| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| DWC Medical Billing and Payment Guide 2011 – Appendix A (Standard Paper Forms) 1.0 CMS 1500 | Field 1a. Insured's ID number.<br><br>Commenter questions if the Social Security Number can be used in this field. Commenter opines that this would be more in keeping with industry standards to use Claim number in this field. (Claim number to be defined as the number assigned by the carrier to the injury)<br><br>The Social Security Number or a truncated version could be entered in field 11, if needed to help identify the patient. | Penelope Rice<br>Office Manager<br>Ethan G. Harris, MD<br>February 2, 2011<br>Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| General comment | The paper billing rules will go into effect 180 days from the Guides being adopted. Commenter opines that it appears based on the language that the 180 day date is based on submission date. Commenter requests clarification that the date is based on the health care providers actual invoice date and not the date of service or bill received date. | Leslie White<br>Product Team Manger<br>StrataCare<br>February 14, 2011<br>Written Comment | **Disagree** with commenter's suggestion that clarification is necessary. Commenter is correct that the language specifies that the regulation will be apply to bills *submitted* 180 after the effective date of the regulation. To address the concern that the "bill received" date is not the operative date, the regulation was already clarified in the 2nd 15-day modification by adding | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | | | language to specify that "This subdivision does not apply to processing or payment of bills submitted before XXXXX, 2011 [180 days after the effective date of this regulation.]" Proposed Section 9792.5.3 (a). The language of the regulations does not reference the date of service, nor imply the date of service as the relevant date. Given the language of the proposed regulations the Division cannot discern a need for further clarification. | |
| DWC Medical Billing and Payment Guide 2011 – Section One – 5.0(d) | This section indicates that a health care provider cannot submit a bill via paper and electronic means. Commenter asks that 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 | Leslie White Product Team Manger StrataCare February 14, 2011 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | so, whether both bills were received via paper or electronic or a combination of those. | | | |
| DWC Medical Billing and Payment Guide 2011 – Section One – 6.0(a) and (b) | These sections indicate that denials to all or any part of a bill must occur within 30 working days of receipt, however payments must be made within 45 working days of receipt. Commenter inquires that if a bill has two line items and one is being paid and the other being denied, does this fall within the 45 working day timeframe or the 30 working day timeframe? One could argue that it falls within the 45 working day timeframe as a payment is being made on the bill, but not necessarily on each line item. Commenter requests that the Division provide scenario examples and clarification. | Leslie White Product Team Manger StrataCare February 14, 2011 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing 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 | Leslie White Product Team Manger StrataCare February 14, 2011 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | including data element editing, second and tertiary level reviews, routing to various PPO networks, etc. 15 working 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 strongly suggests that the DWC consider extending this timeframe to one that is reasonably achievable for carriers. | | | |
| DWC Medical Billing 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. Commenter opines that 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 asks for clarification. | Leslie White Product Team Manger StrataCare February 14, 2011 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and Payment Guide | Commenter is requesting specific billing instructions be added requiring DME items to be billed on the CMS- | Leslie White Product Team Manger | The comment does not address the substantive changes made to the proposed regulations | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| 2011 – Appendix A (Standard Paper Forms) 1.0 CMS 1500 | 1500 form. Commenter opines that 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). | StrataCare February 14, 2011 Written Comment | during the 2nd 15-day comment period. | |
| DWC Medical Billing and Payment Guide 2011 – Appendix A (Standard Paper Forms) 3.0 NCPDP | Commenter is requesting 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 Product Team Manger StrataCare February 14, 2011 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and Payment Guide 2011 – Appendix A (Standard Paper | Commenter is requesting 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 | Leslie White Product Team Manger StrataCare February 14, 2011 | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| Forms) 4.0 ADA 2006 | 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. | Written Comment | | |
| DWC Medical Billing and Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Commenter opines that the fields outlined in the table may or may not be applicable, depending on the type of bill. Commenter recommends adding another column to the table so that the applicable bill types can be noted for each field. | Leslie White Product Team Manger StrataCare February 14, 2011 Written Comment | **Disagree.** The fields that are "required," denoted by an "R" in the third column are not specific to particular types of bills, but are applicable to a broad range of bills. Items that are particular to only a certain type of bill are denoted "Situational," for example Item 39, Diagnostic Group Code is denoted "S" and the comment column states "Required if payment based on DRG". | None. |
| DWC Medical Billing and Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper | Data Item 1 – Date of Review<br><br>Commenter states bill completed or release date can also be used to signify the date of review. | Leslie White Product Team Manger StrataCare February 14, 2011 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|---|---|---|---|---|
| Explanation of Review | | | | |
| DWC Medical Billing and Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Data Item 2 – Method of Payment<br>Data Item 3 – Payment ID Number<br>Data Item 4 – Payment Date<br><br>Commenter states that many bill review companies providing EOR form creation for their clients will not have this information as payments are generated from their clients Claims Administration 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 cause a huge time delay in health care providers receiving paper EOR's. | Leslie White<br>Product Team Manger<br>StrataCare<br>February 14, 2011<br>Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Data Item 16 – Patient Social Security Number<br><br>Commenter questions due to HIPAA and heightened sensitivity around personal data, if it is appropriate to ask that this be printed on the form? Can all digits except the last 4 be masked? | Leslie White<br>Product Team Manger<br>StrataCare<br>February 14, 2011<br>Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and | Data Item 19 – Employer Name<br>Data Item 20 – Employer ID | Leslie White<br>Product Team | The comment does not address the substantive changes made | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Commenter understands that these are required data elements for a claims system, but that these are not typical required data elements for a bill review system. Commenter recommends changing this from Required to Optional. | Manger StrataCare February 14, 2011 Written Comment | to the proposed regulations during the 2nd 15-day comment period. | |
| DWC Medical Billing and Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Data Item 23 – Rendering Provider ID (NPI)<br><br>Commenter states that in order to require this on the EOR, it must be indicated as a Required field on the paper billing forms. | Leslie White Product Team Manger StrataCare February 14, 2011 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Data Item 25 – PPO/MPN ID Number<br><br>Commenter requests that the Division provide an example of each. | Leslie White Product Team Manger StrataCare February 14, 2011 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and | Data Item 30 – Payor Bill Review Contact Name | Leslie White Product Team | The comment does not address the substantive changes made | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Data Item 31 – Payor Bill Review Phone Number<br><br>Commenter opines that this information appears to be duplicative of field 8 and 9 in cases where the carrier is performing the actual bill review. For that instance, commenter recommends changing these two fields to Situational instead of Required. | Manger StrataCare February 14, 2011 Written Comment | to the proposed regulations during the 2nd 15-day comment period. | |
| DWC Medical Billing and Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Data Item 33 – Payment Status Code<br><br>Commenter states that there is no payment status code that indicates a partial payment. 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 reconsideration a) payment is being made, or b) payment is being denied. | Leslie White Product Team Manger StrataCare February 14, 2011 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Data Item 38 – Bill Frequency Type<br><br>Commenter questions if the full bill type (all 3 characters) are present on the form, will this meet the requirement (examples: 131, 133, 831). | Leslie White Product Team Manger StrataCare February 14, 2011 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| DWC Medical Billing and Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Data Item 41 – Date Bill Received<br><br>Commenter recommends adding Carrier in this field name so that it is clear (Date Carrier Received Bill). | Leslie White<br>Product Team Manger<br>StrataCare<br>February 14, 2011<br>Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Data Item 49 – Paid Units<br><br>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. Commenter recommends changing to Optional instead of Required. | Leslie White<br>Product Team Manger<br>StrataCare<br>February 14, 2011<br>Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Data Item 53 – Prescription Number<br><br>Commenter states that if a 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<br>Product Team Manger<br>StrataCare<br>February 14, 2011<br>Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| DWC Medical Billing and Payment Guide 2011 – Appendix B (Standard Explanation of Review) 3.0 Table for Paper Explanation of Review | Data Item 54 – DWC Bill Adjustment Reason Code and DWC Explanatory Message<br><br>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? Due to the amount of real estate available on EOR forms today, commenter opines that it is difficult to have lengthy message fields print on every line item. Can a carrier abbreviate the DWC Explanatory Message wording as long as the context remains the same? Example DWC code PMR reads **This physical therapy medicine extended time service was billed without the "initial 30 minutes" base code.** Abbreviated version could read **PT extended time billed without initial 30 min code.** Commenter ask if this would be considered appropriate and in compliance? | Leslie White<br>Product Team Manger<br>StrataCare<br>February 14, 2011<br>Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Electronic Medical Billing and Payment | These chapters indicate that if claim number is Unknown or not provided that carriers will have a 5 day period | Leslie White<br>Product Team Manger | In reviewing a payment for timeliness, the issue of whether a bill had been placed in | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| Companion Guide 2012 – Chapter 9 – 9.2 | in which to attempt to locate the appropriate claim number, or return the bill to the health care provider. Commenter opines that if a carrier pends a bill for up to 5 days 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? | StrataCare February 14, 2011 Written Comment | 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 could be determined. The Medical Billing and Payment Guide, 7.1 Timeframes contains detail on the time to pay or object, and the effect of the 5 working day pending period for a missing claim number. (See 7.1 Timeframes (a)(3)(A)(i) "All other timeframes are suspended during the time period the bill is pending. The payment timeframe resumes when the claim number is determined…The "pending" period suspends the 15 working-day timeframe during the period that the bill is pending, but upon matching the claim number…the timeframe resumes. The 15 working-day time period to pay the bill does not begin | |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | | | anew.") | |
| DWC Medical Billing and Payment Guide 2011 – Introduction Page 3, Paragraph 1 | Commenters opine that for the purpose of consistency with language throughout Labor Code and regulation, he/she urges the Division to reverse its decision delete reference to "Third Party Billers" in this section. Commenters state that many contractual agreements between physicians and health plans, commercial health insurance companies and other risk baring organizations, i.e., Independent Physician Associations (IPA) contain provisions that allow physicians to bill the contracted payor, and, in turn, authorize the contracted payor to seek reimbursement from the appropriate workers' compensation insurer. | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and Payment Guide 2011 – Introduction Page 3, Paragraph 2 | Commenters have no objection with specifying the exact date for which it will become mandatory for claims administrators to accept electronic bills. Commenters request that the Division substitute the word "approximately" with the word "within" 18 months after adoption. Commenters believe that this change will encourage insurers to accept | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | electronic bills sooner rather than later. | | | |
| DWC Medical Billing and Payment Guide 2011 – Introduction Page 3, Paragraph 6 | As commenters have previously stated, for purposes of consistency with language throughout Labor Code and regulation, he/she urges the Director reverse its decision to strike reference to "Third Party Billers" in this section. Many contractual agreements between physicians and health plans, commercial health insurance companies and other risk baring organizations, i.e., Independent Physician Associations (IPA) contain provisions that allow physicians to bill the contracted payor, and in turn, authorize the contracted payor to seek reimbursement from the appropriate workers' compensation insurer. | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 4, 1.0 – Standardized Paper and Electronic Billing Definitions | (a) Assignee<br>Commenters believe that it is neither necessary nor prudent for the Division to recognize an entity "that has purchased the rights to payments for medical goods or services" in these regulations. Moreover, the proposed phrase, "as authorized by law" without specific reference to the law, has no meaning. The rationale for adopting | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | standardized billing regulations is that they apply to everyone seeking payment for services or goods provided to an injured worker.<br><br>Commenters recommend that the Division use the following substitute language and incorporate additional language for hospital, surgery center, dental, pharmacy, and other billing formats:<br><br>"(a) Assignment of benefits" means of a bill for services or goods for the treatment of a work related injury is be deemed assigned and payment shall be made directly to; the health care provider, health care facility, emergency department or other supplier of medical treatment, services, or goods. For physician services, payable to the provider listed in box 30 (a) and (b) of the CMS 1500 form or equivalent electronic billing data field." | | | |
| DWC Medical Billing and Payment Guide 2011 – Section | (c) "Balance Forward Bill<br><br>Commenters understand that there have been instances of providers | Frank D. Navarro California Medical Association | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| One – Business Rules, Page 4, 1.0 – Standardized Paper and Electronic Billing Definitions | submitting "statement like" bills; however, commenter believes the inclusion of this definition will no longer be necessary with adoption of these regulations. Commenters opine that if the Division decides to retain this definition, he/she believes there needs to be further clarification with regard to the billing of multiple dates of service on the same bill. For example, many physicians submit bills once per week. In such cases, billing systems will automatically create a single bill, which will include multiple dates of services, which have not, been previously submitted. This same example also occurs when billing hospital inpatient services, i.e., to from dates. Commenters respectfully request that the Division include, by addition, the following sentence:<br><br>"This definition shall not prohibit a health care provider, health care facility, or supplier of goods of medical treatment, services, or goods from billing for multiple dates of service on a single bill." | Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | comment period. | |
| DWC Medical | (q) "Itemization" - -"**Itemization"** | Frank D. Navarro | The comment does not address | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| Billing and Payment Guide 2011 – Section One – Business Rules, Page 5, 1.0 – Standardized Paper and Electronic Billing Definitions | **means the list of medical treatment, goods, or services provided using the codes required by Section One – 3.0 to be included on the uniform billing form.**<br><br>To better conform, to language used by AMA CPT coding guidelines, commenters respectfully request that the Division adopt the following substitute definition for (q) Itemization:<br><br>"(q) "Itemization" means a listing of identifying codes for reporting medical services and procedures that accurately describe medical, surgical, diagnostic services, supplies, goods, and administration of drugs and/or biologicals either performed or provided by a physician for the treatment of an injured worker." 4603.2 | California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 6, 1.0 | **(~~t~~x) "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** | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| – Standardized Paper and Electronic Billing Definitions | **claims administrator or an invoice required for payment of the DME item being billed.**<br><br>Commenters opine that with these regulations there is an important opportunity to rein in unreasonable and unnecessary demands for documentation and significantly reduce costs. Requests from claims administrators for "supporting documentation" far exceed requirements of any other government health care program or its fiscal intermediary, commercial health insurer selling HMO, PPO, Medicare Advantage, Managed Medi-Cal, or ERISA product. For example, payors, no longer automatically require chart notes be submitted when modifier -25 is reported. While some payors had such policies in the past, they quickly determined the increased cost of manually processing attachments, i.e. chart notes is an inefficient means of identifying over utilization of the -25 modifier and/or fraudulent billing.<br><br>Commenters opine that as written, the proposed language legitimizes | Association<br><br>February 16, 2011 Written Comments | | |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | requests for documentation that may never be reviewed or truly necessary to process a bill. One comment made by an insurance representative during an Advisory Panel meetings, was "documentation was necessary in the event that an injured worker and/or employer filed a lawsuit." Commenters believe that such reasoning is not only preposterous, it is without merit given that insurers already have three bites at the apple, i.e., prospectively through utilization review, retrospectively, or concurrently, as the case may be.<br><br>Moreover, commenter emphasizes that physicians must, by law to retain medical records for an indefinite period. Thus, physicians would be able to provide all relevant documentation, upon request, should a lawsuit arise.<br><br>Commenters strongly urge the Division to work with us in developing language that more clearly describes what supporting documentation is reasonable and necessary adjudicate a bill for a | | | |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | specific date of service. | | | |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 6, 1.0 – Standardized Paper and Electronic Billing Definitions | For purposes of consistency and clarity, commenter believes the proposed regulations must define parameters under which a claims administrator may reject a bill. In addition, commenters believe the definition must specify that the only a claims administrator may reject a bill and is liable for the actions of an employee, contractor, subcontractor or any other entity for which it holds an agreement to process a bill.<br><br>Commenters state that claims administrators attempt to evade liability for payment of medical bills by subcontracting with outside entities such as bill review companies and clearinghouses that have the technology to scrub bills for required information. While commenter does not object to such agreements, the Division must not overlook the unfettered financial incentives bill review companies reap through unfair payment practices such as; rejecting, delays, denials, underpayments, inappropriate discounts, or other abusive tactics. Claims adjusters | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | routinely insist they have no authority to intervene or direct their contractors, i.e., bill review companies to resolve such matters.<br><br>Commenters also believe the claims administrator must automatically pay the increase of 15% and interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill.<br><br>Commenters urge that the Division adopt the following language which it believes will lower costs:<br>"(cc) "Rejected bill" – Only the claims administrator may reject a bill and must comply with the all of the following:<br>1. The claims administrator shall be liable for the actions of an employee, contractor, subcontractor, or any other entity for which it holds an agreement to process a bill on the claims administrators' behalf, and<br>2. the claims administrator shall not reject a bill, submitted in the appropriate format and the bill includes all the required data elements, and if applicable, required | | | |

| ELECTRONIC AND STANDARDIZED BILLING REGULATIONS | RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | reports or documentation specified in these regulations, and<br>3. The claims administrator must automatically pay a 15% increase and interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill for rejection of a bill submitted in the required format which includes the required data elements and required attachments specified in these regulations." | | | |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 8, 3.0 – Complete Bills | (b) all required reports and supporting documentation…<br><br>Commenters opine that the proposed language in this section radically expands the definition of a complete bill. Commenters strenuously object to the proposed language as written for the following additional reasons.<br><br>Every physician is required to document each procedure(s) and/or service(s) provided, and must report those services according to AMA CPT coding guidelines, selecting code(s) that most accurately describes the medical service(s), procedure(s), and supplies documented in the physician's chart notes, and/or | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | **Disagree.** The language "sufficient to support the level of service or code that has been billed" does not "radically expand" the definition of "complete bill." The proposed language of 3.0 (b) already stated "All required reports and supporting documentation must be submitted as follows:…" The addition of the language "sufficient to support the level of service or code that has been billed" merely clarifies the scope of "all *required* reports and supporting documentation…." [emphasis added.] The whole point of | None. |

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| | operative report.<br><br>While these documentation and coding requirements are universal across all payors, only claims administrators and insurers in the California Workers' Compensation program seek to impose such arbitrary and capricious reporting demands on physicians. Moreover, key goals of the Advisory Panel process were to reach consensus on best practices for streamlining paper and electronic billing processes, identify the minimum documentation necessary to adjudicate a bill, eliminate redundancies and lower costs whenever possible<br><br>Commenters opine that if adopted, under the proposed language, claims administrators will continue, to require physicians to submit attachments with every single bill. Thus, defeating the basic principles under which the Advisory Panel worked and diminish potential cost savings benefits of "standardization." The Advisory Panel specifically discussed, eliminating the need for chart notes | | submitting reports and documentation is to demonstrate that the code submitted on the bill accurately reflects the service performed or the level of service, for example the level an Evaluation and Management code which depend on the extent of the history, extent of exam, and complexity of medical decision-making. The propriety of including the concept of "sufficient to support the level of service or code that has been billed" as a modifier of "required reports and supporting documentation" is evidenced by Labor Code §4603.2(d)(2). This subdivision evidences the legislative intent that bill reviewers may examine documentation to see if it supports the code billed, and that they may recommend payment based on an alternate code if documentation shows a different service. Labor Code | |

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| | when billing electronically for follow-up evaluation and management (E&M) services, except for "required reports." While commenter did not agree that documentation should not be necessary for the highest level of follow-up E&M code 99215, he/she recalls reaching consensus that documentation should not be necessary for the lower level E&M codes (99211-99214) unless needed to meet reporting requirements.<br><br>Commenters strongly urge that the Division strike **"supporting documentation sufficient to support the level of service or code that has been billed"** and adopt language the following substitute language:<br><br>**"(b) All required reports and other documentation must be included with a paper bill or received within 5 days of acknowledgement of receipt of an electronically transmitted bill as follows:"** | | §4603.2(d)(2) states in pertinent part: "(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 | |

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| | | | amount recommended for payment more accurately represents the service performed." | |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 8, 3.0 – Complete Bills | (b) (1) A Doctor's First Report…<br><br>Commenters respectfully recommend that the Division consider revising the requirement that each new physician submit a 1st Report of Injury. Commenters believe that this requirement is redundant and provides no additional value to the treatment of the injured worker. Commenters understand that he/she may have to work with other agencies to accomplish this change and ask for the Division's support in this matter.<br><br>Commenters respectfully request that the Division consider the following alternative language:<br><br><u>"A 1st Report of Injury shall only be completed by the physician who initially examined and/or provided medical treatment to an injured worker for a new injury. This provision shall also apply to any new injury sustained</u> | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.<br>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. |

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| | by the same worker." | | | |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 8, 3.0 – Complete Bills | (b) (5) A report must be submitted when. . .<br><br>Commenters opine that it is unnecessary to submit supporting documentation for an evaluation and management service (CPT E&M code) appended with modifier -25. If an insurer suspects inappropriate coding they may request documentation, but an attachment should not be mandatory to be considered a "complete bill."<br><br>Commenters strenuously urge the Director to delete reference to modifier -25 from proposed language.<br><br>(5) A report must be submitted when the provider uses the following Modifiers – 19, – 21, – 22, – 23 and – ~~25.~~ | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business | (b)(6) A descriptive report of the procedure…A descriptive report of the procedure, drug, DME or other item must be submitted when the provider uses any code that is payable "By | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

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| Rules, Page 8, 3.0 – Complete Bills | Report."<br><br>Commenters dislike being picayune, however, **"descriptive report"** is a new term that commenter believes should be included in the definition section or replaced with the following alternative phrase: "A report that describes…"<br><br>**(6) A report that describes the procedure, drug, DME or other item must be submitted when the provider uses any code that is payable "By Report".** | California Orthopedic Association<br><br>February 16, 2011 Written Comments | | |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 9, 3.0 – Complete Bills | (b)(7) A descriptive report…<br><br>A descriptive report must be submitted when the Official Medical Fee Schedule indicates that a report is required.<br><br>Commenters reiterate the argument for (b)(6). "**A report that describes the"** | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 9, 3.0 | (b)(8) An operative report<br><br>(b) (8). An operative report is required when the bill is for either professional or facility Surgery Services fees. | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

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| – Complete Bills | Commenters state that generating an operative report for a surgery performed in a hospital or outpatient facility is the responsibility of the rendering physician(s) and typically submitted with the physician's bill for payment. While commenter agrees that a facility may need to provide certain documentation with its bill requiring a physician's operative report, commenter opines that this is a perfect example of excessive documentation demands by claims administrators.<br>Commenters strongly recommend that the Division adopt the following substitute language:<br><br>"An operative report is required for surgical procedure(s) provided in an inpatient or outpatient facility setting." | Association<br><br>February 16, 2011 Written Comments | | |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 9, 3.0 – Complete Bills | (b)(10) Appropriate additional information…<br><br>(b)(10) Appropriate additional information reasonably requested by the claims administrator or its agent to support a billed code when the request | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association | | |

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| | 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. (This does not prohibit the claims administrator from requesting additional appropriate information during further bill processing.)<br><br>Commenters appreciate there are legitimate reasons for a claims administrator to request and receive documentation needed to determine medical necessity and financial liability.<br><br>Commenters strenuously oppose the proposed language of section and urge the Director to delete this section in its entirety for the following reasons:<br><br>• The language does not identify the necessity for adopting proposed requirements. As written, the proposed language creates an unfair loophole in the prior authorization regulations, which state, in part, that once a procedure or service, is authorized that authorization may not be | February 16, 2011 Written Comments | **Disagree.**<br><br>(b)(10) does not create a "an unfair loophole in the prior authorization." The first sentence states the requirement that the "complete bill" documentation includes appropriate additional information *reasonably requested* when the request was made *prior to* the submission of the bill. This language does not reference | None. |

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| | rescinded, after the service, was provided by the physician in good faith. **For this reason, (b) 10., must be deleted in its entirety.** | | prior authorization. Depending on the factual circumstances, a request made prior to bill submission may or may not be *reasonable* (as required by (b)(10)) where a prior authorization is given. Similarly, a request for "additional information" after the bill is submitted must be appropriate. If information was was unreasonably requested, the claims administrator would not be permitted to claim the bill is incomplete under this section. The fact of prior authorization is just one issue that may bear upon whether a request for information is appropriate. A prior authorization does not automatically preclude all requests for information as commenters appear to imply. | |
| | • As written, the proposed language creates a loophole that allows a claims administrator to request "additional information" that would otherwise be considered a | | **Disagree.** Subdivision (b)(10) does not regulate what constitutes a report, nor whether a report is or is not reimbursable. (See 8 CCR | None. |

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| | special report without being required to reimburse the physician under the OMFS rules regarding special reports. **For this reason, (b) 10., must be deleted in its entirety.**<br><br>• The second and third sentences are redundant. Restating requirements for documentation and coding is unnecessary and inappropriate as they do not support nor establish a need for such an exemption. **For this reason, (b) 10., must be deleted in its entirety.** | | §9789.11(a)(1), the Official Medical Fee Schedule for physician services, General Information and Instructions revised for services on or after July 1, 2004 for regulation relating to reimbursement for treatment reports.)<br><br>**Disagree.** First, the Division does not understand the comment's reference to "the second and third sentences" as the modified proposal only has two sentences. In addition, the Division does not believe there is any redundancy in (b)(10). The first sentence is intended to specify that "complete bill" includes additional information reasonably requested before bill submission. The second sentence is needed for clarification as previous commenters were concerned that providers may erroneously perceive the first sentence to mean that a payer could not request reasonable additional information after bill | None. |

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| | | | submission. | |
| | • As written, the proposed language does not provide clarity of purpose or the specific circumstances under which physicians must comply. The language is extremely vague. As written, the claims administrator may request information that a physician may not have ownership of; i.e., documents belonging to another physician, facility, etc., or simply not able to access. **For this reason, (b) 10., must be deleted in its entirety.** | | **Disagree.** Due to the infinite variety of medical treatment scenarios the language must of necessity be somewhat broad. Additional information requested must be "appropriate" and "reasonably requested" which will vary tremendously with the factual circumstances. | None. |
| | • The proposed language conflicts with statute that clearly states that only a claims administrator may request additional or duplicate documentation. As written, the proposed language would allow an outside entity the authority to request information. **For this reason, (b) 10., must be deleted in its entirety.** | | **Disagree.** The commenter has not identified the statute it claims is in conflict. It is assumed that commenter may be referencing Labor Code §4603.2 subdivision (d). However, subdivision (d) is intended to address the situation where a bill review entity makes *duplicate* requests for documentation that has already been submitted to the claims administrator. It does | None. |

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| | | | not contain a prohibition on a claims administrator using an agent to request additional appropriate information or documentation that has not been submitted by the medical provider. Labor Code §4603.2(d)(1) requires the employer or insurer who has employed an individual or contracted with an entity to conduct an itemization [i.e. bill] review to "make available to that individual or entity all documentation submitted together with that itemization by the physician or medical provider" and requires the individual or entity to "contact 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)." However, there is nothing in the statute that prohibits the bill review individual or entity from contacting the provider | |

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| | | | for information that was not submitted by the provider with the bill. | |
| | Commenter opines that requests for supporting documentation, continues to be an extremely challenging issue, particularly for physicians who treat work related injuries. In fact, complaints about documentation requests, is second only to the hassles physicians experience with the utilization review process. As mentioned previously, regulatory efforts governing documentation requests from commercial insurers have played an important role in reducing the number of physician complaints. Commenter believes that similar results are achievable in the workers' compensation system, and is more than willing to work with the Division to develop regulatory language. To that end, commenter has included relevant sections of Health & Safety and Insurance Code that may be useful as guide below:<br><br>"Reasonably relevant information" Means the minimum amount of | | **Disagree** that provisions of the Health and Safety Code, the Insurance Code, or regulations for Knox-Keene health plans are appropriate for workers' compensation. The legal obligations of workers' compensation claims administrators are different from payers governed by the cited statutes and regulations. For example, the workers' compensation payer is obligated to apply the workers' compensation Medical Treatment Utilization Schedule adopted pursuant to Labor Code 5307.27 and codified in 8 CCR §9792.20 et seq. In addition, medical-legal issues surrounding workers' compensation may engender a need for different or more comprehensive medical information for the payer to determine whether it is liable | None. |

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| | itemized, accurate and material information generated by or in the possession of a provider related to the billed services that enables a claims adjudicator with appropriate training, experience, competence, and timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or plan's capitated provider's liability, if any, and to comply with any governmental information requests. (28 C.C.R. §1300.71(a)(10).)<br><br>"Information necessary to determine payor liability" means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and the extent of the plan's or plan's capitated provider's liability, if any, and to comply with any governmental information requirements. (28 C.C.R. §1300.71(a)(11).) | | for medical treatment. For example, medical information may be needed to determine liability for cumulative trauma injuries or occupational disease in light of Labor Code §5500.5 which imposes liability on the employer(s) during the last year of injurious exposure to the hazard causing the injury or illness.<br>In addition, health plans are subject to the HIPAA provisions while workers' compensation payers are not. | |

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| | Unfair payment pattern: The failure to establish, upon the Department's written request, that requests for medical records more frequently than in three (3%) percent of the claims submitted to a plan or a plan's capitated provider by all providers over any twelve (12) month period was reasonably necessary to determine payor liability for those claims consistent with the section (a)(2) (defining a complete claim as including "reasonable relevant information" and "information necessary to determine payor liability") constitutes an unfair payment pattern. (28 C.C.R. §1300.71(a)(8)(H).)<br><br>Health plans are prohibited from requesting more information than is reasonably necessary to determine whether the services are covered and medically necessary. Under California law, Knox-Keene plans and health insurers are authorized to request "only the information reasonably necessary to make the determination" when seeking medical | | | |

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| | information to determine whether to approve, modify, or deny requests for authorization. (Health & Safety Code §1367.01; Insurance Code §10123.135.).<br><br>Information Requests From Physician Must Be Reasonable. If a plan requests further information from physicians in order to determine whether to approve, modify, or deny requests for authorization, *the plan must request only the information reasonably necessary to make the determination*. (Health & Safety Code §1367.01(g); Insurance Code §10123.135(g).) | | | |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 9, 5.0 – Duplicate Bills, Bill Revisions and Balance Forwarding Billing | (a) A duplicate bill…<br><br>While commenter is confident that adoption of the requirements that a claims administrator must confirm receipt of both paper and electronic claims will significantly curb or eliminate the need for physicians to submit duplicate claims, **for clarity, commenter believes that it is essential, for the Division to add the following language to this section:** | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

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| | **"Confirmation of Receipt of Electronic Billing" -"A claims administrator must confirm receipt of electronic bill(s) via electronic notice within one-day after proof of transmission by the physician."**<br><br>**"Confirmation of Receipt of Paper Billing" -"A claims administrator must confirm receipt of paper bill(s) by providing written notice to the physician via US Postal Service within 15-days of receipt of a paper bill."** | | | |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 10, 5.0 – Duplicate Bills, Bill Revisions and Balance Forwarding Billing | (b) "revised" bill…<br><br>Commenter supports the general provision of this section, but notes that "revised" bill is not an industry standard terminology. As a key element of standardization, commenter believes the Division should adopt terms that are widely known and used by all government and commercial payors.<br><br>**Commenter strongly recommends the Director replace "revised" with the word "corrected" bill.** | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

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| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 10, 5.0 – Duplicate Bills, Bill Revisions and Balance Forwarding Billing | (d) A bill which has been previously submitted in one manner…<br><br>While this is a requirement used by Medicare program, commenter does not believe such a provision appropriate for the purposes of workers' compensation program.<br><br>**Commenter urges the Division to delete this requirement and revisit the issue 18 months after adoption of these regulations.** | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 10, 6.0 – Medical Treatment Billing and Payment Requirements for Non-Electronically Submitted Bills | Subsection (a)<br><br>Commenter states that there is a long, well documented history of claims administrators failing to pay the required increase (penalty) and/or required interest for failure to physician bills within the required time limits. With adoption of the regulations, commenter urges that the Division seize this opportunity, by taking appropriate action that commenter believes is within the Division's authority to adopt regulations to ensure enforcement of | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

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| | the statute for late payment.<br><br>Commenter strongly urges the Division to adopt the following additional language:<br><br>**"(a) 1. – The claims administer is required to automatically pay the required increase of 15% and interest at the same rate as judgments in civil actions for failure meet timely payment requirements of 15-days for electronically bills and within 45 working days for paper claims. The 15% increase and interest shall apply to all unpaid services listed on the billed, and"**<br><br>**"2. The 15% increase and applicable interest shall be calculated on the OMFS rate fee for each unpaid service not paid within the required timeframes in this section, and"**<br><br>**"3. Applicable interest described in this section shall carry an additional penalty of $100.00 per bill."** | | | |

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| DWC Medical Billing and Payment Guide 2011 – Section One – Business Rules, Page 10, 6.0 – Medical Treatment Billing and Payment Requirements for Non-Electronically Submitted Bills | Subsection (b)<br><br>Commenters state while this section primarily applies to electronic billing, it uses objection timeframes for paper bills. Commenters urge that the Division adopt objection timeframes that fall within the 15-day payment requirement for electronic bills.<br><br>Commenters urge the Division require a claims administrator to object within (7) seven-days of receipt of an electronically submitted bill. | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. Moreover, the Division does not understand the comment which states that "while this section primarily applies to electronic billing, it uses objection timeframes for paper bills." Section 6.0 is expressly for non-electronically submitted bills. (See the heading of section 6.0 "Medical Treatment Billing and Payment Requirements for Non-Electronically Submitted Medical Treatment Bills.") | None. |
| Billing and Payment Guide 2011 – Section One – Business Rules, Page 10, 6.0 – Medical Treatment Billing and Payment Requirements for Non-Electronically Submitted Bills | (b)(2) If additional information is necessary…<br><br>Commenters opine that the proposed language is vague and requires further language to provide clarity of the reasonableness of the requested information.<br><br>Commenters respectfully request that the Division revise the proposed | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |

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| | language as follows:<br><br>**<u>"If additional information, within the physician's control, is reasonably necessary to adjudicate the payment of a contested bill or portions thereof, the claims administrator shall provide the physician with a clear and concise description of the specific information required to complete process and payment of the contested portion of the bill."</u>** | | | |
| Billing and Payment Guide 2011 – Section One – Business Rules, Page 10, 6.0 – Medical Treatment Billing and Payment Requirements for Non-Electronically Submitted Bills | (b)(3) The name address…<br><br>Commenters strongly recommend the **"facsimile number"** and **"secure e-mail address,"** be added to this section. | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | None. |
| Billing and Payment Guide 2011 – Section One – Business Rules, Page 12, 7.1 | Section (1)<br><br>Commenters opine that for clarity, this entire section must include provisions for both paper and electronic bill | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. Moreover, | None. |

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| - Timeframes | processing. Commenter urges the Division to consider adopting language to clarify the following: While commenter does not object to a claims administrator contracting with an outside entity, it must be clear that such agreements, do not transfer liability from the claims administrator to the contractor for compliance with state laws or regulations. For example, the claims administrator has sole responsibility to ensure the physician receives acknowledgement of paper and/or electronic bills.<br><br>Commenter urges the Division to adopt the following additional language:<br><br>**1. "The claims administrator is solely responsible for acknowledgement of receipt of both electronic and paper bills as follows:**<br><br>**a. For electronic billing, the claims administrator must acknowledge receipt electronically within (1) one-day of transmission by the physician, and** | California Orthopedic Association<br><br>February 16, 2011 Written Comments | the Division believes that the commenters may have overlooked the fact that this section 7.1 is expressly for electronically submitted bills, whereas Section 6.0 is expressly for non-electronically submitted bills. (See the heading of section 6.0 "Medical Treatment Billing and Payment Requirements for Non-Electronically Submitted Medical Treatment Bills" and heading of section 7.0 Medical Treatment Billing and Payment Requirements for Electronically Submitted Bills"; "7.1 Timeframes.") | |

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| | b. **For paper billing, the claims administrator must acknowledge receipt by notifying the physician within 15-days working days."** | | | |
| Billing and Payment Guide 2011 – Section One – Business Rules, Page 13, 7.1 - Timeframes | Subsection (iii) If the required information is not received by the claims administrator within the five working days, or the claims administrator is not able to locate and affix the claim number, the bill may be rejected as being incomplete utilizing the ASC X12N/005010X214.<br><br>Commenters agree that a claims administrator may reject a bill if required information has not received within five working days. However, commenter strongly disagrees with language that allows a claims administrator to reject a bill, if it is unable to locate a claim number. Under such circumstances, the bill must be a denied as injured workers' claim of injury is denied.<br><br>Commenters urge the Division to delete the following: ~~"or the claims administrator is not able to locate and~~ | Frank D. Navarro California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | **Disagree.** The claim number is an important criterion for matching an electronic medical bill to a workers' compensation claim in the claims administrator's system. However, since this number is generated by the claims administrator and may not be available to the medical provider or facility at the time of bill submission, it is appropriate to allow the bill to be put in "pending" status for up to five working days while the claims administrator attempts to match the bill to a claim in its system so that the claim number can be attached. However, if the claims administrator cannot locate a claim in its system by the end of the 5 working days, then it is appropriate to reject the bill | None. |

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| | ~~affix the claim number."~~ In addition, add the following language:<br><br>**"If a claims administrator is unable to locate and affix a claim number within the five working day period, the claims administrator shall deny the bill as injured worker's claim of injury is denied."** | | and language is added to 7.1(a)(3)(A)(iii) to allow rejection of the bill as incomplete. The Division disagrees with the suggestion to add language that "the claims administrator shall deny the bill as injured workers' claim of injury is denied" if the claims administrator can't attach the claim number. The fact that the claim (and thus claim number) cannot be found in the claims administrator's system *does not* mean that the claim of injury is denied. In order to "deny an injured worker's claim of injury" the claims administrator would need to have the claim in its system and have a basis for denying the claim of injury. "Rejecting the bill" is not a substantive rejection of liability for the injured worker's claim. | |
| Billing and Payment Guide 2011 – Section One – Business | (1) Complete Bill – Payment for Uncontested Medical Treatment.<br><br>Commenter states that the provision | Frank D. Navarro California Medical Association | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day | None. |

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| Rules, Page 13, 7.1 - Timeframes | LC 4603.4 (d) will significantly limit the number of providers able to submit electronic billing at or below the OMFS fee schedule rates. The vast majority of physicians are unable to bill at rates other than their usual and customary fee (UCR) schedule (UCR). Commenter opines that this requirement eviscerates the benefits of electronic billing.<br><br>While commenter continues to support the Division's tremendous efforts with regard to these regulations, commenter recommends that the Division add language to this section that would deem UCR billing as the equivalent of billing at the OMFS rates.<br><br>To accomplish this commenter urges the Division to add the following language to this section:<br><br>**"To indicate that a physician is billing using UCR, but expects to be paid at the OMFS rate, the physician shall enter "OMFS" in box 19 on the CMS 1500 form."** | Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | comment period. | |
| Billing and | While commenter appreciates the | Frank D. Navarro | The comment does not address | None. |

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| Payment Guide 2011 – Section One – Business Rules, Page 14, 7.2 - Penalty | Division's effort to ensure payment of late payment increase and interest, commenter believes that the the phrase "self executing" may be misunderstood and that a requirement that the increase and interest "shall be automatically paid to the physician."<br><br>"(b) In addition, any electronically submitted complete bill that is 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 billing agent/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, **"and shall be automatically paid to the physician."** | California Medical Association<br><br>Diane Przepiorski California Orthopedic Association<br><br>February 16, 2011 Written Comments | the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | |
| Medical Billing | Commenter states that depending on | Kathleen Burrows | **Disagree.** The Division is | None. |

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| and Payment Guide<br>Appendix A – Standard Paper Form<br>CMS 1500<br>Field 14 | the circumstances of the employee's injury or occupational disease, 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 may be correct. Commenter states that to eliminate one of these options could result in incorrectly identifying an employee's date of injury for reporting purposes.<br><br>Commenter acknowledges that the current instructions may cause confusion over which date of injury providers and claims administrators might use when there are two choices. Instead of deleting one of the choices, Commenter believes the instruction should be revised to help clarify when to use definition number 1 and when to use definition number 2.<br><br>Commenter recommends the following revision: | Claims Operations Manager<br>State Compensation Insurance Fund<br>February 16, 2011<br>Written Comment | unaware of how it could define rules to give direction on making a consistent choice of definitions "depending on the circumstances of the employee's injury or occupational disease." Commenter has not described what directions would be given, other than its suggestion to "enter whichever occurred first." Determining the "date of injury" for cumulative claims may involve very complex legal and factual issues. For purposes of billing rules, the Division believes that it would be clearer to provide one consistent date to be used for the date of injury for cumulative claims, since there is not an apparent way to give rules for a choice of date by the doctor. The Division believes that it is more appropriate to utilize definition one, "the last date of occupational exposure to the hazards of the occupational disease or cumulative injury" | |

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| | For Cumulative Injury or Occupational Disease **enter whichever occurred first:**<br><br>1) the last date of occupational exposure to the hazards of the occupational disease or cumulative injury or<br>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 | | rather than the second definition which has been deleted in this comment period: "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." 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. Moreover, 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. The employer can raise the issue of the | |

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| | | | applicability of definition number two, from Labor Code section 5412, if the issue of the statute of limitations is relevant. The billing rules identify the usage of the "date of current illness or injury" field for purposes of billing only; the ultimate legal issue of the "date of injury" is complex and may need to be resolved through litigation at the workers' Compensation Appeals Board if the parties to a claim cannot reach agreement. | |
| 9792.5, 9792.5.2, and Medical Billing and Payment Guide | Commenter strongly recommends that the 90 day effective date for paper billings be retained. When this regulation was first proposed, the DWC provided for only 30 days. Commenter states that this was insufficient for the amount of programming and training that will be necessary, even for paper bills. Ninety days should provide ample time and commenter believes that delaying the effective date of the regulation will only continue the many current problems this regulation was | Steve Suchil<br>Assistant Vice President<br>American Insurance Association<br>February 16, 2011<br>Written Comment | **Disagree.** It is noted that commenter is in error in stating that the DWC provided only 30 days for implementation when the regulation was first proposed. In the initial 45-day proposal, the text of proposed section 9792.5.2 stated in part: "(a) On and after XXXX, 2010, [approximately 90 days after the effective date of this regulation] all paper bills for medical treatment … shall be submitted on claim forms set | None. |

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| | designed to solve.<br><br>Further, recent revisions to the WCIS regulations are set to become effective on November 15, 2011. This date was chosen to make sure that the Standardized Billing regulations would become effective - requiring provision of various data elements by providers -before state reporting requirements - for payors - were in place. With six months lead time following completion of the formal rulemaking process commenter notes that this timing is highly unlikely, if not impossible.<br><br>Again, commenter recommends returning to the 90 day effective date. If accepted, this change will also be required in the Payment Guide, Section 2.0 (a). | | forth in the *California Division of Workers' Compensation Medical Billing and Payment Guide*.<br>(b) On and after XXXX, 2010, [approximately 90 days after the effective date of this regulation] all medical bills shall conform to the provisions of the *California Division of Workers' Compensation Medical Billing and Payment Guide w*hich includes coding, billing standards, timeframes and other rules."<br>In addition, the Medical Billing and Payment Guide, page 3, stated: "Health Care Providers, Health Care Facilities, Claims Administrators, Third Party Billers/Assignees and Clearinghouses<br>that submit bills on paper must adhere to the rules relating to use of the standardized billing forms for bills submitted on or after XX-XX-2011 [approximately 90 days after adoption]." | |

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| | | | In light of the fact that these regulations for the first time mandate standardized billing forms, and standardized bill adjustment reason codes, it is reasonable to allow 6 months for the programming that may be needed, adjustment of systems/procedures, and training of staff. Although many providers and payors would have sufficient time with 90 days, based on comments received it appears that 90 days would not be sufficient for some entities to comply.<br>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 | |

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| | | | ongoing since 2006; the fact that an update becomes effective in November of 2011 does not necessitate that billing regulations be adopted in tandem. | |
| DWC Medical Billing and Payment Guide 2011 – 3.0 Complete Bills | Commenter recommends the following modifications to this section to clarify that these reports must contain enough documentation to support the level of service/code that is billed:<br><br>(b) All required reports and supporting documentation must be sufficient to support the level of service or code that has been billed must be submitted and be submitted together with the bill as follows:<br><br>(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. (This does not prohibit the claims administrator from requesting | Steve Suchil<br>Assistant Vice President<br>American Insurance Association<br>February 16, 2011<br>Written Comment | **Disagree.** First, it is noted that it is difficult to discern the modifications intended since the formatting was apparently stripped off prior to submission or due to software issues. The Division requested the commenter to resubmit with formatting, and he agreed, but the Division has not received a resubmission.<br>It appears that in the first sentence of subdivision (b) commenter has added a second "must be" and that additional language is added to require the documentation to be submitted "together with the bill." The Division disagrees with adding "must be" as it would be redundant and unnecessary. The Division disagrees with adding "together with the bill" since | None. |

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| | additional appropriate information during prior to further bill processing.)<br><br>Commenter opines that without this modification a payor could incur audit penalties for awaiting documentation to support the billing. | | the regulations allow the documentation to be sent separately from the bill. Subdivision (c) of 3.0 Complete Bills provides that where required reports and supporting documentation are not submitted in the same mailing envelope as the bill there must be a header or attachment cover sheet as defined in Section One-7.3. For electronic bills, there is currently no HIPAA adopted attachment standard which would assure that bills and attachments are submitted together. The regulations allow various methods, which are set forth in Section One 7.3. The Electronic Medical Billing and Payment Companion Guide allows up to 5 working days for the attachment to arrive. (See Chapter 9.)<br>The Division cannot discern if commenter is suggesting a change to (b)(10).<br>The Division disagrees that modification is needed to | |

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| | | | avoid audit penalties. Audit penalties can be avoided by paying undisputed portions of the bill promptly, and timely notifying the provider of objections to the bill or if there is a reasonable need for additional documentation.<br><br>**Agree.** The Division overlooked the fact that Labor Code §4603.2, the statute for paper billing, specifies that "written authorization for services that may have been received by the physician" is to be submitted by the provider. | Modify the Medical Billing and Payment Guide, 3.0 Complete Bills to add a new subdivision (b)(11) to the list of required reports and supporting documentation: "For paper bills, any written authorization for services that may have been received by the physician." |
| | (11) Written authorization for services shall be provided where one was given.<br><br>Commenter states that this requirement should be retained as it is required by Labor Code Sec. 4603.2 (b) (1). Commenter opines that without retaining this language the regulation will be in conflict, and inconsistent, with the Labor Code. | | | |
| DWC Medical Billing and Payment Guide 2011 – 7.1 Timeframes | Commenter recommends the following changes:<br><br>(a) Acknowledgements<br><br>(3) (A) ASC X12N 277 005010X214 Claim Pending Status Information | Steve Suchil Assistant Vice President American Insurance Association February 16, 2011 Written Comment | **Disagree.** First, it is noted that it is difficult to discern the modifications intended since the formatting was apparently stripped off prior to submission or due to software issues. The Division requested | None. |

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| | (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 | | the commenter to resubmit with formatting, and he agreed, but the Division has not received a resubmission. However, it appears that commenter is suggesting that this deleted sentence be reinstated: "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." The Division disagrees with this suggestion for several reasons. First, it is possible for billing entities to match a bill and a claim in the payor's system based on criteria other than the claim number. Allowing automatic rejection of the bill for a missing claim number is inefficient. 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 | |

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| | not begin anew.<br><br>Commenter states that the recently deleted phrase that is underlined above was a compromise between the payors and providers who were members of the Division's Standard Billing and E-Billing Task Force. Payors initially wanted all bills to have a claim number included, stating this speeds review and payment while providers stated that they didn't always know the Claim Number. After much discussion it was agreed that this was a legitimate problem for first visits or if the Payor failed to advise the Provider of the Claim Number. But, once it was provided, it was to be a required piece of documentation required on all subsequent bills. Matching names can be a very time-consuming process and is open to errors. Further, it delays the review and payment of the bill. This will present problems with the shortened time frame for payment of e-billings.<br><br>Commenter strongly recommends the reinstatement of the sentence underlined above. If this | | 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 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. | |

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| | recommendation is accepted, reinstatement of the following will be needed in field 11 of the Field Table for the CMS 1500: "Unknown can only be entered if it is a first billing by the provider." | | | |
| DWC Medical Billing and Payment Guide 2011 – 7.1 Timeframes (a)(3)(A)(i) | Commenter notes that the Division corrected one instance where 15 days rather than 15 working days was stated but this also needs to occur in the second to the last sentence in the section. | Steve Suchil Assistant Vice President American Insurance Association February 16, 2011 Written Comment | **Agree.** | Modify 7.1 Timeframes (a)(3)(A)(i) to insert "working" into the penultimate sentence, to read "15 working-day." |
| DWC Medical Billing and Payment Guide 2011 – Appendix A. Standard Paper Forms | Commenter appreciates the responsiveness of the Division to his comment during the first 15 day Comment Period regarding a preference for having only one definition for the cumulative injury/illness date of injury. Commenter again states his preference for language that states: "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."<br><br>Commenter believes this to be preferable because it comports with | Steve Suchil Assistant Vice President American Insurance Association February 16, 2011 Written Comment | **Disagree.** For "cumulative injury" and "occupational disease," the "date of injury" can be a very factually and legally complex issue, many times leading to litigation. The Division has proposed the instruction to enter the "date of last occupational exposure to the hazards of the occupational disease or cumulative injury" to provide a clear date for the medical provider to enter for a cumulative injury. This instruction has also been selected as it is consistent | None. |

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| | Labor Code Secs. 5412 and 3208.1, and as such the regulation should be consistent with this definition. It is also more proximate to any actual perceived disability, allowing for timely intervention.<br><br>This comment refers to the following provisions, where the changes should be made: 1.1 CMS 1500 field 14; 2.1 UB-04 field 31-34 (a) (b), 3.1 NCPDP field 11; and, 4.1 ADA field 46. | | with the date used for cumulative trauma or occupational disease claims in the Electronic Adjudication Management System (EAMS) (which is the court case management system for the workers' compensation adjudication system) and in the Workers' Compensation Information System (WCIS) established pursuant to Labor Code §138.6. The Division disagrees with the suggestion to adopt "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." This definition is from Labor Code section 5412, in a portion of the Labor Code dealing with statute of limitations. The employer can raise the issue of the applicability of Labor Code §5412, if the issue of the statute of limitations is relevant. The billing rules | |

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| | | | identify the usage of the "date of current illness or injury field" for purposes of billing only; the ultimate legal issue of the "date of injury" is complex and may need to be resolved through litigation at the Workers' Compensation Appeals Board if the parties to a claim cannot reach agreement. The instruction preferred by the Division, the last date of occupational exposure to the hazards of the occupational disease or cumulative injury, is based on Labor Code section 5500.5 which provides that liability for cumulative injury or disease is "limited to those employers who employed the employee during [the one year] immediately preceding either the date of injury, as determined pursuant to Section 5412, or the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational | |

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| | | | disease or cumulative injury, whichever occurs first." However, for clarity and consistency, for purposes of billing only, the "last exposure" date is preferable and is proposed for the billing rules. | |