California Workers' Compensation Institute
1111 Broadway Suite 2350, Oakland, CA 94607 • Tel: (510) 251-9470 • Fax: (510) 251-9485

December 15, 2009

VIA E-MAIL to dwcrules@dir.ca.gov

Maureen Gray, Regulations Coordinator
Division of Workers' Compensation, Legal Unit
Post Office Box 420603
San Francisco, CA 94142

RE: Workers' Compensation Information System – Written Testimony on Proposed Regulatory Changes

Dear Ms. Gray:

This written testimony 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~~.

The California Workers' Compensation Institute recommends 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.

CWCI 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. Continuous SROI reportings result in multiple data errors and are burdensome and costly. Periodic reportings provide a more efficient and cost-effective way to collect the data.

The Institute recommends adding all necessary information from the IAIABC implementation guides and from other sources into the California implementation guides. 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.

In addition, CWCI offers the following specific feedback on the draft regulations.

Section 9701 – Definitions

Recommendations – Section 9701

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. If the DWC decides to

continue incorporating the IAIABC guides, modify the IAIABC guide references as indicated in the changes recommended below.

(b) California EDI Implementation Guide for 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 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 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.

(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, (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.

Discussion

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 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 ~~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.

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."

The remaining changes are recommended for clarity and accuracy.

Section 9702 – Electronic Data Reporting

Recommendation -- Section 9702(a)

Add 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.

Discussion

The language included in the Section 9701 definitions regarding implementation guides 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.

Recommendations – Section 9702(b)

Delete 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).

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~~.

Discussion
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 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) 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 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.

DN 39 (initial treatment code): 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 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 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.

Recommendation -- Section 9702(c)

Delete the proposed new data elements.

Discussion
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 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.

Recommendation -- Section 9702(d)
Delete proposed new data elements that are not essential.

Discussion
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 other data submitted, such as the existence of indemnity payments.

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).

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 relationships), because the numbers can be derived from the underlying reporting.

Recommendation -- Section 9702(e)

Delay WCIS changes until billing standard regulations have been adopted.

Modify 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 on a complete bill ~~will be~~ is denied. Each claims administrator shall submit all lump sum payments on disputed bills ~~following the filing of a lien claim for the payment of such 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).

Modify 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 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 known 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.

Discussion
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, 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.”

California EDI Implementation Guides

General Recommendations
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.

Replace 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 Guides, but for the sake of brevity are not duplicated.

Discussion
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.

California EDI Implementation Guide for First and Subsequent Reports of Injury

Recommendation – Section B -- List of EDI Service Providers

Set minimum standards for EDI providers and exclude providers that fail to meet those standards from the listing of EDI providers that is posted on the DWC web site.

Discussion

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.

Recommendation – Section F – Trading Partner Profile

Clarify on page 27 whether the claims administrator or the trading partner should complete the trading partner profile form.

Post the Trading Partner Profile List with claim administrator FEINs on the WCIS website or remove the reference from page 27 of this section.

Modify the time listed on page 29 for "Production Response Period" to the typical response period.

Modify the Trading Partner Types list on page 32 as follows:

***Trading Partner Types**
1 = Self-Administered Insurer
2 = Self-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): _____

Explain the abbreviations and terms used in the "FTP Account Information" section on pages 36 and 37 and elsewhere.

Make 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.

Discussion

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.

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.

Recommendation – Section J – Events that Trigger Required EDI Reports
Modify Release 1 table on page 81 as follows and add definitions and technical specifications for each MTC below the tables.

Release 1

First Report of Injury

For claims with date of injury March 1, 2000 or later.

MTC†	Event	Time Report is Due
00	A new Employer’s Report OR A new Doctor’s First Report of Injury OR An Application for Adjudication OR Information that an injury requires medical treatment by a physician.	Within 10 business days of claims administrator knowledge (report all data known to the claims administrator)
01	A previously sent First Report was sent in error.	Within 10 business days of ~~event~~ claims administrator knowledge
02	Previously sent First Report was incomplete.	Within 60 days of ~~original first report submission~~ receipt of missing information
02	Data in previous First Report have changed.	By next date a submission is due for the claim
AU	Claim acquired from another claims administrator.	Within 10 business days of event
CO	Correction of previously reported data, in response to a TE (transaction accepted with error) acknowledgment.	By next date a submission is due for the claim
04	Denial of Claim and no benefits were paid.	Within 10 business days of ~~event~~ the denial

†MTC is the Maintenance Type Code and is included in all EDI transactions to identify the 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.

Discussion
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.

Recommendation – Section K -- Required Data Elements

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.

If the Division accepts changes to the regulations recommended by the Institute, including changes to data elements, make all corresponding changes to the Guides.

The proposed version of the California Guides must be revised to properly indicate all changes proposed in the regulations. 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.

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, 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 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 Medical Bill Payment Records

Recommendation – Section A – Electronic data interchange in California

Modify the language on page 4 as follows:

- **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~~ date**s** 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 self-insured employers, as well as bill review companies.

Discussion
The changes are recommended for accuracy and clarity.

Recommendation – Section C – Implementing Medical EDI

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.

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

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 facility license numbers referenced in the paragraph on page 15 (copied for your convenience below), the WCIS mandatory 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**.**

Recommendation – Section K -- Required Medical Data Elements

Replace the columns headed IA, Payeer, HCP, JBL and SNDR, in the California Medical Data Elements by Source table with columns for the other standard billing forms; complete the standard form field numbers for the data elements each column; and make corresponding changes to the introductory paragraph.

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

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

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).

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).

Clarify mandatory trigger language for DN # 502 (Billing Type Code).

Discussion

Because there is uncertainty and overlap in IA, Payeer, 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
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
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.

Recommendation – Section L -- Data Edits and Error Messages

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

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.

Recommendation – Section M – Unmatched Transactions

Retain 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 will be made available.

Discussion

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.

Recommendation – Section N -- Code Lists and State License Numbers

Include a link to the OMFS (jurisdiction) 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 each reference.

Discussion
California fee schedule uses OMFS codes that may not be current CPT codes.

If a single source for NDCs is to be listed, it 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.

Recommendation – Section O – California-adopted IAIABC data elements

Add a data dictionary and all other associated technical information for all data elements to be used in California.

Discussion
A one-stop Guide will improve compliance and efficiency.

Recommendation – Section P – Lump sum ~~bundled lien~~ disputed medical bill payment

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, modify the language in this section 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 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 ~~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.)~~

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 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

Medical bill reporting process bundled lump sum medical bills

1. Sender transmits all original disputed medical bill(s), including all lines, utilizing a BSRC "00".
2. The DWC sends a 997 "A" and a "TA" 824 acknowledgement to sender.
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".

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

Medical lump sum data requirements
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 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.

Discussion
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 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.

Recommendation – Section Q – Medical Glossary and Acronyms
Retain the Glossary and Acronym listing.

Discussion
The Glossary and Acronym listing is a helpful reference that adds clarity and promotes accurate reporting.

Recommendation – Section R – Standard Medical Forms
Retain the standard medical billing forms reference.

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

Thank you for considering these comments from the California Workers' Compensation Institute on behalf of its members. Please contact me for further clarification or if I can be of any other assistance.

Sincerely,

Brenda Ramirez
Claims and Medical Director

BR/by

cc: Carrie Nevans, DWC Deputy Administrative Director
Destie Overpeck, DWC Chief Legal Counsel
CWCI Regular members
CWCI Associate Members
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Return to Work Committee
CWCI OMFS Committee