

**STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION**

INITIAL STATEMENT OF REASONS

Subject Matter of Regulations: Workers' Compensation – Electronic and Standardized Medical Treatment Billing

**TITLE 8, CALIFORNIA CODE OF REGULATIONS
Section 9792.5 et seq.**

Section 9792.5	Payment for Medical Treatment [Amend]
Section 9792.5.0	Definitions [Adopt]
Section 9792.5.1	Medical Billing and Payment Guide; Medical Billing and Payment Companion Guide; Various Implementation Guides. [Adopt]
Section 9792.5.2	Standardized Medical Treatment Billing Forms/Formats, Billing Rules, Requirements for Completing and Submitting Form CMS 1500, Form CMS 1450 (or UB 04), American Dental Association Form, Version 2002, NCPDP Workers' Compensation / Property and Casualty Universal Claim Form, Payment Requirements. [Adopt]
Section 9792.5.3	Medical Treatment Bill Payment Rules. [Adopt]

BACKGROUND TO REGULATORY PROCEEDING

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Labor Code section 4600 requires an employer to provide medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury. Under existing law, payment for medical treatment shall be no more than the maximum amounts set by the administrative directive in the Official Medical Fee Schedule or the amounts set pursuant to a contract. Prior to reform legislation in 2002, there was no statutory requirement that medical treatment bills be prepared on a standardized form, nor was there a statutory requirement that claims administrators accept bills in electronic form. Assembly Bill 749 (Statutes 2002, Chapter 6) adopted Labor Code section 4603.4 to require the administrative director adopt regulations to:

- Ensure that medical treatment bill be presented on standardized forms
- Require claims administrators to accept electronic claims for payment
- Ensure confidentiality of medical information submitted on electronic claims for payment

In 2003 the legislature passed SB 228 (Statutes of 2003, Chapter 639), amending Labor Code section 4603.4 to state that the administrative director must adopt regulations by January 1, 2005 and that the regulations must mandate that employers accept electronic claims for payment of medical services on or before July 1, 2006. The amendment also stated that payment for medical treatment provided or authorized by the treating physician shall be paid within 15 working days of electronic receipt of a billing for services at or below the fees set forth in the official medical fee schedule. The statute also provides that if the billing is contested, denied, or incomplete, the payment shall be made in accordance with Labor Code section 4603.2 which sets forth the rules relating to payment of non-electronic medical treatment bills. It specifically requires that the employer: 1) notify the provider if a bill is contested, denied or considered incomplete within 30 working days of receipt of the bill and 2) pay the bill, or pay uncontested portions of the bill, within 45 working days of receipt of the bill (or within 60 working days if the employer is a public entity.) SB 228 also amended Labor Code section 4603.2 by changing the payment period for paper medical bills from sixty days to forty five working days, and by changing the increase payable for late bills from 10% to 15%

The Administrative Director now proposes to amend and adopt administrative regulations governing electronic and standardized medical treatment billing. These regulations implement, interpret, and make specific sections 4600, 4603.2 and 4603.4 of the Labor Code.

TECHNICAL, THEORETICAL, OR EMPIRICAL STUDIES, REPORTS, OR DOCUMENTS

The Division relied has relied upon the following documents:

AHIP Center for Policy and Research, *An Updated Survey of Health Care Claims Receipt and Processing Times*, May 2006.

<http://www.ahipresearch.org/pdfs/PromptPayFinalDraft.pdf>

CMS, *Electronic Media Claims (EMC) Rates for Medicare Carriers and Electronic Media Claims (EMC) Rates for Medicare Fiscal Intermediaries for Calendar Year 2008*.

<http://www.cms.hhs.gov/EDIPerformanceStatistics>

CMS, *Medicare Part B Participating Physicians and Other Practitioners by State*, December 2009, Table VII.20, *Data Compendium, State Data*:

http://www.cms.gov/DataCompendium/15_2009_Data_Compndium.asp#TopOfPage .

California Dept. of Insurance, *2008 California Property and Casualty Market Share Report* <http://www.insurance.ca.gov/0400-news/0200-studies-reports/0100-market-share/Marketshare2008/upload/IndMktShr2008WP.pdf>

Vogt, WB & Romley JA. *California Ambulatory Surgical Centers: A Comparative Statistical and Regulatory Description*. 2009. Santa Monica, CA: RAND Corporation.

http://www.rand.org/pubs/technical_reports/2009/RAND_TR757.pdf

California Office of Statewide Health Planning Development, *California Hospitals Licensed as of June 30, 2009*.

http://www.oshpd.ca.gov/HID/Products/FacilityList/HospitalList_0609.xls

California Office of Statewide Health Planning Development, *California Specialty Care Clinics Licensed as of June 30, 2009*.

http://www.oshpd.ca.gov/HID/Products/FacilityList/SCList_0609.xls

California Workers' Compensation Information System, *Summary of Extract of Data - December 2009: Ambulance Providers, Laboratory Providers, Optometry Providers*.

OTHER DOCUMENTS IN THE RULEMAKING FILE

Memorandum from Suzanne Honor, Workers' Compensation Manager to Rulemaking File regarding Public Consultation on Development of Electronic and Standardized Medical Billing Regulations / Guides (Govt. Code §11346.45) – December 9, 2009

Comparison of the Security Rule Proposed for Adoption in the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide (Appendix D Security Rule) to the HIPAA Security rule (Title 45 Subpart C §§164.302-164.316, and Appendix A Matrix) – December 2009

SPECIFIC TECHNOLOGIES OR EQUIPMENT

Labor Code section 4603.4 requires that the standards for electronic billing be consistent with HIPAA to the extent feasible. HIPAA requires specific computer technology insofar as specified transaction standards are mandated. For these workers' compensation rules, HIPAA transaction standards are mandated where feasible, but the rules provide an option for the parties to use different standards upon mutual agreement so long as the same data elements are provided in the alternate billing format. The regulations do not adopt specific equipment requirements.

FACTS ON WHICH THE AGENCY RELIES IN SUPPORT OF ITS INITIAL DETERMINATION THAT THE REGULATIONS WILL NOT HAVE A SIGNIFICANT ADVERSE IMPACT ON BUSINESS

Medical providers will not be negatively impacted by the electronic billing regulations as it is optional for providers to bill electronically. It is anticipated that providers that do engage in electronic billing will experience cost savings due to more efficient communication and expedited payment (bills will be payable in 15 working days rather than 45 working days.) There will be some minimal costs for providers to utilize the standardized paper billing forms, primarily due to training and the need to purchase paper implementation guides. Many providers already use the standardized forms.

Claims administrators will have costs to comply with the mandate to accept electronic bills. Those costs will vary widely depending on a number of factors, including whether the claims administrator handles the bills in-house or uses a clearinghouse, and the current level of technological capabilities of the claims administrator. However, it is anticipated that there will be a large net gain for claims administrators as it is much less costly to process electronic bills than paper bills. In addition, many features of the regulations should improve efficiency and reduce costs for the claims administrator, such as the restriction on duplicate billing, the prohibition of balance billing, and the use of standardized remittance remark codes and claims adjustment reason codes. The costs of claims administrator to comply with the standardized paper billing process will involve some minimal costs for staff training, procurement of implantation guides and adjustment of processes. However, the costs will be negligible and will be offset by efficiencies.

REASONABLE ALTERNATIVES TO THE PROPOSED REGULATION AND REASONS FOR REJECTING THOSE ALTERNATIVES

The Administrative Director has not identified any effective alternative, or any equally effective and less burdensome alternative to the regulations at this time.

SPECIFIC PURPOSE AND NECESSITY OF EACH SECTION – GOVERNMENT CODE 11346.2(b)(1)

The specific purpose of each adoption, and the rationale for the determination that each adoption is reasonably necessary to carry out the purpose for which it is proposed, together with a description of the public problem, administrative requirement, or other condition or circumstance that each adoption is intended to address, is set forth below.

Proposed Section 9792.5 Payment for Medical Treatment.

Section 9792.5 will be amended to provide that the section is applicable to medical treatment rendered before a specified date.

Necessity

This is necessary to coordinate the applicability date of the current rule with the new billing rules so that the new rules are prospective.

Subdivisions (b) and (d) are amended to reflect that the claims administrator must pay a medical treatment bill within forty five working days, rather than sixty days, from receipt of the bill and required reports.

Necessity

These changes are necessary to conform to the statutory amendment made by SB 228 (Statutes of 2003, Chapter 639) which changed “sixty days” to “forty five working days.”

Subdivision (b) is amended to provide that bills that are neither paid nor objected to within the required time period will be increased 15% rather than 10%.

Necessity

This change is necessary to conform to the statutory amendment made by SB 228 (Statutes of 2003, Chapter 639) which changed the increase for late objection or payment from “10%” to “15%.”

Subdivision (c), which states that a bill exceeding the fee schedule must be accompanied by an itemization and explanation for the excess charge, is deleted.

Necessity

Elimination of this subdivision is necessary because SB 228 repealed the following provision of Labor Code section 5307.1 (b): “Nothing in this section shall prohibit a medical provider or a licensed health care facility from being paid by an employer or carrier fees in excess of those set forth on the official medical fee schedule, provided that the fee is:

- (1) Reasonable.
 - (2) Accompanied by itemization and justified by an explanation of extraordinary circumstances related to the unusual nature of the medical services rendered.
- In no event shall a physician charge in excess of his or her usual fee.”

Proposed Section 9792.5.0 Definitions.

This section sets out definitions of various types of entities.

Necessity

The definitions are necessary so that members of the public can identify which entities will be subject to the standardized and electronic billing rules.

Subdivision (a): “Claims Administrator” is defined as “a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority”

Necessity

It is a fundamental principle of workers' compensation law in California that it is the employer's financial responsibility to provide all medical treatment that is reasonably required to "cure or relieve" the injured worker from the effects of the industrial injury. (Lab. Code, §4600) Labor Code sections 4603.2 and 4603.4 refer to the employer's obligations relating to payment for medical treatment. This responsibility is often delegated from the employer to "the claims administrator" who actually administers the claim. Thus, it is necessary to define the term "claims administrator" as "a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority" in order to make it clear that the entity actually administering the claim is subject to the regulation.

Subdivision (b): "Health Care Facility" is defined to specify the types of entities that constitute an inpatient or outpatient "facility" by reference to licensing under specific Health and Safety Code sections, the accreditation of the facility by an accrediting agency approved by the California Medical Board or the certification of the facility to participate in the Medicare program.

Necessity

It is necessary to define a health care facility by reference to the statutes or accreditation status as these are the entities that will be entitled to bill for facility services.

Subdivision (c): "Health Care Provider" is defined to include providers of medical treatment, goods and services so that it is clear that physicians and non-physicians are covered by the regulations if they furnish medical treatment, goods or services as all of these are part of the employer's obligation to provide medical care pursuant to Labor Code section 4600.

Necessity

It is necessary to define "health care provider" broadly as persons who provide treatment, goods or services under the workers' compensation medical treatment statute, Labor Code section 4600, since they may all be billing in compliance with these regulations.

Subdivision (d): "Physician" is defined to conform to the definition of "physician" in Labor Code section 3209.3.

Necessity

This definition is necessary as the term "physician" is broader in workers' compensation than in many other contexts.

Subdivision (e): “Third Party Biller / Assignee” is defined as a person or entity authorized by law and acting under contract as the agent or assignee of a rendering physician, health care provider or healthcare facility to bill and/or collect payment from the responsible payor.

Necessity

The definition is necessary to recognize that, where permitted by law, persons or entities other than the rendering provider may be involved in billing and subject to the regulations.

Proposed Section 9792.5.1 Medical Billing and Payment Guides; Medical Billing and Payment Companion Guide; Various Implementation Guides.

This section identifies medical billing guides and implementation guides and incorporates them by reference into the regulation. Each of these documents is too voluminous to be published in the text of the regulations and thus it is necessary to incorporate them by reference.

Section 9792.5.1 Subdivision (a): this section incorporates by reference the *California Division of Workers’ Compensation Medical Billing and Payment Guide* which sets forth billing, remittance/payment and coding rules for paper and electronic medical treatment bill submissions. The section identifies how to obtain the guide by downloading it from the Division’s website or writing to the Division.

The *California Division of Workers’ Compensation Medical Billing and Payment Guide* (hereafter *Medical Billing and Payment Guide*) was created by the Division, with input from the Electronic and Standardized Medical Treatment Billing Advisory Committee. This committee included representatives of providers and payers that met periodically for more than two years.

The *Medical Billing and Payment Guide* contains provisions necessary to implement billing rules as set forth below.

Introduction

The introduction is intended to provide very brief essential information on the authority for the *Medical Billing and Payment Guide*, scope of the guide, and effective date of the guide.

Section One – Business Rules

1.0 Standardized Billing/Electronic Billing Definitions

Section One lists and defines the terms used in the *Medical Billing and Payment Guide*. The purpose of the definitions is to implement, interpret, and make specific sections 4600, 4603.2 and 4603.4 of the Labor Code and to ensure that the meanings of the terms are clearly understood by the workers’ compensation community. The specific purposes and necessity of each definition is set forth below.

(a) “Authorized medical treatment” is defined to make it clear that it includes treatment in accordance with the Labor Code provision which specifies the scope of allowed workers’ compensation medical treatment (section 4600) and which has been authorized pursuant to the workers’ compensation utilization review statute (section 4610.) It is necessary to define “authorized medical treatment” as the statute being implemented, Labor Code section 4603.4 subdivision (d), requires that treatment provided or “*authorized*” by the treating physician be paid within 15 days of receipt of the electronic bill.

(b) “Bill” is defined to specify that it includes the itemization of services on uniform billing forms that are in the Appendix and to specify that it includes the required reports and supporting documentation. An essential purpose of these regulations is to adopt standardized billing forms and procedures to carry out Labor Code section 4603.4. Therefore it is necessary for the term “bill” to be defined very specifically by reference to the billing forms which are set forth in the regulations. It is also necessary to make it clear that the required reports and supporting documentation are part of the “bill.”

(c) The purpose of including the definition of the “California Electronic Medical Billing and payment Companion Guide” is to inform the public of the existence of this separate guide. It is necessary to make it clear that this separate billing guide gives detailed information for electronic billing and payment.

(d) “Claims Administrator” is defined to conform to the definition of “claims administrator” set forth in the text of Section 9792.5.0. It is necessary to define “claims administrator” because the employer’s duties in relation to payment of medical treatment bills are often delegated to a “claims administrator” who carries out the duties on behalf of the employer.

(e) “Clearinghouse” is defined as a public or private entity that 1) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into a standard data elements or a standard transaction, and/or receives standard transaction from another entity and processes the information into nonstandard format or data content for the receiving entity. It is necessary to include this definition as many claims administrators and medical providers will utilize these types of entities to process data and transactions. Moreover, the definition utilized is identical to the definition of “clearinghouse” used in the HIPAA regulations, Title 45, Code of Federal Regulations section 160.103.

(f) “Complete Bill” is defined to be a bill submitted on the correct uniform billing form, using the correct uniform billing codes sets, filled out in compliance with the format requirements of Appendix A (paper billing forms) or the Companion Guide (electronic billing formats), with the required reports, written authorization, if any, and or supporting documentation as defined in Section One – 3.0. It is necessary to define what constitutes a “complete” bill as certain obligations of the payer are triggered upon receipt of the

complete bill. A comprehensive definition of “complete bill” will reduce disputes between providers and payers and expedite payment of bills.

(g) “CMS” is defined as the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. It is necessary to include and define the abbreviation of “the Centers for Medicare and Medicaid Services” for ease of reading the *Medical Billing and Payment Guide*.

(h) “Electronic signature” is defined as a signature that conforms to the requirements for digital signatures adopted by the Secretary of State in Title 2, California Code of Regulations §§ 22000 – 22003 pursuant to Government Code § 16.5 or a signature that conforms to other applicable provisions of law. Since the statute being implemented, Labor Code section 4603.4, is the first statute *requiring* claims administrators to accept electronic bills, it is necessary to specify what will constitute an electronic signature since certain documents are required to be signed. The Labor Code section 4603.4 states that the standards adopted shall be consistent with existing HIPAA standards to the extent feasible. The HIPAA statute requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for electronic signatures. On August 12, 1998 the HHS issued a proposed rule for security standards and electronic signature standards. Federal Register, Vol. 63, No. 155, page 43242. The HHS adopted the security rule on February 20, 2003, but has not yet adopted a signature standard for HIPAA compliant electronic billing. (Federal Register, Vol. 68, No. 34, page 8334.) Since there is no HIPAA standard, the Medical Billing and Payment Guide utilizes the Secretary of State’s digital signature definition. It was adopted to carry out Government Code § 16.5 to allow a member of the public to utilize a digital signature in communication with a public entity. The Government Code section and Secretary of State’s rules are included as Appendix for Section Two, Appendix A.

It is necessary for the Division’s definition of “electronic signature” to also include “a signature that conforms to other applicable provisions of law” in order to allow parties to have the flexibility to utilize other types of electronic signatures that have legal validity.

(i) “Electronic Standard Format” is defined as the ASCX12N standard format developed by the Accredited Standards Committee X12 Insurance Subcommittee of the American National Standards Institute and the retail pharmacy specifications developed by the National Council for Prescription Drug Programs. The definition also cross references to the Companion Guide. It is necessary to identify the electronic standard formats that will be required by the regulations and these formats were chosen as they are the HIPAA compliant formats that are required by the statute.

(j) “Explanation of Review” (EOR) is defined as the explanation of payment or denial of payment using the standard code set found in Appendix B. It is necessary to specify that the EOR is a specific code set forth in the manual. Adoption of standard EOR language and codes is important to improving communication relating to billing.

(k) “Health Care Provider” is defined as a provider of medical treatment, goods and services including a physician, non-physician or any other person or entity who furnishes medical treatment, goods, or services in the normal course of business. It is necessary to define the term “health care provider” in the context of the medical billing manual so that it is clear that providers of all types of medical treatment, goods and services are subject to the billing rules. It is also necessary to specify one term to signify a broad range of persons and entities subject to the rules in order to avoid unwieldy repetition that would interfere with clarity of the provisions.

(l) “Health Care Facility” is defined to include those facilities that are entitled to bill for facility fees for treatment of workers’ compensation patients. It is necessary to define the “health care facility” to cover the same entities which are entitled to facility fees pursuant to Title 8, California Code of Regulation sections 9789.21, 9789.32(b) as follows:

- Inpatient facilities licensed under Health and Safety Code section 1250.
- Hospital outpatient departments of hospitals that are licensed under Health and Safety Code section 1250.
- Outpatient surgical facilities licensed under subdivision (b) of Section 1204 of the Health and Safety Code (surgical clinics.)
- Outpatient surgical facilities defined in Health and Safety Code section 1248 (“outpatient settings”) which are accredited by an accrediting agency approved by the Medical Board of California pursuant to Health and Safety Code sections 1248.15 and 1248.4.)
- Hospital outpatient departments or ambulatory surgical centers that are certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act.

(m) “Itemization” must be defined as it is used in Labor Code section 4603.2 but it lacks specificity. The term is defined to mean the list of medical treatment, goods or services provided using the codes required by Section One – 3.0 to be included on the uniform billing form. It is necessary to require the itemization of services to utilize the adopted code sets as this will facilitate communication between the provider and payer.

(n) “Medical Treatment” is defined as the treatment, goods and services as defined by Labor Code section 4600. This is necessary as section 4600 is the section that sets forth the scope of treatment that an employee is entitled to under the workers’ compensation law, and hence is the treatment that is billed in accordance with these regulations.

(o) “National Provider Identification Number” or “NPI” is defined as the unique identifier assigned to a health care provider or health care facility by the Secretary of the U.S. Department of Health and Human Services. It is necessary to use the NPI as this is the identifier that has been mandated by HIPAA. Labor Code section 4603.4 directs the administrative director to adopt electronic billing regulations that are consistent with HIPAA to the extent possible. CMS has described the NPI as follows:

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard.

The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses will use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
<http://www.cms.hhs.gov/NationalProvIdentStand/>

(p) “NCPDP” is defined as the National Council for Prescription Drug Programs. This is necessary as the NCPDP is an organization chartered by the American National Standards Institute (ANSI) to specify standards for electronic pharmacy billing. The NCPDP pharmacy standards are used for HIPAA transactions and thus are adopted by the administrative director for workers’ compensation in order to be consistent with the HIPAA standard.

(q) “Official Medical Fee Schedule (OMFS)” is defined as all the fee schedules found in Article 5.3 of Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations (Sections 9789.10 – 9789.111.) It is necessary to specify the regulation sections that constitute the fee schedule so it is clear to the public that the billing rules apply to all of the workers’ compensation fee schedules.

(r) “Physician” is defined to have the same meaning as specified in Labor Code section 3209.3. The regulation sets forth the specific provisions defining the professionals who are “physicians”. This is necessary as “physician” in workers’ compensation law has a broader meaning than “physician” in other contexts.

(s) “Required report” is defined to mean a report which must be submitted pursuant to section 9785 or the OMFS (Doctor’s First Report of Injury, PR-2, PR-3, and PR-4 and their narrative equivalents and “By Report code billing”.) It is necessary to define what reports are “required” in the context of these billing rules so that there will not be disputes between providers and payers about which reports are required to be provided. The legally required reports that are issued to report on treatment and to support “by report” billing are identified as the required report.

(t) “Supporting Documentation” is defined as items other than a required report that are necessary to support a bill such as a written authorization and all items listed in the complete bills section of the manual. In order to minimize disputes between providers and payers it is necessary to define the scope of items needed to be provided in addition to the required medical reports.

(u) “Third Party Biller” is defined as a person or entity that submits medical treatment billing on behalf of a health care provider or health care facility, other than an employee of the health care provider or health care facility. Some medical treatment providers

utilize outside billing services rather than handling the billing internally. Since these “third party billers” will be required to comply with the billing rules, it is necessary to include a definition in the regulation.

(v) “Treating Physician” is defined as the primary treating physician or the secondary physician as defined by section 9785. It is necessary to make it clear which physicians are covered by the billing rules by defining treating physician to include both primary and secondary treating physicians as these are the doctors that actually render treatment. Thus it is clear that “treating physician” does not include such physicians as qualified medical evaluators and agreed medical evaluators.

(x) “Uniform Billing Forms” are defined as the CMS 1500, UB 04, NCPDP Universal Claim Form and the ADA 2006 set forth in Appendix A. It is necessary for clarity to specify the names of the uniform forms and to include copies of them in the appendix. In order to streamline billing, comply with the statutory mandate (L.C. §4603.4(a)(1)), and create efficiency it is necessary to adopt these standard forms that are utilized generally by the medical community rather than create unique forms for workers’ compensation billing.

(y) “Uniform Billing Codes” are defined as:

(1) "CDT-4 Codes" means the current dental codes and nomenclature prescribed by the American Dental Association.

(2) "CPT-4 Codes" means the procedural terminology and codes contained in the “Current Procedural Terminology, Fourth Edition,” as published by the American Medical Association and as adopted in the appropriate fee schedule contained in sections 9789.10-9789.100.

(3) “Diagnosis Related Group (DRG)” means the inpatient classification scheme used by CMS for hospital inpatient reimbursement.

(4) "HCPCS" means CMS’ Healthcare Common Procedure Coding System, a coding system which describes products, supplies, procedures and health professional services and includes, the American Medical Association’s (AMA's) Physician “Current Procedural Terminology, Fourth Edition,” (CPT-4) codes, alphanumeric codes, and related modifiers.

(5) "ICD-9-CM Codes" means the diagnosis and procedure codes in the International Classification of Diseases, Ninth Revision, Clinical Modification published by the U.S. Department of Health and Human Services.

(6) "NDC" means the National Drug Codes of the Food and Drug Administration.

(7) “Revenue Codes” means the 4-digit coding system developed and maintained by the National Uniform Billing Committee for billing inpatient and outpatient hospital services, home health services and hospice services.

(z) “Working days” are defined as Mondays through Fridays, and exclude Saturdays and Sundays and specified holidays. It is necessary to have a uniform list of days which will constitute working days for purposes of counting timeframes for performing various billing and bill-paying actions. The holidays specified are: New Year’s Day (January 1st), Dr. Martin Luther King Jr. Day (third Monday in January); Washington Day or

President's Day (third Monday in February); Cesar Chavez Day (March 31st); Memorial Day (last Monday in May); Independence Day (July 4th); Labor Day (first Monday in September); Veteran's Day (November 11th); Thanksgiving Day (third Thursday in November); Day After Thanksgiving; Christmas Day (December 25th). If January 1st, , March 31st, July 4th, November 11th, or December 25th falls upon a Sunday, the Monday following is a holiday. If November 11th falls upon a Saturday, the preceding Friday is a holiday. The workers' compensation billing statutes do not specify what will constitute a "working day" and there is no single statewide definition of "holiday" or "working day." The Administrative Director has considered the following statutory definitions in crafting the definition of "working day": Government Code sections 6700 (state holidays) and 6701 (holidays falling on Saturdays and Sundays); Code of Civil Procedure section 135 (judicial holidays); Civil Code section 7 (holidays); Civil code section 7.1 (optional bank holidays); Civil Code section 9 (business days; optional bank holidays).

2.0 Standardized Medical Treatment Billing Format

(a) This section sets forth the identification of the standard medical billing forms: the form CMS-1500 health insurance claim form for health care providers; form CMS 1450 or UB-04 for institutional care providers and home health providers; the American Dental Association, Version 2006, uniform dental claim form for dentists; NCPDP Universal Claim form for pharmacy bills. The section specifies the date that the use of the forms or formats becomes mandatory, specifies that the forms must be typewritten, and specifies that they must be completed in accordance with Appendix A. This section is necessary to implement the statute's requirement to adopt standardized forms and to provide uniform rules for completing those forms.

(b) This section sets forth the date by which claims administrators are required to accept electronic submission of medical treatment bills, and indicates that the medical provider may choose to submit bills electronically after that date. The section specifies that the bills shall conform to the Medical Billing and payment Guide and the Companion Guide. It is necessary to clearly specify the effective date of the electronic billing rules as the statute contemplates that there will be a period of 18 months between adoption of the regulation and the mandatory acceptance of electronic bills.

3.0 Complete Bills

(a) This section provides that both electronic and paper bills must be complete before payment time frames begin.

(b) This section sets forth the criteria that a bill must meet in order to be "complete": use of correct billing form/format, use of correct uniform billing codes, completion of the form/format in accordance with the requirements in Appendix A and/or the Companion Guide.

(c) This section provides that required reports and supporting documentation must be submitted as specified: 1) Doctor's First Report of Occupation Injury (5021) when the bill includes an Evaluation and Management code and a 5021 is required under 8 CCR section 9785; 2) PR-2 (physician progress report) when the bill includes an Evaluation and Management codes and the PR-2 is required under 8 CCR section 9785; 3) PR-3, PR-4 (permanent and stationary report) when the bill includes an Evaluation and

Management code and the injured worker has been declared permanent and stationary with permanent disability or need for future medical care; 4) narrative report when bill includes an Evaluation and Management code for a consultation; 5) when the provider uses the following modifiers: -19, -21, --22, -23 and -25; 6) descriptive report when provider uses a "By Report" code; 7) OMFS requires a report; 8) operative report when provider bills surgery services; 9) an invoice when one is required for reimbursement; 10) appropriate additional information when reasonably requested by the claims administrator prior to submission of the bill; 11) written authorization if one was given. (d) This subdivision provides that a header or attachment cover sheet shall be submitted if the bill and supporting documentation are not submitted in the same envelope.

Necessity

It is necessary for the rule to specify what triggers the commencement of the payment time frames in order to reduce disputes and expedite timely payment of bills. In the past there have been disagreements between providers and payers regarding the sufficiency of bills to trigger the payment obligation and regarding whether a report was required to support the bill. Clarity regarding the triggers for time frames for payment will reduce disputes between provider and payer.

4.0 Third Party Billers/Assignees

- (a) This section requires third party billers and assignees to submit bills in the same manner as the original rendering provider would have been required to do.
- (b) This section specifies that the rendering provider and third party biller / assignee information shall be entered in the appropriate fields.

Necessity

It is necessary to have consistency of the information submitted on bills so that the payer will have adequate information about the provider and services rendered in order to pay the bill. It would be disruptive to streamlined communication if a third party biller or assignee could submit bills in a different manner than the original rendering provider. The payer needs to know both the identity of the rendering provider and the identity of the third party biller or assignee. The Division has been informed that some third party billers or assignees have submitted bills for treatment that lack information on who actually rendered the treatment. This makes it very difficult for the claims administrator to properly review the claim, ensure receipt of necessary reports and documentation, and follow the progress of the treatment.

5.0 Duplicate Bills, Bill Revisions and Balance Forward Billing

- (a) This section requires a duplicate bill to be clearly marked as duplicate and to contain the same information as the original bill. The section prohibits the addition of new dates of service to a duplicate bill.

(b) This section requires that a bill revised to correct an error or make a coding correction be marked as revised. The section prohibits the addition of new dates of service to the revised bill.

(c) This section prohibits “balance forward billing” which is a bill that includes a balance carried over from a previous bill along with additional services.

(d) This section prohibits a provider from submitting an electronic bill if the provider has already submitted a paper bill.

Necessity

It is necessary to have bills clearly marked as duplicate bills or revised bills so that they can be handled properly. If they are not marked as duplicate or revised bills the claims administrator may treat them as new bills, possibly causing improper payment level. Similarly, bills that include new dates of service, or carry forward balances from prior bills substantially increase the difficulty of properly reviewing and paying the bill.

Confusing bills which carry balances forward, are not clearly marked as duplicate or revised, or which duplicate an electronic bill may result in overpayment or incorrect payment, often leading to time consuming and costly corrective action later.

6.0 Medical Treatment Billing and Payment Requirements for Non-electronically Submitted Medical Treatment Bills

(a) This section provides that a non-electronic bill not paid within 45 working days (or 60 working days if the employer is a governmental entity) shall be increased by 15% and shall carry interest at the same rate as civil judgments retroactive to the date of receipt of the bill unless the billing entity is notified within 30 working days of receipt that the bill is contested, denied or considered incomplete. The increase and interest are self-executing and apply to the portion of the bill that is neither timely paid nor objected to.

(b) This section specifies that a claims administrator who objects to all or a portion of a medical treatment bill shall notify the billing entity within 30 working days after receipt of the bill and any required report or supporting documentation necessary to support the bill and shall pay any uncontested amount within 45 working days after receipt of the bill, or with 60 working days if the employer is a governmental entity. If the required report or supporting documentation is not received with the bill, the period to pay or object begins on the date of receipt of the report or documentation, whichever is received later. The claims administrator must notify the health care provider within 30 working days of receipt of the bill if the claims administrator believes a required report or documentation is missing. An objection is timely if sent by the specified means on or before the thirtieth working day. The section specifies that the objection shall include or be accompanied by:

1) A clear and concise explanation of the basis for the objection using DWC Bill Adjustment Reason codes. If the objection is based on coding, the explanation shall include both the code reported by the provider and code believed reasonable by the claims administrator. The Explanation of Review should contain all the elements identified in Appendix B-2.0.

2) If additional information is necessary to payment of a contested bill or portions of a bill, a clear description of the information required.

- 3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection.
- 4) A statement that the treating physician or authorized provider may adjudicate the issue of contested charges before the Workers' Compensation Appeals Board.
- (c) This section provides that an objection to a hospital, outpatient surgery center or independent diagnostic facility is sufficient if the provider is advised that a request has been made for an audit of the billing, when the audit results are expected, and contact information for additional information concerning the audit.
- (d) This section specifies that the section does not prohibit a claims administrator from conducting a retrospective utilization review.
- (e) This section states that providers and claims administrators may utilize alternative forms or procedures provided such forms or procedures are specified in a written agreement and as long as the alternative billing format provides all the required information set forth in the Medical Billing and Payment Guide.
- (f) This section prohibits providers and claims administrators from disclosing individually identifiable health information contained on the billing form except where disclosure is permitted by law or is necessary to confer workers' compensation benefits.
- (g) This section requires Explanations of Review (EOR) to contain all of the specified elements and requires the EOR to use the DWC Bill Adjustment Reason codes and descriptions

Necessity

It is necessary to have this guide set forth in subsections 6(a) and 6(b) the time frames for payment of bills and for notification if there is an objection to a bill as those are very important requirements related to billing. The timeframes for payment and objection are set by statute, Labor Code section 4603.2, and they are included in the regulation for the convenience of the public so that these important provisions relating to billing are easily accessible. Any "duplication" of the provisions of the statute is necessary to make the billing rules comprehensive. Subsection 6(b)(1) is necessary to implement Labor Code section 4603.2's provision that the objection to a bill be clear. The reference to the EOR subsection ensures consistency of payer's messages so that the reasons for an objection are clear and do not vary from payer to payer. The requirement of 6(b)(2) is necessary to ensure that a claims administrator who wants specific information in order to evaluate a bill provide specific description of the information needed. The DWC has received reports of claims administrators rejecting a bill without specifying what information it needs to make a decision. This provision induces both parties to communicate clearly. Similarly, 6(b)(3)'s requirement that an objection contain contact information is necessary to facilitate good faith communication between provider/biller and claims administrator. 6(b)(4)'s requirement that the objection state that the matter may be adjudicated at the Workers' Compensation Appeals Board is necessary to carry out the statutory directive that the objection must set forth the remedies available to the physician. The WCAB is the entity that has authority to adjudicate disputes over medical bills. Labor Code section 4603.2(d)(3). 6(c) is necessary as the statute requires a request for an audit to be recognized as an objection. This section implements this statutory provision by requiring the objection to include an expected date for audit results and contact information for additional information concerning the audit. These additions are

necessary to ensure the audit process for bills progresses in a timely manner since there is no specific deadline in the statute for completing the audit. 6(d) is necessary to clarify the interaction of these billing/objection rules and the utilization review statute and rules. Utilization review is the utilization management function that is used to prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services. Where the utilization review is retrospective, a medical service has already been performed and the medical necessity of that treatment is being reviewed. It is necessary for these rules to clarify that the utilization procedure is not impeded by the billing/objection rules. 6(e) is necessary to allow flexibility for parties to use alternate formats. Although flexibility is desirable, it is necessary to require the alternate formats or procedures to be embodied in a written agreement so that disputes may be avoided about the scope of the alternate forms or procedures. In addition, it is necessary to specify that the alternative billing format must have all of the information required by the Medical Billing and Payment Guide because these elements have been determined to be critical to communication and accurate payment of medical benefits. 6(f) is necessary to preserve the privacy interests of injured workers. 6(g) is necessary as it adopts a critical component of streamlined communication regarding billing – the Standard Explanation of Review and the DWC Bill Adjustment Reason Codes. Making the bill adjustment reason codes mandatory is necessary so that providers and payers will understand the communications relating to bill review. In the current unregulated environment, each claims administrator or bill review company creates its own bill adjustment messages so there is no uniformity to the messages. Some of the messages are unclear or inadequate. Using of standardized codes will result in a common “language” across the biller/provider and payer communities, streamlining communication. In addition, having the required contents of the EOR set out in the 3.0 Field Table of Appendix B is necessary to ensure that sufficient information is conveyed to the provider.

7.0 Medical Treatment Billing and Payment Requirements for Electronically Submitted Bills

7.1 Timeframes

(a) Acknowledgements.

This section sets forth the three types of acknowledgment transmissions that are to be sent by the claims administrator, and specifies the time frames.

(1) Interchange Acknowledgement (ASC X12 TA-1) is to be sent within one working day of receipt of the electronically submitted bill, using the TA 1 transaction set defined in the Companion Guide. This transaction acknowledges that a trading partner agreement exists.

(2) The Functional Acknowledgment (ASC X12 997) is to be sent within one working day of receipt of the electronically submitted bill, using the 997 transaction set defined in the Companion Guide.

(3) The Health Care Claim Acknowledgment (ASC X12N 277) is to be sent within two working days of receipt of an electronically submitted bill, using the 277 transaction set

defined in the Companion Guide. This transaction informs the bill submitter whether the bill submission is complete. The bill may be rejected if it is not submitted in the required standard electronic format or is not complete in accordance with Section One – 3.0.

(A) Pending transaction. A claim that is incomplete or missing an attachment is to be held as pending for up to five working days. The claims administrator shall issue the acknowledgment ASC X12N 277 indicating the specific reason for pending the claim. If the required information/attachment is not received by the claims administrator within the five working days the bill may be rejected as incomplete. If the bill was held pending due to a missing claim number, during the five working day time frame the claims administrator shall locate and affix the claim number to the bill. If the claims administrator has already provided the claim number to the billing entity the bill may be rejected as incomplete.

(B) Bill Rejection Error Message. Bill rejection error messages include: invalid form or format; missing fields; invalid data; missing attachments; missing required documentation; injured workers' claim of injury is denied; no coverage by the claims administrator.

(C) Bill is complete. The ASC X12N 277 is to be issued indicating that the bill is complete and has moved into bill review.

(b) Payment and Remittance Advice.

The Healthcare Claim Payment (ASC X12 N 835) Remittance Advice is to be issued when uncontested medical treatment provided or authorized by the treating physician is being paid. Payment for uncontested medical treatment shall be made within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule. Explanations of Review shall use the codes listed in Appendix B – 1.0.

If a claims administrator receives a bill and believes that it has not received a required report and/or supporting documentation to support the bill, the claims administrator shall so inform the health care provider within 15 working days of receipt of the bill. Any notice of objection shall include the following: specific explanation of basis for the objection to each contested procedure and charge using the DWC bill adjustment reason codes in Appendix B Standard Explanation of Review; additional information necessary for payment, if any; name, address and phone number of person or office to contact for additional information concerning the objection; statement that the bill submitter may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board. This section sets forth the Labor Code section 4903.5 subdivisions (a) and (b) which constitute a statute of limitations for filing medical lien claims at the WCAB.

Necessity

It is necessary for this section of the Medical Billing and Payment Guide to specify which electronic transaction sets are required and to specify timeframes for issuing transactions. Labor Code section 4603.4 subdivision (b) requires that the standards for electronic billing claims be "consistent with existing standards" under HIPAA to the extent feasible. The ASC X12 TA-1, ASC X12 997, adopted by the Medical Billing and Payment Guide are standard acknowledgment transactions within the HIPAA transaction standards. In order to ensure timely exchange of information the guide establishes mandatory

timeframes for issuance of the two acknowledgments (trading partner status and receipt of claim transmission.) The deadline for these is set at one day from receipt of the bill which is adequate for the initial acknowledgements.

The ASC X12N 277 and the ASC X12N 835 adopted by the Medical Billing and Payment Guide are the transaction standards adopted by the Department of Health and Human Services (HHS) to carry out HIPAA. 45 CFR §162.1102. These transaction standards were effective and mandatory for HIPAA-covered entities until March 16, 2009. As of March 17, 2009 the HIPAA regulations allow the use of either the specified transaction standards or updated versions of those standards. (Final rule adopted January 16, 2009, Federal Register, vol. 74, No. 11, page 3296.) The current ASC X12 Version 4010 has been updated to Version 5010. However, under the HIPAA regulations the 5010 is not mandatory until January 1, 2012. The HHS website explains: “For Version 5010 and Version D.0 [referral authorization for pharmacy], the compliance date for all covered entities is January 1, 2012. This gives the industry enough time to test the standards internally, to ensure that systems have been appropriately updated, and then to test between trading partners before the compliance date.” (http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage) Since compliance with the updated HIPAA transaction sets will not be mandatory until 2012 they will not be made mandatory for California workers’ compensation at this time. The 4010 Versions of the transaction standards will be the mandatory workers’ compensation standards. Trading partners may use the 5010 if they agree to do so. (7.4 (c) - Medical Billing and Payment Guide, page 13.)

The use of the ASC X12N 277 for pending a transaction is necessary to streamline the billing and payment process. If a bill is incomplete or missing an attachment it is more efficient to hold the claim as pending for five days in an effort to obtain the missing material rather than to reject the claim outright.

It is necessary to specify that payment must be made within 15 days of receipt of the electronically submitted bill as this is the time frame mandated by statute. The statute requires that an objection to a bill must specify the reasons for objection. It is necessary to standardize the communication of these message by adopting and referring to the Explanation of Review Codes adopted in Appendix B – 1.0. Standardization will improve communication and efficiency by avoiding vague or ambiguous communications from payers to providers. The Division is aware that some payers issue notices of objection to bills that do not adequately communicate the reasons for the objection. This increase conflict and costs in the system by delaying resolution of billing issues and payment.

7.2 Penalty

This section sets forth an advisement that an electronically submitted bill, if complete, will be subject to audit penalties if it is not paid or objected to within 15 working days of receipt. It also provides that any electronically submitted complete bill not paid within

45 working days of receipt (60 if a governmental agency) shall be increased 15% unless the provider is notified within 30 working days of receipt that the bill is contested.

Necessity

The electronic billing statute, Labor Code §4603.4, does not itself have a penalty provision. However, failure to pay when due the reasonable costs of medical treatment, and failure to comply with regulations of the administrative director may give rise to an administrative audit penalty pursuant to Labor Code § 129.5(a)(2),(3). Inclusion of the audit penalty advisement in the Medical Billing and Payment Guide is intended to serve as a deterrent to poor performance.

The inclusion of the 15% increase where the bill is not paid within 45 working days of receipt unless an objection is sent within 30 working days of receipt is adopted to make it clear that the penalty provisions of Labor Code §4603.2 are applicable to electronically submitted bills. There is nothing in Labor Code §4603.2 which restricts its applicability to paper bills; however it is useful to make it explicit to the regulated public that it applies to electronically submitted bills.

7.3 Electronic Bill Attachments

(a) This section prescribes the information that must be on a header on the attachment or on a cover sheet to the attachment: claims administrator name, employer name, unique attachment indicator number, billing provider NPI number, billing provider name, bill transaction identification number, document type, number of pages and contact name/phone number. Where applicable, the section specifies the applicable loop of the ASC X12 837. The section cross-references to Appendix D of the Companion Guide for Report Type Codes.

(b) The attachment itself or a cover sheet to the cover sheet shall have: patient's name, claims administrator's name, date of service, date of injury, social security number (if available), claim number (if available), unique attachment indicator number.

(c) The section requires attachments to comply with the rules regarding Complete Bills and Security and specifies that they shall be submitted according to the protocols in the Companion Guide.

(d) The section specifies attachment submission methods: FAX, electronic submission (with recommended but not required ASC X12N 275) and e-mail.

(e) The section specifies 4 attachment types: reports, supporting documentation, written authorization, and miscellaneous/other.

Necessity

It is often necessary for a medical provider to submit medical reports or other documentation to support a bill. In order to avoid the delays in matching attachments to the electronic bills, it is necessary to prescribe standards for identifying the attachments. CMS issued a proposed HIPAA rule for Electronic Health Care Claims Attachments on September 23, 2005, however a final rule has not been adopted. (Federal Register, September 23, 2005, vol. 70, no. 184, page 55990.) Therefore it is necessary for the Medical Billing and Payment Guide to establish attachment rules.

7.4 Miscellaneous

(a) The section states that the Medical Billing and Payment Guide does not prohibit a claims administrator from conducting a retrospective utilization review.

(b) The section states that the Medical Billing and Payment Guide does not prohibit a claims administrator and a biller from using alternative forms/formats or procedures provides there is a specific written agreement allowing those alternatives and the alternative billing and transmission format provides all required information.

(c)The section

Necessity

The utilization review statute, Labor Code §4610, provides a claims administrator with a right to perform review of the medical necessity of treatment to cure or relieve the industrial illness or disease. It is necessary to clarify that the billing / payment rules and timeframes do not interfere with the right to perform retrospective utilization review.

The provision stating that a claims administrator and a biller may agree to utilize alternate formats and procedures is necessary to allow flexibility in electronically conveying bill information as long as specified information is transmitted. This assures that the desired result is achieved while allowing the regulated community to use alternate means that are mutually agreeable. For example, although the billing guide adopts the ASC X12N 837 Version 4010, the parties can agree to use the updated Version 5010.

Since HIPAA excludes workers' compensation from its coverage, the HIPAA privacy rules do not apply to California workers' compensation. However, injured workers have a privacy interest in their medical information under California constitutional privacy protections. It is therefore necessary to restrict release of individually identifiable health information.

7.5 Trading Partner Agreements

(a), (b) The sections require that health care providers, facilities and third party billers/assignees choosing to submit their bills electronically must enter into a Trading Partner agreement either directly with the claims administrator or with the claims administrator's clearinghouse. The Trading Partner Agreement memorializes the rights, duties and responsibilities of each party to the agreement.

Necessity

In order for electronic billing to function efficiently the parties to the transaction must have legally binding contracts in the form of trading partner agreements. These types of agreements are used for HIPAA-covered electronic data interchange transactions. CMS has described some of the issues that may be addressed in a trading partner agreement, such as: the method for accepting and sending transactions, the use of disks, tapes, dial-up connectivity, identification of clearing houses, and details for the testing phase.

Appendices for Section One

Appendix A Standard Paper Forms

The Appendix A contains introductory language specifying that the paper forms contained in the Medical Billing and Payment Guide are the only forms to be used for California workers' compensation medical treatment billing unless there is a written contract specifying something different. The introduction explains that each form is followed by a table which identifies the fields to be filled out, the field number, the ANSI X12 835 equivalent, the field designation of required, situational, optional or not applicable and comments.

Necessity

It is necessary to specify that the forms are mandatory unless there is an agreement to use other forms because the statute being implemented specifies that health care providers and facilities shall submit medical bills on standardized forms. Currently there is no required format for a bill and claims administrators receive and process bills in a multitude of formats. The proposed rule provides flexibility to use a different form if the parties agree, allowing divergence from the standard if the parties deem it to be more efficient.

1.0 CMS 1500 and 1.1 Field Table CMS 1500

This section adopts the CMS 1500 form (version 08/05). It describes where the form may be obtained. The section incorporates by reference the National Uniform Claim Committee's 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 08/05, Version 5.0 07/09. The sample CMS 1500 is included. The table "1.1 Field Table CMS 1500" sets forth each field number, a field description, a notation of "required," "situational," "optional," or "N/A" and comments.

Necessity

The CMS 1500 form has been adopted by CMS and is utilized for billing physician and other medical provider services in many different payment systems. It is commonly, but not universally, used by physicians and medical providers billing for treatment in workers' compensation. Adopting the CMS 1500 as the mandatory standard billing form is efficient as it is already widely utilized.

The National Uniform Claim Committee's Reference Instruction Manual standardizes the use of the form in order to gain efficiencies by setting nationwide usage protocols. The NUCC describes itself as follows:

"The National Uniform Claim Committee (NUCC) is a voluntary organization that replaced the Uniform Claim Form Task Force in 1995. The committee was created to develop a standardized data set for use by the non-institutional health care community to transmit claim and encounter information to and from all third-party payers. It is chaired by the American Medical Association (AMA), with the Centers for Medicare and Medicaid Services (CMS) as a critical partner. The committee is a diverse group of health

care industry stakeholders representing providers, payers, designated standards maintenance organizations, public health organizations, and vendors.”
<http://www.nucc.org/>

The NUCC, in conjunction with the AMA, publishes the 1500 Claim Form Reference Instruction Manual in order to “help standardize nationally the manner in which the form is being completed.” <http://www.nucc.org/> A notice at the beginning of the manual explains the background and intended function of the 1500 Claim Form Reference Instruction Manual:

This document is published in cooperation with the National Uniform Claim Committee (NUCC) by the American Medical Association (AMA). Permission is granted to any individual to copy and distribute this material as long as the copyright statement is included, the contents are not changed, and the copies are not sold or licensed. Applicable FARS/DFARS restrictions apply. The 1500 Health Insurance Claim Form is in the public domain. The NUCC has developed this general instructions document for completing the 1500 Health Insurance Claim Form. This document is intended to be a guide for completing the 1500 Claim Form and not definitive instructions for this purpose. Any user of this document should refer to the most current federal, state, or other payer instructions for specific requirements applicable to using the 1500 Claim Form. The NUCC Reference Instruction Manual must remain intact. Any payer-specific or other organization-specific instructions for completion of the 1500 Claim Form need to be maintained in a separate document.

[Access the Reference Manual at:

[http://www.nucc.org/index.php?option=com_content&task=view&id=33
&Itemid=42](http://www.nucc.org/index.php?option=com_content&task=view&id=33&Itemid=42)]

It is necessary to supplement the NUCC’s reference manual by including California Workers’ Compensation Instructions in field table 1.1 to adapt the general protocols to the unique situation of workers’ compensation. In addition, the field table sets forth a notation for each field of whether the field is required, situational (i.e. required only in specified situations), or not applicable. This is necessary so that providers and payers know what is required on the form in order to minimize disputes regarding adequate completion of the form.

2.0 UB 04

This section adopts the UB 04 for billing institutional claims in workers’ compensation. The section incorporates by reference the National Uniform Billing Committee’s (NUBC’s) Data Specifications Manual for the UB 04. The section includes a field table that sets forth each field number, a field description, a notation of “required,” “situational,” or “N/A” and California Workers’ Compensation Instructions.

Necessity

The UB 04 (CMS 1450) is the form adopted by CMS for billing services of institutional providers such as hospitals, ambulatory surgical centers, and skilled nursing facilities. Since May 17, 2007 the form has been mandatory for Medicare billing for institutional providers that are exempt from electronic billing. The UB 04 is also widely used in other payment systems, including institutional billing in workers' compensation claims. The UB 04 was created by the National Uniform Billing Committee (NUBC). The history of the NUBC, creation of the UB 04 and composition of the NUBC is explained in the NUBC's publication *Protocol*, approved July 15, 2009 as follows:

The NUBC is an unincorporated association formally organized in May 1975. The goal of the NUBC is to develop and maintain a national uniform billing instrument for use by the institutional health care community. After seven years of analysis and discussion, the NUBC approved the Uniform Billing (UB) data set and form. It was designed to convey a core set of data containing pertinent information about patient services, the clinical basis for treatment, related events surrounding the care, as well as other information typically needed by third-party payers, and health researchers.

The first adopted form was the UB-82; it was in use for 10 years. Its successor the UB-92 form was in use for 12 years. The current form is the UB-04. The numeric suffix indicates the year the paper form was approved for use. The development of the paper form, along with its corresponding data set, paved the way for the creation of an electronic equivalent.

NUBC representation includes national provider and payer organizations, electronic standard setting organizations, state associations, public health agencies, and other committees or associations. The members of the NUBC provide an authoritative voice regarding the development of the data content and data definitions for the institutional claim.

<http://www.nubc.org/about.html> *Protocol*, page 3.

The UB 04 is used in a wide variety of payment systems. The NUBC UB 04 Data Specification Manual provides instructions for completing the form in order to encourage national standardized protocols for completing each field. It is efficient for the division to adopt these national standards for workers' compensation. However, it is necessary to supplement the NUBC's data specifications manual by including California workers' compensation instructions in field table 1.1 to adapt the general protocols to the unique situation of workers' compensation. In addition, the field table sets forth a notation for each field of whether the field is required, situational (i.e. required only in specified situations), or not applicable. This is necessary so that providers and payers know what is required on the form in order to minimize disputes regarding adequate completion of the form.

3.0 NCPDP

The section adopts the NCPDP Workers' Compensation / Property and Casualty Claim Form Version 1.0 – 05/2008 as the mandatory pharmacy claim form. The section also adopts and incorporates by reference the NCPDP Manual Claim Forms Reference Implementation Guide, Version 1.0, except pages 13-36 relating to the Universal Claim Form. The section includes a field table which sets forth the paper field numbers/descriptors, a notation of "required," "situational," "optional," or "N/A," a column cross referencing the paper field to the NCPDP 5.1 electronic transaction standard data element, comments on field usage, and specialized California workers' compensation instruction.

Necessity

It is beneficial to adopt the NCPDP's revised Workers' Compensation / Property and Casualty Universal Claim Form for pharmaceutical billing as the mandatory paper form because it has been tailored for use in workers' compensation as well as property and casualty. In addition, it has been developed to make sure there is a correspondence between the paper form fields and the electronic transaction data elements in the NCPDP Version D.0 which will be the mandatory HIPAA electronic transaction set as of January 1, 2012, and which is currently an optional HIPAA transaction set. The use of the updated form will allow for a more efficient move to the electronic transactions in the future.

Although the form has been adopted to use in workers' compensation, NCPDP recognizes that additional instructions may be needed. The NCPDP states: "Each state develops and adopts billing rules associated with the completion of a billing claim form for workers' compensation. Some states have no specific rules; others have very specific rules that determine what data elements are required or situational for the billing form to be considered payable. One should review the specific jurisdictional state rules associated with the claim to ascertain the specific requirements for that jurisdiction." Manual Claim Forms Reference Implementation Guide, Version 1.0, page 9. It is necessary to supplement the Implementation Guide in relation to several fields that require special instruction for California workers' compensation. The Implementation Manual and field table are necessary so that providers and payers know what is required on the form in order to minimize disputes regarding adequate completion of the form.

4.0 ADA 2006

The section adopts and incorporates by reference the American Dental Association (ADA) Dental Claim Form © 2006 as the mandatory form for dental claims. The section adopts and incorporates by reference the most recent Current Dental Terminology, Fourth Edition published by the American Dental Association. The section provides information regarding where to purchase copies of the form and CDT-4. The section includes a Field Table that sets forth a field number, field description, a notation for each field of whether the field is required, situational (i.e. required only in specified situations), or optional. The table includes comments specific to use of the form for workers' compensation.

Necessity

It is efficient to adopt the paper ADA Dental Claim Form 2006 as the standard paper dental claim form because it is already widely used by providers and private and public payers. In addition, the form's data content is aligned with the HIPAA standard electronic dental claim transaction, ASCX12N 837D 004010X97A1 which is also adopted for California workers' compensation. The HHS Secretary has adopted the ADA dental codes as the HIPAA mandated codes, and the Secretary's regulations specify that each code set is valid within the dates specified by the organization that maintains the codes. 45 CFR §§ 162.1000, 162.1002, 162.1011. Labor Code §4603.4(b) requires that the billing regulations must be consistent with HIPAA to the extent feasible. Therefore it is necessary for the Medical Billing and Payment Guide to mandate the use of billing codes that are valid for the date of service. This will assure that the codes used for billing are always the current codes and are consistent with the HIPAA code sets.

The ADA website states:

“Accurate recording and reporting dental treatment is supported by a set of codes that have a consistent format and are at the appropriate level of specificity to adequately encompass commonly accepted dental procedures. These needs are supported by the *Code on Dental Procedures and Nomenclature (Code)*.

On August 17, 2000 the *Code* was named as a HIPAA standard code set. Any claim submitted on a HIPAA standard electronic dental claim must use dental procedure code from the version of the *Code* in effect on the date of service. The *Code* is also used on dental claims submitted on paper, and the ADA maintains a paper claim form whose data content reflects the HIPAA standard electronic dental claim.”

<http://www.ada.org/prof/resources/topics/cdt/index.asp>

The ADA maintains a Code Revision Committee that “is comprised of equal representation from third-party payers and the ADA. Six third-party payer organizations represented are: America's Health Insurance Plans, Blue Cross and Blue Shield Association, Centers for Medicare and Medicaid Services, Delta Dental Plans Association, National Association of Dental Plans, National Purchaser of Dental Benefits. The ADA is represented by six dentists in practice appointed by the President of the Association.”

<http://www.ada.org/prof/resources/topics/cdt/committee.asp>

The reverse side of the ADA form is adopted as it provides important instructions on completion of the form in order to minimize disputes regarding adequate completion of the form. It is necessary to adopt the field table to provide comments that are specific to workers' compensation.

Appendix B Standard Explanation of Review

The section states that a standard form for the paper Explanation of Review (EOR) has not been developed, but all of the elements indicated as required in 2.0 Field Table Standard Explanation of Review must be included in an EOR. The section sets forth the time frames for objecting to a bill (thirty working days after receipt of the bill), and paying uncontested bill amounts (45 working days after receipt of the bill, 60 working days for governmental entities). The section provides that if a required report or supporting documentation is not received with a bill, the time to object or pay shall commence on the date of receipt of the bill or report. The claims administrator shall inform the provider within thirty working days of receipt of a bill if a report or documentation is missing. The section requires that an objection contain: a clear and concise explanation of the basis for the objection to each contested procedure and charge using the DWC Bill Adjustment Reason Codes contained in Table 1 California DWC ANSI Matrix Crosswalk.

Necessity

It is necessary to adopt a rule that will implement Labor Code section 4603.2's requirement that the claims administrator inform the provider if additional information is required to review the bill and the reasons for contesting a bill. The Division has determined that it is advantageous to allow the claims administrator the flexibility to develop its own format for the Explanation of Review as long as all of the specified data elements as set forth in the field table are included in the EOR. The adoption of the DWC Bill Adjustment Reason Codes is necessary to improve communication between provider and payor. The standardization of the reason codes will increase efficiency by eliminating the variation in EOR messages, allowing providers to easily and quickly understand the EOR.

Section Two – Transmission Standards

The section specifies the effective date for the electronic standard formats. The section explains that HIPAA-compliant standards have been used wherever feasible.

1.0 California Electronic Medical Billing and Payment Companion Guide. The section alerts the reader to the existence of the Medical Billing and Payment Companion Guide, sets forth the Division's web address to download the Guide, and states that compliance with the provisions is mandatory as the Guide is adopted as a regulation.

2.0 Electronic Standard Formats. The section sets forth the specific electronic standard formats / implementation guides, including version numbers and publishers, for billing: the ASC X12N 837 Version 4010 for Dental, Professional, and Institutional/Hospital, the NCPDP Telecommunication Standard Implementation Guide Version 5.1 for retail pharmacy; for Acknowledgment: the TA1 Interchange Acknowledgment and the 997 Functional Acknowledgment contained in the ASC X12N 837 standards and for Pharmacy the responses contained in the NCPDP Telecommunication Standard

Implementation Guide Version 5.1; for Remittance the ASC X12N 835, Version 4010 and Addenda; for Documentation / Attachments to Support a Claim, the ASC X12N 275, Version 4050, additional information to support a health care claim, the ASC X12N 277 health care claim request for additional information, Version 4050.

3.0 Obtaining Transaction Standards / Implementation Guides. The section sets forth the addresses, phone numbers, and web addresses of the publishers of the standards / implementation guides.

4.0 Electronic Signature. The section provides that an electronic or digital signature shall be recognized as valid if it conforms to Government Code §16.5 and the Secretary of State's implementing regulations. The section cross-references to the Medical Billing and Payment Companion Guide which sets for the statute and regulations. The section provides the Secretary of State's web address that can be used to access the "Approved List of Digital Signature Certification Authorities."

Necessity

It is necessary to make the regulated public aware that the standard formats will go into effect 18 months after the effective date of the regulations, to carry out the statutory intent that claims administrators have 18 months before the mandatory acceptance of electronic billing. Labor Code §4603.4 subdivision (b) states that "To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996." Subdivision (a) requires the Division to adopt regulations that ensure that all health care providers and facilities submit medical bills on standardized forms, require acceptance by employers of electronic claims for payment of medical services, and ensure confidentiality of medical information submitted on electronic claims for payment. It is necessary to inform the public that the Division has adopted HIPAA-compliant standard wherever feasible, as the statute requires.

The Division has determined that it is necessary to specify which transaction standards are mandated by listing each standard and the version number and date so that the public will have adequate description of the adopted standards. The Division has decided to adopt the current mandatory HIPAA standards, but has not adopted the HIPAA standards which were recently adopted for HIPAA, but which are not mandatory under HIPAA until January 12, 2012. (45 CFR § 162.1102.) For example, the current ASC X12N 837 *Version 4010* is mandatory under HIPAA, but the ASC X12N 837 *Version 5010* will not be mandatory under HIPAA until January 12, 2012. Providers and claims administrators in workers' compensation that wish to adopt the 5010 standards can do so by agreement, but the Division is not adopting the 5010 at this time.

All of the mandatory billing, acknowledgment and remittance standards are HIPAA-mandated standards except for the ASC X12N 277 Health Care Claim Acknowledgment Version 4040. Although the ASC X12N 277 Health Care Claim Acknowledgment Version 4040 has not been adopted by HIPAA, it is a national standard adopted by the

Accredited Standards Committee, X12N Insurance Subcommittee. The Division has determined it is necessary to adopt this standard in order to provide the functionality needed by the circumstances that pertain specifically to workers' compensation. This standard allows an electronic claim to be pended if the claim lacks information needed to process the claim, instead of immediately rejecting the claim. For example, the medical provider in workers' compensation often does not have the "claim number" that has been assigned by the claims administrator. Instead of rejecting the claim, causing delay in processing the bill, the ASC X12N 277 Health Care Claim Acknowledgment Version 4010 can be used to inform the provider that the claim is pended in order to obtain the claim number.

It is appropriate to adopt the documentation / attachments standards are set forth in the guide as optional formats that can be used upon mutual agreement. They are not HIPAA adopted standards, and there may be other methods the parties choose to utilize for submission of documentation and to request additional information. On September 23, 2005, the ASC X12N 275 was proposed by the Secretary of Health and Human Service under HIPAA as the standard for submitting electronic documentation. Federal Register, Vol. 70, No. 184, page 55990. However, the standard has not been adopted in a final rule.

It is necessary to specify the publishers' contact information so the regulated public can readily access the standards. The standards of the Accredited Standards Committee and the National Council for Prescription Drug Programs are copyrighted products therefore it is necessary for members of the public to purchase the standards.

It is necessary to include language alerting the regulated public of the fact that the California Electronic Medical Billing and Payment Companion Guide is a regulation which must be consulted for detailed information on electronic billing. The Division will make the Companion Guide readily available by download from the internet.

In order to carry out the statutory purpose of establishing electronic billing as an alternative to paper billing it is necessary to establish an electronic means of signature that will assure the integrity of signatures submitted. There is currently no HIPAA standard for electronic signatures in medical billing, as the signature rule proposed by HHS in 1998 was not adopted. Since there is no national HIPAA standard for signature in the medical billing context it is necessary for the Division to establish a standard for workers' compensation. The Secretary of State has established regulations to govern the technologies that may be used for digital signatures that are received or sent by public entities as required by the Government Code §16.5. These regulations adopt Public Key Cryptography and Signature Dynamics technologies in order to ensure that the digital signature is: "unique to the person using it," "capable of verification," "under the sole control of the person using it" and "linked to data in such a manner that if the data are changed, the digital signature is invalidated." The regulations provide a sound methodology for defining acceptable technologies for electronic signatures in workers' compensation. The Secretary of State's "Approved List of Digital Signature Certification Authorities" which is available on the Secretary of State's website provides the assurance

that the certification authority has been reviewed and found to be compliant. The list is dynamic, as other digital signature providers can apply for inclusion on the list. The Secretary of State's Initial Statement of Reasons for title 2, CCR section 22003 explains:

The field of digital signature technology, including the creation, transmittal and validation of signatures is a rapidly emerging industry. Although internationally recognized technological standards exist for some aspects of digital signature technology, there does not appear to be an exclusive dominant technology that has emerged as the one and only method of conducting digital signature transactions.

Historically, computer software and hardware have evolved and improved at an exponential rate. Understanding that a technology which may appear to be dominant in the marketplace one day may be obsolete in a matter of years, the secretary of state has determined that there exists a need to develop a dynamic list of technologies which create digital signatures that are acceptable for use by public entities in California.

The absence of such a list could result in public entities accepting as reliable, digital signatures created by technologies that do not meet the standards established by the legislature in Government Code Section 16.5.

It is necessary to adopt the Secretary of State's digital signature regulations for use in workers' compensation so that all participants in workers' compensation matters will have a readily available method for determining the validity of digital signatures used in electronic transactions. In order to facilitate the public's access to the Secretary of State's regulations and digital signature certification authorities list, it is necessary to provide references. In order to recognize digital signatures that have legal validity under other provisions of law, the language of the guide specifically so specifies.

Section 9792.5.1 Subdivision (b): this section incorporates by reference the *California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide* which sets forth transaction standards, code sets and technical specifications for electronic medical treatment bill submission and payment remittance. The section identifies how to obtain the Guide by downloading it from the Division's website or writing to the Division.

The *California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide* (hereafter *Electronic Medical Billing and Payment Companion Guide*) was created by the Division, with input from the Electronic and Standardized Medical Treatment Billing Advisory Committee. This committee included representatives of providers and payers that met periodically for more than two years. The Division also sought input from the public by posting draft regulations, draft Medical Billing and Payment Guide, and draft Electronic Medical Billing and Payment

Companion Guide on the Division's internet Forum website from August 10, 2007 to September 10, 2007. (See Rulemaking File, Other Documents, Memorandum from Suzanne Honor, Workers' Compensation Manager December 9, 2009)

The *Electronic Medical Billing and Payment Companion Guide* contains a preface page that states that the guide has been adopted into 8 CCR section 9792.5.1. The preface explains the purpose of the guide is to supplement the national standard implementation guides of the Accredited Standards Committee and the National Council for Prescription Drug Programs which have been adopted as part of the HIPAA rules. The preface also provides reference to other important billing rules: the California Division of Workers' Compensation Medical Billing and Payment Guide and the billing regulations at title 8 CCR section 9792.5.0 et seq. The Division of Workers' Compensation Medical Unit contact information is provided.

Necessity

It is necessary for the preface to provide essential information about the nature of the guide as a regulation and as a supplement to the national standard implementation guides so that the regulated public will understand the status of the guide. In order to alert readers of the guide to the existence of other rules that impact billing it is necessary to include reference to those rules. Inclusion of contact information for the Division will facilitate the public's communication with the agency.

Chapter 1 Introduction and Overview

1.1 HIPAA

This section references the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and describes the mandate for the Secretary of the Department of Health and Human Services to adopt national standards for electronic health care transactions. It sets forth the federal purpose to adopt standards to improve efficiency and effectiveness of the health care system by encouraging use of electronic data interchange. The section states that HIPAA does not apply to workers' compensation, and states that the California legislature has directed that workers' compensation electronic billing standards be consistent with HIPAA wherever feasible.

Necessity

It is important to highlight the existence of HIPAA since it provides an important context for electronic billing. HIPAA regulations establish national standards for electronic health care transactions, including provisions for security of electronic protected health information. However, it is necessary to make the public aware that HIPAA does not directly govern workers' compensation transactions. A covered entity under HIPAA includes a variety of health insurers and plans but does not include a workers' compensation insurer. 42 U.S.C. § 300gg-91(a), (b), (c)(1)(D), 45 C.F.R. §§ 160.102(a)(1), 160.103. It is also necessary to alert the public to the fact that the

Legislature has directed the Division to establish electronic billing standards that are consistent with HIPAA “to the extent feasible.”

1.2 California Labor Code 4603.4

This section explains that Labor Code section 4603.4 mandates that: 1) employers accept electronic bills for medical goods and services, 2) electronic billing is optional for medical providers and health facilities, and 3) the electronic medical billing regulations must be compliant with HIPAA to the extent feasible. The section states that health care providers, health care facilities and third party billers/assignees shall use the HIPAA-adopted ASC X12N 87 Professional, Institutional or Dental transaction formats and the NCPDP Telecommunication 5.1 and NCPDP Batch Standard 1.1 for billing. Claims administrators will use the HIPAA-adopted ASC X12N 835 Remittance Advice to report an explanation of payments, reductions, and denial to the health care provider, health care facility, or third-party billers/assignees. The section provides the web addresses for the Washington Publishing Company and the National Council on Prescription Drug Programs to obtain the billing and remittance standards. The section states that the Medical Billing and Payment Companion Guide supplements the national guides and provides clarifications for California workers’ compensation usage. If there is a difference between the national standard and the Medical Billing and Payment Companion Guide, the companion guide prevails.

Necessity

It is necessary for the companion guide to inform the public of the statutory basis for the guide, and for the public to understand that electronic billing is mandatory for payors but optional for providers. It is also important that the public understand that the statute provides that the electronic standards are to be compliant with HIPAA *to the extent feasible* so that providers and payors do not erroneously assume the workers’ compensation regulations conform to HIPAA. It is important that the overview alerts the public that the companion guide prevails if there are discrepancies with the national standards because differences which exist are intended to provide critical adaptation of the national standards to the unique issues in workers’ compensation.

Chapter 2 California Workers’ Compensation Requirements

2.1 Compliance

The section states that claims administrators must accept electronic submission of medical bills and adhere to the provisions of the companion guide by a date to be specified, which will be approximately 18 months after adoption. The entity submitting the bill has the option of submitting the bill on paper or electronically. An entity submitting a bill electronically must be able to receive electronic acknowledgements and remittance advice. The section states that providers and claims administrators may utilize agents for electronic billing and states that the method of connectivity is not mandated by the billing rules. The section states that the parties must be able to exchange electronic medical bills in the prescribed standard formats and may exchange data in non-prescribed

formats by mutual agreement as long as all required data elements are in the agreed-upon formats.

Necessity

It is necessary to specify the date that claims administrators must comply with the electronic billing requirements as 18 months after the effective date of the rule in order to carry out the Legislative intent which is apparent in Labor Code section 4603.4. The statute makes electronic billing optional on the part of the medical provider therefore it is necessary for the section to include this provision. The Division has determined that it is necessary to require that an entity that submits an electronic bill be able to receive electronic acknowledgment and remittance advice in order to achieve the efficiency intended by adoption of electronic billing. It would increase costs and hinder the streamlined billing and payment system if claims administrators were required to provide paper remittance advice and explanation of review for electronic bills. In order to allow flexibility, the section allows the parties to the billing transaction to determine the connectivity method. Similarly, the parties are allowed flexibility to utilize non-prescribed formats as long as the required data elements are present. This flexibility ensures that parties can agree to use different formats where that meets their business needs or is more cost effective.

2.1.2 Agents

The section specifies that parties may use agents to accomplish electronic billing and provides that the entities using agents are responsible for the acts or omissions of those agents.

Necessity

It is necessary to allow entities to use an agent in the billing/payment process in order to make electronic billing economically advantageous. Many providers and claims administrators may find it more efficient to utilize the services of a clearinghouse to process billing transactions rather to set up its own internal electronic billing/payment process. There are costs for the hardware and software infrastructure that may be more efficiently absorbed by a clearinghouse that is in the business of handling electronic transactions, especially for small providers or claims administrators. The use of an agent to perform legally required billing and payment obligations cannot insulate the principal from responsibility to perform the obligations correctly; therefore the section makes that fact known.

2.1.3. Confidentiality of Medical Information Submitted on Electronic Claims / Security

The section states that health care providers, health care facilities, third-party biller/assignees, and claims administrators, and their agents must comply with rules related to security of confidential medical data contained in Appendix D. The section

states that the security rule parallels the HIPAA security rule but is modified to conform to the workers' compensation environment.

Necessity

It is necessary to adopt security standards to implement Labor Code section 4603.4's provision requiring that the regulation ensure confidentiality of medical information submitted on electronic claims for payment. The HIPAA standards provide appropriate security standards, but must be modified since HIPAA itself does not apply to workers' compensation. (This is discussed in more detail below regarding Appendix D.)

2.2 National Standard Formats

The section identifies the national standard formats for billing and remittance adopted in 45 CFR Part 162 that are adopted for California workers' compensation: the 837 Health Care Claim (Professional, Institutional and Dental), the 835 Health Care Claim Payment/Advice, the pharmacy billing standards NCPDP Telecommunication Standard Implementation Guide 5.1 and NCPDP Batch Standard Implementation Guide 1.1. The section identifies national standards that are adopted or suggested for use for workers' compensation which are not adopted by HIPAA rules: the 277 Health Care Claim Acknowledgement, the 277 Health Care Claim Request for Additional Information, and the 275 Additional Information to Support a Health Care Claim or Encounter.

Necessity

Since Labor Code section 4603.4 directs the adopted standards to be as consistent with HIPAA as feasible, it is necessary to inform the public regarding which standards are aligned with the HIPAA standards and which are non-HIPAA standards.

2.2.1 California Prescribed Formats

The section incorporates by reference specified electronic transaction standards for electronic transactions occurring on or after "XXXX, 2011 [18 months after effective date of regulation]." The standards for billing, acknowledgment, remittance, and documentation / attachments to support a claim are specified:

(1) Billing:

(a) Dental Billing: The ASC X12N 837 -- Health Care Claim: Dental, Version 4010, May 2000, 004010X097 and Addenda to Health Care Claim: Dental, Version 4010, October 2002, 004010X097A1.

(b) Professional Billing: The ASC X12N 837 -- Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, 004010X098 and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, 004010X098A1.

(c) Institutional/Hospital Billing: The ASC X12N 837 -- Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, 004010X096 and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, 004010X096A1.

(d) Retail Pharmacy Billing:

(i) The Telecommunication Standard Implementation Guide Version 5, Release 1 (Version 5.1), September 1999, National Council for Prescription Drug Programs.

(ii) The Batch Standard Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000, supporting Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record, National Council for Prescription Drug Programs.

(2) Acknowledgment:

(a) Electronic responses to ASC X12N 837 transactions:

(i) The TA1 Interchange Acknowledgment contained in the adopted ASC X12N 837 standards.

(ii) The 997 Functional Acknowledgment contained in the adopted ASC X12N 837 standards.

(b) Electronic responses to NCPDP Pharmacy transactions:

The Responses contained in the adopted NCPDP Telecommunication Standard Implementation Guide Version 5.1 and the Batch Standard Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000.

(c) The ASC X12N 277: Health Care Claim Acknowledgement Version 4040, February 2004, 004040X167.

(3) Remittance:

The ASC X12N 835 -- Health Care Claim Payment/Advice, Version 4010, May 2000, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, 004010X091A1.

(4) Documentation / Attachments to Support a Claim:

(a) The ASC X12N 275 -- Additional Information to Support a Health Care Claim or Encounter, Version 4050, June 2004, 004050X151. [Optional.]

(b) The ASC X12N 277 Health Care Claim Request for Additional Information, Version 4050, June 2004, 004050X150 [Optional.]

Necessity

It is necessary to specify an implementation date that is 18 months from the adoption of the regulation in order to carry out the statutory intent to allow 18 months before a claims administrator is required to accept electronic bills. It is necessary to incorporate each of the standards by reference as they are too voluminous to publish in the California Code of

Regulations, amounting to thousands of pages. Additionally, the standards are copyrighted documents which must be purchased from the publisher by the regulated entity that will use the standards. These copyrighted documents may not be republished in the California Code of Regulations. All of the standards are available for inspection as part of the rulemaking file. They may not be photocopied due to the copyright of the documents.

In order to carry out the statutory intent to adopt standards that are consistent with HIPAA to the extent feasible, the Division adopts the 4010 version of the 837 Professional, Institutional, and Dental Claim standard implementation guides and 835 Health Care Claim Payment/Advice. These are the mandatory HIPAA standards at this time. The Division is not adopting the 5010 standards which HIPAA adopts as optional standards until January 1, 2012, at which time the 5010 standards become mandatory HIPAA standards. Workers' compensation providers and payers may utilize the 5010 upon mutual agreement.

Similarly, the Division adopts the current HIPAA pharmacy claim standards, the NCPDP Telecommunication Standard Implementation Guide Version 5.1 and the Batch Standard Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000. The Division is not adopting the NCPDP Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, and equivalent Batch Standard Implementation Guide, Version 1, Release 2 (Version 1.2), which HIPAA adopts as optional standards until January 1, 2012, at which time the new NCPDP standards become mandatory HIPAA standards. Workers' compensation providers and payers may utilize the updated NCPDP standards upon mutual agreement.

The Health Care Claim Acknowledgment ASC X12N 277, although not adopted by HIPAA, is mandated for use in workers' compensation because of unique needs engendered by the workers' compensation system. Unlike Medicare, in workers' compensation the claim number assigned to a patient's benefit claim is needed to efficiently and accurately match medical bills to a claimant in the payor's system. The Division has determined that it would be more efficient to hold a bill that lacks a claim number for a period of 5 days rather than reject the claim outright for a missing claim number. The Health Care Claim Acknowledgment ASC X12N 277 Version 4040 is the most appropriate standard that can be adopted to give notice of a pending status of a claim. It is also used to provide the clean bill accept/reject notice.

The Division has determined it is necessary to provide guidance to the public by adoption of two "optional" standards relating to documentation that are not HIPAA standards. The Division has proposed to adopt the ASC X12N 275 -- Additional Information to Support a Health Care Claim or Encounter, Version 4050, June 2004, Washington Publishing Company as an optional standard for providers to use to transmit documentation to support a claim. The Division has also proposed to adopt the ASC X12N 277 Health Care Claim Request for Additional Information, Version 4050, June 2004 as an optional standard for claims administrators to use to request submission of additional information. Both of these standards were proposed by CMS for adoption as HIPAA standards in

2005, but CMS has not issued a final rule. Federal Register, Vol. 70, No. 184, page 55990. The 275 provides an effective way for a provider to transmit documentation to support a claim. The 277 provides an effective way for the claims administrator to request additional documentation to support the bill. However, the parties are free to agree to use other methods to send and request documentation.

2.2.2 Summary of Adopted Formats and Correlation to Paper Form

This section sets forth a table that summarizes the adopted formats, the corresponding paper standardized billing forms and describes the function of the formats.

Necessity

The summary table is a helpful concise display of the adopted mandatory formats/paper forms.

2.2.2 Optional Formats

This section sets forth a table that summarizes two optional formats relating to documentation, the corresponding paper process and describes the function of the formats/process.

Necessity

The summary table is a helpful concise display of the optional formats.

2.4 Companion Guide Usage

This section explains the role of the Electronic Medical Billing and Payment Companion Guide as a supplement to the HIPAA-adopted national implementation guides. It states that the companion guide provides “additional instruction on situational implementation factors that are different in workers’ compensation than the HIPAA implementation.” The section sets forth information regarding the table format used to provide additional workers’ compensation – specific clarification, code values, etc. It sets forth a sample table, indicating that shaded row represent “segments” in the ASC X12N implementation guide, and non-shaded rows represent “data elements.”

Necessity

Because of the differences in workers’ compensation and other payment systems it is necessary to adapt the standard implementation guides for use in workers’ compensation through specialized instructions. It is necessary to inform the regulated public of the role of the companion guide in accomplishing this adaptation.

2.5 Description of ASC X12 Transaction Identification Numbers

The section states that transaction identification requirements are defined in the ASC X12N implementation guides and states that additional information regarding transaction identification number requirements is as follows:

- 2.5.1 Sender/Receiver Trading Partner Identification
Use Federal Employer Identification Number (FEIN) or agreed upon identification numbers to identify trading partners in specified loops
- 2.5.2 Claims Administrator Identification
Use FEIN or agreed upon identification number in specified loops
- 2.5.3 Health Care Provider Identification
Use National Provider Number or state license number if no NPI
- 2.5.4 Injured Employee Identification (Member ID Number)
Identified by social security number (SSN), date of birth, date of injury and workers' compensation claim number. Use SSN, or if not available a default 9-digit code of 999999999 in the SSN data element
- 2.5.5 Claim Identification
Use claim number assigned by the claims administrator in specified segment/loop. REF02 segment requires provider, facility or biller to submit claim identification number, if known, and if not known, value "unknown" must be reported in REF02 segment
- 2.5.6 Bill Identification
Explains that the ASCX12 Implementation Guides refer to a medical bill as a claim for electronic billing transactions. The companion guide refers to the transactions a "bill" in order to avoid confusion since "claim" is generally thought of as the employee's overall claim for benefits relating to an injury. Health care provider, facility or third-party biller/assignee assigns a unique identification number to the electronic bill transaction in the specified loop/segment.
- 2.5.7 Document/Attachment Identification
Documentation or attachments that will be submitted using the 275 are to be identified in the ASC X12N 837 format in PWK Claim Supplemental Information Segment is Loop 2300. Indicates that an attachment is expected, type, delivery method, and attachment control number. These will allow claims administrator to match attachment to the bill. Documentation may be submitted by fax, email, or 275 electronic standard or other agreed upon format. Documentation must be submitted within 5 days of bill submission and must identify patient name, claims administrator name, date of service, date of injury, SSN if available, claim number if available, unique attachment control number which shall include report type code..
Use Jurisdictional Report Type Codes listed in Appendix C. These adapt report type codes used in the 5010 standard because the 4010 standard lacks these workers' compensation-specific report type codes.

Necessity

Although the transaction identification requirements are contained in the ASC X12N implementation guides, it is necessary to set forth the specialized workers' compensation provisions in the companion guide. In order for efficient matching of the bill to the supporting documentation it is necessary to have explicit instruction on the identifiers utilized and it is important to require provision of the claim number if available. Although the Division is not currently mandating the 5010 standard, it is necessary to adopt the report type codes from 5010, which have codes for workers' compensation reports, for use with the 4010 which lacks such codes.

2.6 Claim Administrator Validation Edits

The section states that claims administrators may apply validation edits based on the California DWC Workers' Compensation Billing and Payment Guide rules, ASC X12N Implementation Guide requirements, and Medicare billing policies that have been adopted by the DWC. Claims administrators may not apply Medicare rules or policies not adopted by DWC.

Claims administrators use ASC X12N 277 Health Care Claim Acknowledgement to communicate acceptance or rejection of a bill transaction and to communicate what errors are present by use of the error rejection codes.

Necessity

It is necessary to make it clear what validation edits may be applied and which transaction set is used to communicate error codes. It is necessary to make it clear that Medicare billing rules should only be applied if they have been adopted in order to decrease the number of disputes.

2.7 Description of Formatting Requirements

The section states that the formatting requirements are defined in the ASC X12N, Implementation Guides Appendices A.1, and references the specialized hierarchical structure for workers' compensation.

Necessity

It is useful for the regulated public to highlight the location of the formatting requirements and specialized workers' compensation hierarchical structure.

2.7.1 Hierarchical Structure

This section set forth the assumption that the formats, except for the 997 Acknowledgment, are used at the transaction level. The parent/child hierarchical structure requires each transaction to contain the necessary hierarchical levels, qualifiers,

and relationships. Each transmission must contain at least one billing provider loop containing at least one Subscriber, which is the employer, and at least one patient child loop, which is the injured employee. The section provides reference to the Section 2.3.2.1 HL Segment of the *ASC X12N Implementation Guides* for further information on the hierarchical structure.

Necessity

It is necessary to provide that the employer is the “subscriber” to adapt the format for workers’ compensation because the employer is the purchaser of the workers’ compensation insurance policy, or if self-insured, provides the security for the payment of compensation. For convenience of the public it is necessary to provide reference to the implementation guides for further information on the hierarchical structure.

2.8 Description of Transmission/Transaction Dates

The section provides reference for the required transaction/transmission dates.

Necessity

Transaction and transmission date protocols are important features of electronic billing and it is useful to the reader to be alerted that these are contained in the *ASC X12N Implementation Guides*.

2.9 Description of Code Sets

The section states that the applicable code sets utilized in electronic billing and reimbursement are prescribed by the workers’ compensation medical fee schedule, *ASC X12N Implementation Guides*, *NCPDP Implementation Guide*, Division rule, this companion guide and the California Division of Workers’ Compensation Medical Billing and Payment Guide. The section requires parties to utilize current valid codes based on the date the service or process occurred. The section provides reference to sources of code sets.

Necessity

It is necessary to inform the regulated public of the identity and source of the code sets utilized in electronic billing. Moreover, it is necessary to require parties to utilize current valid codes as of the date of service or process in order to improve communication between provider and payor and to reduce disputes.

2.10 Participant Roles

The section states that participant roles are generally the same in workers’ compensation and the HPA implementation, but employer, insured, injured employee and patient are used differently in workers’ compensation. The section outlines the roles below:

- 2.10.1 Trading Partner

- 2.10.2 Sender
- 2.10.3 Receiver
- 2.10.4 Employer – is the subscriber
- 2.10.5 Subscriber – is the employer
- 2.10.6 Insured – the employer
- 2.10.7 Injured Employee - always the patient in workers' compensation
- 2.10.8 Patient – always the injured worker in workers' compensation

Necessity

It is helpful to the public to have the electronic billing participant roles outlined in the guide. In addition, it is necessary to define the special roles of the employer, subscriber, injured employee and patient which are different in workers' compensation than in group health.

2.11 Health Care Provider Agent/Claims Administrator Agent Roles

The section states that Health Care Providers and Facilities and Claims Administrators may utilize agents to comply with electronic billing requirements. It provides that entities or persons using agents are responsible for the acts or omissions of the agents executed in performance of services for the entity or person. The section states that the electronic billing rules do not mandate, nor regulate the use of agents for electronic billing. The parties are free to utilize a billing agent and may agree upon methods of connectivity and non-standard formats.

Necessity

It is necessary that health care providers, facilities and claims administrators be allowed to utilize agents in the electronic billing process in order to make the system as cost effective as possible. Many providers, facilities and claims administrators will find it more convenient and economically advantageous to use an established clearinghouse rather than establish an electronic billing infrastructure in-house. It is necessary that providers, facilities or claims administrators that utilize an agent be legally responsible for the acts of the agent as they are ultimately responsible for accomplishing the billing/payment processes and use of an agent does not relieve them of the legal obligation. It is helpful to the public to reiterate in this section that the parties may agree upon alternate formats and methods of connectivity.

2.12 Duplicate, Appeal/Reconsideration and Corrected Bill Resubmissions

- 2.12.1 Claim Resubmission Code - ASC X12N 837 Billing Formats
Provides technical information about using the 837 for resubmission of prior medical bills, including loop and segment identification, claim frequency type codes, document control number/internal control number
- 2.12.2 Duplicate Bill Transaction Prior To Payment

Provides technical direction on code, segments for use in the 837 when submitting a duplicate bill. Provides that a duplicate bill transaction shall be submitted no earlier than 30 working days after the claims administrator has acknowledged receipt of a complete electronic bill transaction and prior to receipt of an 835 Health Care Claim Remittance Advice. Provides that a claims administrator may use an 835 transaction to deny the duplicate bill if the bill is received within 30 working days after transmission of the 997 acknowledgment, the bill has been processed and an 835 has been generated or the claims administrator does not have a corresponding accepted original transaction with the same bill identification number.

- **2.12.3 Corrected Bill Transactions**

Provides technical direction on use of the 837 to submit a corrected bill where an element of data on the original bill was either not previously sent or needs to be corrected. Provides that claims administrator may reject a revised bill transaction if the claims administrator does not have a corresponding adjudicated bill transaction with the same bill identification number or if there is inadequate documentation supporting the request for correction.

- **2.12.4 Appeal/Reconsideration Bill Transactions**

Provides technical directions on use of the 837 for reconsideration transactions. Reconsideration bill transactions may only be submitted after receipt of an 835 transaction for the corresponding accepted original bill. The same bill identification number is used on both the original and the reconsideration bill. All data elements, fields, values must be identical except for the specific qualifiers and segments to identify the reconsideration request.

Necessity

In order to streamline the billing process, avoid duplication of effort and miscommunication it is necessary to standardize the use of the 837 for billing submissions that are resubmissions, duplicate bills and corrected bills. It is necessary for the guide to address technical issues relating to the loops and segments and codes to be used to indicate the type of bill (duplicate, corrected, resubmission for appeal etc.) For duplicate bills, it is necessary to restrict submission of the bill for 15 working days after the claims administrator has acknowledged receipt of a complete electronic bill transaction in order to avert inefficient and premature re-billing. Since the claims administrator is allowed 15 working days to remit payment, sending a duplicate bill before this time period has elapsed would cause wasteful expenditure of resources. Resubmissions are allowed *after* issuance of the 835 remittance advice in order to improve efficiency so that the provider has information regarding what the claims administrator finds lacking in the initial billing prior to resubmission of a bill.

2.13 Balance Forward Billing

The section prohibits “balance forward, billing” in which bills carry over a balance from a previous bill and include billing for additional services.

Necessity

Balance forward billing is inefficient, potentially leading to extra handling by the claims administrator and possible overpayment. Bill processing is streamlined when there is no overlap in the items billed on separate bills.

2.14 California-Specific Requirements that Relate to Multiple Electronic Formats

The section indicates that it covers California-specific workers' compensation requirements that apply to more than one electronic format, and indicates that requirements related to a specific format are identified in the chapter related to that format. The section contains technical instructions concerning the following.

- 2.14.1 Claim Filing Indicator
- 2.14.2 Transaction Set Purpose Code
- 2.14.3 Transaction Type Code
- 2.14.4 FEIN/NPI
- 2.14.5 NCPDP Telecommunication Standard 5.1 Pharmacy Format and NCPDP Batch Standard 1.1
- 2.14.6 Jurisdictional State Code: Compliance State Identification

Necessity

It is necessary to set forth the technical instructions for the electronic formats that are specifically adopted for California workers' compensation. For convenience these instructions which apply to many formats are set forth here.

Chapter 3 Companion Guide 837 Professional

The introductory paragraph states that the companion guide has been created to use as a supplement to the ASC X12N 837 004010A1 Professional Health Care Claim Implementation Guide. It states that wherever the standard differs from the California rules, the California rules prevail.

Necessity

It is necessary to make clear to the regulated public the role of the California guide as a supplement to the national guide and not a replacement for it. It is necessary for the California guide to supersede the national guide where a conflict exists because the California guide has been drafted specifically to adapt the national standards for California workers' compensation needs.

3.1 Reference Information

The section states that the ASC X12N 837 004010A1 Professional can be obtained from the Washington Publishing Company and provides the web address.

Necessity

The 837 Professional is a copyrighted document that must be obtained from the publisher, therefore it is necessary to provide the publisher information.

3.2 Trading Partner Agreements

The section states that the companion guide is not intended to replace the trading partner agreement and that trading partners may utilize non-prescribed electronic formats by mutual agreement. The section provides that such alternate formats must, at a minimum, contain all the same required data elements the prescribed formats.

Necessity

Many aspects of the electronic data exchange relationship will need to be set out in trading partner agreements so it is important to make the public aware that the companion guide does not replace the trading partner agreement. There may be business reasons that the trading partners may want to utilize alternate formats. It is necessary to mandate that the required data elements be present in any agreed upon alternate format since the required data elements are needed for accurate benefit provision and also to facilitate the claims administrator's reporting to the Workers' Compensation Information System as required by Labor Code section 138.6.

3.3 Workers' Compensation Health Care Claim: Professional ASC X12N 837 Instructions and 3.3.1 Table

The introductory material explains that the table in 3.3.1 identifies application/instructions for California workers' compensation that are different than the HIPAA implementation. The table contains five columns labeled: loop, segment or element, value, description, and California Workers' Compensation Instructions. The data in the cells provides technical details for use of the 837 transaction standard.

Necessity

It is necessary to adapt the standard 837 for use in workers' compensation due to unique features of the workers' compensation system. The table is a convenient format for informing the regulated public of the technical adaptations required for the 837 Professional.

Chapter 4 Companion Guide 837 Institutional

The introductory paragraph states that the companion guide has been created to use as a supplement to the ASC X12N 837 004010X096 Institutional Health Care Claim Implementation Guide. It states that wherever the standard differs from the California rules, the California rules prevail.

Necessity

It is necessary to make clear to the regulated public the role of the California guide as a supplement to the national guide and not a replacement for it. It is necessary for the California guide to supersede the national guide where a conflict exists because the California guide has been drafted specifically to adapt the national standards for California workers' compensation needs.

4.1 Reference Information

The section states that the ASC X12N 837 004010X096 Institutional can be obtained from the Washington Publishing Company and provides the web address.

Necessity

The 837 Institutional is a copyrighted document that must be obtained from the publisher, therefore it is necessary to provide the publisher information.

4.2 Trading Partner Agreements

The section states that the companion guide is not intended to replace the trading partner agreement and that trading partners may utilize non-prescribed electronic formats by mutual agreement. The section provides that such alternate formats must, at a minimum, contain all the same required data elements the prescribed formats.

Necessity

Many aspects of the electronic data exchange relationship will need to be set out in trading partner agreements so it is important to make the public aware that the companion guide does not replace the trading partner agreement. There may be business reasons that the trading partners may want to utilize alternate formats. It is necessary to mandate that the required data elements be present in any agreed upon alternate format since the required data elements are needed for accurate benefit provision and also to facilitate the claims administrator's reporting to the Workers' Compensation Information System as required by Labor Code section 138.6.

4.3 Workers' Compensation Health Care Claim: Institutional ASC X12N 837 Instructions and 4.3.1 Table

The introductory material explains that the table in 4.3.1 identifies application/instructions for California workers' compensation that are different than the HIPAA implementation. The table contains five columns labeled: loop, segment or element, value, description, and California Workers' Compensation Instructions. The data in the cells provides technical details for use of the 837 transaction standard.

Necessity

It is necessary to adapt the standard 837 for use in workers' compensation due to unique features of the workers' compensation system. The table is a convenient format for informing the regulated public of the technical adaptations required for the 837 Institutional.

Chapter 5 Companion Guide 837 Dental

The introductory paragraph states that the companion guide has been created to use as a supplement to the ASC X12N 837 004010X097 Dental Health Care Claim Implementation Guide. It states that wherever the standard differs from the California rules, the California rules prevail.

Necessity

It is necessary to make clear to the regulated public the role of the California guide as a supplement to the national guide and not a replacement for it. It is necessary for the California guide to supersede the national guide where a conflict exists because the California guide has been drafted specifically to adapt the national standards for California workers' compensation needs.

5.1 Reference Information

The section states that the ASC X12N 837 004010X097 Dental can be obtained from the Washington Publishing Company and provides the web address.

Necessity

The 837 Dental is a copyrighted document that must be obtained from the publisher, therefore it is necessary to provide the publisher information.

5.2 Trading Partner Agreements

The section states that the companion guide is not intended to replace the trading partner agreement and that trading partners may utilize non-prescribed electronic formats by mutual agreement. The section provides that such alternate formats must, at a minimum, contain all the same required data elements of the prescribed formats.

Necessity

Many aspects of the electronic data exchange relationship will need to be set out in trading partner agreements so it is important to make the public aware that the companion guide does not replace the trading partner agreement. There may be business reasons that the trading partners may want to utilize alternate formats. It is necessary to mandate that the required data elements be present in any agreed upon alternate format since the

required data elements are needed for accurate benefit provision and also to facilitate the claims administrator's reporting to the Workers' Compensation Information System as required by Labor Code section 138.6.

5.3 Workers' Compensation Health Care Claim: Dental ASC X12N 837 Instructions and 5.3.1 Table

The introductory material explains that the table in 5.3.1 identifies application/instructions for California workers' compensation that are different than the HIPAA implementation. The table contains five columns labeled: loop, segment or element, value, description, and California Workers' Compensation Instructions. The data in the cells provides technical details for use of the 837 transaction standard.

Necessity

It is necessary to adapt the standard 837 for use in workers' compensation due to unique features of the workers' compensation system. The table is a convenient format for informing the regulated public of the technical adaptations required for the 837 Dental.

Chapter 6 Companion Guide Pharmacy NCPDP 5.1

The introductory paragraph states that the companion guide has been created to use as a supplement to the *NCPDP Telecommunication Standard Implementation Guide Version 5.1* and the *NCPDP Batch Standard Implementation Guide Version 1.1*. It states that wherever the standard differs from the California rules, the California rules prevail.

Necessity

It is necessary to make clear to the regulated public the role of the California guide as a supplement to the national guide and not a replacement for it. It is necessary for the California guide to supersede the national guide where a conflict exists because the California guide has been drafted specifically to adapt the national standards for California workers' compensation needs.

6.1 NCPDP Reference

The section states that the *NCPDP Telecommunication Standard Implementation Guide Version 5.1* and the *NCPDP Batch Standard Implementation Guide Version 1.1* can be obtained from the National Council for Prescription Drug Programs and provides the web address.

Necessity

The *NCPDP Telecommunication Standard Implementation Guide Version 5.1* and the *NCPDP Batch Standard Implementation Guide Version 1.1* are copyrighted documents

that must be obtained from the publisher, therefore it is necessary to provide the publisher information.

6.2 Trading Partner Agreements

The section states that the companion guide is not intended to replace the trading partner agreement and that trading partners may utilize non-prescribed electronic formats by mutual agreement. The section provides that such alternate formats must, at a minimum, contain all the same required data elements the prescribed formats.

Necessity

Many aspects of the electronic data exchange relationship will need to be set out in trading partner agreements so it is important to make the public aware that the companion guide does not replace the trading partner agreement. There may be business reasons that the trading partners may want to utilize alternate formats. It is necessary to mandate that the required data elements be present in any agreed upon alternate format since the required data elements are needed for accurate benefit provision and also to facilitate the claims administrator's reporting to the Workers' Compensation Information System as required by Labor Code section 138.6.

6.3 Pharmacy Invoice Number

The section provides direction on use of the Prescription/Service Reference Number field to identify the invoice number for electronic billing.

Necessity

It is important to utilize a unique number in order to identify a specific billing, which serves as the electronic equivalent of the paper invoice number.

6.4 Billing Date

The section states that the date of service is considered the Billing Date, unless other transactional verification information is provided to the claims administrator to confirm the date the bill was transmitted. The section specifies the technical details of the billing date placement.

Necessity

In electronic pharmacy billing the date of service is usually the same day the billing is transmitted, and thus it is most convenient to consider the date of service as the default billing date. If the billing is actually done at a later date, the provider will provide transactional verification of the later date. It is useful to the public to provide the technical instruction on field usage in this guide.

6.5 Dispensing Pharmacy Billing and Pharmacy Billing Agents

The section states that when the dispensing pharmacy is also the billing entity, the Federal Employer Identification Number (FEIN) is reported in the specified Service Provider field and the NPI number is reported in the Provider ID field.

The section states that the current version of the NCPDP Telecommunication Standard Implementation Guide Version 5.1 does not support the use of third party billing agents by use of a designated field, identifier or qualifier flag. When a third party biller is the billing and payee of the claim, the FEIN of the third party biller is reported in the specified Service Provider ID field and the dispensing pharmacy information will be identified by their NPI number in the Provider ID field in the Pharmacy Provider Segment. The section states that it is important for these issues to be addressed in the trading partner agreement.

Necessity

It is necessary to provide technical guidance for use of the NCPDP Telecommunication Standard Implementation Guide Version 5.1 when the dispensing pharmacy is billing directly and when it uses a billing agent in order to assure that the claims administrator has necessary information. These instructions, along with the advisement to address billing agent issues in the trading partner agreement, should provide an effective adaptation to the Version 5.1's lack of a billing agent identifier.

6.6 Fill Number v. Number of Fills Remaining

The section specifies the field identification of the Fill Number and the Number of Refills Authorized, and the corresponding paper fields and explains that the two fields taken together indicates the number of refills remaining.

Necessity

It is useful to the regulated public to highlight the fill number information in the companion guide.

6.7 Compound Medications

The section states that Division rules require the components of compound medications be identified and specifies the Compound Code field and the corresponding paper field number.

Necessity

It is necessary to provide technical guidance for use of the Compound Code field within the NCPDP Telecommunication Standard Implementation Guide Version 5.1 when the pharmacy is dispensing a compound medication because workers' compensation payments are calculated using the NDC numbers of the compound components.

6.8 Brand v. Generic

The section identifies the field and corresponding paper field for indicating the Dispense As Written (DAW)/ Product Selection Code. The section explains that some of the DAW codes do indicate the generic availability status, but that the brand/generic status is not communicated for each medication. The section advises that this information may be obtained from purchased code sets.

Necessity

The California Labor Code section 4600.1 provides that any person dispensing medicine shall dispense the generic drug equivalent unless the prescribing physician specifically provides in writing that a nongeneric drug must be dispensed. It is therefore important to draw the public's attention to the DAW provisions, and to highlight the limitations of the Telecommunication Standard Version 5.1 in relation to identifying brand versus generic drugs.

6.9 Prescribing Physician

The section specifies that the Prescribing Physician Identification Number will be the NPI, or the state license number if the physician does not have an NPI, and specifies the field number and corresponding paper field number.

Necessity

It is desirable to use the NPI to identify physicians as that number is intended to replace all other provider identifiers in the HIPAA standards transactions. HIPAA covered providers must share their NPI with other entities that may need it for billing purposes. Some physicians may not be covered health providers under HIPAA and therefore may not have an NPI. In that case it is necessary to provide for an alternate identification number. The state license number is a universally available and convenient number to use where no NPI number is available.

6.10 California Pharmacy Workers' Compensation Instructions and 6.10.1 Table

The introductory sentence directs the use of the *NCPDP Telecommunication Standard Implementation Guide Version 5* for electronic transactions, except as set forth in the Table labeled 6.10.1. The table contains five columns labeled: NCPDP Field Description, NCPDP Paper Field Number, NCPDP Workers' Compensation Requirements, NCPDP 5.1 Data Element, and California Workers' Compensation Instructions. The data in the cells provides technical details for use of the NCPDP transaction standard, and indicates whether provision of the data element is required, optional, or situational for each field.

Necessity

It is necessary to adapt the standard *NCPDP Telecommunication Standard Implementation Guide Version 5* for use in workers' compensation due to unique features of the workers' compensation system. The table is a convenient format for informing the regulated public of the technical adaptations required for the NCPDP standard.

6.11 Optional Transaction Set Based on ASC X12N 837 004010A1

The section provides that the ASC X12N 837 004010A1 is also referred to as the "Alternate Pharmacy Billing Format" and may be used as an alternative to the NCPDP standard if the electronic billing partners agree to this in the trading partner agreement.

Necessity

Although the *NCPDP Telecommunication Standard Implementation Guide Version 5* is the preferred transaction standard and is prescribed absent an agreement, it is useful to let the regulated public know that the ASC X12N 837 004010A1 is an alternative as there may be some parties who, for business reasons, prefer to use the 837.

Chapter 7 Companion Guide 835 Payment & Remittance Advice

The introductory section states that the 835 is the method for providing remittance advice and notice of contesting a bill. It sets forth the statutory provision in Labor Code section 4603.2(b)(1)(B) that requires the payor to "advise [the provider] in the manner prescribed by the administrative director" of the items being contested, the reasons for contesting the items and the remedies available if the provider disagrees. The section advises that the Explanation of Review standards set forth in the Medical Billing and Payment Guide, Appendix B are to be utilized to satisfy the statutory requirement of Labor Code section 4603.2(b)(1)(B). In electronic billing, the Explanation of Review function is accomplished through use of ASC X12N 835 004010A1 Health Claim Payment/Advice.

Necessity

This provides necessary context for the public regarding the role of the 835 in serving as remittance advice and in satisfying the statutory provisions regarding contesting a bill. The reference to the Medical Billing and Payment Guide, Appendix B is necessary to alert the public to the location of the substantive rules relating to the Explanation of Review.

It is necessary to make clear to the regulated public the role of the California guide as a supplement to the national HIPAA adopted guide and not a replacement for it. It is necessary for the California guide to supersede the national guide where a conflict exists because the California guide has been drafted specifically to adapt the national standards for California workers' compensation needs. This is in compliance with the statutory directive to adopt standards that comply with HIPAA "to the extent feasible."

7.1 Reference Information

The section states that the ASC X12N 835 004010A1 Health Claim Payment/Advice can be obtained from the Washington Publishing Company and provides the web address.

Necessity

The 837 Health Claim Payment/Advice is a copyrighted document that must be obtained from the publisher, therefore it is necessary to provide the publisher information.

7.2 Trading Partner Agreements

The section states that the companion guide is not intended to replace the trading partner agreement and that trading partners may utilize non-prescribed electronic formats by mutual agreement. The section provides that such alternate formats must, at a minimum, contain all the same required data elements of the prescribed formats.

Necessity

Many aspects of the electronic data exchange relationship will need to be set out in trading partner agreements so it is important to make the public aware that the companion guide does not replace the trading partner agreement. There may be business reasons that the trading partners may want to utilize alternate formats. It is necessary to mandate that the required data elements be present in any agreed upon alternate format since the required data elements are needed for accurate benefit provision and also to facilitate the claims administrator's reporting to the Workers' Compensation Information System as required by Labor Code section 138.6.

7.3 Claim Adjustment Group Code

The section prescribes the use of the most current valid ANSI Claim Adjustment Group Codes in the ASC 835 X12N format. The section explains that the ANSI Group Code represents the general category of payment, reduction, or denial. The section advises that the ANSI Group Code is the same code that is transmitted in the IAIABC 837 Medical State Reporting EDI reporting format for reporting to the Workers' Compensation Information System.

Necessity

The ASC 835 X12N adopted under the HIPAA rules utilizes the most current Claims Adjustment Group Codes. These codes, which categorize the general nature of the adjustment, are appropriate for use in workers' compensation remittance advice. It is helpful to the public to describe the role of the Claim Adjustment Group Codes and the fact that the Group Codes are the same codes used in the Workers' Compensation Information System.

7.4 Claim Adjustment Reason Code

The section states that the ASC X12N 835 uses the ANSI Claim Adjustment Reason Codes as the electronic means of providing specific payment, reduction, or denial information. The section states that specific Claim Adjustment Reason Codes are prescribed by the Division and may be found in the Medical Billing and Payment Guide, Appendix B – 1.0.

Necessity

The ASC 835 X12N utilizes the Claims Adjustment Reason Codes (CARC), therefore it is necessary to explain the role of the Claim Adjustment Reason Codes. The Implementation Guide for the 835 states: “A standardized list of claim adjustment reason codes is used in the Claim Adjustment and Service Adjustment Segments. See Appendix C, External Code Sources, for the list of codes. These codes provide the ‘explanation’ for the positive or negative financial adjustments specific to particular claims or services that are referenced in the transmitted 835.” ASC X12N 835 004010A1 Health Claim Payment/Advice, Transaction Set Implementation Guide, page 24. It is necessary to specify that only a subset of these codes is used in order to adapt the codes to use in workers’ compensation. This divergence from the 835 CARC specifications is in compliance with the statutory directive to adopt standards that comply with HIPAA “to the extent feasible.”

7.5 Remittance Advice Remark Codes

The section states that the ASC 835 X12N supports the use of the ANSI Remittance Advice Remark Codes (RARC) to provide supplemental explanation for a payment, reduction or denial already described by an ANSI Claims Adjustment Reason Code. The section states that a specified subset of the Remittance Advice Remark Codes are prescribed by the Division and may be found in the Medical Billing and Payment Guide, Appendix B – 1.0.

Necessity

The ASC 835 X12N utilizes the ANSI Remittance Advice Remark Codes (RARC), therefore it is necessary to explain the role of the RARC. These codes provide more detailed information regarding the adjustment than the CARCs.

It is necessary to specify that only a subset of these codes is used in order to adapt the codes to use in workers’ compensation. This divergence from the 835 RARC specifications is in compliance with the statutory directive to adopt standards that comply with HIPAA “to the extent feasible.”

7.6 California Jurisdictional EOR Statement ID Qualifier

The section states that paper EORs require a “remedies” statement informing the provider of how to seek review of contested charges at the Workers’ Compensation Appeals Board. In electronic billing, the remedies statement is represented by a “jurisdictional code” in a specific segment and loop. The section sets forth the text represented by the code, relating to invoking WCAB jurisdiction by way of a lien and the statute of limitations for lien filing.

Necessity

Since the electronic billing formats eliminate lengthy text, the remedies message must be conveyed through use of a code. It is necessary to provide the technical information regarding use of this code in the 835 so that providers will have the notice relating to invoking the jurisdiction of the WCAB and the limitations period for such review.

7.7 Product/Service ID Qualifier

The section states that the Product/Service ID number transmitted in the inbound electronic billing format is returned in the 835 SVC Service Payment Information Segment with the appropriate qualifier, and provides an example.

Necessity

It is necessary to provide technical information regarding use of the Product/Service ID Qualifier.

7.8 California 835 Workers’ Compensation Instructions

7.8.1 ASC X12N 835 004010A1 Healthcare Claim Payment and Remittance

The introductory material explains that the table in 7.8.1 identifies application/instructions for California workers’ compensation that are different than the HIPAA implementation. The table contains five columns labeled: loop, segment or element, value, description, and California Workers’ Compensation Instructions. The data in the cells provides technical details for use of the 835 transaction standard.

Chapter 8 Companion Guide 275 Additional Information to Support a Health Care Claim or Encounter (Documentation/Medical Attachment)

The introductory paragraph states that the *ASC X12N 275 004050 Additional Information to Support a Health Care Claim or Encounter Implementation Guide* contains the recommended (but not required) standard electronic format for electronic submission of documentation. The section states that the providers may also submit documentation by fax or email in accordance with Chapter 2 and the Medical Billing and Payment Guide. The section states that parties engaging in electronic billing must be able to exchange electronic documentation.

Necessity

There is currently no HIPAA-adopted electronic standard for documentation attachment. The *ASC X12N 275 004050* was proposed for adoption by the Secretary of the Department of Health and Human Services in 2005, but a final rule has not been published. The 275 is recommended by the Division for transmission of attachments but is not prescribed. In order to derive the most efficiency from electronic billing it is necessary to require that providers submitting electronic bills also be able to submit documentation electronically. If documentation were submitted in paper format it would substantially interfere with the efficiency for claims administrators processing the bills. In order to allow some flexibility, providers are allowed to submit documentation by fax or email.

8.1 Reference Information

The section states that the *ASC X12N 275 004050 Additional Information to Support a Health Care Claim or Encounter Implementation Guide* can be obtained from the Washington Publishing Company and provides the web address.

Necessity

The *275 Additional Information to Support a Health Care Claim or Encounter Implementation Guide* is a copyrighted document that must be obtained from the publisher, therefore it is necessary to provide the publisher information.

8.2 Documentation Requirements

The section states that the documentation requirements are defined in the Medical Billing and Payment Guide in Section One – 7.3 Electronic Bill Attachments.

Necessity

It is necessary to provide cross reference to the Medical Billing and Payment Guide because that guide contains the rules regarding what constitutes a complete bill and which documents are required to support a bill.

Chapter 9 Companion Guide Acknowledgments

The introductory paragraph states that acknowledgments are used to respond to the receipt of a bill and describes six different purposes served by the acknowledgments.

Necessity

Providing the general overview of the role of acknowledgments assists the reader in understanding the material that follows.

9.1 Clean Bill Acknowledgement Flow and Timing Diagrams

9.1.2 Process Steps

Section 9.1 and 9.1.2 provide a graphical diagram and narrative description, respectively, of the basic acknowledgments that are generated by the receiver of the bill, including the bill processing timeline.

Necessity

The graphical diagram and narrative description provide a very useful synthesis of the steps involved in issuing the bill acknowledgments, including the use of the TA1, the 997 and the 277.

9.2 Clean Bill-Missing Claim Number Pre-Adjudication Hold (Pending) Status

9.2.1 Missing Claim Number 277 Health Care Claim Acknowledgment Process Steps

The section provides for a pre-adjudication hold whereby a bill that is submitted without a claim number is placed in a pending status for up to five business days. During this time the claims administrator will try to match the bill to an existing claim in their system, and will use the 277 to inform the bill submitter of the delay, and if the claim is identified, to provide the claim number to the bill submitter for use in future billing. If the bill cannot be matched within the five business days, the bill may be rejected as incomplete. The section provides direction on use of the segments in the 277. The section also contains a graphical diagram illustrating the steps involved in processing a bill that is submitted with a missing claim number. The section 9.2.1 sets forth a table with detailed instructions for use of the 277 Health Care Claim Acknowledgement.

Necessity

In order for a claims administrator to determine its liability for a medical bill it must have the claim number. However, a medical provider may not have the number at the time the bill is submitted, especially for treatment rendered shortly after the injury. In order to expedite the ultimate resolution of the claim, it is preferable to allow the claim to be pending for five days in order to attach the claim number as an alternative to immediate rejection of the claim as incomplete. The graphical diagram provides a useful synthesis of the steps involved in processing a bill with a missing claim number. The table provides necessary technical instruction on use of the 277.

9.3 Clean Bill-Missing Report Pre – Adjudication Hold (Pending) Status

9.3.1 Missing Report – ASC X12N 277 Health Care Claim Acknowledgement Process Steps

The section provides for a pre-adjudication hold whereby a bill may be placed in a pending status for up to five business days in order to receive and match the bill to

required documentation. If the bill cannot be matched within five days, or the documentation is not received, the bill may be rejected as incomplete. The claims administrator will use the 277 to inform the bill submitter of the delay, and the ultimate resolution of the issue. The section also contains a graphical diagram illustrating the steps involved in processing a bill that is submitted with a missing documentation. The section 9.3.1 sets forth a table with detailed instructions for use of the 277 Health Care Claim Acknowledgement.

Necessity

In order for a claims administrator to determine its liability for a medical bill it must have the documentation that is necessary to support the bill. However, the documentation may not be transmitted with the bill, but may come by fax or email. In order to expedite the ultimate resolution of the claim, it is preferable to allow the claim to be pended for five days in order to receive the required documentation and match it with the bill as an alternative to immediate rejection of the claim as incomplete. The graphical diagram provides a useful synthesis of the steps involved in processing a bill with missing documentation. The table provides necessary technical instruction on use of the 277.

9.4 Transmission Responses

9.4.1 ASC X12N TA1 – Interchange Acknowledgement

9.4.2 ASC X12N 997 – Functional Acknowledgement

9.4.3 ASC X12N 277 Health Care Claim Acknowledgement

9.4.4 ASC X12N 835 – Remittance Advice

The sections summarize the transmission responses that are sent in response to the billing transaction. The TA1 is sent only if there is an error in the interchange header and trailer; the entire transaction is rejected at the header level. The 997 Functional Acknowledgement is used to provide the bill submitter with a positive or negative confirmation of the structure of the 837 file. If the 837 contained syntactical errors, the segments and elements where the errors occurred will be reported. The 277 is used to provide the bill submitter with a positive or negative confirmation of each bill within the EDI file. The 277 details what errors are present, and if necessary, what action the submitter should take. There are specific instructions relating to the use of the 277. The 835 Remittance Advice replaces a paper remittance advice. It provides the submitter information regarding payment, adjustment, or denial of the bill.

Necessity

The 9.4 and related sections provide a very useful summary of the transmission responses.

Appendix A - Glossary of Terms

The appendix sets forth a table with two columns -- terms or abbreviations used in the guide and the corresponding definition.

Necessity

The inclusion of the glossary provides a consolidated list of terms and abbreviations that will assist the reader in using the *Electronic Medical Billing and Payment Companion Guide*.

Appendix B – Code Set References

The appendix sets forth a table which includes code set names, definitions, and identification and address of the publishing entity for code sets referenced in the *Electronic Medical Billing and Payment Companion Guide* or which are referenced in the adopted implementation guides.

Necessity

The inclusion of the code set matrix provides a consolidated list of code sets for easy reference.

Appendix C Jurisdictional Report Type Codes and DWC Descriptions

The appendix sets forth a table with a column for Jurisdictional List of Report Type Codes and a Column of California DWC Descriptions.

Necessity

Documentation, or the attachment to the 837 claim, is identified in the ASC X12N 837 format in PWK Claim Supplemental Information (Attachment) Segment in Loop 2300. The PWK Claim Supplemental Information (Attachment) Segment indicates that an attachment is expected, the type of attachment, delivery method (i.e. electronic, email or fax) and an attachment control number. It is the combination of these attachment identification data elements that will allow a claims administrator to appropriately match the incoming attachment to the electronic medical bill. The PWK Segment and the associated documentation identify the type of documentation through use of ASC X12N standard Report Type Codes. However, the code sets currently available for version 4010A1 do not include some of the workers' compensation specific codes to identify the type of medical report. The ASC X12N 5010 Standard Report Type Codes do include specific workers' compensation report type codes. In order to enhance the communication between the health care provider and claims administrator, the use of specific ASC X12N 5010 Report Type Codes, defined as Jurisdictional Report Type Codes are set forth in Appendix D for use in the 4010 837.

Appendix D – Security Rule

The Appendix contains an introductory paragraph which mandates providers, clearinghouses and claims administrators to implement procedures and utilize

mechanisms to ensure the confidentiality of medical information submitted on electronic claims for payment of medical services. The paragraph explains that the security rule adapts the HIPAA security rule for use in workers' compensation electronic billing and provides the citation to the HIPAA security rule. It explains that the HIPAA rules have been adapted for California workers' compensation in the following ways: the rule is applicable to "health care providers, health care facilities, third party billers/assignees, clearinghouses and workers' compensation claims administrators" instead of "covered entities;" the rule uses the term "medical information" instead of "protected health information;" the rule refers to "the security rule" instead of "this subpart;" the rule refers to "applicable privacy laws" instead of "requirements of subpart E [of HIPAA rule]."

Necessity

In order to implement Labor Code section 4603.4 subdivision (a)(3)'s directive that the regulations "ensure confidentiality of medical information submitted on electronic claims for payment of medical services" it is necessary to adopt security standards.

Neither the HIPAA security rule nor the HIPAA privacy rule apply to workers' compensation. A covered entity under HIPAA includes a variety of health insurers and plans but does not include a workers' compensation insurer. 42 U.S.C. § 300gg-91(a), (b), (c)(1)(D), 45 C.F.R. §§ 160.102(a)(1), 160.103. Even for covered entities such as medical providers, HIPAA allows release of protected health information without the authorization of the individual "...to the extent that such use or disclosure is required by law..." 45 C.F.R. § 164.512(a). The federal rule specifically allows disclosure to comply with laws relating to workers' compensation as follows: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault." 45 C.F.R. § 164.512(l). Although the HIPAA privacy rule is not appropriate for workers' compensation, the HIPAA security standards do provide appropriate standards to ensure confidentiality of electronic information. However, they must be adapted to workers' compensation since the HIPAA rule does not itself apply. The rulemaking record contains a document entitled "Comparison of the Security Rule Adopted in the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide (Appendix D Security Rule) to the HIPAA Security rule (Title 45 Subpart C §§164.302-164.316, and Appendix A Matrix)" which shows the differences between the HIPAA rule and the proposed workers' compensation security rule in strikethrough and underline format. (See Rulemaking File, tab "Other Documents in Rulemaking File.")

Appendix E – Electronic and Digital Signature

The appendix sets forth the text of California Government Code section 16.5 relating to digital signatures and sections 22000 – 23000 of the Secretary of State's implementing regulations which are codified in title 2, California Code of Regulations.

Necessity

In order to carry out the statutory purpose of establishing electronic billing as an alternative to paper billing it is necessary to establish an electronic means of signature that will assure the integrity of signatures submitted. There is currently no HIPAA standard for electronic signatures in medical billing, as the signature rule proposed by HHS in 1998 was not adopted. Since there is no national HIPAA standard for signature in the medical billing context it is necessary for the Division to establish a standard for workers' compensation. The Secretary of State has established regulations to govern the technologies that may be used for digital signatures that are received or sent by public entities as required by the Government Code §16.5. These regulations adopt Public Key Cryptography and Signature Dynamics technologies in order to ensure that the digital signature is: "unique to the person using it," "capable of verification," "under the sole control of the person using it" and "linked to data in such a manner that if the data are changed, the digital signature is invalidated." The regulations provide a sound methodology for defining acceptable technologies for electronic signatures in workers' compensation. The Secretary of State's "Approved List of Digital Signature Certification Authorities" which is available on the Secretary of State's website provides the assurance that the certification authority has been reviewed and found to be compliant. The list is dynamic, as other digital signature providers can apply for inclusion on the list. The Secretary of State's Initial Statement of Reasons for title 2, CCR section 22003 explains:

The field of digital signature technology, including the creation, transmittal and validation of signatures is a rapidly emerging industry. Although internationally recognized technological standards exist for some aspects of digital signature technology, there does not appear to be an exclusive dominant technology that has emerged as the one and only method of conducting digital signature transactions.

Historically, computer software and hardware have evolved and improved at an exponential rate. Understanding that a technology which may appear to be dominant in the marketplace one day may be obsolete in a matter of years, the secretary of state has determined that there exists a need to develop a dynamic list of technologies which create digital signatures that are acceptable for use by public entities in California.

The absence of such a list could result in public entities accepting as reliable, digital signatures created by technologies that do not meet the standards established by the legislature in Government Code Section 16.5.

It is necessary to adopt the Secretary of State's digital signature regulations for use in workers' compensation so that all participants in workers' compensation matters will have a readily available method for determining the validity of digital signatures used in electronic transactions. In order to facilitate the public's access to the Secretary of State's regulations and digital signature certification authorities list, it is necessary to provide references. In order to recognize digital signatures that have legal validity under other provisions of law, the language of the guide specifically so specifies.

Section 9792.5.1 Subdivision (c):

The section provides that the HIPAA-approved billing implementation guides listed are incorporated by reference, may be obtained for a fee, and gives the name and contact information for the publisher. The subdivisions (c)(1) through (c)(3) set forth the adoption of the 4010 versions of the ASC X12N 837 Health Care Claim Dental, Professional, and Institutional.

Necessity

The Division is required to adopt electronic billing standards that are compliant with HIPAA to the extent feasible. The 4010 standard is adopted as mandatory as the 5010 standard is optional under HIPAA rules at this time. The standards adopted are copyrighted material and therefore they must be purchased from the publisher and it is necessary to provide the contact information. The billing standards are also incorporated by reference into the Electronic Medical Billing and Payment Guide; further detail regarding the necessity for adopting these standards is set forth above. It is necessary to set forth the incorporation by reference in the text of the regulations so that the public may have ready reference to the list of standards adopted in the codified regulation text.

Section 9792.5.1 Subdivision (d):

The section provides that the HIPAA-approved pharmacy billing implementation guides listed are incorporated by reference, may be obtained for a fee, and gives the name and contact information for the publisher. The subdivisions (d)(1) and (d)(2) set forth the adoption of the NCPDP Telecommunication Standard Implementation Guide Version 5.1 and the Batch Standard Implementation Guide Version 1.1 for pharmacy billing.

Necessity

The Division is required to adopt electronic billing standards that are compliant with HIPAA to the extent feasible. The NCPDP Version 5.1 and Batch Version 1.1 are adopted as mandatory since they are mandatory HIPAA standards. Updated NCPDP Version D and Batch Version 1.2 are optional under HIPAA rules at this time. The standards adopted are copyrighted material and therefore they must be purchased from the publisher and it is necessary to provide the contact information. The billing standards are also incorporated by reference into the Electronic Medical Billing and Payment Guide; further detail regarding the necessity for adopting these standards is set forth above. It is necessary to set forth the incorporation by reference in the text of the regulations so that the public may have ready reference to the list of standards adopted in the codified regulation text.

Section 9792.5.1 Subdivisions (e):

The section provides that the HIPAA-approved remittance implementation guides and addenda listed are incorporated by reference, may be obtained for a fee, and gives the name and contact information for the publisher. The subdivision sets forth the adoption of the 4010 versions of the ASC X12N 835 Health Care Claim Payment/Advice and Addenda.

Necessity

The Division is required to adopt electronic standards that are compliant with HIPAA to the extent feasible. The 835 Version 4010 remittance/advice standard is adopted as mandatory since it is a HIPAA-compliant standard. The updated 835 Version 5010 is optional under HIPAA rules at this time. The standards adopted are copyrighted material and therefore they must be purchased from the publisher and it is necessary to provide the contact information. The 835 remittance standards are also incorporated by reference into the Electronic Medical Billing and Payment Guide; further detail regarding the necessity for adopting these standards is set forth above. It is necessary to set forth the incorporation by reference in the text of the regulations so that the public may have ready reference to the list of standards adopted in the codified regulation text.

Section 9792.5.1 Subdivisions (f),(g),(h):

These subdivisions incorporate by reference the billing manuals for the paper forms for professional billing, the National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for the 08/05 Version, the National Uniform Billing Committee Data Specifications Manual for the UB 04, and the National Council of Prescription Drug Programs Data Specifications Manual for the NCPDP paper form for retail pharmacy billing. The paper forms are included within the manuals.

Necessity

Labor Code section 4603.4 subdivision (a) requires the Division to adopt rules to ensure that all health care providers and facilities submit medical bills for payment on standardized forms. The forms and associated manuals adopted are nationally recognized forms and manuals that are appropriate for standardization of workers' compensation paper medical bills. The paper billing form and manuals are also incorporated by reference into the Medical Billing and Payment Guide; further detail regarding the necessity for adopting these forms are set forth above. It is necessary to set forth the incorporation by reference in the text of the regulations so that the public may have ready reference to the list of paper form manuals adopted in the codified regulation text.

Section 9792.5.2 Standardized Medical Treatment Billing Forms/Formats, Billing Rules, Requirements for Completing and Submitting Form CMS 1500, Form CMS 1450 (or UB 04), American Dental Association Form, Version 2002, NCPDP Universal Claim Form, Payment Requirements

Subdivision (a) states that on and after a date approximately 90 days after the effective date of the regulation, all paper medical bills shall be submitted on claims forms set forth in the California Division of Workers' Compensation Medical Billing and Payment Guide.

Subdivision (b) states that on and after a date approximately 90 days after the effective date of the regulation, all medical bills shall conform to the provisions of the California Division of Workers' Compensation Medical Billing and Payment Guide, which includes coding, billing standards, timeframes and other rules.

Subdivision (c) states that on and after a date approximately 18 months after the effective date of the regulation, all bills for medical treatment may be electronically submitted to the claims administrator for payment. Electronic bills shall conform to the applicable provisions of the California Division of Workers' Compensation Medical Billing and Payment Guide and the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide.

Subdivision (d) states that except as specifically provided, legally authorized third party billers and assignees shall submit bills in the same manner as the original rendering provider or facility would be required to do and shall conform to the California Division of Workers' Compensation Medical Billing and Payment Guide and the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide.

Necessity

It is necessary to clearly set out the effective dates of the rules and billing guides. The 90 day implementation period for standardized paper forms and general billing rules is intended to provide sufficient lead time for workers' compensation participants to prepare for the use of the new forms and rules. The 18 month implementation period is intended to carry out the statutory intent that there be 18 months between the adoption of the regulation and the date on which claims administrators are required to accept electronic bills. It is necessary to specify that legally authorized third party billers/assignees are required to bill in the same manner as the rendering provider would have been required to do in order to ensure that the claims administrator receives all of the necessary information about the medical service that was rendered. Third party billers/assignees have billing rights only to the extent that they are legally authorized. The billing rules do not in themselves confer billing rights on third party billers/assignees.

Section 9792.5.3 Medical Treatment Bill Payment Rules

Subdivision (a) states that on and after a date approximately 90 days after the effective date of the regulation, claims administrators shall conform to the payment, communication, penalty, and other provisions of the Medical Billing and Payment Guide, except that provisions relating to the payment of electronic medical bills shall be effective 18 months after the effective date of the regulation.

Subdivision (b) states that on and after a date approximately 18 months after the effective date of the regulation, claims administrators shall conform to the payment,

communication, penalty, and other provisions of the Electronic Medical Billing and Payment Companion Guide.

Necessity

It is necessary to clearly set out the effective dates of the rules and billing guides. The 90 day implementation period for claims administrators to adhere to the Medical Billing and Payment Guide is intended to provide sufficient lead time for workers' compensation participants to prepare for the new rules. The 18 month implementation period is intended to carry out the statutory intent that there be 18 months between the adoption of the regulation and the date on which claims administrators are required to accept and process electronic bills.

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