GEORGIA
MEDICAL BILLING AND REIMBURSEMENT FOR WORKERS' COMPENSATION

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Section 1: Purpose and Scope

A. The purpose of this appendix to the fee schedule is to provide a procedural framework for electronic billing, processing, and payment of medical services and products provided to an injured employee subject to the Georgia workers' compensation regulations and fee schedules.

B. Georgia State Board of Workers' Compensation allows claims administrators to accept electronic bills. The effective date is as specified in the Section 11 of this appendix.

C. This appendix is adopted by the Georgia State Board of Workers' Compensation under Rule 205(a). This appendix specifies the billing, payment and coding rules for electronic medical bill submissions in the Georgia workers' compensation system. Entities responsible for adherence to these rules include, but are not limited to, health care

providers, health care facilities, insurance carriers and/or their claims administrators, third party billers/assignees and clearinghouses.

D. This appendix allows for providers and claims administrators to use agents to accomplish the requirement of electronic billing, but this appendix does not mandate the method of connectivity, the use of connectivity to clearinghouses or similar types of vendors.

E. Health care providers, health care facilities, third party biller/assignees and claims administrators should exchange electronic bills in the prescribed standard formats and may exchange data in non-prescribed formats by mutual agreement. All jurisdictionally required data content must be present in mutually agreed upon formats.

F. If a billing entity chooses to submit bills electronically, it must be able to receive an electronic response from the payer or their claims administrator. This includes electronic acknowledgements and electronic remittance advices (Explanations of Benefits).

G. Nothing in this document prevents the parties from utilizing Electronic Funds Transfer (EFT) to facilitate payment of electronically submitted bills. Use of Electronic Funds transfer is optional.

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

Section 2: Definitions

For the purposes of this appendix, the following definitions shall apply:

A. "Agent" means 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, bill preparation, electronic transmission, forwarding or receipt of documentation, review of reports, adjudication of the bill and payment.

B. “Associate” means any entity which is not covered under subsection A of this section that is handling electronic transactions on behalf of another.

C. “Claims administrator" means an entity or person that is responsible for the adjudication and payment of medical bills as the employer or the agent of an insurer or employer legally responsible for the payment of workers’ compensation benefits.

D. “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 does either of the following functions:

1. Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction for further processing of a bill related transactions; 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.

E. “Complete electronic bill” means a medical bill that meets all of the criteria as described in Section 6, letter F of this appendix.

F. “CMS” is the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services (HHS).

G. “Days” means when a required time is stated in “days” it means business days, excluding weekends and holidays as established by the State Board of Workers’ Compensation. When the requirement is seven (7) or less, it shall be working days, and when it is eight (8) or more days, it shall be calendar days.

H. “Georgia Electronic Billing and Payment Companion Guide” is based on the IAIABC Workers’ Compensation Electronic Medical Billing and Payment Companion Guides, which gives detailed information for

Electronic Data Interchange (EDI), medical billing and payment for the workers' compensation industry using national ASCX12 standards and Georgia specific jurisdictional procedures.

I. "Electronic" refers to a communication between computerized data exchange systems that complies with the standards enumerated in Section 3 of this appendix.

J. "Health care provider" means any provider of goods or services to an injured employee, under O.C.G.A. § 34-9-1 et. seq., for treatment of the injury.

K. "Health care provider agent or assignee" 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 the Georgia workers' compensation regulations and fee schedule.

L. "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.

M. "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.

N. "Supporting documentation" means those documents, other than reports, necessary to support a bill. These include, but are not limited to, any written authorization received from the third party administrator or any other record as required by the Georgia workers' compensation regulations and fee schedules.

O. "Electronic Standard Format" means the ASC X12 N standard format developed by the Accredited Standards Committee X12 Insurance Subcommittee of the American National Standards Institute and the retail

pharmacy specifications developed by the National Council for Prescription Drug Programs (NCPDP). See the Companion Guide for specific format information.

P. "Electronic Remittance" means an explanation of benefits (EOB/EOR) submitted electronically regarding payment or denial of a medical bill, recoupment request, or receipt of a refund.

Q. "Employer" as defined in O.C.G.A. 34-9-1(3).

R. "Health care facility" as defined in O.C.G.A. 31-7-1.

S. "Medical treatment" as defined in O.C.G.A. 34-9-200(a).

T. "NCPDP" means the National Council for Prescription Drug Programs.

U. "Physician" as defined in O.C.G.A. 34-9-201(a).

V. "Third party biller/assignee" means a person or entity that is either billing and/or collecting payment in place of, or on behalf of, the rendering health care provider or health care facility.

W. "Trading Partner Agreement" means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

X. "Unique Attachment Indicator Number" as defined by the IAIABC Electronic Medical Billing and Payment Guide is the number assigned by the provider to all documentation. The unique Attachment Indicator Number is the combination of data populated in the ASCX12N 005010X222 and or 005010X223 Loop 2300, PWK Segment: Report Type Code, the Report Transmission Code, Attachment Control Qualifier (AC) and the Attachment Control Number. For example, an operative note (report type code OB) sent by fax is identified as OBFXAC12345. It is the combination of these data elements that will allow an insurance

carrier to appropriately match the incoming attachment to the electronic medical bill.

Section 3: Formats for Electronic Medical Bill Processing

A. The following standard electronic formats, or the applicable HIPAA-approved successor formats, and related implementation guides are adopted for transactions between medical health care providers and payers. Unless medical providers and payers have a mutual agreement to exchange electronic data in non-prescribed formats as stated in letter C of this section, medical providers and payers shall utilize the standard electronic formats referenced below or the successor formats when exchanging electronic data.

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 and Type 3 Errata to Health Care Claim: Professional (837), June 2010, ASC X12, 005010X222A1.
   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, 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, and Type 3 Errata to Health Care Claim: Institutional (837), June 2010, ASC X12,005010X223A2.

   c. 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 A, number 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 A, number 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 12N/005010X221 and Type 3 Errata to Health Care Claim Payment/Advice (835), June 2010, ASC X12, 005010X221A1.

4. Documentation of Report:
   Documentation submitted with an electronic medical bill in accordance with Section 8 of this appendix (relating to Medical Documentation): ASC X12N Additional Information to Support a Health Claim or Encounter (275), February 2008, ASC X12, 005010X210.

B. Health care providers and payers may contract with other entities for electronic medical bill processing. Payers and health care providers are responsible for the acts or omissions of its agents executed in the performance of services for the insurance carrier or health care provider.

C. Payers and health care providers or their agents may exchange electronic data in a non-prescribed format by mutual agreement. All data elements specified in the Georgia Bill and Payment Companion Guide must be present in a mutually agreed upon format.

D. An entity choosing to submit bills electronically must be able to receive an electronic response. This includes electronic acknowledgements, notices and remittances.

E. 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 the rules stated in this appendix.

F. Whenever the formats enumerated in Section 3, subsection A for billing, acknowledgment, 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

G. 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, and Falls Church, VA 22043; Telephone (703) 970–4480; and FAX (703) 970–4488. They are also available through the Internet at *http://store.x12.org/*. A fee is charged for all implementation specifications.

H. 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; and FAX (480) 767–1042. They are also available through the Internet at *http://www.ncpdp.org*. A fee is charged for all implementation specifications.

Section 4: Uniform Billing Codes

The billing codes and modifiers as identified in the Georgia Workers' Compensation Medical Fee Schedule shall be utilized in the submission of electronic medical bills.

Section 5: Applicability

When health care providers choose to submit medical bills electronically to the insurer/payer, the health care provider must utilize the methodologies contained within this appendix.

A. Applicability:

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

2. Health care providers submitting bills electronically 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; and

   b. Submit medical bills in accordance with the adopted standards or the mutually agreed upon format to payers that have established connectivity to the health care provider's system or clearinghouse; and

   c. Submit required documentation in accordance with this section and;

   d. Receive and process acceptance or rejection acknowledgment from the payer; and

   e. Receive and process reimbursement transactions.

3. Payers or their agents shall:

   a. Accept electronic medical bills submitted in accordance with the adopted standards; and

b. Transmit acknowledgements 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.

4. Payers and health care providers may voluntarily exchange electronic medical bill data after July 1, 2010.

Section 6: Electronic Medical Billing

A. Health care providers, health care facilities and third party billers/assignees choosing to submit their bills electronically must enter into a Trading Partner agreement, as defined in Section 2, either directly with the claims administrator or with the entity that will handle the claims administrator's electronic transactions.

B. Trading Partner agreement means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

C. The purpose of a Trading Partner Agreement is to memorialize the rights, duties and responsibilities of the parties when utilizing electronic transactions for medical billing.

D. Per this appendix, Trading Partners shall utilize the adopted standards to electronically exchange claims information or through agreement may utilize other mutually agreed upon formats and forms (e.g. document index file or naming convention or fax cover sheet).

E. Third party billers, assignees, clearinghouses and other associates and vendors shall submit bills utilizing the adopted standards or other mutually agreed upon formats as detailed in this rule.

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

1. Be submitted in the correct billing format, with the correct billing code sets as presented in Section 4 of this appendix; and

2. Be transmitted in compliance with the format requirements described in Section 3 of this appendix; and

3. Include in legible text all medical reports and records, including, but not limited to, 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 reasonably be expected by the payer or its agent as defined in the Rules and Regulations of the Georgia State Board of Workers' Compensation; and

4. Identify all of the following:

   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.

5. Any other requirements as presented in the Georgia Electronic Medical Billing and Payment Companion Guide.

6. Shall be submitted in accordance with O.C.G.A. 34-9-203(c)(4).

G. 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

H. The received date of an electronic medical bill is the date all of the contents of a complete electronic bill as defined in this section, subsection F, numbers 1, 2 and 3 are successfully received by the claims processor.

I. For electronic medical bills, the resubmission of a duplicate bill shall clearly be marked as a duplicate using the appropriate NUBC Condition Code in the field designated for that information. Duplicate bills shall contain all the same information as the original bill. No new dates of service or itemized services may be included.

J. When there is an error or a need to make a coding correction, a revised electronic medical bill may be submitted to replace a previously submitted bill. Revised bills shall be marked as revised using the appropriate NUBC Condition Code in the field designated for that information. 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.

K. A bill which has been previously submitted on paper may not be also submitted as an electronic bill.

Section 7: Medical Bill Acknowledgements

A. 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.

1. The subsequent rejection must occur no later than 7 business days from the date of receipt of the complete electronic medical bill.

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

B. A payer shall not return a medical bill except as provided in subsection D of this section. When returning an electronic medical bill, the payer shall clearly identify the reason(s) for returning the bill by utilizing the appropriate Reason and Rejection Code standards identified in Section 9.

C. A payer or its agent may not reject a standard transaction on the basis that is contains data elements not needed or used by the insurance carrier/payer or agent.

D. The following standards shall be utilized to acknowledge receipt of an electronic medical bill:

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

2. An Implementations Acknowledgement (ASCX12 999) 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.

3. Health Care Claim Status Response (ASCX12 277) or Acknowledgement transactions is an electronic notification to the sender of an electronic transaction (individual electronic bill) that has been received and has been:

   a. Accepted as a complete, correction submission; or

   b. Rejected with a valid rejection code.

E. A payer must acknowledge receipt of an electronic medical bill by returning an Implementation Acknowledgment (ASC X12 999) within one (1) business day of receipt of the electronic submission.

1. 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 as described in Section 6, subsection F or does not meet the edits defined in the applicable

implementation guide or guides.

2. A health care provider or its agent may not submit a duplicate electronic medical bill earlier than 30 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.

F. A payer must acknowledge receipt of an electronic medical bill by returning a Health Care Claim Status Response or Acknowledgment (ASC X12 277) transaction (detail acknowledgment) within two (2) business days of receipt of the electronic submission.

1. 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.

2. A health care provider or its agent may not submit a duplicate electronic medical bill earlier than 30 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.

G. Transmission of an Implementation Acknowledgment under Section 7, subsection D, number 2, and acceptance of a complete, structurally correct file serves as proof of the received date for an electronic medical bill as defined in Section 6, subsection F.

Section 8: Medical Bill Documentation

A. Complete electronic documentation may be submitted by fax, electronic mail, or in an electronic format as defined in Section 3 and in accordance with state and federal Privacy and Security regulations.

B. 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 the Georgia workers' compensation regulation and fee schedule.

C. Any request by the payer for additional documentation to process a medical bill shall:

1. Be documented contemporaneously with the request; and

2. Be specific to the bill or the bill's related episode of care; and

3. Describe with specificity the clinical and other information to be included in the response; and

4. Be relevant and necessary for the resolution of the bill; and

5. 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 that has not previously been submitted as medical documentation in the electronic billing transaction at issue; and

6. Indicate the specific purpose for which the payer is requesting the information.

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

1. The name of the injured employee ; and

2. Identification of the worker's employer, the employer's insurance carrier, or the third party administrator or its agent handling the workers' compensation claim; and

3. Identification of the health care provider billing for services to the injured worker, and where applicable, its agent; and

4. Date(s) of service; and

5. The workers' compensation claim number assigned by the payer, if known; and

6. Page Number/Number of Pages – the number reported shall include the cover sheet; and

7. Unique Attachment Indicator Number.

F. The electronic transmittal by electronic mail must contain the following details prominently:

1. The name of the injured employee; and

2. Identification of the worker's employer, the employer's insurance carrier, or the third party administrator or its agent handling the workers' compensation claim; and

3. Identification of the health care provider billing for services to the injured worker, and where applicable, its agent; and

4. Date(s) of service; and

5. The workers' compensation claim number assigned by the payer, if known; and

6. Unique Attachment Indicator Number.

G. When requested by the payer, a health care provider or its agent must submit additional electronic documentation within 7 business days of the request. If the additional documentation is not received by the payer within the specified time frame of 7 business days, the payer will send to the health care provider or its agent an electronic remittance advice as specified in Section 3, subsection A, number 3 identifying denial of the claim based upon missing information.

H. Electronic documentation may be submitted separately from the electronic medical bill within 7 business days of successful submission of the electronic medical bill.

Section 9: Electronic Remittance Notification

A. Payment and Remittance Advice.

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 this appendix as specified in Section 3, subsection A, number 3.

3. If the electronically submitted bill has been determined to be complete, 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 30 days as established within O.C.G.A. 34- 9**-**203 after electronic receipt of an itemized electronic billing for services.

4. A claims administrator who objects to all or any part of an electronically submitted bill for medical treatment shall notify the Health Care Provider, health care facility or third party biller/assignee of the objection within 30 days as established within O.C.G.A. 34-9-203 after receipt of the bill that complies with Section 6 (F) and shall pay any uncontested amount within 30 days as established within O.C.G.A. 34-9-203 after receipt of the bill. If the claims administrator receives a bill and believes that it has not received a required report and/or supporting documentation to support the bill, the receipt of the bill as established within O.C.G.A. 34-9-203. An objection will be deemed timely if sent electronically on or before the 30th day after receipt as established within O.C.G.A.34-9-203.

5. 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 835 implementation guide or for pharmacy charges,

the National Council for Prescription Drugs Program (NCPDP) Reject Codes, denoting the reason for payment, adjustment, or denial.

Section 10: Transaction Processing- Connectivity

A. 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.

B. 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.

C. 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.

D. 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.

Section 11: Effective Date

This Appendix applies to all medical services and products provided on or after July 1, 2010. For medical services and products provided prior to July 1, 2010 medical billing and processing shall be in accordance with the rules in effect at the time the health care was provided.