ICD-10	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General Comment	Commenter opines that the proposed regulations are unnecessarily complex and place an undue burden on the medical provider community. Commenter states that the goal "to update regulations and forms to refer to ICD-10 instead of ICD-9" can be achieved much more simply and with far less disruption of current practice. Commenter opines that the systems redesign effort and expense required to implement the proposed changes to the Doctor's First Report of Occupational Injury or Illness, Form 5021 ("DFR") and Primary Treating Physician's Progress Report, Form PR-2 ("PR2") make it impossible to comply with the ICD-10 implementation date of October 1, 2015. Commenter estimates a six-month time commitment and costs of approximately $400,000 for programming and testing in Northern California alone. Commenter states that a number of the proposed changes to the DFR and PR2 forms are impractical and diminish, rather than enhance, their utility and	Alan Jenkins, Senior Consultant, Regional Occupational Health The Permanente Medical Group July 7, 2015 Written Comment	Disagree. This was the only comment from the regulated community regarding undue cost, and while the DWC cannot comment on the figures put forth by this commenter, the changes made are very few and are limited to the change from ICD-9 to ICD-10. ICD-10 billing rules require 12 diagnosis spaces.	DWC has added to the regulations language stating that an ICD-10 coding error will not be the basis for denying payment of the bill, provided certain requirements are met. Further, entities will have until December 31, 2015 to transition to the new forms.

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	effectiveness.			
Form 5021 – Doctor's First Report and Form PR-2 – Primary Treating Physician's Progress Report	Commenter states that the proposed changes to these forms would require significant investment in resources and programming. Commenter quotes the Initial Statement of Reasons (May 2015), page 11, section "Economic Impact Analysis*"):"...The proposed regulations will not have a significant adverse economic impact on representative private persons or directly affected businesses. … The proposed regulations, in and of themselves, do not impose any additional costs on impacted entities. ..."* Commenter disagrees. Commenter's organization produces 7,000 DFRs and 23,000 PR2s per month, statewide. There are able to do so by programmatically reproducing the forms required by the state of California. Commenter estimates a six-month time commitment and costs of approximately $400,000 for programming and testing to	Alan Jenkins, Senior Consultant, Regional Occupational Health The Permanente Medical Group July 7, 2015 Written Comment	Disagree. This was the only comment from the regulated community regarding undue cost, and while the DWC cannot comment on the figures put forth by this commenter, the changes made are very few and are limited to the change from ICD-9 to ICD-10. ICD-10 billing rules require 12 diagnosis spaces.	DWC has added to the regulations language stating that an ICD-10 coding error will not be the basis for denying payment of the bill, provided certain requirements are met. Further, entities will have until December 31, 2015 to transition to the new forms.

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	implement the proposed forms just in Northern California. Commenter states that at his organization, the system changes mandated by the transition to ICD-10 already are consuming all available resources and programming expertise without the added burden of a wholesale overhaul of the physician reporting forms. Commenter opines that given the short timeframe, even with adequate funding and staff, it would not be possible to implement such significant form changes by the 10/1/15 deadline. Commenter opines that if the stated goal of the DWC is to move towards electronic reporting, it seems unwise to invest such a large amount of resources to rework paper forms. A better approach is to make minimal changes to the current forms and concentrate on developing a practical electronic data exchange framework. Commenter quotes the following from the Initial Statement of Reasons (May			

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	2015), Section 14003 – Physician: *"...The form has been amended to reference ICD-10, instead of ICD-9, and additional space is provided for additional detailed diagnostic information that may be provided under the ICD-10 system. The address in the header of the form is changed from "Division of Labor Standards Research" to "Department of Industrial Relations." ..."* Commenter states that these purposes can be accomplished by eliminating the '9' in 'ICD9 Code' wherever it appears on the current DFR form and replacing 'Division of Labor Standards Research' with 'Department of Industrial Relations.' Allowing individuals and businesses to either print additional ICD codes and diagnoses on the reverse or specify 2 ICD codes/diagnoses and 'flow' the form to add extra space for additional ICD codes & diagnoses only as needed would obviate the need to amend the form to accommodate up to twelve ICD-10 codes & diagnoses.			

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	For the Primary Treating Physician's Progress Report (PR2), removing the -9 in ICD-9 and simply not printing the patient's SSN in the field provided would satisfy the stated purpose of the regulations.			
Form 5021 – Doctor's First Report	**Commenter lists the following concerns and suggested changes to the referenced form:** **1. Proposed formats are wasteful and poorly organized** The addition of space for 12 ICD codes (versus the original forms' space for 2 ICD codes) represents waste due to additional paper, ink, etc. All field labels will have to print each time a form is printed, regardless of the number of codes actually recorded. The forms are not optimized spatially, resulting in dead space that could have held data elements and reduced the total amount of paper used. There is no consistency in the field labels on the form. Some are camel case, some all caps. 2. **Use simple delineating lines, or no lines at all between the fields.** The prior form utilized single lines to	Alan Jenkins, Senior Consultant, Regional Occupational Health The Permanente Medical Group July 7, 2015 Written Comment	Disagree. This was the only comment from the regulated community regarding undue cost, and while the DWC cannot comment on the figures put forth by this commenter, the changes made are very few and are limited to the change from ICD-9 to ICD-10. ICD-10 billing rules require 12 diagnosis spaces. In addition, the Form 5021 has not been updated since 1992. The revised form is now fillable, which it was not before. Although Kaiser may make its own forms, many providers do not and use the forms that are available free of charge on DWC's website. Again, no other commenter took issue with the formatting of the new forms or the	DWC has added to the regulations language stating that an ICD-10 coding error will not be the basis for denying payment of the bill, provided certain requirements are met. Further, entities will have until December 31, 2015 to transition to the new forms. Item 12 on Form 5021 is updated to indicate that it is the address where the injury occurred. Item 21 on Form 5021 has been corrected from "yes" to "no."

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	delineate areas / fields, which are much easier to implement programmatically. **3. Patient Name (item #5) should remain as a single field** As proposed, Patient Name has been separated into 3 distinct boxes. Our system holds the entire patient name as a single data element. Separating the patient name into separate first, middle initial, and last fields will require extensive and complicated programming. (e.g., how to programmatically deal with hyphenated last names and non-hyphenated last names such as Hyde-Smith or Hyde Smith; how to distinguish multiple first names from middle and last names such as Bobbie Ann Jones; how to distinguish appellations such as Jr. or II, etc.) **4. Proposed 'Gender' label (item #6) is not reflected on form** The Initial Statement of Reasons (May 2015) (page 10, Section 14006, Sections 'Specific Purpose of Section:' and 'Necessity:') state that the field 'Sex' has been changed to 'Gender,' but		difficulty in updating electronic version of the forms, the number of fields used, etc. Regarding points 3 and 5, all of the PR forms contain separate fields for patient first and last name and address fields. Regarding point 4, DWC decided not to change "sex" to "gender" and that language was erroneously retained in the Initial Statement of Reasons. Regarding point 6, DWC is legally required to request the social security number on the Form 5021 only. The language about removing the social security number was erroneously retained in the Initial Statement of Reasons. Regarding point 7, agreed. The form has been clarified that this is the address where injury occurred.	Grammar has been corrected in items 21 and 22.

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	the published form still says 'Sex.' If the form is changed to read gender, will the data element still be restricted to M/F or will provisions be made for additional values? **5. Address (item #8) should be held as a single item vs. multiple boxes** **6. Social Security Number (item #11)** The Initial Statement of Reasons (May 2015) (page 10, Section 14006, Sections 'Specific Purpose of Section:' and 'Necessity:') state that the injured worker's social security number was removed but it is still on the form. **7. Definition of item #12 Address No. and Street is not stated.** On the original form, item #12 was labeled 'Injured at Location:'. It is not stated if Item #12 on this form refers to the location of occurrence or some other address. In addition, the following line on the form has a 'City' and a 'County' which are divorced from the Address. If they are related, we request that they remain a single data element 'Injured at Location:'.		Regarding points 8 and 9, the new form has more space to describe subjective complaints and objective findings than the prior version did. In addition, parties are permitted to make all required reports in a manner agreeable to the provider and the claims administrator, including the addition of additional pages and the making of their own electronic versions of the forms. Regarding point 10, the box contains a yes or no option, as before. If the matter is unknown, it can be left blank, as before. Regarding point 11, ICD-10 billing rules require 12 diagnosis spaces. Regarding point 12, agreed. This was an error and has been corrected. Regarding points 12 and 13, agree regarding suggested	

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	8. Subjective Complaints (item #18) There is no text to use reverse side if more space is required. The area is likely too small to hold the necessary data. **9. Objective Findings (item #19):** There is no text to use reverse side if more space is required. The area is likely too small to hold the necessary data. **10. Remove box - Chemical or toxic compounds involved?: (item #20)** As stated above, the boxes are difficult to program. What values are allowed for this data element? The original form had space for Y/N or to be left blank if unknown. Request the box to be removed. **11. Diagnoses: (item #20)** As described in **2.** above, we recommend space for 2 ICD's/diagnoses and allow additional items to print on the reverse side or to flow to additional pages– adding additional diagnoses up to 12 if needed but not having to print empty		grammatical changes. Regarding points 14-16, DWC disagrees. This was the only comment from the regulated community regarding undue cost, and while the DWC cannot comment on the figures put forth by this commenter, the changes made are very few and are limited to the change from ICD-9 to ICD-10. ICD-10 billing rules require 12 diagnosis spaces. In addition, the Form 5021 has not been updated since 1992. The revised form is now fillable, which it was not before. Although Kaiser may make its own forms, many providers do not and use the forms that are available free of charge on DWC's website. In addition, no other commenter took issue with the formatting of the new forms or the difficulty in updating electronic version of the forms, the number of fields used, etc.	

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	spaces and waste paper and ink. Also, numbering the diagnoses 1 – 12 is confusing given the form's numbering of data elements. We recommend designating the diagnoses as Diag1, Diag2, etc. **12. If "yes", please explain. below: (item #21) appears to be a mistake** The question posed remains the same: "Are your findings and diagnosis consistent with the patient's account of injury or onset of illness?" On the old form it was "if 'No' please explain". From a benefit administration standpoint, we see no logical reason for requiring an explanation for "Yes" rather than "No." Furthermore, this would necessitate not only significant programming changes in our systems but also comprehensive retraining of our physicians. Also, the comma belongs inside the double quotes and there should not be a period after 'explain.' There is too much room left for the explanation. **13. If "yes", please explain. below:**		Regarding point 17, this form has not been updated since 1992. The signature page is made more consistent with those of the PR forms. The privacy statement differs from the other forms because the social security number is required on the Form 5021 but not on the other forms. The date field does refer to the date the form is being signed by the doctor or other provider.	

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	(item #22) The comma should be within the double quotes and there should not be a period after 'explain.' **14. Allow more space to report TREATMENT RENDERED: (item #23)** There is not enough room. Text will always have to be continued on the reverse side. **15. If Hospitalized... Date admitted... Estimated length of stay: (item #25)** The first data area is too large and the layout of the 2nd and 3rd items is not spatially efficient. **16. WORK STATUS: (item #26) should be reformatted** Separate yes/no check boxes are difficult to program and take up more space than the original space for Y/N entry. The layout for 'If “no”, date... Regular Work... Modified Work’ is inefficient and wastes space. There is not enough room in the area 'Specify restrictions' and there is no instruction to use reverse side if not enough room.			

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	17. Physician Signature Page: - numerous issues What are the ramifications of the addition of "(original signature, do not stamp)"? Will this affect the ability of businesses to use electronic signatures? There is no place for the physician's NPI. The label "Doctor's Name and Degree" has been changed to "Physician Name" - there is no place for the physician's degree. The IRS Number element has been removed. It is unclear what "Date (mm/dd/yyyy)" refers to – the date the report is signed? The PR2 signature page has a link to the DIR privacy notice but this signature page has the full text, should they be consistent?			
Form PR-2 – Primary Treating Physician's Progress Report	**Commenter lists the following concerns and suggested changes to the referenced form:** **1. Neither the date of the exam nor the date of injury appear anywhere on the new form.** **2. Additional elements permissible?** We assume that per the regulations, we can continue to add additional	Alan Jenkins, Senior Consultant, Regional Occupational Health The Permanente Medical Group July 7, 2015 Written Comment	Regarding points 1- 3 and 6, agreed. These fields were inadvertently left off the reformatted form and have been replaced. Regarding item 4, DWC decided not to change "sex" to "gender" and this language should have been removed from the Initial Statement of	Date fields for date of injury, date of birth and date of exam have been replaced in the PR-2 Form. On page 5 of the Billing Guide, form "DLSR 5021" has been renamed "Form 5021."

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	elements to our version of the form as long as we include all of the headings on the published PR2 form and in the same order. For example, we will likely keep the date of birth and date of injury on the form. **3. Date of injury should remain on the form** Both DOI (date of injury) and DOB (date of birth) have been removed from the form. Since injured workers often have follow-up visits before a claim number has been assigned to their case, it is likely carriers will need the DOI on the form to help identify specific claims for injured workers. **4. Item "Sex":** As stated above, both the Initial Statement of Reasons (May 2015) and the Administrative Rules state that the field 'Sex' has been renamed as 'Gender' but the form still says 'Sex.' **5. Item: "Diagnoses":** It is unlikely most claims will have 12 ICD codes & diagnoses. It is inefficient and wasteful to include space for 12 on every single PR2		Reasons as well. Regarding item 5, see previous responses regarding the need for 12 diagnoses boxes. Regarding item 7, agreed. This change has been made to the Billing Guide.	

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	form. We should be allowed to print as few or as many up to 12 as are applicable to the claim. **6. Signature Area: Date of Exam has been removed.** **7. Strike DLSR** The proposed 'California Division of Workers' Compensation Medical Billing and Payment Guide Version 2.2.2' page 5, section 3(b)(1) refers to "A Doctor's First Report of Occupational Injury (DLSR 5021),..." - the DLSR should be stricken.			
Form PR-4 – Primary Treating Physician's Permanent and Stationary Report	**Commenter recommends applying the same protocols as DFR and PR2** Commenter states that his organization does not programmatically reproduce this form nor is it generally utilized by our providers; however, he recommends applying the same protocols of forms construction as with the Form 5021 and PR-2.	Alan Jenkins, Senior Consultant, Regional Occupational Health The Permanente Medical Group July 7, 2015 Written Comment	DWC disagrees. This was the only comment from the regulated community regarding undue cost, and while the DWC cannot comment on the figures put forth by this commenter, the changes made are very few and are limited to the change from ICD-9 to ICD-10. ICD-10 billing rules require 12 diagnosis spaces. In addition, the Form 5021 has not been updated since 1992.	DWC has added to the regulations language stating that an ICD-10 coding error will not be the basis for denying payment of the bill, provided certain requirements are met. Further, entities will have until December 31, 2015 to transition to the new forms.

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			The revised form is now fillable, which it was not before. Although Kaiser may make its own forms, many providers do not and use the forms that are available free of charge on DWC's website. In addition, no other commenter took issue with the formatting of the new forms or the difficulty in updating electronic version of the forms, the number of fields used, etc.	
General	Commenter states that she and her organization support the proposed regulations as written.	Stacy L. Jones Senior Research Associate California Workers' Compensation Institute (CWCI) July 7, 2015 Written Comment	Thank you for your comment.	
General comment – proposed Form Changes	Commenter notes that new versions of Doctors First reports (#5021), Primary Treating Progress Reports (#PR-2), and Primary Treating Physician's Permanent and Stationary Reports (#PR-3 and PR-4) are being created. Commenter notes that the report templates are significantly different than the current versions and will	Robyn Stryd, Claims Operations Manager State Compensation Insurance Fund (SCIF) July 7, 2015 Written Comment	DWC notes that the Form 5021 has not been updated since 1992, and the remaining forms have not been updated since 2005. The changes made are very few and are limited to the change from ICD-9 to ICD-10. ICD-10 billing rules require 12 diagnosis spaces.	DWC has added to the regulations language stating that an ICD-10 coding error will not be the basis for denying payment of the bill, provided certain requirements are met.

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	require substantial system programming for claims administrators who use Optical Character Recognition (OCR) software to handle claims electronically. Commenter opines that in order to minimize the impact and cost of updating systems, it's preferable that changes are limited to what is necessary. For example, changing data fields in the physicians' reports causes issues with a system's ability to correctly identify information. Identification information used by the system to recognize a claim includes such data as the report heading and location of fields for name, claim number, date of birth, date of service, and other pertinent claim information. It is unclear why the DWC has changed form information for data unaffected by the regulations and required for transition to ICD-10. If the key changes weren't so drastic, the key points (anchors) could still be used to recognize new versions of the forms without having to program an entirely new form.		Although SCIF may make its own forms, many providers do not and use the forms that are available free of charge on DWC's website. In addition, no other commenter took issue with the formatting of the new forms or the difficulty in updating electronic version of the forms, the number of fields used, etc. DWC has added to the regulations language stating that an ICD-10 coding error will not be the basis for denying payment of the bill, provided certain requirements are met. Further, entities will have until December 31, 2015 to transition to the new forms.	Further, entities will have until December 31, 2015 to transition to the new forms.

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	Commenter recommends that the DWC keep the forms as similar to previous forms as possible and as needed to transition to ICD-10. This will allow for a smoother transition in that claims administrators' OCR software may still be able to recognize the forms and readily comply with regulations to transition to ICD-10. Commenter requests that if wholesale changes are required at this time, that the DWC allow sufficient time to make the necessary changes. It may be a challenge to update forms prior to the ICD-10 implementation date of October 1, 2015 unless the DWC finalizes the forms by August 1st. Commenter opines that ideally the DWC should allow a minimum of 60 days for Claims Administrators to update their systems but she understands the urgency and can begin programming immediately upon form being filed with the Office of Administrative Law for approval.			
9792.5.1 – Electronic Medical Billing and	Commenter notes that the DWC has included language adding a new version of the Medical Billing and	Robyn Stryd, Claims Operations Manager State Compensation	These changes do not impact the electronic billing guide. However, DWC will consider	

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Payment Guide	Payment Guide in Section 9792.5.1(a); however, the regulations do not include the addition of language referencing a new version of the Electronic Medical Billing and Payment Guide. Section 9792.5.1(b) lists only the following three versions of the DWC's Electronic Medical Billing and Payment Companion Guide: 1. California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, Version 1.0, dated 2012, for bills submitted on or after October 18, 2012. 2. California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, Version 1.1, for bills submitted on or after January 1, 2013. 3. California Division of Worker's Compensation Electronic Medical Billing and Payment Companion Guide, Version 1.2, for bills submitted on or after February 12, 2014.	Insurance Fund (SCIF) July 7, 2015 Written Comment	this comment and whether revisions to the electronic billing guide may be appropriate.	

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	Commenter states that if a new guide for e-billing is not created, it is likely to cause issues for e-billers who are also required to transition to ICD-10 classification. Commenter recommends that the DWC develop a new version of the Electronic Medical Billing and Payment Companion Guide and include a reference to the new Guide in 8 CCR §9792.5.1(b). Commenter opines that this will clarify rules for e-billers and allow them to appropriately submit bills submitted on or after the ICD-10 implementation date of October 1, 2015.			
General Comments	Commenter would like to alert the Division about some areas that Medicare has been working on to help providers prepare for the ICD-10 transition and provide one comment about the forms. Commenter states that in some Medicare communications it is noted that some group health payors may already be starting the ICD-10 implementation prior to October 1st, if they're ready. Medicare is allowing	Diane Przepriorski, Executive Director California Orthopedic Association (COA) July 7, 2015 Oral Comment	DWC has added to the regulations language stating that an ICD-10 coding error will not be the basis for denying payment of the bill, provided certain requirements are met. Further, entities will have until December 31, 2015 to transition to the new forms.	DWC has added to the regulations language stating that an ICD-10 coding error will not be the basis for denying payment of the bill, provided certain requirements are met. Further, entities will have until December 31, 2015 to transition to the new forms.

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	providers to put in box 21 on the CMS 1500 form whether they're coding under ICD-9 or 10. Commenter opines that this is a good idea. Commenter states that they are certainly encouraging their members to move to ICD-10. Commenter opines that it will be a problem for providers to switch back and forth between ICD-9 and 10. Commenter opines that during this transition period, it would be helpful for the Division to know and collect data on how many providers are actually coding under ICD-10. Commenter states that yesterday CMS announced that they're -- even though they're going to go ahead and implement ICD-10 on October 1st; however, they are allowing one additional year where they will not be denying reimbursement for ICD-10 coding errors. Commenter requests the Division to follow suit. This would mean that payment would not be held up and -- and the provider would have to be within the same coding family. But if they don't code to that seventh digit, they (CMS) are allowing and not			

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	auditing for one additional year. Again, commenter requests that the Division follow suit. Commenter notes that the CMS is also setting up what they call a communication and collaboration center. Commenter opines that this is probably not something the Division can set up, but she would like the Division to urge the payors to set up a communications center that could handle ICD-10 problems as they come up. Commenter recommends that the Division to do some monitoring to make sure that the problems are handled expeditiously. Commenter opines that it is critical for the Division to urge the payors to allow the providers to do some end-to-end testing prior to October 1st. Commenter states that this is the only way that providers can know whether their EMR systems are set up and that the payors are set up to handle the ICD-10 codes. Commenter states that she receives a lot of questions as to whether or not the workers' comp system is even			

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	going to adopt ICD-10. She does not know if the payors have been making any communication with the providers as regard to their intent to implement ICD-10. Commenter opines that testing be stepped up in the next few months and, if not, almost immediately so that everyone is aware that the workers' comp carriers will also be moving to ICD-10. Commenter states that the end-to-end testing is really the only way to know whether people are ready.			
General Comment	Commenter states that her organization, in reference to the ICD-9 and ICD-10, is prepared to accept either starting October 1st. Commenter requests that the Division consider a grace period of maybe approximately six months during which time, if a provider sends in a bill that's ICD-9 and they have the ability to pay it based on their earlier payment model, that they could go ahead and process that bill and pay it correctly based on the information that was provided.	Lisa Anne Forsythe Coventry Aetna July 7, 2015 Oral Comment	DWC has added to the regulations language stating that an ICD-10 coding error will not be the basis for denying payment of the bill, provided certain requirements are met. Further, entities will have until December 31, 2015 to transition to the new forms.	DWC has added to the regulations language stating that an ICD-10 coding error will not be the basis for denying payment of the bill, provided certain requirements are met. Further, entities will have until December 31, 2015 to transition to the new forms.

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	Because her organization deals with all kinds of providers, in all different levels of readiness, here organization has to be ready for ICD-10 and will be ready, so for her organization it doesn't matter one way or another. However, from an overall system expense and practicality standpoint, commenter is concerned that come the second week of October, we are going to have bills hitting the floor in a huge way if a hardline stance is taken and they have to reject all of those. Commenter opines that many people should have already read David DePaolo's article. Commenter notes that there is already a lot of criticism about bills hitting the floor in California anyway. And even though she is on the payor side, she is concerned that that's just going to make that problem much, much worse. Commenter recommends that there be some sort of grace period and notes that there are many, many other states that are adopting a grace period, especially for industrial-only clinics that are not necessarily involved with CMS. Commenter opines that if there			

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	is some leniency allowed, that would probably be beneficial to the system overall. As far as the one-year grace period for level of specificity, from her organization's standpoint, they are not going to be examining that down to the tiniest detail so they are not going to be dropping bills based on level of specificity anyway. Commenter appreciates what CMS is doing as far as the group health side of things is concerned, but from her organization's perspective that's not really going to be an issue. Regarding the question about what comp payors are doing, she can only address this from her organization's perspective. Her organization is ready to handle both and can operate in parallel. Commenter's organization is concerned about the Division's perspective on the state reporting side of the equation. Commenter would like to know, if there is a grace period allowed and we accept those bills and pay them during whatever transition period the state dictates is appropriate,			

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	then will we also be able to pass those downstream to the state reporting and have them not hit the floor on the back end. Commenter requests that whatever is decided, that it match the reporting requirements so that the information submitted is not rejected during the reporting requirement.			