

HIGHLIGHTS OF PROPOSED CALIFORNIA BUSINESS RULES FOR PAPER AND ELECTRONIC BILLING

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▪ Summary of California Business Rules for Standardized Paper and Electronic Billing

The California eBill rules, Labor Code sections §§ 4603.4, 4603.5 and 5307.3, specify the billing, payment and coding rules for paper and electronic medical treatment bill submissions in the California workers' compensation system. The Rules state that such bills may be submitted either on paper or through electronic means. Entities that are required to adhere to these rules include, but are not limited to, Health Care Providers, Health care facilities, Claims Administrators, Third Party

Billers/Assignees and Clearinghouses. The following is a high level overview of certain sections of the California Workers' Compensation Rules.

Labor Code §4603.4 (a) (2) requires claims administrators to accept electronic submission of medical bills. This includes the ability to receive and send ASCX12 Transactions Sets as defined in the regulations. The entity submitting the bill has the option of submitting bills on paper or electronically.

If an entity chooses to submit bills electronically they also must be able to receive an electronic response from the claims administrator. This includes electronic acknowledgements, notices and electronic Explanations of Review.

Use of Electronic Funds Transfer (EFT) is optional, but encouraged by the California DWC. EFT is not a pre-condition for electronic billing.

The technical rules for electronic billing are set forth in the Division of Workers' Compensation Medical Billing and Payment Companion Guide.

- **Security Rule to Protect the Confidentiality of Medical Information Submitted Electronically**

The California Workers' Compensation eBill rule requires that health care providers, health care facilities, third party billers/assignees, clearinghouses and workers' compensation claims administrators must implement procedures and utilize mechanisms to ensure the confidentiality of medical information submitted on electronic claims for payment of medical services. The **California security rule adapts the rules implementing** the federal **Health Insurance Portability and Accountability Act of 1996 for use in California workers' compensation electronic billing.** (45 Code of Federal Regulations Subtitle A, Subchapter C, Part 164, Subchapter C, §§164.302-164.318 and Appendix.) And the Health Care Confidentiality, Privacy, and Security Provisions of the American Recovery and Reinvestment Act (ARRA) of 2009, Public Law 111-5. These rules have been modified slightly for California workers' compensation electronic billing purposes.

- **Standardized Medical Treatment Billing Format**

Paper submitter are required to submit **typewritten** medical, dental and pharmacy bills using the national standard billing formats listed below (CMS 1500- UB04- American Dental Form ADA 2006 and NCPDP Universal Format –Revised 2008 for Property and Casualty). Other Formats are permitted to be used .The Rule defines "Format" to mean a document containing all the same information using the same data elements in the same order as the equivalent uniform billing form. Paper submission rules are to be enforced **90 days** after the effective date of the regulation.

Electronic Billing Submitters may submit bills and attachments electronically to the payer using the DWC prescribed HIPAA ASC X12N transaction sets. Electronic Submitters must be able to receive electronic transactions as specified in the Medical Billing and Payment Guide. Mutually agreed upon formats between trading partners is acceptable as long as the same data elements are present.

Payers must be able to accept the ASC X12N billing formats or mutually agreed upon formats as long as the same data elements are present. Payers also must be able to send the appropriate ASC X12 Acknowledgements as well as ASC X12N 835 transaction or mutually agreed upon format. The **ASC X12N 275** Attachment and Supporting Documentation was not adopted as part of the Rule,

however the transaction maybe used on a voluntary basis as an ancillary transaction related to electronic billing. The Electronic eBill rule is enforced **18 months** after the effective date of the regulation.

- **Definition of a Complete Bill (Clean Bill)**

The Rule specifies that Electronic and Paper bills being submitted for payment must be complete before the payment time frames begin.

A **complete bill submission** must consist of the following:

1. the correct uniform billing form/format for the type of health care provider;
2. the correct uniform billing codes for the applicable portion of the OMFS under which the services are being billed
3. The uniform billing form/format must be filled out according to the requirements specified for each format in the Medical Bill and Payment Guide and or the Companion Guide.
4. The Rule also specifies required Reports and Supporting documentation that must be submitted based on bill type. Submitters of paper bills that do not include the Report or Supporting Documentation in the same envelope are required to submit a separate Attachment Information Form that includes the bill identification information in order for the payer to match the bill to an attachment.

- **Payer Indexing, Editing and Validation of Paper and Electronic Bills**

The Rule defines paper and electronic bill and attachment data requirements. A payer may reject a bill or an attachment that does not meet the defined data requirements and definition of a Complete Bill .The Definition of a Complete Bill (Clean Bill) for electronic bills and attachments will require the Payer to automate their pre adjudication indexing ,editing and validation processes in order to comply with the regulatory timeline requirements.

- **Third Party Biller/ Assignees**

Third party billers and assignees must submit bills in the same manner as the original rendering provider. Third party billers and assignees must include their identifying **information** along with the original rendering provider information in the specified required billing data fields.

- **Duplicate Bills, Corrected Bill Transactions and Balance Forward Billing**

Duplicate Bills: The rule specifies that a resubmission bill paper or electronic must be marked using the **NUBC Condition Code** (W2 - Duplicate of the original bill). Duplicate bills may not be submitted prior to the expiration of the time allowed for payment unless requested by the payer or its agent. Duplicate bills must contain all the same information as the original bill.

Corrected Bills or Revised Bills are required to be marked using the appropriate **NUBC Bill Frequency Code 7** in the field designated for that information. A revised bill is to be submitted when there is an error or a need to make a code correction to replace a previously submitted bill.

Balance forward billing is not permitted.

If a bill is previously submitted on paper then all resubmission must be resubmitted on paper. The same rule applies to electronic submitted bills.

- **Paper Bill Submission and Payment Requirements**

Any **complete paper bill** 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 bill submitter 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. **For the purpose of this document a bill submitter is defined as a health care provider, health care facility or third party biller/assignee.**

A claims administrator who objects to all or any part of a bill for medical treatment shall notify the bill submitter of the **objection within 30 working days** after receipt of the bill and any required report or supporting documentation necessary to support the bill and shall pay any **uncontested amount within 45 working days after receipt of the bill**, or within 60 working days if the employer is a governmental entity.

If the **required report or supporting documentation** necessary to support the bill is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill, report, and/or supporting documentation whichever is received later. 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 must inform the **bill submitter within 30 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. The rule specifies the notice of objection, retrospective utilization review and lien filing requirements

Claim administrator or bill submitter **may use alternative forms or procedures** provided such forms or procedures are specified in a written agreement between the claims administrator and the billing submitter, as long as the alternative billing format provides all the required information that is defined in the Medical Billing and Payment Guide and or Companion Guide.

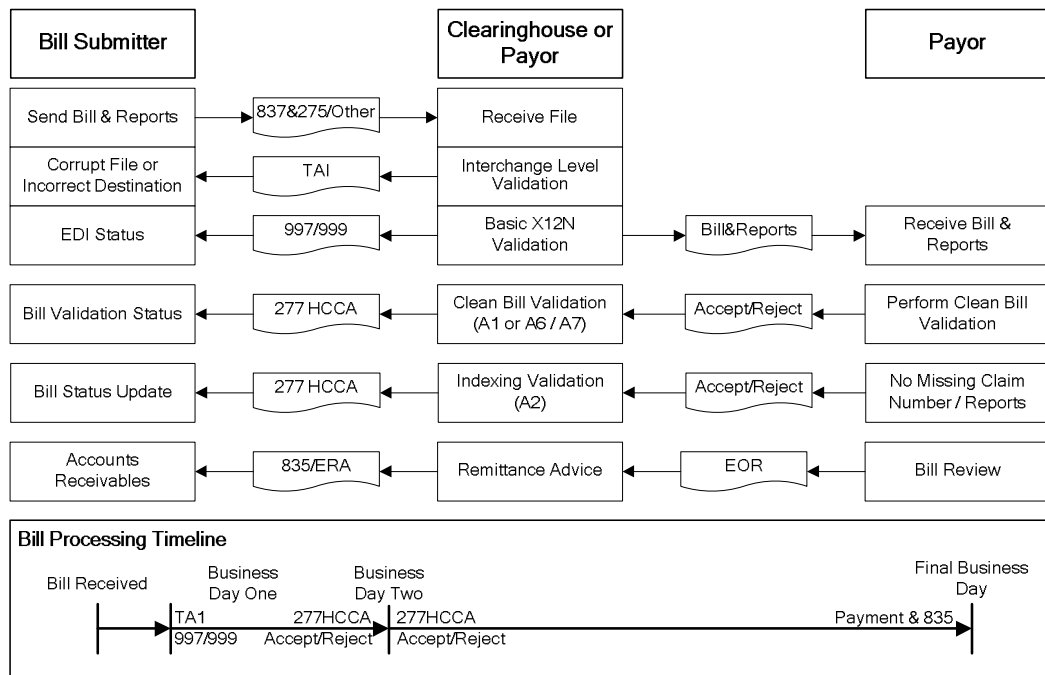
All **individually identifiable health information contained on a uniform billing form may not be disclosed** by either the claims administrator or submitting health provider or health care facility except where disclosure is permitted by law or necessary to confer compensation benefits as defined in Labor Code Section 3207.

The **Explanation of Review must contain all the required data elements** as defined in the Medical Bill and Payment Guide. The payer may **only use** the defined **DWC Bill Adjustment Reason codes and descriptions.**

• **Electronic Billing and Payment Requirements**

Clean Bill Acknowledgement Flow and Timing Diagrams

The process chart below shows how an incoming ASC X12N 837 Professional, Institutional and Dental transaction is validated and processed by the receiver. The diagram shows the basic acknowledgements that are generated by the receiver, including those for validation and final adjudication for those bills that pass validation.



• **Transaction Timeframes**

The following are the defined rule ASC X12 Acknowledgements Timeframes:

Interchange Acknowledgement (ASC X12 TA1) – **within one working day** of the receipt of an electronically submitted bill.

Implementation Acknowledgement (ASC X12 997) - **within one working day** of the receipt of an electronically submitted bill.

Health Care Claim Acknowledgement (ASC X12 N 277) - **within two working days** of receipt of an electronically submitted bill. The ASC X12 N 277 details what error are present, and if necessary, what action the submitter should take. A bill may be rejected if it is not submitted in the required electronic standard format or if it is not complete

ASC X12N 277 Claim Pending Status Information

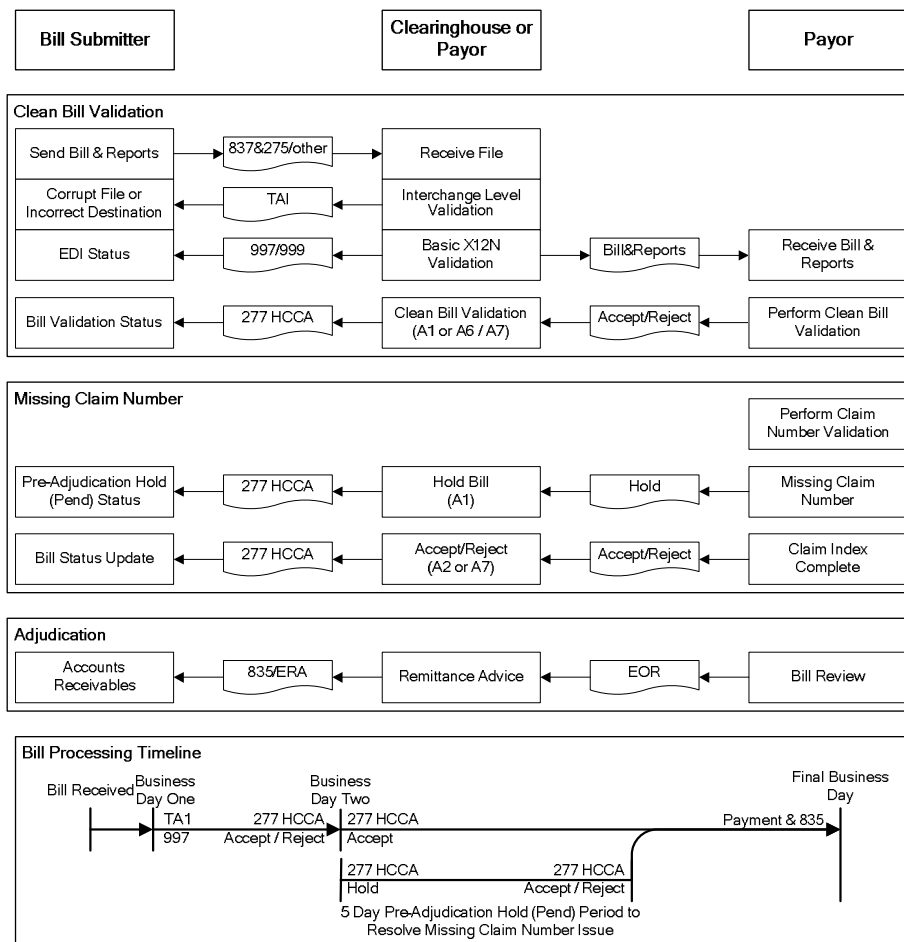
A bill submitted, but missing an **attachment** or the injured **worker's claim number** shall be pended for up to **five working days** while the attachment and/or claim number is provided, prior to being rejected as incomplete.

Clean Bill- Missing Claim Number

In order to prevent medical bills from being rejected due to lack of a claim number, a pre-adjudication hold (pending) period of up to **five business days** is mandated to enable the payor to attempt to match the bill to an existing claim in their system. If the bill cannot be matched within the **five days**, the bill may be rejected as incomplete. If the payor is able to match the bill to an existing claim, it should attach the claim number to the transaction and put it through the adjudication process. **The claim number** should then be provided to the bill submitter using the **ASCX12N 277 HCCA** for use in future billing. The ASCX12N 277 HCCA is also used to inform the bill submitter of the delay and the ultimate resolution of the issue.

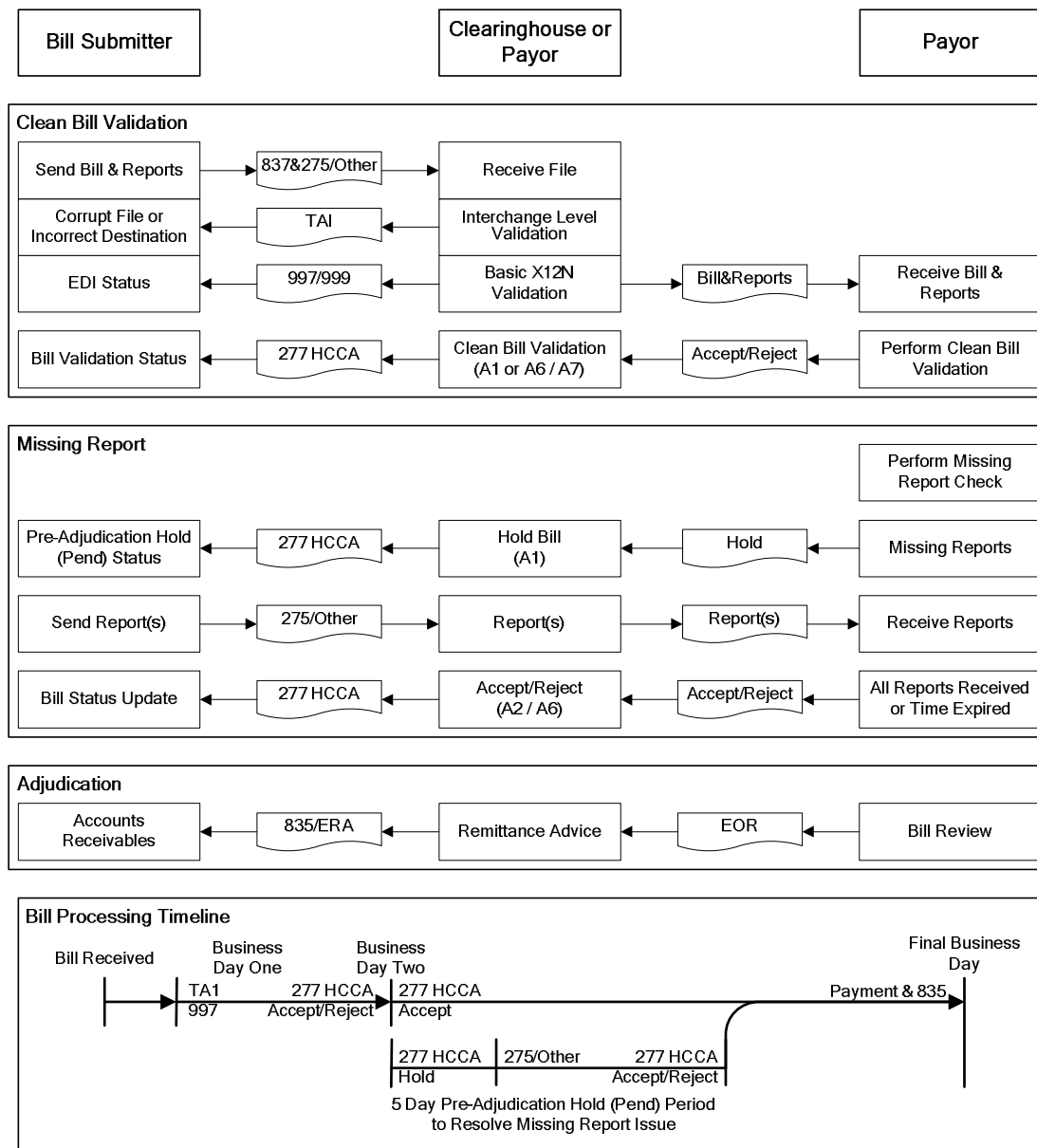
If the claims administrator has **already provided the claim number to the billing entity**, the bill may be **rejected as incomplete without being pended**. All other timeframes are suspended during the time period the bill is pended. The payment timeframe **begins when the missing information** is provided. An extension of the five day pending period may be mutually agreed upon.

• Clean Bill- Missing Claim Number Diagram



• **Clean Bill- Missing Report**

One of the processing steps that a bill goes through prior to adjudication is to verify if all required documentation has been provided. The bill submitter can send the reports using the ASCX12N 275 or other mechanisms such as fax or e-mail. In order to prevent medical bills from being rejected due to lack of a required piece of documentation coming separately from the bill itself, a pre-adjudication holding (pending) period of up to **five business days is mandated** to enable the payor to receive and match the bill to the documentation. If the bill cannot be matched within the five days, or the documentation is not received, **the bill may be rejected as incomplete**. If the payor is able to match the bill to the documentation within the five days, it should put the bill through the adjudication process. The **ASCX12N 277 HCCA** is used to inform the bill submitter of the delay and the ultimate resolution of the issue.



- **277 HCCA Rejection Messages Requirements:**

- Invalid form or format – indicate which form should be used.
- Missing Information- indicate specifically which information is missing by using the appropriate 277 Claim Status Category Code with the appropriate Claim Status Code
- Invalid data – Indicate specifically which information is invalid by using the appropriate Claim Status Category Code with the appropriate Claim Status Code:
- Missing attachments – indicate specifically which attachment(s) are missing.
- Missing required documentation – indicate specifically what documentation is missing.
- Injured worker's claim of injury is denied.
- There is no coverage by the claims administrator

- **Payment and Remittance Advice**

Healthcare Claim Payment/ Advice (ASC X12 N 835) - If the electronically submitted bill has been **determined to be complete, payment for uncontested 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. Use of Electronic Funds transfer is optional, but encouraged by the Division. EFT is not a pre-condition for electronic billing.

A claims administrator **who objects** to all or any part of an electronically submitted 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 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. The Rule defines the content that must be included in the objection notice.

- **Penalty**

Any electronically submitted bill 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).

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/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.

- **Reports and Supporting Documentation Submission Requirements Associate with an Electronic Bill**

Submitters of electronic bills must submit **DWC defined** Reports and Supporting Documentation electronically. The Rules define the submission methodology requirements for secure Fax, email and other electronic mediums. Payers and Providers must comply with the HIPAA Security and Privacy transmission requirements.

- **Attachment Coversheet Requirements**

All attachments accompanying an electronically submitted bill must either have a header or attached cover sheet that provides the following information:

- (1) Attachment Send Date: This is the date that the attachment was sent. The format is MMDDYY (no punctuation).
- (2) Claims Administrator - the name shall be the same as populated in the ASC X12N 837 Loop 2010BB, NM103
- (3) Employer Name - the name must be the same as populated in the ASC X12N 837 Loop 2010BA, NM103
- (4) Each PWK within a bill should use a different cover sheet and have a unique indicator number.
- (5) Unique Attachment Indicator Number: The Unique Attachment Indicator Number must be the same information as populated in the ASC X12 837 Loop 2300, PWK Segment :PWK01 (Report Type Code,), PWK02 (Report Transmission Code,), PWK05 (Attachment Control Qualifier (AC) and PWK06 (Attachment Control Number), Each PWK within a bill should use a different cover sheet and have a Unique Attachment Indicator Number. It is the combination of these data elements that will allow a claims administrator to appropriately match the incoming attachment to the electronic medical bill
- (6) Billing Provider Name: This must be the same name used in the ASC X12N 837 Loop 2010AA, NM103, NM104 and NM105.
- (7) Billing Provider NPI Number: The number must be the same as populated in Loop 2010AA, NM109. If you are ineligible for an NPI, then this number is your atypical billing provider ID. This number must be the same as populated in Loop 2010AA, REF02.
- (8) Bill Transaction Identification Number: the number must be the same number as populated in the ASC X12N 837 transactions, Loop 2300 Claim Information, CLM01.

- (9) Page Number/Number of Pages: The number reported should include the cover sheet. Incomplete transmissions, as indicated by number of pages received compared to the number of pages indicated on the fax cover sheet, may result in bill denials.
- (10) Contact Name/Phone Number including area code: This information is used by the receiver if there is an error in receipt of attachments (for example, something appears to be missing).

- **Required Information in the Body of the Attachment**

All attachments accompanying an electronically submitted bill shall contain the following information in the body of the attachment or on an attached cover sheet:

- (1) Patient's name: The last name, first name and middle name must be the same information as populated in the ASC X12N 837, Loop 2010CA, NM103 (last name) NM104 (first name) and if applicable, NM105 (middle name).
- (2) Claims Administrator's name: This must be the same name as populated in the ASC X12N 837 Loop 2010BB, NM103
- (3) Date of Service
- (4) Date of Injury
- (5) Social Security number (if available)
- (6) Claim number (if available): This must be the same number as populated in Loop 2010CA, REF02 or Loop 2010BA, REF02.
- (7) Unique Attachment Indicator Number: The Unique Attachment Indicator Number must be the same information as populated in the ASC X12N 837 Loop 2300, PWK Segment : PWK01 (Report Type Code), PWK02 (Report Transmission Code) PWK05 (AC- Attachment Control Qualifier) and PWK06 (Attachment Control Number).

- **Attachment submission methods**

- (1) FAX
- (2) Electronic submission – if submitting electronically, the Division strongly recommends using the Claims Attachment (275) transaction set. The Division is not mandating the use of this transaction set. Other methods of transmission may be mutually agreed upon by the parties.
- (3) E-Mail

- **Attachment types**

- (1) Reports
- (2) Supporting Documentation
- (3) Written Authorization
- (4) Misc. (other type of attachment)

- **Miscellaneous**

- (a) This section does not prohibit a claims administrator from conducting a retrospective utilization review as allowed by Labor Code section 4610 and Title 8, California Code of Regulations §§9792.6- (p).
- (b) Required reports and/or supporting documentation required with the bill shall be transmitted as set forth in the Rule
- (c) This section does not prohibit a claims administrator or health care provider, health care facility or third party biller/assignee **from using alternative forms/format or procedures provided such forms/format or procedures are specified in a written agreement between the claims administrator and the health care provider, health care facility, Third party biller/assignee** or clearinghouse, as long as the alternative billing and transmission format provides all the required information as set forth in the Rule and or Companion Guide.
- (d) Individually identifiable health information submitted on a uniform billing form shall not be disclosed by the claims administrator or submitting health provider, health care facility, third party biller/assignee or clearinghouse except where disclosure is permitted by law or necessary to confer compensation benefits as defined in Labor Code Section 3207.

- **Trading Partner Agreements**

Health care providers, health care facilities and third party billers/assignees choosing to submit their bills electronically must enter into a Trading Partner agreement either directly with the claims administrator or with the clearinghouse that will handle the claims administrator's electronic transactions.

Trading partner agreement means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction).

The purpose of a Trading Partner Agreement is to memorialize the rights, duties and responsibilities of the parties when utilizing electronic transactions for medical billing.

Business Associate - any entity which is not covered under paragraph (a) that is handling electronic transactions on behalf of another.