

# **COMMON MEDICAL PAYMENT ISSUES**

**MOST COMMON TIMELY MEDICAL PAYMENT ISSUES**  
**Workers' Compensation Health Billing Payment and Dispute Resolution Process**  
**Effective January 1, 2008**

	ISSUE	PROCESS	APPLICABLE RULE/DOWC COMMENT
<b>Communication</b>	<b>PRIOR AUTHORIZATION OF SERVICES</b>		
	Prior authorization	When requesting prior authorization, providers must explain the medical necessity of the service and submit supporting documentation. The request must be as specific as possible.	Rule 16-9(E)
	Lack of authorization from adjuster	All authorization given to a provider should be <u>specific</u> , in writing, and internally routed to the bill reviewer and all other parties for proper handling of bill.	Rule 16-9(G), Division's recommendation
	Denial of authorization	All denials of prior authorization must be in complete compliance with Rule 16-10	Rule 16-10(E) - allows for automatic authorization if denial is not done timely. Rule 16-10(F): Unreasonable denial may lead to penalties.
	<b>PRIOR TO SUBMITTING BILLS</b>		
	Incomplete or inaccurate bills	Before sending the bill, the provider should verify the billed information on the CMS 1500 to insure the fields are properly filled out and the information is correct.	
	Time Line for Billing	The provider must bill within 120 days of the date of service	Rule 16-11(A)(1)
	Provider tax info not available or wrong	Providers should verify the tax ID number	
	Provider specialty not identified on bill	Bill for only one provider per CMS 1500 (08-05) form. Block 31 of the CMS 1500 (08-05) may be used to identify the supervising provider, and block 19 used to identify the provider rendering the treatment, if different than the supervising provider.	
	Provider's submission of notes and supporting documentation	The Division recommends submitting all billing documentation at the time of submitting the bill unless a private agreement exists between parties.	See Rule 16-7(E), Required Billing Forms and Accompanying Documentation, for rules concerning the submission of initial, interim and closing medical reports using division form WC164.

Hospitals are charging for copies of records	The payers request for records from the hospital needs to be specific. Ex.: A physician's billed ER visit only requires the physician's ER Room note, not the entire hospital chart, to evaluate the services billed.	Rule 16-7(E)(5)e
Provider PPO discounts taken w/o a signed contract or the contract agreement has expired.	Payers need to verify payment reductions are in compliance with PPO contracts.	Rule 16-11(D)(2)
<b>REVIEW AND PROCESSING OF BILLS</b>		
No acknowledgment of receipt of bill	Within thirty days of receipt of a bill, payer should notify the billing provider, either by EOB or letter, of all bills received, even if the claim has not been established, the bill has been submitted to the wrong insurer, or the services billed are non-work related.	Rule 16-11(A)(2) and Division recommendation
Unestablished Claims – "First Report of Injury" has not been filed in a timely manner or the medical services billed are non-work related.	In cases of unestablished claims (no "First Report of Injury"), the provider should inform the patient of the need to file a claim with DOWC.	C.R.S. 8-42-101(4) Worker may use form WC15, "Worker's Claim for Compensation," available on the Division's webpage <a href="http://www.coworkforce.com/DWC/">www.coworkforce.com/DWC/</a>
Second request for medical records	Payer internal documentation routing should not necessitate a second request for documentation and/or a bill going unpaid.	Any second request for medical records by the payer should generate a copying fee billed by the provider and paid by the payer. (Rule 18-6(G)(1))
	The payer verifies all billed codes/modifiers, policy number, etc. and issues a reimbursement check and an explanation of benefits (EOB) within 30 days from receipt of bill.	Rule 16-11(A)
Down-coding or changing of codes	Payers must pay for the services as billed or deny the codes/modifiers not supported by the presented documentation and/or Relative Values for Physicians/DOWC rules. Payers are required to be very clear and specific on why they are denying the billed codes. Payers cannot change billed codes, unless the provider agrees. The provider has 60 days to resubmit the denied codes and modifiers with additional information.	Rule 16-11(B) and (C)
	The provider should contact the payer if no check or EOB is received within 30 days to verify receipt of bills and to cross-verify accuracy of the bill.	Rule 16-11(B)(4)

	<b>PAYMENT OR DENIAL OF PAYMENT RECEIVED</b>	
Re-review of claims	The provider has 60 days to contest reasons for non-payment and present their argument	Rule 16-11(D)(1)
	Payer has thirty days from receipt of resubmission to pay or explain continued denial.	Rule 16-11(D)(1)
Retro-active Audits	Recovery of overpayments to providers must be within 12 months after the date of the original explanation of benefits.	Rule 16-11(E)
	<b>DISPUTE RESOLUTION</b>	
Disputes	In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.	Rule 16-11(D)(3) & (4)
	Unresolved disputes may follow the procedures in Rule 9.	