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| Section One – Business Rules<br>1.0 Standardized Billing/Electronic Billing Definitions | Commenter notes subsection x.<br><br>*x) "Supporting Documentation" means those documents, other than a required reports, necessary to support a bill. These included but are not limited to an invoice required for payment of DME item being billed. For paper supporting documentation includes any written authorization for services that may have been received by the physician.*<br><br>Commenter strongly suggests that for electronic bills this documentation requirement be struck for EDI billing. Today, commenter's organization electronically bills in 40 states and does not have to electronically attach invoices or authorizations. Commenter opines that this will be burdensome without any real benefit to the overall processing of the claim.<br><br>Commenter suggests that a copy of the invoice or authorization is not needed on every bill and should be handled by exception and allowed to be sent via paper to the requestor. Commenter also states that his organization rarely | Greg M. Gilbert<br>SVP Reimbursement and Governmental Relations<br>Concentra, Inc.<br>February 23, 2011<br>Written Comment | **Agree in part.** Agree that for electronic bills, the "complete bill" should not require the written authorization. The ASCX12N 005010X222 Health Care Claim: Professional (837) has a Loop and segment to identify the prior authorization number (See page 194, Loop 2300 REF Prior Authorization which is a Situational data element: "Required when an authorization number is assigned by the payer or UMO AND<br>the services on this claim were preauthorized.")<br>The rule proposed in the 2nd 15-day comment period eliminated the requirement to submit written authorization. The 3rd 15-day comment period reinstituted the requirement to submit the written authorization for paper bills only, as submission is required for paper bills by Labor Code §4603.2.<br>**Disagree** that the requirement | None. |

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| | receives a written authorization from the payor. Commenter opines that a written authorization number on the HCFA should be sufficient.<br><br>Commenter states that these types of documents are not required in the group health or Medicare world as part of the original EDI billing packet. Commenter states that the Division is asking for new and unique processes to be followed by a provider who treats workers' compensation patients without any real data that supports the need for these additional efforts. Commenter opines that the Division is adding insult to injury, by doing this in the face of a fee schedule that is beyond inadequate to cover for these labor intensive additions to normal EDI billing. | | for supporting documentation should be eliminated for electronic billing. Claims administrators have repeatedly emphasized the need for documentation to support the bill. Commenter may enter into agreements with payers to reduce the quantity of documentation submitted if payers believe the information is not needed. Workers' compensation is very different from Medicare, which is a single payer system and in which providers are subject to audit. Group health is also different than workers' compensation as there are contracts between the providers and the payers. This is often not the case in workers' compensation as there may be no contractual relationship between the provider and the payer. For DME not included in the Medicare DMEPOS fee schedule which is contained in the Official Medical Fee | |

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| | | | Schedule's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, the fee is subject to the formula set forth in the fee schedule. "Dispensed durable medical equipment: cost (purchase price plus sales tax plus shipping and handling) plus 50% of cost up to a maximum of cost plus $25.00 not to exceed the provider's usual and customary charge for the item." (See 8 CCR 9789.11(a)(1), OMFS General Information and Instructions, page 5.) The invoice is needed to substantiate the billed charges for the DME item since it does not have a set fee schedule price. | |
| | Commenter again requests that the Division provide a definition of DME versus ordinary supplies. If the Division still deems the invoice documentation necessary, commenter requests that this be required for only those DME codes that have a value of $75.00 or greater. Of the states that | | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. Moreover, the dividing line between "ordinary supplies" versus "DME" is more appropriately | None. |

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| | require invoices (which are only two), a threshold for requirement of an invoice is established since the costs of doing this for small dollar items is counterproductive for all parties. Commenter states that these requirements do not fit into the normal work flow of EDI billing and we urge you to remove this language. Commenter opines that if the Division's stated goal was to be as standardized as possible with the national EDI regulations; these one-offs are not supporting that goal. | | addressed in the Official Medical Fee Schedule rather than the billing rules. (See 8 CCR 9789.11(a)(1), OMFS General Information and Instructions, page 4 which sets forth the rules for reimbursable supplies relating to physician services.) | |
| Section 3.0 Complete Bills | Commenter notes subsection (b):<br><br>*(b) All required reports and supporting documentation sufficient to support the level of service or code that has been billed must be submitted as follow…..*<br><br>Commenter states that he supports the requirement that the medical documentation support the charges on a bill, he is concerned that payors will use this language to arbitrarily deny the total bill, not just the level of service code. Suffice to say, the notion that medical notes should | Greg M. Gilbert<br>SVP Reimbursement and Governmental Relations<br>Concentra, Inc.<br>February 23, 2011<br>Written Comment | **Disagree** with comment that language regarding required reports and supporting documentation is not appropriate for "an EDI guide document." First, the "complete bill" provisions are in the Medical and Billing Payment Guide which is intended to set forth the general billing rules applicable to both paper billing and EDI (electronic data interchange.) It is entirely appropriate that the guide include instruction on what constitutes a "complete | None. |

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| | support the charges is a standard in the industry and he questions why this type of language is even included in an EDI guide document? Commenter has not seen this in any other states that are using the IAIABC guides? At a minimum, commenter opines that it does not belong in this document.<br><br>Today, if the documentation is not supportive of the coding, the payor will pay a lower level of service code and the provider can appeal if they feel this is in error. Commenter believes that this process works well and feels that the wording needs to be struck, and if that is not done, the language needs to be reworked to be clear that the entire bill needs to be paid. Commenter fears huge increases in liens as a result of misinterpretation of this language. Commenter notes that it appears under this same section item (b) 10 that this language is deleted? | | bill." In contrast, the "EDI guide" being adopted is the Electronic Medical Treatment and Billing Payment Companion Guide" which has the technical specifics for electronic transactions.<br><br>The Medical Billing and Payment Guide retains current requirements that undisputed portions of the bill are to be paid. (See Medical Billing and Payment Guide, 7.1 Timeframes subdivision (b).) The "supporting documentation to support the level of service or code billed" language was indeed stricken from (b)(10) and moved up to the introductory sentence of subdivision (b) as it is generally applicable to all of the listed items and not just to documentation requested prior to submission of the bill. | |
| General Comment | Commenter again recommends that more definition needs to be provided as to when a payor can decide to use | Greg M. Gilbert SVP Reimbursement and Governmental | The comment does not address the substantive changes made to the proposed regulations | None. |

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| | the "S" code for a HCFA field. Commenter is concerned that the use of this code may be abused by the payor resulting in improper rejection of claims. | Relations<br>Concentra, Inc.<br>February 23, 2011<br>Written Comment | during the 3rd 15-day comment period. | |
| Section 3.0<br>Complete Bills<br><br>Page 8, (b) | Commenter quotes from comments made by the California Medical Association during the Second 15 Day Comment period and indicates his support.<br><br>Commenter also supports the current 15-day comments made by Greg Gilbert of Concentra regarding section 3.0 as noted above. | Tim Madden<br>Randlett Nelson Madden<br>March 2, 2011<br>Written Comment | The Division notes the commenter's support of the comments submitted by California Medical Association. See the Division's response to the CMA comment on the 2nd 15-day comment chart, page 22.<br><br>The Division notes the commenter's support of the comments submitted by Concentra. See the Division's response above to the Concentra comment. | None.<br><br>None. |
| General Comment | Commenter would like to thank the Division of Workers Compensation for the time and effort put into the Medical Billing Standards and Electronic Billing Regulations. Commenter has no additional comments regarding the proposed Medical Billing Standards and Electronic Billing Regulations. | Kathleen Burrows<br>Operations Manager<br>State Compensation Insurance Fund<br>March 4, 2011<br>Written Comment | Comment noted. | None. |
| CA DWC Medical | Commenter states that subsection (i) | Steve Suchil, | **Disagree.** The Section 1.0 | None. |

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| Billing and Payment Guide 2011, Section 1.0 Standardized Billing/Electronic Billing Definitions | "written authorization, if any" should be retained.<br><br>Commenter states that this is required under Labor Code section [sic] 4603.2(b) (11) and should be included here in the "complete bill" definition for clarity rather than requiring a second reference cite. | Assistant Vice President<br>American Insurance Association<br>March 4, 2011<br>Written Comment | subdivision (i) "Complete Bill" applies to both paper and electronic bills, and references the required reports and/or supporting documentation set forth in 3.0 as part of the complete bill. The Division disagrees with inserting "written authorization" here as it is required for paper billing pursuant to Labor Code §4603.2(b)(1), but is not required by the electronic billing statute Labor Code §4603.4. | |
| CA DWC Medical Billing and Payment Guide 2011, Section 3.0 Complete Bills | Commenter notes that subsection (b)(11) provides:<br><br>For paper bills, any written authorization for services that may have been received by the physician.<br><br>Commenter states that the requirement is found in Labor Code section 4603.2(b)(11) and is not confined to paper bills. Commenter opines that it will be even more important for this attachment to come with electronic bills as the payment time is so much shorter. | Steve Suchil,<br>Assistant Vice President<br>American Insurance Association<br>March 4, 2011<br>Written Comment | **Disagree.** Labor Code §4603.2 subdivision (b)(1)'s direction to submit a written authorization does not apply to electronically submitted bills. The language of Labor Code §4603.2(b)(1) states in pertinent part that: "Payments shall be made by the employer within 45 working days after receipt of each separate, itemization of medical services provided, together with any required reports and any written authorization for | None. |

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| | Commenter recommends amending this provision as follows:<br><br>Any written authorization for services that may have been received by the physician. | | services that may have been received by the physician." Labor Coode §4603.4 subdivision (d) states that "Payment for medical treatment provided or authorized by the treating physician…shall be made by the employer 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 adopted pursuant to Section 5307.1. If the billing is contested, denied, or incomplete, payment shall be made in accordance with Section 4603.2." Therefore the initial electronic billing is not governed by Labor Code §4603.2(b)(1); the "written authorization" language is linked to the 45 day payment period for paper bills. | |
| General Comment | Commenter especially urges the Division to do the following:<br><br>1. Permit billings without claim | Brenda Ramirez Claims and Medical Director California Workers' | **Agree** that the 2010CA REF is | None. |

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| | numbers only for initial billings as negotiated and agreed to by the taskforce, or conform with the required status of the field in the ASC 005010X12 national standards. | Compensation Institute<br>March 4, 2011<br>Written Comment | a required segment, however, the 2010CA REF02 data may be either the claim number or the default value of "unknown." **Disagree** that billings without claim numbers should be allowed only for first billings. Provider representatives have indicated that many payers are able to, and do in fact, perform claim matching on data elements other than the claim number. Since the claim number is not within the control of the provider it makes sense to allow bills to be submitted without the claim number. Providers have pointed out that more than one bill may be submitted before the provider is notified of the claim number, likely resulting in rejection of the bills and needless delay. Since payers will not want to have a 5 working day delay in bill processing they have incentive to attach the claim number once it is received. | |

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| | | | The payer may reject the bill at the end of the 5 working days pending period if the claims administrator is unable to match the bill and a claim in the system so it is not anticipated that there will be any adverse consequence to the claims administrator. | |
| | 2. Adhere to the statutory definition of date of injury for Cumulative Injury or Occupational Disease. The proposed language conflicts with Labor Code section 5412. The conflicting language is referenced in Labor Code section 5500.5, but only with respect to determining which employers may be held liable for occupational disease or cumulative injury; not with respect to the date of the injury. Indeed Labor Code section 5500.5 also refers to "the date of injury, as determined pursuant to Section 5412…." | | The comment does not address the substantive changes made to the proposed regulations during the 3rd 15-day comment period. | None. |

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| | 3. Clarify that for a billing to be complete, any written authorization for services that may have been received by the physician must be provided, together with any required reports, as Labor Code section 4603.2(b)(1) requires. | | **Disagree** that there is a need for further clarification. In the 3rd 15-day comment period proposal the Division did provide clarification by adding language that "written authorization" received by the provider is required for paper bills. The language was added to Section One, 1.0(x) definition of supporting documentation and in the 3.0 Complete Bill by adding a new subdivision (b)(11). Labor Code §4603.2(b)(1) only requires that written authorization received by the provider is to be submitted for paper bills. | None. |
| | 4. Retain the 90-day effective date interval in sections 9792.5 and 9792.5.0 so that efficiencies will materialize as quickly as possible. 90 days provides adequate preparation time and when implemented the changes will reduce the number of duplicate billings, disputes and liens; increase bill processing efficiency; speed | | The comment does not address the substantive changes made to the proposed regulations during the 3rd 15-day comment period. | None. |

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| | payments; and improve WCIS reporting and data quality. | | | |
| Billing and Payment Guide 2011, Section 1.0 Business Rules - Definitions | Commenter recommends the following changes:<br><br>(i) "Complete Bill" means a bill submitted on the correct uniform billing form/format, with the correct uniform billing code sets, filled out in compliance with the form/format requirements of Appendix A and/or the Companion Guide with the required reports, written authorization, if any and/or supporting documentation as set forth in Section One – 3 0.<br><br>(x) "Supporting Documentation" means those documents, other than a required report, necessary to support a bill. These include, but are not limited to an invoice required for payment of the DME item being billed~~. For paper bills,~~ and ~~supporting documentation includes~~ any written authorization for services that may have been<br><br>**Discussion supporting changes**<br>The only exceptions to Labor Code section 4603.2 are those specified in Labor Code section 4603.4 and | Brenda Ramirez<br>Claims and Medical Director<br>California Workers' Compensation Institute<br>March 4, 2011<br>Written Comment | **Disagree.** See response above to commenter's issue number 3.<br><br>**Disagree.** See response above to commenter's issue number 3. In addition, in commenter's discussion, the excerpt of Labor Code §4603.2(b)(1) leaves out a critical portion of the section. The section does not merely require "timely payment" after receipt of the itemization together with any required report and any written authorization. Instead, it requires that "Payments shall | None.<br><br>None. |

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| | contracts authorized under section 5307.11. Labor Code section 4603.2(b)(1) requires timely payment *"after receipt of each separate itemization of medical services provided,* ***together with any required reports and any written authorization for services that may have been received by the physician"*** (emphasis added) and these Labor Code section 4603.2 conditions apply in all circumstances. It is necessary to specifically include written authorization in the complete bill and supporting documentation requirements in this section, and in 3.0 (b) as a complete bill condition. If they are not added, a billing may be considered complete under the regulation, contrary to the express requirements of Labor Code section 4603.2. | | be made by the employer *within 45 working days* after receipt of each separate, itemization of medical services provided, together with any required reports and any written authorization…." But electronic medical bills are to be paid within 15 working days after receipt of an itemized electronic billing for services…" pursuant to Labor Code §4603.4. It is apparent that the legislative intent is that §4603.2(b)(1) applies to paper bills. It is only where the electronic bill is "contested, denied, or incomplete, [that] payment shall be made in accordance with Section 4603.2." Labor Code §4603.4(d). Therefore the initial electronic billing is not governed by Labor Code §4603.2(b)(1) | |
| CA DWC Medical Billing and Payment Guide 2011, Section 3.0 Complete Bills | Commenter recommends the following changes:<br><br>(b) All required reports and supporting documentation sufficient to support | Brenda Ramirez Claims and Medical Director California Workers' Compensation | **Disagree.** See response above to commenter's issue number 3. In addition, in commenter's discussion, the excerpt of Labor Code §4603.2(b)(1) | None. |

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| | the level of service or code that has been billed must be submitted together with the billing as follows:<br>….<br>(11) ~~For paper bills, any~~ Any written authorization for services that may have been received by the physician.<br><br>**Discussion supporting changes**<br>Labor Code section 4603.2(b)(1) requires timely payment *"after receipt of each separate itemization of medical services provided,* (emphasis added). The only exceptions to Labor Code section 4603.2 are those specified in Labor Code section 4603.4 and contracts authorized under section 5307.11, and these exceptions are not triggered here. It is necessary to add *"together with the billing"* and to delete *"For paper bills,"* because these Labor Code section 4603.2 conditions apply to paper bills and electronic bills alike. If they are not, a billing may be considered complete under the regulation, contrary to express requirements in Labor Code section 4603.2. Utilization review applies whether or not services are billed electronically or via paper, and | Institute<br>March 4, 2011<br>Written Comment | leaves out a critical portion of the section. The section does not merely require "timely payment" after receipt of the itemization together with any required report and any written authorization. Instead, it requires that "Payments shall be made by the employer *within 45 working days* after receipt of each separate, itemization of medical services provided, together with any required reports and any written authorization…." But electronic medical bills are to be paid within 15 working days after receipt of an itemized electronic billing for services…" pursuant to Labor Code §4603.4. It is apparent that the legislative intent is that §4603.2(b)(1) applies to paper bills.<br><br>The Division agrees that an authorization *can* be submitted with either a paper or electronic billing. The provider *may choose* to submit a copy | |

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| | the written authorization can be submitted with either a paper billing or an electronic billing | | of a written authorization received but should not be required to do so. It is noted that the TR3 5010 guides have segment REF02 in Loop 2300 to provide an authorization number as a data element. The instructions state: "Required when an authorization number is assigned by the payer or UMO[Utilization Management Organization] AND the services on this claim were preauthorized." (See for example the ASC X12 005010X222 Health Care Claim: Professional, page 194.) | |
| CA DWC Medical Billing and Payment Guide 2011, Section 7.1 Timeframes | Commenter recommends retaining the 15 working-day correction and reverse the claim number modification as follows:<br><br>(a)(3) (A) ASC X12N 277 005010X214 Claim Pending Status Information<br><br>(i) A bill submitted, but missing an attachment, or the injured worker's claim number, shall be held as | Brenda Ramirez<br>Claims and Medical Director<br>California Workers' Compensation Institute<br>March 4, 2011<br>Written Comment | **Disagree.** See the response to commenter's issue number 1 above. | None. |

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| | pending for up to five working days while the attachment and/or claim number is provided, prior to being rejected as incomplete. If the issue is a missing claim number, during the five working-day timeframe the claims administrator shall, if possible, promptly locate and affix the claim number to the bill for processing and payment. If the claims administrator has already provided the claim number to the billing entity, the bill may be rejected as incomplete without placing the bill in pending status. All other timeframes are suspended during the time period the bill is pending. The payment timeframe resumes when the claim number is determined, or when the missing attachment is received. The "pending" period suspends the 15 working-day timeframe during the period that the bill is pending, but upon matching the claim number, or receiving the attachment, the timeframe resumes. The 15 working-day time period to pay the bill does not begin anew. An extension of the five working-day pending period may be mutually agreed upon. | | | |

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| | **Discussion supporting changes**<br>The issue of the claims number was the subject of much discussion and controversy during the DWC eBilling Committee meetings. Locating the claim number for a bill submitted without it is a very labor-intensive process for a claims administrator. Claims administrator representatives explained that requiring them to accept electronic medical bills without claim numbers would add significant time and administrative expense to bill processing. On the other hand, medical provider representatives pointed out that they often do not know the claim number at the time of first medical service, and that it is time consuming to obtain it before submitting the first billing.<br><br>The final consensus compromise was to permit an initial electronic billing without a claim number in the event the claim number is unknown, and to permit the bill to be pended for up to five working days to allow time for a claim number search. When the claim number is returned with an electronic acknowledgement, the billing provider | | | |

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| | now has the claim number, and the claim number is required for subsequent billings.<br><br>As currently written, billing providers could submit all medical billings without claim numbers. Locating claim numbers is so time-intensive that claims administrators have told us that they will not be able to meet the electronic payment timeframes if providers are permitted to bill without claim numbers. If the language that enforces the compromise ("*If the claims administrator has already provided the claim number to the billing entity, the bill may be rejected as incomplete without placing the bill in pending status.*") is not replaced, the claim number must be required on the electronic billing and the field tables adjusted accordingly. Under the ASC 005010X12 national standards, the claim number is a required field and the billing provider may report a claim number as unknown only if the claims administrator chooses to provide a specific code for that purpose. | | | |
| Appendix A. | **Recommendation – CMS 1500** | Brenda Ramirez | The comment does not address | None. |

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| Standard Paper Forms | **paper field 14**<br>Commenter requests that in the comment column of paper field 14, and elsewhere in the regulation and Guides, the Division modify the instruction as follows:<br><br>For Specific Injury: Enter the date of incident or exposure. For Cumulative Injury or Occupational Disease: Enter ~~either: 1) the last date of occupational exposure to the hazards of the occupational disease or cumulative injury or 2)~~ the date that the employee first suffered disability from cumulative injury or occupational disease and knew (or should have known) that the disability was caused by the employment.<br><br>**Discussion supporting changes**<br>Labor Code section 5412 defines the date of injury in cases of cumulative injuries or occupational diseases:<br>*"The date of injury in cases of occupational diseases or cumulative injuries is that date* | Claims and Medical Director<br>California Workers' Compensation Institute<br>March 4, 2011<br>Written Comment | the substantive changes made to the proposed regulations during the 3rd 15-day comment period. | |

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| | *upon which the employee first suffered disability therefrom and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment."*<br><br>Labor Code section 3208.1 also requires the date of injury for cumulative injury to be determined under Labor Code section 5412:<br>*An injury may be either: (a) "specific," occurring as the result of one incident or exposure which causes disability or need for medical treatment; or (b) "cumulative," occurring as repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which causes any disability or need for medical treatment. The date of a cumulative injury shall be the date determined under Section 5412.*<br><br>*"The last day on which the employee was employed in an occupation exposing him or her to the hazards of* | | | |

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| | *the occupational disease or cumulative injury"* is referenced in Labor Code section 5500.5, but only with respect to determining which employers may be held liable for occupational disease or cumulative injury; not with respect to the date of the injury. Indeed this section also refers to *"the date of injury, as determined pursuant to Section 5412…."*<br>Commenter opines that the administrative director does not have the statutory authority to assign a different date of injury for occupational diseases or cumulative injuries from the date of injury defined by the Legislature. | | | |