
- 20 - Urgent Care Facility
- 21 – Hospital Inpatient
- 22 – Hospital Outpatient
- 23 – Hospital Emergency Department
- 24 – Ambulatory Surgical Center (ASC)
- 25 – Birthing Center
- 26 – Military Treatment Facility
- 31 – Skilled Nursing Facility (SNF)
- 32 – Nursing Facility (NF)
- 33 – Custodial Care Facility
- 34 – Hospice
- 41 – Ambulance, Land
- 42 – Ambulance, Air or Water
- 51 – Psychiatric Facility Inpatient
- 52 – Psychiatric Facility, Partial Hospitalization
- 53 – Community Mental Health Center
- 54 – Intermediate Care Facility/Mentally Retarded
- 55 – Residential Substance Abuse Treatment Facility
- 56 – Psychiatric Residential Treatment Center
- 61 – Comprehensive Inpatient Rehab Facility
- 62 – Comprehensive Outpatient Rehab Facility
- 65 – End Stage Renal Disease Treatment Facility
- 71 – State or Local Public Health Clinic
- 72 – Rural Health Clinic (RHC)
- 81 – Independent Laboratory
- 99 – Other Unlisted Facility

24C. Type of service: No entry required.

24D. Procedures, services or supplies: Enter the following information as it applies to each part of the field.

CODE: Enter the five-digit CPT or other HCPCS code.

MODIFIER: When applicable, enter the two-digit modifier code. These codes more fully describe the services performed, so that accurate payment can be determined.



24E. Diagnosis code: Enter either the reference number from Block 21 or the ICD-9-CM code on each line. To avoid delays in payment, providers should enter only one ICD-9-CM code or reference number from Block 21 of the CMS-1500 on each line in block 24 E. If there is more than one ICD-9-CM code or reference number in block 24 E, the MCO has the discretion to either pick the first code or reject the bill with EOB 200 - PAYMENT IS DENIED AS ONLY ONE DIAGNOSIS CODE MAY BE BILLED PER LINE.

24F. Charges: Enter your usual, customary and reasonable charge for the procedure performed. If more than one unit of service is billed, make sure your charges reflect this in the total.

24G. Days or units: Enter the units of service rendered for each detail line.

24H. EPSDT family plan: No entry required.

24I. ID QUAL. (ID qualifier)

24I has 2 parts, a shaded, and a non shaded part.

In the shaded parts of 24I and 24J, the individual servicing (aka Rendering) provider may report additional information regarding identifiers pertaining to the service provider on the bill.

If Taxonomy code is reported, use the appropriate CMS qualifier in 24I to indicate that the value in 24J is a taxonomy code. Taxonomy codes are only used by BWC as additional identifiers, when applicable, to enable the crosswalk of the NPI to the 11 digit BWC Provider Number.

Providers are not required to use either NPIs or taxonomy codes in billing Ohio BWC. See instructions in "processing guidelines" above.

In the non shaded part of 24I the value "NPI" is pre-populated by CMS, therefore, there is no entry in box 24I. If the NPI is being reported in box 24J (non shaded), all line items (all lines 24J) must have the same NPI for line item services billed.

Providers are not required to use either NPIs or taxonomy codes in billing Ohio BWC. See instructions in "processing guidelines" above.

24J. Rendering Provider ID #:

24J has 2 parts, a shaded, and a non shaded part.

In the shaded parts of 24I and 24J, the individual servicing (aka Rendering) provider may report additional information regarding identifiers pertaining to the service provider on the bill.

If Taxonomy code is reported, use the appropriate CMS qualifier in 24I to indicate that the value in 24J is a taxonomy code. Taxonomy codes are only used by BWC as additional identifiers, when applicable, to enable the crosswalk of the NPI to the 11 digit BWC Provider Number.

Providers are not required to use either NPIs or taxonomy codes in billing Ohio BWC. See instructions in "processing guidelines" above.

In the non shaded part of 24I the value "NPI" is pre-populated by CMS, therefore, there is no entry in box 24I. If the NPI is being reported in box 24J



(non shaded), all line items (all lines 24J) must have the same NPI for line item services billed.

Providers are not required to use either NPIs or taxonomy codes in billing Ohio BWC. See instructions in "processing guidelines" above.

24K. Reserved for local use: No entry required. **Note:** 24K replaced by 24J Form CMS-1500 (08-05)

25. Federal Tax I.D. number: This block is **REQUIRED** and cannot be left blank.

Group providers: Enter the 11-digit BWC provider number of the individual treating practitioner.

Individual providers: Enter the 11-digit BWC provider number of the individual treating practitioner.

NOTE: See also block 33.

26. Patient's account no.: Enter the injured worker's patient account number for Provider 837. Any letter or number combination up to 15 characters is acceptable. No entry required on paper bills.

27. Accept assignment: No entry required.

28. Total charge: Add all charges in column 24F and enter the total amount in this block.

29. Amount paid: No entry required.

30. Balance due: Enter the same figure as in block 28.

31. Signature of physician or supplier including degrees or credentials: Enter authorized or handwritten signature on paper bills. No entry required for Provider 837.

32. SERVICE FACILITY LOCATION INFORMATION

The standard use of box 32 on the CMS-1500 is to indicate the suppliers name, address, NPI, and legacy id. For BWC invoices, the use of box 32 optional, but if it is used must be used for Service Provider/Rendering information and agree with the other Service Provider information as submitted elsewhere on the form.

Any use of box 32A or 32B must refer to the Service Provider/Rendering provider. If 32A is used for NPI, it must be the Service Provider/Rendering provider and must not conflict with NPI in box 24J. If box 32B is used for Taxonomy, it must be the Service Provider/Rendering taxonomy, and must not conflict with Taxonomy in box 24J. If box 32B is used for the BWC Provider Number, it must be the Service Provider BWC Provider ID and must not conflict with the Service Provider number required in box 25.

33. BILLING PROVIDER INFO & PH#



Enter the information of the provider that is to receive payment. Enter provider name, provider address, and provider phone number in box 33. Telephone number is not required for Provider 837.

Box 33a is dedicated to the National Provider Identifier (NPI) of the Pay-to provider (aka Billing Provider).
Providers are not required to use either NPIs or taxonomy codes in billing Ohio BWC. See instructions in "processing guidelines" above.

Box 33b – Enter the 11 digit BWC Provider Number in this box.

Providers who choose to use their NPI in billing Ohio BWC, should continue to report the BWC 11 digit provider number in box 33b until they are sure that the NPI in box 33a is being correctly cross-walked to their 11 digit tax id based BWC Provider number.

Tax information will be reported to the IRS for the BWC Provider Number entered in this block. The BWC Provider Number has the tax id embedded in the first 9 digits of the BWC Provider number.

Box 33 Provider identifiers: Bill must be submitted with identifiers as follows

- a. The BWC Provider Number (the 11 digit, tax id based BWC Provider Number) in box 33b, nothing in Box 33a**
or
- b. The BWC Provider Number (the 11 digit, tax id based BWC Provider Number) in box 33b, and the National Provider Identifier (NPI) in Box 33a**
or
- c. NPI in box 33a, and nothing in Box 33b.**

Completion of blocks 24J, 25 and 33 correctly is imperative for accurate processing and reimbursement of your bills. Failure to identify the individual treating provider or individual physician's provider number in block 25 will result in denial of your bill. Failure to correctly identify the pay-to provider or group practice provider number in block 33 may result in warrants and 1099 statements issued to individual practitioners or denial of your bill. If the name or payee number appearing on any payment is incorrect for BWC payments, return the uncashed warrant and remittance advice to BWC Returned Warrants, 30 W. Spring St., L-25, Columbus, OH 43215-2256. If the payment was made to the wrong party because of a BWC error, a corrected payment will be issued. If the payment was made to the wrong party because of a billing error, the payment will be credited. Once the payment has been credited, the provider should rebill the services with correct payee information in block 33. Failure to return the warrant to BWC will result in payments being reported to the IRS according to the information that appeared on the warrant.

The MCO collects/recovers inappropriate payments or payments in error by the MCO. If the name or payee number appearing on any payment is incorrect, return the uncashed warrant and remittance advice to MCO.

To make any changes, additions, or corrections to the provider information as it is recorded in BWC's records submit a written request on company letterhead to BWC Provider Enrollment at the following address:

Ohio BWC Provider Enrollment



FAX (614) 621-1333

Or mail to:
Ohio BWC Provider Enrollment
P.O. Box 182031
Columbus, OH 43218-2031.

Providers wishing to incorporate the use of their NPI into their Ohio workers' compensation billing must make sure that they have provided their information with verification to BWC provider enrollment in the BWC provider relations department. Providers wishing to use NPI in billing should submit a copy of their NPI confirmation received from the Enumerator (Fox Systems Inc) to the fax or address above.

2. Line-by-Line Instructions for CMS-1500 (Dec 1990)

Line-by-line instructions for providers completing the CMS-1500 Billing Form have been revised to cross reference Provider 837 electronic transmission requirements. Complete requirements for the Provider 837 can be found on BWC's Web site at <http://www.ohiobwc.com/p837>.

1. **Type of health-care coverage:** No entry required.
- 1a. **Insured's I.D. number:** Enter the BWC claim number.
2. **Patient's name:** Enter the injured worker's last name, first name and middle initial.
3. **Patient's birth date and sex:** Enter the injured worker's date of birth in month, day, year format. Enter "X" in the appropriate box, indicating male or female.
4. **Insured's name:** Enter the employer's name. Required on self-insured bills only.
5. **Patient's address:** Enter the injured worker's full mailing address including street number, P.O. Box or rural route number, city, state and ZIP code on paper bills. No entry required for Provider 837.
6. **Patient relationship to insured:** No entry required.
7. **Insured's address:** No entry required.
8. **Patient status:** No entry required.
9. **Other insured's name:** No entry required.
 - 9a. **Other insured's policy or group number:** No entry required.
 - 9b. **Other insured's date of birth:** No entry required.
 - 9c. **Employer's name or school name:** No entry required.
 - 9d. **Insurance plan name or program name:** No entry required.
10. **Is patient's condition related to:** No entry required.
11. **Insured's policy group or FECA number:** Enter the Social Security number of the injured worker. Required on self-insured bills only.
 - 11a. **Insured's date of birth:** No entry required.
 - 11b. **Employer's name or school name:** No entry required.
 - 11c. **Insurance plan name or program name:** No entry required.
 - 11d. **Is there another health benefit plan?:** No entry required.
12. **Patient's or authorized person's signature:** Patient medical release indicator required for Provider 837. No entry required on paper bills.
13. **Insured's or authorized person's signature:** Benefits assigned indicator required for Provider 837. No entry required on paper bills.



14. **Date of current injury:** Enter the date of injury on paper bills. No entry required for Provider 837.
15. **If patient has had some similar illness. Give first date:** Enter the date of injury or illness on paper bills. No entry required for Provider 837.
16. **Dates patient unable to work in current occupation:** No entry required. Use the *Request for Temporary Total Compensation (C-84)* to document patient's dates of disability.
17. **Name of referring physician or other source:** Required ONLY for consultation codes 99241 through 99255. Enter the referring physician's full name or BWC provider number, (17a) on paper bills. No entry required for Provider 837.
18. **Hospitalization dates related to current services:** No entry required.
19. **Reserved for local use:** No entry required.
20. **Outside lab:** No entry required.
21. **Diagnosis or nature of illness or injury:** Enter the ICD-9-CM code that corresponds to the primary diagnosis. This is the primary condition you are **treating**. Services should be related to the diagnosis billed. To avoid delays in payment, enter only one ICD-9-CM code. NOTE: Enter the diagnosis code exactly as it appears in the ICD-9-CM codebook. Example: CORRECT: 014.0 for tuberculosis peritonitis. INCORRECT: 14.0 or 014.00. Use the most specific diagnosis code from the ICD-9-CM codebook. If there is a fourth and/or fifth digit, it is a **required** part of the code. BWC will accept V codes for the principal diagnosis on all bills. . BWC will not accept E codes for the principal diagnosis. E and V codes can be accepted as the secondary diagnosis on both inpatient and outpatient bills.
22. **Medicaid resubmission:** No entry required.
23. **Prior authorization number:** No entry required.
24. **Line detail**

24A. Date(s) of service: Enter the beginning date of service in month, day, year format. **BWC will not accept any medical bill that contains more than one (1) date of service per line item.** Line items that contain a different "From" and "To" date will be denied with the following: *EOB 269 – Payment is denied as BWC allows only one date of service per line item.*

24B. Place of service: Enter the place of service code from the list below for each procedure performed:

- 03 – School
- 04 – Homeless Shelter
- 11 – Office
- 12 – Home
- 15 - Mobile Unit
- 20 - Urgent Care Facility



- 21 – Hospital Inpatient
- 22 – Hospital Outpatient
- 23 – Hospital Emergency Department
- 24 – Ambulatory Surgical Center (ASC)
- 25 – Birthing Center
- 26 – Military Treatment Facility
- 31 – Skilled Nursing Facility (SNF)
- 32 – Nursing Facility (NF)
- 33 – Custodial Care Facility
- 34 – Hospice
- 41 – Ambulance, Land
- 42 – Ambulance, Air or Water
- 51 – Psychiatric Facility Inpatient
- 52 – Psychiatric Facility, Partial Hospitalization
- 53 – Community Mental Health Center
- 54 – Intermediate Care Facility/Mentally Retarded
- 55 – Residential Substance Abuse Treatment Facility
- 56 – Psychiatric Residential Treatment Center
- 61 – Comprehensive Inpatient Rehab Facility
- 62 – Comprehensive Outpatient Rehab Facility
- 65 – End Stage Renal Disease Treatment Facility
- 71 – State or Local Public Health Clinic
- 72 – Rural Health Clinic (RHC)
- 81 – Independent Laboratory
- 99 – Other Unlisted Facility

24C. Type of service: No entry required.

24D. Procedures, services or supplies: Enter the following information as it applies to each part of the field.

CODE: Enter the five-digit CPT or other HCPCS code.

MODIFIER: When applicable, enter the two-digit modifier code. These codes more fully describe the services performed, so that accurate payment can be determined.

24E. Diagnosis code: Enter either the reference number from Block 21 or the ICD-9-CM code on each line. To avoid delays in payment, providers should enter only one ICD-9-CM code or reference number from Block 21 of the CMS-1500 on each line in block 24 E. If there is more than one ICD-9-CM code or reference number in block 24 E, the MCO has the discretion to either pick the first code or reject the bill with EOB 200 - PAYMENT IS DENIED AS ONLY ONE DIAGNOSIS CODE MAY BE BILLED PER LINE.

24F. Charges: Enter your usual, customary and reasonable charge for the procedure performed. If more than one unit of service is billed, make sure your charges reflect this in the total.

24G. Days or units: Enter the units of service rendered for each detail line.

24H. EPSDT family plan: No entry required.

24I. EMG: No entry required.

24J. COB: No entry required.

24K. Reserved for local use: No entry required.



25. Federal Tax I.D. number: This block is REQUIRED and cannot be left blank.

Group providers: Enter the 11-digit BWC provider number of the individual treating practitioner.

Individual providers: Enter the 11-digit BWC provider number of the individual treating practitioner.

NOTE: See also block 33.

26. Patient's account no.: Enter the injured worker's patient account number for Provider 837. Any letter or number combination up to 15 characters is acceptable. No entry required on paper bills.

27. Accept assignment: No entry required.

28. Total charge: Add all charges in column 24F and enter the total amount in this block.

29. Amount paid: No entry required.

30. Balance due: Enter the same figure as in block 28.

31. Signature of physician or supplier including degrees or credentials: Enter authorized or handwritten signature on paper bills. No entry required for Provider 837.

32. Name and address of facility where services were rendered (if other than home or office): Enter the name and address where the services were provided on paper bills, if different from block 33. No entry required for Provider 837.

33. Physician's, supplier's billing name, address, ZIP code & phone #: Enter name, address and telephone number to whom payment is to be made in the lower right hand block under GRP#. Telephone number is not required for Provider 837.

Tax information will be reported to the IRS for the provider number entered in this block.

PIN#: No entry required.

GRP#: This block is REQUIRED and cannot be left blank.

Group providers: Enter the 11-digit BWC provider number of the group practice to whom the payment is to be made.

Individual providers: Enter the 11-digit BWC provider number of the individual provider to whom the payment is to be made.



C. INSTRUCTIONS FOR UB-92/UB-04

As required by CMS, starting May 23, 2007, hospitals should use the new UB-04 when submitting bills to BWC. However, because BWC is not a covered entity under HIPAA, the bureau will continue to accept both UB-04 and UB-92. In addition, BWC will continue to accept bills containing only BWC legacy (or current) numbers, as well as bills with both the legacy number and the NPI.

BWC's DRG inpatient reimbursement methodology became effective January 1, 2007. Hospitals are reminded to submit inpatient hospital bills in accordance with the correct coding guidelines per the Coding Clinic of The American Hospital Association. Failure to do so may result in an incorrect DRG assignment and reimbursement calculation.

Documentation, which must be submitted to the managed care organization at the initial bill submission, includes:

- Admission history and physical;
- Emergency department report - if patient was admitted through the ED;
- Operative report - if bill contains operating room charges and patient had surgery;
- Discharge summary - if admission was 48 hours or greater in duration;
- Discharge note - if admission was less than 48 hours in duration.

When submitting inpatient bills, hospitals must also submit medical documentation for the episode of care including emergency department report, history and physical examination report, operative report and discharge summary to the MCO or self insured employer responsible for bill payment.

Split cycle bills with overlapping dates of service will not be accepted.

Line-by-line instructions for hospital providers completing the UB-92 Hospital Billing Form have been revised to cross reference Provider 837 electronic transmission requirements. **Complete requirements for the Provider 837 can be found on BWC's Web site at <www.ohiobwc.com/p837>.**

1. **Untitled:** Enter the hospital's name and address. Entering the hospital's telephone number is optional.
2. **Untitled:** No entry required.
3. **Patient control number:** Enter the injured worker's unique patient account number for Provider 837. Any combination of up to 17 alphanumeric characters is acceptable. No entry required on paper bills.
Note: Enter the injured worker's unique medical record number assigned by the provider for BWC, the MCO and/or the self-insured employer to note when requesting medical record information in field 3A on UB-04
4. **Type of bill:** Enter the appropriate three-digit code for the type of bill from the coding table below:

Inpatient codes:

- 111 - Admit – discharge date
- 112 - Interim first bill
- 113 - Interim continuing bill
- 114 - Interim last claim
- 115 - Late charges only

Outpatient codes:



- 131 - Admit through discharge date
- 132 - Interim first bill
- 133 - Interim continuing bill
- 134 - Interim last claim
- 135 - Late charges only

Type of bill codes 115 and 135 are only acceptable in hard-copy bill submissions. Type of bill codes 116-118 and 136-138 for adjustments, replacements and voids of prior bills are not valid for BWC. Requests for adjustments should be directed to the appropriate MCO.

5. **Federal Tax ID number:** No entry required.
6. **Statement covers period:** Enter the beginning and ending service dates for this bill in month, day, year format. **Important:** Surgery dates and accompanying operating room charges must be within the date span listed in the “statement covers” period. For outpatient bills, the first and last of the line item service dates entered in item 45 must be equivalent to the first and last dates in the statement covers period.
7. **Covered days:** Required for Provider 837. No entry required on paper bills. *Note: unlabeled reserved for national use on UB-04*
8. **Non-Covered days:** No entry required. *Note: field eliminated on UB-04*
9. **Co-insurance days:** No entry required. *Note: field eliminated on UB-04*
10. **Lifetime reserve days:** No entry required. *Note: field eliminated on UB-04*
11. **Untitled:** No entry required. *Note: field eliminated on UB-04*
12. **Patient name:** Enter the injured worker’s last name, first name and middle initial. *Note: field 8 on UB-04*
13. **Patient address:** Enter the injured worker’s address or P.O. box number, city, state and ZIP code on paper bills. No entry required for Provider 837. *Note: field 9 on UB-04*
14. **Patient birth date:** Enter the injured worker’s date of birth in month, day, year format. *Note: field 10 on UB-04*
15. **Patient sex:** Enter the injured worker’s sex. *Note: field 11 on UB-04*
16. **Patient marital status:** No entry required. *Note: field deleted on UB-04*
17. **Admission date:** Required for inpatient bills only. Enter the injured worker’s date of admission in month, day, year format. *Note: field 12 on UB-04*
18. **Admission hour:** Required for inpatient bills only. Enter the hour of admission converted into 24-hour time. *Note: field 13 on UB-04*
19. **Type of admission:** Required for inpatient bills only. Enter the code number indicating the type of admission. *Note: field 14 on UB-04*

1 - Emergency: The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.



2 - Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.

3 - Elective: The patient's condition permits adequate time to schedule the availability of a suitable accommodation.

5 – Trauma Center: Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.

20. Source of admission: Required for inpatient bills only. Enter the code indicating the source for the admission. *Note: field 15 on UB-04*

- 1- Physician referral
- 2- Clinic referral
- 3- HMO referral
- 4- Transfer from a hospital
- 5- Transfer from a skilled nursing facility
- 6- Transfer from another health-care facility
- 7- Emergency room
- 8- Court/law enforcement
- 9- Information not available

21. Discharge hour: Required for inpatient bills only. Enter the hour the injured worker was discharged converted into 24-hour time. *Note: field 16 on UB-04*

22. Patient status: Required for inpatient bills only. Enter the code indicating the patient status as of the "statement covers" period date. *Note: field 17 on UB-04*

- 01 - Discharged to home/self care (routine)
- 02 - Discharged/transferred to another short-term general hospital
- 03 - Discharged/transferred to skilled nursing facility (SNF)
- 04 - Discharged/transferred to intermediate care facility (ICF)
- 05 - Discharged/transferred to another type of institution for inpatient or outpatient services
- 06 - Discharged/transferred to home under care of organized home health service organization
- 07 - Left against medical advice or discontinued care
- 20 - Expired
- 30 - Still a patient
- 62 - Discharge/transferred to another rehabilitation facility including rehabilitation distinct part units of a hospital.
- 63 - Discharge/transferred to a long term hospital.

23. Medical record number: Enter the injured worker's unique medical record number assigned by the provider for BWC, the MCO and/or the self-insured employer to note when requesting medical record information. *Note: moved to field 3b on UB-04*

24-30.1. Condition codes: Enter a condition code used to identify conditions relating to this bill, if applicable. *Note: fields 18-28 on UB-04; Important: field 29- Accident Field on UB-04: No entry required*

31. Untitled: No entry required. *Note: Field 30 on UB-04: no entry required.*

32-35. Occurrence codes and dates: Enter the code and associated date defining a significant event relating to this bill. **Enter occurrence code 04 – accident – employment related and date of injury in item 32.** If more than one code and date are used, they must be entered in items 33 through 35. Enter the date in month, day, year format. *Note: fields 31-34 on UB-04*



36. **Occurrence span code and dates:** No entry required. *Note: fields 35-36 on UB-04; field 37 on UB-04 - Unlabeled: No entry required*
37. **Internal control number/document control number/transaction control number:** No entry required. *Note: moved to field 64 on UB-04*
38. **Responsible party name and address:** No entry required.
- 39-41. **Value codes and amounts:** Enter the value code and its related dollar amount that identifies data of monetary nature, if applicable.
42. **Revenue code:** Enter the appropriate three-digit revenue code itemizing all accommodation and ancillary charges. Revenue codes 960-989 may not be billed on this invoice. Refer to **Chapter 3** of this manual for the list of covered and non-covered revenue codes.
43. **Revenue description:** No entry required.
44. **HCPCS/Rates:** Inpatient: Enter the accommodation rate for accommodation codes. Outpatient: Enter the CPT or HCPCS codes applicable to outpatient services. Refer to **Chapter 3**, for the list of revenue codes that require CPT coding.
45. **Service date:** Required for outpatient bills only. Enter the date the indicated outpatient service was provided, in month, day, year format.
46. **Units of service:** Enter the number of days for accommodations. For all other revenue codes, enter the units of service. Late discharge should not be billed as an additional day.
47. **Total charges:** Enter the total charge for each BWC covered and non-covered revenue code or procedure code entry. MCOs will accept only 21 lines of revenue data per one page bill. BWC requires that line 22 be left blank, and line 23 be titled "Total" and used to record the total of item 47. **Note:** The total in line 23 of item 47 is the total of all BWC covered and non-covered charges. BWC reimburses only for covered services.
48. **Non-Covered charges:** No entry required.
49. **Untitled field:** No entry required.
50. **Payer:** Enter BWC, MCO or the name of the self-insuring employer on paper bills. No entry required for Provider 837.
51. **Provider number:** Enter the 11-digit BWC provider number. **Important:** The dash in the provider number should not be included. Enter the provider number in the following format: 9999999999.
52. **Release of information, certification indicator:** No entry required.
53. **Assignment of benefits, certification indicator:** No entry required.
54. **Prior payments:** No entry required.
55. **Estimated payments:** No entry required
56. **Untitled field:** No entry required.
Note: On UB-04: NPI: Use for hospital NPI.



57. **Untitled field:** No entry required. *Note: Other provider ID on UB-04: Other Provider ID: No entry required.*
58. **Insured's name:** No entry required
59. **Patient's relationship to the insured:** No entry required.
60. **Certificate/Social Security number/health insurance claim/identification number:** Enter the injured worker's Social Security number. *Note: Labeled Insured's Unique ID on UB-04*
61. **Insured's group name:** No entry required.
62. **Insured's group number:** Enter the BWC claim number.
63. **Treatment authorization:** For inpatient bills only, enter prior authorization number, if available, for both paper and electronic bill submission. *Note: same on UB-04; field 64 on UB-04: Document Control Number:*
64. **Employment status code:** No entry required. *Note: Deleted on UB-04*
65. **Employer name:** Enter the name of the employer on paper bills. No entry required for Provider 837.
66. **Employer location:** Enter the location of the employer on paper bills. No entry required for Provider 837. *Note: changed on UB-04 ICD/DX Version Qualifier: No entry required*
67. **Principal diagnosis code:** Enter the ICD-9-CM diagnosis code describing the principal diagnosis. NOTE: Omission of the principal diagnosis allowed in the claim will result in denial of the bill. BWC will accept "V" codes for the principal diagnosis on both inpatient and outpatient bills. BWC will not accept "E" codes for the principal diagnosis.
- 68-75. **Other diagnosis codes (other than principal):** Enter the ICD-9-CM diagnosis code(s) corresponding to additional conditions that coexist at the time of the admission or develop subsequently and which have an effect on the treatment received or the length of stay. NOTE: "V" codes or "E" codes are acceptable for the "other diagnosis codes." *Note: fields 67 A-Q on UB-04; field 68 on UB-04: Unlabeled: No entry required*
76. **Admitting diagnosis code:** For inpatient bills only, enter the ICD-9-CM diagnosis code provided at the time of admission or as stated by the physician. NOTE: "V" or "E" codes are acceptable. . *Note: field 69 on UB-04; field 70 on UB-04: Patient reason for visit code: No entry required; field 71 on UB-04: PPS/DRG code: Enter expected DRG, if applicable.*
77. **External cause of injury code (E code):** No entry required. *Note : field 72 on UB-04;*
78. **Untitled field:** No entry required. *Note: field 73 on UB-04*
79. **Procedure code method used:** No entry required. *Note: field deleted on UB-04*
80. **Principal procedure code and date:** Enter the code identifying the principal ICD-9-CM surgical procedure performed during the period covered by this bill, and the date on which the principal procedure was performed, **if applicable**. Enter the date in month, day, year format. *Note: field 74 on UB-04*



- 81. **Other procedure codes and dates:** Enter the codes and dates identifying the procedures other than the principal procedures, **if applicable.** *Note: fields 74 a-e on UB -04* .
- 82. **Attending physician's identification:** Enter the hospital provider number for Provider 837. No entry required on paper bills. *Note: field 76 UB -04*
- 83. **Other physician's identification:** No entry required. *Note: field 77, 78, & 79 on UB -04*
- 84. **Remarks:** Enter expected DRG, if applicable. *Note: Field 80 on UB-04 No entry required (Use field 71 for expected DRG, if applicable); field 81 on UB-04: Code-Code-Value: Use for taxonomy code, if applicable, with qualifier B3.*
- 85. **Provider representative signature:** No entry required. *Deleted on UB-04*
- 86. **Date bill submitted:** No entry required. *Deleted on UB-04*



D. INSTRUCTIONS FOR BWC SERVICE INVOICE C-19

Line-by-line instructions for completing the BWC Service Invoice for payment services.

1. Untitled - type of bill: Check the appropriate bill type.

- | | |
|-------------------------------------|------------------------------------|
| Dental check "K" | Rehab Providers check "R" |
| Practitioner check "P" | Therapists check "P" |
| Ambulance check "V" | Anesthesia check "P" |
| Vision check "V" | Unlicensed Caregiver check "V" |
| Orthotics and Prosthetics check "V" | Chronic Pain Program check "P" |
| DME check "V" | Traumatic Brain Injury check "R" |
| Nursing Home Services check "N" | Ambulatory Surgical Ctr. check "P" |
| Home Health Agency check "V" | |

2. Claim number: Enter the BWC claim number.

3. Injured worker Social Security number: Enter the injured worker's Social Security number. Required on self-insured bills.

4. Date of injury: Enter the date of injury. Use the month, day, year format. For example, use 08/21/89 for Aug. 21, 1989.

5. Injured worker name: Enter the injured worker's last name, first name and middle initial.

6. Injured worker address: Enter the injured worker's full mailing address including street number, P.O. Box number or rural route number, city, state and ZIP code.

7. Referring physician provider number: Required **ONLY** for consultation codes. If known, enter the referring physician's BWC provider number. Otherwise, enter the full name in item 8.

8. Referring physician's name: Required only for consultation codes.

9. Prior authorization number: Enter the authorization number if prior authorization is required for these services.

10. Patient account number: Enter the injured worker's patient account number. Any letter or number combination up to 15 characters is acceptable. This item is optional. **NOTE:** If you enter a patient account number, it will appear on the remittance advice.

11. Provider number:

GROUP PROVIDERS - Enter the BWC provider number of the individual treating practitioner.

INDIVIDUAL PROVIDERS - Enter the 11-digit assigned BWC provider number and skip items 12 and 14.

12. Provider name:

GROUP PROVIDERS ONLY - Enter the provider name that corresponds to the provider number listed in item 11.

13. Check here if payment is to be made to the injured worker: Check this block if the payment should go to the injured worker.



14. Group payee number:

GROUP PROVIDERS ONLY - Enter the BWC provider number to which payment is to be made. Item 11 must contain the treating practitioner's provider number.

15. Service date: Date(s) of service: Enter the beginning date of service (from date) in month, day and year format, such as 05/01/00 for May 1, 2000. **BWC will not accept any medical bill that contains more than one (1) date of service per line item.** Line items which contain a different "From" and "To" date will be denied with the following: EOB 269: *"Payment is denied as BWC allows only one date of service per line item."*

16. Place of treatment: Enter the place of service code for each procedure performed from the list under 24B of the line-by-line billing instructions for the CMS-1500.

17. Procedure code (CPT): Enter the appropriate CPT or other HCPCS code for the service rendered.

18. Modification code: For certain types of service, a two-digit modifier must be entered after the procedure code. Modifiers describe more completely the services performed so that accurate payment may be determined.

19. Diagnostic code (ICD-9-CM): Enter the ICD-9-CM code that corresponds to the primary diagnosis. Enter only one code per line. This is the primary condition you are treating. **NOTE:** Enter the diagnosis code exactly as it appears in the ICD-9-CM code book.

EXAMPLE: Correct - 014.0 for Tuberculosis Peritonitis
 Incorrect - 14.0 for 014.00

Use the most specific diagnosis code from the ICD-9-CM codebook. If there is a fourth and/or fifth digit, it is a required part of the code. **NOTE:** Each line **MUST** contain a diagnosis. **DO NOT** use ditto marks in this field.

20. Description of service: Enter the description of the procedure code. Abbreviations of the description of service are acceptable.

21. Charges: Enter your usual, customary and reasonable charge for the procedure performed. If more than one unit of service is billed, make sure that you compensate for this in your charges.

22. Units of service: Enter the units of service rendered for each detail line. A unit of service is the number of times a procedure is performed. **NOTE:** When only one procedure is performed, a "1" must appear in this field. When the same procedure is performed on consecutive days, enter the number of days.

23. Tooth number: Enter tooth number(s) if applicable.

24. Provider signature: Enter an authorized signature.

25. Date: Enter the date the bill was signed. Use the month, day, and year format.

26. Total charge: Add together all charges in Column 21 and enter the total amount in this field.

27. Remarks: No entry required. Enter employer's name on self-insured bills.

28. Payee name, address, city, state, ZIP code and telephone number: Enter the name, address, zip and telephone number of provider to whom payment is to be made.



E. INSTRUCTIONS FOR BWC OUTPATIENT MEDICATION INVOICE (FORM C-17)

Line-by-line instructions for completing the **BWC OUTPATIENT MEDICATION INVOICE** for Injured worker reimbursement of outpatient medications obtained from a pharmacy provider.

INJURED WORKER INFORMATION:

1. **BWC claim number:** Enter the claim number assigned by BWC.
2. **Date of Injury:** Enter the date of injury. Use the month, day, year format. For example, use 08/21/89 for Aug. 21, 1989.
3. **Social Security Number:** Enter the injured worker's social security number. Required if BWC claim number is not known.
4. **Name:** Enter the injured worker's last name, first name and middle initial.
5. **Address:** Enter the injured worker's full mailing address including street number, P.O. Box number or rural route number, city, state and ZIP code.

PHARMACY INFORMATION:

6. **Pharmacy name:** Enter the pharmacy name and if applicable, store number.
7. **BWC provider number:** Enter the BWC Provider number assigned to the pharmacy.
8. **NABP/NCPDP number:** Enter the seven-digit number assigned to the pharmacy by the National Council for Prescription Drug Programs (formerly known as NABP number)
9. **Street address, city, state, and nine-digit ZIP Code:** Enter the location address for the pharmacy that dispensed the outpatient medications billed below.
10. **Telephone number:** Enter the area code and telephone number of the pharmacy.

PRESCRIPTION DETAIL:

11. **Date Rx written:** Enter the date the prescription was written by the prescribing physician. Use the month, day, and year format.
12. **Prescribing physician:** Enter the prescribing physician's full name.
13. **Prescribing physician BWC provider number:** If known or supplied by the physician, enter the BWC provider number assigned to the prescribing physician. Otherwise, leave blank.
14. **Prescription number:** Enter the serial prescription number assigned by your pharmacy to the dispensed prescription.
15. **Date dispensed:** Enter the date the prescription was dispensed in the month, day, year format.
16. **National drug code:** Enter an eleven-digit National Drug Code (NDC) from the stock bottle from which the dispensed drug was obtained, or if dispensed in a unit-of-use container, the NDC obtained from the unit-of-use container. The NDC field is separated into three sections as follows:
 - a) **LABELER CODE**
The "Labeler Code" field must contain five digits. If the labeler code has less than five digits, enter as many zeros as is necessary to the left of the number to complete five digits



b) PRODUCT CODE

The "Product Code" field must contain four digits. If the product code does not have four digits, fill zeros to the left of the number to complete four boxes. Do not enter any part of the product code in the "labeler code" field.

c) PACKAGE SIZE

The "package size" field must contain two digits. If a package number does not have two digits, add a zero to the left of the number to complete this 2-digit requirement.

17. Drug name, strength, and dosage form: Enter the generic or the trade/brand name, strength, and dosage form of the drug dispensed.

18. Metric quantity: Enter the number of tablets, capsules, or unit-of-use containers, or the quantity in metric measurement of liquid preparations dispensed. For example, indicate 60 milliliters (mls), not 2 ounces, for liquid measurement, and, in the case of unit-of-use items, use the number of containers dispensed, not the total amount contained in the container.

19. Estimated days supply: Enter the number of days that the prescription will last if consumed at the prescribed rate, or if the prescribed rate is specified (i.e., "*take as directed*"), the estimated number of days the dispensed medication will last based on your professional judgment.

20. Refill: Check the "YES" box to indicate this billing is for a refill of an existing prescription or the "NO" box if this dispensing was a new prescription authorized by the physician (new prescription number assigned).

21. Total charge: Enter the total amount paid by the injured worker for the dispensed drug. NOTE: BWC will not reimburse for copayments made by the injured worker as a result of the prescription bill being submitted to a group health insurance or other third-party payer.

22. Pharmacist's signature: Enter an authorized signature.

23. Date signed: Enter the date the invoice was signed in the month, day, year format.

24. Name and mailing address of reimbursement recipient: Enter the name and complete mailing address including street number, P.O. Box number or rural route number, city, state and ZIP code to whom payment is being made. If blank, payment will be sent to injured worker address on record in BWC claim information.

24. Special notes/remarks: This field should be utilized whenever an item billed is a compounded prescription or if any of the items billed were written "dispense as written" or "DAW" by the prescribing physician. If an item is a compounded prescription, the ingredients of the compounded prescription should be listed using the NDC of each ingredient, and the metric quantity of each ingredient. Reimbursement will be based on the total documented cost of the prescription.



F. BILLING INSTRUCTIONS FOR AMERICAN DENTAL ASSOCIATION (ADA) FORM

Line-by-line instructions for completing the ADA billing form for payment of dental services.

Header Information

1. **Type of Transaction:** No entry required
2. **Predetermination/Preauthorization number:** Enter the authorization number, if the services require prior authorization.

Primary Payor Information

3. **Name, Address, City, State, Zip Code:** Enter the name and address of BWC, the MCO, or the self-insured employer.

Other Coverage

4. **Other Dental or Medical Coverage:** No entry required
5. **Subscriber Name:** No entry required
6. **Date of Birth:** No entry required.
7. **Gender:** No entry required.
8. **Subscriber Identifier:** No entry required
9. **Plan/Group Number:** No entry required
10. **Relationship to Primary Subscriber:** No entry required.
11. **Other Carrier Name, Address, City, State, Zip Code:** No entry required

Primary Subscriber Information

12. **Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:** Enter the Injured Worker's name and address
13. **Date of Birth:** No entry required
14. **Gender:** No entry required
15. **Subscriber Identifier:** Enter the Injured Worker's **claim number**.
16. **Plan/Group Number:** No entry required.
17. **Employer Name:** No entry required.

Patient Information

18. **Relationship to Primary Subscriber:** No entry required.
19. **Student Status:** No entry required.
20. **Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code:** No entry required
21. **Date of Birth:** No entry required
22. **Gender:** No entry required
23. **Patient ID/Account # (Assigned by Dentist):** Enter account number assigned by provider

Record of Services Provided

24. **Procedure Date (MM/DD/CCYY):** Enter date service was performed
25. **Area of Oral Cavity:** Enter the place of service code for each procedure performed
26. **Tooth System:** Enter the units of service rendered for each detail line
27. **Tooth Number(s) or Letter(s):** Enter tooth number
28. **Tooth Surface:** Enter the ICD-9-CM code that corresponds to the primary diagnosis.
29. **Procedure Code:** Enter HCPCS code that describes service provided
30. **Description:** Enter narrative description of service
31. **Fee:** Enter usual customary and reasonable fee
32. **Other Fee(s):** No entry required
33. **Total Fee:** Enter the total fee charged for all services listed
34. **Place an 'X' on each missing tooth:** No entry required



35. **Remarks:** No entry required.

Authorizations

36. **Patient/Guardian signature:** No entry required.

37. **Subscriber Signature:** No entry required.

Ancillary Claim/Treatment Information

38. **Place of Treatment (Check Appropriate box):** No entry required

39. **Number of Enclosures (0 to 99):** No entry required.

40. **Is Treatment for Orthodontics?:** No entry required.

41. **Date Appliance Placed(MM/D/CCYY):** No entry required.

42. **Month of Treatment Remaining:** No entry required

43. **Replacement of Prosthesis?:** No entry required.

44. **Date of Prior Placement (MM/DD/CCYY):** No entry required.

45. **Treatment Resulting from (Check Applicable box):** Check "Occupational illness/injury" box for worker's compensation claims

46. **Date of Accident (MM/DD/CCYY):** No entry required

47. **Auto Accident State:** No entry required.

Billing Dentist or Dental Entity

48. **Name, Address, City, State, Zip Code:** Enter the name and billing address of the provider to whom payment is to be made.

49. **Provider ID:** Enter the 11-digit BWC assigned provider number of individual dentist or dental group to whom payment will be made. National Provider Identifier (NPI) also accepted beginning Jan. 1, 2007

50. **License Number:** No entry required

51. **SSN or TIN:** No entry required

52. **Phone Number:** No entry required .

Treating Dentist and Treatment Location Information

53. **Signature:** Enter an authorized signature and the date the invoice was signed.

54. **Provider ID:** Enter the treating dentist's 11-digit BWC assigned provider number. NPI accepted Jan. 1, 2007

55. **License Number:** No entry required

56. **Address, City, State, Zip Code:** Enter the address where treatment was performed.

57. **Phone Number:** Enter the office telephone number including the area code

58. **Treating Provider Specialty:** No entry required



G. EOB Quick Reference Guide

All MCOs are required to use the Explanation of Benefits (EOB) and EOB descriptions found in the following EOB Quick Reference Guide when communicating to providers. Please refer to the following quick reference guide if you have questions regarding the EOB you receive from an MCO.

EOB	EOB Description	Definition / Resource / Resolution
30	Payment denied as no modifier was billed with this anesthesia procedure code	Refer to Chapter 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
90	Payment denied as, except for the servicing provider, this is a duplicate of a previously paid service.	Another provider in the same group billed for the same services, contact the MCO if you believe this is a reimbursable service and not a duplicate.
97	Payment denied as, except for billed charges and units of service, this is a duplicate of a previously paid service.	If a change is made in the amount or units billed, the provider must submit a request for an adjustment with the documentation to support the change.
99	Payment denied as the MCO's records indicate this is a duplicate charge for a service that has been paid or is being processed.	If you are unable to locate the remittance, contact the MCO.
100	Payment denied as this is a duplicate, except for the MCO, billed amount and units of service.	If you are unable to locate the remittance and you do not know who the previous MCO was, call BWC at 1-800-OHIOBWC.
101	Payment denied as this bill is a duplicate of another previously paid bill or another bill being processed.	If you are unable to locate the remittance and you do not know who the previous MCO was, call BWC at 1-800-OHIOBWC.
104	Payment denied as the office/hospital visit falls within the post-surgical follow-up period.	Managed Care Organizations (MCOs) are not required to use CMS assigned global surgery timeframes. Direct questions about this issue to the MCO
105	Payment denied as the procedure code conflicts with the diagnosis code on the invoice.	Verify the procedure is appropriate for the treatment of the condition allowed in claim. If this is not a conflict, please contact the MCO.
107	Payment denied as the MCO does not reimburse for missed appointments.	Refer to Chapter 1 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
110	Payment is denied as the combination of modifiers is invalid.	All valid modifiers are designated as Information, Role, or Location modifiers. If more than one information or role modifier (for example, 80 & 81) is billed on a line, the bill will be rejected. Refer to Chapter 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> for additional information
113	Payment denied because this procedure exceeds the limit for procedures (CPT 10000-69999) per date of service.	If you believe the additional procedures were warranted, submit documentation to support the necessity of the additional procedures to the MCO for review.
115	Payment denied as the units of service for this room rate conflict with the covered dates of hospitalization.	The number of units does not equal the number of days covered on the bill. Please correct the bill and resubmit it to the MCO.
116	Payment denied as the line item date of service is missing or invalid.	Correct the bill and resubmit it to the MCO.



EOB	EOB Description	Definition / Resource / Resolution
117	Payment denied as the modifier is invalid.	Refer to Chapter 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
118	Payment denied because modifier billed was not valid on the date of service.	Refer to Chapter 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
119	Payment denied because the servicing provider is not eligible to use the modifier billed.	The servicing provider cannot use the modifier billed. If you believe this bill was denied in error, submit documentation to support the modifier and submit to the MCO.
120	Invalid UB-92 bill type.	Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
121	Payment denied as pay-to and servicing provider information is missing.	On CMS-1500 form box 25 and box 33. On UB-92 form box 5 and box 51. Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
122	Payment denied as the line item date of service is not within the covered dates.	Verify the line item date of service. If incorrect, correct it and resubmit the bill to the MCO.
123	Payment denied as a date field on the invoice contained an invalid year, month or day.	The date of service is not a valid day, month and/or year. Correct the error and resubmit bill to the MCO.
124	Payment denied as the beginning or ending service date is missing or invalid.	Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> . Correct the bill and resubmit to the MCO.
125	Payment denied as the bill was not received within two years of the date of service as required by statute.	The MCO received date is not within the two years of the date of service. If you have documentation that supports the bill was submitted within two years of the date of service, contact the MCO.
128	Payment denied as the admitting diagnosis is missing.	The admitting diagnosis is required on all inpatient hospital bills (block 76). Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
131	Payment is denied as this bill contains duplicate line item numbers.	Line item numbers on one bill are duplicates. For example, there are two line items, but both are listed as line item 1. Correct and resubmit only the unpaid line item charges to the MCO.
132	Payment is denied as provider total charge is missing.	The bill will be rejected if the provider total charge is missing. Correct and resubmit only the unpaid line item charges to the MCO.
133	Payment is denied as the provider total doesn't equal the line item totals.	The bill will be rejected if the provider total doesn't equal the total of all of the line items. Correct and resubmit only the unpaid line item charges to the MCO.
134	Payment is denied as the MCO charge is missing.	The sum of the line items does not equal the total charge on the bill. Correct and resubmit only the unpaid line item charges to the MCO.
145	Payment denied as the place of service is missing or invalid.	The place of service on a non-facility bill is missing or invalid (CMS-1500 form is box 24B and BWC C-19 form is box 16). The billed place of service is not a CMS standard value. Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
147	Payment denied as the daily room rate was omitted.	The daily room rate was omitted when billing an accommodation revenue code on an inpatient hospital bill. Correct the bill and resubmit it to the MCO.



EOB	EOB Description	Definition / Resource / Resolution
148	Payment denied as the revenue code is missing.	There is no revenue code on a hospital bill line. Correct the bill and resubmit it to the MCO.
149	Payment denied as the first and last dates of service cannot coincide for inpatient hospitalizations.	The first and last date of service are the same on an inpatient hospital bill. Correct the bill and resubmit it to the MCO. Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
158	Payment is denied as the accommodation billed total is not equal to the daily rate times the number of days.	On an inpatient hospital bill, the total billed for an accommodation code must equal the daily rate times the number of days.
165	Payment denied as the modifier is invalid for anesthesia services.	A modifier was used that is not valid for anesthesia codes. Refer to Chapter 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
167	Payment denied as the patient status is invalid.	The patient status code on an inpatient hospital bill is invalid. Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
169	Payment denied as this modifier is not valid with the procedure code billed.	The modifier billed is not valid with the procedure code. Please refer to Chapter 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
172	Payment denied as the procedure code is missing.	There is no HCPCS Level I, II or III code on a non-facility bill. Correct the bill and resubmit it to the MCO.
173	Payment denied as the admission date and the service date conflict.	Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
174	Payment denied as the admission and/or discharge hour is missing.	Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> . Correct the bill and resubmit it to the MCO.
175	Payment denied as the admission source is missing or invalid.	Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> . Correct the bill and resubmit it to the MCO.
181	Payment denied as ICD-9 E diagnosis codes are not allowed on non-facility bills.	BWC never accepts E diagnosis codes as the primary diagnosis.
183	Payment denied as the units of service are missing or invalid.	The units of service are missing or non-numeric. Correct the bill and resubmit it to the MCO.
184	Payment denied as the line item charge is missing or invalid.	A line item charge is missing or non-numeric. Correct the bill and resubmit it to the MCO.
185	Payment denied as the admission date is missing.	Admission date is missing on an inpatient hospital bill. Correct the bill and resubmit it to the MCO.
191	Payment denied as the admission type is invalid.	The admission type is missing or invalid on an inpatient hospital bill. Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> . Correct the bill and resubmit it to the MCO.
192	Payment denied as ICD-9 E codes are not acceptable for the principal diagnosis.	ICD-9 E codes will be rejected if billed as the principal diagnosis on a hospital bill. BWC never accepts E diagnosis codes as the primary diagnosis.
193	Payment is denied as the date of the principal procedure is not within the covered dates.	The date the principal procedure was performed is not within the covered dates indicated on a hospital bill.



EOB	EOB Description	Definition / Resource / Resolution
196	Payment is denied as ICD-9 procedure code is not valid.	The ICD-9 procedure on a hospital bill is invalid.
200	Payment is denied as only one diagnosis code may be billed per line.	BWC does not accept more than one diagnosis code per line item on nonfacility bills (CMS-1500, C-19). A bill containing this error cannot be transmitted to BWC electronically so this is one of the few errors that can be rejected by an MCO without submission to BWC. The MCO should use this EOB in conjunction with the MPRG guidelines for rejecting bills.
210	BWC cannot reimburse these services as this claim is part of the \$1,000 Medical-Only Program. Submit medical bills to the injured worker's employer.	Employers who participate in this program are responsible for all bills in eligible claims until the \$1,000 limit has been met. For additional information, refer to Chapter 1 of the <i>BWC Provider Billing and Reimbursement Manual</i>
244	Payment denied as the date of service is prior to the HPP implementation date. Submit this bill directly to the BWC.	Phase one (Alpha) claims with dates of service prior to March 1, 1997. Alpha claims are claims with dates of injury on or after March 1, 1997. MCOs began medically managing Alpha claims on March 1, 1997. Phase two (Beta) claims with dates of service prior to Sept. 1, 1997. Beta claims are claims with dates of injury between Oct. 20, 1993 and Feb. 28, 1997. MCOs began medically managing Beta claims on Sept. 1, 1997. Phase three (Gamma) claims with dates of service prior to Dec. 15, 1997. Gamma claims are claims with dates of injuries prior to and including Oct. 20, 1993. MCOs began medically managing Gamma claims on Dec. 15, 1997.
245	Payment denied as claim number has changed. Please re-bill using current claim number.	The claim number has been combined into another claim. Two claim records exist for the same incident and the number billed is not associated with the most current information. Direct questions about this issue to the HPP Inquiry Unit. Call 1-800-644-6292.
250	Payment denied as the claim number is not valid.	The claim number billed does not exist in BWC's claim data base. Verify the BWC claim number with the injured worker. Correct the bill and resubmit it to the MCO.
251	Payment denied as this claim has been settled. This bill is the injured worker's responsibility.	This bill is the injured worker's responsibility. Direct questions about settlements to the BWC customer service specialist.
253	Payment denied as self-insuring employers pay their own bills directly.	The claim number billed indicates that the injured worker's employer is self-insured in Ohio for workers' compensation. Bill the employer directly for these services.
254	BWC's jurisdiction over medical-only claims ends six years after the date of injury. This bill is the injured worker's responsibility.	For medical-only claims with dates of injury prior to Oct. 20, 1993, no payments can be made for dates of services more than six years past the date of injury. This bill is the injured worker's responsibility.
256	This claim has been disallowed. The injured worker is responsible for bills.	BWC will not pay for any services in a claim that has been disallowed. This bill is the injured worker's responsibility.
257	Payment denied as this claim has reached the statute of limitations. The claimant is responsible for bills.	Statute of limitations has been reached. The injured worker is responsible for any additional services received on this claim. Direct questions about this issue to the BWC customer service specialist.
262	Payment denied as the date of service is after the injured worker's date of death.	Services were billed for a date of service after the injured worker's date of death. If this is a late charge, correct the bill and resubmit it to the MCO as a late charge.



EOB	EOB Description	Definition / Resource / Resolution
267	MCO cannot make a payment decision at this time as a determination of relatedness has not yet been made.	This EOB will prevent payment until a reactivation review is completed. This EOB cannot be used for services that do not require prior authorization unless a C-9 has triggered a review. Example: Claim is inactive and MCO receives a bill for an office visit along with a C-9 for an MRI. The C-9 requires a review so it is appropriate to delay payment of the office visit using this EOB. If reactivation is approved, then the bill can be adjusted or resubmitted.
269	Payment denied as BWC only allows one date of service per line item.	On non-facility bills, BWC allows only one date of service per line item. Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
270	Payment denied as this diagnosis has been formally disallowed and there is no proof of relationship to the allowed injury.	BWC cannot reimburse services rendered for a condition that has been formally disallowed. Bill the injured worker for services rendered for this condition.
276	Payment denied as the billed diagnosis is not allowed in this claim.	The condition treated is not allowed in the claim. If the condition is related to the industrial injury, submit medical documentation to the MCO with your request for consideration. If the condition is not related to the industrial injury, bill the injured worker.
279	Payment denied as the disc level treated has not been allowed in this claim.	The condition treated is not allowed in the claim. If the condition is related to the industrial injury, submit medical documentation to the MCO with your request for consideration. If the condition is not related to the industrial injury, bill the injured worker.
281	Payment denied as the date of admission is prior to the date of injury.	The date of admission on an inpatient hospital bill is prior to the date of injury associated with this claim. If this is an occupational disease claim where treatment has been rendered prior to the date of diagnosis, contact the MCO. If this is not an occupational disease claim, bill the injured party.
283	Payment denied as the date of service is prior to the date of injury.	The date of service on a non-facility bill is prior to the date of injury associated with this claim. If this is an occupational disease claim where treatment has been rendered prior to the date of diagnosis, contact the MCO. If this is not an occupational disease claim, bill the injured party.
293	Payment denied as BWC's jurisdiction over medical-only claims with date of injury on or after Oct. 20, 1993, ends six years after the last payment date. This bill is the injured worker's responsibility.	This denial code applies to medical-only claims with a date of injury after Oct. 20, 1993. The injured worker is responsible for any additional services received on this claim. Direct questions about this issue to the BWC customer service specialist.



EOB	EOB Description	Definition / Resource / Resolution
294	Payment denied as BWC's jurisdiction over lost-time claims ends 10 years after the last payment date. This bill is the injured worker's responsibility.	The last compensation and medical payment was made more than 10 years prior to the date of service. The injured worker is responsible for any additional services received on this claim. Direct questions about this issue to the BWC customer service specialist.
296	Payment denied as the servicing provider number billed belongs to a group practice.	The servicing provider billed has a provider type of 12 (group practice). The servicing provider number must always be that of the individual rendering the services. The provider number is an 11-digit number assigned to the individual by BWC. Please verify the servicing provider number and submit a corrected bill to the MCO. Refer to Chapter 1 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
315	Payment denied as the servicing provider number is invalid.	The servicing provider number is not found on BWC's data base. The servicing provider number must always be that of the individual rendering the services. The provider number is an 11-digit number assigned to the individual by BWC. Please verify the servicing provider number and submit a corrected bill to the MCO. Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
323	Payment denied as the diagnosis billed does not match the diagnosis code listed in the accompanying reports.	Submitted medical documentation indicates that the diagnosis treated differs from the diagnosis submitted on the bill. Submit additional documentation to the MCO to support the treatment rendered.
326	Payment denied as this procedure was not valid on this date of service.	Either a new code was billed before its effective date or an expired code was billed after its expiration date. Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
327	Payment denied as the medical documentation provided is not adequate to justify reimbursement.	Submit additional documentation to the MCO.
329	Payment denied as reimbursement is not made for experimental or investigational procedures.	Refer to Chapter 1 of the <i>BWC Provider Billing and Reimbursement Manual</i> . MCO performs clinical editing functions to ensure relatedness and appropriateness with treatment guidelines. You may submit additional documentation to the MCO to request a review for necessity of the procedure.



EOB	EOB Description	Definition / Resource / Resolution
330	Payment denied as the type of service or procedure does not appear to be related to the allowed compensable condition.	The procedure billed is not related to the allowed diagnosis in the claim. If the procedure is related to the industrial injury, submit medical documentation to the MCO with your request for consideration. If the procedure is not related to the industrial injury, bill the injured worker.
331	Payment denied as the claim is not recognized for the diagnosis code billed. Submit medical documentation to the MCO if the treatment is related to the industrial injury.	The condition treated is not allowed in the claim. If the condition is related to the industrial injury, submit medical documentation to the MCO with your request for consideration. If the condition is not related to the industrial injury, bill the injured worker.
332	Payment denied as the servicing provider is not eligible for reimbursement.	The service billed is not within the provider's scope of service. Direct questions about this issue to the MCO.
340	Payment denied as the condition billed is allowed in a different claim.	Submit a corrected bill to the MCO.
341	Payment is denied as a hospital cannot be the servicing or payee provider on a nonfacility bill.	Hospital providers cannot bill on the nonfacility form.
343	Payment denied as the diagnosis code billed is not eligible as a claim allowance.	The diagnosis code billed is on the list of invalid diagnosis codes maintained by the BWC and is not one of the diagnosis codes allowed in the claim. MCO performs clinical editing functions to ensure relatedness and appropriateness with treatment guidelines. Refer to Chapter 1 of the <i>BWC Provider Billing and Reimbursement Manual</i> . Submit a corrected bill to the MCO.
344	Payment denied as the ICD-9 code is invalid.	The ICD-9 code does not exist in BWC's ICD-9 code data base. MCO performs clinical editing functions to ensure relatedness and appropriateness with treatment guidelines. Refer to Chapter 1 of the <i>BWC Provider Billing and Reimbursement Manual</i> . Submit a corrected bill to the MCO.
345	Payment denied following reconsideration with documentation submitted by your office.	Medical staff has reviewed the documentation and found the service to be ineligible or incomplete for reimbursement. Refer to Chapter 1 of the <i>BWC Provider Billing and Reimbursement Manual</i> for instructions on the Dispute Resolution Process.
347	Payment denied as submitted medical documentation does not include a description of all the components the item provided.	Submit additional documentation to the MCO.
348	Payment denied as documentation does not justify use of a non-specific procedure code.	Documentation indicates a more specific CPT code or HCPCS code may be more appropriate. Submit a corrected bill to the MCO.
349	Payment denied as medical documentation doesn't clearly describe the service.	Submit additional documentation to the MCO.
351	Payment denied as the procedure code billed indicates treatment of a condition not allowed in the claim.	The condition treated is not allowed in the claim. If the condition is related to the industrial injury, submit medical documentation to the MCO with your request for consideration. If the condition is not related to the industrial injury, bill the injured worker.



EOB	EOB Description	Definition / Resource / Resolution
352	Payment denied as the report submitted does not sufficiently describe the service or procedure billed under the unlisted procedure code.	Submit additional documentation to support the necessity and relatedness of the procedure to the MCO.
353	Payment denied as prior authorization is required for this service.	Refer to Chapter 1 of the <i>BWC Provider Billing and Reimbursement Manual</i> for the standardized prior authorization table. Submit a request for the services with documentation on a C-9 or like form to the MCO.
356	Payment denied as treatment or services billed do not correspond to treatment or services described in medical documentation.	Submitted medical documentation indicates that the treatment rendered is different from the diagnosis submitted on the bill. Submit additional documentation to the MCO to support the treatment rendered.
357	Payment denied as this physical medicine modality exceeds the maximum allowed without prior authorization.	CPT 97001-98943 exceeds the maximum allowed without prior authorization. Direct questions about this issue to the MCO.
358	Payment denied as BWC policy only allows reimbursement for up to four allowed procedures for ambulatory surgery centers	Refer to Chapter 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
360	Payment denied as the submitted report does not indicate that significant, separately identifiable E/M services were provided.	Direct questions about this issue to the MCO.
361	Payment denied as the procedure code is invalid.	The level I, II or III HCPCS code billed does not exist in BWC's data base. Submit a corrected bill to the MCO.
369	Payment denied as the revenue center code is invalid for the date billed.	Refer to 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> . Submit a corrected bill to the MCO.
370	Payment denied as the revenue center code is invalid.	Refer to Chapter 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> . Submit a corrected bill to the MCO.



EOB	EOB Description	Definition / Resource / Resolution
379	Payment denied as this procedure or service is not eligible for reimbursement to an ambulatory surgical center.	Refer to Chapter 2 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
380	Payment denied as the anesthesia modifier is not appropriate to be billed with this procedure code.	Refer to Chapter 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
382	Payment denied as the revenue center code requires a HCPCS code and the HCPCS code is missing.	Refer to Chapter 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> . Submit a corrected bill to the MCO.
384	Procedure was reimbursed up to the maximum number allowed per day.	The units of service billed exceed the maximum allowed for a procedure. Reimbursement will be made only for the maximum number of units allowed; BWC will not process adjustments to reimbursement above the maximum.
385	The units of service for a daily rate procedure cannot exceed the days covered between the first and last dates of service on the line item. One unit per day is allowed.	This denial code applies only to hospital bills.
388	Payment denied as the diagnosis code is required when billing a HCPCS procedure.	Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> . Submit a corrected bill to the MCO.
393	Payment denied as the date of service is after the date the bill was received.	Neither the BWC nor the MCO will reimburse for services rendered in the future.
394	Payment denied as the revenue center code is not covered by BWC.	Refer to Chapter 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> . Submit a corrected bill to the MCO.
395	Payment denied as the service does not appear to be related to an industrial injury.	Direct questions about this issue to the MCO.
396	Payment denied as the MCO's pay-to provider is not on file.	The pay to provider does not exist in BWC's data base. Direct questions about this issue to the HPP Inquiry Unit by calling 1-800-644-6292 or submit a corrected bill to the MCO.
397	Payment denied as MCO's pay-to provider was not active on the DOS.	The pay to provider number was not active on the date of service. Direct questions about this issue to the HPP Inquiry Unit by calling 1-800-644-6292 or submit a corrected bill to the MCO.
398	Payment cannot be made directly to a physician assistant.	Physician assistants may not practice independently and are not eligible to be reimbursed directly. Payment for their services must be made to the physician or group employing them. Only services rendered on or after July 1, 1999 are eligible for reimbursement. Refer to Chapter 3 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
399	All providers on an ASC bill must be ASC's.	Ambulatory Surgical Centers bills must contain only the ASC provider number. This ensures that facility services will be reimbursed correctly.
400	Payment denied as BWC records indicate the servicing provider was not active on the date of service.	The servicing to provider number was not active on the date of service. Direct questions about this issue to the HPP Inquiry Unit by calling 1-800-644-6292 or submit a corrected bill to the MCO.



EOB	EOB Description	Definition / Resource / Resolution
429	Procedure must be billed directly to BWC.	The MCO has submitted a bill containing a procedure which is reimbursed by BWC directly to the provider. These procedures are related to services, such as file reviews and independent medical exams, which are requested directly by BWC. Please submit the bill directly to BWC.
447	Payment is denied as provider is not eligible for recertification.	All BWC-certified providers must be recertified periodically. A provider who no longer meets the requirements for certification will be put in Denied Recertification status. Dates of service after the effective date for the denied recertification status will deny unless approved by an MCO with override EOB 756. Refer to Chapter 1 of the <i>BWC Provider Billing and Reimbursement Manual</i> for additional information.
448	Payment is denied as provider's certification has lapsed.	All BWC-certified providers must be recertified periodically. A provider who fails to submit the recertification application within 90 days or who requests removal from HPP will be put in Lapsed Status. Dates of service after the effective date for the lapsed status will deny unless approved by an MCO with override EOB 756. Refer to Chapter 1 of the <i>BWC Provider Billing and Reimbursement Manual</i> for additional information.
449	Payment denied as this service was performed by a non-BWC-certified provider.	Direct questions about this issue to the MCO's provider relations department.
450	Payment denied as the claim was not associated with this MCO on the billed dates of service.	Either the MCO never managed the claim or the date of service is after the MCO managed the claim. Direct questions about this issue to the HPP Inquiry Unit, Call 1-800-OHIO BWC.
452	Payment is denied as authorization for this service was requested and disapproved.	The MCO is responsible for determining medical necessity and authorizing services for all claims. Requests for medical services that require prior authorization must be submitted by the physician of record (POR) or treating physician to the appropriate MCO prior to initiating any non-emergency treatment.
454	Payment denied as documentation indicates that the service was not performed.	Direct questions about this issue to the MCO.
455	Payment denied as the documentation requested has not been received.	Submit documentation to the MCO.
461	Payment denied as this claim is pending settlement of medical payments. Please contact the injured worker to ensure that payment of this bill is included in the settlement.	There is a 30 day waiting period in effect. Payment of this bill may be included in the settlement. Contact the injured worker or the BWC lump sum settlement specialist to ensure that payment of this bill is included in the settlement.



EOB	EOB Description	Definition / Resource / Resolution
462	Payment denied as this claim is pending settlement of medical payments and compensation. Please contact the injured worker to ensure that this bill is included in the settlement.	There is a 30 day waiting period in effect. Payment of this bill may be included in the settlement. Contact the injured worker or the BWC lump sum settlement specialist to ensure that payment of this bill is included in the settlement.
463	Payment denied as this claim is dismissed. The injured worker is responsible for the payment of this bill.	The injured worker requested the claim be dismissed. The injured worker is responsible for these services.
470	Facility bills must have a hospital payee 34, 35, 36, or 37.	MCO will not reimburse for services billed on a UB-92 unless the provider is a hospital. Refer to Chapter 4 of the <i>BWC Provider Billing and Reimbursement Manual</i> .
479	Payment denied as this procedure is a duplicate of another procedure billed on this invoice.	Direct questions about this issue to the MCO.
481	Payment denied as this service has already been reimbursed the maximum number of times allowed.	Direct questions about this issue to the MCO.
482	Payment denied as this service has already been reimbursed the maximum number of times per day.	Direct questions about this issue to the MCO.
496	Payment is denied as an Urgent Care cannot be a servicing provider.	Type 96 (Urgent Care) providers cannot be the servicing provider on a bill. An individual must be billed as the servicing with the Urgent Care as the payee.
503	Payment for the rental of this equipment has been made up to the allowed purchase amount.	Total billed for rental equipment should not exceed the amount allowed for the purchase of the equipment. Payment for rental equipment will not be authorized at an amount greater than the cost to purchase the item.
509	Payment denied as this procedure may not be billed with other TENS codes.	Direct questions about this issue to the MCO.
514	This bill denied. Please re-submit form UB-92 with an authorization number.	Direct questions about this issue to the MCO.
515	Payment denied as the hospitalization was not authorized and unrelated charges have been identified. Please re-submit with related services only.	Direct questions about this issue to the MCO.



EOB	EOB Description	Definition / Resource / Resolution
516	Payment denied as the hospital bill has an incorrect authorization number. Please re-submit form UB-92 with the correct authorization number in block 63.	Please Note: Not all MCOs require authorization numbers. Direct questions about this issue to the MCO.
518	Payment denied as this service is considered to be part of a global fee.	Multiple procedures in the 10000-69999 range have been billed and a service which is part of the global fee has been identified. Direct questions about this issue to the MCO.
522	Payment denied pending receipt of report for medical review.	Submit medical documentation for the date(s) of service(s) billed to the MCO.
523	Payment denied as payment for this service/similar service has been made to a different provider.	Another provider saw the injured worker for the same or similar services. Payment is considered a duplicate. Direct questions about this issue to the MCO.
524	Payment denied as a consulting physician is not permitted to treat.	Services other than a consultation were provided. Direct questions about this issue to the MCO.



EOB	EOB Description	Definition / Resource / Resolution
525	Payment denied as this procedure is mutually exclusive to another code billed.	The other procedure(s) billed cannot be performed without this procedure being done. Direct questions about this issue to the MCO.
532	Payment is denied as the number of treatments authorized has been exceeded.	If an MCO authorizes a specific number of treatments and the provider renders more than authorized, the MCO may deny the treatments that exceed the authorized amount.
533	Payment is denied while services are being reviewed by the MCO for retroactive authorization. Provider should not re-submit bill.	As long as the bill is otherwise payable (contains no billing errors that would result in rejection or denial by BWC), the MCO cannot make the provider re-bill.
535	Payment is denied following retroactive review of authorization request for this service.	Bill is received after retroactive authorization is denied for the billed service.
551	Payment denied because more than one diagnostic/evaluative procedure was billed for this date of service.	Direct questions about this issue to the MCO.
553	Payment is denied as this procedure is not covered by BWC.	The billed procedure code will not be reimbursed by BWC; it cannot be overridden or adjusted to pay.
555	Payment denied as both work hardening and physical medicine procedures will not be reimbursed for the same date of service.	Direct questions about this issue to the MCO.
560	Payment is denied as documentation has not been received by MCO for presumptive authorization to apply.	BWC's presumptive approval policy requires providers to take specific steps before initiating any of the services covered by the policy. Refer to BWC's presumptive approval policy and standardized prior authorization requirements at ohiobwc.com
561	Payment is denied as prior authorization is required for epidural injections.	Refer to BWC's presumptive approval policy and standardized prior authorization requirements at ohiobwc.com
562	Payment is denied as these physical medicine/OMT/CMT services/visits exceed 10 in the initial time frame and have not been authorized.	Refer to BWC's presumptive approval policy and standardized prior authorization requirements at ohiobwc.com
563	Payment for this procedure is denied as prior authorization is required for more than three injections in the claim's initial time frame.	Refer to BWC's presumptive approval policy and standardized prior authorization requirements at ohiobwc.com
564	Payment is denied as these physical medicine/OMT/CMT services exceed the initial time frame.	Refer to BWC's presumptive approval policy and standardized prior authorization requirements at ohiobwc.com



EOB	EOB Description	Definition / Resource / Resolution
565	Payment is denied as prior authorization is required for psychiatric &/or chronic pain programs.	Refer to BWC's presumptive approval policy and standardized prior authorization requirements at ohioabc.com
566	Payment is denied as prior authorization is required as the diagnostic test exceeds the claims initial time frame.	Refer to BWC's presumptive approval policy and standardized prior authorization requirements at ohioabc.com
567	Payment for the purchase of this equipment has been made up to the allowed purchase amount.	This EOB is used when the amount billed for the purchase of equipment exceeds the maximum allowed purchase price. Payment will be authorized at an amount that will not exceed the allowed purchase price and attach this EOB.
568	Payment is denied as this service or supply has been previously reimbursed up to the maximum allowed.	This EOB can be used if a provider re-bills in an attempt to obtain additional payment for services or supplies previously reimbursed for the maximum allowed (either maximum dollar amount or maximum number of occurrences).
579	Payment is denied as the billed diagnosis code is in a pending, non-payable status in this claim.	This EOB will be sent when the billed diagnosis code is in alleged, allow/appeal, disallow/appeal or hearing status. These statuses cannot be overridden.
601	Payment denied as the ICD-9 code indicates a condition that is not a part of the allowed condition in the claim.	The treated condition is not allowed in the claim. If the condition is related to the industrial injury, submit medical documentation to the MCO with your request for consideration. If the condition is not related to the industrial injury, bill the injured worker.
602	Payment denied as records indicate that both inpatient and outpatient services have been billed for the same time span.	Direct questions about this issue to the MCO.
603	Payment denied because the diagnosis code billed does not appear to be related to the industrial injury.	The treated condition is not allowed in the claim. If the condition is related to the industrial injury, submit medical documentation to the MCO with your request for consideration. If the condition is not related to the industrial injury, bill the injured worker.
605	Payment denied as this claim is in a non-payable status.	This claim has not been determined to be a compensable injury in Ohio. Once the claim has been determined the bill will be processed. Direct questions about this issue to the MCO.
606	Payment denied because the bill contains no prior authorization number.	Please Note: Not all MCOs require authorization numbers. Direct questions about this issue to the MCO.
607	Payment denied as procedure will be reimbursed one line item per date of service. This is regardless of date of service or number of body areas. CPT language includes one or more areas.	Direct questions about this issue to the MCO.



EOB	EOB Description	Definition / Resource / Resolution
609	Payment denied as reactivation denied by the Industrial Commission.	Reactivation has been formally denied by the Industrial Commission.
610	Payment denied-IW has intervening injury and/or newer claim.	A BWC investigation has uncovered that the injured worker sustained an intervening injury, which may or may not have resulted in a new Workers Compensation claim. Current services are the result of the intervening injury and are not causally related to the claim that was billed.
611	Payment denied – prior authorization for service(s) was requested and denied.	Prior authorization was requested but was denied by the MCO.
612	Payment denied as medical documentation does not support medical necessity of continuing evaluation/management services in this claim.	Evaluation/management services do not require prior authorization but at any stage of a claim’s life cycle, they must be medically necessary.
631	Payment denied as this service is not allowed in this claim.	A BWC order restricts the procedure billed. Any services rendered over and above the authorized amount are the injured worker’s responsibility. Direct questions about this issue to the MCO.
632	Payment denied as the services allowed in this claim have been limited by an Industrial Commission of Ohio order.	The procedure billed has been restricted by an Industrial Commission of Ohio order. Any services rendered over and above the authorized amount are the injured worker’s responsibility. Direct questions about this issue to the MCO.
633	Payment denied as the services in this claim have been limited by a court order.	A court order restricts the procedure billed. Any services rendered over and above the authorized amount are the injured workers responsibility. Questions about this issue should be directed to the MCO.
634	Payment denied as a physician review has determined that this service was not medically necessary or is not covered in this claim.	A physician has reviewed the medical documentation and found the service ineligible or incomplete for reimbursement. Refer to Chapter 1 of the BWC <i>Provider Billing and Reimbursement Manual</i> for instructions on the Dispute Resolution Process.
635	Payment denied. Please rebill with appropriate J code.	Refer to Chapter 2 of the BWC <i>Provider Billing and Reimbursement Manual</i> . Resubmit a corrected bill to the MCO.
766	Payment denied as this procedure is mutually exclusive to another procedure billed.	Indicates payment is denied for services which are contraindicated with other services billed by the provider.
784	Bill cannot be authorized until the injured worker appears for an exam.	This EOB applies to bills which cannot be authorized under Gamma IME Guidelines. Direct questions about this issue to the MCO.
786	Payment denied as charges for hot/cold packs should be bundled with another procedure	Effective October 1, 2003 BWC no longer reimburses for hot or cold packs.



EOB	EOB Description	Definition / Resource / Resolution
937	Payment denied as records indicate that related services have previously been paid or are being processed.	Direct questions about this issue to the MCO.
951	Payment denied as this is a federally-funded claim. Please contact the assigned customer service specialist.	Contact the BWC information line at 1-800-OHIOBWC to find out where to send the bill.
967	No payment has been made as there were no charges listed or your total charges did not match the sum of the line item charges.	Resubmit a corrected bill to the MCO.
989	Payment denied as the claim number was omitted from the bill. Please resubmit the invoice with the appropriate claim number.	Resubmit a corrected bill to the MCO.



H. NATIONAL PROVIDER IDENTIFIER (NPI) EOB

EOB	EOB Description	Criteria	Code Type
968	BWC ID ADDED AFTER SPECIAL HANDLING OF NPI- ONLY BILL.	If the bill comes into the MCO with no BWC ID, but with an NPI (or with an NPI with Taxonomy), but the MCO cannot identify the provider, the MCO should include this EOB if the provider supplies the MCO with the BWC ID upon request.	Informational
969	PAYMENT IS DENIED AS THE PAY-TO PROVIDER DOES NOT HAVE A TAX ID ON FILE WITH BWC.	Payment is being denied because the pay-to provider on the bill does not have a tax identifier enrolled. Provider must contact provider Enrollment if they are to be paid.	Denial Code
031	PAY-TO PROVIDER BWC ID IS INVALID.	The 11-digit BWC ID was submitted but is not in the provider file data	Reject Code
032	PAY-TO PROVIDER IDENTIFIERS ARE MISSING.	Neither the 11-digit BWC ID, nor the NPI were submitted	Reject Code
033	PAY-TO PROVIDER NPI INFORMATION BILLED IS NOT ENROLLED.	NPI information was submitted, but is not in the provider file data	Reject Code
034	PAY-TO PROVIDER NPI INFORMATION BILLED IS NOT UNIQUE.	The bill was submitted without a BWC ID. There is NPI information on the bill, but the NPI information provided is not adequate to match the NPI to the BWC ID.	Reject Code
035	SERVICING PROVIDER BWC ID IS INVALID.	The 11-digit BWC ID was submitted but is not in the provider file data.	Reject Code
036	SERVICING PROVIDER IDENTIFIERS ARE MISSING.	Neither the 11-digit BWC ID, nor the NPI were submitted.	Reject Code
037	SERVICING PROVIDER NPI INFORMATION BILLED IS NOT ENROLLED.	The NPI was submitted, but is not in the provider file data.	Reject Code
038	SERVICING PROVIDER NPI INFORMATION BILLED IS NOT UNIQUE.	The bill was submitted without a BWC ID. There is NPI information on the bill, but the NPI information provided is not adequate to cross walk the NPI to the BWC ID, and must be rejected.	Reject Code
039	ATTENDING PROVIDER BWC ID IS INVALID.	The 11-digit BWC ID was submitted but is not in the provider file data	Informational
040	ATTENDING PROVIDER NPI INFORMATION BILLED IS NOT ENROLLED.	The NPI was submitted, but is not in the provider file data	Informational
041	ATTENDING PROVIDER NPI INFORMATION BILLED IS NOT UNIQUE.	The NPI was submitted, but there are multiple matches in the provider file data	Informational



EOB	EOB Description	Criteria	Code Type
042	OTHER PHYSICIAN BWC ID IS INVALID.	The 11-digit BWC ID was submitted but is not in the provider file data	Informational
043	OTHER PHYSICIAN NPI INFORMATION BILLED IS NOT ENROLLED.	The NPI was submitted, but is not in the provider file data	Informational
044	OTHER PHYSICIAN NPI INFORMATION BILLED IS NOT UNIQUE.	The NPI was submitted, but there are multiple matches in the provider file data	Informational
045	OPERATING PHYSICIAN PROVIDER BWC ID IS INVALID.	The 11-digit BWC ID was submitted but is not in the provider file data	Informational
046	OPERATING PHYSICIAN NPI INFORMATION IS NOT ENROLLED.	The NPI was submitted, but is not in the provider file data	Informational
047	OPERATING PHYSICIAN NPI INFORMATION IS NOT UNIQUE.	The NPI was submitted, but there are multiple matches in the provider file data	Informational
970	PAY-TO NPI CROSSWALK SUCCESS-NPI ONLY.	The NPI was submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The pay-to provider number has the tax id embedded in the first 9 digits, will be included on the 835 remittance advice as well as the successfully cross walked NPI.	Informational
971	PAY-TO NPI CROSSWALK SUCCESS-NPI/TAXONOMY ONLY.	The NPI and Taxonomy were submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The pay-to provider number has the tax id embedded in the first 9 digits, will be included on the 835 remittance advice as well as the successfully cross walked NPI.	Informational
972	PAY-TO NPI CROSSWALK SUCCESS-NPI/TAXONOMY/ZIP ONLY.	The NPI, Taxonomy and Physical Location ZIP were submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The pay-to provider number has the tax id embedded in the first 9 digits, will be included on the 835 remittance advice as well as the successfully cross walked NPI.	Informational



EOB	EOB Description	Criteria	Code Type
973	PAY-TO NPI CROSSWALK SUCCESS-NPI/ZIP ONLY.	The NPI and Physical Location ZIP were submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The pay-to provider number has the tax id embedded in the first 9 digits, will be included on the 835 remittance advice as well as the successfully cross walked NPI.	Informational
974	SERVICING NPI CROSSWALK SUCCESS-NPI ONLY.	The NPI was submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill and will not be returned on the 835. The successfully cross walked NPI will be the only servicing provider identifier on the 835 remittance.	Informational
975	SERVICING NPI CROSSWALK SUCCESS-NPI/TAXONOMY ONLY.	The NPI and Taxonomy were submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill and will not be returned on the 835. The successfully cross walked NPI will be the only servicing provider identifier on the 835 remittance.	Informational
976	SERVICING NPI CROSSWALK SUCCESS-NPI/TAXONOMY/ZIP ONLY.	The NPI, Taxonomy and Physical Location ZIP were submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill and will not be returned on the 835. The successfully cross walked NPI will be the only servicing provider identifier on the 835 remittance.	Informational
977	SERVICING NPI CROSSWALK SUCCESS-NPI/ZIP ONLY.	The NPI and Physical Location ZIP were submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill and will not be returned on the 835. The successfully cross walked NPI will be the only servicing provider identifier on the 835 remittance.	Informational



EOB	EOB Description	Criteria	Code Type
978	ATTENDING NPI CROSSWALK SUCCESS.	The NPI was submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The Attending Physician NPI is not sent back on the 835 (only servicing and pay-to provider identifiers are currently included in the 835 remittance), but this informational EOB is sent to communicate the successful cross walk of the Attending Physician.	Informational
979	OTHER PHYSICIAN NPI CROSSWALK SUCCESS.	The NPI was submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The Other Physician NPI is not sent back on the 835 (only servicing and pay-to provider identifiers are currently included in the 835 remittance), but this informational EOB is sent to communicate the successful cross walk of the Other Physician.	Informational
980	OPERATING PHYSICIAN NPI CROSSWALK SUCCESS.	The NPI was submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The Operating Physician NPI is not sent back on the 835 (only servicing and pay-to provider identifiers are currently included in the 835 remittance), but this informational EOB is sent to communicate the successful cross walk of the Operating Physician.	Informational
048	BILL PROCESSED USING BWC ID - PAY-TO PROVIDER NPI BILLED IS NOT ENROLLED.	The BWC ID and the NPI are on the bill. The bill is processed using the BWC ID but the NPI that is on the bill has not been enrolled with BWC. The NPI will not be on the 835 since it was a cross walk failure.	Informational
049	BILL PROCESSED USING BWC ID. PAY-TO PROVIDER NPI NOT BILLED BUT ENROLLED.	The BWC ID is on the bill. There is no NPI on the bill, and the bill is processed using the BWC ID. This EOB is informational only to let the provider know that there is an NPI in the provider file. While providers may enroll their NPI with BWC, providers are not required by to use NPI in BWC billing.	Informational



EOB	EOB Description	Criteria	Code Type
050	BILL PROCESSED USING BWC ID. PAY-TO PROVIDER NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The BWC ID and the NPI are on the bill. They match which indicates successful enrollment and billing using NPI. The pay-to provider NPI will be included on the 835.	Informational
051	BILL PROCESSED USING BWC ID. PAY-TO PROVIDER NPI BILL CONFLICTS WITH NPI ENROLLED.	The BWC ID and the NPI are on the bill. The BWC ID is used to process the bill. The BWC ID on the bill conflicts with the provider file data indicating a problem with either the enrollment or the billing use of NPI.	Informational
052	PAY-TO PROVIDER NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	Pay-to provider NPI information (including either Taxonomy and/or Practice Zip) is on the bill and matches a single BWC provider eligibility record (11-digit BWC ID). This indicates successful enrollment and billing using NPI information. The NPI will be included along with the BWC ID on the 835.	Informational
053	PAY-TO PROVIDER NPI/TAXONOMY BILLED, PARTIAL MATCH - TAXONOMY NOT ENROLLED.	NPI information (including Taxonomy) is on the bill. The NPI is used to obtain a single match (successful crosswalk) but the Taxonomy is not in the provider file data. The NPI will be included along with the BWC ID on the 835.	Informational
054	BILL PROCESSED USING BWC ID. SERVICING PROVIDER NPI BILLED NOT ENROLLED.	The BWC ID and the NPI are on the bill. The bill is processed using the BWC ID but the NPI that is on the bill has not been enrolled with BWC. The NPI will not be on the 835 since it was a cross walk failure.	Informational
055	BILL PROCESSED USING BWC ID. SERVICING PROVIDER NPI NOT BILLED BUT ENROLLED.	The BWC ID is on the bill. There is no NPI on the bill, and the bill is processed using the BWC ID. This EOB is informational only to let the provider know that there is an NPI in the provider file. While providers may enroll their NPI with BWC, providers are not required by to use NPI in BWC billing.	Informational
056	BILL PROCESSED USING BWC ID. SERVICING PROVIDER NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The BWC ID and the NPI are on the bill. They match which indicates successful enrollment and billing using NPI. The servicing provider NPI is included along with the BWC ID on the 835.	Informational



EOB	EOB Description	Criteria	Code Type
057	BILL PROCESSED USING BWC ID. SERVICING PROVIDER NPI BILLED CONFLICTS WITH NPI ENROLLED.	The BWC ID and the NPI are on the bill. The BWC ID is used to process the bill. The BWC ID on the bill conflicts with the provider file data indicating a problem with either the enrollment or the billing use of NPI.	Informational
058	SERVICING PROVIDER NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	Servicing provider NPI information (including either Taxonomy and/or Practice Zip) are on the bill and match a single BWC provider eligibility record (11-digit BWC ID). This indicates successful enrollment and billing using NPI information. The NPI will be included on the 835. The BWC ID will be included if submitted on the bill.	Informational
059	SERVICING PROVIDER NPI/TAXONOMY BILLED, PARTIAL MATCH. TAXONOMY NOT ENROLLED	The NPI is used to obtain a single match (successful crosswalk) but the Taxonomy is not in the provider file data.	Informational
060	BILL PROCESSED USING BWC ID. ATTENDING PHYSICIAN NPI BILLED IS NOT ENROLLED.	The BWC ID and the NPI are on the bill. The bill is processed using the BWC ID but the NPI that is on the bill has not been enrolled with BWC.	Informational
061	BILL PROCESSED USING BWC ID. ATTENDING PHYSICIAN NPI NOT BILLED BUT ENROLLED.	The BWC ID is on the bill. There is no NPI on the bill, and the bill is processed using the BWC ID. This EOB is informational only to let the provider know that there is an NPI in the provider file. While providers may enroll their NPI with BWC, providers are not required by to use NPI in BWC billing.	Informational
062	BILL PROCESSED USING BWC ID. ATTENDING PROVIDER NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The BWC ID is on the bill. The NPI information on the bill matches the NPI information in the provider file data.	Informational
063	BILL PROCESSED USING BWC ID. ATTENDING PROVIDER NPI BILLED CONFLICTS WITH NPI ENROLLED.	The BWC ID and the NPI are on the bill. The BWC ID is used to process the bill. The BWC ID on the bill conflicts with the provider file data indicating a problem with either the enrollment or the billing use of NPI.	Informational
064	ATTENDING PROVIDER NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The NPI information on the bill matches the NPI information in the provider file data.	Informational



EOB	EOB Description	Criteria	Code Type
065	BILL PROCESSED USING BWC ID. OTHER PHYSICIAN #1 NPI BILLED NOT ENROLLED.	The BWC ID and the NPI are on the bill. The bill is processed using the BWC ID but the NPI that is on the bill has not been enrolled with BWC.	Informational
066	BILL PROCESSED USING BWC ID. OTHER PHYSICIAN #1 NPI NOT BILLED BUT ENROLLED.	The BWC ID is on the bill. There is no NPI on the bill, and the bill is processed using the BWC ID. This EOB is informational only to let the provider know that there is an NPI in the provider file. While providers may enroll their NPI with BWC, providers are not required by to use NPI in BWC billing.	Informational
067	BILL PROCESSED USING BWC ID. OTHER PHYSICIAN #1 NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The BWC ID is on the bill. The NPI information on the bill matches the NPI information in the provider file data.	Informational
068	BILL PROCESSED USING BWC ID. OTHER PHYSICIAN #1 NPI BILLED CONFLICTS WITH NPI ENROLLED.	The BWC ID and the NPI are on the bill. The BWC ID is used to process the bill. The BWC ID on the bill conflicts with the provider file data indicating a problem with either the enrollment or the billing use of NPI.	Informational
069	OTHER PHYSICIAN #1 NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The NPI information on the bill matches the NPI information in the provider file data.	Informational
981	BILL PROCESSED USING BWC ID. OPERATING PHYSICIAN NPI BILLED NOT ENROLLED.	The BWC ID and the NPI are on the bill. The bill is processed using the BWC ID but the NPI that is on the bill has not been enrolled with BWC.	Informational
982	BILL PROCESSED USING BWC ID. OPERATING PHYSICIAN NPI NOT BILLED BUT ENROLLED.	The BWC ID is on the bill. There is no NPI on the bill, and the bill is processed using the BWC ID. This EOB is informational only to let the provider know that there is an NPI in the provider file. While providers may enroll their NPI with BWC, providers are not required by to use NPI in BWC billing.	Informational
983	BILL PROCESSED USING BWC ID. OPERATING PHYSICIAN NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The BWC ID is on the bill. The NPI information on the bill matches the NPI information in the provider file data.	Informational



EOB	EOB Description	Criteria	Code Type
984	BILL PROCESSED USING BWC ID. OPERATING PHYSICIAN NPI BILL CONFLICTS WITH NPI ENROLLED.	The BWC ID and the NPI are on the bill. The BWC ID is used to process the bill. The BWC ID on the bill conflicts with the provider file data indicating a problem with either the enrollment or the billing use of NPI.	Informational
985	OPERATING PHYSICIAN NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The NPI information on the bill matches the NPI information in the provider file data.	Informational