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Medical Billing Standards and E-Billing

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Suzanne Honor-Vangerov



- Associate Attorney –
Floyd Skeren & Kelly LLP
- Prior Manager of the Division of Workers
Compensation Medical Unit, in charge of the
QME program, MPN, Independent Medical
Review, Utilization Review, Spinal Surgery
Second Opinion, and the Official Medical Fee
Schedule.
- She headed the team that put together these
regulations.

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Sherry Wilson



- Executive Vice President of Jopari Solutions, Inc., a national technology service provider, specializing in electronic medical billing and payment solutions for the workers' compensation, auto and healthcare industry.
- Has played an active role in the eBill initiatives at the national level as well as participated in the California, Texas, Minnesota and Georgia initiatives.
- A member of the IAIABC , the ASC X12 and WEDI. Serves as the ASC X12 Liaison to the IAIABC.
- One of the industry champions in the effort to establish national workers' compensation electronic medical billing and payment standards.
- 25 years of experience in workers' compensation ranging from being a provider, to being involved in claims and risk management.
- Bachelor of Science from the University of Reno and her Graduate Degree in Physical Therapy from the University of Iowa Medical School.

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Overview



- Legislative History
- The Development Process
- The Regulations
- Medical Billing Standards
- Electronic Standards
- Questions?

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Legislative History



- AB 749 added 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.

Legislative History – cont.



- SB 228 added two additional provisions:
 - (c) The rules and regulations requiring employers to accept electronic claims for payment of medical services shall be adopted on or before January 1, 2005, and shall require all employers to accept electronic claims for payment of medical services on or before July 1, 2006.
 - (d) 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. If the billing is contested, denied, or incomplete, payment shall be made in accordance with Section 4603.2.

The Development Process



- WCIS asked for input on data elements for use in claims administrator medical bill reporting.
- WCIS is tied to national standard as set by IAIABC.
- Realization that much of the data needed to come from medical providers so claims administrators can report to WCIS.
- Realization that there was no national standard for ebilling.
- DWC put together a small group of stakeholders to discuss what the standards should be.
- Group grew to include representatives from medical, claims, bill review and data exchange entities.
- DWC started working with IAIABC to develop the national standard.

Regulations



- Reg §9792.5 is updated to match the current statute in terms of time to pay, penalties and interest.
- Definitions – DWC is specifically defining terms it hasn't defined before.
- Incorporates the Medical Billing and Payment Guide, Medical Billing and Payment Companion Guide, billing forms, as well as various implementation guides by reference.
- Gives the timeframes for the mandatory application of the rules.

Medical Billing Standards



- The Medical Billing Payment Guide is divided into two sections:
 - Section One – Business Rules
 - Appendix A Standard Paper Forms
 - Appendix B Standard Explanation of Review
 - Section Two – Transmission Standards

Section One – Business Rules



- Definitions
- Billing Format
- Complete Bills
- Billing Agents/Assignees
- Duplicate Bills, Bill Revisions and Balance Forward Billing
- Billing and Payment Requirements for Non-Electronically Submitted Bills
- Billing and Payment Requirements for Electronically Submitted Bills
 - Timeframes
 - Penalty
 - Electronic Bill Attachments
 - Miscellaneous
 - Trading Partner Agreements

Definitions

- Assignee
- Authorized medical treatment
- Balance forward bill
- Bill
- Billing Agent
- California Electronic Medical Billing and Payment Companion Guide
- Claims Administrator
- Clearinghouse
- Complete Bill
- CMS
- Duplicate bill
- Electronic signature
- Explanation of Review (EOR)
- Health Care Provider
- Health Care Facility
- Itemization
- Medical Treatment
- National Provider Identification Number or NPI
- NCPDP
- Official Medical Fee Schedule (OMFS)
- Physician
- Required report
- Supporting Documentation
- Treating Physician
- Uniform Billing Forms
- Uniform Billing Codes
 - California Codes
 - CDT-4 Codes
 - CPT-4 Codes
 - Diagnosis Related Group (DRG)
 - Medicare Severity-Diagnosis Related Codes (MS-DRG)
 - HCPCS
 - ICD-9-CM Codes
 - NDC
 - Revenue Codes
 - UB-04 Codes
- Working days



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Billing Format

- CMS 1500
- CMS 1450 or UB-04
- NCPDP Universal Claim Form
- ADA 2006



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Complete Bills



- The correct uniform billing form/format for the type of health care provider.
- The correct uniform billing codes for the applicable portion of the OMFS under which the services are being billed.
- The uniform billing form/format must be filled out according to the requirements specified.
- A complete bill includes required reports and supporting documentation specified.
- 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.

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Required Reports

State of California Additional pages attached
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or PR-4.

Periodic Report (required 45 days after last report) Change in treatment plan Released from care

Change in work status Need for referral or consultation Response to request for information

Change in patient's condition Need for surgery or hospitalization Request for authorization

Other: _____

Patient: First _____ MI _____ Sex _____
Last _____ City _____ State _____ Zip _____
Address _____
Date of Injury _____ Date of Birth _____
Occupation _____ SS # _____ Phone (____) _____
City Administrator _____

- All required reports and supporting documentation sufficient to support the level of service or code that has been billed must be submitted as follows:
 - A Doctor's First Report of Occupational Injury (DLSR 5021).
 - A PR-2 report or its narrative equivalent.
 - A PR-3, PR-4 or their narrative equivalent.
 - A narrative report must be submitted for a consultation.
 - A report when use of Modifiers – 22, – 23 and – 25.

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Required Reports – cont.

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

This form is required to be used for reports prepared pursuant to the 2007 Permanent Disability Rating Schedule and the AMA Guides to the Evaluation of Permanent Impairment (5th Ed.). It is designed to be used by the primary treating physician to report the initial evaluation of permanent impairment to the claims administrator. It should be completed if the patient has residual effects from the injury or may require future medical care. In such cases, it should be completed once the patient's condition becomes permanent and stationary.

This form should not be used by a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) to report a medical/legal evaluation.

Patient:

Last Name _____ Middle Initial _____ First Name _____ Sex _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Occupation _____ Social Security Number _____ Phone No _____

Claim Administrator Name: _____

- A descriptive report for any code that is payable “By Report”.
- A descriptive report when the Official Medical Fee Schedule indicates that a report is required.
- An operative report when the bill is for Surgery Services fees.
- An invoice or other proof of documented paid costs when required by the OMFS for reimbursement.
- Appropriate additional information reasonably requested by the claims administrator.

Billing Agents/Assignees



- Billing agents and assignees shall submit bills in the same manner as the rendering provider.
- The original rendering provider information will be provided in the fields where that information is required along with identifying information about the billing agent/assignee submitting the bill.
- The billing agent/assignee has no greater right to reimbursement than the principal or assignor.

Duplicate Bills



- A duplicate bill is one that is exactly the same as a bill that has been previously submitted with no new services added, except that the duplicate bill may have a different billing date.
- Duplicate bills shall not be submitted prior to expiration of the time allowed for payment unless requested by the claims administrator or its agent.
- A bill which has been previously submitted in one manner (paper or electronic) may not subsequently be submitted in the other manner.

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Bill Revisions



- 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 include the original dates of service and the same itemized services rendered as the original bill.
- No new dates of service may be included.

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Balance Forward

Billing

- Balance forward billing is not permissible.
- Balance forward bills are bills that include a balance carried over from a previous bill along with additional services.
- Also included as a balance forward bill is a summary of accumulated unpaid balances.
- Use DWC Bill Adjustment Reason Code G56 (crosswalks to CARC 18) to reject this type of bill.
- A bill which has been previously submitted in one manner (paper or electronic) may not subsequently be submitted in the other manner



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Non-Electronically Submitted Bills

- Complete bills must be paid within 45 working days (60 working days for govt. entities) or objected to in 30 working days.
- Penalties are 15% and interest is 10% and are self-executing.
- EOR must include all of the required information listed in the guide under Appendix B – Standard Explanation of Review.
- May file a lien to adjudicate disputes.



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Electronically Submitted Bills



- Timeframes
- Penalty
- Electronic Bill Attachments
- Miscellaneous
- Trading Partner Agreements

Timeframes



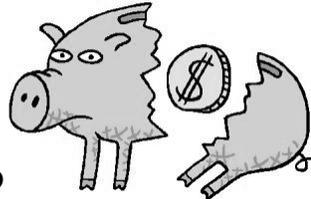
- Interchange and Implementation Acknowledgment (TA1/999) – one working day.
- Health Care Claim Acknowledgment (277) – two working days.
 - Pending claims – up to five working days.
 - Lack of claim number
 - Missing attachment
 - Bill rejection
 - Bill is complete

Timeframes – cont.



- **Payment and Remittance/Denial/Objection (835)**
 - Complete Bill – payment for uncontested treatment. Must be paid within 15 working days.
 - Objection to Bill/Denial of Payment. Must send objection/denial within 15 working days.

Penalty



- Audit penalties for failure to pay or object within 15 working days.
- 15% penalty plus interest for failure to pay within 45 working days or object within 30 working days.

Electronic Bill Attachments



- Header
 - Claims administrator
 - Employer
 - Unique Attachment Indicator Number
 - Billing provider NPI Number
 - Billing provider name
 - Bill transaction ID number
 - Document type
 - Page number or number of pages
 - Contact name/phone number

Electronic Attachments – cont.



- Body or Cover sheet
 - Patient's name
 - Claims administrator
 - Date of Service
 - Date of Injury
 - SS#
 - Claim #
 - Unique Attachment Indicator Number
- Can be sent via FAX, electronic submission, or e-mail

Miscellaneous



- The Medical Billing and Payment Guide doesn't prohibit the claims administrator from conducting a retrospective review.
- Alternative forms/formats or transmission standards are permitted with prior agreement so long as all the required information is provided.
- Individually identifiable health information shall not be disclosed by the claims administrator, bill submitter or clearinghouse except where permitted by law.

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Trading Partner Agreements



- Billers must enter into a trading partner agreement with either the claims administrator or a clearinghouse.
- Trading partner agreement means an agreement related to the exchange of information in electronic transactions.
- Purpose is to memorialize the rights, duties and responsibilities of the parties
- Business associate is any entity which is handling electronic transactions on behalf of another that is not listed under paragraph (a).

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Appendix A - Standard Paper Forms

- CMS 1500
- UB-04
- NCPDP UCF
- ADA 2006
- Field Tables for each

1500 HEALTH INSURANCE CLAIM FORM			
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (UCC)			
PATIENT			
1. MEDICARE	MEDICARE	TRICARE	CHAMPVA
<input type="checkbox"/> Medicare A	<input type="checkbox"/> Medicare B	<input type="checkbox"/> Medicare C/D	<input type="checkbox"/> Member (S)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT ID#
5. PATIENT'S ADDRESS (Incl. Street)			6. PATIENT ZIP
CITY			STATE
ZIP CODE			TELEPHONE (Include Area Code)
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			9. OTHER INSURED'S POLICY OR GROUP NUMBER
			10. IS PA EMPLOYER

Field Table

2.1 Field Table UB-04

UB-04 Form Loc	UB-04 Field Description	Workers' Compensation Requirements (Required/Situational/ Not Applicable)	California Workers' Compensation Instructions
01	Billing Provider Name, Address and Telephone Number	R	
02	Pay-to Name and Address	S	
03a	Patient Control Number	R	
03b	Medical/Health Record Number	S	
04	Type of Bill	R	When reporting a corrected bill use Type of Bill 7 - Replacement of a Prior Claim. When submitting a bill for an appeal or as a duplicate enter the appropriate NUBC Condition Code in Form Locator 18-28 to indicate bill resubmission type.
05	Federal Tax Number	R	
06	Statement Covers Period	R	
07	Reserved for Assignment by the NUBC	N	
08a	Patient Identifier	R	Enter the patient's Social Security Number. If the patient does not have a Social Security Number, enter the following 9 digit number: '999999999'.

Appendix B - Standard Explanation of Review



- DWI Bill Adjustment Reason Codes
 - CARC/RARC
- Matrix list in CARC order
- Field Table

DWC Bill Adjustment Reason Code/CARC/RARC Matrix

1.0 California DWC ~~ANSI~~ Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payor Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
G1	Provider's charge exceeds fee schedule allowance.	The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.		W1	Workers' Compensation jurisdictional State Fee Schedule Adjustment Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the R35 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the R35 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).		
G2	The OMFS does not include a code for the billed service.	The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service.	Indicate code for comparable service.	W1	Workers' Compensation jurisdictional State Fee Schedule Adjustment Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the R35 Class of Contract Code	N448	This drug/service/ supply is not included in the fee schedule or contracted/legislated fee arrangement.

Matrix List in CARC Order

DWC Bill Adjustment Reason Code	CARC	RARC
G59	4	
G63	8	
PM1	8	
G55	11	
G72	15	<u>N175</u>
<u>G73</u>	<u>15</u>	
G9	18	N350
G10	18	N29
G11	18	M30
G12	18	N238
G13	18	N240
G14	18	M31
G15	18	N451
G16	18	N452
G17	18	M118
G18	18	N456
G19	18	N455
G20	18	N497
G21	18	N498
G22	18	N499
G23	18	N500
G24	18	N501
G25	18	N502
G26	18	N503
G27	18	N504
G28	18	N453
G29	18	N454
G30	18	N28
G31	18	N455
G32	18	N456
G33	18	N394

Section Two – Transmission standards.



- Companion Guide
- Electronic Standard Formats
 - Billing
 - Acknowledgment
 - Payment/Advice/Remittance
 - Documentation
- Obtaining Transaction Standards

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Electronic Standards



- Introduction and Overview
- California Workers' Compensation Requirements
- Health Care Claim: Professional (837)
- Health Care Claim: Institutional (837)
- Health Care Claim: Dental (837)
- Pharmacy (NCPDP D.0)
- Payment Advice (835)

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Electronic Standards – cont.



- Attachments (275)
- Acknowledgments (TA 1/999/277/835)
- Appendix A – Glossary of Terms
- Appendix B – Code Set References
- Appendix C – Jurisdictional Report Type Codes and DWC Descriptions
- Appendix D – Security Rule

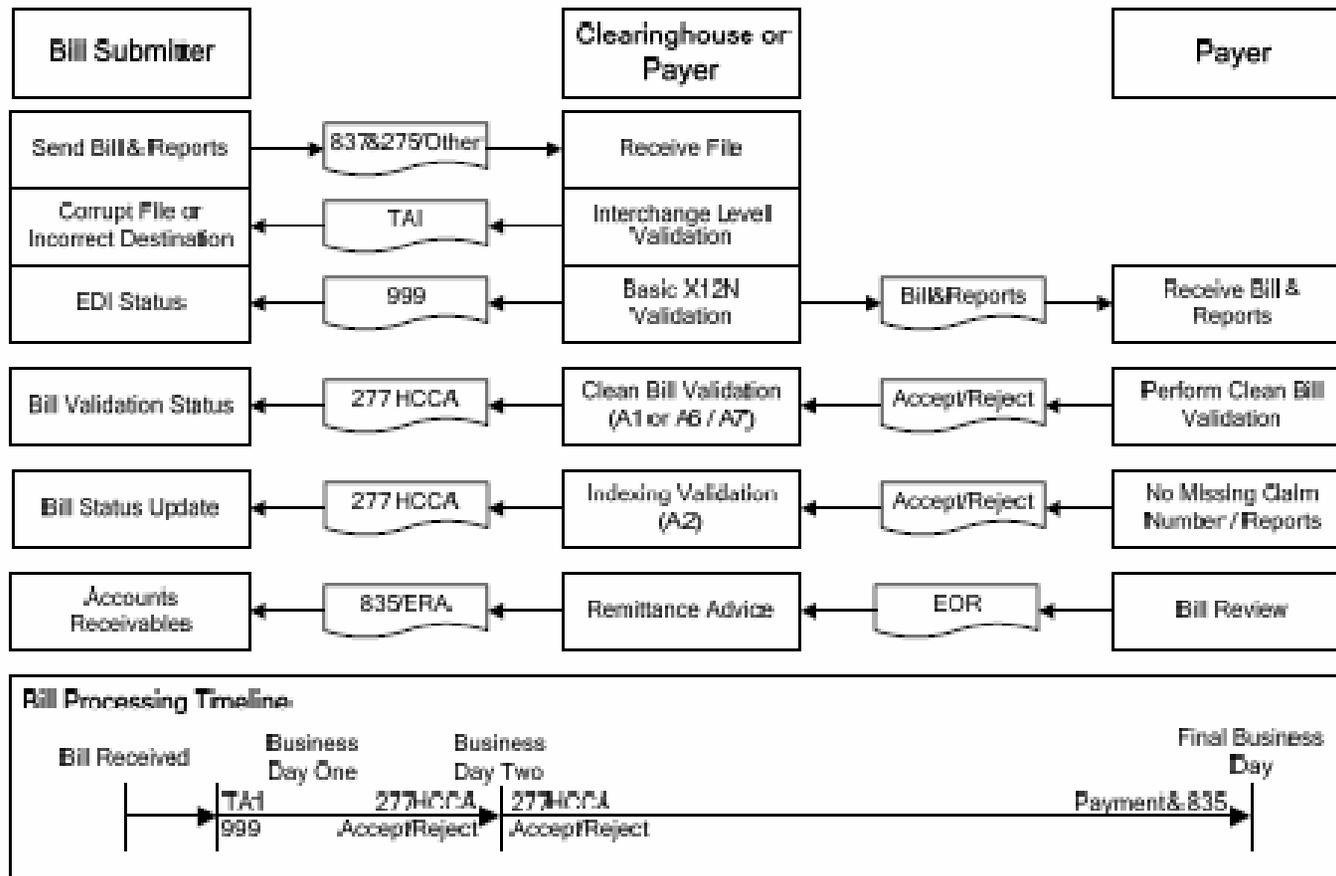
Adopted/Optional Formats and Correlation to Paper Forms

Format	Corresponding Paper Form	Function.
005010X222	CMS-1500	Professional Billing
005010X223	UB-04	Institutional/Hospital Billing
005010X224	ADA-2006	Dental Billing
NCPDP D.0	NCPDP UCF	Pharmacy Billing
NCPDP Batch 1.2	None	Pharmacy Billing
005010X221	None	Explanation of Review (EOR)
TA1	None	Interchange/Acknowledgment Implementation
005010X231	None	Acknowledgment for Health Care Insurance
005010X214	None	Health Care Claim Acknowledgement
Format	Corresponding Process	Function
005010X210	Documentation/Attachments	Submit documentation to support bill
005010X213	Documentation/Attachments	Request for Additional Information

Example of Instructions

Loop	Segment or Element	Value	Description	California Workers' Compensation Instructions
2000B	SBR		Subscriber Information	In Workers' Compensation, the Subscriber is the Employer
	SBR04		Group or Plan Name	Required when the Employer Department Name/Division is applicable and is different than the Employer reported in Loop 2010BA NM103.
	SBR09	WC	Claim Filing Indicator Code	Value must be 'WC' to indicate Workers' Compensation bill.

Complete Bill Flow & Timing Chart



Questions?



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- Jopari Solutions is one of the national leading connectivity services for providers and payers in the Workers' Compensation market place.
- Today, Jopari's vast network includes over 500 payers /bill review organizations and thousands of providers currently exchanging bills, attachments, acknowledgements and remittance information, and continues to grow.
- For more information, contact:
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The advertisement features a central graphic with a map of California on the left, a large black arrow pointing right, and a collage of sticky notes on the right. The sticky notes contain the text 'THEN WE CAME TO THE END'. Above the map and arrow is the FS&K logo and the tagline 'This Firm Means Business' next to a gavel. Below the map is the text '60 Attorneys in 14 Locations in California and Nevada'. To the right of the arrow is the name 'Suzanne Honor-Vangerov, Esq.' and contact information: 'www.fsklaw.com' and 'shonor@fsklaw.com'. At the bottom left is the copyright notice '© 2011 Floyd, Skeren & Kelly, LLP All rights reserved.' and at the bottom right is the number '42'.