ADVISORY NO. 491

TOPIC: REPORTING REQUESTS FOR RECONSIDERATION

The data window for the 2014 Performance Based Oversight process for carrier performance will open on January 1, 2014. The agency has retained the four measures used in 2012 (timely initiation of TIBs; timely processing of initial medical bills; timely submission of initial payment of TIBs data; and timely submission of initial medical bill processing) while adding a fifth measure (timely processing of request for reconsideration of medical bills).

Based on industry feedback, DWC allocated the following weight to the timeliness of medical bill and reconsideration measures as follows:

- Timely processing of initial medical bills by the insurance carrier – 30% weight
- Timely processing of request for reconsideration medical bills by the insurance carrier – 10% weight

All measures will be based on data transactions occurring between January 1, 2014 and June 30, 2014.

The inclusion of a new measure based on requests for reconsideration has caused many system stakeholders to evaluate their EDI reporting performance for the reconsideration transaction.

The DWC will be monitoring the reporting of reconsiderations to ensure that insurance carriers are using the proper ANSI code to report reconsiderations and to make sure the W3 code is used to report payments made as the result of the reconsideration of a denied medical bill.

There is a great deal of confusion within the industry over when reporting a W3 is required. The Division has stated its belief that Rule 134.804(a), which took effect September 1, 2011, requires insurance carriers to report a W3 data element in every reconsideration situation. Reporting the W3 in this manner allows the Division to track the number of reconsiderations there have been requested, regardless of whether there has been an additional payment. Note also that Rule 134.804(d)(2) provides, in part, that an EDI record is considered to have been accurately submitted when the record, where applicable, contains the same data as the source medical bill and explanation of benefits.

Reporting the Request for Reconsideration Transaction

The Division has provided the following explanation of its expectations to our office regarding the reporting of a request for reconsideration. The guidance is different, depending upon whether a payment is being made, or not, on reconsideration.

When no Addition Payment is Made

When the carrier makes no additional payment on reconsideration, the Division expects the following reporting to occur. The trading partner should report the W3 (for reporting purposes) (see also Rule 134.804(d)), as well as the fact a zero payment has been made. It is not wrong to include the CARC 193 with this report, but that is considered to be an optional data element. The W3 must always be reported when it is a reconsideration bill – along with any other applicable CARCs to explain why payment wasn't made (e.g. not medically necessary, no documentation, past timeframe, etc.).

When Additional Payment is Made

When the carrier makes an additional payment on reconsideration, the Division expects the following reporting to occur. The trading partner should report the W3 (for reporting purposes) (see also Rule 134.804(d)), as well as the amount of the additional payment that has been made. The carrier should also report the CARC code (or multiple CARC codes, where appropriate) that explains the additional payment (when less than the charged amount). The W3 must always be reported when it is a reconsideration bill.