California Workers' Compensation Institute
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February 16, 2011

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: 2nd 15-Day Comment Period -- modifications to proposed regulations on medical billing standards and electronic billing

Dear Ms. Gray:

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

The Institute appreciates the Division's modifications to the proposed regulations that were recommended in the Institute's written comments.

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

Article 5.5. Application of the Official Medical Fee Schedule

Recommendation – §9792.5. Payment for Medical Treatment.
Retain the 90 day interval. If 90 days is determined to provide insufficient preparation time, reduce the interval from 180 days to no more than 120 days.

Discussion
Implementation of the billing standards for paper billings are expected to reduce the number of duplicate billings, disputes and liens; increase bill processing efficiency; and speed payments. According to the feedback I have received, 90 days provides ample time for preparation. The implementation interval should be minimum number of days necessary for preparation. The sooner the standards are implemented, the sooner all stakeholders will benefit from them, and the sooner system savings will be realized.

In addition, as noted by the Institute and others, in public commentary on the Workers' Compensation Information System (WCIS) regulatory proposals, until medical billing standard regulations are effective, claims administrators are unable to accurately and efficiently report many of the WCIS data elements. Once the standards are effective, medical bills must contain more of the information necessary for accurate reporting. The sooner the standards are effective, the sooner this will be possible, and the sooner data in WCIS will improve.

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

Recommendation – 3.0 Complete Bills

(b) All required reports and supporting documentation must be sufficient to support the level of service or code that has been billed ~~must be~~ and submitted together with the billing as follows:

….

(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 or after submission of the billing. (This does not prohibit the claims administrator from requesting additional appropriate information during further bill processing.)

(11) Written authorization for services shall be provided where one was given.

Discussion

Moving "must be" prior to "sufficient…" will clarify that required reports and supporting documentation that are not sufficient to support the level of service or code that has been billed, are not exempted from (b).

Since the listing (1) through (10) does not specify all conceivable circumstances, additional supporting documentation will sometimes be necessary to support the billed code. An example of such a circumstance is a billed evaluation and management service for an office visit that did not trigger a required report. The regulation requires payment within the 45/60/15 working-day timeframe for a complete bill, and under the present language, such an unsupported billing may be considered "complete" even when the billing provider refuses to submit reasonably requested information for the billing. This loophole offers the unscrupulous a way to bill inappropriate codes with impunity by bypassing bill review coding scrutiny, and this loophole needs to be closed. The language can be modified so that it is clear that to be complete, a submission must include information reasonably requested either before or after the submission.

Labor Code section 4603.2(b)(1) requires timely payment *"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****"* (emphasis added). It is necessary to add *"together with the billing"* and *"written authorization for services shall be provided where one was given"* because these Labor Code section 4603.2 conditions apply in all circumstances. If they are not added, a billing may be considered complete under the regulation, contrary to the express requirements of Labor Code section 4603.2.

7.1 Timeframes
Recommendation – (a) Acknowledgements

(a)(3) (A) ASC X12N 277 005010X214 Claim Pending Status Information

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

Discussion

The issue of the claims number was the subject of much discussion and controversy during the DWC eBilling Committee meetings. Locating the claim number for a bill submitted without it is a very labor-intensive process for a claims administrator. Claims administrator representatives explained that requiring them to accept electronic medical bills without claim numbers would add significant time and administrative expense to bill processing. On the other hand, medical provider representatives pointed out that they often do not know the claim number at the time of first medical service, and that it is time consuming to obtain it before submitting the first billing.

The final consensus compromise was to permit an initial electronic billing without a claim number in the event the claim number is unknown, and to permit the bill to be pended for up to five working days to allow time for a claim number search. When the claim number is returned with an electronic acknowledgement, the billing provider now has the claim number, and the claim number is required for subsequent billings.

As currently written, billing providers could submit all medical billings without claim numbers. Locating claim numbers is so time-intensive that claims administrators have told us that they will not be able to meet the electronic payment timeframes if providers are permitted to bill without claim numbers. If the language that enforces the compromise ("*If the claims administrator has already provided the claim number to the billing entity, the bill may be rejected as incomplete without placing the bill in pending status."*) is not replaced, the claim number must be required on the electronic billing and the field tables adjusted accordingly. We note that under the ASC 005010X12 national standards, the claim number is a required field and the billing provider may report a claim number as unknown only if the claims administrator chooses to provide a specific code for that purpose.

The Division has corrected the time frame references in this sub-section to indicate working-days for all periods except the one in the second to last sentence that appears to have been overlooked. For consistency, and to avoid confusion and dispute, the language in that sentence also needs to be corrected to "fifteen working-day period."

Appendix A. Standard Paper Forms

Recommendation – CMS 1500 paper field 14

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

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

Discussion

Labor Code section 5412 defines the date of injury in cases of cumulative injuries or occupational diseases:

> *"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."*

Labor Code section 3208.1 also requires the date of injury for cumulative injury to be determined under Labor Code section 5412:

> *An injury may be either: (a) "specific," occurring as the result of one incident or exposure which causes disability or need for medical treatment; or (b) "cumulative," occurring as repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which causes any disability or need for medical treatment. The date of a cumulative injury shall be the date determined under Section 5412.*

"The last day on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury" is referenced in Labor Code section 5500.5, but only with respect to determining which employers may be held liable for occupational disease or cumulative injury; not with respect to the date of the injury. Indeed this section also refers to *"the date of injury, as determined pursuant to Section 5412…."*

The administrative director does not have the statutory authority to assign a different date of injury for occupational diseases or cumulative injuries from the date of injury defined by the Legislature.

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

Sincerely,

Brenda Ramirez
Claims and Medical Director

BR/pm

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