

Chapter 4 - Billing Instructions

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A. GENERAL INFORMATION

- Questions relating to provider billing should be directed to BWC Provider Relations at 1-800-644-6292.
- Bill submission must be timely. Ohio Revised Code 4123.52(B) and Ohio Administrative Code 4123-3-23 set forth billing and adjustment request timelines and are noted below:

Service Date	Time to Submit Bills *	Time to File Adjustment
Before July 29, 2011	Two years	No limit
July 29- to Sept 11, 2011	One year	No limit
September 12, 2011 and after	One year	1 year, 7 days of adjudication of initial fee bill

* For bills with a date of service prior to July 29, 2011, a fee bill to be timely filed must be submitted either within two years from the date of service or within six months from the date of mailing of the final order of allowance of the claim or the condition being treated, whichever period of time is longer.

* For bills with a date of service on or after July 29, 2011, a fee bill to be timely filed must be submitted either within one year from the date of service or one year from the earlier of (i) the Staff Hearing Officer order or (ii) the final administrative or judicial order allowing payment, whichever period of time is longer.

- Providers may bill utilizing their BWC legacy number, BWC legacy number and NPI number, or registered NPI number. [Click here](#) for further information regarding NPI registration. Providers that do not know their provider number should contact the MCO that is medically managing the claim or contact BWC Provider Relations at the number noted above.
- Providers may experience delays if bills are not completed correctly. Improperly completed bills may also be returned for correction and re-submission.
 - Failure to correctly identify the pay to provider or group practice provider number may result in warrants and 1099 statements issued to individual practitioners or denial of a bill.
 - 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 the MCO.
 - If the name or payee number appearing on any payment is incorrect for BWC payments, return the uncashed warrant and remittance advice to BWC Cash Control,

30 W. Spring St., L 24, Columbus, Ohio 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 recovered. Once the payment has been recovered, the provider should rebill the services with correct payee information. 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.

B. PROVIDER BILL TYPE FORM REQUIREMENTS

- Except as otherwise noted below, all BWC provider types shall bill utilizing the CMS 1500 form.

Provider Type	Provider Type Name	Billing Form
34	Hospital – General/Acute Care	UB-04
35	Hospital – Drug/Alcohol	UB-04
36	Hospital – Psychiatric	UB-04
37	Hospital – Rehabilitation	UB-04
76	Rehab Service Credentialed	C-19
78	Retraining Providers (Rehab)	C-19
79	Rehab Service Non-Cred	C-19
80	Retail Stores (Rehab)	C-19
81	Supervised Conditioning Facility (Rehab)	C-19
86	Employment Specialist	C-19
87	Vocational Case Management Intern	C-19
99	Interpreter	C-19

C. GENERAL FORM INSTRUCTIONS

- Forms shall be filled out in accordance with national standard practices except as noted.
- Only one servicing provider ID may be submitted per bill.
- The BWC claim number must be noted on the bill.
- Providers should bill in accordance with national correct coding guidelines. All information should be typed, not handwritten. If computer generated, use letter quality forms.
- Enter all information completely within the lines of the appropriate block. Do not enter two lines of information in one block.
- All paper billing forms should be submitted flat, not folded.
- To avoid tearing forms, use paper clips. Do not use staples.
- Do not attach documents unless requested or billing unlisted procedures and modifiers.
- Do not use correction fluid, correction tape or markers.
- 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. 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 above). In order to ensure correct information on your 1099, please submit a current IRS form W-9 to Provider Enrollment.
- If applicable, providers may include Taxonomy Code information. Taxonomy Codes are not required in BWC billing but may be helpful in cross-waking the NPI to the BWC Provider number.

D. CMS-1500 FORM

- BWC will accept the 08/05 (through 12/31/14) or 2/20/12 Health Insurance Claim Form (CMS-1500).
 - [Click here](#) for a link to a sample version 8/05 CMS-1500 form.
 - [Click here](#) for a link to a sample version 2/20/12 CMS-1500 form.

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).

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 electronic transmission requirements. [Click here](#) to obtain complete requirements for electronic transmission.

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-CM code(s) that correspond(s) to the conditions treated, in accordance with National Correct Coding Initiative guidelines.. The billed diagnoses must be related to the services billed. NOTE: Enter the diagnosis code exactly as it appears in the ICD-CM code set. Example: CORRECT: 014.0 for tuberculosis peritonitis. INCORRECT: 14.0 or 014.00. Use the most specific diagnosis code from the ICD-9-CM code set. 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:** Optional but no entry required.
- 24. Line detail**
- 24A. Date(s) of service:** Enter the beginning date of service in month, day, and 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:
- 01 – Pharmacy
 - 03 – School
 - 04 – Homeless Shelter
 - 11 – Office
 - 12 – Home
 - 13 – Assisted Living Facility
 - 15 - Mobile Unit

- 18 – Place of Employment/Worksite
- 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
- 49 – Independent Clinic
- 50 – Federally Qualified Health Center
- 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. Emergency: 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(s). These codes more fully describe the services performed, so that accurate payment can be determined.

24E. Diagnosis code: Enter applicable references from Block 21 in accordance with national standards.

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: Federal Tax I.D. number: This block is REQUIRED on bills submitted directly to BWC. For bills submitted to MCOs, it cannot be left blank unless information is provided in 24J.

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 electronic billing.

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 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.

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 15249
Columbus, OH 43218-2031.

E. UB-04 FORM

BWC accepts UB-04 forms only from hospitals. Other provider types that may be able to bill Medicare or Medicaid on a UB-04 should refer to the Provider Bill Type Form Requirements list noted in section B.

Hospitals should use the UB-04 when submitting bills for workers' compensation services. Hospitals may use their NPI number or BWC's 11 digit provider number when billing.

Hospitals are reminded to submit 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 reimbursement calculation.

See Chapter 3 for medical documentation requirements.

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

Line-by-line instructions for hospital providers completing the UB-04 Billing Form have been revised to cross reference electronic transmission requirements. [Click here](#) to obtain complete requirements for electronic transmission.

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, and 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, and 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, and 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*

BWC accepts all patient discharge status codes that are considered to be valid by the Uniform Hospital Discharge Data Set (UHDDS).

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, and 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, and 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, and 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 UBF.* **SERVICE INVOICE C-19 FORM**

This form will be obsolete as of April 1, 2014. If you are eligible to bill using the CMS 1500, you should begin to do so immediately. BWC will publish a new form for providers not eligible to bill on the CMS 1500 prior to April 1, 2014. See BWC Provider updates.

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, and 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-CM): Enter the ICD-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-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.

F. OUTPATIENT MEDICATION INVOICE (FORM C-17)

Injured workers only use this form for reimbursement of outpatient medication. [Click here](#) to view information regarding this form. Line-by-line instructions for completing the **BWC OUTPATIENT MEDICATION INVOICE** for injured worker reimbursement of outpatient medications obtained from a pharmacy provider follow.

Mail completed forms to:

Catamaran
P.O. Box 968066
Schaumburg, IL 60196-8066

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, and 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, and 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.
- 22. Injured Worker's Signature:** Enter the signature acknowledgement and belief that the information on this form is true.
- 22. Pharmacist's signature:** Enter an authorized signature.
- 23. Date signed:** Enter the date the invoice was signed in the month, day, and year format.

G. INSTRUCTIONS FOR AMERICAN DENTAL ASSOCIATION (ADA) FORM

Line-by-line instructions for completing the ADA billing form for payment of dental services. [Click here](#) to access the Guide for Dental Providers.

Header Information

1. Type of Transaction: No entry required

2. Predetermination/Preauthorization number: Enter the authorization number, if the services require prior authorization.

Primary Payer Information

3. Name, Address, City, State, and 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, and Zip Code: No entry required

Primary Subscriber Information

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, and 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, and 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, and 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

H. EOB REFERENCE CHART

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
007	Payment is denied as BWC Records indicate that for date billed there is another hospital bill paid or in process from another MCO.	This EOB will post when a hospital bill is submitted that has already been submitted and paid to a different MCO.
008	Payment is denied as BWC records indicate that for dates billed there is another hospital bill paid or in process.	This EOB will post when a hospital bill is submitted that has already been submitted and paid to the same MCO.
009	Payment is denied as this is a duplicate line item on an inpatient bill. All charges for a revenue code must be bundled onto 1 line item for inpatient bills.	This EOB will post when the same revenue center code is billed more than once on an inpatient bill. Multiple charges for a revenue center code must be bundled on one line.
035	Servicing provider BWC ID is invalid.	The 11-digit BWC ID was submitted but is not in the provider file data.
036	Servicing provider identifiers are missing.	Neither the 11-digit BWC ID nor the NPI were submitted.
037	Servicing provider NPI information billed is not enrolled.	The NPI was submitted but is not in the provider file data.
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.
080	This bill meets criteria for BWC's post-acute care transfer policy. The DRG payment rate is overridden by PACT payment rate. See Provider Billing & Reimbursement Manual for policy details.	Informs the MCO and hospital of the pricing methodology used to pay the bill. This indicates that the bill is reimbursed using Medicare's post-acute care transfer per diem methodology
081	Bill meets criteria for BWC's special post-acute care transfer policy. The DRG payment rate is overridden by the special PACT payment rate. See Provider Billing & Reimbursement Manual for details.	Informs the MCO and hospital of the pricing methodology used to pay the bill. This indicates that the bill is reimbursed using Medicare's special post-acute care transfer per diem methodology

085	Payment is denied as the admission history and physical is missing. Please fax documentation to MCO & resubmit bill.	Attached by BWC if admission history and physical is required to determine whether an inpatient hospital bill can be paid and has not been submitted by the provider.
086	Payment is denied as the emergency department report is missing. Please fax documentation to the MCO and resubmit bill.	Attached by BWC if emergency department report is required to determine whether an inpatient hospital bill can be paid and has not been submitted by the provider.
087	Payment is denied as the operative report is missing. Please fax documentation to the MCO and resubmit bill.	Attached by BWC if the op report is required to determine whether an inpatient hospital bill can be paid and has not been submitted by the provider.
088	Payment is denied as the progress notes and/or the discharge summary are missing. Please fax documentation to the MCO and resubmit bill.	Attached by BWC if progress notes or a discharge summary are required to determine whether an inpatient hospital bill can be paid and has not been submitted by the provider.
089	Corrected payment is being made on an inpatient hospital bill.	Attached by BWC if an inpatient hospital bill has been reconsidered and is being paid at a corrected rate.
096	Payment is denied - duplicate outpatient bill processed under OPPS.	This denial applies to outpatient bills with dates of service 1/1/2011. If the bill is from the same provider and for the same claim number, service type (therapy or non-therapy) and service date range as a previously approved outpatient hospital bill and includes changes to services, units or charges, the MCO should request an adjustment to correct the original bill. If the bill is an exact duplicate of a previously-paid bill, the MCO should use this EOB to deny the bill as a duplicate.
098	Payment denied - different provider, same MCO, same service, same injured worker.	This EOB will be effective in early 2011. This EOB will apply to professional bills where the same services have been billed by two different providers for the same claim number on the same date. If the MCO has verified that the services are not duplicates, it can attach override EOB 745 to authorize payment of the distinct services.
099	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.
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.
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 BWC Provider Billing and Reimbursement Manual.
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 BWC Provider Billing and Reimbursement Manual for additional information
115	Payment denied as the total units of service from the accommodation revenue codes on the bill are greater than the total number of covered days of hospitalization.	The number of units is greater than 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.
117	Payment denied as the modifier is invalid.	Refer to Chapter 3 of the BWC Provider Billing and Reimbursement Manual.
118	Payment denied because modifier billed was not valid on the date of service.	Refer to Chapter 3 of the BWC Provider Billing and Reimbursement Manual.
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 BWC Provider Billing and Reimbursement Manual.
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 BWC Provider Billing and Reimbursement Manual.
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 BWC Provider Billing and Reimbursement Manual. 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 BWC Provider Billing and Reimbursement Manual.
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 BWC Provider Billing and Reimbursement Manual.

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 is the same on an inpatient hospital bill. Correct the bill and resubmit it to the MCO. Refer to Chapter 4 of the BWC <i>Provider Billing and Reimbursement Manual</i> .
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 BWC <i>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 BWC <i>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 BWC <i>Provider Billing and Reimbursement Manual</i> .
171	Payment denied as the line item dates of service do not match the	Header dates must equal earliest and latest line dates on an outpatient hospital bill.

	header date of service range on an outpatient bill.	
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.
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.
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.
196	Payment is denied as ICD-9 procedure code is not valid.	The ICD-9 procedure on a hospital bill is invalid.
204	The covered days on an interim hospital bill type 112 or 113 is less than 30.	BWC expects covered days for interim hospital bills, type 112 and 113, to be equal or greater than 30 days.
205	HOSPITAL SUBMITTED BILL FOR REHAB/PSYCH SERVICES USING ACUTE CARE PROVIDER NUMBER. RESUBMIT WITH CORRECT NUMBER. IF CORRECT NUMBER IS NOT KNOWN CONTACT PROVIDER RELATIONS AT 1-800-OHIOBWC	Applied when a BWC review looks at the psych/rehab serviced billed by a hospital using an Acute Care provider number and determines that these services should have been billed by a hospital using a psych or rehab provider number.
206	LATE CHARGES BILL IS DENIED. SUBMIT ON HOSPITAL BILL TYPE 115 ALONG WITH A REQUEST FOR ADJUSTMENT TO THE MCO	Applied when late charges are not submitted on a bill type 115, the bill/line will be denied.
207	The interim hospital bill, type 113, is not eligible for additional reimbursement	BWC has reviewed the interim hospital bill, type 113 and determined that it is not eligible for additional reimbursement.
208	Requested medical documentation has not been received by BWC.	BWC has requested medical documentation for bill validation and has not received it in a timely manner.
209	Inpatient hospital readmission is not eligible for additional reimbursement.	The bill has been reviewed and determined that the readmission is not eligible for additional reimbursement. The readmission is covered under the original admission.
210	BWC cannot reimburse these services as this claim is part of the	Employers who participate in this program are responsible for all bills in eligible claims until the \$1,000 limit has been

	\$1,000 Medical-Only Program. Submit medical bills to the injured worker's employer.	met. For additional information, refer to Chapter 1 of the BWC Provider Billing and Reimbursement Manual
211	The claim is part of the Medical-Only Program. The employer is responsible for all bills until the \$1,000/5,000/15,000 limit has been met.	Employers who participate in the BWC Medical-Only Program choose to directly pay for medical services related to a compensable work related injury. The employer may pay for all medical treatment in their employee's medical-only claim up to a specific dollar limit (\$1,000, \$5,000, or \$15,000 depending on the date of injury of the claim and the date the employer enrolled in the program). During the period of time that the employer is responsible for bills, providers should seek reimbursement from the employer. The employer may choose to remove a claim from the program at any time, but is responsible for the amount (up to \$1,000, \$5,000, or \$15,000) as long as the claim is part of the Medical-Only Program. \$1,000 Medical-Only Program (H.B. 107 1993): DOI 7/1/1995 through DOI 6/29/06. \$5,000 Medical-Only Program (S.B. 7 2006): DOI 6/30/06 through 9/9/07. \$15,000 Medical-Only Program (H.B. 100 2007): DOI 9/10/07 and after.
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.
265	Payment is denied as because the claim is inactive. Please refer to the Billing and Reimbursement Manual or contact the MCO for additional	If services are greater than 24 months from the Last Paid Date of Service and the claim is in an Inactive status, BWC will systematically deny the bill. MCOs are to follow BWC guidelines, policies and procedures regarding

	information.	handling requests for treatment that fall under Claim Reactivation Guidelines. (Effective date applies to description only; changed from 13 months to 24 months.)
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 BWC <i>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.
291	As of April 1, 2014 MCOs and BWC will no longer accept the C-19 form for the services you have billed. Please begin to use the new CMS-1500 (02/12) form at your earliest opportunity.	The recommendation has been made to discontinue the C-19 and create a form that will be used by certain workers'-comp specific provider types or to bill specific procedure codes. Once the provider and code types are identified, this document will be updated. This EOB is being published so that MCOs can add the EOB to their systems while adding other new EOBs to their systems.
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.

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.
295	Payment is denied as this procedure is not covered by BWC on outpatient hospital bills.	The billed procedure code will not be reimbursed by BWC on an outpatient hospital bill; it cannot be overridden or adjusted to pay. BWC has created a separate EOB for outpatient hospital bills as the systematic criteria for coverage are different than on professional or ASC bills.
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 BWC Provider Billing and Reimbursement Manual.
301	This bill is paid as a BWC outlier	Informs the MCO and hospital of the pricing methodology used to pay the bill. This indicates that the bill meets the criteria of a BWC outlier.
302	This bill is paid as a BWC DRG	Informs the MCO and hospital of the pricing methodology used to pay the bill. This indicates that the bill meets the criteria of a BWC DRG...
303	This bill was priced using a non-DRG method	Informs the MCO and hospital of the pricing methodology used to pay the bill. This indicates that the bill could not be eligible for DRG pricing and was priced using a non-DRG method.
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 BWC Provider Billing and Reimbursement Manual.
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 BWC Provider Billing and Reimbursement Manual.
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 BWC Provider Billing and Reimbursement Manual. 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.
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 no facility bill.	Hospital providers cannot bill on the no facility 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 BWC Provider Billing and Reimbursement Manual. 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 BWC Provider Billing and Reimbursement Manual. 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 BWC Provider Billing and Reimbursement Manual for instructions on the Dispute Resolution Process.
346	Payment is denied as the billing provider is not documented as the injured worker's vendor of choice for the DME item billed.	This EOB should be used to deny payments if a vendor continues to provide and bill for DME items after the injured worker has selected another vendor.

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.
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 BWC Provider Billing and Reimbursement Manual 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.
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 BWC Provider Billing and Reimbursement Manual. Submit a corrected bill to the MCO.
370	Payment denied as the revenue center code is invalid.	Refer to Chapter 3 of the BWC Provider Billing and Reimbursement Manual. Submit a corrected bill to the MCO.

379	Payment denied as this procedure or service is not eligible for reimbursement to an ambulatory surgical center.	Refer to Chapter 2 of the BWC Provider Billing and Reimbursement Manual.
382	Payment denied as the revenue center code requires a HCPCS code and the HCPCS code is missing.	Refer to Chapter 3 of the BWC Provider Billing and Reimbursement Manual. 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.
388	Payment denied as the diagnosis code is required when billing a HCPCS procedure.	Refer to Chapter 4 of the BWC Provider Billing and Reimbursement Manual. 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 BWC Provider Billing and Reimbursement Manual. 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 BWC Provider Billing and Reimbursement Manual.
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.
407	Payment is denied as this procedure does not warrant an assistant surgeon.	This EOB is used to identify all lines where modifiers 80 (assistant surgeon), 81 (minimum assistant surgeon) and 82 (assistant surgeon when qualified resident surgeon not available) were used inappropriately. When BWC has applied the EOB, it is using the criteria in its professional clinical editing software.
408	Payment is denied as this is considered to be part of a global fee.	Visits or procedures will be allowed if the sum of the billed amounts for visits or procedures is less than the maximum fee schedule for the identified surgical code. All bills with modifiers 54 (surgical care only), 55 (Post-operative management only) and 56 (Preoperative management only) with surgical CPT codes will be subject to this edit. When BWC applies this EOB, it uses the criteria in its professional clinical editing software.
409	Payment is denied as history shows a previously reimbursed visit with this provider within the past three years and therefore does not meet AMA "new patient" definition.	BWC uses the industry standard for this EOB - a patient can only be a new patient to a provider once in three years. When BWC applies this EOB, it uses its professional clinical editing software.
410	Payment is denied as the office/hospital visit falls within the post-surgical follow-up period.	This EOB is applied for all bills for visits/consults billed by the non-operating or operating provider, performed within the surgical global fee period that has a related diagnosis. Logic for this EOB identifies all professional services provided within the global fee period. Modifiers 54, 55, 56, and 57 will permit bypass of this edit. The global fee periods are as follows: zero (0) days, ten (10) days for certain minor procedures and Sixty (60) days for major surgeries. Payment is reduced based on the modifier billed. If no modifier is appended, payment is denied. When BWC applies this EOB, it is using its professional clinical editing software.
411	Payment is denied as the office/hospital visit falls within the pre-operative global period.	This EOB is applied to all bills for visits/consults billed by the non-operating or operating provider, performed within the surgical global fee period that have a related diagnosis. Logic for this EOB identifies all professional services provided within the global fee period. Modifiers 54, 55, 56, and 57 will permit bypass of this edit. The global fee periods are as follows: zero (0) days, ten (10) days for certain minor procedures and Sixty (60) days for major surgeries. Payment is reduced based on the modifier billed. If no modifier is appended, payment is denied. When BWC applies this EOB, it is using its professional clinical editing software.
412	Payment is denied as the set of codes listed should be grouped together under one procedure code as a panel.	This EOB is applied following review of lab procedures billed by the same provider on the same date of service to determine if they are individual components of a disease-oriented panel or an automated chemistry panel code. When BWC applies this EOB, it is using its professional clinical editing software.

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.
430	Payment is denied. The billed procedure must be billed directly to the Pharmacy Benefits Manager	The billed procedure is for a prescription. These services will not be reimbursed through an MCO.
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 BWC Provider Billing and Reimbursement Manual 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 BWC Provider Billing and Reimbursement Manual 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.
453	Payment is being made as prior authorization was requested and approved.	MCOs should attach this EOB to bills received for services that were pre-authorized. This will serve as documentation that the provider adhered to BWC policy for requesting prior authorization for specific services.
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.

456	Payment denied as documentation for supplies billed with revenue codes 270 - 279 has not been received from provider.	MCO are required to obtain and review documentation from providers for every hospital bill that contains more \$10,000 in charges for revenue codes 270 - 279. If no documentation is received, MCOs must attach this EOB and price the line(s) at 0.00.
457	Payment denied as documentation received from provider does not substantiate use of revenue codes 270 - 279.	MCO are required to obtain and review documentation from providers for every hospital bill that contains more \$10,000 in charges for revenue codes 270 - 279. If the documentation received does not justify the use of these codes, MCOs must attach this EOB and price the line(s) at 0.00
458	Payment authorized for revenue codes 270 - 279 following review of documentation submitted by provider.	MCO are required to obtain and review documentation from providers for every hospital bill that contains more \$10,000 in charges for revenue codes 270 - 279. If the documentation justifies the use of these codes, MCOs must attach this EOB and price the line(s) to pay.
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.
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.
465	Payment is denied as a request to reactivate the claim was reviewed and denied.	This may only be used by the MCO to deny bills when BWC has issued a decision to deny the claim reactivation request and the services billed are related to that request.
466	Payment is being made following the approval of a request to reactivate the claim.	This may be used by the MCO to process bills or request adjustments to bills that are now payable due to the granting by BWC of a claim reactivation request.
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 BWC Provider Billing and Reimbursement Manual.
472	Payment is denied as the medical documentation provided is not legible. Payment for these services will be reconsidered once legible documentation is submitted.	Medical documentation submitted has been determined to be illegible by at least two people. The MCO must maintain documentation of who determined the documentation was illegible.
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.
490	The payment rate for this service/supply is \$0.00 as it is a covered, bundled service under the fee schedule.	These services are not denied but are considered bundled into other services that have been provided.
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.
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.
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.
519	Hospital bill is being paid in full but sent to audit because no authorization was obtained.	Charges will be paid in full. Bill will be sent to audit because prior authorization was not obtained.
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.

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.
534	Payment is approved following retroactive review and authorization of service.	MCOs should attach this EOB to bills or adjustments when retroactive authorization has been approved for the services.
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.
537	MCO Alternative Dispute in process for services requested. Services are not payable at this time.	If disputed services are performed and billed to the MCO prior to the rendering of a decision at MCO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 537 EOB. If the services are later authorized at the MCO level, and the decision is not appealed to the BWC, the MCO may use the 538 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.
539	MCO decision on ADR issue was appealed to the BWC. Services are not payable at this time.	If disputed services are performed and billed to the MCO prior to the rendering of a decision at BWC level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 539 EOB. If the services are later authorized at the BWC level, and the decision is not appealed to the DHO, the MCO may use the 540 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.
541	BWC decision on ADR issue appealed to DHO. Services are not payable at this time.	Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at the DHO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 541 EOB. If the services are later authorized at the DHO level, and the decision is not appealed to the SHO, the MCO may use the 542 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.

543	DHO decision on ADR issue appealed to SHO. Services are not payable at this time.	If disputed services are performed and billed to the MCO prior to the rendering of a decision at the SHO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 54 3 EOB. If the services are later authorized at the SHO level the MCO may use the 54 4 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills.
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
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 ohiobwc.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 ohiobwc.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.
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.
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.
614	Claim is managed by BWC's catastrophic claim vendor. The MCO has forwarded bills to the vendor. Please contact Paradigm Outcomes at 800-676-6777 for assistance.	To be used when MCO receives a bill for a claim that is being managed by BWC's catastrophic claim vendor. The MCO should deny the bill with this EOB and submit on the 837, but should also forward the bill to Paradigm.
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 Provider Billing and Reimbursement Manual for instructions on the Dispute Resolution Process.
703	The number of days billed exceeds the days authorized. Payment has been made pending an audit of this billing.	The number of days authorized is less than the number of days billed. Payment has been made pending an audit.
704	Payment has been made at BWC's fee schedule rate. Medical documentation submitted does not justify use of the unusual services modifier.	A -22 modifier was used, but medical documentation does not indicate that unusual services were rendered.
705	Payment is being made to comply with an Industrial Commission order.	The service would not normally be authorized, but an Industrial Commission order requires reimbursement of the service.
706	The unlisted procedure code has been changed following physician review of documentation submitted with invoice.	The procedure code billed by the provider did not conform to coding standards. Price this line item at zero and add new line item with replacement code and EOB 769.
707	This claim was in the Medical Only Program. This item has been priced to reflect partial payment by the employer.	Employer has reimbursed the first \$1,000/5,000/15,000 of injured workers claim. BWC is responsible for additional reimbursement.

716	No payment decision can be made at this time as a determination of relatedness has not yet been made.	This EOB will be used by BWC when there is an ongoing investigation of relatedness of current activity or period of disability to original injury. The payment is neither approved nor disapproved but the bill is being released with \$0.00 payment and this EOB so that provider will be advised of status.
741	Reimbursement is discounted in accordance with OAC Rule 4123-6-16.3.	In accordance with OAC Rule 4123-6-16.3, this EOB indicates retroactive medical treatment and that the payment has been reduced.
742	Reimbursement is discounted in accordance with OAC Rule 4123-6-16.3.	Applied by the MCO in accordance with OAC Rule 4123-6-16.3 to indicate retroactive medical treatment. The payment will be reduced.
751	Procedure was reimbursed up to the maximum number allowed per day.	This EOB should be used to indicate that the provider billed in excess of the maximum units allowed. The priced amount will equal the reimbursement level for the maximum allowed.
764	Payment is denied as this procedure code is part of the service billed with a different code.	This EOB is to be used when unbundled or incidental services are identified by the MCO. The MCO-priced amount should be \$0.00.
765	This procedure has been added as it covers unbundled charges originally billed by the provider.	This EOB is to be used to identify a procedure which has been added by the MCO. It is to be used when the MCO determines that the provider had unbundled charges. The MCO should total the provider's charges for unbundled items and list them as the provider-billed charges in the added line-item detail.
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.
767	This unlisted code has been replaced by another, more specific code.	This EOB is to be used when payment is denied for services billed with an unlisted code because another, more specific code describes the services. The MCO should price services billed with this code at \$0.00. The replacement code should be added with EOB 768.
768	This procedure has been added to replace an unlisted code.	This EOB is to be used when the MCO has identified a specific code to describe services billed with an unlisted or miscellaneous procedure code. The MCO should list the charges originally billed with the unlisted code as the provider's billed charges.
769	This procedure has been added to replace a procedure that was billed incorrectly.	Use when reimbursing an added procedure that replaces a procedure that did not meet CPT or HCPCS coding standards.
770	Unbundled or unlisted code provider charges have been transferred to a re-bundled or specific code.	May be attached with EOB 767 on a line that has been priced at \$0.00

773	Multiple lines billed by the provider have been bundled into a single line item.	MCOs should attach this EOB to 837s when the provider has billed a single procedure multiple times for a single date of service, but the service should have been billed on a single line with multiple units (e.g. bilateral radiology procedures). The line containing this EOB should also contain the multiple units of service and appropriate dollar amounts.
775	Payment denied as line item charges have been bundled into charges for another procedure code.	This is the companion EOB to 773. This should be attached to lines that are to be bundled into the line containing 773. The MCO priced amount for the line(s) containing 775 must be zero.
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.
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.