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

INITIAL STATEMENT OF REASONS

Subject Matter of Regulations:
Workers' Compensation Information System

TITLE 8, CALIFORNIA CODE OF REGULATIONS
SECTIONS 9701 and 9702

Amended section 9701	Definitions
Amended section 9702	Electronic Data Reporting

BACKGROUND TO REGULATORY PROCEEDING

Labor Code section 138.6 requires the Administrative Director of the Division of Workers' Compensation (DWC) to develop a cost-efficient workers' compensation information system (WCIS) to accomplish four objectives:

1. Assist the Department of Industrial Relations to manage the workers' compensation system in an efficient and effective manner.
2. Facilitate the evaluation of the efficiency and effectiveness of the benefit delivery system.
3. Assist in measuring how adequately the system indemnifies injured workers and their dependents.
4. Provide statistical data for research into specific aspects of the workers' compensation system.

The statute requires that the data collected electronically by the WCIS be compatible with the Electronic Data Interchange (EDI) system of the International Association of Industrial Accident Boards and Commissions (IAIABC). The statute further directs the Administrative Director to adopt regulations specifying the data elements to be collected by electronic data interchange (EDI).

The initial regulations implementing Labor Code section 138.6 (California Code of Regulations, title 8, sections 9700 – 9704) became operative November 5, 1999. The regulations were amended in April 2006, primarily to require the electronic reporting of medical bill payment data. Currently, workers' compensation claims administrators adjusting approximately 95% of all workers' compensation claims in the State are electronically reporting claim data information to WCIS.

The proposed regulations seek to refine WCIS reporting by eliminating unnecessary data elements, adding relevant data elements, correcting errors in the text of the regulation,

adding lien payment data elements for medical bill payment reporting, and updating the two California-specific implementation guides. The California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records, in conjunction with the more comprehensive guides issued by the IAIABC, explain how the data transmission is accomplished, explain how to edit data transactions, provide the required codes for transmitting data, and set forth the system specifications.

These proposed regulations implement, interpret, and make specific Labor Code section 138.6, which mandates the development of the WCIS, requires data to be collected electronically to be compatible with the IAIABC EDI system, and requires data elements to be collected through EDI to be set forth in regulations.

TECHNICAL, THEORETICAL, OR EMPIRICAL STUDIES, REPORTS, OR DOCUMENTS

The Division relied upon:

(1) 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.

(2) IAIABC EDI Implementation Guide for Medical Bill Payment Records. IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, approved July 1, 2009, by the International Association of Industrial Accident Boards and Commissions.

(3) IAIABC Issue Resolution Request Form; IRR:MED547R1.0 (concerning the reporting of lien payment).

SPECIFIC TECHNOLOGIES OR EQUIPMENT

As Labor Code section 138.6 mandates that the data submitted electronically to the WCIS to be compatible with the EDI system of the IAIABC, the use of computer technology is necessary. As set forth in the proposed regulations, claim information data must be transmitted by a claims administrator to WCIS through File Transfer Protocol (FTP). The IAIABC standard file format for reporting medical bill payment data is the ANSI X12 837 (Health Care Claim).

REASONABLE ALTERNATIVES TO THE PROPOSED REGULATIONS AND REASONS FOR REJECTING THOSE ALTERNATIVES

The Administrative Director has not identified any effective alternative, or any equally effective and less burdensome alternative to the regulation at this time. The public is invited to submit such alternatives during the public comment process.

FACTS ON WHICH THE AGENCY RELIES IN SUPPORT OF ITS INITIAL DETERMINATION THAT THE REGULATIONS WILL NOT HAVE A SIGNIFICANT ADVERSE IMPACT ON BUSINESS

The Administrative Director has determined that the proposed regulations will not have a significant adverse impact on business. Claims administrators are already required under existing regulations to provide medical bill payment data to WCIS; the lien payment reporting obligations of proposed section 9702(e) do not require the collection of data elements beyond that already required under existing regulations. However, the existing regulations do not provide a mechanism for reporting lump sum settlements of workers' compensation medical bills. The proposed lien payment reporting obligations, devised by the IAIABC, provides that mechanism. The cost of the proposed regulations, including the revisions to the California implementation guides, will primarily be limited to the cost of upgrade computer programming. The cost of collecting newly added data elements should be effectively offset by the elimination of unnecessary date elements and efficiencies in the system resulting from changes in the two California implementation guides. It is estimated that the cost of the proposed WCIS regulations may be approximately $5-10,000 for each claims administrator who contracts with a third party vendor. Claims administrators who report directly to WCIS and use their own systems may incur a cost of approximately $20,000.

SUMMARY OF PROPOSED CHANGES

Section 9701 – Definitions

Specific Purpose of Section:

Section 9701 lists and defines the terms used in the WCIS regulations (sections 9700 – 9704). The purpose of the definitions is to implement, interpret, and make specific Labor Code section 138.6 and to ensure that the meanings of the terms are clearly understood by the workers' compensation community.

Necessity:

It is necessary to define each of the key terms used in the WCIS regulations to ensure that the content and meaning of the regulations are clearly understood by the workers' compensation community.

Initially, the defined terms in the regulation are now individually lettered in alphabetical order to allow for ease of reference by the regulated community. Also, the formats of several regulatory citations in the section have been corrected.

§ 9701(b): The amendment of the definition of "California EDI Implementation Guide for First and Subsequent Reports of Injury," now at subsection (b), is necessary to reflect revisions to the current version, Version 2.1 (dated February 2006). The new

version of the implementation guide, Version 3.0 (dated January 2010), must be used for reporting six months following the effective date of the regulation. Both versions of the implementation guide for first and subsequent reports of injury, which are incorporated by reference into the regulation, can be found at the Division's web site at http://www.dir.ca.gov/dwc/WCIS.htm. Revisions to the implementation guide 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.

§ 9701(c): The amendment of the definition of "California EDI Implementation Guide for Medical Bill Payment Records," now at subdivision (c), is necessary to reflect revisions to the current version, Version 1.0 (dated December 2005). The new version of the implementation guide, Version 1.1 (dated January 2010), must be used for reporting six months following the effective date of the regulation. Both versions of the implementation guide for medical bill payment records, which are incorporated by reference into the regulation, can be found at the Division's web site at http://www.dir.ca.gov/dwc/WCIS.htm. Revisions to the implementation guide 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.

§ 9701(d): A new definition for the term "California Jurisdiction Code" has been added for clarity. The proposed definition describes a group of medical billing codes (for a procedure, service, or product) that are specific to California and not identified by the current national Healthcare Common Procedure Coding System (HCPCS). California jurisdiction codes are set forth in 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 proposed section 9702(e), footnote 13, regarding lump-sum settlements. The proposed definition will assist WCIS reporters in distinguishing between national codes and those that are specific to California.

§ 9701(*l*): A new definition for HCPCS has been added for clarity. The widely-recognized acronym stands for the national Healthcare Common Procedure Coding System.

§ 9701(m): The amendment of the definitions of "IAIABC EDI Implementation Guide, Release 1," now at subdivision (k), is necessary since the guide can no longer by accessed through the Division's web site. The revised definition contains the necessary IAIABC contact information for obtaining the IAIABC guide.

§ 9701(n): The amendment of the definition of "IAIABC EDI Implementation Guide for Medical Bill Payment Records," now at subdivision (*l*), is necessary to reflect a new release of the guide. The new release, Release 1.1 (dated July 1, 2009), must be used for reporting six months following the effective date of the proposed regulations. The adoption of the new IAIABC guide is necessary to ensure that the WCIS complies with

Labor Code section 138.6's statutory mandate: the WCIS must be compatible with the EDI system of the IAIABC. The revised definition contains the necessary IAIABC contact information for obtaining the IAIABC guide.

§ 9701(q): The amendment of the definition of "International Association of Industrial Accident Boards and Commissions," now at subdivision (o), is necessary to update the office address of the association. The correct address of the IAIABC is 5610 Medical Circle, Suite 24, Madison, Wisconsin 53719-1295.

Section 9702 – Electronic Data Reporting

Specific Purpose of Section:

Section 9702 sets forth the list of data elements required to be electronically transmitted to the WCIS, the timing of the submission of these data elements, and the claims on which these data elements are to be submitted. The required data elements, compatible with the EDI system of the IAIABC, are essentially divided into three categories: the first report of injury (subdivision (b)), subsequent reports of benefit payments (subdivision (d)), and medical bill payment data (subdivision (e)).

Necessity:

§ 9702(b): This subdivision, the First Report of Occupational Injury (FROI), is first amended to increase the period for reporting from five (5) business days to ten (10) business days. This increase will allow claims administrators to submit a more accurate FROI.

The subdivision is also amended by adding IAIABC Data Element (DN) Nos. 39 ("Initial Treatment Code"); 26 ("Insured Report Number"); 29 ("Policy Effective Date"); and 30 ("Policy Expiration Date"); 28 ("Policy Number"); 33 ("Postal Code of Injury Site"); and 32 ("Time of Injury"). The Research Unit of DWC has determined that the addition of these data elements, available in the IAIABC EDI system but not required under the existing regulation, can provide relevant information on the adequacy of benefit delivery system. Further, the data elements will assist the division in implementing Assembly Bill (AB) 2181 (Chapter 740, Statutes of 2008). AB 2181, 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 new employer's report, which will replace the current Form 5020 administered by the Division of Labor Statistics and Research (DLSR), will be submitted to DWC by insurers and self-insured employers via the WCIS.

The subdivision is further amended to correct the alphabetical position of DN 11 ("Claim Administrator Address Line 2") and to include a footnote indicating that if DN 42 ("Social Security Number") is not known, a claims administrator should report either: (a) a string of eight zeros followed by a six; (b) a string of eight zeros followed by a seven; or (c) a string of nine consecutive nines. The footnote is necessary because while the

data element is mandatory and an error message will issue if it is not provided, an injured worker's social security number may not be known or may not exist for every claim. A default value for DN 42 allows the reporting of mandatory information without the indication of a transmission error.

§ 9702(c): Subdivision (c), which provides linkage data for submissions under subdivisions (b), (d), (e), (f), or (g), is amended to revise the name of DN 5, which was previously listed as "Jurisdiction Claim Number," to "Agency/Jurisdiction Claim Number." This revision is necessary to reconcile the fact that DN 5 is referred to as "Agency Claim Number" in IAIABC EDI Implementation Guide, Release 1, but as "Jurisdiction Claim Number" in IAIABC EDI Implementation Guide for Medical Bill Payment Records. DN 1 ("Transaction Set ID") and DN 4 ("Jurisdiction") are added to subdivision (c) to ensure better linkage between individual claims and data elements submitted to WCIS. For DN 42 ("Social Security Number"), footnote 3 is amended to provide that if a Social Security Number is not known, a claims administrator should report either: (a) a string of eight zeros followed by a six; (b) a string of eight zeros followed by a seven; or (c) a string of nine consecutive nines. The necessity for this amendment is set forth above in the justification for the amendments to § 9702(b).

§ 9702(d): For subdivision (d), the Subsequent Report of Occupational Injury (SROI), the Division's Research Unit has determined that several data elements now required under the existing regulation would not provide the Division with information needed to answer whether, as mandated by Labor Code section 138.6(b), the current benefit delivery system adequately indemnifies injured workers and their dependants. These data elements are: DN 68 ("Date of Return to Work"); and DN 58 ("Employment Status Code"). The proposed revisions remove these data elements from the subdivision. Equally, the Research Unit has also found that data elements available in the IAIABC EDI system that are not currently required under the existing regulation can provide relevant information on the adequacy of indemnification under the current benefit delivery system. These data elements are: Nos. 92 ("Benefit Adjustment Code"); 94 ("Benefit Adjustment Start Date"); 93 ("Benefit Adjustment Weekly Amount") 14 ("Claim Administrator Postal Code"); 74 ("Claim Type"); 57 ("Employee Date of Death"); 26 ("Insured Report Number"); 80 ("Number of Benefit Adjustments"); 82 ("Number of Death Dependent/Payee Relationships"); 55 ("Number of Dependents"); 81 ("Number of Paid To Date/Reduced Earnings/Recoveries"); 79 ("Number of Payments/Adjustments"); 78 ("Number of Permanent Impairments"); 71 ("Return to Work Qualifier"); and 67 ("Salary Continued Indicator"). The proposed revisions add these data elements to the subdivision.

§ 9702(e): The subdivision is first amended to provide that medical bill payment data should be reported to WCIS 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 denied. This amendment is necessary to clarify that reporting should only occur when a final decision to either pay or not pay for medical services (a "zero pay") has been made by a claims administrator. Interim determinations, for example those made based on

incomplete billings (i.e., a failure to submit a required medical report) will not trigger a reporting obligation to WCIS.

Subdivision (e) is also amended to include the addition of several data elements in the IAIABC EDI system that are not currently required under the existing regulation. These data elements are: Nos. 634 ("Billing Provider National Provider ID"); 682 ("Facility National Provider ID"); 699 ("Referring Provider National Provider ID"); 647 ("Rendering Bill Provider National Provider ID"); and 667 ("Supervising Provider National Provider ID"). The Division's Research Unit has determined that these data elements can provide relevant information on medical billing under the current benefit delivery system. Specifically, they can provide a more definite identification of the medical provider than the state license number.

Subdivision (e) is primarily amended to provide for the collection of data elements for medical services, whether reflected in one or more 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 with the Workers' Compensation Appeals Board (WCAB). Such lien claims for unpaid medical expenses are authorized by Labor Code sections 4903 and 4903.1. The required data elements and codes (see proposed footnote 13), available in the IAIABC EDI system, have been identified as providing the necessary data for all medical bill payments made subsequent to the filing of a lien claim. The collection of this data is necessary to fill in a gap in the existing regulation, which did not provide a means to report a medical bill or bills that are settled by a single lump sum payment. Under the current scheme of reporting, a claims administrator would need to cancel the original bill previously reported to WCIS, apportion the lump-sum settlement payment across bills spanning months or years, and then re-submit the bill as an original. The proposed standard for reporting lien data has been established by the IAIABC. See IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1 (July 1, 2009); IAIABC Issue Resolution Request Form; IRR:MED547R1.0. The proposed amendment is compatible with the IAIABC EDI system.

Additional amendments have been made to subdivision (e)'s footnotes. The amendment to Footnote 7, applicable to data elements Nos. 647 ("Rendering Bill Provider National Provider ID"); 630 ("Facility State License Number"); 649 ("Rendering Bill Provider Specialty License Number"); 643 ("Rendering Bill Provider State License Number"); and 599 ("Rendering Line Provider State License Number"), allows claims administrators to submit a default value if the necessary identifying information is not known. Currently, billing regulations do not exist which require physicians to provide this information to claims administrators. The amendment to Footnote 8 for data elements Nos. 718 ("Jurisdiction Modifier Billed Code"), 730 ("Jurisdiction Modifier Paid Code"), 715 ("Jurisdiction Procedure Billed Code"), and 729 ("Jurisdiction Paid Code") is necessary to specify the source of reporting codes for physician services and medical-legal expenses. Footnote 11, for data element 512 ("Date Insurer Paid Bill"), is necessary to account for the payment of a physician's deposition fee, which must paid in advance of the deposition. See California Code of Regulations, title 8, section 10536. Footnote 12, for data element 643 ("Rendering Bill Provider State License Number"), allows the

reporting of mandatory medical bill data in the absence of a physician's state license number, which may be difficult to obtain. Footnote 13, for data element 42, ("Employee Social Security Number"), is necessary because while the data element is mandatory and an error message will issue if it is not provided, an injured worker's social security number, or other forms of identification such as a green card or passport number, may not be known or may not exist for every claim. A default value for data element 42 allows the report of mandatory information without the indication of a transmission error. (See also the justification for substantially the same amendment in § 9702(b).)

The additional lien payment data, along with the data collected under the existing medical bill payment regulation, will allow the Division to analyze the cost of workers' compensation medical care, the treatments provided; the types and number of physicians providing care, and billing and payment practices. Medical bill payment data will also allow researchers to study relationships among medical treatment and payment patterns, as well as the interrelationships between medical data and other factors, such as claimant demographic and employer industrial characteristics.

§ 9702(g): The amendment to subdivision (g) is necessary to remove obsolete and redundant terms which may be confusing to reporting claims administrator. The legal citations in subdivisions (h) and (i) are amended to reflect the correct legal form.