Technical Specifications

Interface to Health Care Systems

April 2014
Version 4.0

Ontario

Ministry of Health and Long-Term Care
Claims Services Branch
Current as of June 2015

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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.

This manual specifies the content and format of the information exchanged with the Ministry of Health and Long-Term Care (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 and Long-Term Care Service Support Contact Centre at 1 800-262-6524 or email at SSContactCentre.MOH@ontario.ca. The desk is staffed from 8:00 am to 5:00 pm, Monday to Friday. After business hours an answering service is available and your call will be returned the following business day.

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.

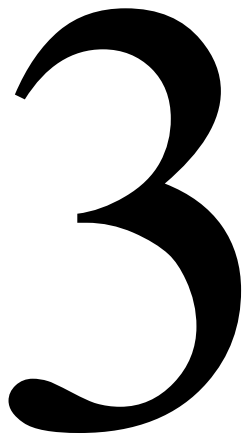
Medical Claims Electronic Data Transfer (MC EDT)

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.

MC EDT 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** http://www.health.gov.on.ca/en/pro/publications/ohip/mcedt_mn.aspx for additional information.

3. CLAIMS SUBMISSION



3. Claims Submission

3.1 Claims Submission References

Master Numbering System

http://www.health.gov.on.ca/en/common/ministry/publications/reports/master_numsys/master_numsys.aspx

Medical Claims Electronic Data Transfer Reference Manual

http://www.health.gov.on.ca/en/pro/publications/ohip/mcedt_mn.aspx

Resource Manual for Physicians

http://www.health.gov.on.ca/english/providers/pub/ohip/physmanual/physmanual_mn.html

Schedule of Benefits for Physician Services

http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html

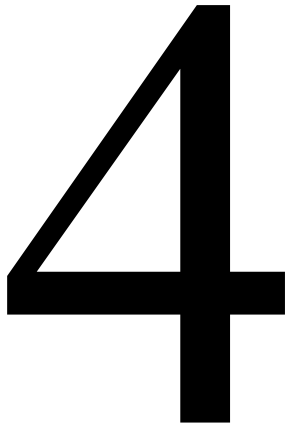
or order at: http://www.publications.gov.on.ca

Service codes requiring diagnostic codes, prior authorization or supporting documentation are located in Section 4.9 Services Requiring Diagnostic Codes and Section 4.12 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) MC EDT
    - MC EDT wsdl.zip [zip file]
- Technical Specifications for Electronic Business Services (EBS)
- Technical Specification for Health Card Validation (HCV) Service via Electronic Business Services (EBS)
    - HCV wsdl.zip [zip file]
- Technical Specifications for the Outside Use Report (Patients with Signed Consent)
- Technical Specifications Questions and Answers for Medical Claims Electronic Data Transfer (MC EDT), Health Card Validation (HCV), e-Business Services and Conformance Test

4. ELECTRONIC INPUT SPECIFICATIONS



4. Electronic Input Specifications

4.1 Media Types

MC EDT

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-I Record**

A Claim Header-I 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-I Record.

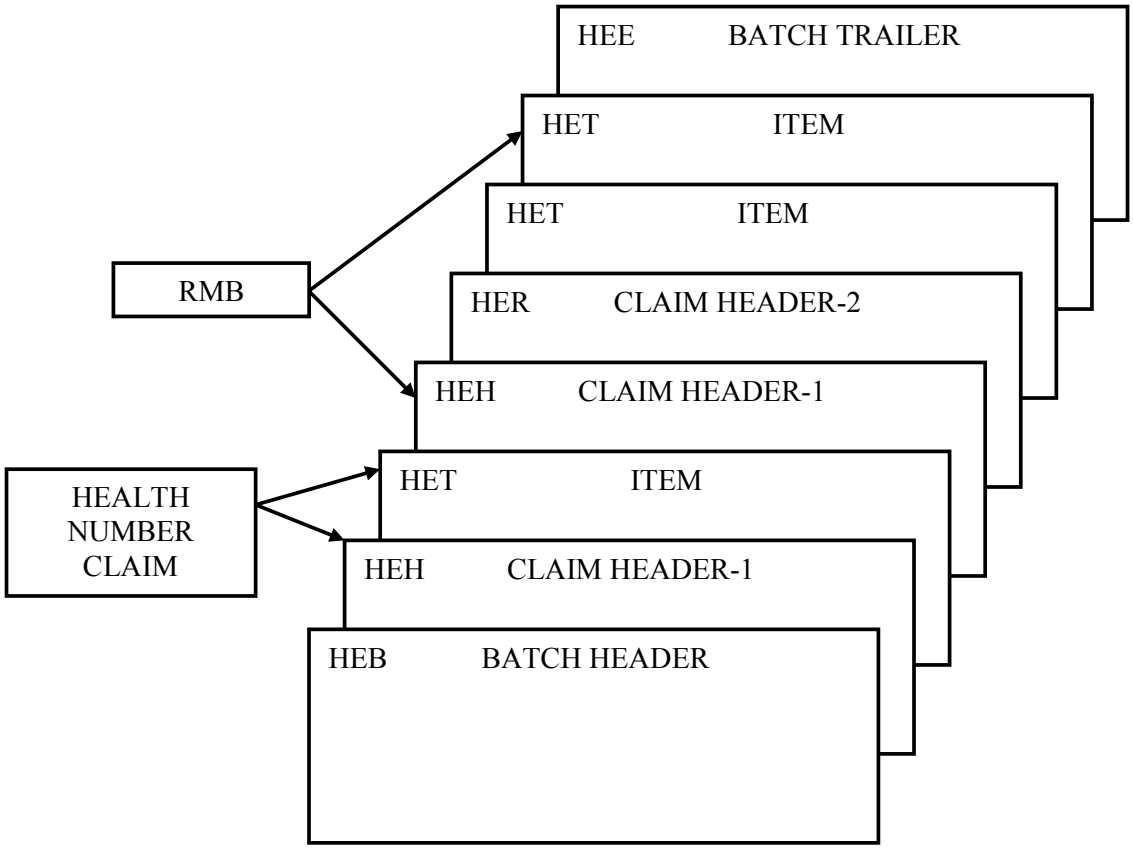
T **Item Record**

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-I Records (H), Claim Header-2 Records (R) and Item Records (T).

4.5 Batch File Submission Sample



Fixed Record Length: must be 79 Characters

4.6 Summary of Data Requirements

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

* 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 (¢¢).

4.7 Electronic Input Record Layout (continued)

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
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

continued…

4.7 Electronic Input Record Layout (continued)

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 Section 4.8 – 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'

continued…

4.7 Electronic Input Record Layout (continued)

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 Section 4.14 – 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.
Patient's Birthdate	16	8	D or S	M	▪ Required for all claims except must be blank for non-patient encounter claims.

continued…

4.7 Electronic Input Record Layout (continued)

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 Section 4.16 – 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.
Master Number	42	4	X/N	C	▪ A valid Master Number as assigned by the ministry in the current Master Numbering System book. (Section 4.10 – Fee Schedule Code Relationships). Must be present if the Service Location Indicator is HDS, HED, HIP, HOP,HRP, or RTF.

continued…

4.7 Electronic Input Record Layout (continued)

Claim Header – 1 Record – Health Encounter					
Required for All Claims					
Field Name	**Field Start Position**	**Field Length**	**Format**	**Data Req**	**Field Description**
					▪ (Section 4.13 – Service Location Indicator Codes). Not applicable to laboratory claim.
In-Patient Admission Date	46	8	D	C	▪ If present, Admission Date must be the same as or prior to Service Date (refer to Section 4.10 – 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 .
Referring Laboratory Licence Number	54	4	N	C	▪ For laboratory claims if referred. ▪ Must be Laboratory Licence Number assigned by the ministry .

continued…

4.7 Electronic Input Record Layout (continued)

Claim Header – 1 Record – Health Encounter					
Required for All Claims					
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 Section 4.12 – Service Codes Requiring Specialized Submissions)
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 Section 4.13 – Service Location Indicator Codes). ▪ Four numeric characters continue to be acceptable for non-hospital diagnostic service.

continued…

4.7 Electronic Input Record Layout (continued)

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'
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 Section 4.15 – Province Codes and Numbering).
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.
Patient's Sex	30	1	N	M	▪ '1' for Male or '2' for Female.

continued…

4.7 Electronic Input Record Layout (continued)

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 Section 4.15 – 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'

4.7 Electronic Input Record Layout (continued)

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**
Item 1					
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 Ontario 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.
Number of Services	17	2	N	M	▪ Within the range 01 to 99. ▪ Must divide into Fee Submitted evenly.

continued…

4.7 Electronic Input Record Layout (continued)

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 Section 4.9 – 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.

continued…

4.7 Electronic Input Record Layout (continued)

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**
Item 2 – Optional					
Service Code	42	5	A	M	
Reserved for MOH Use	47	2	S		
Fee Submitted	49	6	N	M	**Note:** *Field Descriptions are the same as listed under Item 1.* *All fields must be spaces if this optional Item 2 is not used.*
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		

continued…

4.7 Electronic Input Record Layout (continued)

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

Health Care Provider Specialty Codes

This is a list of specialties or disciplines recognized by the Royal College of Physicians and Surgeons of Canada relevant to services covered under the Ministry of Health and Long-Term Care.

Code	Physician
00	Family Practice and Practice In General
01	Anaesthesia
02	Dermatology
03	General Surgery
04	Neurosurgery
05	Community Medicine
06	Orthopaedic Surgery
07	Geriatrics
08	Plastic Surgery
09	Cardiovascular and Thoracic Surgery
12	Emergency Medicine
13	Internal Medicine
15	Endocrinology
16	Nephrology
17	Vascular Surgery
18	Neurology
19	Psychiatry
20	Obstetrics and Gynaecology
22	Genetics
23	Ophthalmology
24	Otolaryngology
26	Paediatrics
28	Pathology
29	Microbiology
30	Clinical Biochemistry
31	Physical Medicine
33	Diagnostic Radiology
34	Therapeutic Radiology
35	Urology
41	Gastroenterology
44	Medical Oncology
46	Infectious Diseases
47	Respiratory Diseases
48	Rheumatology
60	Cardiology
61	Hematology
62	Clinical Immunology
63	Nuclear Medicine
64	Thoracic Surgery

4.8 Specialty Codes (continued)

Code	Dental
49	Dental Surgery
50	Oral Surgery
51	Orthodontics
52	Paedodontics
53	Periodontics
54	Oral Pathology
55	Endodontics
70	Oral Radiology
71	Prosthodontics

Code	Practitioner
56	Optometry
57	Osteopathy
58	Chiropody (Podiatry)
59	Chiropractics
75	Midwife (referral only)
76	Nurse Practitioners
80	Private Physiotherapy Facility (Approved to Provide Home Treatment Only)
81	Private Physiotherapy Facility (Approved to Provide Office and Home Treatment)

Code	Other
27	Non-medical Laboratory Director (Provider Number Must Be 599993)
76	Nurse Practitioner
85	Alternate Health Care Profession
90	IHF Non-Medical Practitioner (Provider Number Must Be 991000)

4.9 Services Requiring Diagnostic Codes

Fee Schedule Codes	Exceptions
A—A	A330A, A331A, A332A, A335A, A338A, A585A, A903A, A960A, A962A, A963A, A964A, A990A, A991A, A994A, A995A, A996A, A997A, A998A
B—A	B910A, B911A, B914A-B917A
C—A	C101A, C102A - C108A, C109A, C110A, C111A, C330A, C335A, C585A, C903A, C960A - C964A, C986, C987, C989A - C997A
D—A	
E—A	E015A, E077A, E078A, E100A - E359A, E507A, E570A, E687A, E985A
F—A	
G—A	G390A, G391A, G395A, G400A - G402A, G405A - G407A, G423A, G424A, G460A, G461A, G521A - G523A, G557A - G559A, G597A - G602A, G610A, G611A, G620A, G621A, G631A, G632A, G634A, G635A, G800A - G805A, G814A, G870A - G875A, G880A
H—A	H001A, H007A, H106A, H110A, H112A, H113A, H261A, H267A, H400A - H450A, H960A - H964A, H980A - H989A
K—A	K009A, K017A, K018A, K021A, K035A, K036A, K038A, K050A - K055A, K056A, K061A, K099A, K112A, K130A - K132A, K267A, K269A, K400A, K960A - K964A, K990A - K997A, K998A, K999A
M—A	
N—A	
P—A	P001A, P002A, P003A - P008A, P016A, P018A, P020A, P025A, P030A, P041A, P042A
S—A	

4.9 Services Requiring Diagnostic Codes (continued)

Fee Schedule Codes	Exceptions
T—A	T100A - T999A
V—A	V201A - V203A, V302A - V305A, V404A - V409A, V450A, V451A, **V829A, V830A, V831A, V840A, V842A, V843A, V844A, V845A, V846A, V847A, V848A, V849A
W—A	W010A, W109A, W239A, W269A, W279A, W419A, W903A, W960A - W964A, W990A - W997A, W998A, W999A
Z—A	Z080A - Z917A, Z086A - Z099A, Z430A - Z459A, Z520A, Z540A, Z562A, Z777A

* These ranges require valid chiropractor diagnostic codes.
** These ranges require valid physiotherapy diagnostic codes.
Diagnostic Codes are detailed in the Resource Manual for Physicians, Section 4.

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 Health Care 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.	▪ Master Number ▪ Referring Health Care 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
All physiotherapy services.	▪ Referring Health Care 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.

4.10 Fee Schedule Code Relationships (continued)

Table

A – Fee Schedule Code
B – Referring/ Requisitioning Health Care Provider Number
C – Master Number
D – In-Patient Admission Date

A	B	C	D	A	B	C	D	A	B	C	D
A005A	Y	N	N	A245A	Y	N	N	A606A	Y	N	N
A006A	Y	N	N	A246A	Y	N	N	A615A	Y	N	N
A015A	Y	N	N	A265A	Y	N	N	A616A	Y	N	N
A016A	Y	N	N	A266A	Y	N	N	A625A	Y	N	N
A025A	Y	N	N	A285A	Y	N	N	A626A	Y	N	N
A026A	Y	N	N	A286A	Y	N	N	A635A	Y	N	N
A035A	Y	N	N	A315A	Y	N	N	A636A	Y	N	N
A036A	Y	N	N	A316A	Y	N	N	A645A	Y	N	N
A045A	Y	N	N	A325A	Y	N	N	A646A	Y	N	N
A046A	Y	N	N	A335A	Y	N	N	A655A	Y	N	N
A055A	Y	N	N	A345A	Y	N	N	A665A	Y	N	N
A065A	Y	N	N	A346A	Y	N	N	A667A	Y	N	N
A066A	Y	N	N	A355A	Y	N	N	A675A	Y	N	N
A075A	Y	N	N	A356A	Y	N	N	A695A	Y	N	N
A076A	Y	N	N	A365A	Y	N	N	A735A	Y	N	N
A085A	Y	N	N	A375A	Y	N	N	A745A	Y	N	N
A086A	Y	N	N	A385A	Y	N	N	A775A	Y	N	N
A095A	Y	N	N	A395A	Y	N	N	A795A	Y	N	N
A096A	Y	N	N	A405A	Y	N	N	A813A	Y	N	N
A100A	N	Y	N	A415A	Y	N	N	A815A	Y	N	N
A135A	Y	N	N	A416A	Y	N	N	A835A	Y	N	N
A136A	Y	N	N	A425A	Y	N	N	A895A	Y	N	N
A145A	Y	N	N	A435A	Y	N	N	A905A	Y	N	N
A185A	Y	N	N	A475A	Y	N	N	A933A	N	Y	Y
A186A	Y	N	N	A476A	Y	N	N	A935A	Y	N	N
A195A	Y	N	N	A485A	Y	N	N	A945A	Y	N	N
A196A	Y	N	N	A486A	Y	N	N	C002A	N	Y	Y
A197A	Y	N	N	A515A	Y	N	N	C003A	N	Y	Y
A198A	Y	N	N	A525A	Y	N	N	C004A	N	Y	Y
A205A	Y	N	N	A545A	Y	N	N	C005A	Y	Y	N
A206A	Y	N	N	A565A	Y	N	N	C006A	Y	Y	N
A215A	Y	N	N	A575A	Y	N	N	C007A	N	Y	Y
A225A	Y	N	N	A585A	Y	N	N	C008A	N	Y	Y
A226A	Y	N	N	A586A	Y	N	N	C009A	N	Y	Y
A235A	Y	N	N	A595A	Y	N	N	C010A	N	Y	Y
A236A	Y		N	A605A	Y	N	N	C012A	N	Y	Y

4.10 Fee Schedule Code Relationships (continued)

A – Fee Schedule Code
B – Referring/ Requisitioning Health Care Provider Number
C – Master Number
D – In-Patient Admission Date

A	B	C	D
C013A	N	Y	Y
C014A	N	Y	Y
C015A	Y	Y	N
C016A	Y	Y	N
C017A	N	Y	Y
C018A	N	Y	Y
C019A	N	Y	Y
C022A	N	Y	Y
C023A	N	Y	Y
C024A	N	Y	Y
C025A	Y	Y	N
C026A	Y	Y	N
C027A	N	Y	Y
C028A	N	Y	Y
C029A	N	Y	Y
C032A	N	Y	Y
C033A	N	Y	Y
C034A	N	Y	Y
C035A	Y	Y	N
C036A	Y	Y	N
C037A	N	Y	Y
C038A	N	Y	Y
C039A	N	Y	Y
C042A	N	Y	Y
C043A	N	Y	Y
C044A	N	Y	Y
C045A	Y	Y	N
C046A	Y	Y	N
C047A	N	Y	Y
C048A	N	Y	Y
C049A	N	Y	Y
C055A	Y	Y	Y
C062A	N	Y	Y
C063A	N	Y	Y
C064A	N	Y	Y
C065A	Y	Y	N
C066A	Y	Y	N
C067A	N	Y	Y

A	B	C	D
C068A	N	Y	Y
C069A	N	Y	Y
C071A	N	Y	Y
C072A	N	Y	Y
C073A	N	Y	Y
C074A	N	Y	Y
C075A	Y	Y	N
C076A	Y	Y	N
C077A	N	Y	Y
C078A	N	Y	Y
C079A	N	Y	Y
C082A	N	Y	Y
C083A	N	Y	Y
C084A	N	Y	Y
C085A	Y	Y	N
C086A	Y	Y	N
C087A	N	Y	Y
C088A	N	Y	Y
C089A	N	Y	Y
C092A	N	Y	Y
C093A	N	Y	Y
C094A	N	Y	Y
C095A	Y	Y	N
C096A	Y	Y	N
C097A	Y	Y	N
C098A	N	Y	Y
C099A	N	Y	Y
C101A	N	Y	N
C109A	N	Y	N
C110A	N	Y	N
C121A	N	Y	Y
C122A	N	Y	Y
C123A	N	Y	Y
C124A	N	Y	Y
C131A	N	Y	Y
C132A	N	Y	Y
C133A	N	Y	Y
C134A	N	Y	Y

A	B	C	D
C135A	Y	Y	N
C136A	Y	Y	N
C137A	N	Y	Y
C138A	N	Y	Y
C139A	N	Y	Y
C142A	N	Y	Y
C143A	N	Y	Y
C181A	N	Y	Y
C182A	N	Y	Y
C183A	N	Y	Y
C184A	N	Y	Y
C185A	Y	Y	N
C186A	Y	Y	N
C187A	N	Y	Y
C188A	N	Y	Y
C189A	N	Y	Y
C192A	N	Y	Y
C193A	N	Y	Y
C194A	N	Y	Y
C195A	Y	Y	N
C196A	Y	Y	N
C197A	N	Y	Y
C198A	N	Y	Y
C199A	N	Y	Y
C202A	N	Y	Y
C203A	N	Y	Y
C204A	N	Y	Y
C205A	Y	Y	N
C206A	Y	Y	N
C207A	N	Y	Y
C208A	N	Y	Y
C209A	N	Y	Y
C215A	Y	Y	Y
C225A	Y	Y	N
C226A	Y	Y	N
C232A	N	Y	Y
C233A	N	Y	Y
C234A	N	Y	Y

4.10 Fee Schedule Code Relationships (continued)

A – Fee Schedule Code
B – Referring/ Requisitioning Health Care Provider Number
C – Master Number
D – In-Patient Admission DateABCD

A	B	C	D
C235A	Y	Y	N
C236A	Y	Y	N
C237A	N	Y	Y
C238A	N	Y	Y
C239A	N	Y	Y
C242A	N	Y	Y
C243A	N	Y	Y
C244A	N	Y	Y
C245A	Y	Y	N
C246A	Y	Y	N
C247A	N	Y	Y
C248A	N	Y	Y
C249A	N	Y	Y
C250A	N	Y	Y
C262A	N	Y	Y
C263A	N	Y	Y
C264A	N	Y	Y
C265A	Y	Y	N
C266A	Y	Y	N
C267A	N	Y	Y
C268A	N	Y	Y
C269A	N	Y	Y
C283A	N	Y	Y
C285A	Y	Y	N
C286A	Y	Y	N
C288A	N	Y	Y
C311A	N	Y	Y
C312A	N	Y	Y
C313A	N	Y	Y
C314A	N	Y	Y
C315A	Y	Y	N
C316A	Y	Y	N
C317A	N	Y	Y
C318A	N	Y	Y
C319A	N	Y	Y
C325A	Y	Y	N
C335A	Y	Y	N
C341A	N	Y	Y
C342A	N	Y	Y
C343A	N	Y	Y
C344A	N	Y	Y
C345A	Y	Y	N
C346A	Y	Y	N
C347A	N	Y	Y
C348A	N	Y	Y
C349A	N	Y	Y
C352A	N	Y	Y
C353A	N	Y	Y
C354A	N	Y	Y
C355A	Y	Y	N
C356A	Y	Y	N
C357A	N	Y	Y
C358A	N	Y	Y
C359A	N	Y	Y
C365A	Y	Y	Y
C375A	Y	Y	N
C385A	Y	Y	N
C395A	Y	Y	N
C405A	Y	Y	Y
C411A	N	Y	Y
C412A	N	Y	Y
C413A	N	Y	Y
C414A	N	Y	Y
C415A	Y	Y	N
C416A	Y	Y	N
C417A	N	Y	Y
C418A	N	Y	Y
C419A	N	Y	Y
C425A	Y	Y	Y
C435A	Y	Y	N
C471A	N	Y	Y
C472A	N	Y	Y
C473A	N	Y	Y
C474A	N	Y	Y
C475A	Y	Y	N
C476A	Y	Y	N
C477A	N	Y	Y
C478A	N	Y	Y
C479A	N	Y	Y
C481A	N	Y	Y
C482A	N	Y	Y
C483A	N	Y	Y
C484A	N	Y	Y
C485A	Y	Y	N
C486A	Y	Y	N
C487A	N	Y	Y
C488A	N	Y	Y
C489A	N	Y	Y
C515A	Y	Y	N
C525A	Y	Y	N
C545A	Y	Y	N
C565A	Y	Y	N
C575A	Y	Y	N
C585A	Y	Y	N
C586A	Y	Y	Y
C595A	Y	Y	N
C601A	N	Y	Y
C602A	N	Y	Y
C603A	N	Y	Y
C604A	N	Y	Y
C605A	Y	Y	N
C606A	Y	Y	N
C607A	N	Y	Y
C608A	N	Y	Y
C609A	N	Y	Y
C611A	N	Y	Y
C612A	N	Y	Y
C613A	N	Y	Y
C614A	N	Y	Y
C615A	Y	Y	N
C616A	Y	Y	N
C617A	N	Y	Y
C618A	N	Y	Y
C619A	N	Y	Y

4.10 Fee Schedule Code Relationships (continued)

A – Fee Schedule Code
B – Referring/ Requisitioning Health Care Provider Number
C – Master Number
D – In-Patient Admission Date

A	B	C	D
C621A	N	Y	Y
C622A	N	Y	Y
C623A	N	Y	Y
C624A	N	Y	Y
C625A	Y	Y	N
C626A	Y	Y	N
C627A	N	Y	Y
C628A	N	Y	Y
C629A	N	Y	Y
C635A	Y	Y	N
C636A	Y	Y	N
C642A	N	Y	Y
C643A	N	Y	Y
C644A	N	Y	Y
C645A	Y	Y	N
C646A	Y	Y	N
C647A	N	Y	Y
C648A	N	Y	Y
C649A	N	Y	Y
C655A	Y	Y	N
C661A	N	Y	Y
C665A	Y	Y	N
C667A	Y	Y	Y
C675A	Y	Y	N
C695A	Y	Y	Y
C735A	Y	Y	N
C745A	Y	Y	N
C771A	N	Y	Y
C775A	Y	Y	Y
C777A	N	Y	Y
C795A	Y	Y	Y
C813A	Y	Y	Y
C815A	Y	Y	Y
C882A	N	Y	N
C895A	Y	Y	N
C903A	N	Y	Y
C905A	Y	Y	N
C933A	N	Y	Y
C935A	Y	Y	N

A	B	C	D
C945A	Y	Y	N
C982A	N	Y	N
C988B	N	Y	N
C989A	N	Y	N
C990A	N	Y	N
C991A	N	Y	N
C992A	N	Y	N
C993A	N	Y	N
C994A	N	Y	N
C995A	N	Y	N
C996A	N	Y	N
C997A	N	Y	N
C998B/C	N	Y	N
C999B/C	N	Y	N
E015A	Y	N	N
E101B	N	Y	N
E475A	N	Y	N
E530A	N	Y	N
G185A	N	Y	N
G400A	N	Y	N
G401A	N	Y	N
G402A	N	Y	N
G405A	N	Y	N
G406A	N	Y	N
G407A	N	Y	N
G408A	N	Y	N
G409A	N	Y	N
G412A	N	Y	N
G557A	N	Y	N
G558A	N	Y	N
G559A	N	Y	N
G600A	N	Y	N
G601A	N	Y	Y
G602A	N	Y	Y
G603A	N	Y	Y
G604A	N	Y	Y
G610A	N	Y	N
G611A	N	Y	N
G620A	N	Y	N

A	B	C	D
G621A	N	Y	N
H002A	N	Y	N
H003A	N	Y	N
H007A	N	Y	N
H055A	Y	Y	N
H065A	Y	Y	N
H101A	N	Y	N
H102A	N	Y	N
H103A	N	Y	N
H104A	N	Y	N
H105A	N	Y	N
H112A	N	Y	N
H113A	N	Y	N
H121A	N	Y	N
H122A	N	Y	N
H123A	N	Y	N
H124A	N	Y	N
H131A	N	Y	N
H132A	N	Y	N
H133A	N	Y	N
H134A	N	Y	N
H151A	N	Y	N
H152A	N	Y	N
H153A	N	Y	N
H154A	N	Y	N
H262A	N	Y	N
H263A	N	Y	N
H267A	N	Y	N
H312A	N	Y	Y
H317A	N	Y	Y
H319A	N	Y	Y
K061A	N	Y	Y
K121A	N	Y	Y
K191A	N	Y	Y
K196A	N	Y	Y
K199A	N	Y	Y
K990A	N	Y	N
K991A	N	Y	N
K992A	N	Y	N

4.10 Fee Schedule Code Relationships (continued)

A – Fee Schedule Code
B – Referring/ Requisitioning Health Care Provider Number
C – Master Number
D – In-Patient Admission Date

A	B	C	D
K993A	N	Y	N
K994A	N	Y	N
K995A	N	Y	N
K996A	N	Y	N
K997A	N	Y	N
S900C	N	Y	N
T---A	N	Y	N
U990A	N	Y	N
U991A	N	Y	N
U992A	N	Y	N
U993A	N	Y	N
U994A	N	Y	N
U995A	N	Y	N
U996A	N	Y	N
U997A	N	Y	N
V821A	Y	N	N
V822A	Y	N	N
V823A	Y	N	N
V824A	Y	N	N
V825A	Y	N	N
V826A	Y	N	N
V827A	Y	N	N
V828A	Y	N	N
V829A	Y	N	N
V830A	Y	N	N
V831A	Y	N	N
V840A	Y	N	N
W001A	N	Y	N
W002A	N	Y	N
W003A	N	Y	N
W004A	N	Y	N
W008A	N	Y	N
W010A	N	Y	N
W021A	N	Y	N
W022A	N	Y	N
W023A	N	Y	N
W025A	Y	Y	N
W026A	Y	Y	N
W028A	N	Y	N
W031A	N	Y	N
W032A	N	Y	N
W033A	N	Y	N
W035A	Y	Y	N
W036A	Y	Y	N
W038A	N	Y	N
W045A	Y	Y	N
W046A	Y	Y	N
W055A	Y	Y	N
W061A	N	Y	N
W062A	N	Y	N
W063A	N	Y	N
W065A	Y	Y	N
W066A	Y	Y	N
W068A	N	Y	N
W071A	N	Y	N
W072A	N	Y	N
W073A	N	Y	N
W074A	N	Y	N
W075A	Y	Y	N
W076A	Y	Y	N
W078A	N	Y	N
W085A	Y	Y	N
W086A	Y	Y	N
W095A	Y	Y	N
W096A	Y	Y	N
W102A	N	Y	Y
W104A	N	Y	Y
W105A	Y	Y	N
W106A	Y	Y	N
W107A	N	Y	Y
W109A	N	Y	Y
W121A	N	Y	N
W131A	N	Y	N
W132A	N	Y	N
W133A	N	Y	N
W134A	N		YN
W138A	N	Y	N
W181A	N	Y	N
W182A	N	Y	N
W183A	N	Y	N
W184A	N	Y	N
W185A	Y	Y	N
W186A	Y	Y	N
W188A	N	Y	N
W196A	Y	Y	N
W225A	Y	Y	N
W226A	Y	Y	N
W232A	N	Y	Y
W234A	N	Y	Y
W235A	Y	Y	N
W236A	Y	Y	N
W237A	N	Y	Y
W239A	N	Y	N
W261A	N	Y	N
W262A	N	Y	N
W265A	Y	Y	N
W266A	Y	Y	N
W269A	N	Y	N
W272A	N	Y	Y
W274A	N	Y	Y
W277A	N	Y	Y
W279A	N	Y	N
W305A	Y	Y	N
W306A	Y	Y	N
W310A	Y	Y	N
W311A	N	Y	N
W312A	N	Y	N
W313A	N	Y	N
W314A	N	Y	N
W318A	N	Y	N
W325A	Y	Y	N
W345A	Y	Y	N
W346A	Y	Y	N
W355A	Y	Y	N

4.10 Fee Schedule Code Relationships (continued)

A – Fee Schedule Code
B – Referring/ Requisitioning Health Care Provider Number
C – Master Number
D – In-Patient Admission Date

A	B	C	D	A	B	C	D	A	B	C	D
W356A	Y	Y	N	W535A	Y	Y	N	W795A	Y	Y	N
W375A	Y	Y	N	W536A	Y	Y	N	W872A	N	Y	Y
W385A	Y	Y	N	W564A	N	Y	Y	W882A	N	Y	N
W395A	Y	Y	N	W565A	Y	Y	N	W895A	Y	Y	N
W405A	Y	Y	N	W567A	N	Y	Y	W903A	N	Y	N
W419A	N	Y	N	W645A	Y	Y	N	W972A	N	Y	N
W435A	Y	Y	N	W646A	Y	Y	N	W982A	N	Y	N
W512A	N	Y	Y	W667A	Y	Y	N	W990A	N	Y	N
W514A	N	Y	Y	W695A	Y	Y	N	W992A	N	Y	N
W515A	Y	Y	N	W771A	N	Y	N	W994A	N	Y	N
W516A	Y	Y	N	W775A	Y	Y	N	W996A	N	Y	N
W517A	N	Y	Y	W777A	N	Y	N	Z777A	N	Y	N

Note:

1. *A referring/requisitioning Health Care Provider number is required for all claims that are billed by Independent Health Facilities that are either grandfathered, 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 and Long-Term Care 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:

C988B	C998B,C	C999B,C		
E005C	E007C	E008C	E009C	E049C
E052C	E054C	E055C	E056C	E100C
E101B	E400B,C	E401B,C	E450B,C	E451B,C
E475C	E505C	E572C	E721C	E722C
E757C	E787C	E850C	E955C	
G176B	G177B	G178B	G179B	G249B
G254B	G261B	G262B	G263B	G265B
G266B	G267B	G286B	G288B	G289B
G290B	G291B	G292B	G293B	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	Z459C

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
F130	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	Z848		

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	
HIP	**H**ospital **I**n-**P**atient	
HOP	**H**ospital **O**ut-**P**atient	
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	
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.

4.13 Service Location Indicator Codes (continued)

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:

A1: Nuclear Medicine – In Vivo	**A5: Magnetic Resonance Imaging**
A2: Diagnostic Radiology	**A6: Diagnostic and Therapeutic Procedures**
A3: Diagnostic Ultrasound	**A7: Technical Fee Codes**
A4: Pulmonary Function Studies	

4.13 Service Location Indicator Codes (continued)

A1: Nuclear Medicine – in Vivo

J602C	J640C	J686C	J823C	J865C	Y615C
J604C	J641C	J687C	J824C	J866C	Y616C
J606C	J643C	J700C	J825C	J867C	Y617C
J607C	J647C	J701C	J826C	J868C	Y618C
J608C	J648C	J702C	J827C	J869C	Y620C
J609C	J649C	J703C	J829C	J870C	Y621C
J610C	J650C	J704C	J830C	J871C	Y623C
J611C	J651C	J705C	J831C	J872C	Y624C
J612C	J652C	J706C	J832C	J873C	Y625C
J613C	J653C	J707C	J833C	J874C	Y626C
J614C	J657C	J708C	J834C	J875C	Y627C
J615C	J658C	J709C	J835C	J876C	Y629C
J616C	J659C	J710C	J836C	J877C	Y630C
J617C	J660C	J711C	J837C	J878C	Y631C
J618C	J661C	J712C	J838C	J879C	Y632C
J619C	J662C	J713C	J839C	J880C	Y633C
J620C	J663C	J802C	J840C	J881C	Y634C
J621C	J664C	J804C	J841C	J882C	Y635C
J623C	J665C	J806C	J843C	J883C	Y636C
J624C	J671C	J807C	J847C	J884C	Y637C
J625C	J672C	J808C	J848C	J885C	Y638C
J626C	J673C	J809C	J849C	J886C	Y639C
J627C	J674C	J810C	J850C	J887C	Y640C
J629C	J675C	J811C	J851C	Y602C	Y641C
J630C	J676C	J812C	J852C	Y604C	Y643C
J631C	J677C	J813C	J853C	Y606C	Y647C
J632C	J678C	J814C	J857C	Y607C	Y648C
J633C	J679C	J815C	J858C	Y608C	Y649C
J634C	J680C	J816C	J859C	Y609C	Y650C
J635C	J681C	J817C	J860C	Y610C	Y651C
J636C	J682C	J818C	J861C	Y611C	Y652C
J637C	J683C	J819C	J862C	Y612C	Y653C
J638C	J684C	J820C	J863C	Y613C	Y657C
J639C	J685C	J821C	J864C	Y614C	Y658C

continued…

4.13 Service Location Indicator Codes (continued)

Y659C	Y676C	Y810C	Y831C	Y853C	Y873C
Y660C	Y677C	Y811C	Y832C	Y857C	Y874C
Y661C	Y678C	Y812C	Y833C	Y858C	Y875C
Y662C	Y679C	Y813C	Y836C	Y859C	Y876C
Y663C	Y681C	Y814C	Y837C	Y860C	Y877C
Y664C	Y682C	Y815C	Y838C	Y861C	Y878C
Y665C	Y683C	Y816C	Y839C	Y862C	Y879C
Y667C	Y684C	Y817C	Y840C	Y864C	Y880C
Y668C	Y685C	Y820C	Y841C	Y865C	Y881C
Y669C	Y686C	Y823C	Y843C	Y867C	Y882C
Y670C	Y687C	Y824C	Y847C	Y868C	Y883C
Y671C	Y802C	Y825C	Y848C	Y869C	Y884C
Y672C	Y804C	Y826C	Y849C	Y870C	Y885C
Y673C	Y806C	Y827C	Y850C	Y871C	Y886C
Y674C	Y807C	Y829C	Y851C	Y872C	Y887C
Y675C	Y808C	Y830C	Y852C		

4.13 Service Location Indicator Codes (continued)

A2: Diagnostic Radiology

X001C	X049C	X112C	X150C	X185C	X220C
X003C	X050C	X113C	X151C	X188C	X221C
X004C	X051C	X114C	X152C	X189C	X223C
X005C	X052C	X116C	X153C	X190C	X224C
X006C	X053C	X117C	X154C	X191C	X225C
X007C	X054C	X120C	X155C	X192C	X226C
X008C	X055C	X121C	X156C	X193C	X227C
X009C	X056C	X122C	X158C	X194C	X228C
X010C	X057C	X123C	X159C	X195C	X229C
X011C	X058C	X124C	X160C	X196C	X230C
X012C	X060C	X125C	X161C	X197C	X231C
X016C	X063C	X126C	X162C	X198C	X232C
X017C	X064C	X127C	X163C	X199C	X233C
X018C	X065C	X128C	X164C	X200C	X234C
X019C	X066C	X129C	X165C	X201C	X235C
X020C	X067C	X130C	X166C	X202C	X400C
X025C	X068C	X131C	X167C	X203C	X401C
X027C	X069C	X132C	X168C	X204C	X402C
X028C	X072C	X133C	X169C	X205C	X403C
X031C	X080C	X134C	X170C	X206C	X404C
X032C	X081C	X135C	X171C	X207C	X405C
X033C	X090C	X136C	X172C	X208C	X406C
X034C	X091C	X137C	X173C	X209C	X407C
X035C	X092C	X138C	X174C	X210C	X408C
X036C	X096C	X139C	X176C	X211C	X409C
X037C	X100C	X140C	X177C	X212C	X410C
X038C	X101C	X141C	X178C	X213C	X412C
X039C	X103C	X142C	X179C	X214C	X413C
X040C	X104C	X145C	X180C	X215C	X415C
X045C	X108C	X146C	X181C	X216C	X416C
X046C	X109C	X147C	X182C	X217C	X417C
X047C	X110C	X148C	X183C	X218C	
X048C	X111C	X149C	X184C	X219C	

continued…

4.13 Service Location Indicator Codes (continued)

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					

4.13 Service Location Indicator Codes (continued)

A5: Magnetic Resonance Imaging (MRI)

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

G105A	G112A	G120A	G126A	G138A	G139A
G141A	G142 A	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			

4.13 Service Location Indicator Codes (continued)

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:

E450B	G455A	G815A	J161B	J304B	J406B
E451B	G466A	G850A	J162B	J305B	J407B
G104A	G519A	G851A	J163B	J306B	J408B
G111A	G540A	G852A	J164B	J307B	J422B
G121A	G542A	G853A	J165B	J308B	J425B
G140A	G544A	G854A	J180B	J310B	J427B
G143A	G554A	G855A	J182B	J311B	J428B
G146A	G560A	G856A	J183B	J313B	J435B
G149A	G566A	G857A	J190B	J315B	J438B
G152A	G570A	G858A	J191B	J316B	J457B
G167A	G574A	J102B	J192B	J318B	J458B
G174A	G577A	J103B	J193B	J319B	J459B
G181A	G651A	J105B	J194B	J320B	J460B
G209A	G652A	J106B	J195B	J322B	J461B
G284A	G654A	J107B	J196B	J323B	J462B
G308A	G655A	J108B	J197B	J324B	J463B
G310A	G661A	J122B	J198B	J327B	J464B
G311A	G682A	J125B	J200B	J330B	J476B
G315A	G683A	J127B	J201B	J331B	J480B
G414A	G684A	J128B	J202B	J332B	J482B
G416A	G685A	J135B	J203B	J333B	J483B
G440A	G686A	J138B	J204B	J334B	J490B
G441A	G687A	J149B	J205B	J335B	J491B
G442A	G688A	J157B	J206B	J340B	J492B
G443A	G689A	J158B	J207B	J402B	J493B
G448A	G692A	J159B	J301B	J403B	J494B
G451A	G693A	J160B	J303B	J405B	J495B

continued…

4.13 Service Location Indicator Codes – Technical Fee Codes (continued)

J496B	J618B	J649B	J674B	J811B	J841B
J497B	J619B	J650B	J675B	J812B	J843B
J498B	J620B	J651B	J676B	J813B	J847B
J500B	J621B	J652B	J677B	J814B	J848B
J501B	J623B	J653B	J678B	J815B	J849B
J502B	J624B	J654B	J679B	J819B	J850B
J503B	J625B	J655B	J680B	J820B	J851B
J504B	J626B	J656B	J681B	J821B	J852B
J505B	J627B	J657B	J682B	J823B	J853B
J506B	J629B	J658B	J683B	J824B	J854B
J507B	J630B	J659B	J684B	J825B	J855B
J602B	J631B	J660B	J685B	J826B	J856B
J604B	J632B	J661B	J686B	J827B	J857B
J606B	J633B	J662B	J687B	J829B	J858B
J607B	J634B	J663B	J688B	J830B	J859B
J608B	J635B	J664B	J689B	J831B	J860B
J609B	J636B	J665B	J690B	J832B	J861B
J610B	J637B	J666B	J691B	J833B	J862B
J611B	J638B	J667B	J802B	J834B	J863B
J612B	J639B	J668B	J804B	J835B	J864B
J613B	J640B	J669B	J806B	J836B	J865B
J614B	J641B	J670B	J807B	J837B	J866B
J615B	J643B	J671B	J808B	J838B	J873B
J616B	J647B	J672B	J809B	J839B	J874B
J617B	J648B	J673B	J810B	J840B	J875B

continued…

4.13 Service Location Indicator Codes – Technical Fee Codes (continued)

J876B	X010B	X053B	X109B	X144B	X181B
J877B	X011B	X054B	X110B	X147B	X182B
J878B	X012B	X055B	X111B	X149B	X183B
J879B	X016B	X056B	X112B	X150B	X184B
J880B	X017B	X057B	X113B	X151B	X185B
J881B	X018B	X058B	X114B	X152B	X186B
J882B	X019B	X060B	X116B	X153B	X187B
J883B	X020B	X063B	X117B	X154B	X189B
J884B	X025B	X064B	X120B	X155B	X190B
J885B	X027B	X065B	X121B	X156B	X191B
J886B	X033B	X066B	X122B	X157B	X192B
J887B	X034B	X067B	X123B	X158B	X193B
J888B	X035B	X068B	X129B	X159B	X194B
J889B	X036B	X069B	X130B	X160B	X195B
J890B	X037B	X072B	X131B	X161B	X196B
J891B	X038B	X080B	X132B	X162B	X197B
J893B	X039B	X081B	X133B	X169B	X198B
J894B	X040B	X090B	X134B	X170B	X199B
X001B	X045B	X091B	X135B	X171B	X200B
X003B	X046B	X092B	X136B	X173B	X201B
X004B	X047B	X096B	X137B	X174B	X202B
X005B	X048B	X100B	X138B	X175B	X203B
X006B	X049B	X101B	X139B	X176B	X204B
X007B	X050B	X103B	X140B	X177B	X205B
X008B	X051B	X104B	X141B	X179B	X206B
X009B	X052B	X105B	X143B	X180B	X207B

continued…

4.13 Service Location Indicator Codes – Technical Fee Codes (continued)

X208B	Y612B	Y647B	Y677B	Y824B	Y860B
X209B	Y613B	Y648B	Y678B	Y825B	Y861B
X210B	Y614B	Y649B	Y679B	Y826B	Y862B
X211B	Y615B	Y650B	Y680B	Y827B	Y863B
X212B	Y616B	Y651B	Y681B	Y829B	Y864B
X213B	Y617B	Y652B	Y682B	Y830B	Y865B
X214B	Y618B	Y653B	Y683B	Y833B	Y867B
X215B	Y620B	Y654B	Y684B	Y834B	Y868B
X216B	Y621B	Y655B	Y685B	Y835B	Y869B
X217B	Y623B	Y656B	Y686B	Y836B	Y870B
X218B	Y624B	Y657B	Y687B	Y837B	Y871B
X219B	Y625B	Y658B	Y688B	Y838B	Y872B
X220B	Y626B	Y659B	Y802B	Y839B	Y873B
X221B	Y627B	Y660B	Y804B	Y840B	Y874B
X223B	Y628B	Y661B	Y806B	Y841B	Y875B
X224B	Y629B	Y662B	Y807B	Y843B	Y876B
X225B	Y630B	Y663B	Y808B	Y847B	Y877B
X226B	Y631B	Y664B	Y810B	Y848B	Y878B
X227B	Y632B	Y665B	Y811B	Y849B	Y879B
X228B	Y633B	Y667B	Y812B	Y850B	Y880B
X229B	Y634B	Y668B	Y813B	Y851B	Y881B
X230B	Y635B	Y669B	Y814B	Y852B	Y882B
Y602B	Y636B	Y670B	Y815B	Y853B	Y883B
Y604B	Y637B	Y671B	Y816B	Y854B	Y884B
Y606B	Y638B	Y672B	Y817B	Y855B	Y885B
Y607B	Y639B	Y673B	Y818B	Y856B	Y886B
Y608B	Y640B	Y674B	Y820B	Y857B	Y887B
Y610B	Y641B	Y675B	Y821B	Y858B	Y888B
Y611B	Y643B	Y676B	Y823B	Y859B	

continued…

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

4.15 Province Codes and Numbering

Province	Prov Code	Format
Alberta	AB	9 numerics-individual registration (Effective Oct. 1/94)
British Columbia	BC	10 numerics-individual registration (Effective Jan. 1/91)
Manitoba	MB	9 numerics- individual registration (Effective Apr 1/2005)
Newfoundland/Labrador	NL	12 numerics-individual registration
New Brunswick	NB	9 numerics-individual registration
Northwest Territories	NT	8 character-individual registration ONE alpha – N, D, M or T and 7 numerics
Nova Scotia	NS	10 numerics-individual registration (Effective Jan. 1/94)
Ontario	ON	10 numerics-individual registration plus 2 character version code (if applicable) (Effective Jan. 1/91)
Prince Edward Island	PE	8 numerics-individual registration (Effective Dec. 1/96)
Saskatchewan	SK	9 numerics-individual registration (Effective Apr. 1/91)
Territory of Nunavut	NU	9 numerics-individual registration
Yukon	YT	9 numerics-individual registration

Note: *The Province of Quebec does not participate fully in the Reciprocal Medical Billing System. Claims for Quebec residents cannot be submitted on Electronic Input.*

4.16 Valid Payment Program/Payee Combinations

Payment Program	Payee
HCP	P
HCP	S
WCB	P
RMB	P
All other combinations are invalid.	

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 Section 4.12 – Service Codes Requiring Specialized Submissions.

5. ELECTRONIC OUTPUT SPECIFICATIONS FOR REPORTS

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 Section 6.2 – 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 Section 5.8 – 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
MOHLTC Office Code	2	1		
Patients 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

5.3 Remittance Advice Data Sequences (continued)

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

MC EDT

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

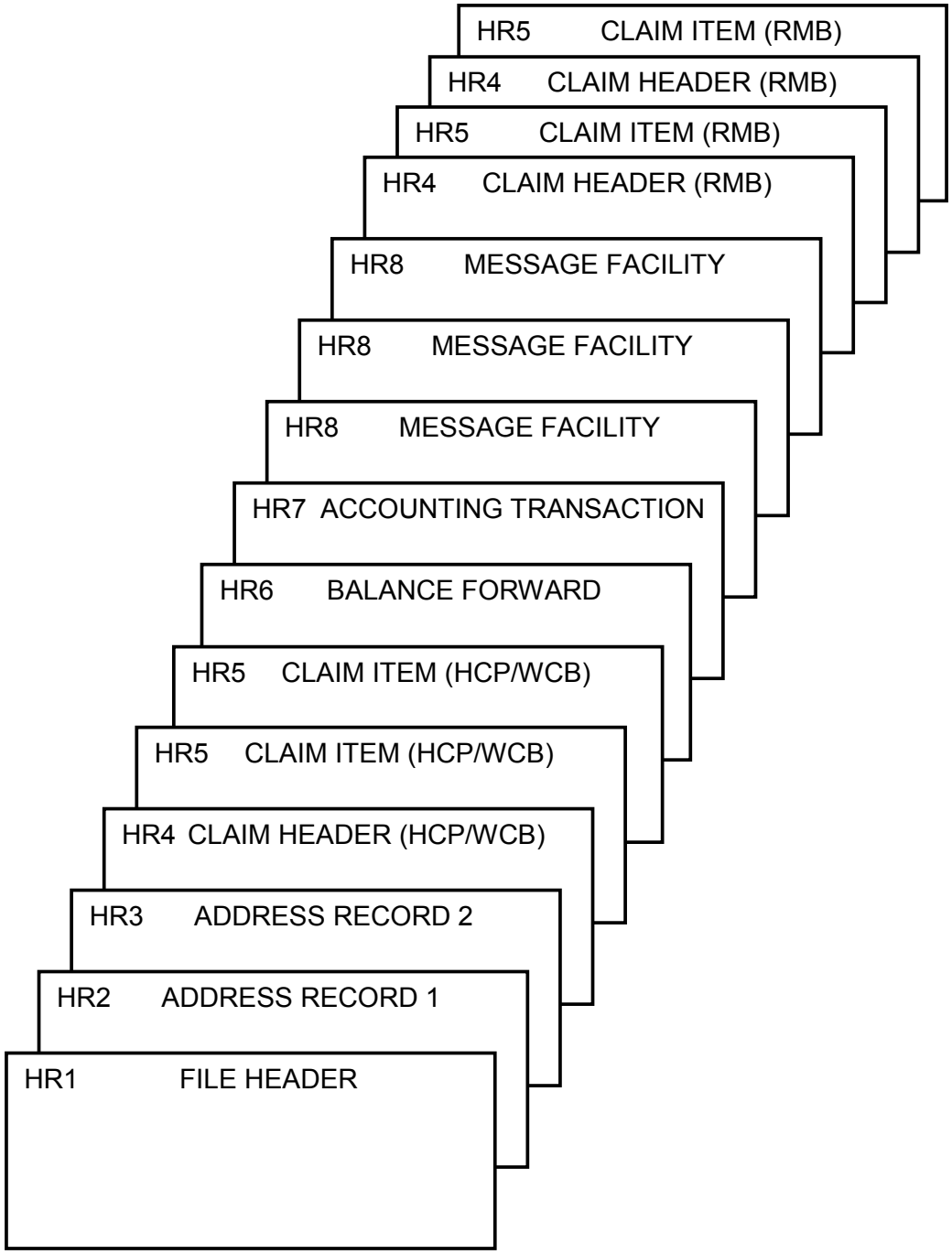
5.5 Format Summary

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.
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.

5.5 Format Summary (continued)

Health Reconciliation Sample



Fixed Record Length: 79 Characters

5.6 Remittance Advice (RA) Record Layout

Health Reconciliation

Format Legend

A = Alphabetic

N = Numeric

X = Alphanumeric

D = Date (YYYYMMDD)

S = Spaces

Notes:

All alphabetic characters will be upper-case unless otherwise stated. The last 2 digits of all the amount fields are cents (¢¢). Refer to Section 4.7 – EI Record Layouts *for additional field description details, where applicable.*

5.6 RA Record Layout (continued)

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
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)

continued…

5.6 RA Record Layout (continued)

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

continued…

5.6 RA Record Layout (continued)

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

continued…

5.6 RA Record Layout (continued)

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.
Reserved for MOH Use	54	26	S	▪ Spaces

continued…

5.6 RA Record Layout (continued)

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 Section 4.15 –Province Codes and Numbering.
Health Registration Number	53	12	X or S	▪ Left justified

continued…

5.6 RA Record Layout (continued)

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

continued…

5.6 RA Record Layout (continued)

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.
Explanatory Code	45	2	X	▪ Refer to Section 5.8 –Remittance Advice Explanatory Codes
Reserved for MOH Use	47	33	S	▪ Spaces

continued…

5.6 RA Record Layout (continued)

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.
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.

continued…

5.6 RA Record Layout (continued)

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 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*** *1. Claim adjustments* *2. Advances* 3. *Reductions*

continued…

5.6 RA Record Layout (continued)

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 Section 6.6 – 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	
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

continued…

5.6 RA Record Layout (continued)

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

Eligibility

EA Service date is not within an eligible period - services provided on or after the 20th of this month will not be paid unless eligibility status changes

EV Check health card for current version

EF Incorrect version code - services provided on or after the 20th of this month will not be paid unless the current version code is provided

E1 Service date is prior to start of eligibility

E2 Incorrect version code for service date

E4 Service date is after the eligibility termination date

E5 Service date is not within an eligible period

J7 Claim submitted six months after service date

GF Coverage lapsed - bill patient for future claims

General

09 Fee Schedule Code(s) used is not correct – resubmit using appropriate code(s) from OHIP Schedule of Benefits

16 Premium not applicable

30 This service is not a benefit of the ministry

32 Ministry records show that this service has already been claimed for payment to the patient

35 Ministry records show this service rendered by you has been claimed previously

36 Ministry records show this service has been rendered by another practitioner, group, lab

37 Effective April, 1993 the listed benefit for this code is 0 LMS units

40 This service or related service allowed only once for same patient

41 FSC billed – no evidence in supporting documentation provided

42 FSC billed included in other procedure

46 Paid per 2nd review by MA

47 Not paid per 2nd review by MA

48 Paid as submitted - clinical records may be requested for verification purposes

49 Paid according to the average fee for this service - independent consideration will be given if clinical records/operative reports are presented

50 Fee allowed according to the appropriate item in the current ministry Schedule of Benefits for Physician Services

51 Fee Schedule Code changed in accordance with Schedule of Benefits

5.8 Remittance Advice Explanatory Codes (continued)

52 Fee for service assessed by medical consultant

53 Fee allowed according to appropriate item in a previous ministry Schedule of Benefits

54 Interim payment claim under review

55 This deduction is an adjustment on an earlier account

56 Claim under review

57 This payment is an adjustment on an earlier account

58 Claimed by another physician within your group

59 Health Care Provider's notification - WCB claims

61 OOC claim paid at greater than $9999.99 (prior approval on file)

62 Claim assessed by assessment officer

65 Service included in approved hospital payment

68 Hospital accommodation paid at standard ward rate

69 Elective services paid at 75% of insured costs

70 OHIP records show corresponding procedure(s)/visit(s) on this day claimed previously

80 Technical fee adjustment for hospitals and IHFs

AH Not allowed in addition to health exam

AP This payment is in accordance with legislation-if you disagree with the payment you may appeal

EB Additional payment for the claim shown

IA Services billed are not eligible for premium

I2 Service is globally funded

J3 Approved for stale date processing

MR – Minimum service requirements have not been met

Q8 Laboratory not licensed to perform this test on date of service

SR Fee reduced based on ministry utilization adjustment - contact your physician/ practitioner

TH Fee reduced per ministry Payment Policy - contact your physician

5.8 Remittance Advice Explanatory Codes (continued)

Consultations and E-Assessments

C1 Allowed as repeat/limited consultation/midwife-requested emergency assessment

C2 Allowed at reassessment fee

C3 Allowed at minor assessment fee

C4 Consultation not allowed with this service - paid as assessment

C5 Allowed as multiple systems assessment

C6 Allowed as Type 2 Admission Assessment

C7 An admission assessment C003A or general re-assessment C004A may not be claimed by any physician within 30 days following a pre-dental/pre-operative assessment

C8 Payment reduced to geriatric consultation fee – maximum number of comprehensive geriatric consultations has been reached

C9 Allowed as in-patient interim admission orders – initial assessment already claimed by other physician

KA K-prefix time based service paid in the 30 day period following the e-assessment

UA E-Assessment with same diagnosis paid in previous 60 days. Claim reduced to specific/partial assessment

UK E-Assessment paid within the previous 30 days – fee reduced

UV Visit other than a specific/partial assessment with same diagnosis paid within 60 days following the e-assessment

Critical Care

G1 Other critical/comprehensive care already paid

Dental Services

T1 Fee allowed according to surgery claim

Diagnostic and Therapeutic Procedures

D1 Allowed as repeat procedure; initial procedure previously claimed

D2 Additional procedures allowed at 50%

D3 Not allowed in addition to visit fee

D4 Procedure allowed at 50% with visit

D5 Procedure already allowed - visit fee adjusted

D6 Limit of payment for this procedure reached

D7 Not allowed in addition to other procedure

D8 Allowed with specific procedures only

D9 Not allowed to a hospital department

5.8 Remittance Advice Explanatory Codes (continued)

DA Maximum for this procedure reached - paid as repeat/chronic procedure

DB Other dialysis procedure already paid

DC Procedure paid previously not allowed in addition to this procedure - fee adjusted to pay the difference

DD Not allowed as diagnostic code is unrelated to original major eye exam

DE Laboratory tests already paid - visit fee adjusted

DF Corresponding fee code has not been claimed or was approved at zero

DG Diagnostic/miscellaneous services for hospital patients are payable on a fee-for-service basis - included in hospital global budget

DH Ventilatory support allowed with Haemodialysis

DL Allowed as laboratory test in private office

DM Paid/disallowed in accordance with MOH policy regarding an Emergency Department Equivalent

DN Allowed as pudendal block in addition to procedure as per stated policy

DP Procedure paid previously allowed at 50% in addition to this procedure - fee adjusted to pay the difference

DS Not allowed – mutually exclusive code billed

DT In-patient technical fee not allowed

DV Service is included in Monthly Management Fee for Long-Term Care Patients

DW Procedure paid previously not allowed in addition to monthly management for long-term care patients, fee adjusted to pay the difference

DX Diagnostic code not eligible with FSC

Fractures

F1 Additional fractures/dislocations allowed at 85%

F2 Allowed in accordance with transferred care

F3 Previous attempted reductions (open or closed) allowed at 85%

F5 Two weeks aftercare included in fracture fee

F6 Allowed as Minor/Partial Assessment

Health Examinations

R1 Only one health exam allowed in a 12-month period

Hospital Visits

H1 Admission assessment or ER assessment already paid

H2 Allowed as subsequent visit; initial visit previously claimed

H3 Maximum fee allowed per week after 5th week

5.8 Remittance Advice Explanatory Codes (continued)

H4 Maximum fee allowed per week after 6th week to paediatricians

H5 Maximum fee allowed per month after 13th week

H6 Allowed as supportive or concurrent care

H7 Allowed as chronic care

H8 Master number and/or admission date required for in-hospital service

H9 Concurrent care already claimed by another doctor

HA Admission assessment claimed by another physician - hospital visit fee applied

HB Subsequent visit already paid same day

HF Concurrent or Supportive Care already claimed in period

HM Invalid master number used on date of service

Independent Health Facilities (IHF) Explanatory Codes

FF Additional payment for the claim shown

I2 Service is globally funded

I3 FSC is not on the IHF licence profile for the date specified

I4 Records show this service has been rendered by another practitioner, group or IHF

I5 Service is globally funded and FSC is not on IHF licence profile

I6 Premium not applicable

I7 Claim date does not match patient enrolment date

I8 Confirmation not received

I9 Payment not applicable/expired

Laboratory

L1 This service paid to another laboratory

L2 Not allowed to non-medical laboratory director

L3 Not allowed in addition to this laboratory procedure

L4 Not allowed to attending physicians

L5 Not allowed in addition to other procedure paid to another laboratory

L6 Procedure paid previously to another laboratory, not allowed in addition to this procedure - fee adjusted to pay difference

L7 Not allowed - referred specimen

L8 Not to be claimed with prenatal/fetal assessment as of July 1, 1993

L9 Laboratory services for hospital in-patients are not payable on a fee-for-service basis-included in the hospital global budget

5.8 Remittance Advice Explanatory Codes (continued)

LA Lab service is funded by special lab agreement

LS Paid in accordance to Special Lab Agreement

Maxima

M1 Maximum fee allowed or maximum number of services has been reached same/any provider

M2 Maximum allowance for radiographic examination(s) by one or more practitioners

M3 Maximum fee allowed for prenatal care

M4 Maximum fee allowed for these services by one or more practitioners has been reached

M5 Monthly maximum has been reached

M6 Maximum fee allowed for special visit premium - additional patient seen

MA Maximum number of sessions has been reached

MC Maximum of 2 patient case conferences has been reached in a 12-month period

ME Maximum number of e-assessments paid

MN Maximum allowable for sleep studies in a 12-month period by one physician has been reached

MO Maximun number of OCT services has been reached

MS Maximum allowable for sleep studies in a 12 month period by one physician has been reached

MU Maximum units exceeded

MX Maximum of 2 arthroscopy ‘R’ codes with E595 has been reached

Obstetrics

O1 Fee for obstetric care apportioned

O2 Previous prenatal care already claimed

O3 Previous prenatal care already claimed by another doctor

O4 Office visits relating to pregnancy and claimed prior to delivery included in obstetric fee

O5 Not allowed in addition to delivery

O6 Medical induction/stimulation of labour allowed once per pregnancy

O7 Allowed as subsequent prenatal visit. Initial prenatal visit already claimed

O8 Allowed once per pregnancy

O9 Not allowed in addition to post-natal care

5.8 Remittance Advice Explanatory Codes (continued)

Office and Home Visits

V1 Allowed as repeat assessment - initial assessment previously claimed

V2 Allowed as extra patient seen in the home

V3 Not allowed in addition to procedural fee

V4 Date of service was not a Saturday, Sunday, or a statutory holiday

V5 Only one oculo-visual assessment (OVA) allowed within a 12-month period for age 19 and under or 65 and over and one within 24 months for age 20-64

V6 Allowed as minor assessment - initial assessment already claimed

V7 Allowed at medical/specific reassessment fee

V8 This service paid at lower fee as per stated ministry policy

V9 Only one initial office visit allowed within 12-month period

VA Procedure fee reduced. Consultation/visit fees not allowed in addition

VB Additional OVA is allowed once within the second year for patients aged 20-64, following a periodic OVA

VC Procedure paid previously not allowed in addition to visit fee. Fee adjusted to pay the difference

VG Only one geriatric general assessment premium per patient per 12-month period

VM Oculo-visual minor assessment is allowed within 12 consecutive months following a major eye exam

VP Allowed with specific visit only

VS Date of service was a Saturday, Sunday or statutory holiday

VX Complexity Premium not applicable to visit fee

Paediatric Care

P2 Maximum fee allowed for low-birth weight care

P3 Maximum fee allowed for newborn care

P4 Fee for newborn/low-birth weight care is not billable with neonatal intensive care

P5 Over-age for paediatric rates of payment

P6 Over-age for well baby care

Radiology

X2 G.I. tract includes cine and video tape

X3 G.I. tract includes survey film of abdomen

X4 Only one BMD allowed within a 24 month period for a low risk patient

5.8 Remittance Advice Explanatory Codes (continued)

X5 Only one bone mineral density allowed within 12 months for a high risk patient

X6 Only one bone mineral density allowed within 60 months for a low risk patient

Reciprocal Medical Billing (RMB)

60 Not a benefit of RMB agreement

RD Duplicate, paid by RMB

Surgical Procedures

S1 Bilateral surgery, one stage, allowed at 85% higher than unilateral

S2 Bilateral surgery, two stage, allowed at 85% higher than unilateral

S3 Second surgical procedure allowed at 85%

S4 Procedure fee reduced when paid with related surgery or anaesthetic

S5 Not allowed in addition to major surgical fee

S6 Allowed as subsequent procedure-initial procedure previously claimed

S7 Normal pre-operative and post-operative care included in surgical fee

S9 Initial procedure not found

SA Surgical procedure allowed at consultation fee

SB Normal pre/post-operative visit(s) included in surgical fee - visit fee previously paid-surgical fee adjusted

SC Not allowed major pre-operative visit already claimed

SD Not allowed-team/assist fee already claimed

SE Major pre-operative visit previously paid and admission assessment previously paid - surgery fee reduced by the admission assessment

SF MRP visit not allowed during post-operative period, surgical fee adjusted

SM Multiple surgical assist. Documentation of separate surgeries same day/same patient required

SV MRP visit not allowed during post-operative period, fee reduced to subsequent visit fee

SW ICU per diem code paid to another physician-MRP subsequent visit reduced to subsequent visit

SX – ICU per diem code paid to another physician – MRP premium not allowed

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 (MC EDT).

Each 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 (AHCS), 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	
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
Reserved for MOH Use	116	20	X	

continued…

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.
Reserved for MOH Use	119	17	X	

continued…

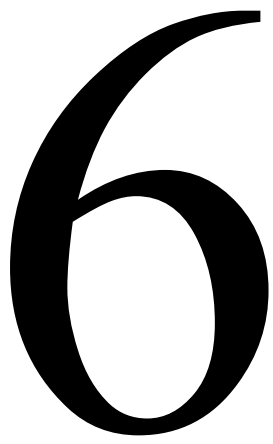
Governance Total Conversion Payment

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	

6. REJECTION CONDITIONS



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

6.2 Rejection Categories (continued)

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.

6.2 Rejection Categories (continued)

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

continued…

6.2 Rejection Categories (continued)

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

6.2 Rejection Categories (continued)

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).*

6.2 Rejection Categories (continued)

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 Claims Batch Acknowledgement. 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)

6.2 Rejection Categories (continued)

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
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

continued…

6.2 Rejection Categories (continued)

Batch Edit Report Record – Claims Batch

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

continued…

6.2 Rejection Categories (continued)

Batch Edit Report Record – Claims Batch				
Consists of One Record Type of 132 Characters				
				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.*

6.2 Rejection Categories (continued)

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 Benefit (error code(s) prefixed with A)

Note: *Once corrected, these claims may be resubmitted for payment on a subsequent file. Corrected claims must be submitted within six months from the date of service.*

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 Claims Error Report. 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)

6.2 Rejection Categories (continued)

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.

6.2 Rejection Categories (continued)

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

continued…

6.2 Rejection Categories (continued)

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
Service Location Indicator	58	4	X	▪ From claim header
Reserved for MOH Use	62	3	X	▪ Spaces

continued…

6.2 Rejection Categories (continued)

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

continued…

6.2 Rejection Categories (continued)

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
Patients Last Name	16	9	X	▪ From claim header 2
Patients 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
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

continued…

6.2 Rejection Categories (continued)

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
Error Code 5	77	3	X	▪ Refer to error code list

continued…

6.2 Rejection Categories (continued)

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

continued…

6.2 Rejection Categories (continued)

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

continued…

6.2 Rejection Categories (continued)

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

6.2 Rejection Categories (continued)

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 Codes

Explanatory Codes/Messages for Use on Re-Routed Electronic Input Claims

The following explanatory codes/messages are used for routing internally rejected EI claims to the Providers' Error Report.

Explanatory Code	Message to Error Report
03	Date of Service does not match OP report – correct and resubmit
04	Special Visit premium payable only when submitted with FSC from the general listings
05	No receipt of supporting documentation requested by MOH
10	Resubmit as RMB claim
11	Bill patient or Quebec medicare
12	Advise patient to contact the ministry re: eligibility/card status
13	Service date is prior to newborn's date of birth
14	Fee billed low - check for current SOB fee
15	No. of services exceed maximum allowed
16	Cannot be claimed alone/service date mismatch
17	E409/E410 N/A - resubmit with appropriate assist/anaesthetic premium codes
18	Resubmit with manual review indicator, submit letter from surgeon explaining medical necessity for two assistants and OP report
19	Resubmit with manual review indicator and forward copy of OP Report
20	Resubmit with manual review documentation
21	Records indicate patient deceased - clarify or confirm
22	Code submitted requires prior approval

continued…

6.3 Error Report Explanatory Codes (continued)

Explanatory Code	Message to Error Report
23	Hospital visits claimed by more than one physician - clarify role in patient's care
24	Claims appearing on previous remittance advice(s) as over/under payments should not be resubmitted - use inquiry form for payment adjustment requests
25	Incomplete newborn registration - have parent/guardian contact the ministry
26	One house call assessment (A901) allowed per visit - resubmit claim with appropriate service code
27	Claim previously submitted and currently under review
28	Resubmit with manual review indicator with written explanation for detention, total time spent with patient including consultation/assessment indicated

6.4 Error Report Rejection Conditions – Error Codes

The following error rejection conditions/ error codes will be reported on the Claims Error Report.

General

Error	Reason(s) for Rejection
AC1	Maximum reached-resubmit alternate fee schedule code
AC4	▪ A valid Referring/Requisitioning Health Care Provider number must be present for this service code ▪ The fee schedule code is C813, C815 and the referral number is not in the Midwife range (700000-722899) ▪ Referring number is 299999 and lab FSC is not in the L700-L899 range ▪ Referring number is 722900-744292 (Nurse Practitioner) and the billing provider is not a lab (5000 series)
AD9	Premium not allowed alone
AHF	CON/SUP Care Same Period. Corresponding Procedure Invalid, Omitted or Paid at zero.
AH8	In-Patient Admission Date and/or Master Number are missing and are required for this service code
ADF	Corresponding Procedure Invalid, Omitted or Paid at Zero
AMR	Minimum service requirements not met
ARF	Missing referring physician number
ARP	Referring physician number required
ASP	Not allowed with surgical procedure
A2A	Patient is outside of age limit
A2B	This service is not normally performed for this gender - please check your records
A3E	No such service code for date of service
A3F	No fee exists for this service code on this date of service
A3G	Fee Billed Low – Check
A3J	Fee Outside Accept Range
A3L	Other new patient fee already paid
A34	Multiple duplicate claims
A4D	Invalid specialty for this service code

continued…

6.4 Error Report Rejection Conditions – Error Codes (continued)

Error	Reason(s) for Rejection
A34	Multiple duplicate claims
A4D	Invalid specialty for this service code
CNA	Counselling is not allowed same day as previously paid assessment/procedure
DF	Corresponding Procedure Invalid, Omitted or Paid at Zero
EH1	Service date is not within an eligible period
EH2	PCN billing not approved
EH3	VC not found
EH4	Patient not rostered/rostered to another PCN
EH5	Roster/HRR payment discrepancy
EH6	Eligible term – deceased
EH9	Eligible term – no response
ENP	Invalid service for Nurse Practitioner
EPA	▪ Patient not eligible for program
EPC	▪ Solo or affiliated Health Care Provider is not registered with the ministry
EPF	Enrolment date mismatch
EPP	Incorrect code for eligible person. Person not eligible for program indicated but is eligible for other program
EPS	Patient not eligible for program
EP1	Enrolment transfer not allowed
EP2	Not for enrolment/re-enrolment
EP3	Check service date/enrolment date
EP4	Enrolment restriction
EP5	Incorrect service for group type
EP6	Health number not activated

continued…

6.4 Error Report Rejection Conditions – Error Codes (continued)

Error	Reason(s) for Rejection
EQB	▪ Group Number is not actively registered with the ministry on this date of Service ▪ Health Care Provider is not registered with the ministry as an affiliate of this Group on this date of service
EQC	Group not registered with ministry
EQD	Group inactive on service date
EQE	Practitioner not in group on service date
EQF	Health care provider is not actively registered with the ministry as an affiliate of this group on date of service
EQG	Referring laboratory is not registered with the ministry
EQJ	Practitioner not eligible on service date
EQK	MNI doesn't meet criteria
EQL	Physician not eligible to claim
EQM	Not registered for use
EQN	REG use error on service date
EQP	Enrolment type not eligible
EQS	Practitioner criteria not met
EQ1	Clinic not on file
EQ2	Specialty mismatch
EQ3	▪ Health Care Provider is registered as OPTED-IN for date of service ▪ Claim submitted as Pay Patient
EQ4	▪ Health Care Provider is registered as OPTED-OUT for date of service. ▪ Claim submitted as Pay Provider
EQ5	Laboratory Licence number not actively registered with the ministry on this date of service
EQ6	Referring Health Care Provider number is not registered with the ministry

continued…

6.4 Error Report Rejection Conditions – Error Codes (continued)

Error	Reason(s) for Rejection
EQ9	Laboratory licence number is not registered with ministry
ERF	Referring physician number is currently ineligible for referrals
ESD	APP group affiliation on service date
ESF	▪ A non-encounter service claim submitted by a physician not eligible to bill FSC ▪ Group number is in the range CAAA – CAJ9 and the FSC is not K400A
ESH	Not eligible for blank health card number
ESN	Invalid blank health number claim
HCC	Not Eligible
HCE	Enrolment after 3 months
PAA	No initial fee previously paid
PA1	Invalid PA service
PA2	Invalid PA claim
PA3	Not registered for PA
PA4	PA registration on service date error
PA5	PA affiliation error
PA6	PA affiliation on service date error
VJ5	▪ Date of Service is missing/not eight (8) numerics ▪ Month is not in the range 01-12 ▪ Day is outside acceptable range for month ▪ Date of Service is greater than ministry system run date
VJ7	Date of Service is six (6) months prior to ministry system run date
VJ8	Date of Service is two (2) months prior to ministry system run date
VS1	Invalid SEAMO provider code
VS2	Invalid venue type
VS3	Invalid clinic number
VS4	Invalid health care item

continued…

6.4 Error Report Rejection Conditions – Error Codes (continued)

Error	Reason(s) for Rejection
VS5	Invalid IP/OP indicator
VS6	Invalid HC item code
V02	Incorrect ministry office code. Missing/not D, E, F, G, J, N, P, R, or U
V05	Date of service is greater than Ministry of Health system run date
V06	Incorrect clinic code
V07	Health Care Provider number is missing/not 6 numerics
V08	▪ Specialty code is missing/not 2 numerics ▪ Not a valid specialty code ▪ Specialty Code is 27 and provider number is not 599993 ▪ Specialty Code is 90 and provider number is not 991000 ▪ Specialty Code is 49, 50, 51, 52, 53, 54, 55, 70, or 71 and Health Care Provider number does not begin with 4 ▪ Specialty Code is 56 and Health Care Provider number does not begin with 80 or 81 ▪ Specialty Code is 57 and Health Care Provider number does not begin with 86 or 839985 ▪ Specialty Code is 58 and Health Care Provider number does not begin with 87 ▪ Specialty Code is 59 and Health Care Provider number does not begin with 88 or 89 or not in range 830000 – 839984 ▪ Specialty Code is 80 or 81 and Health Care Provider number does not begin with 82
V09	▪ Referring Health Care Provider number is not six (6) numerics. ▪ Health Care Provider number is 82XXXX and referring Health Care Provider number is missing or begins with 4 or 8 ▪ Group number begins with 5 or 7 or 8000 - 8599 and referring Health Care Provider is missing or begins with 4 or 8 ▪ Group number is 6008, 6100, 8600-8999 or 9XXX and referring Health Care Provider number is missing or begins with 4 or 8 (except for 830000 - 839984, 86XXXX, 88XXXX, 89XXXX) ▪ Referring number is 299999 and the billing provider is not a lab (5000 series) ▪ Referring number is 900100-900600 (Alternate Health Care Professional) ▪ Referring number is 700000-722899 (MIDWIFE) and the billing provider is not a LAB (5000 series)

continued…

6.4 Error Report Rejection Conditions – Error Codes (continued)

Error	Reason(s) for Rejection
V10	▪ Referring number is 900100-900600 (Alternate Health Care Professions) ▪ Patient's last name is missing/not alphabetic (A - Z) ▪ The first field position is blank ▪ RMB claim only
V12	▪ Patient's first name is missing/not alphabetic (A - Z) ▪ The first field position is blank ▪ RMB claim only
V13	▪ Patient's date of birth is missing/invalid format ▪ Month not in the range of 01 - 12 ▪ Not 8 numerics ▪ Day is outside acceptable range for month
V14	▪ Patient Sex must be 1 (male) or 2 (female) ▪ RMB claim only
V16	▪ Not numeric ▪ Health Care Provider number is 82XXXX and diagnostic code is not four (4) numerics or is three (3) numerics and not 070, 072, or 880 to 971 ▪ Fee schedule code is G423, G424 and diagnostic code is not 360, 371, or 376
V17	▪ Payee must be P (Provider) or S (Patient)
V18	▪ In-patient admission date is not eight (8) numerics ▪ Month of admission is not in the range of 01-12 ▪ Day of admission is outside the acceptable range for month ▪ In-patient admission date is later than ministry system run date
V19	▪ Chiropractic Diagnostic Code is missing/invalid ▪ Chiropractic Diagnostic Code is not C followed by two (2) numerics ▪ Health Care Provider number is 830000 - 839984, 88XXXX or 89XXXX and diagnostic code not C01-C15, C20-C24, C30-C33, C40-C48, C50-C54 or C60-C62
V20	▪ Service code is A007, patient is over two (2) years old and diagnostic code is 916; or service code is A003 and the patient is under sixteen (16) years old and the diagnostic code is 917
V21	Diagnostic Code is required for this service

continued…

6.4 Error Report Rejection Conditions – Error Codes (continued)

Error	Reason(s) for Rejection
V22	Diagnostic Code is not a valid code
V23	Service code ends in B or C and the number of services is not greater than 01
V28	Master Number is not four (4) numerics or is not a valid master number on date of service
V29	Invalid in-out patient indicator
V30	FSC/DX Code combination NAB
V31	Missing all of the following: Group Number, Health Care Provider Number, Specialty Code, Health Number
V34	▪ Service code begins with V1 and Health Care Provider number does not begin with 88 or 89, or in range 830000 - 839984 (and the reverse of this condition) ▪ Service code begins with V2 and Health Care Provider number does not begin with 86 or is 839985 (and the reverse of this condition) ▪ Service code begins with V3 and Health Care Provider number does not begin with 87 (and the reverse of this condition) ▪ Service code begins with V4 and Health Care Provider number does not begin with 80, 81, 84, or 85 (and the reverse of this condition) ▪ Service code begins with V8 and Health Care Provider number does not begin with 82 (and the reverse of this condition) ▪ Service code is prefixed with T and Health Care Provider number does not begin with 4, excluding Fee Schedule Codes J99 (and the reverse of this condition) ▪ Service code begins with H4 and Health Number is not a sessional reference number
V35	Invalid OOP/OOC service
V36	Check input criteria required for sessional billing
V39	Number of Items exceeds the maximum (99)
V40	Service code is missing ▪ Service code is not in the format ANNNA where: – A is alphabetic (A-Z) – NNN is numeric (001-999) – A is alphabetic (A-C)
V41	Fee Submitted is missing/not six (6) numerics Fee Submitted is not in the range 000000 - 500000 ($$$$cc)

continued…

6.4 Error Report Rejection Conditions – Error Codes (continued)

Error	Reason(s) for Rejection
V42	Number of Services is missing/not two (2) numerics Number of Services is not in the range 01-99
V47	Fee Submitted is not evenly divisible (to the cent) by the number of services
V50	Service pre-initial visit date
V51	Invalid Service Location Indicator (SLI) - must be blank or four numerics - if present, must be valid based on MOH Residency Code Manual
V53	Invalid service magnetic tape/disk
V62	Invalid service location indicator – assigned when a Service Location Indicator code included with a hospital diagnostic service billing from a participating hospital physician/group is not one of the six valid SLI codes: HDS, HED, HIP, HOP, HRP or OTN
V63	Referring Laboratory Number must start with 5 (5###)
V64	Missing service location indicator – assigned when a hospital diagnostic service is billed by a participating hospital physician/group but a service location indicator code was not included
V65	Missing master number – assigned when SLI code HDS, HED, HIP, HOP, HRP or OTN is included with a diagnostic service billing from a participating hospital physician/group but a master number was not included
V66	Missing admission date – assigned when SLI code HIP is included with a diagnostic service billing from a participating hospital physician/group but an admission date was not included
V67	Missing master number and admission date – assigned when SLI code HIP is included with a diagnostic service billing from a participating hospital/group but a master number and admission date were both not included
V68	Incorrect service location indicator – assigned when a diagnostic service is billed from a participating hospital physician/group with a master number and admission date but the SLI code is not HIP
V69	Service date invalid for SLI code
V70	Date of Service is greater than the file/batch creation date
V71	Invalid Dental master number
V98	Wrong preventative care DOS

continued…

6.4 Error Report Rejection Conditions – Error Codes (continued)

Independent Health Facilities (IHF)

Error	Reason(s) For Rejection
EF1	IHF number not approved for billing on the date specified
EF2	IHF not licensed or grandfathered to bill FSC on the date specified
EF3	Insured services are excluded from IHF billings
EF4	Provider is not approved to bill IHF fee on date specified
EF5	IHF practitioner 991000 is not allowed to bill insured services
EF6	Referring physician not affiliated IHF
EF7	Referring physician number is required for the IHF facility fee billed
EF8	I Service codes are exclusive to IHFs
EF9	Mobile site number required

Reciprocal Medical Billing (RMB)

Error	Reason(s) For Rejection
R01	Missing HSN
R02	Invalid HSN
R03	Invalid/missing province code
R04	Service excluded from RMBS
R05	‘ON’ (Ontario Province Code) not valid from RMB
R06	Wrong provider for RMB
R07	Invalid pay type for RMB
R08	Invalid referral number
R09	Claim header 2 is missing and the payment program is RMB

continued…

6.4 Error Report Rejection Conditions – Error Codes (continued)

Telemedicine

Error	Reason(s) For Rejection
ET1	Provider not registered for telemedicine program
ET4	Telemedicine premium/tracking code missing
ET5	Telemedicine SLI code missing or invalid
TM1	Duplicate telemedicine claim for same patient
TM2	Service not billable for missed/cancelled/abandoned appointment
TM3	Invalid physician telemedicine service
TM4	Non telemedicine claim already paid for this patient
TM5	Telemedicine claim already paid for this patient
TM6	Telemedicine registration not in effect on service date
TM7	Dental service not allowed under telemedicine
TM8	Provider not eligible for telemedicine store and forward

Workplace Safety and Insurance Board (Workers Compensation Board (WCB))

Error	Reason(s) For Rejection
VW1	Service not valid for WCB

continued…

6.4 Error Report Rejection Conditions – Error Codes (continued)

Health Number

Error	Reason(s) For Rejection
VHA	OHIP number not registered with ministry for health number
VHB	A non-encounter service claim submitted with a Health Number
VH0	Claim Header-2 present on MRI claim submitted with Health Number in Claim Header-1
VH1	Health Number is missing/invalid (does not pass MOD 10 Check routine) Health Number is a number reserved for testing purposes
VH2	Health Number is not present (Payment program is HCP or WCB)
VH3	The payment program is missing or is not equal to HCP, RMB, WCB
VH4	Invalid Version Code
VH5	Claim Header-2 is missing (service is before January 1, 1991 and Payment Program is HCP)
VH6	Mixed service dates
VH7	Health number and OHIP number on same claim
VH8	Date of birth does not match the Health Number submitted
VH9	Health Number is not registered with ministry

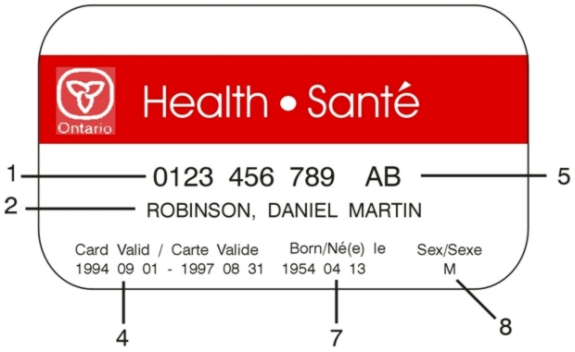
Note:

These error codes and their associated descriptions are subject to change.

7. HEALTH CARD MAGNETIC STRIPE SPECIFICATIONS

7. Health Card Magnetic Stripe Specifications

7.1 Health Card Types



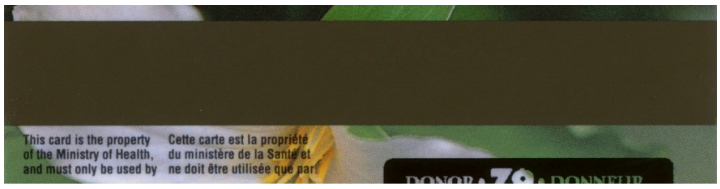
1	Health Number	**5**	Version code – on replacement cards only
2	Name	**6**	Health 65 Indicator – signifies eligibility for Ontario Drug Benefit (available only in Ontario)
3	OHIP number		
4	Expiry date of coverage (month/year) not on all cards	**7**	Date of Birth
		8	Sex

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

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



Mag stripe of original photo health card

Mag stripe of the enhanced photo health

7.2 Magnetic Stripe Specifications (continued)

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:

Expiry Date	3001	=	203001
Expiry Date	2901	=	202901
Expiry Date	3101	=	193101
Issue Date	000101	=	20000101
Issue Date	980101	=	19980101
Issue Date	890101	=	19890101

7.2 Magnetic Stripe Specifications (continued)

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.*

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 MOHLTC 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.

8.1 Information Management System Connect (continued)

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		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[1]; 2. the input transaction record (if required)[2]; 3. the EOM segment. Send the contents of the buffer as a single write.
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.
5	Repeat	Repeat IDENTIFIED VOLUME USERS ONLY: repeat process starting at step 3.
6	Close	Terminate connection and release socket resources.

[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 [3]	Ensure: • user ID and password entered correctly, and that password has not expired4	Change password, continue • If problem persists call Service Support Contact Centre

[3] 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

[4] An expired password causes RSMReasCode "105"

8.1.2 TCP/IP Socket Troubleshooting (continued)

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	

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 and Long-Term Care
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)
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 refer to page 9-4, for User IDs, refer to page 9-6.*

8.1.3 IMS Connect Information (continued)

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 and Long-Term Care
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*’

8.1.3 IMS Connect Information (continued)

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.

8.1.3 IMS Connect Information (continued)

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
Length	01	02	02	Set to x‘00CD’ (205)
Reserved	03	04	02	Set to x‘0000’ (0)
Transaction Code	05	13	09	RPVR0300 (followed by 1 blank)
Health Number	14	23	10	Must be provided for a keyed transaction and omitted for a swiped transaction.
Version Code	24	25	02	
MOH User ID	26	33	08	Authorization ID (HECSnnnn) issued by the ministry. In the case of a network host, this will be the same for all of the networked sites.
EITHER MOH Facility ID **OR**	34	40	07	Represents the ministry issued facility or provider number. At least one of these fields must be present on all transactions.
MOH Provider ID	41	50	10	Data must be left justified and, if necessary, padded with spaces.

8.1.3 IMS Connect Information (continued)

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 Section 7 – 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	

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	
Local Device ID	22	29	08	
Health Number	30	39	10	

8.1.3 IMS Connect Information (continued)

TCP/IP Output Transaction (continued)

Description	Start	End	Length	Notes
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 Specifications

Transaction Request Message **(TRM**):

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 and Long-Term Care.

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

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

Completion Status Message (**CSM**):

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

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

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

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

8.2 GO Net TCP/IP Data Specifications for use with IMS Listener (continued)

*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 a 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 a EOM, output may have been discarded.
8.	**CLOSE**	Terminate connection and release socket resources

9. APPENDIX

9

9. Appendix

9.1 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).

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 on machine-readable media for processing by the ministry and/or to reconcile payment data on machine-readable media 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 and Long-Term Care 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.

9.1 Glossary (continued)

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 and Long-Term Care 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 and Long-Term Care 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 and Long-Term Care to identify persons lawfully entitled to provide insured services or assigned for non-medical operators of licensed Independent Health Facilities.

9.1 Glossary (continued)

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 and Long-Term Care 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 Licensing 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 MC EDT user and the ministry.

Medical Consultant

A physician or dentist employed by the Ministry of Health and Long-Term Care 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.

9.1 Glossary (continued)

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 and Long-Term Care 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).

9.1 Glossary (continued)

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 insured 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 hospital 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.

9.1 Glossary (continued)

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).