§ 9702. Electronic Data Reporting

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The variance period for reporting data elements under subdivisions (a)(1)(A)and (B) shall not be extended. The variance period for reporting data elements under subdivision (a)(1)(C) may be extended for additional twelve month periods if the claims administrator resubmits a written request for a variance. A claims administrator granted a variance shall submit to the WCIS all data elements that were required to be submitted under subdivision (e) during the variance period

except for data elements that were not known to the claims administrator, the claims administrator's agents, or not captured on the claims administrator's electronic data systems. The data shall be submitted in an electronic format acceptable to the Division.

(b) Each claims administrator shall submit to the WCIS on each claim, within five (5) business days of knowledge of the claim, each of the following data elements known to the claims administrator:

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

INSURER NAME	7
JURISDICTION	4
MAINTENANCE TYPE CODE	2
MAINTENANCE TYPE CODE DATE	3
MARITAL STATUS CODE (2)	54
NATURE OF INJURY CODE	35
NUMBER OF DEPENDENTS (2)	55
OCCUPATION DESCRIPTION	60
PART OF BODY INJURED CODE	36
POSTAL CODE OF INJURY SITE	33
SALARY CONTINUED INDICATOR	67
SELF INSURED INDICATOR	24
SOCIAL SECURITY NUMBER (1)	42
THIRD PARTY ADMINISTRATOR FEIN	8
THIRD PARTY ADMINISTRATOR NAME	9
WAGE (1)	62
WAGE PERIOD (1)	63
(1) Required only when provided to the claims administrator. (2) Death Cases Only. (3) Required for insured claims only; optional for self-insured claims.	

Data elements omitted under this subsection because they were not known by the claims administrator shall be submitted within sixty (60) days from the date of the first report under this subsection.

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

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

Administrator Claim Number (DN 15) need not be submitted if the Jurisdiction Claim Number (DN 5) accompanies the transmission, except for transmissions required under Subsection (f). (4) If the Jurisdiction Claim Number (DN 5) is not provided, trading partners must provide the Claim Administrator Claim Number (DN 15) and the Third Party Administrator FEIN (DN 8), or, if there is no third party administrator, the Insurer FEIN (DN 6).	

(d) Each claims administrator shall submit to the WCIS within fifteen (15) business days the following data elements, whenever indemnity benefits of a particular type and amount are started, changed, suspended, restarted, stopped, delayed, or denied, or when a claim is closed or reopened, or when the claims administrator is notified of a change in employee representation. Submissions under this subsection are required only for claims with a date of injury on or after July 1, 2000, and shall not include data on routine payments made during the course of an uninterrupted period of indemnity benefits.

DATA ELEMENT NAME	DN
AGREEMENT TO COMPENSATE CODE	75
CLAIM ADMINISTRATOR POSTAL CODE	14
CLAIM STATUS	73
DATE DISABILITY BEGAN	56
DATE OF MAXIMUM MEDICAL IMPROVEMENT	70
DATE OF REPRESENTATION	76
~~DATE OF RETURN TO WORK~~	~~68~~
DATE OF RETURN ~~TO WORK~~/ RELEASE TO WORK	72
~~EMPLOYMENT STATUS CODE~~	~~58~~
LATE REASON CODE	77
NUMBER OF BENEFIT ADJUSTMENTS	80
NUMBER OF DEATH DEPENDENT/PAYEE RELATIONSHIPS	82
NUMBER OF DEPENDENTS	55
NUMBER OF PAID TO DATE/REDUCED EARNINGS/RECOVERIES	81
NUMBER OF PAYMENTS/ADJUSTMENTS	79
NUMBER OF PERMANENT IMPAIRMENTS	78
PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES AMOUNT	96
PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES CODE	95
PAYMENT/ADJUSTMENT CODE	85
~~PAYMENT/ADJUSTMENT DAYS PAID~~	~~91~~
PAYMENT/ADJUSTMENT END DATE	89
PAYMENT/ADJUSTMENT PAIDTO DATE	86
PAYMENT/ADJUSTMENT START DATE	88
~~PAYMENT/ADJUSTMENT WEEKLY AMOUNT~~	~~87~~
~~PAYMENT/ADJUSTMENT WEEKS PAID~~	~~90~~
PERMANENT IMPAIRMENT BODY PART CODE (1) (2)	83
PERMANENT IMPAIRMENT PERCENTAGE (2)	84
RETURN TO WORK QUALIFIER	71
SALARY CONTINUED INDICATOR	67
WAGE	62
WAGE PERIOD	63

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

(e)(1) On and after September 22, 2006, claims administrators handling one hundred and fifty (150) or more total claims per year shall submit to the WCIS on each claim with a date of service on or after September 22, 2006, the following data elements for all medical services for which the claims administrator has received a billing or other report of provided medical services. The California EDI Implementation Guide for Medical Bill Payment Records sets forth the specific California reporting requirements. The data elements required in this subdivision are taken from California EDI Implementation Guide for Medical Bill Payment Records and the IAIABC EDI Implementation Guide for Medical Bill Payment Records. The claims administrator shall submit the data within ninety (90) calendar days of the medical bill payment. Each claims administrator shall transmit the data elements by electronic data interchange in the manner set forth in the California EDI Implementation Guide for Medical Bill Payment Records.

DATA ELEMENT NAME	DN
ACKNOWLEDGMENT TRANSACTION SET ID	110
ADA PROCEDURE BILLED CODE	719
ADA PROCEDURE PAID CODE	722
ADMISSION DATE	513
ADMITTING DIAGNOSIS CODE	535
AGENCY/JURISDICTION CLAIM NUMBER	5
APPLICATION ACKNOWLEDGMENT CODE	111
BASIS OF COST DETERMINATION CODE	564
BATCH CONTROL NUMBER	532
BILL ADJUSTMENT AMOUNT	545
BILL ADJUSTMENT GROUP CODE (5)	543
BILL ADJUSTMENT REASON CODE (12)	544
BILL ADJUSTMENT UNITS	546
BILL SUBMISSION REASON CODE	508
BILLING FORMAT CODE	503
BILLING PROVIDER FEIN	629
BILLING PROVIDER LAST/GROUP NAME	528
BILLING PROVIDER POSTAL CODE	542
~~BILLING PROVIDER PRIMARY SPECIALTY CODE (4)~~	~~537~~
BILLING PROVIDER STATE LICENSE NUMBER (4)	630
BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	523
BILLING TYPE CODE	502
CLAIM ADMINISTRATOR CLAIM NUMBER	15
CLAIM ADMINISTRATOR FEIN	187
CLAIM ADMINISTRATOR NAME	188
CONTRACT TYPE CODE	515
DATE INSURER PAID BILL	512

DATE INSURER RECEIVED BILL	511
~~DATE OF BILL~~	~~510~~
DATE OF INJURY	31
DATE PROCESSED	108
DATE TRANSMISSION SENT	100
DAYS/UNITS BILLED	554
DAYS/UNITS CODE	553
DIAGNOSIS POINTER	557
DISCHARGE DATE	514
DISPENSE AS WRITTEN CODE	562
DME BILLING FREQUENCY CODE	567
DRG CODE	518
DRUG NAME	563
DRUGS/SUPPLIES BILLED AMOUNT	572
DRUGS/SUPPLIES DISPENSING FEE	579
DRUGS/SUPPLIES NUMBER OF DAYS	571
DRUGS/SUPPLIES QUANTITY DISPENSED	570
ELEMENT ERROR NUMBER	116
ELEMENT NUMBER	115
EMPLOYEE FIRST NAME	44
EMPLOYEE LAST NAME	43
~~EMPLOYEE MIDDLE NAME/INITIAL~~	~~45~~
EMPLOYEE EMPLOYMENT VISA	152
EMPLOYEE GREEN CARD	153
EMPLOYEE PASSPORT NUMBER	156
~~EMPLOYEE SOCIAL SECURITY NUMBER~~	~~42~~
FACILITY CODE	504
FACILITY FEIN	679
~~FACILITY MEDICARE NUMBER~~	~~681~~
FACILITY NAME	678
FACILITY POSTAL CODE	688
~~FACILITY STATE LICENSE NUMBER~~	~~680~~
HCPCS BILL PROCEDURE CODE	737
HCPCS LINE PROCEDURE BILLED CODE	714
HCPCS LINE PROCEDURE PAID CODE	726
HCPCS MODIFIER BILLED CODE	717
HCPCS MODIFIER PAID CODE	727
HCPCS PRINCIPLE PROCEDURE BILLED CODE	626
ICD-9 CM DIAGNOSIS CODE	522
ICD-9 CM PRINCIPAL PROCEDURE CODE	525
ICD-9 CM PROCEDURE CODE	736
INSURER FEIN	6
INSURER NAME	7
INTERCHANGE VERSION ID	105
~~JURISDICTION CLAIM NUMBER~~	~~5~~
JURISDICTION MODIFIER BILLED CODE (8)(10)	718
JURISDICTION MODIFIER PAID CODE (8)	730
JURISDICTION PROCEDURE BILLED CODE (8)	715
JURISDICTION PROCEDURE PAID CODE (8)(9)	729
LINE NUMBER	547
MANAGED CARE ORGANIZATION FEIN (1)	704
~~MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER~~	~~208~~

~~MANAGED CARE ORGANIZATION NAME~~	~~209~~
~~MANAGED CARE ORGANIZATION POSTAL CODE~~	~~712~~
NDC BILLED CODE	721
NDC PAID CODE	728
ORIGINAL TRANSMISSION DATE	102
ORIGINAL TRANSMISSION TIME	103
PLACE OF SERVICE BILL CODE	555
PLACE OF SERVICE LINE CODE	600
PRESCRIPTION BILL DATE	527
PRESCRIPTION LINE DATE	604
PRESCRIPTION LINE NUMBER	561
PRINCIPLE DIAGNOSIS CODE	521
PRINCIPLE PROCEDURE DATE	550
PROCEDURE DATE	524
PROVIDER AGREEMENT CODE (3)	507
RECEIVER ID	99
~~RELEASE OF INFORMATION CODE~~	~~526~~
RENDERING BILL PROVIDER FEIN	642
RENDERING BILL PROVIDER LAST/GROUP NAME	638
RENDERING BILL PROVIDER POSTAL CODE	656
RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	651
~~RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER~~	~~649~~
RENDERING BILL PROVIDER STATE LICENSE NUMBER (11)	643
RENDERING LINE PROVIDER NATIONAL ID (7)	592
RENDERING LINE PROVIDER FEIN	586
RENDERING LINE PROVIDER LAST/GROUP NAME (6)	589
RENDERING LINE PROVIDER POSTAL CODE	593
RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (6)	595
RENDERING LINE PROVIDER STATE LICENSE NUMBER (6)	599
REPORTING PERIOD	615
REVENUE BILLED CODE	559
REVENUE PAID CODE	576
SENDER ID	98
SERVICE ADJUSTMENT AMOUNT	733
SERVICE ADJUSTMENT GROUP CODE (5)	731
SERVICE ADJUSTMENT REASON CODE (5) (12)	732
SERVICE BILL DATE(S) RANGE	509
SERVICE LINE DATE(S) RANGE	605
SOCIAL SECURITY NUMBER (13)	42
TEST/PRODUCTION INDICATOR	104
TIME PROCESSED	109
TIME TRANSMISSION SENT	101
TOTAL AMOUNT PAID PER BILL (2)	516
TOTAL AMOUNT PAID PER LINE (2)	574
TOTAL CHARGE PER BILL	501
TOTAL CHARGE PER LINE - PURCHASE	566
TOTAL CHARGE PER LINE - RENTAL	565
TOTAL CHARGE PER LINE	552
TRANSACTION TRACKING NUMBER	266
UNIQUE BILL ID NUMBER	500

(1) For HCO claims use the FEIN of the sponsoring organization in DN 704.
(2) Not required on non-denied bills if amount paid equals amount charged.

(3) For MPN claims use code P "Participation Agreement"
(4) Does not apply if billing provider is an organization.
(5) Required if charged and paid amounts differ.
(6) Optional if rendering provider equals billing provider.
(7) To be provided following the assignment of a National Provider Identifier by the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS").
(8) The codes for this data element are the codes that are set forth in the California Official Medical Fee Schedule, a publication of the State of California, Department of Industrial Relations (adopted pursuant to Labor Code § 5307.1 and Title 8, California Code of Regulations § 9790 et seq.).
(9) Optional if procedure billed equals procedure paid.
(10) Use when a modifier has been provided.
(11) If the Rendering Provider State License Number is unavailable or prohibitively costly to document use a string of eight consecutive nines.
(12) Includes codes in the California Division of Workers' Compensation Medical Billing and Payment Guide,Title 8, California Code of Regulations § 9792.5.1(a).
(13) If the Employee is not a United States Citizen and has no other form of identification (DN 153, DN 152, or DN 156), use string of nine consecutive nines.

(2) Each claims administrator subject to the medical bill reporting requirements of this subdivision shall submit to the WCIS on each claim the following data elements for multiple billings for medical services provided on or after September 22, 2006, whether reflected in one or more medical bills, that are fully satisfied by a single lump sum payment following the filing of a lien claim for the payment of such medical services pursuant to Labor Code sections 4903 and 4903.1. The claims administrator shall submit the data within ninety (90) calendar days of the lump sum payment. Each claims administrator shall transmit the data elements by electronic data interchange in the manner set forth in the California EDI Implementation Guide for Medical Bill Payment Records.

DATA ELEMENT NAME	DN
BATCH CONTROL NUMBER	532
BILL SUBMISSION REASON CODE (1)	508
BILLING FORMAT CODE	503
BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	523
CLAIM ADMINISTRATOR FEIN	187
CLAIM ADMINISTRATOR NAME	188
CLAIM ADMINISTRATOR CLAIM NUMBER	15
DATE INSURER PAID BILL (2)	512
DATE INSURER RECEIVED BILL (3)	511
DATE OF INJURY	31
DATE TRANSMISSION SENT	100
EMPLOYEE FIRST NAME	44
EMPLOYEE LAST NAME	43
FACILITY CODE	504
INSURER FEIN	6
INSURER NAME	7
JURISDICTION PROCEDURE BILLED CODE (4)	715

LINE NUMBER	547
PRINCIPLE DIAGNOSIS CODE	521
RECEIVER IDENTIFICATION	99
RENDERING BILL PROVIDER LAST/GROUP NAME	638
RENDERING BILL PROVIDER STATE LICENSE NUMBER	643
REPORTING PERIOD	615
SENDER IDENTIFICATION	98
SERVICE BILL DATE(S) RANGE (5)	509
SOCIAL SECURITY NUMBER	42
TIME TRANSMISSION SENT	101
TOTAL AMOUNT PAID PER BILL (6)	516
TRANSACTION TRACKING NUMBER	266
TOTAL CHARGE PER BILL (7)	501
UNIQUE BILL ID NUMBER	500

(1) Use (00) Original.
(2) The date final payment was made for the disputed amount.
(3) The date on the first bill received.
(4) Use the following codes:

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.

(5) The date of service.
(6) The settled or ordered amount.
(7) The amount in dispute. The amount will not be added into the total charges for the claim.

(f) Notwithstanding the requirement in Subsection (b) to submit data elements omitted from the first report within 60 days from the date of transmission of the first report, when a claims administrator becomes aware of an error or need to update data elements previously transmitted, or learns of information that was previously omitted, the claims administrator shall transmit the corrected, updated or omitted data to WCIS no later than the next submission of data for the affected claim.

(g) No later than January 31 of every year, ~~commencing in 2001,~~ claims administrators shall~~, for each claim with a date of injury on or after July 1, 2000 and with any payment in any benefit category in the previous calendar year,~~ report for each claim the total paid in ~~each~~ any payment category ~~through~~ in the previous calendar year by submitting the following data elements:

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

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

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

(2) Reserved.

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

(j) The data submitted pursuant to this section shall not have any application to, nor be considered in, nor be admissible into, evidence in any personal injury or wrongful death action, except as between an employee and the employee's employer. Nothing in this subdivision shall be construed to expand access to information held in the WCIS beyond that authorized in section 9703 and Labor Code section 138.7.

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

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

Reference: Section 138.4, 138.6, and 138.7, Labor Code.