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Electronic Medical Billing & Payment Companion Guide Chapter 9, Section 9.2	Commenter references the following sentence which appears on page 48: "Once the claim number has been provided to the bill submitter, subsequent bill submissions are not subject to the pre-adjudication hold status and may be denied for being incomplete due to lack of the claim number." Commenter opines that while it seems reasonable to expect a bill submitter to send the claim number on subsequent bill submissions, the payer will already know the claim number and that this clause allows the bill to be rejected anyway. If the payer takes steps to identify the bill is for a claim that was previously responded to, the payer will have also determined the claim number in that process. Commenter also suggests that timing issues could arise if a bill submitter sends daily submissions for bills that pertain to the same claim. Subsequent bills could potentially be sent during the time it takes the payer to notify the bill submitter of the claim number and the time that it takes the bill submitter to update its systems.	Brendan Friar Senior Vice President WorkCompEDI, Inc. January 10, 2011 Written Comment	**Agree.** Commenter has raised two persuasive arguments against allowing the claims administrator to reject an electronic bill missing a claim number if the claims administrator is nevertheless able to match the bill to a claim. Since the purpose of submitting the claim number in electronic billing is to match the bill with a claim in the claim administrator's system, the purpose is fulfilled if the claims administrator is able to make the match in the process of determining whether it has previously sent the claim number to the provider. In addition, it does appear that a provider's second and subsequent bills could be rejected merely for lack of a claim number if they are submitted shortly after the first bill. It would be most efficient to allow subsequent bills missing a claim number to be pended for up to five days just as is done for a first bill. If the claims administrator is unable to match the bill after 5 days, it can then reject the bill. If it is able to match the bill and a claim it can move the bill into the next phase of adjudication. There will be no	Modify: Electronic Medical Billing & Payment Guide, Chapter 3, 3.3.1 ASC X12N/005010X222 Health Care Claim: Professional (837) change workers' compensation instruction for Loop 2010CA REF for Property and Casualty Claim Number to Situational rather than required, and explain that situational becomes required where the claim number is known by the provider. Make same change to table 4.3.1 ASC X12N/005010X223 Health Care Claim: Institutional (837), 5.3.1 ASC X12N/005010X224 Health Care Claim: Dental (837) and 6.10.1 NCPDP Telecommunication Standard

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			incentive for providers to purposely omit the claim number if they have the number as it will delay processing of the bill for up to 5 days.	Implementation Guide D.0. 9.2 to eliminate the last sentence of first paragraph which allowed automatic rejection of a bill missing a claim number after the provider was notified of the claim number.
9792.5.3(a) and (b) Recommendation on extending effective date of proposed regulations	Commenter's main concern with pending regulations is the short time frame for implementation upon final adoption of rules. Commenter notes that paper billing requirements in the proposed regulations are set to take effect within 90 days from date of final adoption. Commenter remains significantly concerned that this time frame is extremely short and does not provide marketplace stakeholders enough time to fully comply. As a provider, coordinator and biller of pharmacy and other medical services and products, commenter's organization estimates that required system enhancements to reach full compliance (with transition from limited regulatory billing requirements	Kevin C. Tribout Director of Government Affairs PMSI January 11, 2011 Written Comment	**Agree.** It is reasonable to extend the time frame for compliance with paper billing / remittance to 180 days. Commenter has illustrated the need for a longer implementation period for some entities that have a large number of clients and that use proprietary billing formats.	Modify the Text of the regulation 9792.5 Article 5.5.0 heading 9792.5.2(a), (b) 9792.5.3(a) Modify the Medical Billing and Payment Guide, page 3, page 7,

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	and no forms, to established billing forms and billing requirements) will take well beyond the prescribed 90 days implementation period Simple programming, transitioning of systems and revision of billing and payment protocols to conform to new requirements, not to mention programming required to adjust for utilization of new forms, is very time consuming. Commenter's organization currently engages in proprietary billing formats with well over 100+ California based and national clients, and knows first-hand 90 days is not enough time to properly adjust each and every billing format. Commenter suggests the Department extend the billing compliance time frame from the current 90 days post implementation to 180 days.			
Electronic Medical Billing & Payment Companion Guide Chapter 9, Section 9.2	Commenter has previously stated the requirement of a claim number is an unreasonable expectation, especially for claims that are early in their claim life cycle (ER, primary care). Commenter appreciates the inclusion of the "provider's first billing" clause, however, it really needs to state "not	Greg M. Gilbert Senior Vice President Reimbursement & Government Relations Concentra, Inc. January 21, 2011 Written Comment	**Agree in part.** The Division agrees that the provisions relating to the claim number should be modified, however disagrees that the rule should state that the number is "not required until the employer reports the claim to the payer." The medical provider will not be able to provide the	Modify Modify 9.2 to delete language that restricts the five-day "hold" to first bills. Modify Medical Billing and Payment Guide 7.1(a)(3)(A)(i) to delete

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	required until the employer reports the claim to the payer" Since the payer will know this sooner than anyone else, doesn't this make sense to have them control this process and not the provider? Commenter opines that it appears that even if it is a "first claim" billing, the payer will hold the bill, waiting on the claim number and if it is not received after a certain time frame it will be returned? There are many cases in which the employer never communicates with the payer that a worker's compensation claim has taken place and thus a claim number will never be established. What is the providers' recourse in this case? Chasing down the employer to report the claim? Is this not the responsibility of the payer?		claim number on an 837 submission until it has been provided with the claim number. There may be more than one bill submitted before the claims administrator notifies the medical provider of the claim number. The Division recognizes that it is not efficient to allow automatic rejection of the bill for a missing claim number if the claims administrator is able to match the electronic bill to a claim in its system. Therefore, all bills missing a claim number will be pended for up to five working days to match the bill with a claim.	language that allows the bill to be rejected if it is missing a claim number if the payer has already provided the claim number to the provider.
	Commenter states that it is well known that the sooner a payer becomes aware of a Workers' Compensation claim the sooner they can become involved in managing that claim. Why would the DWC promulgate a rule that encourages the payer, after the first billing, to ignore claims that have not been reported by		The Division agrees that early notification to the claims administrator of a claim is important. Moreover, it is the legal duty of the employer to report the claim promptly. Although it may be a "best practice" for a claims administrator to implement a	None.

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	the employer? Commenter relates that when Hartford began e-billing in California with his organization in late 1999, they took all claims into their system and performed "Reverse Telephone Claims" on those claims that did not have a claim reported yet by the employer. They then called the employer and asked why the claim had not been reported yet. They already knew the value of early intervention into a work comp claim leads to a better overall outcome of the case. Commenter states that in Texas, they do not require the claim number as they understand the need to have all parties aware, sooner than later, of the Workers' Compensation claim. In fact, they consider a bill to be first notice to a payer of a claim and require them to set up a claim, regardless of if the employer has reported that claim yet.		"reverse telephone claims" process such as that ascribed to Hartford, it remains the employer's obligation to report the claim. The legal context in Texas is different than that in California. In Texas, there is a statute which specifically provides that an insurance carrier may be put on notice of injury by any communication to the carrier. 28 Texas Administrative Code (TAC) §124.1(a)(3) includes within the purview of "Notice of Injury" the following: "if no Employer's First Report of Injury has been filed, any other communication regardless of source, which fairly informs the carrier of the name of the injured employee, the identity of the employer, the approximate date of	None.

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	Commenter opines that the Division's regulations appear to go in the opposite direction, making the provider responsible for finding out why the employer has not filed the claim? In essence letting the payer place their "head in the sand" and remain ignorant of the claim while asking the provider to do much more than expected in a non work comp claim. All this under a fee schedule that is considered to the lowest in the nation, and well below the commercial market (especially for primary care providers). Commenter opines that primary care providers are at most risk as often these claims are medical only and the employers "chooses" to not report.		the injury and information which asserts the injury is work related." Agree in part. The Division recognizes that it is not efficient to allow automatic rejection of the bill for a missing claim number if the claims administrator is able to match the electronic bill to a claim in its system. Therefore, all bills missing a claim number will be pended for up to five working days to match the bill with a claim. **Disagree** that the Division is asking the provider to do much more than expected in a non-workers' compensation claim. When submitting a bill electronically the medical provider in any payment system must provide sufficient information to allow the payer to determine if there is coverage and benefits for the service. For example, in HIPAA-covered transactions the provider uses the ASC X12N/005010X279 Health Care Eligibility Benefit Inquiry and Response (270/271) to make "an inquiry from a health care provider to a health plan…to obtain any of the following information about a benefit plan	See above description of modifications.

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			for an enrollee…eligibility to receive health care under the health plan….coverage of health care under the health plan, benefits associated with the benefit plan." 45 CFR §162.1201, 162.1202. Although the Division disapproves of the failure of an employer to promptly report claims to the claims administrator and subsequent delays, these regulations do not address that issue. In addition, these regulations do not concern medical provider fee schedules. **Agree in part.** The Division is modifying the proposal to provide that all bills missing a claim number will be pended for up to five working days to match the bill to a claim. The claims administrator will not be allowed to reject a claim merely for a missing claim number.	See above description of modifications
Electronic Medical Billing & Payment Companion Guide Section 2.4.6	As it relates to the detailed mapping of values in the 837, commenter has encountered a concern related to how his organization currently maps the value in Loop 2300, CLM01 to Box 26 of the CMS-1500; commenter's organization is not able to supply a unique bill	Greg M. Gilbert Senior Vice President Reimbursement & Government Relations Concentra, Inc. January 21, 2011 Written Comment	**Disagree.** The Division understands the commenter's concerns, but disagrees that a change is necessary in the Medical Billing and Payment Companion Guide. The Division notes that the Accredited Standards Committee (ASC) X12	None.

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	identifier in that data element. Currently, they provide the Concentra Bill ID in Loop 2300, REF02 with a "D9" qualifier in REF01. For the 5010 implementation / California guidelines, commenter requests that the Division allow the ability to continue to provide the patient account number and Bill ID in the same positions of the 837, and have them returned in the 277 and 835 accordingly.		includes the following statement on page 158 of the ASC X12N 005010X222 regarding the CLM01, Claim Submitter's Identifier: "(t)he developers of this implementation guide strongly recommend that submitters use unique numbers for this field for each individual claim." The commenter notes that they do create a unique bill identifier, but report it in a different segment of the electronic medical bill. While it may require some automation changes, the commenter can modify their automated systems to report their unique bill identifier in the CLM01 and populate that value in the CMS-1500. The Loop 2300 REF02 is for the number assigned for Claim Identifier for Transmission Intermediaries, and is indicated by the D9 qualifier is segment REF01. (pages 202-203 of the ASC X12N 005010X222.) The Division notes that the Accredited Standards Committee (ASC) X12 is the entity responsible for the development and maintenance of the Technical Report Type 3's.	

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			The Division notes that the commenter's recommendations would require changes to the technical infrastructure of those transaction set. Accordingly, it is recommended that the commenter work with the International Association of Industrial Accident Boards and Commissions which will coordinate with the ASCX12 to consider those change considerations in future versions of the implementation guides.	
9792.5.3 (a) and (b) Recommendation on extending effective date of proposed regulations	Commenter notes that it appears the effective date for required acceptance of electronic bills will be sometime in 2012, which is 18 months after adoption of regulations. However, the effective date for standardization of paper bills will be 90 days after adoption. Commenter urges the Division to make the effective dates equal given the fact many providers systems will need to be updated with the proposed changes to the paper bills. Commenter states that 90 days is not enough time to make these changes.	Greg M. Gilbert Senior Vice President Reimbursement & Government Relations Concentra, Inc. January 21, 2011 Written Comment	**Agree in part.** The Division is persuaded that it would be beneficial to provide additional time for implementation of the paper billing / remittance rules and will extend the time from 90 to 180 days. However, there is no evidence that the paper billing / remittance changes would require 18 months to implement.	Modify the Text of the regulation 9792.5 Article 5.5.0 heading 9792.5.2(a), (b) 9792.5.3(a) Modify the Medical Billing and Payment Guide, page 3, page 7,
9792.5 – Timely payment	Commenter appreciates the change related to the increase in the penalty for nonpayment; however, he opines that	Greg M. Gilbert Senior Vice President Reimbursement &	The comment does not address the substantive changes made to the proposed regulations during	None.

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	the real issue is this payment is self-executing by the payer with no real teeth to assure compliance with the payer. Commenter states that his organization has one payer that self-executes to date; all others fail to pay the fine and the cost to pursue the fine outweighs the fine itself. Commenter recommends that the payer be penalized for not paying the fine. Payer audits will obviously have to take place to assure compliance.	Government Relations Concentra, Inc. January 21, 2011 Written Comment	the 1st 15-day comment period.	
9792.5.0 – Supporting Documentation	Commenter opines that there is a need for the Division to provide a definition of DME vesus ordinary supplies.	Greg M. Gilbert Senior Vice President Reimbursement & Government Relations Concentra, Inc. January 21, 2011 Written Comment	**Disagree.** The definitions in the text of the regulations are only those necessary for the public to understand who is subject to the regulations. Section 9792.5.0 is not a comprehensive set of definitions relating to medical billing. Moreover, the dividing line between "ordinary supplies" versus "DME" is more appropriately addressed in the Official Medical Fee Schedule rather than the billing rules. (See 8 CCR 9789.11(a)(1), OMFS General Information and Instructions, page 4 which sets forth the rules for reimbursable supplies relating to physician services.)	None.

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Workers' Compensation Medical Billing & Payment Guide – Appendix A. Standard Paper Forms – CMS 1500	Commenter states that his organization is using the most current version CMS-1500 (08-05). The new rules require a new version 6.0 07/10. Commenter states that there are several changes to the existing form that must be contemplated as it relates to the timing of implementation. Commenter also opines that more definition needs to be provided as to when a payer can decide to use the "S" code for a HCFA field. Commenter is concerned that the use of this code may be abused by the payer resulting in improper rejection of claims.	Greg M. Gilbert Senior Vice President Reimbursement & Government Relations Concentra, Inc. January 21, 2011 Written Comment	**Disagree.** The commenter appears to misunderstand the language in Appendix A. The language in 1.0 CMS 1500, page 18, provides that the CMS 1500 Version 08/05 is adopted. There is no new CMS 1500 form. It is the "1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 08/05" that is updated to Version 6.0 07/10. This is the annual update and is proposed as it supersedes the Version 5.0 07/09 that was in effect at the time the 45-day proposal was issued. The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None. None.
Workers' Compensation Medical Billing & Payment Guide– Appendix A. Standard Paper Forms – CMS 1500	**Field 1A-Social Security Number** Requires entering either the patient's SSN number or "999999999". Commenter feels that this is a positive change.	Greg M. Gilbert Senior Vice President Reimbursement & Government Relations Concentra, Inc. January 21, 2011 Written Comment	Commenter's support is noted.	None.

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Workers' Compensation Medical Billing & Payment Guide– Appendix A. Standard Paper Forms – CMS 1500	**Field 6-X in "Other"** Commenter notes that historically this was not required and not programmed into the system software.	Greg M. Gilbert Senior Vice President Reimbursement & Government Relations Concentra, Inc. January 21, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. In addition, although commenter notes the "historical" handling of the Field 6, it has not offered any substantive reason to revise the proposal.	None.
Workers' Compensation Medical Billing & Payment Guide– Appendix A. Standard Paper Forms – CMS 1500	**Field 11-Claim Number** This is considered an "S" field. Commenter would like the Division to review his prior comments 45 Day related to this field and it being a required field after the providers' first billing.	Greg M. Gilbert Senior Vice President Reimbursement & Government Relations Concentra, Inc. January 21, 2011 Written Comment	**Agree in part.** The Division agrees that the provider should be able to enter "unknown" after the first billing if it does not know the claim number. However, it will enhance communication if the claim number is Situational, i.e. required if known as it will facilitate the claims' administrator's process of matching the bill to a claim.	Modify Field 11 to delete provision that "Unknown" can only be entered on a first billing.
Workers' Compensation Medical Billing & Payment Guide– Appendix A. Standard Paper Forms – CMS 1500	**Field 12-Patient's or Authorized Person's signature** Commenter seeks clarification of the regulations that an actual patient signature is <u>not</u> required for paper billing. Commenter states that signature on file is the norm.	Greg M. Gilbert Senior Vice President Reimbursement & Government Relations Concentra, Inc. January 21, 2011 Written Comment	**Agree in part.** Agree that this field should not be listed as "Required." The NUCC 1500 Claim Form Instruction Manual for Item Number 12 allows the box to state "Signature on File," "SOF," or contain the legal signature. In addition, it allows the field to be left blank or to state "No Signature on File" if a signature is not on file. This field should be optional for workers' compensation.	Modify 1.1 Field Table CMS 1500 for field 12 to delete "R" and insert "O" so that the field in optional.

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Article 5.5 – Application of the Official Medical Fee Schedule (Treatment)	Commenter supports electronic transmission of a "complete bill" to the claims administrator; however, commenter is concerned when claims administrators transfer their responsibility for bill review to a third party bill review company and fails to send the accompanying report (or copy thereof). Under current DWC policy, providers are required to submit a "complete report" along with paper billing. The claims administrator is responsible for assuring that relevant reports necessary to adjudicate the paper billing are forwarded to the third party bill review company. Too often, the relevant paper documentation to support the billing is not forwarded to the bill review company, resulting in a denial of billing for the provider. When providers protest, they are advised to resubmit the paper documentation to the bill review company, or file a lien. This process creates a huge burden for providers, in essence requiring that they submit documentation twice and also causes an unreasonable delay in	Kenneth Winer, DC President California Chiropractic Association January 27, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. In addition, as commenter has pointed out, the physician reporting regulation and physician fee schedule require the medical provider to submit one copy of his/her report in order to satisfy the reporting duty. (8 CCR §9785(b)(4) and §9789.11(a)(1).) Moreover, Labor Code section 4603.2 subdivision (d) specifies: "(d) (1) Whenever an employer or insurer employs an individual or contracts with an entity to conduct a review of an itemization submitted by a physician or medical provider, the employer or insurer shall make available to that individual or entity all documentation submitted together with that itemization by the physician or medical provider. When an individual or entity conducting a itemization review determines that additional information or documentation is necessary to review the itemization, the individual or entity shall contact	None.

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	reimbursement (despite having issued a Proof of Service with the original submittal). Also, since the billing review company itself is not party to the action, it is inappropriate for providers to send reports discussing the patient to anyone other than the parties of the action. Commenter states that the original regulations were intended to streamline the process by requiring the physician to submit the report only once, as exemplified by the below references: CCR 9785(b)(4) states, " A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. A claims administrator may designate any person or entity to be the recipient of its copy of the required report." 8 CCR § 9789.11(a) (1) states, "A primary treating physician has fulfilled his or her reporting duties by sending one copy of a required report to the claims administrator or to a		the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the physician or medical provider pursuant to subdivision (b). (2) An individual or entity reviewing an itemization of service submitted by a physician or medical provider shall not alter the procedure codes listed or recommend reduction of the amount of the payment unless the documentation submitted by the physician or medical provider with the itemization of service has been reviewed by that individual or entity. If the reviewer does not recommend payment for services as itemized by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or changed other parts of the itemization and the specific deficiency in the itemization or documentation that caused the reviewer to conclude that the altered procedure code or amount recommended for payment more	

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	person designated by the claims administrator to be the recipient of the required report. Requests for duplicate reports related to billings shall be in writing. Duplicate reports shall be separately reimbursable." Commenter states that the intent of the regulation was to place the responsibility for dissemination of required reports and complete bills on the claims administrator. Commenter strongly encourages the Division to address this issue before finalizing adoption of the new medical billing regulation.		accurately represents the service performed." In light of the Labor Code provisions regarding bill review and the section 9785 and section 9789.11 regulations, there does not appear to be a necessity for inserting a duplicative rule in the proposed billing regulations.	
General Comment	Commenter expresses appreciation to the Division for its consideration and application of his many comments that were made during the Informal Rulemaking process, and as a result of his testimony submitted for the Public Hearing. Commenter reiterates his belief that the critical need for this version of Section 9792.5 to become final consistent with the version of the Physician Reporting regulations that	Steven Suchil Assistant Vice President American Insurance Association January 27, 2011 Written Comment	Commenter's appreciation is noted. **Disagree.** The Division cannot discern any reason that changes to Section 9792.5 need to be effective at the same time as changes to the physician reporting regulations or the physician fee	None. None.

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	was previously posted on the Forum as a part of the Physician Reporting and Physician Fee Schedule package. Commenter stresses the importance that the two revisions are consistent and their effective dates precede the finalized WCIS effective date in order to minimize confusion and conflict. If this does not occur, commenter believes that there will be many situations where the data required for state reporting by the payer will not be required from the provider until the reporting and standardized/e-billing regulations become effective.		schedule. In particular, the only changes to Section 9792.5 are to conform to statutory changes to Labor Code section 4603.2 made over the course of the last few years. Regarding the Workers' Compensation Information System (WCIS) the medical data reporting requirement has been in place since September of 2006. The revised WCIS regulations on data reporting were adopted on November 15, 2010 but become effective on November 15, 2011, thus allowing one year for implementation. The medical data reporting has been ongoing since 2006; the fact that an update becomes effective in November of 2011 does not necessitate that billing regulations be adopted in tandem.	
California DWC Medical Bill and Payment Guide 2011 3.0 Complete Bills	Commenter notes that subparagraph (a) (3) provides: Nothing in this paragraph precludes the claims administrator from populating missing information field if the claims administrator has previously received the missing information. Commenter opines that as long as this	Steven Suchil Assistant Vice President American Insurance Association January 27, 2011 Written Comment	Comment is noted.	None.

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	remains volitional, he has no concern. However, he believes it to be the health provider's responsibility to present the required data for timely bill payment.			
California DWC Medical Bill and Payment Guide 2011 3.0 Complete Bills	Commenter notes that subparagraph (a)(4) provides: A complete bill includes required reports and supporting documentation specified in subdivision (b). Commenter states this issue engendered many hours of work by Task Force members, who were attempting to clarify what elements of medical billing and reporting needed to be present in order to promptly review bills and reimburse providers. At the same time, the group wanted to try to reduce the friction between payers and providers that occurs when bills are adjusted. Commenter believes that the difficulties on both sides regarding upcoding and down-coding are usually a result of the absence of, or different interpretations given to, the documentation. It was decided that in addition to previously "required" reports in Sec. 9785 and the Official Medical Fee Schedule, there would be an attempt to identify other "supporting	Steven Suchil Assistant Vice President American Insurance Association January 27, 2011 Written Comment	**Agree in part.** The Division agrees that the concept of documentation "sufficient to support the level of service or code that has been billed" should not be restricted to subdivision (b)(10) which concerns additional information reasonable requested by the claims administrator prior to submission of the bill. However, the Division believes that instead of inserting the phrase into a separate subdivision, it should be placed in the introductory clause so that it applies to all documentation.	Modify page 9, 3.0 Complete Bills: "(b) All required reports and supporting documentation sufficient to support the level of service or code that has been billed must be submitted as follows:" Also, modify page 9 (b)(10) to delete the sentence "Supporting documentation should be sufficient to support the level of service or code that has been billed.."

	documentation" that would be necessary for a complete bill, thus combating much of the friction and delay in areas where it is most common. By placing the need for documentation to support the level of service within (b) (10) which deals with "additional information" it appears that the lack of adequate initial documentation that comes with the bill will continue, creating more work for payers and delayed payments to providers. Commenter strongly recommends a separate bullet point for "documentation to support level of service codes."			
7.1 Timeframes	Commenter recommends that in Subsection (i) of Subparagraph (a)(3)(A) 00501 OX214 Claim Pending Status Information, that the word "working" be added to keep it in compliance, and consistent with Labor Code 4603.4: The payment timeframe begins resumes when the claim number is determined, or when the missing attachment is received missing information is provided. The	Steven Suchil Assistant Vice President American Insurance Association January 27, 2011 Written Comment	**Agree.**	Modify 7.1 (a)(3)(A)(i) to add the word "working" to the 15-day timeframe.

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	"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 day pending period may be mutually agreed upon.			
Appendix A. Standard Paper Forms – 1.0 CMS 1500 field 14	Commenter recommends the following revision to this instruction, on page 22, and elsewhere, because for the collected data to be useful, it must be uniform. Commenter recommends the following amendment, as it complies with Labor Code Sec. 5412: 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	Steven Suchil Assistant Vice President American Insurance Association January 27, 2011 Written Comment	**Agree in part.** The Division agrees that it would be clearer to provide one consistent date to be used for the date of injury for cumulative claims. However, the Division believes that it would be more appropriate to utilize definition one, "the last date of occupational exposure to the hazards of the occupational disease or cumulative injury" rather than the second definition which is preferred by commenter: "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 employment." Definition number two is from Labor Code section 5412, in a	Modify tables to delete definition #2: 1.1 Field Table CMS 1500 Field 14 2.1 Field Table UB-04 Loc. 31-34a,b 3.1 Field Table NCPDP Field 11 4.1 Field Table ADA 2006 Field 46 Also, similar changes are made to the Electronic Medical Billing and Payment Companion Guide.

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	occupational disease and knew (or should have known) that the disability was caused by the employment.		portion of the Labor Code dealing with statute of limitations. The definition preferred by the Division, the last date of occupational exposure to the hazards of the occupational disease or cumulative injury, is based on one prong of the liability period under Labor Code section 5500.5. This definition which requires a medical opinion on "the last date of occupational exposure to the hazards of the occupational disease or cumulative injury" is more appropriately determined by the treating doctor than "when the employee knew or should have known" that disability was caused by the employment. In addition, this date is consistent with the date used in the Electronic Adjudication Management System and the Workers' Compensation Information System established pursuant to Labor Code §138.6.	
Appendix A. Standard Paper Forms – 1.0 CMS	Commenter believes that the "N" in paper field 16 should be retained so that the bill cannot be construed as a	Steven Suchil Assistant Vice President	**Disagree.** The fact that a doctor enters data in the Field 16 "Dates Patient Unable to Work in	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
1500 field 16	medical report which must then be filed and served, adding unnecessary expense.	American Insurance Association January 27, 2011 Written Comment	Current Occupation" does not turn the bill into a medical report, just as entry of diagnosis codes on the bill does not turn the bill into a report. A doctor should not be precluded from utilizing Field 16; the data field should remain optional.	
Appendix A. Standard Paper Forms – 1.0 CMS 1500 field 31	Commenter is concerned about no longer requiring the physician to sign the bill. It is a field on the CMS 1500 and is crucial for fraud prosecution. Commenter recommends retaining the "R" - required for this field.	Steven Suchil Assistant Vice President American Insurance Association January 27, 2011 Written Comment	**Disagree.** Currently there is no requirement to sign a medical bill and there are still prosecutions for billing fraud. Moreover, for electronic billing there is no requirement in the 837 Professional for the physician signature. There is a required data element to indicate whether or not a physician signature is on file, but the value can be yes or no. See page 159, ASCX12N5010222 **REQUIRED CLM06 1073 Yes/No Condition or Response Code O 1 ID 1/1** Code indicating a Yes or No condition or response **SEMANTIC:** CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file; an "N" value indicates the provider signature is not on file. **IMPLEMENTATION NAME: Provider or Supplier Signature Indicator** **CODE DEFINITION** **N No** **Y Yes**	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Appendix A. Standard Paper Forms – 4.0 ADA 2006	Commenter point out that the phone number has been deleted from field 48 as has the "R". There are various other data elements in Field 48, however, and as amended there is no indication for completion requirements.	Steven Suchil Assistant Vice President American Insurance Association January 27, 2011 Written Comment	**Agree.** This technical error will be corrected.	Add "R" to 4.1 Field Table ADA 2006, Field 48.
Appendix B. Standard Explanation of Review – 3.0 Field Table For Paper Explanation of Review	For purposes of clarity, and because there is no standardized form for reporting paper EORs, commenter recommends re-titling this section "Paper Explanation of Review Table" and removing the Field numbers. Commenter is concerned that the title and numbering of items will create confusion.	Steven Suchil Assistant Vice President American Insurance Association January 27, 2011 Written Comment	**Agree in part.** Agree that it would be better to remove the word "field" as it may be confusing as it could be interpreted to imply that there is a form with fields. Moreover, several "field" numbers have comments indicating that they are not used for workers compensation. These will be deleted as they are unnecessary and confusing.	Modify 3.0 Table name to delete the word "Field" from Field Table for Paper Explanation of Review. Also, modify column one heading to say "Data Item No." rather than "Paper Field". Modify the table to delete Fields 2, 25, 26, and 36 since they are unnecessary and renumber the "data item no." column.
Appendix B. Standard Explanation of Review – 4.0 Electronic Signature	Commenter is concerned with the Division's proposal to remove the need for health care providers to sign their bills. This is a critical need in fraud prosecutions. Commenter recommends continuing this requirement.	Steven Suchil Assistant Vice President American Insurance Association January 27, 2011 Written Comment	**Disagree.** See response above to the same comment by this commenter in regard to Appendix A, Standard Paper Forms – 1.0 CMS 1500 field 31.	None.
9792.5.2	Commenter requests that the Division add	Sandy Shtab	**Disagree.** This is unnecessary as	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	a subsection to clarify the ability of payers and providers to utilize mutually agreed upon non-standard electronic billing formats. Commenter recommends the following sample language: (e) Medical providers, payers, and their authorized agent may use mutually agreed upon electronic formats for transmissions and payment of electronic bills. Commenter opines that the addition of this language will ensure there is no interruption to existing non-standard data exchange between providers and payers. Commenter notes that the Division has also proposed the electronic billing rules are mandatory for all payers, but not mandatory for all providers. Significant resources are required of payer to implement e-billing processes. Commenter believes that payers who have made that investment should receive an equitable offset to their costs by way of	Compliance Manager Healthesystems January 27, 2011 Written Comment	the Electronic Medical Billing and Payment Companion Guide section 2.1 allows the parties to "exchange data in non-prescribed formats by mutual agreement." Section 2.4.7 Documentation/Attachment Identification states that documentation may be submitted "using the prescribed format or a mutually agreed upon format." Also, in Section 2.9.1 trading partner is defined as "…entities that have established EDI relationships and exchange information electronically in standard or mutually agreed upon formats." The Division believes these provisions are sufficient to ensure that existing non-standard data exchange can continue between consenting providers and payers. **Disagree.** The statute requires that claims administrators accept electronic bills but does not require that medical providers bill electronically. Although the Division agrees that it would be beneficial if there is widespread adoption of electronic billing by medical providers it cannot	None.

	reduction in paper bill processing. Federal and state initiatives are well underway to require healthcare data exchange and reduce administrative costs; commenter believes that mandatory e-billing in workers' compensation claims would align with those efforts. Commenter suggests that for providers or payers that cannot comply with the regulation due to financial hardship that the Division considers a temporary exception process or an extended implementation period.		mandate that they do so. The Division believes that the 18 month implementation period will be sufficient time for claims administrators to prepare for electronic billing/remittance transactions. This is especially true in light of the fact that the claims administrators can contract for electronic bill handling to be done by clearinghouses and need not establish their own internal electronic bill handling capability.	
General Question	Commenter notes that the paper billing rules will go into effect 90 days from the Guides being adopted. Commenter asks if the 90 day date is based on date of service, bill received date or on bill processed date.	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The regulation text ties the applicability of the paper billing rules to the bill submission date: "(a) On and after XXXX, ~~2010~~ 2011, [~~approximately 90~~ 180 days after the effective date of this regulation] all paper bills for medical treatment provided by ~~physicians,~~ health care providers, and health care facilities shall be submitted on ~~claim~~ billing forms set forth in the *California Division of Workers' Compensation Medical Billing and Payment Guide*." The 2.0 page 7 Medical Billing and Payment Guide subdivision (a) also utilizes the bill *submission* as the date for	Modify Section 9792.5.3 to add a clarifying sentence: "This subdivision does not apply to processing or payment of bills submitted before XXXX, 2011 [180 days after the effective date of this regulation]."

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			applicability of the new rules. In order to provide further clarity the regulation text of section 9792.5.3(a) will be modified.	
California DWC Medical Bill and Payment Guide 2011 – Section One 5.0(d)	Commenter notes that this section indicates that a health care provider cannot submit a bill via paper and electronic means. If this scenario occurs, should a carrier send the 2nd bill back to the health care provider? Or should they deny the charges with a specific reason code that illustrates this is not allowed? Commenter opines that this item will most likely cause exception workflow issues for carriers as it would be a manual determination as to whether the 2nd bill had already been submitted, and if so, whether both bills were received via paper or electronic or a combination of those.	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	**Disagree** that further instruction is warranted. In order to decrease the chance of duplicate billing, it is necessary to prohibit the same bill from being submitted in both paper and electronic format. If it does come to the attention of the claims administrator that a bill has been re-submitted in a different format it will need to determine appropriate bill handling action depending on the circumstances.	None.
California DWC Medical Bill and Payment Guide 2011 – Section One – 6.0(a) and (b)	Commenter notes that denials to all or any part of a bill must occur within 30 days of receipt, however payments must be made within 45 days of receipt. If a bill has two line items and one is being paid and the other being denied, does this fall within the 45 day timeframe or the 30 day timeframe? One could argue that it falls within the 45 day timeframe as a payment is	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	**Disagree.** The Division does not believe there is a need for clarification. The statute is quite clear that objections to bills must be made within 30 working days of receipt of the bill and payment must be made within 45 working days of receipt of the bill. Labor Code §4603.2 provides in pertinent part: "Payments shall be made by the employer within 45	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	being made on the bill, but not necessarily on each line item. Commenter requests that the Division provide scenario examples and clarification.		working days after receipt of each separate, itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician. If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in writing, that the itemization is contested, denied, or considered incomplete, within 30 working days after receipt of the itemization by the employer."	
California DWC Medical Bill and Payment Guide 2011 – Section One – 7.1(b)	Commenter opines that instituting a 15 working day turnaround time will cause a burden on claims administrators. There are many workflow processes that a bill follows once a clean bill has been received by a carrier or its bill review agent. Bills can go through a number of steps including data element editing, second and tertiary level reviews, routing to various PPO networks, etc. 15 days is very aggressive and carriers will be held to that even though they have little control over other 3rd parties turnaround time (example Pend & Transmit processing.) Commenter	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	**Disagree.** The 15-day timeframe is statutory and the Division does not have discretion to alter it.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	strongly suggests that the DWC consider extending this timeframe to one that is reasonably achievable.			
California DWC Medical Bill and Payment Guide 2011 – Section One – 7.2(b)	This section states that an increase and interest will be applied to complete bills not paid within 45 working days of receipt unless notice was made within 30 working days of receipt to the health care provider that the bill was contested, denied or incomplete. This is somewhat contradictory to Section One – 7.1 (b) (1) and (2) as the timeframe in these two areas state the 835 is due within 15 working days. Commenter requests clarification.	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	**Disagree.** There is no contradiction between 7.1 and 7.2, as 7.1 concerns time frames for payment and objection and 7.2 concerns when penalties attach. The interest and increase referenced in 7.2(b) attach when an uncontested electronic bill remains unpaid for the time period specified in Labor Code §4603.2. The Labor Code §4603.4 which requires payment within 15 days does not specify a penalty. However, uncontested bills that remain unpaid for the time period specified in §4603.2 are subject to penalty.	None.
California DWC Medical Bill and Payment Guide 2011 – Appendix A – 1.0 CMS 1500	Commenter requests that specific billing instructions be added requiring DME items to be billed on the CMS-1500 form. By adding a rule on this, it will alleviate backend state reporting issues. This would allow DME items to be reported in the SV1 segment and would prohibit pharmacies from billing DME on an NCPDP or pharmacy billing form (since DME cannot be reported in the SV4 segment).	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
California DWC Medical Bill and Payment Guide 2011 – Appendix A – 3.0 NCPDP	Commenter requests that specific billing instructions be added for pharmacies to bill shipping and handling charges, dispensing fees, and compound ingredients that do not have a specific NDC assigned. Commenter opines that by adding clarity around this, it will alleviate backend state reporting issues. These charges are typically being billed on the pharmacy billing form, therefore these charges would need to be reported in the SV4 segment.	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	**Disagree.** The Division is unable to discern what additional instruction is needed beyond the Field Comments and the NCPDP *Manual Claims Form Reference Implementation Guide Version 1.Ø, October 2008.* In addition, the comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 – 4.0 ADA 2006	Commenter requests that specific billing instructions be added for dental bills to require only ADA codes to be billed on the ADA billing form and all other non-ADA codes to be billed on the CMS-1500 form. Commenter opines this would alleviate backend state reporting issues as this would allow the ADA dental codes to be reported in the SV3 segment and the non-ADA codes to be reported in the SV1 segment.	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 – 4.1 Field Table ADA 2006 – Paper	Commenter points out that this section states "When a duplicate bill is being submitted, the word "Duplicate" shall be written in this field". Commenter	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	**Disagree** that there is a need to specify what options are open to the claims administrator if a "duplicate" is not written in field one of the ADA Dental billing	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Field 1	questions what are carriers options if a bill is received that is a duplicate, however the provider failed to handwrite "Duplicate" in this field?		form. Medical Billing and Payment Guide 5.0 prohibits duplicate bills until the expiration of the time allowed for payment unless a duplicate has been requested by the claims administrator. The word "duplicate" is to expedite communication so that the claims administrator will recognize the bill as a duplicate, but there is no specific penalty for failing to write "duplicate" on the bill. The claims administrator should handle the bill appropriately based on substantive issues relating to the bill, and is free to communicate with the provider regarding the lack of the word "duplicate."	
California DWC Medical Bill and Payment Guide 2011- Appendix B - Paper Explanation of Review	Commenter states that many bill review companies software allows clients to be very descriptive in explaining the payment or denial of a line item utilizing message/reason code functions. Per the proposed guide, for paper EOR's the DWC Bill Adjustment Reason Codes and DWC Explanatory Messages are required. Commenter queries can carriers continue to also add their own message/reason code descriptions on	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	**Agree** that it would be useful to clarify that a payer can add additional messages.	Modify the instructions for paper EORs in Appendix B, Standard Explanation of Review to clarify that additional language may be added: "The payer may include additional messages and data in order to provide further detail to the provider."

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	the EOR as long as they are complying with the new requirements?			
California DWC Medical Bill and Payment Guide 2011 – Appendix B – 3.0 Field Table for Explanation of Review	Commenter states as there is no standard form for the paper EOR, she recommends changing the title to Paper Explanation of Review Table and removing field numbers as it is misleading.	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	**Agree.** See response above to same comment made by Steven Suchil, Assistant Vice President, American Insurance Association January 27, 2011	See above.
California DWC Medical Bill and Payment Guide 2011– 3.0 Field Table for Explanation of Review	Paper Field 1 – Date of Review Commenter asks if this is the bill completed or released date and notes that it can also be used to signify the date of review.	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 3 – Method of Payment Paper Field 4 – Payment ID Number Paper Field 5 – Payment Date Commenter states that many bill review companies providing EOR form creation for their clients will not have this information for the field referenced above as payments are generated from their claims systems. Commenter opines that by asking carriers to send this information to the bill review company prior to being able to create and send out EOR's will	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Additionally, payment information is an important part of the EOR and claims administrators will need to coordinate procedures with bill review entities that are utilized to ensure that there is no delay and that appropriate information is included in the EOR.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	cause a huge time delay in health care providers receiving paper EOR's.			
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 14a – Pay to Provider State License Number Commenter requests that the Division provide clarity in which situations this would be required. If pay to provider state license number is not present, can a default of eight 9's be used?	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 16 – Patient Social Security Number Commenter questions due to HIPAA and heightened sensitivity around personal data, is it appropriate to ask that this be printed on the form? Can all digits except the last 4 be masked?	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 19 – Employer Name Paper Field 20 – Employer ID Commenter understands that these are required data elements for a claims system but states that these are not typical required data elements for a bill review system. Recommends changing this from Required to Optional.	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011	Paper Field 22 Rendering Provider ID (NPI)	Leslie White Manager Product Team StrataCare, LLC	The comment does not address the substantive changes made to the proposed regulations during	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
- 3.0 Field Table for Explanation of Review	Commenter states that in order to require this on the EOR, it must be indicated as a Required field on the paper billing forms.	January 28, 2011 Written Comment	the 1st 15-day comment period.	
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 24 – PPO/MPN ID Number Commenter requests that the Division provide an example of each.	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 29- Payer Bill Review Contact Name Paper Field 30 – Payer Bill Review Phone Number Commenter notes that this appears to be duplicative of field 9 and 10 in cases where the carrier is performing the actual bill review. For that instance, she recommends changing these two fields to Situational instead of Required.	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 32 – Payment Status Code Commenter notes that there is no payment status code that indicates a partial payment. Commenter asks which code is to be used when part of the bill is paid and part is denied? What code is to be used on a	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	reconsideration a) payment is being made, or b) payment is being denied.			
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 35 – Claim Filing Indicator Code Commenter states this is an Optional field. Commenter asks if the word Workers' Compensation is noted in the title or heading of the EOR, does this have to be a field of its own?	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. However, the Division has decided to delete Field 35 as it is unnecessary.	Modify 3.0 Table to delete Field 35.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 37 – Bill Frequency Type Commenter queries if the full bill type (all 3 characters) are present on the form, will this meet the requirement (examples: 131, 133, 831)?	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 40 – Date Bill Received Commenter recommends adding Carrier in this field name so that it is clear (Date Carrier Received Bill).	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 47 – Paid Units Commenter states that many bill review systems do not capture the number of units that were paid if a line item is entered with multiple units. This will be very difficult to determine programmatically. Recommends changing to Optional instead of	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Required.			
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 51 – Prescription Number Commenter states if DME is billed on a CMS 1500, there is no field available to indicate the prescription number. Commenter opines that this needs clarification to avoid confusion.	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table for Explanation of Review	Paper Field 52 – DWC Bill Adjustment Reason Code and DWC Explanatory Message Commenter asks if the Bill Adjustment Reason Code is listed on the service line on the EOR, however the Explanatory Message is listed in another section on the form, does this meet the requirement? Commenter opines that due to the amount of real estate available on EOR forms today, it is difficult to have lengthy message fields print on every line item.	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	The Division is not prescribing the precise layout of the EOR. It must be structured in a manner that the provider who receives it is able to understand the basis of objections or adjustments. If the layout clearly indicates the reason code for each line adjustment, it would be permissible to have the Explanatory Message for each reason code set forth in full once in a separate section.	None.
Electronic Medical Billing and Payment Companion Guide 2012 – Chapter 9 – 9.2	Commenter states that this indicates that if claim number is Unknown or not provided that carriers will have a 5 day period in which to attempt to locate the appropriate claim number, or return the bill to the health care provider. Commenter conjectures that if a carrier pends a bill for up to 5 days	Leslie White Manager Product Team StrataCare, LLC January 28, 2011 Written Comment	In reviewing a payment for timeliness, the issue of whether a bill had been placed in pending status due to lack of a claim number would be a matter of proof. In an audit documentation of the facts surrounding the billing and payment would need to be provided so that timeliness	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	and then pays/denies the bill within 15 days afterward, it could appear to the DWC that the bill was paid late. What are the carrier's options for defending this type of scenario if it were to come up in a DWC audit? How will the DWC monitor this scenario that would potentially fall outside of the 15 day turnaround time?		could be determined.	
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table NCPDP	Commenter notes Items 5 – 8 (Patients address, city, state, zip) are listed as required; however, these data elements are considered optional in the National Council of Prescription Drug Programs (NCPDP) Implementation Guide for Pharmacy Transactions. Commenter recommends that these regulations be consistent with the NCPDP nationally recognized standards.	Kristie Griffin Compliance Manager Express Scripts January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table NCPDP	Commenter notes Items 19-22 (Carrier's address, city, state, zip) are listed as required; however, these data elements are considered situational in the NCPDP Implementation Guide for Pharmacy Transactions. NCPDP requires only the carrier ID on submission. Commenter recommends the regulations be consistent with the NCPDP nationally recognized standards.	Kristie Griffin Compliance Manager Express Scripts January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011	Commenter notes Item 33 (Pharmacy ID Qualifier, qualifying the Service Provider ID) is required; however, commenter	Kristie Griffin Compliance Manager Express Scripts	The comment does not address the substantive changes made to the proposed regulations during	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
- 3.0 Field Table NCPDP	requests clarification on what the DWC expects should be entered in this field.	January 28, 2011 Written Comment	the 1st 15-day comment period.	
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table NCPDP	Commenter notes Item 41 (Prescriber ID Qualifier, qualifying the Prescriber ID) is required; however, commenter requests clarification on what the Division expects should be entered in this field.	Kristie Griffin Compliance Manager Express Scripts January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table NCPDP	Commenter notes Item 50 (Payee ID Qualifier, qualifying the Pay-To ID) is required; however, commenter requests clarification on what the Division expects should be entered in this field.	Kristie Griffin Compliance Manager Express Scripts January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table NCPDP	Commenter notes Item 63 (Prescription Service Reference # Qualifier, indicated the type of bill being submitted) is required; however, commenter requests clarification on what the Division expects should be entered in this field.	Kristie Griffin Compliance Manager Express Scripts January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table NCPDP	Commenter notes Item 69 (Product/Service ID Qualifier, qualifying Product/Service ID) is required; however, commenter requests clarification on what the Division expects should be entered in this field.	Kristie Griffin Compliance Manager Express Scripts January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and Payment Guide 2011 - 3.0 Field Table NCPDP	Commenter notes Item 101 (Ingredient Cost Submitted) is listed as situational; however, this data element is required for electronic submissions (NCDPD D.0). Commenter recommends the regulations be consistent with the NCPDP nationally recognized standards.	Kristie Griffin Compliance Manager Express Scripts January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
California DWC Medical Bill and	Commenter notes Item 102 (Dispensing Fee Submitted) is listed as required;	Kristie Griffin Compliance Manager	The comment does not address the substantive changes made to	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Payment Guide 2011 - 3.0 Field Table NCPDP	however, this data element is considered optional in the NCPDP Implementation Guide for pharmacy transactions. Commenter recommends the regulations be consistent with NCPDP nationally recognized standards.	Express Scripts January 28, 2011 Written Comment	the proposed regulations during the 1st 15-day comment period.	
California DWC Medical Bill and Payment Guide 2011- Appendix B – Standard Explanation of Review	Commenter understands the need for the use of standard EOR codes; however, in pharmacy transactions, NCPDP codes are accepted nationally by payers and providers. Commenter recommends that the Division allow for the use of standard NCPDP codes for electronic Explanation of Review when electronically sharing information on rendered pharmacy services.	Kristie Griffin Compliance Manager Express Scripts January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Additionally, commenter appears to overlook the fact that the ASCX12N 005010X221 Health Care Claim Payment/Advice does provide for use of NCPDP codes. (ASCX12N 005010X221 Page 215, page A9.)	None.
General Comment	Commenter commends the Division for the thoughtful, inclusive approach to developing the e-billing standards. Commenter particularly would like to acknowledge the Division's effort to confirm to and help develop and advance a national standard that provides continuity to the many workers' compensation stakeholders operating across multi-state boundaries. Commenter states that the proposed standards and implementation guides are exceptional and could and should be used as a model nationally.	Brian Allen Government Relations Stone River Pharmacy Solutions January 28, 2011 Written Comment	Commenter's positive comments are noted.	None.
California DWC Medical Bill and	Commenter states that the current rules allow a payer to reject a bill if a claim	Brian Allen Government Relations	**Agree.** See response above to same comment made by Brendan	See above.

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Payment Guide 2011 – 7.1(a)(3)(A)(i)	number had been previously provided to the billing entity. Commenter suggests that the language be revised to require the payer to insert the claim number if it is otherwise identifiable by the payer. Commenter maintains that it does not make sense to reject a bill for a piece of information that the payer can readily access in their system.	Stone River Pharmacy Solutions January 28, 2011 Written Comment	Friar, Senior Vice President, WorkCompEDI, Inc., January 10, 2011.	
California DWC Medical Bill and Payment Guide 2011 – 4.0 (c)	Commenter recommends the following language: The billing agent/assignee is not entitled to reimbursement for bills that would not be compensable to the original rendering provider and may not be reimbursed at amounts greater than the fee schedule or as agreed upon by contract between the payer and the billing entity. The billing guides and rules do not themselves confer a right to bill; they provide direction for billing agents and assignees that are legally entitled to submit bills under other provisions of law. Commenter's organization acts as a default biller when no information is presented to the pharmacy at the time of the fill regarding a network or PBM	Brian Allen Government Relations Stone River Pharmacy Solutions January 28, 2011 Written Comment	**Disagree.** Assignee cannot have rights greater than assignor. If an entity acts in some other role than as billing agent or assignee that carries a legal right to bill for provision of pharmaceuticals it could pursue those rights. But an agent or assignee has no greater rights than the principal or assignor.	None.

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	relationship to that particular prescription. His organization then does research on the employer, carrier, claim, compensability, etc. Commenter is concerned that the language as presently written would subject his organization to a PBM contract to which they are not a party and to which they do not enjoy any of the benefits that the pharmacy would have enjoyed had the injured worker or person present the claim provided PBM or network information properly indentifying the prescription as an in-network service. Should this language be interpreted to subject his organization to a contracted rate to which they are not a party, it would, in effect, cause his organization to do the job of the PBM for them without any economic benefit.			
California DWC Medical Bill and Payment Guide 2011 – Electronic Funds Transfer	Commenter stresses that electronically submitting a claim is a good first step, but an EFT completes the electronic billing process. Commenter appreciates the Division encouraging payers to include the EFT in their electronic process. However, commenter does not believe that will be sufficient to result in Workers'	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011	**Disagree.** The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.

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	Compensation carriers actually offering this feature. While EFT offers efficiencies and the potential for savings for carriers, regrettably, there are insurers that will continue to find it more advantageous to continue "float" monies due to physicians for as long as they possibly can. Without a requirement from the Division that their systems include EFT, commenter's question that they will be supportive of paying providers more quickly through the electronic transfer of funds. Commenter strongly urges the Division to require payers to offer EFT to providers who request that their payments be electronically deposited. This will provide an important incentive for providers to participate in electronically submitting their claims/reports.	Written Comment		
California DWC Medical Bill and Payment Guide 2011 – Section 1 - Definitions	Definition of "Complete Bill" Commenter supports this definition with one comment: as we move the system to an electronic system of data sharing, it is important to eliminate and/or reduce unnecessary and burdensome reporting requirements.	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical	**Agree.** Although a medical provider may choose to submit a copy of the authorization to expedite the bill processing, it is not necessary to require the medical provider to submit the authorization document which was approved by the claims	Modify 3.0 Complete Bill provision to delete (b)(11) which listed the written authorization, where one was given, as a required document for a complete bill.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	For example, there is absolutely no reason a physician should be required to submit a copy of the "written authorization" in order for the bill to be complete. The payer must already have a record of the authorizations that they have approved. Also, many providers still receive oral authorizations, some followed up with a written confirmation and/or confirmation numbers, but many other times, the payer never issues a written confirmation of the authorization. In these cases, the provider will never be able to comply and achieve a complete claim status. **Commenter recommends that the requirement that the provider submit a copy of the written authorization be deleted.**	Association January 28, 2011 Written Comment	administrator to the claims administrator.	
California DWC Medical Bill and Payment Guide 2011 – Section 1 - Definitions	Definition of "Required Report" Commenter states that it is not the practice for payers to require specialists to submit a Doctor's First Report of Injury when they take over the care of an injured worker. Commenter finds it to be confusing to the payer if the specialist also submits the report. This second or maybe third, or fourth copy of the Doctor's First	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. It appears commenters are opposed to the provisions of the reporting regulation in 8 CCR section 9785; that regulation is not at issue in this rulemaking action.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Report of Injury must be investigated by the carrier each time to ensure that it is not a new injury. **Commenter strongly believes that only the first provider that treats the injured worker should be required to complete the Doctor's First Report of Injury**. **Commenter urges the Division to clarify this point to eliminate unnecessary and sometimes confusing reporting required of providers.**			
California DWC Medical Bill and Payment Guide 2011 – Section 1 - Definitions	Definition of "Uniform Billing Forms and Codes" Commenter states that these billing forms are continually subject to updates by the respective parties responsible for the development of these billing forms. It is commenters' understanding that Medicare is currently updating the CMS 1500 form. Commenter strongly believes that the Division should encourage the use of the most current version of these billing forms to again ensure uniformity with other billing systems. Commenter suggests changing this definition to state that "Uniform Billing Forms" are the most current version of the CMS 1500, UB-04,	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Disagree.** The paper billing forms are not changed very frequently and it would be best for the forms to be adopted as regulations after due consideration to any special instructions needed for workers' compensation.	None.

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	NCPDP Universal Claim Form and the ADA examples of which are set forth in Appendix A. Commenter suggests that the Division require the use of the most current version of the billing codes – e.g., CPT-4 Codes and ICD-9, both of which are either updated annually or are currently in the process of being updated.		**Disagree.** The billing codes are tied to the fee schedules, and rules governing coding are best included in the fee schedule sections and should be updated in tandem with fee schedule updates.	None.
California DWC Medical Bill and Payment Guide 2011 – Section 2 – Standardized Medical Treatment Billing Format	Commenter understands that some Workers' Compensation payers already accept electronic claims/reports. Commenter would not want those payers to suspend their electronic system until 18 months after the effective date of the regulations. Commenter would like for them to transition their system to comply with the new requirements as soon as possible. **Commenter urges the Division to adopt language in this section that would encourage payers to implement their electronic billing/payment system as soon as possible, but no later than 18 months after the effective date of the regulations.**	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Agree** that it would be useful to clarify that electronic billing may take place prior to the effective date of the regulations.	Modify 2.0(b) to add language "Parties may engage in electronic billing and remittance prior to the effective date of the regulation upon mutual agreement and are encouraged to do so."

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California DWC Medical Bill and Payment Guide 2011 – Section 2 – Standardized Medical Treatment Billing Format	(b) – sets up the timeframe for payers to comply, but it only refers to "medical bills." Commenter suggests, for clarity, adding "medical bills and attachments" so there is no question that the Division expects the payer to be able to electronically accept both the medical bill and any required reports/documentation. Commenter requests that the Division clarify that physicians will be able to submit electronically and fax any required attachments. Doing this would be in keeping with Medicare's policy on this issue.	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Disagree.** The additional language is not necessary and may be confusing since the Division is not mandating an electronic document submission method at this time. Section 7.3 sets out the details regarding electronic bill attachments, including the permissible methods. Since there is no HIPAA-approved medical bill attachment standard the Division has not adopted an electronic standard. The Electronic Medical Billing and Payment Companion Guide refers to the ASCX12N/005010X210 (275) as optional for document submission. Section 7.3(d) specifically describes three methods allowed: fax, the 275 (upon mutual agreement) and encrypted email.	None.
California DWC Medical Bill and Payment Guide 2011 Section 3.0 Complete Bills (A)	Commenter stresses that the definition of a "Complete Bill" and a provider's ability to be able to achieve a complete bill status with their claims will be critical to the success and acceptance of this program by providers. If payers are allowed to take advantage of providers and not	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association	**Agree in part.** The Division agrees that the claim number should not be a basis for rejecting the bill if the claims administrator is able to match the bill to a claim during the 5 working day pending period. However, the Division does not believe it is necessary to specify what data elements should	See description above in response to comment by Brendan Friar Senior Vice President WorkCompEDI, Inc. January 10, 2011.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	pay their electronic claims in a timely manner, providers will not see the advantage of investing in the technology needed to allow them to electronically submit their bills/reports. While commenter is supportive of most of the required fields, both CMA and COA representatives to the Advisory Panel strenuously objected to language requiring physicians to provide claim numbers on each bill. The carriers have sole responsibility for assigning both claim numbers and/or issuing authorization numbers. Data elements which would deem a claim complete must be reasonable and within the physician's control. Commenter opines that requiring physicians to provide information that providers simply do not have access to or cannot obtain at the time they are submitting their bills is unnecessary, unfair and creates a loophole that will allow carriers to delay payment. More often than not physicians do not have, nor are they able to obtain the claim number. While it is an improvement to not require the claim number on the	January 28, 2011 Written Comment	be used for matching the bill to the claim. The Division believes that it should not restrict the 5 working day matching period and will revise the rules to require up to 5 working day pending period to match the bill to claim whenever the bill is lacking the claim number. See also response above to Brendan Friar, Senior Vice President, WorkCompEDI, Inc. January 10, 2011	

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	initial bill submitted by the provider, this does not go far enough. Frequently, physicians may need to treat the injured worker several times in a relatively short period of time. All of those bills will potentially be held up until the provider receives the first payment from the payer with the claim number. This is likely to be 60 days or more, for example, dependant on the employers/payer's acceptance of the claim notwithstanding the timeliness of the payer's processing of the first bill. Finally, there are several data elements that will allow the carrier to validate the bill. Commenter strongly urges the Division to delete the requirement that a claim number can only be listed as unknown if it is the first billing by the provider. Providers should be allowed to list either a Social Security number, the claim number, or the physical location where the employee works if the Social Security number or claim number is unknown and still have the claim considered complete.			
California DWC Medical Bill and Payment Guide 2011 – Section 3 (B)	Commenter agrees that the claims administrator should be allowed to fill in missing identifying information if	Diane Przepiorski Executive Director CA Orthopaedic Association	**Disagree.** The comment is vague; it is unclear what the phrase "lines 1-13" refers to. Assuming it refers to Fields 1-13	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	they have the information – lines 1-13. Claims administrators should not be allowed to change the claim form information in lines 14 and above.	Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	of the 1500 form, the commenter has not specified any reason that the claims administrator should be precluded from populating missing information if the claims administrator has previously received the missing information.	
California DWC Medical Bill and Payment Guide 2011 – Section 3 (C)	Required report and supporting documentation (1) Doctor's First Report of Occupational Injury – should only be required of the first physician who treats the injured worker. (3) There is confusion in the OMFS Ground Rules about how to bill the final permanent and stationary report when there are no residual disability levels. Specialists commonly bill PR-3/PR-4 for this final report and many payers reimburse the provider for these reports. Other payers point to the discrepancy in the Ground Rules which says, the provider is only required to complete a PR-2 form when there are no residual disabilities. This may be appropriate for a minor injury, but not for injuries treated by specialists. Many times, the specialist submits the PR-3/PR-4 report and the	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. It is directed to the reporting rules and the regulations governing reimbursement levels for reports. These regulations are not at issue in this rulemaking action.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	payer downcodes the billing to a PR-2 report. The Division's staff has previously indicated that when the provider prepares the PR-3/PR-4 report, they should be paid for the more comprehensive report, but some payers disregard this and continue to reimburse at the PR-2 level. Providers cannot afford to produce a PR-3/PR-4 report for the low PR-2 reimbursement levels. Commenter urges the Division to clarify that a specialist is allowed to bill a PR-3/PR-4 for all injured workers' Permanent and Stationary reports, even for those injured workers with no residual disability.			
California DWC Medical Bill and Payment Guide 2011 – Section 3 (5)	Commenter objects to requiring a report when the provider uses a Modifier -25. This is an unnecessary reporting requirement for injection codes which may be performed on the same day as an Evaluation and Management service. Commenter urges the Division to delete the requirement for a report when Modifier -25 is utilized.	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Disagree.** The CPT Modifier 25 indicates a "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service." Since the "surgical package" generally includes an evaluation and management component, the Division believes the use of Modifier 25 should be supported by a report. It is likely that this report will often already be issued as a required PR-2 under 8 CCR §9785.	None.

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California DWC Medical Bill and Payment Guide 2011 – Section 3 (6) and (7)	Commenter refers to a "descriptive report." Descriptive reports are not defined. More often these reports are referred to as a "narrative" report. **Commenter recommends that the Division refer to these reports as a "narrative report" not a descriptive report.**	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. In addition, the term "descriptive report" is preferable to "narrative report" since the "descriptive report" could be included within a Progress Report (PR-2) or even within chart notes. The use of the term "narrative report" might be confusing since that term has a particular meaning within the physician reporting requirements of 8 CCR §9785 et seq.	None.
California DWC Medical Bill and Payment Guide 2011 – Section 3 (11)	Commenter opines that written authorization should not be required of the provider because the carrier should already have this information in their system.	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Agree.** The provider should be able to submit the authorization if he/she wishes to do so, but it should not be required for a complete bill.	Modify 3.0 Complete Bill to delete requirement to provide the written authorization.
California DWC Medical Bill and Payment Guide 2011 – Section 3 (c)	Commenter strongly objects to this section. If a paper claim and required reports are mailed to the payer, it is unnecessary to require the provider to include a header or attachment cover sheet. This only unnecessarily adds to the provider's overhead/postage costs.	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. In addition, the Division disagrees with the comment**.** It	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	It should be apparent to the payer that the claim and reports go together. Moreover, the advisory panel agreed that "header" requirements should apply not apply to paper bills with attachments, mailed together in the same envelope and sent to the payer via the US Postal Service or other parcel delivery vendor.	California Medical Association January 28, 2011 Written Comment	appears commenters are mis-reading subdivision (c). This provision already states that the header or attachment cover sheet are only required if the bill and reports/documentation are not in the same envelope.	
California DWC Medical Bill and Payment Guide 2011 – Section 5 – Duplicative Bills, Bill Revisions, and Balance Forward Billing (c)	Commenter understands the payers' objection to balance forward or "statement type" billing. While commenter believes that adoption of standardized billing formats will alleviate the problem, these regulations should not be misconstrued to prohibit physicians from billing for multiple dates of service on a single form (electronic or paper). For example, physicians may find it necessary to see a patient multiple times in a single week, yet many practices submit bills once per week. This would also be a problem for billing inpatient services. Thus, commenter respectfully requests that the Division to clarify this issue.	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Disagree** that the duplicate bill provisions could be interpreted to preclude billing for more than one date of service on the 1500 form. There is nothing in the duplicate bill provisions that implies that only one date of service is allowed. Moreover, the 1500 Form, Field 24A has six lines for "date(s)of service", thus clearly indicating that more than one date of service may be billed on the form.	None.

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California DWC Medical Bill and Payment Guide 2011 – Section 5 – Duplicative Bills, Bill Revisions, and Balance Forward Billing (d)	Commenter strongly objects to the prohibition that once a provider submits a bill either electronically or on paper, they are not allowed to submit the claim in another manner. Commenter believes that there will be legitimate circumstances when the provider may need to submit the claim or additional information in another manner. Commenter believes that this requirement does nothing to incent, improve, or streamline the bill submission process. While Medicare does have such a requirement, no other payer or program has implemented such a restriction and, neither should the Division. Commenter strongly urges the Division to delete this section.	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Disagree.** This rule is intended to reduce the possibility of duplicate billings that would be hard to detect when one comes in electronically and a second comes in on paper. Commenters have not indicated why there would be a need to submit in one manner and then another.	None.
California DWC Medical Bill and Payment Guide 2011 – Section 7.1 – Medical Treatment Billing and Payment Requirements for Electronically Submitted Bills – Timeframes (3)(A)	Claim Pending Status – Commenter refers to previous comments on definition of a "Complete Claim."	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Agree** that changes should be made to require that a bill missing a claim number shall be placed in pending status for up to 5 working days to match the bill to the claim. See response above to the commenters' comment regarding Section 3.0 Complete Bills (A).	See action above.

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California DWC Medical Bill and Payment Guide 2011 – Section 7.1 – Medical Treatment Billing and Payment Requirements for Electronically Submitted Bills – Timeframes (3)(C)	Commenter recommends that "The submitted bill is complete and has moved into bill review" should be changed to "The submitted bill is complete and has moved to the claims administrator." Commenter does not believe the Division intended to infer that all bills will be sent to "bill review." The claim should be sent to the claims administrator who has responsibility for the timely processing of the claim.	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Disagree.** The language proposed is not useful or accurate. The bill is submitted to the claims administrator, or to its agent, and the language "The submitted bill is complete and has moved into bill review" is an acknowledgment back to the bill submitter that the submission is "complete" and will be processed further. This further process is to review the bill for appropriateness of payment. It does not make sense to say the bill has moved to the claims administrator. Commenters may be interpreting "moved into bill review" to mean that the bill is sent to an outside "bill review company." However, bill review may be done by the claims administrator or its bill handling agent.	None.
California DWC Medical Bill and Payment Guide 2011 – Section 7.1 – Medical Treatment Billing and Payment Requirements for Electronically Submitted Bills – Timeframes 7.1 (b)	Payment and Remittance Advice/Denial/Objection Commenter states that if the provider submits their claim electronically, the payer should be required to send back an electronic remittance advice. It would be unreasonable to expect the provider to wait for a mailed copy of the remittance advice. Commenter	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Disagree.** The proposal already requires the payer to return an electronic remittance advice if the bill is submitted electronically. The introductory language in 7.1 Timeframes states: "When a medical treatment bill has been submitted electronically, the claims administrator must transmit the Acknowledgments and Payment/Advice as set forth	None.

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	urges the Division to clarify that the remittance advice must be electronically sent to the provider who submitted the claim electronically.		below using the specified transaction sets. These transactions are used to notify the provider regarding the entire bill or portions of the bill including: acknowledgment, payment, adjustments to the bill, requests for additional information, rejection of the bill, objection to the bill, or denial of the bill." It would be redundant to repeat that requirement in subdivision (b).	
California DWC Medical Bill and Payment Guide 2011 – Section 7.1 – Medical Treatment Billing and Payment Requirements for Electronically Submitted Bills – Timeframes	(1) – Complete bill – payment for uncontested medical treatment Commenter states that the incentive for providers to participate in this electronic system, is their ability to be paid more quickly. Providers do not maintain separate billing systems for various payers or types of patients. They bill their usual and customary fee for the service and the payer reduces the bill to fee schedule or contract levels. This is common for all types of billings: Workers' Compensation, group health, Medicare, etc. Commenter opines that it would be cost prohibitive for medical offices to maintain a different billing system for each payer or type	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Disagree.** Although the Division appreciates the desire of providers to bill their usual and customary charge, that is not the language of the statute. The regulation is drafted to parallel Labor Code section 4603.4 which requires payment within 15 days of bills submitted at or below the fee schedule.	None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	of payer contract that they accept. Commenter urges the Division to remove language in this section that requires the provider to bill at or below the official medical fee schedule reimbursement levels in order to be paid more quickly for a complete claim.			
California DWC Medical Bill and Payment Guide 2011 – Section 7.1 – Medical Treatment Billing and Payment Requirements for Electronically Submitted Bills – Timeframes	(b)(2) Objection to Bill/Denial of Payment Commenter believes that these billing guides must be very clear that if the payer objects to a line item of billing on a claim form, that they are required to pay the other uncontested line items and not hold up payment for the entire bill. Again, another key issue for providers. This section goes on to discuss when the claims administrator could object to a bill – they could also dispute the service if the required documentation was not received. Commenter envisions the payer would raise all of the objections to the claim at once during the one 15 working day delay. If there are multiple objections to the claim and the payer is entitled to a	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Disagree** that further clarification is needed. Commenters have not suggested a specific alteration. The Division believes the language already requires the payer to pay uncontested portions of the bill. **Disagree** that there is a need to clarify that all objections are to expected to be raised in one 15 working day time period. The claims administrators have incentive to include all objections because uncontested portions of the bill must be paid or are subject to penalty. In addition, there could be an argument that the objection was waived if it is	None. None.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	new 15 working day delay for each objection, providers would experience long delays in receiving the deficiency notices and in receiving payment. **Commenter urges the Division to clarify that the payer would be expected to raise all objections to the claim in one 15 working day period of time.**		not raised.	
California DWC Medical Bill and Payment Guide 2011 – Section 7.2 – Penalty (b)	Commenter opines that since the track record of payers paying interest and penalties when owed to providers has not been good, that it is important for the Division to clarify that the expectation is that the payer would automatically increase the reimbursement of the claim by the interest and penalty owed to the provider. It is a waste of the time of the providers and ultimately, the Workers' Compensation Appeals Board if the provider is required to file a lien to collect these unpaid monies. They should be automatically paid when the claim is paid.	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	Disagree that there is a need to clarify that the payer would automatically issue the increase and penalty. The guide already contains such a provision. The last sentence of 7.2 (b) states: "The increase and interest are self-executing and shall apply to the portion of the bill that is neither timely paid nor objected to."	None.
California DWC Medical Bill and Payment Guide 2011 – Section 7.3 Electronic Bill Attachments	Commenter states that the P2P is the clearing house used by several of our members who are already submitting their Workers' Compensation claims and attachments electronically. P2P is	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro	**Agree** in part. The Division agrees that the parties should be able to agree to forgo the attachment header or cover sheet upon mutual agreement. However, the Division believes	Modify 7.3(a) Electronic Bill Attachments to state "Unless otherwise agreed by the parties…." All

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	able to match up the claim and any attachments without the use of a header or cover sheet through the use of some naming formatting rules. The provider is required to name their attachments in such a way that identifies the patient so the documents can be matched up after the clearing house receives them. The following are some naming formats used by P2P: Matching Method 1 "Standard Matching" · Exact match on Patient SSN and Date of Service · Doc License Number can be used as wild card Example: SSN_DOS_AttachTypeID.pdf Matching Method 2 "Patient Name Matching" · Exact match on Patient Last Name, Patient First Name and Date of Service · Doc License Number can be used as wild card Example: PtLastName_PtFirstName_DOS_AttachTypeID.pdf Matching Method 3 "Patient Account	Associate Director California Medical Association January 28, 2011 Written Comment	the attachment or cover sheet should be mandated absent agreement. Therefore, language will be added to all parties to agree to an alternative.	attachments to support an electronically submitted bill must either have a header or attached cover sheet….

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	Number" · Exact match on Patient Account Number Example: PtAcctNo_AttchTypeID.pdf Matching Method 4 "Paperwork ID Matching" · Exact match on unique ID Example: PWBillID_AttachTypeID.pdf Naming conventions may include more information than is needed, but must contain at a minimum the required field from one of the Matching Methods above. We believe that it is unnecessary to require the provider to provide these headers and cover sheets. **Commenter recommends that cover sheets only be required when the bill is faxed.** This also raises some additional process issues that commenter did not see addressed in the DWC regulations: 1. Payers should not be allowed to enter into an exclusive arrangement with a single clearinghouse. Providers' should be able to choose the clearinghouse that works best with		**Disagree** that the Division should regulate the clearinghouses that payers or providers use. There are many factors that may enter into the decision to utilize a clearinghouse or to use more than	None.

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	their billing system. 2. Payers should be required to establish a working relationship with all clearinghouses to avoid the delay of a clearinghouse having to physically mail the claim/attachments to the payers.		one clearinghouse. It is also likely that connectivity between various clearinghouses will steadily increase as electronic billing becomes more widespread in workers' compensation.	
California DWC Medical Bill and Payment Guide 2011- Appendix A	CMS1500 Box 23 – commenter suggests that providers should be able to input in this field either the written confirmation number or indicate that the authorization was verbal.	Diane Przepiorski Executive Director CA Orthopaedic Association Frank Navarro Associate Director California Medical Association January 28, 2011 Written Comment	**Disagree.** The authorization number in this field communicates specific information to link a prior authorization to some numerical tracking system established by the claims administrator. This is in accord with the National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual, page 31, which provides for the entry of a number, not text: **"For Workers Compensation and Other Property & Casualty Claims:** Required when prior authorization, referral, concurrent review, or voluntary certification was received. **Description:** The prior authorization number refers to the payer assigned number authorizing the service(s). **Field Specification:** This field allows for the entry of 29	None.

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			characters."	
California DWC Medical Bill and Payment Guide 2011- 3.0 Complete Bills	Commenter suggests the following revised language: (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	Brenda Ramirez Claims and Medical Director CWCI January 28, 2011 Written Comment	**Agree in part.** The Division agrees that (b)(10) needs alteration. However, instead of deleting the words "should be", the Division has inserted the concept that the documentation should be "sufficient to support the level of service or code that has been billed" into the introductory sentence so that it applies to all of the subdivisions of (b). **Agree in part** that (b)(10) needs clarification. The commenter's statement that "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" evidences a misunderstanding of the proposed language. The listing of items in (b) are those items that are part of the	Modify page 9, 3.0 Complete Bills: "(b) All required reports and supporting documentation sufficient to support the level of service or code that has been billed must be submitted as follows:" Also, modify page 9 (b)(10) to delete the sentence "Supporting documentation should be sufficient to support the level of service or code that has been billed.." Modify (b)(10) page 9 to add clarifying language: "(This does not prohibit the claims administrator from requesting additional appropriate information during further bill processing.)"

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	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		"complete bill." Logically, the provider can only include "requested" documents at the time of bill submission if the requested documents were in fact requested prior to submission of the bill. The misunderstanding of commenter indicates that the language is in need of clarification.	

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	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.			
California DWC Medical Bill and Payment Guide 2011- 7.1 Timeframes	Commenter suggests the following revised language: (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	Brenda Ramirez Claims and Medical Director CWCI January 28, 2011 Written Comment	**Agree.**	The word "working" will be added as indicated in 7.1(a)(3)(i).

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	attachment and/or claim number is provided, prior to being rejected as incomplete. … 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			

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	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."			
California DWC Medical Bill and Payment Guide 2011- Appendix A – Standard Paper Forms	CMS 1500 paper field 14 Commenter suggests the following revised language: 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.	Brenda Ramirez Claims and Medical Director CWCI January 28, 2011 Written Comment	**Agree in part.** See response above to the same comment made by Steven Suchil, Assistant Vice President, American Insurance Association, January 27, 2011.	See above.

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	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."*			
California DWC Medical Bill and Payment Guide 2011- Appendix A – Standard Paper Forms	CMS 1500 paper field 16 In paper field 16, commenter suggests that the Division 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	Brenda Ramirez Claims and Medical Director CWCI January 28, 2011 Written Comment	**Disagree.** See response above to same comment made by Steven Suchil, Assistant Vice President American Insurance Association January 27, 2011.	None.

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	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.			
California DWC Medical Bill and Payment Guide 2011- Appendix A – Standard Paper Forms	CMS 1500 paper field 31 Commenter 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.	Brenda Ramirez Claims and Medical Director CWCI January 28, 2011 Written Comment	**Disagree.** There has never been a requirement that physicians sign workers' compensation medical treatment bills. The Division is not aware of any statute requiring physicians to do so. Prosecutions can still be pursued if the provider is engaged in billing fraud. In the absence of evidence of a need for physician signature, the Division believes adopting a new signature requirement is not warranted and would be overly burdensome	None.
California DWC Medical Bill and Payment Guide 2011- Appendix A – Standard Paper Forms 4.1 Field Table ADA 2006 Field 48	ADA 2006 Commenter recommends restoring "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.	Brenda Ramirez Claims and Medical Director CWCI January 28, 2011 Written Comment	**Agree.** The error will be corrected.	Modify Appendix A 4.1 Field Table ADA 2006 Field 48 to restore the "R."

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California DWC Medical Bill and Payment Guide 2011- Appendix B – Standard Explanations of Review	3.0 Field Table Standard EORs – Bill Level Adjustment Commenter recommends deleting the term "Field" and "Fields" from the table. Commenter states that the Division is not proposing to adopt a specific paper EOR from; however, the term "Field" and "Fields" in the table implies specific location(s) on a form. Commenter believes deleting these terms will avoid confusion.	Brenda Ramirez Claims and Medical Director CWCI January 28, 2011 Written Comment	**Agree.** See response above to same comment made by Steven Suchil, Assistant Vice President American Insurance Association January 27, 2011.	See above.
California DWC Medical Bill and Payment Guide 2011- Appendix B – Standard Explanations of Review	Section Two – Transmission Standards 4.0 Electronic Signature Commenter recommends retaining 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.	Brenda Ramirez Claims and Medical Director CWCI January 28, 2011 Written Comment	**Disagree.** See response above regarding the lack of a requirement for signatures on workers' compensation medical treatment bills.	None.

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California DWC Electronic Medical Billing & Payment Companion Guide – Version 1.0 2012 – Chapter 9	**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.	Brenda Ramirez Claims and Medical Director CWCI January 28, 2011 Written Comment	**Agree in part.** The Division agrees that the language should be changed. However, the Division disagrees that the specific categories and status codes should be inserted into the guide. The ASC X12N/005010X214 Health Care Claim Acknowledgement (277) transaction set specifies the codes to be used. The Division should not set forth all the codes into the Companion Guide as it would be unnecessary and redundant. The Companion Guide is intended only to supplement the national transaction guides where necessary for the workers' compensation implementation.	Modify 9.4.3 to delete the direction to utilize the "most current" codes and instead provide that the payers should use the codes "prescribed by the 005010X214."
General Comment – Implementation Date	Commenter requests a 90-day grace period instead of 60 days to allow for system revisions.	Dale Clough Sr. Compliance Consultant Travelers Insurance January 28, 2011 Written Comment	**Agree** that the period for implementation should be lengthened. The Division is unaware of what "60 days" commenter is referring to. However, the Division will extend the effective date for provisions relating to paper billing and remittance advice from 90 days to 180 days. See response above to Kevin C. Tribout, Director of Government Affairs, PMSI, January 11, 2011.	See above.

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	Clean Bills Commenter agrees with the concept of allowing a "clean bill" to be expedited through the system but anticipates challenges determining the precise definition of clean. Commenter would like to see additional information or clarifications which will avoid unnecessary conflict. Common billing issues include down-coding, bill charges, and documentation problems. Commenter believes that providers would benefit greatly from clarifying the follow questions: a. Is a down-coded bill considered clean, and therefore payable within 15 days?	Paul Papanek Western Occupational & Environmental Medical Association January 28, 2011 Written Comment	a. The Complete Bill section defines a complete bill while other provisions require that uncontested portions of bills be paid within 15 days. If the payer believes that there is not sufficient documentation to support the level of the bill, it may need to request additional documentation which may lead to payment beyond 15 days, and possibly "downcoding" if a lower level of service is supported. The Division is unaware of how there could be clarification of the issue as	None.

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	b. If an appropriate CPT code is used, should it matter if the charges are listed as OMFS or as Usual and Customary?		framed by commenter since the question of whether a code is payable within 15 days will depend largely on the factual circumstances and documentation received. b. The statutory language states that payment must be made within 15 days of billing at or below the fee schedule. It is anticipated that many payers will process bills within the 15 working days regardless of whether the bill is at or below the fee schedule since bill review will identify bills that are above the fee schedule and will recommend reduction. However, due to the statutory language the Division is unable to address "Usual and Customary Charge" billings that are above the fee schedule.	None.
	c. What is the allowable time frame between receiving both the billing information and the appropriate documentation?		c. This question is somewhat ambiguous, as the inclusion of the word "both" makes it appear that the sentence has been truncated. The Division will assume that "both" is surplusage and that the question is directed at the allowable time between the	None.

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			payer receiving the bill and the payer receiving the documentation. For both paper and electronic billing the Medical Billing and Payment Guide defines "Complete Bill" to include "required reports and supporting documentation." For paper billing, Labor Code §4603.2 states that "Payments shall be made by the employer within 45 working days after receipt of each separate, itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician." Section 4603.2(d)(2) also references the "documentation submitted together with that itemization." Thus, by statute the bill and documentation are to be sent together. Subdivision (b)(1) provides that if the itemization is considered incomplete the physician is to be notified within 30 working days of receipt of the itemization. The regulation is consistent with these statutory provisions, by	

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			incorporating the following language in the Medical Billing and Payment Guide, 6.0 Medical Treatment Billing and Payment Requirements for Non-Electronically submitted bills. "If the required report or supporting documentation necessary to support the bill is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill report and/or supporting documentation whichever is received later. If the claims administrator receives a bill and believes that it has not received a required report and/or supporting documentation to support the bill, the claims administrator shall so inform the health care provider, health care facility or billing agent/assignee with 30 working days of receipt of the bill." For electronic bills, as with paper bills, the Medical Billing and Payment Guide, 3.0 Complete Bills provides that a complete bill includes the supporting documentation. It	

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	d. Would a provider be penalized if non-vital information is not available? Please clarify what billing information is vital.		is clear from the guide that the supporting documentation must be submitted within 5 working days of the bill. Section 7.1 Timeframes subdivision (a)(3)(A) provides that a bill missing an attachment shall be placed in pending status for up to 5 working days for receipt of the attachment. Also, the Electronic Medical Billing and Payment Companion Guide, Chapter 9, Section 9.3 sets forth details about the 5-working day hold period for missing documentation . d. The guide sets forth what elements make up a complete bill, and what supporting documentation is required. The Division is unaware of how to make this information more specific given the broad range of possible treatment scenarios.	None.
	Notification deadline Commenter is concerned about an apparent inconsistency between the proposed regulations and part of the authorizing statute in the Labor Code.	Paul Papanek Western Occupational & Environmental Medical Association January 28, 2011	**Disagree**. The Division does not believe that there is a need to clarify that the ASC X12C/005010X214 Health Care Claim Acknowledgment (277) which is used to issue notice of an	None.

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	In the new regulations, a provider must be notified about an incomplete bill within 48 hours of the payer's receipt. However, Section 4603.4 (d) of the Labor Code provides that any billing that is "contested, denied or incomplete" shall be paid according to the standards for paper billing. Those standards require payers to notify providers of incompleteness or denial within 30 days, not 48 hours. Seemingly, a payer could be justified in choosing either deadline – 48 hours or 30 days. Until the language of statute can be adjusted, the regulation should clarify that the 48-hour deadline is the operative one.	Written Comment	incomplete bill must be issued within two working days rather than 30 days. The 277 is clearly required by the regulations to be issued within two working days to communicate the initial "complete bill" determination. (See Medical Billing and Payment Guide, Section 7.1(a)(3) and Electronic Medical Billing and Payment Companion Guide Chapter 9.) Uncontested bills or portions of bills must be paid within 15 days, and the 835 Health Care Claim Payment/Advice must be issued within 15 days to communicate the objections to bills or the adjustment of bills. (Medical Billing and Payment Guide, Section 7.1(b).) The statutory provision in Labor Code section 4603.4(d) which states "If the billing is contested, denied, or incomplete, payment shall be made in accordance with Section 4603.2" is addressed in the Medical Billing and Payment Guide, Section 7.1(b)(2). That section states that the 835 Health Care Claim Payment/Advice is used to object to a bill that has not been rejected at the	

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			Acknowledgment stage [which includes the 277 at two working days] and concludes the paragraph by stating "Any contested portion of the billing shall be paid in accordance with Labor Code section 4603.2." This provision gives effect to the subdivision (d) of Labor Code section 4603.4.	
Medical Billing and Payment Guide, Introduction	Electronic payment The regulations state that DWC "encourages" but does not require payers to offer the option of electronic payment. Commenter believes payers should be required to offer electronic payment, although the regulations should set an implementation date far enough ahead so that payers currently without that capacity have time to add it to their systems.	Paul Papanek Western Occupational & Environmental Medical Association January 28, 2011 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
Electronic Medical Billing and Payment Companion Guide	The Definition of Complete Bill and requirement that a Claim Number must be provided. Commenter opines that the very nature of occupational clinic medicine, the injured worker will be seen at his/her initial visit and for a number of visits afterward, without a claim number	Steven J. Cattolica Director of Government Relations Advocal CSIMS & CSPM&R January 28, 2011 Written Comment	**Agree in part.** The Division agrees that it may be difficult in some cases for the provider to obtain the claim number. Nevertheless, the claim number is an important identifier which helps speed processing of the bill. The Division agrees that it would be appropriate to eliminate the payer's ability to automatically	See the modifications set forth above in response to a comment by Brendan Friar Senior Vice President WorkCompEDI, Inc.

ELECTRONIC AND STANDARDIZED BILLING REGULATIONS	RULEMAKING COMMENTS 1st 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	being assigned for the provider to use on its bill. Regardless of the manifold reasons for this fact, mandating a claim number on bills for those initial visits will assure that the provider realizes no benefit from the efficiencies of electronic billing. In order to submit a complete bill, the provider must wait for a claim number. This wait will be at the very least a number of days, but could stretch into several weeks. Commenter states that in the early years of this decade, when WCIS first began to collect First Report of Injury statistics from carriers, it was discovered that the average time from date of employers' first knowledge (of the injury) to the date of reporting to the carrier was approximately 21 days! Once reported, many carriers take a few more days to assign a claim number. Commenter opines that in the electronic billing realm, the medical provider is thus at the mercy of a process that he/she cannot control. In today's paper system, this problem largely doesn't exist. Primary treaters commonly submit bills without claim		reject a bill because of a missing claim number and that it would be preferable to require the payer to pend a claim whenever the bill comes in without a claim number.	

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	numbers and are paid relatively promptly. Forcing them to wait for a claim number before submitting a bill turns the economic efficiencies of electronic billing upside down and works to the advantage of the claims administrator. Commenter requests that the Division reconsider the requirement that bills for the initial visits of an injury require a claim number before being considered complete. During stakeholder discussions on this item, a number of solutions were put forward by providers and payers alike. There is a way to eliminate this disincentive.			
	Commenter requests that the Division build in Electronic Funds Transfer (EFT) as a mandatory feature. Electronic funds transfer (EFT) remains optional for payers and yet represents the majority of the cost savings for both the payer and provider.	Steven J. Cattolica Director of Government Relations Advocal CSIMS & CSPM&R January 28, 2011 Written Comment	**Disagree.** The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.
Future revision to Labor Code Section 4603.4(d)	Commenter states that the last comment involves an issue that is admittedly outside the authority of the Division and is instead vested in the	Steven J. Cattolica Director of Government Relations Advocal CSIMS & CSPM&R	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	None.

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	legislature. Commenter respectfully requests the Division's support when the legislature begins consideration of amendments to Labor Code 4603.4 (d). Commenter anticipates legislation that would make the criteria for processing uncontested amounts on bills for medical services in the work comp system the same whether the bill is submitted on paper or electronically. Under present statute (Labor Code Sections 4603.2 and 5307.1) when a bill for medical services in work comp is submitted on paper (hard copy), the employer (insurance company/claims administrator) may contest some portion of the billed services. If so, they must nevertheless, pay the uncontested amounts within a 45 day time frame (from the date of receipt of the bill). The provider and employer figure out the contested amounts later. However, under present statute (Labor Code 4603.4 (d)) the same provider properly submitting that same bill electronically must be paid within 15 working days (this is an incentive to participate in electronic billing).	January 28, 2011 Written Comment		

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	However, this same statute allows the employer (insurance company/claims adn1inistrator), to delay payment of the entire bill even if they contest only one portion of it. Commenter opines that it should not matter whether the bill is submitted on paper or electronically. The employer should pay uncontested amounts within the applicable time frame and not be able to delay payment of electronic bills simply because they find a single item not to their liking. Commenter believes that this two-tier system will cause many electronic bills to be paid no sooner than 45 days even though the intent of the statute is to reward participation in electronic billing with a more rapid payment of properly billed services.			