



E-Billing

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Introduction

This manual is adopted by the Administrative Director of the Division of Workers' Compensation pursuant to the authority of Labor Code sections §§ 4603.4, 4603.5 and 5307.3. It specifies the billing, payment and coding rules for paper and electronic medical treatment bill submissions in the California workers' compensation system. Such bills may be submitted either on paper or through electronic means. Entities that need 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.

Labor Code §4603.4 (a)(2) requires claims administrators to accept electronic submission of medical bills. The effective date is XX-XX-2011 [approximately 18 months after adoption]. The entity submitting the bill has the option of submitting bills on paper or electronically.

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.

Nothing in this document prevents the parties from utilizing Electronic Funds Transfer to facilitate payment of electronically submitted bills. Use of Electronic Funds transfer is optional, but encouraged by the Division. EFT is not a pre-condition for electronic billing.

For electronic billing, parties must also consult the Division of Workers' Compensation Medical Billing and Payment Companion Guide which sets forth rules on the technical aspects of electronic billing.

Health Care Providers, Health Care Facilities, Claims Administrators, Third Party Billers/Assignees and Clearinghouses that submit bills on paper must adhere to the rules relating to use of the standardized billing forms for bills submitted on or after XX-XX-2011 [approximately 90 days after adoption].

The Division would like to thank all those who participated in the development of this guide. Many members of the workers' compensation, medical, and EDI communities attended meetings and assisted in putting this together. Without them, this process would have been much more difficult.

Section One – Business Rules

1.0 Standardized Billing / Electronic Billing Definitions

- (a) “Authorized medical treatment” means medical treatment in accordance with Labor Code section 4600 that was authorized pursuant to Labor Code section 4610 and which has been provided or authorized by the treating physician.
- (b) “Bill” means the uniform billing form setting forth the itemization of services provided found in Appendix A along with the required reports and/or supporting documentation as described in Section One – 3.0.
- (c) “California Electronic Medical Billing and Payment Companion Guide” is a separate document which gives detailed information for electronic billing and payment. The guide outlines the workers’ compensation industry national standards and California jurisdictional procedures necessary for engaging in Electronic Data Interchange (EDI) and specifies clarifications where applicable. It will be referred to throughout this document as the “Companion Guide”.
- (d) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.
- (e) “Clearinghouse” means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that provides either of the following functions:
 - (1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
 - (2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.
- (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.
- (g) “CMS” means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.
- (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.
- (i) "Electronic Standard Formats" means the ASC X12N standard formats developed by the Accredited Standards Committee X12N Insurance Subcommittee of the American National Standards Institute and the retail pharmacy specifications developed by the National Council for Prescription Drug Programs (“NCPDP”) identified in Section Two - Transmission Standards, which have been and adopted by the Secretary of Health and Human Services under HIPAA.. See the Companion Guide for specific format information.
- (j) “Explanation of Review” (EOR) means the explanation of payment or the denial of the payment using the standard code set found in Appendix B – 1.0. EOR’s use the following standard codes:
 - (1) DWC Bill Adjustment Reason Codes provide California specific workers’ compensation explanations of a payment, reduction or denial. They are found in Appendix B – 1.0 DWC ANSI Matrix Crosswalk.

- (2) ANSI Claims Adjustment Group Codes represent the general category of payment, reduction, or denial. The most current, valid codes should be used as appropriate for workers' compensation. These codes are obtained from the Washington Publishing Company <http://www.wpc-edi.com>.
- (3) ANSI Claims Adjustment Reason Codes (CARC) represent the national standard explanation of payment, reduction or denial information. These codes are obtained from the Washington Publishing Company <http://www.wpc-edi.com>.
- (4) ANSI Remittance Advice Remark Codes (RARC) represent supplemental explanation for a payment, reduction or denial. These are always used in conjunction with a ANSI Claims Adjustment Reason Code. These codes are obtained from the Washington Publishing Company <http://www.wpc-edi.com>.
- (k) "Health Care Provider" means a provider of medical treatment, goods and services, including but not limited to a physician, a non-physician or any other person or entity who furnishes medical treatment, goods or services in the normal course of business.
- (l) "Health Care 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, any surgical facility accredited by an accrediting agency approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, or any ambulatory surgical center or hospital outpatient department 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.
- (m) "Itemization" means the list of medical treatment, goods or services provided using the codes required by Section One – 3.0 to be included on the uniform billing form.
- (n) "Medical Treatment" means the treatment, goods and services as defined by Labor Code Section 4600.
- (o) "National Provider Identification Number" or "NPI" means the unique identifier assigned to a health care provider or health care facility by the Secretary of the United States Department of Health and Human Services.
- (p) "NCPDP" means the National Council for Prescription Drug Programs.
- (q) Official Medical Fee Schedule (OMFS) means all of the fee schedules found in Article 5.3 of Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations (Sections 9789.10 - 9789.111), adopted pursuant to Section 5307.1 of the Labor Code for all medical services, goods, and treatment provided pursuant to Labor Code Section 4600. These include the following schedules: Physician's services; Inpatient Facility; Outpatient Facility; Clinical Laboratory; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); Ambulance; and Pharmaceutical.
- (r) "Physician" has the same meaning specified in Labor Code Section 3209.3: physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.
- (1) "Psychologist" means a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.
- (2) "Acupuncturist" means a person who holds an acupuncturist's certificate issued pursuant to Chapter 12 (commencing with Section 4925) of Division 2 of the Business and Professions Code.
- (s) "Required report" means a report which must be submitted pursuant to Section 9785 or pursuant to the OMFS. These reports include the Doctor's First Report of Injury, PR-2, PR-3, PR-4 and their narrative equivalents, as well as any report accompanying a "By Report" code billing.

- (t) “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 required for payment of the DME item being billed.
- (u) “Third Party Biller/Assignee” means a person or entity authorized by law and acting under contract as the agent or assignee of a rendering physician, health care provider or healthcare facility to bill and/or collect payment from the responsible payor.
- (v) “Treating Physician” means the primary treating physician or secondary physician as defined by section 9785(a)(1), (2).
- (x) “Uniform Billing Forms” are the CMS 1500, UB 04, NCPDP Universal Claim Form and the ADA 2006 set forth in Appendix A.
- (y) “Uniform Billing Codes” are defined as:
 - (1) “California Codes” means those codes adopted by the Administrative Director for use in the Physician’s Services section of the Official Medical Fee Schedule (Title 8, California Code of Regulations §§ 9789.10-11).
 - (2) “CDT-4 Codes” means the current dental codes, nomenclature, and descriptors prescribed by the American Dental Association in “Current Dental Terminology, Fourth Edition.”
 - (3) “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 adopted in the appropriate fee schedule contained in sections 9789.10-9789.100.
 - (4) “Diagnosis Related Group (DRG)” means the inpatient classification scheme used by CMS for hospital inpatient reimbursement. The DRG system classifies patients based on principal diagnosis, surgical procedure, age, presence of co morbidities and complications and other pertinent data.
 - (5) “HCPCS” means CMS’ Healthcare Common Procedure Coding System, a coding system which describes products, supplies, procedures and health professional services and includes, the American Medical Association’s (AMA’s) Physician “Current Procedural Terminology, Fourth Edition,” (CPT-4) codes, alphanumeric codes, and related modifiers.
 - (6) “ICD-9-CM Codes” means the diagnosis and procedure codes in the International Classification of Diseases, Ninth Revision, Clinical Modification published by the U.S. Department of Health and Human Services.
 - (7) “NDC” means the National Drug Codes of the Food and Drug Administration.
 - (8) “Revenue Codes” means the 4-digit coding system developed and maintained by the National Uniform Billing Committee for billing inpatient and outpatient hospital services, home health services and hospice services.
 - (9) “UB 04 Codes” means the code structure and instructions established for use by the National Uniform Billing Committee (NUBC).
- (z) “Working days” means Mondays through Fridays but shall not include Saturdays, Sundays or the following State Holidays.
 - (1) January 1st (“New Year’s Day”.)
 - (2) The third Monday in January (“Dr. Martin Luther King, Jr. Day.”)
 - (3) The third Monday in February (“Washington Day” or “President’s Day.”)
 - (4) .March 31st (“Cesar Chavez Day.”)
 - (5) The last Monday in May (“Memorial Day.”)

- (6) July 4th (“Independence Day.”)
- (7) The first Monday in September (“Labor Day.”)
- (8) November 11th (“Veterans Day.”)
- (9) The third Thursday in November (“Thanksgiving Day.”)
- (10) The Friday After Thanksgiving Day
- (11) December 25th (“Christmas Day.”)
- (12) If January 1st, March 31st, July 4th, November 11th, or December 25th falls upon a Sunday, the Monday following is a holiday. If November 11th falls upon a Saturday, the preceding Friday is a holiday.

2.0 Standardized Medical Treatment Billing Format

- (a) On and after XXXX, 2010, [90 days after the effective date of this regulation] all, health care providers, health care facilities and third party billers/assignees shall submit medical bills for payment on the uniform billing forms or utilizing the format prescribed in this section, completed as set forth in Appendix A. All information on the paper version of the uniform billing forms shall be typewritten when submitted. Format means a document containing all the same information using the same data elements in the same order as the equivalent uniform billing form.
 - (1) “Form CMS-1500” means the health insurance claim form maintained by CMS, revised August 2005, for use by health care providers.
 - (2) “CMS Form 1450” or “UB04” means the health insurance claim form maintained by CMS, revised 2005, for use by health facilities and institutional care providers as well as home health providers.
 - (3) “American Dental Association, Version 2006” means the uniform dental claim form approved by the American Dental Association for use by dentists.
 - (4) “NCPDP Universal Claim Form” means the NCPDP claim form, revised 2008, for pharmacy bills.
- (b) On and after XXXX, 2011, [18 months after the effective date of this regulation], all health care providers, health care facilities and third party billers/assignees providing medical treatment may electronically submit medical bills to the claims administrator for payment. All claims administrators must accept bills submitted in this manner. The bills shall conform to the electronic billing standards and rules set forth in this Medical Billing and Payment Guide and the Companion Guide.

3.0 Complete Bills

- (a) All bills being submitted for payment, whether electronically or on paper must be complete before payment time frames begin.
- (b) To be complete a 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 Appendix A and/or the Companion Guide.

- (c) All required reports and supporting documentation must be submitted as follows:
- (1) A Doctor's First Report of Occupational Injury (DLSR 5021), must be submitted when the bill includes Evaluation and Management services and a Doctor's First Report of Occupational Injury is required under Title 8, California Code of Regulations § 9785.
 - (2) A PR-2 report or its narrative equivalent must be submitted when the bill is for Evaluation and Management services and a PR-2 report is required under Title 8, California Code of Regulations § 9785.
 - (3) A PR-3, PR-4 or their narrative equivalent must be submitted when the bill is for Evaluation and Management services and the injured worker's condition has been declared permanent and stationary with permanent disability or a need for future medical care. (Use of Modifier – 17)
 - (4) A narrative report must be submitted when the bill is for Evaluation and Management services for a consultation.
 - (5) A report must be submitted when the provider uses the following Modifiers – 19, – 21, – 22, – 23 and – 25.
 - (6) A descriptive report of the procedure, drug, DME or other item must be submitted when the provider uses any code that is payable "By Report".
 - (7) A descriptive report must be submitted when the Official Medical Fee Schedule indicates that a report is required.
 - (8) An operative report is required when the bill is for Surgery Services.
 - (9) An invoice or other proof of documented paid costs must be provided when required for reimbursement.
 - (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.
 - (11) Written authorization for services shall be provided where one was given.
- (d) For paper bills, if the required reports and supporting documentation are not submitted in the same mailing envelope as the bill, then a header or attachment cover sheet as defined in Section One – 7.3 for electronic attachments must be submitted.

4.0 Third Party Billers/Assignees

- (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.
- (b) The original rendering provider information will be provided in the fields where that information is required along with identifying information about the third party biller/assignee submitting the bill.

5.0 Duplicate Bills, Bill Revisions and Balance Forward Billing

- (a) The resubmission of a duplicate bill shall clearly be marked as a duplicate using the appropriate NUBC Bill Frequency Code 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. For the time frame for payment of paper submissions see 6.0 (b) and for time frame for payment of electronic submission see 7.1(b).

