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VIA E-MAIL: dwcrules@dir.ca.gov

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

RE: Regulations on medical billing standards and electronic billing

Dear Ms. Gray:

This written testimony on proposed regulations for medical billing standards and electronic billing is presented on behalf of the California Workers' Compensation Institute's members. Institute members include insurers writing 87% of California's workers' compensation premium, and self-insured employers with $30B of annual payroll (20% of the state's total annual self-insured payroll).

The Institute commends the Division of Workers' Compensation on its exceptional efforts on this large and challenging project. In particular, DWC Medical Unit Manager Susan Honor Vangerov worked hard to ensure that representatives of all stakeholders were included in its advisory committees and workgroups and listened carefully their input. As a result of Ms. Vangerov's leadership, stakeholder participants were able to work together to develop some innovative solutions to difficult and divisive issues.

Recommended modifications are indicated by underline and ~~strikethrough~~. Some recommendations and discussion apply to the same issues in more than one section of the proposed regulations including the two Guides, but are not repeated in each section.

Article 5.5. Application of the Official Medical Fee Schedule

Recommendation

Address all changes contemplated to section 9792.5 in a single rulemaking.

Discussion

The DWC posted on the DWC Forum section of its web site other changes it drafted for §9792.5 and solicited informal comment from the public on those changes. Those draft changes are not included in these proposed modifications. Addressing any and all

changes to this section in one rulemaking will avoid the confusion, disruption and unnecessary expense that otherwise will be generated by adopting two separate changes to this section within a short period of time.

§9792.5. Payment for Medical Treatment.

Recommendation – Effective date

This section is applicable to medical treatment rendered between April 18, 2004 and ~~before~~ XXXX, 2010 *[approximately 90 days after the effective date of this regulation]*.

Discussion

The proposed revisions to this section are made to conform to amendments enacted by SB 899 to Labor Code section 4603.2. Per section 47 of SB 899, those amendments apply prospectively from the date of enactment, April 19, 2004. Claims administrators continue to receive bills and amended bills for services provided more than six years ago. The regulatory language must be revised to clarify that the current language remains effective for services provided before that enactment date, and that the proposed revisions apply only to services provided between April 18, 2004 and the date 90 days after the effective date of this proposed regulatory change.

Section 9792.5(b),(d)

Recommendation – Governmental Entity

Modify the language in (b) and (d) to clarify that payment for a properly documented bill is due within 60 working days if the employer is a governmental entity.

Discussion

Labor Code section 4603.2(b)(2) specifies that if the employer is a governmental entity, that the time allowed for payment is 60 days.

Recommendation – Interest on Contested Charges

~~(f) Any contested charge for medical treatment provided or authorized by the treating physician which is determined by the appeals board to be payable shall carry interest at the same rate as judgments in civil actions from the date the amount was due until it is paid.~~

Discussion

While section 4603.2(b)(1) provides for 15% penalty and interest if a bill is neither paid within 45 working days nor properly contested, the subsection that previously imposed interest if the appeals board subsequently determined a contested charge to be payable was deleted from section 4603.2(b)(1)(B) by the legislature in the Assembly Bill 1806 budget trailer bill, effective July 1, 2006. This deletion repealed the statutory authority for the appeals board to impose interest when it determines a contested charge is payable.

Article 5.5.0 Rules for Treatment Billing and Payment…

Section 9792.5.1(c),(d),(e),(f),(g),(h)
Recommendation – Guides and Manuals
Delete subsections (c) through (h) and instead include all necessary information in the DWC's Guides.

Discussion
To avoid possible contradictions and confusion it is necessary to include all information needed by the user in the DWC's Guides, otherwise modifications to these other guides manuals may create unexpected contradictions and confusion since the referenced manuals are not under the Division's control. As proposed, in order to comply with these regulations, or even to see what is required to comply with these regulations, the regulated public must purchase guides and manuals at considerable expense. This will not be necessary if the Division includes the necessary information in its guides. In instances where this is not possible, the Division can centrally arrange availability to the regulated public by paying multi-use fees if necessary and posting those guides/manuals on its web site. This will provide availability in the most cost-effective way to the regulated community.

Section 9792.5.2
Recommendation -- Terminology

(a) On and after XXXX, 2010, [approximately 90 days after the effective date of this regulation] all paper bills for medical treatment provided by ~~physicians~~, health care providers, and health care facilities shall be submitted on ~~claim~~ billing forms set forth in the *California Division of Workers' Compensation Medical Billing and Payment Guide*.

(c) On and after XXXX, 2011 [approximately 18 months after the effective date of regulation], all bills for medical treatment provided by ~~physicians,~~ health care providers, and health care facilities may be electronically submitted to the claims administrator for payment. Electronic bills submitted on or after that date shall conform to the applicable provisions of the *California Division of Workers' Compensation Medical Billing and Payment Guide* and the *California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide*.

Discussion
Since the definition of health care provider encompasses physicians, it is not necessary to separately reference them. To avoid confusion, it is better to use the replace the term "claim" with "billing" here and wherever else it appears in these regulations when the intended meaning concerns a charge for medical goods or services. The term "claim" has another meaning in the California workers' compensation venue.

1.0 Standardized Billing / Electronic Billing Definitions

Recommendation – Bill

(b) "Bill" means the medical services and corresponding billed amounts as itemized in Appendix A, and set forth in the uniform billing form/format ~~setting forth the itemization of services provided found in Appendix A~~ along with the required reports and/or supporting documentation as described in Section One – 3.0.

Discussion

The Institute suggests that a "bill" is more accurately described as information supplied on the form/format than the form/format where the information is set out.

Recommendation – Explanations of Review

Clarify in (j) whether an EOR can serve as an objection.
Clarify that EORs are not required for bills that are rejected during the initial clean bill screens.

(j) "Explanation of Review" (EOR) means the explanation of payment or ~~the denial of the payment~~ non-payment using the standard code set found in Appendix B – 1.0. EOR~~'~~s use the following standard codes:

(1) DWC Bill Adjustment Reason Codes provide California specific workers' compensation explanations of a payment, reduction or denial. They are found in Appendix B ~~– 1.0 DWC ANSI Matrix Crosswalk.~~

~~(2) ANSI Claims Adjustment Group Codes represent the general category of payment, reduction, or denial. The most current, valid codes should be used as appropriate for workers' compensation. These codes are obtained from theWashington Publishing Company http://www.wpc-edi.com.~~

~~(3) ANSI Claims Adjustment Reason Codes (CARC) represent the national standard explanation of payment, reduction or denial information. These codes are obtained from the Washington Publishing Company http://www.wpcedi.com.~~

~~(4) ANSI Remittance Advice Remark Codes (RARC) represent supplemental explanation for a payment, reduction or denial. These are always used in conjunction with a ANSI Claims Adjustment Reason Code. These codes are obtained from the Washington Publishing Company http://www.wpc-edi.com.~~

Discussion

For claims that have been denied as non-compensable, most claims administrators now send separate written notice of the denial to the medical provider after which the provider is prohibited from sending any more medical billings to the claims administrator. It would be helpful to clarify whether an EOR message may serve as an objection for this and other purposes.

Some bills are rejected when they fail the clean bill screens. These bills fail to advance to the bill review level where EORs are triggered. Language clarifying that EORs are not generated for such bills would be helpful.

The purpose of claims adjustment reason codes (CARCs), remittance advice remark codes (RARCs), and ANSI Claims Adjustment Group Codes are to provide clear explanation for the payment of medical bills. The reason that stakeholders expended considerable time and effort in 2005 and 2006 to jointly develop California-specific language for explanations of review (EORs) was to improve language currently being used (including CARC and RARC language) to explain medical payments. The California-specific language was designed to give billing medical providers information that is clearer and more specific so that providers would better understand the reasons for the way they were paid. They were intended to replace inferior existing language; and not intended to add another layer with complex crosswalks that will result in confusion rather than clarity for providers. It will be better, if possible, for the DWC to either require old explanations (CARCs and RARCs and Claims Adjustment Group Codes) or the ones developed to replace them, but not both, in medical billing standards and WCIS requirements.

If the administrative director decides to adopt only the California-specific explanations of review, all references to claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs), ANSI Claims Adjustment Group Codes, and related references such as ANSI Matrix Crosswalk need to be removed from this section and wherever else they appear in the Guide.

Recommendation – Required Report

> (s) "Required report" means a report which must be submitted pursuant to Section 9785 or pursuant to the OMFS. These reports include the Doctor's First Report of Injury, PR-2, PR-3, PR-4 and their narrative equivalents, as well as any report accompanying a "By Report" or "unlisted service" code billing.

Discussion

An "unlisted service" code billing also requires a report to determine reasonable reimbursement.

Recommendation – Supporting Documentation

> (t) "Supporting Documentation" means those documents, other than a required report, necessary to support a bill. These include, but are not limited to: any written authorization received from the claims administrator or an invoice required for payment of the DME item being billed, and any other reports or other documents necessary to support a billed code.

Discussion

Since (c) describes "required reports and supporting documentation" any documents that are not required reports but that are necessary to support a billed code must fall under the definition of "supporting documentation" and including language to clarify this in the definition will avoid confusion and disputes.

Recommendation – Third Party Biller and Assignee

~~(u) "Third Party Biller/Assignee" means a person or entity authorized by law and acting under contract as the agent or assignee of a rendering physician, health care provider or healthcare facility to bill and/or collect payment from the responsible payor.~~

(u) "Third party biller" means a person or entity authorized by law and paid by a health care provider to bill for medical goods or services on behalf of the health care provider, and who is not an employee, affiliate or subsidiary of the health care provider, and no transfer of rights or benefits has occurred between the health care provider and the third party biller.

(v)"Assignee" means a person or entity that has purchased the right to payments for medical goods or services from the health care provider, and is authorized by law to collect payment from the responsible payor.

Discussion

The recommended definitions are more accurate and complete, and separate definitions are necessary because a third party biller and an assignee have different meanings. If this recommendation is accepted, renumbering will be necessary.

Recommendation – Treating Physician

(~~v~~w) "Treating Physician" means the primary treating physician ~~or secondary physician~~ as defined by section 9785(a)~~(1), (2)~~.

Discussion

The recommended definition is in accord with the language in Labor Code sections 4603.2(b)(1) and 4603.4(d) and consistent with CCR section 9785(a)(1). The primary treating physician has the responsibility to "provide or authorize medical treatment" and to submit required reports. Including secondary physicians in this definition would conflict with statutory language and create confusion.

Recommendation – Uniform Billing Codes

Add "as of" dates to the definitions in (y).

In (y)(4), replace "Diagnosis Related Group (DRG)" with "Medicare severity-diagnosis related codes (MS-DRG)" and "DRG" with "MS-DRG."

Discussion

Billing codes are updated periodically, even within a single version or edition of a coding system.

The currently adopted DRG codes were recently re-sequenced and are now known as MS-DRG (Medicare severity-diagnosis related codes).

3.0 Complete Bills

Recommendation – Complete Bills

(b) To be complete a submission must consist of the following:

(1) The correct uniform billing form/format for the type of health care provider.

(2) The correct uniform billing codes for the applicable portion of the OMFS under which the services are being billed.

(3) The uniform billing form/format must be filled out according to the requirements specified for each format in Appendix A and/or the Companion Guide.

(4) Required reports and supporting documentation sufficient to substantiate the codes billed.

Discussion

As discussed at length with the advisory committee, a billing is not complete if it is submitted without the required reports and supporting documentation that substantiate it.

Recommendation – Required Reports and Supporting Documentation

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

(8) An operative report is required when the bill is for Surgery Services or for use of the Health Care Facility where surgery services were provided.

(9) ~~An invoice or other p~~Proof of documented paid costs must be provided when required for surgical implant reimbursement and an invoice when required for DME reimbursement.

(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.

(12) A report shall be submitted to support a level of service or a time-based code.

(13) A third party biller shall submit documentation that it is authorized by law and paid by the rendering health care provider to bill for medical goods or services on behalf of the health care provider, and who is not an employee, affiliate or subsidiary of the health care provider, and no transfer of rights or benefits has occurred between the health care provider and the third party biller.

(14) An assignee shall submit proof that the person or entity is an agent has purchased the right to payments for medical goods or services from the health care provider, and is authorized by law to collect payment from the responsible payor.

(15) An itemization and explanation for the excess charge must accompany a bill for medical treatment that exceeds the maximum reasonable fee in the Official Medical Fee Schedule.

(16) A written notice from the prescribing physician specifying that a nongeneric drug must be dispensed

Discussion

(c)(8) An operative report is also necessary when the bill is from the Health Care Facility where Surgery Services were provided.

(c)(9) Documented paid costs are required for certain surgical implants and invoices DME for certain DME.

(c)(10) While the listed reports and supporting documentation will usually be sufficient for accurate bill review, the list does not cover all conceivable circumstances and additional supporting documentation will sometimes be necessary. The billing medical provider generally selects and submits other documentation from the medical file to support billed codes in unusual circumstances. Only if the submitted documentation is inadequate is additional information needed, and therefore it is necessary for (c)(10) to allow claims administrators to request appropriate additional documentation after receiving the billing and to receive it before payment is due.

If no request for authorization was submitted, the claims administrator or its agent does not even know that the services or goods were provided until the bill is received. A failure to request authorization and to submit appropriate supporting documentation should not reward the billing provider, third party biller or assignee. For this reason, too, a claims administrator must be permitted to reasonably request appropriate additional information after receiving a billing. The potential for fraud or abuse will increase if the rules permit a medical providers, third party billers and assignees to submit medical bills, secure in the knowledge that they are not required to submit other necessary supporting documentation before the claims administrator is required to make payment.

The following circumstances that were discussed during the advisory committee meetings, or required by law and are missing from the list and must be added to avoid potential fraud, abuse and dispute.

(c)(12) As discussed and agreed during the advisory committee meetings, documentation to substantiate a level of service or time spent for time-based codes is necessary.

(c)(13) and (14) In the case of a billing by a third party biller or assignee, proof of the right to bill on behalf of, or in lieu of the original provider is necessary.

(c)(15) To be properly documented, section 9792.5(c) requires that an itemization and explanation for any charge that exceeds the maximum reasonable OMFS allowance accompany a bill for medical treatment.

(c)(16) Labor Code section 4600.1 requires the prescribing physician to specify in writing that a nongeneric drug must be dispensed.

4.0 Third Party Billers/Assignees

Recommendation – Proof of Agent and Assignee Status and Right to Reimbursement

(a) Third party billers and assignees shall submit bills in the same manner as the original rendering provider would be required to do had the bills been submitted by the provider directly and shall have no greater right to reimbursement than that provider.

(c) A third party biller or assignee shall submit proof that the person or entity is an agent or assignee of the original provider.

Discussion

(a) Clarification is needed that third party billers and assignees have no greater right to reimbursement than the original provider to prevent to prevent inappropriate practices such as attempts to obtain higher reimbursement than allowed under the Official Medical Fee Schedule or a contract with the original provider.

(c) Proof of a third party biller's or assignee's right to bill on behalf of, or in lieu of the original provider is needed so that the payer has assurance of its responsibility for payment. Since any payment made to an assignee is paid to its tax id number it is necessary to verify that an assignee has the right to bill for services provided by a different entity. Proof of assignment is needed before paying an assignee in order to avoid conflicts or incorrect payments when the service provider later says that an assignee did not have the right to receive payment.

5.0 Duplicate Bills, Bill Revisions and Balance Forward Billing

Recommendation – Revised bills

Add language specifying how duplicate bill submissions must be identified for all required paper forms as well as electronic submissions

(a) The resubmission of a duplicate bill shall clearly be marked as a duplicate using the appropriate NUBC Bill Frequency Code in the field designated for that information. Duplicate bills shall contain all the same information as the original bill. No new dates of service or itemized services may be included. Duplicate bills shall not be submitted prior to expiration of the time allowed for payment unless requested by the claims administrator or its agent. For the time frame for payment of paper submissions see 6.0 (b) and for time frame for payment of electronic submission see 7.1(b).

(b) When there is an error or a need to make a coding correction, a revised bill may be submitted to replace a previously submitted bill. Revised bills shall be marked as revised using the appropriate NUBC Condition Code and the revised lines identified in the fields designated for that information. Revised bills shall include the original dates of service and the same itemized services rendered as the original bill. No new dates of service may be included.

Discussion

To avoid duplicate payments, duplicate bills need to be easily identified.

(b) Many bills include a large number of billing lines. In order to increase efficiency and pay bills more quickly, CWCI recommends identifying a field in which to identify the line(s) that have been revised. Without a way to identify the revised lines, a bill reviewer cannot know the number of revisions or on which billing lines they occur, and must waste time comparing multiple lines to identify every revision.

6.0 Medical Billing and Payment Requirements for Non-Electronically Submitted Medical Treatment Bills

Recommendation – Statutory Language and EORs

(a) Any complete bill submitted in other than electronic form or format not paid within 45 working days of receipt, or within 60 working days if the employer is a governmental entity, shall be increased 15%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill unless the health care provider, health care facility ~~or third party biller/assignee~~ is notified within 30 working days of receipt that the bill is contested, denied or considered incomplete. The increase and interest are self-executing and shall apply to the portion of the bill that is neither timely paid nor objected to.

(b) A claims administrator who objects to all or any part of a bill for medical treatment shall notify the health care provider~~,~~ or health care facility ~~or third party biller/assignee~~ of the objection within 30 working days after receipt of the bill and any required report or supporting documentation necessary to support the bill and shall pay any uncontested amount within 45 working days after receipt of the bill, or within 60 working days if the employer is a governmental entity. If the required report or supporting documentation necessary to support the bill is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill, report, and/or supporting documentation whichever is received later. If the claims administrator receives a bill and believes that it has not received a required report and/or supporting documentation to support the bill, the claims administrator shall so inform the health care provider, health care facility or third party biller/assignee within 30 working days of receipt of the bill. An objection will be deemed timely if sent by first class mail and postmarked on or before the thirtieth working day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth working day after receipt. Any notice of objection shall include or be accompanied by all of the following:

(1) A clear and concise explanation of the basis for the objection to each contested procedure and charge using the DWC Bill Adjustment Reason codes contained in Appendix B Standard Explanation of Review ~~along with the appropriate ANSI Claims Adjustment Group Codes~~.

(2) If additional information is necessary as a prerequisite to payment of ~~the contested~~ a bill that is considered incomplete ~~or portions thereof~~, a clear description of the information required.

(4) A statement that the health care provider~~,~~ or health care facility~~, or third party biller/assignee~~ may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board.

(5) To adjudicate contested charges before the Workers' Compensation Appeals Board, the health care provider~~,~~ or health care facility ~~or third party biller/assignee~~ must file a lien. Liens are subject to the statute of limitations spelled out in Labor Code § 4903.5.

> 4903.5. (a) No lien claim for expenses as provided in subdivision (b) of Section 4903 may be filed after six months from the date on which the appeals board or a workers' compensation administrative law judge issues a final decision, findings, order, including an order approving compromise and release, or award, on the merits of the claim, after five years from the date of the injury for which the services were provided, or after one year from the date the services were provided, whichever is later.
>
> 4903.5. (b) Notwithstanding subdivision (a), any health care provider, health care service plan, group disability insurer, employee benefit plan, or other entity providing medical benefits on a nonindustrial basis, may file a lien claim for expenses as provided in subdivision (b) of Section 4903 within six months after the person or entity first has knowledge that an industrial injury is being claimed.

(e) This section does not prohibit the claims administrator or health care provider~~,~~ or health care facility ~~or third party biller/assignee~~ from using alternative forms or procedures provided such forms or procedures are specified in a written agreement between the claims administrator and the health care provider~~,~~ or health care facility ~~or third party biller/assignee~~, as long as the alternative billing format provides all the required information set forth in this Medical Billing and Payment Guide.

(g) Explanations of Review shall use the DWC Bill Adjustment Reason codes and descriptions listed in Appendix B Standard Explanation of Review – 1.0 California DWC Bill Adjustment Reason Codes ~~ANSI Matrix Crosswalk along~~

~~with the appropriate ANSI Claims Adjustment Group Codes~~. The Explanations of Review shall contain all the required elements listed in Appendix B Standard Explanation of Review – 2.0 Field Table Standard Explanation of Review.

Discussion
(a) Because statutory language, including Labor Code sections 4603.2(b) and 4903.5 covers physicians and other providers but not third party billers/assignees the term should be deleted.

(b)(1) The purpose of claims adjustment reason codes (CARCs), remittance advice remark codes (RARCs), and ANSI Claims Adjustment Group Codes are to provide clear explanation for the payment of medical bills. The reason that stakeholders expended considerable time and effort in 2005 and 2006 to jointly develop California-specific language for explanations of review (EORs) was to improve language currently being used (including CARC and RARC language) to explain medical payments. The California-specific language was designed to give billing medical providers information that is clearer and more specific so that providers would better understand the reasons for the way they were paid. They were intended to replace inferior existing language; and not intended to add another layer with complex crosswalks that will result in confusion rather than clarity for providers. It will be better if the DWC can either require old explanations (CARCs and RARCs and Claims Adjustment Group Codes) or the ones developed to replace them, but not both, in medical billing standards and WCIS requirements.

If the administrative director decides to adopt only the California-specific explanations of review, all references to claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs), ANSI Claims Adjustment Group Codes, and related references such as ANSI Matrix Crosswalk need to be removed from this section and wherever else they appear in the Guide.

The modifications in (b)(2) are recommended to conform to the statutory language and requirements in Labor Code section 4603.2(b), which refers to bills that are "contested, denied, or considered incomplete." The statute specifies different requirements for bills that are considered incomplete from those with contested items.

7.0 Medical Billing and Payment Requirements for Electronically Submitted Medical Treatment Bills

7.1 Timeframes

Recommendation – (a) Acknowledgements
Revise (a)(3) and (B) and (C) to clarify that this first step uses high-level clean-bill screens that identify some but not all "incomplete bills."

> (a)(3) Health Care Claim Acknowledgement (ASC X12 N 277) – within two working days of receipt of an electronically submitted bill, the claims administrator shall send a Health Care Claim Acknowledgement ASC X12N 277 electronic notice of whether or not the bill submission is complete. The ASC X12 N 277 details what errors are present, and if necessary, what action the submitter

should take. A bill may be rejected if it is not submitted in the required electronic standard format or if it is not complete as set forth in Section One – 3.0. Such notice must use the ASC X12N 277 transaction set as defined in Companion Guide Chapter 9 and must include specific information setting out the reason for rejection.

(B) Bill rejection error messages ~~shall~~ include the following:

(i) Invalid form or format – indicate which form should be used.

(ii) Missing. Information- ~~indicate specifically which information is missing by using the appropriate 277 Claim Status Category Code with the appropriate Claim Status Code.~~

~~(iii) Invalid data – Indicate specifically which information is invalid by using the appropriate Claim Status Category Code with the appropriate Claim Status Code~~

(iv) Missing attachments – indicate specifically which attachment(s) are missing.

~~(v) Missing required documentation – indicate specifically what documentation is missing.~~

(vi) Injured worker's claim of injury is denied.

(vii) There is no coverage by the claims administrator.

(C) The submitted bill ~~is complete and~~ has moved into bill review.

Discussion

(B) Unfortunately it is not clear that all of these complete bill validations can be automated and/or determined within the required 2 or 5 days at this level. I am told that several cannot.

(i) The validation for Invalid form or format - is probably not a problem

(ii) Missing Information - Identifying required fields where data has not been submitted is not a problem, however, identifying which specific data is missing may be.

(iii) Invalid data - while incorrect data formats may be identifiable, it may be a problem to identify invalid information that is provided in the correct format.

(iv) If Missing attachments – means simply matching the number and type of attachments received to the number stated in the bill data transmission, this might not be a problem.

(v) Missing required documentation - if no documentation is submitted it will be possible to determine when at least one required document is missing. If at least one required document is submitted, it will be difficult or impossible to timely identify specifically what documentation is missing without the manual review that is done at a later level, particularly as one document may support several, but not all codes on a bill.

(vi) Injured worker's claim of injury is denied – it can usually be determined at this level, but under some circumstances, not until a later level.

(vii) There is no coverage by the claims administrator – coverage determination may be determined at this or a later level.

Dictating that "missing information", "invalid data", and "missing required attachments" must be specified at this level may inadvertently allow a provider to state that all information on their bill was accepted as complete if the specificity is lacking in the 277. While the code sets used in the 277 are detailed, the lack of specificity that will actually be provided at this stage may be used by billing providers as an argument that they did not receive timely notice of a deficiency.

(C) Most bills without gross errors will probably be accepted with one of the following "pending" codes:

PO Pending: Adjudication/Details - This is a generic message about a pended claim. A pended claim is one for which no remittance advice has been issued, or only part of the claim has been paid.

P1 Pending/In Process - The claim or encounter is in the adjudication system.

P2 Pending/Payer Review - The claim/encounter is suspended and is pending review (e.g. medical review, re-pricing, Third Party Administrator processing).

The " is complete and" needs to be stricken from (C) as so that it does not appear to billing providers that the bills are accepted as "complete." When bills move into bill review, it would be more accurate and less confusing to describe them as "pending", the term used in the Claim Status Category Code description.

Recommendation – (b) Payment and Remittance Advice

If the electronically submitted bill ~~has been determined to be complete~~ is not contested, denied, or incomplete, payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made by the employer within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Section §5307.1. Nothing prevents the parties from agreeing to submit bills electronically that are being paid per contract rates under Labor Code § 5307.11. Remittance advice will be sent using the (835) Healthcare Claim Payment transaction set as defined in Companion Guide Chapter 9. Explanations of Review shall use the codes listed in Appendix B – 1.0.

If an electronic billing is contested, denied, or incomplete, payment shall be made pursuant to Labor Code section 4603.2.

A claims administrator who objects to all or any part of an electronically submitted complete bill for medical treatment shall notify the health care provider~~,~~ or health care facility ~~or third party biller/assignee~~ of the objection within 15 working days after receipt of the bill and any required report and/or supporting documentation and shall pay any uncontested amount within 15 working days after receipt of the bill and any required report and/or supporting documentation. If the claims administrator receives a bill and believes that it has not received a required report and/or supporting documentation to support the bill, the claims administrator shall so inform the health care provider within 15 working days of receipt of the bill. An objection will be deemed timely if sent electronically on or before the 15th working day after receipt. Any notice of objection shall include or be accompanied by all of the following:

(1) A specific explanation of the basis for the objection to each contested procedure and charge. The notice shall use the DWC Bill Adjustment Reason codes contained in Appendix B Standard Explanation of Review ~~along with the ANSI Claims Adjustment Group Codes~~

(2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the ~~specific~~ information required shall be included.

(3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection.

(4) A statement that the health care provider~~,~~ or health care facility ~~or third party biller/assignee~~ may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board.

(5) To adjudicate contested charges before the Workers' Compensation Appeals Board, the health care provider~~,~~ or health care facility ~~or third party biller/assignee~~ must file a lien. Liens are subject to the statute of limitations spelled out in Labor Code § 4903.5.

> 4903.5. (a) No lien claim for expenses as provided in subdivision (b) of Section 4903 may be filed after six months from the date on which the appeals board or a workers' compensation administrative law judge issues a final decision, findings, order, including an order approving compromise and release, or award, on the merits of the claim, after five years from the date of the injury for which the services were provided, or after one year from the date the services were provided, whichever is later.
>
> 4903.5. (b) Notwithstanding subdivision (a), any health care provider, health care service plan, group disability insurer, employee benefit plan, or other entity providing medical benefits on a nonindustrial basis, may file a

lien claim for expenses as provided in subdivision (b) of Section 4903 within six months after the person or entity first has knowledge that an industrial injury is being claimed.

Discussion
Per Labor Code section 4603.4(d), an electronic bill must be paid within 15 working days only if it is complete, uncontested, not denied, and billed at or below the maximum fees provided in the Official Medical Fee Schedule. If those conditions are not met, the bill must be paid in accordance with Labor Code Section 4603.2. The language added to is necessary to conform to the Labor Code section 4603.4(d) requirements.

See discussion on third party biller/assignee definition on page 5 of these comments.

The Institute recommends deleting "specific" from (B) because the claims administrator cannot know what the provider has in the medical record that s/he can submit to support the billing. The billing provider should be free to select and submit the specific documentation from the medical file that will support the billed codes.

7.2 Penalty
Recommendation – (a) Audit Penalty
(a) Any electronically submitted complete billing at or below the maximum fees in the Official Medical Fee Schedule for medical treatment reasonably required to cure or relieve an injured employee from the effects of a workers compensation injury that is ~~determined to be complete~~ not paid or objected to within the 15 working day period shall be subject to audit penalties per Title 8, California Code of Regulations section 10111.2 (b) (10), (11).

Discussion
The language added to is necessary to conform to Labor Code sections 4603.4(d) and 4600(b). Per Labor Code section 4603.4(d), an electronic bill must be paid within 15 working days only if it is complete, uncontested, and billed at or below the maximum fees provided in the Official Medical Fee Schedule. If those conditions are not met, the bill must be paid in accordance with Labor Code Section 4603.2. The billed treatment must also be reasonably required to cure or relieve the injured employee from the effects of a workers' compensation injury as defined in Labor Code section 4600 (b).

7.3 Electronic Bill Attachments
Recommendation – (a) Bill Transaction Number and (e) Attachment Types
(a)(6) Bill Transaction Identification Number – The Provider, or ~~their~~ its agent, assigns a unique identification number to the electronic bill transaction. This standard HIPAA implementation allows for a patient account number but ~~"~~strongly recommends that submitters use completely unique numbers for this field for each individual bill ~~claim.~~"

(e) Attachment types

(1) Required Reports
(2) Supporting Documentation
(3) ~~Requests for~~ Written Authorization

(4) Misc. (other type of attachment)

Discussion
(a)(6) Unless "bill" replaces "claim," some users will submit a claim number instead of the intended bill tracking number. Other changes are to correct minor typographical errors.

(e)(1) The proposed edit distinguishes required reports from other reports. Reports other than required reports are considered supporting documentation.

(e)(3) "Requests for Authorization" appears to be a typographical error. Providers need to attach "Written Authorization."

Version of Forms
Recommendation – 2.0 Standardized Medical Treatment Billing Format
Specify the revision date for each standard form/format.

Discussion
Specifying the "as of" date in addition to any version number for each standard billing form/format will avoid confusion. Sometimes a particular version is modified after its adoption.

California Division of Workers' Compensation Medical Billing and Payment Guide 2010
Appendix A. Standard Paper Forms
Recommendation – CMS 1500
Paper Field 11 Required for all billings except a first billing. Required for a first billing if known ~~Enter claim number, if known~~ or if claim number is not known then enter the value of 'Unknown' to indicate unknown claim number. This box requires one of the above values and cannot be left blank or may result in the bill being rejected.

Paper Field 14 The Institute recommends adding instruction on determining what date to enter for a cumulative trauma injury.

Paper Field 17 Required if referred ~~when other providers are associated with the bill~~

Paper Field 17b Enter NPI number of referring provider ~~If known~~

Paper Field 22 Required when the bill is a resubmission. Enter the Original Reference Number assigned to the bill by the claims administrator ~~Workers' Compensation Carrier~~.

Paper Field 23 Required ~~when~~ if a prior authorization, referral, concurrent review, or voluntary certification number was received. Enter the number/name as assigned by the payer for the current service. Do not enter hyphens or spaces within the number.

Paper Field 31 The Institute recommends clarifying which physician or supplier must sign the form.

Either an additional field on the CMS 1500 at the line level is needed to capture the name of the rendering provider or the rendering provider name needs to be removed from the EOR field 21.

Recommendation – UB 04
A field is needed for the Medicare ID number. This number is important because it programmed into software to trigger the hospital payment factors, including the composite factor, cost to charge ratio, cost outlier threshold and length of stay.

Field 52a needs to be changed from R (required) to N (not applicable). This is required under HIPAA rules, however not for workers' compensation because workers' compensation is exempt from HIPAA.

Recommendation – "NCPDP" Workers' Compensation/Property & Casualty Universal Claim Form ("WC/PC UCF")
It would be helpful to describe in the instructions the patient ID that must be entered in field 12.

Since the pharmacy's usual and customary charge is required to be entered for California, The institute suggests changing the paper field requirement indicator from O (optional) to R (required).

Recommendation – ADA 2006
A field is needed to identify a third party biller or assignee.

Appendix B. Standard Explanations of Review
Recommendation – 3.0 Field Table Standard EORs – Bill Level Adjustments

> ~~Payor may use the bill level adjustment codes if an adjustment causes the amount paid to differ from the amount originally charged.~~ The Bill Level Adjustment is used when an adjustment cannot be made to a single service line. ~~The bill level adjustment is not a roll up of the line adjustments. The total adjustment is the sum of the bill and line level adjustment~~

The reason for reporting bill level adjustment information is expressed clearly in the second sentence. The Institute recommends deleting the other language because it is somewhat confusing and not necessary.

California DWC Electronic Medical Billing & Payment Companion Guide Version 1.0 2010

Please consider the above comments and recommendations to apply to similar issues in this Companion Guide.

Chapter 1 Introduction and Overview
Recommendation – 2.5.3 Health Care Provider Identification

Health Care Providers and Health Care Facilities are required to use the National Provider Identification number (NPI). If the provider or facility does not qualify for ~~have~~ an NPI, then the provider or facility must use his/her/its state license number.

Discussion
Almost all medical providers qualify for and can request and receive an NPI. We believe that only those providers who don't qualify should be relieved of the responsibility to report one on their billings. Reporting NPIs helps to prevent medical fraud and abuse because when NPIs are reported, changing the billing entity will no longer mask a duplicate billing or evade a contracted rate.

Chapter 6 Companion Guide Pharmacy
Recommendation – 6.4 Billing Date

For electronically submitted ~~claims~~ pharmacy bills, the date of service is considered the Billing Date, unless other transactional verification information is provided to the claims administrator to confirm the date the bill was transmitted. This date is communicated in the Claim Segment of the NCPDP Telecommunication Standard Implementation Guide Version 5.1 Date of Service field (4Ø1-D1) (Field #66 on WC/PC UCF), which is included in the Transaction Header Segment.

Discussion
Typographical error.

Recommendation – 6.9 Prescribing Physician

For California workers' compensation claims, the Prescribing Physician Identification Number will be the NPI. This data is supported in the NCPDP Telecommunication Standard Implementation Guide Version 5.1 in Fields 411-DB (Prescriber ID) (Field # 40 on WC/PC UCF) and 466-EZ (Field # 41 on WC/PC UCF) (Qualifier (12) DEA Number). ~~If the prescribing physician does not have an NPI, the prescribing physician's state license number should be populated.~~ The NCPDP Telecommunication Standard Version 5.1 contains qualifiers for all the identifiers detailed.

Discussion
Since all physicians qualify to receive an NPI, there is no reason to make an exception here.

Recommendation – 9.4.3 Health Care ~~Claim~~ Bill Acknowledgement
Replace the term "claim" with "bill" throughout this section.

Discussion
This modification is necessary to avoid confusion over the workers' compensation meaning for "claim" as previously discussed.

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

Sincerely,

Brenda Ramirez
Claims and Medical Director

BR/pm

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