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9792.5(a)(5) Medical Billing & Payment Guide 2010 – 7.1(b); 7.2(a) and (b)	Commenter notes that insurers must remit payment within 15 days after receiving a clean claim electronically. However, it appears that penalty and interest still would not be applicable until 45 days after receipt of a clean claim. Commenter inquires if the Division has considered adjusting the penalty/interest timeframe to 15 days in correlation with the new time limit for payment. If this was considered and not addressed in these regulations, the commenter questions why.	Matt Absher Senior Associate Triage Consulting Group March 8, 2010 Written Comment	**Disagree.** Although Labor Code §4603.4 provides a 15-day time period for payment of bills, it does not provide a penalty or interest for failure to pay within the 15-day period. The statutory authority for penalty and interest is under Labor Code §4603.2 which requires payment within 45 working days of receipt of the bill (or 60 working days for a governmental entity.)	None.
Medical Billing & Payment Guide 2010 – 7.1(b); 7.2(a) and (b)	Commenter finds that these proposed regulations as well as the required forms will be beneficial to the California Workers' Compensation program. Commenter is concerned that the payment for medical treatment provided or authorized by the treating physician shall be paid within 15 working days. Commenter opines that this is a very short time frame considering how many claims a case manager reviews and the amount of medical bills related to those claims. Commenter opines that California is very complex and would like to know	Vallerie Gallaway Supervisor, Bill Processing Review Claims Management, Inc. April 19, 2010 Written Comment	**Disagree.** The requirement to pay electronically submitted bills within 15 working days is a statutory requirement. The Division does not have the discretion to extend the timeframe for payment to 21 days. The electronic billing statute, Labor Code §4603.4 does not have a penalty for failure to pay within 15 working days. However, undisputed bills remaining unpaid at 45 working days would be subject to Labor Codes §4603.2's penalty provisions. The regulations have been drafted to conform to these time frames and penalty provisions.	None.

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	if the Division would consider extending that time frame to at least 21 days. Commenter also questions if the payment of electronic bills will be subject to the same type of penalty as paper bills.			
9792.5.1(c)(1)-(3)	Commenter opines that the California DWC should be adopting payment rules and guidelines based on the HIPAA version 5010, not version 4010. If version 4010 is adopted, California will be out of step with the industry. Most significantly, the compliance date (18 months after the effective date of this regulation) coincides and conflicts with the HIPAA 5010 adoption and implementation. Commenter strongly urges that California base all requirements on version 5010, not 4010. Moving forward with version 4010 will require an almost immediate migration to version 5010 to support the impending ICD-10 requirements. However, if version 4010 is going to be implemented, it should be consistent with the requirements implemented by Texas. Any additional requirements made to the existing version 4010 implemented by Texas would not be beneficial or productive for the workers' compensation system when the rest of the industry is	Susan Leonardi, Senior Application Business Analyst Mitchell International April 23, 2010 Written Comments	**Agree** that the Division should revise the regulations to utilize the 5010 standards instead of the 4010 standards.	The regulations will be revised to propose adoption of the 5010 standards / implementation guides instead of the 4010 guides.

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	working to implement version 5010.			
9792.5 - General	Commenter states that providers should be required to submit eBills. Commenter points out that Texas adopted the mandate for both providers and claim administrators/payers. The fact that claim administrators are required to support the electronic eBilling while providers are not can negatively affect the cost/benefit of implementing the eBill requirements. Implementation can be quite costly (especially for the new 277 transaction) and without a requirement that providers send eBills, the return on investment is likely to be low.	Susan Leonardi, Senior Application Business Analyst Mitchell International April 23, 2010 Written Comments	**Disagree.** In Texas, the statute mandates electronic billing for both providers and payers. In California, Labor Code §4603.4 only mandates that employers (i.e. claims administrators) accept electronic bills. It would be beyond the statutory authority to require providers to utilize electronic billing.	None.
Medical Billing & Payment Guide 2010 – 7.1(b); 7.2(a) and (b)	Medical payments for eBills are due within 15 working days according to 7.2 Penalty (a) of the proposed Medical Billing and Payment Guide. Commenter questions if this will be enforced when a directive is issued from CMS for payers to hold claims for 10 days? Commenter references the following recent example received from CMS via email: *"Information Regarding the Holding of April Claims for Services Paid Under the 2010 Medicare physician Fee Schedule (3-26-2010)*	Susan Leonardi, Senior Application Business Analyst Mitchell International April 23, 2010 Written Comments	Directives from the CMS to hold bills for payment under the Medicare Physician Fee Schedule are not applicable to payments under the California Official Medical Fee Schedule, including the physician schedule and all other workers' compensation fee schedule. The statutory requirement to pay within 15 working days is not affected by Medicare payment holds.	None.

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	The Centers for Medicare & Medicaid Services (CMS) is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of claims for physicians, non-physician practitioners, and other providers of services paid under the Medicare Physician Fee Schedule (MPFS). As you are aware, the Temporary Extension Act of 2010, enacted on March 2, 2010, extended the zero percent (0%) update to the 2010 MPFS through March 31, 2010. *CMS believes Congress is working to avert the negative update that will take effect April 1. Consequently, CMS has instructed its contractors to hold claims containing services paid under the MPFS (including anesthesia services) for the first 10 business days of April. This hold will only affect claims with dates of service April 1, 2010, and forward. In addition, the hold should have*			

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	minimum impact on provider cash flow because, under the current law, clean electronic claims are not paid any sooner than 14 calendar days (29 for paper claims) after the date of receipt. *Be on the alert for more information about the 2010 Medicare Physician Fee Schedule Update.*"			
Medical Billing & Payment Guide 2010 – 6.0 (b)(1)	Commenter states that this section indicates that both the DWC Bill Adjustment Reason Codes and ANSI Claims Adjustment Codes should be used. For consistency, commenter recommends the use of only the ANSI CARCs rather than both the ASNI CARCs and the DWC Bill Adjustment Reason Codes. This would be consistent with other states' adoptions of eBilling per their companion guides.	Susan Leonardi, Senior Application Business Analyst Mitchell International April 23, 2010 Written Comments	**Disagree.** The commenter's statement that the Section 6.0(b)(1) requires both the DWC Bill Adjustment Reason Codes and the ANSI Claims Adjustment Reason Codes (CARC) is incorrect. The section requires the ANSI Claims Adjustment Group Codes, not the Claims Adjustment Reason Codes. The Claims Adjustment Group Codes classify the general nature of the adjustment reason, and are not duplicative of the DWC Bill Adjustment Reason Code. In regard to the suggestion to use the CARCs instead of the DWC Bill Adjustment Reason Code, the DWC disagrees. The DWC Bill Adjustment Reason Codes provide	None.

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			more specific information than the CARCS and that information has been tailored to California and will improve communication of the reason for a bill adjustment.	
Medical Billing & Payment Guide 2010 – Appendix B and Electronic Medical Billing and Payment Companion Guide, Chapter 7	Commenter asks how "self-executing" penalties and interest will be paid. If the penalties and interest are supposed to be paid and reflected on the EOB (paper or 835), then the guide needs to include instructions for how this should be reflected (what adjustment codes would be used, etc.).	Susan Leonardi, Senior Application Business Analyst Mitchell International April 23, 2010 Written Comments	**Agree.** A new DWC Bill Adjustment Reason Code is needed to explain that payment is being made for interest and increase due to late payment for paper EOBs and a corollary CARC is needed for electronic remittance advice.	Add a new DWC Bill Adjustment Reason Code G81 and add reference to CARC 225 to 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk.
Electronic Medical Billing & Payment Companion Guide 2.2.1 California Prescribed Formats	It is proposed that 277 4040 be required for Health Care Claim Acknowledgement versus 277 4050 Optional for Health Care Claim Request for Additional Information. Can the 277 4050 be used for both the acknowledgement and the additional information?	Susan Leonardi, Senior Application Business Analyst Mitchell International April 23, 2010 Written Comments	**Disagree.** This comment is technically moot as the modified proposal no longer requires use of the 277 4040 and 277 4050, but instead requires use of the ASC X12N/5010X214 Technical Report Type 3 Health Care Claim Acknowledgment (277) January 2007 and the ASC X12/005010X213 Technical Report Type 3 Request for Additional Information (277). However, anticipating a similar comment regarding the new proposal, the DWC responds as	None.

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			follows. The ASC X12N/5010X214 Health Care Claim Acknowledgment (277) has a different purpose than the ASC X12/005010X213 Health Care Claim Request for Additional Information (277). The Acknowledgment's purpose is stated in the Technical Report Type 3: "The ASC X12 Health Care Claim Acknowledgement (277) implementation guide is a business application level acknowledgement for the ASC X12 Health Care Claim (837) transaction(s). This acknowledges the validity and acceptability of the claims at the pre-processing stage. Payers may pre-process claims to determine whether or not to introduce them to their adjudication system. This pre-adjudication process is performed so claims that are incorrectly formatted or missing information can be corrected and resubmitted by the provider. The level of editing in pre-adjudication programs will vary from system to system. Although the level of editing may vary, this transaction provides a standard method of reporting acknowledgement of	

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			claims. The business function identifies claims that are accepted for adjudication as well as those that are not accepted. This 277 transaction is the only notification of pre-adjudication claim status." This 277 Acknowledgment is sent out early (within 2 days) and is an initial screen of the submission. On the other hand, the 277 Request for Additional Information purpose is for the payer or bill processor to request additional information. "The ASC X12 Health Care Claim Request for Additional Information (277) implementation guide addresses usage of the 277 as a **request for additional information to support a health care claim or encounter.** The 277 transaction provides the mechanism for asking questions or making requests for information about specific claims or service lines. The actual answer or additional information response is provided in the ASC X12 Additional Information to Support a Health Care Claim or Encounter (275)." [Emphasis in original, page 3.]	
Medical Billing & Payment Guide	The first sentence of Appendix B in the DWC Medical Billing and	Susan Leonardi, Senior Application	**Agree in part.** The DWC disagrees with the statement that	Correct first sentence on page

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2010 – Appendix B. Standard Explanation of Review	Payment Guide (page 47) states: "Any EOR must include all of the data elements indicated as required in Appendix B - 2.0 Field Table for Standard Explanation of Review." The table of required elements seems to be missing.	Business Analyst Mitchell International April 23, 2010 Written Comments	the table of required elements is missing, but agrees that the first sentence is not correct. Due to a typographical error, the first sentence of page 47 refers to Appendix B – 2.0 Field Table whereas it should refer to Appendix B – 3.0 Field.	47 to refer to Appendix B – 3.0.
General Comment: Electronic Medical Billing & Payment Companion Guide	Commenter supports the mandate that Claims Administrators must be able to accept and process electronic medical bill transactions where the provider or other billing entity has elected to submit them in that manner. The mandate further requires that when the Claims Administrator receives the bills electronically, functional responses should be provided to the submitter and that the remittance (the description of payments of or adjustments to the bill) should occur electronically. However, commenter opines that there should be more language in the mandate that either directs provider adoption (that language is currently not present) or provides greater incentive for provider adoption. Workers' Compensation Claims Administrators currently not or only partly capable of transacting electronically may incur significant	Andy Tolsma Director of Product Management Ingenix April 25, 2010 Written Comments	**Agree in part.** DWC agrees that it would be beneficial to have widespread adoption of electronic billing by providers. **Disagree** that the mandate should "direct provider adoption" as the statute makes electronic billing mandatory for the payer but optional for the biller/provider. DWC appreciates the commenter's suggestion that the regulation "provide greater incentive for provider adoption," however the commenter provides no specific suggestion on what regulatory incentive could be built into the regulation in light of the statutory language. DWC is not aware of any regulatory means to incentivize provider adoption.	None.

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	expense in order to achieve that ability. Efforts should be exerted to ensure that the investment of time and money to achieve compliance is not done merely for the sake of compliance.			
Electronic Medical Billing & Payment Companion Guide: 2.2.1. California Prescribed Formats; Chapter 9 Companion Guide Acknowledgments	FUNCTIONAL RESPONSES (997/TA1, 277, etc): The mandate requires the use of functional responses to receipt of electronic billing transactions within specific time periods. Commenter supports the use of functional responses and feels that the proposed time-limits for their delivery are correct. However, few claims administrators are currently capable of generating the required functional responses. Further, few submitters are capable of consuming them. Commenter opines that it might be wise to either move to an incremental mandate that first requires the adoption of the billing transactions and then later requires the use of the functional responses.	Andy Tolsma Director of Product Management Ingenix April 25, 2010 Written Comments	**Disagree.** Functional responses are an integral part of electronic billing. Moreover, there will be 18 months between adoption of the regulations and the mandatory compliance date. This is plenty of time to build the capacity for functional responses along with the other components of electronic billing.	None.
Electronic Medical Billing & Payment Companion Guide: Chapter 9 Companion Guide Acknowledgments;	FIVE-DAY PEND PERIOD FOR ATTACHMENTS OR CLAIM NUMBERS: The Mandate proposes that a bill received without required supportive documentation or a claim number should be pended for up to 5	Andy Tolsma Director of Product Management Ingenix April 25, 2010 Written Comments	**Disagree.** It is important to provide for the bill to be put in pending status for 5 days as this is more efficient than rejecting the bill initially and requiring it to be resubmitted.	None.

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Chapter 8 Companion Guide 275 Additional Information to Support a Health Care Claim of Encounter	days to afford the submitter the opportunity to provide it. Commenter supports this provision in concept; but not necessarily in practice. Commenter proposes that these two issues be considered separately and proposes the following: • An electronic bill should only be submitted and should only be accepted if it contains the claim number; which allows the claims administrator the opportunity to allocate the loss to the correct workers' compensation event. A bill submitted without the claim number should be rejected as incomplete by the Claims Administrator or the Claims Administrator's Clearinghouse. • Where a clearinghouse is used, that clearinghouse can retain a bill in a pended state for up to five days, giving the submitter the opportunity to provide the required supportive documentation. The pending of the bill will be in response to the presence of a PWK in the 2300 loop of the electronic		**Disagree** with the comment suggesting that a bill without a claim number should be rejected by the claims administrator or clearinghouse rather than placed in pending status. Although it is true that the claim number is important to allocate the loss to the correct workers' compensation event, the claim number is generated by the claims administrative and is within the control of the claims administrator. The physician should not be prevented from submitting the bill if he/she does not have the claim number. It may frequently occur that the doctor treats a patient before the claim number is known. **Disagree** with the comment suggesting that the regulation should allow the bill to be put in pending status for up to five days for submission of supporting documentation only where the payer is using a clearinghouse. There is no reason to distinguish between a claims administrator utilizing a clearinghouse and a	

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	transaction or where supportive documentation is required in order for the bill to be considered "Complete" according to the Medical Bill Payment Guide. • If the documentation is not submitted within the five-day period, it can be rejected by the clearinghouse using the 277 response informing the submitter that the bill was deemed incomplete and therefore rejected. Alternatively, the incomplete bill could be forwarded to the payer who would then issue the rejection in the form of the 277 transaction.		claims administrator who sets up a bill handling operation in house. In either situation, "pending for submission of documentation" is needed to allow submission of the supporting documentation by fax or email as allowed in the Medical Billing and Payment Guide, Chapter 2. Although the ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter is listed in the regulation as "recommended" it is not the required standard due to the fact that it has not been adopted as the HIPAA standard. There is a need to allow providers to submit documentation by fax or email.	
Medical Billing and Payment Guide, 7.0 Medical Treatment Billing and Payment Requirements for Electronically Submitted Bills, 7.1(b)	15-DAY PAYMENT REQUIREMENT: A "complete" bill for services provided by a provider, either employer-approved or employee-selected, submitted at or below the approved fee-schedule, must be paid within 15 calendar days. Commenter supports this requirement. This may be the single most obvious inducement for provider adoption.	Andy Tolsma Director of Product Management Ingenix April 25, 2010 Written Comments	**Agree in part.** Agree that the requirement for expedited payment of electronically submitted bills provides an inducement for providers to adopt electronic billing. However, commenter erroneously suggests that payment must be made within 15 calendar days of submission of a complete bill. The statute, Labor Code §4603.4(d) and the regulation require payment within 15 *working days*, not 15 calendar days.	None.

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Electronic Medical Billing & Payment Companion Guide, Chapter 7.	ELECTRONICALLY SUBMITTED BILLS MUST BE ELECTRONICALLY REMITTED: A bill that has been received electronically by the Claims Administrator must be remitted electronically using the X12 4010 835. Commenter supports this requirement. However, it must be noted that, like the functional responses, few submitter/providers are able to consume the 835. Commenter questions if it would be appropriate to consider that the Claims Administrator continue to produce a payer remittance document in addition to the 835.	Andy Tolsma Director of Product Management Ingenix April 25, 2010 Written Comments	**Disagree.** In order to achieve the benefits of electronic billing and payment, providers who choose to engage in electronic billing must become capable of receiving the 835 electronic remittance advice or utilize a clearinghouse that can receive the 835. There will be 18 months between adoption of the regulations and the mandatory compliance date which is plenty of time to develop or contract for the capability of receiving the 835 electronic remittance advice. It would be wasteful to require the claims administrator to produce a remittance document in addition to the 835.	None.
Medical Billing and Payment Guide, Chapter 7, 7.2 Penalty	BILLS NOT PAID TIMELY WILL RESULT IN PENALTIES FOR THE CLAIMS ADMINISTRATOR: Any electronically submitted bill determined to be complete, not paid or objected to within the 15 working day period, shall be subject to audit penalties per Title 8, California Code of Regulations section 10111.2 (b) (10), (11). Commenter supports this requirement. There must be penalties for non-compliance if the mandate is to result in adoption by the provider/submitters.	Andy Tolsma Director of Product Management Ingenix April 25, 2010 Written Comments	Commenter's support is noted.	None.

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Medical Billing and Payment Guide, Chapter 7, 7.2 Penalty	PENALTIES FOR ELECTRONICALLY-SUBMITTED BILLS NOT PAID WITHIN 45 DAYS (OR 60 IF THE EMPLOYER IS GOVERNMENTAL ENTITY): If an electronically-submitted bill is not paid within 45 (or 60) days after receipt, the bill is increased by 15% and interest is accrued at a proscribed [sic] rate. Commenter supports a penalty where payment is not made timely. However this strategy seems complex and difficult to administer.	Andy Tolsma Director of Product Management Ingenix April 25, 2010 Written Comments	**Disagree.** This penalty provision is in Labor Code §4603.2 which has been in place for many years. The commenter has not provided any information to support its assertion that the provision is complex or difficult to administer, nor has the commenter suggested an alternate mechanism for penalties that would be consistent with the statute.	None.
Medical Billing and Payment Guide, Chapter 7, 7.3 Electronic Bill Attachments (a)(3)	REQUIREMENTS REGARDING SUPPORTIVE DOCUMENTATION (ATTACH-MENTS): The Unique Attachment Indicator Number shall be the same as populated in the ASC X12 837 Loop 2300, PWK Segment : Report Type Code, the Report Transmission Code, Attachment Control Qualifier (AC) and the unique Attachment Control Number. Commenter supports this standard as it is in standard use throughout the industry.	Andy Tolsma Director of Product Management Ingenix April 25, 2010 Written Comments	Commenter's support is noted.	None.
Medical Billing and Payment Guide, Chapter 7, 7.3 Electronic Bill	THE NPI REQUIREMENT STANDARD: The Billing Provider NPI Number must be the same as populated in Loop 2010AA, NM109.	Andy Tolsma Director of Product Management Ingenix	**Disagree** with the suggestion to use state license number if the NPI is "not available." Providers who are eligible for an NPI should get	None.

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Attachments (a)(4)	If the provider is ineligible for an NPI, then this number must be the atypical billing provider ID. This number must be the same as populated in Loop 2010AA, REF02. Commenter supports the requirement for standard provider identifiers. It may be simpler and as effective to simply use the provider's state license number in the event that an NPI is not available.	April 25, 2010 Written Comments	one as this is the most streamlined method of identifying a provider since there is one source for identifying all providers as opposed to multiple sources for provider licenses. In addition, some billing providers may not have a "state license number" and are "atypical providers." See the TR3s regarding usage of the NPI and identifiers for "providers not eligible for enumeration," i.e. not eligible for assignment of an NPI. (837P 005010X222, page 43; 837I 005010X223, page 41; 837D 005010X224, page 40.)	
Medical Billing and Payment Guide, Chapter 7, 7.4 Miscellaneous (b)	ALTERNATE FORMATS BY AGREEMENT: The mandate allows for stakeholders to agree amongst themselves to use alternative forms or formats to those described in the mandate. Commenter supports this concept. In some cases strict compliance with the mandate may be unnecessarily difficult or expensive. In those cases alternative forms and/or formats might be more effective and/or efficient ways of exchanging information; while still complying with the spirit of the mandate.	Andy Tolsma Director of Product Management Ingenix April 25, 2010 Written Comments	Commenter's support is noted.	None.
Medical Billing	TRADING PARTNER	Andy Tolsma	Commenter's support is noted.	None.

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and Payment Guide, Chapter 7, 7.5 Electronic Bill Attachments	AGREEMENTS: Health care providers, health care 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 clearinghouse that will handle the claims administrator's electronic transactions. Commenter supports this requirement as a means to document the rights and responsibilities of each participant in the process.	Director of Product Management Ingenix April 25, 2010 Written Comments		
9792.5.2(c) and 9792.5.3(b)	IMPLEMENTATION: The mandate becomes effective 18 months after adoption. Commenter fundamentally supports that time table. However, an appropriate alternative might be to iteratively implement the mandate. Initial implementation could include the 837 and NCPDP portion. This might at a reasonable interval be followed by the functional responses and, finally, again at a reasonable interval by the 835 remittance requirement.	Andy Tolsma Director of Product Management Ingenix April 25, 2010 Written Comments	**Disagree.** The lead time of 18 months is adequate time to implement all portions of electronic billing and remittance including the 837, NCPDP, functional responses and 835. The goal of streamlining billing through electronic transaction requires that the two way communication be done electronically.	None.
9792.5(b)	This section provides that any properly documented bill for treatment which is provided or authorized by the	Kathleen Burrows Claims Operations Manager	**Agree in part.** Labor Code §4603.2 allows a governmental entity to pay a medical bill within	Add language to §9792.5 subdivision (b) to

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	treating physician shall be paid within 45 working days. **Discussion** Pursuant to LC §4603.2(b)(2), governmental entities are provided 60 working days after receipt of each separate itemization to make payment on a bill. Additionally, within the 2010 Medical Billing and Payment Guide [under section 6.0 (a) Medical Treatment Billing and Payment Requirements for Non-Electronically Submitted Medical Treatment Bills] the Guides acknowledge that payment by government entities shall be paid within 60 working days. By not including the 60 working day language for government entities in proposed section 9792.5(b), unnecessary confusion or penalty payments disputes may arise when a government entity provides payment after 45 working days, but within the 60 working day period. **Recommendation** Commenter recommends that this subsection also include the required timeframe for payment by an employer who is a governmental entity and offers the following language:	State Compensation Insurance Fund April 26, 2010 Written Comments	60 working days of receipt rather than 45 working days. **Disagree** with the suggestion to add language that the provisions of 9792.5 are restricted to billings which are "submitted non-electronically." Although Labor Code §4603.4 has a shorter time frame for payment (15 days) it does not provide an increase or interest for late payment. There is nothing in §4603.4 which would prevent the 15% increase and interest provisions of §4603.2 from applying to an electronically submitted bill if the non-payment continues for the 45 or 60 day time periods set forth in §4603.2. Therefore it is not appropriate to add language restricting the increase and interest to non-electronically submitted bills.	recognize that Labor Code §4603.2 gives governmental entities 60 working days to pay a medical bill.

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	(b) Any properly documented bill for medical treatment within the planned course, scope and duration of treatment reported under Section 9785 which is provided or authorized by the treating physician shall be paid by the claims administrator within forty five working days*, or sixty working days if the employer is a governmental entity and the billing is submitted non-electronically,* from receipt of each separate itemized bill and any required reports, unless the bill is contested, as specified in subdivisions (d), and (e), within thirty working days of receipt of the bill. Any amount not contested within the thirty working days or not paid within the forty five working day period, *or sixty working days if the employer is a governmental entity and the billing is submitted non-electronically,* shall be increased 15%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill.			
9792.5(d)	This section provides that a claims administrator who objects to all or part of a bill for treatment shall issue an objection within 30 working days after receive of the bill and shall pay any uncontested amount within 45	Kathleen Burrows Claims Operations Manager State Compensation Insurance Fund April 26, 2010	**Agree.**	Add language to §9792.5 subdivisions (b) and (d) to recognize that Labor Code

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	working days. **Discussion** Within the 2010 Medical Billing and Payment Guide [under section 6.0 (b) Medical Treatment Billing and Payment Requirements for Non-Electronically Submitted Medical Treatment Bills, under section 7.2 (b) Penalty and in Appendix B - Standard Explanation of Review], the Guides acknowledge that a claims administrator who objects to all or part of a bill within 30 days working days after the receipt of the bill shall pay the uncontested amount within 60 working days if the employer is a governmental entity. **Recommendation** Commenter recommends including the timeframe for payment by governmental entities which is 60 working days. (d) A claims administrator who objects to all or any part of a bill for medical treatment shall notify the physician or other authorized provider of the objection within thirty working days after receipt of the bill and any required report and shall pay any uncontested amount within forty five	Written Comments		§4603.2 gives governmental entities 60 working days to pay a medical bill.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	working days, *or sixty working days if the employer is a governmental entity* after receipt of the bill….			
9792.5(f)	This subsection states that when a contested charge for medical treatment is determined payable by the appeals board, the payment shall carry interest from the date the amount was due until it is paid. **Discussion** LC Section 4603.2(b)(1)(B) which required the employer to pay interest on contested charges for medical treatment from the due date to the payment date when ordered by the appeals board was repealed by Assembly Bill 1806 in 2006. **Recommendation** Commenter recommends deleting this subsection.	Kathleen Burrows Claims Operations Manager State Compensation Insurance Fund April 26, 2010 Written Comments	**Agree.** Commenter is correct in pointing out that AB 1806, Statutes 2006, Chapter 69 repealed the portion of Labor Code §4603.2 subdivision(b)(1)(B) which allowed the appeals board to award interest on contested bill amounts that were later determined by the appeals board to be payable.	Delete subdivision (f) of §9792.5.
9792.5.0(e)	This subsection defines "Third Party Biller/Assignee" 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. **Discussion** While the roles of a "Third Party	Kathleen Burrows Claims Operations Manager State Compensation Insurance Fund April 26, 2010 Written Comments	**Agree in part.** DWC agrees that a "third party biller" and an "assignee" are legally distinct and that it would be preferable not to have a combined definition. **Disagree** that the suggested language would be appropriate. In addition. The Division believes that it would be better to use the term "billing agent" rather than "third party biller." The division	Modify Section 1.0 Definitions to delete definition of "third party biller" and insert new definitions of assignee and billing agent: "Assignee" means a person or entity that has

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	Biller" and an "Assignee" are similar, there is a significant difference between the two regarding the transfer of rights/benefits to whom payment is made. If the entity is an "Assignee," all payments are payable directly to the assignee, as they have purchased the rights to the health care provider's payment of services. If the entity is a "Third Party Biller," payment is made to the health care provider who provided the service. **Recommendation** Commenter strongly recommends separating these two terms and offers the following definitions. The definition in the Medical Billing and Payment Guides will also need to be updated. ~~"Third Party Biller/Assignee" means 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.~~ *"Assignee" means a person or entity who has purchased the*		has learned that the term "third party biller" is sometimes used to refer to someone who is acting under an assignment of rights; however the division intended the phrase to cover persons acting as agents rather than assignees. Therefore for clarity a definition of "billing agent" is added and it replaces "third party biller" throughout the document and the guide and companion guide. A separate definition of "assignee" is inserted to improve clarity.	purchased the right to payments for medical goods or services from the health care provider or health care facility and is authorized by law to collect payment from the responsible payor. "Billing Agent" means a person or entity that has contracted with a health care provider or health care facility to process bills for services provided by the health care provider or health care facility. The regulation text, and the Medical Billing and Payment Guide and the Electonic Medical Billing and Payment Companion

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	right to claim payments from the health care provider, and there has been a transfer of rights or benefits between the health care provider and the assignee. *"Third party biller" means a person or entity who is paid by a health care provider to process claims or claim payments on behalf of the health care provider, and that is not an employee, affiliate or subsidiary of the health care provider, and no transfer of rights or benefits has occurred between the health care provider and the third party biller.*			Guide are modified throughout to replace the term "third party biller/assignee" with the term "billing agent/assignee."
Medical Billing & Payment Guide – 4.0 Third Party Billers/Assignees	**Discussion** Since payments are paid directly to the assignee, it should be required that an assignee provides documentation that a transfer of rights or benefits between the health care provider and the assignee is in place. Without such documentation, it significantly increases the administrative burden on claims administrators who will be required to create and maintain a database of agent/assignee agreements throughout the bill adjudication	Kathleen Burrows Claims Operations Manager State Compensation Insurance Fund April 26, 2010 Written Comments	**Disagree.** It would be overly burdensome and inefficient to require each "complete bill" submitted by a billing agent or assignee to include documentation to prove the bill submitter's status as an assignee or billing agent. If the claims administrator is concerned with the bona fides of a billing agent or assignee, it can request additional information. In addition, the issue could be addressed at the time the claims	None.

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	process. There is also the likelihood for payment disputes when the relationship between the principal/assignor and agent/assignee ends and duplicate bills for the same dates of service are received by the claims administrator. This is especially true when receivables are sold multiple times to different assignees. **Recommendation** Commenter recommends requiring that assignees provide documentation of their assignment with each billing and offers the following language: (c) an assignees shall submit with each bill documentation verifying the transfer of ownership rights between the health care provider and the assignee.		administrator and bill submitter enter into a trading partner agreement. The current national electronic 5010 standards being adopted do not specifically identify billing agents or assignees. The Division understands that the new 6020 format, which has not yet been adopted as a HIPAA standard, will allow a greater level of identification of clearinghouses, billing agents, etc.	
Medical Billing and Payment Guide – 7.3 – Electronic Bill Attachments	**Discussion** The attachment submission methods under section **(d)(3)** indicates that attachments may be submitted via e-mail. Since these attachments may include medical reports and unsecured 'e-mail' generally passes through multiple non-secure servers that can be intercepted or compromised, attachments submitted via e-mail should be submitted via secure e-mail	Kathleen Burrows Claims Operations Manager State Compensation Insurance Fund April 26, 2010 Written Comments	**Agree in part.** Agree with commenter's suggestion that the email of attachments should be done in a secure manner. However, disagree that the regulation should specify "secure file," as this is too ambiguous and the regulations specify that "Other methods of transmission may be mutually agreed upon by the parties."	Modify California Division of Workers' Compensation Medical Billing and Payment Guide, 2010, 7.3(d)(3) to specify that email attachments must

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	or secure file only. **Recommendation** To ensure confidentiality and data integrity, commenter recommends specifying that attachments may be submitted via secure email or a secure file transfer process and offers the following language. The "Electronic Medical Billing and Payment Companion Guide" under 2.11 will also require updating. (3) Secure E-mail or secure file.			be encrypted email.
Medical Billing and Payment Guide – Appendices for Section One	Clarification is requested regarding the data fields for Professional (CMS 1500) and Institutional (UB04) billing requirements. The following comments also apply to the 'California Electronic Medical Billing and Payment Companion Guide.' CMS 1500: • Change Box #32 requirement status to "R – required" information and Box #32b instructions to: required information (state license number) if entity is a licensed health care provider. • There is no current requirement to	Kathleen Burrows Claims Operations Manager State Compensation Insurance Fund April 26, 2010 Written Comments	**Agree.** Box 32 should be required so that every billing using the Form 1500 will indicate where the services were performed. **Disagree.** The NUCC 1500 Health	Change the "California Workers' Compensation Instructions" column to indicate "R" rather than "S." None.

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	provide information on medical bills for a supervising physician when a physician assistant (PA) or nurse practitioner (NP) renders the service. When the rendering vendor is a PA or NP, State Fund recommends including the name of the physician, license number, and NPI on the bill. This will assist claims administrators and bill reviewers to recognize that the PA and NP are under the supervision of an authorized vendor which will help to expedite the authorization and processing of a medical bill. o Add instructions to Box #31 with Note: provide supervising physician's name when services are rendered by PA or NP.		Insurance Claim Form Reference Instruction Manual has definitions of billing provider, rendering provider, and supervising provider, and instructions for entering the information into various fields. The commenter has not demonstrated any workers' compensation – related reason to diverge from the national standard instructions. **Disagree** that instructions are needed on the Box 31 "Signature of Physician or Supplier" relating to PAs or NPs as commenter has not shown a need for further instruction specifically related to PAs and NPs as opposed to other providers. However, reexamination of Box 31 and the NUCC Instruction Manual has lead to the decision to modify the Workers' Compensation Requirement to Optional rather than Required. The signature block refers to the reverse of the form, which does not relate to workers' compensation. In addition, there is	Modify 1.1 Field Table CMS 1500, Field 31 "Workers' Compensation Requirement" column to delete "R" and insert "O."

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			no statutory requirement that bills be signed by the physician or provider. Moreover, the electronic 837 Professional TR3 does not utilize a signature. Therefore, the Field 31 signature should be an optional field.	
	UB 04 • Change Box #56 instructions to: NPI required for all health care facilities.		**Agree in part.** Agree that the instructions should clarify what circumstances give rise to "situational" being a required data element. If the provider is eligible for an NPI, the NPI becomes a mandatory data element.	Add language to 2.1 Field Table UB 04 Box 56 to specify that the NPI is a required data element if the provider is eligible for an NPI.
	• Change Box #57 instructions to: Enter hospital's Medicare ID Number when services were for inpatient procedures.		**Agree** that the hospital's Medicare ID # must be provided since 8 CCR §9789.22(d) requires the Medicare ID # to determine inpatient hospital reimbursement. In addition, hospital outpatient department reimbursement utilizes the Medicare ID #.	Modify 2.1 Field Table UB-04, page 26, Form location 57 instructions to provide that the situational data element becomes required if the billing provider has a Medicare Provider ID Number. For facilities without

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				a Medicare Provider ID Number it is required to provide the State License Number.
Medical Billing and Payment Guide, 7.1(b)	Commenter objects to the following mandate: *"....payment for medical treatment provided or authorized by the treating physician shall be paid within **15 days** of electronic receipt of the billing for services at or below the fees set forth in the official medical fee schedule."* The 15 day payment period is not a realistic allocation of time given the fact that the bill review provider needs sufficient time to review the bills even if they are electronically transmitted. Currently, commenter's organization is able to make payment to medical providers within the 60 working days allowed public agencies by statute. However, to meet the new 15 day period will significantly impact their operation. Commenter disagrees with the Division's assertion that there will be no fiscal impact on public agencies. Commenter opines that her agency	Mary Jo Castruccio Assistant Risk Manager - Workers' Compensation Contra Costa County April 26, 2010 Written Comment and Oral Comment	**Disagree.** The 15-day time period for payment of electronically submitted bills is a statutory mandate. The Legislature has implicitly determined that 15 days is an adequate period to perform bill review, issue payment etc. An employer is free to create the capacity in house or to contract with a clearinghouse to carry out the payment functions. The DWC does not have discretion to adopt a different payment period. **Disagree.** The commenter points out the costs of adopting electronic billing, but has not examined the savings to be realized. The DWC	None. None.

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	will bear the added cost to purchase PGP key software in order to receive the medical bill images. There will be added costs to have their workers' compensation claims software provider either write a program or develop a module to receive the images electronically. Additionally, the bill review provider may need to increase personnel in order to review the bills at a faster pace than is currently required. As a result, her agency will be charged for any enhancement. Commenter believes that this regulation will require her agency to increase the days taken to process medical payments which may impact claims adjusting and clerical staff. Commenter states that her agency does not have the luxury of being able to add much needed human resources to fulfill the legal expectations these proposed regulations impose. As a public agency, they are unable to pass increased costs on to their "customers" like a private employer may do. Commenter opines that using SCIF as representative of a large public entity is comparing apples to oranges. SCIF is a *quasi-public agency* and is an *insurance company.* They are financed by written premium which is		has evaluated the economic impact on employers and believes that there will be a net savings from electronic billing. In addition, the commenter has not suggested any methods of reducing the cost impacts that are within the statutory parameters.	

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	significantly different from a fully, publicly funded employer, like cities, counties, school districts, who are self-administered. Commenter requests that reconsideration be given to allow public entities to receive e-billing on an optional basis. In the alternative, commenter requests that more time be allowed for them to make payment. Commenter believes it more reasonable that payment could be made within 30 days of electronic receipt.		**Disagree.** Commenter is suggesting changes that are in conflict with Labor Code §4603.4 which requires all employers to accept electronic bills and which requires all payers to pay within 15 days of receipt of a complete bill.	None.
Medical Billing and Payment Guide, 7.1(b)	Commenter objects to the mandate to payment for services within 15 days of electronic receipt of the billing. Commenter does not believe that this is a realistic payment deadline considering all of the things that have to occur between receipt of the bill and issuance of a check. Currently, the time limit for payment to medical providers is 60 working days. Commenter opines that shortening this to 15 days will significantly impact her employer's operation and cost money. Commenter's agency is small and will bear the cost of either setting up a secure process in house to receive	Janet Selby Workers' Compensation Manager Municipal Pooling Authority April 26, 2010 Written Comment	**Disagree.** See response above to comment of Mary Jo Castruccio Assistant Risk Manager - Workers' Compensation Contra Costa County April 26, 2010. **Disagree** with the implication that the small size of the agency is a ground for altering the payment	None. None.

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	electronic billings or will have to contract with an outside provider to receive its behalf at a cost.		timeframe. All employers, large and small, are required by the statute to meet the 15 day payment deadline and will have to decide whether to handle bills in house or contract with an outside provider.	
	Commenter opines that their bill review provider may need to increase personnel in order to review the bills at a faster pace than is currently required and the agency will be charged for any enhancement needed.		**Disagree.** Commenter is speculating about increased bill review costs, but has not submitted evidence to support the speculation. Even if there were increased costs, commenter does not evaluate the counterbalancing efficiencies that lead to savings.	None.
	Commenter states that this regulation will require the processing of medical payments more frequently than currently performed, adding workload to existing claims staff. Payments cannot be generated until after the bill review process has occurred. In addition, checks over a certain amount have a specific check signing process that can take several days. Considering the 15 day deadline, commenter's agency will have to process payments more often, possibly every day, to ensure this deadline is met. This will add to their workload.		**Disagree.** The statute requires payment in 15 working days for electronic bills instead of the current 45 working days (or 60 working days for governmental agencies), which evidences the Legislature's intention that bills be paid faster. It can be inferred that this would necessitate some adjustments in payment processing and check issuance. The need to make changes does not alter the statutory requirement for payment within 15 days.	None.
	In addition, the 15% penalty for late		**Disagree.** The regulations apply	None.

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	payment regardless of the reason is a burden to their members. As a public agency, any cost increases are passed on to our cities, adding to their budget deficit problems. Commenter opines that this is taxpayer money be spent on a process that does not benefit public agencies.		the 15% "penalty" only where payment delay under Labor Code §4603.4 continues for the period specified in Labor Code §4603.2, 45 working days or 60 working days. Long before the electronic billing statute was enacted the Legislature determined that late paid bills which were not objected to should carry a 15% increase and interest. Labor Code §4603.2 does not distinguish between public and private employers in this regard – both are subject to the 15% increase and interest. The regulations do not alter this legislative determination of the appropriate deterrent for late payment of bills. An employer can avoid the penalty and interest by paying and objecting to bills in a timely manner.	
	Commenter requests that reconsideration be given to allow public entities to receive e-billing on an optional basis based on an analysis of the cost involved. In the alternative, commenter requests that more time be allowed to make payment. Commenter states that payment within 30 days of electronic receipt is more reasonable, and still		**Disagree.** See response above to comment of Mary Jo Castruccio Assistant Risk Manager - Workers' Compensation	None.

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	provides incentive to providers.			
General Comment	Commenter acknowledges that the purpose of these proposed regulations are to accelerate standardization of workers' compensation medical payment transactions and increase usage of electronic transactions as required by state legislation that amends CA Labor Code Section 4603.4. Commenter states that the proposed regulations will bring greater efficiency, standardization and measurable cost savings to the State of California. California's efforts to align workers' compensation transactions with HIPAA will help to create greater overall consistency in medical billing practices, thus relieving administrative and cost burdens for providers and payers alike. Even though the regulation does not require compliance with version 5010 at this time, implementation of 4010 standards will help all stakeholders move towards a higher level of standardization and efficiency.	Miriam Paramore Senior Vice President Clinical & Government Services Emdeon, Inc. April 26, 2010 Written Comment	**Agree.** **Agree in part.** Agree that the effort to align workers' compensation transactions with HIPAA will be beneficial and reduce administrative burdens. DWC appreciates the commenter's suggestion that moving to 4010 will help move to higher level of standardization and efficiency even though the proposal does not mandate 5010. However, the DWC has determined that it should mandate the 5010 standards and bypass the 4010 standards since the 5010 will be a mandatory HIPAA standard as of January 1, 2012. It would be wasteful to require the 4010 standards which	None. The regulation text and the Medical Billing and Payment Guide and the Electronic Medical Billing and Payment Companion Guide will be modified to reflect the 5010 standards rather than the 4010 standards.

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	Commenter strongly supports efforts to achieve savings through administrative simplification, and has worked to help raise awareness of potential savings at the national level by automating the most basic healthcare transactions. In 2008, the company founded the U.S. Healthcare Efficiency Index® (USHEI), an industry forum for measuring the transition from a manual- and paper-based healthcare system to an electronic one. The first phase of the USHEI identified nearly $30 billion per year in estimated potential savings if five basic medical claims-related transactions were fully automated (eligibility, claims submission, claims status, remittance advice and payment). Later phases of the USHEI will examine other segments, including workers' compensation.		will be superseded by the 5010 standards very soon. DWC notes the support to achieve savings through administrative simplification.	
Medical Billing and Payment Guide, 7.1(b)	Commenter is concerned about the time allowed from receipt of the billing to payment. Commenter states that a large number of small local agencies have constitutional and or charter obligation that require their boards to approve payments over a specific level. Often these boards only meet biweekly or once a month. For	Mark Ferguson Claims Administrator REMIF April 26, 2010 Written Comment	**Disagree** that regulations should provide a 60 day payment period for public agencies to pay electronically submitted bills. The statute provides 15 working days to pay electronically submitted bills and does not provide a longer time frame for public agencies. The DWC does not have discretion	None.

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	this reason, public agencies currently have 60 days to pay medical bills. Commenter opines that under this proposal, it would be fiscally impossible to receive a bill, have it go thought the necessary approval process and make a payment without being penalized. Commenter requests that the proposed regulations be amended to allow public agencies to maintain the current 60 day period.		to alter this payment period. Absent a legislative change, public agencies may need to alter their procedures to meet the statutory time frame. If there is a legal impediment to paying large bills within 15 days due to constitutional or charter obligations to obtain board approval for payment the governmental agency could issue a notice explaining the legal justification for the delay.	
General Question – Comments on Regulations	Commenter inquires if the Division will be publishing a document that outlines all written and public comments received related to the proposed guide? If so, will those be posted on the www.dir.ca.gov site? Is there a targeted timeline for publishing?	Leslie White Manager Product Team StrataCare, LLC April 26, 2010 Written Comment	In accordance with Government Code §11346.9(a)(3), the DWC will be publishing the summary of written comments and oral comments made at the public hearing as part of the Final Statement of Reasons (FSOR) upon completion of the rulemaking action.	DWC will compile a summary of comments and responses to comments and will publish it as part of the FSOR.
General Question – References to ANSI 4010 and NCPDP 5.1 versions	Commenter is concerned with using the current versions because there is a federal mandate for the industry moving to ANSI 5010 and NCPDP D.O effective 1/1/2012. Commenter opines that if the proposed CA rules are adopted and the implementation timeline is 18 months after, that will most likely overlap with the federal mandate of 1/1/2012. If this is the case, commenter asks what are the	Leslie White Manager Product Team StrataCare, LLC April 26, 2010 Written Comment	**Agree.** The 5010 implementation guides and the NCPDP D.0 will be mandatory HIPAA standards by the time the regulations are effective. The DWC should adopt the 5010 and NCPDP D.0 rather than the 4010 and NCPDP version 5.1.	Revise the regulation text and the Electronic Medical Billing and Payment Companion Guide to adopt the 5010 and NCPDP D.0.

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	plans for CA to create a revised Medical Billing and Payment Guide that will correctly reference the ANSI 5010 and NCPDP D.0? Will the timing of a revision to the Guide be in place and adopted prior the 1/1/2012 deadline?			
General – ICD-9 coding	Commenter is concerned with using the current version because there is a federal mandate for the industry to utilize ICD-10 coding effective 10/1/2013. Revisions to the Medical Billing and Payment Guide will need to be made as ICD-10 comes into effect. Commenter would like to know the division's plans for creating this revision along with the timing of when this should be adopted in order to meet the federal deadline.	Leslie White Manager Product Team StrataCare, LLC April 26, 2010 Written Comment	**Agree** that the proposed 4010 transaction sets will not be compatible with the ICD-10. The Division is aware that the ICD-10 coding will become HIPAA mandated coding on October 1, 2013. The 5010 TR3 formats accommodate the ICD-10, therefore as ICD-10 becomes adopted into the various fee schedules there will not be a need to alter the electronic billing formats.	Modify the proposal to utilize the 5010 TR3s instead of the 4010 transaction sets.
Medical Billing & Payment Guide – Section One – 5.0(c)	This section indicates that balance forward billing is not permissible. Commenter would like additional clarification for the definition of "balance forward billing". If a bill is submitted that contains one line item that has previously been submitted and a line item for a new charge is that considered "balance forward billing"? What are the carriers' options for handling such a bill? Will carriers be allowed to reject the bill? Or deny the bill with an explanation code that	Leslie White Manager Product Team StrataCare, LLC April 26, 2010 Written Comment	**Agree** that further clarification would be helpful regarding "balance forward billing." The definition will be expanded to include a "summary of accumulated unpaid balances." In addition, the Division agrees that it would be helpful to explain how the balance forward bill can be handled, so language will be added to specify that a balance forward bill may be rejected, and a DWC Bill Adjustment Reason Code will	Add clarifying language to 5.0 (c) to include a broader definition of balance forward billing. Add language indicating that a balance forward billing may be rejected until a bill is submitted that does not

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	illustrates it is a balance forward bill? If the bill was submitted via paper, can carriers send the bill back to the health care provider with a letter explaining that it is a balance forward bill? Commenter opines that it would be helpful to have example scenarios from the DWC to help illustrate the process and options available.		be added for the claims administrator to use to communicate rejection of a balance forward bill.	carry over previous charges/ Add reference to DWC Bill Adjustment Reason Code G56 and CARC 18 to communicate rejection of a balance forward bill and add clarifying language to G56.
Medical Billing & Payment Guide – Section One – 5.0(d)	This section indicates that a health care provider cannot submit a bill via paper and electronic means. If this scenario occurs, should a carrier send the 2nd bill back to the health care provider? Or should they deny the charges with a specific explanation code that illustrates this is not allowed? Commenter opines that this item will most likely cause exception workflow issues for carriers as it would be a manual determination as to whether the 2nd bill had already been submitted, and if so, whether both bills were received via paper or electronic or a combination of those.	Leslie White Manager Product Team StrataCare, LLC April 26, 2010 Written Comment	**Disagree** that the provision prohibiting a billing from being submitted in paper and electronic form will give rise to problems. This provision prohibits a particular kind of "duplicate bill." A claims administrator can use the DWC bill adjustment reason code G56 or the CARC 18 to reject a duplicate bill.	None.
Medical Billing & Payment Guide – Section One –	This section indicates that denials to all or any part of a bill must occur within 30 days of receipt; however	Leslie White Manager Product Team	**Disagree** that the language is susceptible to the interpretation suggested by the commenter. The	None.

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6.0(a) and (b)	payments must be made within 45 days of receipt. If a bill has two line items and one is being paid and the other being denied, does this fall within the 45 day timeframe or the 30 day timeframe? One could argue that it falls within the 45 day timeframe as a payment is being made on the bill, but not necessarily on each line item. Commenter requests that the division provide scenario examples and clarification.	StrataCare, LLC April 26, 2010 Written Comment	language of Section 6.0 (b) states in pertinent part that a "claims administrator who objects to all or any part of a bill for medical treatment shall notify the health care provider…within 30 working days after receipt of the bill and any required report or supporting documentation…and shall pay any uncontested amount within 45 working days after receipt of the bill…" The language goes on to provide that if a required report or supporting documentation is not received with the bill the claims administrator shall notify the provider within 30 days of receipt of the bill. The language parallels the language of the statute, Labor Code §4603.2. It is clear that the claims administrator must send objection and/or notification of missing reports within 30 working days and pay undisputed amounts within 45 working days. In addition, DWC is not aware of "scenario examples" that would be helpful in relation to these sections.	
Medical Billing & Payment Guide – Section One – 7.1(b)	The first sentence states that payment shall be made by employer within 15 working days of electronic receipt. Commenter seeks verification if it	Leslie White Manager Product Team StrataCare, LLC	**Agree** that the claims administrator shall make the payment. The Labor Code requires *the employer* to provide medical	Modify the language in section 7.1 subdivision (b) to

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	would actually be the carrier or claims administrator versus the employer.	April 26, 2010 Written Comment	treatment (Labor Code §4600) and pay electronically submitted bills (Labor Code §4603.4). However, these employer responsibilities are carried out through the claims administrator (which could be the employer itself, or its insurer or a third party administrator.) The other subdivisions of section 7.01 refer to "claims administrator" and it would be appropriate for subdivision (b) to refer to "claims administrator" also.	substitute "claims administrator" for "employer."
	Commenter opines that instituting a 15 working day turnaround time will cause a burden on claims administrators. There are many workflow processes that a bill follows once a clean bill has been received by a carrier or its bill review agent. Bills can go through a number of steps including data element editing, second and tertiary level reviews, routing to various PPO networks, etc. 15 days is very aggressive and carriers will be held to that even though they have little control over other 3rd parties' turnaround time (example Pend & Transmit processing). Commenter strongly suggests that the DWC consider extending this timeframe to one that is reasonably achievable for	Mary Jo Castruccio Assistant Risk Manager - Workers' Compensation Contra Costa County April 26, 2010	**Disagree.** See response above to	None.

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	carriers.			
Electronic Medical Billing & Payment Companion Guide Chapter 9 – 9.2	Commenter states that these chapters indicate that if claim number is Unknown or not provided that carriers will have a 5 day period in which to attempt to locate the appropriate claim number, or return the bill to the health care provider. If the carrier is able to locate or establish the appropriate claim number within the 5 day period and proceed to the adjudication process, at which day does the 15 day turnaround time begin? Does the clock begin to tick after the 5 day pend period, or on the first date of electronic receipt? Commenter requests that the Division provide clarification. If a carrier pends a bill for up to 5 days and then pays/denies the bill within 15 days afterward, it could appear to the DWC that the bill was paid late. Commenter questions what are the carriers' options for defending this type of scenario if it were to come up in a DWC audit? How will the DWC monitor this scenario that would potentially fall outside of the 15 day turnaround time?	Leslie White Manager Product Team StrataCare, LLC April 26, 2010 Written Comment	**Agree in part.** Agree that the time frame for payment should be clarified for the situation where an electronically submitted bill is placed in pending status for up to five days for a missing attachment or claim number. The DWC's intent is that the electronic bill will be paid or objected to within 15 days of receipt of the bill. The "pending" period suspends the 15 day timeframe during the period that the bill is pending, but upon matching the claim number, or receiving an attachment, the timeframe resumes. The 15 days do not begin anew. This will be clarified in the Medical Billing and Payment Guide, section 7.1 Timeframes, and also in the Electronic Medical Billing & Payment Companion Guide, Chapter 9.	Modify the Medical Billing and Payment Guide, Chapter 7, section 7.1 to clarify the acknowledgment and payment time frames where the bill is put in pending status. Modify Chapter 9 of the Companion Guide to cross reference the Medical Billing and Payment Guide Chapter 7.
Electronic Medical Billing & Payment Companion Guide – Clearing houses	Commenter states that this guide does not clearly indicate the process for selection of clearinghouse vendors either from a carrier or health care provider perspective. Commenter	Leslie White Manager Product Team StrataCare, LLC April 26, 2010	**Agree** that the guide does not govern the process by which a provider or claims administrator may select a clearinghouse. A health provider or claims	None.

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	asks if the reason for this is that the selection of a clearinghouse vendor is to be considered a coordinated effort between these two parties and falls outside of the DWC realm?	Written Comment	administrator is free to handle its billing or payment obligations in house or through a clearinghouse or other agent and may enter contracts for services. There is no necessity to regulate the selection of a clearinghouse.	
Electronic Medical Billing & Payment Companion Guide Chapter 1, 1.2; 9792.5.3	Commenter notes that these proposed rules mandate that all payers must accept electronic bills within a specified timeframe while making the use of electronic billing voluntary for providers. Commenter opines that this will create inefficiencies and compliance burdens for payers, who will be required to maintain dual processes for receiving and processing both paper and electronic bills. While mandatory electronic billing may arguably create some difficulties for providers who do not see a significant volume of workers' compensation patients, commenter suggests that most providers already utilize electronic billing for other types of payment systems, so the burden should not be as great as some would suggest. It would not seem unreasonable to require electronic billing, at least for the majority of providers, within a reasonable time frame.	Harry J. Monroe, Jr. Director, Government Relations – Workers' Compensation Services Coventry Health Care April 26, 2010 Written Comment	See response above to comment by Susan Leonardi, Senior Application Business Analyst Mitchell International April 23, 2010	None.
Medical Billing &	Commenter states that this section	Harry J. Monroe, Jr.	**Agree in part.** Agree that the	Modify the

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Payment Guide – Section 7.1(b)	provides reimbursement for electronically submitted bills must be made within 15 working days of receipt of the bill. Commenter opines that this time frame will create significant burdens for bills that require special review – for example, bills that need to be further reviewed to determine whether services provided were medically necessary in accordance with state requirements. Commenter requests that the Division either clarify that payers can comply by issuing an interim explanation of review that would allow for an extended reimbursement time frame or, alternatively, extend the time frame for all electronically submitted bills.	Director, Government Relations – Workers' Compensation Services Coventry Health Care April 26, 2010 Written Comment	regulations should address the situation where there is a need to conduct a retrospective utilization review which is allowed under Labor Code §4610. For retrospective review, the claims administrator is allowed 30 days from receipt of information that is reasonably necessary to make the determination of medical necessity. There is a DWC Bill Adjustment Reason Code G71 that communicates a denial during a retrospective utilization review, and CARC 216 that states an adjustment is "Based on findings of a review organization." However, it will improve communication to adopt an addtional DWC Bill Adjustment Reason Code (new G72) that explains that the billing is in the process of utilization review. The corollary CARC 15 and RARC N175 combination is included in the chart for use in electronic transactions. Since the payment or objection to an electronic bill must be made within 15 days of receipt of the complete billing, the new G72 code and corollary CARC 15 and RARC N175 will be particularly useful since the statute	Medical Billing & Payment Guide, to add a new DWC Bill Adjustment Reason Code G72 (Charge being submitted for Retrospective Review) and combination of CARC 15 (The authorization number is missing, invalid, or does not apply to the billed service) and RARC N175 (Missing review organization approval.) which correlates to G72. Medical Billing and Payment Guide, Appendix B, Table 1.0.

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			allows 30 days to complete the retrospective review. **Disagree** that the timeframe should be extended for all electronically submitted bills since this would violate the electronic billing statute, Labor Code §4603.4.	
9792.5.0(c) - Definitions	Commenter points out that this section includes usage of the term "good or services" in the definition of "health care provider". This term is overly broad and needs clarification. For example are the goods and services limited to medical treatment and durable medical equipment, or is the intent to include translation services and other non-medical services in this definition. Clarify the definition to limit it to medical treatment and other medical services if that is the intent, or in the alternative, provide a definition of "goods and services".	Alissen Korsgard, CPC – National Compliance Specialist – Bill Review Department Zenith Insurance April 26, 2010 Written Comment	**Agree in part.** Labor Code §4603.4 refers to "medical services" and "medical bills." There is no definition of this in that section, but it would be helpful to refer to Labor Code §4600 which sets out the employer's obligation to pay for various types of medical treatment and services. The 5010 TR3s can accommodate billing from "atypical providers." **"1.10.1 Providers who are Not Eligible for Enumeration** Atypical providers are service providers that do not meet the definition of health care provider. Examples include taxi drivers, carpenters, personal care providers, etc. Although they are not eligible to receive an NPI, these providers perform services that are reimbursed by some health plans. As a result, this implementation guide has been	Modify §9792.5.0(c) to include reference to Labor Code §4600.

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			enhanced to accommodate both the NPI (to identify health care providers) and proprietary identifiers (to identify atypical/non-health care providers)." 837P, page 42. Although the mandatory medical billing rules apply to health providers and facilities, billing by atypical providers in electronic format could be addressed by the parties to a trading partner agreement.	
Medical Bill & Payment Guide – Section 3.0(b)(3)	Commenter recommends that this subdivision be modified to permit claims administrators to input data for certain blank fields on a submitted bill to expedite the billing process. For example, a bill may be submitted with all appropriate information but be missing one required field that the claims administrator already has in its system because a prior bill was submitted that included the missing data element. Commenter supports making this a permissible practice, but not mandatory. Proposed language is set forth below in bold print. (b) To be complete a submission must consist of the following:	Alissen Korsgard, CPC – National Compliance Specialist – Bill Review Department Zenith Insurance April 26, 2010 Written Comment	**Agree.** The suggestion to allow, but not require, the claims administrator to supply missing data elements could help expedite payment.	Modify the Medical Billing & Payment Guide 3.0(b)(3) to add the language suggested by the commenter.

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	(3) The uniform billing form/format must be filled out according to the requirements specified for each format in Appendix A and/or the Companion Guide. **Nothing in this paragraph precludes the claims administrator from populating missing information fields if the claims administrator has previously received the missing information.**			
Medical Bill & Payment Guide – Section 3.0(c)(2) and (3)	Commenter proposes that language be added to make it clear that any narrative report be appropriately titled as required by Title 8 CCR 9785. See proposed language in bold below: (c) All required reports and supporting documentation must be submitted as follows: (2) A PR-2 report or its **appropriately** titled narrative equivalent must be submitted when the bill is for Evaluation and Management services and a PR-2 report is required under Title 8, California Code of Regulations section 9785. (3) A PR-3, PR-4 or their	Alissen Korsgard, CPC – National Compliance Specialist – Bill Review Department Zenith Insurance April 26, 2010 Written Comment	**Disagree.** A "narrative" equivalent to the PR-2 form is already defined in 8 CCR §9785(f)(8), and includes various requirements in addition to the title. It could be confusing to insert the phrase "appropriately titled narrative equivalent" since that does not encompass all the requirements in the reporting regulation for a narrative PR-2. In regard to the PR-3 and PR-4, the reporting regulation provides that when the employee's condition becomes permanent and stationary, the physician shall report within 20 days and states that "the information may be submitted on the [Form PR-3 or PR-4]… or in such other manner which provides	None.

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	appropriately titled narrative equivalent must be submitted when the bill is for Evaluation and Management services and the injured worker's condition has be declared permanent and stationary with permanent disability or a need for future medical care. (Use of Modifier – 17)		all the information required by Title 8, California Code of Regulations, section 10606." There is no requirement in relation to the title of the report and it would be confusing to insert the phrase "appropriately titled" into the billing regulations.	
Medical Billing & Payment Guide – Section 3.0(c)(5)	Commenter proposes that the language in this subsection be made less restrictive so that a report is received any time a modifier is used that alters payment. This way, claims administrators will receive the explanation and supporting documentation for use of the modifier at the time the bill is submitted. The proposed language is noted by bold font and is underscored. (5) A report must be submitted **any time** ~~when~~ the provider uses **a** ~~the following~~ Modifier~~s~~ that **increases or decreases reimbursement.** ~~– 19, - 21, -22, -23 and -25.~~	Alissen Korsgard, CPC – National Compliance Specialist – Bill Review Department Zenith Insurance April 26, 2010 Written Comment	**Disagree.** The language proposed by commenter is ambiguous and it is not clear what necessity there is for adding the proposed language. What is meant by "increases or decreases reimbursement"? Modifiers often play a role in determining the calculation of the reimbursement, but it could engender disputes to have providers and payers determining whether the modifier "increases or decreases reimbursement" or merely describes a circumstance that determines the payment amount. For example, modifier 80 assistant surgeon means the physician will receive 20% of the listed reimbursement. Does this fall within the rubric of "increase or decrease" or is it just the methodology for determining the assistant physician fee? In addition, it is not clear that there is	Delete modifiers 19 and 21 from the listing in Section 3.0(c)(5).

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			necessity for a requirement of a report whenever a modifier "increases or decreases reimbursement." Operative reports are already required for surgery; Doctor's First Report of Injury 5021, PR-2, Pr-3 or PR-4 are already required where they are needed to support an Evaluation and Management Code, and reports are required for all "By Report" billing. DWC believes it is clearer and more appropriate to list specific modifiers requiring a report and disagrees with the suggestion to delete the listing. However, two of the modifiers suggested for deletion (19 and 21) should be deleted as they no longer exist.	
Medical Billing & Payment Guide – Section 3.0(c)(9), (10), (11)	Commenter recommends that a new item be added to require that the anesthesia record be provided when billing for anesthesia. Proposed modification set forth below in bold type. **(9) The anesthesia record is required when the bill is for anesthesia services.** ~~**(9)**~~**(10)** An invoice or other proof of documented paid costs must be provided when required for	Alissen Korsgard, CPC – National Compliance Specialist – Bill Review Department Zenith Insurance April 26, 2010 Written Comment	**Disagree.** The CMS Form 1500, Field 24 allows for indication of anesthesia time. (See the NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 08/05, July 2010, page 44.) If the claims administrator needs further documentation it may request additional appropriate information.	None.

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	reimbursement. **~~(10)~~(11)** Appropriate additional information reasonably requested by the claims administrator or its agent to support a billed code when the request was made prior to submission of the billing. Supporting documentation should be sufficient to support the level of service or code that has been billed. **~~(11)~~(12)** Written authorization for services shall be provided where one was given.			
Medical Billing & Payment Guide – Section 3.0(d)	Commenter points out that the word "supporting" is misspelled.	Alissen Korsgard, CPC – National Compliance Specialist – Bill Review Department Zenith Insurance April 26, 2010 Written Comment	**Agree.**	Typographical error will be corrected.
Medical Billing & Payment Guide – Section 5.0(a)	Commenter points out that under this subsection the language states that duplicate bills shall include "all the same information." Box 31 requires a billing date, which could be different depending on the date the bill is submitted. This becomes problematic for claims administrators, because technically if the billing date is different, then the information is not "all the same" and bill cannot be considered a duplicate. Commenter	Alissen Korsgard, CPC – National Compliance Specialist – Bill Review Department Zenith Insurance April 26, 2010 Written Comment	**Agree.** The DWC agrees that a "duplicate bill" may have a different billing date than the original bill, and is still a "duplicate" if all other information is the same. The point of designating something as a "duplicate" is to make sure it is clear the same substantive bill for services has previously been submitted. In addition, DWC agrees that it would be useful to	Modify the language of 5.0(a) to clarify that a duplicate bill may have a new billing date and also add a definition of "duplicate bill" to Section One – Business Rules, 1.0 Standardized

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	would like this to be clarified so that "all the same information" means all information except the billing date for the services. Commenter has experienced this issue in other states and therefore believes it is important to include this clarification. Commenter recommends that a definition be provided for the term "duplicate bill" and that the definition be added to the definitions section.		add the definition of duplicate bill to the Section One definitions.	Billing/Electronic Billing Definitions.
Medical Bill & Payment Guide – Section 5.0(c)	Commenter recommends adding a definition of "balance forward bills" to the definitions section.	Alissen Korsgard, CPC – National Compliance Specialist – Bill Review Department Zenith Insurance April 26, 2010 Written Comment	**Agree.** See response to same comment made by Leslie White, Manager Product Team, StrataCare, LLC, April 26, 2010.	See action described above in relation to comment by Ms. White of StrataCare.
Medical Bill & Payment Guide – Section 7.0(b)	Commenter has previously stated that the 15 day period to make payment on a billing is aggressive. Commenter understands that this is statutory but believes this still needs to be addressed due to the cost and burden of complying with such an aggressive turn around period. Commenter continues to support a 30 day period for electronic transactions and therefore has retained this comment although she understands the requested change cannot be made at	Alissen Korsgard, CPC – National Compliance Specialist – Bill Review Department Zenith Insurance April 26, 2010 Written Comment	**Agree** that the requirement to pay within 15 working days is a statutory requirement that cannot be changed by regulation.	None.

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	this time.			
9792.5	Commenter recommends addressing all changes contemplated to this section in a single rulemaking. **Discussion** The DWC posted on the DWC Forum section of its web site other changes it drafted for §9792.5 and solicited informal comment from the public on those changes. Those draft changes are not included in these proposed modifications. Addressing any and all changes to this section in one rulemaking will avoid the confusion, disruption and unnecessary expense that otherwise will be generated by adopting two separate changes to this section within a short period of time.	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Agree in part.** Agree that it would be best to make all changes to section 9792.5 in one rulemaking action unless there is a particular reason to separate some items in a separate rulemaking. DWC has incorporated the changes into the section that are believed to be appropriate at this time. Commenter has not set forth a description of "changes [that] are not included in these proposed modifications" and the DWC is not aware of what commenter is referring to.	None.
9792.5 – Recommend Effective Date	Commenter recommends the following change: This section is applicable to medical treatment rendered between April 18, 2004 and ~~before~~ XXXX, 2010 *[approximately 90 days after the effective date of this regulation]*. **Discussion** The proposed revisions to this section are made to conform to amendments enacted by SB 899 to Labor Code	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Agree in part.** DWC agrees with commenter that it would be appropriate to acknowledge the different statutory interest rate and time period for payment which existed prior to the current 15% rate and 45 working day deadline for bill payment (60 working day for government entities). However, the change to the statute bringing in the 45 working day/60working day period, and which changed the interest from 10% was not SB 899, but rather	Modify §9792.5 to add a subdivision specifying the 60 day period for payment and specifying 10% interest for bills not timely contested or paid.

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	section 4603.2. Per section 47 of SB 899, those amendments apply prospectively from the date of enactment, April 19, 2004. Claims administrators continue to receive bills and amended bills for services provided more than six years ago. The regulatory language must be revised to clarify that the current language remains effective for services provided before that enactment date, and that the proposed revisions apply only to services provided between April 18, 2004 and the date 90 days after the effective date of this proposed regulatory change.		SB 228 (Stats. 2003, Chapter 639) adopted in 2003, effective January 1, 2004. In addition, it would not be appropriate to limit the entire section to a period between 2004 and 90 days after the effective date of the regulations. There may be bills for services prior to January 1, 2004 which are still being adjudicated and which would be subject to the statutory 60 day payment period , 10% interest, and other provisions incorporated into the regulation.	
9792.5(b) and (d)	Commenter requests that the language in (b) and (d) be modified to clarify that payment for a properly documented bill is due within 60 working days if the employer is a governmental entity as specified in Labor Code section 4603.2(b)(2).	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Agree.**	Modify §9792.5 subdivisions (b) and (d) to recognize that Labor Code §4603.2 gives governmental entities 60 working days to pay a medical bill.
9792.5(f)	Commenter opines that this subsection should be removed. **Discussion** While section 4603.2(b)(1) provides	Brenda Ramirez Claims & Medical Director California Workers' Compensation	**Agree.**	Modify §9792.5 to delete subdivision (f).

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	for 15% penalty and interest if a bill is neither paid within 45 working days nor properly contested, the subsection that previously imposed interest if the appeals board subsequently determined a contested charge to be payable was deleted from section 4603.2(b)(1)(B) by the legislature in the Assembly Bill 1806 budget trailer bill, effective July 1, 2006.	Institute (CWCI) April 26, 2010 Written Comment		
9792.5.1(c) through (h)	Commenter recommends these subsections be removed and the information instead be incorporated into the DWC Guides. **Discussion** To avoid possible contradictions and confusion it is necessary to include all information needed by the user in the DWC's Guides, otherwise modifications to these other guides manuals may create unexpected contradictions and confusion since the referenced manuals are not under the Division's control. As proposed, in order to comply with these regulations, or even to see what is required to comply with these regulations, the regulated public must purchase guides and manuals at considerable expense. This will not be necessary if the Division includes the necessary information in its guides. In	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** It is not possible to include all necessary information in the DWC's Guides. The electronic billing standards are complex, technical standards for electronic billing that are copyrighted by the creating entities (the ANSI X12 committee, the National Council on Prescription Drugs Program). These must be procured and licensed by the users from the copyright holders. It would not be feasible, nor efficient, for the State to become a "middleman" in the licensing of the products. The standards mandated are, in accordance with the statute, HIPAA adopted standards to the extent feasible. It can be inferred that the Legislature intended for end users to license the standards needed to engage in electronic	None.

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	instances where this is not possible, the Division can centrally arrange availability to the regulated public by paying multi-use fees if necessary and posting those guides/manuals on its web site. This will provide availability in the most cost-effective way to the regulated community.		billing, or to contract with clearinghouses that would obtain the licenses and carry out the transactions. Commenter is incorrect in stating that the public must purchase the guides and manuals to see what is in them. The Division has all of the implementation guides in the rulemaking file, which are available for public inspection.	
9792.5.2 (a) and (c)	Commenter suggests the following revision: (a) On and after XXXX, 2010, [approximately 90 days after the effective date of this regulation] all paper bills for medical treatment provided by ~~physicians~~, health care providers, and health care facilities shall be submitted on ~~claim~~ billing forms set forth in the *California Division of Workers' Compensation Medical Billing and Payment Guide*. (c) On and after XXXX, 2011 [approximately 18 months after the effective date of regulation], all bills for medical treatment provided by ~~physicians,~~ health care providers, and health care facilities may be electronically submitted to	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Agree.** The term "physician" is included in the definition of "health care provider" and therefore listing it separately is redundant. Agree that it would be clearer to use the term "billing form" rather than "claim form."	Modify §9792.5.2 subdivision (a) to delete the term "physician" and to substitute the term "billing" for "claim." Modify subdivision (c) to delete the term "physician."

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	the claims administrator for payment…. **Discussion** Since the definition of health care provider encompasses physicians, it is not necessary to separately reference them. To avoid confusion, it is better to use the replace the term "claim" with "billing" here and wherever else it appears in these regulations when the intended meaning concerns a charge for medical goods or services. The term "claim" has another meaning in the California workers' compensation venue.			
Medical Billing & Payment Guide – 1.0 Standardized Billing	Commenter suggests the following changes: (b) "Bill" means the medical services and corresponding billed amounts as itemized in Appendix A, and set forth in the uniform billing form/format ~~setting forth the itemization of services provided found in Appendix A~~ along with the required reports and/or supporting documentation as described in Section One – 3.0. **Discussion** Commenter suggests that a "bill" is more accurately described as	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** The definition already includes the concept of the "information supplied" in that it says a bill is "the uniform billing form setting forth the itemization of services provided…." **Agree** that the concept of billing "format" should be included to account for electronic bills which are not "forms," but can be looked at as "formats." However, DWC will be modifying the proposal to clarify what constitutes an electronic bill as follows:	Modify the definition of "bill" to encompass the electronic bills.

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	information supplied on the form/format than the form/format where the information is set out.		(b) "Bill" means: (1) the uniform billing form found in Appendix A setting forth the itemization of services provided ~~found in Appendix A~~ along with the required reports and/or supporting documentation as described in Section One – 3.0~~.~~ Complete Bills or (2) the electronic billing transmission utilizing the standard formats found in Section Two – Transmission Standards 2.0 Electronic Standard Formats, 2.1 Billing, along with the required reports and/or supporting documentation as described in Section One – 3.0 Complete Bills.	
Medical Billing & Payment Guide – 1.0 Standardized Billing	Commenter suggests that the division clarify in (j) whether an EOR can serve as an objection. Commenter requests that the division clarify that EORs are not required for bills that are rejected during the initial clean bill screens. Suggests the following revision: (j) "Explanation of Review" (EOR) means the explanation of payment or ~~the denial of the payment~~ non-payment using the standard code set found in Appendix B – 1.0. EOR~~'~~s use the following standard codes: (1) DWC Bill Adjustment Reason Codes provide California specific workers' compensation explanations	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** It would not be helpful to modify the definition of EOR in (j) to define the usage of the EOR. For electronic bills, the method of objecting to the billing transmission at the initial stage is addressed in Chapter 7, section 7.1 subdivision (a) which directs the use of the TA1, 999, and 277 transactions to notify the provider of an incomplete or defective bill. These are all issued within two days of receipt of the billing to notify the provider of initial "clean bill" concerns. After that time, Section 7.1 subdivision (b) provides for the use of the 835	None.

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	of a payment, reduction or denial. They are found in Appendix B ~~—1.0 DWC ANSI Matrix Crosswalk. (2) ANSI Claims Adjustment Group Codes represent the general category of payment, reduction, or denial. The most current, valid codes should be used as appropriate for workers' compensation. These codes are obtained from theWashington Publishing Company http://www.wpc-edi.com. (3) ANSI Claims Adjustment Reason Codes (CARC) represent the national standard explanation of payment, reduction or denial information. These codes are obtained from the Washington Publishing Company http://www.wpcedi.com. (4) ANSI Remittance Advice Remark Codes (RARC) represent supplemental explanation for a payment, reduction or denial. These are always used in conjunction with a ANSI Claims Adjustment Reason Code. These codes are obtained from the Washington Publishing Company http://www.wpc-edi.com.~~ **Discussion** For claims that have been denied as non-compensable, most claims		Health Care Payment/Advice as the Explanation of Review. **Agree** that some clarification would be useful in regard to objections to paper bills. For paper bills, Chapter 6, section 6.0 subdivision (b)(1) provides that objections must be issued within 30 working days of receipt of the bill using DWC Bill Adjustment Reason codes contained in Appendix B. Chapter 6, section 6.0 subdivision (b)(1) will be modified to clarify that the EOR Field Table is applicable, not just the Bill Adjustment Reason Codes. The EOR using the data elements is satisfactory for conveying early "clean bill" type objections as well as objections based on later stage substantive review of medical necessity, etc. There is no need to have a separate "clean bill" objection data element table for paper EORs since the table provides for "S" situational data elements so that the fields that would not be applicable to an early clean bill objection can be indicated. **Disagree** that a medical provider	Modify Chapter 6, Subdivision (b)(1). Modify Appendix B, Field Table 3.0, Fields 3, 4, 5 regarding payment from R to S to accommodate the situation where no payment is being made. Also modify Fields 9 and 10 comments to clarify that these are only required when there is no payment or payment at less than billed charges. None.

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	administrators now send separate written notice of the denial to the medical provider after which the provider is prohibited from sending any more medical billings to the claims administrator. It would be helpful to clarify whether an EOR message may serve as an objection for this and other purposes. Some bills are rejected when they fail the clean bill screens. These bills fail to advance to the bill review level where EORs are triggered. Language clarifying that EORs are not generated for such bills would be helpful. The purpose of claims adjustment reason codes (CARCs), remittance advice remark codes (RARCs), and ANSI Claims Adjustment Group Codes are to provide clear explanation for the payment of medical bills. The reason that stakeholders expended considerable time and effort in 2005 and 2006 to jointly develop California-specific language for explanations of review (EORs) was to improve language currently being used (including CARC and RARC language) to explain medical payments. The California-specific language was designed to give billing		is prohibited from sending any more medical billings after a claims administrator has denied a claim as non-compensable. **Agree** that the Claim Adjustment Group Code is not needed for the paper EOR. **Disagree** with the suggestion to eliminate the ANSI Claims Adjustment Group Codes, the ANSI Claims Adjustment Reason Codes and the ANSI Remittance Advice Remark Codes. The statute directs the DWC to adopt electronic standards which are compatible with HIPAA "to the extent feasible." The CAGCs, CARCs and RARCs are national standards which are HIPAA mandated codes. The DWC has selected a subset of those national HIPAA approved codes for use in workers' compensation and has crosswalked them to DWC Bill Adjustment Reason Codes. The national standard Payment/Advice 835 does not support use of DWC Bill Adjustment Reason Codes.	Modify Chapter 6 section 6.0 (b)(1) to delete the Claims Adjustment Group Code.. None.

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	medical providers' information that is clearer and more specific so that providers would better understand the reasons for the way they were paid. They were intended to replace inferior existing language; and not intended to add another layer with complex crosswalks that will result in confusion rather than clarity for providers. It will be better, if possible, for the DWC to either require old explanations (CARCs and RARCs and Claims Adjustment Group Codes) or the ones developed to replace them, but not both, in medical billing standards and WCIS requirements.		The DWC Bill Adjustment Reason Codes were developed with public input to provide information especially tailored to workers' compensation which could be provided on the paper EOR. For electronic billing, the California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk serves as a "translator" between the DWC Bill Adjustment Reason Codes and the CARCs and RARCs that will appear in the 835 electronic payment advice.	
Medical Billing & Payment Guide – 1.0 Standardized Billing	Commenter recommends the following revised language: (s) "Required report" means a report which must be submitted pursuant to Section 9785 or pursuant to the OMFS. These reports include the Doctor's First Report of Injury, PR-2, PR-3, PR-4 and their narrative equivalents, as well as any report accompanying a "By Report" or "unlisted service" code billing. **Discussion** An "unlisted service" code billing also requires a report to determine reasonable reimbursement.	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** All of the "unlisted service" codes are already "By Report" so it is not necessary to list them separately here.	None.

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Medical Billing & Payment Guide – 1.0 Standardized Billing	Commenter recommends the following revised language: (t) "Supporting Documentation" means those documents, other than a required report, necessary to support a bill. These include, but are not limited to: any written authorization received from the claims administrator or an invoice required for payment of the DME item being billed, and any other reports or other documents necessary to support a billed code. **Discussion** Since (c) describes "required reports and supporting documentation" any documents that are not required reports but that are necessary to support a billed code must fall under the definition of "supporting documentation" and including language to clarify this in the definition will avoid confusion and disputes.	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** The commenter's suggested language does not add specificity, and doesn't help to define the universe of "supporting documentation." The language of (t) already allows for documents other than the ones specified by stating that supporting documentation "includes but is not limited to…."	None.
Medical Billing & Payment Guide – 1.0 Standardized Billing	Commenter recommends the following revised language: ~~(u) "Third Party Biller/Assignee" means a person or entity authorized by law and acting under contract as the agent or assignee of a rendering~~	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010	**Disagree.** See Response above to substantially identical comment by Kathleen Burrows, Claims Operations Manager, State Compensation Insurance Fund, April 26, 2010	See modifications described above.

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	~~physician, health care provider or healthcare facility to bill and/or collect payment from the responsible payor.~~ (u) "Third party biller" means a person or entity authorized by law and paid by a health care provider to bill for medical goods or services on behalf of the health care provider, and who is not an employee, affiliate or subsidiary of the health care provider, and no transfer of rights or benefits has occurred between the health care provider and the third party biller. (v)"Assignee" means a person or entity that has purchased the right to payments for medical goods or services from the health care provider, and is authorized by law to collect payment from the responsible payor. **Discussion** The recommended definitions are more accurate and complete, and separate definitions are necessary because a third party biller and an assignee have different meanings.	Written Comment		
Medical Billing & Payment Guide –	Commenter recommends the following revised language:	Brenda Ramirez Claims & Medical	**Disagree.** Both Labor Code §§4603.2 (b)(1) and 4603.4(d)	None.

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1.0 Standardized Billing	(~~v~~w) "Treating Physician" means the primary treating physician ~~or secondary physician~~ as defined by section 9785(a)~~(1), (2)~~. **Discussion** The recommended definition is in accord with the language in Labor Code sections 4603.2(b)(1) and 4603.4(d) and consistent with CCR section 9785(a)(1). The primary treating physician has the responsibility to "provide or authorize medical treatment" and to submit required reports. Including secondary physicians in this definition would conflict with statutory language and create confusion.	Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	refer to "the treating physician," not the "primary treating physician." It would not comport with the statute to make the billing rules apply to only the "primary treating physician" as the statutes do not restrict applicability to the primary physician. The secondary treating physician provides much of the care in workers' compensation and is also subject to the billing statutes and regulations.	
Medical Billing & Payment Guide – 1.0 Standardized Billing	Commenter suggests adding "as of" dates to the definitions of uniform billing codes in (y). **Discussion** Billing codes are updated periodically, even within a single version or edition of a coding system.	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** Inserting dates into the definitions of the billing codes would not be helpful. The coding is embedded in each fee schedule, and the appropriate code set will depend on the date the service is rendered, or for inpatient services, the date of discharge. Commenter is correct that codes are updated periodically, but the specification of the code set will be in the fee schedule itself. The Medical Billing and Payment Guide's	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			section 3.0 Complete Bills (b)(2) states that the complete bill must include "The correct uniform billing codes for the applicable portion of the OMFS under which the services are being billed."	
	Commenter recommends that in the Uniform Billing Codes definition, (y)(4), replace "Diagnosis Related Group (DRG)" with "Medicare severity-diagnosis related codes (MS-DRG)" and "DRG" with "MS-DRG." **Discussion** The currently adopted DRG codes were recently re-sequenced and are now known as MS-DRG (Medicare severity-diagnosis related codes).		**Agree in part.** CMS adopted the Medicare Severity Diagnosis Related Group (MS-DRG) codes effective October 1, 2007. DWC adopted these new MS-DRGs effective January 1, 2008. The inpatient hospital fee schedule incorporates these codes. DWC agrees that the definitions should include the MS-DRGs. However, it is not necessary to delete the DRG definition. Indeed, it is conceivable that bills may still be submitted related to discharges that use the DRGs rather than the MS-DRGs.	Modify the definition of "Diagnosis Related Group" to include MS-DRG in Section One – Business Rules, 1.0 (x)(4) Standardized Billing / Electronic Billing Definitions.
Medical Billing & Payment Guide – 3.0 – Complete Bills	Commenter recommends adding additional subsection: (b) To be complete a submission must consist of the following: (1) The correct uniform billing form/format for the type of health care provider. (2) The correct uniform billing	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Agree in part.** Agree that the "complete bill submission" which triggers the time frames for payment or objection must have the required reports and documentation. However, disagree with adding "sufficient to substantiate the codes billed" because this goes beyond the threshold determination that the	Add a new subdivision (b)(4) to specify that a complete bill submission includes required reports and supporting documentation as specified in

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	codes for the applicable portion of the OMFS under which the services are being billed. (3) The uniform billing form/format must be filled out according to the requirements specified for each format in Appendix A and/or the Companion Guide. (4) Required reports and supporting documentation sufficient to substantiate the codes billed. **Discussion** As discussed at length with the advisory committee, a billing is not complete if it is submitted without the required reports and supporting documentation that substantiate it.		bill submission is "complete." The sufficiency of the reports and documentation is an issue that is separate from the "completeness" determination.	subdivision (c).
Medical Billing & Payment Guide – 3.0 – Complete Bills	Commenter recommends the following revisions: (c) All required reports and supporting documentation must be submitted together with the billing as follows:	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** As discussed with stakeholders at the advisory committee meetings, attachments may be submitted by fax or email. After a HIPAA-approved electronic attachment standard is adopted the Division will consider mandating the electronic attachment and eliminating the fax and email submission of attachments. In the meantime, electronic bills may utilize the 275 transaction or may use fax or	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			email to submit attachments. For paper bills, subdivision (d) specifies that attachments that are not submitted in the same envelope with the bill must utilize specified header or attachment cover sheet to facilitate matching of bills and attachments.	
	(8) An operative report is required when the bill is for Surgery Services or for use of the Health Care Facility where surgery services were provided. [An operative report is also necessary when the bill is from the Health Care Facility where Surgery Services were provided.]		**Agree** that (c)(8) should also reference bills for facility fees.	Modify language to clarify that the operative report is required for health care provider fees and facility fees for surgery services.
	(9) ~~An invoice or other p~~Proof of documented paid costs must be provided when required for surgical implant reimbursement and an invoice when required for DME reimbursement. [Documented paid costs are required for certain surgical implants and invoices DME for certain DME.]		**Disagree** with the suggestion to add language specifically referring to surgical implants and DME in the billing guide. The circumstances giving rise to the need for an invoice are set forth in the Official Medical Fee Schedule provisions. It would be confusing to insert the suggested language as it is not complete. However, it would be appropriate to modify the language to reference the requirements of the OMFS, as that will determine which	Modify (c)(9) to reference the OMFS.

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	(10) Appropriate additional information reasonably requested by the claims administrator or its agent to support a billed code ~~when the request was made prior to submission of the billing~~. Supporting documentation should be sufficient to support the level of service or code that has been billed. [While the listed reports and supporting documentation will usually be sufficient for accurate bill review, the list does not cover all conceivable circumstances and additional supporting documentation will sometimes be necessary. The billing medical provider generally selects and submits other documentation from the medical file to support billed codes in unusual circumstances. Only if the submitted documentation is inadequate is additional information needed, and therefore it is necessary for (c)(10) to allow claims administrators to request appropriate additional documentation after receiving the		procedures/services/goods require an invoice or proof of documented paid costs. **Disagree.** The provision (c)(10) is part of the "complete bill" determination. For circumstances where a claims administrator has appropriately requested additional information beyond the required reports and documentation *before* the bill submission, the bill is not "complete" unless it contains the additional information. For example, a claims administrator may give preauthorization for a course of physical therapy, but due to particular circumstances reasonably request that chart notes be submitted with the bills. In such a case the bill submission would not be "complete" unless the chart notes were also submitted. There is nothing in the language of (c)(10) that would prevent a claims administrator from requesting additional information after reviewing the documentation received as part of the complete bill submission. See 6.0 Medical Treatment Billing and Payment Requirements for Non-	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	billing and to receive it before payment is due. If no request for authorization was submitted, the claims administrator or its agent does not even know that the services or goods were provided until the bill is received. A failure to request authorization and to submit appropriate supporting documentation should not reward the billing provider, third party biller or assignee. For this reason, too, a claims administrator must be permitted to reasonably request appropriate additional information after receiving a billing. The potential for fraud or abuse will increase if the rules permit a medical providers, third party billers and assignees to submit medical bills, secure in the knowledge that they are not required to submit other necessary supporting documentation before the claims administrator is required to make payment.] The following circumstances that were discussed during the advisory committee meetings, or required by law and are missing from the list and must be added to avoid		Electronically Submitted Medical Treatment Bills subdivision (b)(2): "If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the specific information required shall be included." Section 7.1 subdivision (b) has the equivalent provision for electronically submitted bills.	

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	potential fraud, abuse and dispute. (12) A report shall be submitted to support a level of service or a time-based code. [(c)(12) As discussed and agreed during the advisory committee meetings, documentation to substantiate a level of service or time spent for time-based codes is necessary.]		**Disagree.** The language suggested by commenter is too broad, and would require reports that are not necessary or which are already required by other provisions. The reason for suggesting a report to support a "level of service" is not clear. Section (c)(2), (c)(3), and (c)(4) already require reports for most Evaluation and Management services. The request for a report for every "time based code" is unwarranted. Many codes include a time element in the descriptor of the procedure, but that should not by itself necessitate a report.	None.
	(13) A third party biller shall submit documentation that it is authorized by law and paid by the rendering health care provider to bill for medical goods or services on behalf of the health care provider, and who is not an employee, affiliate or subsidiary of the health care provider, and no transfer of rights or benefits has occurred between the health care provider and the third party biller. (14) An assignee shall submit proof that the person or entity is an agent		**Disagree.** See response above to substantially similar comment by Kathleen Burrows, Claims Operations Manager, State Compensation Insurance Fund, April 26, 2010.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	has purchased the right to payments for medical goods or services from the health care provider, and is authorized by law to collect payment from the responsible payor. (15) An itemization and explanation for the excess charge must accompany a bill for medical treatment that exceeds the maximum reasonable fee in the Official Medical Fee Schedule. [(c)(15) To be properly documented, section 9792.5(c) requires that an itemization and explanation for any charge that exceeds the maximum reasonable OMFS allowance accompany a bill for medical treatment.]		**Disagree.** The current rulemaking action proposes to delete subdivision (c) of section 9792.5. Many providers bill their usual and customary charges which may be higher than the rates in the workers' compensation OMFS. The claims administrator will apply the fee schedule and remit no more than the maximum fee schedule amount. There is no statutory requirement for the provider to explain the charge which is in excess of the OMFS, nor is there a statutory requirement that the claims administrator pay in excess of the OMFS. The suggestion appears to be based on language that was previously in the Labor Code section 5307.1 subdivision (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	None.

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			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." This provision was deleted effective 2004 by Senate Bill 228, Statutes of 2003, Chapter 639.	
	(16) A written notice from the prescribing physician specifying that a nongeneric drug must be dispensed. [Labor Code section 4600.1 requires the prescribing physician to specify in writing that a nongeneric drug must be dispensed.]		**Disagree.** It would be overly burdensome and inefficient to require each pharmaceutical bill for a nongeneric drug to provide a written notice from the doctor specifying that the nongeneric must be dispensed. The 2008 Workers' Compensation /Property and Casualty NCPDP form Field 72 includes a "DAW" "dispense as written" code to support a nongeneric. The NCPDP D.2 Telecommunication Standard Data Element 408-D8 includes a code to indicate whether the prescriber's instructions regarding generic substitution were followed. If the claims administrator has reason to question whether a physician has	None.

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			specified that there should be no generic substitution, it can ask the biller for additional documentation. But this documentation should not be required at the time of the "complete bill" determination.	
Medical Billing & Payment Guide – 4.0 Third Party Billers/Assignees	Commenter recommends the following revisions: (a) Third party billers and assignees shall submit bills in the same manner as the original rendering provider would be required to do had the bills been submitted by the provider directly and shall have no greater right to reimbursement than that provider. **Discussion** (a) Clarification is needed that third party billers and assignees have no greater right to reimbursement than the original provider to prevent to prevent inappropriate practices such as attempts to obtain higher reimbursement than allowed under the Official Medical Fee Schedule or a contract with the original provider. (c) A third party biller or assignee	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Agree in part.** Agree that it would be helpful to clarify that the billing agent or assignee has no greater right to reimbursement that the provider or facility would have. However, language suggested by the American Insurance Association will be inserted into the modified proposal. Also, language will be inserted to clarify that the billing rules themselves do not give rise to the right to bill, but provide billing instruction where entities are entitled to bill under other provisions of law. **Disagree.** The Division is not	Modify language in 4.0 to clarify that the billing agent or assignee has no greater right to reimbursement than the principal or assignor, and to clarify that the billing rules themselves do not give rise to the right to submit bills. None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	shall submit proof that the person or entity is an agent or assignee of the original provider. **Discussion** (c) Proof of a third party biller's or assignee's right to bill on behalf of, or in lieu of the original provider is needed so that the payer has assurance of its responsibility for payment. Since any payment made to an assignee is paid to its tax id number it is necessary to verify that an assignee has the right to bill for services provided by a different entity. Proof of assignment is needed before paying an assignee in order to avoid conflicts or incorrect payments when the service provider later says that an assignee did not have the right to receive payment.		aware of any evidence that third party billers or assignees are misrepresenting their status as billing agents or assignees which would give rise to an across the board need to require proof of the billing contract or assignment. If the claims administrator is concerned with the bona fides of a third party biller or assignee, it can request additional information. In addition, the issue could be addressed at the time the claims administrator and bill submitter enter into a trading partner agreement.	
Medical Billing & Payment Guide – 5.0 Duplicate Bills, Bill Revisions and Balance Forward Billing	Commenter requests that the division add language specifying how duplicate bill submissions must be identified for all required paper forms as well as electronic submissions (a) The resubmission of a duplicate bill shall clearly be marked as a duplicate using the appropriate NUBC Bill Frequency Code in the field designated for that	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Agree.** It would be useful to clarify the manner of indicating duplicate bills, especially since some of the forms/formats do not provide a standard way to code duplicates. DWC will modify 5.0 to set out the standard method for indicating a duplicate. For the non-standard situations the Division proposes: the ADA Dental Claim Form be marked "duplicate" in	Modify Section One, 5.0 (a) to add subdivisions (a)(1) through (a)(8) to address handling of duplicate bills for each paper form / electronic format.

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	information. Duplicate bills shall contain all the same information as the original bill. No new dates of service or itemized services may be included. Duplicate bills shall not be submitted prior to expiration of the time allowed for payment unless requested by the claims administrator or its agent. For the time frame for payment of paper submissions see 6.0 (b) and for time frame for payment of electronic submission see 7.1(b). (b) When there is an error or a need to make a coding correction, a revised bill may be submitted to replace a previously submitted bill. Revised bills shall be marked as revised using the appropriate NUBC Condition Code and the revised lines identified in the fields designated for that information. Revised bills shall include the original dates of service and the same itemized services rendered as the original bill. No new dates of service may be included. **Discussion** (b) Many bills include a large number of billing lines. In order to increase		Field 1; NCPDP WC/PC Claim Form and NCPDP Telecommunications Standard version D.0: trading partners to work out a mutually acceptable way of indicating a duplicate. **Disagree.** There is not sufficient space on the paper bill to identify each revised data element. In addition, the replacement bill will override the previous bill and the claims administrator will need to review the entire bill submission.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	efficiency and pay bills more quickly, CWCI recommends identifying a field in which to identify the line(s) that have been revised. Without a way to identify the revised lines, a bill reviewer cannot know the number of revisions or on which billing lines they occur, and must waste time comparing multiple lines to identify every revision.			
Medical Billing & Payment Guide – 6.0 Medical Billing and Payment Requirements for Non-Electronically Submitted Medical Treatment Bills	Commenter recommends the following revisions: (a) Any complete bill submitted in other than electronic form or format not paid within 45 working days of receipt, or within 60 working days if the employer is a governmental entity, shall be increased 15%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill unless the health care provider, health care facility ~~or third party biller/assignee~~ 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 shall apply to the portion of the bill that is neither timely paid nor objected to. Commenter makes similar suggestion	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** In instances where legally authorized billing agnts and assignees submit medical bills to payers, the payment timeframes and objection timeframes should be the same as they would be if the rendering provider were submitting the bill directly. For a billing agent, the entity acts as the agent for the provider. For an assignee the entity has been assigned the rights of the provider. There is nothing in Labor Code §4603.2 that would indicate that the right to prompt notification of objections and payment of claims is eliminated by virtue of being a legally authorized agent or assignee. Commenter is incorrect is stating that Labor Code §4903.5 covers physicians and other providers but not billing agents/assignees. Section 4903.5	None.

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	to delete "third party/biller assignee" from (b), (b)(1), (b)(4), (5), (e). **Discussion** (a) Because statutory language, including Labor Code sections 4603.2(b) and 4903.5 covers physicians and other providers but not third party billers/assignees the term should be deleted.		subdivision (a) states "No lien claim for expenses as provided in subdivision (b) of Section 4903 may be filed after six months from the date on which the appeals board … issues a final decision….after five years from the date of the injury for which the services were provided, or after one year from the date the services were provided, whichever is later…***" Section 4903(b) in turn allows a lien for "The reasonable expense incurred by or on behalf of the injured employee, as provided by Article 2 (commending with Section 4600)…." Subdivision (b) of section 4903 is worded broadly to refer to the reasonable expense incurred by or on behalf of the employee for medical treatment, it does not restrict liens to "physicians and other providers" as suggested by the commenter. There is nothing in the other subdivisions which would warrant removing "billing agent/assignee" language.	
	(b) A claims administrator who objects to all or any part of a bill for medical treatment shall notify the		**Agree** that the Claim Adjustment Group Code is not needed for the paper EOR.	Modify Chapter 6 section 6.0 (b)(1) to delete the

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	health care provider~~,~~ or health care facility ~~or third party biller/assignee~~ of the objection 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 within 60 working days if the employer is a governmental entity. *** Any notice of objection shall include or be accompanied by all of the following: (1) 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 Appendix B Standard Explanation of Review ~~along with the appropriate ANSI Claims Adjustment Group Codes~~. **Discussion** (b)(1) The purpose of claims adjustment reason codes (CARCs), remittance advice remark codes (RARCs), and ANSI Claims Adjustment Group Codes are to provide clear explanation for the		**Disagree** with the suggestion to choose between the DWC Bill Adjustment Reason Codes and the CARCs/RARCS and Claim Adjustment Group Codes. The Division acknowledges and appreciates the time spent by the committee in drafting DWC Bill Adjustment Reason Code language and is proposing to use them for paper bills. However, for electronic claims remittance, the national HIPAA compliant standard is the 835 which does not allow use of DWC Bill Adjustment Reason Codes. Therefore electronic billing uses specified national standard Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs.) Ideally, the Division would use only national standard CARCs and RARCs. However, for workers' compensation cases the CARCs and RARCs do not contain all of the messages needed to communicate important information from the payer to the	Claims Adjustment Group Code.. None.

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	payment of medical bills. The reason that stakeholders expended considerable time and effort in 2005 and 2006 to jointly develop California-specific language for explanations of review (EORs) was to improve language currently being used (including CARC and RARC language) to explain medical payments. The California-specific language was designed to give billing medical providers' information that is clearer and more specific so that providers would better understand the reasons for the way they were paid. They were intended to replace inferior existing language; and not intended to add another layer with complex crosswalks that will result in confusion rather than clarity for providers. It will be better if the DWC can either require old explanations (CARCs and RARCs and Claims Adjustment Group Codes) or the ones developed to replace them, but not both, in medical billing standards and WCIS requirements. (2) If additional information is necessary as a prerequisite to payment of ~~the contested~~ a bill that is considered incomplete ~~or portions thereof~~, a clear		provider. The International Association of Industrial Accident Boards and Commissions (IAIABC) has been working with the X12N committee to adopt additional codes to address issues particular to workers' compensation. The IAIABC has made progress in obtaining some new codes, but not all workers' compensation issues are addressed as yet. Therefore, the Division believes it is still useful to maintain the DWC Bill Adjustment Reason Codes and the ANSI CARCs/RARCs/CAGCs. For EORs on paper bills, the DWC Bill Adjustment Reason Codes are used. For electronic remittance/EOR the CARCs and RARCs and Claim Adjustment Group Codes are used in the transmission, not the DWC Bill Adjustment Reason Codes. The 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk provides linkage between the paper and electronic EORs. **Disagree.** The language proposed is too narrow as it only refers to bills that are "incomplete." A bill	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	description of the information required. **Discussion** (b)(2) The modifications in (b)(2) are recommended to conform to the statutory language and requirements in Labor Code section 4603.2(b), which refers to bills that are "contested, denied, or considered incomplete." The statute specifies different requirements for bills that are considered incomplete from those with contested items. (g) Explanations of Review shall use the DWC Bill Adjustment Reason codes and descriptions listed in Appendix B Standard Explanation of Review – 1.0 California DWC Bill Adjustment Reason Codes ~~ANSI Matrix Crosswalk along with the appropriate ANSI Claims Adjustment Group Codes~~. The Explanations of Review shall contain all the required elements listed in Appendix B Standard		may be "complete" and yet the claims administrator still needs additional information in order to determine payment. **Agree** that the Claims Adjustment Group Codes are not needed for paper EORs. See further explanation above in regard to 6.0(b)(1).	Modify 6.0 (b)(1) to delete the Claims Adjustment Group Codes.

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	Explanation of Review – 2.0 Field Table Standard Explanation of Review.			
Medical Billing & Payment Guide – 7.1 Timeframes	Commenter suggests that the division revise (a)(3) and (B) and (C) to clarify that this first step uses high-level clean-bill screens that identify some but not all "incomplete bills." (a)(3) Health Care Claim Acknowledgement (ASC X12 N 277) – within two working days of receipt of an electronically submitted bill, the claims administrator shall send a Health Care Claim Acknowledgement ASC X12N 277 electronic notice of whether or not the bill submission is complete. The ASC X12 N 277 details what errors are present, and if necessary, what action the submitter should take. A bill may be rejected if it is not submitted in the required electronic standard format or if it is not complete as set forth in Section One – 3.0. Such notice must use the ASC X12N 277 transaction set as defined in Companion Guide Chapter 9 and must include specific information setting out the reason for rejection.	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** It is not necessary to add language specifying that these are "high-level clean bill screens" as that is adequately addressed in the 005010X214 (277) transaction set. The 005010X214 (277) Technical Report Type 3 states in relevant part: "The ASC X12 Health Care Claim Acknowledgement (277) implementation guide is a business application level acknowledgement for the ASC X12 Health Care Claim (837) transaction(s). This acknowledges the validity and acceptability of the claims at the pre-processing stage. Payers may pre-process claims to determine whether or not to introduce them to their adjudication system. This pre-adjudication process is performed so claims that are incorrectly formatted or missing information can be corrected and resubmitted by the provider. The level of editing in pre-adjudication programs will vary from system to system. Although the level of editing may vary, this transaction provides a standard method of reporting acknowledgement of claims. The business function identifies claims	None. None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	(B) Bill rejection error messages ~~shall~~ include the following: (i) Invalid form or format – indicate which form should be used. (ii) Missing. Information- ~~indicate specifically which information is missing by using the appropriate 277~~		that are accepted for adjudication as well as those that are not accepted. This 277 transaction is the only notification of pre-adjudication claim status. Claims failing the pre-adjudication editing process are not forwarded to the claims adjudication system and therefore are never reported in the ASC X12 Health Care Claim Payment/Advice (835). Claims passing the pre-adjudication editing process are forwarded to the claims adjudication system and handled according to claims processing guidelines. Final adjudication of claims is reported in the 835." (005010X214 (277), page 8, 1.4 Business Usage.) **Agree.** The word "shall" may erroneously imply that bill rejection error messages always include the listed items. It would be more accurate to remove "shall" so that the section states that "bill rejection error messages include the following…." **Disagree.** Commenter has not indicated why it would not be feasible to "indicate specifically	None. Delete the word "shall" from 7.1(a)(3)(B). None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	~~Claim Status Category Code with the appropriate Claim Status Code.~~ ~~(iii) Invalid data – Indicate specifically which information is invalid by using the appropriate Claim Status Category Code with the appropriate Claim Status Code~~ (iv) Missing attachments – indicate specifically which attachment(s) are missing. ~~(v) Missing required documentation – indicate specifically what documentation is missing.~~ (vi) Injured worker's claim of injury is denied. (vii) There is no coverage by the claims administrator. (C) The submitted bill ~~is complete and~~ has moved into bill review. **Discussion** (B) Unfortunately it is not clear that		which information is missing" or to "indicate specifically which information is invalid" "by using the appropriate 277 Claim Status Category code with the appropriate Claim Status Code." The 277 is a national standard which is designed to address these issues, as evidenced by language the 277 Technical Report Type 3: "Payers may pre-process claims to determine whether or not to introduce them to their adjudication system. This pre-adjudication process is performed so claims that are incorrectly formatted or missing information can be corrected and resubmitted by the provider." (005010X214 (277), page 8, 1.4 Business Usage.) **Disagree.** If the claims administrator identifies that documentation is missing, it should use the error message as specified in the 005010X214 (277) The Health Care Claim Acknowledgment 005010X214 (277) supports the transmission of codes to notify the provider of missing information, invalid data, and missing required attachments.. There is nothing in the language that precludes the claims	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	all of these complete bill validations can be automated and/or determined within the required 2 or 5 days at this level. I am told that several cannot. (i) The validation for Invalid form or format - is probably not a problem (ii) Missing Information - Identifying required fields where data has not been submitted is not a problem, however, identifying which specific data is missing may be. (iii) Invalid data - while incorrect data formats may be identifiable, it may be a problem to identify invalid information that is provided in the correct format. (iv) If Missing attachments – means simply matching the number and type of attachments received to the number stated in the bill data transmission, this might not be a problem. (v) Missing required documentation - if no		administrator from objecting to the bill during the bill adjudication stage if it determines that the documentation is not sufficient. The 835 Health Care Claim Payment/Advice transaction set supports messages to notify the provider of missing documentation at that later stage. **Disagree.** An injured worker's claim of a workers' compensation injury may have been denied at the time a bill is submitted, in which case the bill should be rejected with the appropriate error message. If denial occurs later it can be communicated to the provider at a later stage of bill processing by use of the 835. **Disagree.** If the claims administrator has already determined that there is no coverage by the time a bill is submitted, this should be communicated to the provider. There is nothing that prohibits a determination of no coverage after the initial acknowledgment stage. Indeed the 835 provides for notification of no coverage.	None. None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	documentation is submitted it will be possible to determine when at least one required document is missing. If at least one required document is submitted, it will be difficult or impossible to timely identify specifically what documentation is missing without the manual review that is done at a later level, particularly as one document may support several, but not all codes on a bill. (vi) Injured worker's claim of injury is denied – it can usually be determined at this level, but under some circumstances, not until a later level. (vii) There is no coverage by the claims administrator – coverage determination may be determined at this or a later level. Dictating that "missing information", "invalid data", and "missing required attachments" must be specified at this level may inadvertently allow a provider to state that all information on their bill was accepted as complete			None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	if the specificity is lacking in the 277. While the code sets used in the 277 are detailed, the lack of specificity that will actually be provided at this stage may be used by billing providers as an argument that they did not receive timely notice of a deficiency. (C) Most bills without gross errors will probably be accepted with one of the following "pending" codes: *PO Pending: Adjudication/Details* - This is a generic message about a pended claim. A pended claim is one for which no remittance advice has been issued, or only part of the claim has been paid. *P1 Pending/In Process* - The claim or encounter is in the adjudication system. *P2 Pending/Payer Review* - The claim/encounter is suspended and is pending review (e.g. medical review, re-pricing, Third Party Administrator processing). The " is complete and" needs to be stricken from (C) as so that it does not appear to billing providers that the		**Disagree.** The "pending" codes are likely to be used in response to an inquiry by the provider regarding status of a claim. The Acknowledgment transaction transmitted by the claims administrator is likely to use the Acknowledgment codes, not the pending codes, for example: "A2 Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system." **Disagree.** The complete bill determination does not preclude later denial or adjustment of the	None. None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	bills are accepted as "complete." When bills move into bill review, it would be more accurate and less confusing to describe them as "pending", the term used in the Claim Status Category Code description.		bill, or request for further information if warranted during the period of bill review.	
Medical Billing & Payment Guide – 7.1 Timeframes	Commenter recommends the following change to (b) Payment and Remittance Advice: If the electronically submitted bill ~~has been determined to be complete~~ is not contested, denied, or incomplete, payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer 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. Nothing prevents the parties from agreeing to submit bills electronically that are being paid per contract rates under Labor Code § 5307.11. Remittance advice will be sent using the (835) Healthcare Claim Payment transaction set as defined in Companion Guide Chapter 9. Explanations of Review shall use the codes listed in Appendix B – 1.0.	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** Commenter has misquoted the provisions of the billing guide, as she leaves out the word "uncontested." The guide states "If the electronically submitted bill has been determined to be complete, payment for *uncontested* medical treatment … shall be made by the employer within 15 working days…." [Emphases added.] Commenter's suggestion to add the phrase "is not contested, denied, or incomplete" would be confusing and unnecessary as the paragraph addresses *complete* bills for *uncontested* medical treatment.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	If an electronic billing is contested, denied, or incomplete, payment shall be made pursuant to Labor Code section 4603.2. A claims administrator who objects to all or any part of an electronically submitted complete bill for medical treatment shall notify the health care provider~~,~~ or health care facility ~~or third party biller/assignee~~ of the objection within 15 working days after receipt of the bill and any required report and/or supporting documentation and shall pay any uncontested amount within 15 working days after receipt of the bill and any required report and/or supporting documentation. If the 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. An objection will be deemed timely if sent electronically on or before the 15th working day after receipt. Any notice of objection shall include or be accompanied by all of the following:		**Agree in part.** The Division agrees that reference to Labor Code 4603.2 is warranted, but has drafted alternate language that is clearer so that it is clear that uncontested portions of the bill must be paid within 15 days. **Disagree** with language suggesting insertion of the word "complete" as the reason for objection may be that the billing is incomplete. The language suggested regarding required report and/or supporting documentation is not necessary as language is being inserted relating to the timeframe for payment where an Acknowledgment was sent on a case that had been put in "pending" status.	Modify 7.1(b)(2) Objection to Bill/Denial of Payment to add language "Any contested portion of the billing shall be paid in accordance with Labor Code section 4603.2 None. Modify 7.1(b)(2) to add language regarding the pending status as it relates to the payment timeframe.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	(1) A specific explanation of the basis for the objection to each contested procedure and charge. The notice shall use the DWC Bill Adjustment Reason codes contained in Appendix B Standard Explanation of Review ~~along with the ANSI Claims Adjustment Group Codes~~ (2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the ~~specific~~ information required shall be included. (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 health care provider~~,~~ or health care facility ~~or third party biller/assignee~~ may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board. (5) To adjudicate contested		**Disagree** with the specific suggestions; in addition, (b)(1) through (5) are eliminated to improve clarity and eliminate duplication.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	charges before the Workers' Compensation Appeals Board, the health care provider~~,~~ or health care facility ~~or third party biller/assignee~~ must file a lien. Liens are subject to the statute of limitations spelled out in Labor Code § 4903.5. 4903.5. (a) No lien claim for expenses as provided in subdivision (b) of Section 4903 may be filed after six months from the date on which the appeals board or a workers' compensation administrative law judge issues a final decision, findings, order, including an order approving compromise and release, or award, on the merits of the claim, after five years from the date of the injury for which the services were provided, or after one year from the date the services were provided, whichever is later. 4903.5. (b) Notwithstanding subdivision (a), any health care provider, health care service plan, group disability			

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	insurer, employee benefit plan, or other entity providing medical benefits on a nonindustrial basis, may file a lien claim for expenses as provided in subdivision (b) of Section 4903 within six months after the person or entity first has knowledge that an industrial injury is being claimed. **Discussion** Per Labor Code section 4603.4(d), an electronic bill must be paid within 15 working days only if it is complete, uncontested, not denied, and billed at or below the maximum fees provided in the Official Medical Fee Schedule. If those conditions are not met, the bill must be paid in accordance with Labor Code Section 4603.2. The language added to is necessary to conform to the Labor Code section 4603.4(d) requirements. Commenter recommends deleting "specific" from (B) because the claims administrator cannot know what the provider has in the medical record that s/he can submit to support the billing. The billing provider should be free to select and submit the specific			

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	documentation from the medical file that will support the billed codes.			
Medical Billing & Payment Guide – 7.2 Penalty	Commenter suggests the following revised language: (a) Any electronically submitted complete billing at or below the maximum fees in the Official Medical Fee Schedule for medical treatment reasonably required to cure or relieve an injured employee from the effects of a workers' compensation injury that is ~~determined to be complete~~ not paid or objected to within the 15 working day period shall be subject to audit penalties per Title 8, California Code of Regulations section 10111.2 (b) (10), (11). **Discussion** The language added to is necessary to conform to Labor Code §§ 4603.4(d) and 4600(b). Per Labor Code §4603.4(d), an electronic bill must be paid within 15 working days only if it is complete, uncontested, and billed at or below the maximum fees provided in the Official Medical Fee Schedule. If those conditions are not met, the bill must be paid in accordance with Labor Code Section 4603.2. The billed treatment must also be reasonably required to cure or relieve the injured	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** This section provides that an audit penalty may be applied if a *complete* bill is not *paid* or *objected to* within the 15 working day period. This is consistent with Labor Code §4603.4 which states that "If the billing is contested, denied, or incomplete, payment shall be made in accordance with Section 4603.2." Commenter's suggested language is confusing and unnecessary. The current language already includes the concept of completeness and "contesting" or "denying" the bill are components of objecting to the bill. If the bill is complete, it must be paid within 15 days if an objection has not been issued. The claims administrator may deny liability for the treatment or may contest the bill by raising any relevant objection, which may include that the treatment is not required to cure or relieve the effects of the injury. It would not be helpful to add the suggested language.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	employee from the effects of a workers' compensation injury as defined in Labor Code § 4600 (b).			
Medical Billing & Payment Guide – 7.3 Electronic Bill Attachments	Commenter suggests the following revised language: (a)(6) Bill Transaction Identification Number – The Provider, or ~~their~~ its agent, assigns a unique identification number to the electronic bill transaction. This standard HIPAA implementation allows for a patient account number but "strongly recommends that submitters use completely unique numbers for this field for each individual bill ~~claim~~." (e) Attachment types (1) Required Reports (2) Supporting Documentation (3) ~~Requests for~~ Written Authorization (4) Misc. (other type of attachment) **Discussion** (a)(6) Unless "bill" replaces "claim," some users will submit a claim number instead of the intended bill tracking number. Other changes are to correct minor typographical errors. (e)(1) The proposed edit distinguishes required reports from other reports.	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** (a)(6) The language commenter sets forth is not the language in 7.3 (a)(6). The Division is unaware of where commenter obtained this language as it is not the language contained in the proposal. (e)(1) It would not be appropriate to narrow the attachment type in (e)(1) to "required reports" as report may be attached that does not fall within the definition of "required report" set forth in Section One – Business Rules 1.0 Standardized Billing / Electronic Billing Definitions, (s). (e)(2) The language commenter sets forth is not the language in 1.0 (e)(3). The Division is unaware of where commenter obtained this language as it is not the language contained in the proposal. The section (e)(3) already states	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Reports other than required reports are considered supporting documentation. (e)(3) "Requests for Authorization" appears to be a typographical error. Providers need to attach "Written Authorization."		"Written Authorization".	
Medical Billing & Payment Guide – Version of Forms – 2.0 Standardized Medical Billing Treatment Format	Commenter would like the division to specify the revision date for each standard form/format. **Discussion** Specifying the "as of" date in addition to any version number for each standard billing form/format will avoid confusion. Sometimes a particular version is modified after its adoption.	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Agree in part.** Agree that all forms should be identified clearly. All of the forms except the UB-04 are already identified by a revision date in the Appendix A. 1.0 CMS 1500 Version 08/05, page 16. 3.0 NCPDP Workers' Compensation/Property & Casualty Universal Claim Form Version 1.0, 05/2008, page 29. 4.0 ADA 2006 Dental Claim Form, page 42. However, it appears that the 2.0 description of the UB-04 does not identify the date of revision. This language will be added, although its usefulness will be somewhat limited as the form itself does not include a revision date.	Modify language in 2.0 UB-04 to identify that the UB-04 is revised in 2007.
Workers' Compensation Medical Billing & Payment Guide 2010 – Appendix A. Standard Paper	Commenter suggests the following: Paper Field 11 Required for all billings except a first billing. Required for a first billing if known ~~Enter claim number, if known~~ or if	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI)	**Agree in part.** Agree that it should be clarified that the value "unknown" may only be entered on a first billing, but disagree with language	Modify proposal to provide that the value "unknown" claim

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Forms – CMS 1500	claim number is not known then enter the value of 'Unknown' to indicate unknown claim number. This box requires one of the above values and cannot be left blank or may result in the bill being rejected.	April 26, 2010 Written Comment	proposed by commenter. It would be confusing to adopt the language suggested "Required for all billings except a first billing…" since these are specialized instructions for workers' compensation use of field 11. The first sentence in this instruction is "Enter claim number…." This is important since the field title is "Insured's Policy Group or FECA Number," but workers' compensation will use this field for the claim number.	number may only be entered in field 11 if the bill is a first billing.
	Paper Field 14 Commenter recommends adding instruction on determining what date to enter for a cumulative trauma injury.		**Agree.** The California Workers' Compensation Instructions column should provide instruction regarding entering the date. For specific injuries the appropriate date is fairly straightforward. However, for cumulative trauma or occupational disease the appropriate date is more uncertain. Labor Code §5412 states: "The date of injury in cases of occupational diseases or cumulative injuries is that date 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	Modify Paper Field 14 to add "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

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	Paper Field 17 Required if referred ~~when other providers are associated with the bill~~		caused by his present or prior employment." However, under Labor Code section 5500.5 liability is imposed upon the employer employing the employee during the last year immediately preceding 1) the date of injury as determined by Labor Code §5412 or 2) the last date on which the employee was employed in an occupation exposing him to the hazards of the occupational disease or cumulative injury. There are many legal and factual issues surrounding "date of injury" for purposes of cumulative trauma and occupational disease. For electronic billing purposes, the date of injury is used for matching a bill to a claim of injury, and for determining liability for injury. Therefore, the Division proposes inserting a date of injury instruction for cumulative trauma/occupational disease which allows the doctor to enter either the Labor Code §5412 date of injury or the last date of exposure as described in Labor Code §5500.5. **Disagree.** The proposed language would narrow the requirement to	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." None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Paper Field 17b Enter NPI number of referring provider ~~If known~~		use the field only if there is a referring provider, but the field is also used if there is an ordering or supervising provider. See NUCC 1500 Health Insurance Claim Form Reference Instruction Manual For Form Version 08/05. **Disagree.** The proposed language would narrow the requirement to use the field only if there is a referring provider, but the field is also used if there is an ordering or supervising provider.	None.
	Paper Field 22 Required when the bill is a resubmission. Enter the Original Reference Number assigned to the bill by the claims administrator ~~Workers' Compensation Carrier~~.		**Agree.** The phrase "Workers' Compensation Carrier" is too narrow as it may be an entity other than an insurance carrier who receives the bill and assigns the number, such as a self-insured employer or a third party administrator.	Modify Field 22 instructions to substitute "claims administrator" for "Workers' Compensation Carrier."
	Paper Field 23 Required ~~when~~ if a prior authorization, referral, concurrent review, or voluntary certification number was received. Enter the number/name as assigned by the payer for the current service. Do not enter hyphens or spaces within the number.		**Agree.** Commenter's suggestion to insert the word "number" will improve the clarity of the field 23 instructions since it is the receipt of an authorization *number* which triggers the need to complete the field; an authorization by the payer without a number will not be indicated in the field. Also,	Modify the Paper Field 23 Instructions, page 21 to replace "when" with "if" and to insert the word "number."

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			substituting "if" in place of "when" improves the grammatical accuracy of the sentence.	
	Paper Field 31 Commenter recommends clarifying which physician or supplier must sign the form.		**Disagree.** The Form 1500 is used by a wide variety of physicians, health care providers and suppliers and the Division is unaware of what kind of clarification would be useful.	None.
	Either an additional field on the CMS 1500 at the line level is needed to capture the name of the rendering provider or the rendering provider name needs to be removed from the EOR field 21.		**Disagree.** The Field 24J is used for the rendering provider NPI. The name of the person or entity assigned a particular NPI can be ascertained by using the National Plan & Provider Enumeration System (NPPES). The NPI registry enables a user to query the data base; it can be accessed at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do . NPIs may also be accessed through downloadable files: http://nppes.viva-it.com/NPI_Files.html .	None.
Workers' Compensation Medical Billing & Payment Guide 2010 – Appendix A. Standard Paper Forms – UB 04	Commenter opines that a field is needed for the Medicare ID number. This number is important because it programmed into software to trigger the hospital payment factors, including the composite factor, cost to charge ratio, cost outlier threshold and length	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010	**Agree.** The inpatient hospital fee schedule and the outpatient hospital department and ambulatory surgery center fee schedule both use the Medicare provider number because that is the number CMS uses in its fee	Modify the 2.1 Field Table UB-04, Field 57 instruction to require the Medicare Provider number

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	of stay. Field 52a needs to be changed from R (required) to N (not applicable). This is required under HIPAA rules, however not for workers' compensation because workers' compensation is exempt from HIPAA.	Written Comment	schedules. Therefore, the health facility submitting the bill should provide its Medicare ID number. **Agree.** The HIPAA rules do not require a signed release for disclosure of personal health information where release is for workers' compensation purposes. 42 CFR §164.512 subdivision (b)(v), subdivision (l).	if the facility has one. Also modify to require State License Number if the provider does not have a Medicare Provider Number and is not eligible for an NPI. Modify field 52 instruction to delete R and insert N.
Workers' Compensation Medical Billing & Payment Guide 2010 – Appendix A. Standard Paper Forms - NCPDP	Commenter opines that it would be helpful to describe in the instructions the patient ID that must be entered in field 12. Since the pharmacy's usual and customary charge is required to be entered for California, commenter suggests changing the paper field requirement indicator from O (optional) to R (required).	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Disagree.** There is no single patient ID number that is required for workers' compensation. The Field 13 Patient ID Qualifier specifies the six codes that may identify the source of the patient ID number. The NCPDP's Manual Claim Forms Reference, Implementation Guide, page 40 sets forth these codes and descriptions. Commenter has not shown that there is a need to depart from the national standard implementation.	None.
Workers'	Commenter states that a field is needed	Brenda Ramirez	**Disagree.** The American Dental	None.

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Compensation Medical Billing & Payment Guide 2010 – Appendix A. Standard Paper Forms – ADA 2006	to identify a third party biller or assignee.	Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	Association form does not contain a field to identify a billing agent or assignee. The Division has not identified any free fields, nor has commenter suggested a field to be used.	
Workers' Compensation Medical Billing & Payment Guide 2010 – Appendix B – 3.0 Field Table Standard EORs – Bill Level Adjustments	Commenter suggests the following revision: ~~Payor may use the bill level adjustment codes if an adjustment causes the amount paid to differ from the amount originally charged.~~ The Bill Level Adjustment is used when an adjustment cannot be made to a single service line. ~~The bill level adjustment is not a roll up of the line adjustments. The total adjustment is the sum of the bill and line level adjustment~~ The reason for reporting bill level adjustment information is expressed clearly in the second sentence. Commenter recommends deleting the other language because it is somewhat confusing and not necessary.	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Agree in part.** Agree that the first sentence should be deleted as it is not very clear. However, the last two sentences convey information regarding the relationship between the line level adjustment and the bill level adjustment and it is therefore useful to retain them.	Modify 3.0 Field Table for Standard Paper Explanation of Review to delete one sentence.
DWC Electronic Medical Billing &	Commenter suggests the following revision:	Brenda Ramirez Claims & Medical	**Agree in part.** The Division agrees that the rule should require	Modify Chapter 2, section 2.5.3 to

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Payment Companion Guide Version 1.0 2010 - Chapter 2 2.5.3 Health Care Provider Identification	Health Care Providers and Health Care Facilities are required to use the National Provider Identification number (NPI). If the provider or facility does not qualify for ~~have~~ an NPI, then the provider or facility must use his/her/its state license number. **Discussion** Almost all medical providers qualify for and can request and receive an NPI. Commenter believes that only those providers who don't qualify should be relieved of the responsibility to report one on their billings. Reporting NPIs helps to prevent medical fraud and abuse because when NPIs are reported, changing the billing entity will no longer mask a duplicate billing or evade a contracted rate.	Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	all health care providers and health care facilities that are able to obtain an NPI to use the NPI in workers' compensation billing. However, the Division will use the phrase "eligible for an NPI" rather than "qualify for an NPI" since "eligible" is the term used in the federal NPI implementation. The HIPAA final rule on NPI published in the Federal Register makes it clear that all "health care providers" as defined (whether the provider is a "covered entity" under HIPAA or not) are eligible to obtain an NPI. "…while all health care providers (as defined in § 160.103) are eligible to be assigned NPIs and may, therefore, obtain NPIs, health care providers that are covered entities must obtain NPIs. As mentioned earlier in this section, a health care provider that is not a covered entity and which has been assigned an NPI does not become a covered entity as a result of NPI assignment." Federal Register Vol. 69, No. 15, p. 3438, January 23, 2004. 45 CFR §162.410(b) is the federal regulation that allows a non-covered health care provider to	require the medical provider or facility to use the NPI if the provider or facility is "eligible" for an NPI.

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			obtain an NPI. 45 CFR §160.103 states that: "Health care provider means a provider of services (as defined in section 1861(u) of the Act, 42 USC 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 USC 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business." 42 USC 1395x(u) Provider of services: "The term "provider of services" means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program…." 42 USC 1395x(s) "Medical and other health services The term "medical and other health services" means any of the following items or services: (1) physicians' services; (2)(A) services and supplies (including drugs and biologicals…) furnished as incident to a physiciay service… (B) hospital services… (C) diagnostic services… (D) outpatient physical therapy services… (E) rural health clinic servces…. (F) home dialysis supplies and equipment…. (G) antigens….	

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			(I) blood clotting factors… (K) …services…performed by a physician assistant…." [See regulation for complete list of services.]	
DWC Electronic Medical Billing & Payment Companion Guide Version 1.0 2010 - Chapter 6 Companion Guide Pharmacy 6.4 Billing Date	Commenter suggests the following revision: For electronically submitted ~~claims~~ pharmacy bills, 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. This date is communicated in the Claim Segment of the NCPDP Telecommunication Standard Implementation Guide Version 5.1 Date of Service field (4Ø1-D1) (Field #66 on WC/PC UCF), which is included in the Transaction Header Segment.	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Agree** that it will be clearer to replace the word "claims" with "pharmacy bills."	Modify to replace the word "claims" with "pharmacy bills."
DWC Electronic Medical Billing & Payment Companion Guide Version 1.0 2010 - Chapter 6 Companion Guide Pharmacy 6.9 Prescribing Physician	Commenter suggests the following revision: 6.9 Prescribing Physician For California workers' compensation claims, the Prescribing Physician Identification Number will be the NPI. This data is supported in the NCPDP Telecommunication Standard Implementation Guide Version 5.1 in	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Agree.**	Delete the indicated sentence from 6.9 of Chapter 6.

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	Fields 411-DB (Prescriber ID) (Field # 40 on WC/PC UCF) and 466-EZ (Field # 41 on WC/PC UCF) (Qualifier (12) DEA Number). ~~If the prescribing physician does not have an NPI, the prescribing physician's state license number should be populated.~~ The NCPDP Telecommunication Standard Version 5.1 contains qualifiers for all the identifiers detailed. **Discussion.** Since all physicians qualify to receive an NPI, there is no reason to make an exception here.			
DWC Electronic Medical Billing & Payment Companion Guide Version 1.0 2010 – 9.4.3 Health Care Claim Acknowledgement	Commenter recommends replacing the term "claim" with "bill" throughout this section, including the title. **Discussion** This modification is necessary to avoid confusion over the workers' compensation meaning for "claim" as previously discussed.	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) April 26, 2010 Written Comment	**Agree in part.** Agree that in the workers' compensation community the term "claim" is often thought of as the injured workers' claim for workers' compensation benefits rather than the medical provider's claim for payment for medical services. However, the national standards refer to medical "claims." Indeed, the Health Care Claim Acknowledgment is the official Accredited Standards Committee title of the transmission standard being adopted – the ASX X12N 004040X167 277 Health Care Claim Acknowledgment. The instructions in 9.4.3 would be	Modify 9.4.3 to add a sentence explaining that "claim" does not mean the injured workers' underlying claim for workers' compensation benefits, but rather means "bill" for medical services.

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			confusing if the term "bill" was inserted instead of "claim" because the official standard uses terms such as "claim status category" and "claim status codes." However, the Division can clarify the meaning of the word "claim" in this context by adding a sentence to explain its usage.	
General comment	Commenter opines that his version of Section 9792.5 will become final prior to the version of the Physician Reporting regulations that was recently on the Forum as a part of the Physician Reporting and Physician Fee Schedule package. Commenter states that it will be important that the two revisions are consistent, and their effective dates, along with the finalized WCIS effective date, are the same in order to minimize confusion and conflict. Commenter is concerned about the large number of instructional manuals and Implementation Guides that these proposed regulations will require the regulated public to purchase and utilize, both in terms of expenses incurred and the potential for confusion and error that comes with needing to reference so many sources to complete a task.	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree in part.** Agree that regulations should be consistent. However, disagree that the Physician Reporting regulations and Workers' Compensation Information System regulations should have the same effective dates. **Disagree** that the number of instructional manuals and Implementation Guides will cause confusion or error. The paper forms, paper form instruction manuals, and electronic implementation guides are nationally used and have been created and refined to streamline billing and remittance/payment.	None. None.

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			Adoption of standardized paper and electronic billing / remittance will create efficiencies through standardized formats and processes instead of the enormous variety of billing / remittance formats that currently exist. Regarding costs, some of the forms and guides may be downloaded for free from the internet (the Form 1500 and instruction manual, the California Medical Billing and Payment Guide, the California Electronic Medical Billing and Payment Guide). Other paper forms/manuals and electronic implementation guides do have costs. However, claims administrators may choose to use a clearinghouse to process transactions which would obviate the need for the claims administrator to purchase the standards. Moreover, although there will be some startup expense, costs of processing electronic bills have been shown to be less than the costs of processing paper bills.	
9792.5	Commenter suggests the following language: This section is applicable to medical	Steven Suchil Assistant Vice President American Insurance	**Disagree.** Commenter has not stated any reason for its suggestion and the Division is unaware of the basis for the suggestion. However,	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	treatment rendered between 1/1/2004 and ~~before~~ XXXX, 2010 [approximately 90 days after the effective date of this regulation].	Association April 26, 2010 Written Comment	a similar comment has been made by Brenda Ramirez, Claims & Medical Director, California Workers' Compensation Institute in a comment dated April 26, 2010. See the response to her comment on page 45.	
9792.5(a)(4)	Commenter opines that the definition of a "required report" needs augmentation as Section 9785 does not include a definition for required report and this will become increasingly more contentious with the advent of E-billing. Commenter recommends a definition here that explicitly names the "required reports" as well as those found in the Official Medical Fee Schedule Ground Rules. Necessary documentation to support the billing could be included here or a separate definition added. But this too should be clearly defined to prevent conflict. Commenter notes that a definition for necessary documentation to support a bill is included in the California OWC Medical Billing and Payment Guide 2010 Section 1.0 (u). Commenter recommends that the Division restate it here.	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Disagree.** The Division is proposing amendments to this section to conform to statutory changes that have been made to Labor Code §4603.2. The effective date of the changes includes retroactive application because the regulation did not conform to statutory changes that have been made. The commenter's proposal suggests adding a definition to specifically name "required reports" and "necessary documentation." However, it would not be helpful to add a retroactive definition of these terms. Definitions in the proposed DWC Medical Billing and Payment Guide are prospective only and it is not appropriate to insert the same definitions into this regulation.	None.
9792.5(b)	Commenter recommends the following revised language:	Steven Suchil Assistant Vice President	**Disagree.** The sentence already says "any properly documented bill…." It would be redundant to	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Any properly documented bill for medical treatment within the planned course, scope and duration of treatment reported under Section 9785 which is provided or authorized by the treating physician shall be paid by the claims administrator within forty five working days from receipt of each separate itemized bill and any required reports **or documentation necessary to support the bill and written authorizations**, unless the bill is contested, as specified in subdivisions (d), and (e), within thirty working days of receipt of the bill.	American Insurance Association April 26, 2010 Written Comment	add the language "documentation to support the bill" suggested by the commenter. Adding "and written authorizations" could be seen to erroneously imply that pre-authorization is required. Moreover, as detailed in the response above to section 9792.5(a)(4), the proposed changes to this section are confined to making changes to adhere to the statutory amendments.	
9792.5(d)	Commenter recommends the following revised language: A claims administrator who objects to all or any part of a bill for medical treatment shall notify the physician or other authorized provider of the objection within thirty working days after receipt of the bill and any required report and shall pay any uncontested amount within forty five working days after receipt of the bill. If a required report **or necessary documentation to support the billing** is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill or report, whichever is received	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Disagree.** The suggested language is redundant to the language in the section that states: "If the claims administrator receives a bill and believes that it has not received a required report or *adequate documentation* to support the bill ..." [Emphasis added.] Also, see responses above to comments on section 9792.5.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	later. If the claims administrator receives a bill and believes that it has not received a required report or adequate documentation to support the bill ... "			
9792.5(f)	While Labor Code Section 4603.2(b)(1) provides for a 15 percent penalty and interest if a bill is neither paid within 45 working days nor properly contested, the subsection that previously imposed interest if the appeals board subsequently determined a contested charge to be payable was deleted from Labor Code Section 4603.2(b)(1)(B) by the legislature in the Assembly Bill 1806 budget trailer bill, effective July 1, 2006. This deletion repealed the statutory authority for the appeals board to impose interest when it determines a contested charge is payable. Commenter recommends that this sub-section be removed from the proposed regulations.	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree.** See Response above to comment by Kathleen Burrows Claims Operations Manager State Compensation Insurance Fund, April 26, 2010 (page 18.)	Delete subdivision (f) of §9792.5.
9792.5.2	In subdivision (a) this section states that providers "shall" submit their bills on standardized forms, subdivision (b) provides that all bills "shall" conform to the DWC Medical Billing and Payment Guide, subdivision (c) states that all E-bills "shall" conform to the Division of Workers' Compensation Medical Billing and Payment	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Disagree.** This section sets forth the basic obligation to comply with the billing rules and guides and the effective dates for compliance by providers and health facilities. The section 9792.5.3 sets forth the basic obligation for claims administrators to conform to the	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Companion Guide, and (d) provides that third party billers and assignees "shall" also comply as above. Commenter is concerned that there is no stated consequence should these mandates not be followed. Commenter recommends adding language to the effect that bills that do not comply with these mandates "shall" be rejected.		billing rules and guides. It would not be efficient or clear to set forth the consequences for failure to conform to the billing obligations or the payment obligations in these general sections. The details of compliance requirements for billers and payers are set forth in the guides. Commenter's suggestion that this section provide that bills that do not conform "shall be rejected" is overbroad as not all bills that fail to conform to the billing rules are to be rejected. For example, a bill missing an attachment shall be put in "pending" status for up to five days for receipt of the bill.	
CA DWC Medical Billing & Payment Guide – Section 1 Business Rules – 1.10 Definitions	Commenter recommends the following changes, provided in underline, be made: (b) "Bill" means the uniform billing form <u>or format found in Appendix A</u> setting forth the itemization of services ~~provided found in Appendix A~~ along with the required reports and/or supporting documentation as described in Section One 3.0.	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree in part. Agree** that the concept of billing "format" should be included to account for electronic bills which are not "forms," but can be looked at as "formats." DWC will be modifying the proposal to clarify what constitutes an electronic bill as follows: (b) "Bill" means: <u>(1)</u> the uniform billing form <u>found in Appendix A</u> setting forth the itemization of services	Modify the definition of "bill" in subdivision (b) to encompass the electronic bill formats.

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			provided ~~found in Appendix A~~ along with the required reports and/or supporting documentation as described in Section One – 3.0~~.~~ Complete Bills or (2) the electronic billing transmission utilizing the standard formats found in Section Two – Transmission Standards 2.0 Electronic Standard Formats, 2.1 Billing, along with the required reports and/or supporting documentation as described in Section One – 3.0 Complete Bills.	
	e) "Clearinghouse" "means a public or private entity, including but not limited to a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that provides either of the following functions: ..." (1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction and transmits to the receiving entity.		**Disagree.** The definition of "clearinghouse" in the proposal uses the HIPAA definition, which is codified in 45 CFR §160.103. The language suggested by commenter is not necessary and commenter has not explained why the additional language would be useful.	None.

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	(2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content ~~for~~ and transmits to the receiving entity (s) "Required report" means a report which must be submitted pursuant to Section 9785 or pursuant to all rules in the OMFS. These reports include the Doctor's First Report of Injury, PR-2, PR-3, PR-4 and their narrative equivalents, as well as any report accompanying a "By Report" code billing or any other instance where the Official Medical Fee Schedule dictates a report requirement.		**Disagree.** The suggested language is unnecessary and redundant. The section already states that a "required report" is one required by the Official Medical Fee Schedule. The proposed additions do not add any substance.	None.
CA DWC Medical Billing & Payment Guide – Section 1 Business Rules – 1.10 Definitions	Commenter states that there are many other services/situations in the Official Medical Fee Schedule that "require" a report. (u) [sic] "Supporting Documentation" "means those documents, other than a required report, necessary to support a bill. These include, but are not limited to: report to support level of service codes, any written authorization received from the claims administrator or an invoice required for payment of the DME item being billed or proof of	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Disagree** that the language "report to support level of service codes" should be inserted into (t) [misidentified by commenter as (u)] as it is both redundant and ambiguous. The definition states that it means documents "other than a required report" but a "report to support a level of service codes" may sometimes be a "required" report and sometimes not. To the extent that the report is already required the language is redundant. It is ambiguous in that	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	payment for implantable hardware. See Section 1 § 3.0 Complete Bills."		there is no clarity as to when a report would be required to "support a level of service code." **Agree in part.** Agree that it would be useful to add reference to the Complete Bills provision. In addition, subdivision (t) should be modified, but disagree that it should refer specifically to implantable hardware. The section will be modified so that it refers more broadly to invoices required by the OMFS. The provisions of the OMFS may change over time to require various supporting documentation. The billing rules here need to give precedence to the OMFS requirements because that is the place that substantive documentation requirements for fees are most often adopted. The subdivision (t) will be modified as follows: "Supporting Documentation" means those documents, other than a required report, necessary to support a bill. These include, but are not limited to: any written authorization received from the claims administrator or an invoice required by the OMFS for payment of the ~~DME~~ item being billed. See Section 1 § 3.0	Modify subdivision (t) "supporting documentation" definition to refer to invoices required by the OMFS and to reference the Complete Bills section.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			Complete Bills.	
	(w) "Treating Physician" "means the primary treating physician or secondary physician as defined by section 9785(a)(1),(2)." Also, this definition includes the Primary Treating Physician and the secondary physician(s) yet there are occasions in the Guide where the term "treating physician" is used where Labor Code Section 4603.2 (b)(1) confines the activity to the Primary Treating Physician. Commenter suggests adding a definition for Primary Treating Physician and searching the document for occurrences of the use of treating physician when it should be only the Primary Treating Physician.		**Disagree.** Commenter has not given any examples of portions of the Guides that are inconsistent with the Labor Code §4603.2 and the Division is not aware of any inconsistency. The Division is not aware of the basis for commenter's assertion that "there are occasions in the Guide where the term "treating physician" is used where Labor Code Section 4603.2(b)(1) confines the activity to the Primary Treating Physician." Labor Code §4603.2 *does not* state that it only applies to the primary treating physician.	None.
	(y) "Uniform Billing Codes" Commenter opines that this definition should include a version date for these codes which are updated annually in order to advise the regulated public as to which version is to be adhered to. If the Division is unable to keep up with the annual update schedule, a specific version date must be provided to prevent confusion and conflict.		**Disagree** that the "uniform billing codes" definition should include effective dates. For codes which are updated annually with fee schedule updates the fee schedule indicates the code versions to use. For dental services, there is no fee schedule but the Medical Billing & Payment Guide 4.0 ADA 2006, page 42 specifies that the codes in effect on the date of service are to	None.

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			be used. For the NUBC "Revenue Codes" and NUBC "UB-04 Codes," they are set forth in the NUBC Official UB-04 Data Specifications Manual 2010, Version 4.0, incorporated by reference (page 22.)	
CA DWC Medical Billing & Payment Guide –3.0 Complete Bills	Commenter states that the issue of Complete Bills engendered many of work by the Task Force who were attempting to clarify what elements of the medical billing and reporting needed to be present in order to promptly review the bill and reimburse the provider. At the same time the group wanted to try to reduce the friction between payor and provider that occurs when bills are adjusted. Commenter believes that the difficulties on both sides regarding up-coding and downcoding is usually a result of the absence of, or different interpretations given to, the documentation. It was therefore decided that in addition to previously "required" reports in Section 9785 and the Official Medical Fee Schedule, they would attempt to identify other "Supporting documentation" that would be necessary for a complete bill and this would help limit much of the	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment		

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	friction in areas where it is most common. While much of the group's work has been captured here, commenter notes some omissions. Commenter recommends that the following changes, provided in underline, be made: (c) All required reports and supporting documentation must be submitted as follows: (6) A descriptive report of the procedure, drug, DME or other item must be submitted when the provider uses any code that is payable "By Report" <u>or is a timed code</u>. (8) An operative report is required when the bill is for Surgery Services <u>or from a Surgery Facility.</u>		**Disagree.** Commenter has not shown a need for a report for every "timed code" nor has commenter provided a definition of "timed code." There are many CPT codes whose descriptors include an element of time, but this fact alone would not in and of itself give rise to the need for a report. **Agree in part.** Agree that bills for facility fees should, like bills for physician surgery services, be supported by an operative report. However, the Division will use other language than that proposed in order to clarify the provision.	None. Modify language of 3.0 Complete Bills (c)(8)to clarify that the operative report is required for health care provider fees and facility fees for surgery services.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	(9) ~~An invoice or other~~ A proof of documented paid costs must be provided when required for reimbursement of spinal hardware while an invoice must be submitted for DME.		**Disagree** with the suggestion to add language specifically referring to surgical implants and DME in the billing guide. The circumstances giving rise to the need for an invoice are set forth in the Official Medical Fee Schedule provisions. It would be confusing to insert the suggested language as it is not complete. However, it would be appropriate to modify the language to reference the requirements of the OMFS, as that will determine which procedures/services/goods require an invoice or proof of documented paid costs.	Modify (c)(9) to reference the OMFS.
	(10) Appropriate additional information reasonably requested by the claims administrator or its agent to support a billed code. ~~when the request was made prior to submission of the billing.~~ Commenter opines that there is no way to determine the need for "additional" documentation before the bill/report is received and retaining the proposed language effectively prevents the Claims Administrator from ever being able to request		**Disagree.** See response above to the same comment submitted by Brenda Ramirez, Claims & Medical Director, California Workers' Compensation Institute (CWCI), April 26, 2010, page 62.	None.

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	additional information.			
CA DWC Medical Billing & Payment Guide –4.0 Third Party Billers/Assignees	Commenter recommends that the following changes, provided in underline, be made: (a) Third party billers and assignees shall submit bills in the same manner as the original rendering provider would be required to do had the bills been submitted by the provider directly <u>and shall have no greater right to reimbursement than the principal or assignor.</u> (b) The original rendering provider information will be provided in the fields where that information is required along with identifying information about the third party biller/assignee submitting the bill. <u>(c) Each billing submitted by a third party billing agent or assignee shall contain proof that the entity is an agent or assignee of the original provider.</u>	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree.** The proposed language will improve the clarity of the section. Also, language will be inserted to clarify that the billing rules themselves do not give rise to the right to bill, but provide billing instruction where entities are entitled to bill under other provisions of law. **Disagree.** See answer above (page 65) to substantially the same comment posed by Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI)	Modify language in 4.0 to clarify that the billing agent or assignee has no greater right to reimbursement than the principal or assignor, and to clarify that the billing rules themselves do not give rise to the right to submit bills. None.
CA DWC Medical Billing & Payment Guide –5.0 Duplicate Bills,	The language in (a) discusses identifying Duplicate bills that arrive electronically but no mention is made of identification on paper bills. We	Steven Suchil Assistant Vice President American Insurance	**Agree in part.** The instructions for the CMS 1500 and the UB-04 on how to indicate a duplicate using data codes are in the Field	Modify 5.0 to specify how to indicate a duplicate paper

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Bill Revision and Balance Forward Billing	suggest a large Duplicate stamp placed prominently of the form.	Association April 26, 2010 Written Comment	Tables in Section One Appendix A. Duplicate Bills on the CMS 1500 form are indicated in field 10d. Duplicate Bills on the UB-04 are indicated in fields 18-28. See Appendices for Section One, Appendix A Standard Paper Forms: 1.1 Field Table CMS 1500 (page 19); 2.1 Field Table UB-04 (page 25.) For the ADA Dental form the regulation is modified to instruct marking "duplicate" in Field 1. For the NCPDP there is no space available and the trading partners can work out a mutually agreeable way to identify a duplicate.	bill as follows: (1) CMS 1500: See 1.1 Field Table CMS 1500, Field 10d. (2) UB-04: See 2.1 Field Table UB-04, UB-04 Form Locator 18-28. (3) NCPDP WC/PC Claim Form: There is no applicable field for duplicate reports. Trading Partners may work out a mutually acceptable way of indicating a duplicate bill. (4) ADA Dental Claim Form: the word "Duplicate" should be written in Field 1.
CA DWC Medical Billing & Payment Guide – 6.0 Medical Treatment Billing and Payment Requirements for Non-Electronically Submitted Medical Treatment Bills	Commenter recommends that the following changes, provided in underline, be made: (b) A claims administrator who objects to all or any part of a complete bill for medical treatment shall notify the health care provider, health care facility or third party biller/assignee of the objection within 30 working days	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Disagree.** Commenter has not indicated a rationale for removing the word "complete" and the Division is unable to discern the reason for the comment. The claims administrator must object	None.

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	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 within 60 working days if the employer is a governmental entity. If the required report or supporting documentation necessary to support the bill is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill, report, and/or supporting documentation whichever is received later. If the 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, health care facility or third party biller/assignee within 30 working days of receipt of the bill. An objection will be deemed timely if sent by first class mail and postmarked on or before the thirtieth working day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth working day after receipt. Any notice of objection shall include or be accompanied by all of the following:		to a paper bill within 30 days, and the objection may be based on the fact that the bill is incomplete. Moreover, it is conceivable that a bill will have several services listed and the bill submission may be incomplete in relation to a particular service and complete in relation to another service. Thus, subdivision (b) appropriately states that "a claims administrator who objects to all or any part of a bill…shall notify the health care provider...." **Disagree.** Although the language "believes that it has not received a required report and/or supporting documentation to support the bill" may appear to have a redundant use of "support," it is necessary because "supporting documentation" is the term of art used repeatedly to describe items other than "required reports." The phrase "to support the bill" applies to both the "required report" and "supporting documentation" and is necessary to show the linkage between the reports and supporting documentation and the bill.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
CA DWC Medical Billing & Payment Guide - 7.0 Medical Treatment Billing and Payment Requirements for Electronically Submitted Medical Treatment Bills – 7.1 Timeframes	For the (B) Bill Rejection error messages, the level of detail suggested here does not occur until the bill gets to the Bill Reviewer. The Clearinghouse's initial acknowledgement could indicate which field has invalid data if the format within the field is non-compliant and could identify what codes require attachments. Also, there may not be a difference, at this level of review, between (iv) and (v) as to attachments and documentation. Perhaps they could be combined. Finally, the Clearinghouse would not have knowledge of denied claims.	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Disagree.** The "level of detail" does often exist at the Acknowledgment stage and if a reason for rejection is apparent at the Acknowledgment stage it should be rejected using the proper error messages. (See Chapter 9, Electronic Medical Billing and Payment Companion Guide, Health Care Claim Acknowledgement 277, and the Health Care Claim Request for Additional Information 277 implementation guides for further detail.) If grounds for rejecting the claim are discovered after the bill has moved into the bill review stage, the bill may be rejected using the 835 Healthcare Claim Payment / Remittance Advice. (See Chapter 7, Electronic Medical Billing and Payment Companion Guide.) The Bill rejection error messages referred to in 7.1 (a)(3)(B)(iv) missing attachment and (v) missing required documentation cannot be combined as they are not coextensive. Missing attachment is used when the bill submission indicates that an attachment will be submitted but no attachment	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			arrives whereas missing required documentation means that supporting documentation is missing whether or not the bill has indicated there would be an attachment. If the claims administrator uses a clearinghouse it will need to assure that the clearinghouse can determine if a claim has been denied. The mechanism for this can be addressed in the trading partner agreement. Moreover, if a claim of injury is denied after the Acknowledgment stage, the bill may be denied by use of the Health Care Claim Payment/Advice (835).	
	Commenter recommends that the following changes, provided in underline, be made: (b) Payment and Remittance Advice. Healthcare Claim Payment/Advice (ASC X12 N 835) - If the electronically submitted bill has been determined to be complete, payment for uncontested medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be		**Agree in part.** The Division agrees that reference to Labor Code §4603.2 would be useful. However, adding the language suggested by the commenter in the first paragraph of (b) would be confusing as that is a general statement that payment for uncontested medical treatment shall be made within 15 working	Modify 7.1(b) to insert the following language: "<u>Any contested portion of the billing shall be processed in accordance with LC § 4603.2.</u>"

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	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. <u>If an e-bill is contested, denied or incomplete; payment shall be made pursuant to Labor Code 4603.2.</u> Nothing prevents the parties from agreeing to submit bills electronically that are being paid per contract rates under Labor Code § 5307.11. Remittance advice shall be sent using the Healthcare Claim Payment Advice (ASC X12 N (835) Payment transaction set as defined in Companion Guide Chapter 9. Explanations of Review shall use the codes listed in Appendix B - 1.0.		days. The Division believes that reference to Labor Code §4603.2 (which contains the longer period for objection to and payment of paper bills) would be more appropriate and clear in the second paragraph of (b) which deals with "A claims administrator who objects to all or any part of an electronically submitted bill…	
	Commenter is concerned that more general code descriptions found in the CARC and RARC listings will lead to many misunderstandings by providers and increased friction between the parties. Commenter recommends that the Division put a crosswalk for these codes to the DWC Bill Adjustment Reasons on their website.		**Agree** that it is helpful to have the CARC and RARC crosswalked to the DWC Bill Adjustment Reason Codes. The Division created a crosswalk which is contained in the Medical Billing and Payment Guide , Appendix B, 1.0 California DWC ASC Matrix Crosswalk. The Medical Billing and Payment Guide will be posted on the Division's website.	Post the Medical Billing and Payment Guide on the Division website after it is adopted and filed with the Secretary of State as a regulation.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
CA DWC Medical Billing & Payment Guide - 7.0 Medical Treatment Billing and Payment Requirements for Electronically Submitted Medical Treatment Bills – 7.2. Penalty	Commenter recommends that the following changes, provided in underline, be made: (a) Any electronically submitted ~~bill~~ <u>billing at or below the Official Medical Fee Schedule</u> determined to be complete, <u>medically necessary and in keeping with Official Medical Fee Schedule ground rules not paid within the 15 working day period shall be subject to audit penalties per Title 8, California Code of Regulations 10111.2 (b) (10), 11.</u>	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Disagree.** Commenter's formatting of the suggested deletions and additions is not accurate. It has omitted the language that a bill "not objected to" within 15 days is subject to audit penalty. An important aspect of electronic billing is the quick turnaround time; claims administrators must pay within 15 working days or inform the provider of an objection within 15 days. The Audit Unit has authority to penalize claims handling that does not meet the regulatory time frame. In addition, the suggestion to add modifiers to describe the electronic bill – "at or below the OMFS," "medically necessary" and "in keeping with the OMFS ground rules" is not well taken. Those modifiers are items that the claims administrator may raise in defense as part of a timely objection.	None.
CA DWC Medical Billing & Payment Guide - 7.0 Medical Treatment Billing and Payment Requirements for Electronically	Commenter recommends that the following changes, provided in underline, be made: (a) Required reports and/or ~~supporting~~ documentation to support a bill as defined in Complete Bill Section 3.0 shall be submitted in accordance with	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Disagree.** See response above to similar comment regarding the term "supporting documentation."	None.

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Submitted Medical Treatment Bills – 7.3. Electronic Bill Attachments	this section. All attachments to support an electronically submitted bill must either have a header or attached cover sheet that provides the following information: (4) Billing Provider NPI Number - the number must be the same as populated in Loop 201 OAA, NM109. If the provider is ~~you are~~ ineligible for an NPI, then this number is ~~you're~~ the provider's atypical billing provider ID. This number must be the same as populated in Loop 201 OAA, REF02. (6) Bill Transaction Identification Number - ~~The~~ This shall be the same number as populated in the ASC X12N 837 transactions, Loop 2300 Claim Information, CLM01		**Agree.** **Agree.**	Modify subdivision (a)(4) to adopt the proposed language which uses the third person "the provider" rather than "you are" and "your." Modify (a)(6) as suggested.
Appendix A Standard Paper Forms – 1.0 CMS 1500	Field 14: Commenter states that a standardized direction needs to be provided for what date to use for Continuous Trauma injuries. This comment pertains to all forms/formats. Field 22:	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree.** See response above to same comment from Brenda Ramirez, Claims & Medical Director, California Workers' Compensation Institute (CWCI), April 26, 2010. Also, same date of injury instruction is added to: UB-04 Form Locator 31-34a,b NCPDP WC/PC Form Field 11 NCPDP Telecommunications D.0	Modify Field 14 as specified above in response to comment of Brenda Ramirez and also add same language to UB-04, ADA Dental Form, NCPDP WC/PC

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	Commenter recommends that the following changes, provided in underline, be made:		data element 434-DY ADA Dental From Field 46.	Form, 837 Professional, 837 Institutional, 837 Dental, and NCPDP Telecommunica-tions version D.0.
	Required when the bill is a resubmission. Enter the Original Reference Number assigned to the bill by the ~~Workers' Compensation Carrier~~ Claims Administrator.		**Agree.** See response to CWCI above.	Modify Field 22 instructions: delete "Workers' Compensation Carrier" and insert "Claims Administrator."
	7 - Replacement of prior ~~claim~~ bill 8 - Void/cancel of prior ~~claim~~ bill		**Agree in part.** It is not appropriate to delete the word "claim" as this is the term used in the NUBC Frequency Code. However, it would be helpful to insert the word "bill" in parentheses since that is the term with which the workers' compensation participants are more familiar.	Modify Field instructions to 22 to insert "(bill)" after the word "claim."
	Field 31: Commenter requests clarification which physician/supplier (Rendering/Referring/Billing) is to sign in Comment section.		**Disagree** that clarification is needed on the Box 31 "Signature of Physician or Supplier" as commenter has not shown a need for instruction specifically related	Modify 1.1 Field Table CMS 1500, Field 31 "Workers' Compensation

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			to workers' compensation. However, reexamination of Box 31 and the NUCC Instruction Manual has lead to the decision to modify the Workers' Compensation Requirement to Optional rather than Required. The signature block refers to the reverse of the form, which does not relate to workers' compensation. In addition, there is no statutory requirement that bills be signed by the physician or provider. Moreover, the electronic 837 Professional TR3 does not utilize a signature. Therefore, the Field 31 signature should be an optional field.	Requirement" column to delete "R" and insert "O."
	Field 33 Commenter seeks clarification if this is where the 3rd Party Biller/Assignee would identify themselves? If so, commenter suggests stating this in the Comment column.		**Agree** that it would be beneficial to clarify that Field 33 is the field where an Assignee would be identified.	Field 33 instructions will be modified. Will insert language as follows: "Required as provided in 1500 Health Insurance Claim Form Reference Manual, however, if a third party biller or assignee

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				is to be the payee, identify here."
Appendix A Standard Paper Forms – 2.0 UB 04	Commenter states that it does not appear that a field for Medicare Number is provided. This is the mechanism used by the Division to advise the regulated community of the Composite Factor and is currently required for facility billers to report. If the NPI number is to replace the Medicare Number, we need to make sure this transmission will not create delays or create the need for yet another crosswalk. Field 52a: Commenter states that it is not clear why this field necessary. Commenter believes it would be required via HIPAA, but Workers' Compensation is exempted. Commenter believes that it should be O or N in order to facilitate completion and transmission.	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree** that the Medicare Provider Number must be provided for facilities that have been assigned a number. See response to same comment made by Brenda Ramirez Claims & Medical Director, California Workers' Compensation Institute (CWCI) Above, page 90. **Agree.** HIPAA does not apply to workers' compensation so this field should not be required. However, it should be listed as optional instead of not applicable as there is nothing in workers' compensation law which would prohibit a provider from obtaining a release of information signature from the patient.	See the page 90 for description of the modifications that will be made to require the Medicare Provider Number in Field 57. Field 52a will be changed from "R" to "O."
Appendix A Standard Paper Forms – 3.0 NCPDP	If the references to other manuals in the Guides are to be left in, then commenter recommends that language be added, used for the CMS and UB	Steven Suchil Assistant Vice President American Insurance	**Agree.**	Modify Medical Billing and Payment Guide page 29 to add

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	forms, that where there are differences, this Guide supersedes the underlying manual. Field 12: In the interest of clarity commenter recommends putting the type of ID coding that is to be placed here. Field 99: Commenter states that it is not clear why the Usual and Customary Charge is listed as Optional but the California Workers' Compensation Instruction column says it is required. It would seem that this should be listed as a Required field to reduce errors.	Association April 26, 2010 Written Comment	**Disagree.** The NCPDP Manual Claims Form Reference Manual addresses Field 12, and Field 13 which has the coding to identify the source of the data in field 12. **Agree** that the Field 99 should be required rather than optional. In addition, the Division will add clarifying language in the Instruction column that the pharmacy is to enter the usual and customary "price" rather than "charge" as this is the terminology used for the workers' compensation fee calculation. Also, the comments column will be clarified to specifically exclude the dispensing fee.	language stating that the Guide takes precedence over the NCPDP manual if there is a conflict. None. Field 99 Comments column will be modified to make it clear that the dispensing fee is not to be set forth here, but rather in Field 102. The California Workers' Compensation Instruction will be modified to direct the pharmacy to enter the usual and customary *price*.
Appendix A Standard Paper	If the references to other manuals in the Guides are to be left in, then	Steven Suchil Assistant Vice	**Agree.**	Modify language regarding the

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Forms – 4.0 ADA 2006	commenter recommends that language be added, used for the CMS and UB forms, that where there are differences, this Guide supersedes the underlying manual. Field 49/50: Commenter asks who, other than a Dentist or possibly a Hygienist, would use this form. Commenter opines that it would seem that these 2 fields should be Required. Field 52: Commenter notes that it appears that the phone number is provided in Field 48.	President American Insurance Association April 26, 2010 Written Comment	**Agree** that Field 49 should be Required as the billing dentist or dental entity will be eligible to obtain an NPI. **Disagree** that Field 50 should be required. Field 49 must be Situational since the NPI will Agree **in part.** **Agree** that it appears that the phone number is in both Field 48 and Field 52. This is because the phone number is erroneously listed in Field 48.	ADA Current Dental Terminology Reference manual page 42 to add language stating that the Guide takes precedence over the ADA manual if there is a conflict. Modify 4.1 Field Table ADA 2006, Field 49 to insert "R" and delete "S" and delete comment. Modify Field 48 to delete the "phone number" since it is not indicated on the ADA 2006 form and is actually in Field 52.
Appendix B Standard	Commenter recommends that the following changes, provided in	Steven Suchil Assistant Vice	**Disagree** with the specific suggestions submitted by	Delete the paragraph that is

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Explanation of Review	underline, be made: In addition, a claims administrator who objects to all or any part of a complete bill for medical treatment shall notify the physician or other authorized provider of the objection within 30 working days after receipt of the bill, any required reports and supporting documentation and shall pay any uncontested amount within forty-five working days after receipt of the bill, or, for governmental entities, within 60 working days. If a required report or supporting documentation is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill or report, whichever is received later. If the claims administrator receives a bill and believes that it has not received required reports and supporting documentation to support the bill, the claims administrator shall so inform the medical provider within thirty working days of receipt of the bill. The suggested additional language conforms this sentence to the sentences that precede and follow it.	President American Insurance Association April 26, 2010 Written Comment	commenter. **Agree** that the language should be clarified. The paragraph that the commenter has proposed for revision has been deleted from the modified proposal. In addition, the modified proposal contains a substantial revision to the narrative language regarding the paper and electronic Explanations of Review.	the subject of the commenter's suggestion. Modify the entire narrative provisions regarding paper and electronic Explanation of Review to improve the clarity.
Appendix B	Commenter recommends that the	Steven Suchil	**Disagree** with the specific	Delete the

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Standard Explanation of Review – How to use the tables	following changes, provided in underline, be made: The DWC ANSI Matrix Crosswalk includes the DWC Bill Adjustment Reason Codes, a description of the billing problem the code is describing, the Explanatory Message, and any special instructions for the payor on additional information required when using that code. <u>The DWC Bill Adjustment Reason Codes are for use on paper EOR's.</u> It <u>also</u> crosswalks <u>to</u> the ANSI Claims Adjustment Reason Codes (CARC) and the ANSI Remittance Advice Remark Codes (RARC). This sub set of the CARC and RARC codes are the only acceptable codes from these data sets for use on an EOR for California workers' compensation purposes unless there is a written contract agreed to by the parties specifying something different. <u>The CARC and RARC codes are for use on electronic EOR's.</u> The table is divided into sections that correspond with the different fee schedules or sections of fee schedules being used for medical billing. General explanations may be used for any section, but the section specific codes should only be used for bills being submitted under that	Assistant Vice President American Insurance Association April 26, 2010 Written Comment	suggestions submitted by commenter regarding the "How to Use the Tables" language, because although the insertions are correct statements of the intended use of DWC Bill Adjustment Reason Codes, CARCs and RARCs, there is a need for a broader revision. **Agree** that the language should be clarified. The paragraph that the commenter has proposed for revision has been deleted from the modified proposal. In addition, the modified proposal contains a substantial revision to the narrative language regarding the paper and electronic Explanations of Review.	paragraph that is the subject of the commenter's suggestion. Modify the entire narrative provisions regarding paper and electronic Explanation of Review to improve the clarity.

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	section. We are concerned that the more general CARC and RARC EOR explanations required for electronic EOR's will lead to greater friction between the payor and provider communities rather than a lessening it, as was the goal of developing the DWC Adjustment Codes. If it is truly impossible to use these codes for electronically generated EOR's we strongly recommend that the Division place the crosswalk on their website for reference by the provider community. Commenter recommends that the following changes, provided in underline, be made: The <u>3.0</u> Field Table for Standard Explanation of Review provides the required elements for a paper EOR. <u>Paper EOR's do not require the use of CARC/RARC codes.</u>		**Disagree** with the suggestion to use the DWC Bill Adjustment Reason Codes on electronic EORs and disagree that the CARCs and RARCs used in electronic EORs will lead to greater friction. The national standard 005010X221 Payment/Advice (835) does not support use of the DWC Bill Adjustment Reason Codes. The Crosswalk will be appear on the DWC website as part of the Medical Billing and Payment Guide which will be posted for public access. A payor receiving an electronic EOR can use the crosswalk to "translate" the possibly more general CARC/CARC to a DWC Bill Adjustment Code and Explanatory Message. **Disagree** with the specific suggestion submitted by commenter because, although the insertion is a correct statement of the intended use of CARCs and RARCs, there is a need for a	None. Modify the entire narrative provisions regarding paper and electronic Explanation of

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			broader revision. **Agree** that clarification is needed.	Review to improve the clarity.
	It is commenter's understanding that Paper EOR's do not require the use of the RARC codes, instructions for their use is included in G9, G10, G77 and G78. It appears that these instructions misplaced.		**Agree** that paper EORs do not require use of the RARCs and it may be confusing to include instructions for RARCs in the "CA Payor Instructions" column. The language will be clearer in the RARC Column.	Modify the G9, G10, G79 (renumbered, formerly G79), G80 (renumbered, formerly G78.)
	This one line title is followed by 1.0, the California DWC ANSI Matrix Crosswalk and the 2.0, the Matrix in CARC Order. Commenter suggests that this should this be moved to precede the 3.0 Field Table.		**Disagree.** The DWC does not understand what the commenter is suggesting. In addition, insofar as he is suggesting a reordering of the tables the DWC cannot discern a benefit to doing so.	None.
1.0 California DWC ANSI Matrix Crosswalk – G54	Commenter recommends that the following changes, provided in underline, be made: Provider's documentation does not support level <u>of</u> service billed	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree.**	Modify 1.0 California DWC ANSI Matrix Crosswalk, G54 to insert missing word "of."
1.0 California DWC ANSI Matrix Crosswalk – G73	Commenter states that the DWC Explanatory Message column is a duplicate of Issue column language. Commenter opines that the DWC Explanatory Message should read: <u>Requested documentation to support</u>	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree.** Commenter has correctly pointed out an error in column three which erroneously duplicates column two. Commenter's suggested language is appropriate.	Modify DWC explanatory message and CA Payor Instructions in G74 (renumbered, formerly G73) to

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	the bill was absent or incomplete. Commenter also recommends adding the following to the CA Payor Instructions column: Identify necessary item(s.)		**Agree.**	insert language suggested by commenter. Modify G74 to insert the suggested language.
1.0 California DWC ANSI Matrix Crosswalk – G77	The How to Use the Tables states that only the specified RARC codes may be used. Commenter states that N437 is referenced and it appears not to be anywhere in the table.	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree.**	Modify G79 (renumbered, previously G77) to include N437 in the RARC column. Also added to G80 (formerly G78.)
1.0 California DWC ANSI Matrix Crosswalk – G78	Commenter states it appears that part of the DWC Explanatory Message was truncated. Likely, it is intended to read as in G77. N437 is referenced here as well.	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree.** Language is missing from the Explanatory Message column and N437 is referenced but does not appear.	Modify G80 (formerly G78) to include N437 language in the RARC column, and add missing language to the DWC Explanatory Message column.
1.0 California DWC ANSI Matrix Crosswalk Physical Medicine DWC Explanatory Messages	Commenter states that with the imminent move to current CPT codes with 15 minute Physical Medicine procedure codes, separate Occupational Therapy codes and the proposed changes to the Physical Medicine Ground Rules much of this	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree** that when new Physician Fee Schedule coding and ground rules are adopted that new DWC Adjustment Reason Codes may be needed.	No action needed currently, but calendar the DWC Bill Adjustment Reason Codes for review when the

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	section of EOR's will need updating. PM1, PM3, PM4, PM5, PM6, PM7, PM8 and PM9, PM11 will all require revision. This may not be done before the Physician Fee Schedule is finalized, but it needs to be calendared to be done concurrently with the finalization of the Physician Fee Schedule.			Physician Fee Schedule is updated.
1.0 California DWC ANSI Matrix Crosswalk – PM7	The current Issue language is identical to the OWC Explanatory Message column. Commenter states that the Issue column should be amended as below: ~~No~~ M~~m~~ore than four physical medicine procedures including Chiropractic Manipulation and Acupuncture codes are ~~reimbursable~~ billed during the same visit without prior authorization pursuant to Physical Medicine Rule 1 (d)	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree** that the Issue and DWC Explanatory Message erroneously have the same language. However, the language will be revised to be more consistent with the format of other Issue entries by starting with "Provider bills…."	The "Issue" entry for PM7 is modified to read "Provider bills more than four physical medicine procedures and/or chiropractic manipulation and/or acupuncture codes during the same visit without prior authorization."
1.0 California DWC ANSI Matrix Crosswalk – PM12	The current language needs to specify that this code refers to Pre-Surgery visits. A new EOR(s) needs to be created for post-surgical visits. In the case of the current PM12 commenter suggests:	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree** that there should be a specialized message for the pre-surgery visits in excess of 24**.** **Disagree** that a separate EOR message needs to be created for post-surgical Physicial Therapy/Occupational Therapy/Chiropracitc vistis since	PM12 will be modified as suggested.

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	Issue: Pre-surgical ~~V~~visits in excess of 24 are charged without prior authorization for additional visits. Commenter recommends that the following changes, provided in underline, be made: DWC Explanatory Message: Charge is denied as there is a 24-visit limitation on Pre-surgical Physical Therapy, Chiropractic and Occupational Therapy encounters for injuries on/after January 1, 2004 without prior authorization for additional visits.		those would be dealt with using the regular codes such as G68, G70, G71, G72, G73, G76, or G78.	
1.0 California DWC ANSI Matrix Crosswalk – S8	Commenter recommends that the following changes, provided in underline, be made: The DWC Explanatory Message has been dropped from this EOR. The Forum language was "Your bill is rejected as we have not received the operative report. Resubmit your bill with the report for reconsideration."	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree** that the language suggested should be inserted, but slightly modified for consistency of format with other messages.	Modify S8 to insert the DWC Explanatory Message: "The Surgeon's bill has been rejected as we have not received the operative report. Resubmit bill with the operative report for reconsideration."
2.0 Matrix List in CARC Order	The How to Use the Tables state that only the specified RARC codes may be used. It does not appear that N437 is in the matrix, but it is referenced for use with G77 and G78	Steven Suchil Assistant Vice President American Insurance Association	**Agre**e that the RARC N437 should be in the table. (Note that the "How to Use the Tables" has been deleted and the narrative description has been substantially	Add the RARC N437 to Table 2.0 Matrix List in CARC Order.

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		April 26, 2010 Written Comment	rewritten for clarity.)	
Medical Billing & Payment Companion Guides 2.1.3	This section cites the Security Rule as Appendix E. It should be Appendix D.	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree.**	Typographical error will be corrected.
Medical Billing & Payment Companion Guides 9.2	Commenter states that the Task Force spent a lot of time on this issue. This solution was only for the first submission by any given provider. After they were electronically advised of the Claim Number, subsequent bills with the Claim Number absent would be determined Incomplete. Commenter strongly recommends this be added to this section.	Steven Suchil Assistant Vice President American Insurance Association April 26, 2010 Written Comment	**Agree.** The Medical Billing and Payment Guide already provides that the "pending for missing claim number" process is only for bills submitted prior to the provider being electronically advised of the claim number. The Medical Billing and Payment Guide states in pertinent part: "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." Medical Billing and Payment Guide, 7.1 Timeframes (a)(3)(A)(i.) The DWC agrees with the commenter's suggestion to add a provision to the Companion Guide, 9.2 to make it clear that the bill must be pended for a missing claim number only if the claims administrator has not	Modify 9.2 of the Companion Guide to clarify that the "pending for missing claim number" process is only for the first bill submission: "Once the claim number has been provided to the bill submitter, subsequent bill submissions are not subject to the pre-adjudication hold status and may be denied for being incomplete due to lack of the claim number".

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			previously provided the claims number.	
General Comment	Commenter is really excited and supportive of the proposed regulations and is eagerly anticipating their adoption. Commenter states that Texas implemented e-billing requirements two years ago and have 80 percent compliance. Minnesota implemented mandatory e-billing requirements in July 2009 and they only have 3 percent compliance. Commenter recommends that there be an 18-month implementation period after adoption of these regulations before they are mandatory. Commenter states that in 2012 there will be changes with the ICD-10 and the electronic standards from 4010 to 5010 so the 18 month period would be better. Commenter states that the CMS website indicates that 95 percent or more of all medical providers have established electronic connectivity with Medicare and there are a lot of companies assisting to connect the physicians or the medical providers to the payers and that this will result in	Sandy Shtab Healthesystems, Inc. April 26, 2010 Oral Comment	DWC appreciates the support for e-billing. **Agree** that 18 month period should be allowed prior to mandatory acceptance of ebills due to the fact that this is the timeframe allowed in Labor Code 4603.4. Agree that HIPAA requires use of the 5010 standards in 2012. However, ICD-10 is not mandatory for HIPAA covered transactions until October of 2013. DWC appreciates this information as background, although it is not addressed to the substance of the regulatory proposal.	None. None. None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	significant savings to the system as a whole.			
Medical Billing & Payment Guide 2010 -- 7.1(b); 7.2(a) and (b)	Commenter does not believe that the 15 day time limit for payment is workable.	Sandy Shtab Healthesystems, Inc. April 26, 2010 Oral Comment	**Disagree.** See response above to comment of Mary Jo Castruccio Assistant Risk Manager - Workers' Compensation Contra Costa County April 26, 2010.	None.
Medical Billing & Payment Guide 2010 -- 7.1(b); 7.2(a) and (b)	Commenter does not think that the Division needs to have an 18 month implementation period for e-billing regulations. Commenter works for a clearinghouse that connects providers to payers. Commenter states that her organization allows the provider to simply fax in the attachments at no charge and her company marries it with the e-bill and sends it to the payer. Commenter does not feel that the 15 day requirement is an issue for remittance advice, especially for the workers' compensation payers that are using her organizations connectivity with the providers. Commenter opines that if they have to route it to a third party for bill review, her organization can route it to that third party and bring it back to the payer for adjudication.	Linda Wikler Emdeon April 26, 2010 Oral Comment	**Disagree** that with the suggestion that there should not be an 18 month implementation period. Labor Code 4603.4 specified a time period for ebilling to become mandatory that allowed 18 months. Parties who wish to engage in ebilling may enter into agreements to do so prior to the mandatory implementation date. DWC appreciates commenter's statement that the 15 day period for issuing remittance advice is achievable for her organization.	None. None.