STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

FINAL STATEMENT OF REASONS AND UPDATED INFORMATIVE DIGEST

Subject Matter of Regulations: Workers' Compensation – Electronic and Standardized Medical Treatment Billing

TITLE 8, CALIFORNIA CODE OF REGULATIONS
Section 9792.5 et seq.

The Acting Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.4, 4603.5, and 5307.3, has amended and adopted the following sections of Division 1, Chapter 4.5, Subchapter 1, of title 8, California Code of Regulations, relating to electronic and standardized medical treatment billing:

Section 9792.5	**Payment for Medical Treatment. [Amend]**
Section 9792.5.0	**Definitions. [Adopt]**
Section 9792.5.1	**Medical Billing and Payment Guide; Electronic Medical Billing and Payment Companion Guide; Various Implementation Guides. [Adopt]**
Section 9792.5.2	**Standardized Medical Treatment Billing Forms/Formats, Billing Rules, Requirements for Completing and Submitting Form CMS 1500, Form CMS 1450 (or UB 04), American Dental Association Form, Version 2002, NCPDP Workers' Compensation / Property and Casualty Universal Claim Form, Payment Requirements. [Adopt]**
Section 9792.5.3	**Medical Treatment Bill Payment Rules. [Adopt]**

UPDATED INFORMATIVE DIGEST

The Acting Administrative Director incorporates the Informative Digest prepared in this matter. There have been no changes in applicable laws or to the effect of the proposed regulations from the laws and effects described in the Notice of Proposed Regulatory Action.

UPDATE OF INITIAL STATEMENT OF REASONS

The Acting Administrative Director incorporates the Initial Statement of Reasons prepared in this matter. The purposes and rationales for the regulations as set forth in the

Initial Statement of Reasons continue to apply unless otherwise noted in the Final Statement of Reasons. The proposed regulations changes are summarized below.

THE FOLLOWING SECTIONS WERE ADOPTED OR AMENDED FOLLOWING THE PUBLIC HEARING AND WERE CIRCULATED FOR A 15-DAY COMMENT PERIOD (There were three 15-day comment periods as follows: Revised first 15-day comment period: January 13, 2011 -January 28, 2011; Second 15-day comment period: February 1 – 16, 2011; Third 15-day comment period: February 17 – March 4, 2011)

Modifications to Section 9792.5 Payment for Medical Treatment

The introductory sentence was modified to specify that the section is applicable to medical treatment rendered before a date that is exactly 180 days after the effective date of the regulation. The Division will be requesting OAL to insert the exact date here, and in all other points in the regulations where an exact date is to be determined in relation to the effective date of the regulations.
Specific Purpose of Change: Based on comments from the stakeholders, it was determined that the effective date of the regulations, essentially the date when the new standardized billing rules will go into effect for paper billing, should be 180 days to allow sufficient time for the reprogramming of existing systems and training of staff to comply with the new requirements. The modification is intended to clarify that the existing section will continue to apply to bills/payments that are not subject to the new rules.

Subdivisions (b), (c): Added language indicating that a governmental entity must pay a medical bill within 60 working days rather than 45 working days, and would be subject to penalty and interest for failure to pay within 60 working days.
Specific Purpose of Change: The purpose of the change is to conform to the statutory provision that governmental entities have 60 working days to pay a bill.

Subdivision (f): Deleted this subdivision which refers to the appeals board ordering payment of interest on contested bills later determined to be payable.
Specific Purpose of Change: The statutory authority for the provision was repealed in 2006 by AB 1806 (Statutes 2006, Chapter 69.)

Add new subdivision (f) which was re-lettered (e) to provide that for services rendered prior to January 1, 2004 the claims administrator shall pay any uncontested amount within 60 days after receipt of the bill and that any amount not contested within the 30 working days or not paid within the sixty day period shall be increased 10% and carry interest retroactive to the date of receipt of the bill.
Specific Purpose of Change: This subdivision is needed to maintain the payment period, objection period, interest rate, and penalty increase that were applicable to services prior to the statutory amendment which took effect in 2004.

Modifications to Heading for Article 5.5.0

The heading was modified to specify that the Article is effective for medical treatment billing and payment on or after a date that is 180 days after the effective date of the regulation.
Specific Purpose of Change: Based on comments from the stakeholders, it was determined that the effective date of the regulations, essentially the date when the new standardized billing rules will go in effect, should be 180 days to allow sufficient time for the reprogramming of existing systems and training of staff to comply with the new requirements.

Modifications to Section 9792.5.0 Definitions

Added definitions of “assignee” and “billing agent” and deleted definition of “third party biller/assignee.”
Specific Purpose of Change: This was done to clarify the roles of assignees and billing agents. Additionally, the division has learned that the term “third party biller” is sometimes used to refer to someone who is acting under an assignment of rights, however the division intended the phrase to cover persons acting as agents rather than assignees. Therefore for clarity a definition of “billing agent” was added and it replaces “third party biller” throughout the regulations.

Added language to the definition of “health care provider” to state that the term means a provider of medical treatment, goods and services “provided pursuant to Labor Code section 4600….”
Specific Purpose of Change: This was necessary for clarification since Labor Code section 4600 defines the scope of compensable medical treatment.

The definitions were renumbered due to the addition/deletion of definitions.

Modifications to Section 9792.5.1 Medical Billing and Payment Guide; Medical Billing and Payment Companion Guide; Various Implementation Guides.

Section 9792.5.1 (a):
The date of the *California Division of Workers’ Compensation Medical Billing and Payment Guide* was updated from 2010 to 2011 since it will not become effective until 2011.
Specific Purpose of Change: The purpose of this change was to reflect the year the Guide will become effective.

The website to obtain the Guide was changed to the main Department of Industrial Relations’ website address.
Specific Purpose of Change: This will provide greater stability for the web address since interior links may change more frequently as the web site is periodically reorganized.

California Division of Workers' Compensation Medical Billing and Payment Guide, 2011, which is incorporated by reference, was modified as follows.

- Modified title page to insert 2011 instead of 2010. **Specific Purpose of Change:** The purpose of this change was to reflect the year the Guide will become effective.
- Updated Table of Contents. **Specific Purpose of Change:** To reflect the changes made throughout the Guide.
- Modified Introduction page to: specify that the effective date for required acceptance of electronic bills will be in 2012, 18 months after adoption of the regulations, specify that the paper billing rules become effective 180 days after adoption, and the term "Third Party Billers" was replaced with the term "Billing Agents." **Specific Purpose of Change:** The purpose of these changes was to reflect the year the Guide will become effective and to comply with the statutory requirement that the electronic billing regulations are effective 18 months after the effective date; to clarify that the paper billing rules are effective 180 days after adoption to allow sufficient time for the reprogramming of existing systems to comply with the new requirements; and to be consistent with the new definition of "billing agents."
- 1.0(a) Added a definition of "assignee" as assignees are required to adhere to the billing rules. The former definition of "Third Party Biller/Assignee" was deleted. **Specific Purpose of Change:** The definition was added for clarity.
- 1.0(c) Added a definition of "balance forward bill". **Specific Purpose of Change:** The definition was added for clarity.
- 1.0(d) Modified definition of "bill" to include the concept of the electronic bill format. **Specific Purpose of Change:** The revision was made to clarify that "bills" refers to both paper bills on the uniform billing forms and electronic bills in the proper format.
- 1.0(e) Added a definition of "Billing Agent" to replace the term "Third Party Biller" for clarity. **Specific Purpose of Change:** The division has learned that the term "third party biller" is sometimes used to refer to someone who is acting under an assignment of rights, however the division intended the phrase to cover persons acting as agents rather than assignees. Therefore for clarity a definition of "billing agent" was added and it replaces "third party biller" throughout the document.
- 1.0(i) was modified to delete "written authorization" from the definition of "complete bill." **Specific Purpose of Change:** The statute does not require the "written authorization" to be provided with an electronic bill, so it was deleted from the definition of "complete bill" which applies to both paper and electronic bills.
- 1.0(k) Added a definition of "duplicate bill." **Specific Purpose of Change:** to clarify that a bill that is exactly the same as a previous bill except for the "billing date" is a duplicate.
- 1.0(n) Modified definition of "Explanation of Review" and deleted "ANSI" (American National Standards Institute) from the title of the Claim Adjustment Group Codes, Claim Adjustment Reason Codes, and Remittance Advice Remark

Codes. **Specific Purpose of Change:** to improve clarity of which codes to use for paper bills and which to use for electronic bills.

- 1.0(t) Modified definition of "supporting documentation" to reference "written authorization" only for paper bills.
  Specific Purpose of Change: To conform to Labor Code §4603.2 which requires any written authorization that the provider has received to be submitted with the bill. There is no legal requirement to submit a copy of written authorization with an electronic bill.
- 1.0(u) Deleted the definition of the term "Third Party Biller/Assignee" as the combined term was ambiguous since "third party biller" may be used to refer to either an agent or, especially in the area of pharmaceutical billing, an assignee.
  Specific Purpose of Change: The division has learned that the term "third party biller" is sometimes used to refer to someone who is acting under an assignment of rights, however the division intended the phrase to cover persons acting as agents rather than assignees. Therefore for clarity a definition of "billing agent" was added and it replaces "third party biller" throughout the document.
- 1.0(w) Modified the definition of "required report." **Specific Purpose of Change:** to provide further detail on the citations of the reports.
- 1.0(x) Modified to delete "any written authorization received from the claims administrator" from the initial definition of "supporting documentation." However, a sentence was added to state: "For paper bills, supporting documentation includes any written authorization for services that may have been received by the physician." **Specific Purpose of Change:** The changes were made to conform to Labor Code §4603.2.
- 1.0(aa) Added reference to "Medicare Severity Diagnosis Related Group (MS-DRG)" to the definition of "Diagnosis Related Group." **Specific Purpose of Change:** to improve the clarity.
- 1.0 Renumbered the definitions due to the deletion and insertion of definitions.
- 2.0(a) Standardized Medical Treatment Billing Format subdivision (a) was modified to provide that the rules for paper medical treatment billing will be effective for bills submitted 180 days after the adoption of the regulation rather than 90 days and to clarify name and dates of paper forms/forms manuals.
  Specific Purpose of Change: Based on comments from the stakeholders, it was determined that the effective date of the regulations, essentially the date when the new standardized billing rules will go into effect, should be 180 days to allow sufficient time for the reprogramming of existing systems and training of staff to comply with the new requirements. The corrections to the names of the paper forms and manuals were made for clarity.
- 2.0(b) was modified by changing the date from 2011 to 2012 and to add language clarifying that parties may engage in electronic billing and remittance prior to the effective date of the regulation upon mutual agreement. **Specific Purpose of Change:** to correct the year that the electronic billing rules will be effective and clarify that the parties may engage in electronic billing and remittance prior to the effective date of the regulation upon mutual agreement.
- 3.0 Deleted subdivision (a) that stated that bills must be complete before payment time frames begin. **Specific Purpose of Change:** The statement may have

caused confusion regarding the time frames for payment where a bill is placed in "pending status" due to a missing claim number or attachment.

- Renumbered remaining subdivisions.
- 3.0(a) Modified the complete submission language. **Specific Purpose of Change:** to clarify that a claims administrator may populate missing information if it has previously been received.
- 3.0(a)(4) Added subdivision (a)(4) to specify that a "complete bill submission" includes required reports and supporting documentation as specified in subdivision (b). **Specific Purpose of Change:** to clarify what constitutes a "complete bill."
- 3.0(b) Modified to add clarifying language that the required reports and supporting documentation are to be "sufficient to support the level of service or code that has been billed". **Specific Purpose of Change:** This language was moved up from subdivision (b)(10) to improve accuracy and clarity. Subdivision (b)(10) has language added to clarify that the claims administrator may request appropriate additional information after the bill is received, and not only prior to receipt of the bill.
- 3.0(b)(5) Deleted modifiers -19 and -21 from the listing of modifiers giving rise to the need for a medical report. **Specific Purpose of Change:** to delete modifiers that no longer exist.
- 3.0(b)(8) Added a requirement that an operative report be provided for facility fees for surgical services. **Specific Purpose of Change:** to clarify the operative report is required for either professional or facility surgery services fees.
- 3.0(b)(9) Added language indicating that an invoice or other proof of documented paid costs should be submitted when required by the Official Medical Fee Schedule for reimbursement. **Specific Purpose of Change:** to clarify that if there is a requirement to provide proof of documented paid costs, it can be found in the OMFS.
- 3.0(b)(10) Deleted language regarding supporting documentation that was moved to the introductory sentence of (b). Added language to clarify that the claims administrator may request appropriate additional information after the bill is received, and not only prior to receipt of the bill. **Specific Purpose of Change:** The deleted language was moved to subdivision (b) to improve accuracy and clarity. The new sentence was added to clarify that the claims administrator may request appropriate additional information after the bill is received, and not only prior to receipt of the bill.
- 3.0(b)(11) Added language that written authorization that was received by the physician must be provided for paper bills. **Specific Purpose of Change:** This was added to comply with the requirement in Labor Code section 4603.2(b)(1).
- 4.0(a) and (b) Substituted the term "Billing Agent" for the term "Third Party Biller." **Specific Purpose of Change:** The division has learned that the term "third party biller" is sometimes used to refer to someone who is acting under an assignment of rights, however the division intended the phrase to cover persons acting as agents rather than assignees. Therefore for clarity a definition of "billing agent" was added and it replaces "third party biller" throughout the document.

- 4.0(c) Added a new subdivision (c) to insert language to clarify that the billing agent or assignee has no greater right to reimbursement than the principal or assignor. **Specific Purpose of Change:** to clarify that the billing rules themselves do not give rise to the right to submit bills.
- 5.0(a) Revised explanation of duplicate bill. **Specific Purpose of Change:** to clarify what constitutes a "duplicate bill" and to specify how such bills are marked as duplicates at the time of bill submission.
- 5.0(c) Revised language regarding how balance forward bills will be handled. **Specific Purpose of Change:** to clarify what constitutes a "balance forward bill" and how it may be rejected.
- 6.0(a) Added modifying language regarding submitted complete bills. **Specific Purpose of Change:** to clarify the language regarding the time frame for payment of uncontested medical treatment.
- 6.0(b)(1) and (g) Modified to delete term "ANSI," inserted language to require the DWC Explanatory Messages to be used along with the DWC Bill Adjustment Reason Codes for providing the basis for objections to the bill submitter for paper bills, and modified the references to the DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk and Explanation of Review Paper Table to conform to the changes to the titles of those tables. **Specific Purpose of Change:** to revise the references' names and to clarify what must be in the notice of objection and explanation of review.
- 7.1 Added introductory language. **Specific Purpose of Change:** to improve clarity by providing context for the acknowledgment and payment processes involved in handling a bill that is received electronically.
- 7.1 Medical Treatment Billing and Payment Requirements for Electronically Submitted Bills is modified to insert the words "Health Care Claim" into the title of "ASC X12N/005010X221 Health Care Claim Payment/Advice (835)" and modified the provisions to utilize the updated 5010 versions of the acknowledgments rather than the 4010 versions. **Specific Purpose of Change:** to accurately refer to the document update to the 5010 versions which are the versions that will be mandatory under the Health Insurance Portability and Accountability Act (HIPAA) as of January 1, 2012. This carries out the statutory directive of Labor Code §4603.4 to be as consistent with HIPAA as feasible.
- 7.1(a)(3)(A) Added language to clarify the process for "pending" a claim for up to five days if the claim number is missing or if there is a missing attachment. Clarify that the 15 day timeframe to pay or object to the electronic bill is suspended while the bill is pending, but that the timeframe resumes when the claim number is affixed to the claim, or the attachment is received. The 15 day time period does not begin anew. Modified timeframes to conform the timeframe for payment to other provisions by specifying that the timeframe for payment is 15 "working" days, and the pending period is 5 "working" days. **Specific Purpose of Change:** to clarify the 15 day timeframe process and to be consistent and clear that the 15 days are "working days."
- 7.1(a)(3)(A) Modified timeframes to delete language allowing a claims administrator to reject a bill as incomplete if it has previously provided the claim number to the provider and the bill does not have the claim number. Subdivision

(a)(3)(A) is also modified to provide that the claims administrator may reject a bill as incomplete if it is unable to locate and affix a claim number to a bill within the five working day pending period. **Specific Purpose of Change:** to clarify how to handle a bill if the claim number is not included.

- 7.1(a)(3)(B) Deleted the word "shall" in the phrase "bill rejection error messages shall include…." **Specific Purpose of Change:** to correct the meaning of the phrase. Any one of the error messages may be used.
- 7.1(b) Added the words "Denial" and "Objection" in the title and added an introductory paragraph to clarify the time frame for paying/objecting to an electronic bill, and the effect of the "pending period" to extend the time frame by the number of days the bill was in pending status. **Specific Purpose of Change:** to clarify how to transmit bills that have not been rejected at the acknowledgment stage.
- 7.1(b)(1) and (2) Modified the language to specify that the "claims administrator," rather than "the employer," must pay uncontested medical treatment within 15 working days after receipt of an electronic bill. Modified the language to provide separate subdivisions for "Complete Bill – Payment for Uncontested Medical Treatment" and "Objection to Bill / Denial of Payment" to clarify the provisions. Modified the subdivision to insert the words "Health Care Claim" into the title of "ASC X12N/005010X221 Health Care Claim Payment/Advice (835)" to correct an erroneous omission. Add language stating that any contested portion of the billing shall be paid in accordance with Labor Code section 4603.2, to conform to the last sentence of Labor Code section 4603.4. **Specific Purpose of Change:** to clarify the process of paying for uncontested medical treatment and objecting to the bill.
- 7.1(b)(2) Deleted language regarding the objection and explanation that is duplicative of provisions set forth in other provisions of the Medical Billing and Payment Guide, the Electronic Medical Billing and Payment Companion Guide, or in the electronic transaction sets. **Specific Purpose of Change:** the deleted language was duplicative.
- 7.3 Modified to make grammatical changes.
- 7.3(a) Electronic Bill Attachments subdivision (a) was revised to say that "Unless otherwise agreed by the parties" all attachments to support an electronically submitted bill must have a header or attached cover sheet as provided. **Specific Purpose of Change:** to clarify that the parties may agree to other methods for attachments.
- 7.3(d)(3) Modified the provision regarding bill attachment method to specify that email must be encrypted email. **Specific Purpose of Change:** to provide greater security for the transmission of personal health information.
- Appendix A, 1.0 CMS 1500. Modified to adopt the newest version of the 1500 Health Insurance Claim Form Reference Instruction Manual, Version 6.0 07/10. **Specific Purpose of Change:** to adopt the newest version of the 1500 Health Insurance Claim Form Reference Instruction Manual.
- Appendix A, 1.1 Field Table CMS 1500, Field 11 was modified to delete the provision that only a first billing by the provider could enter the value of "unknown" for the claim number field. **Specific Purpose of Change:** to provide

that if the provider does not know the claim number, they may still submit the bill whether it is the first bill or a subsequent bill.

- Appendix A, 1.1 Field Table CMS 1500, Field 12 was modified to provide that Patient's or Authorized Person's Signature is Optional rather than Required. **Specific Purpose of Change:** to allow the signature to be "Optional" because the NUCC 1500 Claim Form Instruction Manual for Item Number 12 allows the box to state "Signature on File," "SOF," or contain the legal signature. In addition, it allows the field to be left blank or to state "No Signature on File" if a signature is not on file. There is no workers' compensation law requiring a signature on a medical treatment bill.
- Appendix A, 1.1 Field Table CMS 1500, Field 14 "Date of Current Illness, or Injury or Pregnancy" was modified to provide further direction on the date to enter. The initial California Workers' Compensation Instruction stated "Enter the Date of Accident/Illness." The adopted instruction is: "For specific injury: Enter the date of incident or exposure. For Cumulative Injury or Occupational Disease Enter: The last date of occupational exposure to the hazards of the occupational disease or cumulative injury." **Specific Purpose of Change:** To improve the clarity the instructions were expanded. For a specific injury, the word "incident" is more accurate than "accident" as it is broader and covers more of the specific occurrences that can give rise to a workers' compensation claim, such as an on-the-job assault, or an injury sustained by lifting a heavy box. For an illness that occurs as a result of a one-time event, the instruction to enter "the date of exposure" is clearer than the initial instruction to enter the "date of illness." For "cumulative injury" and "occupational disease," the "date of injury" can be a very factually and legally complex issue, many times leading to litigation. The Division has adopted the instruction to enter the "date of last occupational exposure to the hazards of the occupational disease or cumulative injury" to provide a clear date for the medical provider to enter for a cumulative injury. This instruction has also been selected as it is consistent with the date used for cumulative trauma or occupational disease claims in the Electronic Adjudication Management System (EAMS) (which is the court case management system for the workers' compensation adjudication system) and in the Workers' Compensation Information System (WCIS) established pursuant to Labor Code §138.6. The Division rejected some public suggestions to adopt the following definition: "the date that the employee first suffered disability from cumulative injury or occupational disease and knew (or should have known) that the disability was caused by employment." This definition is from Labor Code section 5412, in a portion of the Labor Code dealing with statute of limitations. The employer can raise the issue of the applicability of Labor Code §5412, if the issue of the statute of limitations is relevant. The billing rules identify the usage of the "date of current illness or injury field" for purposes of billing only; the ultimate legal issue of the "date of injury" is complex and may need to be resolved through litigation at the Workers' Compensation Appeals Board if the parties to a claim cannot reach agreement. The instruction preferred by the Division, the last date of occupational exposure to the hazards of the occupational disease or cumulative injury, is based on Labor Code section 5500.5 which

provides that liability for cumulative injury or disease is "limited to those employers who employed the employee during [the one year] immediately preceding either the date of injury, as determined pursuant to Section 5412, or the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury, whichever occurs first." However, for clarity and consistency, for purposes of billing only, the "last exposure" date is preferable and is adopted for the billing rules.

- Appendix A, 1.1 Field Table CMS 1500, Field 16. Changed this data element relating to dates patient unable to work in current occupation from "N" not applicable, to "O" optional, and deleted the workers' compensation instructions. **Specific Purpose of Change:** The language is deleted because there is no necessity for the prior language which stated that inclusion of data regarding the dates unable to work could cause rejection of the bill. Although the "dates unable to work" are not necessary to determine if the bill is payable, the data should be optional for the provider as there is no harm caused by providing it.
- Appendix A, 1.1 Field Table CMS 1500, Field 22. Added language to clarify the instructions for resubmitting a bill as a revision or for reconsideration. **Specific Purpose of Change:** to clarify the instructions.
- Appendix A, 1.1 Field Table CMS 1500, Field 23 Added language to the instructions to provide that the data element is required if a prior authorization, referral, concurrent review, or voluntary certification *number* was received. **Specific Purpose of Change:** to include the word "number" in order to improve the clarity of the instruction.
- Appendix A, 1.1 Field Table CMS 1500, Field 31 "signature of physician or supplier" was changed from "R" (required) to "O" (optional). **Specific Purpose of Change:** There is no statutory requirement that providers sign a medical bill.
- Appendix A, 1.1 Field Table CMS 1500, Field 32 "service facility location information" was changed from "S" (situational) to "R" (required). **Specific Purpose of Change:** to require the service facility location information. The location that the service was provided is important information that should be provided to the payer. The facility location codes cover a broad range of service locations and provide necessary information to the claims administrator.
- Appendix A, 1.1 Field Table CMS 1500 , Field 32b "other ID #" for service facility location was modified to add a comment directing the provider to enter the state license number if the provider is not eligible for an NPI. **Purpose of Change:** This directive will ensure that important identifying information is provided to the claims administrator.
- Appendix A, 1.1 Field Table CMS 1500, Field 33 Added language to give further instruction regarding the billing provider field if an assignee is to be the payee. **Purpose of Change:** to require identification if the assignee is the payee .
- Appendix A, 2.0 UB-04. Added language to 2.0 UB-04 to identify that the UB-04 form incorporated into the NUBC Data Specifications Manual is revised in 2005, and to incorporate by reference the latest version of the manual, i.e. the National Uniform Billing Committee Official UB-04 Data Specifications Manual 2011, Version 5.0, July 2010, including the UB-04 form revised 2005. **Specific Purpose of Change:** to adopt the newest version of the NUBC manual.

- Section One, Appendix A, 2.1 Field Table UB-04, Form Loc 31-34a, b was modified to provide further direction on entering the date in the field "Occurrence Codes and Dates" The adopted additional instruction is: "For specific injury: Enter the date of incident or exposure. For Cumulative Injury or Occupational Disease Enter: The last date of occupational exposure to the hazards of the occupational disease or cumulative injury." **Specific Purpose of Change:** To improve the clarity the instructions were expanded. For a specific injury, the word "incident" is adopted as it is broad enough to cover the range of specific occurrences that can give rise to a workers' compensation claim, such as an on-the-job assault, or an injury sustained by lifting a heavy box. For an illness that occurs as a result of a one-time event, the instruction to enter "the date of exposure" is clearer than the initial instruction to enter the "date of occupational injury/illness." For "cumulative injury" and "occupational disease," the "date of injury" can be a very factually and legally complex issue, many times leading to litigation. The Division has adopted the instruction to enter the "date of last occupational exposure to the hazards of the occupational disease or cumulative injury" to provide a clear date for the medical provider to enter for a cumulative injury. This instruction has also been selected as it is consistent with the date used for cumulative trauma or occupational disease claims in the Electronic Adjudication Management System (EAMS) (which is the court case management system for the workers' compensation adjudication system) and in the Workers' Compensation Information System (WCIS) established pursuant to Labor Code §138.6. The Division rejected some public suggestions to adopt the following definition: "the date that the employee first suffered disability from cumulative injury or occupational disease and knew (or should have known) that the disability was caused by employment." This definition is from Labor Code section 5412, in a portion of the Labor Code dealing with statute of limitations. The employer can raise the issue of the applicability of Labor Code §5412, if the issue of the statute of limitations is relevant. The billing rules identify the usage of the "date of current illness or injury field" for purposes of billing only; the ultimate legal issue of the "date of injury" is complex and may need to be resolved through litigation at the Workers' Compensation Appeals Board if the parties to a claim cannot reach agreement. The instruction preferred by the Division, the last date of occupational exposure to the hazards of the occupational disease or cumulative injury, is based on Labor Code section 5500.5 which provides that liability for cumulative injury or disease is "limited to those employers who employed the employee during [the one year] immediately preceding either the date of injury, as determined pursuant to Section 5412, or the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury, whichever occurs first." However, for clarity and consistency, for purposes of billing only, the "last exposure" date is preferable and is adopted for the billing rules.
- Appendix A, 2.0 UB-04. 2.1 Field Table UB-04, Form Locator 52a, the Release of Information Certification Indicator was changed from "R" to "O" to ensure that a release of information form executed by the patient is optional but not required. **Specific Purpose of Change:** HIPAA does not apply to workers' compensation,

and information released to comply with workers' compensation laws does not require the patient's signed release. Since the patient's signed release is not required for workers' compensation it should be an optional field.

- Appendix A, 2.0 UB-04. 2.1 Field Table UB-04, Form Locator 56, instructions were inserted to clarify the applicability of the "situational" requirement of the National Provider Identifier – Billing Provider. The situational requirement to provide the NPI becomes a mandatory requirement if the billing provider is *eligible* for an NPI. **Specific Purpose of Change:** to require the use of the NPI for all providers who are eligible to obtain an NPI in order to streamline processing of bills through the national standard identifier.
- Appendix A, 2.0 UB-04. 2.1 Field Table UB-04, Form Locator 57, instructions were inserted to require the provision of the Medicare ID number if the facility has been assigned one, or the state license number if no Medicare ID number has been assigned. **Specific Purpose of Change:** to allow efficient processing of the bills because determining the maximum allowable payment to inpatient hospitals, outpatient hospital departments, and ambulatory surgical centers depends in large part on fee schedule provisions that are linked to the Medicare Provider ID number.
- Appendix A, 3.1 Field Table NCPDP Workers' Compensation/Property and Casualty UCF. For consistency, amended the Table Heading NCPDP 5.1 Data Element to NCPDP D.0 Data Element.   **Specific Purpose of Change:** to update the table to the most current electronic standard being adopted.
- Section One, Appendix A, 3.1 Field Table NCPDP, Field 11 was modified to provide one date for specific injury and one date for cumulative injury. **Specific Purpose of Change:** To improve the clarity the instructions were expanded. For a specific injury, the word "incident" is adopted as it is broad enough to cover the range of specific occurrences that can give rise to a workers' compensation claim, such as an on-the-job assault, or an injury sustained by lifting a heavy box. For an illness that occurs as a result of a one-time event, the instruction to enter "the date of exposure" is clearer than the initial instruction to enter the "date of occupational injury/illness." For "cumulative injury" and "occupational disease," the "date of injury" can be a very factually and legally complex issue, many times leading to litigation. The Division has adopted the instruction to enter the "date of last occupational exposure to the hazards of the occupational disease or cumulative injury" to provide a clear date for the medical provider to enter for a cumulative injury. This instruction has also been selected as it is consistent with the date used for cumulative trauma or occupational disease claims in the Electronic Adjudication Management System (EAMS) (which is the court case management system for the workers' compensation adjudication system) and in the Workers' Compensation Information System (WCIS) established pursuant to Labor Code §138.6. The Division rejected some public suggestions to adopt the following definition: "the date that the employee first suffered disability from cumulative injury or occupational disease and knew (or should have known) that the disability was caused by employment." This definition is from Labor Code section 5412, in a portion of the Labor Code dealing with statute of limitations. The employer can raise the issue of the applicability of Labor Code §5412, if the

issue of the statute of limitations is relevant. The billing rules identify the usage of the "date of current illness or injury field" for purposes of billing only; the ultimate legal issue of the "date of injury" is complex and may need to be resolved through litigation at the Workers' Compensation Appeals Board if the parties to a claim cannot reach agreement. The instruction preferred by the Division, the last date of occupational exposure to the hazards of the occupational disease or cumulative injury, is based on Labor Code section 5500.5 which provides that liability for cumulative injury or disease is "limited to those employers who employed the employee during [the one year] immediately preceding either the date of injury, as determined pursuant to Section 5412, or the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury, whichever occurs first." However, for clarity and consistency, for purposes of billing only, the "last exposure" date is preferable and is adopted for the billing rules.

- Appendix A, 3.1 Field Table NCPDP Workers' Compensation/Property and Casualty UCF, Field 99 modified to provide that the "Usual & Customary Charge" field is "R" instead of "O". In addition, language is added to the Comments column to explain that the usual and customary price does not include the dispensing fee, which is to be entered in Field 102. Also, the California Workers' Compensation Instruction Column is modified to delete an erroneous reference to Labor Code section 5307.1(a) and to direct the provision of the usual and customary *price* which is the term used in the DWC fee schedule calculator. **Specific Purpose of Change:** Since the OMFS for pharmaceuticals is the lesser of the usual and customary price or the amount that would be paid under Medi-Cal, it is necessary for the usual and customary price to be required and to delete the incorrect cite.
- Appendix A, 4.0 ADA 2006 was modified to specify the updated dental coding manual, the CDT 2011-2012: ADA Practical Guide to Dental Procedure Codes, including the ADA 2006 Dental Claim Form, and delete reference to the Current Dental Terminology Fourth Edition (CDT-4) 2009/2010. **Specific Purpose of Change:** to adopt the newest version of the ADA Guide and Form.
- Appendix A, 4.1 Field Table ADA 2006, field 1 was modified to specify that the field shall be used to indicate a duplicate bill by writing the word "duplicate" in the field. The data element is indicated to be situational. **Specific Purpose of Change:** to provide that the data element is only required where a duplicate was being submitted.
- Appendix A, 4.0 ADA 2006, Field 46 was modified to provide one date for specific injury and one date for cumulative injury. **Specific Purpose of Change:** To improve the clarity the instructions were expanded. For a specific injury, the word "incident" is adopted as it is broad enough to cover the range of specific occurrences that can give rise to a workers' compensation claim. For an illness that occurs as a result of a one-time event, the instruction to enter "the date of exposure" is clearer than the initial instruction to enter the "date of occupational injury/illness." For "cumulative injury" and "occupational disease," the "date of injury" can be a very factually and legally complex issue, many times leading to litigation. The Division has adopted the instruction to enter the "date of last

occupational exposure to the hazards of the occupational disease or cumulative injury" to provide a clear date for the medical provider to enter for a cumulative injury. This instruction has also been selected as it is consistent with the date used for cumulative trauma or occupational disease claims in the Electronic Adjudication Management System (EAMS) (which is the court case management system for the workers' compensation adjudication system) and in the Workers' Compensation Information System (WCIS) established pursuant to Labor Code §138.6. The Division rejected some public suggestions to adopt the following definition: "the date that the employee first suffered disability from cumulative injury or occupational disease and knew (or should have known) that the disability was caused by employment." This definition is from Labor Code section 5412, in a portion of the Labor Code dealing with statute of limitations. The employer can raise the issue of the applicability of Labor Code §5412, if the issue of the statute of limitations is relevant. The billing rules identify the usage of the "date of current illness or injury field" for purposes of billing only; the ultimate legal issue of the "date of injury" is complex and may need to be resolved through litigation at the Workers' Compensation Appeals Board if the parties to a claim cannot reach agreement. The instruction preferred by the Division, the last date of occupational exposure to the hazards of the occupational disease or cumulative injury, is based on Labor Code section 5500.5 which provides that liability for cumulative injury or disease is "limited to those employers who employed the employee during [the one year] immediately preceding either the date of injury, as determined pursuant to Section 5412, or the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury, whichever occurs first." However, for clarity and consistency, for purposes of billing only, the "last exposure" date is preferable and is adopted for the billing rules.

- Appendix A, 4.0 ADA 2006, Field 48 billing dentist or dental entity field was modified to restore the "R" that was inadvertently deleted from the table. Phone number was deleted as this is duplicative of Field 52 that requires the phone number of the entity listed in box 48. **Specific Purpose of Change:** to require the billing dentist or dental entity identifying information and to delete the duplicative request for the phone number.
- Appendix A, 4.1 Field Table ADA 2006, Field 49. Provider ID NPI Number's Comments column was modified to specify that the situational data element is required if the billing provider is eligible for an NPI. **Specific Purpose of Change:** to require the use of the NPI for all providers who are eligible to obtain an NPI in order to streamline processing of bills through the national standard identifier.
- Appendix A, 4.1 Field Table ADA 2006, Field 50. The Comments column regarding "License Number (state license)" was modified to specify that the situational data element is required if the billing provider is not eligible for an NPI. If the provider is not eligible for an NPI the state license number will be required in order to provide an identifier that can be confirmed by the claims administrator. **Specific Purpose of Change:** to require the use of the NPI for all

providers who are eligible to obtain an NPI in order to streamline processing of bills through the national standard identifier.

- Appendix B. Standard Explanation of Review (EOR). This section was substantially rewritten to improve the clarity of the provisions. The language was separated into a section for paper EORs and Electronic EORs. For paper EORs there is improved language explaining the use of 3.0 Table for Paper Explanation of Review. Language was added to allow a claims administrator to include additional messages and data in order to provide further detail to the provider in a paper Explanation of Review. There is also clarified language regarding the use of the Table 1.0 DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk. For electronic EORs additional instruction is given relating to four specified CARCs that will require the payer to communicate statutory code reference to the provider to explain the reason for reduction or denial. This approach is based on the International Association of Industrial Accident Boards and Commission's work with the ASC X12 committee to adapt the HIPAA-compliant 835 for workers' compensation usage. **Specific Purpose of Change:** to adapt the national standards for the special needs of workers' compensation. Language was deleted in order to improve clarity and eliminate duplicative provisions.
- Appendix B, Table 1.0. Modified the title to "*California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk.*" **Specific Purpose of Change:** to improve the clarity regarding the contents of the table.
- Appendix B, Table 1.0. G1, G2, G6 are kept the same, but the corollary CARC W1 was modified. **Specific Purpose of Change:** to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. G3. Deleted the words "(Note: To be used for Workers; Compensation.)" **Specific Purpose of Change:** to delete unnecessary language.
- Appendix B, Table 1.0. G9 and G10 language was moved over from the CA Payer Instructions column to the Remittance Advice Remark Code Descriptions column as a note. **Specific Purpose of Change:** the notes are related to RARCs and do not apply to the paper EORs.
- Appendix B, Table 1.0. G56. The DWC Explanatory Message was expanded to include a balance forward bill which contains a duplicate charge. The CA Payer Instructions column is also modified to clarify that the code may be used to reject a complete duplicate or a balance forward bill. **Specific Purpose of Change:** to clarify the explanatory message and to provide a code to reject a bill that is a complete duplicate or balance forward bill.
- Appendix B, Table 1.0. G60 is kept the same, but the corollary CARC 191 was modified. **Specific Purpose of Change:** to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. G72 Modified to add a DWC Bill Adjustment Reason Code G72 that would notify the provider of an interim Explanation of Review informing the provider of the conduct of a retrospective utilization review as there was no indication of prior authorization. The Table also adopts CARC and RARC codes that together will equate to the G72 message. **Specific Purpose of Change:** to provide a code that would notify the provider of an interim

Explanation of Review informing the provider of the conduct of a retrospective utilization review where there was no indication of prior authorization.

- Appendix B, Table 1.0. The DWC Bill Adjustment Reason Codes are renumbered due to the addition of G72.
- Appendix B, Table 1.0. G74 (former G73) was corrected as the "Issue" column was erroneously repeated in the DWC Explanatory Message Column. New language is added to the Explanatory Message and CA Payer Instructions column for clarity. The CARC is revised to delete CARC 17 which was eliminated by the national code committee. The CARC 226 is added. Conforming change is made to the Table 2.0 Matrix in CARC Order. **Specific Purpose of Change**: to correct errors, provide greater clarity, and conform to the changes made by the national code committee.
- Appendix B, Table 1.0 G75 (former erroneously numbered "second" G73) Modified the DWC Explanatory Message column to provide greater clarity as the prior message was inconsistent with the Issue column. Code numbers and language were added to the CARC and RARC columns. The CARC "Patient cannot be identified as our insured" was deleted as it is not a good fit for workers' compensation and could be confusing. **Specific Purpose of Change**: to correct errors and provide greater clarity.
- Appendix B, Table 1.0. G79 (former G77) Moved language erroneously listed in the CA Payer Instructions column to the RARC column. **Specific Purpose of Change**: to correct an error.
- Appendix B, Table 1.0. G80 (former G78). Language was added that was inadvertently omitted. Deleted CA Payer Instruction column language as it is not an instruction for the paper EOR. Move the Alert language that is RARC N437 from the CA Payer Instruction column to the RARC column where it belongs. **Specific Purpose of Change**: to correct errors and provide greater clarity.
- Appendix B, Table 1.0. G81 A new code G81 was added. **Specific Purpose of Change**: to adopt a message to explain that penalty and interest are being added to the payment and to adopt a corollary CARC.
- Appendix B, Table 1.0. PM7 Issue column regarding the provider billing more than four physical medicine and/or chiropractic and/or acupuncture codes on the same visit without prior authorization was reworded. **Specific Purpose of Change**: to provide greater clarity.
- Appendix B, Table 1.0. PM10 is kept the same, but the corollary CARC W1 is modified. **Specific Purpose of Change**: to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. PM12 was modified. **Specific Purpose of Change**: to clarify that the code is to be used where *pre-surgical* physical therapy, chiropractic or acupuncture exceeds the 24-visit cap. For post-surgical visits, other messages regarding authorization would be applicable; there is no need for a specialized code.
- Appendix B, Table 1.0. S5, S6, S7 and S10 were kept the same, but the corollary CARC W1 was modified. **Specific Purpose of Change**: to add new language adopted by the national code maintenance committee.

- Appendix B, Table 1.0. S8 was modified to add DWC Explanatory Message language to notify the surgeon that the bill is rejected as no operative report has been received and directs the surgeon to resubmit the bill with operative report for reconsideration. **Specific Purpose of Change**: This language is important as it conveys critical information to the provider about what is missing to support the bill.
- Appendix B, Table 1.0. S11 was modified to add the word "surgeon." **Specific Purpose of Change**: the word was erroneously omitted and was therefore inserted for clarity.
- Appendix B, Table 1.0. P1 is kept the same, but the corollary CARC W1 was modified. **Specific Purpose of Change**: to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. DME4 is kept the same, but the corollary CARC W1 was modified. **Specific Purpose of Change**: to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. SS2 and SS4 are kept the same, but the corollary CARC W1 was modified. **Specific Purpose of Change**: to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. F3, F4, F5 and F6 are kept the same, but the corollary CARC W1 was modified. **Specific Purpose of Change**: to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. M1 is kept the same, but the corollary CARC 214 was modified. **Specific Purpose of Change**: to add new language adopted by the national code maintenance committee.
- Appendix B, Table 1.0. M4 is kept the same, but the corollary CARC 221 was modified. **Specific Purpose of Change**: to add new language adopted by the national code maintenance committee.
- Appendix B, Table 2.0 Matrix List in CARC Order. This list was modified to reflect the modifications in Table 1.0 California DWC ANSI Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk. **Specific Purpose of Change**: to be consistent the modifications in Table 1.0 California DWC ANSI Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk.
- Appendix B, Table 3.0 Table for Paper Explanation of Review. The title of the table was revised to remove the word "standard" and replace it with "for Paper." Deleted the word "field" from the title of the table and from the first and third column headers. First column is renamed "Data Item No." Some rows have been deleted because they did not contain data requirements and the items have been renumbered. **Specific Purpose of Change**: The term "Standard" does not convey useful meaning and the words "Data Item No." and "for paper" have been added to improve the clarity regarding the scope of the table. The term "Field" in the title was unnecessary and confusing.
- Appendix B, Table 3.0. former Fields 2 (Purpose) and 36 (Claim Filing Indicator Codes) were deleted. **Specific Purpose of Change**: These fields were unnecessary and therefore confusing.
- Appendix B, Table 3.0. Fields 2 (method of payment), 3 (payment ID number), 4 (payment date) and 33 (total paid) were changed from "R" to "S" and language is

added to the comments column. Since the EOR is used where there is a denial of all payment, as well as to explain payment, there would be no data for Fields 2, 3, and 4 in a denial of payment circumstance. Thus, these Fields must be Situational, i.e. only required where there is a payment. **Specific Purpose of Change**: to correct the requirements indicator so that if there is no payment made, there is no requirement for the data item.

- Appendix B, Table 3.0. Fields 8 (payer contact name) and 9 (payer contact number). Language has been added to explain that the situational field becomes required if there is no payment or payment less than billed charges, and in Field 9, column 3, a typographical error is deleted. **Specific Purpose of Change**: This extra language is necessary because a provider may need the contact name and phone number to discuss non-payment or reduced payment, but is unlikely to need the contact name and number if payment is made in full.
- Appendix B, Table 3.0. Bill Level Adjustment Information – Situational. The first sentence is deleted because it may be confusing. **Specific Purpose of Change**: to improve clarity.
- Appendix B, Table 3.0. Field 39 and Field 51 Field Description columns are revised to delete the word "description" and insert the phrase "and DWC Explanatory Message." Field 39 was made plural as there may be more than one DWC bill adjustment reason code and explanatory message. Conforming changes were made to the comments column. **Specific Purpose of Change**: This is necessary as the word "description" is ambiguous, and what is intended is that the paper EOR will include the DWC Bill Adjustment Reason Code and the DWC Explanatory Message.
- Section Two – Transmission Standards. This section was modified to show that the effective date of electronic transaction standards is 18 months after adoption which will be in 2012 rather than 2011. This section lists all of the transaction standards used in electronic billing, acknowledgment, remittance/payment/advice and documentation, for the convenience of the public. The transaction sets are incorporated by reference into the regulation text and the Electronic Medical Billing and Payment Companion Guide, not in the Medical Billing and Payment Guide but are listed here for convenience. **Specific Purpose of Change**: The listing is modified to reflect the updated transaction standards which are proposed for adoption and the effective date is updated to reflect the proper year.
- Section Two Transmission Standards, 3.0 Obtaining Transaction Standards was modified to delete reference to Washington Publishing Company and insert reference to Data Interchange Standards Association (DISA) as the source for purchasing the standards. The NCPDP internet address was moved for clarity. **Specific Purpose of Change**: to provide the correct reference for purchasing the standards.
- Section Two Transmission Standards, 4.0 Electronic Signatures. This section was deleted as it is unnecessary. **Specific Purpose of Change**: There is no legal requirement for the electronic bills to be signed. In addition, although an electronic signature rule was proposed for HIPAA implementation, a final rule has never been adopted.

Section 9792.5.1 (b):

The date of the *California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide* was updated from 2011 to 2012 since it will not become effective until 2012.
Specific Purpose of Change: The purpose of this change was to reflect the year the Guide will become effective.

The website to obtain the Guide was changed to the main Department of Industrial Relations' website address.
Specific Purpose of Change: This will provide greater stability for the web address since interior links may change more frequently as the web site is periodically reorganized.

California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, 2012, which is incorporated by reference, was modified as follows:

The date of the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide was updated from 2010 to 2012, since the guide will not become effective until 18 months after adoption. **Specific Purpose of Change**: The effective date is updated to reflect the proper year.

Modifications are made throughout the Companion Guide to make the provisions more consistent with the ASC X12N 005010 Technical Reports Type 3, including changes made because of comments received from the ASC X12 as a result of their preliminary review of the guide.

- Correction of the references to Technical Reports Type 3, including elimination of the use of the term "implementation guide" to refer to the ASC X12 Technical Reports.
- Revision of the references to Technical Reports Type 3 to adhere to the format conventions of the ASC X12 as requested by the Data Interchange Standards Association (DISA) that holds the copyright to the Technical Reports Type 3.
- The Source of the ASC X12 Technical Reports is changed to the Data Interchange Standards Association (DISA) and the Washington Publishing Company is deleted.
- Reference to the American National Standards Institute (ANSI) is deleted.
- Changes are made to correct various technical references, including Loops and Segments, and to delete material that duplicates material in the Technical Reports Type 3.
- Modifications were made to eliminate any usage of the K3 segment for the Technical Reports Type 3 as they must be pre-approved by the ASC X12.
- The "Value" column is deleted from each of the tables for the ASC X12 Technical Reports since the value information is included in the comments column where the value requires special workers' compensation instruction.

Specific Purpose of Change: to make the provisions more consistent with the ASC X12N 005010 Technical Reports Type 3.

The website to obtain the Guide is changed to the main Department of Industrial Relations' website address. **Specific Purpose of Change:** This will provide greater stability for the web address since interior links may change more frequently as the web site is periodically reorganized.

- The first page was modified by titling it "Preface" and an entry is added to the Table of Contents. Information is inserted to acknowledge the copyrights held by the Data Interchange Standards Association on behalf of the ASC X12 committee and the National Council on Prescription Drug programs respectively. The ASC X12's copyrighted guides are set forth by name, with an indication of the shortened titles of each guide. The NCPDP's copyrighted electronic billing guides are set forth by name. **Specific Purpose of Change**: to acknowledge the copyrights held by the Data Interchange Standards Association on behalf of the ASC X12 committee and the National Council on Prescription Drug programs respectively.
- A Change Control Table template and explanatory language was proposed to alert the public to changes in the Companion Guide over time. Information is set forth regarding the method of changing the Companion Guide, including the fact that changes will be accomplished through formal rulemaking under the Administrative Procedure Act. **Specific Purpose of Change**: to provide a procedure to alert the public to changes in the Companion Guide over time.
- The Table of Contents was modified. **Specific Purpose of Change**: to update headings and page numbers.
- The term "third party biller/assignee" was replaced throughout the documents with "billing agent/assignee." **Specific Purpose of Change:** The division has learned that the term "third party biller" is sometimes used to refer to someone who is acting under an assignment of rights, however the division intended the phrase to cover persons acting as agents rather than assignees. Therefore for clarity a definition of "billing agent" was added and it replaces "third party biller" throughout the document.
- 1.2 The references to the electronic transaction standards were modified to reflect the updated standards proposed for adoption. For clarity, "IAIABC" is spelled out to reflect the organization's complete name - the International Association of Industrial Accident Boards and Commissions. Also, language that stated "Wherever there is a difference between the national standard and this guide, the rules from this guide will prevail" was deleted. **Specific Purpose of Change**: The sentence was deleted to improve clarity as the sentence could cause confusion and was also deleted to improve consistency with the ASC X12 Type 3 Technical Reports. The references were updated and IAIABC was spelled out for clarity.
- 2.1 The compliance date was modified to specify exactly 18 months after adoption, and the year 2012 is inserted to replace 2011. **Specific Purpose of Change**: This will update the effective date in light of the date of completion of the rulemaking action.

- 2.1.3 Confidentiality of Medical Information was modified to make grammatical corrections and to correct the reference to the Security Rule which is in Appendix D, not Appendix E. **Specific Purpose of Change**: to correct the grammatical and typographical errors.
- 2.2 National Standard Formats was modified to correct the references to the titles of the ASC X12 electronic billing standards. It was also modified to update the 5010 ASC X12 transaction sets (deleting the 4010 transaction sets) and to insert references to the updated retail pharmacy NCPDP Telecommunication standard D.0 (deleting version 5.1) and Batch Standard 1.2 (deleting 1.1). Deleted one paragraph regarding acknowledgments and moved substance of information, with reorganization, to the bulleted list of non-HIPAA national standards. In addition the language is changed to refer to billing and remittance standards specified by federal regulations rather than "contained in" federal regulations. **Specific Purpose of Change**: to reference the updated titles, transaction sets, and references and to improve clarity
- 2.2.1 California Prescribed and Optional Formats. Modified the title to include the word "and Optional." Modified date to specify 2012 effective year rather than 2011, as the rulemaking will not be complete in time for 2011 effective date due to 18 month lead in time. Deleted each reference to an electronic transaction standard document incorporated by reference and inserted replacement references to updated electronic transaction standard documents. This updates all of the ASC X12 documents to the 5010 standards from the 4010 standards, and updates the retail pharmacy documents to NCPDP Telecommunication standard D.0 (deleting version 5.1) and Batch Standard 1.2 (deleting 1.1). This section was also modified to incorporate by reference the errata and addenda to ASC X12N/005010 Technical Reports Type 3. **Specific Purpose of Change**: It is necessary to delete the old standards and adopt the new standards in order to prevent the workers' compensation electronic billing standards to be out of step with the national standards at the time the regulations take effect. As of January 1, 2012 the electronic standards under HIPAA rules will require use of the 5010 standards and the NCPDP Telecommunication standard version D.0 and Batch Standard 1.2. Labor Code section 4603.4 requires the Division to adopt electronic billing rules that are consistent with HIPAA to the extent feasible. The 5010 standards and the updated NCPDP standards support the use of ICD-10CM and ICD-10PCS code sets which will be HIPAA mandated codes sets as of October 2013. The Division is anticipating moving to the ICD-10 from the current ICD-9 and the use of billing standards which accommodate ICD-10 is an important feature of the billing system.
- 2.2.2 Added a new section 2.2.2 Source of Prescribed Formats to provide information regarding reference to Data Interchange Standards Association (DISA) as the source for purchasing the standards. The NCPDP internet address was moved for clarity. **Specific Purpose of Change**: to provide the corrected reference for purchasing the standards and improving clarity.
- 2.2.3 Renumbered, previously 2.2.2. Updated the table which is a "Summary of Adopted Formats and Correlation to Paper Form." **Specific Purpose of Change**:

to correct the reference to the National Council on Prescription Drug Programs (NCPDP) Workers' Compensation Property and Casualty Universal Claim Form.

- 2.2.4 Renumbered, previously 2.2.3. Revised the table which sets forth suggested Optional Formats. **Specific Purpose of Change**: to update the table.
- 2.3 Renumbered to correct error, previously 2.4. All the sections which follow in Chapter two are renumbered.
- 2.3 Companion Guide Usage was modified to spell out "Technical Report Type 3" in place of "TR3s." Language is added to clarify that the Guide is not intended to exceed the requirements or usage of the ASC X12 Technical Reports Type 3 or the NCPDP Implementation Guides. **Specific Purpose of Change**: to make the provisions more consistent with the ASC X12N 005010 Technical Reports Type 3.
- 2.4.1 Language was modified to reference the ASC X12 Technical Reports for submitter/receiver information rather than duplicating Loop instructions that are contained in the Technical Reports. "Sender" is changed to "submitter" to use the Technical Reports language. **Specific Purpose of Change**: to conform to the terminology used in the TR3s for consistency.
- 2.4.4 Injured Employee Identification was modified to specify that the Social Security Identification Number is to be populated in the REF segment of Loop 2010 CA rather than in the NM109 segment of Loop 2010BA. **Specific Purpose of Change**: This is the result of changes made in the usage by the 5010 errata that have been issued.
- 2.4.5 Claim Identification (initially 2.5.5) Modified to specify that the claim number is reported in "REF02 in Loop 2010CA" rather than in "REF segment of Loop 2010CA." Modified to specifically name each of the Type 3 Technical Reports: the 005010X222, 005010X223 and 005010X224. The section was also modified to delete the second and third paragraphs. **Specific Purpose of Changes**: The identification of the segment was changed in order to make a technical correction to the identification of the segment for the property and casualty claim number which is REF02 in Loop 2010CA. Specific reference to each of the Type 3 Technical Reports for billing was adopted in order to improve the clarity of the section. The second paragraph of the initial proposal, which stated that the California companion guide instructions for the REF02 segment of Loop 2010CA differ from the ASC X12N 837 Implementation Guide, was deleted as it was redundant and unnecessary. The introductory material to each data element table in the Companion Guide for each Type 3 Technical Report (Professional, Institutional, Dental) states that the table identifies instructions that are different from the HIPAA implementation so there is no reason to reiterate that in 2.4.5. (Section 3.3, Section 4.3, Section 5.3.) The third paragraph of the initial proposal was deleted as redundant and unnecessary because it is a narrative reiteration of the data instructions for REF02 contained in the data element table for each of the Type 3 Technical Reports: 3.3.1 ASC X12N/00501X222 Health Care Claim: Professional (837); 4.3.1 ASC X12N/00501X223 Health Care Claim: Institutional (837); and 5.3.1 ASC X12N/00501X224 Health Care Claim: Dental (837).

- 2.4.7 Document/Attachment Identification (formerly 2.5.7) deleted a paragraph regarding identification of documentation or attachments because it is duplicative of information in the TR3s, the Medical Billing and Payment Guide, and the Electronic Medical Billing and Payment Companion Guide. Added the word "encrypted" to electronic mail to conform to the requirement that email be encrypted in the Medical Billing and Payment Guide and the word "working" to describe the 5 day period. Also deleted a paragraph which is obsolete as it references the 4010 standard, and has broad and vague language that is not helpful. **Specific Purpose of Changes**: Deleted duplicative paragraph, added the word "encrypted" to comply with the requirement in the Guide, added the word "working" for clarity, and deleted an obsolete paragraph.
- 2.6.1 Hierarchical Structure (formerly 2.6.1) deleted the substantive information about the hierarchical structure of the transaction sets but retains the reference to the ASC X12N's Technical Report Type 3s. This section was also modified to change the source of the ASC X12 Technical Reports Type 3 from Washington Publishing Company to Data Interchange Standards Association (DISA.) **Specific Purpose of Change**: This modification was made to avoid duplication of material in the Technical Report Type 3s that are incorporated by reference, and to avoid ambiguity that can result from truncating the technical hierarchal information. DISA is the correct source for the ASC X12 Technical Reports Type 3.
- 2.6 Description of Formatting Requirements was modified to add reference to the NCPDP guide. **Specific Purpose of Change**: for clarity.
- 2.6.1, 2.7 and 2.8 are modified to correct the source of the Technical Reports Type 3 to DISA. **Specific Purpose of Change**: for consistency and clarity.
- 2.8 Description of Code Sets was modified to update the reference to the dental codes to those contained in CDT 2011-2012: ADA Practical Guide to Dental Procedure Codes. The term "ANSI" was deleted. **Specific Purpose of Change**: to update to the most recent dental codes and to properly refer to the title of the codes.
- 2.9 was modified by deleting the word "guides." **Specific Purpose of Change**: to correct the syntax of the sentence.
- 2.9.2 and 2.9.3 were modified by replacing the word "sender" with "submitter," replacing the word "third party biller" with "billing agent", and correcting the transaction standards. **Specific Purpose of Change**: for consistency and clarity.
- 2.9.10 was modified by replacing the word "third party biller" with "billing agent." **Specific Purpose of Change**: for consistency and clarity.
- 2.11.1 (formerly 2.12.1) added updated reference to identify the segments to be used for the professional and dental NUBC Condition Codes for a resubmission to conform with the updated 5010 billing transaction standards. **Specific Purpose of Change:** to conform with the updated 5010 billing transaction standards.
- 2.11.2 (formerly 2.12.2) Duplicate Bill Transaction Prior to Payment added updated reference to identify segments to be used for indicating a duplicate billing for professional billing and dental billing to conform with the updated 5010 billing transaction standards. This section was also modified to add a provision that the NUBC Condition Codes are not used for dental Billing as the 0050X224

does not accommodate them. **Specific Purpose of Change:** to conform with the updated 5010 billing transaction standards.

- 2.11.3 (formerly 2.12.3) deleted a paragraph. **Specific Purpose of Change:** the deleted paragraph was confusing in part, and duplicative in part.
- 2.11.4 Appeal/Reconsideration Bill Transactions was modified to conform to Technical Report Type 3 language which strongly recommends, rather than requires, the CLM01 is a unique identifier. **Specific Purpose of Change:** to conform with the Technical Report Type 3.
- 2.12 Balance Forward Billing was modified to specify that a "balance forward bill" is also a "summary of accumulated unpaid balances." **Specific Purpose of Change**: for consistency and clarity.
- 2.13.2 Transaction Set Purpose Code replaced the term "insurance carriers" with the term "claims administrators." **Specific Purpose of Change**: for consistency and clarity because California workers' compensation claims are not handled only by insurance carriers. "Claims administrator" is the more accurate term used to reference the entity that will be using the transaction set purpose code.
- 2.14.4 FEIN/NPI. The entire section was deleted. **Specific Purpose of Change**: The section was duplicative of instructions contained in the TR3s and NCPDP guides.
- 2.13.5 Jurisdictional State Code: Compliance State Identification was deleted. **Specific Purpose of Change**: The section was not compliant with ASC X12 Technical Report Type 3 usage.
- Chapter 3 Introductory paragraph modified the references to the professional billing transaction standard to update to the 5010 standard adopted in Section 2.2.1. Also, to improve clarity: 1) the last sentence which states that California rules prevail where national standards differ from California rules is deleted, and 2) language is added to explain that the Companion guide is a supplement to the ASC X12 guide where specialized workers' compensation direction is needed. Chapter 3 is modified throughout to spell out "Technical Report Type 3" in place of "TR3s," to delete "implementation guide," to more fully identify the 005010X222 by adding the words "Health Care Claim: Professional (837)" and to correct the source for the reference information to DISA. **Specific Purpose of Change**: to make the provisions more consistent with the ASC X12N 005010 Technical Reports Type 3, to update the reference information and provide the reference for purchasing the standards.
- 3.3.1 Deleted the entire chart that set forth specialized California workers' compensation instructions for the 4010 professional billing transaction standard. Adopted an updated chart that sets forth specialized California workers' compensation instructions for the 5010 professional billing transaction standard (ASC X12N/005010X222 Health Care Claim: Professional (837)). The Workers' Compensation Instructions column for 2010CA REF, Property and Casualty Claim Number was changed: to add language providing that a bill missing a claim number shall be placed in pending status for up to 5 working days to attach the claim number; and to delete the language "for California Workers' Compensation." The Workers' Compensation Instructions column for 2300 DTP Accident Date was changed; the initial proposal stated merely "Required when

the condition reported is for an occupational accident/injury" while the adopted version adds instructions for the date to enter for a "specific injury" and for a "cumulative injury or occupational disease."

Specific Purpose of Change: The new chart is necessary to provide instructions for using the national standard, HIPAA-compliant, 005010X222 for workers' compensation instead of the 4010 standards initially proposed. This is intended to carry out Labor Code §4603.4's direction to adopt standards that are compliant with HIPAA to the extent feasible. HIPAA mandates the use of the 5010 standards for HIPAA-covered entities as of January 1, 2012. The prior chart for the 4010 needed to be altered to conform to the 5010 technical changes as some loops and segments have a different usage in the 5010, to delete language that duplicates material in the Technical Report Type 3, and to conform to changes required by the Data Interchange Standards Association (DISA), the entity that holds the copyright of the Type 3 Technical Reports on behalf of the Accredited Standards Committee X12 subcommittee (ASC X12), and to improve the clarity of the chart. The instruction for 2010CA REF requiring a bill missing a claim number to be pended for up to 5 working days was adopted in order to increase efficiency in the billing process. Since providers may not know the claim number assigned by the claim administrator, the bill processing will be expedited by specifying that the claims administrator shall use up to 5 working days to match the bill to the claim and claim number in its system. The language "for California workers' compensation" was deleted from the 2010CA REF instruction as it was redundant since the title of the column is "California Workers' Compensation Instructions." Additional instruction was added to the 2300 DTP Accident Date in order to provide greater clarity for the public as to the date to enter and to increase the consistency of the date used for purposes of billing. Modifications to the chart to delete usage of the K3 segment were adopted in order to comply with the intellectual property requirements of DISA, which will not approve a Companion Guide to the Type 3 Technical Report which uses a K3 segment unless exemptions have been granted.

- Chapter 4, Introductory paragraph modified the references to the institutional billing transaction standard to update to the 5010 standard adopted in Section 2.2.1. Chapter 4 was modified throughout to spell out "Technical Report Type 3" in place of "TR3s" and updated the reference to the institutional billing standard to the ASC X12N/005010X223 Health Care Claim: Institutional (837). Also, 1) the last sentence which states that California rules prevail where national standards differ from California rules is deleted, and 2) language is added to explain that the Companion guide is a supplement to the ASC X12 guide where specialized workers' compensation direction is needed. **Specific Purpose of Change**: to update the reference information, to make the provisions more consistent with the ASC X12N 005010 Technical Reports Type 3 and to improve clarity.
- 4.3.1 Deleted the entire chart that set forth specialized California workers' compensation instructions for the 4010 institutional billing transaction standard. Adopted an updated chart that sets forth specialized California workers' compensation instructions for the 5010 institutional billing transaction standard

(ASC X12N/005010X223 Health Care Claim: Institutional (837)). The Workers' Compensation Instructions column for 2010CA REF, Property and Casualty Claim Number was changed: to add language providing that a bill missing a claim number shall be placed in pending status for up to 5 working days to attach the claim number; and to delete the language "for California Workers' Compensation." The Workers' Compensation Instructions column for 2300 DTP Accident Date was changed; the initial proposal stated merely "Required when the condition reported is for an occupational accident/injury" while the adopted version adds instructions for the date to enter for a "specific injury" and for a "cumulative injury or occupational disease."

Specific Purpose of Change: The new chart is necessary to provide instructions for using the national standard, HIPAA-compliant, 005010X223 for workers' compensation instead of the 4010 standards initially proposed. This is intended to carry out Labor Code §4603.4's direction to adopt standards that are compliant with HIPAA to the extent feasible. HIPAA mandates the use of the 5010 standards for HIPAA-covered entities as of January 1, 2012. The prior chart for the 4010 needed to be altered to conform to the 5010 technical changes as some loops and segments have a different usage in the 5010, to delete language that duplicates material in the Technical Report Type 3, and to conform to changes required by the Data Interchange Standards Association (DISA), the entity that holds the copyright of the Type 3 Technical Reports on behalf of the Accredited Standards Committee X12 subcommittee (ASC X12), and to improve the clarity of the chart. The instruction for 2010CA REF requiring a bill missing a claim number to be pended for up to 5 working days was adopted in order to increase efficiency in the billing process. Since providers may not know the claim number assigned by the claim administrator, the bill processing will be expedited by specifying that the claims administrator shall use up to 5 working days to match the bill to the claim and claim number in its system. The language "for California workers' compensation" was deleted from the 2010CA REF instruction as it was redundant since the title of the column is "California Workers' Compensation Instructions." Additional instruction was added to the 2300 DTP Accident Date in order to provide greater clarity for the public as to the date to enter and to increase the consistency of the date used for purposes of billing. Modifications to the chart to delete usage of the K3 segment were adopted in order to comply with the intellectual property requirements of DISA, which will not approve a Companion Guide to the Type 3 Technical Report which uses a K3 segment unless exemptions have been granted.

- Chapter 5, Introductory paragraph modified the references to the dental billing transaction standard to update to the 5010 standard adopted in Section 2.2.1. Also, to improve clarity: 1) the last sentence which states that California rules prevail where national standards differ from California rules is deleted, and 2) language is added to explain that the Companion guide is a supplement to the ASC X12 guide where specialized workers' compensation direction is needed. Chapter 5 is modified throughout to spell out "Technical Report Type 3" in place of "TR3s" and updated the reference to the institutional billing standard to the ASC X12N/005010X223 Health Care Claim: Dental (837)." **Specific Purpose**

of Change: to update the reference information, to make the provisions more consistent with the ASC X12N 005010 Technical Reports Type 3 and to improve clarity.

- 5.3.1 Deleted the entire chart that set forth specialized California workers' compensation instructions for the 4010 dental billing transaction standard. Adopted an updated chart that sets forth specialized California workers' compensation instructions for the 5010 dental billing transaction standard (ASC X12N/005010X224 Health Care Claim: Dental (837)). The Workers' Compensation Instructions column for 2010CA REF, Property and Casualty Claim Number was changed: to add language providing that a bill missing a claim number shall be placed in pending status for up to 5 working days to attach the claim number; and to delete the language "for California Workers' Compensation." The Workers' Compensation Instructions column for 2300 DTP Accident Date was changed; the initial proposal stated merely "Required when the condition reported is for an occupational accident/injury" while the adopted version adds instructions for the date to enter for a "specific injury" and for a "cumulative injury or occupational disease."
  Specific Purpose of Change: The new chart is necessary to provide instructions for using the national standard, HIPAA-compliant, 005010X224 for workers' compensation instead of the 4010 standards initially proposed. This is intended to carry out Labor Code §4603.4's direction to adopt standards that are compliant with HIPAA to the extent feasible. HIPAA mandates the use of the 5010 standards for HIPAA-covered entities as of January 1, 2012. The prior chart for the 4010 needed to be altered to conform to the 5010 technical changes as some loops and segments have a different usage in the 5010, to delete language that duplicates material in the Technical Report Type 3, and to conform to changes required by the Data Interchange Standards Association (DISA), the entity that holds the copyright of the Type 3 Technical Reports on behalf of the Accredited Standards Committee X12 subcommittee (ASC X12), and to improve the clarity of the chart. The instruction for 2010CA REF requiring a bill missing a claim number to be pended for up to 5 working days was adopted in order to increase efficiency in the billing process. Since providers may not know the claim number assigned by the claim administrator, the bill processing will be expedited by specifying that the claims administrator shall use up to 5 working days to match the bill to the claim and claim number in its system. The language "for California workers' compensation" was deleted from the 2010CA REF instruction as it was redundant since the title of the column is "California Workers' Compensation Instructions." Additional instruction was added to the 2300 DTP Accident Date in order to provide greater clarity for the public as to the date to enter and to increase the consistency of the date used for purposes of billing. Modifications to the chart to delete usage of the NTE and K3 segments were adopted in order to comply with the intellectual property requirements of DISA, which will not approve a Companion Guide to the Type 3 Technical Report which uses a NTE or K3 segment unless exemptions have been granted.
- Chapter 6 introduction, and 6.1-6.10.1 updated references to the *NCPDP Telecommunication Standard Implementation Guide Version* D.0 (instead of

version 5.1) and the *NCPDP Batch Standard Implementation Guide Version 1.2* (instead of 1.1). **Specific Purpose of Change:** to conform to the updated pharmacy transaction standards adopted in 2.2.1. Other changes within the chapter include:

- 6.4 Billing Date. Changed the reference to "electronically submitted pharmacy bills" rather than "electronically submitted pharmacy claims." The section was also modified to make a technical correction by deleting "Claim Segment of the" in referring to the location to communicate the date. **Specific Purpose of Change:** for clarity since the word "bills" is more common in workers' compensation and to make a technical correction.
- 6.6 Fill Number v. Number of Fills Remaining was modified to delete the statement regarding derivation of the number of refills remaining. **Specific Purpose of Change:** to delete an erroneous statement.
- 6.10.1 Deleted the entire chart that sets forth specialized California workers' compensation instructions for the NCPDP Telecommunication Standard Implementation Guide Version 5.1. Inserted an updated chart that sets forth specialized California workers' compensation instructions for the NCPDP Telecommunication Standard Implementation Guide Version D.0. Within the new chart, NCPDP Telecommunication Standard Implementation Guide D.0 was modified for Field 435-DZ to specify that the claim number is a situational data element – required only if known by the provider. Language was added to require a bill missing a claim number to be placed in pending status for up to 5 working days to attach the claim number. **Specific Purpose of Change:** The new chart is necessary to provide instructions for using the national standard, HIPAA-compliant, NCPDP Version D.0 for workers' compensation.
- 6.11 Deleted the entire section designating the ASC X12N 004010A1 as the Alternate Pharmacy Billing Format. **Specific Purpose of Change:** The 4010 transaction standard is no longer suggested for use as it will be superseded by the 5010 standard. In addition, the NCPDP D.0 has made many improvements over the NCPDP 5.1 and should accommodate users efficiently. In addition, the billing rules allow trading partners to agree on alternate formats, so inserting language to that effect in Chapter 6 is duplicative and unnecessary.
- Chapter 7, Introductory paragraph modified the references to the payment/advice transaction standard to update to the 5010 ASC X12N/005010X221 standard adopted in Section 2.2.1. Also, to improve clarity: 1) the last sentence which states that California rules prevail where national standards differ from California rules is deleted, and 2) language is added to explain that the Companion guide is a supplement to the ASC X12 guide where specialized workers' compensation direction is needed. Chapter 7 was modified throughout to spell out "Technical Report Type 3" in place of "TR3s" and modified to correct references to Remittance Advice Remark Codes, Claim Adjustment Reason Codes and Claim Adjustment Group Codes. Technical changes are made to conform to ASC X12N/005010X221 Health Care Claim Payment/Advice (835) usage. **Specific Purpose of Change**: to update the reference information, to make the provisions more consistent with the ASC X12N 005010 Technical Reports Type 3 and to improve clarity.

- 7.4.1 Claim Adjustment Reason Code. A new section was inserted to give more detailed instruction for using CARCs 191, 214, 221 and W1 for the payer to communicate the statutory basis for denial of a claim or reduction at the line level. **Specific Purpose of Change**: These instructions are necessary adaptations of the national standards for the workers' compensation situation.
- 7.5 Remittance Advice Remark Codes were modified to correct name of the matrix in Appendix B – 1.0. **Specific Purpose of Change**: to improve clarity.
- 7.8.1 Deleted the entire chart that sets forth specialized California workers' compensation instructions for the 4010 payment/advice transaction standard. Inserted an updated chart that sets forth specialized California workers' compensation instructions for the 5010 payment/advice transaction standard. **Specific Purpose of Change**: The new chart is necessary to provide instructions for using the national standard, HIPAA-compliant, 005010X221 for workers' compensation.
- Chapter 8 Revisions were made to update references to the ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) and to delete references to the 4010 version of 275. It was also modified to delete unnecessary language "Documentation/Medical Attachment" from the chapter title. Chapter 8 is modified to spell out "Technical Report Type 3" in place of "TR3s." **Specific Purpose of Change**: to update the reference information, to make the provisions more consistent with the ASC X12N 005010 Technical Reports Type 3 and to improve clarity.
- Chapter 9 Acknowledgments. A new introductory paragraph was inserted to provide greater clarity by cross-referencing to Chapter 7 of the Medical Billing and Payment Guide which sets forth time frames for acknowledgments, payment, and remittance advice and for placing bills in a "pending status." Revisions were made to update references to the 5010 ASC X12C/005010X231 Implementation Acknowledgment (999) and the ASC X12N/005010X214 Health Care Claim Acknowledgment (277), deleting references to the 4010 Functional Acknowledgment (997) and the 4010 Health Care Claim Acknowledgment (277). References to the other transaction standards were also updated to the 5010 standards throughout the chapter. Also, spelling was changed from "Acknowledgement" to "Acknowledgment" to conform to the spelling used in the ASC X12 standards. The chapter was further modified by replacing existing flow charts with new flow charts. The new charts correct the references to the Technical Reports Type 3 and also change the timeline language from "Business Day" to "Working Day" to conform to the usage in the Companion Guide and Medical Billing and Payment Guide which are based on working days. **Specific Purpose of Change**: to update the reference information, to make the provisions more consistent with the ASC X12N 005010 Technical Reports Type 3, and to improve clarity.
- 9.2 Clean Bill-Missing Claim Number was modified to clarify that the 5-day pending period is five working days. The section was also modified to delete language allowing a claims administrator to reject a bill as incomplete if it has previously provided the claim number to the provider and the bill does not have

the claim number. **Specific Purpose of Change:** to clarify the time period and how to handle a bill if the claim number is not included.

- 9.3 Clean Bill-Missing Report Pre-Adjudication Hold (Pending Status) and 9.3.1 Missing Report are modified to clarify that the 5-day pending period is five working days. **Specific Purpose of Change**: for consistency and clarity.
- 9.4.3 Health Care Claim Acknowledgment. Added a sentence clarifying that the word "claim" refers to the bill for medical services or goods, not the injured worker's claim for workers' compensation benefits. The section was also modified to state that payers need to use the claim status category and claims status codes as prescribed by the 005010X214 rather than the "most current" codes. **Specific Purpose of Change**: This language is needed because in the workers' compensation context, the word "claim" is often interpreted to be the underlying workers' compensation claim and for clarity.
- Appendix A – Glossary of Terms. "UCF" was deleted as it is a pharmaceutical paper form that is no longer used for workers' compensation billing, and "NCPDP WC/PC UCF" was inserted as it is the paper billing form created by the National Council for Prescription Drug Programs for workers' compensation. **Specific Purpose of Change**: The revisions were made to update the references to the transaction standards.
- Appendix E Electronic and Digital Signature. This section was deleted as it is unnecessary. **Specific Purpose of Change**: There is no legal requirement for the electronic bills to be signed. In addition, although an electronic signature rule was proposed for HIPAA implementation, a final rule has never been adopted.

Section 9792.5.1 (c)

This section was modified to change the source of the ASC X12 Technical Reports Type 3 from Washington Publishing Company to Data Interchange Standards Association (DISA.) The address to obtain the HIPAA approved Technical Reports Type 3 was updated and reformatted for clarity. The term "implementation guide" was changed to "Technical Report Type 3" since this is the term used by the Accredited Standards Committee X12N for the 5010 technical guides. Specifically, this section was modified to adopt the following electronic billing standards:

ASC X12N/005010X222 Health Care Claim: Professional (837)
ASC X12N/005010X222E1 Health Care Claim: Professional Errata (837)
ASC X12N/005010 Technical Reports Type 3 Health Care Claim: Professional Errata (837)
ASC X12N/005010X223 Health Care Claim: Institutional (837)
ASC X12N/005010X223A1 Health Care Claim: Institutional Errata (837)
ASC X12N/005010X223E1 Health Care Claim: Institutional Errata (837)
ASC X12N/005010 Technical Reports Type 3 Health Care Claim: Institutional Errata (837)
ASC X12N/005010X224 Health Care Claim: Dental (837)
ASC X12N/005010X224A1 Health Care Claim: Dental Errata (837)
ASC X12N/005010X224E1 Health Care Claim: Dental Errata (837)

ASC X12N/005010 Technical Reports Type 3 Health Care Claim: Dental Errata (837)

Specific Purpose of Change: The previously proposed 4010 implementation guides will be out of date by the time the regulation is effective; the 5010 guides will be the mandated billing transaction standards for HIPAA-covered entities effective January 1, 2012. Adoption of these standards carries out the statutory directive that the electronic standards be consistent with HIPAA to the extent feasible.

Section 9792.5.1 (d)

This section was modified to adopt updated retail pharmacy billing standards, and to delete the former pharmacy billing standards. The new standards which are adopted are:

- Telecommunication Standard Implementation Guide Version D.0, August 2007, National Council for Prescription Drug Programs
- Batch Standard Implementation Guide, Version 1.2, January 2006, National Council for Prescription Drug Programs

Specific Purpose of Change: The previously proposed pharmacy billing standards will be out of date by the time the regulation is effective; the adopted pharmacy standards will be the mandated billing transaction standards for HIPAA-covered entities effective January 1, 2012. Adoption of these standards carries out the statutory directive that the electronic standards be consistent with HIPAA to the extent feasible.

Section 9792.5.1 (e)

This section was modified to change the source of the ASC X12 Technical Reports Type 3 from Washington Publishing Company to Data Interchange Standards Association (DISA.)

The address to obtain the HIPAA approved Technical Reports Type 3 for acknowledgment and payment/advice was updated and reformatted for clarity. The term "implementation guide" was changed to "Technical Report Type 3" since this is the term used by the Accredited Standards Committee X12N for the 5010 technical guides. Specifically, this section was modified to adopt the following electronic billing standards:
ASC X12C/0050X231 Implementation Acknowledgment for Health Care Insurance (999)
ASC X12N/0050X214 Health Care Claim Acknowledgment (277)
ASC X12N/005010X221 Health Care Claim Payment/Advice (835)
ASC X12N/005010X221E1 Health Care Claim Payment/Advice Errata (835)

Specific Purpose of Change: to reference the proper source for the ASC X12 Technical Reports Type 3 and to reference the most recent standards and guides. The previously proposed 4010 implementation guides will be out of date by the time the regulation is effective; the 5010 guides will be the mandated billing transaction standards for HIPAA-covered entities effective January 1, 2012. Adoption of these standards carries out the

statutory directive that the electronic standards be consistent with HIPAA to the extent feasible.

Section 9792.5.1 (f)

Subdivision (f) was modified to adopt the updated *National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version,* Version 6.0 07/10. The July 2010 version replaces the July 2009 version as the initially proposed version is outdated. **Specific Purpose of Change:** to reference the most recent manual.

Section 9792.5.1 (g)

Subdivision (g) was modified to update the *National Uniform Billing Committee Official UB-04 Data Specifications Manual* from the Version 4.0 dated July 2009 to the Version 5.0 dated July 2010. This modification is necessary as the initially proposed version is outdated. **Specific Purpose of Change:** to reference the most recent manual.

Section 9792.5.1 (i)

Subdivision (i) was modified to update the Current Dental Terminology procedure codes and manual from the 2009/2010 version to the 2011-2012 version. **Specific Purpose of Changes:** to incorporate by reference the most recent procedure codes and manual.

Modifications to Section 9792.5.2: Standardized Medical Treatment Billing Forms/Formats, Billing Rules, Requirements for Completing and Submitting Form CMS 1500, Form CMS 1450 (or UB-04), American Dental Association Form, Version 2002, NCPDP Workers' Compensation / Property and Casualty Universal Claim Form, Payment Requirements. [Adopt]

Subdivisions (a), (c): The sections were modified to specify that the date for compliance with paper medical treatment billing rules is 180 days after the effective date of the regulation rather than 90 days. **Specific Purpose of Changes:** This will allow sufficient time for implementation.

Subdivisions (a), (c): Deleted the term "physician." **Specific Purpose of Changes: "Physicians"** is redundant since physicians are already included in the definition of "health care provider" set forth in section 9792.5.0.

Subdivision (a) substituted the term "billing form" for "claim form." **Specific Purpose of Changes:** to improve clarity since "claim form" often has a specialized meaning in workers' compensation and may be confusing.

Subdivisions (a) and (b) were modified to remove the word "approximately." The placeholder date in subdivisions (a) and (b) was updated to 2011 since the regulation was not effective in 2010. **Specific Purpose of Changes:** to indicate that the subdivisions

will be effective 180 days after adoption of the rule in order to allow adequate implementation time for the public. The date was changed for consistency in light of the date of rulemaking completion.

Subdivision (c) was modified to remove the word "approximately" so that the parenthetical indicates the subdivision will be effective 18 months after adoption of the rule. The placeholder date is updated to 2012 since the regulation will not be effective in 2011. **Specific Purpose of Changes:** A specification of exactly 18 months provides the public the full implementation period set forth in Labor Code §4603.4. The year was changed for clarity.

Subdivision (d) was modified to replace the term "Third Party Biller" with "Billing Agent" for clarity. **Specific Purpose of Change:** The division has learned that the term "third party biller" is sometimes used to refer to someone who is acting under an assignment of rights, however the division intended the phrase to cover persons acting as agents rather than assignees. Therefore for clarity a definition of "billing agent" was added, and the term replaces "third party biller" throughout the regulations.

Modifications to Section 9792.5.3: Medical Treatment Bill Payment Rules. [Adopt]

Subdivision (a): The subdivision was modified to specify that the date for compliance with bill processing and remittance for paper medical treatment billing is 180 days after the effective date of the regulation rather than 90 days. The section parenthetical note was also modified to remove the word "approximately." The placeholder date was updated to 2011. **Specific Purpose of Change:** Based on comments from the stakeholders, it was determined that the implementation date of the regulations, essentially the date when the new standardized billing rules will go in effect, should be exactly 180 days after the effective date to allow sufficient time for the reprogramming of existing systems and training of staff to comply with the new requirements. The changes were made to clarify when the rules will be implemented.

The section was also modified to specify that the subdivision does not apply to processing or payment of bills submitted before the implementation date of the regulation. **Specific Purpose of Change:** This is intended to clarify the applicability of the regulations.

Subdivision (b): The subdivision was modified to remove the word "approximately" so that the parenthetical indicates the provisions relating to payment of electronic medical bills will become effective 18 months after the effective date of the regulation. The placeholder date was updated to 2012. **Specific Purpose of Change:** The changes were made to clarify when the rules will be implemented and to provide the public with the full implementation period set forth in Labor Code §4603.4.

Non-substantive modifications following the close of the 3rd 15-Day Comment Period:

The following nonsubstantive changes that appear in the adopted regulations were made after the close of the 3rd 15-day comment period. They do not have a substantive impact on the regulated public.

Modification to Section 9792.5 Payment for Medical Treatment

Subdivisions (d), (e) and (f) are renumbered to (c), (d), and (e).
Specific Purpose of Change: To correct a numbering error that occurred when the former subdivision (c) was deleted but the remaining subdivisions were not renumbered.

Modification to Section 9792.5.0

Subdivision (a) is modified to replace "payor" with "payer."
Specific Purpose of Change: To conform to the more common spelling.

Modifications to Section 9792.5.1 Medical Billing and Payment Guide; Electronic Medical Billing and Payment Companion Guide; Various Implementation Guides.

The section heading of Section 9792.5.1 is modified to insert the word "Electronic" before the words "Medical Billing and Payment Companion Guide."
Specific Purpose of Change: To improve the clarity of the section heading by identifying the Companion Guide as the *electronic guide*, which is incorporated by reference in Section 9792.5.1(b).

Medical Billing and Payment Guide Section 9792.5.1 subdivision (a)

The word "payor" was changed to "payer" throughout the document (88 replacements.)
Specific Purpose of Change: To conform to the more common spelling.

The pagination was modified to use lower case Roman numerals for the Table of Contents and Introduction, with Arabic numerals starting with page 1 at Section One – Business Rules.
Specific Purpose of Change: To improve the style by conforming to standard pagination and to be consistent with the Electronic Medical Billing and Payment Companion Guide which uses Roman and Arabic numerals for pagination.

The Table of Contents was modified by inserting new page numbers.
Specific Purpose of Change: To update the Table of Contents to accurately reflect the pagination after the strikethrough language was removed.

Section One-Business Rules, 1.0 Standardized Billing / Electronic Billing Definitions is modified to delete subdivision (l), the definition of "electronic signature." The remaining definitions are renumbered.

Specific Purpose of Change: To delete the unnecessary definition as the term is not used anywhere in the Medical Billing and Payment Guide. The provision relating to electronic signature which had been initially proposed in Section Two Transmission Standards, 4.0 was deleted in the 1st 15-day comment period but the conforming deletion to the definition was overlooked.

Appendix A, 2.1 Field Table UB-04 was modified to correct the header placement on the second page and to add the table header to the third page.
Specific Purpose of Change: To correct the formatting of the table.

Appendix A, 4.1 Field Table ADA 2006 was modified to correct the header placement on the second and third pages.
Specific Purpose of Change: To correct the formatting of the table.

Appendix B, Paper Explanation of Review, first paragraph, page 44, deleted the word "Field" in the reference to 3.0 Table for Paper Explanation of Review.
Specific Purpose of Change: To correct the reference to the 3.0 Table as its name was changed in the 2nd 15-day comment period, but this conforming change was overlooked.

Appendix B, 1.0 California DWC Bill Adjustment Reason Code / CARC /RARC / Matrix Crosswalk was modified to add the header to every page of the table as it was missing from several pages.
Specific Purpose of Change: To correct the formatting of the table.

Appendix B, 3.0 Table for Paper Explanation of Review was modified to correct the header placement on page two.
Specific Purpose of Change: To correct the formatting of the table.

<u>Electronic Medical Billing and Payment Companion Guide Section 9792.5.1 subdivision (b)</u>

The word "payor" was changed to "payer" throughout the document (36 replacements.)
Specific Purpose of Change: To conform to the more common spelling.

The Preface was modified on page iii to add the word "address" so that the public is directed to contact the Division at the above "address/phone number" regarding change requests.
Specific Purpose of Change: To correct an omission in the reference to the Division's contact information.

The Table of Contents was modified by inserting new page numbers.
Specific Purpose of Change: To update the Table of Contents to accurately reflect the pagination after the strikethrough language was removed.

2.2.1 California Prescribed and Optional Formats (2) Acknowledgments was modified to correct the title of the ASC X12C/005010X231A1 Implementation Acknowledgment errata to substitute a "C" for an "N." Also, the numbering of the Acknowledgments was

modified in (2)(a)(ii) to remove the further subdivision numbers from the errata. (4) Documentation / Attachments to Support a Claim was modified to conform the numbering and layout to (4)(b).
Specific Purpose of Change: To correct the title of the Implementation Acknowledgment and for consistency to conform the numbering style of (2) and (4) to other sections that do not separately number each errata.

2.4.5 Claim Identification (initially 2.5.5) was modified to delete the second and third paragraphs.
Specific Purpose of Change: The second paragraph of the initial proposal, which stated that the California companion guide instructions for the REF02 segment of Loop 2010CA differ from the ASC X12N 837 Implementation Guide, was deleted as it was redundant and unnecessary. The introductory material to each data element table in the Companion Guide for each Type 3 Technical Report (Professional, Institutional, Dental) states that the table identifies instructions that are different from the HIPAA implementation so there is no reason to reiterate that in 2.4.5. (Section 3.3, Section 4.3, Section 5.3.) The third paragraph of the initial proposal was deleted as redundant and unnecessary because it is a narrative reiteration of the data instructions for REF02 contained in the data element table for each of the Type 3 Technical Reports: 3.3.1 ASC X12N/00501X222 Health Care Claim: Professional (837); 4.3.1 ASC X12N/00501X223 Health Care Claim: Institutional (837); and 5.3.1 ASC X12N/00501X224 Health Care Claim: Dental (837).

2.9.1 Trading Partner and 2.9.3 were modified to substitute “Submitter” for “Sender.”
Specific Purpose of Change: To conform the language to usage in the 5010 Technical Reports Type 3 and correct these references which were overlooked when “Sender” was changed to “Submitter” in 2.9.2 during a comment period.

3.3.1 ASC X12N/00501X222 Health Care Claim: Professional (837)
4.3.1 ASC X12N/00501X223 Health Care Claim: Institutional (837)
5.3.1 ASC X12N/00501X224 Health Care Claim: Dental (837)
For each of the Type 3 Technical Reports Tables, the Workers’ Compensation Instructions column for 2010CA REF, Property and Casualty Claim Number was changed: to delete language stating that the segment is “Situational (Required if claim number known by provider),” leaving the original language “this Segment is Required” and to delete the language “for California Workers’ Compensation.”
Specific Purpose of Change: The language stating that “this segment is situational, required if known” is deleted and replaced with language from the original 45 day comment “this segment is required” as a syntax correction of the usage of “situational” and “required.” Using either the “This Segment is Situational, (Required if claim number known…)” language, or the “This Segment is Required” language, the segment must be populated by either the claim number or the value “unknown” as specified in the REF02. Therefore deletion of the word “Situational” does not change the regulatory effect of the provision. The phrase “for California Workers’ Compensation” is deleted to improve the clarity as it is redundant and has no substantive effect because the column heading already states “California Workers’ Compensation Instructions.”

9.1.2 Acknowledgments - Process Steps was modified to change references to 9.2 Clean Bill Missing Claim Number and 9.3 Clean Bill Missing Report, which both erroneously used the phrase “Clean Claim”. Also corrected “9.2 Clean Bill Missing Report” to *9.3*.
Specific Purpose of Change: To correct errors in reference to other sections.

UPDATE OF MATERIAL RELIED UPON

The following additional documents beyond those identified in the Initial Statement of Reasons were relied upon by the Acting Administrative Director and added to rulemaking file after close of the 45 day comment period. They were identified in the Notice of Modification to Text of Proposed Regulations and the Revised Notice of Modification to Text of Proposed Regulations and were available for 15 day public review and comment from January 13 through January 28, 2011.

- The California Division of Workers’ Compensation Medical Billing and Payment Guide, 2011.

- The California Division of Workers’ Compensation Electronic Medical Billing and Payment Companion Guide, 2012

- ASC X12N/005010X222
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Professional (837)
  MAY 2006

- ASC X12N/005010X222E1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Professional (837)
  January 2009

- ASC X12N/005010X223
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Institutional (837)
  May 2006

- ASC X12N/005010X223A1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Institutional (837)

Errata Type 1
October 2007

- ASC X12N/005010X223E1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Institutional (837)
  Errata
  January 2009

- ASC X12N/005010X224
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Dental (837)
  MAY 2006

- ASC X12N/005010X224A1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Dental (837)
  Errata Type 1
  October 2007

- ASC X12N/005010X224E1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Dental (837)
  Errata
  January 2009

- Telecommunication Standard Implementation Guide, Version D.0, August 2007. National Council for Prescription Drug Programs

- Batch Standard Implementation Guide, Version 1.2, January 2006, National Council for Prescription Drug Programs

- ASC X12C/005010X231
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Implementation Acknowledgment for Health Care Insurance (999)
  June 2007

- ASC X12N/005010X214
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Acknowledgment (277)
  January 2007

- ASC X12N/005010X221
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Payment/Advice (835)
  April 2006

- ASC X12N/005010X221E1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Payment/Advice (835)
  Errata
  January 2009

- ASC X12N/005010X210
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Additional Information to Support a Health Care Claim or Encounter (275)
  February 2008

- ASC X12N/005010X213
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Request for Additional Information (277)
  July 2007

- National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version, Version 6.0 07/10, and the 1500 Form (revised 08-05)

- National Uniform Billing Committee Official UB-04 Data Specifications Manual 2011, Version 5.0, July 2010, including the UB 04 form

- CDT 2011-2012: ADA Practical Guide to Dental Procedure Codes, including the ADA 2006 Dental Claim Form

The following documents added to the rulemaking file after the close of the first revised 15 day comment period were identified in the Notice of Further Modification to Text of Proposed Regulations (2nd 15-Day Comment Period) and were available for 15 day public review and comment from February 1, 2011 through February 16, 2011.

- ASC X12N/005010X222A1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Professional (837)
  June 2010

- ASC X12N/005010X223A2
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Institutional (837)
  June 2010

- ASC X12N/005010X224A2
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim: Dental (837)
  June 2010

- ASC X12C/005010X231A1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Implementation Acknowledgment for Health Care Insurance (999)
  June 2010

- ASC X12N/005010X214 E1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Acknowledgment (277)
  April 2008

- ASC X12N/005010X214 E2
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Acknowledgment (277)

January 2009

- ASC X12N/005010X221A1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Payment/Advice (835)
  June 2010

The following documents added to the rulemaking file after the close of the second 15 day comment period were identified in the Notice of Further Modification to Text of Proposed Regulations (3rd 15-Day Comment Period) and were available for 15-day public review and comment from February 17, 2011 through March 4, 2011.

- ASC X12N/005010X210E1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Additional Information to Support a Health Care Claim (275)
  Errata
  January 2009

- ASC X12N/005010X213E1
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Request for Additional Information (277)
  Errata
  April 2008

- ASC X12N/005010X213E2
  Based on Version 5, Release 1
  ASC X12 Standards for Electronic Data Interchange
  Technical Report Type 3
  Health Care Claim Request for Additional Information (277)
  Errata
  January 2009

- Federal Register, Vol. 75, No. 197 / Wednesday, October 13, 2010, pages 62684-62686
  Health Insurance Reform;
  Announcement of Maintenance
  Changes to Electronic Data
  Transaction Standards Adopted Under
  the Health Insurance Portability and
  Accountability Act of 1996

LOCAL MANDATES DETERMINATION

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district. The potential costs imposed on all public agency employers by these proposed regulations, although not a benefit level increase, are not a new State mandate because the regulations apply to all employers, both public and private, and not uniquely to local governments. The Administrative Director has determined that the proposed regulations will not impose any new mandated programs on any local agency or school district. The California Supreme Court has determined that an increase in workers' compensation benefit levels does not constitute a new State mandate for the purpose of local mandate claims because the increase does not impose unique requirements on local governments. See County of Los Angeles v. State of California (1987) 43 Cal.3d 46. The potential costs imposed on all public agency employers and payers by these proposed regulations, although not a benefit level increase, are similarly not a new State mandate because the regulations apply to all employers and payers, both public and private, and not uniquely to local governments.

- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. (See "Local Mandate" section above.)
- Other nondiscretionary costs/savings imposed upon local agencies: None. (See "Local Mandate" section above.)

CONSIDERATION OF ALTERNATIVES

The Division considered all comments submitted during the public comment periods, and made modifications based on those comments to the regulations as initially proposed. The Acting Administrative Director has now determined that no alternatives proposed by the regulated public or otherwise considered by the Division of Workers' Compensation would be more effective in carrying out the purpose for which these regulations were proposed, nor would they be as effective as and less burdensome to affected private persons and businesses than the regulations that were adopted.

JUSTIFICATION FOR INCORPORATION BY REFERENCE

As specifically identified above, numerous documents have been incorporated by reference into the regulations. Incorporation by reference is necessary because all of the documents incorporated by reference are voluminous (amounting to hundreds of pages) and it would be cumbersome and otherwise impractical to publish the entire publications in the California Code of Regulations. (1 CCR § 20(c)(1), (c)(2)) Moreover, many of the documents incorporated by reference are documents that are copyrighted intellectual property of private entities and may not be published in the California Code of

Regulations. The regulations specify how each of the documents incorporated by reference may be obtained.

SUMMARY OF COMMENTS RECEIVED AND RESPONSES THERETO CONCERNING THE REGULATIONS ADOPTED

The summaries and responses to comments of each organization or individual which were received during the 45-day comment period and the three 15-day comment periods are contained in the rulemaking file and are incorporated by reference herein.

The public comment periods were as follows:

Initial 45-day comment period on proposed regulations: March 4, 2010 through April 26, 2010.

Revised first 15-day comment period on modified text: January 13, 2011 through January 28, 2011.

Second 15-day comment period on modified text: February 1, 2011 through February 16, 2011.

Third 15-day comment period: February 17, 2011 through March 4, 2011.

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