California Workers' Compensation Institute
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March 4, 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: 3rd 15-Day Comment Period – further 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 especially urges the Division to:

1. Permit billings without claim numbers only for initial billings as negotiated and agreed to by the taskforce, or conform with the required status of the field in the ASC 005010X12 national standards.
2. Adhere to the statutory definition of date of injury for Cumulative Injury or Occupational Disease. The proposed language conflicts with Labor Code section 5412. The conflicting language 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 Labor Code section 5500.5 also refers to "the date of injury, as determined pursuant to Section 5412…."
3. Clarify that for a billing to be complete, any written authorization for services that may have been received by the physician must be provided, together with any required reports, as Labor Code section 4603.2(b)(1) requires.
4. Retain the 90-day effective date interval in sections 9792.5 and 9792.5.0 so that efficiencies will materialize as quickly as possible. 90 days provides adequate preparation time**,** and when implemented the changes will reduce the number of duplicate billings, disputes and liens; increase bill processing efficiency; speed payments; and improve WCIS reporting and data quality.

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.

Recommendation -- Section One – Business rules – Definitions

(i) "Complete Bill" means a bill submitted on the correct uniform billing form/format, with the correct uniform billing code sets, filled out in compliance with the form/format requirements of Appendix A and/or the Companion Guide with the required reports, written authorization, if any and/or supporting documentation as set forth in Section One – 3 0.

(x) "Supporting Documentation" means those documents, other than a required report, necessary to support a bill. These include, but are not limited to an invoice required for payment of the DME item being billed~~. For paper bills,~~ and ~~supporting documentation includes~~ any written authorization for services that may have been received by the physician.

Discussion

The only exceptions to Labor Code section 4603.2 are those specified in Labor Code section 4603.4 and contracts authorized under section 5307.11. 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) and these Labor Code section 4603.2 conditions apply in all circumstances. It is necessary to specifically include written authorization in the complete bill and supporting documentation requirements in this section, and in 3.0 (b) as a complete bill condition. 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.

Recommendation – 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 together with the billing as follows:

….

(11) ~~For paper bills, any~~ Any written authorization for services that may have been received by the physician.

Discussion

Labor Code section 4603.2(b)(1) requires timely payment *"after receipt of each separate itemization of medical services provided,* (emphasis added). The only exceptions to Labor Code section 4603.2 are those specified in Labor Code section 4603.4 and contracts authorized under section 5307.11, and these exceptions are not triggered here. It is necessary to add *"together with the billing"* and to delete *"For paper bills,"* because these Labor Code section 4603.2 conditions apply to paper bills and electronic bills alike. If they are not, a billing may be considered complete under the regulation, contrary to express requirements in Labor Code section 4603.2. Utilization review applies whether or not services are billed electronically or via paper, and the written authorization can be submitted with either a paper billing or an electronic billing

7.1 Timeframes

Recommendation – (a) Acknowledgements

Retain the 15 working-day correction and reverse the claim number modification as follows:

(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. 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.

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