Brenda Ramirez   August 5, 2013
Claims and Medical Director
CWCI

These Forum comments on a draft WCIS Implementation Guide for Medical Bill Payment
Records Release 2 are presented on behalf of members of the California Workers' Compensation
Institute (the Institute). Institute members include insurers writing 70% of California's workers'
compensation premium, and self-insured employers with $42B of annual payroll (24% of the
state's total annual self-insured payroll).

Insurer members of the Institute include ACE, AIG, Alaska National Insurance Company,
AmTrust North America, Chubb Group, CNA, CompWest Insurance Company, Crum & Forster,
Employers, Everest National Insurance Company, Farmers Insurance Group, Fireman's Fund
Insurance Company, The Hartford, Insurance Company of the West, Liberty Mutual Insurance,
Pacific Compensation Insurance Company, Preferred Employers Insurance Company,
Springfield Insurance Company, State Compensation Insurance Fund, State Farm Insurance
Companies, Travelers, XL America, Zenith Insurance Company, and Zurich North America.

Self-insured employer members are Adventist Health, Agilent Technologies, City and County of
San Francisco, City of Santa Ana, City of Torrance, Contra Costa County Schools Insurance
Group, Costco Wholesale, County of San Bernardino Risk Management, County of Santa Clara
Risk Management, Dignity Health, Foster Farms, Grimmway Enterprises Inc., Kaiser
Foundation Health Plan, Inc., Marriott International, Inc., Pacific Gas & Electric Company,
Safeway, Inc., Schools Insurance Authority, Sempra Energy, Shasta County Risk Management,
Southern California Edison, Sutter Health, University of California, and The Walt Disney
Company.

Introduction
With programming sources already under stress from multiple concurrent programming demands
necessary to address SB 863 regulatory changes, this is a difficult time to make a switch to a new
Implementation Guide release that will require yet more programming changes to comply. An
implementation date that is twelve months after the date of adoption, and a six month grace period
during which bugs can be identified and fixed will be appreciated.

The Institute offers the recommendations and comments that follow.

Recommendation – version number
Replace "Release 2" with "Version 2.0" on the cover page.

Discussion

The current California EDI Implementation Guide for Medical Bill Payment Records uses the nomenclature "Version 1.1." The term "Version 2.0" should be used for consistency to avoid confusion.

Recommendation – version effective date
Replace "January 1, 2014" with "(DATE TO BE INSERTED BY OAL – 12 MONTHS FOLLOWING APPROVAL AND FILING WITH SECRETARY OF STATE)" on the cover page.

Discussion
The DIR Newsline 49-13 stated that "The Division of Workers' Compensation (DWC) is planning to transfer the Workers' Compensation Information System (WCIS) from International Association of Industrial Accident Boards and Commissions (IAIABC) Medical Release 1.1 to IAIABC Medical Release 2 in the fall of 2014" therefore "January 1, 2014 is not appropriate. When adopted and approved by the Office of Administrative Law, sufficient time is necessary to permit programming changes, testing, workflow changes, training, and implementation prior to the implementation that should appear on the cover page.

Recommendation – unnecessary medical data elements
Delete unnecessary medical data element from the tables that begin on pages 40, 48 and 57 of the draft Guide, and from the draft validation table.

Discussion
Not all the data elements added in these drafts appear to be necessary. The following are examples of added data elements that may not be necessary:
- 0505 – bill frequency type code – a mandatory code (M), may be listed in error as it does not appear to match the fields and bill type information listed in the tables, and if not listed in error, correction and clarification is necessary
- 0548 – billed DRG code -- a mandatory conditional code (MC), is not necessary because there is no field for a billed DRG code on the standard billing form, and if a DRG code is not billed it cannot be reported
- 0539 – billing provider secondary address – a mandatory conditional code (MC), is not necessary, and no field is provided for this information on any of the four standard billing forms
- 0685 – facility secondary address – applicable/available item accepted (AA), is not required, is not necessary, and no field is provided for this information on the standard billing forms
- 0625 – HIPPS rate code (MC) – is not necessary because there is no California workers' compensation fee schedule that uses HIPPS codes and they are therefore neither captured nor used
- 0551 – procedure description (MC) – it is neither reasonable nor necessary to require the claims administrator to devise and enter manual descriptions of procedures over and above the standard codes and descriptors

- 0660 – supervising provider middle name/initial -- surely it is not necessary to report the supervising provider's middle name or initial.

Recommendation – medical data element tables
Revise the medical data element tables that begin on pages 48 and 57 of the draft Guide, and the draft validation table to make them consistent with the data elements listed in the table that begins on page 40.

Discussion
The data element listings in each of the tables in the draft Guide and validation are inconsistent:

- Twelve data element codes (102, 103, 104, 108, 109, 110, 111, 115, 116, 593, and 743) appear in the *California Medical Data Elements by Source* table that begins on page 40 of the draft Guide, but not in the *Medical Data Element Requirement Table* that begins on page 48
- Five codes (255, 500, 529, 640, and 663) appear in the *Medical Data Element Requirement Table* that begins on page 48, but not in the *California Medical Data Elements by Source* table that begins on page 40
- Four codes (255, 640, 663, and 683) appear in the *Medical Data Element Requirement Table* that begins on page 48, but do not appear in the list of *California adopted IAIABC data edits and California specific data edits and error messages* that begins on page 57
- Two codes (660 and 761) appear in the list of *California adopted IAIABC data edits and California specific data edits and error messages* that begins on page 57, but not in the *Medical Data Element Requirement Table* that begins on page 48
- Five codes (586, 587, 589, 592, and 595) are accidentally duplicated in on page 52 in the *Medical Data Element Requirement Table* that begins on page 48
- Two data elements (640 and 663) appear in the draft *Validation* table but not in the list of *California adopted IAIABC data edits and California specific data edits and error messages* that begins on page 57
- Eight data elements (98, 99, 100, 101, 532, 595, 615, and 660) appear in the list of *California adopted IAIABC data edits and California specific data edits and error messages* that begins on page 57, but not in the draft *Validation* table
- Fields are named for Req #s 26, 65, 78, 83, 87, and 142 and described as "not DNs" in the draft *Validation* table; should codes be assigned to them
- Req # 116 of the draft *Validation* table appears to be missing its code number (DN) and data field name without explanation
- Three data elements (521, 535, and 522) appear in the draft *Validation* table multiple times with different Req #s; this may cause confusion if not cross-referenced or grouped.

Making the tables consistent will eliminate confusion over which elements are adopted and the rules associated with them.

Recommendation – medical data element field discrepancies
Make WCIS data fields consistent with the Medical Billing and Payment Guides.

Discussion
We note the WCIS tables use different names for data fields than the Medical Billing and Payment regulations and guides.

Recommendation – other medical data element issues
Review the data element information in the tables and correct errors and omissions in the tables.

Discussion
Some information is missing from data element tables, such as the source for some data elements and some source fields for standard billing forms. Data element 741- contract line type code, has no source listed, and as this data is not available to bill review, is often proprietary information, and is not captured, it should be deleted. Some information is incorrect, such as the name for data element 0527 on page 50, as well as incorrect billing field references and unexplained question marks in the first table.   The duplicate listings for data elements 0586, 0587, 0589, 0592, and 0595 on page 52 and in the validation table should be removed. Since DME is subject to payment under the DMEPOS fee schedule, DME language should be removed from the business condition/mandatory trigger language on page 55 for data element 0728 – NDC paid code.

Recommendation – legend for California specific bill type code
Clarify that the "bill type" in the legend for bill type code table on page 48 is determined by the type of standard billing form applicable if the billing was a paper submission.

Discussion
Clarification of how to determine the correct bill type code is necessary. For example, when a physician bills for a drug that dispensed from his or her office, is the correct bill type code P or RX?

Recommendation – lump sum bundled lien bill payment section
Provide the code options for all fields in the Guide.

Discussion
Compliance will improve if the code options are made available.

Recommendation – lump sum bundled lien bill payment section
Revise this section to conform to Senate Bill 863 changes, and clarify for users under what circumstances they must report, and what, when and how they must report.

Discussion

The information in this section is outdated and incomplete. It is important to update this section to comply with the recent statutory changes and to provide all the information necessary for users to understand what, when and how they must report. Referring the user instead to purchase an IAIABC Guide that does not address the recent statutory changes in California will result in unnecessary confusion and non-compliance.

Brad Upchurch   August 5, 2013
Western Region Gatekeeper

Will WCIS allow for gradual adoption as the trading partners are ready; accepting two formats (1.1 and 2.0), phasing out 1.1 at the cutover date in fall 2014?

Peggy Thill, Claims Operations Manager   August 5, 2013
State Compensation Insurance Fund

Implementation Date

Comment: Migrating to the new IAIABC Medical Release implementation guide will require more programming changes on top of the demands for programming changes that have been and are still being made to comply with the SB 863 regulatory changes.

Recommendation: The implementation date of the new Medical Release should be twelve months from the adoption date, with a six-month grace period to fix any defects.

Version Number

Comment: The version name and number "Release 2" is not consistent with the name "Version 1.1" currently being used for the California EDI Implementation Guide for Medical Bill Payment Records.

Recommendation: The name "Version 2.0" should be used for consistency to avoid confusion.

Unnecessary Medical Data Elements

Comment: There are proposed data elements that appear to be unnecessary.

Recommendation: Delete the following unnecessary codes from tables beginning on pages 40, 48, and 57 of the draft Guide, and from the draft validation table.

- Code 0505, "bill frequency type" (Mandatory), needs to be removed or clarified if the intent is to identify resubmitted bills. DN0505, identified as Mandatory for inpatient bills, would be correct for this bill type, but reflects lack of consistency with information identified for 1500 form. It does not appear to match the fields and bill type information listed in the tables; correction and clarification is necessary if it is listed in error.

- Code 0548, "billed DRG code" (Mandatory Conditional), is not necessary because there is no field for a billed DRG code on the standard billing form, and because it cannot be reported if a DRG code is not billed. Clarification is also needed regarding the association of Billed DRG DN0548 and Contract Type Code DN0515.

- Code 0539, "billing provider secondary address (Mandatory Conditional), is not necessary, and no field is provided for this information on any of the four standard billing forms. Clarification is needed to show the reason why the secondary address is required.

- Code 0685, "facility secondary address", is not required and is not necessary because no field is provided for this information on the standard billing forms. Clarification is necessary to show the reason why this is listed as a data element.

- Code 0625, "HIPPS rate Code (Mandatory Conditional), is not necessary because there is no California workers' compensation fee schedule that uses HIPPS codes and they are therefore neither captured nor used.

- Code 0551, "procedure description (Mandatory Conditional), is not necessary because it is unreasonable to require a claims administrator to enter manual descriptions of procedures beyond the standard codes and descriptors.

Lump Sum Bundled Lien Bill Payment Section

Comment: This section is unclear, outdated, and incomplete. It does not conform to the SB 863 regulatory changes.

Recommendation: Update this section to conform to the SB 863 regulatory changes. Clarify as to what, when, and how to report the information.

Joan Henchey, State Reporting Business Analyst   August 5, 2013
Coventry Workers' Compensation Services

Please confirm the following:

  a.) source for DN625 (document indicates UB form - "44,71??")
  b.) ICD indicator of ABK = ICD10 / BK = ICD9 is required
  c.) expectations surrounding NPI reporting requirements.   Many of the fields are
      mandatory/conditional "if provider is eligible for an NPI (DN592)".   If the provider did
      not bill with an NPI, the bill is being reported as the provider billed it – without an
      NPI.   The onus is on the provider to bill correctly.

Kathleen Garrety   August 5, 2013
Liberty Mutual

It's my understanding that the IAIABC documentation was created to have all jurisdictions
utilizing the same formats in creating their data element requirements and edit matrix tables.
The proposed Release 2 Medical Bill Reporting Implementation Guide posted out on the website
is confusing. The IAIABC created templates for the Data Element requirements that display the
data elements as they are to be transmitted in the Loop and Segment format. The template gives
a clear picture by bill type and submission type of the data elements requirements. The
Implementation guide lists the data elements in numerical order. This will mean that a submitter
will need to translate California's requirements to the loop and segment format which is already
in the IAIABC data element template. The Implementation Guide should be rewritten using the
IAIABC templates so all states adopting Release 2 are utilizing the same documentation.

There is a separate WCIS Requirement table which does follow the IAIABC Data Element or
Edit matrix template. This requirement table lists errors out under the 997 and 824
categories. Almost all elements are either Mandatory or Mandatory Conditional.   The technical
requirements are listed on this document. The IAIABC Data Element matrix which has a

separate tab that contains both the business requirements and the technical requirements for the Mandatory Conditional fields. These templates should be utilized so all jurisdictions are using the same documentation.

The proposed implementation guide does not have a timeframe for when the 824s will be returned to the submitter. This has been an issue under Release 1.1.

The ANSI Definition section on Page 27 is confusing. Some of the names are separated by a line space.

Page 37 indicates that the trading partner must change the password every 90 days. Since this is a secured transaction, why does this password need to be changed every three months? This creates an issue for submitters to have to change this password in their programs.

In the California Medical Data Elements by Source beginning on Page 40, several of the elements have ? in the space. These should be clarified.

In view of the issues that still exist for some submitters with Release 1.1 (824s not being sent back timely and bill missing bills in the 824s), the migration to Release 2 should be moved to 1/1/2015 or later.

Steve Mackey   July 26, 2013

With the advent of IMR usage the EAMS search function should add the WCIS or JCN number that is now required by the IMR application to the list of what information is returned to the searcher.