Interface to Health Care Systems Technical Specifications

Claims Services Branch,
OHIP, Pharmaceuticals and Devices Division,
Ministry of Health
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Chapter 1 Introduction

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1. Introduction

1.1. Introduction

This manual is provided for developers of computer systems used by health care providers.

It specifies the content and format of the information exchanged with the Ministry of Health (ministry) and the operational procedures to be followed.

The technical specifications contained in this text are subject to change by the ministry. The ministry will attempt to provide 60 days' notice of any change.

1.2. Contact Number and Email

Any questions or concerns regarding the content of this manual should be directed to the Ministry of Health Service Support Contact Centre at 1 800-262-6524 or email at SSContactCentre.MOH@ontario.ca. The desk is staffed from 8:00 a.m. to 5:00 p.m., Monday to Friday, except holidays.

Chapter 2 General information

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2. General Information

2.1. Processing Schedules

Claims should be submitted frequently, for example, daily or weekly throughout the month to facilitate smooth processing and timely correction of errors.

2.2. Medical Claims Electronic Data Transfer (MCEDT)

The ministry operates on a monthly processing cycle. Submissions received by the 18th of the month will typically be processed for approval the following month. When the 18th falls on a weekend or a holiday, the deadline will be extended to the next business day.

MCEDT submissions received after the 18th may not be approved until the next monthly processing cycle (i.e. submissions received on November 18th will appear on the December Remittance Advice (RA) submissions received after November 18th may not appear until the January RA).

Please see the Medical Claims Electronic Data Transfer Reference Manual for additional information.

Chapter 3 Claims Submission

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3. Claims Submission

3.1. Claims Submission References

Master Numbering System

Medical Claims Electronic Data Transfer Reference Manual

Resources for Physicians

Schedule of Benefits for Physician Services

Service codes requiring diagnostic codes, prior authorization or supporting documentation are located in Services Requiring Diagnostic Codes and Service Codes Requiring Specialized Submissions.

3.2. Other Technical Specifications

Technical Specification for Medical Claims Electronic Data Transfer (MCEDT) Service via Electronic Business Services (EBS) MCEDT

Technical Specifications for Electronic Business Services (EBS)

Technical Specification for Health Card Validation (HCV) Service via Electronic Business Services (EBS)

Technical Specifications for the Outside Use Report (Patients with Signed Consent)

Technical Specifications Questions and Answers for Medical Claims Electronic Data Transfer (MCEDT), Health Card Validation (HCV), e-Business Services and Conformance Test

Chapter 4 Electronic Input Specifications

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4. Electronic Input Specifications

4.1. Media Types

MCEDT

ASCII Data Content

Logical Record Length must be 79 characters

Internet connection

4.2. File Naming Convention

The Input Claims Submission must have file names in the following format:

H Month Group Number or Provider Number Sequence Number

Example: HA123456.001 or HA1234.001

Field 1 H represents the claims input billing

Field 2 Alpha representation for current processing cycle (e.g. A for January, B for February)

Field 3 Health care provider's **registered group number or solo health care provider number**

Field 4 Three digit sequence number assigned by the health care provider

Each input file must have a Batch Trailer Record at the end of the file(s). The file names must have a unique sequence number when there is more than one file per submission.

There must be a carriage return (hex value 0D) at the end of each record. The end of the file must be indicated by a CTRL Z (hex value of 1A) or CTRL D (hex value of 04).

4.3. Claim Submission

Submissions include:

- In-province medical claims detailed in the Schedule of Benefits, including services that require additional information or prior authorization (referred to as Health Claim Payment (HCP) Claims)
- Reciprocal Medical Billing (RMB) claims
- Workplace Safety and Insurance Board (formally WCB now WSIB) claims

These categories are identified as Payment Programs HCP, RMB, and WCB respectively. Other types of submissions may be included in the future (refer to

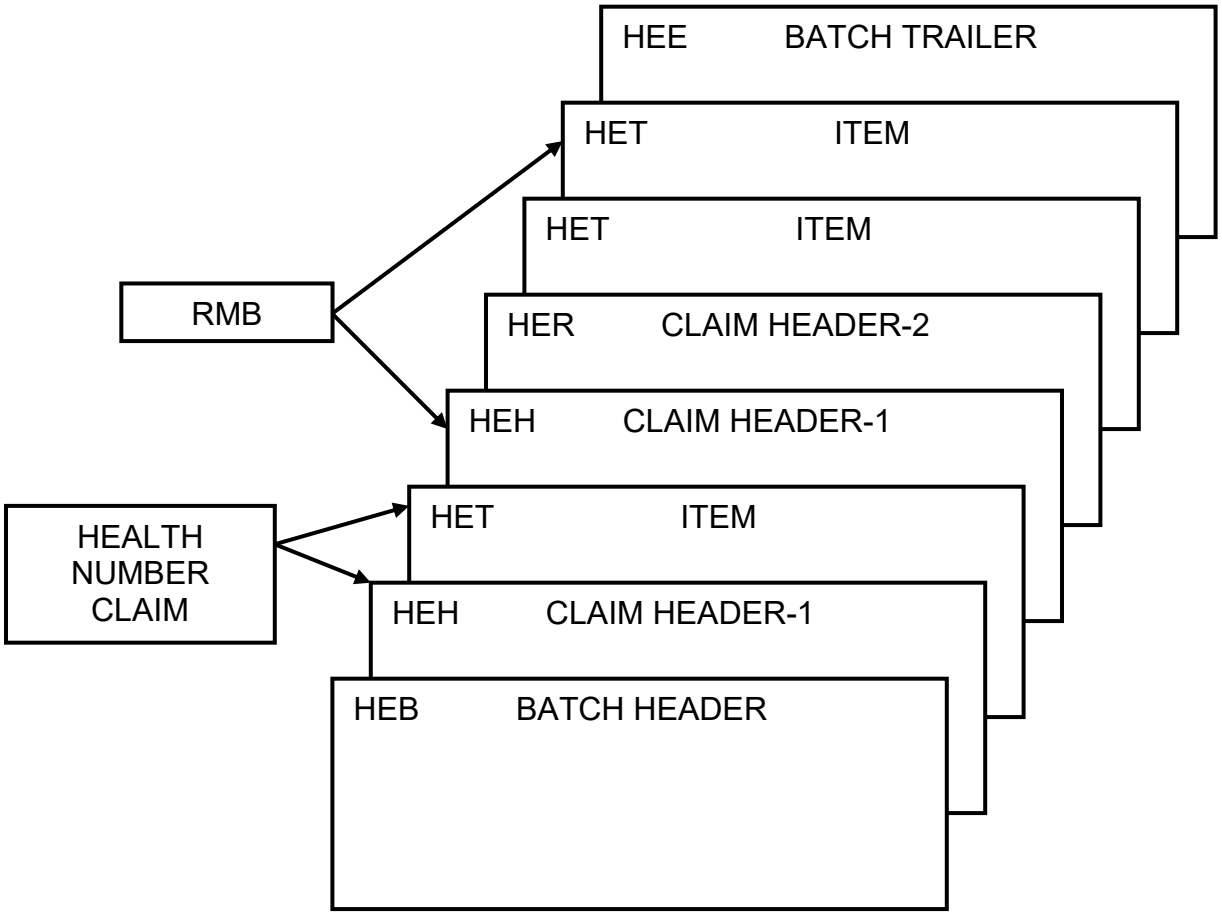
Section 4.16 – Valid Payment Program/Payee Combinations).

Billing software must allow for electronic submission of all payment programs.

4.4. Format Summary

Record Type	Description
B - Batch Header Record	The first record of each batch must be a Batch Header Record. In multiple batch submissions, the first record of each subsequent batch must always be a Batch Header Record.
H - Claim Header-1 Record	A Claim Header-1 Record must always follow each Batch Header Record and must always be present for each claim.
R - Claim Header-2 Record	A Claim Header-2 Record is required only for reciprocal claims. If required, a Claim Header-2 Record must follow the Claim Header-1 Record.
T - Item Record	An option of having two items per Item Record has been provided and may be utilized.
E - Batch Trailer Record	A Batch Trailer Record must be present at the end of every batch and contain the appropriate counts of the number of Claim Header-1 Records (H), Claim Header-2 Records (R) and Item Records (T).

4.5. Batch File Submission Sample



Fixed Record Length: must be 79 Characters

The above illustration is a visual representation of the record types outlined on the previous page to assist in understanding the record types and information contained within.

4.6. Summary of Data Requirements

Record Field	Payment Program HCP / WCB	Payment Program RMB	Non Patient Encounter Claims
Claim Header-1	**Mandatory**	**Mandatory**	
Health Number	Mandatory	Not Required	Not Required
Version Code	Mandatory	Not Required	Not Required
Patient Birthdate	Mandatory	Mandatory	Not Required
Accounting Number	Optional	Optional	Optional
Payment Program	Mandatory	Mandatory	Mandatory
Payee	Conditional	Conditional	
Ref./Reg. Provider No.	Conditional	Conditional	
Master Number	Conditional	Conditional	
In-Pat. Admission Date	Conditional	Conditional	
Ref.Laboratory No.	Conditional	Conditional	
Manual Review Indicator	Conditional	Conditional	
Service Location Indicator *	Conditional	Conditional	
Claim Header-2	**Not Required**	**Mandatory**	
Registration Number	Not Required	Mandatory	
Patient Last Name	Not Required	Mandatory	
Patient First Name	Not Required	Mandatory	
Patient Sex	Not Required	Mandatory	
Province Code	Not Required	Mandatory	
Item	**Mandatory**	**Mandatory**	

Record Field	Payment Program HCP / WCB	Payment Program RMB	Non Patient Encounter Claims
Service Code	Mandatory	Mandatory	
Fee Submitted	Mandatory	Mandatory	
Number of Services	Mandatory	Mandatory	
Service Date	Mandatory	Mandatory	
Diagnostic Code	Conditional	Conditional	

* Effective April 1, 2006

4.7. Electronic Input (EI) Record Layout

Health Encounter

Format Legend

A = Alphabetic

N = Numeric

X = Alphanumeric

D = Date (YYYYMMDD)

S = Spaces

Data Requirements

M = Mandatory

O = Optional

C = Conditional

N/R = Not Required

Note:

If a field is ‘Not Required’ it should be spaces unless otherwise indicated.

All alphabetic characters must be upper-case.

The last 2 digits of all the amount fields are cents (¢¢).

Batch Header Record – Health Encounter

First Record of Every Batch

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Transaction Identifier	1	2	A	M	'HE'
Record Identification	3	1	A	M	'B'
Tech Spec Release Identifier	4	3	X	M	'V03'
MOH Office Code	7	1	A or S	N/R*	(space) a value will be ignored
Batch Identification	8	12	N	M	'YYYYMMDD####' First 8 digits are the Creation Date (the date the input file is created). Last 4 digits are a sequential number assigned by the Health Care Provider/Billing Agent. Service Date on the Item Records cannot be greater than the Creation Date.
Operator Number	20	6		N/R	Zero fill

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Group Number or Laboratory Licence Number or Independent Health Facility Number	26	4	X	M	A group number registered with the ministry or ‘0000’ (zeros) for a solo Health Care Provider/Private Physiotherapy Facility.

*N/R = Not required

Batch Header Record – Health Encounter

First Record of Every Batch

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Health Care Provider/ Private Physio Facility/ Laboratory Director/ Independent Health Facility Practitioner Number	30	6	N	M	A ministry assigned registration number for the Health Care Provider.
Specialty	36	2	N	M	Refer to Specialty Codes
Reserved for MOH Use	38	42	S		Spaces

Note: All claims in a batch must be for the same Health Care Provider. The first record in a batch must be a Batch Header Record. A Batch Header Record must always be followed by a Claim Header-1 Record.

Claim Header – 1 Record – Health Encounter

Required for All Claims

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Transaction Identifier	1	2	A	M	'HE'
Record Identification	3	1	A	M	'H'

Batch Header Record – Health Encounter

First Record of Every Batch

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Health Number	4	10	N or S	M N/R	Satisfies the Mod 10 Check Digit routine (refer to MOD 10 Check Digit). Not required for RMB Claims and blank for non-patient encounter claims.
Version Code	14	2	A or S	M N/R	Version of health card (can be 1 or 2 alpha characters). A one character version code may be left or right justified. Required for HCP claims. Must be present if version code appears on health card. Not required for RMB claims and blank for non-patient encounter claims.

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Patient's Birthdate	16	8	D or S	M	Required for all claims except must be blank for non-patient encounter claims.

Claim Header – 1 Record – Health Encounter

Required for All Claims

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Accounting Number	24	8	X	O	Available for use by the health care provider for claim identification.
Payment Program	32	3	A	M	HCP, WCB or RMB HCP for non-patient encounter claims (refer to Valid Payment/Payee Combinations).
Payee	35	1	A	M	P (Provider) or S (Patient). P (Provider) for non-patient encounter claims.
Referring/ Requisitioning Health Care Provider Number	36	6	N	C	A ministry assigned health care provider number.

Claim Header – 1 Record – Health Encounter

Required for All Claims

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Master Number	42	4	X/N	C	A valid Master Number as assigned by the ministry in the current Master Numbering System book. (Fee Schedule Code Relationships). Must be present for C, H and W prefix codes and/or if the Service Location Indicator is HDS, HED, HIP, HOP, HRP, or RTF.

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
In-Patient Admission Date	46	8	D	C	If present, Admission Date must be the same as or prior to Service Date (refer to Fee Schedule Code Relationships). Must be present if Service Location Indicator is HIP or RTF and for long-term care facility admission assessment fee codes. Not applicable to laboratory claims.

Claim Header – 1 Record – Health Encounter

Required for All Claims

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Referring Laboratory Licence Number	54	4	N	C	For laboratory claims if referred. Must be Laboratory Licence Number assigned by the ministry.

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Manual Review Indicator	58	1	A	C	Must be blank or 'Y'. A 'Y' brings the claim to the attention of the ministry. Supporting documentation required (e.g. can be used to suppress health services verification letters) (refer to Service Codes Requiring Specialized Submissions)

Claim Header – 1 Record – Health Encounter

Required for All Claims

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Service Location Indicator	59	4	X or S	C	Required for hospital diagnostic services and for telemedicine billings. Must be three alphas and left justified. Ministry identifier of the location where the insured diagnostic service was provided (refer to Service Location Indicator Codes). Four numeric characters continue to be acceptable for non-hospital diagnostic service.

Claim Header – 2 Record – Health Encounter

Required for RMB Claims Only

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Reserved for OOC	63	11	S		Must be spaces unless authorized by the ministry.
Reserved for MOH Use	74	6	S		Must be spaces.
Transaction Identifier	1	2	A	M	'HE'

Claim Header – 2 Record – Health Encounter

Required for RMB Claims Only

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Record Identification	3	1	A	M	'R'
Registration Number	4	12	X	M	Registration numbers less than 12 digits must be left justified and blank filled (refer to Province and Territory Codes).
Patient's Last Name	16	9	A	M	Special characters not accepted (e.g. quotes, hyphens, imbedded spaces). Left justified. From health card.
Patient's First Name	25	5	A	M	Special characters not accepted (e.g. quotes, hyphens, imbedded spaces). Left justified. From health card or from patient.

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Patient's Sex	30	1	N	M	'1' for Male or '2' for Female.

Claim Header – 2 Record – Health Encounter

Required for RMB Claims Only

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Province Code	31	2	A	M	(refer to Province Codes and Numbering)
Reserved for MOH Use	33	47	S		Must be spaces

Item Record – Health Encounter

Required for All Claims
There must be at least one item per claim (Item 1)

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Transaction Identifier	1	2	A	M	'HE'
Record Identification	3	1	A	M	'T'

Item Record – Health Encounter

Required for All Claims
There must be at least one item per claim (Item 1)

Item 1

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Service Code	4	5	X	M	Present for all claims in the format 'ANNNA'. Prefix must be alpha, except I, O, or U. 'NNN' must be numeric. Suffix must be A, B, or C. For Laboratory Claims, Prefix must be L, Suffix must be A. 'NNN' must not be 700 if Referring Laboratory Licence Number is present (refer to OHIP Schedule of Benefits and Fees).
Reserved for MOH Use	9	2	S		Must be spaces
Fee Submitted	11	6	N	M	Required for all claims except laboratory claims. Must be in the range 000000 to 500000 ($$$$cc). Fee submitted must be a multiple of the Number of Services.

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Number of Services	17	2	N	M	Within the range 01 to 99. Must divide into Fee Submitted evenly.

Item Record – Health Encounter

Required for All Claims
There must be at least one item per claim (Item 1)

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Service Date	19	8	D	M	Less than or equal to the Creation Date (Batch Identification field in Batch Header).
Diagnostic Code	27	4	X	C	If required, must be a valid Diagnostic Code (refer to Services Requiring Diagnostic Codes). Left justify if 3 digit diagnostic code is used. Not required for laboratory claims.
Reserved for OOC	31	10	S		Must be spaces unless authorized by ministry.
Reserved for MOH Use	41	1			Must be spaces.

Item Record – Health Encounter

Required for All Claims
There must be at least one item per claim (Item 1)

Item 2 – Optional

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Service Code	42	5	A	M	
Reserved for MOH Use	47	2	S		
Fee Submitted	49	6	N	M	
Number of Services	55	2	N	M	
Service Date	57	8	D	M	
Diagnostic Code	65	4	X	C	
Reserved for OOC	69	10	S		
Reserved for MOH Use	79	1	S		

Note: Field Descriptions are the same as listed under Item 1.

All fields must be spaces if this optional Item 2 is not used.

Batch Trailer Record – Health Encounter
Last Record of Every Batch

Field Name	Field Start Position	Field Length	Format	Data Req	Field Description
Transaction Identifier	1	2	A	M	'HE'
Record Identification	3	1	A	M	'E'
H Count	4	4	N	M	Right justified with leading zeros Total of Claim Header – 1 Records within the batch
R Count	8	4	N	M	Right justified with leading zeros Total of Claim Header – 2 Records within the batch
T Count	12	5	N	M	Right justified with leading zeros Total of Item Records within the batch
Reserved for MOH Use	17	63	S		Must be spaces

4.8. Specialty Codes

Find a full list of Specialty Codes by visiting our website

4.9. Services Requiring Diagnostic Codes

Fee Schedule Codes	Exceptions
A—A	A330A, A331A, A332A, A335A, A338A, A585A, A960A, A962A, A963A, A964A, A990A, A994A, A996A, A998A
B—A	B400
C—A	C101A - C110A, C330A, C332A, C335A, C585A, C903A, C960A - C964A, C986A, C987A, C989A - C997A
D—A	
E077A, E078A, E102A - E359A, E687A, E985A	
F—A	
G390A, G391A, G395A, G400A - G402A,G405A - G407A, G423A, G424A, G460A, G461A, G521A - G523A, G557A - G559A, G600A - G602A, G610A, G611A, G620A, G621A, G800A - G805A, G814A, G870A - G875A, G880A	
H—A	H001A, H007A, H112A, H113A, H261A, H267A, H350A - H355A, H400A – H408A, H960A – H964A, H980A -H989A

Fee Schedule Codes	Exceptions
K—A	K017A, K018A, K021A, K035A, K036A, K038A, K050A - K056A, K061A, K112A, K130A - K132A, K267A, K269A, K960A - K964A, K990A - K999A
M—A	
N—A	
P—A	P001A - P008A, P016A, P018A, P020A, P025A, P030A, P041A, P042A
For groups G000 - G999, GA00 - GA99, GB00 - GB99 and service dates on/after July 1, 2011 only: Q601A – Q604A, Q619A, Q620A, Q628A, Q629A	
R—A	
S—A	
T100A - T999A	
U021A, U023A, U025A, U026A, U231A, U233A, U235A, U236A	
V302A - V305A, V404A - V409A, V450A, V451A, **V829A, V842A - V850A	
W—A	W010A, W109A, W239A, W269A, W279A, W419A, W903A, W960A – W964A, W990A – W997A, W998A, W999A
Z—A	

** These ranges require valid physiotherapy diagnostic codes.
Diagnostic Codes are detailed on Diagnostic Codes

4.10. Fee Schedule Code Relationships

Summary

The following requirement(s) must be present for the type(s) of services outlined below:

Type of Service	Requirement
All consultations, repeat consultations and limited consultations rendered in **any** location.	Referring Physician or NP Provider No.
All non-emergency hospital in-patient services **except** consultations, repeat consultations and limited consultations.	Master Number In-Patient Admission Date
All consultations in hospital, repeat consultations and limited consultations.	Master Number Referring Physicain or NP Provider No.
All long-term institutional care, emergency department visits, neo-natal care, respiratory care, low birth weight baby care and attendance at maternal delivery for the care of a high-risk baby. All claims for Group Psychotherapy for In-Patients of a Hospital.	Master Number
All special-visit premiums to the Out-Patient Emergency Department. All special visit premiums to long-term institutional care.	Master Number
All special-visit premiums to a hospital in-patient.	Master Number In-Patient Admission Date
All dental services.	Master Number

Type of Service	Requirement
All physiotherapy services.	Referring Physician or NP Provider No
All claims for Laboratory Services, X-rays and other diagnostic procedures rendered in a hospital or a health facility (including IHF).	Referring/Requisitioning Health Care Provider No.
All claims for Laboratory Services referred from one laboratory to another.	Referring Laboratory Licence No.
Midwife Requested Assessments and Optometrist Requested Assessments	Referring Midwife or Optometrist Provider No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
A005A	Yes	No	No
A006A	Yes	No	No
A015A	Yes	No	No
A016A	Yes	No	No
A020A	Yes	No	No
A025A	Yes	No	No
A026A	Yes	No	No
A035A	Yes	No	No
A036A	Yes	No	No
A045A	Yes	No	No
A046A	Yes	No	No
A050A	Yes	No	No
A055A	Yes	No	No
A065A	Yes	No	No
A066A	Yes	No	No
A070A	Yes	No	No
A075A	Yes	No	No
A076A	Yes	No	No
A085A	Yes	No	No
A086A	Yes	No	No
A095A	Yes	No	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
A096A	Yes	No	No
A100A	No	Yes	No
A115A	Yes	No	No
A135A	Yes	No	No
A136A	Yes	No	No
A145A	Yes	No	No
A150A	Yes	No	No
A155A	Yes	No	No
A156A	Yes	No	No
A160A	Yes	No	No
A165A	Yes	No	No
A166A	Yes	No	No
A175A	Yes	No	No
A176A	Yes	No	No
A180A	Yes	No	No
A185A	Yes	No	No
A186A	Yes	No	No
A190A	Yes	No	No
A191A	Yes	No	No
A192A	Yes	No	No
A195A	Yes	No	No
A196A	Yes	No	No
A197A	Yes	No	No
A198A	Yes	No	No
A205A	Yes	No	No
A206A	Yes	No	No
A215A	Yes	No	No
A220A	Yes	No	No
A225A	Yes	No	No
A226A	Yes	No	No
A235A	Yes	No	No
A236A	Yes	No	No
A250A	Yes	No	No
A253A	Yes	No	No
A256A	Yes	No	No
A265A	Yes	No	No
A266A	Yes	No	No
A275A	Yes	No	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
A285A	Yes	No	No
A286A	Yes	No	No
A315A	Yes	No	No
A316A	Yes	No	No
A325A	Yes	No	No
A330A	Yes	No	No
A332A	Yes	No	No
A335A	Yes	No	No
A345A	Yes	No	No
A346A	Yes	No	No
A355A	Yes	No	No
A356A	Yes	No	No
A365A	Yes	No	No
A375A	Yes	No	No
A385A	Yes	No	No
A395A	Yes	No	No
A400A	Yes	No	No
A405A	Yes	No	No
A415A	Yes	No	No
A416A	Yes	No	No
A425A	Yes	No	No
A435A	Yes	No	No
A445A	Yes	No	No
A446A	Yes	No	No
A460A	Yes	No	No
A465A	Yes	No	No
A466A	Yes	No	No
A470A	Yes	No	No
A475A	Yes	No	No
A476A	Yes	No	No
A480A	Yes	No	No
A485A	Yes	No	No
A486A	Yes	No	No
A515A	Yes	No	No
A525A	Yes	No	No
A545A	Yes	No	No
A565A	Yes	No	No
A575A	Yes	No	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
A585A	Yes	No	No
A586A	Yes	No	No
A595A	Yes	No	No
A600A	Yes	No	No
A605A	Yes	No	No
A606A	Yes	No	No
A615A	Yes	No	No
A616A	Yes	No	No
A625A	Yes	No	No
A626A	Yes	No	No
A635A	Yes	No	No
A636A	Yes	No	No
A645A	Yes	No	No
A646A	Yes	No	No
A655A	Yes	No	No
A665A	Yes	No	No
A667A	Yes	No	No
A675A	Yes	No	No
A695A	Yes	No	No
A735A	Yes	No	No
A745A	Yes	No	No
A765A	Yes	No	No
A770A	Yes	No	No
A775A	Yes	No	No
A795A	Yes	No	No
A800A	Yes	No	No
A801A	Yes	No	No
A802A	Yes	No	No
A813A	Yes	No	No
A815A	Yes	No	No
A816A	Yes	No	No
A835A	Yes	No	No
A845A	Yes	No	No
A865A	Yes	No	No
A895A	Yes	No	No
A905A	Yes	No	No
A911A	Yes	No	No
A912A	Yes	No	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
A933A	No	Yes	Yes
A935A	Yes	No	No
A945A	Yes	No	No
C002A	No	Yes	Yes
C003A	No	Yes	Yes
C004A	No	Yes	Yes
C005A	Yes	Yes	No
C006A	Yes	Yes	No
C007A	No	Yes	Yes
C008A	No	Yes	Yes
C009A	No	Yes	Yes
C010A	No	Yes	Yes
C012A	No	Yes	Yes
C013A	No	Yes	Yes
C014A	No	Yes	Yes
C015A	Yes	Yes	No
C016A	Yes	Yes	No
C017A	No	Yes	Yes
C018A	No	Yes	Yes
C019A	No	Yes	Yes
C020A	No	Yes	Yes
C022A	No	Yes	Yes
C023A	No	Yes	Yes
C024A	No	Yes	Yes
C025A	Yes	Yes	No
C026A	Yes	Yes	No
C027A	No	Yes	Yes
C028A	No	Yes	Yes
C029A	No	Yes	Yes
C032A	No	Yes	Yes
C033A	No	Yes	Yes
C034A	No	Yes	Yes
C035A	Yes	Yes	No
C036A	Yes	Yes	No
C037A	No	Yes	Yes
C038A	No	Yes	Yes
C039A	No	Yes	Yes
C042A	No	Yes	Yes

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
C043A	No	Yes	Yes
C044A	No	Yes	Yes
C045A	Yes	Yes	No
C046A	Yes	Yes	No
C047A	No	Yes	Yes
C048A	No	Yes	Yes
C049A	No	Yes	Yes
C050A	Yes	Yes	No
C051A	No	Yes	Yes
C052A	No	Yes	Yes
C053A	No	Yes	Yes
C054A	No	Yes	Yes
C055A	Yes	Yes	Yes
C056A	Yes	Yes	No
C057A	No	Yes	Yes
C058A	No	Yes	Yes
C059A	No	Yes	Yes
C062A	No	Yes	Yes
C063A	No	Yes	Yes
C064A	No	Yes	Yes
C065A	Yes	Yes	No
C066A	Yes	Yes	No
C067A	No	Yes	Yes
C068A	No	Yes	Yes
C069A	No	Yes	Yes
C071A	No	Yes	Yes
C072A	No	Yes	Yes
C073A	No	Yes	Yes
C074A	No	Yes	Yes
C075A	Yes	Yes	No
C076A	Yes	Yes	No
C077A	No	Yes	Yes
C078A	No	Yes	Yes
C079A	No	Yes	Yes
C082A	No	Yes	Yes
C083A	No	Yes	Yes
C084A	No	Yes	Yes
C085A	Yes	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
C086A	Yes	Yes	No
C087A	No	Yes	Yes
C088A	No	Yes	Yes
C089A	No	Yes	Yes
C092A	No	Yes	Yes
C093A	No	Yes	Yes
C094A	No	Yes	Yes
C095A	Yes	Yes	No
C096A	Yes	Yes	No
C097A	Yes	Yes	No
C098A	No	Yes	Yes
C099A	No	Yes	Yes
C101A	No	Yes	No
C102A	No	Yes	No
C103A	No	Yes	No
C104A	No	Yes	No
C105A	No	Yes	No
C106A	No	Yes	No
C107A	No	Yes	No
C108A	No	Yes	No
C109A	No	Yes	No
C110A	No	Yes	No
C113A	No	No	Yes
C121A	No	Yes	Yes
C122A	No	Yes	Yes
C123A	No	Yes	Yes
C124A	No	Yes	Yes
C130A	Yes	Yes	No
C131A	No	Yes	Yes
C132A	No	Yes	Yes
C133A	No	Yes	Yes
C134A	No	Yes	Yes
C135A	Yes	Yes	No
C136A	Yes	Yes	No
C137A	No	Yes	Yes
C138A	No	Yes	Yes
C139A	No	Yes	Yes
C142A	No	Yes	Yes

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
C143A	No	Yes	Yes
C150A	Yes	Yes	No
C151A	No	Yes	Yes
C152A	No	Yes	Yes
C153A	No	Yes	Yes
C154A	No	Yes	Yes
C155A	Yes	Yes	No
C156A	Yes	Yes	No
C157A	No	Yes	Yes
C158A	No	Yes	Yes
C159A	No	Yes	Yes
C160A	Yes	Yes	No
C161A	No	Yes	Yes
C162A	No	Yes	Yes
C163A	No	Yes	Yes
C164A	No	Yes	Yes
C165A	Yes	Yes	No
C166A	Yes	Yes	No
C167A	No	Yes	Yes
C168A	No	Yes	Yes
C169A	No	Yes	Yes
C172A	No	Yes	Yes
C173A	No	Yes	Yes
C174A	No	Yes	No
C175A	Yes	Yes	No
C176A	Yes	Yes	No
C177A	No	Yes	Yes
C178A	No	Yes	Yes
C179A	No	Yes	Yes
C180A	Yes	Yes	No
C181A	No	Yes	Yes
C182A	No	Yes	Yes
C183A	No	Yes	Yes
C184A	No	Yes	Yes
C185A	Yes	Yes	No
C186A	Yes	Yes	No
C187A	No	Yes	Yes
C188A	No	Yes	Yes

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
C189A	No	Yes	Yes
C190A	Yes	Yes	No
C192A	No	Yes	Yes
C193A	No	Yes	Yes
C194A	No	Yes	Yes
C195A	Yes	Yes	No
C196A	Yes	Yes	No
C197A	No	Yes	Yes
C198A	No	Yes	Yes
C199A	No	Yes	Yes
C202A	No	Yes	Yes
C203A	No	Yes	Yes
C204A	No	Yes	Yes
C205A	Yes	Yes	No
C206A	Yes	Yes	No
C207A	No	Yes	Yes
C208A	No	Yes	Yes
C209A	No	Yes	Yes
C215A	Yes	Yes	Yes
C220A	Yes	Yes	No
C222A	No	Yes	Yes
C223A	Yes	Yes	Yes
C225A	Yes	Yes	No
C226A	Yes	Yes	No
C227A	No	Yes	Yes
C229A	No	Yes	Yes
C231A	Yes	Yes	No
C232A	No	Yes	Yes
C233A	No	Yes	Yes
C234A	No	Yes	Yes
C235A	Yes	Yes	No
C236A	Yes	Yes	No
C237A	No	Yes	Yes
C238A	No	Yes	Yes
C239A	No	Yes	Yes
C242A	No	Yes	Yes
C243A	No	Yes	Yes
C244A	No	Yes	Yes

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
C245A	Yes	Yes	No
C246A	Yes	Yes	No
C247A	No	Yes	Yes
C248A	No	Yes	Yes
C249A	No	Yes	Yes
C250A	No	Yes	Yes
C255A	Yes	Yes	No
C260A	Yes	Yes	No
C262A	No	Yes	Yes
C263A	No	Yes	Yes
C264A	No	Yes	Yes
C265A	Yes	Yes	No
C266A	Yes	Yes	No
C268A	No	Yes	Yes
C275A	Yes	Yes	No
C283A	No	Yes	Yes
C285A	Yes	Yes	No
C286A	Yes	Yes	No
C288A	No	Yes	Yes
C311A	No	Yes	Yes
C312A	No	Yes	Yes
C313A	No	Yes	Yes
C314A	No	Yes	Yes
C315A	Yes	Yes	No
C316A	Yes	Yes	No
C317A	No	Yes	Yes
C318A	No	Yes	Yes
C319A	No	Yes	Yes
C325A	Yes	Yes	No
C330A	Yes	Yes	No
C332A	Yes	Yes	No
C335A	Yes	Yes	No
C341A	No	Yes	Yes
C342A	No	Yes	Yes
C343A	No	Yes	Yes
C344A	No	Yes	Yes
C345A	Yes	Yes	No
C346A	Yes	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
C347A	No	Yes	Yes
C348A	No	Yes	Yes
C349A	No	Yes	Yes
C352A	No	Yes	Yes
C353A	No	Yes	Yes
C354A	No	Yes	Yes
C355A	Yes	Yes	No
C356A	Yes	Yes	No
C357A	No	Yes	Yes
C358A	No	Yes	Yes
C359A	No	Yes	Yes
C365A	Yes	Yes	Yes
C375A	Yes	Yes	No
C384A	Yes	Yes	No
C385A	Yes	Yes	No
C395A	Yes	Yes	No
C400A	Yes	Yes	No
C405A	Yes	Yes	Yes
C411A	No	Yes	Yes
C412A	No	Yes	Yes
C413A	No	Yes	Yes
C414A	No	Yes	Yes
C415A	Yes	Yes	No
C416A	Yes	Yes	No
C417A	No	Yes	Yes
C418A	No	Yes	Yes
C419A	No	Yes	Yes
C425A	Yes	Yes	Yes
C435A	Yes	Yes	No
C441A	No	Yes	Yes
C442A	No	Yes	Yes
C443A	No	Yes	Yes
C444A	No	Yes	Yes
C445A	Yes	Yes	No
C446A	Yes	Yes	No
C447A	No	Yes	Yes
C448A	No	Yes	Yes
C449A	No	Yes	Yes

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
C460A	Yes	Yes	No
C461A	No	Yes	Yes
C462A	No	Yes	Yes
C463A	No	Yes	Yes
C464A	No	Yes	Yes
C465A	Yes	Yes	No
C466A	Yes	Yes	No
C467A	No	Yes	Yes
C468A	No	Yes	Yes
C469A	No	Yes	Yes
C470A	Yes	Yes	No
C471A	No	Yes	Yes
C472A	No	Yes	Yes
C473A	No	Yes	Yes
C474A	No	Yes	Yes
C475A	Yes	Yes	No
C476A	Yes	Yes	No
C477A	No	Yes	Yes
C478A	No	Yes	Yes
C479A	No	Yes	Yes
C480A	No	Yes	Yes
C481A	No	Yes	Yes
C482A	No	Yes	Yes
C483A	No	Yes	Yes
C484A	No	Yes	Yes
C485A	Yes	Yes	No
C486A	Yes	Yes	No
C487A	No	Yes	Yes
C488A	No	Yes	Yes
C489A	No	Yes	Yes
C510A	No	Yes	Yes
C511A	No	Yes	Yes
C515A	Yes	Yes	No
C525A	Yes	Yes	No
C545A	Yes	Yes	No
C565A	Yes	Yes	No
C570A	No	Yes	Yes
C575A	Yes	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
C585A	Yes	Yes	No
C586A	Yes	Yes	Yes
C590A	Yes	Yes	No
C595A	Yes	Yes	No
C600A	Yes	Yes	No
C601A	No	Yes	Yes
C602A	No	Yes	Yes
C603A	No	Yes	Yes
C604A	No	Yes	Yes
C605A	Yes	Yes	No
C606A	Yes	Yes	No
C607A	No	Yes	Yes
C608A	No	Yes	Yes
C609A	No	Yes	Yes
C611A	No	Yes	Yes
C612A	No	Yes	Yes
C613A	No	Yes	Yes
C614A	No	Yes	Yes
C615A	Yes	Yes	No
C616A	Yes	Yes	No
C617A	No	Yes	Yes
C618A	No	Yes	Yes
C619A	No	Yes	Yes
C621A	No	Yes	Yes
C622A	No	Yes	Yes
C623A	No	Yes	Yes
C624A	No	Yes	Yes
C625A	Yes	Yes	No
C626A	Yes	Yes	No
C627A	No	Yes	Yes
C628A	No	Yes	Yes
C629A	No	Yes	Yes
C635A	Yes	Yes	No
C636A	Yes	Yes	No
C642A	No	Yes	Yes
C643A	No	Yes	Yes
C644A	No	Yes	Yes
C645A	Yes	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
C646A	Yes	Yes	No
C647A	No	Yes	Yes
C648A	No	Yes	Yes
C649A	No	Yes	Yes
C655A	Yes	Yes	No
C661A	No	Yes	Yes
C662A	Yes	Yes	No
C665A	Yes	Yes	No
C667A	Yes	Yes	Yes
C675A	Yes	Yes	No
C680A	No	Yes	Yes
C682A	Yes	Yes	No
C695A	Yes	Yes	Yes
C735A	Yes	Yes	No
C745A	Yes	Yes	No
C760A	No	Yes	Yes
C765A	Yes	Yes	No
C770A	Yes	Yes	No
C771A	No	Yes	Yes
C775A	Yes	Yes	Yes
C777A	No	Yes	Yes
C795A	Yes	Yes	Yes
C800A	Yes	Yes	Yes
C801A	Yes	Yes	Yes
C802A	Yes	Yes	Yes
C813A	Yes	Yes	Yes
C815A	Yes	Yes	Yes
C816A	Yes	Yes	Yes
C835A	Yes	Yes	Yes
C845A	Yes	Yes	No
C865A	Yes	Yes	No
C882A	No	Yes	Yes
C895A	Yes	Yes	No
C903A	No	Yes	Yes
C904A	No	Yes	Yes
C905A	Yes	Yes	No
C911A	Yes	Yes	No
C912A	Yes	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
C933A	No	Yes	Yes
C935A	Yes	Yes	No
C945A	Yes	Yes	No
C960A	No	Yes	No
C961A	No	Yes	No
C962A	No	Yes	No
C963A	No	Yes	No
C964A	No	Yes	No
C982A	No	Yes	Yes
C983B	No	Yes	No
C985C	No	Yes	No
C987A	No	Yes	No
C988B	No	Yes	No
C989A	No	Yes	No
C990A	No	Yes	No
C991A	No	Yes	No
C992A	No	Yes	No
C993A	No	Yes	No
C994A	No	Yes	No
C995A	No	Yes	No
C996A	No	Yes	No
C997A	No	Yes	No
C998B/C	No	Yes	No
C999B/C	No	Yes	No
E032A	No	Yes	No
E101B	No	Yes	No
E082A	No	Yes	Yes
E083A	No	Yes	Yes
E084A	No	Yes	Yes
E475A	No	Yes	No
E515A	No	Yes	No
E530A	No	Yes	No
E986A	No	Yes	Yes
G185A	No	Yes	No
G254A	No	Yes	Yes
G400A	No	Yes	No
G401A	No	Yes	No
G402A	No	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
G405A	No	Yes	No
G406A	No	Yes	No
G407A	No	Yes	No
G408A	No	Yes	No
G409A	No	Yes	No
G412A	No	Yes	No
G557A	No	Yes	No
G558A	No	Yes	No
G559A	No	Yes	No
G600A	No	Yes	Yes
G601A	No	Yes	Yes
G602A	No	Yes	Yes
G603A	No	Yes	Yes
G604A	No	Yes	Yes
G610A	No	Yes	No
G611A	No	Yes	No
G620A	No	Yes	No
G621A	No	Yes	No
G790A	No	Yes	Yes
G791A	No	Yes	Yes
G792A	No	Yes	Yes
H002A	No	Yes	No
H003A	No	Yes	No
H007A	No	Yes	No
H055A	Yes	Yes	No
H065A	Yes	Yes	No
H100A	?	Yes	No
H101A	No	Yes	No
H102A	No	Yes	No
H103A	No	Yes	No
H104A	No	Yes	No
H105A	No	Yes	No
H112A	No	Yes	No
H113A	No	Yes	No
H121A	No	Yes	No
H122A	No	Yes	No
H123A	No	Yes	No
H124A	No	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
H131A	No	Yes	No
H132A	No	Yes	No
H133A	No	Yes	No
H134A	No	Yes	No
H151A	No	Yes	No
H152A	No	Yes	No
H153A	No	Yes	No
H154A	No	Yes	No
H262A	No	Yes	No
H263A	No	Yes	No
H267A	No	Yes	No
H312A	No	Yes	Yes
H317A	No	Yes	Yes
H319A	No	Yes	Yes
H960A	No	Yes	No
H961A	No	Yes	No
H962A	No	Yes	No
H963A	No	Yes	No
H964A	No	Yes	No
H980A	No	Yes	No
H981A	No	Yes	No
H984A	No	Yes	No
H985A	No	Yes	No
H985A	No	Yes	No
H986A	No	Yes	No
H987A	No	Yes	No
H988A	No	Yes	No
H989A	No	Yes	No
K061A	No	Yes	No
K121A	No	Yes	Yes
K191A	No	Yes	Yes
K199A	No	Yes	Yes
K705A	No	Yes	No
K960A	No	Yes	No
K961A	No	Yes	No
K962A	No	Yes	No
K963A	No	Yes	No
K964A	No	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
K990A	No	Yes	No
K991A	No	Yes	No
K992A	No	Yes	No
K993A	No	Yes	No
K994A	No	Yes	No
K995A	No	Yes	No
K996A	No	Yes	No
K997A	No	Yes	No
K998A	No	Yes	No
K999A	No	Yes	No
R731A	No	Yes	Yes
R766A	No	Yes	Yes
R767A	No	Yes	Yes
S152A	No	Yes	Yes
S207A	No	Yes	No
S752A	No	Yes	No
S756A	No	Yes	No
S785A	No	Yes	No
S900C	No	Yes	No
T---A	No	Yes	No
T652A	No	Yes	Yes
T657A	No	Yes	Yes
U960A	No	Yes	No
U961A	No	Yes	No
U962A	No	Yes	No
U963A	No	Yes	No
U964A	No	Yes	No
U990A	No	Yes	No
U991A	No	Yes	No
U992A	No	Yes	No
U993A	No	Yes	No
U994A	No	Yes	No
U995A	No	Yes	No
U996A	No	Yes	No
U997A	No	Yes	No
U998A	No	Yes	No
U999A	No	Yes	No
V844A	Yes	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
V848A	Yes	Yes	No
W001A	No	Yes	No
W002A	No	Yes	No
W003A	No	Yes	No
W004A	No	Yes	No
W008A	No	Yes	No
W010A	No	Yes	Yes
W021A	No	Yes	No
W022A	No	Yes	No
W023A	No	Yes	No
W025A	Yes	Yes	No
W026A	Yes	Yes	No
W028A	No	Yes	No
W031A	No	Yes	No
W032A	No	Yes	No
W033A	No	Yes	No
W035A	Yes	Yes	No
W036A	Yes	Yes	No
W038A	No	Yes	No
W045A	Yes	Yes	No
W046A	Yes	Yes	No
W055A	Yes	Yes	No
W058A	No	Yes	No
W061A	No	Yes	No
W062A	No	Yes	No
W063A	No	Yes	No
W065A	Yes	Yes	No
W066A	Yes	Yes	No
W068A	No	Yes	No
W071A	No	Yes	No
W072A	No	Yes	No
W073A	No	Yes	No
W074A	No	Yes	No
W075A	Yes	Yes	No
W076A	Yes	Yes	No
W078A	No	Yes	No
W085A	Yes	Yes	No
W086A	Yes	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
W095A	Yes	Yes	No
W096A	Yes	Yes	No
W102A	No	Yes	Yes
W104A	No	Yes	Yes
W105A	Yes	Yes	No
W106A	Yes	Yes	No
W107A	No	Yes	Yes
W109A	No	Yes	Yes
W113A	No	Yes	No
W121A	No	Yes	No
W130A	Yes	Yes	No
W131A	No	Yes	No
W132A	No	Yes	No
W133A	No	Yes	No
W134A	No	Yes	No
W138A	No	Yes	No
W150A	Yes	Yes	No
W151A	No	Yes	No
W152A	No	Yes	No
W153A	No	Yes	No
W154A	No	Yes	No
W155A	Yes	Yes	No
W156A	Yes	Yes	No
W158A	No	Yes	No
W160A	Yes	Yes	No
W161A	No	Yes	No
W162A	No	Yes	No
W163A	No	Yes	No
W164A	No	Yes	No
W165A	Yes	Yes	No
W166A	Yes	Yes	No
W168A	No	Yes	Yes
W171A	No	Yes	No
W172A	No	Yes	No
W173A	No	Yes	No
W175A	Yes	Yes	No
W176A	Yes	Yes	No
W180A	Yes	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
W181A	No	Yes	No
W182A	No	Yes	No
W183A	No	Yes	No
W184A	No	Yes	No
W185A	Yes	Yes	No
W186A	Yes	Yes	No
W188A	No	Yes	No
W190A	Yes	Yes	No
W196A	Yes	Yes	No
W220A	Yes	Yes	No
W221A	No	Yes	No
W222A	No	Yes	No
W223A	No	Yes	No
W224A	No	Yes	No
W225A	Yes	Yes	No
W226A	Yes	Yes	No
W228A	No	Yes	No
W231A	Yes	Yes	No
W232A	No	Yes	Yes
W234A	No	Yes	Yes
W235A	Yes	Yes	No
W236A	Yes	Yes	No
W237A	No	Yes	Yes
W239A	No	Yes	No
W252A	No	Yes	Yes
W254A	No	Yes	Yes
W255A	Yes	Yes	No
W257A	No	Yes	Yes
W261A	No	Yes	No
W262A	No	Yes	No
W265A	Yes	Yes	No
W266A	Yes	Yes	No
W269A	No	Yes	No
W272A	No	Yes	Yes
W274A	No	Yes	Yes
W275A	Yes	Yes	No
W277A	No	Yes	Yes
W279A	No	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
W292A	No	Yes	Yes
W294A	No	Yes	Yes
W297A	No	Yes	Yes
W299A	No	Yes	No
W305A	Yes	Yes	No
W306A	Yes	Yes	No
W310A	Yes	Yes	No
W311A	No	Yes	No
W312A	No	Yes	No
W313A	No	Yes	No
W314A	No	Yes	No
W318A	No	Yes	No
W325A	Yes	Yes	No
W345A	Yes	Yes	No
W346A	Yes	Yes	No
W355A	Yes	Yes	No
W356A	Yes	Yes	No
W375A	Yes	Yes	No
W385A	Yes	Yes	No
W395A	Yes	Yes	No
W400A	Yes	Yes	No
W402A	No	Yes	Yes
W404A	No	Yes	Yes
W405A	Yes	Yes	No
W407A	No	Yes	No
W409A	No	Yes	No
W419A	No	Yes	No
W435A	Yes	Yes	No
W441A	No	Yes	No
W442A	No	Yes	Yes
W443A	No	Yes	Yes
W444A	No	Yes	No
W445A	Yes	Yes	No
W446A	Yes	Yes	No
W448A	No	Yes	No
W460A	Yes	Yes	No
W461A	No	Yes	No
W462A	No	Yes	No

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
W463A	No	Yes	No
W464A	No	Yes	No
W465A	Yes	Yes	No
W466A	Yes	Yes	No
W468A	No	Yes	No
W510A	No	Yes	No
W511A	No	Yes	No
W512A	No	Yes	Yes
W514A	No	Yes	Yes
W515A	Yes	Yes	No
W516A	Yes	Yes	No
W517A	No	Yes	Yes
W535A	Yes	Yes	No
W536A	Yes	Yes	No
W562A	No	Yes	Yes
W564A	No	Yes	Yes
W565A	Yes	Yes	No
W567A	No	Yes	Yes
W645A	Yes	Yes	No
W646A	Yes	Yes	No
W662A	Yes	Yes	No
W667A	Yes	Yes	No
W682A	Yes	Yes	No
W695A	Yes	Yes	No
W760A	No	Yes	No
W765A	Yes	Yes	No
W770A	Yes	Yes	No
W771A	No	Yes	No
W775A	Yes	Yes	No
W777A	No	Yes	No
W795A	Yes	Yes	No
W842A	No	Yes	Yes
W844A	No	Yes	Yes
W845A	Yes	Yes	No
W847A	No	Yes	Yes
W849A	No	Yes	Yes
W862A	No	Yes	Yes
W864A	No	Yes	Yes

Fee Schedule Code	Referring/ Requisitioning Health Care Provider Number	Master Number	In-Patient Admission Date
W865A	No	Yes	Yes
W867A	No	Yes	Yes
W869A	No	Yes	No
W872A	No	Yes	Yes
W882A	No	Yes	No
W895A	Yes	Yes	No
W903A	No	Yes	No
W904A	No	Yes	No
W911A	Yes	Yes	No
W912A	Yes	Yes	No
W960A	No	Yes	No
W961A	No	Yes	No
W962A	No	Yes	No
W963A	No	Yes	No
W964A	No	Yes	No
W972A	No	Yes	No
W982A	No	Yes	No
W990A	No	Yes	No
W991A	No	Yes	No
W992A	No	Yes	No
W993A	No	Yes	No
W994A	No	Yes	No
W995A	No	Yes	No
W996A	No	Yes	No
W997A	No	Yes	No
W998A	No	Yes	No
W999A	No	Yes	No
Z777A	No	Yes	No

Note:

1. A referring/requisitioning Health Care Provider number is required for all claims that are billed by Independent Health Facilities that have legacy agreements, or licensed with group numbers within the series AAAA – A999.
2. A referring/requisitioning Health Care Provider number is required for claims that are billed by groups with the following numbers, or such claims will reject under Review Error Condition V09 – Invalid Referral Number: Begins with 5 or 7; Within the series 8000 – 8599, 8600 – 8999; 6008, 6100 or 9xxx.

The aforementioned list does not include the entire Ministry of Health insured services. The Fee Schedule Code Relationships Table only lists those Fee Schedule Codes, which require a referring/requisitioning health care provider number, a master number, and/or an in-patient admission date.

4.11. Fee Schedule Code Suffix B/C Exceptions

When the Fee Schedule Code Suffix is ‘B’ or ‘C’ the number of services must be greater than ‘01’.

Exceptions to the above are:

C983B	C985C	C988B	C998B,C	C999B,C
E005C	E008C		E049C	
E052C	E054C	E055C	E056C	E100C
E101B	E400B,C	E401B,C	E450B,C	
E451B,C	E475C	E505C		
G176B	G177B	G178B	G179B	G249B
G254B	G261B	G262B	G263B	G265B
G266B	G267B	G286B	G288B	G289B
G290B	G291B	G292B		G294B
G296B	G297B	G298B	G299B	G300B
G301B	G305B	G306B	G321B	G322B
G366B	G509B	G518B	G519B	
J100B,C	TO	J399B,C	INCLUSIVE	
J400C	J402B,C	J403B,C	J405B,C	J406B,C
J407B,C	J408B,C	J422B,C	J425B,C	J427B,C
J428B,C	J435B,C	J438B,C	J459B,C	J462B,C
J463B,C	J464B,C	J480B,C	J482B,C	J483B,C
J489C	TO	J498C		
J490B	TO	J498B		
J500B,C	TO	J507B,C		
J602B,C	TO	J689B,C	INCLUSIVE	
J802B,C	TO	J889B,C	INCLUSIVE	
J894B				

P015C

X___B	X___C			
Y602B,C	TO	Y689B,C	INCLUSIVE	
Y802B,C	TO	Y889B,C	INCLUSIVE	
Z431B	Z434B	Z439B	Z440B	Z441B
Z442B	Z443B	Z448B	Z449B	

4.12. Service Codes Requiring Specialized Submissions

Prior Authorization

The following is a list of service codes requiring specialized submissions for which prior authorization is required:

E200	E201	M013	M014	M019	M024
R026-R028	R110	R112	R319	R320	S318
T901-T912	T925-T928	T936	T950		

Supporting Documentation

The following is a list of service codes requiring specialized submissions for which supporting documentation (e.g. clinical records, operative reports) may be requested:

A935	C121	E304	E307	E308	E409
E410	E411	E531	E532	E540	E544
E555	E556	E564	E569	E586	E906
E911	E925	E958	E977	F124	F125
F131	F146	G272	G383	G423	
G424	G800-G805	J041	K001	K018	K021
K101	L299	L585	L611	L690	L693
M011	M033	M109	M110	M400	R004
R007	R025	R029	R051	R057	R058
R064-R069	R074	R081-R083	R086-R088	R091	R104
R106	R113	R114	R118	R120	R121
R125-R139	R150-R154	R214	R272	R352	R360
R434	R523	R528	R604	R605	R635
R637	R638	R671	R674	R829	R990
R993	S015	S021	S293	S316	S418
S619	S708	S726	S900	T230	T371
T525	T565	T567-T570	T618	T800	T809
T810	W121	X486	Z100	Z148	Z152
Z155	Z165	Z191	Z845		

4.13. Service Location Indicator Codes

Effective November 1, 2013 the acceptable Service Location Indicator (SLI) codes are:

SLI Code	Description	Effective Date
HDS	**H**ospital **D**ay **S**urgery	April 1, 2006
HED	**H**ospital **E**mergency **D**epartment	April 1, 2006
HIP	**H**ospital **I**n-**P**atient	April 1, 2006
HOP	**H**ospital **O**ut-**P**atient	April 1, 2006
HRP	**H**ospital **R**eferred **P**atient	August 1, 2006
IHF	**I**ndependent **H**ealth **F**acility	July 1, 2011
OFF	**Off**ice of community physician	July 1, 2011
OTN	**O**ntario **T**elemedicine **N**etwork	January 1, 2008
PDF	**P**rivate **D**iagnostic **F**acility	November 1, 2013
RTF	**R**ehabilitation **T**reatment **F**acility	November 1, 2013

The Service Location Indicator is a “generic” field and the ministry may introduce SLI codes for other settings in the future to support data collection for planning and forecasting purposes.

Telemedicine Codes

The Service Location Indicator code “OTN” (Ontario Telemedicine Network) is required to identify telemedicine accounts to be processed by the OHIP claims payment processing system.

All accounts submitted to OHIP for telemedicine services from dentists and physicians **must** include the telemedicine SLI code which must be:

Located in field positions 59-62 of the Claim Header-1 Electronic Input Record of the billing
Left justified
Three alpha characters: OTN

The SLI code will be reported in field positions 70-73 of the Claim Header Electronic Output Record.

Diagnostic Services Fee Codes

The professional fee codes that can be billed as of April 1, 2006 by physicians for diagnostic services rendered to hospital in-patients and that require the HIP Service Location Indicator code are listed in the Schedule of Benefits for Physician Services in the following sections:

- Nuclear Medicine – In Vivo (Section B)
- Diagnostic Radiology (Section D)
- Magnetic Resonance Imaging (Section F)
- Diagnostic Ultrasound (Section G)
- Pulmonary Function Studies (Section H)
- Diagnostic and Therapeutic Procedures (Section J)

Hospital diagnostic services that will require a Service Location Indicator commencing April 1, 2006 and no later than October 1, 2006:

Hospital Diagnostic Services April 1, 2006 – October 1, 2006

A1: Nuclear Medicine – In Vivo

A2: Diagnostic Radiology

A3: Diagnostic Ultrasound

A4: Pulmonary Function Studies

A5: Magnetic Resonance Imaging

A6: Diagnostic and Therapeutic Procedures

A7: Technical Fee Codes

A1: Nuclear Medicine – in Vivo

Service Location Indicator Codes

J602C	J604C	J606C	J607C	J608C	J609C
J610C	J611C	J612C	J613C	J614C	J615C
J616C	J617C	J618C	J619C	J620C	J621C
J623C	J624C	J625C	J626C	J627C	J629C
J630C	J631C	J632C	J633C	J634C	J635C
J636C	J637C	J638C	J639C	J640C	J641C
J643C	J647C	J648C	J649C	J650C	J651C
J652C	J653C	J657C	J658C	J659C	J660C
J661C	J662C	J663C	J664C	J665C	J671C
J672C	J673C	J674C	J675C	J676C	J677C
J678C	J679C	J680C	J681C	J682C	J683C
J684C	J685C	J686C	J687C	J700C	J701C
J702C	J703C	J704C	J705C	J706C	J707C
J708C	J709C	J710C	J711C	J712C	J713C
J802C	J804C	J806C	J807C	J808C	J809C
J810C	J811C	J812C	J813C	J814C	J815C
J816C	J817C	J818C	J819C	J820C	J821C
J823C	J824C	J825C	J826C	J827C	J829C
J830C	J831C	J832C	J833C	J834C	J835C
J836C	J837C	J838C	J839C	J840C	J841C
J843C	J847C	J848C	J849C	J850C	J851C
J852C	J853C	J857C	J858C	J859C	J860C
J861C	J862C	J863C	J864C	J865C	J866C
J867C	J868C	J869C	J870C	J871C	J872C
J873C	J874C	J875C	J876C	J877C	J878C
J879C	J880C	J881C	J882C	J883C	J884C
J885C	J886C	J887C	Y602C	Y604C	Y606C
Y607C	Y608C	Y609C	Y610C	Y611C	Y612C

Y613C	Y614C	Y615C	Y616C	Y617C	Y618C
Y620C	Y621C	Y623C	Y624C	Y625C	Y626C
Y627C	Y629C	Y630C	Y631C	Y632C	Y633C
Y634C	Y635C	Y636C	Y637C	Y638C	Y639C
Y640C	Y641C	Y643C	Y647C	Y648C	Y649C
Y650C	Y651C	Y652C	Y653C	Y657C	Y658C
Y659C	Y660C	Y661C	Y662C	Y663C	Y664C
Y665C	Y667C	Y668C	Y669C	Y670C	Y671C
Y672C	Y673C	Y674C	Y675C	Y676C	Y677C
Y678C	Y679C	Y681C	Y682C	Y683C	Y684C
Y685C	Y686C	Y687C	Y802C	Y804C	Y806C
Y807C	Y808C	Y810C	Y811C	Y812C	Y813C
Y814C	Y815C	Y816C	Y817C	Y820C	Y823C
Y824C	Y825C	Y826C	Y827C	Y829C	Y830C
Y831C	Y832C	Y833C	Y836C	Y837C	Y838C
Y839C	Y840C	Y841C	Y843C	Y847C	Y848C
Y849C	Y850C	Y851C	Y852C	Y853C	Y857C
Y858C	Y859C	Y860C	Y861C	Y862C	Y864C
Y865C	Y867C	Y868C	Y869C	Y870C	Y871C
Y872C	Y873C	Y874C	Y875C	Y876C	Y877C
Y878C	Y879C	Y880C	Y881C	Y882C	Y883C
Y884C	Y885C	Y886C	Y887C		

A2: Diagnostic Radiology

Service Location Indicator Codes

X001C	X003C	X004C	X005C	X006C	X007C
X008C	X009C	X010C	X011C	X012C	X016C
X017C	X018C	X019C	X020C	X025C	X027C
X028C	X031C	X032C	X033C	X034C	X035C
X036C	X037C	X038C	X039C	X040C	X045C
X046C	X047C	X048C	X049C	X050C	X051C

X052C	X053C	X054C	X055C	X056C	X057C
X058C	X060C	X063C	X064C	X065C	X066C
X067C	X068C	X069C	X072C	X080C	X081C
X090C	X091C	X092C	X096C	X100C	X101C
X103C	X104C	X109C	X110C	X111C	
X112C	X113C	X114C	X116C	X117C	X120C
X121C	X122C	X123C	X124C	X125C	X126C
X127C	X128C	X129C	X130C	X131C	X132C
X133C	X134C	X135C	X136C	X137C	X138C
X139C	X140C	X141C	X142C	X145C	X146C
X147C	X148C	X149C	X150C	X151C	X152C
X153C	X154C	X155C	X156C	X158C	X159C
X160C	X161C	X162C	X163C	X164C	X165C
X166C	X167C	X168C	X169C	X170C	X171C
X172C	X173C	X174C	X176C	X177C	X178C
X179C	X180C	X181C	X182C	X183C	X184C
X185C	X188C	X189C	X190C	X191C	X192C
X193C	X194C	X195C	X196C	X197C	X198C
X199C	X200C	X201C	X202C	X203C	X204C
X205C	X206C	X207C	X208C	X209C	X210C
X211C	X212C	X213C	X214C	X215C	X216C
X217C	X218C	X219C	X220C	X221C	X223C
X224C	X225C	X226C	X227C	X228C	X229C
X230C	X231C	X232C	X233C	X234C	X235C
X400C	X401C	X402C	X403C	X404C	X405C
X406C	X407C	X408C	X409C	X410C	X412C
X413C	X415C	X416C	X417C		

A3: Diagnostic Ultrasound

E475	J102C	J103C	J105C	J107C	J108C
J122C	J125C	J127C	J128C	J135C	J138C
J149C	J151C	J157C	J158C	J159C	J160C
J161C	J162C	J163C	J164C	J165C	J166C
J167C	J168C	J169C	J180C	J182C	J183C
J186C	J187C	J188C	J189C	J190C	J193C
J196C	J197C	J198C	J199C	J200C	J201C
J202C	J203C	J204C	J205C	J206C	J207C
J290C	J402C	J403C	J405C	J407C	J408C
J422C	J425C	J427C	J428C	J435C	J438C
J457C	J458C	J459C	J460C	J461C	J462C
J463C	J464C	J466C	J468C	J469C	J476C
J480C	J482C	J483C	J486C	J487C	J488C
J489C	J490C	J493C	J496C	J497C	J498C
J499C	J500C	J501C	J502C	J503C	J504C
J505C	J506C	J507C			

A4: Pulmonary Function Studies

E450	E451	J301C	J303C	J304C	J305C
J306C	J307C	J308C	J309C	J310C	J311C
J313C	J315C	J316C	J317C	J318C	J319C
J320C	J322C	J323C	J324C	J327C	J330C
J331C	J332C	J333C	J334C	J335C	J336C
J340C					

A5: Magnetic Resonance Imaging (MRI)

Service Location Indicator Codes

X421C	X425C	X431C	X435C	X441C	X445C
X446C	X447C	X451C	X455C	X461C	X465C
X471C	X475C	X480C	X481C	X486C	X487C
X488C	X489C	X490C	X492C	X493C	X495C
X496C	X498C	X499C			

A6: Diagnostic and Therapeutic Procedures

Service Location Indicator Codes

G105A	G112A	G120A	G126A	G138A	G139A
G141A	G142A	G144A	G145A	G147A	G148A
G150A	G151A	G166A	G180A	G197A	G251A
G252A	G253A	G283A	G307A	G313A	G317A
G319A	G320A	G321A	G332A	G343A	G346A
G350A	G351A	G353A	G354A	G415A	G418A
G425A	G428A	G432A	G433A	G436A	G437A
G438A	G439A	G444A	G450A	G456A	G457A
G459A	G469A	G473A	G477A	G516A	G518A
G524A	G525A	G526A	G529A	G530A	G533A
G543A	G545A	G546A	G555A	G571A	G572A
G575A	G578A	G581A	G583A	G584A	G649A
G650A	G653A	G656A	G657A	G658A	G659A
G660A	G690A	G816A			

A7: Technical Fee Codes

The following technical-fee diagnostics services are **not** billable for hospital in-patient (HIP) services but can be submitted with all other SLI codes as applicable:

Service Location Indicator Codes

E450B	E451B	G104A	G111A	G121A	G127A
G140A	G143A	G146A	G149A	G152A	G153A
G167A	G174A	G181A	G209A	G284A	G308A
G310A	G311A	G315A	G414A	G440A	G441A
G442A	G443A	G448A	G451A	G455A	G466A
G471A	G519A	G540A	G541A	G542A	G544A
G554A	G560A	G570A	G574A	G582A	G685A
G647A	G648A	G651A	G652A	G654A	G655A
G682A	G683A	G684A	G685A	G686A	G687A
G688A	G689A	G694A	G695A	G815A	G850A
G851A	G852A	G853A	G854A	G855A	G856A
G857A	G858A	J102B	J103B	J105B	J107B
J108B	J122B	J125B	J127B	J128B	J135B
J138B	J149B	J157B	J158B	J159B	J160B
J161B	J162B	J163B	J164B	J165B	J166B
J167B	J168B	J169B	J180B	J182B	J183B
J190B	J193B	J196B	J197B	J198B	J199B
J200B	J201B	J202B	J203B	J204B	J205B
	J206B	J207B	J301B	J303B	J304B
J305B	J306B	J307B	J308B	J310B	J311B
J313B	J315B	J316B	J318B	J319B	J320B
J322B	J323B	J324B	J327B	J330B	J331B
J332B	J333B	J334B	J335B	J336B	J340B
J476B	J480B	J482B	J483B	J802B	J804B
J806B	J807B	J808B	J809B	J810B	J811B

J812B	J813B	J814B	J815B	J816B	J817B
J818B	J819B	J820B	J821B	J823B	J824B
J825B	J826B	J827B	J829B	J830B	J831B
J832B	J833B	J834B	J835B	J836B	J837B
J838B	J839B	J840B	J841B	J843B	J847B
J848B	J849B	J850B	J851B	J852B	J853B
J857B	J858B	J859B	J860B	J861B	J862B
J863B	J864B	J865B	J866B	J867B	J868B
J689B	J870B	J871B	J872B	J873B	J874B
J875B	J876B	J877B	J878B	J879B	J880B
J881B	J882B	J883B	J884B	J885B	J886B
J887B	J889B	J890B	J893B	J894B	J895B
J896B	J897B	J898B	J899B	J900B	J901B
X001B	X003B	X004B	X005B	X006B	X007B
X009B	X010B	X011B	X012B	X016B	X017B
X018B	X019B	X020B	X025B	X027B	X028B
X031B	X032B	X033B	X034B	X035B	X036B
X037B	X038B	X039B	X040B	X045B	X046B
X047B	X048B	X049B	X050B	X051B	X052B
X053B	X054B	X055B	X056B	X057B	X058B
X060B	X063B	X064B	X065B	X066B	X067B
X068B	X069B	X072B	X080B	X081B	X090B
X091B	X092B	X096B	X100B	X101B	X103B
X104B	X105B	X106B	X107B	X108B	X109B
X110B	X111B	X112B	X113B	X114B	X116B
X117B	X120B	X121B	X122B	X123B	X124B
X125B	X126B	X127B	X128B	X129B	X130B
X131B	X132B	X133B	X134B	X135B	X136B
X137B	X138B	X139B	X140B	X141B	X142B

X145B	X146B	X147B	X149B	X150B	X151B
X152B	X153B	X154B	X155B	X156B	X157B
X158B	X159B	X160B	X161B	X162B	X163B
X164B	X165B	X166B	X167B	X168B	X169B
X170B	X171B	X172B	X173B	X174B	X175B
X176B	X177B	X178B	X179B	X180B	X181B
X182B	X183B	X184B	X185B	X188B	X189B
X190B	X191B	X192B	X193B	X194B	X195B
X196B	X197B	X198B	X199B	X200B	X201B
X202B	X203B	X204B	X205B	X206B	X207B
X208B	X209B	X210B	X211B	X212B	X213B
X214B	X215B	X216B	X217B	X218B	X219B
X220B	X221B	X223B	X224B	X225B	X226B
X227B	X228B	X229B	X230B	Y602B	Y802B
Y804B	Y806B	Y807B	Y808B	Y810B	Y811B
Y812B	Y813B	Y814B	Y815B	Y816B	Y817B
Y820B	Y823B	Y824B	Y825B	Y826B	Y827B
Y829B	Y830B	Y831B	Y832B	Y833B	Y834B
Y836B	Y837B	Y838B	Y839B	Y840B	Y841B
Y843B	Y847B	Y848B	Y849B	Y850B	Y851B
Y852B	Y853B	Y857B	Y858B	Y859B	Y860B
Y861B	Y862B	Y864B	Y865B	Y867B	Y868B
Y869B	Y870B	Y871B	Y872B	Y873B	Y874B
Y875B	Y876B	Y877B	Y878B	Y879B	Y881B
Y882B	Y883B	Y884B	Y885B	Y886B	Y887B

4.14. MOD 10 Check Digit

To reduce the number of rejected claims, it is recommended that the health number is verified by the MOD 10 Check Digit.

Health Number Example

DIGIT POSITION	1	2	3	4	5	6	7	8	9	10
Health Number Validation	9	8	7	6	5	4	3	2	1	Check (7) Digit
Double 1st, 3rd, 5th, 7th and 9th Digits	(1+ 8)	8	(1+ 4)	6	(1+ 0)	4	6	2	2	
Add The Unit Position Numbers Across	9	8	5	6	1	4	6	2	2	**= 4**(3)

Subtract The Unit Position From Ten

10
-3
(7)

The Check Digit is (**7**) therefore the Health Number 9876543217 is valid

4.15. Province Codes and Numbering

Find a full list of Province and Territory Codes by visiting our website

4.16. Valid Payment Program/Payee Combinations

Payment Program	Payee
HCP	P
HCP	S
WCB	P
RMB	P

All other combinations are invalid.

4.16.1. Legend

Payment Program Types

HCP = Health Claims Payment

WCB = Worker's Compensation Board (Workplace Safety and Insurance Board)

RMB = Reciprocal Medical Billing

Payee Types

P = Provider

S = Patient

4.17. Workplace Safety and Insurance Board (WSIB)

Input Conditions

WSIB related medical services can be submitted to the ministry for payment under the "WCB" payment program.

The following services are excluded from WSIB (WCB) submissions:

- Service codes prefixed by T or V
- Laboratory services provided by private medical laboratory facilities (health care provider group number range 5000 – 5999)
- Services provided by hospital diagnostic departments (health care provider clinic number range 8600 – 9999)
- Services provided by OPTED-OUT health care providers

For further information, refer to Service Codes Requiring Specialized Submissions.

Chapter 5 Electronic Output Specifications for Reports

5

5. Electronic Output (EO) Specifications for Reports

5.1. Claims Batch Edit Reports

If a file is accepted, a Claims Batch Edit Report is sent to acknowledge receipt of each batch submitted. This report is sent to the user ID and notes whether or not the batch is accepted or rejected (refer to Rejection Categories). If a Batch Edit Report is not received either the ministry did not receive the file or month end processing is underway.

5.2. Remittance Advice (RA)

A remittance advice is a monthly statement of approved claims and is issued at the time of payment. The remittance advice file contains accounting details of claims approved during the ministry's previous claims processing cycle. It will also contain explanatory codes to clarify payment exceptions (refer to Remittance Advice Explanatory Codes).

The remittance advice may also contain general bulletins or messages from the ministry. The file is available in several different sort sequences, such as accounting number.

5.3. Remittance Advice Data Sequences

The remittance advice is available in 4 sequences as follows:

Sort Keys	**RA Type 4**	**RA Type 5**	**RA Type 6**	**RA Type 7**
Health Care Provider Group Number	1			1
MOH Office Code	2	1		
Patient's Last Name (not available for EO)				(3)
Health Care Provider Accounting Number	3	2		2
Health/Registration Number	4	3	1	4
Claim Number	5	4	2	5

Note:

1 = primary sort field

RA Type 4: ACCOUNTING NUMBER Sort for Health Care Provider Groups

The file is sorted by Health Care Provider within the Group. If the Health Care Provider had service encounters processed in more than one ministry office, the service encounters are further sorted by ministry Office Code. Within the above sorts, the service encounters are sorted by: Health Care Provider Accounting Number, Health/Registration Number and Service Encounter Number.

RA Type 5: ACCOUNTING NUMBER Sort for Solo Health Care Providers

If the Health Care Provider had service encounters processed in more than one ministry office, the service encounters are sorted by ministry Office Code (will be supplied by the ministry's processing system). Within the above sort, the service encounters are sorted by: Health Care Provider Accounting Number, Health/Registration Number and Service Encounter Number.

RA Type 6: HEALTH/REGISTRATION NUMBER

The file is sorted by: Health/Registration Number and Service Encounter Number.

RA Type 7: ACCOUNTING NUMBER Sort for Health Care Provider Groups

The file is sorted by Heath Care Provider within the Group. Within the above sort, the service encounters are sorted by: Health Care Provider Accounting Number, Health/Registration Number and Service Encounter Number. The sort hierarchy within the Accounting Number is: blanks, alphas, numerics.

One remittance advice file is created for each health care provider for every claims processing cycle regardless of the number of submissions within that cycle.

5.4. File Naming Convention – Remittance Advice

MCEDT

Output file will have file names in the following format:

P	Month	Group Number or Provider Number	Sequence Number

Example: PA123456.001 or PA1234.001

Field 1 P represents the output indicator

Field 2 Alpha representation for current processing cycle (e.g. A for January, B for February)

Field 3 Health care provider's registered group number or solo health care provider number

Field 4 Three digit sequence number assigned by the ministry

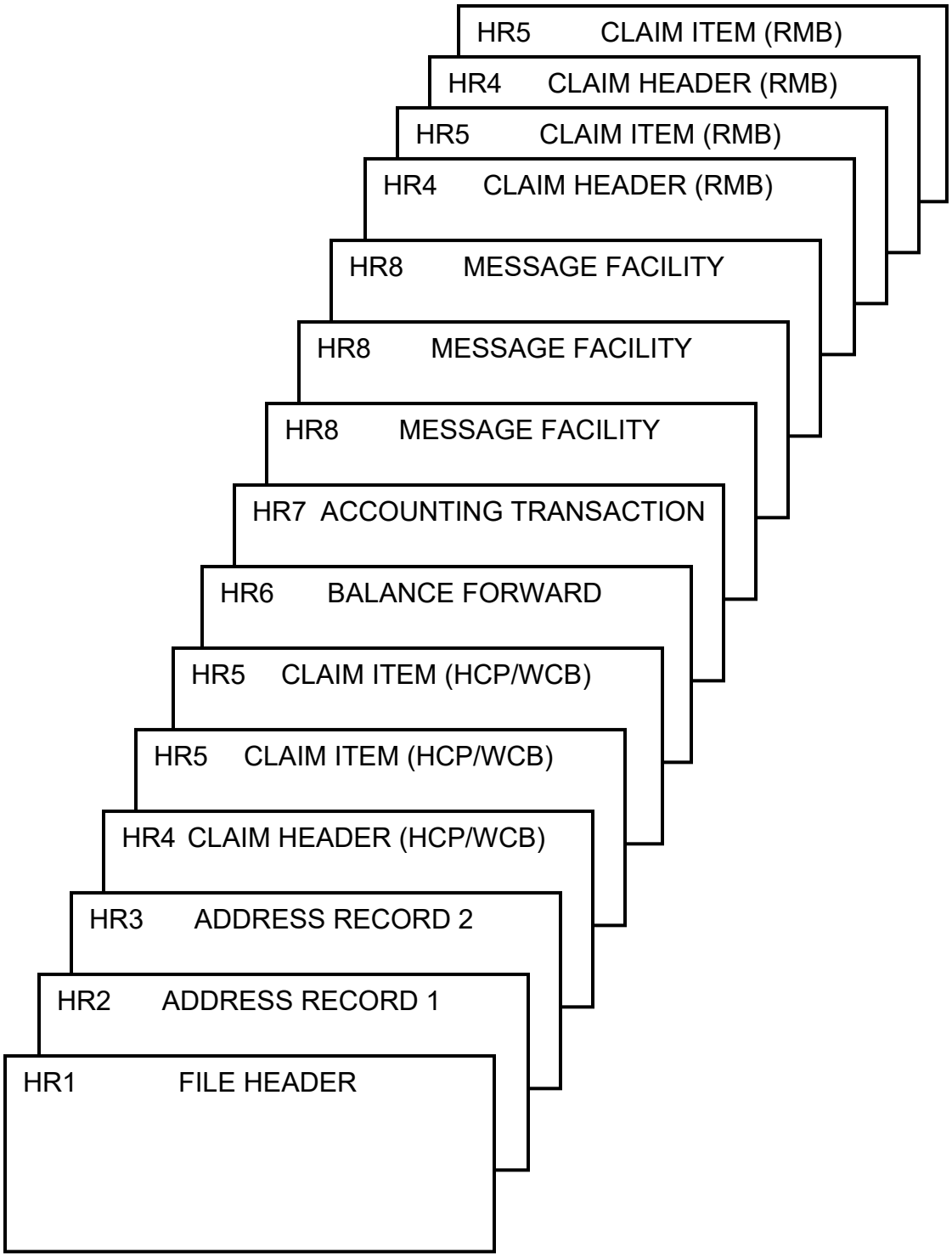
5.5. Format Summary

Record Type	Description
1	**File Header** Health care provider information
2	**Address Record 1** Name and address Line 1 of billing agent as recorded with the ministry **or** Address Line 1 of the health care provider as recorded with the ministry
3	**Address Record 2** Address Lines 2 and 3 of billing agent (if billing agent's name present in Address Record 1) or of health care provider
4	**Claim Header** Common control information for each claim
5	**Claim Item** Detailed information for each item of service within a claim (e.g. service code, service date, amounts)
6	**Balance Forward** This record is present only if the previous month's remittance was NEGATIVE. It indicates any amounts brought forward from the previous month by category (e.g. claim adjustments, advances, reductions).
7	**Accounting Transaction** This record is present only if an accounting transaction is posted to the remittance advice (e.g. advance, reduction, special payment). The sum of the fees paid for approved RMB claims will also appear as an accounting transaction.

Record Type	Description
8	**Message Facility** A facility for the ministry to send messages to all or selected health care providers. This record may or may not be present. If present, can have up to 99,999 occurrences.

Claims that are processed in the Reciprocal Medical Billing (RMB) system will be included with the regular remittance advice data. The RMB records (claim headers and items) appear at the end of the file, after all other non-RMB records.

Health Reconciliation Sample



Fixed Record Length: 79 Characters

The illustration is a visual representation of the record types outlined on the previous page to assist in understanding the record types and information contained within

5.6. Remittance Advice (RA) Record Layout

Health Reconciliation

Format Legend

A = Alphabetic

N = Numeric

X = Alphanumeric

D = Date (YYYYMMDD)

S = Spaces

Note:

All alphabetic characters will be upper-case unless otherwise stated.
The last 2 digits of all the amount fields are cents (¢¢).

Refer to EI Record Layouts for additional field description details, where applicable.

File Header Record – Health Reconciliation

Occurs **Once** in Every File – Always the **First** Record

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	A	Always ‘HR’
Record Type	3	1	X	Always ‘1’
Tech Spec Release Identifier	4	3	X	Always ‘V03’
Reserved for MOH Use	7	1	X	Always ‘0’ (zero)
Group Number or Laboratory Licence No.	8	4	X	
Health Care Provider/ Physio Facility/ Laboratory Director No.	12	6	N	
Specialty	18	2	X	A space if no HR 4/5 records, otherwise it will be numeric.
MOH Office Code	20	1	A	‘A’, ‘B’, ‘C’, ‘H’, ‘K’, ‘L’, ‘M’, ‘S’ or ‘T’
Remittance Advice Data Sequence	21	1	N	Number representing sort sequence.
Payment Date	22	8	D	Cheque or direct bank deposit date

Field Name	Field Start Position	Field Length	Format	Field Description
Payee Name	30	30	X	Name of Payee as registered with the ministry - Subdivided for solo Health Care Providers as follows: - Last Name (25) - Title (3) - Initials (2)

File Header Record – Health Reconciliation

Occurs **Once** in Every File – Always the **First** Record

Field Name	Field Start Position	Field Length	Format	Field Description
Total Amount Payable	60	9	N	Accumulation of the Amount Paid for all claim items appearing on the remittance advice Plus and/or Minus any Accounting Transactions and Balance Forward amounts.
Total Amount Payable Sign	69	1	S or X	Space if Total Amount Payable is positive. Negative (-) sign if Total Amount Payable is negative.
Cheque Number	70	8	X	Pay Provider: number of the cheque or all ‘9’s if Direct Bank Deposit. Pay Patient: spaces
Reserved for MOH Use	78	2	S	Spaces

Address Record One – Health Reconciliation

Occurs **Once** in Every File – Always the **Second** Record

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	A	Always 'HR'
Record Type	3	1	X	Always '2'
Billing Agent's Name	4	30	X	Spaces if a Billing Agent is not registered for this Health Care Provider/ group.
Address Line One	34	25	X	Address Line 1 of Health Care Provider/group or Address Line 1 of Billing Agent. As registered with the ministry.
Reserved for MOH Use	59	21	S	Spaces

Address Record Two – Health Reconciliation

Occurs **Once** in Every File – Always the **Third** Record

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	A	Always 'HR'
Record Type	3	1	X	Always '3'
Address Line 2	4	25	X	As registered with the ministry.
Address Line 3	29	25	X	As registered with the ministry.

Field Name	Field Start Position	Field Length	Format	Field Description
Reserved for MOH Use	54	26	S	Spaces

Claim Header Record – Health Reconciliation

Multiple Records – Occurs **Once for Each Claim in a File**

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	A	Always 'HR'
Record Type	3	1	X	Always '4'
Claim Number	4	11	X	Ministry reference number.
Transaction Type	15	1	N	1 (original claim) or 2 (adjustment to original claim).
Health Care Provider/ Physio Facility/ Laboratory Director No.	16	6	N	
Specialty	22	2	N	Health Care Provider's Specialty Code as on Health Encounter Claim Header-1
Accounting Number	24	8	X	Accounting number as on Health Encounter Claim Header – 1
Patient's Last Name	32	14	S or A	Spaces except for RMB claims
Patient's First Name (First five characters)	46	5	S or A	Spaces except for RMB claims.
Province Code	51	2	A	Refer to Province Codes and Numbering.

Field Name	Field Start Position	Field Length	Format	Field Description
Health Registration Number	53	12	X or S	Left justified

Claim Header Record – Health Reconciliation

Multiple Records – Occurs **Once for Each Claim in a File**

Field Name	Field Start Position	Field Length	Format	Field Description
Version Code	65	2	A or S	Version code as on Health Encounter Claim Header – 1.
Payment Program	67	3	A	Payment program as on Health Encounter Claim Header – 1.
Service Location Indicator	70	4	N or S	4 numerics or spaces Service Location Indicator (SLI) as on Health Encounter Claim Header – 1.
MOH Group Identifier	74	4	X	MOH Group Number Identifier Information for redirection to Health Care Provider.
Reserved for MOH Use	78	2	S	Spaces

Claim Item Record – Health Reconciliation

Multiple Records – Occurs **Once for Each Item in a Claim**

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	A	Always 'HR'
Record Type	3	1	X	Always '5'
Claim Number	4	11	X	Ministry reference number.
Transaction Type	15	1	N	1 (original claim) or 2 (adjustment to original claim).
Service Date	16	8	D	Service date as on Health Encounter Item Record.
Number of Services	24	2	N	Number of Services as on Health Encounter Item Record.
Service Code	26	5	X	
Reserved for MOH Use	31	1	S	Spaces
Amount Submitted	32	6	N	Amount submitted as on Health Encounter Item Record.
Amount Paid	38	6	N	
Amount Paid Sign	44	1	S or X	Space if Amount Paid is positive. Negative (-) sign if Amount Paid is negative.

Claim Item Record – Health Reconciliation

Multiple Records – Occurs **Once for Each Item in a Claim**

Field Name	Field Start Position	Field Length	Format	Field Description
Explanatory Code	45	2	X	Refer to Remittance Advice Explanatory Codes
Reserved for MOH Use	47	33	S	Spaces

Balance Forward Record – Health Reconciliation

Occurs **Once** for Each File
(only if previous month's payment was negative)

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	A	Always 'HR'
Record Type	3	1	X	Always '6'
Amount Brought Forward – Claims Adjustment	4	9	N	Field will contain a value other than zeros when the Total Remittance Payable does not exceed the total debit items for adjusted claims. The debit items are deducted from the Total Remittance Payable starting with the oldest debit. If the Total Remittance Payable is reduced to ZERO, the remaining debits are summarized and appear as a Record Type 6 (Amount Brought Forward – Claims Adjustments) on the next month's remittance. This amount is always negative.
Amount Brought Forward – Claims Adjustment Sign	13	1	S or X	Field will be a space if the Claims Adjustment field contains zeros, otherwise, it will be a negative (-) sign.

Balance Forward Record – Health Reconciliation

Occurs **Once** for Each File

(only if previous month's payment was negative)

Field Name	Field Start Position	Field Length	Format	Field Description
Amount Brought Forward – Advances	14	9	N	Field will contain a value other than zeros when a Record Type 7 (Transaction Code 10 – Advance) on a previous Remittance Advice fails to recover the full value of an advance. The Amount Brought Forward is the unrecovered amount and is always negative.
Amount Brought Forward – Advances Sign	23	1	S or X	Field will be a space if the Advances field contains zeros, otherwise it will be a negative (-) sign.
Amount Brought Forward – Reductions	24	9	N	Field will contain a value other than zeros when a Record Type 7 (Transaction Code 20 – Reduction) on a previous Remittance Advice cannot be satisfied by the Total Remittance Payable. The Amount Brought Forward is the unrecovered amount and is always negative.
Amount Brought Forward – Reductions Sign	33	1	S or X	Field will be a space if the Reductions field contains zeros, otherwise it will be a negative (-) sign.
Amount Brought Forward – Other Deductions	34	9	N	For future use (presently zero filled).
Amount Brought Forward – Other Deductions Sign	43	1	S	For future use (presently a space).
Reserved for MOH Use	44	36	S	Spaces

Note: Priority of Deductions

Claim adjustments

Advances

Reductions

Accounting Transaction Record – Health Reconciliation

Occurs **Once** for Each Accounting Transaction

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	A	Always 'HR'
Record Type	3	1	X	Always '7'
Transaction Code	4	2	X	10 – Recovery of Advance 20 – Reduction 30 – Unused 40 – Payment 50 – Estimated Payment for Unprocessed Claims 70 – Unused Refer to Accounting Transactions for Record Type 7
Cheque Indicator	6	1	X	Ministry use: M – Manual Cheque issued C – Computer Cheque issued I – Interim payment Cheque/ Direct Bank Deposit issued
Transaction Date	7	8	D	Date of transaction created
Transaction Amount	15	8	N	

Accounting Transaction Record – Health Reconciliation

Occurs **Once** for Each Accounting Transaction

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Amount Sign	23	1	S or X	A space if Transaction Amount is positive Negative (-) sign if Transaction Amount is negative
Transaction Message	24	50	S or X	Description of transaction
Reserved for MOH Use	74	6	S	Spaces

Message Facility Record – Health Reconciliation

May be present

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	A	Always ‘HR’
Record Type	3	1	X	Always ‘8’
Message Text	4	70	X	Message (contains upper case and lower case)
Reserved for MOH Use	74	6	S	Spaces

Note: If there is more than one message, they will be separated by a record containing asterisks (e.g. position 4 to 73 of one record type 8).

5.7. Accounting Transactions for Record Type 7

Transaction Code 10 – Recovery of Advance is created to:

- Recover an advance payment.

This amount is always negative and is deducted from the total remittance payable. If it exceeds the total remittance payable it is carried forward to the next month's remittance as a Record Type 6 or part of it (Amount Brought Forward - Advances) with a negative value.

Transaction Code 20 - Reduction is created when:

- A debit is required for claim items purged by the system.
- The Private Medical Laboratory Utilization Discount System requires a deduction.
- Automated estimated payment(s) are recovered.
- Other deductions as requested by various ministry branches.

This amount is always negative and is deducted from the total remittance payable. If the reduction exceeds the total remittance payable, it is carried forward to the next month's remittance as a Record Type 6 or part of it (Amount Brought Forward - Reductions) with a negative value.

Transaction Code 40 - Payment is created when:

- A capitation, premium, or administration payment is required.
- A summary payment or special payment is required.

This amount is always positive and is added to the total remittance payable. Transaction Code 40 is also used to identify RMB accounting transactions.

Transaction Code 50 Estimated Payment for Unprocessed Claims is created when:

- Claims submitted prior to cut-off do not get fully processed for payment (e.g. Automated Estimated Payments).

This amount is always positive and is added to the total remittance payable.

5.8. Remittance Advice Explanatory Codes

Find a full list of Remittance Advice Explanatory Codes by visiting our website

5.9. Generic Governance Report

A Governance Summary Report is generated monthly for all governances that are eligible to use Medical Claims Electronic Data Transfer (MCEDT).

Each of the governance will receive a Governance Summary Report that includes the name and billing number of each affiliated group and the fee for service conversion amount paid to the governance for that month.

For governances that have opted to receive their report at a solo summary level, they will receive a Governance Summary Report as well as a Governance Detail Report which provides a breakdown for each affiliated group including the name and billing number of each affiliated physician within the group and the fee for service conversion amount paid to the governance for that month.

For governances that have opted to receive their report at a group summary level, but some of their affiliated groups have opted for solo level remittance advice, they will receive the Governance Summary Report as well as a Governance Detail Report for each group with a solo level remittance advice.

The following report record layouts are for all generic governance reports including but not limited to Academic Health Science Centres (AHSC), Northern Specialists (NS), Medical Oncology (MO), and Southeastern Ontario Academic Medical Organization (SEAMO).

File Header Record

Governance Fixed Payment

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction ID	1	2	X	Always A1
Record ID Type	3	1	X	Always F
Reserved for MOH Use	4	1	X	
Governance #	5	4	X	
Reserved for MOH Use	9	16	X	
Reserved for MOH Use	9	16	X	
Governance Name	15	75	X	Name of Governance as registered.
Sign Field	90	1	X	Space if Total Amount Payable is positive. Negative (-) sign if Total Amount Payable is negative.
Monthly Payment Amount	91	11	N	Nine (9) digits to the left of the decimal and two (2) digits right of the decimal.
Reserved for MOH Use	102	5		
Reporting Date	107	6	X	Year and Month.
Tech Spec Release	113	3	X	VO1

Field Name	Field Start Position	Field Length	Format	Field Description
Reserved for MOH Use	116	20	X	

Governance Conversion Detail

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction ID	1	2	X	Always A2
Record ID Type	3	1	X	
Reserved for MOH Use	4	1	X	
Group Billing Number	5	4	X	
Solo Billing Number	9	6	X	
Full Name	15	75	X	Name of Governance.
Sign Field	90	1	X	Space if Total Amount Payable is positive. Negative (-) sign if Total Amount Payable is negative.
Conversion Payment Amount	91	11	N	Nine (9) digits to the left of the decimal and two (2) digits right of the decimal.
Conversion Percentage	102	5	N	
Approved Claims Amount Sign Field	107	1	X	Space if Total Amount Payable is positive. Negative (-) sign if Total Amount Payable is negative.
Approved Claims Amount	108	11	N	Nine (9) digits to the left of the decimal and two (2) digits right of the decimal.

Field Name	Field Start Position	Field Length	Format	Field Description
Reserved for MOH Use	119	17	X	

Governance Total Conversion Payment

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction ID	1	2	X	Always A3
Record ID Type	3	1	X	Always C
Reserved for MOH Use	4	86	X	
Sign Field	90	1	X	Space if Total Amount Payable is positive. Negative (-) sign if Total Amount Payable is negative.
Total Conversion Payment Amount	91	11	N	Nine (9) digits to the left of the decimal and two (2) digits right of the decimal.
Reserved for MOH Use	102	34	X	

Governance Total Payment

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction ID	1	2	X	Always A4
Record ID Type	3	1	X	Always T
Reserved for MOH Use	4	86	X	
Sign Field	90	1	X	Space if Total Amount Payable is positive. Negative (-) sign if Total Amount Payable is negative.
Total Payment Amount	91	11	N	Nine (9) digits to the left of the decimal and two (2) digits right of the decimal.
Reserved for MOH Use	102	34	X	

Chapter 6 Rejection Conditions

6

6. Rejection Conditions

6.1. Correction of Errors

An entire batch or file may be rejected; consequently, it is recommended that batches be maintained at a manageable size (i.e., batches should not exceed 500 claims).

Rejected individual claims/items to be corrected by the health care provider will appear on an Error Report with the appropriate error code(s). Once corrected, the claims may be resubmitted on a subsequent EI file.

6.2. Rejection Categories

Claims data in electronic input form may be subject to rejection by the ministry at three levels:

- Rejection of entire file submission
- Rejection of batch within a file
- Rejection of a claim within a batch

Warning messages will be issued when the fields designated as fillers are not spaces.

Rejection of Entire Submission

The entire unprocessed file will be returned to the originator if any of the following conditions exist:

1.1 Not an acceptable media type

1.2 Not readable

1.3 First record in the file is not a Batch Header Record

1.4 Data records not 79 bytes

1.5 Record too long / Record too short

The Claim File Reject Message identifies the file rejected and the reasons for rejection.

File reject messages are sent with a file subject of “Mail File Reject”. These messages have a filename in the following format:

X	**Month**	**File Number**	**Sequence Number**

Example: XA000001.123

Field 1 X is a constant used to identify the File Reject Message

Field 2 Alpha representation for current processing cycle

(e.g. A for January, B for February)

Field 3 Sequential six-digit file number that indicates the position of the file sending container (e.g. 000001)

Field 4 Three digit sequence number that indicates the container the file was delivered in (e.g. 123)

The File Reject Message consists of two record types of 118 characters each: M01 Message Record 1 and M02 Message Record 2.

Reject Message Record 1 (MO1) Claims File

Occurs **once** per message

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	01	X	Always 'M'
Message Reason	4	20	X	Reason for file reject
Invalid Record Length	24	05	X	Actual record length submitted
Message Type	29	03	X	Always to indicate that the first record on the file was not an HEB record
Reserved for MOH Use	32	01	X	Spaces
Filler	33	07	X	Always RECORD=
Record Image	40	37	X	First 37 characters of the first record in the rejected claims file
Reserved for MOH Use	77	42	X	Spaces

Reject Message Record 2 (MO2) Claims File

Occurs **once** per message

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	1	X	Always ‘M’
Record Identifier	2	2	X	Always ‘02’
Filler	4	5	X	Always FILE:
Provider File Name	9	12	X	The file name used to submit the file
Filler	21	5	X	Always DATE:
Mail File Date	26	8	D	Date file was uploaded to the MCEDT service, in format HHMMSS
Filler	34	5	X	Always TIME=
Mail File Time	39	6	T	Time file was uploaded to the MCEDT service in format HHMMSS
Filler	45	6	X	Always PDATE:
Process Date	51	8	D	Date file was processed by MOH in format YYYYMMDD
Reserved for MOH Use	59	60	X	Spaces

Rejection of a Batch

Batches will be rejected to the Batch Edit Report if any of the following error conditions occur:

- FIRST REC ON FILE NOT BATCH HDR
- INVALID DIST CODE ON BATCH HDR
- NO CLAIMS ENCOUNTERED ON FILE
- CLM HDR1 DOES NOT FOLLOW BATCH HEADER
- TRAILER RECORD MISSING
- BATCH HEADER MISSING
- CLM HDR2 REC NOT AFTER REC TYPE H
- TRANSACTION IDENTIFIER MUST BE HE
- RECORD IDENTIFIER MUST BE B, H, R, T, E
- INVALID COUNTS IN TRAILER RECORD
- GROUP# MISSING OR NOT ZEROS
- PROVIDER# MISSING
- GROUP/PROVIDER# BOTH MISSING OR ZEROS
- CREATION DATE INVALID OR NOT YYYYMMDD
- GROUP/PROVIDER NOT APPROVED FOR MRI
- GROUP/PROVIDER OPERATOR NUMBER INVALID
- ITEM REC NOT AFTER REC TYPE H, R OR T
- SOLO PROVIDER NOT APPROVED FOR MRI
- CLM HDR1 NOT AFTER REC TYPE B, OR T
- INVALID CREATION DATE NOT NUMERIC
- TRAILER REC NOT AFTER REC TYPE T
- CREATION DATE>SYSTEM DATE
- GROUP/PROVIDER NOT APPROVED FOR MCEDT
- UNSUPPORTED TECH SPEC REL. IDENTIFIER

Note:

Whenever a large number of claims are submitted in a single batch there is the possibility that the entire submission may reject due to any of the reasons listed above. We recommend that you attempt to maintain the batch input to a manageable size (e.g. no more than 500 claims per batch).

Claims Batch Edit Report

The Claims Batch Edit Report acknowledges receipt of each batch in a claims file and notes if the batch was accepted or rejected.

Claims Batch Edit Reports are sent with a file subject of Batch Edit. These messages have a filename in the following format.

B Month Code File Number Sequence Number

Example:	BA00001.123
Field 1	B is a constant used to identify the Claims Batch Edit Report
Field 2	Alpha representation for current processing cycle (e.g. A for January, B for February)
Field 3	Sequential five-digit batch control number assigned by the ministry (e.g. 00001)
Field 4	Three digit sequence number that indicates the container the file was delivered in (e.g. 123)

Batch Edit Report Record – Claims File

Consists of One Record Type of 132 Characters

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	X	Always 'HB'
Record Identifier	3	1	X	Always '1'
Tech. Spec Release Identifier	4	3	X	Always 'V03'
Batch Number	7	5	X	A number assigned by ministry
Operator Number	12	6	X	From batch header record
Batch Create Date	18	8	D	From batch header record format YYYYMMDD
Batch Sequence Number	26	4	X	From batch header record
Micro Start	30	11	X	Assigned by ministry: identifies the first record in a batch, blank if batch rejected

Field Name	Field Start Position	Field Length	Format	Field Description
Micro End	41	5	X	Assigned by ministry: identifies the last record in a batch, blank if batch rejected
Micro Type	46	7	X	Always 'HCP/WCB' or 'RMB'
Group Number	53	4	X	From batch header record
Provider Number	57	6	X	From batch header record

Batch Edit Report Record – Claims File

Consists of One Record Type of 132 Characters

Field Name	Field Start Position	Field Length	Format	Field Description
Number of Claims	63	5	X	Total number of claims in the batch as calculated by the ministry – see Note 1
Number of Records	68	6	X	Total number of records in the batch as calculated by the ministry
Batch Process Date	74	8	D	Date batch was processed by MOH format YYYYMMDD
Edit Message	82	40	X	'BATCH TOTALS' left justified in the field to indicate an accepted batch or blank if a sub-total line or 'R' at position 40 to indicate a rejected batch, preceded by a reason for the batch rejection – see Note 1 and Note 3
Reserved for MOH Use	122	11	X	Spaces

Note 1

Batch edit reports for accepted batches which contain both HCP/WCP and RMB claims will show three lines:

- one line with HCP/WCB totals
- one line with RMB totals
- one line with batch totals

Note 2

Record count will be zeros if it is a sub-total record**.**

Note 3

When a batch has an error, two or more records will be produced. One record for each error encountered will indicate an error message and the claim and record counts pointing to the error position within the batch. The last record will indicate 'BATCH TOTALS' with a count of the total claims and total records within the batch.

Rejection of a Claim

Claims within a batch will be rejected to the Claims Error Report for any of the following reasons:

- Missing/invalid data as per the field description specified in this manual (error code(s) prefixed with V)
- Ineligible patient/health care provider data (error code(s) prefixed with E)
- Missing/invalid data as specified in the Schedules of Benefits (error code(s) prefixed with A)

Note:

Once corrected, these claims may be resubmitted for payment on a subsequent file.

Claims Error Report

The Claims Error Report lists rejected claims, with the appropriate error codes, for correction. These claims are deleted from the ministry's system and must be corrected and resubmitted in order to be considered for payment.

Claim Error Reports will be sent with a file subject of Error Reports. These messages will have a filename in the following format.

E/F	Month Code	Provider, Group or Operator Number	Sequence Number

Example: EA123456.123 or EA1234.123 or FA123456.123

Field 1 E identifies Regular Claims Error Report

F identifies Individual Claims Error Report Extract

Field 2 Alpha representation for current processing cycle

(e.g. A for January, B for February)

Field 3 Health care provider's solo provider numbers or registered group (e.g. 123456 or 1234)

Field 4 Three digit sequence number that indicates the container the file was delivered in (e.g. 123)

The Claims Error Report consists of 6 record types of 79 characters:

HX1	Group/Provider Header Record
HXH	Claims Header 1 Record
HXR	Claims Header 2 Record (RMB claims only)
HXT	Claim Item Record
HX8	Explan Code Message Record (optional)
HX9	Group/Provider Trailer Record

Note:

- Typically there is one HX1 record per individual solo provider or one HX1 for each member of a group. The HX1 record will precede one or more rejected claim records for that individual. However, if within a group of rejected claims for a particular provider the SPECIALTY CODE changes, then another HX1 record is created to show the different specialty code.
- HXH records will be created for each claim. HXH and HXR records will be created for RMB claims.
- HXT records will be created for each item within the claim. The error report explanatory code will be added to the HXT record and HX8 records will carry the explanatory code description. From one to four HX8 message records will be present if there is an explanatory code on the item level record.
- There will only be one HX9 (trailer) record created for each unique group/provider number that appears in the file. If a provider has rejected claims under two specialties, even though there will be two HX1 records (as noted above), only one HX9 record will be produced.

Error Report Header Record (HX1)

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	X	Always ‘HX’
Record Identifier	3	1	X	Always ‘1’
Tech. Spec Release Identifier	4	3	X	Always ‘V03’
MOH Office Code	7	1	A	‘A’, ‘B’, ‘C’, ‘H’, ‘K’, ‘L’, ‘M’, ‘S’ OR ‘T’
Reserved for MOH Use	8	10	X	Spaces
Operator Number	18	6	X	From batch header
Group Number	24	4	X	From batch header
Provider Number	28	6	X	From batch header
Specialty Code	34	2	X	From batch header
Station Number	36	3	X	Ministry assigned
Claim Process Date	39	8	D	Date claim was processed
Reserved for MOH Use	47	33	X	Spaces

Error Report Claim Header 1 Record (HXH)
Multiple Records Occurs Once for Each Claim in a File

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	X	Always 'HX'
Record Identifier	3	1	X	Always 'H'
Health Number	4	10	X	From claim header
Version Code	14	2	X	From claim header
Patient Birthdate	16	8	X	From claim header
Accounting Number	24	8	X	From claim header
Payment Program	32	3	X	From claim header
Payee	35	1	X	From claim header
Referring Provider Number	36	6	X	From claim header
Master Number	42	4	X	From claim header
Patient Admission Date	46	8	X	From claim header
Referring Lab Licence	54	4	X	From claim header

Field Name	Field Start Position	Field Length	Format	Field Description
Service Location Indicator	58	4	X	From claim header
Reserved for MOH Use	62	3	X	Spaces

Error Report Claim Header 1 Record (HXH)

Multiple Records Occurs Once for Each Claim in a File

Field Name	Field Start Position	Field Length	Format	Field Description
Error Code 1	65	3	X	Refer to error code list
Error Code 2	68	3	X	Refer to error code list
Error Code 3	71	3	X	Refer to error code list
Error Code 4	74	3	X	Refer to error code list
Error Code 5	77	3	X	Refer to error code list

Error Report Claim Header 2 Record (HXR)

RMB Claims Only – Occurs Once Per Each RMB Claim

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	X	Always 'HX'
Record Identifier	3	1	X	Always 'R'
Registration Number	4	12	X	From claim header 2
Patient's Last Name	16	9	X	From claim header 2
Patient's First Name	25	5	X	From claim header 2
Patient Sex	30	1	X	From claim header 2
Province Code	31	2	X	From claim header 2
Reserved for MOH Use	33	32	X	Spaces
Patient Sex	30	1	X	From claim header 2
Province Code	31	2	X	From claim header 2
Reserved for MOH Use	33	32	X	Spaces
Patient Sex	30	1	X	From claim header 2
Province Code	31	2	X	From claim header 2

Error Report Item Record (HXT)

Multiple Records Occurs Once for Each Item in a Claim

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	X	Always 'HX'
Record Identifier	3	1	X	Always 'T'
Service Code	4	5	X	From claim item record
Reserved for MOH Use	9	2	X	Spaces
Fee Submitted	11	6	X	From claim item record
Number of Services	17	2	X	From claim item record
Service Date	19	8	X	From claim item record
Diagnostic Code	27	4	X	From claim item record
Reserved for MOH Use	31	32		Spaces
Explan Code	63	2		Error report explanation code
Error Code 1	65	3	X	Refer to error code list
Error Code 2	68	3	X	Refer to error code list
Error Code 3	71	3	X	Refer to error code list
Error Code 4	74	3	X	Refer to error code list

Field Name	Field Start Position	Field Length	Format	Field Description
Error Code 5	77	3	X	Refer to error code list

Error Report Explanation Code Message Record (HX8)

Optional – Occurs 1 to 4 Times Per Claim Item

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	X	Always ‘HX’
Record Identifier	3	1	X	Always ‘8’
Explan Code	4	2	X	Error report explanatory code
Explan Description	6	55	X	Explanatory code description
Reserved for MOH Use	61	19	X	Spaces

Error Report Trailer Record (HX9)

Occurs Once Per File or Once Per Provider for Groups

Field Name	Field Start Position	Field Length	Format	Field Description
Transaction Identifier	1	2	X	Always ‘HX’
Record Identifier	3	1	X	Always ‘9’
Header 1 Count	4	7	N	Count of HXH records
Header 2 Count	11	7	N	Count of HXR records
Item Count	18	7	N	Count of HXT records
Message Count	25	7	N	Count of HX8 records
Reserved for MOH Use	32	48	X	Spaces

Error Report Samples for Solo Providers

The following sample shows two rejected claims for the same provider. The first claim has two items. The second claim is an RMB claim that has one item.

HX1 Group/Provider Header Record
HXH Claim Header 1
HXT Claim Item
HX8 Explan Code Message Record
HX8 Explan Code Message Record
HXT Claim Item
HX8 Explan Code Message Record
HXH Claim Header 1
HXR Claim Header 2
HXT Claim Item
HX8 Explan Code Message Record
HX8 Explan Code Message Record
HX8 Explan Code Message Record
HX8 Explan Code Message Record
HX9 Group/Provider Trailer Record

Error Report Samples for Group Providers

The following sample shows three rejected claims for two different providers. The first provider has one claim that has two items. The second provider has an RMB claim with one item under one specialty and a second claim with one item under another specialty.

HX1 Group/Provider Header Record
HXH Claim Header 1
HXT Claim Item
HX8 Explan Code Message Record
HX8 Explan Code Message Record
HXT Claim Item
HX8 Explan Code Message Record
HX9 Group/Provider Trailer Record
HX1 Group/Provider Header Record
HXH Claim Header 1
HXR Claim Header 2
HXT Claim Item
HX8 Explan Code Message Record
HX8 Explan Code Message Record
HX8 Explan Code Message Record
HX8 Explan Code Message Record
HX1 Group/Provider Header Record (change in specialty)
HXH Claim Header 1
HXT Claim Item
HX8 Explan Code Message Record
HX9 Group/Provider Trailer Record

6.3. Error Report Explanatory Message Codes

Find a full list of Error Report Explanatory Codes/Error Report Messages by visiting our website

6.4. Error Report Rejection Conditions – Error Codes

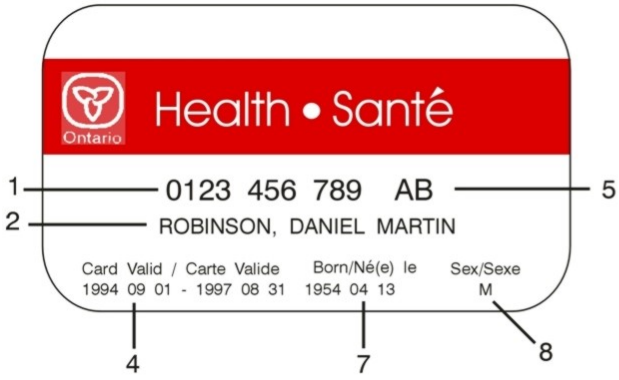
Find a full list of Error Report Rejection Conditions/Error Codes by visiting our website

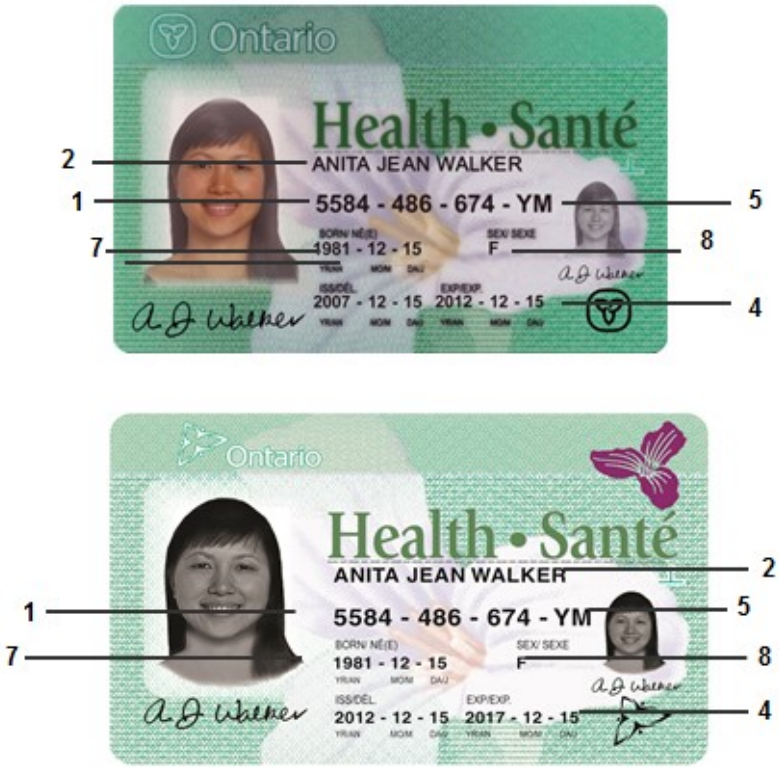
Chapter 7 Health Card Magnetic Stripe Specifications

7

7. Health Card Magnetic Stripe Specifications

7.1. Health Card Types





Health Card Magnetic Stripe Specifications

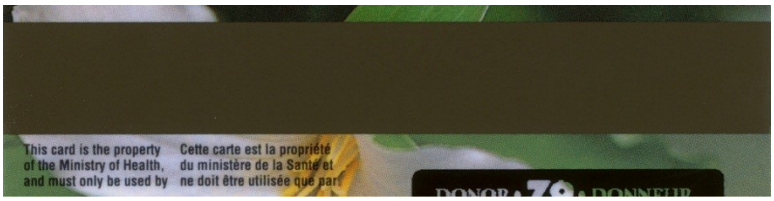
1. Health Number
2. Name
3. OHIP Number
4. Expiry date of coverage (month/year) not on all cards
5. Version Code
6. Health 65 Indicator – signifies eligibility for Ontario Drug Benefit (available only in Ontario)
7. Date of Birth
8. Sex

Cards must be signed. Red cards are signed on the back while a photo card has a digitized signature on the front.

7.2. Magnetic Stripe Specifications for Photo Health Card

Track I Recording density 210 bpi
7 bits per character, 79 alphanumeric characters

Field	Field Name	Size	Comments/Values
1	Start Sentinel	1	Value = “%”
2	Format Code	1	Value = “b”
3	Issuer Identification	6	Value = “610054"
4	Health Number	10	
5	Field Separator	1	Value = “^”
6	Name	26	As per ISO standards. Separated by “/”
7	Field Separator	1	Value = “^”
8	Expiry Date	4	YYMM or zero filled
9	Interchange Code	1	7
10	Service Code	2	Value = “99"
11	Sex	1	1 = Male 2 = Female
12	Date of Birth	8	YYYYMMDD
13	Card Version Number	2	XX (may be blank)
14	First Name-Short	5	First 5 characters of first or middle name
15	Issue Date	6	YYMMDD
16	Language Preference	2	01=EN 02=FR
17	End Sentinel	1	Value = “?”
18	Longitudinal Redundancy Check (Parity)	1	As per ISO standards



Magnetic stripe of original photo health card

Magnetic stripe of the enhanced photo health

Track II Recording density 75 bpi
5 bits per character, 40 numeric characters

Field	Field Name	Size	Comments/Values
1	Start Sentinel	1	Value = ";"
2	Issuer Identification	6	Value = "610054"
3	Health Number	10	
4	Field Separator	1	Value = "="
5	Expiry Date	4	YYMM or zero filled
6	Interchange Code	1	Value = "7"
7	Service Code	2	Value = "99
8	Filler	4	Value = "0000"
9	Card Type	1	1 = REG 2 = 65
10	OHIP Number	8	Number or "00000000"
11	End Sentinel	1	Value = "?"
12	Longitudinal Redundancy Check (Parity)	1	As per ISO standards

For the Expiry Date on Track I & II and the Issue Date on Track I the year remains as a two digit character:

- if the year is 30 or less, then the century is "20"
- if the year is greater than 30, then the century is "19"

Example

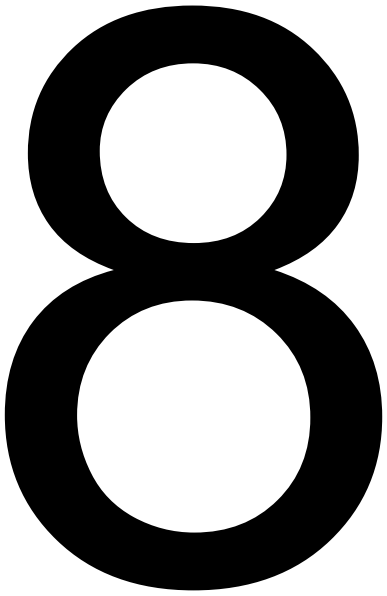
Field	Value	Calendar Date
Expiry Date	3001	= 203001
Expiry Date	2901	= 202901
Expiry Date	3101	= 193101
Issue Date	000101	= 20000101
Issue Date	980101	= 19980101
Issue Date	8901010	= 19890101

Track III Recording density 210 bpi
5 bits per 980 characters, 107 numeric characters

Field	Field Name	Size	Comments/Values
1	Start Sentinel	1	Value = ";"
2	Format Code	2	Value = "90"
3	Issuer Identification	6	Value = "610054"
4	Health Number	10	
5	Field Separator	1	Value = "="
6	Filler	85	Value = "0"
7	End Sentinel	1	Value = "?"
8	Longitudinal redundancy Check (Parity)	1	As per ISO standards

Note: Track III is reserved for possible future use.

Chapter 8 Information Management System (IMS) Connect



8. Information Management System (IMS) Connect

8.1. Information Management System Connect

The ministry upgraded the connection software to ministry applications through IMS Listener to IMS Connect.

Note to Programmers*:* It is recommended that existing IMS Connect applications and all new developments be upgraded to conform to the web enabled service technical specifications.

Please direct any questions you have for the integration of your computer system with the standardized, Internet based protocols, assertions and communication methods described in the web enabled service technical specifications by contacting the Service Support Contact Centre (SSCC) at:

1 800-262-6524

General Message Formats

- Both keyed and swiped transactions are supported.
- Health number/version code fields must be blank for card swipe transactions.
- Magnetic stripe fields must be blank for keyed transactions.
- All fields must be transmitted to the host.
- All fields are considered MANDATORY unless noted to be OPTIONAL.
- MANDATORY fields are subject to audit.
- Fields marked as OPTIONAL are not required for successful processing and must contain spaces if the desired information is unavailable.
- Date format is always YYYYMMDD.
- All data must be left justified.
- Input message character data may be either upper or lower case.
- Output message character data is returned in upper case only.

Resource Access Control Facility – Password Information

The Resource Access Control Facility (RACF) is a software security program that resides on the MOH mainframe computer and limits a user's access to specific areas of the ministry systems and transactions.

RACF limits access to the system as well as to various levels of information on the system based on a user's need.

Passwords must be changed every 35 days and there is a restriction that a password cannot be repeated within 14 occurrences.

Client systems should not perform edits on input passwords that are sensitive to the published rules (e.g. minimum length), and must provide a facility for manually entering any arbitrary password value. Failure to do so will likely render a client system unusable at some point in time.

Password Guidelines

- Organization and/or each user registered and authorized for HCV are assigned a RACF ID and an initial password by the ministry.
- Initial passwords may be up to 8 characters long.
- An initial password is issued in an expired state and clients are required to change initial passwords prior to processing any HCV transactions.
- Subsequent passwords must be 6 to 8 characters long.
- Password changes resulting from ministry reset or revocation will be up to 8 characters long.
- Passwords must be changed every 35 days.
- The system maintains a history of the last 12 passwords and these passwords will not be permitted for re-use during the next 12 password changes.
- Passwords cannot contain your RACF ID.
- If your RACF ID is HEZZXX then these letters cannot be present in your password (e.g. HEZZXX, HEZZXX01, 01HEZZXX).
- These common 3 character abbreviations cannot appear anywhere in the password (e.g. GOV, ONT, JAN, FEB).
- The first 4 characters of the new password cannot match the first 4 characters of the current password.
- The 4th – 8th characters of the new password cannot match the 4th – 8th characters of the old password (e.g. OLDPASSWORD: SPSTST NEWPASSWORD: CONTST).

- Passwords will be checked against a confidential list of passwords commonly used by computer hackers. Passwords found on the list will not be permitted.

Unsuccessful attempts to log on with a RACF ID will result in a “lock-out” from the system. A call to the Service Support Contact Centre at **1 800-262-6524** is required for a “reset”.

Note: A password reset occurs when the ministry reverts a password back to the system default password (e.g. a user forgets the current password or a RACF ID has been revoked and then re-issued).

8.1.1 TCP/IP Data Specifications for use with IMS Connect

The following instructions are for use in developing the client access portion of the application used to access the HCV service using TCP/IP over the integrated network.

TCP/IP Client Access Instructions for IMS Connect

Note: To be used in conjunction with the TCP/IP Data Specifications on the following pages: 8.13 – 8.16.

Every transaction message begins with an IRM header segment and ends with an EOM segment.

The validation message includes the Input Transaction, whereas the other two (User ID/Password Authentication and Password Change) do not.

Step	Name	Description
1	Socket	Obtain a socket descriptor.
2	Connect	Request connection to host address. Specific host name/URL to be provided during conformance testing process.
3	Write	Fill a character buffer with (in sequence): 1. The appropriate IRM header (Note 1); 2. The input transaction record (if required) (Note 2); 3. The EOM segment.
4	Read	Receive response: If a Request Status Message (RSM) is returned it means the submission was rejected, or you have used Data Specification 1 or 2, which only return RSM responses (refer to Health Card Validation Reference Manual, Appendix A - Response Codes). If an HCV Output Transaction is returned, process as you desire. If a CSM message is received, all available output has been received. If an EOM message is received, output may have been discarded - go to step 6.

Step	Name	Description
5	Repeat	Repeat IDENTIFIED VOLUME USERS ONLY: repeat process starting at step 3.
6	Close	Terminate connection and release socket resources.

Notes

1) Check the Validity of the User ID" "Change the Password of the User ID" or "send a Regular Validation Transaction".
2) Input transactions required only when a validation is being submitted.

8.1.2 TCP/IP Socket Troubleshooting

Refer to the steps below before contacting Service Support Contact Centre for assistance.

The first troubleshooting step should always be to ensure that the transaction data has been assembled correctly by referring to the IRM Header and Input Data Specification – ensure all fields are of correct width and are correctly ordered. Some troubleshooting steps are outlined below for steps 1, 2, and 3 of the TCP/IP Client Access for IMS Connect Data Specification.

Step	Symptom	Items to Check	Follow-up
1. Socket	Unable to initialize socket	Ensure: Development environment supports sockets Required libraries and modules are available in your runtime environment	Address further questions to vendor of development environment
2. Connect	Host connection fails	Ensure: Client machine has active network connection Host address and port are correctly set Host is responding (ping)	Contact your local system Administrator If client machine has active connection, and host parameters are correctly set, but ping still fails, call Service Support Contact Centre
	Host connection rejected (Note 1)	Ensure: User ID and password entered correctly, and that password has not expired (Note 2)	Change password, continue If problem persists call Service Support Contact Centre

Step	Symptom	Items to Check	Follow-up
3. Read	Return message appears to be nonsense	Ensure: Output record is being parsed correctly Correct character set is being used (IMS Connect sends and receives ASCII characters) Read buffer correctly initialized between read calls	Ensure that client application always tests type of return record
		Validation returns a response code greater than 90 indicating system problems	Refer to description in Health Card Validation Reference Manual, Appendix A – Response Codes

Notes:

If connection is rejected, host returns a 20-byte Request Status Message (RSM), documenting the source of failure. Ensure that RSMRetCode is set to “8” then evaluate the RSMReasCode to determine the source of the error
An expired password causes RSMReasCode “105”

8.1.3 IMS Connect Information

1. **Check the Validity of the User ID:** Information Management System (IMS) Request Message (IRM)

Description	Length	Notes
IRMLLLL	4 Bytes	Set to x‘00000034’ (decimal 52)
IRMLen	2 Bytes	Set to x‘002C’ (decimal 44)
IRMRsv	2 Bytes	Set to x‘0000’ (decimal zero)
IRMId	8 Bytes	*HCVREQ*
IRMTrnCod	8 Bytes	&&PWDCHK
IRMUsrID	8 Bytes	User ID assigned by Ministry of Health
IRMRsv2	8 Bytes	‘ ’ (8 blanks)
IRMPassw	8 Bytes	Password for the User ID above

2. Change the Password of the User ID: IMS Request Message (IRM)

Description	Length	Notes
IRMLLLL	4 Bytes	Set to x‘00000044’ (decimal 68)
IRMLen	2 Bytes	Set to x‘003C’ (decimal 60)
IRMRsv	2 Bytes	Set to x‘0000’ (decimal zero)
IRMRsv	2 Bytes	Set to x‘0000’ (decimal zero)
IRMId	8 Bytes	*HCVREQ*
IRMTrnCod	8 Bytes	&&PWDCHG
IRMUsrID	8 Bytes	User ID assigned by ministry
IRMRsv2	8 Bytes	‘ ’ (8 blanks)
IRMPassw	8 Bytes	Password for the User ID above
IRMNewPW	8 Bytes	A new password that is either desired or mandated by the host
IRMNwPwC	8 Bytes	A confirmation of the new password

Note:

For information on Passwords or for User IDs, refer to the Glossary.

3. Send a Regular Validation Transaction: IMS Request Message (IRM)

Description	Length	Notes
IRMLLLL	4 Bytes	Set to x‘00000101’ (decimal 257)
IRMLen	2 Bytes	Set to x‘002C’ (decimal 44)
IRMRsv	2 Bytes	Set to x‘0000’ (decimal zero)
IRMId	8 Bytes	*HCVREQ*
IRMTrnCod	8 Bytes	RPVR0300
IRMUsrID	8 Bytes	User ID assigned by Ministry of Health
IRMRsv2	8 Bytes	‘ ’ (8 blanks)
IRMPassw	8 Bytes	Password for the User ID above

4. End of Message Segment (EOM):

Description	Length	Notes
EOMLen	2 Bytes	Set to x‘0004’ decimal 4
EOMRsv	2 Bytes	Reserved (x‘0000’)

5. Completion Status Message (CSM):

Description	Length	Notes
CSMLen	2 Bytes	Will be x‘000C’ decimal 12
CSMRsv	2 Bytes	Reserved (x‘0000’)
CSMId	8 Bytes	‘*CSMOKY*’

6. Request-Status Message (RSM):

Description	Length	Notes
RSMLen	2 Bytes	Will be x‘0014’ decimal 20
RSMRsv	2 Bytes	Reserved (x‘0000’)
RSMId	8 Bytes	‘*REQSTS*’
RSMRetCod	4 Bytes	RSM Return Code*
RSMRsnCod	4 Bytes	RSM Reason Code*

If RSMRetCod has been set to 4, the RSMRsnCod may have the following values:

Info #200 The password has been successfully changed. This is only returned in response to a transaction of “&&PWDCHG”.

Info #201 Successful sign-on (User ID and password are good). This is only returned in response to a transaction of “&&PWDCHK”.

If RSMRetCod has been set to 8, the RSMRsnCod may have the following values:

Error #1 The transaction was not defined to IMS Connect.

Error #2 An IMS error occurred and the transaction was unable to be started.

Error #3 The transaction failed to perform TAKESOCKET call within the 3-minute timeframe.

Error #4 The input buffer is full, as the client has sent more than 32KB of data for an implicit transaction.

Error #5 An AIB error occurred when the IMS Connect tried to confirm if the transaction was available to be started.

Error #6 The transaction is not defined to IMS or is unavailable to be started.

Error #7 The IMS-request message (IRM) segment not in correct format.

Error #101 User ID/Password is missing.

Error #102 Invalid length of User ID/Group/Password data.

Error #103 User ID not defined to the system.

Error #104 Invalid password for this User ID.

Error #105 Password has expired.

Error #106 New password supplied is not a valid one.
Error #107 User ID does not belong to Group.
Error #108 User ID has been revoked – call the Service Support Contact Centre.
Error #109 Access to Group is revoked – call the Service Support Contact Centre.
Error #110 Authorization error.
Error #111 Internal error.
Error #112 Some other error.
Error #114 New password and confirmation of new password do not match.
Error #115 Internal error.

TCP/IP Input Transaction

*Optional fields

Description	Start	End	Length	Notes
EITHER MOH Facility ID	34	40	07	Represents the ministry issued facility or provider number. At least one of these fields must be present on all transactions. Data must be left justified and, if necessary, padded with spaces.
OR MOH Provider ID	41	50	10	Represents the ministry issued facility or provider number. At least one of these fields must be present on all transactions. Data must be left justified and, if necessary, padded with spaces.

TCP/IP Input Transaction (continued)

Description	Start	End	Length	Notes
Local User ID	51	58	08	In the case where a client is routing through another facility, the ministry assigned ID # to the client will be used (HCNP # # # #). For a single hospital or provider, this will be the ID assigned by the ministry (HECS # # # #).
Local Device ID*	59	66	08	Optionally, Local Device ID may identify where the transaction came from within a facility (e.g. Emergency Department).
Client Text*	67	86	20	Optionally, Client Text is echoed back unedited and unchanged. Recommended that the field include a unique identifier assigned to each transaction to facilitate message sequencing.
Magnetic Stripe				**(refer to** Health Card Magnetic Stripe Specifications**)**
Track 1	87	165	79	Mandatory for a card swipe transaction. Ontario health cards conform to ISO 7811/12. Data must be left justified and if necessary, padded with spaces.
Track 2	166	205	40	Mandatory for a card swipe transaction. Ontario health cards conform to ISO 7811/12. Data must be left justified and if necessary, padded with spaces.

TCP/IP Output Transaction

Description	Start	End	Length	Notes
Length	01	02	02	x‘0099’ (153)
Reserved	03	04	02	x‘0000’ (0)
Transaction Code	05	13	09	RPVR0300 followed by 1 space
Local User ID	14	21	08	

Description	Start	End	Length	Notes
Local Device ID	22	29	08	
Health Number	30	39	10	
Version Code	40	41	02	
Response Code	42	43	02	Values may be found in Health Card Validation Reference Manual, Appendix A – Response Codes At a minimum, the Response Code numbers provided in Appendix A must be echoed to the client for troubleshooting purposes
Gender Code	44	44	01	Values are M or F Values represent the data as retained on the ministry database.
Birth Date	45	52	08	Values represent the data as retained on the ministry database.
Expiry Date	53	60	08	Values represent the data as retained on the ministry database.
Client Text	61	80	20	Output as received on input.
Last Name	81	110	30	
First Name	111	130	20	
Second Name	131	150	20	
Redundant Response Code	151	152	02	Available for message delivery verification.
Carriage Return	153	153	01	Indicates the end of the output message.

8.2. GO Net TCP/IP Data Specifications for use with Information Management System (IMS) Listener

The following instructions are for accessing the HCV TCP/IP Socket Server using GONet's Multi-Protocol Router (MPR) network.

Data lengths are indicated as H (half-word - 2 bytes), F (full-word - 4 bytes), and CL8 (8 bytes).

Data Specifications

Transaction Request Message **(TRM**):

Description	Length	Notes
TRMLen	H	Binary length inclusive (high-endian) i.e. x '001C'
TRMRsv	H	Reserved (x'0000')
TRMRId	CL8	'*TRNREQ*'
TRMTrnCod	CL8	'RPVR0500'
TRMUsrID	CL8	User ID assigned by Ministry of Health.

End of Message Segment (**EOM**):

Description	Length	Notes
EOMLen	H	Binary length inclusive (high-endian) i.e. x '0004'
EOMRsv	H	Reserved (x'0000')

Completion Status Message (**CSM**):

Description	Length	Notes
CSMLen	H	Binary length inclusive (high-endian)
CSMRsv	H	Reserved
CSMId	CL8	'*CSMOKY*'

Request-Status Message (**RSM**):

Description	Length	Notes
RSMLen	H	Binary length inclusive (high-endian)
RSMRsv	H	Reserved
RSMId	CL8	'*REQSTS*'
RSMRetCod	F	RSM Return Code
REMRsnCod	F	RSM Reason Code*

*If RSMRetCod has been set to 8, RSMRsnCod may have the following values:

Error #1	The transaction was not defined to the IMS Listener.
Error #2	An IMS error occurred and the transaction was unable to be started.
Error #3	The transaction failed to perform the TAKESOCKET call within the 3 minute timeframe.
Error #4	The input buffer is full as the client has sent more than 32KB of data for an implicit transaction.
Error #5	An AIB error occurred when the IMS Listener tried to confirm if the transaction was available to be started.
Error #6	The transaction is not defined to IMS or is unavailable to be started.
Error #7	The transaction-requested message (TRM) segment was not in the correct format.
Error #101	Unauthorized user or network address
Error #102	Invalid user specification
Error #110	Authorization error

Input Transaction

Description	Status	Start	End	Length	Notes
Length	Mandatory	01	02	02	9
Reserved	Mandatory	03	04	02	10
Transaction Code	Mandatory	05	13	09	1
Health Number		14	23	10	2
Version Code		24	25	02	2
MOH User ID	Mandatory	26	33	08	3
MOH Facility ID *	Mandatory	34	40	07	4
MOH Provider ID *	Mandatory	41	50	10	4
Local User ID	Mandatory	51	58	08	5
Local Device ID	Optional	59	66	08	6
Client Text	Optional	67	86	20	7
Magnetic Stripe					
Track 1		87	165	79	8
Track 2		166	205	40	8

Notes:

1. Transaction code: enter RPVR0500 followed by a space.
2. Health Number/Version Code must be provided for a keyed transaction and omitted for a swiped transaction.
   Refer to the Message Rules for more information.
3. MOH User ID will be the authorization ID (HECSnnnn) issued by the ministry. In the case of a network provider, this will be the same for all of the networked sites.

*4. MOH Facility ID and Provider ID represent the ministry's issued values. At least one of these fields must be present on all transactions. Data must be left justified and, if necessary, padded with spaces.

5. Local User ID should contain the client's authorization ID (HECSnnnn). In the case of a network provider, this will be the ID assigned by the ministry to client of the network provider.
6. Local Device ID may identify where the transaction came from within a facility (e.g. Emergency Department).

7. Client Text is echoed back unedited and unchanged. It is recommended that the field include a unique identifier assigned to each transaction to facilitate message sequencing.
8. Track 1 and Track 2 are mandatory for a card swipe transaction. Ontario health cards conform to ISO 7811/12. Data must be left justified and, if necessary, padded with spaces.
9. Set to x‘00CD’.
10. Set to x‘0000’.

Output Transaction

Description	Start	End	Length	Notes
Length	01	02	02	9
Reserved	03	04	02	10
Transaction Code	05	13	09	1
Local User ID	14	21	08	2
Local Device ID	22	29	08	2
Health Number	30	39	10	3
Version Code	40	41	02	3
Response Code	42	43	02	4
Sex Code	44	44	01	5,6
Birth Date	45	52	08	6
Expiry Date	53	60	08	6
Client Text	61	80	20	7
Last Name	81	110	30	
First Name	111	130	20	
Second Name	131	150	20	
Redundant Response Code	151	152	02	8
Carriage Return	153	153	01	9

Notes:

1. Transaction Code: RPVR0500 followed by a space.
2. Health Number/Version Code must be provided for a keyed transaction and omitted for a swiped transaction. Refer to the Message Rules for more information.

3. MOH User ID will be the authorization ID (HECSnnnn) issued by the ministry. In the case of a network provider, this will be the same for all of the networked sites.
4. Response code values may be found in Appendix A - Response Code Descriptions.
5. Sex code values are M or F.
6. Sex code, birth date and expiry date values represent the data as retained on the ministry database.
7. Client Text will be output as received on input.
8. The Redundant Response Code is available for message delivery verification.
9. Carriage Return indicates the end of the output message.
10. Set to ‘0x0000’.

Client Procedures

1.	**SOCKET**	Obtain a socket descriptor
2.	**CON**	**NECT** Request connection to server port
3.	**WRITE**	Send transaction request message (TRM)
4.	**WRITE n times**	Send one or more Health Card Validation input transactions
5.	**WRITE**	Send EOM segment
6.	**READ**	Receive first response. If a request status message (RSM), response was rejected, go to step 8.
7.	**READ n times**	Receive a Health Card Validation output transaction unless CSM or EOM is received. If a CSM, all available output has been received. If an EOM, output may have been discarded.
8.	**CLOSE**	Terminate connection and release socket resources.

Chapter 9 Glossary

9

Glossary

Accounting Number

An eight (8) character, alpha-numeric field which may be used by the health care provider or billing agent for claim identification. If used, this identifier will be reported on the Remittance Advice (hard copy, or EDT). This may also be identified as invoice number, provider reference number or file number.

Address

A computer system location identified by a name, number, or code label. The address can be specified by the user or by a program.

ASCII File

A file that contains data made up of ASCII characters. Each byte in the file contains one character that conforms to the standard ASCII code. Program source code, DOS batch files, macros and scripts are written as straight text and stored as ASCII files.

Billing Agent

An agent authorized by a health care provider, or a group of health care providers, to prepare their claims data for processing by the ministry and/or to reconcile payment data provided by the ministry.

Communication Software

A type of software used to establish a connection and exchange data with another computer.

Facility Number

Refer to Master Number

Fee Schedule Code

The codes appearing opposite the description of insured benefits listed in the various Ministry of Health Schedules of Benefits and Facility Fee Schedule. The instructions pertaining to its use are included in the Preambles of the Schedule of Benefits. Used inter-changeably with service code.

Government of Ontario Network (GONet)

The interface designed by the Ontario Government that is used to upload and download (send/receive) files.

Group Numbers

A four (4) digit alpha-numeric ministry registration number assigned to organizations to facilitate payment consolidation.

HCP Claim

A regular in-province medical claim (includes Independent Health Facility claims).

Health Care Provider

Any provider, group, licensed laboratory, private physiotherapy facility, or independent health facility that is registered with the ministry to bill for rendering insured services.

Health Care Provider Number

The six (6) digit Ministry of Health registration number assigned to individual providers, private physiotherapy facilities, laboratory directors and independent health facility practitioners who are lawfully entitled to provide insured services.

Health Encounters

A health encounter marks the occurrence of a service by a health care provider for a patient. This service may be billable to the ministry in the format outlined in the MRI specifications section.

Health Numbers

The unique ten (10) digit individual health identification number assigned by the ministry to eligible Ontario residents.

Health Reconciliation

Health reconciliation is the Remittance Advice information supplied by the ministry in the format outlined in section 5.5, to be reconciled with claims for health encounters.

Independent Health Facility Number

A four (4) digit alpha-numeric Ministry of Health registration number identifying each Independent Health Facility (IHF).

Independent Health Facility Practitioner Number

A unique six (6) digit number issued by the Ministry of Health to identify persons lawfully entitled to provide insured services or assigned for non-medical operators of licensed Independent Health Facilities.

In-Patient Admission Date

The date of admission for in-patients to a health care facility. Previously referred to as hospital admission date.

Laboratory Director Number

The unique six (6) digit number issued by the Ministry of Health to persons lawfully entitled to provide insured services, or the unique six (6) digit number assigned for non-medical laboratory directors.

Laboratory Licence Number

Each licensed location of a laboratory facility is registered with the ministry and is assigned a four (4) digit registration number, which is the same as the licence number issued by the Laboratory and Diagnostics Branch.

Log Off

The process of terminating a connection with a computer system or peripheral device in an orderly fashion.

Log On

The process of establishing a connection with, or gaining access to, a computer system or peripheral device.

Mainframe

A multi-user computer designed to meet the computing needs of a large organization.

Manual Review Indicator

A trigger on a Health Encounter Claim Header-1 Record, used to force review by the ministry of additional documentation related to the claim.

Master Number

A four (4) digit number assigned by the ministry to identify specific health care facilities, including hospitals and sites for mobile diagnostic IHF services.

Medical Claims Electronic Data Transfer

Medical Claims Electronic Data Transfer service is a secure method of transferring electronic files to and from an authorized MCEDT user and the ministry.

Medical Consultant

A physician or dentist employed by the Ministry of Health to adjudicate complex or independent consideration (IC) claims, to institute or advise on claims payment policy, to institute and interpret the Schedule of Benefits and to liaise with health care providers and the public.

MOD 10 Check Digit

A program check that validates health numbers.

Modem

A device that allows communication between two computers through telephone lines.

Modulation

The conversion of a digital signal to its analog equivalent, especially for the purposes of transmitting signals via telecommunications.

MOH Office Code

Alpha character which represents the registered practice location of the provider as determined by the ministry.

Operator Number

A six (6) digit number assigned by the Ministry of Health to uniquely identify the processing installation used by health care providers for the EI/EO interface. Refer to Billing Agent definition for further details.

Output

A file sent from the ministry's mainframe in response to an input file.

Password

A security tool used to identify authorized users of a computer program or computer network and to define their privileges, such as: read-only, reading and writing or file copying.

Payee

Pay Provider (**P**): A provider who accepts payment for insured services directly from the ministry (OPTED-IN).

Pay Patient (**S**): A provider who accepts payment from the patient and submits a claim to the ministry on the patient's behalf (OPTED-OUT).

Payment Program

The program that is responsible for the payment of the claim (e.g. Health Claims Payment (HCP), Workers' Compensation Board (WCB) and Reciprocal Medical Billing (RMB).

Peripheral

A device, such as a printer or disk drive, connected to and controlled by a computer, but external to the computer's central processing unit (CPU).

Private Physiotherapy Facility (Number)

A six (6) digit number assigned by the ministry to a facility which has been registered by the ministry to lawfully provide publicly-funded physiotherapy services.

Protocol

A set of standards for exchanging information between two computer systems or two computer devices.

Province Code

A code that is required for reciprocal claims to identify the province of the patient's registration/address.

Reciprocal Medical Billing Claim

A service rendered by an Ontario health care provider to a patient registered with another provincial health plan.

Referring/Requisitioning Health Care Provider

The six-digit number of the health care provider who is referring a patient to another health care provider for consultation or who is requisitioning diagnostic services (e.g. laboratory tests).

Registration Number

The equivalent health number of residents registered in provinces other than Ontario.

Report

A printed output that usually is formatted with page numbers and headings.

Service Location Indicator (SLI)

An SLI is used to identify the setting of insured diagnostic services.

Specialty Codes

The two (2) numerics assigned to a provider depending on area of specialty.

TCP/IP

Transmission Control Protocol/Internet Protocol

Upload

The process of sending a file to another computer.

User Identification (User ID)

Access to the MCEDT services is restricted to authorized users with the appropriate ID and password.

Workplace Safety and Insurance Board (WSIB) Claim

A claim for a service to which WSIB benefits are applicable. This board was formerly referred to as the Workers' Compensation Board (WCB).