WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Date Element 634 – Conditional	Commenter requests clarification on data requested for this data element – questions if DWC is requesting NPI for dispensing pharmacy?	Kevin C. Tribout Director of Government Affairs - PMSI November 13, 2009 Written Comment	The National Provider Identification Number (NPI) for pharmaceuticals, if available, should be reported as follows: Pharmacists NPI as DN592 Rendering Line Provider, if different than DN647; Pharmacy NPI as DN647 Rendering Bill Provider (dispensing pharmacy); Pharmacy Bill Manager (PBM) service provider as DN634 Billing provider.	None.
Data Element 647 – Mandatory	Commenter requests clarification on data requested for this data element – questions if DWC is requesting NPI for dispensing pharmacy	Kevin C. Tribout Director of Government Affairs - PMSI November 13, 2009 Written Comment	See above response.	None
Data element 592 – Conditionally dependent on Data Element 647	Commenter requests clarification on data requested for this data element – questions if DWC is requesting NPI for dispensing pharmacy	Kevin C. Tribout Director of Government Affairs - PMSI November 13, 2009 Written Comment	See above response.	None.
FN [Allow all, except reject transaction if Payment/Adjustment Codes are present that have not been reported previously for this claim.	Commenter is happy to see that the Division will accept the AN but questions why the Division rejects a final report if it includes payment codes not previously reported. Commenter states it has been a pet peeve of his for 10 years. Commenter does not understand why, if a report was missing in the past (weeks, months or years ago) that it is rejected since the Division is getting all of the data and payments on a claim at its closing. Commenter wants to know the logic as applying sequence edits at the benefit level is inconsistent with IAIABC	George Poulin Project Leader Systems & Process Solutions – Electronic State Reporting November 6, 2009 Written Comment	WCIS agrees that a final report (FN) should be accepted by WCIS even though the trading partner has failed to report previously paid benefits.	Benefit sequencing edits will be removed from the FN. See Sequencing Rules in Section M of the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 3.0 (proposed CA FROI/SROI Guide).

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	EDI.			
FTP	Commenter wants to know if a brand new TP Profile for the migration to FTP from Advantis is really needed. Commenter would like to know why the Division is moving away from the VANs.	George Poulin Project Leader Systems & Process Solutions – Electronic State Reporting November 6, 2009 Written Comment	A new trading partner profile will be required as there is File Transfer Protocol (FTP) account information that must be provided by the trading partner. Moving to FTP as the only means of transmitting WCIS data will allow WCIS to process data more efficiently and should lower costs for the trading partner.	None.
Manual Class Codes	Commenter would like to know if accepting only the WCIRB's codes and not the NCCI is a brand new requirement or if it has existed since EDI began in 1999.	George Poulin Project Leader Systems & Process Solutions – Electronic State Reporting November 6, 2009 Written Comment	WCIRB class code reporting has been required since the WCIS began in 2000.	None.
The receiver zip code for WCIS is now 94612-1491 and SSN defaults *(0000000006/7)*	Commenter would like to know if this change can be implemented before final adoption of these regulations.	George Poulin Project Leader Systems & Process Solutions – Electronic State Reporting November 6, 2009 Written Comment	WCIS will not accept the new receiver zip code until the updated guide becomes effective. Regarding the new Social Security Default value, trading partners are currently free to submit this value without adverse consequence.	None.
FROI Data Requirement Table	Commenter states that the Policy Number (DN28), Policy Effective Date (DN29), and Policy Expiration Date (DN30) have been added to this table. Commenter states that they are Conditional/Serious on the FROI00, 02, 04, AU and CO. Commenter questions if the Division understands that for TPA acquired claims they have a Date of Injury that's outside of the	George Poulin Project Leader Systems & Process Solutions – Electronic State Reporting November 6, 2009 Written Comment	WCIS recognizes this "business reality" in California; it will not follow the International Association of Industrial Accident Boards and Commissions (IAIABC) edit for the policy date and the date of injury.	See Data Requirements for DN28, 29, and 30 in Section K of proposed CA FROI/SROI Guide. Data elements are Conditional/Serious; WCIS will not edit data transmissions to correspond the date of injury with the policy

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	policy effective/expiration dates and would like to know if these edits will accept this business reality.			date .
CA EDI Implementation Guide for Medical Bill Payment Records version 1.1	Commenter would like to know if there has been any previous discussion regarding WCIS collecting data on whether or not a physician/provider obtained a prior authorization number of a service(s) and/or procedure(s). Commenter stated that in meetings with members of DWC that the specific rule on reporting this information (CMS1500 form, box 23) was identified. Commenter states that physicians obtain prior authorization via the utilization review process which he claims has dramatically increased medical costs. Commenter would like to know if the Division sees any value in collecting data of the prior authorization /UR Process.	Frank D. Navarro Associate Director CMA Center for Economic Services November 18, 2009 Written Comment	The Division certainly sees value in collecting data regarding the prior authorization /utilization review process. However, the data collected by WCIS must be compatible with the electronic data interchange (EDI) system of the International Association of Industrial Accident Boards and Commissions (IAIABC). The IAIABC has yet to adopt data elements regarding prior authorization.	None.
Permanent Impairment Percent and Body Part	Commenter states that currently the Division expects to have this information and the MMI date on initiating benefit MTC's if PD is paid. Commenter notes that the MMI date is removed from the requirement and the impairment information remains required. Currently the requirement is as follows: If [MTC={IP, AP, SROI 04, CB, PY, FN, SROI 02, SROI CO or SROI UR} AND starting, denying or updated PD benefits (i.e. DN86>0 AND DN85={DN85=020, 021, 030, 040, or 090 or 520, 521, 530, 540, or 590})] then Mandatory. Commenter asks if the Division would	Cheryl Keyes Sedgwick CMS November 25, 2009 Written Comment	Agreed. WCIS will change the requirements on the Permanent Impairment Percentage (DN84) to match the new requirements on the Date of Maximum Medical Improvement (DN70).	Revise Section K, Data Requirements for Subsequent Report of Injury, and SROI Conditional Rules and Implementation Notes, so that requirements for Permanent Impairment Percentage (DN84) match the new requirements on the Date of Maximum Medical Improvement (DN70).

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	consider revising to make this only mandatory when stopping PD benefits. Like the MMI date edit: If reporting and closing permanent disability benefits (DN85=020, 021, 030, 040, or 090 or 520, 521, 530, 540 or 590), then Mandatory. Commenter also notes that the Division is dropping the edit on the AN that requires that no new benefits can be reported. Commenter would like clarification that this means that if they miss a filing, such as a CB-Change in Benefit Type, that the AN will not error for sequencing. And, if they don't go back and file the CB, will the FN go through or will it be rejected at that point? Commenter states that the edit on the FN is a little confusing as it appears twice, once under Transaction level MTC and once under Benefit level and there is technically no Benefit Level in Release 1.		Agreed. WCIS will remove the benefit sequencing edits on the Annual Report (AN) and the FN.	Benefit sequencing edits will be removed from the AN and FN. See Sequencing Rules in Section M of the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 3.0 (proposed CA FROI/SROI Guide).
CA EDI Implementation Guide for Medical Bill Payment Records – Section C, Page 15	Commenter address the first paragraph of the section entitled "Make sure your computer system contains all the required data." Commenter states that if public records are to	Jeffrey Lawliss Coventry Workers' Comp Services – IT Department December 10, 2009 Written Comment	WCIS finds it is reasonable that all medical providers who are required to be licensed in the State of California maintain the appropriate California License. The applicable	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	be source of acquiring data elements like facility license numbers that are not otherwise obtainable in the billing, a billing requirement would need to be regulated to require providers to have their records current with any public entity that shall or could be used to obtain such information. Commenter opines that there is no guarantee that the billing information provided can be successfully matched to public records. Commenter states that the WCIS cannot assume that any and all license data are available or accessible through public licensing departments or that the billing provider is registered with such departments and matching or identifying information can be associated or obtainable.		license number should be provided to the claims administrator upon request.	
CA EDI Implementation Guide for Medical Bill Payment Records – Section C, Page 15	Commenter addresses the second paragraph of the section entitled "Make sure your computer system contains all the required data." Commenter inquires that for data elements that the health care provider is expected to be the source for, how the carrier can be expected to capture the data elements that are not provided by the billing? Commenter opines that it cannot be assumed that all of the date elements are available unit comprehensive billing rules and regulations are implemented.	Jeffrey Lawliss Coventry Workers' Comp Services – IT Department December 10, 2009 Written Comment	WCIS recognizes the value of billing rules. In this regard, WCIS does not require the submission of data elements that are not required to be given by the health care provider to the claims administrator.	None.
Implementation Guide for Medical Bill Payment Records – Section K, Page 79	Commenter addresses the first paragraph of the section entitled "Medical data elements by name and source." Commenter states that California has not adopted the CMS 1500 or the UB92-(UB04) as required billing forms. He states that the claims administrators cannot guarantee that these forms will be used or that all of the data	Jeffrey Lawliss Coventry Workers' Comp Services – IT Department December 10, 2009 Written Comment	As required by Labor Code section 138.6, WCIS has adopted the IAIABC national standards. The medical data element by source columns in the proposed implementation guide are verbatim from the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1,	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	on these forms will be provided. Commenter suggests that this language should state that these forms are a possible source for the data elements requested by the state and reportable when available. Commenter states that the claims administrator cannot guarantee the accuracy of what is billed by the provider. Commenter opines that only regulations requiring the provider to bill using certain data elements, forms and valid information can be regulated.		(July1, 2009), page 1-2.1. and indicate sources that are nationally recognized by both medical providers and payers.	
Implementation Guide for Medical Bill Payment Records – Section K, Page 90 9702(e)	Commenter states that only DN647 Rendering Bill Provider National Provider ID has been given the authority to report a default value. Commenter references Footnote 7 in subdivision (e) of Section 9702 as discussed in the Notice of Proposed Rulemaking. Commenter suggests that the other proposed required NPI data elements should also have the ability to be defaulted using a string of 9s when the data is not available or accessible until such billing requirements are regulated.	Jeffrey Lawliss Coventry Workers' Comp Services – IT Department December 10, 2009 Written Comment	The National Provider ID Number data elements DN634, DN682, DN699, DN647, and DN667 will be made conditional and reportable only if applicable and different from DN647.	Revise Medical Data Element Requirement Table in Section K of California Medical EDI Implementation Guide for Medical Bill Payment Records, Version 1.1 (proposed CA Medical Bill EDI Guide)
9702(e)	Commenter points out the Initial Statement of Reasons state under Section 9702 (e) that: "Currently, billing regulations do not exist which require physicians to provide this information to claims administrators." Commenter agrees with the statement. Commenter believes that the proposed data elements DN634 Billing Provider National Provider ID, DN682 Facility National Provider ID, DN699 Referring Provider National	Jeffrey Lawliss Coventry Workers' Comp Services – IT Department December 10, 2009 Written Comment	The National Provider ID Number data elements (DN634, DN682, DN699, DN647, and DN667) will be made conditional and reportable only if applicable and different from DN647.	Revise Medical Data Element Requirement Table in Section K of California Medical EDI Implementation Guide for Medical Bill Payment Records, Version 1.1 (proposed CA Medical Bill EDI Guide)

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Provider ID, DN647 Rendering Bill Provider National Provider ID, Rendering Line Provider National ID and DN677 Supervising Provider ID should apply to the rational that Billing regulations do not exist which require physicians or any provider to provide this information to claims administrators. Commenter recommends that these data elements should have the ability to be defaulted using a string of 9s when the data is not available or accessible until such billing requirements are regulated.			
DN 42 Employee Social Security Number	Commenter asks why there is a distinction between an employee not having a SSN and refusing to provide a SSN necessary in medical bill reporting. Commenter questions how it is possible for the claims administrator to interpret from billing that contains a blank SSN that an employee has either refused to provide or was unable to provide because they do not have one. Commenter suggests keeping the original mandatory trigger in place allowing the reporting of all 9s when a SSN number, Passport number, Employment VISA number or Green Card number is not available.	Jeffrey Lawliss Coventry Workers' Comp Services – IT Department December 10, 2009 Written Comment	The Social Security Number 000000006 default values for a medical data reporting is being added to be consistent with previously adopted FROI data edits.	Revise footnote 3 in section 9702(c) to allow a string of eight zeros followed by a six if a Social Security Number is not known. Revise footnote 10 in section 9702(e) to allow either a string of eight zeros followed by a six or a string of nine nines if the employee is not a U.S. citizen and has no other form of identification.
9702 (c) and (e)	Commenter asks that if the Data Elements 1 (Transaction Set ID) and 4 (Jurisdiction) are to be included in subdivision (e), why are they not all included in the 2010 EDI Implementation Guide? Commenter states that there is limited information given on some of these data elements included the two referenced above	Jeffrey Lawliss Coventry Workers' Comp Services – IT Department December 10, 2009 Written Comment	Information on DN 1 (Transaction Set ID) and DN 4 (Jurisdiction) can be found in the IAIABC FROI/SROI Guide. The IAIABC Guides and the California Guides are to be read in conjunction with each other; they are not intended to be used as stand-alone guides. If information regarding linking data in section	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	which are newly added. Commenter requests that the Division update the proposed regulations and the Draft Implementation Guide to further explain these data elements, their size, the segment placing, the possible edits, if any, and possible data source etc. if subdivision (e) is currently referenced.		9702(c) is provide in one guide, it is unnecessary to reproduce the same information in another.	
9702(c)	Commenter questions why there are three options for reporting an unknown or unavailable SSN. Commenter requests that the Division define the allowable usage of these variables and their conditions of usage for these SSN defaults.	Jeffrey Lawliss Coventry Workers' Comp Services – IT Department December 10, 2009 Written Comment	See above response regarding SSN default values.	None.
9701 (b)(2), (c)(2), and (n)(2)	Commenter states that these subsections of the regulations are proposing an implementation date six months following the approval of the regulations. Commenter states that there are significant numbers of new data element fields (32) in the proposed regulations. While commenter does not object to including these new data element fields, implementing these changes within the six months following the approval and filing of these regulations with the Secretary of State may not allow enough time for claims administrators and third party vendors to develop, program and test these new fields to comply with the regulations. Commenter recommends that the Division allow 12 months (1 year) to comply with these changes.	Kathleen Burrows Claims Operations Manager – State Compensation Insurance Fund December 10, 2009 Written Comment	Agreed. The phase-in period for the proposed amendments will be extended to 12 months.	The text for Sections 9701(b)(2), 9701(c)(2), and 9701(n)(2) will be amended as follows: For reporting on or after Xxxxxx, XX, 2010, (DATE TO BE INSERTED BY OAL – TWELVE MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE) …..
General comment – E-Billing Regulations and WCIS	Commenter is concerned that the Standard medical billing forms and E-Billing regulations have not yet been adopted. The formal rule-	Steve Suchil Assistant Vice President American Insurance	WCIS recognizes the value of medical billing rules. Upon the adoption of E-billing rules by DWC,	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
requirements	making process has not yet begun for these provisions. Until the forms and billing requirements are effective, many of the data elements contained in this regulation will not be uniformly provided to the Claims Administrator. Commenter opines that this will then lead to an increase in error messaging, rejected transmissions or inordinate expense for the claims administrator in attempting to manually gather the missing data elements from the Health Care Providers. There are fields on the standard forms for some of the data but not all, and currently there is no requirement that the health care provider use the standard forms or complete each field. Commenter strongly believes that making the WCIS regulations effective before the E-Billing regulations are effective is inappropriate.	Association December 15, 2009 Written Comment	WCIS will amend its regulations to correspond with such rules. In this regard, WCIS does not require the submission of data elements that are not required to be given by the health care provider to the claims administrator.	
General comment – IAIABC and California Implementation Guides	Commenter is concerned that the Division is requiring California WCIS submitters to work out of both the IAIABC and California Implementation Guides. Commenter opines that it is cumbersome to be paging back and forth in both documents, and at $95.00 each the workers' compensation community is looking at yet another expense in order to comply with these regulations. Commenter notes that the IAIABC puts out updates between versions and, as a result, he is concerned that this may require keeping up with interim changes there that have not gone through the rule-making process or face audit problems. For this reason, commenter recommends this provision should be made to exclude inter-version updates.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	As required by Labor Code section 138.6, WCIS has adopted the IAIABC national standards as reflected in IAIABC implementation guides (incorporated in the WCIS regulations by reference; see proposed section 9701). The California implementation guides serve as a refinement of the IAIABC guides as they apply to California. Regarding IAIABC updates, it is WCIS's understanding that all interim changes to the IAIABC guides are clarifications and do not constitute substantial changes in the guidelines.	None.
9701(b)(2) and (c)(2)	Commenter states that these subdivisions refer to revised Implementation Guides dated	Steve Suchil Assistant Vice President	Agreed.	The date of the proposed implementation guides

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	January 2010. Commenter suggests using the actual implementation date, i.e. six months following approval and filing with the Secretary of State, in order to provide more clarity. Commenter expects that it would be well into 2010 before formal rulemaking is completed and using the January 2010 date could be misleading.	American Insurance Association December 15, 2009 Written Comment		will reflect their effective date.
9701(d)	Commenter suggests the following revised language: California Jurisdiction Code. "A California-specific code that identifies a medical procedure, service, or product ~~billed~~ that is not identified by a current HCPCS code. California Jurisdiction Codes are either set forth and/or incorporated by reference in California Code of Regulations, title 8, section 9795, regarding reasonable fees for medical-legal expenses, section 9789.11, regarding fees for physician services rendered on or after July 1, 2004, or in section 9702(e)(2), footnote 6, regarding lump-sum ~~settlements~~ payments. Commenter recommends always using the word payment after lump-sum in order to be inclusive of all eventualities. The proposed regulations vary in terminology, sometimes saying lump-sum settlements or lump-sum lien settlements, but all lump-sum payments are not for liens.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	Disagree. The IAIABC standards utilize the terms "lump sum settlements" and "Lump sum Payment" in the definitions of the proposed codes for reporting lump sum medical lien data. WCIS will add the adjectives "medical lien" to both terms in the medical implementation guide and regulations to be consistent. When referring to both, the language will be changed to medical lien lump sum payments or settlements.	None.
9701(m)	Commenter recommends that rather than requiring the purchase of the two IAIABC Implementation Guides, that the Division	Steve Suchil Assistant Vice President American Insurance	Disagree. The IAIABC medical bill payment guide is the source that is referenced for the national standard.	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	incorporate the necessary information into the California Guides. Commenter opines that this will reduce costs and the need to refer back and forth through four different manuals. It will also make the California Implementation Guides more understandable. In their present state, anticipating the use of the IAIABC guides, commenter finds that there are many areas that will require some further definition with or without the use of the IAIABC guides. If use of the IAIABC Implementation Guide is required, commenter recommends titling it as follows, as this is how it is labeled on their website: IAIABC EDI Implementation Guide: Claims, Release 1.	Association December 15, 2009 Written Comment	The California medical implementation guide is the subset of the IAIABC guide which is unique to the California implementation of the national standard. The two guides highlight the differences for clarification.	
9701(n)(1)	Commenter notes at present, the IAIABC website does not show Release 1 as being available for purchase.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	Release 1 can be found on the IAIABC website at: http://www.iaiabc.org/i4a/pages/index.cfm?pageid=3345	None
9702(b)	Commenter states that the Initial Treatment Code-DN 36 does not appear on the Doctor's First Report of Injury or the HCFA 1500. Commenter is concerned that the absence of a field for this item will lead to guesswork and result in faulty data. Insured Report Number-DN 26 appears to have the same definition as Claim Administrator Claim Number-DN 15. If this is so, commenter recommends removing one or the other to eliminate the duplication. If not, commenter suggests improving the descriptions in the Data Dictionary.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	The Initial Treatment Code is optional, per page 87. The Insured Report Number is optional, per page 87.	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter opines that for a number of users, Policy Effective Date-DN 29, Policy Expiration Date-DN 30, and Policy Number-DN 28 will require building a bridge from another system in order to report the data. Commenter questions why this data is now necessary, and if the reason for adoption warrants the expense that will be incurred. Commenter suggests the following re-wording of the paragraph that follows the data elements chart: Data elements omitted under this subsection because they were not known by the claims administrator shall be submitted within ~~sixty~~ ~~(60)~~ XX days from the date the information is obtained by the claims administrator ~~of the first report under this subsection~~." Commenter opines that without this change there will be needless repetitive reporting when data items cannot be obtained. One example might be a Social Security Number that is not being provided, for whatever reason.		Policy information, already given by insured employers to the Workers' Compensation Information Rating Bureau (WCIRB), will provide the Division with additional data in which to analyze claims handling practice. This paragraph, at the end of section 9702(b), has not been amended by the Division. As such, no response is necessary. Regardless, a two month period for claims administrators to submit any data elements that were unknown at the time of the first report is reasonable; an adequate investigation of a claim, required by 8 C.C.R. section 10109, should reveal this basic information.	
9702(d)	Claims Administrator Postal Zone DN14 is described as the postal zone for the "processing facility." Commenter inquires if this is the adjusting location or a possible off-site check processing location? Further definition in the Data Dictionary would clarify this.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	The Claim Administrator Postal Code is the 9-digit postal code of the physical location of the claims administrator handling the claim. All codes should be adequately	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Several new codes have unclear definitions. Specifically they speak of "segment occurrences" but this term is not included in the glossary.		defined in the appropriate IAIABC and California implementation guides.	
9702(e)	Commenter recommends that the fourth sentence of the first paragraph of Subdiv. (e) should be amended as follows: The claims administrator shall submit the data within ninety (90) calendar days of the medical bill payment or the date of the final determination that payment for billed medical services ~~will be~~ <u>are</u> denied. Each claims administrator shall submit all lump sum payments following the filing of a ~~lien~~ claim for the payment of ~~such~~ <u>disputed</u> medical services ~~pursuant to Labor Code sections 4903 and 4903.1~~ within ninety (90) calendar days. ~~of the medical lien payment~~. Each claims administrator shall transmit the data elements by electronic data interchange in the manner set forth in the California EDI Implementation Guide for Medical Bill Payment Records." Commenter recommends the foregoing changes to extend the regulation to cover lump-sum payments for disputed medical where no lien has been filed and/or finalized.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	Disagree. The proposed language is unambiguous and more representative of the intent of the proposed regulations, which is to collect data on lump sum medical billing payments following the filing of a lien claim with the WCAB. Disagree. WCIS will only collect medical lien data pursuant to Labor Code sections 4903 and 4903.1. To be a reportable medical lien bill, a Notice and Request for Allowance of Lien must first be filed with the	None. None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			WCAB.	
	Commenter notes that Footnote 7 appears to be missing from DN 634, 682, 699, 647, 667.		The National Provider ID Number data elements DN634, DN682, DN699, DN647, and DN667 are all conditional and reportable only if applicable and different from DN647.	Revise Medical Data Element Requirement Table in Section K of California Medical EDI Implementation Guide for Medical Bill Payment Records, Version 1.1 (proposed CA Medical Bill EDI Guide)
	Commenter notes that with respect to Footnote 10, Employee Employment Visa, Green Card, and Passport Number are not reported to the Payor. Commenter queries what is the business reason for requesting this data and is it important enough to require this expensive manual query that may, on occasion, have legal ramifications? On this chart a proxy is permitted for these fields but the Data Requirements Table makes one of the fields mandatory. Commenter opines that this responsibility should not be placed upon on the Claims Administrator.		Billing information such as Visa / Green Card / Passport data are conditional under the WCIS reporting requirements. The Employee Employment Visa (DN152), Employee Green Card (DN153), and Employee Passport Number (DN156) all share the same business need as the Employee SSN (DN42), which is to identify the employee in the jurisdiction's system. Note: Footnote 10 does not require the Employee Employment Visa, Green Card, and Passport Number to be reported.	None.
	Commenter understands that the Division of Workers' Compensation has been charged with developing a revised format for the Employer's		See above. At the time the Division promulgates regulations to revise the Employer's First Report of Injury	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	First Report of Injury. If this information is truly needed, commenter points out that the employer is most likely in possession of this data and could provide this information via the Employer's First Report of Injury form/format. Commenter suggests that Footnote 12 should be amended as follows: For medical ~~lien~~ lump sum payment use the date on the first medical bill received. Commenter suggests removing the words "lien" and "settlement" from Lump Sum discussions and replacing those words with "payments." Liens comprise the bulk of lump sum payments but, on occasion, lump sum payments are negotiated without the existence of a lien. If the "lien" language is not removed, these negotiated payments would not be reportable. Commenter opines that this will reflect a late payment in all cases, even if the bills were timely objected to. Commenter expects that these will not be aggregated with total medical when computing timeliness of payments. Commenter suggests the footnotes should be changed as follows: Footnote 14:		(see Labor Code section 6409.1), it will consider if such information can be obtained in a more efficient, cost-effective manner. Disagree. The IAIABC standards utilize the terms "lump sum settlements" and "lump sum payment" in the definitions of the proposed codes for reporting lump sum medical lien data. WCIS will add the adjectives "medical lien" to both terms in the medical implementation guide and regulations to be consistent. When referring to both, the language will be changed to medical lien lump sum payments or settlements. To be a reportable medical lien bill, a Notice and Request for Allowance of Lien must first be filed with the WCAB.	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	If the lump sum payment results from a medical lien ~~lump sum payment~~ use the date of the lien filing. Footnote 15: For a medical ~~lien~~ lump sum payment use the settled or ordered amount. Footnote 16: For a medical ~~lien~~ lump sum payment use the amount in dispute. Footnote 17: Not required for a mixed medical ~~lien~~ lump sum payment. Footnote 18: For a mixed bill medical ~~lien~~ lump sum payment assign a value = 00.			
EDI Implementation Guide for First and Subsequent Reports of Injury – Cover Page	Commenter recommends awaiting adoption of and the effective date for the proposed regulations before dating the Guide. Commenter also recommends delaying the effective date for 90 days, rather than the proposed 60 days, to allow adequate time for re-programming and training.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	Agreed. The phase-in period for the proposed amendments will be extended to 12 months.	See above. The text for Sections 9701(b)(2), 9701(c)(2), and 9701(n)(2) will be amended as follows: For reporting on or after Xxxxxx, XX, 2010, (DATE TO BE INSERTED BY OAL –

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
				TWELVE MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE) …..
EDI Implementation Guide for First and Subsequent Reports of Injury – Page 32 Part E Trading Partner ID List	The EDI Glossary in Section P includes Self Insured in the definition of a Claims Administrator so commenter is confused by Number 5 in the Trading Partner Types. Number 2 is for Self-Administered, Self Insured and Number 4 is for Third Party Administrator of Self Insured. Commenter notes that Number 5 appears to be duplication. Commenter recommends that it be deleted for the sake of clarity.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	Agreed. WCIS will remove trading partner type #5 – Self-Insurer – from the Trading Partner ID List.	Revise Trading Partner Profile, Part E, in Section F of CA FROI/SROI Guide to remove trading partner type #5 – Self-Insurer – from the Trading Partner ID
EDI Implementation Guide for First and Subsequent Reports of Injury – Page 36 Section C2 FTP Account Information	Commenter suggests that the abbreviations "SSL" and "PGP" be defined, or a reference be provided as to where the definitions can be found, before using these abbreviations.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	Agreed.	The commonly-used abbreviations will be defined in Section A of the CA FROI/SROI Guide (see "Sending Data to WCIS.")
EDI Implementation Guide for First and Subsequent Reports of Injury – Page 39 Part E Electronic Partnering Insurer/Claim Administrator ID List	The EDI Glossary in Section P includes an Insurer in the definition of Claims Administrator. Commenter recommends the deletion of the word "Insurer" from the title of this section as well as the words "insurers" and "insurer and" in the body of the section.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	While a self-administered insurer is included under the definition of "claims administrator" in the glossary of Section P, the use of the term "insurer" in the ID List is used to emphasize to trading partners that such entities must be included in the list.	None.
EDI Implementation Guide for First and Subsequent Reports	Commenter states that the words "trading partner profile" at the end of the first sentence in Step 1 should be deleted.	Steve Suchil Assistant Vice President American Insurance	Agreed. The term is redundant and will be deleted.	Section I; Data Transmission with File Transfer Protocol; Delete

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
of Injury – Page 67 Data Transmission with File Transfer Protocol		Association December 15, 2009 Written Comment		"trading partner profile" at end of first sentence in Step. 1
EDI Implementation Guide for First and Subsequent Reports of Injury – Page 81 Release 1 First Report of Injury	With respect to Code 00: Under Time Report is Due, the following is proposed by the Division: Within 10 business days (report all data known to the claims administrator.) Commenter proposes adding the triggering event that starts the timing: <u>Report all data within 10 business days of knowledge by the claims administrator</u>. In addition to providing more clarity, this will bring it into conformance with Number 2 on Page 157, Differences Between Version 2.1 and Version 3.0 of WCIS. For Code 02: Under Time Report is Due, the following is proposed by the Division: Within 60 days of original first report submission. If individual bits of information do not ever become available, this will be a useless transmission. Commenter recommends the following: <u>Within XX business days of receipt of missing data.</u> With respect to Code 04: Under Time Report is Due, the following is proposed by the	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	Disagree. The sole change in the "Time Report is Due" column of the table is the expansion of the initial reporting period (MTC Code 00) from 5 business days to 10 business days. The existing language of the table is not ambiguous and does not warrant addition clarification at this time.	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Division: Within 10 business days of the event. Commenter recommends: <u>Within 10 business days of the denial.</u>			
EDI Implementation Guide for First and Subsequent Reports of Injury – Page 85 Data Requirements for First Report of Injury (FROI)	Commenter notes that there are two asterisks (**) after DN 42 (Social Security Number). The key indicates, however, that two asterisks relate to DN14 and requires the Claims Administrator's Zip Code. Commenter opines that the asterisks next to DN 42 should be deleted.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	Disagree. The two asterisks following DN42 have been struck out.	None.
Updated California EDI Implementation Guide for Medical Bill Payment – Cover Page	Commenter recommends awaiting adoption of the proposed regulations before dating the Guide and delaying the effective date for 90 days to allow adequate time for re-programming and training.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	Agreed. See above response to State Compensation Insurance Fund. The date of the Guide will reflect the effective date of the regulations.	The text for Sections 9701(b)(2), 9701(c)(2), and 9701(n)(2) will be amended as follows: For reporting on or after Xxxxxx, XX, 2010, (DATE TO BE INSERTED BY OAL – SIX TWELVE MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE) …..
Updated California EDI Implementation Guide for Medical Bill Payment – Page 79 Medical Data	Commenter believes that this chart is very confusing. First, in the first paragraph introduction to the chart the various entities are not defined. Who or what is an Insurance Agent? In Workers' Compensation this would	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009	Disagree. WCIS has adopted the IAIABC national standards. The Medical data element by name and source table is taken verbatim from the IAIABC EDI Implementation	Amend Medical data element by name and source table (Section K) in Medical Guide by removing "x" under JLB

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Elements by Name and Source	be a policy sales entity. If, on the other hand, this is an EDI vendor transmitting data, how is it different from the Sender? Is the Payer the Claims Administrator? If so, commenter suggests changing the title to conform to the regulation and Glossary. If a Payer is handling its own transmissions, how is it differentiated from the sender? It may be that the Payer, Insurance Agency and Sender could be one and the same. Or that the Sender can be either the Insurance Agency (if an EDI vendor) or the Payer (if a Claims Administrator). Commenter believes that this terminology needs clarification. Commenter states that the introduction to the chart is unclear as to whether the entities named are the source of information or those having access to the data elements. Commenter opines that identification of entities that are the sources is probably a good idea as the majority of medical elements are potentially "accessible" by all parties, except the Jurisdictional Licensing Boards, and identification of both sources and parties with access would make for a very cluttered chart. Commenter states that there are a number of errors in the Chart. Taking them in the order that they appear on the chart, commenter suggests adding or deleting "x"'s in the following columns: The Health Care Provider (HCP) is the primary source for all medical billing data elements yet none of the following DN numbers show this: 513, 535, 629, 528, 542, 510, 534, 557, 504,	Written Comment	Guide for medical Bill Payment Records, Release 1.1 (July 1, 2009), page 1-2.1, and indicates sources which are nationally recognized by both medical providers and payers.	column for DN 523, 704, and 208.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	678, 688, 737, 714, 717, 626, 522, 525, 208, 600, 521, 550, 524, 642, 638, 656, 649, 559, 501, 552, 566, 565. Conversely, the HCP is not the source of the following DN numbers, yet it is shown to be so, on the chart. To set forth the source of the elements the following should be removed from the HCP column: DN 15, 187, 188, 515,152, 153, 156, 507. Commenter recommends deleting the following from the Payer column if it is, indeed, the Claims Administrator: DN 634, 537, 514, 152, 153,156, 682, 715, 699, 647, 592,595, 615, and adding DN 31, 7, 605. Commenter believes that the Jurisdictional Licensing Board is not responsible for DN 523, 704, 208. Commenter opines that placing "x"s for Insurance Agency, Payer, and Sender is problematic due to their undefined nature. Perhaps bundling them all into Sender (the entity transmitting the data to WCIS) would be simpler. Commenter states that the Insurer/ Self-Insured Employer is ultimately responsible for the data regardless of who sends it. Commenter did not find DN 111, 104 or 105 in the Data Dictionary and no source is listed for DN 105.		WCIS, however, agrees that the Jurisdictional Licensing Board is not responsible for DN523, 704, and 208. The Medical Guide will be amended to reflect this. Disagree. It is better to follow the national standards of the IAIABC. All three are standard IAIABC data	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			elements. DN 111 is contained in the 824 detailed acknowledgement indicating the status of the bill as being accepted (TA), rejected(TR) or accepted with error(TE) on page 6-2.1 of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, (July1, 2009). DN 104 is contained in the 837 ISA15 field of the Interchange Header and is described on page 6-2.3 of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 (July1, 2009). The DN105 is the Version/Release of the X12 EDI standard being utilized and is contained in the BGN02 field of the 824 acknowledgement. It is discussed on page 4-4 of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 (July 1, 2009).	
	Commenter questions the use of DN 526 Release of Information Code because Workers' Compensation is exempted from the HIPAA requirements. Commenter states that Payors do not have DN 537 Billing Provider Primary Specialty Code or DN 651 Rendering Provider Primary Specialty Code unless the provider submits it and there is no such requirement. Until the Standardized Billing Regulations are adopted, commenter opines that these codes should not be mandatory.		DN 526 (Release of Information Code) is optional and not required to be reported. The AMA taxonomy of medical providers is general enough for all medical payers to identify a code for all valid medical bills. For example, the taxonomy includes general codes like Dentist, Pharmacy, Ambulances,	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			Hospitals, Clinics, and Registered Nurses.	
	DN 153 Green Card, DN 152 Employment Visa, and DN156 Passport Number are not collected. While the Table shows Payor and Health Care Providers, this is not the case. Commenter opines that it would be an onerous task for the Claims Administrator to get this data and if anyone has it, it is probably the employer.		Disagree. Billing information such as Visa/Green Card / Passport data is conditional under the WCIS reporting requirements. DN 153 (Green Card), DN 152) Employment Visa), and DN 156 (Passport Number) all share the same business need as DN42 (Employee SSN), which is to identify the employee in the jurisdiction's system.	
Updated California EDI Implementation Guide for Medical Bill Payment – Page 90 Medical Data Element Requirement Table	DN153 Green Card, DN 152 Employment Visa, and DN 156 Passport Number are all conditional elements that must be reported if there is no Social Security Number. Commenter states that none of this data is collected and/or reported to the payor. Commenter requests that these elements be deleted. For DN 651 Rendering Provider Primary Specialty Code, commenter states that this is a mandatory item that the payor may or may not get from the provider. Until the Standardized Billing regulation is adopted, commenter opines that this item should not be required.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	See above answer regarding DN 153 (Green Card), DN 152) Employment Visa), and DN 156 (Passport Number). The AMA taxonomy of medical providers is general enough for all medical payers to identify a code for all valid medical bills. For example, the taxonomy includes general codes like Dentist, Pharmacy, Ambulances, Hospitals, Clinics, and Registered Nurses. WCIS has provided each claims administrator the opportunity to file for a variance for any data element required which is not	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			currently available to the claims administrator on medical bills.	
	DN 647 is currently mandatory "when available." The newly-proposed National Provider ID's (NPI) for various entities are listed as Conditional with a number of different triggering events. For DN 634 the trigger is if this entity is different from the Rendering Provider. For DN 682 it's if the bill is on a UB 04. Commenter opines that with no requirement that this field be completed, this condition is not useful. For DN 699 and DN 667 the triggering event is "when applicable." Commenter states that this needs clarification. Providers are not required to have or report these NPI's, as yet. Commenter suggests removing these until Providers are required to report them. Alternatively, commenter requests that they should be optional or listed as "when available" consistent with DN 647.		The National Provider ID Number data elements DN 634, DN682, DN699, DN647, and DN667 are all optional.	
Updated California EDI Implementation Guide for Medical Bill Payment – Page 97 California Adopted IAIABC Data Edits And Error Messages	Commenter states that any codes that providers are not currently required to report to payors should be removed from this listing. Commenter opines that these can be the subject of a future revision following the adoption of the Standardized Billing/E-Billing regulations.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	WCIS recognizes the value of billing rules. In this regard, WCIS does not require the submission of data elements that are not required to be given by the health care provider to the claims administrator.	System programming change to relax edit dates on bills where payments are made outside of stated date rules set forth on proposed Section L of the Medical Guide.
	There are 2 columns entitled "Must be less than the Date of Injury", and "Must be greater than		Agreed. WCIS has implemented programming on its system which	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	or equal to Date of Service". There are occasions when payments must be made outside of these rules. Deposition fees and mileage payments are frequently made in advance of the date of service while payment for the treatment of Continuous Trauma services sometimes occurs before the stated Date of Injury. Commenter states that changes should be made to accommodate such circumstances.		relaxes the date requirements for specific bill types.	
Updated California EDI Implementation Guide for Medical Bill Payment – Page 116 Code Sources	Commenter states that the specific version or edition of each of the cited documents should be provided. Commenter opines that without this information errors will occur when the wrong version is accessed. Commenter states that the Division of Workers' Compensation Official Medical Fee Schedule should be added, in addition to the CPT, because California is many years behind with updating to current CPT codes. Commenter suggests that it might be best to delete the CPT citation altogether until the Physician's Fee Schedule is revised.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	Proposed Section N provides information on where to obtain valid source codes. As indicated in the introductory paragraph, the code lists are provided as a convenience. The use of such code sets are mandated by the EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 (July 1, 2009). Disagree. The HCPCS data elements capture all of the valid CPT since September 22, 2006 and the jurisdictional data elements capture all California-specific code that identifies a medical procedure, service, or product billed that is not identified by a current HCPCS code. California Jurisdiction Codes are either set forth and/or incorporated by reference in California Code of Regulations, title 8, section 9795, regarding reasonable fees for medical-legal expenses, section 9789.11, regarding fees for physician services rendered on or after July 1, 2004, or in section 9702(e)(2),	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			footnote 6, regarding lump-sum settlements.	
	For NDC codes, it is unclear why only Medispan is cited. Commenter states that it may be useful to provide an explanation.		See above; Proposed Section N provides information on where to obtain valid source codes. Currently, the Division is utilizing Medispan as its source of NDC codes. As indicated in the introductory paragraph, the code lists are provided as a convenience; trading partners are free to utilize other sources.	
Updated California EDI Implementation Guide for Medical Bill Payment – Page 119 Place of Service and Revenue Codes	Commenter notes that these lists are slated for deletion and are being replaced with only a mailing address. If there is a website, commenter states that it too should be provided. Commenter states that a revision date needs to be provided for the specific edition to be accessed. If the regulated community will now have to purchase these documents, commenter prefers to have them retained in the Guide.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	Medicine is a science with constantly changing information. The code sets, as required by the EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 (July 1, 2009), are dynamic and change as new medical procedures, services, and goods are developed to treat injured workers.	None.
Updated California EDI Implementation Guide for Medical Bill Payment – Page 134 List of California Adopted IAIABC Data Elements	In addition to this listing, commenter states that the Data Dictionary for these Data Elements should be added in order to make referencing more efficient.	Steve Suchil Assistant Vice President American Insurance Association December 15, 2009 Written Comment	The IAIABC develops and maintains the nationally accepted data dictionary for workers compensation. See the data dictionary as set forth in Section 6 of the EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 (July 1, 2009).	None.
Updated California EDI Implementation	Commenter believes the lump sum terminology should only refer to "payments", not liens or	Steve Suchil Assistant Vice President	Disagree. The IAIABC standards utilize the terms "lump sum	Change all 'lump sum settlement' to Medical

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Guide for Medical Bill Payment – Page 138 Lump Sum Bundled Lien Bill Payment	settlements. In this way the reporting will be all inclusive for multiple types of lump sum payments. Commenter recommends the following changes: Section P: Lump sum medical ~~bundled lien~~ bill payments California law allows the filing of a lien against any sum to be paid as compensation for the "reasonable expense incurred by or on behalf of the injured employee" for medical treatment (see Labor Code section 4903(b)). The DWC/WCIS has adopted IAIABC medical lien codes as the standard for reporting bundled lump sum medical bills (See 8 C.C.R. § 9702(e)). The six codes below, describe the type of lump sum ~~settlement~~ payment made by the claims payer after the filing of a lien with the Workers' Compensation Appeals Board (WCAB). Reportable lump sum medical ~~liens~~ payments may originate from medical bills filed on DWC WCAB Form 6. (The medical lien form is located at http://www.dir.ca.gov/dwc/FORMS/DWCForm6.pdf.) Commenter states that the word lien should be removed from the Medical lump sum data requirements section where it appears four times.	American Insurance Association December 15, 2009 Written Comment	settlements" and "lump sum payment" in the definitions of the proposed codes for reporting lump sum medical lien data. WCIS will add the adjectives "medical lien" to both terms in the medical implementation guide and regulations to be consistent. When referring to both the language will be changed to "medical lien lump sum payments or settlements". To be a reportable Medical Lien Bill a Notice and Request for Allowance of Lien must first be filed with the WCAB.	Lien Lump Sum Payments or Settlements on page 138, except for the 6 IAIABC codes listed in the table on page 138 in new Section O. Change "lump sum payment" to Medical Lien Lump Sum Payments or Settlements, except for the 6 IAIABC codes listed in the table, in Section O.
Updated California	Commenter notes that these provisions are	Steve Suchil	Disagree. The deleted sections are	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
EDI Implementation Guide for Medical Bill Payment – Page 142 Section Q Medical EDI Glossary and Acronyms and R Medical EDI Glossary and Acronyms	slated for deletion. Commenter recommends retaining them as resources. The forms have not been adopted as yet, but since they are frequently referenced in the Guide, commenter believes that they should be readily available. In addition, commenter states that the IAIABC Data Dictionary should be added.	Assistant Vice President American Insurance Association December 15, 2009 Written Comment	either unnecessary or duplicative of that which is set forth in the EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 (July 1, 2009).	
DN719 – ADA Procedure Billed Code	This code is still not listed on the data element requirement table. Commenter requests clarification if dental bills should be reported. If they should be, how does the state want them reported?	Suzanne L. Jackson Business Systems Analyst Medical Management CS STARS December 15, 2009 Written Comment	Yes, dental procedures provided to injured workers as part of the medical care are to be reported. The Dental Codes are to be reported utilizing the HCPCS Level II "D" series in the SV1 segment of the 837.	None.
DN715 – Jurisdiction Procedure Billed Code	Commenter notes that condition has changed to: "if the jurisdiction procedure billed code is not a HCPCS procedure code." Commenter questions what this means.	Suzanne L. Jackson Business Systems Analyst Medical Management CS STARS December 15, 2009 Written Comment	A California-specific code that identifies a medical procedure, service, or product billed that is not identified by a current HCPCS code. California Jurisdiction Codes are either set forth and/or incorporated by reference in California Code of Regulations, title 8, section 9795, regarding reasonable fees for medical-legal expenses, section 9789.11, regarding fees for physician services rendered on or after July 1, 2004, or in section 9702(e), footnote 13, regarding lump-sum settlements.	None.
DN726 – HCPCS Line Procedure Code; DN728 – NDC Paid Code; DN729 – Jurisdiction Procedure Paid Code	Commenter notes that these codes were all changed to conditional with the condition of "if the line is adjusted." Commenter would like clarification of what this means. If the paid amount does not equal the charged amount, was the line adjusted? Or does the DWC really	Suzanne L. Jackson Business Systems Analyst Medical Management CS STARS December 15, 2009 Written Comment	Both. Adjusted means if DN552 (total charge per line) is not equal to DN574 (total amount paid per line) or if the HCPCS billed code, DN714, is not equal to the HCPCS paid code, DN726, or if the jurisdictional billed	Delete revisions in mandatory trigger language in Medical Data Element Requirement Table (Section K) for DN726, DN728, and

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	mean if different than billed code?		code, DN15, is not equal to the jurisdictional paid code, DN729, or if the NDC billed code, DN721, is not equal to the NDC Paid code, DN728. WCIS will maintain the original wording in the current guide and remove the new wording.	DN729.
DN699 – Referring Provider NPI	This code is conditional and the condition is "when applicable on professional and institutional bills." Commenter notes that there is no box for the referring provider on the UB-04 billing form and the page 81(data element by source spreadsheet) doesn't list a box either. Commenter asks if this should be applicable to hospital bills.	Suzanne L. Jackson Business Systems Analyst Medical Management CS STARS December 15, 2009 Written Comment	Yes. If applicable and known. The IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 (July1, 2009) references the field 17b on the CMS 1500 for a professional bill accompany a hospital bill. The CMS references field 78 and 79 on the UB04 for the referring provider.	None.
DN667 – Supervising Provider NPI	This code is conditional and the condition is "when applicable on institutional bills." Commenter notes that page 82 lists DN as provided by the HCP because there is not box on the UB04 to capture this. Commenter asks if this should be applicable to hospital bills.	Suzanne L. Jackson Business Systems Analyst Medical Management CS STARS December 15, 2009 Written Comment	Agree. Will change the mandatory trigger to "when a non-licensed rendering provider is being directed/supervised by a licensed provider. "	Revise mandatory trigger language in Medical Data Element Requirement Table (Section K) for DN 667.
General Comment	Commenter states that the California provider loops are not in line with the IAIABC standard. According to the standard, the billing provider should be mandatory and the rendering bill provider should be reported if different than the billing provider. California mandates the rendering bill provider and placed a condition on the billing provider (if different than the rendering bill provider). Commenter requests that the Division change the provider loops to be in line with the IAIABC standard.	Suzanne L. Jackson Business Systems Analyst Medical Management CS STARS December 15, 2009 Written Comment	Disagree. Both segments are situational in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, (July1, 2009), page 2-1.4.	None.
General Comment	Commenter states that before any state reporting changes are made, it is very important that the state has appropriate billing rules in	Suzanne L. Jackson Business Systems Analyst Medical Management CS	WCIS recognizes the value of billing rules. In this regard, WCIS does not require the submission of data	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	place. Commenter opines that billing rules requiring data elements have to be in place on the front end prior to requiring any data on the back end (reporting side). The billing rules should address what to do with provider bills when/if they contain invalid or missing data. For example should we send the bill back when it contains invalid data?	STARS December 15, 2009 Written Comment	elements that are not required to be given by the health care provider to the claims administrator.	
9702 (b)	Commenter refers to the addition of Data Element No. 26 "Insured Report Number." Commenter notes that the California EDI Implementation Guide draft dated January 2010 do not reference this element on either the First Report of Injury (FROI) or the Subsequent Report of Injury (SROI) tables. Since this is being added, commenter requests that it be designated as "optional" as not all reporters assign a unique "report number" in their claim systems and to do so would constitute a considerable reporting expense.	Janice Bell Assistant Vice President Zenith Insurance Company December 15, 2009 Written Comment	The Insured Report Number is optional. See Section K, Data Requirements for First Reports of Injury.	None.
California EDI Implementation Guide draft, January 2010 – Section K	Commenter notes that this section has changed Data Element No. 25 "Industry Code" to M/S (Mandatory/Serious). Commenter requests that this be changed to "optional" since Unit Statistical and Policy Reporting in California has never required the capture of the employer's Industry code. Commenter opines that by making this M/S, virtually all FROI's will return errors if this element is not reported. Commenter states that by making this "optional" the Division can collect this from those trading partners that do collect this information on their policies.	Janice Bell Assistant Vice President Zenith Insurance Company December 15, 2009 Written Comment	The Industry Code is M/S but trading partners can report either a valid 2, 4, or 6 digit industry. See Section N, Industry Codes.	None.
General Comments	Commenter recommends that the Division delay further consideration of changes to the WCIS system until regulations on medical	Brenda Ramirez Claims and Medical Director	WCIS recognizes the value of medical billing rules. Upon the adoption of billing rules by DWC,	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	billing standards are adopted. Those standards will determine what medical information will be available for reporting to WCIS. Commenter urges the DWC to consider the feedback presented by CWCI and other members of the WCIS FROI/SROI Task Force that urged the DWC to collect benefit information periodically instead of continuously. Commenter opines that continuous SROI reportings result in multiple data errors and are burdensome and costly and that periodic reportings provide a more efficient and cost-effective way to collect the data. Commenter recommends adding all necessary information from the IAIABC implementation guides and from other sources into the California implementation guides. Commenter believes that consolidating this information will ensure that the regulated public can understand and efficiently comply with the regulations, minimize error messages, and reduce costs as claims administrators will not need to purchase separate materials.	California Workers' Compensation Institute December 15, 2009 Written Comment	WCIS will amend its regulations to correspond with such rules. In this regard, WCIS does not require the submission of data elements that are not required to be given by the health care provider to the claims administrator. DWC agrees that periodic report could be a cost-effective, viable option should, after adoption of the proposed amendments, continuous SROI reporting results in multiple errors by trading partners. Disagree. The IAIABC medical bill payment guide is the source that is referenced for the national standard. The California medical implementation guide is the subset of the IAIABC guide which is unique to the California implementation of the national standard. The two guides highlight the differences for clarification.	
9701	Commenter request that if the DWC decides to continue incorporating the IAIABC guides, modify the IAIABC guide references as indicated in the changes recommended as follows: (b) California EDI Implementation Guide for	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	Labor Code section 138.6 expressly provides that the data collected by WCIS "shall be compatible with the Electronic Data Interchange System of the International Association of Industrial Accident Boards and Commissions. [IAIABC]". The IAIABC implantation guides are	Remove the reference to medical billing electronic forms in section 9701(c). Revise section 9701(d) to correct the footnote citation in subdivision (e) and reference "medical lien lump sum payments

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	First and Subsequent Reports of Injury. Contains California-specific reporting requirements and information excerpted from the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, by the International Association of Industrial Accident Boards and Commissions. The California EDI Implementation Guide for First and Subsequent Reports of Injury is posted on the Division's Web site at http://www.dir.ca.gov/dwc/WCIS.htm , and is available ~~by~~ from the Division of Workers' Compensation upon request. (1) For reporting prior to Xxxxxx, XX, 2010, (DATE TO BE INSERTED BY OAL – SIX MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE) use the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 2.1, dated February 2006, which is incorporated by reference. (2) For reporting on or after Xxxxxx, XX, 2010, (DATE TO BE INSERTED BY OAL – SIX MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE) use the California EDI Implementation Guide for First and		copyrighted material of the IAIABC and are only available through purchase from the organization. See the IAIABC website at: http://www.iaiabc.org/i4a/pages/index.cfm?pageid=3339. The Division would prefer to provide all IAIABC material free to the regulated community in one comprehensive implementation guide. However, the copyright held by the organization over its standards precludes the Division from do so. Regardless, as indicated on the Notice of Rulemaking, the rulemaking file, including the IAIABC implementation guides, were available for public inspection at the Division's office. The was expressly stated on the Division's website: (http://www.dir.ca.gov/dwc/DWCPropRegs/WCIS_Regs/WCIS_Regulations.htm). There was no request by a member of the public to inspect these documents. The Division fully believes that it provided the public with the opportunity to properly understand the proposed changes and to make fully informed comments without cost and encumbrance. The Division does agree to make the following non-substantive changes suggested by the commenter. The Division will: (1) remove the reference to medical billing	or settlements".

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	Subsequent Reports of Injury, Version 3.0, dated ~~January 2010,~~ Xxxxxx, XX, 2010, (DATE TO BE INSERTED BY OAL – SIX MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE) which is incorporated by reference. (c) California EDI Implementation Guide for Medical Bill Payment Records. Contains the California-specific protocols and excerpts from the IAIABC EDI Implementation Guide for Medical Bill Payment Records, explains the technical design and functionality of the WCIS system, testing options for the trading partners, instructions regarding the medical data elements ~~for medical billing, and copies of the required medical billing electronic forms~~ and reporting standards and requirements. The California EDI Implementation Guide for Medical Bill Payment Records is posted on the Division's Web site at http://www.dir.ca.gov/dwc/WCIS.htm, and is available from the Division of Workers' Compensation upon request. (1) For reporting prior to Xxxxxx, XX, 2010, (DATE TO BE INSERTED BY OAL – SIX MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE) use the California EDI Implementation Guide		electronic forms in section 9701(c) as these forms have been deleted in the proposed medical implementation guide; (2) revise proposed subdivision (d) to correct the footnote citation in subdivision (e) and reference "medical lien lump sum payments or settlements". The additional changes suggested by the commenter do not provide greater clarity than the original or proposed language.	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	for Medical Bill Payment Records, Version 1.0, dated December 2005, which is incorporated by reference. (2) For reporting on or after Xxxxxx, XX, 2010, (DATE TO BE INSERTED BY OAL – SIX MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE) use the California EDI Implementation Guide for Medical Bill Payment Records, Version 1.1, dated ~~January 2010,~~ Xxxxxx, XX, 2010, (DATE TO BE INSERTED BY OAL – SIX MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE) which is incorporated by reference. (d) California Jurisdiction Code. A California-specific code that identifies a medical procedure, service, or product, ~~billed~~ that is not ~~identified by~~ a current HCPCS code. California Jurisdiction Codes are either set forth and/or incorporated by reference in California Code of Regulations, title 8, section 9795, regarding reasonable fees for medical-legal expenses, section 9789.11, regarding fees for physician services rendered on or after July 1, 2004, or in section 9702(e)(2), footnote 6, regarding lump-sum ~~settlements~~ payments.			

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	(m) IAIABC EDI Implementation Guide, Release 1. EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, by the International Association of Industrial Accident Boards and Commissions. The IAIABC EDI Implementation Guide, Release 1, February 15, 2002, can be obtained from the IAIABC at either the IAIABC website at http://www.iaiabc.org, or the IAIABC office located at 5610 Medical Circle, Suite 24, Madison, WI, 53719-1295; Telephone: (608) 663-6355. (n) IAIABC EDI Implementation Guide for Medical Bill Payment Records. IAIABC EDI Implementation Guide for Medical Bill Payment Records, by the International Association of Industrial Accident Boards and Commissions. The IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, can be obtained from the IAIABC at either the IAIABC website at http://www.iaiabc.org, or the IAIABC office located at 5610 Medical Circle, Suite 24, Madison, WI, 53719-1295; Telephone: (608) 663-6355. (1) For reporting prior to Xxxxxx, XX, 2010,			

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	(DATE TO BE INSERTED BY OAL – SIX MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE) use the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1, ~~approved~~ July 4, 2002, which is incorporated by reference. (2) For reporting on or after Xxxxxx, XX, 2010, (DATE TO BE INSERTED BY OAL – SIX MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE) use the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, ~~approved~~ July 1, 2009 Edition, which is incorporated by reference. **Argument** Despite the fact that the definition and other information for proposed new data elements resides only in the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, the DWC did not distribute that Guide to interested parties with the other rulemaking documents, and neither did it post that Guide on the WCIS rulemaking page of the DWC web site. The DWC has therefore failed to properly inform the regulated public, and deprived the public of its right to properly understand the proposed changes and to make			

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	fully informed comments without cost and encumbrance. Government Code section 11346.2 specifically enumerates the contents of the notice of the proposed action required to be provided both to the Office of Administrative Law (OAL) and to be made available to the public. The notice includes any "technical, theoretical, and empirical study, report, or similar document, if any, upon which the agency relies in proposing the adoption … of a regulation." Section 11346.5 states that the notice of proposed adoption of the regulation shall include all available information upon which the agency's proposal is based, and has made available the express terms of the proposed action. It is important that all information and requirements are made available in a single implementation guide so that the regulated public is not forced to expend scarce resources searching for information in multiple tomes from disparate locations. Having all the information in a single guide will ensure that the regulated public can understand and comply with the regulations and will thereby reduce the time and effort wasted by regulator and regulatee alike attending to error messages. In addition, the IAIABC's guides cannot be referenced simply by clicking on the IAIABC web site link provided. They must be purchased; and if they are not, the regulated community cannot know and comply with the regulations. Finally, it appears that the IAIABC EDI Implementation Guide for			

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Medical Bill Payment Records, Release 1 is not available at all, as it does not appear on the IAIABC's list of guidelines that may be purchased on the IAIABC web site and it is no longer posted on the DWC web site. For the sake of clarity and consistency, the date on the California implementation guides should reflect the implementation date of the regulations. Since there are no "required medical billing electronic forms," the changes recommended for subsection (c) are intended to clarify the meaning we think was intended. Because the proposed codes for reporting lump sum payments are not limited to settlements, to avoid confusion, both in this section and elsewhere in these regulations and Guides, it is preferable to use the term "lump sum payments" instead of other terms such as "lump sum settlements" or "medical lien lump sum payments."			
9702(a)	Commenter recommends adding language to the beginning of this sub-section 9702(b) to specify that the revised regulations take effect six months after the date the regulations are filed with the Secretary of State. **Argument** The language included in the Section 9701 definitions regarding implementation guides	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	Agreed. In fact, the phase-in period for the proposed amendments will be extended to 12 months.	The text for Sections 9701(b)(2), 9701(c)(2), and 9701(n)(2) will be amended as follows: For reporting on or after Xxxxxx, XX, 2010, (DATE TO BE INSERTED BY OAL – TWELVE MONTHS

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	make it clear that the revised versions of the Guides are to become effective six months after the date the regulations are filed with the Secretary of State. It also needs to be clear that all the changes in the regulations, not only those in the Guides, will take effect six months after the date the regulations are filed with the Secretary of State to allow sufficient time to make necessary programming changes, to train, and to implement the changes.			FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE) …..
9702(b)	Commenter recommends deleting the proposed new data elements from the table in Section 9702(b) and from the proposed revisions to the California EDI Implementation Guide for First and Subsequent Reports of Injury (FROI/SROI). Commenter recommends the following revised language: Data elements omitted under this subsection because they were not known by the claims administrator shall be submitted within sixty (60) days from the date the information becomes known ~~of the first report under this subsection~~. **Argument** The DWC has not provided specific reasons for including each proposed new data element in its Initial Statement of Reasons. The stated necessity is that the additional data elements *"can provide relevant information on the adequacy of the benefit delivery system" and*	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	See specific responses below. The 60 day requirement for submitting FROI data elements not known to the claims administrator at the time of the initial filing is not being amended in this rulemaking proposal. As such, a response is not necessary. Regardless, a good faith investigation of a claim by the claims administrator, required under 8 C.C.R. § 10109, should reveal all basic information regarding a claim.	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	that they "will assist the division in implementing Assembly Bill (AB) 2181 (Chapter 740, Statutes of 2008) ... which was signed into law by the Governor on September 30, 2008, amends Labor Code sections 6409.1 and 6410 by authorizing the DWC to create a new Employer's First Report of Occupational Injury or Illness." The proposed new data elements will not accomplish these goals. **DN 39 (initial treatment code)**: For the DN 39 (initial treatment code) field, according to the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgement Detail, Header, & Trailer Records, the value from the "First Report" is to be reported, and must be one of the following: 0 = No medical treatment 1 = Minor on-site remedies by employer medical staff 2 = Minor clinic/hospital medical remedies and diagnostic testing 3 = Emergency evaluation, diagnostic testing, and medical procedures 4 = Hospitalization > 24 hours 5 = Future Major Medical/Lost Time Anticipated (i.e. hernia cases) It is unclear what "first report" is intended. The employer's first report (Form 5020)		The Initial Treatment Code, DN39, is defined in the IAIABC FROI/SROI Guide, Release 1 (Feb. 2002) as: "A code used to identify the extent of medical treatment received by the employee immediately following the accident." See Dictionary, Section 6. The data element is reporting <u>on</u> the First Report electronically transmitted by the trading partner, not <u>from</u> an undefined First Report. For most claims, the initial treatment code should be apparent to a claims administrator. If this is not the case, the code should not be reported. The data element is an optional. See Section K of proposed CA FROI Guide, Data Requirements for First Reports of Injury.	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	contains no such field, and an employer is not required to report first aid claims. The only related questions on the existing form are whether the employee was hospitalized overnight and whether the employee was treated in an emergency room. In addition, the employer's first report (Form 5020) is often made prior to first treatment, the employer is not qualified to make medical determinations, and above all, an employee's right to medical privacy precludes the employer from asking the injured employee about his or her medical treatment. A doctor's first report form (Form 5021) also does not have a field that captures the required values, but it does have fields that the doctor may use to describe treatment. There no requirement for a doctor to report these values in those fields, however, and the values listed are both confusing and not comprehensive. No doctor's first report (Form 5021) is likely when no medical treatment is provided, or when first aid is provided by a non-physician. It is inappropriate for a claims adjuster or other claims administrator representative to make a medical determination and select one of the required values and an arbitrary selection would be of less than no value. We are aware of no corresponding field in existing claims systems from which such values can be extracted and reported to WCIS. Another point of potential confusion is that in every case, every emergency and urgent care physician must submit a doctor's first report			

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	form following an initial visit to the treatment facility, and the first and every subsequent primary treating physician must also submit a doctor's first report form following an initial visit. From which "first report" should information be reported -- the first received, the earliest date of service? What if a claims administrator receives (as is often the case) an earlier date of service after the first received has been reported? The business need stated in the IAIABC Guide is "to qualify the severity of the injury," however it is not possible to determine the severity of an injury on a first visit, and there are far better ways to determine severity (such as diagnoses and claim costs). For all these reasons, we believe that this data element should be removed. Proposed new data element **DN 26 (insured report number)** is defined in the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgement Detail, Header, & Trailer Records as "a number used by the insured to identify a specific claim." There is no field in the current employer's first report (Form 5020) that asks for a number used by the insured (employer) to identify a specific claim. The number an insured employer uses to identify a specific claim is the claim number assigned by the insurer (DN 15), which is already reported to WCIS. For these reasons it is not necessary to collect DN 26, therefore, that proposed data element should be removed.		DN 26 (insured report number) provides WCIS with another option to match FROI reporting with SROI and medical billing reporting. It is an optional data element and need not be reported by a claims administrator. See Section K of proposed CA FROI Guide, Data Requirements for First Reports of Injury.	

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	DN 28 (policy number): The policy number appears on the current employer's first report (Form 5020), however this information is not required by the controlling Labor Code section 6409.1. **DN 29 (policy effective date) and DN 30 (policy expiration date)**: These dates do not appear on the current employer's first report (Form 5020) and will neither "*provide relevant information on the adequacy of benefit delivery system"* nor *"assist the division in implementing Assembly Bill (AB) 2181 (Chapter 740, Statutes of 2008) ... which was signed into law by the Governor on September 30, 2008, amends Labor Code sections 6409.1 and 6410 by authorizing the DWC to create a new Employer's First Report of Occupational Injury or Illness*." Because policy information generally resides on a separate system from claims information, programming this information to automatically submit to WCIS from the policy system would be costly. In addition, policy information, especially policy dates, is highly confidential proprietary information that insurers should not be required to provide and is not necessary. **DN 32 (time of injury) and DN 33 (postal code of injury site)**: These elements also appear on the current employer's first report (Form 5020), but once again this information is		Both DN32 (time of injury) and DN33 (postal code of injury site) will be required reporting elements under the Division's new Employer's First	

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	not required by the controlling labor code section 6409.1 and is not necessary. These elements neither "*provide relevant information on the adequacy of benefit delivery system"* nor *"assist the division in implementing Assembly Bill (AB) 2181 (Chapter 740, Statutes of 2008) ... which was signed into law by the Governor on September 30, 2008, amends Labor Code sections 6409.1 and 6410 by authorizing the DWC to create a new Employer's First Report of Occupational Injury or Illness*." When the Administrative Director creates a new Employer's First Report of Occupational Injury or Illness, the Institute suggests that she remove questions that ask for non-essential information. **Information that is not known** cannot be reported. To require reporting of unknown data elements undermines the integrity of WCIS. Information can be reported accurately only after it becomes known.		Report pursuant to Labor Code section 6409.1. DN33 (postal code of injury site) provides valuable information regarding the physical location of an injury, which may or may not match the actual location of an employer. DN32 (time of injury) further provides valuable information regarding the nature of occupational injuries (i.e., do specific types of injuries occur during the morning or afternoon) that may lead to new or refined preventative measures. DN32 is an optional data element; it need not be reported by a claims administrator. See Section K of proposed CA FROI Guide, Data Requirements for First Reports of Injury.	
9702(c)	Commenter recommends deleting the proposed new data elements. **Argument** The DWC has not provided specific reasons for including each proposed new data element in its Initial Statement of Reasons. The stated necessity is that the additional data elements *"can provide relevant information on the adequacy of benefit delivery system" and that they "will assist the division in implementing*	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	The data elements identified by the commenter, DN1, DN4, and DN5, are required under the standards set forth by the IAIABC. The IAIABC standards are required by Labor Code section 138.6 and cannot be unilaterally deleted by the Division.	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Assembly Bill (AB) 2181 (Chapter 740, Statutes of 2008) ... which was signed into law by the Governor on September 30, 2008, amends Labor Code sections 6409.1 and 6410 by authorizing the DWC to create a new Employer's First Report of Occupational Injury or Illness," however the proposed new data elements will not accomplish these goals. The cost of programming, training, submissions, etc., far outweighs any potential benefit of these non-essential data elements. The change to **DN 5** (agency/jurisdiction claim number) is merely a non-essential name modification to the existing data element. It is not necessary for claims administrators to report **DN 4** (jurisdiction) because it's value is always CA (California). California is "the governing board or territory whose statutes apply" (as defined in the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgement Detail, Header, & Trailer Records). The DWC knows this without it being reported. **DN 1** (transaction set ID) is also not essential. The transaction set is evident from the group of data elements submitted on a claim.			
9702(d)	Commenter recommends deleing proposed new data elements that are not essential. **<u>Argument</u>**	Brenda Ramirez Claims and Medical Director California Workers'	The Division believes that periodic reporting, such as quarterly reporting, would be the most efficient manner in which to report subsequent	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	The DWC expressed concern about SROI under-reporting requirements and the large number of error messages, and asked a WCIS FROI/SROI task force to address the issues. The task force strongly recommended reducing the number of WCIS data elements and replacing the requirements for continuous WCIS reporting with periodic reporting (such as annual or biannual reporting). Contrary to the task force recommendations, the Division is not moving towards periodic reporting and plans to add 15 additional data elements to this sub-section, while deleting only two. The Institute urges the Division to reconsider and adopt the recommendations of the task force. The necessity for many of the proposed new data elements is questionable. For example: **DN 14** (the claim administrator's postal code) was captured in the FROI reporting for the claim. It is not necessary to capture it again. **If DN 26** (insured report number) is collected as proposed in WCIS FROI reporting it is not necessary to capture it again. See section 9702(b) discussion on DN 26. The **DN 74** (claim type), such as medical only or indemnity can generally be determined by	Compensation Institute December 15, 2009 Written Comment	payments and claim history. However, IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgement Detail, Header, & Trailer Record, Release 1 (February 2002) does not allow this type of reporting in its framework. Until the Division can economically move toward periodic reporting, which would necessitate the adoption of Release 3 of the IAIABC guide, the Division must attempt to refine and improve SROI reporting. The proposed SROI elements move towards this goal. DN14 is necessary as a means to match a SROI report to a FROI report and to match a claim to specific location where claims are adjusted by the claims administrator. See above response regarding the reporting of DN26, an optional data element. DN 74 provides an expedient manner in which to determine the current	

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	other data submitted, such as the existence of indemnity payments.		benefit classification of the claim. Regardless, the data element is optional and need not be reported by the claims administrator. See Section K of proposed CA FROI/SROI guide, Data Requirements for Subsequent Report of Injury	
	DN 92 (benefit adjustment code), **DN 93** (benefit adjustment weekly amount), and **DN 94** (benefit adjustment start date), refer to benefits reduced. These data elements are not essential as payments and adjustments to benefits information is already captured via DN 85 (payment/adjustment code), DN 86 (payment adjustment paid to date), DN 87 (payment/ adjustment weekly amount), DN 88 (payment/adjustment start date), DN 89 (payment/adjustment end date), DN 90 (payment/adjustment weeks paid), and DN 91 (payment/adjustment days paid).		The benefit adjustment codes (DN92, DN93, and DN94) provide a more accurate and efficient way to determine if adjustments being applied to a weekly, continuing benefits, such a temporary disability and permanent disability indemnity payments. Given sporadic SROI reporting and the lack of a penalty structure to enforce such reporting, specific benefit adjustment reporting provides a better picture of changes than simply adding payment amounts. Regardless, the data elements are optional and need not be reported by the claims administrator. See Section K of proposed CA FROI/SROI guide, Data Requirements for Subsequent Report of Injury	
	It is not essential to require **DN 78** (number of permanent impairments), **DN 79** (number of payments/adjustments), **DN 80** (number of benefit adjustments), **DN 81** (number of paid to date/reduced earnings/recoveries), and **DN 82** (number of death dependent/payee		As noted above, sporadic SROI reporting and the lack of a penalty structure to enforce SROI reporting make compiling reported payments an inaccurate means to estimate how indemnity payments are made in the	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	relationships), because the numbers can be derived from the underlying reporting.		state's workers' compensation system. Requiring specific reporting regarding the number of permanent impairments (DN78, the number of payments/adjustments (DN79), the number of benefit adjustments (DN80), the number of paid to date/reduced earnings/recoveries (DN81), and the number of death dependent/payee relationships (DN82), provide a more accurate picture of indemnity payments..	
9702(e)	Commenter recommends delaying the WCIS changes until billing standard regulations have been adopted. Commenter suggests modifying the fourth and fifth sentences as follows: ….The claims administrator shall submit the data within ninety (90) calendar days of the medical bill payment or the date of the final determination that payment for billed medical services <u>on a complete bill</u> ~~will be~~ <u>is</u> denied. Each claims administrator shall submit all lump sum payments <u>on disputed bills</u> ~~following the filing of a lien claim for the payment of such~~	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	WCIS recognizes the value of medical billing rules. Upon the adoption of billing rules by DWC, WCIS will amend its regulations to correspond with such rules. In this regard, WCIS does not require the submission of data elements that are not required to be given by the health care provider to the claims administrator. Disagree. The current language is unambiguous and more representative of the intent of the proposed regulations.	Revise section 9702(e), footnotes 11, 12, 14, 15, 16, 17, and 18 to change all references to medical liens to "medical lien lump sum payments or settlements". Include footnote 17 to DN 667 (supervising provider national provider ID), DN 682 (facility national provider ID), and DN 634 (billing provider national provider ID) in 9702(e).

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	~~medical services pursuant to Labor Code sections 4903 and 4903.1~~ within ninety (90) calendar days of the lump sum ~~medical lien~~ payment. …. Apply footnotes (7) and (17) to all national provider ID data codes including DN 634 (billing provider national provider ID), DN 647 (rendering bill provider national provider ID), DN 667 (supervising provider national provider ID), DN 682 (facility national provider ID), DN 699 (referring provider national provider ID).		Disagree. The National Provider ID Number data elements DN 634, DN682, DN699, DN647, and DN667 are all conditional and reportable only if applicable and different from DN647. To satisfy the reportable condition of being different, the NPI for both data elements must be known. If it is not known to be different than the data elements DN 634, DN682, DN699, DN647, and DN667 are not reportable.	
	Commenter suggests modifying the footnote language as follows: (11) For medical ~~lien bills~~ lump sum payment, use the date final payment was made. ~~(12) For medical lien lump sum payment use the date on the first medical bill received.~~ (13) Use the following codes for reporting a medical ~~lien~~ lump sum payment: MDS10 Lump sum settlement for multiple bills where the amount of reimbursement is in		To increase clarity for footnotes 11, 12, 14, 15, 16, 17, and 18, change all references to medical liens to "medical lien lump sum payments or settlements". It is important to note that the WCIS has been able to load a backlog of medical data into the system.	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	dispute between the claims payer and the healthcare provider. MDO10 Final order or award of the Workers' Compensation Appeals Board requires a lump sum payment for multiple bills where the amount of reimbursement is in dispute between the claims payer and the healthcare provider. MDS11 Lump sum settlement for multiple bills where liability for a claim was denied but finally accepted by the claims payer. MDO11 Final order or award of the Workers' Compensation Appeals Board requires a lump sum payment for multiple bills where claims payer is found to be liable for a claim for which it had denied liability. MDS21 Lump sum settlement for a single medical bill where the amount of reimbursement is in dispute between the claims payer and the healthcare provider. MDO21 Final order or award of the Workers' Compensation Appeals Board requires a lump sum payment for a single medical bill where the amount of reimbursement is in dispute between the claims payer and the healthcare provider. (14) For a medical ~~lien~~ lump sum payment use the first known date of lien filing, if any, otherwise use the first know date of service. (15) For a medical ~~lien~~ lump sum payment, use the settled or ordered amount. (16) For a medical ~~lien~~ lump sum payment use the amount in dispute. (17) Not required for a ~~mixed~~ medical ~~lien~~ lump sum payment. (18) For a ~~mixed bill~~ medical ~~lien~~ lump sum payment assign a value = 00.			

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Argument Data elements now in the WCIS system have seen little or no use. The return on the tremendous investment made by employers, insurers, and all others supplying the user funding for the DWC to spend on the WCIS program is small to non-existent. Especially during the current financial environment in California, additional costs and expenses must be kept to an absolute minimum. It makes sense to consider new data elements only after the Division has been able to load the large backlog of medical data into WCIS and after the billing standards that will determine which data elements are available for reporting to WCIS have been adopted. **DN 634** (billing provider national provider ID), **DN 647** (rendering bill provider national provider ID), **DN 667** (supervising provider national provider ID), **DN 682** (facility national provider ID), **DN 699** (referring provider national provider ID), can be provided only if known, and do not apply to lump sum payments. Disputed medical bills can be settled or ordered paid, regardless of whether or not a lien has been filed. Unless the Division intends to limit lump sum payments for disputed bills to those on which a lien has been filed, for clarity, and to ensure all lump sum payments are reported,		Agree. The national NPI numbers are not required for medical lien lump sum payments. Will add footnote 17 to DN 667 (supervising provider national provider ID), DN 682 (facility national provider ID), and DN 634 (billing provider national provider ID) in 9702(e), Disagree. The Division intends to limit lump sum payments for disputed bills to those on which a lien has been filed. The proposed regulations are consistent with existing Labor Code sections 4903	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	the language for medical lump sum payment in the body of the regulation, in the footnotes, and in the California Guides, needs to be consistent and needs to apply to lump sum payments on disputed bills regardless of whether or not a lien has been filed. Footnote (12) appears to conflict with footnote (14). For consistency and clarity, the term "claims administrator" is preferable and more accurate than "claims payer."		and 4903.1. Disagree. The date of the first medical bill received should always precede the date of lien filing. "Claims payor" is an IAIABC term. The Division has adopted IAIABC standards for reporting medical lien lump sum payments contained in section 3, pages 3-10.1 through pages 3-12-11 of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 July 1, 2009	
California EDI Implementation Guides – General Recommendations	Commenter recommends that instead of incorporating IAIABC implementation guides into these regulations, add all necessary information from the IAIABC implementation guides and from other sources into the California implementation guides. Commenter recommends replacing the January 2010 version date in the title of the California implementation guides with the implementation date of the regulations. Some regulatory comments on one regulatory sub-section or one Guide are applicable to both	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	As required by Labor Code section 138.6, WCIS has adopted the IAIABC national standards as reflected in IAIABC implementation guides (incorporated in the WCIS regulations by reference; see proposed section 9701). The California implementation guides serve as a refinement of the IAIABC guides as they apply to California. The Division agrees to replacing the January 2010 version date in the title of the California implementation guides with the implementation date of the regulations.	Replace the January 2010 version date in the title of the California implementation guides with the implementation date of the regulations.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Guides, but for the sake of brevity are not duplicated. **<u>Argument</u>** It is important that all information and requirements are made available in a single implementation guide so that the regulated public is not forced to expend scarce resources searching for information in multiple tomes from disparate locations. Having all the information ~~is~~ in a single guide will ensure that the regulated public can understand and comply with the regulations and will thereby reduce the time and effort wasted by regulator and regulatee alike attending to error messages. In addition, the IAIABC's guides cannot be referenced simply by clicking on the IAIABC web site link provided. They must be purchased; and if they are not, the regulated community cannot know and comply with the regulations. Finally, it appears that the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1 is not available at all as it does not appear on the IAIABC's list of guidelines that may be purchased on the IAIABC web site and it is no longer posted on the DWC web site. For the sake of clarity and consistency, the date on the California implementation guides should reflect the implementation date of the regulations.		The IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 (July 1, 2009) referenced in the proposed regulations is for sale for $95 at: http://www.iaiabc.org/i4a/pages/index.cfm?pageid=3349	
California EDI Implementation Guide for First and Subsequent Reports	Commenter recommends setting minimum standards for EDI providers and exclude providers that fail to meet those standards from the listing of EDI providers that is posted on	Brenda Ramirez Claims and Medical Director California Workers'	Disagree. The standards for reporting are clearly set forth in the implementation guides.	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
of Injury – Section B – List of EDI Service Providers	the DWC web site. **Argument** Excluding from the listing of EDI providers on the DWC web site EDI providers that fail to meet minimum standards will improve reporting efficiency and reduce the number of errors.	Compensation Institute December 15, 2009 Written Comment		
California EDI Implementation Guide for First and Subsequent Reports of Injury – Section F – Trading Partner Profile	Commenter recommends clarifying on page 27 whether the claims administrator or the trading partner should complete the trading partner profile form. Commenter requests that the Trading Partner Profile List with claim administrator FEINs on the WCIS website or remove the reference from page 27 of this section. Commenter requests that the Division modify the time listed on page 29 for "Production Response Period" to the typical response period. Commenter requests that the Division modify the Trading Partner Types list on page 32 as follows: ***Trading Partner Types** 1 = Self-Administered Insurer 2 = Self-	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	The beginning of Section F, "Who Should Complete the Trading Partner Profile?" clearly states that the entity sending information to WCIS – the trading partner – should complete the form. The blank list will be available on the Division's website upon approval of the proposed implementation guide. Upon the effective date of the regulations, the production response period will be 3 business days. Agreed. The Trading Partner Types List in Part E of the Trading Partner Profile Form, "California EDI Trading Partner Insurer/Claim Administrator ID List", has been clarified regarding self-insured employers.	Modify Part E of the Trading Partner Profile Form, "California EDI Trading Partner Insurer/Claim Administrator ID List", to distinguish self-administered, self-insured employers from third party administrators of self-insured employers. Revise Section A of the proposed CA FROI/SROI guide to define abbreviations and terms.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Administered, ~~Self-Insurer (employer)~~ Self Insured Employer 3 = Third Party Administrator of Insurer 4 = Third Party Administrator of ~~Self-Insurer~~ Self-Insured Employer ~~5 = Self-Insurer~~ 6 = Other (Please specify): _____ Commenter requests an explanation of the abbreviations and terms used in the "FTP Account Information" section on pages 36 and 37 and elsewhere. Commenter requests the following modification to the language in "Part E" on page 39: This ID List includes all ~~insurers and~~ claims administrators whose data will be reported under a given Sender ID. **Argument** It is not clear on page 27 whether the claims administrator or the trading partner should complete the trading partner profile form. The Trading Partner Profile List with claim administrator FEINs is not currently posted on the WCIS web site at the given address. CWCI members report that response periods are typically far longer than the 3 days listed in the table on page 29.		All abbreviations and terms will be defined and explained in Section A of the guide, "Sending Data to the WCIS." The term insurer is used to emphasis the entities that must be named by the trading partner.	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	For the Trading Partner Types list on page 32, the term "self-insurer" is inaccurate. The accurate term is "self-insured employer." Type 5 is duplicative and confusing and needs to be deleted. The abbreviations and terms used in the "FTP Account Information" section are not defined. The modification to the language in "Part E" on page 39 is necessary because insurers are included in the definition of "claims administrator" found on page 151.			
California EDI Implementation Guide for First and Subsequent Reports of Injury – Section J – Events that Trigger Required EDI Reports	Commenter requests that the Division modify Release 1 table on page 81 section "Time Report is Due" and add definitions and technical specifications for each MTC below the tables. 00 - Within 10 business days <u>of claims administrator knowledge</u> (report all data know to the claims administrator) 01 – Within 10 business Days of ~~event~~ <u>claims administrator knowledge</u> 02 – Within 60 days of ~~original first report submission~~ <u>receipt of missing information</u> 04 – Within 10 business days of ~~event~~ <u>the denial</u> MTC is the Maintenance Type Code and is included in all EDI transactions to identify the	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	The Division has increased the reporting time from 10 business days following the event to 15 business days. This period, approximately three weeks, is a reasonable amount of time to report events that are within the claims administrator's or employer's control. Regarding definitions and technical specifications of MTC codes, the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgement Detail, Header, & Trailer Record, Release 1 (February 2002) is the definitive source of information.	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	type of transaction that is being reported. Definitions and technical specifications for each MTC are listed below and in section M, and can be found in the IAIABC EDI Implementation Guide at http://www.iaiabc.org. **Argument** A claims administrator cannot report information it does not have. Clarification is needed that the timeframe for the initial report begins upon the date of the Claims administrator's knowledge; for reporting missing information, upon its receipt; and for reporting a denied claim with no paid benefits, upon denial. To facilitate compliance and meet the needs of claims administrators and their agents, the definitions and technical specifications for each MTC are best listed in section J, in addition to the sections L or M containing a complete listing of definitions of data used in California, their technical specifications, and system specifications			
California EDI Implementation Guide for First and Subsequent Reports of Injury – Section K – Required Data Elements	Commenter recommends, in order to facilitate compliance and consistency, add to this section of the Guide a listing of the data definitions and technical specifications of all the data elements to be used in California. Commenter requests that if the Division accepts changes to the regulations she has recommended, including changes to data elements, that the Division make all	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	The IAIABC Guides and the California Guides are to be read in conjunction with each other; they are not intended to be used as stand-alone guides. If data definitions and technical specifications are provided in one guide, it is unnecessary to reproduce the same information in another. Additionally, the Division's initial	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	corresponding changes to the Guides. Commenter opines that the proposed version of the California Guides must be revised to properly indicate all changes proposed in the regulations. Commenter opines that the changes indicated throughout the tables and elsewhere in the California Guides must be withdrawn or addressed in the Notice of Proposed Rulemaking and the Initial Statement of Reasons. **Argument** Adding to the Guide a listing of definitions of the data elements used in California excerpted from the IAIABC Guides, and added to or modified as necessary, will promote consistency, efficiency, and accuracy. Changes to the Guides will be necessary to correspond to any CWCI-recommended changes that are accepted by the Division. The data element changes proposed in the regulations are not properly indicated in the Data Requirement tables in Section K of the California EDI Implementation Guide for First and Subsequent Reports. For example, DN 33 (Postal Code of Injury Site) and DN 26 (Insured Report Number) appear in the tables of Section K without underlining to indicate they are proposed additions. In addition, there are changes indicated throughout the tables that		statement of reasons provided sufficient notice to the public that updates were to be made to the WCIS Data Requirements Codes List for required data elements, the Data Requirements for First Reports of Injury table, the FROI Conditional Rules and Implementation Notes, the Data Requirements for Subsequent Report of Injury table, and the SROI Conditional Rules and Implementation Notes. DN33 (Postal Code of Injury Site) and DN26 (Insured Report Number) appear in the tables of Section K without underlining as they were, in fact, listed in the current CA FROI/SROI guide, version 2.1 (February 2006) although not being required data elements. As indicated in the Initial Statement of Reasons, revisions to both the FROI/SROI and Medical Billing implementation guides are necessary to: (1) reflect amendments to the WCIS regulations; (2) correct previous errors; and (3) reflect technical modifications to the WCIS system to allow for more efficient, accurate reporting by claims administrators. All revisions to the guides that directly affect reporting (excluding nonsubstantive changes such as grammatical corrections) fall within these three reasons.	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	are not addressed in the Notice of Proposed Rulemaking and the Initial Statement of Reasons. For example the requirement level for reporting is changed from C/M (conditional mandatory) to C/F (conditional fatal) for DN 8 (TPA FEIN), DN 9 (TPA name), and many other data elements.		**California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 3.0** Section A: EDI in California – An Overview California EDI Requirements, First Reports: Revision requiring reporting in 10 business days corresponds to amendment in Section 9702(a). Sending Date to the WCIS: Revision limiting allowed method of transmitting data to File Transfer Protocol (FTP) made to improve reporting accuracy and efficiency. Medical billing data is now only sent via FTP; many trading partners send FROI/SROI data exclusively via FTP. Limiting reporting method to FTP will allow DWC to save resources spent supporting other, rarely used, methods of transmission. Section F: Trading Partner Profile Part C. Trading Partner Transmission Specifications: Removal of Value Added Network (VAN) and Internet File Transfer (email) as accepted methods of data transmission (see FTP discussion above for reason.) Part E. California EDI Trading Partner Insurer/Claim Administrator ID List: This list will improve reporting accuracy. WCIS will be better able to identify claims	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			administrators who are reporting claims data through a third-party trading partner. Currently, there are no penalties for non-reporting or inaccurately reporting WCIS data. Alternate means of verifying identification (of both claims administrators and employees) will improve data quality. Section I: The FTP Transmission Mode The FTP Transmission Mode: Revisions to this section set forth the technical requirements for FTP transmission data. As indicated above, allowing the transfer of data only through the FTP method will improve reporting accuracy and efficiency of the WCIS system. Section J: EDI Service Providers This section was deleted. There are many private businesses that provide EDI services. DWC does not have the resources to continually amend its implementation guide in order to maintain an accurate list of providers. The failure to keep an accurate list in the FROI/SROI guide may give the impression that DWC is favoring one provider over another. DWC intends to maintain a list of providers on its website.	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			Section J: Events that Trigger Required EDI Reports Revisions to Maintenance Type Codes (MTC) are made to correspond with amendments to section 9702(b) and to clarify the specific situations when a report must be made to WCIS. Such clarifications will improve data quality and accuracy of reporting. For example, for FROI reporting, the amendment to the 04 MTC code clarifies that the code should be used if a claim is denied and no benefits are paid. Correspondingly, for SROI reporting, an amendment to the 04 code clarifies that the code should be used if a claim is denied and benefits were paid. A new footnote regarding how to report advances or settlements made as initial payments will further improve reporting accuracy. The amendment to the Annual Summary (AN) MTC clarifies that an AN report is not required when a final report (FN) has been made and no further benefits have been paid. This change will prevent the duplicate reporting of benefit payments. Section K: Required Data Elements Amendments to the data reporting requirements and conditional rules reflect a need by the Division to	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			improve data quality in order to identify claims administrators, track timeliness of payments, and utilize WCIS as an effective research tool. Since there are no administrative penalties for inaccurate reporting, the Division can only develop data quality by refining its data reporting requirements. Data Requirements for First Reports of Injury: Blank spaces have been filled in as optional. Modifications to DN8 (Third Party Administrator FEIN) are made to match requirements for DN6 (Insurer FEIN) and allow the Division to match reported claims to specific audit locations. Section 9703(b)(2) allows the Division to use WCIS data to select claims administrators for audit under Labor Code section 129. Modifications to DN9 (Third Party Administrator Name) are also made to accurately identify the claims administrator. DN25 (Industry Code) and DN 59 (Class Code) are now mandatory to provide the Division with more accurate employment data, which will be useful in analyzing such areas as wage loss based on various occupational injuries. DN28 (Policy Number), DN29 (Policy Effective Date), and DN30 (Policy Expiration Date) are new data elements added to section 9702(b); they will provide the	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			Division with additional data in which to analyze claims handling practice. DN43 (Employee Last Name) and DN44 (Employee First Name) are now Mandatory/Fatal for changes and correction to be consistent with other mandatory type codes. FROI Conditional Rules and Implementation Notes: Revisions explain the conditions requiring the reporting of specific data elements. The revisions to the conditions are intended to: (1) Correspond with amendments to section 9702(a). See DN42 (Social Security Number). (2) Prevent errors in identification. For example, DN8 (Third Party Administrator FEIN) is mandatory if a self insured is not self-administered; the Third Party Administrator's name (DN9) is mandatory if a TPA's FEIN is provided. See also the rules as to when to report DN5 (Jurisdiction Claim Number/Agency Claim Number). (3) Improve data quality. For example, the edit that the Date of Injury (DN31) be on or after 9/1/1999 has been removed to allow the reporting of historical data, claims existing prior to the establishment of the WCIS. Added rules to DN54 (Marital Status Code),	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			DN55 (Number of Dependents), and DN57 (Employee Date of Death) will improve the tracking of benefits in death cases. Revisions to the rules for DN59 (Class Code) will provide the Division with a more accurate description of an injured worker's occupation. Data Requirements for Subsequent Report of Injury: Revisions correspond to those made in FROI data requirements noted above. (See DN8.) Requirements for DN70 (Date of Maximum Medical Improvement) are revised to correspond with DN84 (Permanent Impairment Percentage), as those are necessary components for determining permanent disability indemnity payments. The revisions to the requirements for benefit payments (DN85 through DN91) are made to improve the reporting of when benefit payments were made to injured workers. This will allow the Division to compare its data with that provided by EDD. The revisions to the requirements for benefit adjustments (DN92 through DN94) are relaxed since these specific adjustments are not essential provided benefit payments are accurately reported. SROI Conditional Rules and Implementation Notes: Revisions	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			explain the conditions requiring the reporting of specific data elements. The revisions to the conditions are intended to: (1) Correspond to those made in FROI conditional rules noted above. (See DN31, DN5, DN 55) (2) Improve data quality. For example, if a permanent disability payment is reported under DN85 (Payment/Adjustment Code), then DN83 (Permanent Impairment Body Part Code) is mandatory. See also DN88 and DN89 (Payment/Adjustment Start and End Dates), which are required if DN86 (Payment/Adjustment Paid to Date) is reported and is greater than zero. More specificity in payment data will allow the Division to determine if claims administrators are meeting their obligations to provide indemnity benefits in a timely manner. Section L: California-Specific Data Edits and Sorted Data Element Lists The California specific edits, used in conjunction with the standard IAIABC edits, apply the rules and conditions for the reporting of FROI and SROI data elements. Edits that apply to all transactions (DNs 4, 6, 8, and 15) will allow WCIS to identify claims administrators who are reporting claims data through a third-party trading partner. Revisions	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			made to the SROI edits will provide more accurate reporting of indemnity payments. The list of California-adopted IAIABC data elements is for the convenience of claims administrators. Section M: System Specifications Revisions to this section are intended to facilitate data reporting. Use of the Agency Claim Number/Jurisdiction Claim Number is clarified so that claims administrators may understand the assignment of the 22-digit number. The footnoted explanation for the SROI MTC Code for partial denials (MTC Code 4P) is made to clarify that a specific paid benefit must be made and subsequently denied to trigger use of the code. The section on reporting advances and settlements is expanded to explain how structured settlements used in California workers' compensation cases (involving lump sum settlements, attorneys fees, and medical payments) should be reported using the standard IAIABC codes. The sequencing rules for periodic, annual, and final reports are relaxed to allow a greater number of transactions to be accepted by WCIS. Currently, a missed subsequent report of benefit payment could result in the rejection of an annual or	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			final report. Sequencing changes will allow annual and final reports – reporting all benefits paid – to be accepted and analyzed. Revisions to secondary matching rules will improve ability to match claims to claims administrators. Section N: Code Lists Updates and corrections to the FROI/SROI code lists are intended to improve data accuracy. Part of Body Codes for FROI DN36 (Part of Body Injured Code) and SROI DN83 (Permanent Impairment Body Part Code) are aligned for consistency in reporting. Class Codes (DN 59) are revised to specify the use of California-specific codes from the Workers' Compensation Insurance Rating Bureau (WCIRB) of California. A static list of the codes are deleted and reference to the WCIRB's website is provided. Insured employers are currently required to report such codes to the WCIRB; use of these codes by the WCIS will provide consistency for employers. Payment/Adjustment and Paid to Date (DN 85 and DN 95) Benefit Type Codes are included to provide a code reference for reporting structured settlements. Industry Codes (DN25) are added as a reference to ensure accurate reporting of the primary nature of the	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			employer's business. The WCIS accepts Standard Industrial Classification (SIC) codes and North American Industry Classification System (NAICS) codes. **California EDI Implementation Guide for Medical Bill Payment Records, Version 1.1** Section A: Electronic data interchange in California – an overview Revisions are to reflect amendments in section 9702 and improve efficiency. The WCIS testing procedure for medical data has been expanded from a general four-stage testing procedure to a more comprehensive five-step testing procedure, which includes the cancellation of a medical bill and the replacement of a claim number. This will ease the transition from EDI testing into actual production, or the transmission of live billing data. Section B: Where to get help – contacting WCIS and other information resources Contact information for WCIS has been updated to account for location changes. EDI Service Provider information in Section B expanded to include information from the deleted	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			Section J. (The listing of EDI Service Providers is now available online.) Section C: Implementing medical EDI – a managers' guide Revisions to this section are primarily made to remove unnecessary language, reflect amendments in section 9702, and expressly indicate a change from the former four-step testing process to a more comprehensive five-step process. References to the VAN transmission option is removed since all medical bill reporting data has been made by claims administrators and trading partners via FTP transmission. Section F: Trading Partner Profile Revisions are made to update contact information and remove references to the VAN transmission option. The medical billing data is now only sent via FTP; limiting reporting method to FTP will allow DWC to save resources spent supporting other, rarely used methods of transmission. Date/Time Transmission Sent (DN100 & DN 101) is added to Part D of the form to ensure timely returns of 824 acknowledgement records. Section G: Testing and production	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			phases of medical EDI The current four-step testing process is being expanded to a more comprehensive five-step process to eliminate basic transmission errors and improve the efficiency of reporting. The new process tests FTP connectivity, requires the submission of ANSI 837 medical bill file formats to ensure that the sender can receive and process a 997 functional acknowledgement which indicates structural errors, if any, and the submission of detailed 837 files to ensure that the sender can receive and process a detailed 824 acknowledgement, which indicates whether the data is complete, valid, and accurate (i.e., it has passed through the IAIABC data edits). New testing procedures also include the cancellation of a medical bill and the replacement of a claim number. The parallel pilot procedure is deleted as it has never been utilized nor shown to be useful. Section H: Supported transactions and ANSI file structure Revisions are made to update ANSI definitions (remove special characters from the AN format as they are not used), and include data elements added to section 9702(e) to California ANSI 837 loop, segment,	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			and data element summaries. The data elements are DN634 (Billing Provider National Provider ID); DN682 (Facility National Provider ID"); DN699 (Referring Provider National Provider ID); DN647 (Rendering Bill Provider National Provider ID); DN667 (Supervising Provider National Provider ID), DN657 (Rendering Bill Provider Country Code); and DN734 (Service Adjustment Units). Section I: The FTP Transmission modes Revisions are made to reflect the exclusive use of the File Transfer Protocol (FTP) mode of transmission. Section J: EDI service providers This section is deleted. Section K: Events that trigger required medical EDI reports This section is deleted. The event table definitions have been moved to Medical Event Requirement Table in Section K. The California Event Table is deleted as it is duplicative of information found elsewhere in the implementation guide. Section J: California-adopted	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			IAIABC data elements This section is added for the convenience of claims administrator and trading partners; it provides a numerically-sorted list of the required data elements. Section K: Required medical data elements Revisions are made to correct errors in the data element by source list (the correct sources are listed in the Data Dictionary of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 (July 1, 2009)), and include the data elements added in section 9702(e). (See Section H above for list.) For the convenience of claims administrators, the existing medical data element requirement table is deleted and replaced with new, updated table that is sorted alphabetically by data element name. (Changes made to deleted table are indicated in the new table by underline/strikeout text.) Definitions of the bill submission reason codes have been moved from the former Section K. The new table: (1) includes the data elements added in section 9702(e); (2) clarifies the mandatory trigger language for various data elements (i.e., removing	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			unnecessary text and including names of numbered data elements – see, for example, DN 518 (DRG Code)); and (3) changes reporting conditions for several data elements. DN523 (Billing Provider Unique Bill Identification Number) is now mandatory to allow WCIS to accurately identify duplicate billing. DN31 (Date of Injury) is now mandatory on cancellation or replaced bills to allow for more accurate matching with the original bill. The mandatory trigger language of DN 507 (Provider Agreement Code) is revised to more accurately identify whether an injured worker is in a Medical Provider Network. DNs 586, 589, 592, and 593 have been correctly reordered by number. Section L: Data edits The section is revised to include the additional data elements named above in Section H. All data edits are taken from the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 (July 1, 2009). California-specific data elements have been deleted in favor of the standard IAIABC edits. Section M: System specifications Revisions in this section are to improve the efficiency of the WCIS	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			and promote more accurate reporting. The updated procedures regarding the submission of the jurisdiction claim number will allow for better matching of medical bills with FROI/SROI reporting. Revisions to the procedures for transaction processing and sequencing, correcting and updating data elements, and replacing a Claims Administrator Claim Number do not change existing procedures, but instead provide clarification as to how those procedures are accomplished. New system procedures regarding the correction of batch level duplicates, and matching transmissions, transactions and duplicate medical bills reflect system refinements in the WCIS to identify the reporting of duplicate medical bills by claims administrators. Section O: IAIABC Information This section is deleted as the information is available online. Section N: Code lists and state license numbers Code sources are updated to improve reporting accuracy to the WCIS. Static codes are deleted and source webpages are provided to ensure that claims administrators have access to	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			the most recent codes sets. New code sources are provided to correspond to new data elements (Rendering bill provider country code – DN657, and National plan and provider enumeration system – for DNs 634, 647, 667, 682, and 699). Section O: Lump sum bundled lien bill payments Addition of new section to implement proposed regulation requiring the reporting of lump sum medical lien payments. See proposed amendments to section 9702(e). Jurisdictional codes, data elements, and data edits are taken from Scenarios 10, 11, and 12 of Section 3 of the IAIABC Medical Implementation Guide, Release 1.1 (July 1, 2009). See Initial Statement of Reasons, page 7. Section Q: Medical EDI Glossary and Acronyms This section is deleted. The Division will rely on definitions as used and provided by the IAIABC. Under Labor Code section 138.6, the WCIS is mandated to use standards compatible with the IAIABC. Section R: Standard Medical Forms	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			This section is deleted. The use of standard medical forms is now a component of electronic billing regulations currently being promulgated by the Division.	
California EDI Implementation Guide for Medical Bill Payment Records – Section A – Electronic data interchange in California	Commenter recommends the following changes to language on page 4: • **Medical bill/payment records**: Medical bill payment reporting regulations were adopted on March 22, 2006 and apply to claims with dates of injury on or after March 1, 2006. The regulations ~~and~~ require medical reimbursement information for medical services with ~~a~~ dates of service on or after September 22, 2006 ~~and a date of injury on or after March 1, 2000~~ to be transmitted to the DWC within 90 calendar days of the medical bill payment ~~or the date of the final~~ determination ~~that payment for billed medical services would be denied~~. These medical services need to be reported to the WCIS by all claims administrators handling 150 or more total claims per year. The required data elements are listed in Section K. See also Section E, which references the complete DWC/WCIS regulations. California workers' compensation medical bill payment records are processed by diverse organizations: large multi-state insurance companies, smaller specialty insurance carriers, self-insured employers ~~or insurers~~, third-party administrators handling claims on behalf of	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	Agreed in part. The existing language, with several minor changes, is less ambiguous and more representative of the intent of the requirements.	Revise medical bill/payment records bullet point under California EDI requirements, Section A of proposed CA Medical Guide.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	self-insured employers, as well as bill review companies. **Argument** The changes are recommended for accuracy and clarity.			
California EDI Implementation Guide for Medical Bill Payment Records – Section C – Implementing Medical EDI	Commenter requests that the Division delay further consideration of changes to the WCIS system until regulations on medical billing standards are adopted. Those standards will determine what medical information will be available for reporting to WCIS. Commenter requests that the Division change the requirements for reporting medical billing and payment information from mandatory to optional. **Argument** Because there are, as yet, no standardized and electronic billing regulations, there is no requirement for providers to include all the information that must be submitted to WCIS under these regulations. DWC representatives committed at public meetings to collect in WCIS only the billing information already being captured. Until standardized and electronic billing regulations require that medical providers submit the medical information that WCIS requires, including facility license numbers referenced in the paragraph on page 15 (copied for your convenience below), the WCIS mandatory	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	The Division recognizes the value of billing rules and is currently promulgating regulations for standardized billing. In this regard, the WCIS does not require the submission of data elements that are not required to be given by the health care provider to the claims administrator.	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	reporting requirements for medical billing and payment information are premature and should be made optional. Attempts to gather such missing medical information are resource intensive and needlessly raise costs and expenses, and ultimately premiums. **Make sure your computer system contains all the required data** Submitting medical data by EDI requires the data to be readily accessible on your electronic systems. Review Section K and determine which data elements are readily accessible, which are available but accessible with difficulty, and which are not captured at this time. An example of a required data element not internally captured may be facility license numbers, which are issued, maintained, and distributed by the California Department of Public Health. If all the medical data are electronically available and readily accessible, then you are in great shape. If not, you will need to develop and implement a plan for capturing, storing, and accessing the necessary medical data electronically**.**			
California EDI Implementation Guide for Medical Bill Payment Records – Section K – Required Medical	Commenter requests that the Division replace the columns headed IA, Payer, HCP, JBL and SNDR, in the California Medical Data Elements by Source table with columns for the other standard billing forms; complete the	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009	Disagree. The Division, pursuant to Labor Code section 138.6, has adopted the IAIABC national standards. The medical data elements by source columns are verbatim from the IAIABC EDI	Revise mandatory trigger for DN502 (Billing Type Code) in Medical Data Element Requirement Table, found in Section K of the proposed CA

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Data Elements	standard form field numbers for the data elements each column; and make corresponding changes to the introductory paragraph. Commenter requests that the Division ensure that the reporting information for medical information is optional in the Requirement Table, or mandatory only if provided on the billing. Commenter requests that the Division delete data elements # 152, 153 and 156 (employee employment visa, green card and passport numbers respectively). Commenter requests that the Division replace the language in the Mandatory Trigger column of the Requirement Table for DN 42 (Employee Social Security Number) to language that is consistent with footnote (4) language in Section 9702 (b). Commenter states that the language in the Mandatory Trigger language for DN 42 (Employee Social Security Number) is not	Written Comment	Implementation Guide for Medical Bill Payment Records, release 1.1, July1, 2009, page 1-2.1, and indicates sources which are nationally recognized by both medical providers and payers. The Division recognizes the value of billing rules and are currently promulgating regulations for standardized billing. In this regard, the WCIS is not mandating the reporting of data elements that are not currently available to claims administrators on medical bills. Disagree. Such information provides employee identifying information in the absence of a Social Security Number. Identifying information is necessary to conduct wage studies using information provided by such agencies like the Employment Development Department (EDD). Disagree. The two are consistent. Disagree. The two are consistent.	Medical Guide to: "If Billing Format Code (DN503) equals "B" and the bill contains one hundred percent pharmaceutical codes or one hundred percent durable medical codes."

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	consistent with footnote (4) language in Section 9702 (b). Commenter requests that the Division clarify mandatory trigger language for DN # 502 (Billing Type Code). **Argument** Because there is uncertainty and overlap in IA, Payer, HCP, JBL and SNDR source roles, those columns do more to confuse than clarify relevant sources. Identifying the fields in standard forms where medical billing data element information is submitted, however, is very helpful and provides a useful crosswalk. The following are examples of data elements that are problematic, and that will remain that way until electronic and standardized billing regulations are implemented requiring medical providers to submit them on their medical bills: 537 630 523 31 (clarification is needed on what to do if date of injury on a medical bill differs from the claim form date of injury) 554 553		Agreed. The Division will change the mandatory trigger to "If Billing Format Code (DN503) equals "B" and the bill contains one hundred percent pharmaceutical codes or one hundred percent durable medical codes."	

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	557 514 562 567 563 579 571 570 152 (not available) 153 (not available) 156 (not available) 504 681 688 680 737 (CA uses OMFS codes that are often not current HCPCS codes) 714 " 726 " 717 " 727 " 626 " 522 525 736 209 712 721 555 600 527 604 561 521 550 524 507			

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	526 651 643 592 595 599 559 552 566 565 The language in the Mandatory Trigger language for DN 42 (Employee Social Security Number) is not consistent with footnote (4) language in Section 9702 (b). The language for the mandatory trigger for DN # 502 (Billing Type Code) is not clear.			
California EDI Implementation Guide for Medical Bill Payment Records – Section L – Data Edits and Error Messages	Commenter suggests that the Division allow billings and payments before the date of injury and prior to date of service. **Argument** In some circumstances, such as for cumulative trauma claims, it is appropriate to pay for medical services provided prior to the date of injury. In some circumstances, such as advance payment to evaluators, it is appropriate to make a payment prior to the date of service.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	Currently the WCIS data edits allow medical bills with payments dates before the date of injury and medical bills with payments dates before the date of service.	WCIS has changed programming to certain types of medical bills to pass the IAIABC data edit.
California EDI Implementation Guide for Medical Bill Payment Records – Section M –	Commenter suggests retaining the existing language on DWC plans to produce data quality reports on each trading partner on an annual basis as part of an annual certification process and add a statement on how reports	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute	Agreed. The Division will retain the existing language in the medical implementation guide.	Revise Section G of proposed CA Medical Guide to allow for data quality reports for individual trading

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Unmatched Transactions	will be made available. **Argument** Feedback on the trading partner performance will be useful to claims administrators wanting to know how vendors that are reporting on their behalf, and potential vendors, are performing. This will provide an incentive for better performance.	December 15, 2009 Written Comment		partners on request.
California EDI Implementation Guide for Medical Bill Payment Records – Section N – Code Lists and State License Numbers	Commenter recommends including a link to the OMFS (jurisdiction) codes. Commenter recommends providing a link to NDC codes on the Federal Drug Administration web site if a single source of NDCs is to be provided. Alternatively, list links for all available sources of NDCs, including the FDA and First Databank. Commenter recommends listing the taxonomy codes, and other code sets and lists referenced in the Guides and used in reporting. Retain or add the Facility/Place of Service Codes, and Revenue Codes lists, the Claim Adjustment Group and Reason Codes lists and all other referenced lists. Retain the Medical Bill Payment Records Glossary. Provide web site links for each reference. **Argument** California fee schedule uses OMFS codes that may not be current CPT codes. If a single source for NDCs is to be listed, it	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	The Division will provide a list of California specific OMFS codes on the WCIS website. As to the NDC codes, the Division will continue to utilize the California adopted IAIABC guidelines, which do not refer to the Federal Drug Administration or other available sources of NDCs. See IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 July 1, 2009. Other nationally accepted medical code sets are not developed or maintained by the Division. The California adopted IAIABC national standards in the IAIABC Guide, Version 1.1, refer to the sources of the national codes sets. Disagree. Further, the IAIABC national standards maintain the accepted glossary of terms for use in Workers Compensation.	Provide a list of California specific OMFS codes on the WCIS website.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	should be the Federal Drug Administration. Alternatively, list all available sources for NDCs. The DWC has previously stated that regulations may not rely on "the most current version" of a listing not under its control, therefore the adopted version (version at time of adoption) must be provided. The glossary is useful. If a reference to an outside list is included, it is helpful to provide a link.			
California EDI Implementation Guide for Medical Bill Payment Records – Section O – California-adopted IAIABC data elements	Commenter recommends adding a data dictionary and all other associated technical information for all data elements to be used in California. **Argument** A one-stop Guide will improve compliance and efficiency.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	Disagree. While a one-stop guide would be preferred, the IAIABC develops and maintains the nationally accepted data dictionary for Workers Compensation and is the best source for such information.	None.
California EDI Implementation Guide for Medical Bill Payment Records – Section P – Lump sum bundled lien bill payment	Commenter suggests renaming this section as follows: Section P – Lump sum ~~bundled lien~~ disputed medical bill payment Commenter states that unless the Division intends claims administrators to report only lump sum payments for disputed medical bills on which they are aware liens have been filed, the language in this section should be modified as follows so that all lump sum payments for disputed medical bills can be reported. Revise the loop, segment, data element summary to reflect all possible scenarios, including the	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	Disagree. The Division will only collect lump sum payment or settlement data for medical liens filed with the Workers' Compensation Appeals Board pursuant to Labor Code sections 4903 and 4903.1. The Division has adopted IAIABC standards for reporting medical lien lump sum payments contained in section 3, pages 3-10.1 through pages 3-12-11 of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 July 1, 2009	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	scenario that the codes may report lump sum payments that settle disputed bills and line items whose payment was denied. Remove the data elements that are not suitable for reporting of payment bundled disputed bills and lines, such as DN # 511 (date insurer received bill), DN #638 (rendering provider last/group name), DN #643 (rendering bill provider state license number), DN #503 (billing format code) and DN #504 (facility code). Clarify how to report payments to assignees such as lien collection agencies and when all or some of the billings were from third party billers and when settlements include multiple claims. California law allows the filing of a lien against any sum to be paid as compensation for the "reasonable expense incurred by or on behalf of the injured employee" for medical treatment (see Labor Code section 4903(b)). Reportable lump sum medical liens originate from medical bills filed on DWC WCAB Form 6. (The medical lien form is located at http://www.dir.ca.gov/dwc/FORMS/DWCForm6.pdf.) The DWC\WCIS has adopted IAIABC ~~medical lien~~ lump sum payment codes as the standard for reporting ~~bundled~~ lump sum payments for disputed medical bills including those on which liens were filed (See 8 C.C.R. § 9702(e)). The six codes below, describe the type of lump sum ~~settlement~~ payments made by the claims payer			

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	~~after the filing of a lien with the Workers' Compensation Appeals Board (WCAB)~~. ~~Reportable lump sum medical liens originate from medical bills filed on DWC WCAB Form 6. (The medical lien form is located at~~ http://www.dir.ca.gov/dwc/FORMS/DWCForm6.pdf~~.)~~ Commenter suggests eliminating the language in number 3 and replacing it as follows: ~~3. Sender changes the value of data elements (Lien Settlement amount) on the original bill(s) submitted in step 1.~~ 3. Sender transmits as a BSRC "00" as though for a single new ~~the updated~~ bill for the totaled disputed amount ~~(Lien Settlement)~~, with all individual lines of ~~on~~ all bills bundled into ~~as~~ one lump sum billed amount, and a single lump sum payment, as a BSRC "00". Lump sum bundled bill medical lien payments are reported utilizing Bill Submission reason Code 00 (original). Individual ~~Lump~~ lump sum medical ~~lien~~ payments are required to utilize one of three possible IAIABC 837 file structures in the *IAIABC EDI Implementation Guide for Medical Bill Payment Records*, Release 1.1 July 1, 2009 (http://www.iaiabc.org/i4a/pages/index.cfm?pageid=3349). If the bundled medical bills are being reported as a professional or a pharmaceutical lump sum payment then the			

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	SV1 segment is utilized to report the appropriate IAIABC lump sum medical payment ~~lien~~ code (Scenario 10) as a jurisdictional procedure code. If the bundled medical bill(s) are being reported as an institutional lump sum payment then the SV2 segment is utilized to report the appropriate IAIABC lump sum medical payment ~~lien~~ code (Scenario 11) as a jurisdictional procedure code. If the bill(s) being reported are mixture of professional, pharmaceutical, or institutional lump sum payments then the SVD segment is utilized to report the appropriate IAIABC lump sum medical payment ~~lien~~ code (Scenario 12) as a jurisdictional procedure code. **Argument** Lump sum payments can cover disputed medical bills whether or not liens have been filed on each bill, therefore unless the Division intends to capture lump sum payments for only those bills on which liens have been filed, references to lien claims must be removed. Note that a claims administrator may not be informed that a lien has been filed, or the provider or agent may claim a lien has been filed when it has not. Consider revising the loop, segment, data element summary. These new codes may be used to report settlements that include, for example, multiple bill disputes that settle line items whose payment was denied (some line			

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	items on the bills may have been paid), that involve third party billers or assignees, or that include multiple claims. Item 3 under the heading "Medical bill reporting process bundled lump sum medical bills" is confusing and should be deleted because it appears to incorrectly direct claims administrators to make a correction to the original transmission of the disputed bill.			
California EDI Implementation Guide for Medical Bill Payment Records – Section Q – Medical Glossary and Acronyms	Commenter recommends retaining the Glossary and Acronym listing. **Argument** The Glossary and Acronym listing is a helpful reference that adds clarity and promotes accurate reporting.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	Disagree. The IAIABC guides, incorporated by reference, are the most accurate source for glossary terms and acronym listings.	None.
California EDI Implementation Guide for Medical Bill Payment Records – Section R – Standard Medical Forms	Commenter recommends retaining the standard medical billing forms reference. **Argument** It is important to include the forms in the Guide because field numbers on these forms are specifically referenced in this Guide.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 15, 2009 Written Comment	Disagree. The Division is currently promulgating proposed medical billing regulations that will specially address the use of the standard medical forms and required data elements for medical billing.	None.
General Comment – Improving Medical Provider Networks	Commenter opines that a significant number of MPNs seem to add financial burden to physicians without adding any corresponding value. Commenter states that his members find that some networks pay at deep discount to the Official Medical Fee Schedule, delay payments, or balk at approving payment for treatments that are supported under the Medical Treatment Utilization Schedule. By contrast, other MPNs do not discount payments, and	Don Schinske Legislative Advocate WOEMA December 16, 2009 Written Comment	Medical Provider Networks (MPN), authorized under Labor Code section 4612, are not addressed the current WCIS rulemaking.	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	have established effective preauthorization processes that promote timely treatment and payment while reducing hassle and frictional costs. Aside from leveling the fees for HCOs and MPNs to encourage greater competition, commenter opines that there should be greater encouragement for sharing and adopting best practices around treatment authorization and payment, as well as some effort spent toward limiting egregious gouging.			
General Comment – Streamlining Utilization Review	Commenter encourages the Division to continue monitoring UR performance and refining the UR process. Problem areas are multiple: Employers who delay Employer First Reports of Injury; Claim Adjusters who do not respond to messages and request the same information by fax over and over; and UR physicians who are available only for brief periods. Although much improvement has occurred, physicians continue to report deep frustration with the UR process.	Don Schinske Legislative Advocate WOEMA December 16, 2009 Written Comment	The Utilization Review (UR) procedures, mandated by Labor Code section 4610 and implemented in California Code of Regulations, title 8, section 9792.6, are not addressed in the current WCIS rulemaking.	None.
General Comment – Physician Payments	Commenter states that Primary Treating Physicians billing under the Evaluation & Management codes are struggling to maintain their practices. OMFS drastically undervalues E&M services relative to similar services under Medicare, and makes no allowance for the additional reporting and rating required in Workers Compensation. This undervaluation has forced many providers to discontinue or shrink their participation, often by devoting more resources to other areas of practice. Some physicians simply refuse to perform PR-2 and PR-4 reports because the effort is so poorly paid. Commenter doesn't just suggest that physicians	Don Schinske Legislative Advocate WOEMA December 16, 2009 Written Comment	The revision of the Official Medical Fee Schedule (OMFS) authorized pursuant to Labor Code section 5307.6, is not addressed in the current WCIS rulemaking. The Division is currently in the process of revising the OMFS and has posted proposed changes on its online forum.	None

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	will no longer provide Occupational Health Care in the future. Rather, the effect of under-compensation in a busy clinic is that other, non-Workers Comp patients will be treated preferentially. Providers will invest less energy in communicating with employers, and over time they will attend less and less to the complexities and idiosyncrasies of Workers' Compensation that are crucial to the system. Commenter states that revision of the OMFS is absolutely critical to ensuring that primary treatment in the system remains available, that incentives across the spectrum of care are properly aligned, and appropriate utilization. Commenter urges the Division to revise the OMFS as soon as possible.			
California EDI Implementation Guide for Medical Bill Payment Records – Section I – The FTP transmission modes – Page 65 (File Naming Conventions)	Commenter recommends creating a meaningful file name for the trading partners to use for the 837 file. If a tracking # or Transaction Set Control # were used at the end of the file name, the same Transaction Set Control # could be used on the 997 an 824 acknowledgment file names that are returned from the state. This would make it easier for the trading partners to match the acknowledgements back to the 837 file prior to opening the file. Currently, the 997 & 824 file names do not provide any identifying information to track back to the 837 file.	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and December 16, 2009 Oral and Written Comment	Agreed. The Division is currently developing programming to implement a consistent file naming convention.	WCIS will implement a consistent 824 file naming convention during the FTP testing process.
California EDI Implementation Guide for Medical Bill Payment Records – Section H – Supported transactions and	Commenter recommends creating one 997 and one 824 per 837 file transaction. Multiple batches may be in one 837 file, however, only one 997 & one 824 should be created per 837 file as indicated in the IAIABC EDI Implementation Guide for Medical Bill Payment Records Release 1.1 (IA Medical	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and December 16, 2009 Oral and Written	Agreed. The Division is currently developing programming to comply with the California adopted IAIABC standards. The California Medical Implementation Guide will be changed to contain the California requirements for matching inbound	Located in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, July 1, 2009, page 4.1. Revise Sections G and M of the proposed

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
ANSI file structure – Page 60-61	Guide 1.1) in Section 4 ASC X12 824 Application Advice.	Comment	837 transmissions with multiple ST-SE transactions sets to one outbound 824 detailed acknowledgement.	CA Medical Guide to clarify transmission standards.
California EDI Implementation Guide for Medical Bill Payment Records – Section H – Supported transactions and ANSI file structure – Page 60-61	Commenter recommends returning the Batch Control Number DN532 in the OTI segment of the 824 as indicated in the IA Medical Guide 1.1. The Batch Control Number helps to provide reference of all bills within that batch.	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and December 16, 2009 Oral and Written Comment	The Division has implemented the change in all outbound 824 acknowledgements.	No change needed. It is referenced in the proposed CA Medical Guide, Section H, page 63.
California EDI Implementation Guide for Medical Bill Payment Records – Section J – Events that trigger required medical EDI reports – Page 76	Guide indicates that Replacements "05" are only for replacing the Claim Administrator Claim Number DN15. Commenter would like to know if she should report reconsiderations – which is when a provider resubmits the original bill to the carrier requesting additional payment? If so, how does the Division want such bills reported? Would it be a new "00" bill with a new Unique Bill ID with an ANSI "reconsideration" reason code?	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and December 16, 2009 Oral and Written Comment	The process is outlined in Section M of the proposed CA Medical Guide, under "Updating data elements (BSRC=01)(AAC=TA): 1. Sender transmits original bill, including all lines, utilizing a BSRC "00". 2. DWC/WCIS sends a 997 and a "TA" 824 acknowledgement to sender. 3. Sender changes the value of data elements on the original bill. 4. Sender cancels incorrect original bill by transmitting a BSRC "01". * 5. DWC/WCIS sends a 997 and a "TA" 824 acknowledgement to sender. 6. Sender transmits the updated bill, including all lines, as a BSRC "00". * 7. DWC/WCIS sends a 997 and "TA" 824 acknowledgement to sender.	None

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
California EDI Implementation Guide for Medical Bill Payment Records – Section J – Events that trigger required medical EDI reports – Page 77	Commenter notes that the CA Event Table under the "Value" column for BSRC "01" & Cancellation states that the report is due within 90 days of the original submission—must be greater than date of "00". Commenter seeks clarification as to whether the 90 days is from the original submission date or 90 days from the original bill's paid date? Commenter also wants to know where it states it must be greater than date of "00", what date is the Division referring to? Commenter would also seeks clarification on the date referenced for BSRC "05".	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and December 16, 2009 Oral and Written Comment	The Event Table has been deleted in the CA Medical Guide; the general rule for reporting all bill submission reason codes shall be as stated in the WCIS regulations 9702(e), "…shall submit data within (90) calendar days…"	None.
California EDI Implementation Guide for Medical Bill Payment Records – Section K – Required Medical Data Elements – Page 90	Commenter references the Medical Data Element Requirement Table, Billing Provider Unique Bill ID DN523 should be Mandatory for BSRCs "00", "01" and "05". The Division lists "00" and "01" as Conditional and "05" as Optional. The Billing Provider Unique Bill ID DN523 (CLM01) in the IA guide is a Required field. Commenter recommends changing the Medical Data Element Requirement Table so that the Billing Provider Unique Bill ID DN523 is Mandatory for all BSRCs.	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and December 16, 2009 Oral and Written Comment	Agreed. The Division will change the mandatory trigger to mandatory for DN523 for all bill submission reason codes.	Revise mandatory trigger language for DN523 (Billing Provider Unique Bill Identification Number) in Medical Data Element Requirement Table (Section K of proposed CA Medical Guide).
California EDI Implementation Guide for Medical Bill Payment Records – Section K –	Commenter recommends the Medical Data Element Requirement Table under the Mandatory Trigger column that Billing Format Code DN503 include a note that the Billing Format Code DN503 is not required on	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and	Retraction of comment acknowledged.	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Required Medical Data Elements – Page 90	"Mixed" Bill Types Lien Bills. Commenter would like to retract her comment at the hearing that DN503 is required. Essentially, it is a required field; however, it is a sub-element in CLM05 and this sub section is Situational which means if section CLM05 is not being used, then DN503 (CLM05-2) is not required.	December 16, 2009 Oral and Written Comment		
California EDI Implementation Guide for Medical Bill Payment Records – Section K – Required Medical Data Elements – Page 94 –	The Medical Data Element Requirement Table, Provider Agreement Code DN507 states to enter the value "P" if the injured worker's medical treatment is provided within a Medical Provider Network approved by the DWC. Since this is a Mandatory field for original bills, if the injured worker is not in a network, a value must be present; however "P" would not apply. Commenter recommends that the Division add to the Mandatory Trigger to use the value of "N" (No Agreement) when the injured worker's treatment is not within a network.	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and December 16, 2009 Oral and Written Comment	Agreed. The currently mandatory trigger allows the claims administrator to report a value of "N" if applicable. Will add all four Provider Agreement code definitions for clarity. H = HMO Agreement, N = No Agreement, P = Participation, Agreement, Y = PPO Agreement. Enter the value "P" if the injured workers medical treatment is provided within a Medical Provider Network approved by the DWC	Revise mandatory trigger language for DN 507 (Provider Agreement Code) in Medical Data Element Requirement Table (Section K of proposed CA Medical Guide).
California EDI Implementation Guide for Medical Bill Payment Records – Section K – Required Medical Data Elements – Page 95	Commenter states that in the Medical Data Element Requirement Table, Unique Bill ID Number DN500 should be Mandatory for all BSRCs; however, the Division has BSRC "05" as Optional. Commenter recommends changing the Unique Bill ID Number DN500 for BSRC "05" to Mandatory.	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and December 16, 2009 Oral and Written Comment	Disagree. The REF segment in the 2300 loop is situational and is not required for the 05 change process. See page 2-1.4 of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, release 1.1 (July1, 2009).	None.
IAIABC EDI Implementation Guide for Medical Bill Payment	Commenter references Section 3, Scenario 12. Commenter states that the CA guide in Section F, Page 139 makes reference to this guide for lump sum medical bill payments. Commenter	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix	Disagree. Mixed bills occur within individual SV segments and at a higher level for lien bills where numerous types of bills are bundled	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Records, Release 1.1	realizes that the term "Mixed Bill Types" is in the IAIABC guide but finds it confusing with the California guide's current terminology of "Mixed Bills" which is used to identify regular bills that have mixed codes on a professional bill. For example, a bill with a DME code and an NDC code billed on a professional bill is currently considered a "mixed bill". Commenter recommends changing the term "Mixed Bill Types" to something like "Multi Bill Types" for lien bills so as not to confuse the current term of "mixed bills" which are not related to lien bills.	December 15, 2009 and December 16, 2009 Oral and Written Comment	into one payment. The term "multi" adds no more clarity than the existing language.	
IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1	Commenter references Section 3, Scenario 12. Commenter would like to know how will a bill review know if the lien is for a professional bill, hospital bill or mixed bill? Will the lien identify the types of bills involved in the dispute? Commenter states that even if the lien is identified as a mixed bill by the bill reviewer, there are no identifying codes to enter that will let the program know that this particular lien bill can be submitted without a Billing Format Code and not reject. Commenter would like to know if even though the scenario shows no place of service and no billing format code they can still report a place of service code and billing format code for a mixed lien bill without rejection? Commenter states it would simply be more like a place holder for programming purposes.	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and December 16, 2009 Oral and Written Comment	The comment is not applicable to the proposed WCIS regulations. The IAIABC Guide is the prevue of the IAIABC. Labor Code section 138.6 requires that WCIS be compatible with the IAIABC standards.	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1	Commenter references Section 3, Scenario 12. In the IA scenario for the mixed lien bill, the CAS segment is missing. This bill has an adjusted amount; therefore, a CAS segment should be present. Commenter recommends that CA add a note to the implementation guide that Scenario12 in the IA guide, 3-12.2, should contain a CAS segment and give the appropriate example in your guide in Section F, page 139. Also, let the IA know of the incorrect example. CLM*885372*30000**********P***00 DTP*050*D8*20060714 DTP*472*RD8*20050714-20060302 DTP*666*D8*20070714 AMT*TP*15000 REF*DD*0123456789 REF*2I*004424516 HI*BK: 844.2 NM1*85*2*One Stop Shop Medical Services, Inc*****FI*880586865 N4***933111001 NM1*82*1*One Stop Shop Medical Services, Inc****FI*880586865 N4***96723 LX*00 SVD*XX*15000**ER:MDO10 **Missing CAS segment** SE*31*30001	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and December 16, 2009 Oral and Written Comment	The comment is not applicable to the proposed WCIS regulations. The IAIABC Guide is the prevue of the IAIABC. Labor Code section 138.6 requires that WCIS be compatible with the IAIABC standards.	None.
9702(e)	Commenter recommends that all data elements listed in Footnote 14, individually have a note in the Medical Data Element Requirement Table under the Mandatory Trigger column	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix	Disagree. Footnote 14 of section 9702(e) states: "For medical lien lump sum payment or settlement use date of filing." The Division	None.

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	(Section K, pages 90 – 95) that each of the data elements, respectively, are not required on lien bills.	December 15, 2009 and December 16, 2009 Oral and Written Comment	assumes the commenter is referring to Footnote 17, which states that the footnoted data element is not required for a mixed medical lien lump sum payment or settlement. In this regard, the WCIS regulations are meant to be read in conjunction with the implementation guides. One cannot be read to the exclusion of the other.	
9701(d)	Commenter recommends that the Division provide a list of all "California Jurisdiction Code – or Codes."	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and December 16, 2009 Oral and Written Comment	Agreed. The Division intends to post a list of California specific codes to the DWC website.	Upon effective date, post California specific codes, such as medical-legal codes, to the Division's website.
General Request	In order to assure that her company does not report non-medical bills to the state of California, she provided our office with a list of her company's facility code types for our review. She requests that the Division select the codes that they do not want to have reported. [Copy of code list submitted is in the rulemaking file.]	Sandra A. Guidry Sr. Business Analyst, State Reporting Ingenix December 15, 2009 and December 16, 2009 Oral and Written Comment	The California WCIS has adopted the IAIABC national standard for facility codes. No other codes will be accepted.	None.
California EDI Implementation Guide for Medical Bill Payment Records – Section K – Required Medical Data Elements – Page 94 –	Commenter agrees with Sandra Guidry's observation as follows: The Medical Data Element Requirement Table, Provider Agreement Code DN507 states to enter the value "P" if the injured worker's medical treatment is provided within a Medical Provider Network approved by the DWC. Since this is a Mandatory field for original	Steve Cattolica CSIMS and US Healthworks December 15, 2009 Oral Comment	Agreed. The currently mandatory trigger allows the claims administrator to report a value of "N" if applicable. Will add all four Provider Agreement code definitions for clarity. H = HMO Agreement, N = No Agreement, P = Participation, Agreement, Y = PPO Agreement. Enter the value "P" if the injured	Revise mandatory trigger language for DN 507 (Provider Agreement Code) in Medical Data Element Requirement Table (Section K of proposed CA Medical Guide).

WORKERS' COMPENSATION INFORMATION SYSTEMS (WCIS)	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	bills, if the injured worker is not in a network, a value must be present; however "P" would not apply. Commenter recommends that the Division add to the Mandatory Trigger to use the value of "N" (No Agreement) when the injured worker's treatment is not within a network.		workers medical treatment is provided within a Medical Provider Network approved by the DWC	
California EDI Implementation Guide (FROI/SROI) Pages 89 and 96	Commenter would like to point out that the California edit on the Date of Injury (DN31), "Must be on or after 9/1/1999", is not struck out in the SROI implementation notes but it is struck out in the FROI implementation notes on page 89.	Cheryl Keyes Sedgwick December 15, 2009 Written Comment	Agreed. This edit should be removed.	Remove conditional requirement for Date of Injury (DN31), SROI Conditional Rules and Implementation Notes, Section K, CA Proposed FROI/SROI Guide.
California EDI Implementation Guide (FROI/SROI) Page 99	Commenter states that the edit on the Benefit Adjustment Code (DN92) should be "If DN93 is reported, DN92 must be a valid Benefit Adjustment code."	Cheryl Keyes Sedgwick December 15, 2009 Written Comment	Agreed. The edit should be "**If DN93 is reported, DN92 must be a valid Benefit Adjustment code."**	Revise conditional requirement for Benefit Adjustment Code (DN92), SROI Conditional Rules and Implementation Notes, Section K, CA Proposed FROI/SROI Guide.
California EDI Implementation Guide (FROI/SROI) Pages 117	Commenter would like verification that the benefit sequencing rule, "Closes must follow opens for the same BTC." Will be removed on the SROI S(x), P(x), CB, 04 or 4P.	Cheryl Keyes Sedgwick December 15, 2009 Written Comment	Yes, this rule has been removed.	Revise sequencing rule for Benefit Event Type "Close", Section M, "Transaction Sequencing Requirements for Subsequent Reports", page 119-120.
California EDI Implementation Guide (FROI/SROI) Pages 102	Commenter states that the California edits also has the Date of Injury must be > = 09/01/99.	Cheryl Keyes Sedgwick December 15, 2009 Written Comment	Agreed. This edit should be removed.	Remove "Must be >=09/01/99" data edit for Date of Injury (DN31), Section L, Current Edits, First Reports (FROIs),

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				page 105.