IAIABC Workers' Compensation
Electronic Medical Billing Model Rule

Approved by IAIABC Executive Committee June 1, 2010

Important Notes

1. Assistance requests and documentation error reporting should be made to the IAIABC at 608-663-6355 or contact us at www.iaiabc.org
2. This model rule is a template for jurisdictions to use to create their own regulations on electronic medical billing. The use of this product requires the jurisdiction to tailor requirements to match its regulatory environment and to ensure consistency with the jurisdiction's statutory requirements. This document includes instructions and notes to help guide jurisdictions in developing language that aligns with their specific regulatory and business needs.
3. This model rule is the product of consensus. The IAIABC makes no warranties regarding the fitness for any purpose of any resource, product or service that is mentioned within the guide and assumes no responsibility for consequential damages resulting from the use or reliance thereupon.

Purpose of the Electronic Medical Billing Model Rule

The IAIABC has created this model rule for use by jurisdictions to help improve consistency in the adoption of health industry national standards for the submission and processing of electronic medical bills in workers' compensation. The model rule is a template for each jurisdiction to use as a basis on which to build its own rule, according to state-specific statutory requirements. It is not a complete and ready-made rule, but gives details that each jurisdication must take into consideration when drafting its own rule. Jurisdictions must consider important policy and regulatory framework issues prior to selecting the appropriate drafting options or language in the development of their jurisdictional requirements. Once the regulatory language for the implementation of electronic medical billing is developed, it is recommended that the jurisdiction also use the IAIABC eBill Companion Guide to document the technical requirements associated with its framework.

The standards referenced in this document align with the requirements adopted by the Secretary of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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Chapter 1 Introduction and Overview

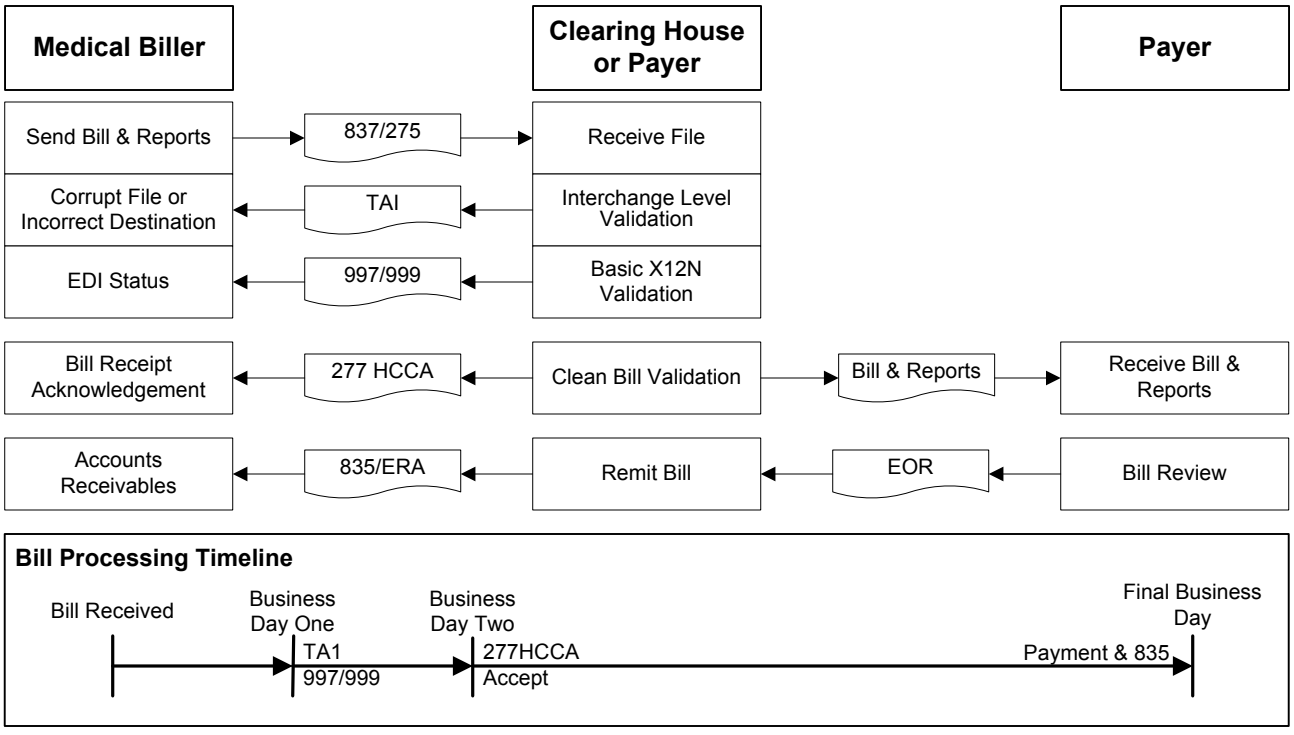
1.1 HIPAA

The Administrative Simplification Act provisions of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) include requirements that national standards for electronic health care transactions and national identifiers for Health Care Providers (Provider), Health Plans, and Employers be established. These standards were adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

1.2 Electronic Medical Billing Processes

Any jurisdiction contemplating requiring the use of electronic medical billing for workers' compensation must understand that the process encompasses more than simply the adoption of an electronic submission framework. In order to ensure the appropriate processing of electronic data sets, a set of processes is required to allow the submission of the electronic medical bill, the screening and processing of the bill, the acknowledgment and/or rejection of the bill, and the transmission of the explanation of benefits (EOB) or explanation of review (EOR). Accordingly, these draft rules attempt to address each of the technical aspects in addition to the workers' compensation process or procedural aspects of medical billing.

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 acknowledgments that are generated by the receiver, including those for validation and final adjudication for those bills that pass validation.



Process steps:

1. **Electronic Bill Submission:** The health care provider uses its practice management system or other automated solution to submit the ASC X12N 837 (medical bill) to the clearinghouse or payer. Most practice management systems contain certain edits to ensure the data is valid and consistent with the electronic format.

2. **Interchange Level Validation**: Basic file format and the trading partner information from the Interchange Header are validated. If the file is corrupt or is not the expected type, the file is rejected. If the trading partner information is invalid or unknown, the file is rejected. A TA1 (Interchange Acknowledgment) is returned to the sender to indicate the outcome of the validation. A rejected EDI file is not passed on to the next step.

3. **Basic X12 Validation**: A determination will be made as to whether the transaction set contains a valid 837. A 997 (Functional Acknowledgment) will be returned to the submitter. The 997 contains ACCEPT or REJECT information. If the file contains syntactical errors, the locations of the errors are reported. Bills that are part of a rejected transaction set are not passed on to the next step. Note: If agreed upon by the sender and receiver, a 999 transaction may be sent instead of the 997 with the same level of X12 validation.

4. **Clean Bill Validation**: The jurisdictional and payer specific edits are run against each bill within the transaction set. A 277 HCCA (Health Care Claim Acknowledgment) is returned to accept or reject the bills. Bills that are rejected are not passed on to the next step.

5. **Bill Review**: The bills that pass through bill review and any post-bill review approval process will be reported in the 835 Remittance Advice. The 835 contains the adjudication information from each bill, plus any paper check or electronic funds transfer (EFT) payment information.

Chapter 2 Workers' Compensation Regulatory Framework Issues

2.1 Code Construction and Administrative Procedure Acts

Prior to the rule development and adoption process, each jurisdiction must consider the regulatory framework provided by jurisdiction statutes related to the manner in which rules may be adopted. While some jurisdictions will be able to select languague that adopts general references, other jurisdictions will be required to use great specificity in the adoption of the national standards. To the extent possible, alternate drafting language has been included in this document to accommodate both approaches. Lastly, the formatting and presentation of the content of the model rule may be different than the Administrative Procedure Act requirements for the individual jurisdiction.

2.2 Mandate and Incentive Approaches

Under the HIPAA regulations, the submission of electronic medical bills is not required. The HHS rules require that standardized formats be used for electronic data interchanges, but not the use of electronic means of communication. Given the differences between certain data requirements between the health industry and workers' compensation (for example, the employer is the "subscriber" for workers' compensation transactions), automated systems designated for health related transactions may not meet all the data needs for workers' compensation bill submission. As such, jurisdictions need to decide how their framework will be applied and how to address the health care provider requirements related to electronic transactions. The key question that must be answered by the jurisdiction is whether to mandate health care providers to submit workers' compensation medical bills electronically, to provide incentives to health care providers for the electronic submission, or to simply permit the submission of electronic bills.

2.3 Jurisdiction-Specific Medical Billing Codes

Jurisdiction-specific medical billing processes and fee guidelines may contain certain code values that are not contained in the nationally recognized code sets. Accordingly, these code values may not be contained in the automated systems or translators used by the health industry to enable HIPAA-compliant electronic transactions. Each jurisdiction must consider the contents of their medical fee guidelines or billing processes to determine what changes may be needed to enable electronic submission of these non-standard codes. While adjusting the jurisdiction's fee guidelines may be an option for certain jurisdictions, it may not be an option for others. Unless the jurisdiction's medical billing and payment processes closely align with the national standards, any substantial use of electronic bill submission should not be expected.

2.4 Jurisdiction-Specific Terminology

While this model rule presents some general language to identify the parties involved in the delivery and payment of workers' compensation health care, individual jurisdictions may be required to refer to these entities using alternate terms or definitions. For example, the term "payer" may be replaced with "insurance carrier" or "claims administrator" depending on the jurisdiction's regulatory framework. Other terminology differences may contain substantive issues, such as the use of the term business days or working days. Since different jurisdictions may use these terms in different manners, any terminology that impacts the timeliness of transaction processing must be carefully considered. In framing its medical billing rules, each jurisdiction must consider the terminology used in its current statutes and rules in order to ensure consistency between various processes (such as indemnity determination processes and medical billing).

2.5 Health Care Provider Identification

In the HIPAA framework, the health industry is moving to a single identifier for health care providers. The typical health care provider (doctors, nurses, physical therapists, hospitals, etc.) is required to secure a National Provider Identification (NPI) number. The ASC X12 standards also support reporting a different idenficiation number for atypical providers that may not have secured a NPI number. Given the technical requirements of the ASC X12 standards, when an NPI number is used to identify a health care provider, other identification numbers are generally not allowed. Any jurisdiction that requires the submission of other identification numbers, such as the state license number, will introduce challenges that may impede the penetration of electronic medical billing.

2.6 Documentation

Generally speaking, medical documentation is typically not submitted with a medical bill in the health insurance environment. Most payers, such as Medicare or group health insurance carriers, require documentation to be submitted upon request. In workers' compensation, the distinct needs of insurance carriers related to compensability and disability determinations often require a higher amount of medical documentation. In addition, a national standard for the submission of electronic documentation has not yet been adopted under the HIPAA framework. Accordingly, many health care providers do not have the systems capable of transmitting documentation in an electronic format. The content of this model rule is written with the understanding that the jurisdiction has, or is able to, clearly define the limited number of medical documents that must be submitted in order to process a medical bill. Jurisdictions that require high amounts of medical documentation should not expect substantial use of electronic bill submission.

Chapter 3 Electronic Medical Billing Model Rule

3.1 Template References

The model rule contains references to the various decision points that are contained in Chapter 2. Jurisdictions are encouraged to answer or address the various questions contained in Chapter 2 prior to selecting appropriate language for their rule development efforts.

3.2 Section Numbering

In order to eliminate confusion on contents of this document and the subsections contained in the Electronic Medical Billing Model Rule Template, the Model Rule contains a simplified numbering schema.

MODEL RULE
ELECTRONIC MEDICAL BILLING FOR WORKERS' COMPENSATION

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Section 1. Purpose

The purpose of this Rule is to provide a legal framework for electronic billing, processing, and payment of medical services and products provided to an injured employee and data reporting subject to (insert state statute or rule citation.)

Section 2. Definitions

Drafting Note: Each state may have its own terminology or special requirements that will need customized definitions; however, adherence to standard terminology will minimize communication problems between the state and covered entities. This will also enhance compliance and minimize development costs, especially for companies operating in multiple states.

For the purposes of this Rule the following definitions shall apply:

A. "Agent" here is broadly construed to mean any person or entity that performs medical bill related processes for the payer responsible for the bill. These processes include, but are not limited to, reporting to government agencies, electronic transmission, forwarding, or receipt of documents, review of reports, adjudication of bill, and final payment.

B. "Business Day" means Monday through Friday, excluding days on which a holiday is observed by this state.

C. "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 is an agent of either the payer or provider and may perform the following functions:

(1) Processes or facilitates the processing of medical billing information received from a client in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction for further processing of a bill related transaction; or

(2) Receives a standard transaction from another entity and processes or facilitates the processing of medical billing information into nonstandard format or nonstandard data content for a client entity.

D. "Complete Electronic Bill" submission means a medical bill that meets all of the following criteria:

(1) it is submitted in the correct uniform billing format, with the correct uniform billing code sets, transmitted in compliance with the format requirements described in this rule;

(2) the bill and electronic attachments provide all information required under [insert relevant workers' compensation law]; and

(3) the health care provider has provided all information that payer requested under [insert relevant workers' compensation law] for purposes of processing the bill.

E. "CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

F. "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 (state specific) jurisdictional procedures necessary for engaging in Electronic Data Interchange (EDI) and specifies clarifications where applicable.

G. "Electronic" refers to a communication between computerized data exchange systems that complies with the standards enumerated in this rule.

H. "Health care provider" means a person or entity, appropriately certified or licensed, as required, who provides medical services or products to an injured worker in accordance with (insert state statute or rule citation.)

I. "Health care provider agent" means a person or entity that contracts with a health care provider establishing an agency relationship to process bills for services provided by the health care provider under the terms and conditions of a contract between the agent and health care provider. Such contracts may permit the agent to submit bills, request reconsideration, receive reimbursement, and seek medical dispute resolution for the health care provider services billed in accordance with (insert state statute or rule citation.)

J. "Implementation guide" is a published document for national electronic standard formats as defined in Section 3 of this rule that specifies data requirements and data transaction sets.

K. "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.

L. "Payer" means the insurer or authorized self insured employer legally responsible for paying the medical bills under workers' compensation, or an agent of one of these entities.

M. "Supporting Documentation" means those documents necessary to process a bill. These include, but are not limited to, any written authorization received from the third party administrator or any other records as required by (insert state statute or rule citation.)

Section 3. Formats for Electronic Medical Bill Processing

[Jurisdictions should consider the Code Construction and Administrative Procedure Act requirements prior to selecting language (*see page 6*).]

Drafting Note : Effective January 1, 2012, the Federal Department of Health and Human Services (HHS) will require health care organizations to be compliant with the ASC X12 005010 and NCPDP D.O standard transactions. If the jurisdiction intends to require electronic medical billing on and after January 1, 2012, subsection (A) should be omitted.

A. For electronic transactions conducted before January 1, 2012, the following electronic medical bill processing standards shall be used:

(1) Billing:

(a) Professional Billing -- the ASC X12N 837, Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098 and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1.

(b) Institutional/Hospital Billing -- the ASC X12N 837, Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096 and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X096A1.

(c) Dental Billing -- the ASC X12N 837, Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097 and Addenda to Health Care Claim: Dental, Version 4010, October 2002, Washington Publishing Company, 004010X097A1.

(d) Retail Pharmacy Billing -- the Telecommunication Standard Implementation Guide Version 5, Release 1 (Version 5.1), September 1999, National Council for Prescription Drug Programs and the Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000, supporting Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP

Data Record in the Detail Data Record, National Council for Prescription Drug Programs.

(2) Acknowledgment:

(a) Electronic responses to ASC X12N 837 transactions:

(i) the TA1 Interchange Acknowledgment contained in the standards adopted under subsection (a)(1) of this section;

(ii) the 997 Functional Acknowledgment contained in the standards adopted under subsection (a)(1) of this section; and

(iii) the ASC X12N 277 – Health Care Claim Status Response, Version 4010, May 2000, and Addenda, October 2002, Washington Publishing Company, 004010X093A1.

(b) Electronic responses to NCPDP transactions:

(i) the Response contained in the standards adopted under subsection (A)(1) of this section.

(3) Remittance -- the ASC X12N 835, Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, Washington Publishing Company, 004010X091A1.

(4) Documentation submitted with an electronic medical bill in accordance with Section 5(E) of this title (relating to Medical Documentation): ASC X12N 275 -- Additional Information to Support a Health Claim or Encounter, Version 4050, May 2004, Washington Publishing Company, 004050X151.

B. For electronic transactions conducted on or after January 1, 2012, the following electronic medical bill processing standards shall be used:

(1) Billing:

(a) Professional Billing -- the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Professional (837), May 2006, ASC X12, 005010X222.

(b) Institutional/Hospital Billing -- the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Institutional (837), May 2006, ASC X12N/005010X223, and Type 1 Errata to Health Care Claim: Institutional

(837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12N/005010X223A1.

(c) Dental Billing--the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Dental (837), May 2006, ASC X12N/005010X224, and Type 1 Errata to Health Care Claim: Dental (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12N/005010X224A1.

(d) Retail Pharmacy Billing -- the Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, National Council for Prescription Drug Programs and the Batch Standard Batch Implementation Guide, Version 1, Release 2 (Version 1.2), January 2006, National Council for Prescription Drug Programs.

(2) Acknowledgment:

(a) Electronic responses to ASC X12N 837 transactions:

(i) the ASC X12 Standards for Electronic Data Interchange TA1 Interchange Acknowledgment contained in the standards adopted under subsection (b)(1) of this section;

(ii) the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Implementation Acknowledgment for Health Care Insurance (999), June 2007, ASC X12N/005010X231; and

(iii) the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim Acknowledgment (277CA), January 2007, ASC X12N/005010X214.

(b) Electronic responses to NCPDP transactions:

(i) the Response contained in the standards adopted under subsection (B)(1) of this section.

(3) Remittance -- the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim Payment/Advice (835), April 2006, ASC X12N/005010X221.

(4) Documentation submitted with an electronic medical bill in accordance with Section 5(E) of this title (relating to Medical Documentation): ASC X12N 275 -- Additional Information to Support a Health Claim or Encounter, Version 004050, May 2004, Washington Publishing Company, 004050X151.

C. nsurance carriers and health care providers may exchange electronic data in a non-prescribed format by mutual agreement. All data elements required in the Division-prescribed formats must be present in a mutually agreed upon format.

D. The implementation specifications for the ASC X12N and the ASC X12 Standards for Electronic Data Interchange may be obtained from the ASC X12, 7600 Leesburg Pike, Suite 430, Falls Church, VA 22043; Telephone (703) 970–4480; and FAX (703) 970–4488. They are also available through the Internet at *http://www.X12.org* . A fee is charged for all implementation specifications.

E. The implementation specifications for the retail pharmacy standards may be obtained from the National Council for Prescription Drug Programs, 9240 East Raintree Drive, Scottsdale, AZ 85260. Telephone (480) 477–1000; FAX (480) 767–1042. They are also available through the Internet at *http://www.ncpdp.org*. A fee is charged for all implementation specifications.

Drafting Note: If permissible under the jurisdiction's regulatory environment, an alternative approach could include the following language instead of the specific references to the transaction sets. It is noted that this alternate language does not address electronic documentation.

A. Beginning [insert date], electronic medical billing transactions shall be conducted using the electronic formats adopted under the Code of Federal Regulations, title 45, part 162, subpart K, N, and P.

B. Nothing in this section shall prohibit payers and health care providers from using a direct data entry methodology for complying with these requirements, provided the methodology complies with the data content requirements of the adopted formats and these rules.

Drafting Note: If permissible under the jurisdiction's regulatory environment, the following language may be used instead of the specific references to future transaction sets contained in subsection (B).

B. Whenever the formats enumerated in section A for billing, acknowledgement, remittance, and documentation are replaced with a newer version, the most recent standard should be used. The requirement to use a new version shall commence on the effective date of the new version as published in the Code of Federal Regulations.

Section 4. Uniform Billing Codes

Billing codes and modifier systems identified below are valid codes for these workers' compensation transactions, in addition to any code sets defined by the standards adopted in Section 3:

A. "CDT-4 Codes" - codes and nomenclature prescribed by the American Dental Association.

B. "CPT-4 Codes" -- 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 (insert state statute or rule citation.)

C. "Diagnosis Related Group (DRG)" -- 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.

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

E. "ICD-9-CM Codes" -- 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.

Drafting Note: ICD-9-CM codes will be replaced by ICD-10-CM Codes effective October 1, 2013.

F. "NDC" -- National Drug Codes of the Food and Drug Administration.

G. "Revenue Codes" -- 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.

H. "UB 04 Codes" -- code structure and instructions established for use by the National Uniform Billing Committee (NUBC), such as occurrence codes, condition codes, or prospective payment indicator codes.

Drafting Note: Special or additional codes in use for the state workers' compensation fee schedule should be referenced here. [Jurisdictions should consider Jurisdiction Specific Medical Billing Code issues prior to selecting language (*see page 6*).]

Section 5. Electronic Medical Billing, Reimbursement, and Documentation

[Jurisdictions should consider the Mandatory and Incentive approaches prior to selecting language (*see page 6*).]

A. Applicability

(1) This section outlines the exclusive process to exchange electronic medical bill and related payment processing data for professional, institutional/hospital, pharmacy, and dental services. This section does not apply to requests for reconsideration or judicial appeals concerning any matter related to medical compensation or requests for informational copies of medical records.

(2) Unless exempted from this process in accordance with subsection (B) of this section, payers or their agents shall:

(a) Accept electronic medical bills submitted in accordance with the adopted standards;

(b) Transmit acknowledgments and remittance advice in compliance with the adopted standards in response to electronically submitted medical bills; and,

(c) Support methods to receive electronic documentation required for the adjudication of a bill, as described in Section 8 below.

(3) A health care provider must:

(a) Implement a software system capable of exchanging medical bill data in accordance with the adopted standards, or contract with a clearinghouse to exchange its medical bill data;

(b) Submit medical bills as defined by section 3(A)(1) to any payers that have established connectivity to the health care provider's system or clearinghouse;

(c) Submit required documentation in accordance with subsection E below; and

(d) Receive and process any acceptance or rejection acknowledgment from the payer.

(4) Payers must be able to exchange electronic data by (insert date) unless exempted from the process in accordance with subsection B of this section.

(5) Health care providers or their agents must be able to exchange electronic data by (insert date) unless exempted from the process in accordance with subsection B of this section.

B. Waivers

(1) A health care provider is waived from the requirement to submit medical bills electronically to a payer if:

(a) The health care provider employs ten (10) or fewer full time employees, and workers' compensation treatment or services constitutes less than 10% of its practice.

Drafting Note: Mandating all providers use electronic billing technology is likely to create hardship and resistance from very small/rural providers and/or providers that do little or no workers' compensation business. Hence, a more liberal exemption standard may be justified economically and politically. A state may use a different standard to determine whether a health care provider may be exempted from electronic medical billing requirement such as:

(a) Only use X number of full-time employees in practice (Used by Medicare), or

(b) The health care provider submitted fewer than (insert number) bills for workers' compensation treatment in the previous calendar year.

Drafting Note: May insert a different subsection regarding approval of individual waivers: "The health care provider requests and the (insert state workers' compensation agency name) approves a waiver. The (insert state workers' compensation agency name) will approve requests on a case-by-case basis and will base the decision on whether or not electronic billing causes an unreasonable financial burden on the health care provider."

(2) A payer is waived from the requirement to receive medical bills electronically from health care providers if:

(a) The payer processed fewer than (insert number i.e. 250) medical bills for workers' compensation treatment or services in the previous calendar year.

Drafting Note: May insert a different subsection regarding approval of individual waivers: "The (insert state workers' compensation agency name) may grant an exception on a case-by-case basis if the payer establishes that electronic billing will result in an unreasonable financial burden."

C. To be considered a complete electronic medical bill, the bill or supporting transmissions must:

(1) Include in legible text all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results that are expressly required by law or can be reasonably be expected by the payer or its agent under the laws of (name the state.)

(2) Identify the:

(a) Injured employee;

(b) Employer;

(c) Insurance carrier, third party administrator, managed care organization or its agent;

(d) Health care provider;

(e) Medical service or product; and

(f) Any other requirements as presented in the electronic billing companion guide

Drafting Note: Drafter may want to add that workers' compensation health care networks established by law may decrease the documentation requirements of this section.

(3) Use current and valid codes and values as defined in the applicable formats defined in Sections 3 and 4.

D. Acknowledgment

(1) Interchange Acknowledgement (TA1) notifies the sender of the receipt of, and certain structural defects associated with, an incoming transaction.

(2) An ASC X12N 997 Functional Acknowledgment or ASC X12N 999 Implementation Acknowledgment transaction is an electronic notification to the sender of the file has been received and has been:

(a) Accepted as a complete and structurally correct, or

(b) Rejected with a valid rejection code.

(3) An ASC X12N 277 Health Care Claim Status Response or Acknowledgment transaction (detail acknowledgment) is an electronic notification to the sender of an electronic transaction (individual electronic bill) that the transaction has been received and has been:

(a) Accepted as a complete, correct submission, or

(b) Rejected with a valid rejection code.

(4) A payer must acknowledge receipt of an electronic medical bill by returning an ASC X12N 997 Functional Acknowledgment or ASC X12N 999 Implementation Acknowledgment within one (1) business day of receipt of the electronic submission.

(a) Notification of a rejected bill is transmitted using the appropriate acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill or does not meet the edits defined in the applicable implementation guide or guides.

(b) A health care provider or its agent may not submit a duplicate electronic medical bill earlier than (jurisdictionally determined number; recommend 60 business) days from the date originally submitted if a payer has acknowledged acceptance of the original complete electronic medical bill. A health care provider or its agent may submit a corrected medical bill electronically to the payer after receiving notification of a rejection. The corrected medical bill is submitted as a new, original bill.

(5) A payer must acknowledge receipt of an electronic medical bill by returning an ASC X12N 277 Health Care Claim Status Response or Acknowledgment transaction (detail acknowledgment) within two (2) business days of receipt of the electronic submission.

(a) Notification of a rejected bill is transmitted in an ASC X12N 277 response or acknowledgment when an electronic medical bill does not meet the definition of a

complete electronic medical bill or does not meet the edits defined in the applicable implementation guide or guides.

(b) A health care provider or its agent may not submit a duplicate electronic medical bill earlier than (jurisdictionally determined number; recommend 60 business) days from the date originally submitted if a payer has acknowledged acceptance of the original complete electronic medical bill. A health care provider or its agent may submit a corrected medical bill electronically to the payer after receiving notification of a rejection. The corrected medical bill is submitted as a new, original bill.

(6) Acceptance of a complete medical bill is not an admission of liability by the payer. A payer may subsequently reject an accepted electronic medical bill if the employer or other responsible party named on the medical bill is not legally liable for its payment.

(a) The subsequent rejection must occur no later than (jurisdictionally determined number; recommend 7 business) days from the date of receipt of the complete electronic medical bill.

(b) The rejection transaction must clearly indicate that the reason for the rejection is due to denial of liability.

(7) Acceptance of an incomplete medical bill does not satisfy the written notice of injury requirement from an employee or payer as required in (insert reference to state workers' compensation statute.)

(8) Acceptance of a complete or incomplete medical bill by a payer does not begin the time period by which a payer must admit or deny liability for any alleged claim related to such medical treatment pursuant to (insert reference to state workers' compensation statute.)

(9) Functional acknowledgment under Section 5(D) (1) above, and acceptance of a complete, structurally correct file serves as proof of the received date for an electronic medical bill in Section 5(C)(3).

E. Electronic Documentation [Jurisdictions should consider the Documentation requirements prior to selecting language (*see page 6*).]

(1) Electronic documentation, including but not limited to medical reports and records submitted electronically that support an electronic medical bill, may be required by the payer before payment may be remitted to the healthcare provider, in accordance with regulations established by (insert state workers' compensation agency name.)

(2) Complete electronic documentation may be submitted by fax, electronic mail, or in an electronic format as defined in Section 3.

(3) The electronic transmittal by fax must contain the following details prominently on its cover sheet or first page of the transmittal:

(a) The name of the injured employee,

(b) Identification of the worker's employer, the employer's insurance carrier, or third party administrator or its agent handling the workers' compensation claim;

(c) Identification of the health care provider billing for services to the injured worker, and where applicable, its agent;

(d) Date(s) of service and

(e) The workers' compensation claim number assigned by the payer, if known.

(4) The electronic transmittal by email must contain the following details prominently:

(a) The name of the injured employee,

(b) Identification of the worker's employer, the employer's insurance carrier, or third party administrator or its agent handling the workers' compensation claim;

(c) Identification of the health care provider billing for services to the injured worker, and where applicable, its agent;

(d) Date(s) of service; and

(e) The workers' compensation claim number assigned by the payer, if known.

Drafting Note: Other data elements may be added to the list above.

(5) When requested by the payer, a health care provider or its agent must submit electronic documentation within (jurisdictionally determined number; recommend 7) business days of the request.

Drafting Note: Add the following: Electronic documentation may be submitted simultaneously with the electronic medical bill.

Drafting Note: Add the following: Electronic documentation may be submitted separately from the electronic medical bill within (jurisdictionally determined number; recommend 7) business days of successful submission of the electronic medical bill.

(6) If electronic transmittal of documentation proves to be impossible or infeasible, the documentation will be sent via first class mail to the address of record for the payer. Electronic transmittal is presumed to be infeasible if the electronic routing information to the payer is not available through normal means of transmittal allowed by this rule.

Drafting Note: When a signed release is required from the injured worker before release of requested records under Subsection (3) above, the request is not complete and actionable until the medical provider or its agent has received a valid, signed release form.

F. Electronic remittance notification

(1) An electronic remittance notification is an explanation of benefits (EOB) or explanation of review (EOR), submitted electronically regarding payment or denial of a medical bill, recoupment request, or receipt of a refund.

(2) A payer must provide an electronic remittance notification in accordance with (insert reference to state law, administrative rules, or fee schedules as applicable).

(3) The electronic remittance notification must contain the appropriate Group Claim Adjustment Reason Codes, Claims Adjustment Reason Codes (CARC) and associated Remittance Advice Remark Codes (RARC) as specified by ASC X12 835N implementation guide or for pharmacy charges, the National Council for Prescription Drugs Program (NCPDP) Reject Codes, denoting the reason for payment, adjustment, or denial.

(4) The remittance notification must be sent within (jurisdictionally determined number; recommend five business) days of:

a) the expected date of receipt by the medical provider of payment from the payer, or

b) the date the bill was rejected by the payer. If a recoupment of funds is being requested, the notification shall contain the proper code described in (3) and a full explanation for the amount and basis of the refund.

G. Health care providers exempted from electronic medical billing pursuant to subsection 5(B) shall submit paper medical bills for payment in the following formats as applicable:

(1) On the current standard forms used by the Centers for Medicare and Medicaid Services (CMS);

(2) On the current National Council for Prescription Drug Programs (NCPDP) Workers' Compensation/ Property and Casualty Universal Claim Form (WC/PC UCF)

(3) On the current American Dental Association (ADA) Claim Form

All information submitted on required paper billing forms must be legible and accurately completed in accordance with (insert state workers' compensation agency name) instructions.

H. A health care provider or its agent may not submit a duplicate paper medical bill earlier than (jurisdictionally determined number; recommend 30 business) days from the date originally submitted unless the payer has returned the medical bill as incomplete in accordance with Section 6 (Employer, Insurance Carrier, Managed Care Organization, or Agents' Receipt of Medical Bills from Health Care Providers). A health care provider or its agent may submit a corrected paper medical bill to the payer after receiving notification of the return of an incomplete medical bill. The corrected medical bill is submitted as a new, original bill.

I. Unless the payer is exempted from the electronic medical billing process in accordance with Section 5 (Electronic Medical Billing, Reimbursement, and Documentation), it must establish connectivity to any clearinghouse that requests the exchange of data in accordance with Section 3 (Formats for Electronic Medical Bill Processing.)

J. A payer or clearinghouse that requests another payer or clearinghouse to receive, process, or transmit a standard transaction may not charge fees or costs in excess of the fees or costs for normal telecommunications that the requesting entity incurs when it directly transmits, or receives, a standard transaction.

K A health care provider agent may charge reasonable fees related to data translation, data mapping, and similar data functions when the health care provider is not capable of submitting a standard transaction. In addition, a health care provider agent may charge a reasonable fee related to:

(1) Transaction management of standard transactions, such as editing, validation, transaction tracking, management reports, portal services and connectivity; and,

(2) Other value added services, such as electronic file transfers related to medical documentation.

L. A payer or its agent may not reject a standard transaction on the basis that it contains data elements not needed or used by the payer or its agent.

M. A health care provider that has not implemented a software system capable of sending standard transactions is required to use an Internet-based direct data entry system offered by a payer if the payer does not charge a transaction fee. A health care provider using an Internet-based direct data entry system offered by a payer or other entity must use the appropriate data content and data condition requirements of the standard transactions.

N. The payer's failure to comply with any requirements of this rule shall result in an administrative violation under (insert state statute or rule citation.)

Section 6 - Employer, Insurance Carrier, Managed Care Organization, or Agents' Receipt of Medical Bills from Health Care Providers

A. Upon receipt of medical bills submitted in accordance with Sections 3, 4, and 5, a payer shall evaluate each bill's conformance with the criteria of a complete medical bill.

(1) A payer shall not return to the health care provider medical bills that are complete, unless the bill is a duplicate bill.

(2) Within (number of days to be filled in by jurisdiction; authors recommend 21 days) calendar days of receipt of an incomplete medical bill, a payer or its agent shall either:

(a) Complete the bill by adding missing health care provider identification or demographic information already known to the payer; or,

(b) Return the bill to the sender, in accordance with this subsection.

B. The received date of an electronic medical bill is the date all of the contents of a complete electronic bill are successfully received by the claims payer.

C. The payer may contact the medical provider to obtain the information necessary to make the bill complete.

(1) Any request by the payer or its agent for additional documentation to pay a medical bill shall:

(a) be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery;

(b) be specific to the bill or the bill's related episode of care;

(c) describe with specificity the clinical and other information to be included in the response;

(d) be relevant and necessary for the resolution of the bill;

(e) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider; and

(f) indicate the specific reason for which the insurance carrier is requesting the information.

(2) If the payer or its agent obtains the missing information and completes the bill to the point it can be adjudicated for payment, the payer shall document the name and telephone number of the person who supplied the information.

(3) Health care providers and payers, or their agents, shall maintain, in a reproducible format, documentation of communications related to medical bill processing.

D. A payer shall not return a medical bill except as provided in subsection (A)(2) of this section. When returning an ASC X12N 837 medical bill, the payer shall clearly identify the reason(s) for returning the bill by utilizing the appropriate Reason and Rejection Code identified in the standards identified in Section 3(B)(2).

E. The proper return of an incomplete medical bill in accordance with this section fulfills the obligation of the payer to provide to the health care provider or its agent information related to the incompleteness of the bill.

F. Payers must timely reject bills or request additional information needed to reasonably determine the amount payable.

(1) For bills submitted electronically, the rejection of all or part of the bill must be sent to the submitter within two business days (or as deemed appropriate based on state law) of receipt.

(2) If bills are submitted in a batch transmission, only the specific bills failing edits shall be rejected.

G. If a payer has reason to challenge the coverage or amount of a specific line item on a bill, but has no reasonable basis for objections to the remainder of the bill, the uncontested portion must be paid timely, as in subsection H below.

H. Payment of all uncontested portions of a complete medical bill shall be made within 30 business days of receipt of the original bill, or receipt of additional information requested by the payer allowed under the law. Amounts paid after this [number of days to be filled in by jurisdiction; recommend 30 days] calendar day review period shall accrue an interest penalty of [fill in number if interest is to be paid] percent per month after the due date. The interest payment must be made at the same time as the medical bill payment.

I. A payer shall not return a medical bill except as provided in subsection (A) of this section. When returning a medical bill, the payer shall also communicate the reason(s) for returning the bill.

J. The payer's failure to comply with any requirements of this rule shall result in an administrative violation in accordance with (give state specific citation).

Section 7. Communication Between Health Care Providers and Payers

A. Any communication between the health care provider and the payer related to medical bill processing shall be of sufficient specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "payer improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position do not satisfy the requirements of this Section.

B. Utilization of the ASC X12N Reason Codes, or as appropriate, the NCPDP Reject Codes, by the payer when communicating with the health care provider or its agent or assignee, provides a standard mechanism to communicate issues associated with the medical bill.

C. Communication between the health care provider and payer related to medical bill processing shall be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery.

D. The payer's failure to comply with any requirements of this rule shall result in an administrative violation (insert state specific reference here).

Section 8. Medical Documentation Necessary for Billing Adjudication

[Jurisdictions should consider the Documentation requirements prior to selecting language (*see page 6*).]

A. Medical documentation includes all medical reports and records permitted or required in accordance with (insert reference to state law, administrative rules, or fee schedules as applicable.)

B. Requests for medical reports must be accompanied by any releases by the patient required by (insert reference to state law).

Drafting Note: Not all states require a specific release from the injured worker. The act of filing the workers' compensation claim automatically establishes the payer's right to access medical records. Also, the scope of the payer's request for additional documentation should be consistent with state law constraints on privacy and the need for medical releases before a patient's records can be released. Some states give the payer broad discretion to ask for any medical records related to episodes of care prior to the billed treatment whether or not related to the work injury creating the need for treatment.

C. Any request by the payer for additional documentation to process a medical bill shall conform to the requirements of Sec 6 (C).

D. It is the obligation of an insurer or employer to furnish its agents with any documentation necessary for the resolution of a medical bill.

E. Health care providers, health care facilities, third-party biller/assignees, and claims administrators and their agents must comply with all applicable Federal and state rules related to privacy, confidentiality, and security.

Section 9. Compliance and Penalty

A. Any electronically submitted bill determined to be complete but not paid or objected to within [ ] days shall be subject to penalties per (insert state rule citation.)

Drafting Note: If a state wishes to specify a specific sanction amount for non-compliance, the following subsection may be added.

B. The Commission/Board may impose a civil monetary penalty if it determines that a payer has failed to comply with the electronic claims acceptance and response process by the effective date adopted in Section 10. The amount of a civil monetary penalty shall be up to $XXX for each violation, but shall not exceed $XXX for identical violations during a calendar year.

Section 10. Effective Date

This chapter applies to all medical services and products provided on or after (insert date). For medical services and products provided prior to (insert date), medical billing and processing shall be in accordance with the rules in effect at the time the health care was provided.

OPTIONAL ADDITIONAL TOPICS

Jurisdictions may want to consider spelling out their guidelines in specific areas

1. Preauthorization
2. Description of medical documentation necessary for billing adjudication