

VIRGINIA WORKERS' COMPENSATION COMMISSION
Workers' Compensation Electronic Medical Billing

CHAPTER 16
ELECTRONIC MEDICAL BILLING

16VAC30-16-10. Effective date.

This chapter applies to all medical services and products provided to injured workers in accordance with § 65.2-603 of the Code of Virginia on or after July 1, 2019. For medical services and products provided prior to July 1, 2019, medical billing and processing shall be in accordance with the rules in effect at the time the medical service or product was provided; however, providers and payers may voluntarily comply with the provisions of this Chapter beginning on December 31, 2018.

16VAC30-16-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Business day" means Monday through Friday, excluding days on which a holiday is observed by the Commonwealth of Virginia.

"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 the health care provider and that 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.

"CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, the federal agency that administers these programs.

"Companion Guide" means the Virginia Workers' Compensation Electronic Billing and Payment Companion Guides, based on International Association of Industrial Accident Boards and Commissions National Companion Guides, a separate document that gives detailed information for electronic data interchange (EDI) medical billing and payment for the workers' compensation industry using national standards and Virginia specific procedures.

"Complete electronic medical bill" means a medical bill that meets all of the criteria enumerated in 16VAC30-16-50 C.

"Electronic" means communication between computerized data exchange systems that complies with the standards enumerated in this chapter.

"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 § 65.2-603 of the Code of Virginia.

"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 §§ 65.2-605 and 65.2-605.1 of the Code of Virginia.

"Payer" means the insurer or authorized self-insured employer legally responsible for paying the workers' compensation medical bills.

"Payer agent" means any person or entity that performs medical bill related processes for the payer responsible for the bill. These processes include reporting to government agencies; electronic transmission, forwarding, or receipt of documents; review of reports; and adjudication of bills and their final payment.

"Supporting documentation" means those documents necessary for the payer to process a bill and includes any written authorization received from the third party administrator or any other records as required by the Virginia Workers' Compensation Commission.

"Technical Report Type 3 (TR3) Implementation Guide" means an ASC X12 published document for national electronic standard formats that specifies data requirements and data transaction sets, as referenced in 16VAC30-16-30.

16VAC30-16-30. Formats for electronic medical bill processing.

A. For electronic transactions, 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 and Errata, Health Care Claim: Professional (837), June 2010, ASC X12, 005010X222A1.

b. Institutional or hospital billing: The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 and Errata, Health Care Claim: Institutional (837), June 2010, ASC X12, 005010X223A2.

c. Dental billing: The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 and Errata to Health Care Claim: Dental (837), June 2010, ASC X12, 005010X224A2.

d. Retail pharmacy billing: The Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, National Council for Prescription Drug Programs (NCPDP) 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 the ASC X12N 837 transactions.

(1) The ASC X12 Standards for Electronic Data Interchange TA1 Interchange Acknowledgment contained in the standards adopted under subdivision A 1 of this section;

(2) 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

(3) 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. The response contained in the standards adopted under subdivision A 1 d of this section.

3. Electronic remittance advice: The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 Errata to Health Care Claim Payment/Advice (835), June 2010, ASC X12, 005010X221A1.

4. ASC X12 ancillary formats.

a. The ASC X12N/005010X213 Request for Additional Information (277) is used to request additional attachments that were not originally submitted with the electronic medical bill.

b. Health Claim Status Request and Response.

The use of the formats in this subdivision 4 is voluntary, and Section 2.2.2 of the Companion Guide presents an explanation of how to use them in workers' compensation.

5. Documentation submitted with an electronic medical bill in accordance with 16VAC30-16-50 E (relating to medical documentation): ASC X12N Additional Information to Support a Health Claim or Encounter (275), February 2008, ASC X12, 005010X210.

B. Payers and health care providers may exchange electronic data in a nonprescribed format by mutual agreement. All data elements required in the Virginia-prescribed formats shall be present in any mutually agreed upon format.

C. 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 online at <http://store.x12.org/>. A fee is charged for all implementation specifications.

D. 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 online at <http://www.ncdp.org>. A fee is charged for all implementation specifications.

E. Nothing in this section will prohibit payers and health care providers from using a direct data entry methodology for complying with the requirements of this section, provided the methodology complies with the data content requirements of the formats enumerated in subsection A of this section and this chapter.

F. The most recent standard for the formats in subsection A of this section shall be used, commencing on the effective date of the applicable standard as published in the Code of Federal Regulations.

16VAC30-16-40. Billing code sets.

Billing codes and modifier systems identified in this section are valid codes for the specified workers' compensation transactions, in addition to any code sets defined by the standards in 16VAC30-16-30.

1. "CDT-4 Codes" are codes and nomenclature prescribed by the American Dental Association.
2. "CPT-4 Codes" are the procedural terminology and codes contained in the "Current Procedural Terminology, Fourth Edition," as published by the American Medical Association.
3. "Diagnosis Related Group" or "DRG" is 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 comorbidities and complications, and other pertinent data.
4. "Healthcare Common Procedure Coding System" or "HCPCS" is a coding system that describes products, supplies, procedures, and health professional services and that includes the American Medical Association's Physician "Current Procedural Terminology, Fourth Edition," CPT-4 codes, alphanumeric codes, and related modifiers.
5. "ICD-10-CM/PCS Codes" are diagnosis and procedure codes in the International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System maintained and published by the U.S. Department of Health and Human Services.
6. "NDC" are National Drug Codes of the U.S. Food and Drug Administration.
7. "Revenue Codes" is the four-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.
8. "National Uniform Billing Committee Codes" are a code structure and instructions established for use by the National Uniform Billing Committee, such as occurrence codes, condition codes, or prospective payment indicator codes. As of (insert effective date of final regulation), these are known as UB04 codes.

16VAC30-16-50. Electronic medical billing, reimbursement, and documentation.

A. Applicability.

1. This section outlines the exclusive process for the initial exchange of electronic medical bill and related payment processing data for professional, institutional or hospital, pharmacy, and dental services provided to injured workers in accordance with § 65.2-603 of the Code of Virginia .
2. Unless exempted from this process in accordance with subsection B 2 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 16VAC30-16-80.
3. Unless exempted from this process in accordance with subsection B 1 of this section, a health care provider shall:
 - 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 provided in 16VAC30-16-30 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 of this section; and
 - d. Receive and process any acceptance or rejection acknowledgment from the payer.
4. Payers shall be able to exchange electronic data by July 1, 2019, unless exempted from the process in accordance with subsection B 2 of this section.
5. Health care providers or their agents shall be able to exchange electronic data by July 1, 2019, unless exempted from the process in accordance with subsection B 1 of this section.

B. Exemptions.

1. A health care provider is exempt from the requirement to submit medical bills electronically to a payer if:

a. The health care provider employs 10 or fewer full-time employees; or

b. The health care provider submitted fewer than 250 medical bills for workers' compensation treatment, services or products in the previous calendar year.

2. A payer is exempt from the requirements to receive and pay medical bills electronically if the payer processed fewer than 250 medical bills for workers' compensation treatment, services or products in the previous calendar year.

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

1. Be submitted in the correct billing format;

2. Be transmitted in compliance with the format requirements described in 16VAC30-16-30;

3. Include in legible text all supporting documentation for the bill, including medical reports and records, evaluation reports, narrative reports, assessment reports, progress reports, progress 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 under the laws of Virginia;

4. Identify the following:

a. Injured employee;

b. Employer;

c. Insurance carrier, third-party administrator, managed care organization, or payer agent;

d. Health care provider;

e. Medical service or product; and

f. Any other requirements as presented in the Companion Guide; and

5. Use current and valid codes and values as defined in the applicable formats referenced in this chapter and the Companion Guide.

D. Acknowledgment.

1. An Interchange Acknowledgment (ASC X12 TA1) notifies the sender of the receipt of, and certain structural defects associated with, an incoming transaction.

2. An Implementation Acknowledgment (ASC X12 999) transaction is an electronic notification to the sender of the file that it has been received and has been:
 - a. Accepted as a complete and structurally correct file; or
 - b. Rejected with a valid rejection error code.
3. A Health Care Claim Acknowledgment (ASC X12 277CA) is an electronic acknowledgment to the sender of an electronic transaction that the transaction has been received and has been:
 - a. Accepted as a complete, correct submission; or
 - b. Rejected with a valid rejection error code.
4. A payer shall acknowledge receipt of an electronic medical bill by returning an Implementation Acknowledgment (ASC X12 999) within one 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 as described in subsection C of this section or does not meet the edits defined in the applicable implementation guide.
 - b. A health care provider or its agent shall not submit a duplicate electronic medical bill earlier than 60 calendar 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 shall acknowledge receipt of an electronic medical bill by returning a Health Care Claim Acknowledgment (ASC X12 277CA) transaction (detail acknowledgment) within two business days of receipt of the electronic submission.
 - a. Notification of a rejected bill is transmitted in an ASC X12N 277CA 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.
 - b. A health care provider or its agent shall not submit a duplicate electronic medical bill earlier than 60 calendar 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 rejection is transmitted by means of a Health Care Claim Payment/Advice ASC X12 835 transaction.

b. The subsequent rejection of a previously accepted electronic medical bill shall occur no later than 45 calendar days from the date of receipt of the complete electronic medical bill.

c. The transaction to reject the previously accepted complete medical bill shall clearly indicate that the reason for rejection is that the payer is not legally liable for its payment.

7. Acceptance of a complete or incomplete medical bill does not satisfy the written notice of injury requirement from an employee or payer as required by §§ 65.2-600 and 65.2-900 of the Code of Virginia.

8. Transmission of an Implementation Acknowledgment under subdivision D 2 of this section and acceptance of a complete, structurally correct file serves as proof of the received date for an electronic medical bill in subsection C of this section.

E. Electronic documentation.

1. Electronic documentation, including 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 health care provider in accordance with this chapter.

2. Complete electronic documentation shall be submitted by secure fax, secure encrypted electronic mail, or in a secure electronic format as described in 16VAC30-16-30.

3. The electronic transmittal, by secure fax, secure encrypted electronic mail, or any other secure electronic format, shall prominently contain the following details 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 the 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. Dates of service;
- e. The workers' compensation claim number assigned by the payer if established by the payer; and
- f. The unique attachment indicator number.

F. Electronic remittance advice and electronic funds transfer.

1. An electronic remittance advice (ERA) 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. The ERA shall contain the appropriate Claim Adjustment Group Codes, Claim Adjustment Reason Codes, and associated Remittance Advice Remark Codes as specified in the Code Value Usage in Health Care Claim Payments and Subsequent Claims Technical Report Type 2 (TR2) Workers' Compensation Code Usage Section and for pharmacy charges, the National Council for Prescription Drugs Program (NCPDP) Reject/Payment Codes, denoting the reason for payment, adjustment, or denial. Instructions for the use of the ERA and code sets are found in section 7.5 of the Companion Guide.
3. The ERA shall be sent before five business days of:
 - a. The expected date of receipt by the health care provider of payment from the payer, or
 - b. The date the bill was rejected by the payer.
4. All payments for services that have been billed electronically in accordance with this chapter are required to be paid via electronic funds transfer unless an alternate method is agreed upon by the payer and health care provider.

G. Requirements for health care providers exempted from electronic billing. Health care providers exempted from electronic medical billing pursuant to subsection B of this section shall submit paper medical bills for payment in the following formats as applicable:

1. On the current standard forms used by CMS, which are available online at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html>;

2. On the current NCPDP Workers' Compensation/Property and Casualty Universal Claim Form (WC/PC UCF), which are available online at <http://www.ncdp.org/Products/Universal-Claim-Forms>;

3. On the current American Dental Association Claim Form, which is available online at <https://www.ada.org/en/publications/cdt/ada-dental-claim-form>.

All information submitted on required paper billing forms under this subsection shall be legible and accurately completed.

H. Resubmissions. A health care provider or its agent shall not submit a duplicate paper medical bill earlier than 60 business days from the date originally submitted unless the payer has rejected the medical bill as incomplete in accordance with 16VAC30-16-60. A health care provider or its agent may submit a corrected paper medical bill to the payer after receiving notification of the rejection of an incomplete medical bill. The corrected medical bill is submitted as a new, original bill.

I. Connectivity. Unless the payer or its agent is exempted from the electronic medical billing process in accordance with subsection B 2 of this section, it should attempt to establish connectivity through a trading partner agreement with any clearinghouse that requests the exchange of data in accordance with 16VAC30-16-30.

J. Fees. No party to the electronic transactions shall charge excessive fees of any other party in the transaction. A payer or clearinghouse that requests another payer or clearinghouse to receive, process, or transmit a standard transaction shall 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 shall not reject a standard electronic transaction on the basis that it contains data elements not needed or used by the payer or its agent or that the electronic

transaction includes data elements that exceed those required for a complete bill as enumerated in subsection C of this section.

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

16VAC30-16-60. Employer, insurance carrier, managed care organization, or agent's receipt of medical bills from health care providers.

A. Upon receipt of medical bills submitted in accordance with 16VAC30-16-30, 16VAC30-16-40, and 16VAC30-16-50, a payer shall evaluate each bill's conformance with the criteria of a complete electronic medical bill.

1. A payer shall not reject medical bills that are complete, unless the bill is a duplicate bill. A payer may subsequently reject a complete medical bill or any portion thereof that is contested or denied in accordance with the requirements of subsection B of § 65.2-605.1 of the Code of Virginia.

2. Within 45 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. Reject the incomplete bill, in accordance with this subsection and the requirements of subsection B of § 65.2-605.1 of the Code of Virginia.

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

C. The payer may contact the health care 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 is 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 that 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 documentation of any pertinent internal or external communications that are necessary to make the medical bill complete.

D. A payer shall not reject or deny a medical bill except as provided in subsection A of this section. When rejecting or denying an electronic medical bill, the payer shall clearly identify the reasons for the bill's rejection or denial by utilizing the appropriate codes in the standard transactions found in 16VAC30-16-50 D 3 b and shall comply with all requirements of subsection B of § 65.2-605.1 of the Code of Virginia.

E. The rejection 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 shall timely reject incomplete bills or request additional information needed to reasonably determine the amount payable.

- 1. For bills submitted electronically, the rejection of the entire bill or the rejection of specific service lines included in the initial bill shall be sent to the submitter as soon as practicable but not more than 45 calendar days after receipt.
- 2. If bills are submitted in a batch transmission, only the specific bills failing edits shall be rejected.
- 3. If there is a technical defect within the transmission itself that prevents the bills from being accessed or processed, the transmission will be rejected with an Interchange

Acknowledgment (ASC X12 TA1) transaction or an Implementation Acknowledgment (ASC X12 999) transaction, as appropriate.

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 shall be paid timely, as described in subsection H of this section.

H. Payment of all uncontested portions of a complete medical bill shall be made within 60 calendar days of receipt of the original bill or receipt of additional information requested by the payer allowed under the law. Amounts paid after this 60-calendar-day review period will accrue interest at the judgment rate of interest as provided in § 6.2-302 of the Code of Virginia. The interest payment shall be made at the same time.

16VAC30-16-70. 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. The payer's utilization of the Claim Adjustment Group Codes, Claim Adjustment Reason Codes, or the Remittance Advice Remark Codes, or as appropriate, the National Council for Prescription Drugs Program Reject/Payment Codes, when communicating with the health care provider or its agent or assignee, through the use of the Health Care Claim Payment/Advice 835 transaction, 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.

16VAC30-16-80. Medical documentation necessary for billing adjudication.

A. Medical documentation includes all medical reports and records permitted or required in accordance with Rule 4.2 of the Rules of the Virginia Workers' Compensation Commission, subdivision 2 of 16VAC30-50-50.

B. Any request by the payer for additional documentation to process a medical bill shall conform to the requirements of 16VAC30-16-60 C.

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

D. Health care providers, health care facilities, third-party biller, third-party assignees, and claims administrators and their agents shall comply with all applicable federal and jurisdictional rules related to privacy, confidentiality, and security.

DOCUMENTS INCORPORATED BY REFERENCE (16VAC30-16)

[Electronic Billing and Payment Companion Guide, Virginia Workers' Compensation Commission, Release 1.0, 12/2018](#)