**Section 2908.60 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/hospital, pharmacy and dental services. This Section does not apply when a hospital, physician, surgeon or other person rendering treatment pursuant to the Act is submitting a standardized form on paper in conformity with 50 Ill. Adm. Code 2017 (Uniform Medical Claim and Billing Forms) as applicable to the service rendered or responding to requests for reconsideration or judicial appeals concerning any matter related to medical compensation or requests for informational copies of medical records.

2) Unless exempted from this process in accordance with subsection (m), payers or their agents shall:

A) Accept electronic medical bills submitted in accordance with the standards set forth in this Part;

B) Transmit acknowledgments and remittance advice in compliance with this Part, 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 Section 2908.90.

3) Before accepting an electronically submitted medical bill, the payer shall ensure that the medical provider or clearing house:

A) has implemented a software system capable of exchanging medical bill data in accordance with the adopted standards or has contracted with a clearinghouse to exchange its medical bill data;

B) is able to submit medical bills in accordance with Section 2908.40(a)(1) to the payer and has established connectivity between the payer and the health care provider's or clearinghouse's system;

C) can submit required documentation in accordance with this Part; and

D) can receive and process any acceptance or rejection acknowledgment from the payer.

b) Complete Electronic Medical Bill

1) To be considered a complete electronic medical bill, the bill or supporting transmission shall:

A) Be submitted in the correct billing format, with the correct billing code sets as set forth in Section 2908.50;

B) Be transmitted in compliance with the format requirements described in Section 2908.40;

C) Include in legible text the supporting documentation that is minimally necessary under the current version of the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) for the bill that is in the possession of the provider, including, but not limited to, medical reports and records, including, but not limited to, evaluation reports, narrative reports, assessment reports, progress reports/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;

D) Identify the:

i) Injured employee;

ii) Employer;

iii) Insurance carrier, third party administrator, managed care organization or its agent;

iv) Health care provider; and

v) Medical service or product.

2) Any electronically submitted bill determined to be complete but not paid or objected to within 30 days shall be subject to interest pursuant to Section 8.2(d)(3) of the Act.

c) Acknowledgment

1) An Interchange Acknowledgment (TA1), as specified in Section 2908.40(a)(2)(A)(i), notifies the sender of the receipt of, and certain structural defects associated with, an incoming transaction.

2) An Implementation Acknowledgment (ASC X12 999) transaction as specified in Section 2908.40(a)(2)(A)(ii) 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) A Health Care Claim Acknowledgment (ASC X12 277CA) transaction as specified in Section 2908.40(a)(2)(A)(iii) 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 code.

4) A payer shall acknowledge receipt of an electronic medical bill by returning an Implementation Acknowledgment (ASC X12 999) within one business day after 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 this subsection (c).

B) A health care provider or its agent shall not submit a duplicate electronic medical bill earlier than 60 business 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 Status Response or Acknowledgment (ASC X12 277CA) transaction (detail acknowledgment) within two business days after 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 or guides.

B) A health care provider or its agent shall not submit a duplicate electronic medical bill earlier than 30 business 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 shall be transmitted by means of an 835 transaction.

B) The subsequent rejection of a previously accepted electronic medical bill shall occur no later than 30 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 the reason for rejection is that the payer is not legally liable for its payment.

7) 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 the medical treatment pursuant to the Act.

8) Transmission of an Implementation Acknowledgment (ASC X12 999) under subsection (c)(2), and acceptance of a complete, structurally correct file, serves as proof of the received date for an electronic medical bill in this subsection (c).

d) Electronic Documentation

1) 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 health care provider.

2) Complete electronic documentation shall be submitted by secure fax, secure encrypted electronic mail, first class U.S. Mail, or in conformity with Section 2908.40(a).

3) The electronic transmittal by fax or electronic mail must be submitted, either by secure fax or by secure encrypted electronic mail or any other secure electronic format, and shall contain the following details prominently on its cover sheet or first page of the transmittal:

A) The name of the injured employee;

B) Identification of the worker's employer if known, 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, when applicable, its agent;

D) Date or 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.

4) When requested by the payer, a health care provider or its agent shall submit electronic documentation within 14 business days after the request. Electronic documentation may be submitted simultaneously with the electronic medical bill or may be submitted separately within 14 business days after successful submission of the electronic medical bill.

5) If electronic transmittal of documentation proves to be impossible or infeasible, the documentation will be sent via first class mail to the address of record for the payer. Documentation transmitted via first class mail must contain the following details prominently:

A) The name of the injured employee;

B) Identification of the worker's employer to the extent known, 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, when applicable, its agent;

D) Dates of service; and

E) The workers' compensation claim number assigned by the payer, if established by the payer.

6) When a signed release is required from the injured worker before release of requested records, the request is not complete and actionable until the medical provider or its agent has received a valid, signed release form.

e) Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)

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) A payer shall provide an ERA in accordance with 50 Ill. Adm. Code 9110.90.

3) The ERA shall contain the appropriate Group Claim Adjustment Reason Codes, Claim Adjustment Reason Codes (CARC) and associated Remittance Advice Remark Codes (RARC) as specified by the ASC X12 Technical Report Type 2 (TR2) Workers' Compensation Code Usage Section for pharmacy charges, the NCPDP Reject Codes, National Council for Prescription Drug Programs, 9240 East Raintree Drive, Scottsdale AZ 85260 (http://www.ncpdp.org/standards\_info.aspx) (July 2012, no later amendments or editions), denoting the reason for payment, adjustment or denial. Instructions for the use of the ERA and code sets are found in section 7.4 of the IAIABC eBill Companion Guide.

4) In addition to the requirements of Section 8.2(d)(2) of the Act, the ERA shall be sent before 5 days after:

A) the expected date of receipt by the medical provider of payment from the payer; or

B) the date the bill was rejected by the payer.

f) Payers shall accept from health care providers paper medical bills for payment in the formats set forth in 50 Ill. Adm. Code 2017 as applicable to the service rendered.

g) A payer shall not accept or submit a duplicate paper medical bill from a health care provider or its agent earlier than 30 business days from the date originally submitted unless the payer has returned the medical bill as incomplete in accordance with Section 2908.70. A payer may accept a corrected paper medical bill after the return of an incomplete medical bill. The corrected medical bill is submitted as a new, original bill.

h) Unless the payer or its agent is exempted from the electronic medical billing process in accordance with 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 Section 2908.40.

i) No party to the electronic transactions shall charge excessive fees to 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.

j) A payer may accept 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 payer may accept 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.

k) 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, or that the electronic transaction includes data elements that exceed those required for a complete bill as enumerated in subsection (b).

l) A payer may offer to a health care provider electing to submit bills electronically, who has not implemented a software system capable of sending standard transactions, an Internet-based direct data entry system 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 must use the appropriate data content and data condition requirements of the standard transactions.

m) Exemption

1) The Director of Insurance may grant exemptions to employers and insurance carriers who are unable to accept medical bills electronically.

2) Requests must be submitted in writing to the Director of Insurance.

3) Grounds for exemption will be based on the following factors:

A) Premium volume;

B) Number of policyholders; and

C) Expense to comply would be burdensome.

(Source: Amended at 43 Ill. Reg. 9237, effective August 19, 2019)