

1. 8 C.C.R. § 9702, changes are to subsection (e).

§ 9702. Electronic Data Reporting

(a) Each claims administrator shall transmit data elements, by electronic data interchange in the manner set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records, to the WCIS by the dates specified in this section. Each claims administrator shall, at a minimum, provide complete, valid, accurate data for the data elements set forth in this section. The data elements required in subdivisions (b), (c), (d) and (e) are taken from California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records. Claims administrators shall only transmit the data elements that are set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records. Each transmission of data elements shall include appropriate header and trailer records as set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records.

(1) The Administrative Director, upon written request, may grant a claims administrator either a partial or total variance in reporting all or part of the data elements required pursuant to subdivision (e) of this section. Any variance granted by the Administrative Director under this subdivision shall be set forth in writing.

(A) A partial variance requested on the basis that the claims administrator is unable to transmit some of the required data elements to the WCIS shall be granted for a six month period only if all of the following are shown:

1. a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;
2. a documented showing that any medical data elements currently being transmitted by the claims administrator or the claims administrator's agent to public or private research or statistical entities shall be reported by the claims administrator to the WCIS ; and
3. submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the request.

(B) A partial variance requested on the basis that the claims administrator is unable to report some of the required data elements to the WCIS because the data elements are not available to the claims administrator or the claims administrator's agent shall be granted for a six month period only if all of the following are shown:

1. a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;

2. a documented showing that any medical data elements currently being transmitted by the claims administrator or the claims administrator's agent to public or private research or statistical entities shall be reported by the claims administrator to the WCIS ;

3. a documented showing that the claims administrator will submit to the WCIS the medical data elements available to the claims administrator or the claims administrator's agents; and

4. submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the request.

(C) A total variance shall be granted for a twelve month period if all of the following are shown:

1. a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;

2. a documented showing that the claims administrator has not contracted with a bill review company to review medical bills submitted by providers in its workers' compensation claims;

3. a documented showing that the claims administrator is unable to transmit medical data to public or private research or statistical entities; and

4. submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within twelve months from the request.

(2) "Undue hardship" shall be determined based upon a review of the documentation submitted by the claims administrator. The documentation shall include: the claims administrator's total required expenses; the reporting cost per claim if transmitted in house; and the total cost per claim if reported by a vendor. The costs and expenses shall be itemized to reflect costs and expenses related to reporting the data elements listed in subdivision (e) only.

(3) The variance period for reporting data elements under subdivisions (a)(1)(A) and (B) shall not be extended. The variance period for reporting data elements under subdivision (a)(1)(C) may be extended for additional twelve month periods if the claims administrator resubmits a written request for a variance. A claims administrator granted a variance shall submit to the WCIS all data elements that were required to be submitted under subdivision (e) during the variance period except for data elements that were not known to the claims administrator, the claims administrator's agents, or not captured on the claims administrator's electronic data systems. The data shall be submitted in an electronic format acceptable to the Division.

(b) Each claims administrator shall submit to the WCIS on each claim, within

ten (10) business days of knowledge of the claim, each of the following data elements known to the claims administrator:

DATA ELEMENT NAME	DN
ACCIDENT DESCRIPTION /CAUSE	38
CAUSE OF INJURY CODE	37
CLAIM ADMINISTRATOR ADDRESS LINE 1	10
CLAIM ADMINISTRATOR ADDRESS LINE 2	11
CLAIM ADMINISTRATOR CITY	12
CLAIM ADMINISTRATOR CLAIM NUMBER	15
CLAIM ADMINISTRATOR POSTAL CODE	14
CLAIM ADMINISTRATOR STATE	13
CLASS CODE (3)	59
DATE DISABILITY BEGAN	56
DATE LAST DAY WORKED	65
DATE OF HIRE (1)	61
DATE OF INJURY	31
DATE OF RETURN TO WORK	68
DATE REPORTED TO CLAIM ADMINISTRATOR	41
DATE REPORTED TO EMPLOYER	40
EMPLOYEE ADDRESS LINE 1 (1)	46
EMPLOYEE ADDRESS LINE 2 (1)	47
EMPLOYEE CITY (1)	48
EMPLOYEE DATE OF BIRTH	52
EMPLOYEE DATE OF DEATH	57
EMPLOYEE FIRST NAME	44
EMPLOYEE LAST NAME	43
EMPLOYEE MIDDLE INITIAL (1)	45
EMPLOYEE PHONE (1)	51
EMPLOYEE POSTAL CODE (1)	50
EMPLOYEE STATE (1)	49
EMPLOYER ADDRESS LINE 1	19
EMPLOYER ADDRESS LINE 2	20
EMPLOYER CITY	21
EMPLOYER FEIN	16
EMPLOYER NAME	18
EMPLOYER POSTAL CODE	23
EMPLOYER STATE	22
EMPLOYMENT STATUS CODE (1)	58
GENDER CODE	53
INDUSTRY CODE	25
INITIAL TREATMENT CODE	39
INSURED REPORT NUMBER	26
INSURER FEIN	6
INSURER NAME	7
JURISDICTION	4
MAINTENANCE TYPE CODE	2
MAINTENANCE TYPE CODE DATE	3
MARITAL STATUS CODE (2)	54
NATURE OF INJURY CODE	35

NUMBER OF DEPENDENTS (2)	55
OCCUPATION DESCRIPTION	60
PART OF BODY INJURED CODE	36
POLICY EFFECTIVE DATE	29
POLICY EXPIRATION DATE	30
POLICY NUMBER	28
POSTAL CODE OF INJURY SITE	33
SALARY CONTINUED INDICATOR	67
SELF INSURED INDICATOR	24
SOCIAL SECURITY NUMBER (± 4)	42
THIRD PARTY ADMINISTRATOR FEIN	8
THIRD PARTY ADMINISTRATOR NAME	9
TIME OF INJURY	32
WAGE (1)	62
WAGE PERIOD (1)	63
(1) Required only when provided to the claims administrator. (2) Death Cases Only. (3) Required for insured claims only; optional for self-insured claims. (4) If the Social Security Number (DN 42) is not known, use a string of eight zeros followed by a six.	

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 of the first report under this subsection.

(c) Each transmission of data elements listed under subdivisions (b), (d), (e), (f), or (g) of this section shall also include the following elements for data linkage:

DATA ELEMENT NAME	DN
AGENCY/JURISDICTION CLAIM NUMBER (2) (3) (4)	5
CLAIM ADMINISTRATOR CLAIM NUMBER (2) (3) (4)	15
DATE OF INJURY (3)	31
INSURER FEIN (4)	6
JURISDICTION (1)	4
MAINTENANCE TYPE CODE (1)	2
MAINTENANCE TYPE CODE DATE (1)	3
SOCIAL SECURITY NUMBER (3)	42
THIRD PARTY ADMINISTRATOR FEIN (4)	8
TRANSACTION SET ID (1)	1
(1) Jurisdiction (DN 4), Maintenance Type Code (DN 2), Maintenance Type Code Date (DN 3), and Transaction Set ID (DN 1) are required for transmissions under subdivisions (b), (d), (f), and (g). (2) The Agency/Jurisdiction Claim Number (DN 5) will be provided by WCIS upon receipt of the first report under subdivision (b). The Agency/Jurisdiction Claim Number (DN 5) is required when changing a Claim Administrator Claim Number (DN 15); it is optional for other transmissions under this subsection. (3) The Date of Injury (DN 31), Social Security Number (DN 42), and	

<p>Claim Administrator Claim Number (DN 15) need not be submitted if the Agency/Jurisdiction Claim Number (DN 5) accompanies the transmission, except for transmissions required under Subsection (f). If the Social Security Number (DN 42) is not known, use a string of eight zeros followed by a six.</p> <p>(4) If the Agency/Jurisdiction Claim Number (DN 5) is not provided, trading partners must provide the Claim Administrator Claim Number (DN 15) and the Third Party Administrator FEIN (DN 8), or, if there is no third party administrator, the Insurer FEIN (DN 6).</p>	
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(d) Each claims administrator shall submit to the WCIS within fifteen (15) business days the following data elements, whenever indemnity benefits of a particular type and amount are started, changed, suspended, restarted, stopped, delayed, or denied, or when a claim is closed or reopened, or when the claims administrator is notified of a change in employee representation. Submissions under this subsection are required only for claims with a date of injury on or after July 1, 2000, and shall not include data on routine payments made during the course of an uninterrupted period of indemnity benefits.

DATA ELEMENT NAME	DN
BENEFIT ADJUSTMENT CODE	92
BENEFIT ADJUSTMENT START DATE	94
BENEFIT ADJUSTMENT WEEKLY AMOUNT	93
CLAIM ADMINISTRATOR POSTAL CODE	14
CLAIM STATUS	73
CLAIM TYPE	74
DATE DISABILITY BEGAN	56
DATE OF MAXIMUM MEDICAL IMPROVEMENT	70
DATE OF REPRESENTATION	76
DATE OF RETURN/ RELEASE TO WORK	72
EMPLOYEE DATE OF DEATH	57
INSURED REPORT NUMBER	26
LATE REASON CODE	77
NUMBER OF BENEFIT ADJUSTMENTS	80
NUMBER OF DEATH DEPENDENT/PAYEE RELATIONSHIPS	82
NUMBER OF DEPENDENTS	55
NUMBER OF PAID TO DATE/REDUCED EARNINGS/RECOVERIES	81
NUMBER OF PAYMENTS/ADJUSTMENTS	79
NUMBER OF PERMANENT IMPAIRMENTS	78
PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES AMOUNT	96
PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES CODE	95
PAYMENT/ADJUSTMENT CODE	85
PAYMENT/ADJUSTMENT DAYS PAID	91
PAYMENT/ADJUSTMENT END DATE	89
PAYMENT/ADJUSTMENT PAIDTO DATE	86
PAYMENT/ADJUSTMENT START DATE	88
PAYMENT/ADJUSTMENT WEEKLY AMOUNT	87
PAYMENT/ADJUSTMENT WEEKS PAID	90
PERMANENT IMPAIRMENT BODY PART CODE (1) (2)	83
PERMANENT IMPAIRMENT PERCENTAGE (2)	84

RETURN TO WORK QUALIFIER	71
SALARY CONTINUED INDICATOR	67
WAGE	62
WAGE PERIOD	63
(1) May use Code 90 (Multiple Body Parts) to reflect combined rating for any/all impairments.	
(2) Use actual permanent disability rating at the time of initial payment of permanent disability benefits. For compromise and release cases and stipulated settlements, use permanent disability estimate as reported to the appropriate rating organization established under Insurance Code § 11750, et seq.	

(e) On and after September 22, 2006, claims administrators handling one hundred and fifty (150) or more total claims per year shall submit to the WCIS on each claim with a date of service on or after September 22, 2006, the following data elements for all medical services for which the claims administrator has received a billing or other report of provided medical services. 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 or the date of the final determination that payment for billed medical services will be denied. Each claims administrator shall submit all medical lien lump sum payments or settlements 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 medical lien lump sum payment or settlement. Each claims administrator shall transmit the data elements by electronic data interchange in the manner set forth in the California EDI Implementation Guide for Medical Bill Payment Records and the IAIABC EDI Implementation Guide for Medical Bill Payment Records.

DATA ELEMENT NAME	DN
ACKNOWLEDGMENT TRANSACTION SET ID	110
ADMISSION DATE (17)	513
ADMITTING DIAGNOSIS CODE	535
APPLICATION ACKNOWLEDGMENT CODE	111
BASIS OF COST DETERMINATION CODE	564
BATCH CONTROL NUMBER	532
BILL ADJUSTMENT AMOUNT(17)	545
BILL ADJUSTMENT GROUP CODE (5)(17)	543
BILL ADJUSTMENT REASON CODE (17)	544
BILL ADJUSTMENT UNITS (17)	546
BILL SUBMISSION REASON CODE	508
BILLING FORMAT CODE	503
BILLING PROVIDER FEIN	629
BILLING PROVIDER LAST/GROUP NAME	528
BILLING PROVIDER NATIONAL PROVIDER ID (17)	634
BILLING PROVIDER POSTAL CODE	542
BILLING PROVIDER PRIMARY SPECIALTY CODE (4)	537
BILLING PROVIDER STATE LICENSE NUMBER (4)(7)	630
BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	523
BILLING TYPE CODE (17)	502

CLAIM ADMINISTRATOR CLAIM NUMBER	15
CLAIM ADMINISTRATOR FEIN	187
CLAIM ADMINISTRATOR NAME	188
CONTRACT TYPE CODE	515
DATE INSURER PAID BILL (9)(11)	512
DATE INSURER RECEIVED BILL (12)	511
DATE OF BILL (17)	510
DATE OF INJURY	31
DATE PROCESSED	108
DATE TRANSMISSION SENT	100
DAYS/UNITS BILLED(17)	554
DAYS/UNITS CODE (17)	553
DIAGNOSIS POINTER	557
DISCHARGE DATE (17)	514
DISPENSE AS WRITTEN CODE	562
DME BILLING FREQUENCY CODE	567
DRG CODE	518
DRUG NAME	563
DRUGS/SUPPLIES BILLED AMOUNT	572
DRUGS/SUPPLIES DISPENSING FEE	579
DRUGS/SUPPLIES NUMBER OF DAYS	571
DRUGS/SUPPLIES QUANTITY DISPENSED	570
ELEMENT ERROR NUMBER	116
ELEMENT NUMBER	115
EMPLOYEE FIRST NAME	44
EMPLOYEE LAST NAME	43
EMPLOYEE MIDDLE NAME/INITIAL	45
EMPLOYEE EMPLOYMENT VISA	152
EMPLOYEE GREEN CARD	153
EMPLOYEE PASSPORT NUMBER	156
EMPLOYEE SOCIAL SECURITY NUMBER (10)	42
FACILITY CODE	504
FACILITY FEIN	679
FACILITY MEDICARE NUMBER	681
FACILITY NAME (17)	678
FACILITY NATIONAL PROVIDER ID (17)	682
FACILITY POSTAL CODE (17)	688
FACILITY STATE LICENSE NUMBER (7)	680
HCPCS BILL PROCEDURE CODE	737
HCPCS LINE PROCEDURE BILLED CODE	714
HCPCS LINE PROCEDURE PAID CODE	726
HCPCS MODIFIER BILLED CODE	717
HCPCS MODIFIER PAID CODE	727
HCPCS PRINCIPLE PROCEDURE BILLED CODE	626
ICD-910 CM DIAGNOSIS CODE	522
ICD-910 CM PRINCIPAL PROCEDURE CODE	525
ICD-910 CM PROCEDURE CODE	736
INSURER FEIN	6
INSURER NAME	7
INTERCHANGE VERSION ID	105
JURISDICTION CLAIM NUMBER	5
JURISDICTION MODIFIER BILLED CODE (8)	718

JURISDICTION MODIFIER PAID CODE (8)	730
JURISDICTION PROCEDURE BILLED CODE (8)(13)(17)	715
JURISDICTION PROCEDURE PAID CODE (8)(9)(13)	729
LINE NUMBER (18)	547
MANAGED CARE ORGANIZATION FEIN (1)(17)	704
MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	208
MANAGED CARE ORGANIZATION NAME	209
MANAGED CARE ORGANIZATION POSTAL CODE	712
NDC BILLED CODE (17)	721
NDC PAID CODE	728
ORIGINAL TRANSMISSION DATE	102
ORIGINAL TRANSMISSION TIME	103
PLACE OF SERVICE BILL CODE (17)	555
PLACE OF SERVICE LINE CODE (17)	600
PRESCRIPTION BILL DATE	527
PRESCRIPTION LINE DATE	604
PRESCRIPTION LINE NUMBER	561
PRINCIPLE DIAGNOSIS CODE (17)	521
PRINCIPLE PROCEDURE DATE	550
PROCEDURE DATE	524
PROVIDER AGREEMENT CODE (3)	507
RECEIVER ID	99
REFERRING PROVIDER NATIONAL PROVIDER ID (17)	699
RELEASE OF INFORMATION CODE (17)	526
RENDERING BILL PROVIDER COUNTRY CODE (17)	657
RENDERING BILL PROVIDER FEIN	642
RENDERING BILL PROVIDER LAST/GROUP NAME	638
RENDERING BILL PROVIDER NATIONAL PROVIDER ID (7)(17)	647
RENDERING BILL PROVIDER POSTAL CODE	656
RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE (17)	651
RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER (7)	649
RENDERING BILL PROVIDER STATE LICENSE NUMBER (7) (17)	643
RENDERING LINE PROVIDER NATIONAL PROVIDER ID (7)(17)	592
RENDERING LINE PROVIDER FEIN	586
RENDERING LINE PROVIDER LAST/GROUP NAME (6)	589
RENDERING LINE PROVIDER POSTAL CODE	593
RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6)	595
RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) (7)	599
REPORTING PERIOD	615
REVENUE BILLED CODE	559
REVENUE PAID CODE	576
SENDER ID	98
SERVICE ADJUSTMENT AMOUNT (17)	733
SERVICE ADJUSTMENT GROUP CODE (5)(17)	731
SERVICE ADJUSTMENT REASON CODE (5) (17)	732
SERVICE ADJUSTMENT UNITS (17)	734
SERVICE BILL DATE(S) RANGE (14)	509
SERVICE LINE DATE(S) RANGE (9) (17)	605
SUPERVISING PROVIDER NATIONAL PROVIDER ID (17)	667
TEST/PRODUCTION INDICATOR	104
TIME PROCESSED	109
TIME TRANSMISSION SENT	101

TOTAL AMOUNT PAID PER BILL (2)(15)	516
TOTAL AMOUNT PAID PER LINE (2)(17)	574
TOTAL CHARGE PER BILL (16)	501
TOTAL CHARGE PER LINE – PURCHASE	566
TOTAL CHARGE PER LINE - RENTAL	565
TOTAL CHARGE PER LINE (17)	552
TRANSACTION TRACKING NUMBER	266
UNIQUE BILL ID NUMBER	500

(1) For HCO claims use the FEIN of the sponsoring organization in DN 704.
(2) Not required on non-denied bills if amount paid equals amount charged.
(3) For MPN claims use code P “Participation Agreement”
(4) Does not apply if billing provider is an organization.
(5) Required if charged and paid amounts differ.
(6) Optional if rendering provider equals billing provider.
(7) To be provided if available. The National Provider Identifier is assigned by the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (“CMS”).
(8) Use codes that 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, and section 9789.11, regarding fees for physician services rendered after January 1, 2004.
(9) For payments made pursuant to California Code of Regulations, title 8, section 10536, the data edit date the insurer paid the bill (DN 512) must be > = date the insurer received the bill (Error Code 073 is waived to allow payment of services); the data edit service line date(s) range (DN 605) must be < = the current date (Error Code 041 is waived to allow payment of services).
(10) If the Employee is not a United States citizen and has no other form of identification (DN 153, DN 152, or DN 156), use either a string of eight zeros followed by a six or a string of nine consecutive nines.
(11) For medical lien lump sum payments or settlements use the date final payment was made.
(12) For medical lien lump sum payments or settlements use the date on the first medical bill received.
(13) Use the following codes for reporting a medical lien lump sum payment or settlement:
MDS10 Lump sum payment or 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 payment or settlement for multiple bills where liability for a claim was denied but finally accepted by the claims payer
MDO11 Final order or award of the Workers’ Compensation Appeals Board requires a lump sum payment for multiple bills where claims payer is found to be liable for a claim which it had denied liability.
MDS21 Lump sum payment or 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 or settlement use the date of lien filing.
(15) For a medical lien lump sum payment or settlement use the settled or ordered amount.

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| <p>(16) For a medical lien lump sum payment or settlement use the amount in dispute.</p> <p>(17) Not required for a mixed medical lien lump sum payment or settlement.</p> <p>(18) For a mixed bill medical lien lump sum payment or settlement assign a value = 00.</p> |
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(f) Notwithstanding the requirement in Subsection (b) to submit data elements omitted from the first report within 60 days from the date of transmission of the first report, when a claims administrator becomes aware of an error or need to update data elements previously transmitted, or learns of information that was previously omitted, the claims administrator shall transmit the corrected, updated or omitted data to WCIS no later than the next submission of data for the affected claim.

(g) No later than January 31 of every year, claims administrators shall report for each claim the total paid in any payment category in the previous calendar year by submitting the following data elements:

DATA ELEMENT NAME	DN
PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES AMOUNT	96
PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES CODE	95
PAYMENT/ADJUSTMENT CODE	85
PAYMENT/ADJUSTMENT END DATE	89
PAYMENT/ADJUSTMENT PAID TO DATE	86
PAYMENT/ADJUSTMENT START DATE	88

(h) Final reports (MTC = FN) are required only for claims where indemnity benefits are paid. For medical-only claims, the final report may be reported under this section or on the annual report (MTC = AN) with claim status = “closed.”

(i)(1) A claims administrator’s obligation to submit copies of benefit notices to the Administrative Director pursuant to Labor Code section 138.4 is satisfied upon written determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under subdivision (d) and continued compliance with that subsection.

(2) Reserved.

(3) On and after September 22, 2006, a claims administrator’s obligation to submit an Annual Report of Inventory pursuant to California Code of Regulations, title 8, section 10104 is satisfied upon determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under subdivisions (b), (d), (e), and (g), and continued compliance with those subsections.

(j) The data submitted pursuant to this section shall not have any application to, nor be considered in, nor be admissible into, evidence in any personal injury or wrongful death action, except as between an employee and the employee’s employer. Nothing in this subdivision shall

be construed to expand access to information held in the WCIS beyond that authorized in California Code of Regulations, title 8, section 9703 and Labor Code section 138.7.

(k) Each claims administrator required to submit data under this section shall submit to the Administrative Director an EDI Trading Partner Profile at least thirty days prior to its first transmission of EDI data. Each claims administrator shall advise the Administrative Director of any subsequent changes and/or corrections made to the information provided in the EDI Trading Partner Profile by filing a corrected copy of the EDI Trading Partner Profile with the Administrative Director.

Authority: Sections 133, 138.4, 138.6, and 138.7, Labor Code.

2. 8 C.C.R. § 9770, changes are to subsection (g)

§ 9770. Definitions.

(a) "Administrative Director" means the administrative director of the Division of Workers' Compensation.

(b) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(c) "Division" means the Division of Workers' Compensation.

(d) "Employer" means an employer as defined in Section 3300 of the Labor Code.

(e) "HCO Enrollee" means a person who is eligible to receive services from an HCO.

(f) "Health care organization" ("HCO") means any entity certified as a health care organization by the administrative director pursuant to Section 4600.5 of the Labor Code and this article.

(g) "International Classification of Diseases--910th Revision (ICD-910) code" means the 4 or 5 digit number which identifies the illness, injury, disease, cause of death, or other morbid state of an enrollee that corresponds to the numeric classifications and descriptions listed in International Classification of Diseases. Clinical Modification. 910th Revision (ICD-910CM) US Department of Health and Human Services, Health Care Financing Administration. Washington DC: Superintendent of Documents, and updated successor revised manuals.

(h) "Material": A factor is "material" with respect to a matter if it is one to which a reasonable person would attach importance in determining the action to be taken upon the matter.

(i) "Participating provider" means a provider who is employed by or under contract with an HCO for purposes of providing occupational medical or health services or services required by this article.

(j) "Patient" means an HCO enrollee who is currently obtaining treatment or services for a work-related injury or illness.

(k) "Primary treating physician" means the treating physician primarily responsible for managing the care of the injured worker in accordance with Section 9785.5.

(l) "Professionally recognized standards of care" means health care practice encompassing the learning, skill and clinical judgment ordinarily possessed and used by a provider of good standing in similar circumstances.

(m) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(n) "Revocation" means the termination of a health care organization's certification to provide services pursuant to Section 4600.5 of the Labor Code and this article.

(o) "Standard Industrial Classification code" means the 4 digit number which identifies the primary type of economic activity which the employer is engaged in that corresponds to the numeric classifications and descriptions listed in The Standard Industrial Classification Manual 1987, Office of Management and Budget, Washington DC: Superintendent of Documents, US Government Printing Office, 1989, and updated successor revised manuals.

(p) "Suspension" means the health care organization's authority to enter into new, renewed, or amended contracts with claims administrators has been suspended by the administrative director for a specific period of time.

(q) "Utilization review" or "Utilization Management" is the system used to manage, assess, improve, or review patient care and decision-making through case by case assessments of the medical reasonableness or medical necessity of the frequency, duration, level and appropriateness of medical care and services, based upon professionally recognized standards of care. Utilization review may include, but is not limited to, prospective, concurrent, and retrospective review of a request for authorization of medical treatment.

NOTE: Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 3300, 4061.5, 4600.5, 5400, 5401 and 5402, Labor Code.

3. 8 C.C.R. §9789.16.2, changes are to subsections (a)(7) and (a)(9).

§9789.16.2 Surgery - Billing Requirements for Global Surgeries.

To ensure the proper identification of services that are, or are not, included in the global package, the following procedures apply.

(a) Procedure Codes and Modifiers

Use of the modifiers in this section apply to both major procedures with a 90-day postoperative period and minor procedures with a 10-day postoperative period (and/or a zero day postoperative period in the case of modifiers “-22” and “-25”).

(1) Physicians Who Furnish the Entire Global Surgical Package.

Physicians who perform the surgery and furnish all of the usual pre-and postoperative work bill for the global package by entering the appropriate CPT code for the surgical procedure only. Billing is not allowed for visits or other services that are included in the global package.

(2) Physicians in Group Practice.

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing (rendering) physician.

(3) Physicians Who Furnish Part of a Global Surgical Package

Where physicians agree on the transfer of care during the global period, the following modifiers are used:

- “-54” for surgical care only; or
- “-55” for postoperative management only.

Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier.

Physicians need not specify on the claim that care has been transferred. However, the date on which care was relinquished or assumed, as applicable, must be shown on the claim. This should be indicated in the remarks field/free text segment on the claim form/format. Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary’s medical record.

Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service. Once the physician has seen the patient, that physician may bill for the period beginning with the date on which he/she assumes care of the patient.

EXCEPTIONS:

- Where a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate evaluation and management code. No modifiers are necessary on the claim.

- If the transfer of care occurs immediately after surgery, the physician other than the surgeon who provides the in-hospital postoperative care bills using subsequent hospital care codes for the inpatient hospital care and the surgical code with the “-55” modifier for the post-discharge care. The surgeon bills the surgery code with the “-54” modifier.
- Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of office visit code. The physician who performs the emergency room service bills for the surgical procedure without a modifier.
- If the services of a physician other than the surgeon are required during a postoperative period for an underlying condition or medical complication, the other physician reports the appropriate evaluation and management code. No modifiers are necessary on the claim. An example is a cardiologist who manages underlying cardiovascular conditions of a patient.

(4) Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery.

Evaluation and management services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be paid separately.

In addition to the CPT evaluation and management code, modifier “-57” (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery.

If evaluation and management services occur on the day of surgery, use modifier “-57,” not “-25.” The “-57” modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit is not separately payable in addition to the procedure.

(5) Return Trips to the Operating Room During the Postoperative Period for Treatment of Complications.

When treatment for complications requires a return trip to the operating room, physicians must bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, use the unlisted procedure code in the correct series, e.g., 47999 or 64999. The procedure code for the original surgery is not used except when the identical procedure is repeated. In addition to the CPT code, use CPT modifier “-78” for return trips (return to the operating room for a related procedure during a postoperative period).

The physician may also need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first procedure, and requires the use of the operating room, report this circumstance by adding the modifier “-78” to the related procedure.

(6) Staged or Related Procedures. Use modifier “-58” for staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.

Modifier “-58” is added to the staged procedure when the performance of a procedure or service during the postoperative period was:

- (A) Planned prospectively or at the time of the original procedure;
- (B) More extensive than the original procedure; or
- (C) For therapy following a diagnostic surgical procedure.

A new postoperative period begins when the next procedure in the series is billed.

(7) Unrelated Procedures or Visits During the Postoperative Period.

CPT modifiers “-79” and “-24” are used for visits and other procedures which are furnished during the postoperative period of a surgical procedure, but which are not included in the payment for the surgical procedure.

(A) Modifier “-79” reports an unrelated procedure by the same physician during a postoperative period. A new postoperative period begins with the unrelated procedure.

(B) Modifier “-24” reports an unrelated evaluation and management service by same physician during a postoperative period. Services submitted with the “-24” modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. An ICD-910-CM code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation. A physician who is responsible for postoperative care using modifier “-55” should also use modifier “-24” to report any unrelated visits.

(8) Significant Evaluation and Management on the Day of a Procedure. Modifier “-25” is used for evaluation and management services on the day of a procedure for which separate payment may be made. It is used to report a significant, separately identifiable evaluation and management service by the same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient’s condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier “-25” to the appropriate level of evaluation and management service.

(9) Critical Care. Critical care services provided during a global surgical period for a seriously injured or burned patient are not considered related to a surgical procedure and may be paid separately under the following circumstances. Preoperative and postoperative critical care may be paid in addition to a global fee if:

- (A) The patient is critically ill and requires the constant attendance of the physician; and
- (B) The critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed. Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

In order for these services to be paid, two reporting requirements must be met:

- Codes 99291/99292 and modifier “-25” (for preoperative care) or “-24” (for postoperative care) must be used; and
- Documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-910-CM code in the range 800.0

through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

(10) Unusual Circumstances. Surgeries for which services performed are significantly greater than usually required may be billed with the “-22” modifier added to the CPT code for the procedure. Surgeries for which services performed are significantly less than usually required may be billed with the “-52” modifier. The biller must provide:

- A concise statement about how the service differs from the usual; and
- An operative report with the claim.

Modifier “-22” should only be reported with procedure codes that have a global period of 0, 10, or 90 days. There is no such restriction on the use of modifier “-52.”

(b) Date(s) of Service

Physicians, who bill for the entire global surgical package or for only a portion of the care, must enter the date on which the surgical procedure was performed in the “From/To” date of service field. This will enable the claims administrator to relate all appropriate billings to the correct surgery. Physicians who share postoperative management with another physician must submit additional information showing when they assumed and relinquished responsibility for the postoperative care. If the physician who performed the surgery relinquishes care at the time of discharge, he or she need only show the date of surgery when billing with modifier “-54.”

However, if the surgeon also cares for the patient for some period following discharge, the surgeon must show the date of surgery and the date on which postoperative care was relinquished to another physician. The physician providing the remaining postoperative care must show the date care was assumed. This information should be shown in Item 19 on the paper Form CMS-1500, or as specified in the ANSI ASC X12N 005010X222A1 Health Care Claim Payment/Advice (837) for electronic claims.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.

Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.