STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

NOTICE OF MODIFICATION TO TEXT OF PROPOSED REGULATIONS

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

TITLE 8, CALIFORNIA CODE OF REGULATIONS
Sections 9792.5 et seq.

NOTICE IS HEREBY GIVEN, pursuant to Government Code section 11346.8(c), that the Acting Administrative Director of the Division of Workers' Compensation, proposes to modify the text of regulations and documents incorporated by reference relating to Electronic and Standardized Medical Treatment Billing. The Notice of Proposed Rulemaking was published in the California Notice Register on March 5, 2010, OAL Notice # Z2010-0223-01, Register # 2010, 10Z. Public hearings were held on April 23 and April 26, 2010 and the written comment period closed on April 26, 2010. After consideration of the oral and written public comment, the Acting Administrative Director proposes sufficiently related modifications to the text (and to the billing guide documents incorporated by reference) of the following proposed regulations:

1. Proposed Section 9792.5 Payment for Medical Treatment [Amend]

2. Proposed Article 5.5.0 Rules for Medical Treatment Billing and Payment on or after XXXX, 2011 [90 days after effective date of regulation] [Adopt]

   Proposed Section 9792.5.0 Definitions [Adopt]

3. Proposed Section 9792.5.1. Medical Billing and Payment Guide; Medical Billing and Payment Companion Guide; Various Implementation Guides [Adopt]

4. Proposed Section 9792.5.2 – Standardized Medical Treatment Billing Forms/Formats, Billing Rules, Requirements for Completing and Submitting Form CMS 1500, Form CMS 1450 (or UB 04), American Dental Association Form, Version 2006, NCPDP Workers' Compensation / Property & Casualty Claim Form, Payment Requirements [Adopt]

5. Proposed Section 9792.5.3 – Medical Treatment Bill Payment Rules [Adopt]

PRESENTATION OF WRITTEN COMMENTS AND DEADLINE FOR SUBMISSION OF WRITTEN COMMENTS

Members of the public are invited to present written comments regarding these proposed modifications. **Only comments directly concerning the proposed modifications to the text of the regulations,**

documents incorporated by reference, and documents added to the rulemaking file will be considered and responded to in the Final Statement of Reasons.

Written comments should be addressed to:

Maureen Gray, Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

The Division's contact person must receive all written comments concerning the proposed modifications to the regulations no later than **5:00 p.m. on Friday, January 21, 2011.** Written comments may be submitted by facsimile transmission (FAX), addressed to the contact person at (510) 286-0687. Written comments may also be sent electronically (via e-mail), using the following e-mail address: dwcrules@dir.ca.gov.

AVAILABILITY OF TEXT OF REGULATIONS AND RULEMAKING FILE

Copies of the original text and modified text with modifications clearly indicated, documents added to the rulemaking file, and the entire rulemaking file, are currently available for public review during normal business hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays, at the offices of the Division of Workers' Compensation. The Division is located at 1515 Clay Street, 17th Floor, Oakland, California.

Please contact the Division's regulations coordinator, Ms. Maureen Gray, at (510) 286-7100 to arrange to inspect the rulemaking file.

NOTICE OF ADDITION OF REFERENCE MATERIAL TO RULEMAKING FILE

Pursuant to the requirements of Government Code section 11347.1, the Division of Workers' Compensation is providing notice that reference materials which the agency has relied upon in proposing the modifications to the proposed regulations have been added to the rulemaking file. The documents are available for public inspection and comment during the written comment period set forth above, see "Presentation of Written Comments and Deadline for Submission of Written Comments." The Division will respond to comments regarding the documents in the Final Statement of Reasons. The documents may be inspected as part of the rulemaking file; see "Availability of Text of Regulations and Rulemaking File" above for the place and time the documents will be available and the name and phone number of the contact person.

Documents added to rulemaking file after close of the 45 day comment period:

- The California Division of Workers' Compensation Medical Billing and Payment Guide, 2011.
- The California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, 2012

- ASC X12N/005010X222
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Professional (837)
  MAY 2006

- ASC X12N/005010X222E1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Professional (837)
  January 2009

- ASC X12N/005010X223
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Institutional (837)
  May 2006

- ASC X12N/005010X223A1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Institutional (837)
  Errata Type 1
  October 2007

- ASC X12N/005010X223E1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Institutional (837)
  Errata
  January 2009

- ASC X12N/005010X224
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Dental (837)
  MAY 2006

- ASC X12N/005010X224A1

Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Dental (837)
Errata Type 1
October 2007

- ASC X12N/005010X224E1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Dental (837)
  Errata
  January 2009

- Telecommunication Standard Implementation Guide, Version D.0, August 2007. National Council for Prescription Drug Programs

- Batch Standard Implementation Guide, Version 1.2, January 2006, National Council for Prescription Drug Programs

- ASC X12C/005010X231
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Implementation Acknowledgment for Health Care Insurance (999)
  June 2007

- ASC X12N/005010X214
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Acknowledgment (277)
  January 2007

- ASC X12N/005010X221
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Payment/Advice (835)
  April 2006

- ASC X12N/005010X221E1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Payment/Advice (835)

Errata
January 2009

- ASC X12N/005010X210
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Additional Information to Support a Health Care Claim or Encounter (275)
  February 2008

- ASC X12N/005010X213
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Request for Additional Information (277)
  July 2007

- National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version, Version 6.0 07/10, and the 1500 Form (revised 08-05)

- National Uniform Billing Committee Official UB-04 Data Specifications Manual 2011, Version 5.0, July 2010, including the UB 04 form

- CDT 2011-2012: ADA Practical Guide to Dental Procedure Codes, including the ADA 2006 Dental Claim Form

FORMAT OF PROPOSED MODIFICATIONS

Proposed Text Noticed for 45-Day Comment Period:

The original codified regulatory text is in plain text.

Deletions from the original codified regulatory text noticed for the 45-comment period are indicated by single strike-through, thus: ~~deleted language~~.

Additions to the original codified regulatory text noticed for the 45-comment period are indicated by single underlining, thus: <u>added language</u>.

The Medical Billing and Payment Guide and the Electronic Medical Billing and Payment Companion Guide proposed for adoption through incorporation by reference are in plain text for the 45-day comment period.

Proposed Text Noticed for First 15-Day Comment Period on Modified Text:

Deletions proposed during the 15-day comment period, to text of regulation and documents incorporated by reference, are indicated by double strikethrough, thus: ~~deleted language.~~

Additions proposed during the 15-day comment period, to text of regulation and documents incorporated by reference, are indicated by double underlining, thus: added language.

SUMMARY OF MODIFICATIONS TO PROPOSED TEXT

Modifications to section 9792.5

Modify introductory sentence to specify that the section is applicable to medical treatment rendered before a date that is exactly 90 days after the effective date of the regulation, rather than approximately 90 days, and to specify that the date will be in 2011 rather than 2010. The Division will be requesting OAL to insert the exact date here, and in all other points in the regulations where an exact date is to be determined in relation to the effective date of the regulations.

Subdivisions (b), (d): Add language indicating that a governmental entity must pay a medical bill within 60 working days rather than 45 working days, and would be subject to penalty and interest for failure to pay within 60 working days, in order to conform to the statutory provision that governmental entities have 60 working days to pay a bill.

Subdivision (f): Delete this subdivision which refers to the appeals board ordering payment of interest on contested bills later determined to be payable as the statutory authority for the provision was repealed in 2006 by AB 1806 (Statutes 2006, Chapter 69.)

Add new subdivision (f) to provide that for services rendered prior to January 1, 2004 the claims administrator shall pay any uncontested amount within 60 days after receipt of the bill and that any amount not contested within the 30 working days or not paid within the sixty day period shall be increased 10% and carry interest retroactive to the date of receipt of the bill. This subdivision is needed to maintain the payment period, objection period, interest rate, and penalty increase that were applicable to services prior to the statutory amendment which took effect in 2004.

Modifications to section 9792.5.0

Added definitions of “assignee” and “billing agent” and deleted definition of “third party biller/assignee.” This was done to improve the clarity of the rules.

Added language to the definition of “health care provider” to state that the term means a provider of medical treatment, goods and services “provided pursuant to Labor Code section 4600….” This was necessary for clarification since Labor Code section 4600 defines the scope of compensable medical treatment.

Definitions are renumbered due to the addition/deletion of definitions.

Modifications to section 9792.5.1 subdivision (a)

The date of the *California Division of Workers' Compensation Medical Billing and Payment Guide* is updated from 2010 to 2011 since it will not become effective until 2011.

The website to obtain the Guide is changed to the main Department of Industrial Relations' website address. This will provide greater stability for the web address since interior links may change more frequently as the web site is periodically reorganized.

California Division of Workers' Compensation Medical Billing and Payment Guide, 2011, which is incorporated by reference, is modified as follows.

- Modify title page to insert 2011 instead of 2010.
- Modify Introduction page to: specify that the effective date for required acceptance of electronic bills will be in 2012, 18 months after adoption of the regulations, specify that the paper billing rules become effective 90 days after adoption, the term "Third Party Billers" is replaced with the term "Billing Agents."
- 1.0 Add a definition of "assignee" for clarity as to the applicability of the regulations, as assignees are required to adhere to the billing rules. The former definition of "Third Party Biller/Assignee" is deleted.
- 1.0 Add a definition of "balance forward bill" for clarity.
- 1.0 (b) Modify definition of "bill" to include the concept of the electronic bill format.
- 1.0 Add a definition of "Billing Agent" to replace the term "Third Party Biller" for clarity. The division 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.
- 1.0 Add a definition of "duplicate bill" to clarify that a bill that is exactly the same as a previous bill except for the "billing date" is a duplicate.
- 1.0 Modify definition of "Explanation of Review" to improve clarity of which codes to use for paper bills and which to use for electronic bills.
- 1.0 Modify the definition of "required report" to provide further detail on the citations of the reports.
- 1.0(t) Modify definition of "supporting documentation" to reference the "complete bills" provision and modify to refer to invoices "required by the OMFS" for the item rather than "invoice required for payment of the DME item."
- 1.0 Delete the definition of the term "Third Party Biller/Assignee" as the combined term was ambiguous since "third party biller" may be used to refer to an assignee, especially in the area of pharmaceutical billing.
- 1.0(y) Add reference to "Medicare Severity Diagnosis Related Group (MS-DRG)" to the definition of "Diagnosis Related Group" to improve the clarity.
- 1.0 Renumber the definitions due to the deletion and insertion of definitions.
- 2.0 Modify effective dates of regulations, clarify name and dates of paper forms/forms manuals.
- 3.0 Delete subdivision (a) that stated that bills must be complete before payment time frames begin as it may cause confusion regarding the time frames for payment where a bill is placed in "pending status" due to a missing claim number or attachment. Renumber remaining subdivisions.

- 3.0 Modify the complete submission language in subdivision (a) (formerly (b)) to clarify that a claims administrator may populate missing information if it has previously been received.
- 3.0 Add a subdivision (a)(4) to specify that a "complete bill submission" includes required reports and supporting documentation as specified in subdivision (b).
- 3.0(b)(5) Delete modifiers -19 and -21 from the listing of modifiers giving rise to the need for a medical report because those two modifiers no longer exist.
- 3.0(b)(8) Add a requirement that an operative report be provided for facility fees for surgical services
- 3.0(c)(9) Add a language indicating that an invoice or other proof of documented paid costs should be submitted when required by the Official Medical Fee Schedule for reimbursement.
- 4.0 Substitute the term "Billing Agent" for the term "Third Party Biller."
- 4.0 Add a new subdivision (c) to insert language 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 right to the right to submit bills.
- 5.0 Modify the language to clarify what constitutes a "duplicate bill" and to specify how such bills are marked as duplicates at the time of bill submission.
- 5.0 Clarify what constitutes a "balance forward bill" and how it may be rejected.
- 6.0 Clarify the language regarding the time frame for payment of uncontested medical treatment.
- 6.0 Insert language to require the DWC Explanatory Messages to be used along with the DWC Bill Adjustment Reason Codes for providing the basis for objections to the bill submitter for paper bills.
- 6.0 Modify the references to the DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk and Explanation of Review paper field table to conform to the changes to the titles of those tables.
- 7.1 Add introductory language to improve clarity by providing context for the acknowledgment and payment processes involved in handling a bill that is received electronically.
- 7.1 Modify the provisions to utilize the updated 5010 versions of the acknowledgments rather than the 4010 versions. The 5010 versions are the versions that will be mandatory under the Health Insurance Portability and Accountability Act (HIPAA) as of January 1, 2012.
- 7.1(a)(3)(A) Add language to clarify the process for "pending" a claim for up to five days if the claim number is missing or if there is a missing attachment. Clarify that the 15 day timeframe to pay or object to the electronic bill is suspended while the bill is pending, but that the timeframe resumes when the claim number is affixed to the claim, or the attachment is received. The 15 day time period does not begin anew.
- 7.1(a)(3)(B) Delete the word "shall" in the phrase "bill ejection error messages shall include…."
- 7.1(b) Add an introductory paragraph to clarify the time frame for paying/objecting to an electronic bill, and the effect of the "pending period" to extend the time frame by the number of days the bill was in pending status.
- 7.1(b) Modify the language to specify that the "claims administrator," rather than "the employer," must pay uncontested medical treatment within 15 working days after receipt of an electronic bill. Modify the language to provide separate subdivisions for "Complete Bill – Payment for Uncontested Medical Treatment" and "Objection to Bill / Denial of Payment" to clarify the provisions. Add language stating that any contested portion of the billing shall be paid in accordance with Labor Code section 4603.2, to conform to the last sentence of Labor Code section 4603.4.

- 7.1(b) Delete language regarding the objection and explanation that is duplicative of provisions set forth in other provisions of the Medical Billing and Payment Guide, the Electronic Medical Billing and Payment Companion Guide, or in the electronic transaction sets.
- 7.3 Modified to make grammatical changes.
- 7.3(d)(3) Modify the provision regarding bill attachment method to specify that email must be encrypted email in order to provide greater security for the transmission of personal health information.
- Appendix A, 1.0 CMS 1500. Modify to adopt the newest version of the 1500 Health Insurance Claim Form Reference Instruction Manual, Version 6.0 07/10.
- Appendix A, Add language to the 1.1 Field Table CMS 1500 , field 11 instructions to indicate that the value of "unknown" may only be used for a first billing by the provider.
- Appendix A, Add language to the 1.1 Field Table CMS 1500, field 14 to give further instruction as to what date to enter for the "date of current illness, or injury." Labor Code section 5411 provides the date of injury for specific injury which is the date of the incident or exposure. Labor Code section 5412 defines injury for occupational disease or cumulative injury as the date upon which the employee first suffered disability and knew or in exercise of reasonable diligence should have known that such disability was caused by present employment. Labor Code 5500.5 currently provides liability in the case of cumulative injury or occupational disease upon the employer who employed the employee during the one year immediately preceding either date of injury as determined under section 5412 or the last date on which employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury, whichever occurs first. The instructions inserted in Field 14 and other paper form tables are adopted to provide clarity and consistency and to provide instructions that take into account Labor Code section 5411, 5412, and 5500.5.
- Appendix A, 1.1 Field Table CMS 1500, Field 16. Change this data element relating to dates patient unable to work in current occupation from "N" not applicable, to "O" optional, and delete the workers' compensation instructions. The language is deleted because there is no necessity for the prior language which stated that inclusion of data regarding the dates unable to work could cause rejection of the bill. Although the "dates unable to work" are not necessary to determine if the bill is payable, the data should be optional if the provider wishes to include the data as there is no harm caused by doing so.
- Appendix A, Add language to the 1.1 Field Table CMS 1500, field 22 to clarify the instructions for resubmitting a bill as a revision or for reconsideration.
- Appendix A, Add language to the 1.1 Field Table CMS 1500, field 23 instructions to provide that the data element is required if a prior authorization, referral, concurrent review, or voluntary certification *number* was received; the original proposal lacked the word "number."
- Appendix A, 1.1 Field Table CMS 1500, field 31 "signature of physician or supplier" is changed from "R" to "O" since there is no statutory requirement that providers sign a medical bill.
- Appendix A, 1.1 Field Table CMS 1500, field 32 "service facility location information" is changed from "S" to "R" because the location that the service was provided is important information that should be provided to the payer. The facility location codes cover a broad range of service locations and provide necessary information to the claims administrator.
- Appendix A, 1.1 Field Table CMS 1500 , field 32b "other ID #" for service facility location is modified to add a comment directing the provider to enter the state license number if the provider is not eligible for an NPI. This directive will ensure that important identifying information is provided to the claims administrator.

- Appendix A, Add language to the 1.1 Field Table CMS 1500, field 33 to give further instruction regarding the billing provider field if an assignee is to be the payee.
- Appendix A, 2.0 UB-04. Add language to 2.0 UB-04 to identify that the UB-04 form incorporated into the NUBC Data Specifications Manual is revised in 2005, and to incorporate by reference the latest version of the manual, i.e. the National Uniform Billing Committee Official UB-04 Data Specifications Manual 2011, Version 5.0, July 2010, including the UB-04 form revised 2005.
- Appendix A, 2.0 UB-04. Add language to the 2.1 Field Table UB-04, Form Locator 31-34a,b to give further instruction as to what date to enter for the "Occurrence Codes and Dates".) The instructions conform to the instructions given in the CMS 1500 field table and instructions for the NCPDP Workers' Compensation and Property & Casualty form and the ADA Dental Form. This is done for clarity and consistency and for the reasons explained above regarding the CMS 1500 form.
- Appendix A, 2.0 UB-04. 2.1 Field Table UB-04, Form Locator 52a, the Release of Information Certification Indicator is changed from "R" to "O" to ensure that a release of information form executed by the patient is optional but not required. HIPAA does not apply to workers' compensation, and information released to comply with workers' compensation laws does not require the patient's signed release.
- Appendix A, 2.0 UB-04. 2.1 Field Table UB-04, Form Locator 56, instructions are inserted to clarify the applicability of the "situational" requirement of the National Provider Identifier – Billing Provider. The situational requirement to provide the NPI becomes a mandatory requirement if the billing provider is *eligible* for an NPI. The NPI will be used for all providers who are eligible to obtain an NPI in order to streamline processing of bills through the national standard identifier.
- Appendix A, 2.0 UB-04. 2.1 Field Table UB-04, Form Locator 57, instructions are inserted to require the provision of the Medicare ID number if the facility has been assigned one, or the state license number if no Medicare ID number has been assigned. This is necessary in order to allow efficient processing of the bills because determining the maximum allowable payment to inpatient hospitals, outpatient hospital departments, and ambulatory surgical centers depends in large part on fee schedule provisions that are linked to the Medicare Provider ID number.
- Appendix A, 3.1 Field Table NCPDP Workers' Compensation/Property and Casualty UCF. For consistency, amend the Table Heading NCPDP 5.1 Data Element to NCPDP D.0 Data Element to update the table to the most electronic standard being adopted.
- Appendix A, 3.1 Field Table NCPDP Workers' Compensation/Property And Casualty UCF Usage Instructions field 11, "Date on which the injury occurred" instructions are added to conform to the instructions given in the CMS 1500 field table and instructions for the UB-04 and the ADA Dental Form. This is done for clarity and consistency and for the reasons explained above regarding the CMS 1500 form.
- Appendix A, 3.1 Field Table NCPDP Workers' Compensation/Property and Casualty UCF., modify Field 99 to provide that the "Usual & Customary Charge" field is "R" instead of "O". Since the OMFS for pharmaceuticals is the lesser of the usual and customary price or the amount that would be paid under Medi-Cal, it is necessary for the usual and customary price to be required. In addition, language is added to the Comments column to explain that the usual and customary price does not include the dispensing fee, which is to be entered in Field 102. In addition, the California Workers' Compensation Instruction Column is modified to delete an erroneous reference to Labor Code section 5307.1(a) and to direct the provision of the usual and customary *price* which is the term used in the DWC fee schedule calculator.

- Appendix A, 4.1 Field Table ADA 2006, field 1 is modified to specify that the field shall be used to indicate a duplicate bill by writing the word "duplicate" in the field. The data element is indicated to be situational, as it would only be required where a duplicate was being submitted.
- Appendix A, 4.1 Field Table ADA 2006, field 46 "Date of Accident" in the Comments column instructions are added to conform to the instructions given in the CMS 1500 field table and instructions for the UB-04 and the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form. This is done for clarity and consistency and for the reasons explained above regarding the CMS 1500 form.
- Appendix A, 4.1 Field Table ADA 2006, field 48. Phone number and "R" are deleted as this is duplicative of Field 52 that requires the phone number of the entity listed in box 48.
- Appendix A, 4.1 Field Table ADA 2006, field 49. Provider ID NPI Number's Comments column is modified to specify that the situational data element is required if the billing provider is eligible for an NPI. The NPI will be used for all providers who are eligible to obtain an NPI in order to streamline processing of bills through the national standard identifier.
- Appendix A, 4.1 Field Table ADA 2006, field 50. The Comments column regarding "License Number (state license)" is modified to specify that the situational data element is required if the billing provider is not eligible for an NPI. If the provider is not eligible for an NPI the state license number will be required in order to provide an identifier that can be confirmed by the claims administrator. It will only be required for providers who are not eligible for an NPI since the national trend is toward using NPIs rather than state license numbers in order to streamline billing and payment across jurisdictions.
- Appendix B. Standard Explanation of Review (EOR). This section is substantially rewritten to improve the clarity of the provisions. The language has been separated into a section for paper EORs and Electronic EORs. For paper EORs there is improved language explaining the use of 3.0 Filed Table for Paper Explanation of Review. There is also clarified language regarding the use of the Table 1.0 DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk. For electronic EORs additional instruction is given relating to four specified CARCs that will require the payor to communicate statutory code reference to the provider to explain the reason for reduction or denial. This approach is based on the IAIABC's work with the ASC X12 committee to adapt the HIPAA compliant 835 for workers' compensation usage. It is necessary to adapt the national standards for the special needs of workers' compensation. Language was deleted in order to improve clarity and eliminate duplicative provisions.
- Appendix B, Table 1.0. Modify the title to "*California DWC* ANSI *Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk"* improve the clarity regarding the contents of the table.
- Appendix B, Table 1.0. For DWC Bill Adjustment Reason Code G9 and G10 language is moved over from the CA Payor Instructions column to the Remittance Advice Remark Code Descriptions column as a note since the notes are related to RARCs and do not apply to the paper EORs.
- Appendix B, Table 1.0. For DWC Bill Adjustment Reason Code G56. The DWC Explanatory Message is expanded to include a balance forward bill which contains a duplicate charge. The CA Payor Instructions column is also modified to clarify that the code may be used to reject a complete duplicate or a balance forward bill.
- Appendix B, Table 1.0. G1, G2, G6 are kept the same, but the corollary CARC W1 is modified to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. G60 is kept the same, but the corollary CARC 191 is modified to add new language adopted by the national code maintenance committee.

- Appendix B, Table 1.0. Modify to add a DWC Bill Adjustment Reason Code G72 that would notify the provider of an interim Explanation of Review informing the provider of the conduct of a retrospective utilization review as there was no indication of prior authorization. The Table also adopts CARC and RARC codes that together will equate to the G72 message.
- Appendix B, Table 1.0. The DWC Bill Adjustment Reason Codes are renumbered due to the addition of G72.
- Appendix B, Table 1.0. G74 (former G73) is corrected as the "Issue" column was erroneously repeated in the DWC Explanatory Message Column. New language is added to the Explanatory Message and CA Payor Instructions column for clarity. The CARC is revised to delete CARC 17 which was eliminated by the national code committee. The CARC 226 is added. Conforming change is made to the Table 2.0 Matrix in CARC Order.
- Appendix B, Table 1.0 G75 (former erroneously numbered "second" G73) modifies the DWC Explanatory Message column to provide greater clarity as the prior message was inconsistent with the Issue column. Code numbers and language are added to the CARC and RARC columns. The CARC "Patient cannot be identified as our insured" is deleted as it is not a good fit for workers' compensation and could be confusing.
- Appendix B, Table 1.0. G79 (former G77) language erroneously in the CA Payor Instructions column is moved to the RARC column.
- Appendix B, Table 1.0. G80 (former G78). Language ia added that was inadvertently omitted. Deleted CA Payor Instruction column language as it is not an instruction for the paper EOR. Move the Alert language that is RARC N437 from the CA Payor Instruction column to the RARC column where it belongs.
- Appendix B, Table 1.0. A new code G81 is added to adopt a message to explain that penalty and interest are being added to the payment, and to adopt a corollary CARC.
- Appendix B, Table 1.0. PM7 Issue column regarding the provider billing more than four physical medicine and/or chiropractic and/or acupuncture codes on the same visit without prior authorization is reworded for clarity.
- Appendix B, Table 1.0. PM10 is kept the same, but the corollary CARC W1 is modified to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. PM12 is modified to clarify that the code is to be used where *pre-surgical* physical therapy, chiropractic or acupuncture exceeds the 24-visit cap. For post-surgical visits, other messages regarding authorization would be applicable; there is no need for a specialized code.
- Appendix B, Table 1.0. S5, S6, S7 and S10 are kept the same, but the corollary CARC W1 is modified to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. S8 is modified to add DWC Explanatory Message language to notify the surgeon that the bill is rejected as no operative report has been received and directs the surgeon to resubmit the bill with operative report for reconsideration. This language is important as it conveys critical information to the provider about what is missing to support the bill.
- Appendix B, Table 1.0. P1 is kept the same, but the corollary CARC W1 is modified to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. DME4 is kept the same, but the corollary CARC W1 is modified to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. SS2 and SS4 are kept the same, but the corollary CARC W1 is modified to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. P1 is kept the same, but the corollary CARC W1 is modified to add new language adopted by the national code maintenance committee.

- Appendix B, Table 1.0. F3, F4, F5 and F6 are kept the same, but the corollary CARC W1 is modified to add new language adopted by the national code maintenance committee.
- ,Appendix B, Table 1.0. M1 is kept the same, but the corollary CARC 214 is modified to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. M4 is kept the same, but the corollary CARC 221 is modified to add new language adopted by the national code maintenance committee.
- Appendix B, Table 2.0 Matrix List in CARC Order. This list is modified to reflect the modifications in Table 1.0 California DWC ANSI Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk.
- Appendix B, Table 3.0 Field Table for Paper Explanation of Review. The title of the table has been revised to remove the word "standard" as it does not convey useful meaning and the words "for paper" have been added to improve the clarity regarding the scope of the table.
- Appendix B, Table 3.0. Fields 3 (method of payment), 4 (payment ID number), 5 (payment date) and 34 (total paid) are changed from "R" to "S" and language is added to the comments column. Since the EOR is used where there is a denial of all payment, as well as to explain payment, there would be no data for Fields 3, 4, and 5 in a denial of payment circumstance. Thus, these Fields must be Situational, i.e. only required where there is a payment.
- Appendix B, Table 3.0. Fields 8 (payor contact name) and 9 (payor contact number). Language has been added to explain that the situational field becomes required if there is no payment or payment less than billed charges, and in Field 9 row a typographical error is deleted. This extra language is necessary because a provider may need the contact name and phone number to discuss non-payment or reduced payment, but is unlikely to need the contact name and number if payment is made in full.
- Appendix B, Table 3.0. Bill Level Adjustment Information – Situational. The first sentence is deleted because it may be confusing.
- Appendix B, Table 3.0. Field 41 and Field 51 Field Description columns are revised to delete the word "description" and insert the phrase "and DWC Explanatory Message." This is necessary as the word "description" is ambiguous, and what is intended is that the paper EOR will include the DWC Bill Adjustment Reason Code and the DWC Explanatory Message. Conforming changes are made to the comments column.
- Section Two – Transmission Standards. This section is modified to show that the effective date of electronic transaction standards is 18 months after adoption which will be in 2012 rather than 2011. This section lists all of the transaction standards used in electronic billing, acknowledgment, remittance/payment/advice and documentation, for the convenience of the public. The transaction sets are incorporated by reference into the regulation text and the Electronic Medical Billing and Payment Companion Guide, not in the Medical Billing and Payment Guide but are listed here for convenience. The listing is modified to reflect the updated transaction standards which are proposed for adoption.
- Section Two – Transmission Standards. This section is modified to update the Washington Publishing Company's address for obtaining transaction standards. The layout of web addresses is modified for clarity.
- Section Two Transmission Standards, 4.0 Electronic Signatures. This section is deleted as it is unnecessary. There is no legal requirement for the electronic bills to be signed. In addition, although an electronic signature rule was proposed for HIPAA implementation, a final rule has never been adopted.

Modifications to section 9792.5.1 subdivision (b)

The date of the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide is updated from 2010 to 2012, since the guide will not become effective until 18 months after adoption.

The website to obtain the Guide is changed to the main Department of Industrial Relations' website address. This will provide greater stability for the web address since interior links may change more frequently as the web site is periodically reorganized.

California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, 2012, which is incorporated by reference, is modified as follows.

- The Table of Contents is modified to update headings and page numbers.
- The term "third party biller/assignee" is replaced throughout the documents with "billing agent/assignee."
- 1.2 The references to the electronic transaction standards are modified to reflect the updated standards proposed for adoption. For clarity, "IAIABC" is spelled out to reflect the organization's complete name - the International Association of Industrial Accident Boards and Commissions.
- 2.1 The compliance date is modified to specify exactly 18 months after adoption, and the year 2012 is inserted to replace 2011. This will provide the public with more certainty about the anticipated effective date.
- 2.1.3 A typographical error in the reference to the appendix which contains the Security Rule is corrected.
- 2.2 Modified to insert the references to the updated 5010 ASC X12 transaction sets (deleting the 4010 transaction sets) and to insert references to the updated retail pharmacy NCPDP Telecommunication standard D.0 (deleting version 5.1) and Batch Standard 1.2 (deleting 1.1); Deleted one paragraph regarding acknowledgments and move substance of information, with reorganization, to the bulleted list of non-HIPAA national standards to improve clarity
- 2.2.1 Modified date to specify 2012 effective year rather than 2011, as the rulemaking will not be complete in time for 2011 effective date due to 18 month lead in time. Deleted each reference to an electronic transaction standard document incorporated by reference and insert replacement references to updated electronic transaction standard documents. This updates all of the ASC X12 documents to the 5010 standards from the 4010 standards, and updates the retail pharmacy documents to NCPDP Telecommunication standard D.0 (deleting version 5.1) and Batch Standard 1.2 (deleting 1.1). It is necessary to delete the old standards and adopt the new standards in order to prevent the workers' compensation electronic billing standards to be out of step with the national standards at the time the regulations take effect. As of January 1, 2012 the electronic standards under HIPAA rules will require use of the 5010 standards and the NCPDP Telecommunication standard version D.0 and Batch Standard 1.2. Labor Code section 4603.4 requires the Division to adopt electronic billing rules that are consistent with HIPAA to the extent feasible. The 5010 standards and the updated NCPDP standards support the use of ICD-10CM and ICD-10PCS code sets which will be HIPAA mandated codes sets as of October 2013. The Division is anticipating moving to the ICD-10 from the current ICD-9 and the use of billing standards which accommodate ICD-10 is an important feature of the billing system.

- 2.2.2 Added a new section 2.2.2 to provide information regarding the address, phone number and web address of the Washington Publishing Company to obtain the 5010 standards and the NCPDP to obtain the retail pharmacy standards.
- 2.2.3 Renumbered, previously 2.2.2. Updates the table which is a "Summary of Adopted Formats and Correlation to Paper Form."
- 2.2.4 Renumbered, previously 2.2.3. Updates the table which sets forth suggested Optional Formats.
- 2.3 Renumbered to correct error, previously 2.4. All the sections which follow in Chapter two are renumbered.
- 2.3 through 2.13.5. Revisions are made to update references to the TR3s and the NCPDP transaction sets to conform to formats adopted in 2.2.1. The sections modify the terminology for the shortened references to the transaction standards to conform to the preferences of the ASC X12 which holds the copyright to transaction standards which are called Technical Reports Type 3 (TR3s) (formerly "implementation guides.") For example, the ASC X12 specifies that the professional billing transaction standard should be referred to as "005010X222" when a shortened reference is needed, and should not be referred to as "837P." Substantive changes within 2.3 through 2.13.5 include the following:
    - 2.4.7 Document/Attachment Identification (formerly 2.5.7) deleted a paragraph regarding identification of documentation or attachments because it is duplicative of information in the TR3s, the Medical Billing and Payment Guide, and the Electronic Medical Billing and Payment Companion Guide. Added the word "encrypted" to electronic mail to conform to the requirement that email be encrypted in the Medical Billing and Payment Guide. Also deletes a paragraph which is obsolete as it references the 4010 standard, and has broad and vague language that is not helpful.
    - 2.6.1 Hierarchical Structure (formerly 2.6.1) deleted the substantive information about the hierarchical structure of the transaction sets but retains the reference to the ASC X12N's TR3s. This is done to avoid duplication of material in the TR3s that are incorporated by reference, and to avoid ambiguity that can result from truncating the technical hierarchal information.
    - 2.11.1 (formerly 2.12.1) added updated reference to identify the segments to be used for the professional and dental NUBC Condition Codes for a resubmission to conform with the updated 5010 billing transaction standards.
    - 2.11.2 (formerly 2.12.2) added updated reference to identify segments to be used for indicating a duplicate billing for professional billing and dental billing to conform with the updated 5010 billing transaction standards.
    - 2.11.3 (formerly 2.12.3) deleted a paragraph that is confusing in part, and duplicative in part.
    - 2.14.4 FEIN/NPI. The entire section is deleted as it is duplicative of instructions contained in the TR3s and NCPDP guides.
- Chapter 3 Introductory paragraph modified the references to the professional billing transaction standard to update to the 5010 standard adopted in Section 2.2.1. Also, to improve clarity: 1) the last sentence which states that California rules prevail where national standards differ from California rules is deleted, and 2) language is added to explain that the Companion guide is a supplement to the ASC X12 guide where specialized workers' compensation direction is needed.
- 3.1 Updated the reference to the professional billing standard to the 005010X222.
- 3.2 Updated the terminology to TR3, deleting "implementation guide."
- 3.3 Updated the reference to the professional billing standard to the 005010X222.

- 3.3.1 Deleted the entire chart that sets forth specialized California workers' compensation instructions for the 4010 professional billing transaction standard. Inserted an updated chart that sets forth specialized California workers' compensation instructions for the 5010 professional billing transaction standard. The new chart is necessary to provide instructions for using the national standard, HIPAA-compliant, 005010X222 for workers' compensation.
- Chapter 4, Introductory paragraph modified the references to the institutional billing transaction standard to update to the 5010 standard adopted in Section 2.2.1. Also, to improve clarity: 1) the last sentence which states that California rules prevail where national standards differ from California rules is deleted, and 2) language is added to explain that the Companion guide is a supplement to the ASC X12 guide where specialized workers' compensation direction is needed.
- 4.1 Updated the reference to the institutional billing standard to the 005010X223.
- 4.3 Updated the reference to the institutional billing standard to the 005010X223.
- 4.3.1 Deleted the entire chart that sets forth specialized California workers' compensation instructions for the 4010 institutional billing transaction standard. Inserts an updated chart that sets forth specialized California workers' compensation instructions for the 5010 institutional billing transaction standard. The new chart is necessary to provide instructions for using the national standard, HIPAA-compliant, 005010X223 for workers' compensation.
- Chapter 5, Introductory paragraph modified the references to the dental billing transaction standard to update to the 5010 standard adopted in Section 2.2.1. Also, to improve clarity: 1) the last sentence which states that California rules prevail where national standards differ from California rules is deleted, and 2) language is added to explain that the Companion guide is a supplement to the ASC X12 guide where specialized workers' compensation direction is needed.
- 5.1 Updated the reference to the institutional billing standard to the 005010X224.
- 5.3 Updated the reference to the institutional billing standard to the 005010X224.
- 5.3.1 Deleted the entire chart that sets forth specialized California workers' compensation instructions for the 4010 dental billing transaction standard. Inserts an updated chart that sets forth specialized California workers' compensation instructions for the 5010 dental billing transaction standard. The new chart is necessary to provide instructions for using the national standard, HIPAA-compliant, 005010X224 for workers' compensation.
- Chapter 6 introduction, and 6.1-6.10.1 updated references to the *NCPDP Telecommunication Standard Implementation Guide Version* D.0 (instead of version 5.1) and the *NCPDP Batch Standard Implementation Guide Version 1.2* (instead of 1.1) to conform to the updated transaction standards adopted in 2.2.1. Substantive changes within the chapter include:
    - 6.4 Billing Date. Change the reference to "electronically submitted pharmacy bills" rather than "electronically submitted pharmacy claims" for clarity since the word "bills" is more common in workers' compensation.
- 6.10.1 Deleted the entire chart that sets forth specialized California workers' compensation instructions for the NCPDP Telecommunication Standard Implementation Guide Version 5.1. Inserts an updated chart that sets forth specialized California workers' compensation instructions for the NCPDP Telecommunication Standard Implementation Guide Version D.0. The new chart is necessary to provide instructions for using the national standard, HIPAA-compliant, NCPDP Version D.0 for workers' compensation.
- 6.11 Deleted the entire section designating the ASC X12N 004010A1 as the Alternate Pharmacy Billing Format for several reasons. The 4010 transaction standard is no longer suggested for use as it will be superseded by the 5010 standard. In addition, the NCPDP D.0 has made many improvements over the NCPDP 5.1 and should accommodate users efficiently. In addition, the

billing rules allow trading partners to agree on alternate formats, so inserting language to that effect in Chapter 6 is duplicative and unnecessary.

- Chapter 7, Introductory paragraph modified the references to the payment/advice transaction standard to update to the 5010 ASC X12N/005010X221 standard adopted in Section 2.2.1. Also, to improve clarity: 1) the last sentence which states that California rules prevail where national standards differ from California rules is deleted, and 2) language is added to explain that the Companion guide is a supplement to the ASC X12 guide where specialized workers' compensation direction is needed.
- 7.1 through 7.8.1 2.3. Revisions are made to update references to the 5010 ASC X12N/005010X221, deleting references to the 4010 standard.
- 7.4.1 Claim Adjustment Reason Code. A new section is inserted to give more detailed instruction for using CARCs 191, 214, 221 and W1 for the payor to communicate the statutory basis for denial of a claim or reduction at the line level. These instructions are necessary adaptations of the national standards for the workers' compensation situation.
- 7.8.1 Deleted the entire chart that sets forth specialized California workers' compensation instructions for the 4010 payment/advice transaction standard. Inserts an updated chart that sets forth specialized California workers' compensation instructions for the 5010 payment/advice transaction standard. The new chart is necessary to provide instructions for using the national standard, HIPAA-compliant, 005010X221 for workers' compensation.
- Chapter 8 Revisions are made to update references to the ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) and to delete references to the 4010 version of 275.
- Chapter 9 Acknowledgments. A new introductory paragraph is inserted to provide greater clarity by cross-referencing to Chapter 7 of the Medical Billing and Payment Guide which sets forth time frames for acknowledgments, payment, and remittance advice and for placing bills in a "pending status."
- Chapter 9. Revisions are made to update references to the 5010 ASC X12C/005010X231 Implementation Acknowledgment (999) and the ASC X12N/005010X214 Health Care Claim Acknowledgment (277), deleting references to the 4010 Functional Acknowledgment (997) and the 4010 Health Care Claim Acknowledgment (277). References to the other transaction standards are also updated to the 5010 standards throughout the chapter. Also, spelling is changed from "Acknowledgement" to "Acknowledgment" to conform to the spelling used in the ASC X12 standards.
- 9.1 Clean Bill Acknowledgment Flow and Timing Diagrams and 9.2 Clean Bill-Missing Claim Number Pre-Adjudication Hold (Pending) Status. Deleted the prior flow charts and inserts new flow charts that update the references to the new transaction standards.
- Chapter 9, 9.4.3 Health Care Claim Acknowledgment. Revision is made to add a sentence clarifying that the word "claim" refers to the bill for medical services or goods, not the injured worker's claim for workers' compensation benefits. This clarifying language is needed because in the workers' compensation context, the word "claim" is often interpreted to be the underlying workers' compensation claim.
- Appendix A – Glossary of Terms. Revisions are made to update the references to the transaction standards. "UCF" is deleted as it is a pharmaceutical paper form that is no longer used for workers' compensation billing, and "NCPDP WC/PC UCF" is inserted as it is the paper billing form created by the National Council for Prescription Drug Programs for workers' compensation which is proposed for adoption.

- Appendix E Electronic and Digital Signature. This section is deleted as it is unnecessary. There is no legal requirement for the electronic bills to be signed. In addition, although an electronic signature rule was proposed for HIPAA implementation, a final rule has never been adopted.

Modifications to section 9792.5.1 subdivision (c)

The address to obtain the HIPAA approved Technical Reports Type 3 is updated and reformatted for clarity. The term "implementation guide" is changed to "Technical Report Type 3" since this is the term used by the Accredited Standards Committee X12N for the 5010 technical guides. Specifically, this section is modified to propose the following electronic billing standards:

ASC X12N/005010X222 Health Care Claim: Professional (837)
ASC X12N/005010X222E1 Health Care Claim: Professional Errata (837)
ASC X12N/005010X223 Health Care Claim: Institutional (837)
ASC X12N/005010X223A1 Health Care Claim: Institutional Errata (837)
ASC X12N/005010X223E1 Health Care Claim: Institutional Errata (837)
ASC X12N/005010X224 Health Care Claim: Dental (837)
ASC X12N/005010X224A1 Health Care Claim: Dental Errata (837)
ASC X12N/005010X224E1 Health Care Claim: Dental Errata (837)

The previously proposed 4010 implementation guides will be out of date by the time the regulation is effective; the 5010 guides will be the mandated billing transaction standards for HIPAA-covered entities effective January 1, 2012. Adoption of these standards carries out the statutory directive that the electronic standards be consistent with HIPAA to the extent feasible.

Modifications to section 9792.5.1 subdivision (d)

This section is modified to propose adoption of updated retail pharmacy billing standards, and to delete the former pharmacy billing standards. The new standards proposed for adoption are:

Telecommunication Standard Implementation Guide Version D.0, August 2007, National Council for Prescription Drug Programs
Batch Standard Implementation Guide, Version 1.2, January 2006, National Council for Prescription Drug Programs

The previously proposed pharmacy billing standards will be out of date by the time the regulation is effective; the newly proposed pharmacy standards will be the mandated billing transaction standards for HIPAA-covered entities effective January 1, 2012. Adoption of these standards carries out the statutory directive that the electronic standards be consistent with HIPAA to the extent feasible.

Modifications to section 9792.5.1 subdivision (e)

The address to obtain the HIPAA approved Technical Reports Type 3 for acknowledgment and payment/advice is updated and reformatted for clarity. The term "implementation guide" is changed to "Technical Report Type 3" since this is the term used by the Accredited Standards Committee X12N for the 5010 technical guides. Specifically, this section is modified to propose the following electronic billing standards:
ASC X12C/0050X231 Implementation Acknowledgment for Health Care Insurance (999)

ASC X12N/0050X214 Health Care Claim Acknowledgment (277)
ASC X12N/005010X221 Health Care Claim Payment/Advice (835)
ASC X12N/005010X221E1 Health Care Claim Payment/Advice Errata (835)

The previously proposed 4010 implementation guides will be out of date by the time the regulation is effective; the 5010 guides will be the mandated billing transaction standards for HIPAA-covered entities effective January 1, 2012. Adoption of these standards carries out the statutory directive that the electronic standards be consistent with HIPAA to the extent feasible.

Modifications to section 9792.5.1 subdivision (f)

Subdivision (f) is modified to adopt the recently updated *National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version*, Version 6.0 07/10. The July 2010 version replaces the July 2009 version as the previously proposed version is outdated.

Modifications to section 9792.5.1 subdivision (g)

Subdivision (f) is modified to update the National Uniform Billing Committee Official UB-04 Data Specifications Manual from the Version 4.0 dated July 2009 to the Version 5.0 dated July 2010. This modification is necessary as the previously proposed version is outdated.

Modifications to section 9792.5.1 subdivision (i)

Subdivision (i) is modified to update the Current Dental Terminology procedure codes and manual from the 2009/2010 version to the 2011-2012 version.

Modifications to section 9792.5.2

Subdivisions (a), (c): Delete the term "physician" as it is redundant since physicians are already included in the definition of "health care provider" set forth in section 9792.5.0.

Subdivision (a) will substitute the term "billing form" for "claim form" to improve clarity since "claim form" often has a specialized meaning in workers' compensation and may be confusing.

Subdivisions (a) and (b) are modified to remove the word "approximately" so that the parenthetical indicates the subdivision will be effective 90 days after adoption of the rule. A specification of exactly 90 days will be adequate implementation time and provides greater clarity for the public. The placeholder date is updated to 2011 since the regulation will not be effective in 2010.

Subdivision (c) is modified to remove the word "approximately" so that the parenthetical indicates the subdivision will be effective 18 months after adoption of the rule. A specification of exactly 18 months will be adequate implementation time and provides greater clarity for the public. The placeholder date is updated to 2012 since the regulation will not be effective in 2011.

Modifications to section 9792.5.3

Subdivisions (a) and (b) are modified to remove the word “approximately” so that the parenthetical indicates the subdivision will be effective 90 days after adoption of the rule, except for provisions relating to payment of electronic medical bills which bill become effective 18 months after the effective date of the regulation. The placeholder dates are updated to 2011 and 2012. A specification of exactly 90 for complying with the Medical Billing and Payment Guide and 18 months for compliance with the Electronic Medical Billing and Payment Companion Guide will be adequate implementation time and provides greater clarity for the public.