Workers' Compensation Information System (WCIS)	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General Comment Claims FROI reporting –Medical Bill reporting	There is a contradiction in the requirements for Claims FROI reporting and Medical Bill reporting. Social Security Number (DN42) has been changed from Conditional/Minor to Mandatory/Serious for FROI reporting. The data edit requiring SSN to be reported on Medical Bill submissions has been removed, citing in the Errata, "This change is necessary because some employees do not have Social Security Numbers." If this logic is applied to Medical Bill submissions, then it should be applied to FROI submissions as well. SSN is not used for report matching purposes nor is it checked for validity. Many claimants may not have a SSN or they may use some other form of identification, such as a Green Card or Passport. The TE acknowledgement that results from a missing SSN is only going to waste time, space and effort. If we, as a trading partner, do not have the SSN at the time we report the Original FROI, it is unlikely that we will be able obtain it later. And while we can ignore the resulting TE acknowledgement, that error will sit dormant in our system, taking up space and showing up on every error report we run from then on. If WCIS absolutely must have the SSN populated, please allow the Trading Partner to submit a dummy number, such as 999999999, in order to communicate to WCIS that the	Ryan Hill EDI Coordinator Applied Underwriters January 3, 2006 Written Comment	This is incorrect. The medical bill errata number 19, states "Remove error code 040 from DN42 Employee social Security Number on page 84." All implementation guides allow for a transmission to be accepted with default values for the social security number, if the injured worker has no other form of identification and is not a US citizen.	None.

	number is unknown or that the claimant uses an alternate form of identification. This change would save time and effort on both WCIS's and the TP's part.			
Industry Code (DN25) Footnote	The footnote associated with Industry Code (DN25) makes the requirement for this data element unclear. The footnote states, "**DN42: if the Claims Administrator does not know the SSN, the resulting TE error code can be ignored". The association of this footnote with Industry Code can mean one of two things: a. It was simply associated with Industry Code in error and just needs to be corrected in the implementation guide, OR b. It contradicts the Conditional/Serious classification of the data element. If an error will be generated every time the Industry Code is submitted as blank, then that means it is a Mandatory/Serious data element. If this is true, it will be an extremely difficult, if not impossible, task for many carriers, TPAs and other reporting entities to comply with the requirement and the suggestions I made for SSN above would apply here as well.	Ryan Hill EDI Coordinator Applied Underwriters January 3, 2006 Written Comment	We disagree. The IAIABC has made a change in the IAIABC EDI Implementation Guide for Medical Bill Payment Records". Release 1, July 4, 2002, pages 11.25 -11.43. The change affects the California EDI Implementation Guide for Medical Bill Payment Records". December, 2006, on page 80. The footnote: * Adjustments to DN501, DN552, DN565, DN566, or DN572 in accordance with the California Official Medical Fee Schedule, the California Inpatient Hospital Fee Schedule, or any other Official DWC Fee Schedule (pharmaceuticals etc.) can use Bill\Service Adjustment Group Code = "MA" and Bill\Service Adjustment Reason Code = '45" for medical bill payment record reporting purposes to the DWC\WCIS. is no longer valid.	None.
Section 9701(e)	Commenter objects to the inclusion of CIGA within the definition of the term "Claims Administrator." The sole purpose for CIGA is to provide protection to insureds and claimants of	Richard E. Guilford Guilford Steiner Sarvas & Carbonara, LLP on behalf of the California Insurance Guarantee Association (CIGA)	We disagree. Ins. Code section 1063.2 provides: "b) The association shall be a party in interest in all proceedings involving a covered claim, and shall have the same rights as the insolvent insurer would have	None.

	insolvent member insurers. CIGA is not engaged in the business of insurance, and it " . . . issues no policies, collects no premiums, makes no profits, and assumes no contractual obligations to the insureds…" (*Isaacson, supra* at page 787). To facilitate the statutorily-circumscribed and limited function of CIGA, the Legislature vested day-to-day operational control solely in the Insurance Commissioner. The Department of Industrial Relations, through the Administrative Director, does not have the power to impose regulations on CIGA which would effectively place the day-to-day operations of CIGA within the control of the Administrative Director. The DIR cannot usurp the exclusive operation control vested in the Insurance Commissioner by the Legislature.	January 3, 2006 Written Comment	had if not in liquidation, including, but not limited to, the right to: (1) appear, defend, and appeal a claim in a court of competent jurisdiction; (2) receive notice of, investigate, adjust, compromise, settle, and pay a covered claim; and (3) investigate, handle, and deny a noncovered claim. The association shall have no cause of action against the insureds of the insolvent insurer for any sums it has paid out, except as provided by this article." Because CIGA is adjusting the claims of the injured workers, it is acting as a claims administrator. Labor Code section 138.6 allows the division to collect data from claims administrators. In CIGA v. WCAB (April 26, 2005) the WCAB held that CIGA is an insurer for purposes of Labor Code section 4616(a)(1) and may establish a medical provide network for the provision of medical treatment to injured employees. (MPNs are regulated by the DWC.) Ins. Code section 1063.1 (c)(1)(vi) provides that CIGA has the obligation to pay covered claims which includes "in the case of workers' compensation insurance, to provide workers' compensation benefits under the workers' compensation laws of this state…" Because CIGA administrates claims,	

			it must follow the workers' compensation regulations.	
General Comments	Commenter states that the cost to upgrade their software to support SROI reporting is significant and that SROI reporting requirements will create a much higher frequency of reports than FROI. The number of triggering events is significantly higher and often occur multiple times on a given claim. The payment data elements are almost all mandatory fatal which means that they will have more rejected reports. Commenter questions why there is a need to report each and every adjustment, change, denial, suspension, reinstatement, etc. within 10 days. Commenter doubts that this data will ever be used in real time. Instead, commenter suggests that the process be streamlined by reporting events when the claim closes or settles or reporting events on an annual basis.	Janet Selby Workers' Compensation Manager – Municipal Pooling Authority January 3, 2006 Written Comment	We disagree. Claims administrators have been required to report First Report of Injury and Subsequent Report of Injury data elements since 2000. Very few changes to the SROI data elements have been made. The 10 day period was changed prior to the 15 day comment period to 15 days. Section 9702(d). In order to produce timeliness of payment reports on a periodic basis, it is necessary top receive the data more frequently than annually. It is also necessary in order to be useful for auditing purposes.	None. None.
Section 9702 – Data Element	Element "Industry Code" - DN 25 being added - Comment: Industry Code (SIC/NAICS) is assigned at the Policy level for the insured. Since California has never required Industry Code for Policy or Unit Statistical reporting, this element does not exist our systems. In order to require this code on a First Report, you would first need to require it on the Policy. In addition, the industry would need a minimum of 12 months after implementing this on the Policy, before we could reasonably expect to provide it on the First Report. With only (5) days to report the data, we would need to capture this at the	Janice Bell Director, Data Reporting The Zenith January 4, 2006 Written Comment	We disagree. This code is conditional only. If the claims administrator does not have this information, it is not required to report it.	None.

	time the claim is called in. Employers will not know this information which leaves Call Center employees to populate an industry code. Commenter believes the quality of data would not be of use.			
Section 9702(3)(b)	The requirement to report First Report data within (5) days of knowledge of the claim is unreasonable and causes a lot of additional resources both for the carrier and for the state in processing Errors, Rejects, Changes, etc. due to missing information. Even for automated systems, we need to extract at (3) days in order to edit and transmit to the state. DWC increased the timeframe on Subsequent Reports to (15) business days, but we need more time on the First Report. Suggest (10) business days, minimum.	Janice Bell Director, Data Reporting The Zenith January 4, 2006 Written Comment	We disagree. The five days reporting time is required by the Division of Labor Statistics and Research pursuant to Labor Code section 6410 and 8CCR 14001, 14002, and 14004.	None.
CA EDI Implementation Guide for Medical Payment Records – Page 25	Commenter is confused about the procedure for filing the Trading Partner Profile. Commenter has been instructed elsewhere as to what his procedure should be as a Bill Reviewer, but has trouble recognizing that process in the guide's description. Commenter is also having trouble distinguishing trading partner and sender in the final paragraph. Is a sender the organization that submits bills (either directly or via a third party), while the trading partner is the organization actually transmitting the files? Commenter seeks clarification.	Robert G. Watkins Sr. Business Analyst Specialist Intracorp IT Stephen Kinlin EDI Analyst Intracorp EDI Support January 5, 2006 Written Comment	We agree. In the electronic world the terms "trading partner" and "sender" are synonymous	We will make the nonsubstantive change of replacing the words "claims administrators (insurers, self-administered self-insured employers, and third party administrators)" with "trading partners, i.e. senders," on page 5 for clarification.
CA EDI Implementation Guide for Medical Payment Records – Pages 37 through 44	**Transmission** Commenter notes no mention of sFTP (secure FTP), so he is concluding that this will not be an option. There is no mention of any limitation on the	Robert G. Watkins Sr. Business Analyst Specialist Intracorp IT Stephen Kinlin	Reader is referred to page 57 where the writer specifies "The Internet file transfer protocol is defined in RFC 959 by the Internet Engineering Task Force and the Internet Engineering	None.

	number of transactions in a transaction set, so he is concluding that there will be none. **DWC Responses** Commenter has questions about 997 and 824 files from DWC. Commenter opines that if even one of the transaction sets in a transmission is rejected, he will not receive any 824 files until all of the transaction sets in the file are accepted. How soon after an 837 transmission can he expect a 997 response? Commenter also has questions about the 824 response. Now that the TE (transmission error) response process has been modified, will an 824 transmission correspond to an 837 transmission, or can 824 responses to bills from the 837 file come back at different times? The guide says that TA (transmission accepted), TE (transmission error), TR (transmission rejected) responses will be used. Does that mean that BA and BR responses will not be used? If batch level acknowledgments are used, how will they interact with transaction level acknowledgments? If a batch is accepted or rejected, will the transactions within be implicitly accepted or rejected, or vice versa? Or will batches and transactions be treated independently of each other? If a batch is rejected, will the constituent transactions be explicitly rejected as well? What identifiers will be returned on an 824? If an error occurs at the line level, will DWC	EDI Analyst Intracorp EDI Support January 5, 2006 Written Comment	Steering Group. Data files are confidential through authentication and encryption, using secure socket layer (SSL)." Reader is referred to page 37 where the writer specifies "Trading partners should receive an electronic 997 acknowledgment within 48 hours of sending the test transmission." Reader is referred to page 41 where the writer specifies "The WCIS will process the ST-SE transaction set in which the error occurred until 20 errors per ST-SE transaction set have been detected. The 824 detailed acknowledgements will contain information about all detected errors for each 837 transmission." Correct Reader is referred to page 41 where the writer specifies "The WCIS will process the ST-SE transaction set in which the error occurred until 20 errors per ST-SE transaction set have been detected. The 824 detailed acknowledgements will contain information about all detected errors for each 837 transmission." Reader is referred to page 55 where the RED segment of the 824 specifies the identifiers to be used.	None. None. None. None.

	commit to returning the DN547 Line Number as one of the supplementary identifiers?			
CA EDI Implementation Guide for Medical Payment Records – Page 42	Under what circumstances would the following 824 error codes occur? 063 064	Robert G. Watkins Sr. Business Analyst Specialist Intracorp IT Stephen Kinlin EDI Analyst Intracorp EDI Support January 5, 2006 Written Comment	An 063 will occur if a trading partner sends a BSRC =01 before the senders sends a BSRC =00. A 064 will occur if one of many circumstances happen for instance if DN535 (Admitting Diagnosis) is sent without sending DN513 (Date of Admission)	None. None.
CA EDI Implementation Guide for Medical Payment Records – Page 48	Commenter would like to know if he could consider other characters as separators. Common characters like * and : can be confused with EDI separators. Less common characters like | and ^ often make better choices.	Robert G. Watkins Sr. Business Analyst Specialist Intracorp IT Stephen Kinlin EDI Analyst Intracorp EDI Support January 5, 2006 Written Comment	No. IAIABC guidelines require * : ~ be used. See section 5 of the IAIABC Implementation Guide	None.
CA EDI Implementation Guide for Medical Payment Records – Page 49	Commenter believes that NM1 is a typo and should be MN1.	Robert G. Watkins Sr. Business Analyst Specialist Intracorp IT Stephen Kinlin EDI Analyst Intracorp EDI Support January 5, 2006 Written Comment	We agree.	We have corrected the typographical error.
CA EDI Implementation Guide for Medical Payment Records – Page 55	Commenter asks if the LM segment is missing or if it was intentionally removed.	Robert G. Watkins Sr. Business Analyst Specialist Intracorp IT	This is a situation segment in the 824 and is not necessary, but we will add it for clarification purposes.	We have inserted the reference to the segment on page 55.

		Stephen Kinlin EDI Analyst Intracorp EDI Support January 5, 2006 Written Comment		
General Comments – Economic Impact	In the Initial Statement of Reasons from the November draft of the regulations the Division states that the proposed regulations will not have a significant adverse financial impact. In the Notice of Proposed Rulemaking, issued simultaneously, the Division concludes the opposite: that the proposed regulations may have "a significant, statewide adverse economic impact directly affecting business …" and the Division requested suggested alternatives. Some commentators noted this discrepancy earlier, but the Division has not altered the language, nor provided any explanation. The Institute has argued that the cost of compliance has been vastly underestimated and that the proposed regulations will have "a significant, statewide adverse economic impact directly affecting business …".	Michael McClain General Counsel & Vice President Brenda Ramirez Medical & Rehabilitation Director CWCI January 5, 2006 Written Comment	We disagree. The Initial Statement of Reasons and the Notice both state: "Other insurance carriers who are not yet providing medical data may contract with a third party vendor and incur costs of approximately $8000 per year. Insurance companies who report directly to WCIS and use their own systems will need to upgrade their programming for the medical data reporting and may incur an initial cost of approximately $50,000." Commenter is referring to the heading titles out of context. The estimates are based ion the following: ❑ One vendor reported that the total initial fixed cost for a sender that wants to establish an entirely in-house reporting system could reach a total of $250,000 to $300,000, *not* on an amortized basis. The amortized annual cost is a fraction of this cost. ❑ The yearly set fee corresponding to the in-house reporting system according to this vendor	None.

	In a WCIS e.News memo, issued on		would be $8,000. ❑ Multiple respondents indicated that bill review companies could send their clients' medical reporting data at very low cost, perhaps as low as $.05-$.10 per transaction. A cost of $.50 per transaction was stated by one vendor as being the top of his company's estimated range of total variable cost, or client fee. ❑ The total number of medical bills/transactions per workers' compensation claim averages about 5-7. This figure is likely to be falling significantly due to the system reforms that have dramatically reduced medical costs for workers' compensation claims. ❑ State Fund's estimated annual cost of $338,000 represents an average cost per claim of about $1.40, assuming that the annual number of SCIF claims averages 236,000 (which is the average number of FROI reports sent to the WCIS in the 2001-2004 period). Labor Code section 138.6 required	

	December 29, 2005 (Attachment A), the WCIS managers noted that the system contains FROI reports on more than 4.6 million claims, but that DWC reports some SROI information for only "about 850,000 claims, or only half of the expected number of indemnity claims." While the memo deals primarily with data reporting issues, some of the points raised reflect on the direction and content of the proposed regulations. By comparing the reported FROIs in the WCIS database with information from the DWC's Audit Unit (via its Annual Report of Inventory), the WCIS managers concluded that "a significant majority of reporters are not reporting SROI data, in particular, according to DWC's standards as stated in the California Implementation Guide for FROI and SROI Reporting." This analytical process raises the question of whether the current WCIS is a functioning and stable system, as the WCIS managers have so often described it. It should be a simple task to use the WCIS database to identify all reporting entities for either or both reports, provide a percentage run for SROIs at various levels, and/or match the FROIs and SROIs to estimate the follow up reporting levels. If the WCIS database cannot accomplish this straightforward analysis on its own, then the Division and the community should be concerned that the system is, at this juncture, not functional. The WCIS memo states that a significant number of data reporters are not providing		DWC to establish the WCIS and to adopt regulations specifying the data elements to be collected. The WCIS is fully functioning. Claims administrators have been required to report since 2000. The failure of claims administrators to report goes beyond the scope of these regulations. However, the division will adopt regulations that will penalize claims administrators who fail to report. DWC does do this. The failure of claims administrators to report goes beyond the scope of	

	SROIs according to the DWC standards as stated in the California Implementation Guide. The memo asks the workers' compensation community for help in identifying the reasons for the apparent underreporting and ideas for improving the system. One of the potential solutions proposed in the memo is to simplify the system. At the same time, the Division is moving forward with the implementation of the third phase, the reporting of all medical billing data – a truly massive undertaking. Adding more complexity to the system by imposing the medical billing reporting, when the FROI/SROI system is not fully functional, would be unwise at best. In exploring the possible reasons why SROI reporting would be lagging the WCIS managers note: "For SROI data, TPs (Trading Partners) have had to invest in computer systems and claims administrator training to submit data that are subject to sequencing rules, generating significant additional costs for complying with reporting requirements." (Emphasis added.) Some of the proposed solutions include additional training, monetary penalties, and user groups – all of which add to the cost of compliance. These statements fly in the face of the Division's previous assertion that the average cost of compliance would be in the range of $50,000.		these regulations. However, the division will adopt regulations that will penalize claims administrators who fail to report. Adding medical data is not a "massive undertaking." The FROI/SROI system is fully functional. The division cost estimate addresses medical data reporting only, as FROI/SROI reporting has been required since 2000. The systems should now be in operation. Reporting medical data is not as complex as reporting the FROI/SROI data (for example, there are no sequencing rules for medical data reporting). It should be noted that DWC's regulations are requesting the same information that major insurers are already reporting to CWCI. However, DWC's reporting guidelines follow the national standards that most carriers are familiar with.	
General Comment –	If the reporting of the FROIs and SROIs is not	Michael McClain	We disagree.	None.

Coordinating WCIS Implementation	yet stable and functional, or if that reporting system needs to be "simplified" to assist with compliance, as suggested in the WCIS memo, then these proposed final regulations should be withdrawn until the first 2 phases are tested, stable and functional.	General Counsel & Vice President Brenda Ramirez Medical & Rehabilitation Director CWCI January 5, 2006 Written Comment	The implementation guide has been BETA tested and no further changes are anticipated until a new version of the guide is implemented in the future do to legislative or administrative changes. Reporting medical data is not as complex as reporting the FROI/SROI data (for example, there are no sequencing rules for medical data reporting)	
Section 9701(e)	The Institute recommends that the Uninsured Employers Fund be added to the definition of claims administrator in subsection (e). The definition has been expanded to ensure that the data flowing into WCIS is as comprehensive as possible. The reporting requirements of WCIS should be applied to every claims organization in the state and according to the 2005 Legislative Summary of the Senate Labor and Industrial Relations Committee, about 1,000 to 1,500 new claims are filed with the UEF annually, at a cost of about $24 million per year. This puts the UEF well above the 150 case limit included in the proposed regulations and it should provide data to the system.	Michael McClain General Counsel & Vice President Brenda Ramirez Medical & Rehabilitation Director CWCI January 5, 2006 Written Comment	We disagree. UEF data is in the process of being captured and incorporated into the WCIS. There is no need for the DWC to become a trading partner with itself, when the data can be transferred internally.	None.
Section 9701(k) and (l)	The references to the IAIABC websites should be eliminated. These sites are difficult to locate, do not contain all the sections necessary for California, and are not within the control of the DWC. The DWC regulations should not refer California users to secondary sources that are incomplete and not regulated by the Division. Specifically, 9701(l) refers to sections 1 through 3and 5 through 14 of the IAIABC Implementation Guide, but sections 12 through 14 cannot be	Michael McClain General Counsel & Vice President Brenda Ramirez Medical & Rehabilitation Director CWCI January 5, 2006 Written Comment	We agree to correct the typographical error. The IAIABC ends at section 11. The reference to section 14 will be changed to 11. However, referencing the IAIABC is required. Labor Code section 138.6 requires that the data collected electronically be compatible with the EDI system of the IAIABC.	The reference in section 9701(l) to section 14 will be changed to 11.

	accessed from the Division's website.			
Section 9202(a)(1)(C)(ii)	Implied in this subsection is the erroneous notion that if a claims organization is using a bill review company, the WCIS data reporting will not be burdensome. While the existence of the bill review entity may make the reporting of data possible, the cost to have WCIS regulatory mandates met through the review company may also be exorbitantly expensive and unmanageable.	Michael McClain General Counsel & Vice President Brenda Ramirez Medical & Rehabilitation Director CWCI January 5, 2006 Written Comment	We disagree. The per unit costs of transferring data between a bill review company and the DWC is marginal and not burdensome because it is merely a copy of the information being exchanged between the bill reviewer and the payer.	None.
Section 9702(d) Footnote 2	In the first sentence the phrase "actual permanent disability rating at the time of initial payment" is vague and undefined. First, there may not be any permanent disability rating available at the time of the initial payment. Secondly, what is meant by "actual" rating? Is it a judicial determination, a DEU rating, or a claims administrator estimated permanent disability rating? This must be clarified for consistency. Lastly, the concluding permanent disability rating reported under the Unit Statistical Plan is not provided until the claim has been concluded, so that reporting it to WCIS, as instructed, may delay the information significantly.	Michael McClain General Counsel & Vice President Brenda Ramirez Medical & Rehabilitation Director CWCI January 5, 2006 Written Comment	We disagree. This language was in the original implementation guide, has not been changed by these proposed regulations, and is not a problem.	None.
Section 9702(e)	Commenter recommends this section be revised as follows: On and after **(OAL TO INSERT A DATE 6 MONTHS AFTER THE DATE OF FILING WITH SECRETARY OF STATE HERE)**, claims administrators handling one hundred and fifty (150) or more total claims per year shall submit to the WCIS	Michael McClain General Counsel & Vice President Brenda Ramirez Medical & Rehabilitation Director CWCI January 5, 2006		

	on each claim with a date of service on or after **(OAL TO INSERT A DATE 6 MONTHS AFTER THE DATE OF FILING WITH SECRETARY OF STATE HERE)**, the following data elements for all medical services for which the claims administrator has received a billing ~~**or other report of**~~ **for** provided medical services **on a workers' compensation claim that has not been denied**. The California EDI Implementation Guide for Medical Bill Payment Records sets forth the specific California reporting requirements. The data elements required in this subdivision are taken from California EDI Implementation Guide for Medical Bill Payment Records and the IAIABC EDI Implementation Guide for Medical Bill Payment Records. The claims administrator shall submit the data within ninety (90) calendar days of the medical bill 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.	Written Comment	We disagree. This appears to be unnecessary and extra verbiage. Statute requires the claim be paid before the 90 calendar day reporting requirement in section 9702(e). To be paid the claim must be accepted, therefore the language is unnecessary.	None.
	This section, as proposed, requires the claims administrator to submit medical billing data from bills received or "other report of provided medical services". The "other report" reference should be eliminated because it is vague, confusing and meaningless in this context. The section seeks		We disagree. The required data elements are specifically set forth in the regulations. Therefore, the required data is not vague.	None.

	medical bill data and should be limited to that. In the Data Elements portion of section (e), there are repeated references to "paid" codes. These references must be clarified to avoid confusion and the development of erroneous data reports. To the extent that this data will be coming from bill review organizations, it must be clear that "paid" in this context means, "recommended for payment," as the bill review entities only provide recommendations and make no payments.		We disagree. Bill review companies adjust bills in accordance with Official Medical Fee Schedules and/or contractual relationships. Payers and bill review companies claims adjusters utilize the same businesses practices with the exact same results.	None.
California EDI Implementation Guide for Medical Payment Records Section D – Authorizing statutes	This section contains outdated versions of Labor Code sections 138.6 and 138.7. CWCI recommends replacing them with the current versions.	Michael McClain General Counsel & Vice President Brenda Ramirez Medical & Rehabilitation Director CWCI January 5, 2006 Written Comment	We agree.	We will correct the improper references.
California EDI Implementation Guide for Medical Payment Records Section F – Trading partner profile	There is no definition for the term "trading partner." Commenter suggests adding one here. On page 26 in A, the trading partner type list is inconsistent with section 9701(e). The Institute recommends modifying the list to conform to the claims administrator definition in section 9701(e): Trading partner type (check all that apply) __ Self Administered Insurer __ Service Bureau	Michael McClain General Counsel & Vice President Brenda Ramirez Medical & Rehabilitation Director CWCI January 5, 2006 Written Comment	In the electronic world the terms "trading partner" and "sender" are synonymous. We will make a nonsubstantive change to replace the words "claims administrators (insurers, self-administered self-insured employers, and third party administrators)" with "trading partners, i.e. senders," on page 5 for clarification. We disagree that the trading partner form needs to be changed.	We will make a nonsubstantive change to replace the words "claims administrators (insurers, self-administered self-insured employers, and third party administrators)" with "trading partners, i.e. senders," on page 5 for clarification. None.

	__ Self Administered Self-Insurer (employer) __ Other: __ Third Party Administrator of insurer __ Third Party Administrator of self-insurer __ CIGA __ Legally uninsured employer __ Joint powers authority If the Administrative Director accepts the recommendation to extend the claims administrator definition in section 9701(e), then the Institute also recommends that the Uninsured Employers' Fund be added to the definition.		CIGA can check the "other" field. We disagree. UEF data is in the process of being captured and incorporated into the WCIS. There is no need for the DWC to become a trading partner with itself, when the data can be transferred internally.	None.
California EDI Implementation Guide for Medical Payment Records Section L – Medical data elements by name and source	The table does not include the ADA and NCPDP Forms that are included in Section R, and a source is not specified or a field is not identified for many data elements. Billing standards, including required billing data elements and field locations, are still under construction. As we have previously testified, billing standard regulations need to be finalized prior to the implementation of the WCIS medical billing regulations.	Michael McClain General Counsel & Vice President Brenda Ramirez Medical & Rehabilitation Director CWCI January 5, 2006 Written Comment	We disagree. All data element sources are identified on the sources and clarified in the directions which accompany the forms. The Table in section L conforms to the IAIABC standards. Weekly discussion with payers and venders indicate no ambiguity with respect to where the data required elements are on the four standard forms.	None.
California EDI Implementation Guide for Medical Payment Records Section Q – Medical billing payment records glossary	The claims administrator definition needs to be modified to make it consistent with section 9701(f). A trading partner definition needs to be added to the glossary.	Michael McClain General Counsel & Vice President Brenda Ramirez Medical & Rehabilitation Director CWCI January 5, 2006 Written Comment	We disagree. The entities covered in section 9701(f) including third party administrators, bill reviewers, utilization review vendors, and electronic data interchange vendors can be accommodated in the existing framework and do not need to be added to the Trading Partner Form. However, we will clarify the first reference to "trading partner" on	We will make a nonsubstantive change by replacing the words "claims administrators (insurers, self-administered self-insured employers, and third party administrators)" with "trading partners, i.e. senders," on page 5 for clarification.

			page 5.	
General Comment Economic Impact	On November 22, 2005, commenter submitted extensive comments regarding the conflicting economic impact statements in the original Notice of Proposed Rulemaking and Initial Statement of Reasons. In each instance, he noted that, based on his members' input, the cost impact was unrealistically low. Their estimated startup cost range from $390,000 to $500,000 and on-going cost range up to $100,000 annually. As several have pointed out to him, these cost estimates do not include the likely increase in fees bill review vendors will charge because of the increased amount of data being reported, or the complexities and cost of the interface between bill review vendors and insurer claims personnel. The failure to address the conflicting economic impact statements and the unrealistically low cost estimates came as a surprise. More importantly, that failure raises substantial doubt about the validity of the proposed rule and its compliance with Government Code 11346.2 requirements.	Steve Suchil Assistant Vice President State Affairs American Insurance Association January 5, 2006 Written Comment	We disagree. The Initial Statement of Reasons and the Notice both state: "Other insurance carriers who are not yet providing medical data may contract with a third party vendor and incur costs of approximately $8000 per year. Insurance companies who report directly to WCIS and use their own systems will need to upgrade their programming for the medical data reporting and may incur an initial cost of approximately $50,000." Commenter is referring to the heading titles out of context. The estimates are based ion the following: • One vendor reported that the total initial fixed cost for a sender that wants to establish an entirely in-house reporting system could reach a total of $250,000 to $300,000, *not* on an amortized basis. The amortized annual cost is a fraction of this cost. • The yearly set fee corresponding to the in-house reporting system according to this vendor would be $8,000. • Multiple respondents indicated that bill review companies could send their clients' medical reporting data at very low cost, perhaps as low as $.05-$.10 per	None.

			transaction. A cost of $.50 per transaction was stated by one vendor as being the top of his company's estimated range of total variable cost, or client fee. • The total number of medical bills/transactions per workers' compensation claim averages about 5-7. This figure is likely to be falling significantly due to the system reforms that have dramatically reduced medical costs for workers' compensation claims. • State Fund's estimated annual cost of $338,000 represents an average cost per claim of about $1.40, assuming that the annual number of SCIF claims averages 236,000 (which is the average number of FROI reports sent to the WCIS in the 2001-2004 period).	
General Comment Startup Date	Commenter is please to see a change in the startup date from June 1, 2006 to six months from the effective date of the rule. However, commenter recommends that the mandatory reporting date commence no less than nine months from the effective date to allow claims administrators adequate time. Programming time must be scheduled in advance; WCIS compliance is not the sole programming demand placed on his members. Nine months is a more realistic time frame.	Steve Suchil Assistant Vice President State Affairs American Insurance Association January 5, 2006 Written Comment	We disagree. The six month adjustment period plus the six month variance period allows 1 year for adjustment which is three months longer than the request. • At national meetings of the IAIABC, CA indicated that it would provide 6 months lead time for med data reporting and industry participants found this to be acceptable. • According to one major vendor,	None.

			claims administrator with no experience sending med data would need 6-7 man-months, while one familiar with sending such data would need 2-3 months. • Another major vendor indicated that, for a company already sending health care data, the reporting would require only "a few weeks" of preparation. • A third vendor indicated that giving claims administrators 6 months to prepare to send the med data was absolutely	
General Comment Medical Data Reporting	Previously commenter recommended phasing-in medical data reporting, and commencing with those claims administrators who do not report any transactional data to other entities such as the WCIRB and research organizations. The recommendation is reiterated here.	Steve Suchil Assistant Vice President State Affairs American Insurance Association January 5, 2006 Written Comment	We disagree. The DWC is required by statute LC138.6 to establish and maintain the WCIS. Currently this includes the proposed FROI/SROI/ Medical data elements in the proposed regulations. In response to the previous comment, we included a six month adjustment period and a variance in the proposed regulations.	None.
Section 9702(b) First Report of Injury/Subsequent Report of Injury (FROI/SROI)	Industry Code DN 25 was added in Section 9702(b) and page E-7 of the Implementation Guide as a Conditional/Serious FROI data element. However, the Conditional Rules and Implementation Notes for FROI were not updated. Please provide implementation note(s) so we can determine what the conditions are when WCIS requires this data element to be reported.	Jose Ruiz Assistant Claims – Rehabilitation Manager State Compensation Insurance Fund January 5, 2006 Written Comment		
Medical Data Element Basis of Cost	The method used to calculate drug allowance payments is not available in a reportable	Jose Ruiz Assistant Claims –	We disagree. The IAIABC data element DN564	None.

Determination (DN 564)	format or in the resulting Explanation of Review (EOR). The calculations in the bill review software may consider any of the available methods such as the Average Wholesale Price (AWP), Maximum Allowable Cost (MAC), Usual, Customary & Reasonable (UCR), etc. and select the lowest possible allowance subject to the Pharmacy Fee Schedule. Similarly, for those pharmacy bills where the payable allowance is calculated by using the Pharmacy Fee Schedule calculator available on DWC's website, this information is not available either. The resulting "Payment Price" does not indicate which method was used to calculate the final cost. We therefore request that this data element be downgraded from Conditional status to Optional.	Rehabilitation Manager State Compensation Insurance Fund January 5, 2006 Written Comment	Basis of Cost Determination is located in field 14 of the NCPDP universal claim form identified in section R of the Medical Implementation Guide. We disagree. Code 6 of the Basis of Cost Determination data element is "maximum allowable cost" which corresponds to the California pharmacy fee schedule price. We disagree as stated above.	
Medical Data Element Bill Adjustment Units (DN 546)	Commenter requests more information on this data element. Please provide clarification on what is referred to as the "units" at the bill level. Are units the number of services being adjusted?	Jose Ruiz Assistant Claims – Rehabilitation Manager State Compensation Insurance Fund January 5, 2006 Written Comment	DN546 Bill Adjustment Units are measured: DA = Days MJ = minutes UN = units (these are what ever units are used, ie pints for blood, number for bandages, number for rolls of tape etc.	None.
Medical Data Element Dispense as Written Code (DN 562)	This may be an unnecessary data element because LC §4600.1 already requires pharmacies to fill brand name drug prescriptions with their available generic drug equivalents, unless the prescribing physician specifically provides otherwise in writing. The drug's unique NDC code will	Jose Ruiz Assistant Claims – Rehabilitation Manager State Compensation Insurance Fund January 5, 2006 Written Comment	We disagree Dispense as written code number 4 = No generic available 5 = Brand dispensed as generic 8 = Substitution not allowed–generic not available in marketplace.	None.

	indicate whether the drug dispensed was generic or brand name. Since NDC BILLED CODE (DN 721) and NDC PAID CODE (DN 728) are already required, collecting DN 562 would be duplicative and unnecessary.		This provides useful information to the WCIS database.	
Medical Data Element Revenue Billed Code (DN 559)	Revenue Billed Code is misspelled as "Revenue Bill Code" in Section P of the Implementation Guide, pages 104-115. Please correct.	Jose Ruiz Assistant Claims – Rehabilitation Manager State Compensation Insurance Fund January 5, 2006 Written Comment	We agree.	Corrected the misspelled word in section P pages 104-115.
Section 9703(d)(2) and (f) – Individually Identifiable Information	The correct Civil Code section that pertains to the Information Practices Act of 1977 is 1798.24(t). In the proposed draft regulations, there is a typographical error - reference is to Civil Code section 1789.24 which is part of the Credit Services Act of 1984 and does not include a subsection (t).	Jose Ruiz Assistant Claims – Rehabilitation Manager State Compensation Insurance Fund January 5, 2006 Written Comment	We agree.	We will correct this typographical error.
Section 9702	Commenter thanks the division for addressing the need for a variance period.	Jose Ruiz Assistant Claims – Rehabilitation Manager State Compensation Insurance Fund January 5, 2006 Written Comment	Thank you.	None.
General Comment – Lack of e-billing standards to date	In order for carriers to collect and submit the data elements requested, the medical providers must provide the required data elements. However, the electronic billing standards that would require the providers to submit such information are not yet in force. Since the WCIS medical reporting requirements and electronic billing standards are interrelated, it would be more reasonable to wait until both sets of regulations are	Jose Ruiz Assistant Claims – Rehabilitation Manager State Compensation Insurance Fund January 5, 2006 Written Comment	We disagree. All data elements have been discussed with members of the providing and paying communities who have indicated the data elements are available. The data elements within the ANSI 837 have been tested and several trading partners have indicated the data elements and procedures outlined in the regulations	None.

	finalized.		are functional at this time.	