California Workers' Compensation Institute
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VIA E-MAIL: dwcrules@dir.ca.gov

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

RE: 1st 15-Day Comment Period -- modifications to proposed regulations on medical billing standards and electronic billing

Dear Ms. Gray:

This written testimony on modifications to proposed regulations for medical billing standards and electronic billing is presented on behalf of the California Workers' Compensation Institute's members. Institute members include insurers writing 80% of California's workers' compensation premium, and self-insured employers with $36B of annual payroll (20% of the state's total annual self-insured payroll).

The Institute appreciates the Division's modifications to the proposed regulations that were recommended in the Institute's written testimony. Other changes to section 9792.5 and related sections have recently been drafted and vetted in the DWC Forum. The Institute urges the Division to address all such changes in a single rulemaking to avoid the confusion, disruption and unnecessary expense of adopting them piecemeal.

Recommended additional modifications are indicated by underline and ~~strikethrough~~. Some recommendations and discussion are stated once but apply to more than one section of the proposed regulations and both the Guides.

Article 5.5. Application of the Official Medical Fee Schedule

California Division of Workers' Compensation
Medical Billing and Payment Guide 2011

Recommendation – 3.0 Complete Bills

(b) All required reports and supporting documentation must be submitted together with the billing as follows:

(10) Supporting documentation ~~should be~~ sufficient to support the level of service or code that has been billed.

(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~~.

Discussion

The following complete bill condition (4) has been added to 3.0(a) (previously 3.0(b)):

"(4) A complete bill includes required reports and supporting documentation specified in subdivision (b)."

Because of this modification, it is necessary to comment on (10) in subdivision 3.0(b) (previously 3.0(c)) that addresses "supporting documentation" in its second sentence. The two sentences currently in (10) address two disparate conditions:

"(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."

These two sentences need to be separately listed. This is a minor error that appears to have been inadvertently overlooked. It can be corrected by dividing (10) into two separate items. Reversing the order in which the sentences are listed provides a more logical flow.

The billing medical provider will generally select appropriate documentation from the medical file to support billed codes, but since the list does not specify all conceivable circumstances, additional supporting documentation will sometimes be necessary. Under the current language, additional information may be requested only prior to submission of a billing, precluding claims administrators from reasonably requesting additional information to support a previously submitted billing. This is illogical because only if the submitted documentation is inadequate is additional information needed. The language needs to be modified so that claims administrators may request appropriate additional documentation after receiving an unsupported billing.

Further, when no request for authorization is prospectively submitted, the claims administrator or its agent is not aware of the provision of services or goods until receiving a bill, and therefore does not have the opportunity to request additional information prior to its submission. A claims administrator must be permitted to reasonably request appropriate additional information after receiving a billing. A billing provider, billing agent or assignee should not be rewarded for failing to request authorization or failing to submit appropriate supporting documentation. Allowing them to submit medical bills secure in the knowledge that they are not required to submit other necessary supporting documentation increases the potential for fraud and abuse.

7.1 Timeframes
Recommendation – (a) Acknowledgements
(a)(3) (A) ASC X12N 277 005010X214 Claim Pending Status Information

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

Discussion
The payment timeframe is 15 working days, not 15 days. This appears to be an inadvertent typographical error that can be easily corrected. If not corrected, the timeframes will be inconsistent with Labor Code section 4603.4(a)(d) that specifies a timeframe of 15 working days. Likewise, the pending period in the last sentence that is described as five days also appears to be an inadvertent typographical error. The pending period is specified to be five working days in the first two sentences. For consistency, and to avoid confusion and dispute the language in the last sentence needs to be corrected to "five working-day period."

Appendix A. Standard Paper Forms

Recommendation – CMS 1500 paper field 14
In the comment column of paper field 14, and elsewhere in the regulation and Guides, modify the instruction as follows:

> For Specific Injury: Enter the date of incident or exposure.
> For Cumulative Injury or Occupational Disease: Enter ~~either: 1) the last date of occupational exposure to the hazards of the occupational disease or cumulative injury or 2)~~ the date that the employee first suffered disability from cumulative injury or occupational disease and knew (or should have known) that the disability was caused by the employment.

Discussion
To be useful, the date entered and captured for a cumulative trauma injury must be consistently determined and reported. The recommended language is consistent with Labor Code section 5412 which 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 caused by his present or prior employment."

Recommendation – CMS 1500 paper field 16
In paper field 16, retain the "N" (not applicable) requirement and retain the proposed instruction.

Discussion
If the dates the patient is unable to work are reported on this form, the unintended consequence is that it may be classified as a medical report. Unlike medical bills, medical reports are subject to file and serve requirements. Filing and serving medical bills would add unnecessary administrative burdens and costs. In addition, it is not clear how electronically submitted billings can be properly filed and served.

Recommendation – CMS 1500 paper field 31
The Institute recommends retaining the "R" (required) status for signature in paper field 31.

Discussion
It is much more difficult to prove and prevent medical fraud and abuse without the signature. If the "R" (required) status for signatures is retained, perpetrators of billing abuse and billing fraud can be appropriately prosecuted and such activities will be deterred.

Recommendation – ADA 2006
Restore "R" (required) status that appears to have been inadvertently deleted when the "Phone Number" sub-field was deleted. A status is necessary for the remaining sub-fields.

Appendix B. Standard Explanations of Review

Recommendation – 3.0 Field Table Standard EORs – Bill Level Adjustments
Delete the term "Field" and "Fields" from the table.

The Division is not proposing to adopt a specific paper EOR form, however the term "Field" and "Fields" in the table implies specific location(s) on a form. Deleting these terms will avoid confusion.

Section Two – Transmission Standards

4.0 Electronic Signature
Recommendation – Electronic Signature
Retain the proposed language.

Discussion
It is important that medical bills are signed so that perpetrators of billing abuse and billing fraud can be appropriately prosecuted and to deter such activities. Electronic signature is supported by Government codes and regulations and should be addressed here to provide an alternative to a "wet" signature on medical billings.

California Division of Workers' Compensation
Electronic Medical Billing & Payment Companion Guide Version 1.0 2012

Chapter 6 Companion Guide Pharmacy

Recommendation – 9.4.3 ASC X12N/005010X214 Health Care Claim Acknowledgement
Replace "the most current claim status category and claims status codes" with the specific categories and status codes to be used, or with information on how to locate the categories and status codes already in effect on a specified date.

Discussion
The Division is precluded from adopting standards under another entity's control without following the rulemaking procedures in the Administrative Procedure Act and in the regulations adopted by the Office of Administrative Law.

Thank you for considering these comments. Please contact me for further clarification or if I can be of any other assistance.

Sincerely,

Brenda Ramirez
Claims and Medical Director

BR/pm

cc: Carrie Nevans, DWC Acting Administrative Director
Destie Overpeck, DWC Chief Counsel
Jacqueline Schauer, DWC Attorney
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Regular Members
CWCI Associate Members
CWCI Legal Committee