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

NOTICE OF FURTHER 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 further 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 proposed sufficiently related modifications to the text (and to the billing guide documents incorporated by reference) of the proposed regulations and a 15-day comment period was held, which closed on January 28, 2011. After consideration of the comments received, further modifications are proposed to the following 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 [180 days after effective date of regulation] [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 Wednesday, February 16, 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:

- ASC X12N/005010X222A1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Professional (837)
  June 2010

- ASC X12N/005010X223A2
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Institutional (837)
  June 2010

- ASC X12N/005010X224A2
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Dental (837)
  June 2010

- ASC X12C/005010X231A1
  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 2010

- ASC X12N/005010X214 E1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Acknowledgment (277)
  April 2008

- ASC X12N/005010X214 E2
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Acknowledgment (277)
  January 2009

- ASC X12N/005010X221A1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Payment/Advice (835)
  June 2010

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: added language.

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.

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

Text proposed during 2nd 15-Day Comment Period to be added is displayed in grey shaded double underscore type.
Text proposed during 2nd 15-Day Comment Period to be deleted is displayed in grey shaded double strikeout type: ~~deletion~~.

SUMMARY OF MODIFICATIONS TO PROPOSED TEXT

Modifications to section 9792.5

The introductory sentence is modified to specify that the section is applicable to medical treatment rendered before a date that is exactly 180 days after the effective date of the regulation, rather than 90 days.

Modifications to Heading for Article 5.5.0

The heading is modified to specify that the Article is effective for medical treatment billing and payment on or after a date that is 180 days after the effective date of the regulation rather than 90 days.

Modifications to section 9792.5.1 subdivision (a)

Modifications are made to the *California Division of Workers' Compensation Medical Billing and Payment Guide* which is incorporated by reference into the section. Modifications include the following:

- The Introduction is modified to provide that the rules for paper medical treatment billing will be effective for bills submitted 180 days after the adoption of the regulation rather than 90 days.
- 2.0 Standardized Medical Treatment Billing Format subdivision (a) is modified to provide that the rules for paper medical treatment billing will be effective for bills submitted 180 days after the adoption of the regulation rather than 90 days. 2.0 subdivision (b) is modified to add language clarifying that parties may engage in electronic billing and remittance prior to the effective date of the regulation upon mutual agreement.
- 3.0 Complete Bills subdivision (b) is modified to add clarifying language that the required reports and supporting documentation are to be "sufficient to support the level of service or code that has been billed". This language is moved up from subdivision (b)(10) to improve accuracy and clarity. Subdivision (b)(10) has language added to clarify that the claims administrator may request appropriate additional information after the bill is received, and not only prior to receipt of the bill.
- 7.1 Timeframes subdivision (a)(3)(A)(i) is modified to delete language allowing a claims administrator to reject a bill as incomplete if it has previously provided the claims number to the provider and the bill does not have the claim number. The subdivision is also modified to specify that the timeframe for payment is 15 "working" days, and the pending period is 5 "working" days. Subdivision (a)(3)(A)(i) is also modified to provide that the claims administrator may reject a bill as incomplete if it is unable to locate and affix a claim number to a bill within the five working day pending period.
- 7.3 Electronic Bill Attachments subdivision (a) is revised to say that "Unless otherwise agreed by the parties" all attachments to support an electronically submitted bill must have a header or attached cover sheet as provided.
- Section One, Appendix A, 1.1 Field Table CMS 1500, Field 11 is modified to delete the provision that only a first billing by the provider could enter the value of "unknown" for the claim number field. Field 12 is modified to provide that Patient's or Authorized Person's Signature is Optional rather than Required. Field 14 is modified to delete the alternative dates of cumulative injury by deleting the second description: 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.
- Section One, Appendix A, 2.1 Field Table UB-04, Form Loc 31-34a,b is modified to delete the alternative dates of cumulative injury by deleting the second description: 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.
- Section One, Appendix A, 3.1 Field Table NCPDP, Field 11 is modified to delete the alternative dates of cumulative injury by deleting the second description: 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.
- Section One, Appendix A, 4.0 ADA 2006 is modified to specify the updated dental coding manual, the CDT 2011-2012: ADA Practical Guide to Dental Procedure Codes, including the ADA 2006 Dental Claim Form, and delete reference to the Current Dental Terminology Fourth

Edition (CDT-4) 2009/2010. This updated Guide was included in the text of regulations in the 1st 15-day comment period and was also listed in the 1st 15-day Notice of Modification of proposal as a document added to the rulemaking file and available for public comment. However, through oversight the text of Section One, Appendix A was not modified during the 1st 15-day comment period. The correction is being made now, and the document is once again available for public inspection in the rulemaking file during this 2nd 15-day comment period.

- Section One, Appendix A, 4.0 ADA 2006, Field 46 is modified to delete the alternative dates of cumulative injury by deleting the second description: 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. Field 48 billing dentist or dental entity field is modified to restore the "R" that was inadvertently deleted from the table.
- Appendix B Standard Explanation of Review is modified to allow a claims administrator to include additional messages and data in order to provide further detail to the provider in a paper Explanation of Review.
- Appendix B, 3.0 Field Table for Paper Explanation of Review is modified to delete the word "field" from the title of the table and from the first and third column headers. First column is renamed "Data Item No." Some rows have been deleted because they did not contain data requirements and the items have been renumbered.
- Section Two – Transmission Standards, Sections 2.1 and 2.2 have been modified to add references to the errata and addenda to ASC X12N/005010 Technical Reports Type 3 for 837 Professional, 837 Institutional, 837 Dental, 835 Payment/Remittance Advice, 999 Implementation Acknowledgment, and 277 Health Care Claim Acknowledgment.

Modifications to section 9792.5.1 subdivision (b)

Modifications are made to the *California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide*, dated 2012, which is incorporated by reference into the section. Modifications include the following:

- The first page is modified by titling it "Preface" and an entry is added to the Table of Contents. Information is inserted to acknowledge the copyrights held by the Data Interchange Standards Association on behalf of the ASC X12 committee and the National Council on Prescription Drug programs respectively. The ASC X12's copyrighted guides are set forth by name, with an indication of the shortened titles of each guide. The NCPDP's copyrighted electronic billing guides are set forth by name.
- A Change Control Table template and explanatory language is proposed to alert the public to changes in the Companion Guide over time. Information is set forth regarding the method of changing the Companion Guide, including the fact that changes will be accomplished through formal rulemaking under the Administrative Procedure Act.
- Section 1.2 California Labor Code §4603.4 is modified to delete language that stated "Wherever there is a difference between the national standard and this guide, the rules from this guide will prevail." The section is also modified for clarity to spell out the acronym "IAIABC" – International Association of Industrial Accident Boards and Commissions.
- 2.1.3 Confidentiality of Medical Information is modified to make grammatical corrections and to correct the reference to the Security Rule which is in Appendix D, not Appendix E.
- 2.2 National Standard Formats is modified to correct the references to the titles of the ASC X12 electronic billing standards. In addition the language is changed to refer to billing and remittance standard *specified* by federal regulations rather than "contained in" federal regulations.

- 2.2.1 California Prescribed and Optional Formats is modified to incorporate by reference the errata and addenda to ASC X12N/005010 Technical Reports Type 3 for 837 Professional, 837 Institutional, 837 Dental, 835 Payment/Remittance Advice, 999 Implementation Acknowledgment, and 277 Health Care Claim Acknowledgment. These documents are available for public review and comment as described above.
- 2.2.2 Source of Prescribed Formats is modified to reference the Technical Report Type 3 documents which are used in the 5010 formats instead of the "implementation guides" which were used in the 4010 formats. The words "ASC X12" are added for clarity.
- 2.3 Companion Guide Usage is modified to spell out "Technical Report Type 3" in place of "TR3s."
- 2.4.4 Injured Employee Identification is modified to specify that the Social Security Identification Number is to be populated in the REF segment of Loop 2010 CA rather than in the NM109 segment of Loop 2010BA. This is the result of changes made in the usage by the 5010 errata that have been issued.
- 2.4.5 Claim Identification is modified to spell out "Technical Report Type 3" in place of "TR3s."
- 2.4.7 is modified to specify that documentation must be submitted within five *working* days of submission of the electronic medical bill.
- 2.6.1 and 2.7 are modified to spell out "Technical Report Type 3" in place of "TR3s."
- 2.8 Description of Code Sets is modified to update the reference to the dental codes to those contained in CDT 2011-2012: ADA Practical Guide to Dental Procedure Codes.
- 2.12 Balance Forward Billing is modified to specify that a "balance forward bill" is also a "summary of accumulated unpaid balances."
- 2.13.2 Transaction Set Purpose Code replaces the term "insurance carriers" with the term "claims administrators."
- Chapter 3 is modified to spell out "Technical Report Type 3" in place of "TR3s."
- 3.1 Reference Information is modified to more fully identify the 005010X222 by adding the words "Health Care Claim: Professional (837)."
- 3.3.1 ASC X12N/005010X222 Health Care Claim: Professional (837) is modified to:
    - Alter the workers' compensation instruction for Loop 2010CA in the REF segment by changing the workers' compensation claim number from Required to Situational, with a parenthetical explanation that the Situational data element is required if known. The language which required only a first bill submitted by a provider to be pended for five days has been deleted. The word "working" has been added to clarify that the 5-day pending period is five *working* days.
    - Alter the workers' compensation instruction for Loop 2300 segment DTP Accident Date to delete the alternative dates of cumulative injury by deleting the second description: "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."
- Chapter 4 is modified to spell out "Technical Report Type 3" in place of "TR3s."
- 4.1 Reference Information is modified to more fully identify the 005010X223 by adding the words "Health Care Claim: Institutional (837)."
- 4.3.1 ASC X12N/005010X223 Health Care Claim: Institutional (837) is modified to:
    - Alter the workers' compensation instruction for Loop 2010CA in the REF segment by changing the workers' compensation claim number from Required to Situational, with a parenthetical explanation that the Situational data element is required if known. The language which required only a first bill submitted by a provider to be pended for five

days has been deleted. The word "working" has been added to clarify that the 5-day pending period is five *working* days.
    - Alter the workers' compensation instruction for Loop 2300 segment DTP Accident Date to delete the alternative dates of cumulative injury by deleting the second description: "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."
- Chapter 5 is modified to spell out "Technical Report Type 3" in place of "TR3s."
- 5.1 Reference Information is modified to more fully identify the 005010X224 by adding the words "Health Care Claim: Dental (837)."
- 5.3.1 ASC X12N/005010X224 Health Care Claim: Dental (837) is modified to:
    - Alter the workers' compensation instruction for Loop 2010CA in the REF segment by changing the workers' compensation claim number from Required to Situational, with a parenthetical explanation that the Situational data element is required if known. The language which required only a first bill submitted by a provider to be pended for five days has been deleted. The word "working" has been added to clarify that the 5-day pending period is five *working* days.
    - Alter the workers' compensation instruction for Loop 2300 segment DTP Accident Date to delete the alternative dates of cumulative injury by deleting the second description: "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."
- 6.4 Billing Date is modified to make a technical correction by deleting "Claim Segment of the" in referring to the location to communicate the date.
- 6.6 Fill Number v. Number of Fills Remaining is modified to delete an erroneous statement regarding derivation of the number of refills remaining.
- 6.10.1 NCPDP Telecommunication Standard Implementation Guide D.0 is modified for Field 435-DZ to specify that the claim number is a situational data element – required only if known by the provider. Language is added to require a bill missing a claim number to be placed in pending status for up to 5 working days to attach the claim number.
- Chapter 7 is modified to spell out "Technical Report Type 3" in place of "TR3s."
- 7.1 Reference Information is modified to more fully identify the 005010X221 by adding the words "Health Care Claim" and "(835)."
- 7.5 Remittance Advice Remark Codes is modified to correct name of the matrix in Appendix B – 1.0.
- Chapter 8 is modified to delete unnecessary language "Documentation/Medical Attachment" from the chapter title. Chapter 8 is modified to spell out "Technical Report Type 3" in place of "TR3s."
- 9.2 Clean Bill-Missing Claim Number is modified to clarify that the 5-day pending period is five *working* days. The section is also modified to delete language allowing a claims administrator to reject a bill as incomplete if it has previously provided the claim number to the provider and the bill does not have the claim number.
- 9.3 Clean Bill-Missing Report Pre-Adjudication Hold(Pending Status) and 9.3.1 Missing Report are modified to clarify that the 5-day pending period is five *working* days.
- 9.4.3 ASC X12N/005010214 Health Care Claim Acknowledgment (277) is modified to state that payors need to use the claim status category and claims status codes as prescribed by the 005010X214 rather than the "most current" codes.

Modifications to section 9792.5.1 subdivision (c)

The section is modified to add references to the errata and addenda to ASC X12N/005010 Technical Reports Type 3 for 837 Professional, 837 Institutional, 837 Dental, 835 Payment/Remittance Advice, 999 Implementation Acknowledgment, and 277 Health Care Claim Acknowledgment.

Modifications to section 9792.5.2 subdivisions (a) and (c)

The sections are modified to specify that the date for compliance with paper medical treatment billing rules is 180 days after the effective date of the regulation rather than 90 days. This will allow sufficient time for implementation.

Modifications to section 9792.5.3 subdivision (a)

The section is modified to specify that the date for compliance with bill processing and remittance for paper medical treatment billing is 180 days after the effective date of the regulation rather than 90 days. This will allow sufficient time for implementation.

The section is also modified to specify that the subdivision does not apply to processing or payment of bills submitted before the effective date of the regulation. This is intended to clarify the applicability of the regulations.