

**California Division of Workers' Compensation**  
**WORKERS' COMPENSATION INFORMATION SYSTEM**  
**WCIS Advisory Meeting**



Oakland, California  
June 1, 2009

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**EAMS WCIS Interface**

**Glenn Shor**

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## WCIS provides a Research Data Base

- The information system shall do the following:
- (1) Assist the department to manage the workers' compensation system in an effective and efficient manner.
- (2) Facilitate the evaluation of the efficiency and effectiveness of the benefit delivery system.
- (3) Assist in measuring how adequately the system indemnifies injured workers and their dependents.
- (4) Provide statistical data for research into specific aspects of the workers' compensation program.

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## The Goals of EAMS

- Integrate disparate DWC units into one seamless case management model
- Simplify and improve DWC's case management process
- Streamline process of creating cases, setting hearings, serving decisions, orders/awards
- Improve access to electronic case records while preserving confidentiality and strengthening security
- Ease transfer of case information between district offices
- Reduce environmental and physical stress—along with storage needs—through reduced use of paper
- Gather information to help guide policy decisions and better allocate resource work load

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## EAMS is system of record for DWC

- EAMS and WCIS both provide information on work related injuries and claims in California
- WCIS collects information on claims, costs, and medical care
- EAMS is repository for all interactions between injured workers and other case parties and all units of the DWC
- EAMS retains case and contact information, and electronic documents pertaining to cases

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## Interactions between WCIS and EAMS

- EAMS will share data with WCIS through a combination of three interfaces. These interfaces are:
  - Online Query Interface: to match incoming data on EAMS forms (during scanning) against existing claims in WCIS
  - Nightly Case Opening Interface: to transmit FROI information to WCIS when a case is opened in EAMS, but no match was found in WCIS
  - JCN Retrieval Interface: to establish a link between EAMS and WCIS through the JCN#

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## Online Query Interface

- The purpose of the Online Query interface is to match data from scanned paper forms against existing claims in WCIS using real-time queries
- If a match is found, EAMS will retrieve the following data from WCIS:
  - Employer Details (Name and Address)
  - Insurer Details (Name and Address)
  - Claims Administrator Details (Name and Address)
  - JCN

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## Nightly Case Opening Interface

- The purpose of the WCIS - Daily Case Opening interface is to create a nightly output file containing those cases for which a first report of injury (FROI) was not found in WCIS during the scanning operation
- The following data will be transmitted to WCIS in a file:
  - Case Information
  - Injured Worker Details
  - Insurer Details
  - Employer Details
  - Third Party Administrator Details
  - Claim Administrator Details

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## JCN Retrieval Interface

- The purpose of the WCIS - JCN Retrieval interface is to receive a file every night containing JCN and the corresponding EAMS case number from WCIS. This JCN number will be populated into the EAMS database.
- The following data will be accepted by EAMS:
  - JCN#
  - EAMS case reference number

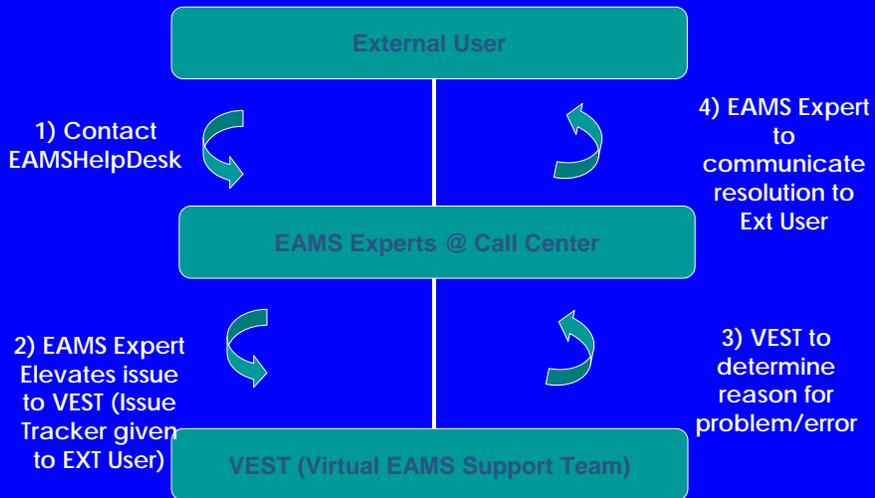
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## EAMS Help Desk Procedures

- External users with questions or problems e-mail [EAMSHelpDesk@dir.ca.gov](mailto:EAMSHelpDesk@dir.ca.gov)
  - Provide detailed information about question. Are you an e-Form filer or OCR filer?
  - Example of a good e-mail:  
"I am an external e-form trial participant. I have a batch # where I cannot confirm the filing.  
Batch ID 252390 – On 10/06/08 at 10:07 a.m. I filed a Petition for Contribution on these two cases. It is not showing as being filed yet. This is for ADJ11192118 and ADJ2423696 - IW is Mickey Mouse."
- EAMS expert will research problem and assist you via e-mail or by phone (please provide your contact information)
- If it's not a quick fix/answer and needs further investigation, your problem may be submitted to "issue tracker"

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## Problem Solving Chain of Command



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## Want More Information?

- On the Web at [www.dwc.ca.gov/eams](http://www.dwc.ca.gov/eams)
    - ✓ Project updates
    - ✓ Fact sheets
    - ✓ Frequently asked questions
    - ✓ Glossary
    - ✓ EAMS *Insider*—bi-monthly e-newsletter for external users
- Questions, comments or feedback about EAMS? Write to [eams@dir.ca.gov](mailto:eams@dir.ca.gov)

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## Future ?

- Combinations of WCIS and EAMS information can help understand the process of WC cases
- Research can focus on division-wide resources needed to adjudicate and resolve disputes
- EAMS can provide information to help plan for better and more targeted services

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## FROI SROI Data Collection

Martha Jones  
Manager, Research Unit

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## WCIS Data Collection – First Report of Injury (FROI)

	1/2009
■ Trading Partners Submitting Data	165
■ Total Number of Claims	7.0 m

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## Goals for the Workers' Compensation Information System (WCIS)

- Help DWC Manage WC system
- Facilitate Evaluation of Benefits Delivery
- Assist in Measuring Benefit Adequacy
- Provide Statistical Data for Research

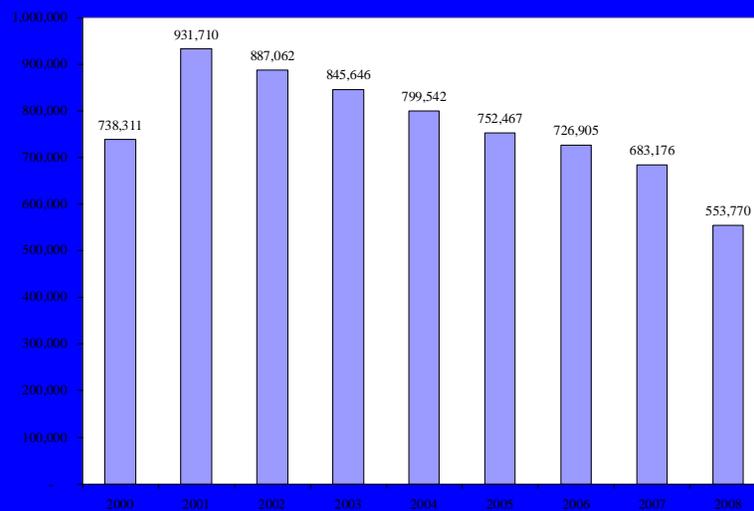
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## Components of WCIS

- First Reports—FROI
- Subsequent Reports—SROI
- Medical/Bill Payment Reports

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## Number of Claims Reported to WCIS, 2000-2008 Total Claims = 6,975,976 as of January 2009



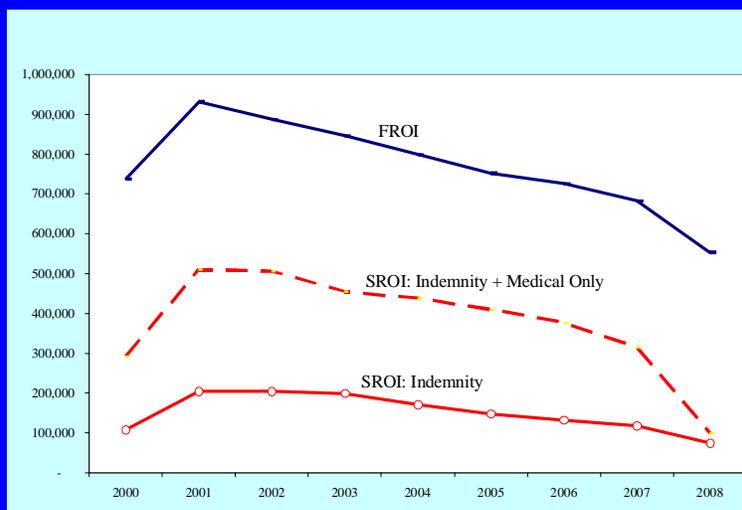
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## WCIS Data Collection – Subsequent Reports of Injury (SROI)

	1/2009
■ Trading Partners Submitting Data	112
■ Total Number of SROI Reports	3.4 m
■ Indemnity	1.4 m
■ Medical Only	2.0 m

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## SROI Reporting is not complete



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## Updated Annual Web Reports

Claims by Year of Injury, 2000-2008:

1. Part of Body
2. Cause of Injury
3. Nature of Injury
4. Market Share
5. Age
6. Gender
7. Geographic Region

[http://www.dir.ca.gov/dwc/wcis/WCIS\\_Reports.html](http://www.dir.ca.gov/dwc/wcis/WCIS_Reports.html)

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## Updated Annual Web Reports - Detail

Claims by Year of Injury, 2000-2008:

- Table 1a: Part of Body
- Table 2a: Cause of Injury
- Table 3a: Nature of Injury
- Table 7a: Geographic Region by County

[http://www.dir.ca.gov/dwc/wcis/WCIS\\_Reports.html](http://www.dir.ca.gov/dwc/wcis/WCIS_Reports.html)

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## New Monthly Web Reports – by month of injury, 2000-2008

- Table 9 – FROI and SROI Summary
- Table 10 – FROI, Total Reported Injuries
- Table 11 – SROI, Total Reported Medical Only
- Table 12 - SROI, Total Reported Indemnity
  - *Table 12a – SROI Indemnity, No Medical*
  - *Table 12b – SROI Indemnity, With Medical*
- Table 13 – Total Denied Claims
- Table 14 – Total Other Claims, not otherwise classified

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## Examples of Proposed Changes to the FROI SROI CA Implementation Guide

- FROI reporting due date will be within 10 days of claim administrator knowledge of the claim.
- Trading partners will send all data to an FTP server hosted by the WCIS
- New data elements to be collected: policy number, policy effective date, policy expiration date.
- For the Social Security Number, a default value will be accepted if the employee has no SSN or refuses to provide it.

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## Examples of Proposed Changes to the FROI SROI CA Implementation Guide

- The Payment/Adjustment Weeks and Days Paid will be Mandatory Fatal for some SROI MTCs.
- The SROI Annual and Final Reports will now be accepted if a previously reported indemnity benefit is missing in the AN or FN.
- The SROI Annual will now be accepted with error if a previously unreported indemnity benefit is reported in the AN.

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## In general, please do not send the following DN85 Codes to the WCIS

- 040, 540 (unscheduled PD)
  - For permanent disability, use 030 and 530 (scheduled PD)
  - PD payments in California are currently based on the 1/1/2005 Permanent Disability Rating Schedule (PDRS).
  - <http://www.dir.ca.gov/dwc/PDR.pdf>
  - Under the 1997 PDRS, the 040 & 540 codes were appropriate in some cases.
- 410, 541 (Voc Rehab payments)
  - The Legislature repealed vocational rehabilitation payments effective 1/1/2009.
  - For Supplemental Job Placement Benefits use DN95, code 390 (Voc Rehabilitation Education paid-to-date).
- 051, 551 (temporary total catastrophic)
- 080, 580 (employer liability)

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## WCIS and WCIRB

- WCIS – Workers' Compensation Information System, Division of Workers' Compensation, California Department of Industrial Relations
  - <http://www.dir.ca.gov/dwc/WCIS.htm>
- WCIRB – Workers' Compensation Insurance Rating Bureau – The WCIRB is a licensed rating organization and the designated statistical agent of the California Insurance Commissioner, California Department of Insurance.
  - <https://wcirbonline.org/wcirb/>

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## WCIS and WCIRB Reporting

- We would like to ask our trading partners to consistently report claim administrator claim number to both WCIS and WCIRB.
- Reporting to the WCIS uses IAIABC standards; Reporting to WCIRB uses the CA. Workers' Compensation Uniform Statistical Reporting Plan. These two reporting mechanisms differ.
- For class code (DN 59), the WCIS collects California-specific WCIRB codes  
[https://wcirbonline.org/wcirb/Answer\\_center/classification\\_information.html](https://wcirbonline.org/wcirb/Answer_center/classification_information.html)

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## Uses of WCIS Data in 2008

In 2008, WCIS claim and medical billing data were used to:

- Identify several samples of claims used in the update of DWC's Medical Access Study. One sample was identified to reconstruct temporary disability benefit periods for a select group of low-back claims. These back claims will be used in a prospective analysis of the association of access and quality of care issues on disability outcomes. Two additional WCIS samples were also identified: a simple random sample of workers injured in June 2007 as well as a stratified random sample of physicians.
- Inform cross-walk development for specific OMFS codes for the DWC-commissioned study on the conversion of the physician fee schedule to an RBRVS-based fee schedule: *The Lewin Group. Adapting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule*, December 19, 2008. As part of this project, WCIS data were also used to assess the representativeness of data from the California Workers' Compensation Institute (CWCI).
- Assess the economic fiscal impact of adopting the ACOEM-revised elbow disorders chapter and post-surgical physical medicine guidelines for DWC's Medical Treatment Utilization Schedule.

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## Uses of WCIS Data in 2008

WCIS data extracts were provided to various state agencies:

DIR's Division of Labor Statistics and Research, DIR's Division of Occupational Safety and Health, the Department of Public Health (Occupational Health Branch), CSHWC, the Bureau of State Audits, and the Employment Development Department.

WCIS data have been used for law-enforcement related to fraud for the Department of Insurance and for claim denial analysis for the California Workers' Compensation Insurance Rating Bureau.

A CHSWC study released in August 2008 compared counts of lost-time injuries from the WCIS to those reported to the U.S. Bureau of Labor Statistics to determine whether underreporting is a significant issue in the California workers' compensation system.

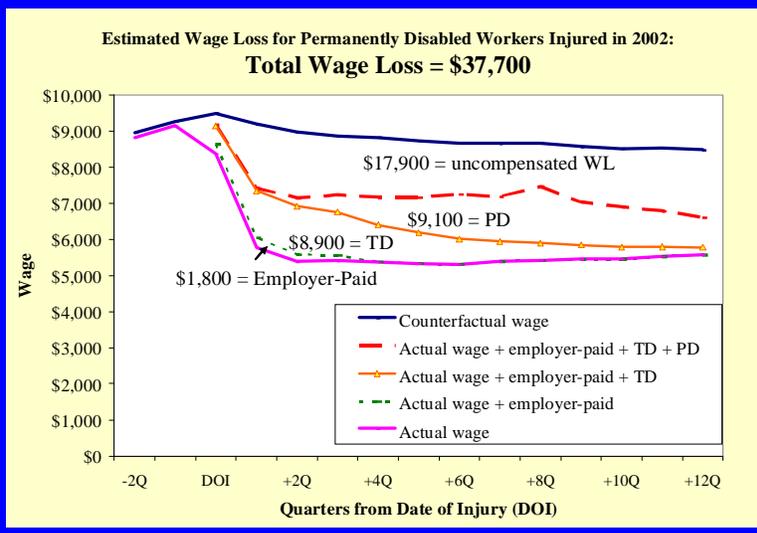
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# Permanent Disability Research

- Return-to-Work
- Wage Loss
- Uncompensated Wage Loss
- These studies use data from WCIS, EDD (base wage file) and DEU.
- Posted under "Research Studies"
  - <http://www.dir.ca.gov/dwc/WCIS.htm>

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# Three-year Wage Loss



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## CHSWC/RAND Medical Study on the Impact of Recent Reforms: Selected Key Issues

### CHSWC/RAND Study Scope and Objectives:

A series of legislative changes affecting medical care provided to California's injured workers has been enacted over the past few years to address medical utilization and cost issues.

### Senate Bills (SB) 228 and 899 changes included:

- The repeal of the treating physician presumption
- Evidence-based medical treatment guidelines. (e.g., ACOEM *Guidelines*).
- Limits on the number of chiropractic, physical therapy and occupational therapy visits
- New utilization review (UR) requirements established
- Employer control of medical care through medical provider networks
- Qualified medical evaluator (QME), agreed medical evaluator (AME) and medical dispute resolution.

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## CHSWC/RAND Medical Study on the Impact of Recent Reforms: Selected Key Issues

### The CHSWC/RAND study will:

- Develop measures that could be used in an ongoing system of monitoring of the cost and quality of care provided to injured workers
- Generate aggregate payment information by type of service and average payment levels for high-volume services for Medical Provider Network (MPN) and non-MPN care.
- Test a set of measures that could be used for on-going monitoring of the medical care provided to workers with back injuries.
- Assess the representativeness and reliability of the medical data (MD) reported in WCIS and compare the data to external sources of information, including the Workers' Compensation Insurance Rating Bureau and the California Department of Statewide Health Planning and Development.

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# Detailed Medical Data

David Henderson  
Research Unit

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## Data Collection Medical Billing Data

April, 2009

### Entities Submitting Data

➤ Senders	43
➤ Insurers	986
➤ Claims Administrators	463

### Data

➤ Claims (millions)	1.6
➤ Medical Bills (millions)	27
➤ Bill Lines (millions)	55

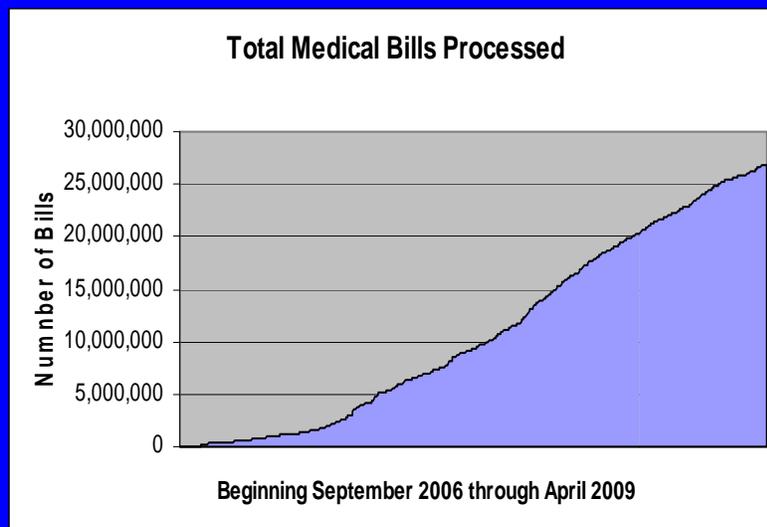
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## IAIABC Medical Data Collection

- Version 1.1 of the Medical Implementation Guide
- Published July 1, 2009
- Effective October 1, 2009
- Includes Lump Sum Bundled Payments
- Includes a data edit for the National Provider ID

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## Total Medical Bills Processed



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## Medical Bill Processing Back Log

- Increase processing capacity
  - purchasing new computers
- Increase processing speed
  - streamlining business processes
  - fine tuning the programming processes

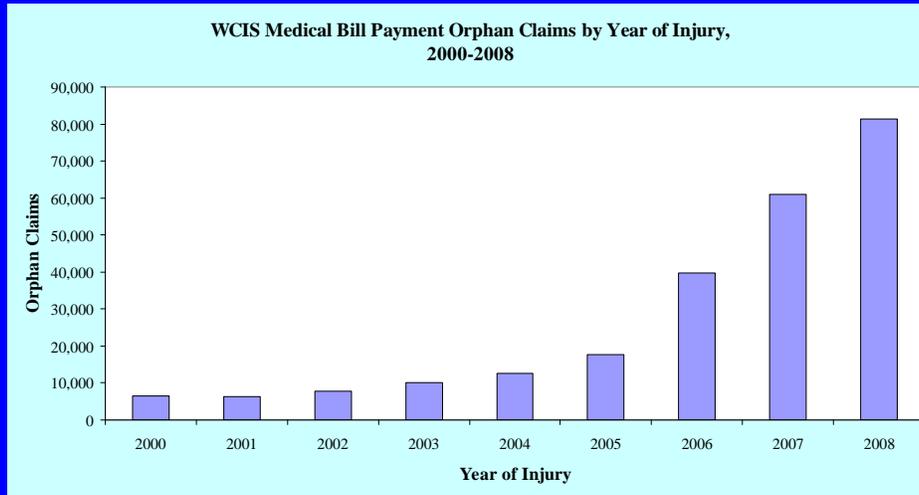
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## Data Quality Errors

Rank	Error Code	Message
1	039	No Match on Database
2	057	Duplicate transmission/transaction
3	058	Code/ID invalid
4	001	Mandatory field not present
5	063	Invalid event sequence/relationship
6	034	Must be >= date of injury
7	028	Must be numeric (0-9)
8	030	Must be A-Z, 0-9, or spaces
9	040	All digits cannot be the same
10	075	Must be <= thru service date
11	073	Must be >= date payer received bill
12	041	Must be <= current date
13	074	Must be >= from date of service
14	029	Must be a valid date (CCYYMMDD)
15	064	Invalid data relationship

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## Medical Orphanage, No Match on Database



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## Changes to the Medical Data Collection

- Added five new data elements to be consistent with forthcoming e-billing regulations. The five new data elements reflect the switch to the National Provider Identification number as the primary identifier for medical providers.
- Added the Lump Sum Bundled Medical Lien Reporting requirements.

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## IAIABC Guidelines

- ZERO PAY: The standard supports the reporting of zero-dollar payments.
- LUMP SUM PAYMENTS: Jurisdictions can adopt six jurisdictional codes that are recommended to become a part of the IAIABC ANSI 837 standard.

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## Lump Sum Bundled Lien Bill Payment

- 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)).
- The DWC\WCIS has adopted six IAIABC medical lien codes as the standard for reporting bundled lump sum medical bills (See 8 C.C.R. § 9702(e)(2)). The six codes describe the type of lump sum settlement payment 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>.)

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## Jurisdictional Codes for Bundled Bills

- MDS10 Lump sum settlement for multiple bills where the amount of reimbursement is in dispute between the claims payer and the healthcare provider.
- MDO10 Final order or award of the Workers' Compensation Appeals Board requires a lump sum payment for multiple bills where the amount of reimbursement is in dispute between the claims payer and the healthcare provider.
- MDS11 Lump sum settlement for multiple bills where liability for a claim was denied but finally accepted by the claims payer.
- MDO11 Final order or award of the Workers' Compensation Appeals Board requires a lump sum payment for multiple bills where claims payer is found to be liable for a claim which it had denied liability.
- MDS21 Lump sum 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.

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## Medical bill reporting process bundled lump sum medical bills

- Sender transmits all original "Zero Pay" medical bill(s), including all lines, utilizing a BSRC "00".
- The DWC sends a 997 "A" and a "TA" 824 acknowledgement to sender.
- Sender changes the value of data elements (Lien Settlement amount) on the original bundled bill(s).
- Sender transmits the updated bill (Lien Settlement), with all individual lines on all bills bundled as one lump sum payment, as a BSRC "00".
- DWC sends a 997 "A" and a "TA" 824 acknowledgement to sender.

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## Medical lump sum data requirements

- Lump sum bundled bill medical lien payments are reported utilizing Bill Submission reason Code 00 (original). Individual Lump sum medical lien payments are required to utilize one of three possible IAIABC 837 file structures ([www.dir.ca.gov/dwc/WCIS/WCIS\\_Training\\_Presentations/WCIS\\_Presentations.htm](http://www.dir.ca.gov/dwc/WCIS/WCIS_Training_Presentations/WCIS_Presentations.htm)).
- 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 medical lien code (Scenario A) 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 medical lien code (Scenario B) 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 medical lien code (Scenario C) as a jurisdictional procedure code.

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## WCIS Trading Partner Liaisons

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## Questions?

- Martha Jones, Research Manager, [mjones@dir.ca.gov](mailto:mjones@dir.ca.gov)
- David Henderson, Research Program Specialist, [dhenderson@dir.ca.gov](mailto:dhenderson@dir.ca.gov)
- Genet Daba, Research Program Specialist, [gdaba@dir.ca.gov](mailto:gdaba@dir.ca.gov)

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## WCIS Administrative Penalties

George Parisotto  
DWC Legal Unit

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## Timeline for Office of Administrative Law (OAL) Approval of Implementation Guides

- DWC submits revised regulations and Implementation Guides to OAL
- 10-day period – OAL publishes notice of revised regulations
- 45-day comment period
- Public hearing at the end of the 45-day comment period
- DWC considers comments (unspecified time...say, two weeks)
- If changes are made, then another 15-day comment period
- Steps 6 and 7 are repeated if necessary
- DWC submits final regulations and Guides to OAL
- OAL final approval within 30 working days; filing with the Secretary of State (SoS)
- Regulations and Guides are effective 30 days after filing date with SoS
- Trading partners given six months to implement changes

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## AB 2181 Employers' First Report, Form 5020

- AB 2181, which was signed into law by the Governor on September 30, 2008, amends Labor Code sections 6409.1 and 6410 by authorizing the Division of Workers' Compensation (DWC) to create a new employer's first report of occupational injury or illness. The new employer's report, which will replace the current Form 5020 administered by the Division of Labor Statistics and Research (DLSR), will be submitted to DWC by insurers and self-insured employers via the Workers' Compensation Information System (WCIS).

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## AB 2181 Employers' First Report, Form 5020

- The changes to the Labor Code made by AB 2181 will become effective on the same day that the DWC regulations implementing the bill become effective. (A transition period of up to 18 months for employers to comply with the law is required to be part of the regulations.)

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## AB 2181 Employers' First Report, Form 5020

- DWC is currently drafting the new employer's report and will begin the regulatory process, which includes the opportunity for public comment, within the next several months. Please check DWC's website on a regular basis for updates and information. If you are subscribed to DWC newslines, you will be automatically notified.
- ([http://www.dir.ca.gov/dwc/dwc\\_home\\_page.htm](http://www.dir.ca.gov/dwc/dwc_home_page.htm))

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## WCIS and Annual Report of Inventory (ARI) – Regulation 9702

- On and after September 22, 2006, a claim administrator's obligation to submit an ARI...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.

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## Proposed ARI Regulations §10104 Annual Report of Inventory

- (d)(1) A claims administrator's obligation to submit an Annual Report of Inventory under subdivision (a) of this section is waived upon a determination by the Administrative Director that the claims administrator is in compliance with the electronic data reporting requirements of the Workers' Compensation Information System, as set forth in California Code of Regulations, title 8, section 9702.

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## Proposed ARI Regulations

### §10104 Annual Report of Inventory

- (d)(2) Each claims administrator whose obligation to submit an Annual Report of Inventory is satisfied under subdivision (c)(1) of this section shall maintain and file with the Administrative Director an Annual Report of Adjusting Locations.

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## Proposed ARI Regulations

### §10104 Annual Report of Inventory

- (d)(4) The waiver granted to a claims administrator under subdivision (d)(1) of this section shall be rescinded if the total number of claims reported by the claims administrator to the Audit Unit in a claim log submitted pursuant to California Code of Regulations, title 8, section 10107.1(a) is not within one percent of the total number of claims electronically reported by the claims administrator to the Workers' Compensation Information System for the same period of time as covered in the submitted claim log.

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## Medical Billing Standards and E-Billing

Presented by

Suzanne Honor-Vangerov,  
Workers' Compensation Manager  
Division of Workers' Compensation Medical Unit

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## Medical Billing Standards

- Labor Code §4603.2
  - Required reports
  - Authorizations
  - Properly documented list of services
- Labor Code § 4603.4
  - Requires standardized forms
- No current definition of a complete bill for payment.

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## Standardized Forms

- CMS 1500 – new version
  - For professional services
- CMS 1450 a.k.a. UB-04
  - For facility charges
- NCPDP
  - For pharmacy charges
- ADA 2004
  - For dental services

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## Documentation

- Required Reports
  - Doctor's First Report of Injury (5021)
  - PR-2
    - Currently being revised to be more useful for bill review
      - Will document level of E/M service
      - Will have a separate attachment for UR authorization purposes
      - Will have a separate attachment for physical medicine treatment
      - Will provide information about treatment received to date
  - PR-3/PR-4
  - Operative Report
  - Narrative Reports
  - Reports required by the fee schedule, i.e. "By Report" codes

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## Code Sets

- CPT codes
  - For professional services
- HCPCS codes
  - For other services
- DRG's
  - For Inpatient Hospital stays
- ADA Dental Codes
  - For Dental claims
- NDC numbers
  - For pharmaceutical claims
- ICD-9 codes
  - For standardized diagnoses

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## "Complete Bills"

- DWC defining what makes a complete bill for payment.
  - Uses correct forms
  - Fills in all required fields
  - Attaches required reports or documentation
  - Uses correct code set to describe services
- Complete bills should be paid timely provided that:
  - The charges are reasonable
  - Liability has been accepted
  - Covered under \$10,000 of treatment during claims investigation

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## Electronic Bills

- Employers required to accept them
  - Eighteen months after the regulations are adopted.
- Providers not required to submit electronically
  - It's optional on the part of the provider.
    - Quicker payment
    - Less paperwork
    - Quicker acknowledgment
    - Possible electronic payment

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## Transmission

- Transmissions per IAIABC standards
  - Data elements meet IAIABC definitions
  - National standard
- Meets HIPAA requirements
- Use of Clearing Houses permitted

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## Standard Notices

- Electronic acknowledgment of receipt
  - Within 24 hours
- Detailed acknowledgment
  - Indicates complete or incomplete billing
  - Within 48 hours
- Remittance
  - Indicates payment or no payment
  - Standard remittance advice codes
    - These Standard Explanations of Review were developed by participants from both the payor and provider sides
  - Made within 15 days of receipt of a complete billing

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## DWC Regulations and Documents

- Article 5.5 § 9792.5 – being revised to reflect changes in the statutes and the new regulations.
- Article 5.5.0 §9792.5.0 - §9792.5.3 – being added to cover new billing standards and electronic billing rules.
- Medical Billing and Payment Guide – being created to cover rules for both paper and electronic billing. This document is incorporated into the regulations by reference and will be available on the web site for free download once the rulemaking is final.
- Article 5 §9785 will be revised to reflect new PR-2 format and reporting requirements.

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## Timeframe

- Proceeding to formal rulemaking
- Paper version of the billing standards become effective 90 days after the rule becomes final
- Electronic transmission and receipt become effective 18 months after the rule becomes final.
- Parties can agree to start electronic transmission early

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## For More Information

- For information on-line go to our web site
  - <http://www.dir.ca.gov>
    - Click on Workers' Compensation
      - What's New at DWC
      - DWC Newslines
      - DWC/WCAB Forum
      - Proposed Rulemaking
  - Send me an e-mail at [shonor@dir.ca.gov](mailto:shonor@dir.ca.gov)

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## Question and Answer Session

2:00pm – 4:00pm

Questions received from Trading Partners are listed in this section.

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## Questions from Trading Partners

1. I'd like to get a defined process for submitting SROIs for wage loss. What MTC are used and in what order?
2. Can you confirm codes 410 & 541 – the new implementation draft doesn't state that these 2 codes should not be sent. Also, are there plans to reject a SROI if we submit one of the payment codes listed below?
3. Right now EDI is filing 11 different SROI steps (IP, S1, S7, CT, CA, RB, PY, 4P, CO, AN and FN). We file the steps that are needed based on our review but in some states not all steps are required (ex TN lists the CBT on the event table but it is not a required step). Are there any steps in CA that are not required but are accepted if sent?

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## Questions from Trading Partners

4. There is no detailed scenario guide for R1 like there is for R3 so we are submitting steps as they appear appropriate based on questions we have asked and the limited scenarios in the R1 guide. Should we be showing a sweep of all indemnity benefits paid with every step or only the benefits and payment detail associated with that step? Ex. When we reinstate benefits, do we reflect all benefits paid to date on the claim or only the benefit type and period associated with the current uninterrupted period of the benefits being reported due to the RB?
5. Is the paid to date for the benefit type always cumulative regardless of interruptions (as per the IAABC definition) or only tied to the MTC period being reported?

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## Questions from Trading Partners

6. What is the interpretation of each field from the Payment/Adjustment segment specific to each MTC type being filed (or are the definitions the same or every MTC type)?
  - \*Start date:
  - \*Through date:
  - \*Weekly amount:
  - \*Weeks/days paid:
  - \*Paid to date:
7. We currently only file a sweep of all benefits paid to date on the Final and Annual report to include medical paid to date. Should medical paid to date be submitted on every step?

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## Questions from Trading Partners

8. If the proposed change to file an AN out of sequence is implemented will we be required to go back and catch up the missing steps? Ex. To file an annual report with current paid to date detail we have to report TTD and PPD that has not been reported yet. If we file the annual report do we have to go back and file the CBT and other missing steps or can we go on from the payment detail reported on the AN.
9. Are they planning on providing an R1 scenario book with examples like the IAIABC has for R3? If so do they have an expected timetable?
10. Have they considered triggering the annual reports based on the DOI so they are not all due during 1 month of the year? We have noticed the response time for acknowledgements are much slower (5-10 business days) for months surrounding the annual reports. If the annual reports could be done throughout the year it would make the volume of data going out more consistent and manageable for the state and carriers.

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## Questions from Trading Partners

11. Is there a reference available addressing which legal and/or investigative expense costs are reportable?
12. You have indicated that we are to report EDD payments. Is there any indication if/when you may be able to obtain this information directly from EDD?
13. When do you anticipate rule making will begin for the new employer's first report? How will this affect current and proposed EDI filing requirements?
14. When do you anticipate rule making will begin for e-billing?
15. When do you anticipate EAMS will open e-filing beyond the test participants?

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## Questions from Trading Partners

16. Do you anticipate system changes that will allow the filing of multiple steps in one transaction? Currently, filers must wait to submit a second step until the first has been accepted.
17. What is the status of potential electronic filing of the Doctor's first report?
18. Has the zero pay and subsequent lien payment reporting process been formally adopted?
19. IS WCIS considering accepting quarterly reports?

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## Questions from Trading Partners

20. When might we expect the promised billing guidelines/rules for paper bills? Not having a uniform billing rule for providers and having implemented state reporting has presented a unique set of circumstances. We are unable to refer a provider to a billing rule for guidance, yet as a carrier are expected to somehow obtain this information. It is an unexpected expense in that we have to return and eventually reprocess countless bills that do not contain the information we are required to report. If there were a common set of guidelines, as found in FL and TX, so much of this rework would go away.
21. When can we expect the new physician fee schedule with current codes? The outdated codes present numerous problems too lengthy to discuss in this forum. We kindly ask that this endeavor be completed as soon as possible.

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## General Comments/Questions from Trading Partners

- **"Pure" and "Mixed" Bills**
- CA DWC staff have mentioned "Pure" and "Mixed" bills in emails, and how they affect the data requirements and mapping of some elements. The draft updated IG does not mention anything about "Pure" and "mixed" bills. Can you add an explanation of the requirement and mapping differences for the "pure" and mixed" bills?
- It would also be very helpful if this distinction is included in requirements specified in the "Medical Element Requirement Table". For some elements, satisfying the stated requirements are not possible for a "mixed" bill. For example, DN 561 (Prescription Line Number), 562 (Dispense as Written Code) and 564 (Basis of Cost Determination) all have the requirement of "If a pharmacy bill submitted on universal claim form/NCPDP format". Satisfying this requirement for these DNs is not possible for a "mixed" bill because all of these elements are only used in the SV4 segment, and the SV1 segment must be used for "mixed" bills (so we have been told).

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## General Comments/Questions from Trading Partners

- **Section ML: Data edits**
- The "California-adopted IAIABC data edits and error messages" subsection was retained, but the "California specific data edits" subsection was deleted. What does this mean? The following questions apply:
- Is CA using only the IAIABC edits, thereby removing the "California Specific" edits?
- If the "California Specific" edits are still being used, will they be documented?
- If the "California Specific" edits are still being used, have any changed?

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## General Comments/Questions from Trading Partners

- Facility Elements
- Page 93 contains the following Facility elements.
- Why are there three different Mandatory Trigger criteria for the six BSRC "00" Conditional elements? Do these different criteria actually mean different things? Is it possible that under certain circumstances one or more, but not all six elements would be required?
- If the same criteria can be applied to all six elements, could the Mandatory Trigger criteria be changed to show the same criteria statement for all elements?

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## General Comments/Questions from Trading Partners

- It makes good sense for the bill level Rendering Provider elements (DNs 656, 642, 638 & 651) to be Mandatory, and for the line level Rendering Provider elements (DNs 595 and 593) to be conditional - with a criteria stating that they are required if different from the corresponding bill level elements.
- But, then you make DN 592 Rendering Line Provider National Provider ID Mandatory and DN647 Rendering Bill Provider National Provider ID Conditional (if different than DN592). This completely reverses the basic logic of bill level elements being Mandatory and line level elements being Conditional.

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## General Comments/Questions from Trading Partners

- We realize that this may be based upon where the Rendering Provider NPI occurs on the hardcopy (bill or line level). But, since the Rendering Bill Provider NPI is required "If different from ... DN592", are we correct to assume that this mean that the bill level NPI is required if different from any of the line level NPIs? If this assumption is correct, then the bill level NPI will have to be determined (perhaps by matching bill level data with line level data) and then compared with all of the line level NPIs – to determine if it needs to be included.
- Also, would it be possible that the bill level provider would not the same as any line level provider? In this case, where would the bill level NPI come from? If this situation would not occur, then the bill level NPI could always be determined by the sender from the line level data.
- Also, DN592 should be "Rendering Line Provider National Provider ID".

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## General Comments/Questions from Trading Partners

- Therefore, we recommend that you consider the following changes.
- Change DN647 Rendering Bill Provider National Provider ID from "C" to "M" and remove the Mandatory Trigger criteria.
- Change DN592 Rendering Line Provider National Provider ID from "M" to "C" and add the Mandatory Trigger criteria of "If different from Rendering Bill Provider National Provider ID (DN647)".
- An alternative (not as desirable) would be to make ALL of the Rendering Bill Provider elements and ALL of the Rendering Line Provider elements Mandatory. It might be "overkill" but it would be simpler to map and program than the proposed changes in the draft IG.

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## General Comments/Questions from Trading Partners

- Page 95 contains the facility element DN699.
- Does this mean that if the Referring Provider NPI would be required if different from **any** of the line level NPIs?
- Based up the above comments and recommendations on the Rendering Bill and Rendering Line Provider elements above, we recommend that the Mandatory Trigger criteria be changed to "If different from Rendering Bill Provider National Provider ID (DN647)".

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## General Comments/Questions from Trading Partners

- The current California specific edit for DN561 is "Must be numeric, not less than 1 or more than 99". Since the "California specific edits" were removed from the draft updated IG, I cannot tell if this edit could be changed. On this basis, I will assume that this edit has not changed in the draft update IG?
- This edit & communication with CA staff indicates that CA is treating this element as a "Line Number". I believe that the IAIABC Medical Reporting IG indicates that this element is properly used for the "Prescription Number" and not the "Line Number". Please consider the following from the IAIABC Medical Reporting IG (Version 1.0).
  - The DN561 definition (Page 9.26) is "Unique number assigned by the dispenser to identify the prescription at the line level".
  - DN 561 is mapped to SV401, and the SV4 segment example for the SV4 segment (page 5.1-80) is "SV4\*7777777\*ND:12345678901\*\*\*0\*\*\*\*\*1~". I think that we can safely assume that "7777777" is not indicating Line Number "7777777", but is indicating "Prescription Number "7777777".
- We recommend that CA requirements for DN 561 Prescription Line Number change to match the intent of the IAIABC standards.

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