California Workers' Compensation Institute
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September 10, 2007

VIA E-MAIL

Suzanne Honor-Vangerov
Manager, Medical Unit
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

RE: Regulations on medical billing standards and electronic billing

Dear Ms. Honor-Vangerov:

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

Recommended modifications are indicated by underline and ~~strikethrough~~.

Article 5.5. Application of the Official Medical Fee Schedule

Section 9792.5(b),(d)
Recommendation – Governmental Entity and Interest on Contested Charges
Modify the language in (b) and (d) to clarify that payment for a properly documented bill is due within 60 working days if the employer is a governmental entity.

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

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

(f) The language formerly under section 4603.2(b)(B) of the Labor Code that provided statutory support for the imposition of interest and lien filing fee reimbursement when the appeals board determined a contested charge to be payable, was repealed by the 2006 Budget Trailer Bill on July 1, 2006.

Article 5.5.0 Rules for Treatment Billing and Payment…

Section 9792.5.0(e)
Recommendation – Definition of Third Party Biller/Assignee
~~(e) "Third Party Biller/Assignee" means a person or entity who is either billing or collecting payment in place of, or on behalf of, the rendering physician, health care provider or health facility.~~

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

(f)"Assignee" means a person or entity that has purchased the right to payments for medical goods or services from the health care provider, and is authorized by law to do so, and there has been a transfer of rights or benefits between the health care provider and the assignee.

Discussion
CWCI believes the definitions it recommends are more accurate, and since a third party biller and an assignee have different meanings, separate definitions are necessary.

Section 9792.5.1(e),(f),(g)
Recommendation – Manuals
Delete subsections (e),(f) and (g) and instead include all necessary information in the Guides.

Discussion
To avoid possible contradictions and confusion it is necessary to include all information needed by the user in the Guides. Since the referenced manuals are under the Division's control, modifications to these manuals may create unexpected contradictions and confusion. We note that the manuals references in (f) and (g) do not contain revision or version dates.

Section 9792.5.2
Recommendation -- Terminology
(a) On and after XXXX, 2008, [90 days after the effective date of this regulation] all paper bills for medical treatment provided by ~~physicians,~~ health care providers~~, and health care facilities~~ shall be submitted on ~~claim~~ billing forms set forth in the California Division of Workers' Compensation Medical Billing and Payment Guide.

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

Medical Billing and Payment Guide

Introduction
Recommendation – Effective date
Labor Code §4603.4 (a)(2) requires claims administrators to accept electronic submission of medical bills. The effective date is XX-XX-200X. The entity submitting the bill has the option of submitting bills on paper or electronically. As of XX-XX-200X, ~~I~~if an entity chooses to submit bills electronically it must be able to receive an electronic response from the claims administrator. This includes electronic acknowledgements, notices and electronic Explanations of Review.

Discussion
CWCI recommends inserting the effective date of the regulations (i.e. the date 18 months after the adoption of the Rules for Medical Treatment Billing and Payment regulations) so that it is clear when the requirement begins.

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

Discussion
Adding format clarifies that the correct format must be used for electronic billing.

1.0 Standardized Billing / Electronic Billing Definitions
Recommendation – Electronic Signature
(h) "Electronic signature" means a signature that conforms to the requirements for digital signatures adopted by the Secretary of State in Title 2, California Code of Regulations §§ 22000 – 22003 pursuant to Government Code § 16.5 ~~or a signature that conforms to other applicable provisions of law~~.

Discussion
To avoid uncertainty and dispute, other applicable provisions of law, if any, must be specified in (h) and if there are not any, the phrase "other applicable provisions of law " must be removed.

1.0 Standardized Billing / Electronic Billing Definitions
Recommendation – Employer
~~(j) "Employer" as defined in this manual means any of the following: an Employer as defined in Labor Code section § 3300, an Insurer as defined in Labor Code section § 3211, and any person performing the duties of an employer under Division 4, Part 2, Chapter 2, Article 2 of the Labor Code.~~

Discussion
This proposed definition would cause confusion and errors because it does not comport with the various uses of the term in the regulations, the guides, the manuals, the forms and explanations of review.

1.0 Standardized Billing / Electronic Billing Definitions
Recommendation – Supporting Documentation
(u) "Supporting Documentation" means those documents, other than a required report, necessary to support a bill. These include, but are not limited to: any written authorization received from the claims administrator, ~~or an~~ invoice or proof of payment required for payment of ~~the~~ DME or surgical hardware ~~item being billed~~, and any other reports or other documents necessary to support the billed code.

Discussion
Since (c) describes "required reports and supporting documentation" reports and other documents necessary to support the billed code must fall under the definition of supporting documentation and to avoid confusion should be included in the language of the definition.

1.0 Standardized Billing / Electronic Billing Definitions
Recommendation – Third Party Biller/Assignee
~~(v) "Third Party Biller/Assignee" means a person or entity who is either billing or collecting payment in place of, or on behalf of, the rendering physician, health care provider or health facility.~~

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

(w)"Assignee" means a person or entity that has purchased the right to payments for medical goods or services from the health care provider, and is authorized by law to do so, and there has been a transfer of rights or benefits between the health care provider and the assignee.

Discussion
CWCI believes the definitions it recommends are more accurate, and since a third party biller and an assignee have different meanings, separate definitions are necessary. If this recommendation is accepted, it will be necessary to renumber the subsequent definitions accordingly.

1.0 Standardized Billing / Electronic Billing Definitions
Recommendation – Treating Physician
(~~w~~x) "Treating Physician" means the primary treating physician selected by the employee or designated by the employer ~~or secondary physician as defined by section 9785(a)(1), (2)~~.

Discussion
The recommended definition is in accord with the language in Labor Code sections 4603.2(b)(1) and 4603.4(d) and consistent with CCR section 9785(a)(1). The primary treating physician has the responsibility to "provide or authorize medical treatment" and

to submit required reports, which are the requests for authorization. Including secondary physicians in this definition would interfere with the responsibilities of the primary treating physician and create confusion.

1.0 Standardized Billing / Electronic Billing Definitions
Recommendation – Uniform Billing Codes
(2) "~~California~~ Official Medical Fee Schedule Codes" means those codes adopted by the Administrative Director for use in the Official Medical Fee Schedule (Title 8, California Code of Regulations §§ 9789.10-100). The ~~California~~ Official Medical Fee Schedule codes include those codes found in the 1999 OMFS book, as well as the CDT, CPT, HCPCS, DRG, ASA, and NDC codes.

Discussion
The term "California codes" is defined as CPT codes modified by the DWC, or codes introduced by the DWC for use in the California Official Medical Fee Schedule. Using the term "Official Medical Fee Schedule" will eliminate potential confusion.

1.0 Standardized Billing / Electronic Billing Definitions
Recommendation – Working Days
Add to the list of holidays in this state:

(12) Good Friday from 12 noon to 3 p.m.

(13) The fourth Thursday and Friday in November

Discussion
According to Government Code section 6700, the holidays in this state include Good Friday from 12 noon to 3 p.m as well as Thanksgiving Day and the day after Thanksgiving Day (the fourth Thursday and Friday in November).

2.0 Standardized Medical Treatment Billing Format
Recommendation – Version of Forms
Add "2005 version" to (a)(2) and "200 version" to (a)(4).

Discussion
It is necessary to specify the specific version of each form to be used as the standard billing form..

3.0 Complete Bills
Recommendation – Required Reports and Supporting Documentation
(10) Appropriate additional information reasonably requested by the claims administrator or its agent to support a billed code ~~when the request was made prior to submission of the billing~~. Supporting documentation should be sufficient to support the level of service or code that has been billed.

(12) Documentation sufficient to support the level of service of each Evaluation and Management service billed.

(13) Documentation of prescribing physician's written order that a nongeneric drug must be dispensed.

(14) A report must be submitted to support a time-based code.

(15) Proof of payment must be provided when one is required for reimbursement.

(16) Any written authorization for services received by the physician must be submitted.

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

(18) A third party biller or assignee shall submit proof that the person or entity is an agent

Discussion

(10) A claims administrator or its agent must be permitted to reasonably request appropriate additional information to support a billed code either before or after submission of the billing. The claims administrator or its agent does not necessarily know that services or goods have been provided until the bill is received. The list cannot cover every conceivable billing circumstance that will necessitate supporting documentation. Potential for fraud or abuse will rise if the regulations allow a medical provider, third party biller or assignee to bill, assured that the claims administrator or its agent may not request any other documentation to support its billing.

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

(12) A documentation format and instructions prompting information sufficient to support the level of service of each Evaluation and Management service billed was developed by the Advisory Committee. Including the documentation format and instructions developed by the Advisory Committee in these regulations would promote appropriate documentation, billing and payment of Evaluation and Management services.

(13) Per Labor Code section 4600(b), a person or entity shall not be required to dispense a generic drug equivalent when the prescribing physician specifically provides in writing that a nongeneric drug must be dispensed.

(14) Documentation of the time is necessary to validate time-based codes.

(15) Proof of payment is required when implantable hardware is separately billed by hospitals in the case of certain DRGs.

(17) Per Labor Code section 4603.2(b) any written authorization for services received by the physician must be submitted together with the billing.

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

4.0 Third Party Billers/Assignees

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

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

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

Discussion

Clarification is needed that third party billers and assignees have no greater right to reimbursement than the original provider to prevent to prevent inappropriate practices such as deliberate attempts to obtain higher reimbursement than the Official Medical Fee Schedule or a contract with the original provider allows. Proof of a third party biller's or assignee's right to bill on behalf of, or in lieu of the original provider is necessary so that the payer has assurance of its responsibility for payment.

5.0 Duplicate Bills, Bill Revisions and Balance Forward Billing

Recommendation – Timing, Identification and Billing Method

(a) The resubmission of a duplicate bill shall clearly be marked as a duplicate in the field designated for that information. Duplicate bills shall contain all the same information as the original bill. No new dates of service or itemized services may be included. Duplicate bills shall not be submitted prior to expiration of the time allowed for payment unless requested by the claims administrator or its agent.

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

(d) A bill which has been previously submitted in one manner, paper or electronic, ~~on paper~~ may not be also or subsequently submitted in the other manner ~~as an electronic bill~~.

Discussion

(a) Duplicate bills received prior to the expiration of the time allowed for payment slow down payments of bills because identifying them as duplicates takes time away from processing other bills. A significant percentage of all bills received are premature duplicates. All bills will be paid more quickly if duplicate bills are not submitted prematurely.

(b) Many bills include a large number of billing lines. CWCI recommends identifying a field to identify the line(s) that have been revised. This will increase efficiency and will permit bills to be process and paid more quickly. Without this field to identify the revised line, a bill reviewer, who cannot know how many revisions there may be or on which billing lines they occur, must spend time comparing multiple lines to identify every revised line.

(d) To avoid potential duplicate reviews and payments and other problems, it is important that a bill which has been previously submitted in one manner, paper or electronic, may not be also or subsequently submitted in the other manner.

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

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

Discussion
(a) The struckout language is supported by the underlying statute, Labor Code section 4603.2(b).
(b)
(d) The language formerly under section 4603.2(b)(B) of the Labor Code that provided statutory support for the imposition of interest and lien filing fee reimbursement when the appeals board determined a contested charge to be payable, was repealed by the 2006 Budget Trailer Bill on July 1, 2006.

7.1 Timeframes
7.0 Medical Billing and Payment Requirements for Electronically Submitted Medical Treatment Bills
Recommendation – (a) Acknowledgements
(A) Modify the language to reflect that only a first billing may be pended for the five days because of a missing claim number.

(A)(ii) Clarify the format for the required pending notice.

(B) ~~Incomplete bill~~ Bill Rejection error messages shall include the following:

(i) Invalid form or format – indicate which form should be used ~~and why~~

(ii) Missing fields- indicate ~~specifically missing~~ which field number identifier or field name identifier is missing

(iii) Invalid data – indicate in which ~~for each~~ field ~~of~~ the data type is ~~i~~nvalid. ~~data, indicate specifically the proper data type~~ Delete (iii) if the data type is not validated at this level

(iv) Missing attachments – indicate ~~specifically which~~ the number and type of attachments indicated on the billing that are ~~attachment is~~ missing. Delete (iv) if missing attachments are not validated at this level

(v) Missing required documentation – indicate which codes require attachments ~~specifically what documentation is missing~~. Delete (v) if required attachments are not validated at this level

(vi) Injured worker's claim of injury is denied. Delete if a denied claim is not determined at this level

(vii) There is no coverage by the claims administrator. Delete if coverage is not determined at this level

Discussion

(A) The Advisory Task Force after much discussion reached a compromise and recommended that after the first billing, a billing must include the claim number to be considered complete. Searching for a claim number is very resource intensive and slows the down the review and payment system. A provider must therefore provide the claim number for the first billing unless unable to obtain it. Since a missing claim number is promptly provided to provider electronically, a provider must submit the claim number on subsequent billings.

(A)(ii) The format for the notice is unspecified and I did not identify a pending notification in the 824 detailed acknowledgement.

(B) Rejected bills may be a better descriptor than incomplete bills.

(i) It is sufficient to indicate which form or format is required

(ii) This suggested edit is for clarity only

(iii) I have received some feedback that data is not validated until it is entered into the bill review application. If validation of the data type is performed at this level it is sufficient to indicate in which field the data is invalid

(iv) When the number and type of attachments are indicated in the billing but one or more are missing, it is sufficient to indicate the number and type of the missing attachments. I have received some feedback that attachments are not validated at this level.

(v) When attachments are required for a billed code but are not indicated on the billing, it is sufficient to indicate which codes require documentation. I have received some feedback that attachments are not validated at this level.

(vi) Injured worker's claim of injury is denied. I have received some feedback that a denied claim is not determined at this level at this level

(vii) There is no coverage by the claims administrator. I have received some feedback that a coverage is not determined at this level at this level

7.1 Timeframes
7.0 Medical Billing and Payment Requirements for Electronically Submitted Medical Treatment Bills
Recommendation – (b) Payment and Remittance Advice
(b) Payment and Remittance Advice.

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

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

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

(A) A specific explanation of the basis for the objection to each contested procedure and charge. The notice shall use the DWC Bill Adjustment Reason codes contained in Appendix B Standard Explanation of Review – 1.0. If the objection is based upon appropriate coding of a procedure, the explanation shall include both the code reported by the submitter/provider and the code believed reasonable by the claims administrator.

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

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

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

Discussion
Per Labor Code section 4603.4(d), an electronic bill must be paid within 15 working days only if it is complete, uncontested, and billed at or below the maximum fees provided in the Official Medical Fee Schedule. If those conditions are not met, the bill must be paid in accordance with Labor Code Section 4603.2. The language added to (1) is necessary to conform to the Labor Code section 4603.4(d) requirements.

7.2 Penalty
Recommendation – (a) Audit Penalty
(a) Any electronically submitted bill<u>ing at or below the maximum fees in the Official Medical Fee Schedule</u> determined to be complete not paid or objected to within the 15 working day period shall be subject to audit penalties per Title 8, California Code of Regulations section 10111.2 (b) (10), (11).

Discussion
Per Labor Code section 4603.4(d), an electronic bill must be paid within 15 working days only if it is complete, uncontested, and billed at or below the maximum fees provided in the Official Medical Fee Schedule. If those conditions are not met, the bill must be paid in accordance with Labor Code Section 4603.2. The language added to (1) is necessary to conform to the Labor Code section 4603.4(d) requirements.

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

(e) Attachment types

(1) <u>Required</u> Reports
(2) Supporting Documentation
(3) ~~Requests for~~ <u>Written</u> Authorization
(4) Misc. (other type of attachment)

Discussion
(a)(6) Unless "bill" replaces "claim," users will likely submit a claim number instead of the bill tracking number intended.

(e)(3) The proposed edit distinguishes required reports from supporting documentation. We have recommended that reports other than required reports be considered part of the supporting documentation.

7.4 Miscellaneous
Recommendation – Confidentiality
(c) This section does not prohibit a claims administrator or health care provider, health care facility or third party biller/assignee from using alternative form<u>at</u>s or procedures provided such form<u>at</u>s or procedures are specified in a written agreement between the claims administrator and the health care provider, health care facility or third party

biller/assignee, and clearinghouse, or an agent thereof, as long as the alternative billing and transmission format provides all the required information set forth in the Appendix A or the Companion Guide.

(d) Individually identifiable health information submitted on a uniform billing form shall not be disclosed by ~~either~~ the claims administrator or submitting health provider, health care facility or third party biller/assignee, or clearinghouse, or one of their agents, except where disclosure is permitted by law or necessary to confer compensation benefits as defined in Labor Code Section 3207.

Discussion
For electronic billings, the term "format" applies instead of "form." A clearinghouse or an agent should also be included in the listings of these subsections.

Version of Forms
Recommendation – 2.0 Standardized Medical Treatment Billing Format
Add "2005 version" to (a)(2) and "200 version" to (a)(4).

Discussion
It is necessary to specify the specific version of each form to be used as the standard billing form..

Appendix A. Standard Paper Forms
Recommendation – CMS 1500
Paper Field 11 Required for all billings except a first billing. For a first billing required if known ~~Enter claim number, if known in field 11~~ or if claim number is not known then enter a two digit numeric value 00 to indicate unknown claim number.

Paper Field 17 Required if referred. Enter the name of the referring physician or other source~~(if different than field 31)~~

Paper Field 17b Required if field 17 is populated. Enter NPI number of referring provider

Paper Field 23 Required if a preauthorization or certification number was issued. Enter ~~prior~~ preauthorization or certification number ~~assigned by payer, if known~~

Paper Field 24I Required when rendering line provider is different than provider listed in box 33 ~~31~~. Enter in the shaded area of 24I the ID qualifier "OB" indicating State License Number

Paper Field 24J_1 Required when rendering line provider is different than provider listed in box 33 ~~31~~. Enter state license number or certification number in the shaded area of the field.

Paper Field 24J_2 Required when rendering line provider is different than provider listed in box 33 ~~31~~. Enter the NPI number in the unshaded area of the field.

Paper Field 17b Required if Billing Provider is a health care entity. ~~When Billing and Rendering Provider are the same, Billing Provider NPI is populated. When Rendering Provider is different than Billing Provider populate Rendering Provider NPI number~~

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

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

Sincerely,

Brenda Ramirez
Claims and Medical Director

BR/pm

cc: Carrie Nevans, DWC Deputy Administrative Director
Jackie Shauer, DWC Attorney
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Regular Members
CWCI Associate Members
CWCI Legal Committee