SUBCHAPTER 23F –ELECTRONIC BILLING RULES

SECTION .0100 –ADMINISTRATION

11 NCAC 23F .0101 ELECTRONIC MEDICAL BILLING AND PAYMENT REQUIREMENT

Carriers and licensed health care providers shall utilize electronic billing and payment in workers' compensation claims. Carriers and health care providers shall develop and implement electronic billing and payment processes consistent with 45 CFR 162. Carriers and health care providers shall comply with this Rule on or before March 1, 2014. 45 CFR 162 is hereby incorporated by reference and includes subsequent amendments and editions. A copy may be obtained at no charge from the National Archives and Records Administration's website, http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr162_main_02.tpl, or upon request, at the offices of the Commission, located in the Dobbs Building, 430 North Salisbury Street, Raleigh, North Carolina, between the hours of 8:00 a.m. and 5:00 p.m.

History Note: *Authority G.S. 97-26(g1); 97-80;*
Eff. July 1, 2014;
Recodified from 04 NCAC 10F .0101 Eff. June 1, 2018.

11 NCAC 23F .0102 DEFINITIONS

As used in this Subchapter:

(1) "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 provider and that may perform the following functions:
  (a) 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
  (b) 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.

(2) "Complete electronic bill" submission means a medical bill that meets all of the criteria enumerated in this Subchapter.

(3) "Electronic" refers to a communication between computerized data exchange systems that complies with the standards enumerated in this Subchapter.

(3) "Health Care Provider" is as set forth in G.S. 97-2(20).

(4) "Health Care Provider Agent" is 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.

(5) "Implementation guide" is a published document for national electronic standard formats as defined in this Subchapter that specifies data requirements and data transaction sets.

(6) "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.

(7) "Payer" means the insurance carrier, third-party administrator, managed care organization, or employer responsible for paying the workers' compensation medical bills.

(8) "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, adjudication of bill, and final payment.

History Note: *Authority G.S. 97-26; 97-26(g1); 97-80;*
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11 NCAC 23F .0103 FORMATS FOR ELECTRONIC MEDICAL BILL PROCESSING

(a) Beginning March 1, 2014, electronic medical billing transactions shall be conducted using the electronic formats adopted under the Code of Federal Regulations, Title 45, part 162, subparts K, N, and P. Whenever a standard format is replaced with a newer standard, the most recent standard shall 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.

(b) Nothing in this Subchapter 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.

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Recodified from 04 NCAC 10F .0102 Eff. July 1, 2014;
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Recodified from 04 NCAC 10F .0103 Eff. June 1, 2018.

11 NCAC 23F .0104 BILLING CODE SETS

Billing codes and modifier systems identified below are valid codes for the specified workers' compensation transactions, in addition to any code sets defined by the standards adopted in 11 NCAC 23F .0103:

(1) "CDT-4 Codes" that refers to the codes and nomenclature prescribed by the American Dental Association.
(2) "CPT-4 Codes" that refers to the procedural terminology and codes contained in the "Current Procedural Terminology, Fourth Edition," as published by the American Medical Association.
(3) "Diagnosis Related Group (DRG)" that refers to the inpatient classification scheme used by CMS for hospital inpatient reimbursement.
(4) "Healthcare Common Procedure Coding System" (HCPCS) that refers to a coding system which describes products, supplies, procedures, and health professional services and that includes CPT-4 codes, alphanumeric codes, and related modifiers.
(5) "ICD-9-CM Codes" that refers to diagnosis and procedure codes in the International Classification of Diseases, Ninth Revision, Clinical Modification published by the United States Department of Health and Human Services.
(6) "ICD-10-CM/PCS" that refers to diagnosis and procedure codes in the International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System.
(7) National Drug Codes (NDC) of the United States Food and Drug Administration.
(8) "Revenue Codes" that refers to 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.
(9) "National Uniform Billing Committee Codes" that refers to the code structure and instructions established for use by the National Uniform Billing Committee (NUBC).

History Note: *Authority G.S. 97-26(g1); 97-80;*
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11 NCAC 23F .0105 ELECTRONIC MEDICAL BILLING, REIMBURSEMENT, AND DOCUMENTATION

(a) Payers and payer agents shall:

(1) accept electronic medical bills submitted in accordance with the standards adopted in this Subchapter;
(2) transmit acknowledgments and remittance advice in compliance with the standards adopted in this Subchapter in response to electronically submitted medical bills; and
(3) utilize methods to receive electronic documentation required for the adjudication of a bill.

(b) A health care provider shall:

(1) exchange medical bill data in accordance with the standards adopted in this Subchapter;

(2) submit medical bills as defined by this Rule to any payers who have established connectivity with the health care provider system or clearinghouse;
(3) submit required documentation in accordance with Paragraph (d) of this Rule; and
(4) receive and act upon any acceptance or rejection acknowledgment from the payer.

(c) To be considered a complete electronic medical bill, the bill or supporting transmissions shall:
(1) be submitted in the correct billing format, with the correct billing code sets as presented in this Rule;
(2) be transmitted in compliance with the format requirements described in this Rule;
(3) include in legible text all medical reports and records, including evaluation reports, narrative reports, assessment reports, progress reports and notes, clinical notes, hospital records and diagnostic test results that are necessary for adjudication;
(4) identify the:
(A) injured employee;
(B) employer;
(C) insurance carrier, third party administrator, managed care organization or its agent;
(D) health care provider; and
(E) medical service or product;
(5) comply with any other requirements as presented in a companion guide published by the Commission; and
(6) use current and valid codes and values as defined in the applicable formats defined in this Subchapter.

(d) Electronic Acknowledgment:
(1) Interchange Acknowledgment (TA1) notifies the sender of the receipt of, and structural defects associated with, an incoming transaction.
(2) As used in this Paragraph, 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 code.
(3) As used in this Paragraph, Health Care Claim Status Response (ASC X12 277) 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 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.
(5) Notification of a rejected bill shall be transmitted when an electronic medical bill does not meet the definition of a complete electronic medical bill as described in this Rule or does not meet the edits defined in the applicable implementation guide or guides.
(6) A health care provider or its agent may not submit a duplicate electronic medical bill earlier than 60 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 shall be submitted as a new, original bill.
(7) A payer shall 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 business days of receipt of the electronic submission.
(8) Notification of a rejected bill shall be transmitted in an ASC X12 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.
(9) A health care provider or its agent may not submit a duplicate electronic medical bill earlier than 60 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 shall be submitted as a new, original bill.

(10) 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.
(11) The subsequent rejection shall occur no later than seven days from the date of receipt of the complete electronic medical bill.
(12) The rejection transaction shall indicate that the reason for the rejection is due to denial of liability.
(13) Acceptance of an incomplete medical bill does not satisfy the written notice of injury requirement from an employee or payer as required in G.S. 97-22.
(14) Acceptance of a complete or incomplete medical bill by a payer does not begin the time period by which a payer shall accept or deny liability for any alleged claim related to such medical treatment pursuant to G.S. 97-18 and 11 NCAC 23A .0601.
(15) Transmission of an Implementation Acknowledgment under Subparagraph (d)(2)of this Rule and acceptance of a complete, structurally correct file serves as proof of the received date for an electronic medical bill in this Rule.

(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. Electronic documentation may be submitted simultaneously with the electronic medical bill.
(2) Electronic transmittal by electronic mail shall contain the following information:
(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 employee, and where applicable, its agent;
(D) the date(s) of service; and
(E) the workers' compensation claim number assigned by the payer, if known.

(f) Electronic remittance notification
(1) As used in the Paragraph, 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 shall provide an electronic remittance notification in accordance with G.S. 97-18.
(3) The electronic remittance notification shall contain the appropriate Group Claim Adjustment Reason Codes, Claim Adjustment Reason Codes (CARC) and associated Remittance Advice Remark Codes (RARC) 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 shall be sent within two 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. If a recoupment of funds is being requested, the notification shall contain the proper code described in Subparagraph (e)(3) of this Rule and an explanation for the amount and basis of the refund.

(g) A health care provider or its agent may not submit a duplicate paper medical bill earlier than 30 days from the date originally submitted unless the payer has returned the medical bill as incomplete in accordance with this Subchapter. A health care provider or its clearinghouse or 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 shall be submitted as a new, original bill.

(h) A payer shall establish connectivity with any clearinghouse that requests the exchange of data in accordance with this Subchapter. 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.

(j) A health care provider that does not send standard transactions shall 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 shall use the appropriate data content and data condition requirements of the standard transactions.

History Note: *Authority G.S. 97-26(g1); 97-80;*
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11 NCAC 23F .0106 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 the rules in this Subchapter, a payer shall evaluate each bill's conformance with the criteria of a complete medical bill. A payer shall not return to the health care provider medical bills that are complete, unless the bill is a duplicate bill. Within 21 days of receipt of an incomplete medical bill, a payer or its agent shall either:

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

(2) Return the bill to the sender, in accordance with this Paragraph.

(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 health care provider to obtain the information necessary to make the bill complete. Any request by the payer or its agent for additional documentation to pay a medical bill shall:

(1) 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;

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

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

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

(5) 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

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

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. 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 this Rule. When returning an electronic medical bill, the payer shall identify the reason(s) for returning the bill by utilizing the appropriate Reason and Rejection Code identified in the standards identified in this Subchapter.

(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 shall timely reject bills or request additional information needed to reasonably determine the amount payable as follows:

(1) For bills submitted electronically, the rejection of all or part of the bill shall be sent to the submitter within two days 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 shall be paid timely, as required in this Rule.

(i) Payment of all uncontested portions of a complete medical bill shall be made within 30 days of receipt of the original bill, or receipt of additional information requested by the payer allowed under the law. After 60 days an amount equal to 10 percent shall be added to an unpaid bill.

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

History Note: *Authority G.S. 97-18(a); 97-26(g1); 97-80;*
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Recodified from 04 NCAC 10F .0106 Eff. June 1, 2018.

11 NCAC 23F .0107 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 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 Rule.

(b) When communicating with the health care provider, agent, or assignee, the payer may utilize the ASC X12 Reason Codes, or the NCPDP Reject Codes, to communicate with the health care provider, agent, or assignee.
(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.

History Note: *Authority G.S. 97-26(g1); 97-80(a);*
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11 NCAC 23F .0108 EFFECTIVE DATE

This Chapter applies to all medical services and products provided on or after March 1, 2014. For medical services and products provided prior to March 1, 2014, medical billing and processing shall be in accordance with the rules in effect at the time the health care was provided.

History Note: *Authority G.S. 97-26(g1); 97-80;*
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