Labor Code § 4603.4.

(a) The administrative director shall adopt rules and regulations to do all of the following:

(1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms.
(2) Require acceptance by employers of electronic claims for payment of medical services.
(3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.

(b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996.

Draft Proposed Electronic Billing Regulations

Chapter 4.5
Division of Workers' Compensation
Subchapter 1
Administrative Director – Administrative Rules

Article 5.5
Application of the Official Medical Fee Schedule (Treatment)

Section 9792.20 – Standardized Billing / Electronic Billing Definitions

(a) As used in sections 9792.20- 9792.5:

(1) "Authorized medical treatment" means medical treatment that was authorized pursuant to Labor Code section 4610 and which has been provided or authorized by the treating physician.

(2) "California Medical Bill Payment Dictionary." California Medical Bill Payment Dictionary, Version 1.0, dated April 2005, contains California specific reporting requirements and information excerpted from Section 9 of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release I, issued July 4, 2002, by the International Association of Industrial Accident Boards and Commissions. Section 9 of the California Medical Bill Payment Dictionary contains copies of the Uniform Claim Forms and sets forth the required data elements required for each form. The California Medical Bill Payment Dictionary, Version 1.0, dated April 2005 is posted on the Division's Web site at http://www.dir.ca.gov/dwc/WCIS.htm, will be made available by the

Division of Workers' Compensation upon request, and is incorporated by reference.

(3) "Claims Administrator" has the same meaning specified in Section 9785(a)(3).

(4) "CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, formerly known as the Health Care Financing Administration of the U.S. Department of Health and Human Services. ("HCFA").

(5) "Electronic signature" means

(6) "Electronic Standard Format" means the ASCX12N standard format developed by the Accredited Standards Committee X12N Insurance Subcommittee of the American National Standards Institute and the retail pharmacy specifications developed by the NCPDP.

(7) "Employer" has the same meaning specified in subdivision (a) of Section 9780.

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

(9) "Health Facility" means any facility as defined in Section 1250 of the Health and Safety Code, any surgical facility which is licensed under subdivision (b) of Section 1204 of the Health and Safety Code, any outpatient setting as defined in Section 1248 of the Health and Safety Code, or any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act.

(10) "Itemization" means list of medical services provided.

(11) "Medical Services" means those goods and services provided pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(12) "Medical Treatment" means the treatment to which an employee is entitled under Labor Code Section 4600.

(13) "NCPDP" means the National Council for Prescription Drug Programs.

(14) “Physician” has the same meaning specified in Labor Code Section 3209.3.

(15) "Required report" means a report which must be submitted pursuant to Section 9785.

(16) “Treating Physician” has the same meaning as section 9792.5 (a)(5) and 9785(a)(1).

(17) “Uniform Claim Forms” are defined as:

(A) “Form HCFA-1500 or Form CMS-1500 (12-90)” means the health insurance claim form maintained by CMS for use by heath care providers. A copy of the forms are available in section 9 of the California Medical Bill Payment Dictionary which is incorporated by reference.

(B) “CMS Form 1450” or “UB92” means the health insurance claim form maintained by CMS for use by heath facilties and institutional care providers. A copy of the forms are available in section 9 of the California Medical Bill Payment Dictionary which is incorporated by reference.

(C) “American Dental Association, 1999 Version 2000” means the uniform dental claim form approved by the American Dental Association for use by dentists. A copy of the form is available in section 9 of the California Medical Bill Payment Dictionary which is incorporated by reference.

(D) “NCPDP Universal Claim Form” means the NCPDP claim form or its electronic counterpart. A copy of the form is available in section 9 of the California Medical Bill Payment Dictionary which is incorporated by reference.

(18) “Uniform Claim Codes” are defined as:

(A) "ASA Codes" means the codes contained in the ASA Relative Value Guide developed and maintained by the American Society of Anesthesiologists to describe anesthesia services and related modifiers.

(B) “California Codes” means those codes adopted by the Administrative Director for use in the Official Medical Fee Schedule (Title 8, California Code of Regulations § 9791.1).

(C) "CDT-1 Codes" means the current dental terminology prescribed by the American Dental Association.

(D) "CPT-4 Codes" means the procedural terminology and codes contained in the “Current Procedural Terminology, Fourth Edition,” as published by the American Medical Association and as set forth in the appropriate fee schedule et 9789 et seq. Physician, Pharm, Outpatient 9789.30(j)(k).

(E) "HCPCS" means CMS’ Common Procedure Coding System, a coding system which describes products, supplies, procedures and health professional services and includes, the American Medical Associations (AMA's) Physician “Current Procedural Terminology, Fourth Edition,” (CPT-4) codes, alphanumeric codes, and related modifiers.

(F) "ICD-9-CM Codes" means the diagnosis and procedure codes in the International Classification of Diseases, Ninth revision, clinical modifications published by the U.S. Department of Health and Human Services.

(G) "NDC" means the National Drug Codes of the Food and Drug Administration.

(H) "UB92 Codes" means the code structure and instructions established for use by the National Uniform Billing Committee.

(I) “Revenue Codes” means (insert definition) and incorporate by reference.

Authority cited: Sections 133, 4603.4, 4603.5 and 5307.3, Labor Code.

Reference: Sections 3209.3 and 4600, Labor Code; Sections 1204 and 1248, Health and Safety Code.

Section 9792.30 – Standardized Medical Treatment Billing Forms and Electronic Billing

(a) On and after October 1, 2006, all physicians, health care providers, and health care facilities providing medical treatment and/or medical 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.

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

(2) Health facilities shall submit bills using the Form HCFA/CMS1450 or UB92 for all services.

(3) Dentists shall submit bills using the American Dental Association, 1999 Version 2000.

(4) Pharmacists shall submit bills using the "NCPDP Universal Claim Form" or the electronic claims procedures endorsed by the NCPDP.

Authority cited: Sections 133, 4603.4, 4603.5 and 5307.3, Labor Code.

Reference: Section 4603.4, Labor Code.

Section 9792.31. Electronic Medical Treatment Billing and Payment Requirements

(a) On or after January 1, 2007, claims administrators shall accept uniform claim 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 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 form is rejected, the claims administrator must electronically inform the health provider that the claim was rejected.

(b) Except as set forth in (a), within 15 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 adopted pursuant to Labor Code section 5307.1 or, if applicable, according to the contracted reimbursement rate authorized by Labor Code section 5307.11. Any electronically submitted uniform claim form not paid at 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.

(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.

(d) Medical reports 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 ha been certified with the Division of Workers' Compensation.

(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.

(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 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").

Authority cited: Sections 133, 4603.4, 4603.5 and 5307.3, Labor Code.

Reference: Sections 3207, 4603.2, 5307.1, and 5307.11, Labor Code.

Section 9792.32. Requirements for Completing Form HCFA/CMS 1500

Section 9792.33. Requirements for Completing Form HCFA/CMS1450 (or UB92)

Section 9792.34. Requirements for Completing American Dental Association, 1999 Version 2000.

Section 9792.35. Requirements for Completing "NCPDP Universal Claim Form"

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

~~(a) As used in this section:~~

~~(1) "Claims Administrator" has the same meaning specified in Section 9785(a)(3).~~

~~(2) "Medical treatment" means the treatment to which an employee is entitled under Labor Code Section 4600.~~

~~(3) "Physician" has the same meaning specified in Labor Code Section 3209.3.~~

~~(4) "Required report" means a report which must be submitted pursuant to Section 9785.~~

~~(5) "Treating physician" means the "primary treating physician" as that term is defined by Section 9785(a)(1).~~

~~(b)~~ (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 ~~which is provided or authorized by the treating physician~~ shall be paid by the claims administrator within ~~sixty~~ forty five working days from receipt of each separate itemization ~~itemized bill~~ and any required reports, unless the bill is contested, as specified in subdivisions ~~(d)~~(c), and ~~(e)~~(d), within thirty working days of receipt of the bill. Any amount not contested within the thirty working days or not paid within the ~~sixty~~ forty five working day period shall be increased 15% ~~10%~~, 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).

~~(c)~~ (b) To be properly documented, a bill for medical treatment which exceeds the amount presumed reasonable in the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1, must be accompanied by an itemization and explanation for the excess charge.

~~(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 shall pay any uncontested amount within ~~sixty~~ forty five working days after receipt of the bill. If a required report is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill or report, whichever is received later. If the claims administrator receives a bill and believes that it has not received a required report 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:

(1) An explanation of the basis for the objection to each contested procedure and charge. The original procedure codes used by the physician or authorized provider shall not be altered. If the objection is based on appropriate coding of a procedure, the explanation shall include both the code reported by the provider and the code believed reasonable by the claims administrator.

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

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

(4) A statement that the treating physician or authorized provider may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board.

~~(e)~~ (d) An objection to charges from a hospital, outpatient surgery center, or independent diagnostic facility shall be deemed sufficient if the provider is advised, within the thirty working day period specified in subdivision ~~(d)~~(c), that a request has been made for an audit of the billing, when the results of the audit are expected, and contains the name, address, and telephone number of the person or office to contact for additional information concerning the audit.

~~(f)~~ (e) 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.

(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.

(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").

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4603.2 and 5307.1, Labor Code.