

Electronic and Standardized Billing Regulations
Title 8, California Code of Regulations
Chapter 4.5 Division of Workers' Compensation
Subchapter 1 Administrative Director – Administrative Rules

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

§9792.5 Payment for Medical Treatment.

This section is applicable to medical treatment rendered before October 15, 2011.

(a) As used in this section:

- (1) "Claims Administrator" has the same meaning specified in Section 9785(a)(3).
- (2) "Medical treatment" means the treatment to which an employee is entitled under Labor Code Section 4600.
- (3) "Physician" has the same meaning specified in Labor Code Section 3209.3.
- (4) "Required report" means a report which must be submitted pursuant to Section 9785.
- (5) "Treating physician" means the "primary treating physician" as that term is defined by Section 9785(a)(1).

(b) Any properly documented bill for medical treatment within the planned course, scope and duration of treatment reported under Section 9785 which is provided or authorized by the treating physician shall be paid by the claims administrator within forty five working days from receipt of each separate itemized bill and any required reports, or within sixty working days if the employer is a governmental entity, unless the bill is contested, as specified in subdivisions (d), and (e), within thirty working days of receipt of the bill. Any amount not contested within the thirty working days or not paid within the forty five working day period, or within sixty working days if the employer is a governmental entity, shall be increased 15%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill.

For purposes of this Section, treatment which is provided or authorized by the treating physician includes but is not limited to treatment provided by a "secondary physician" as that term is defined by Section 9785(a)(2).

(c) A claims administrator who objects to all or any part of a bill for medical treatment shall notify the physician or other authorized provider of the objection within thirty working days after

receipt of the bill and any required report and shall pay any uncontested amount within forty five working days, or within sixty working days if the employer is a governmental entity, after receipt of the bill. If a required report is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill or report, whichever is received later. If the claims administrator receives a bill and believes that it has not received a required report to support the bill, the claims administrator shall so inform the medical provider within thirty working days of receipt of the bill. An objection will be deemed timely if sent by first class mail and postmarked on or before the thirtieth working day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth working day after receipt. Any notice of objection shall include or be accompanied by all of the following:

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

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

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

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

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

(e) The above provisions are altered for services rendered prior to January 1, 2004, as follows:

(1) Claims administrators shall pay any uncontested amount within sixty days after receipt of the bill, and

(2) Any amount not contested within the thirty working days or not paid within the sixty day period shall be increased 10% and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill.

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

Reference: Sections 4603.2 and 5307.1, Labor Code.

Article 5.5.0 Rules for Medical Treatment Billing and Payment on or after October 15, 2011

Section 9792.5.0 Definitions.

As used in this article:

(a) "Assignee" means a person or entity that has purchased the right to payments for medical goods or services from the health care provider or health care facility and is authorized by law to collect payment from the responsible payer.

(b) "Billing Agent" means a person or entity that has contracted with a health care provider or health care facility to process bills for services provided by the health care provider or health care facility.

(c) "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.

(d) "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.

(e) "Health Care Provider" means a provider of medical treatment, goods and services provided pursuant to Labor Code section 4600, 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.

(f) "Physician" includes 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.

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

Reference: Sections 3209.3, 4603.2, 4603.4 and 5307.1, Labor Code.

Section 9792.5.1 Medical Billing and Payment Guide; Electronic Medical Billing and Payment Companion Guide; Various Implementation Guides.

(a) The *California Division of Workers' Compensation Medical Billing and Payment Guide*, dated 2011, which sets forth billing, payment and coding rules for paper and electronic medical treatment bill submissions, is incorporated by reference. It may be downloaded from the Division of Workers' Compensation through the Department of Industrial Relations' website at www.dir.ca.gov or may be obtained by writing to:

Division of Workers' Compensation
Medical Unit
Attn: Medical Billing and Payment Guide
P.O. Box 71010
Oakland, CA 94612

(b) The *California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide* dated 2012, which sets forth billing, payment and coding rules and technical information for electronic medical treatment bill submissions, is incorporated by reference. It may be downloaded from the Division of Workers' Compensation website at www.dir.ca.gov or may be obtained by writing to:

Division of Workers' Compensation
Medical Unit
Attn: Medical Billing and Payment Companion Guide
P.O. Box 71010
Oakland, CA 94612

(c) The HIPAA-approved Technical Reports Type 3 for billing listed in subdivision (c)(1) through (3) are incorporated by reference. They may be obtained for a fee from the ASC X12's Secretariat, the Data Interchange Standards Association (DISA):

Data Interchange Standards Association (DISA) at <http://store.x12.org>

(1)(A) ASC X12N/005010X222
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Professional (837)
MAY 2006

- (B) ASC X12N/005010X222E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Professional (837)
Errata
January 2009

- (C) ASC X12N/005010X222A1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Professional (837)
Errata
June 2010

- (2)(A) ASC X12N/005010X223
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Institutional (837)
MAY 2006

- (B) ASC X12N/005010X223A1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Institutional (837)
Errata Type 1
OCTOBER 2007

- (C) ASC X12N/005010X223E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Institutional (837)
Errata
JANUARY 2009

- (D) ASC X12N/005010X223A2
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3
Health Care Claim: Institutional (837)
Type 1 Errata
June 2010

(3)(A) ASC X12N/005010X224
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Dental (837)
MAY 2006

(B) ASC X12N/005010X224A1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Dental (837)
Errata Type 1
OCTOBER 2007

(C) ASC X12N/005010X224E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Dental (837)
Errata
JANUARY 2009

(D) ASC X12N/005010X224A2
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Dental (837)
Errata
June 2010

(d) The HIPAA-approved implementation guides for pharmacy billing listed in subdivision (d)(1) and (2) are incorporated by reference. They may be obtained for a fee from the National Council for Prescription Drug Programs (NCPDP), 9240 E. Raintree Drive, Scottsdale, AZ 85260; Telephone (480) 477-1000; and FAX (480) 767-1042. They may also be obtained through the Internet at <http://www.ncdp.org>.

(1) Telecommunication Standard Implementation Guide Version D.0, August 2007, National Council for Prescription Drug Programs.

(2) The Batch Standard Implementation Guide, Version 1.2, 2006, National Council for Prescription Drug Programs.

(e) The following HIPAA-approved Technical Report Type 3 and errata, for acknowledgment and remittance are incorporated by reference:

(1)(A) ASC X12C/005010X231

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Implementation Acknowledgment for Health Care Insurance (999)

June 2007

(B) ASC X12C/005010X231A1

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Implementation Acknowledgment for Health Care Insurance (999)

June 2010

(2)(A) ASC X12N/005010X214

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim Acknowledgment (277)

January 2007

(B) ASC X12N/005010X214E1

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim Acknowledgment (277)

April 2008

(C) ASC X12N/005010X214E2

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3

Health Care Claim Acknowledgment (277)

January 2009

(3)(A) ASC X12N/005010X221
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Payment/Advice (835)
APRIL 2006

(B) ASC X12N/005010X221E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Payment/Advice (835)
Errata
JANUARY 2009

(C) ASC X12N/005010X221A1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Payment/Advice (835)
Errata
June 2010

They may be obtained for a fee from the Data Interchange Standards Association (DISA) at:
<http://store.x12.org>

(f) The *National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version*, Version 6.0 07/10, and the 1500 Form (revised 08-05) are incorporated by reference. The manual can be obtained directly from the National Uniform Claim Committee at:

http://www.nucc.org/index.php?option=com_content&task=view&id=33&Itemid=42 .

(g) The *National Uniform Billing Committee Official UB-04 Data Specifications Manual 2011, Version 5.0, July 2010*, including the UB-04 form, is incorporated by reference. The manual can be obtained from the National Uniform Billing Committee at <http://www.nubc.org/become.html> by becoming a UB-04 committee paid subscriber.

(h) The *Manual Claim Forms Reference Implementation Guide Version 1.0*, October 2008, National Council of Prescription Drug Programs (NCPDP) Data Specifications Manual including the NCPDP paper WC/PC Universal Claim Form Version 1.0 05/2008, except pages 13-36, is

incorporated by reference. The manual can be obtained from the NCPCP's vendor at:
www.communiform.com/ncpdp.

(i) The CDT 2011-2012: ADA Practical Guide to Dental Procedure Codes, including the ADA 2006 Dental Claim Form, is incorporated by reference. The manual can be obtained from the American Dental Association at:

American Dental Association
<http://www.ada.org/>
211 East Chicago Ave.
Chicago, IL 60611-2678

Or on the web at:

<http://www.ada.org/>

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

Reference: Section 4600, 4603.2 and 4603.4, Labor Code.

Section 9792.5.2 – Standardized Medical Treatment Billing Forms/Formats, Billing Rules, Requirements for Completing and Submitting Form CMS 1500, Form CMS 1450 (or UB-04), American Dental Association Form, Version 2006, NCPDP Workers' Compensation / Property & Casualty Universal Claim Form, Payment Requirements.

(a) On and after October 15, 2011, all paper bills for medical treatment provided by health care providers and health care facilities shall be submitted on billing forms set forth in the *California Division of Workers' Compensation Medical Billing and Payment Guide*.

(b) On and after October 15, 2011, all medical bills shall conform to the provisions of the *California Division of Workers' Compensation Medical Billing and Payment Guide* which includes coding, billing standards, timeframes and other rules.

(c) On and after October 18, 2012, all bills for medical treatment provided by health care providers and health care facilities may be electronically submitted to the claims administrator for payment. Electronic bills submitted on or after that date shall conform to the applicable provisions of the *California Division of Workers' Compensation Medical Billing and Payment Guide* and the *California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide*.

(d) Except as otherwise specifically provided, legally authorized billing agents and assignees shall submit bills in the same manner as the original rendering provider or facility would be required to do had the bills been submitted by the provider or facility directly and shall conform

to applicable provisions of the *California Division of Workers' Compensation Medical Billing and Payment Guide* and the *California Division of Workers' Compensation Medical Billing and Payment Companion Guide*.

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

Reference: Section 4600, 4603.2 and 4603.4, Labor Code.

Section 9792.5.3 – Medical Treatment Bill Payment Rules.

(a) On and after October 15, 2011, claims administrators shall conform to the payment, communication, penalty, and other provisions contained in the *California Division of Workers' Compensation Medical Billing and Payment Guide*, except that the provisions relating to the payment of electronic medical bills shall become effective on October 18, 2012. This subdivision does not apply to processing or payment of bills submitted before October 15, 2011.

(b) On and after October 18, 2012 claims administrators shall conform to the payment, communication, penalty, and other provisions contained in the *California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide*.

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

Reference: Section 4600, 4603.2 and 4603.4, Labor Code.