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WHAT'S NEW IN WORKERS COMPENSATION...

The Division of Workers' Compensation has started the formal rule making process for adoption of standards for electronic billing of industrial claims, known as E-billing.

The idea behind this process is to eliminate much of the paperwork in the Workers' Compensation system, as was the intent behind the implementation of the Electronic Adjudication Management System (EAMS) in 2008.

In EAMS, the parties are able to litigate in a virtually paperless system before the Workers' Compensation Appeals Board (WCAB), eliminating for many the need for a paper file.

Unfortunately, for some, this had a reverse effect, and actually lead to the creation of *more* paperwork within the system by the creation of new forms such as Document Cover Sheets and Separator Sheets, to name a few. Many other forms, such as liens, which were previously only one or two pages, are now multiple pages in length.

It is hoped that the E-billing process, once it makes its way through formal rulemaking, will provide a more streamlined process that EAMS has not quite been able to achieve as of yet. The idea behind electronic claims submission for hospitals is to provide prompt and accurate payment of services (even faster than the timeframe currently allowed by the Labor Code).

Clean claims will be paid faster, and the current proposed regulations even provide the option of electronic remittance (EFT). Of course, paper billing will still be allowed in the system, but providers are enticed to utilize E-billing through the use of optional EFT and guarantee of faster payment.

For many hospitals already participating in some form of electronic billing in other streams outside of industrial claims, there should be a fairly smooth transmission. For others, it is anticipated there will be a learning curve to get up to speed on Workers' Compensation E-billing.

Much of the rulemaking with respect to E-billing focuses on what constitutes a "clean claim." The rules are further specific that once a claim is submitted in one manner, paper or electronic, it may not be cleaned and resubmitted in another manner.

The coding on the UB-04 and HCFA 1500 forms will now have to be scrutinized, more than ever, for proper coding – including modifiers – before initial claim submission. The days of resubmitting a claim simply marked "Tracer" are over. Resubmitted claims will now have to be marked with frequency indicators. All requested supporting documentation would also have to be sent to the payor before resubmission.

Should a dispute arise, either with amount or timeliness of payment, the same rules with respect to lien filing before the WCAB would apply. It is important to watch the statute of limitations contained in Labor Code 4903.5. It is the later of 5 years from the date of injury, 1 year from the date of service, or 6 months from when the injured worker settles his or her case.

In the context of E-billing, the industrial carrier would be required to send back acknowledgement of receiving the hospital's claim within one working day. If the claim is being rejected, for any reason, that acknowledgement is to be sent within 5 days.

If the rejection is for missing information, all timeframes are tolled until the requested information is provided. Once the carrier receives this information, the timeframe would start again. For now, the Labor Code still provides that industrial carriers are to make payment within 45-working-days upon receipt of all requested supporting documentation, lest it pay penalty and interest.

As part of the proposed E-billing process, supporting documentation would be allowed to be submitted in the following forms: (1) Fax, (2) Electronic submission, (3) e-mail. It will be important to watch what information is ultimately required for clean claim submission to ensure prompt payment processing.

The proposed regulations will also include what information is to be on the Explanation of Benefits sent from the payor to the provider. It does not appear there will be a required form, per se, only required elements that must be communicated.

All appeals for reconsideration, for instance, have specific appeal codes that must be used for all first, second and third level appeals. It will now be more important than ever to get all required information from the injured worker in the initial engagement. Later obtaining accurate information for clean claim submission will be a time consuming process.

Getting the correct employer name and address, for instance, will now be required. The claim number will also become a required element for all claims which already have a claim number assigned to a particular injured worker's date of injury.

For hospitals, the Medicare provider number and physical address where the services were performed also become required elements. When possible, the social security number of the patient is also to be listed.

As part of this new process, providers will also be required to make available the name, address and contact information of a contact person at the facility should the payor require further information to process the claim.

We will be updating this information in the coming months as we get closer to the implementation and effective date of these new regulations. In the interim, please feel free to contact the undersigned for any further information.