California Workers' Compensation Institute
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October 31, 2007

VIA E-MAIL

Destie Overpeck
Chief Legal Counsel
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

RE: **Workers' Compensation Information System – Forum Comments on Draft Regulatory Changes**

Dear Ms. Overpeck:

This Forum commentary on draft changes to the Workers' Compensation Information System regulations is presented on behalf of the California Workers' Compensation Institute's members. Institute members include insurers writing 87% of California's workers' compensation premium, and self-insured employers with $30B of annual payroll (20% of the state's total annual self-insured payroll).

Recommended modifications are indicated by underline and ~~strikethrough~~.

CWCI offers below specific feedback on the draft regulations. In addition, CWCI urges the DWC to consider the feedback presented by CWCI and other members of the WCIS FRO/SROI Task Force that urged the DWC to collect benefit information periodically via annual reports instead of continuously via SROI reportings. Continuous SROI reportings are burdensome and costly. Annual reportings provide a far more efficient and cost-effective way to collect the data.

Definitions – Section 9701

Date of Implementation Guides

Change the date of the revised versions of the California EDI Implementation Guide for First and Subsequent Reports of Injury, and the California EDI Implementation Guide for

Medical Bill Payment Records, Version 3.0, from January 2008 to the effective date for the regulations, at least three months after the date the regulations are adopted.

Discussion
A minimum of three months from the adoption date will be needed to make necessary programming changes, as well as to train, and implement the changes. The date on the implementation guide should reflect the implementation date of the regulations.

Electronic Data Reporting – Section 9702

Effective date of Regulations
Clarify that the revised regulations and the revised versions of the California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 3.0 and the California EDI Implementation Guide for Medical Bill Payment Records, Version 1.1 are effective a minimum of three months after the date the regulations are adopted.

Discussion
A minimum of three months from the adoption date will be needed to make necessary programming changes, as well as to train, and implement the changes. Under the current wording, the changes may be interpreted as retroactively effective.

ADA Codes – Section 9702(e)(1)
Delete the proposed ADA codes from the table in Section 9702(e)(1) and from the medical implementation guide. If the Division chooses to retain them, change the requirement for reporting of dental bills as well as other medical services from mandatory to optional.

Discussion
Because there are as yet no standardized and electronic billing regulations, there is no requirement for providers to bill for dental services with these codes, and nor are the codes included in the Official Medical Fee Schedule. Until standardized and electronic billing regulations are implemented, any mandatory reporting requirements are premature for dental bills and indeed all medical services.

Service Adjustment Reason Codes – Section 9702(e)(1)
Delete footnote (12).

Discussion
Footnote (12) references a non-existent Medical Billing and Payment Guide regulation.

Lump Sum Payment of Disputed Medical Bills – Section 9702(e)(2)
(2) Each claims administrator subject to the medical bill reporting requirements of this subdivision shall submit to the WCIS on each claim the following data elements for ~~multiple~~ billings for medical services provided on or after September

22, 2006, ~~whether~~ reflected in one or more disputed medical bills, that are fully satisfied by a single lump sum payment ~~following the filing of a lien claim for the payment of such medical services pursuant to Labor Code sections 4903 and 4903.1~~. The claims administrator shall submit the data within ninety (90) calendar days of the lump sum 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 and the California EDI Implementation Guide for First and Subsequent Reports of Injury.

Revise the required data elements in the table.

Discussion
The descriptors of proposed new jurisdictional codes MDS21 and MDO21 relate to a single medical bill, therefore the "multiple" reference is inaccurate and should be removed. Lump sum payments cover disputed bills whether or not liens have been filed on each bill, therefore references to lien claims and related statutes are unnecessary. Some of the data elements in the table are listed only in the California EDI Implementation Guide for First and Subsequent Reports of Injury.

Some of the data elements proposed in the table are problematic. Since this is a single payment that often represents multiple disputed bills, reporting, for example, a principal diagnosis, a rendering provider last/group name, a billing provider unique bill identification number, or a single code to identify a bill submission reason, a billing format, or a facility, is problematic. This is especially true when the payment is to a third party biller or a lien collection agency.

California EDI Implementation Guide for First and Subsequent Reports of Injury

List of EDI Service Providers – Section B, page 9
Set minimum standards for EDI providers and include only providers that meet those standards.

Discussion
It will be helpful to exclude from the listing EDI providers that fail to meet minimum standards such as a minimum percentage of errors.

List of EDI Service Providers – Section F, page 25
Post the Trading Partner Profile List with claim administrator FEINs on the WCIS website or remove the reference from this section.

Discussion
The Trading Partner Profile List with claim administrator FEINs is not currently posted on the WCIS web site at the given address.

Valid Data – Definitions of Data Elements for California – Section G, page 47

To facilitate consistency, add to the Guide a listing of the definitions of the data elements to be used in California, and reference the listing here.

Discussion

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 and accuracy.

Social Security Number – Section K, pages 85-86

Retain the double asterisks (**) after "Social Security Number" at DN #42, and change the associated footnote language to "Use "999999999" as a default value if SSN is unknown."

Discussion

The recommended language is consistent with the language on page 99 in Section L, and elsewhere.

California Edit Date – Section K, page 87

Change the date in the California Edit associated with DN #31 to 3/1/00.

Discussion

In accordance with Section 9701(d), WCIS requirements apply only to claims with dates of injury on or after March 1, 2000.

California EDI Implementation Guide for Medical Bill Payment Records

List of EDI Service Providers – Section A, page 7

Medical bill/payment reports: Medical bill payment ~~reports~~ regulations were adopted on March 22, 2206 and require medical services provided on and after September 22, 2006, ~~began~~ to be transmitted to the DWC ~~six months from March 22, 2006. Medical bill payment reports must be transmitted to the DWC~~ within 90 days ~~after the medical bill~~ of payment ~~is made by Insurers to medical service and equipment providers~~. The required data elements are listed in Section K. ~~Required data elements.~~ See also Section E – WCIS Regulations, which reference the complete DWC\WCIS regulations.

Discussion

The changes are recommended for clarity and specify the pertinent dates of service.

Required medical data – Section C, page 17

Submitting medical data by EDI requires the data be readily accessible on your electronic systems. Review Section K– Required medical data elements 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 none internally captured required data element may be medical provider state license numbers issued, maintained, and distributed by the California Department of Consumer Affairs (see Section O).~~

Change the requirements for reporting medical billing and payment information from mandatory to optional.

Change “none” to “one.”

Discussion
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 medical license numbers, the WCIS mandatory reporting requirements for that information are premature and should be made optional. Attempts to gather the missing medical information are resource intensive and needlessly raise costs and expenses, and ultimately premiums.

“None” appears to be a typographical error.

List of EDI Service Providers – Section C, page 17

…. The initial requirement of reporting ~~all~~ medical payments ~~became effective~~ was adopted March 22, 2006 for medical services provided after September 21, 2006, to employees injured on and after March 1, 2000.

Discussion
The recommended changes clarify which claims and services are covered.

Electronic Partnering Insurer/Claim Administrator List – Section F, page 31

Post the Electronic Partnering Insurer/Claim Administrator Identification (ID) List on the WCIS website at the given address or remove the reference from this section.

Discussion
The List is not currently posted on the WCIS web site at the given address.

Page numbers – Sections F through R, page ~~32~~ - end

Insert page numbers, and preface each page number with the section letter or insert the section letter elsewhere on each page throughout the Guides.

Discussion
Page numbers have been deleted starting with page 32 in section F and are non-existent starting in section K. Inserting page numbers and section numbers on each

page will make it easier to find and reference and comply with a particular item in the Guide.

Valid Data – Testing and paper reports – Section G, page ~~50~~

Revise testing procedure to address a realistic selection of bill formats, information and errors.

Discussion

The current testing procedure assumes bills are submitted on standard forms and include the medical reporting information required to be reported to WCIS. Since billing standards have not yet been adopted, those assumptions are false and for the testing make it necessary to identify bills that conform to those assumptions. This process does not result in a true test of the billing formats and information actually received and reported.

Required Medical Data Elements – Section K,

Remove data elements # 152, 153 and 156 (employee employment visa, green card and passport numbers respectively).

Ensure that the reporting information for medical information is optional in the Requirement Table or mandatory only if provided on the billing.

Replace the language in the Mandatory Trigger column of the Requirement Table to"Use "<u>999999999" as a default value if SSN is unknown.</u>"

Replace the language in the Mandatory Trigger column of the Requirement Table to "If DN 503 equals "B" and only pharmaceuticals or DME are billed" or similar language.

Discussion

Until such time as electronic and standardized billing regulations are implemented, the following data elements are examples of data elements that are problematic for the reasons previously described:

719
722
537
630
523
31 (what to do if date of injury on bill is not the same as claim form date of injury?)
554
553
557
514
562
567
563

579
571
570
152 (not available)
153 (not available)
156 (not available)
504
681
681
680
737 (CA uses OMFS codes that are not always HCPCS codes)
714 “
726 “
717 “
727 “
626 “
522
525
736
209
712
721
555
600
527
604
561
521
550
524
507
526
651
643
592
595
599
559
552
566
565

The recommended language for social security number reporting is consistent with the language on page 99 in Section L, and elsewhere.

The language for the mandatory trigger for DN # 502 is not clear.

Data Edits and Error Messages – Section L

Allow billings and payments before the date of injury and prior to date of service.

If the ADA data elements are removed, delete the DN 719 and 722 error messages.

Discussion

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.

If the ADA data elements are removed, DN 719 and 722 error messages will be unnecessary.

AAC codes – Section M

Change “ACC” to “AAC” in the various locations.

Discussion

This appears to be a typographical error.

Unmatched Transactions – Section M

Make results of annual certification process available.

Discussion

Feedback on the trading partner annual certification will be useful to claims administrators wanting to know how vendors reporting on their behalf, and potential vendors are performing.

Code Lists and State License Numbers – Section O

Include a link to the OMFS codes.

Provide 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.

List 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 every reference.

Discussion

California fee schedule s use OMFS codes that may not be current CPT codes.

If a single source for NDCs is to be listed, it should 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. The glossary is useful. If a reference to an outside list is included, it is helpful to provide a link.

Standard Medical Forms – Section R

Retain the commonly used medical billing forms. as the elsewhere in the Guide field numbers on the forms are referenced .

Discussion

It is important to include the forms in the Guide because field numbers on these forms are specifically referenced in this Guide.

Required Medical Data Elements for Lump Sum Payments – Section P

Replace the word "lien" with the term "disputed medical bill."

Revise the loop, segment, data element summary to reflect all possible scenarios, including the 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.

> **"Lump sum ~~bundled lien~~ disputed medical bill payment introduction**
>
> 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). Although medical treatment liens constitute a ~~substantial~~ significant portion of paid medical bills in the workers' compensation system, the IAIABC 837 as initial adopted by DWC in 2006 was only designed to report individual unbundled bills; the medical bill payment reporting standards could not account for multiple medical bills in dispute that are paid in one lump sum (either through a settlement or by order) following the filing of a lien claim with the WCAB.
>
> To resolve this omission, the IAIABC Medical Committee formed a sub committee composed of stakeholders from the industry and the state to develop IRR: MED547R1.0 as a basis for an IAIABC standard to report bundled medical lien payments to the WCIS utilizing the IAIABC 837. The IAIABC medical sub committee has determined that the 837 can be used to report a lump sum payment on single or multiple medical bills (see http://www.dir.ca.gov/dwc /WCIS/IAIABC issue Resolution Request_(IRR)MED547R1.0.pdf)).

Based on the recommendation, DWC\WCIS has adopted special ~~CPT~~ codes as the standards for reporting bundled lump sum medical ~~bills~~ payments within the California adopted IAIABC 837. See 8 C.C.R. § 9702(e)(2). These codes, set forth below, describe the types of lump sum settlement payments of disputed medical bills that may be reported ~~made~~ by the claims ~~payer~~ administrator ~~after the filing of a lien with the 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.) Currently, the~~ The resolution is only for claims for which liability has been accepted or for which the claims ~~payer~~ administrator has been found liable."

Code Description

MDS10 Lump sum settlement for multiple bills where the amount of reimbursement is in 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 which it had denied liability.

MDS21 ~~Lump sum~~ sSettlement 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

Medical bill reporting process bundled lump sum medical bills

1. Sender transmits original "~~Zero Pay~~" bill, including all lines, utilizing a BSRC "00"

2. DWC sends a 997 "A" and a "TA" 824 acknowledgement to sender

~~3. Sender changes the value of data elements (Lien Settlement) on the original bills~~

4. Sender transmits the updated bill (Lien Settlement), *with all individual lines on all bills bundled as one lump sum payment ,* as a BSRC "00"

5. DWC sends a 997 "A" and a "TA" 824 acknowledgement to sender

IAIABC recommended data elements

The following ~~seventeen~~ IAIABC data elements should be included in the 837 when reporting a bundled lump sum payment for disputed medical bills ~~lien payment~~ to the DWC\WCIS.

California adopted bundled lump sum medical lien bill data edits
The California DWC adopted IAIABC data elements edit matrix provides the standard data edits and error codes the WCIS applies to the ANSI 837 EDI medical bill payment transmissions. The error codes will be transmitted back to each trading partner in the 824 acknowledgments. See the *IAIABC EDI Implementation Guides for Medical Bill Payment Records*, *Release 1* July 2002 for more information on the standard IAIABC edits. The ~~four~~ six additional jurisdiction codes are available at **http://www.dir.ca.gov/dwc/WCIS/IAIABC issue Resolution Request_(IRR)MED547R1.0.pdf).**

Discussion
Lump sum payments cover disputed medical bills whether or not liens have been filed on each bill, therefore references to lien claims and related statutes are unnecessary.

The new codes may not be called “CPT” codes since this term is coprighted by the AMA and the codes are in fact, not CPT codes.

Revise 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 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 appears to incorrectly direct a correction to the original transmission of the disputed bill, and should be deleted.

Six, not four additional jurisdictional codes have been proposed.

Thank you for considering these comments. Please contact me for further clarification or if I can be of any other assistance.

Sincerely,

Brenda Ramirez
Claims and Medical Director

BR:pm

cc: Carrie Nevans, DWC Administrative Director
Bill Kahley, WCIS Unit Manager
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Return to Work Committee
CWCI Regular members
CWCI Associate Members
OMFS Committee