California Workers' Compensation Institute
1111 Broadway Suite 2350, Oakland, California 94607 • Tel: (510) 251-9470 • Fax: (510) 251-9485
Website: www.cwci.org

August 19, 2005

VIA E-MAIL

Jackie Schauer
Division of Workers' Compensation – 9th Floor
Post Office Box 420603
San Francisco, CA 94142

RE: E-Billing and Standardized Billing

Dear Ms. Schauer:

We offer the following comments and recommendations on behalf of California Workers' Compensation Institute members. Recommended modifications are indicated by ***underline*** and ~~*strikethrough*~~. The E-billing Taskforce and its subcommittees continue to work on a number of issues that are not as yet included in the draft regulations, but that will need to be addressed. These issues include definitions and requirements for complete billings and itemizations, supporting documentation; standards for communications between the billing medical provider and the claims administrator's bill reviewer, such as explanations of review; and standards for electronic transmission of attachments to billings, such as medical reports, written authorizations, and other supporting documentation.

Section 9792.20 – Standardized Billing / Electronic Billing Definitions

Recommendation
Define "authorized medical treatment" in (a)(1) as medical treatment with authorization: authorization is defined in section 9792.6(b).

Discussion
A definition that is consistent with the language in the Utilization Standard regulations is necessary.

Recommendation
(5) "Electronic signature" means …

Discussion
The E-billing Committee has not finished its work on this issue. Digital signatures and related requirements are addressed in Government Code sections 16.5 and 811.2, and California Code of Regulations sections 22000, 22001, 22002, 22003, 22004 and 22005. The Committee is also considering whether or not to recommend accepting "signatures on file" on billings. We believe that "signatures on file" should be permitted on medical billings only if they are actually and verifiably on file with a signed stipulation that the provider accept full responsibility for the submitted billing and if the requirements are included in these regulations.

Recommendation
Delete (a)(7).

Discussion
This proposed definition is not necessary since the term does not appear in these draft regulations.

Recommendation

(8) "Health Care Provider" means a provider of medical goods and/or services~~, including but not limited to an individual provider, a health care service plan, a health care organization, or a preferred provider organization~~.

Discussion
The recommended change provides a more straightforward definition. The language we recommend deleting confuses rather than clarifies.

Recommendation

(10) "Itemization" means a detailed list of medical goods and/or services provided, including but not limited to uniform billing codes and related descriptors, detailed breakout of billed fees, quantities, service providers, service locations, and all other data elements together with supporting documentation as required by Article 5.5.

Discussion
The itemization should describe the components needed to review and pay a medical bill without delay.

Recommendation
Substitute "billing" for "claim" in section (17) and elsewhere in these regulations.

Discussion
In the worker' compensation venue, a "claim" means a claimed injury, whereas in non-workers' compensation venues it means a billing. To avoid confusion, "billing" should be the term used throughout these regulations.

Section 9792.30 – Standardized Medical Service Billing Forms and Electronic Billing

Recommendation

(a) On and after October 1, 2006, or six months after adoption of this section, whichever is later, all ~~physicians,~~ health care providers~~, and health care facilities~~ providing medical treatment and/or medical goods and/or services shall submit medical bills for payment on the uniform claim forms prescribed in this section completed as set forth in sections 9792.32, 9792.33, 9792.34 and 9792.35. All information on the uniform claim forms shall be legible when submitted and shall be readable by optical character recognition (OCR) technology.

Discussion

This language will ensure that medical providers and claims administrators have at least six months from the date of adoption in which to gear up for implementation and that paper billings are legible, including by optical character recognition (OCR) technology. OCR capability increases the efficiency of medical bill review processing and data collection, permitting faster payment to medical providers and more accurate data collection and transmission.

Recommendation

(a)(1) For all covered medical services provided or ~~authorized~~ prescribed by the treating physician, health care providers shall submit medical bills using the Form HCFA/CMS 1500.

Discussion

Since "authorized" is the accepted terminology used in the context of services approved for payment in utilization review, it is less confusing to use the term "prescribed" to describe the services proposed by the treating physician's in his/her treatment plan.

Recommendation

(a)(2) Health facilities shall submit bills for facility fees and any services provided in conjunction with those billed facility services using the Form HCFA/CMS1450 or UB92.

Discussion

Facility fees and all the goods and services provided by the facility in direct conjunction with services corresponding to the facility fee should be billed on the same UB92 form. All other services (such as physical therapy) should be billed by a health facility on a CMS 1500 in the same way as other providers of those services.

Recommendation

(a)(5) Medical-Legal evaluators shall submit bills using the Form HCFA/CMS 1500.

Discussion

It will be helpful for these regulations to address the format for billing Medical legal evaluations. Such evaluations can be billed in the standard CMS 1500 format. This will allow medical legal evaluators the option of submitting such bills electronically in a standard format that claims administrators can accept.

Recommendation

(b) If the billing is contested, denied or incomplete, payment shall be made in accordance with section 4603.2.

Discussion

The condition in (b) is specified by Labor Code section 4603.4(d).

Section 9792.31 – Electronic Medical Services Billing and Payment Requirements

Recommendation

(a) ~~On or after January 1, 2007,~~ Eighteen months after adoption of this section, claims administrators shall accept uniform ~~claim~~ billing forms that are submitted electronically by heath providers in the electronic standard format set forth in sections 9792.32, 9792.33, 9792.34 and 9792.35. Claims administrators may reject electronically submitted uniform ~~claim~~ billing forms that are not transmitted in the electronic standard format set forth in sections 9792.32, 9792.33, 9792.34 and 9792.35. If the uniform ~~claim~~ billing form is rejected, the claims administrator must electronically inform the health provider that the ~~claim~~ billing was rejected.

Discussion

This language will ensure that claims administrators will have eighteen months from the date of adoption for the planning, purchasing, programming, testing and training necessary to successfully implement an e-billing program. In addition, the term "billing" needs to be substituted for "claim" here and elsewhere in this regulation since "claim" as used in the workers' compensation venue means a claimed injury which is not the intended meaning here.

Recommendation

(b) Except as set forth in (a), unless an itemized electronic billing for medical goods and/or services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Labor Code section 5307.1 is contested, denied, or incomplete, within 15 working days of receipt of the electronically submitted uniform claim form, the claims administrator shall pay for the authorized medical treatment at or below the maximum fees provided in the official medical fee schedule or, if applicable, according to the contracted reimbursement rate authorized by Labor Code section 5307.11. Payment for billings that are contested, denied, or incomplete shall be made in accordance with Section 4603.2. A billing is complete when 1) it is submitted on the correct Uniform Billing Form, 2) all required fields and relevant conditional fields on the form are properly and legibly competed, and 3) the submitted documentation supports the billed codes. ~~Any electronically submitted uniform claim form not paid at or below the official medical fee schedule rates or the contracted reimbursement rates within the 15 calendar day period shall be increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the uniform claim form.~~.

Discussion

Labor Code section 4603.4(d) states:

"(d) Payment for medical treatment provided or ~~authorized~~ prescribed 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. If the billing is contested, denied, or incomplete, payment shall be made in accordance with Section 4603.2.****"* (Emphasis added).

It is therefore necessary to modify this subsection to conform to Labor Code section 4602.4(d), requiring:

1) payment of electronic bills within 15 working days for services billed at or below the maximum fee schedule allowance, except for bills that are rejected, contested or incomplete: and
2) payment per 4603.2 for contested, denied or incomplete billings.

There is no authority in the statute for increasing billings by 15% if not paid within 15 days.
A definition of a "complete" billing is needed in order to determine when a billing is "incomplete."

Recommendation

~~*(c) This section does not prohibit a claims administrator from reasonably requesting additional information that is necessary to administer the claim.*~~

~~*(1) "Necessary" information is that which directly affects the provision of compensation benefits as defined in Labor Code Section 3207. A request for additional information does not relieve the claims administrator from its obligation to pay within 15 days unless the bill was not transmitted in the electronic standard format set forth in section 9 of the California Medical Bill Payment Dictionary.*~~

~~*(2) Additional information beyond that which is required by 9785(f) may be requested, but shall not relieve the claims administrator from its obligation to pay within 15 days.*~~

Discussion

Per Labor Code section 4603.2(b), the period permitted for payment of billings is measured from the time the billing is received together with any required reports and any written authorization received by the physician, and if a billing is considered to be incomplete, the provider must be notified in writing within 30 working days of all additional information needed to make a decision. Public policy should not reward medical providers for withholding documentation to support their billings. A significant percentage of bills include codes that are incorrectly reported based on the documentation. The change proposed in this subsection would increase that percentage and result in increased medical costs, legal costs, disputes, potential fraud and abuse.

The change proposed in (2) requires up-front payment of unsupported bills. After up-front payment, a provider has no incentive to comply with any request to provide supporting documentation – indeed there is a disincentive to do so. If a provider does supply supporting documentation after up-front payment, and a review discovers that the documentation does not support the codes billed then an overpayment has been made. The claims administrator may demand reimbursement, but such demands for reimbursement are often ignored by medical providers, and future payments to the

provider generally may not be withheld to recover such overpayments. Correct payment the first time is the most efficient and fairest solution and requires itemization, including supporting documentation.

Recommendation

(d) Medical reports, supporting documentation, and/or attachments required with the uniform claim forms shall also be transmitted electronically as set forth in section 9 of the California Medical Bill Payment Dictionary. Medical reports may be authenticated with an electronic signature when the provider's signature has been certified with the Division of Workers' Compensation.

Discussion

Clarification is needed that all required or supporting documents shall be transmitted electronically in the required manner.

Recommendation

~~(e) This section does not prohibit a claims administrator or physician from using alternative forms or procedures provided such forms or procedures are specified in a written agreement between the claims administrator and the physician, as long as the alternative billing format provides all the required information.~~

Discussion

Adhering to standard billing formats is advisable.

Recommendation

(f) All individually identifiable health information contained on a uniform claim form shall not be disclosed by either the claims administrator or submitting health provider or health facility except where disclosure is required or permitted by law or necessary to confer compensation benefits as defined in Labor Code Section 3207. Health providers and claims administrators who create, receive, maintain, or transmit electronic individually identifiable health information shall comply, with the standards for the security of electronic protected health information, adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 and set forth at 45 Code of Federal Regulations Parts 160, 162, and 164. See 68 Federal Register 8333 ("Final Rule").

Discussion

Health information may be disclosed where permitted by law.

Section 9792.5. ~~Payment for~~ Medical Treatment Billing and Payment Requirements for Non-Electronically Submitted Medical Treatment Bills

Recommendation

(a) Any properly documented non-electronically submitted bill for authorized medical treatment within the planned course, scope and duration of treatment reported under Section 9785 shall be paid by the claims administrator within forty five working days if the employer is not a government entity, and within 60 working days if the employer is a government entity, from receipt of each separate itemization and any required reports

and written authorization for services received by the physician, unless the bill is contested, as specified in subdivisions (c), and (d), within thirty working days of receipt of the bill. Any amount not contested within the thirty working days or not paid within the forty five working day period 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. The increase and interest is self-executing.

For purposes of this Section, treatment which is provided or authorized by the treating physician includes but is not limited to treatment provided by a "secondary physician" as that term is defined by Section 9785(a)(2).

Discussion

The section must comply with Labor Code section 4603.2(b)(2) that requires payment within 60 working days if the employer is a governmental entity. The 45 or 60 day period is measured from receipt of each itemization together with required reports, and written authorizations.

Recommendation

~~(d)~~ (c) A claims administrator who objects to all or any part of a bill for medical treatment shall notify the physician or other authorized provider of the objection within thirty working days after receipt of the bill and any required report and written authorization for services received by the physician, and shall pay any uncontested amount within ~~sixty~~ forty five working days after receipt of the bill and written authorization, if the employer is not a government entity, and within 60 working days after receipt of the bill and written authorization, if the employer is a government entity. If a required report or written authorization received by the physician is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill or report, or written authorization, whichever is received later. If the claims administrator receives a bill and believes that it has not received a required report-, any written authorization for services that may have been received by the physician, or other documentation needed to support the bill, the claims administrator shall so inform the medical provider within thirty working days of receipt of the bill. An objection will be deemed timely if sent by first class mail and postmarked on or before the thirtieth working day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth working day after receipt. Any notice of objection shall include or be accompanied by all of the following:

Discussion

The section must comply with Labor Code section 4603.2(b)(2) that requires payment within 60 working days if the employer is a governmental entity. The claims administrator must also notify the provider if it believes it has not received the required report, written authorization or other supporting documentation.

Recommendation

~~(f) This section does not prohibit a claims administrator from reasonably requesting additional information that is necessary to administer the claim.~~

~~(1) "Necessary" information is that which directly affects the provision of~~

~~*compensation benefits as defined in Labor Code Section 3207. A request for additional information does not relieve the claims administrator from its obligation to pay within 45 working days except as set forth in (c).*~~

~~*(2) Additional information beyond that which is required by 9785(f) may be requested, but shall not relieve the claims administrator from its obligation to pay within 45 working days.*~~

~~*(g) This section does not prohibit an or physician from using alternative forms or procedures provided such forms or procedures are specified in a written agreement between the claims administrator and the physician, as long as the alternative billing format provides all the required information.*~~

Discussion
See comment for section 9792.31(c).

Recommendation

~~*(h) All individually identifiable health information contained on a uniform claim form shall not be disclosed by either the claims administrator or submitting health provider or health facility except where disclosure is required by law or necessary to confer compensation benefits as defined in Labor Code Section 3207. Health providers and claims administrators who create, receive, maintain, or transmit electronic individually identifiable health information shall comply with the standards for the security of electronic protected health information, adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 and set forth at 45 Code of Federal Regulations Parts 160, 162, and 164. See 68 Federal Register 8333 ("Final Rule").*~~

Discussion
The statute applies only to electronically transmitted medical information, and the HIPAA security standards do not apply to medical information not submitted electronically.

Thank you for your consideration. Please contact me for further clarification or if I can be of any other assistance.

Sincerely,

Brenda Ramirez
Medical and Rehabilitation Director

BR/pm

cc: Andrea Hoch
Anne Searcy
Destie Overpeck
CWCI Medical Care Committee
CWCI Claims Committee
CWCI Legal Committee
CWCI Associate Members