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10002	Commenter requests that this section be modified a bit to exclude employees on temporary, under one year, job assignments. Commenter states that sometimes employer hire employees to perform short term job assignments and that these assignments are often completed in days, weeks or months (less than one year). Commenter opines that these employees should be excluded from being eligible for the 15% payment increase of permanent partial disability.	Celsa Flores November 18, 2008 Written Comment	The comment does not address the amended audit regulations, the subject of this rulemaking. No response is necessary.	None.
10100.2 – 10115.2	Liberty Mutual Group (Liberty) is a member of the California Workers' Compensation Institute (CWCI); Liberty supports the comments made by CWCI.	Kathleen Bissell Assistant Vice President Regional Director Liberty Mutual December 15, 2008 Written Comments	See response to CWCI comments.	None.
10101.1	Liberty appreciates that the regulations continue to allow claim file and claim log information in electronic format; Liberty supports CWCI comments regarding the amended regulation.		The Division of Workers' Compensation (DWC) recognizes that claims can be efficiently administered if files are maintained in an electronic format. See response to CWCI comments.	None.
10101.1	How can a carrier ensure that they have a copy of every correspondence that an injured worker has sent to the DWC? The	Mary Rountree, Manager Farmers' Insurance	DWC cannot possibly impose administrative penalties on claims administrator for failing to	Amend section 10101.1 such that any piece of correspondence that

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	text of the proposed regulation does not indicate that the file must include correspondence sent by the injured worker.	Group December 12, 2008 Written Comment	include in a claims file a piece of correspondence that was never received. Regardless, DWC will clarify the proposed amendment by expressly stating that correspondence in a claim file must be either initiated or received.	must be included in a claim file shall be either initiated or received by the claims administrator.

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Sections 10100.2 – 10115.2	<p>The current audit process has failed to correct the egregious claim handling that continues to plague the system and harm injured workers. The Legislature enacted the audit statutes in the early 1990s because Division reports showed a consistently high percentage of late first payments of temporary disability indemnity. Unfortunately, however, as shown in DWC’s report on 2006 audits, although the audit process has been in place for nearly 15 years, that shameful performance has not improved. The payment of first temporary disability indemnity was late in one of every five claims (21%). In addition, the 2006 audits cited 306 violations for late first payment of permanent disability indemnity and 1,543 violations for late subsequent indemnity payments. Year after year the audit results show that, on average, the claim adjuster has failed to pay uncontested benefits to a worker in one out of every six or seven claims audited. Reviewing fewer than 5,000 claims, auditors found that claim adjusters failed to pay almost \$700,000 in uncontested benefits in 2006. CAAA strongly recommends that the Division amend these regulations to better fulfill their intended purpose; namely to provide a meaningful disincentive for bad claim handling.</p>	<p>Todd McFarren, President California Applicants’ Attorneys’ Association December 15, 2008 Written Comment</p>	<p>DWC appreciates general comments regarding its current audit procedures and invites suggestions from the public as to how to improve the audit program. The statements and recommendations made by the commenter have been reviewed and considered. However, the general comments regarding the purported failure of the audit program do not specifically address the proposed amendment to the audit regulations and therefore do not require a response in this rulemaking procedure.</p>	<p>None.</p>

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Sections 10100.2 – 10115.2	<p>The standards for "passing" the PAR and FCA in section 10107.1 should be revised. Currently a claim adjuster "passes" the PAR audit – and is therefore excused from all penalties – as long as its performance rating is better than the worst 20% of audits conducted over the past three years. In other words, the adjuster doesn't have to have a "good" performance rating to be excused from all penalties, it just has to be better than the worst performers. DWC should adopt a new process for determining "satisfactory" performance in the PAR and FCA audits (note that "satisfactory" performance is the statutory standard as set forth in Labor Code section 129(b)). A "satisfactory" performance should be based upon objective standards, such as timely payment of first payment of temporary disability indemnity in at least 90% of claims. Merely being better than the worst 20% of all audits should not be a "get out of jail free card" for adjusting firms. In our opinion, the current toothless audit is an ineffective use of both time and money, and we strongly urge the Division to amend section 10107.1 to establish a revised procedure for determining a "satisfactory" performance rating that will provide a real incentive for poorly performing claim adjusters to improve. This change would increase the number of audits conducted by the</p>		<p>See above. Comments regarding the standards for "passing" the PAR and FCA audits do not specifically address the proposed amendment to the audit regulations and therefore do not require a response in this rulemaking procedure.</p>	None.

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	<p>Division each year. However, it must be recognized that a properly designed audit process would provide a strong incentive to improve claim handling. Further, since the Division is user funded, any expansion of the number of audits would have no impact on the state budget. Rather than increasing costs, to adopt objective performance standards would lead to lower costs for employers, while also helping to improve the lives of injured workers, by improving the claim adjustment process.</p>			
Sections 10100.2 – 10115.2	<p>DWC must increase the number of civil penalty investigations. No new civil penalty investigations were initiated in 2006; this lack of action is extremely disturbing in view of the poor claim adjusting documented in the 2006 audit report. Where an adjustor has unpaid and uncontested compensation due to workers in one of every three or four claims there is clear evidence of a general business practice in violation of Labor Code section 129.5(d).</p>		<p>See above. Comments regarding civil penalty investigations do not specifically address the proposed amendment to the audit regulations and therefore do not require a response in this rulemaking procedure.</p>	None.
10101.1	<p>Several of the subdivisions of this section have added the phrase "whether stored on paper or in electronic form...." However, some subdivisions with similar content do not include this new phrase. We recommend that instead of adding this</p>		<p>Agreed in part. DWC recognizes that claims can be efficiently administered if files are maintained in an electronic format. In fact, the proposed subdivision (p), which will be</p>	<p>Amend section 10101.1 to move subdivision (p) to the introductory paragraph.</p>

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	phrase to individual subdivisions (or in addition to), that it be placed in the introductory paragraph of this section so that it applies to every subdivision.		now become part of the introductory paragraph, expressly provides that the contents of claims files may be in hard copy or electronic form.	
10101.1(p)	This subdivision is incorrectly formatted. The subdivisions of the regulation are a listing of the materials that should be included in the claim file. However, subdivision (p) is a specific requirement, not a description of something that should be in the claim file.		Agreed. Subdivision (p) is not a description of documents but rather a specific requirement regarding the format of the claim file. The subdivision should be set aside from the required contents of a claim file.	Amend section 10101.1 to move subdivision (p) to the introductory paragraph.
10106.1(c)(1)(C)	The last sentence of this subparagraph has been deleted in the proposed regulations. We are not certain why it is being deleted. Because this section does not define the application or amount of penalties, we do not believe the deletion of this sentence in any way changes the fact that all penalties are required to be assessed and collected when an audit subject fails to meet or exceed the worst 10% of performance ratings in a FCA. Nevertheless, deleting this sentence, particularly considering the fact that the deletion is not even mentioned in the Initial Statement of Reasons issued for these regulatory changes, could create some misunderstanding of the intent of this change. We recommend that the sentence		Disagree. "The return target audit shall be conducted in addition to any penalties assessed as a result of the qualifying audit." This sentence is unnecessary and its deletion is appropriate. It is not pertinent to target audit criteria or the designation of an audit subject for a target audit. The deletion of this sentence does not change the fact that all administrative penalties are required to be assessed and collected when an audit subject fails to meet or exceed the worst 10% of performance ratings in a FCA.	None.

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	be reinstated as it does not appear to conflict with or otherwise affect the intent and application of this subdivision.			
10107.1(m)	<p>We support the change to the last sentence of this subdivision that reduces the time period to provide requested documentation or other information pursuant to a request from the Audit Unit from 30 days to 10 days. However, this change appears to conflict with the language of subdivision (f) which states that: "If any additional requested documentation is not provided within thirty days of receipt of the report, additional audit penalties may be assessed under California Code of Regulations, title 8, section 10111.2(b)(23) of these Regulations."</p> <p>We recommend that the time limits in sections 10107.1(f) and 10111.2(b)(23) be amended to 10 days to conform with the changes to section 10107.1(m). Alternatively, if it is determined that those sections apply to situations other than that described in section 10107.1(m), any differences should be described.</p>		Disagree. The section is not in conflict with subdivision (f). Subdivision (m) applies to requests made during the course of an audit. The subdivision provides, "The Audit Unit may at any time request additional information or documentation related to the claims being audited <i>in order to complete its audit.</i> " (Emphasis added.) Requests for documents made under subdivision (f) apply following the conclusion of the audit. The different timeframes are reasonable; a shorter period during the course of the audit expedites the audit process and allows for more efficient use of auditor resources.	None.
10111.2(a)(10)	One proposed change to paragraph (10) states that penalty amounts "will not exceed \$5000 except as provided by Labor Code section 129.5(c)(3)." This reference appears to be misplaced because		Disagree. Audit subjects who fail the FCA are subject to the assessment of administrative penalties set forth in both subdivisions (a) and (b). As such,	None.

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	<p>subdivision (a) of section 10111.2 applies to full compliance audits that fail to meet or exceed PAR performance standards but meet the performance standards for the FCA. Labor Code section 129.5(c)(3), however, describes a penalty structure where the audit subject has failed the full compliance audit. Consequently, we recommend that this Labor Code reference be deleted from subdivision (a). Instead we recommend that references to the \$40,000 penalty cap under Labor Code section 129.5(c)(3) be added to subdivision (b) and subdivision (c)(7) of section 10111.2.</p>		<p>the reference to the penalty cap in Labor Code section 129.5(c) is appropriate. Administrative penalties for audit subjects who do not fail the FCA are limited by the \$5,000 cap set forth in section 129.5(b).</p>	
10111.2(a)(10)	<p>In addition, we strongly disagree with the change in paragraph (10) to delete the word "by" and instead provide that the penalty for failure to pay or late payment in violation of an award or order will be increased by "up to" 100%. We do not understand why this penalty should be reduced where the failure to pay or the late payment is in violation of an award or order of the WCAB. This is not a benefit that is in question in any way. The adjuster has received full legal notice of its responsibility to provide the benefit. What possible reason can there be to reduce this penalty for failure to comply with a Board award or order? We strongly recommend that this change be deleted</p>		<p>Agree in part. DWC does not believe that there is a significant distinction between the word "by" and phrase "up to." Use of the phrase "up to" anticipates situations where the imposition of 100% increase in administrative penalties would result in the assessment of a penalty that is over the \$5,000 penalty cap (or \$40,000 for subject that fails the FCA). Regardless, to avoid misunderstanding, DWC will substitute the word "by" for the phrase "up to".</p>	<p>Amend section 10111.2(a)(10) to substitute the "by" for the phrase "up to".</p>

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	and that the current language providing that the penalty "will be increased by 100%" be reinstated.			
10111.2(b)(27), (28), and (29).	These new paragraphs establish penalties for violations regarding the Supplemental Job Displacement Benefit (SJDB). Paragraph (27) establishes penalties of up to \$500 for failure to issue a notice of the SJDB, while paragraphs (28) and (29) establish penalties up to \$1,000 for failure to issue or pay the voucher. We believe the failure to provide notice of this benefit is, particularly where the worker does not have legal representation, equivalent to simply extinguishing the worker's right to this important benefit. Consequently, we believe the failure to provide notice should not have a lower penalty than the other violations. We recommend that paragraph (27) be amended to conform to paragraph (28) by adding a new penalty of "\$1,000 for each failure to issue the notice of supplemental job displacement if the notice was issued more than 51 days late or was not issued."		Disagree. The administrative penalties under subdivision (b)(27), for each failure to comply with the supplemental job displacement benefit notice requirements, are comparable to the administrative penalties assessed for similar notification violations. See, for example, the administrative penalty structure under section 10111.2(b)(18), for a failure to notify an injured worker of his or her possible entitlement to permanent disability benefits.	None.
10111.2(c)(2)	We strongly recommend deletion of the new sentence allowing mitigation of penalties in an amount greater than 20% in extraordinary circumstances. We believe that the current audit structure, and particularly the total elimination of		Disagree. Mitigation in an amount greater than 20% will only be applied only in extraordinary circumstances where the assessment of 80% of the full penalty amount will be	None.

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	<p>penalties from the majority of audits, has completely eroded any possible advantage from this procedure. Under the current system most audit subjects pay zero penalties. A minority of audit subjects (9 out of 74 in 2006) is required to pay only those penalties associated with late payment or failure to pay indemnity benefits, and only a minuscule number (2 in 2006) must pay the assessed penalties for all violations. Because the rules limit the payment of penalties to only the worst performers, we do not believe "mitigation" of the assessed penalties is justified under any circumstances. Until and unless the audit process is amended as recommended in the introduction of this letter to establish objective standards for "passing" audits, the Division should seriously consider eliminating any provision for "mitigation" of penalties.</p>		<p>clearly inequitable. Administrative penalties serve as a disincentive to engage in improper and illegal claims handling practices. Such penalties should not be rigidly assessed in a fixed amount in circumstances where an audit subject has demonstrated good faith attempts to comply with its legal obligations.</p>	
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10100.2 (a), (e), and (ee)	<p>Proposed regulations that include satellite offices as adjusting locations will affect operating costs that will be passed onto all employers. The proposed changes to these definitions will have an impact on various phases of the audit process. Many claims administrators are re-evaluating their business structure, eliminating multiple adjusting locations and creating regional offices, and, only as needed, establishing satellite offices.</p>	<p>Marie W. Wardell, Claims Operations Manager State Fund December 15, 2008 Written Comments</p>	<p>Disagree. DWC recognizes that the current economic environment may compel claims administrators to restructure their current business operations. However, the changes proposed by the commenter would essentially allow each claims administrator unfettered discretion to control the number of their adjusting locations</p>	None

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	<p>Local Management - The proposed definition does not address the various management structures throughout the industry and will create different standards for audit subjects and their adjusting locations. Further, if there is a Supervisor at a satellite office, it is deemed an adjusting location. It is not uncommon for an adjusting location supervisor and a satellite office supervisor to be accountable to the same adjusting location manager who is physically located at the adjusting location. The proposed regulations are depicting the supervisor's role at the satellite office at the same level of responsibility as their manager.</p> <p>Adjusting Location - Claims administrators may create temporary satellite offices as a business decision due to limited office space, availability of claims staff, or cost effectiveness. Their job classification, responsibility and authority level is the same as the supervisors located at the adjusting location. Including temporary satellite offices as a separate adjusting location creates a new hierarchy in job responsibility, function and accountability for satellite office staff. Expecting greater responsibility on a satellite office supervisor could create personnel/union issues, which may result in an increase in</p>		<p>through the number of individuals they choose to designate as managers who have "ultimate managerial responsibility, accountability and authority over claims administration." In one sense, there can be only one person who fits the description proposed by the commenter: the chief executive officer of the organization.</p> <p>It would be difficult for DWC to tailor its definitions to accommodate the business needs of claims administrators. The proposed amendments by DWC provide a simple, common sense approach to defining "adjusting location": if a location has staff with supervisory authority over claims administration, it may be considering an adjusting location. It is important to note the word "may". Should a claims administrator demonstrate that an office or location with supervisory personnel cannot properly be considered a separate adjusting location, the Audit Unit has the discretion to combine the audit of that office with the more appropriate location.</p>	

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	<p>the overall costs of doing business.</p> <p>The proposed change in the definition ‘adjusting location’ will require temporary satellite offices to file an Annual Report of Inventory (ARI) separate and distinct from the adjusting location. Reporting an ARI for a satellite office that is part of the adjusting location may require unnecessary procedures for a new ‘location’ set-up and associated systems/technical changes.</p> <p>Existing audit regulations require a claim log for each adjusting location. Adding satellite offices as adjusting locations and requiring claims logs will have the same procedural and systematic impact as noted above for the Annual Report of Inventory.</p> <p>State Fund recommends the following changes:</p> <p>(a) Adjusting Location. The office where claims are administered. Separate underwriting companies, self-administered, self-insured employers, and/or third-party administrators operating at one location shall be combined as one audit subject for the purposes of audits conducted pursuant to Labor Code section 129(b) only if claims are administered under the same local management at that location.</p>			

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	<p>For auditing purposes, any separate office or location, <u>including a satellite office, whose staff reports to one individual who has includes personnel assigned supervisory final managerial responsibility, accountability and authority over claims administration <del>may be shall be</del> considered a single adjusting location.</u></p> <p>(e) Audit Subject. <u>A single adjusting location of a claims administrator which has been selected for audit. Any separate office or location, including a satellite office, whose staff reports to one manager who has ultimate managerial responsibility, accountability and authority over claims administration is considered a single adjusting location.</u> If a claims administrator has more than one adjusting location, other locations shall be considered as separate audit subjects for the purposes of implementing Labor Code Sections 129(a) and 129(b). However, the Audit Unit at its discretion may combine more than one adjusting location of a claims administrator as a single targeted audit subject, or may designate one insurer, insurer group, or self-insured employer at one or more third-party administrator adjusting locations as a single targeted audit subject.</p>			
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	<p>(ee) Local Management. Claims <del>personnel</del> management, regardless of their job titles, who have <u>final supervisory managerial responsibility, accountability and authority over claims administration of at an adjusting location, including a satellite office.</u> <del>over claims administration.</del></p>			
10106.1(c)(5)(C)	<p>Subsection (c) (5) (C) will allow the audit unit to target an audit subject based upon a failure to comply with requirements and timelines of the Workers' Compensation Information System (WCIS)</p> <p>Electronic transmittal of WCIS data is done through new and emerging technology. The process is technical and contingent upon the DWC's ability to accept electronic data and to communicate timely to claims administrator when there is a problem with data transmittal. The transmittal process is done daily by the industry collectively with the DWC accepting and responding at a similar frequency.</p> <p>This subsection does not specify in terms of what will trigger a target audit; what kind of errors will be evaluated; the error frequency that constitutes a violation; the timeframe involved for same errors that will result in an assessment; which errors</p>		<p>Disagree. Labor Code section 138.6 conferred authority on the Administrative Director to create the Workers' Compensation Information System (WCIS), an electronic data interchange system which allows claims administrators to electronically submit specific claim information to DWC. California Code of Regulations, title 8 (8 C.C.R.), section 9702 requires all claims administrators to submit specific data elements on each claim as defined in 8 C.C.R. § 9701. The failure to comply with the WCIS regulations may indicate the existence of improper claims handling practices; it is appropriate to consider a target audit for any express violation of the WCIS regulations.</p> <p>It must be noted that a failure to</p>	None

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	<p>are more serious than others, etc. How will the audit unit determine if a claims administrator is not in compliance? At the time of the target audit, what information will be required to show evidence that they were in compliance? What, if any, mitigating factors will be allowed?</p> <p>Recommendation: Compliance with WCIS regulations is important to the industry and the DWC. However, inclusion of WCIS reporting compliance within the Target Audit regulation has too great of an impact on the claims administrator. State Fund recommends that the proposed subsection (c) (5) (c) be removed and further developed when the WCIS regulations are finalized.</p> <p><del>(C) — Failure to comply with the Workers’ Compensation Information System (WCIS) requirements and timelines set forth in Labor Code section 138.6 or California Code of Regulations, title 8., sections 9700 et seq.</del></p>		<p>comply with the WCIS mandates does not mean that a target audit will take place; subdivision (c)(5) provides that the Audit Unit “may” target an audit subject for such a failure. Further, if an audit subject believes that its selection for a target audit based on its failure to comply with the WCIS reporting requirements has no legal or factual basis, it can appeal the selection under section 10106.1(d)(4).</p>	
10107.1(c)(5) and (e)	<p>Subsections (c)(5) and (e) both address the time frame for an audit subject to demonstrate to the Audit Unit an error in the PAR Audit or Failed Full Compliance Audit calculation has occurred. The proposed regulations allow two (2) working days from when the audit</p>		<p>Disagree. Two working days from the date of receipt of the PAR performance rating is a reasonable amount of time for an audit subject to demonstrate that the factual basis for the Audit</p>	None.

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	<p>subject was provided information by the audit unit of the rating, or at post profile audit review conference to demonstrate that there is an error. If the audit subject fails to do so within the allotted time frame shall constitute a waiver of appeal on those issues. Considering the consequence of not demonstrating miscalculation, two days is a short period of time. Consideration should be given and incorporate into the time frame for instances when information was provided at the end of the audit phrase and/or review of the assessment is complex.</p> <p>Recommendation State Fund recommends DWC reconsider the two day time frame and extend to no more than five (5) working days after receipt and offers the following change in the proposed regulation:</p> <p>§ 10107.1 (c) (5) “If the audit subject's profile audit review performance rating fails to meet or exceed the rating of the worst 20% of performance ratings as calculated based on all final audit findings as published in the Annual DWC Audit Reports...Unless the audit subject demonstrates that the factual basis for the Audit Unit’s calculation of the profile audit review performance rating is incorrect within <del>two</del> five working days <del>after</del> of the receipt of the rating or at the</p>		<p>Unit’s calculation of the performance rating is incorrect. During the entire course of the audit, the audit subject is fully aware of the claim files that are selected and audited. If the audit subject conducts a simultaneous review of the files or maintains open, continuous dialogue with the Audit Unit during file review, it should take little time to verify the facts that are the basis for violations considered in the calculation of the rating.</p> <p>It must be noted that the audit subject can provide its evidence either within two working days of receiving the performance rating <u>or</u> at a post profile audit review conference. Since there is no requirement that the conference be held within two-working days after receipt of the performance rating, an audit subject may, through mutually-convenient scheduling with the Audit Unit, obtain additional time to provide its factual challenge.</p> <p>The two-working day deadline ensures that Audit Unit resources and personnel are utilized in an efficient manner and that audits</p>	

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	<p>post profile audit review conference, the Audit Unit may complete the full compliance audit. The audit subject may appeal the issues pursuant to California Code of Regulations, title 8, section 10115.1 following the issuance of the final audit report. Failure of the audit subject to raise factual issues related to failing to meet or exceed the profile audit review performance standard within <del>two</del> <u>five</u> working days <del>after</del> <u>of</u> the receipt of the profile audit review performance rating or during the post-profile audit review conference shall constitute a waiver of appeal on those issues.</p> <p>§ 10107.1 (e) “If the audit subject's full compliance audit performance rating fails to meet or exceed the rating of the worst 10% of performance ratings for all final audit reports. ...Unless the audit subject demonstrates that the factual basis for the Audit Unit’s calculation of the full compliance audit performance rating is incorrect within <del>two</del> <u>five</u> working days <del>after</del> <u>of</u> the receipt of the rating or at the meet and confer audit review conference, the Audit Unit may continue with complete the Full Compliance Audit.”... “Failure of the audit subject to raise factual issues related to failing to meet or exceed the full compliance audit performance standard within <del>two</del> <u>five</u> working days <del>after</del> <u>of</u> the receipt of the</p>		<p>are completed in timely manner. Providing additional time for a response from an audit subject regarding the initial PAR performance standard will preclude the auditing staff from starting the first level full compliance audit, as provided in subdivision (d), or, if necessary, the second level full compliance audit, as provided for in subdivision (e).</p>	

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	full compliance audit performance rating or during the meet and confer audit review conference shall constitute a waiver of appeal on those issues.”			
10100.2(o)	<p>Subdivision (o) should be amended as follows:</p> <p>A claim file that is selected for audit because the Audit Unit has received <u>credible</u> information indicating the existence of <del>possible</del> <u>probable</u> claims handling violations of the kind which, if found, would be subject to the assessment of an administrative penalty, the issuance of a notice of compensation due, or the assessment of a civil penalty. These clarifications will make this definition conform with Tit. 8 C.C.R. Sec. 10106.1 (c)(2)(C)(3) and maximize Audit Unit efficiency by preventing or, at least, minimizing the need to investigate frivolous complaints.</p> <p>Additionally, these regulations contain two instances where the terms "credible complaints" and "credible information" are used. All other sections merely refer to "complaints" or "information". We believe these differing descriptors create inconsistency and ambiguity and require clarification. Unnecessary audits instituted by frivolous complaints</p>	<p>Steven Suchil Assistant Vice President American Insurance Association December 15, 2008 Written Comments</p>	<p>Disagree. The Audit Unit may select an adjusting location for a target audit based on the credible complaints. See section 10106.1(c)(3). The target audit criteria in this regard has not been changed in this rulemaking, out of a provision allowing the Audit to contact a claims administrator and request information necessary to determine the validity of a complaint. See proposed section 10106.1(c)(3). However, section 10107.1(c)(2) and (d)(2) allow the Audit Unit to audit, in addition to claims randomly selected in the course of an audit, any claims any for which it has received a complaint or information over the past three years that indicate a failure to pay indemnity or late-paid indemnity. These subdivisions allow the Audit Unit to investigate and determine the validity of such complaints and determine whether penalties or other corrective actions are necessary. In this regard, the</p>	None.

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	<p>constitute a drain for both the Audit Unit and the subject of an audit, and should be avoided.</p> <p>We recommend creating a standard for determining credibility consistent with that found in the new Utilization Review standards, Tit. 8 C.C.R. Sec. 9792.11 (e).</p>		<p>proposed definition is accurate. Clearly, the Audit Unit does not want to look at frivolous complaints. However, in certain cases the only way in which to determine the validity of the complaint is to audit the file.</p>	
10100.2(w)	<p>Commenter opines that this definition for a General Business Practice is not consistent with common English usage and is not consistent with Lab. C. Sec. 129.5. Webster’s Dictionary defines “general” as “. . . belonging to, or prevailing throughout, a whole class or body collectively, irrespective of individuals: a general belief.”</p> <p>The plain language of Lab. C. Sec. 129.5(e) requires the auditor to indentify a pattern of practice or company policy. A single practice, or a few acts or omissions, do not constitute general business practices. At the very least, the auditor must identify a pattern of omissions or commissions knowingly occurring with a frequency that rises to the level of a “General Business Practice.”</p>		<p>The subdivision is amended only to clarify that the definition of “general business practice” applies for the purposes of Labor Code section 129.5(e) (the civil penalty provision). The substantive definition of “general business practice” has not been changed in this rulemaking. As such, no response to this comment is required.</p>	None.
10100.2(cc)	<p>Commenter accepts the fact that a corporation must take responsibility for its employees when their actions comply</p>		<p>Disagree. The definition is based on California Code of Regulations, title 8, section</p>	None.

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	<p>with company policy and within the scope of their employment. Under this provision, however, it appears that if an isolated individual’s conduct is outside of that policy and such actions are unknown to management, this would still fit into this definition. To the extent that this section includes actions committed without the knowledge of management, this expansion of liability exceed the Division’s authority.</p> <p>As written the definition would allow application of the civil penalty for negligence alone, rather than a willful and knowing omission or commission of misconduct by an individual employee. To levy this penalty, commenter believes that the auditor must be able to show that the company management were aware of and directed or supported the conduct. That the information appears in records does not rise to the level of knowledge needed for imposition of penalties. The language expanding insurer liability for the action of a third party administrator should be deleted and knowledge should be evidenced by affirmative action by a management representative.</p> <p>Further, it is not clear what the effect removal of the presumptions will be. Is it the Division’s intent that a corporation will no longer be able to rebut the</p>		<p>10225(q), relating to administrative penalties under Labor Code section 5814.6, the general laws of agency, and case law. “[A] corporation, as such, cannot know, ... and ... its knowledge ... must ultimately be the knowledge ... of the people – the officers, managers, and employees – who link the corporate abstraction to the real world. <i>FMC Corp. v. Plaisted &amp; Cos.</i> (1988) 61 Cal.App.4th 1132, 1213. <i>FMC</i> held that knowledge of rank-and-file employees may be imputed to a corporation. Corporate knowledge is not restricted to matters known by corporate managers.</p> <p>More specifically, <i>FMC</i> held that knowledge of rank-and-file employees could be imputed to an insured corporation to find that the corporation “expected” its activities to cause pollution damage. Its liability insurance policies did not cover “expected” pollution damage. The court applied normal rules of agency that impute an agent’s knowledge to the principal:</p> <p>“Civil Code §2332: [B]oth principal and agent are deemed to</p>	

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	presumption of knowledge?		<p>have notice of whatever either has notice of, and ought, in good faith and the exercise of ordinary care and diligence, to communicate to the other.”</p> <p>In line with normal rules of agency, <i>FMC</i> noted the rule is limited to “[k]nowledge ... [the] employee receives or has in mind when acting in the course of his or her employment ..., [and that] concerns a matter within the scope of the employee’s duties.” (Id., p. 1212-1213.) Also in line with normal rules of agency, <i>FMC</i> held that a corporation has the knowledge of its employee “whether [the] employee communicated [that] knowledge to the [corporation] or not”. Id. at 1212.</p> <p>In the case of <i>Endo v. State Board of Equalization</i> (1956) 143 Cal.App.2d 395, 402, the appellate court held that an owner of a bar is responsible for the acts of the bartender who “knowingly permitted” the illegal sale of narcotics, despite the fact that the owner testified that she spent little time at the bar, that she did not personally know of the illegal activities and that she had no reason to suspect the illegal</p>	

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			<p>activities. The bartender’s “knowledge and permission are imputed to appellant as his employer (the owner, operator and licensee) within the scope of the principle that a ‘licensed employer may be disciplined to the extent or revocation of his license for the acts of his employees. (Cites omitted).”</p> <p>Finally, in <i>People v. Taylor</i> (1992) 7 Cal.App.4th 677, 692, the court analyzed the meaning of “knowingly” as it is used in Health and Safety Code §25189.5, which provides that it is unlawful for a person to “knowingly” dispose of hazardous waste. The defendant argued that he did not know that his action of abandonment constituted an unlawful “disposal” and therefore, the act was not done “knowingly.” The court held that knowingly does not require any knowledge of the unlawfulness of the act, but simply the knowledge that the facts exist which bring the act or omission within the provisions of the code. “California case law has long held that the requirement of ‘knowingly’ is satisfied where the person involved has</p>	

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			<p>knowledge of the facts, though not the law.” (Id. at p. 692) In the Taylor case, the court determined that the defendant was aware of the actual facts surrounding his vacating of the manufacturing premises and his permanently leaving behind hazardous waste materials.</p> <p>The removal of the presumption does not affect the ability of the corporation to challenge, pursuant to California Code of Regulations, title 8, section 10113.1(a), any allegation made by the Administrative Director that an action subject to civil penalty was “knowingly committed” by the corporation.</p>	
10100.2(ff)	<p>The proposed added language is inconsistent with other definitions for the same term found in the California Code of Regulations. Further, plain English and industry usage of the term “Medical-Only Claim” means that no indemnity payment has been paid or accrued. At the point that an indemnity payment is made, it is converted to and becomes an Indemnity Claim.</p> <p>Commenter suggests that the language be</p>		Disagree. The proposed definition allows for easier designation between true medical-only claims, where there will no indemnity payments such as temporary disability and permanent disability, and indemnity claims where no indemnity benefits have been paid but are clearly expected. (For example, a finger amputation that is not yet permanent and	None.

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	<p>amended as follows:</p> <p>Medical-Only Claim. A work-injury claim in which no indemnity benefits have been paid, <del>or would reasonably be anticipated or expected to be paid.</del></p>		<p>stationary. A determination that the injury is permanent and stationary would trigger the clear obligation to pay permanent disability benefits.)</p> <p>The proposed definition is similar to that found in California Code of Regulations, title 8, section 15201(bb). This regulation, which applies to self-insured plans, defines a “medical-only claim” as a “work-injury case which does not result in compensable lost time but results in medical treatment beyond first aid.” Note that section 15201(w) defines “indemnity claim” as a “work-injury case which has or may result in any of the following benefits: (1) Temporary Disability or salary in lieu thereof; (2) Permanent Disability; (3) Life Pension; (4) Death Benefits; (5) Vocational Rehabilitation. Under this regulation, the fact that a payment has not been made does not transform an indemnity claim a medical-only claim.</p>	
10100.2(11)	Commenter suggests that the language be		Disagree. The definition of	None.

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>amended as follows:</p> <p>For the purpose of audit or investigation, a random sample is a selection of claim files selected pursuant to Title 8, California Code of Regulations Section 10107.1, subdivisions (c)(1), (d)(1) or (e)(1). A random sample may also include companion case files, <u>where necessary, additional claim files, or complaint claim files as defined in these regulations.</u></p> <p>The proposed definition of random sample would interfere with a random selection process. It would skew tabulation of violations for the audit subject as well as the calculation for the Annual Performance Standard as a result of mixing random samples which, with the above additions, become stratified samples and are no longer representative for the entire population of claims at the audit site.</p>		<p>“random sample” under subdivision (II) is limited to “a selection of claim files selected pursuant to Title 8, California Code of Regulations Section 10107.1, subdivisions (c)(1), (d)(1) or (e)(1).” Additions to the random sample are limited to companion files, as allowed by section 10108(j), and complaint files that are randomly selected. See section 10107.1(c)(2) and (d)(2).</p>	
10104(b) and (d)(3)	<p>The subdivisions provide for two different reports, required for the same event, to be sent to two different entities at the Division with two different deadlines for reporting this event. Commenter recommends that these provisions be combined to provide for one report with one submission deadline.</p>		<p>Agreed. Two different entities are not named in subdivision (b) and (d)(3). Both require that notice be provided to the Administrative Director. However, subdivision (b) is more specific, stating the written notice must be sent directly to the Audit Unit.</p>	<p>Amend section 10104(d)(3) by providing that the “claims administrator shall notify the Administrative Director, by mailing written notice to the</p>

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			<p>Although the Audit Unit will be the ultimate recipient of the notice provided under subdivision (d)(3), for consistency the subdivision will be amended such that the notice must also be sent directly to the Audit Unit.</p> <p>The 30-day notification period set forth in subdivision (d)(3) for any change in the information provided in the Annual Report of Adjusting Location is entirely reasonable given the basic information that must be provided. However, for consistency, the subdivision will be amended to 45 calendar days, the same period set forth in subdivision (b).</p>	<p>manager of the Audit Unit, of any change in the information provided in the Annual Report of Adjusting Locations.” Amend the 30-day calendar notification period to 45-days.</p>
10106.1(c)(2)(A)	<p>Commenter suggests that the language be amended as follows:</p> <p>The Division of Workers’ Compensation will regularly submit to the Audit Unit copies of WCAB decisions, findings, and/or awards issued pursuant to Labor Code section 5814, <del>and reports of WCAB cases involving section 5814 violations to</del></p>		<p>Disagree. The target audit criteria regarding Labor Code section 5814 penalties has not changed. Only decisions, findings, and/or awards issued pursuant to the statute will be considered in determine whether to select an audit subject for a target audit under the criteria. See</p>	None.

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	<p><del>the Audit Unit.</del></p> <p>Commenter supports the Division’s responsibility to investigate probable misdeeds, especially in regard to the unreasonable delay or denial in the payment of benefits. This charge is properly met by reporting by the WCAB of all “decisions, findings, and/or awards issued pursuant to Labor Code section 5814” in the current rule.</p> <p>Commenter is concerned that under the proposed language the WCAB will report unsubstantiated allegations of Labor Code section 5814 violations to the Audit Unit. Allegations are routinely made for purposes other than an unreasonable delay or denial in the payment of benefits. Where no decision, finding, or award has been issued, we believe that an allegation has not been shown to be credible and does not warrant referral to the Audit Unit.</p> <p>Subdivision (c)(2)(B) should be amended to provide that only those decisions, findings, or awards that issue a penalty be tabulated. Commenter often sees awards finding no Labor Code section 5814 violations.</p>		<p>subdivision (c)(2). Reports of WCAB cases involving section 5814 violations provide the Audit Unit with another source of information as to whether a decision, finding, and/or award has issued in a case and also provides information as to the number of cases with exposure to such penalties.</p>	
10107.1(c)	Commenter recommends that this		Disagree. The purpose of the	None.

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	subdivision be removed. Commenter opines that excluding files from a random selection process had the same effect as adding files. There is no longer a random sample to use in calculations for the individual audit subject or for use in the Annual Performance Standard calculation.		PAR audit is to efficiently determine whether a claims administrator is meeting its obligations under the law. This is accomplished through an audit of indemnity claims from which a performance score is calculated. An indemnity claim is defined as a work-injury claim “that has resulted in the payment of any of the following benefits: temporary disability indemnity, including temporary partial disability indemnity, or salary continuation in lieu of temporary disability indemnity, permanent disability indemnity, death benefits, or vocational rehabilitation maintenance allowance.” Claim samples with a single indemnity payment that cannot be classified under the above categories, primarily claims that are settled by one agreed-upon payment, cannot be used in calculating a performance rating and are of little value in determining whether a claims administrator is meeting is legal obligations.	
10107.1(c)(2), (d)(2) and (e)(2)	Commenter recommends that the language in the first paragraphs of all of these subsections be deleted and the		Disagree. See above response to comment regarding 10100.2(o). The proposed changes would not	None.

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	<p>following language be inserted in its place:</p> <p>In addition to the randomly selected indemnity claims, the Audit Unit may audit any claims for which it has received a credible complaint or information indicating a failure to pay indemnity, including any companion claim needed to ascertain the extent to which benefits have been provided.</p> <p>Commenter believes the proposed changes would interfere with the random selection process as he outlined in his comments regarding Section 10100.2(II).</p>		interfere with the random selection process because complaint files that are not randomly selected are not considered when calculating the audit subject's performance standard.	
10107.1(c)(5) and (e)	<p>Commenter requests that the two working day time limit in the last sentence in subdivision (c)(5) and the last three sentences of subdivision (e) should be increased to 10 days. The two working day time limit for raising factual issues on determinations that frequently take weeks, if not months, for the Audit Unit to identify is far too short. Commenter opines that this meager time limit, along with the waiver of appeal, would compromise due process.</p>		Disagree. See above response to comment by State Fund regarding section 10107.1(c)(5) and (e).	None.
10108(j)	<p>Commenter states that subdivision (j), as proposed to be amended, appear to be in conflict with Section 10107(c)(2), which</p>		Disagree. The regulation is not in conflict with section 10107(c)(2). Although claim files with a	None.

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	states that compliant file errors will be included in the assessment. Further, the definition for “Random Sample” in Section 10100.2(II) includes complaint files. These inconsistencies from section to section should be harmonized and clarified.		complaint may be audited under section 10107(c)(2), (d)(2), and (e)(2), they are not included in the calculation of the performance standard unless they have also been randomly selected.	
10111.2(b)(10) and (11)	The amendments to these subdivisions propose to double the penalty if treatment was approved by Utilization Review. This penalty is not equitable. The late payment of the medical bill or failure to pay the increase, or interest, is unrelated as to whether a Utilization Review approval was received. Many, if not most, Utilization Review approvals are for a general course of treatment such as for four weeks of Physical Therapy, rather than for a specific coding which would need no further review at the time of bill payment. There should be no multiplying of the penalty as a result of an unrelated act.		Disagree. The proposal to double the penalty if medical treatment was approved by a physician reviewer under a utilization review program is entirely reasonable. “Authorization”, as defined in section 9792.6(b), regarding definitions for utilization review standards, means “assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment ....” The failure of claims administrator to pay or object to a medical bill following assurance by that claims administrator that appropriate reimbursement will be made merits a doubling of the standard penalty. Note that the doubling of the penalty will only occur if treatment is authorized within the utilization review process. See section 9792.6(q).	None.

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10111.2(b)(13)	<p>Commenter believes that the addition to this subsection should be removed. The addition of a \$50 penalty is objectionable for the same reason as commenter stated regarding Section 10100.2(ff). Commenter does not believe that there is such a thing as an indemnity claim without an indemnity payment.</p>		Disagree. See response to comment regarding section 10100.2(ff). DWC finds that a distinction exists between medical-only claims and indemnity claims without an indemnity payment.	None.
10100.2(a)	<p>Commenter suggests that the language be amended as follows:</p> <p>For auditing purposes, any separate office or location whose <u>claims are administered under the same local management at that location</u> <del>staff includes personnel assigned supervisory responsibility over claims administration</del> may be considered a single adjusting location.</p> <p>Consistency: Sometimes reference is made to “the same local management” but elsewhere in the same section, reference is made to “staff includes personnel assigned supervisory responsibility over claims administration.” Generally accepted principles of determining the drafter’s intent will lead to the conclusion that these are two different groups, but the difference between the two is not defined. As presently drafted the regulation is ambiguous and should be clarified by using the same definition in both</p>	<p>Michael McClain, General Counsel &amp; Vice President Brenda Ramirez, Claims &amp; Medical Director California Workers’ Compensation Institute December 15, 2008 Written Comments</p>	Agreed. The phrase “personnel assigned supervisory responsibility over claims administration” is essentially the definition of “local management”.	Amend section 10100.2(a) to provide: “For auditing purposes, any separate office or location whose staff includes local management may be considered a single adjusting location.”

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	<p>circumstances. Since the term “local management” is defined in the regulation that terminology should be consistently used throughout.</p>			
10100.2(e)	<p>Commenter recommends deleting the last sentence of this subdivision.</p> <p>The discretion to combine adjusting locations in this subdivision is directly contrary to subsection (a) defining “adjusting location” in relation to “local management” and staff with “supervisory responsibility.” Because a “targeted audit” is aimed at a specific adjusting location’s practices for which there have been complaints (or aimed at multiple adjusting locations with complaints) each should be viewed as a separate “targeted audit.”</p>		<p>Disagree. The discretion to combine adjusting locations is not contrary to subsection (a). Regardless, no substantive amendment was made to the definition of “Audit Subject” in this rulemaking. As such, no response is necessary.</p>	None.
10100.2(o)	<p>Commenter suggests that the language be amended as follows:</p> <p>Complaint claim file: A claim file that is selected for audit because the Audit Unit has received <u>credible</u> information indicating the existence of <del>possible</del> <u>probable</u> claims handling violations of the kind which, if found, would be subject to the assessment of an administrative penalty, the issuance of a notice of compensation due, or the assessment of a</p>		<p>Disagree. See above response to similar comment by the American Insurance Association regarding section 10100.2(o).</p>	None.

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	<p>civil penalty.</p> <p>While it is incumbent on the administrative director (AD) to make it clear that complaints against the audit subject will be reviewed by the Audit Unit, it is equally important to ensure that only credible complaints supported by reliable information are sufficient to trigger a specific file review by the Audit Unit.</p> <p>In these proposed regulations, there are only two references to “credible complaints”; both are in section 10106.1(c). But there are multiple references to “complaints” and supporting “information.” Making the recommended changes to the definition of a “complaint claim file” may be sufficient to define all the other references used throughout the regulations, but for internal consistency, the administrative director must make it clear that the audit unit will act only on credible complaints supported by verified, reliable information.</p> <p>This proposed audit regulation is confusing because it is inconsistent with sections 9792.11(c)(1)(A) and (B) which require “credible complaints” and “credible information.” Also, the Division has already adopted a straightforward method to determine credibility in the</p>			

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	<p>new utilization review standards, section 9792.11(e). In part that section requires:</p> <p>Complaints received by the Division of Workers' Compensation will be reviewed and investigated, if necessary, to determine if the complaints are credible and indicate the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.</p> <p>If the "complaint audit" is not qualified, as recommend, then the audit process will be wide open and subject to abuse. Whenever a claims organization refuses to provide medical care that is patently deleterious, and the injured worker complains, an audit could be triggered. If an applicant's attorney, who believes that the 2005 permanent disability rating schedule is grossly unfair, decided to file a complaint on every single PD rating, then these regulations would trigger an audit for every complaint.</p> <p>DWC audits are a costly exercise in terms of data gathering and lost production time for audit subjects, and a significant use of the Division's resources. No one wants to chase specious complaints. Therefore, the "information" must be verified, the "complaints" must be in a sufficient number to justify an investigation, and the</p>			

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	<p>evidence must lead to “the probable existence of” a serious statutory violation before the Division resorts to an audit.</p> <p>There must also be some stated consequence for providing false information and making fraudulent complaints. The Institute and its members agree that complaints against claims administrators must be taken seriously by the Division, if they are genuine. But accusations are easy to make and if there are no consequences for making false or fraudulent allegations, then the resources of both the audit unit and the audit subject will be wasted and these regulations will devolve into a means of harassment rather than quality assurance. Relying on verified, credible evidence will ensure that the audits are well founded and that the resources of both the Division and the regulated community are properly employed.</p>			
10100.2(w)	<p>Commenter suggests that the language be amended as follows:</p> <p>(w) General Business Practice. For the purposes of Labor Code section 129.5(e), <u>a pattern of conduct that can be distinguished by a reasonable person from an isolated event. The pattern of violations must occur in the handling of</u></p>		<p>The subdivision is amended only to clarify that the definition of “general business practice” applies for the purposes of Labor Code section 129.5(e) (the civil penalty provision). The substantive definition of “general business practice” has not been changed in this rulemaking. As</p>	None.

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	<p><u>20% or more of the claims under review.</u> The conduct can include a single practice and/or separate, discrete acts or omissions in the handling of several one or more claims.</p> <p>Section 129.5(e) imposes the second highest single penalty contained in the Labor Code. From the plain language of the statute, it is clear that the civil fine exists in order to sanction employers and insurers who have failed to meet their statutory obligations on multiple files with a frequency that indicates a general business practice of dishonest, unreasonable, or injurious claims administration.</p> <p>The appropriate application of the standards set forth in section 129.5, therefore, requires an auditor to establish a pattern of conduct equivalent to a company policy. The proposed regulatory definition is too simplistic and fails to address the statutory standards that are essential for the application of this separate, enhanced fine. Consequently, the proposed regulation is an invalid exercise of administrative authority that violates the scope of the enabling statute. Government Code section 11342.2 states:</p> <p style="padding-left: 40px;">Whenever by the express or implied terms of any statute a state agency has</p>		such, no response to this comment is required.	

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	<p>authority to adopt regulations to implement, interpret, make specific or otherwise carry out the provisions of the statute, no regulation adopted is valid or effective unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute.</p> <p>In <i>Boehm &amp; Associates</i> (1999) 64 CCC 1350 the Court held that a regulation allowing the insurer to avoid interest payments until the claim was adjudicated was invalid. The court stated:</p> <p>“... we note that the Legislature possesses the plenary constitutional authority to create and enforce a workers' compensation system (Cal. Const., art. XIV, § 4); therefore, any decision of the appeals board or regulation promulgated by the Director of the Division of Workers' Compensation in contradiction to the Workers' Compensation Act is invalid. (See <i>Coca-Cola Co. v. State Bd. of Equalization</i> (1945) 25 Cal.2d 918, 922 [administrative regulations may not contravene terms of statutes under which they are adopted].)”</p> <p>The determination of the legality of a regulation adopted by the AD includes whether it is within the scope of authority</p>			

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	<p>conferred by the statute and whether it is reasonably necessary to effectuate the purpose of the statute. <i>San Diego Nursery Co., Inc. v. Agricultural Labor Relations Bd.</i> (1979) 160 CR 822, 100 Cal.App.3d 128. The proposed regulation here fails to define a pattern of conduct or a business practice and changes the meaning of the statute, which it cannot do.</p> <p>The work of the auditor is more difficult than that suggested by the proposed regulation. The regulatory standard contained in Labor Code section 129.5(e) is that a civil penalty may be assessed based “upon a finding, after hearing, that an employer, insurer, or third-party administrator for an employer has knowingly committed or performed with sufficient frequency so as to indicate a general business practice any of the following ... (specific claims practices are then enumerated (See: page 6, below))”</p> <p>Therefore, the regulation must define not just a general pattern of conduct, but a pattern of conduct knowingly performed with a frequency that rises to the level of a general business practice. The regulations fail to consider the number of files managed by a claims organization as a factor in determining whether “a pattern of violations” exists. Establishing a pattern of intentional misconduct involves</p>			

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	<p>the consideration of the size of the claims organization, the scope of the conduct (whether it was an isolated incident or pervasive), the awareness and involvement of management, and other factors that will be unique to each review. The term “general business practice” is not defined in the statute, so we may look to the common understanding of the words, i.e., the dictionary definition. “General” is defined as “prevalent, usual or widespread (Webster's Third New International Dictionary). “Practice” means “performance or application habitually engaged in or repeated or customary action.” For clarity and consistency, this regulation must include these definitional elements. While the Institute suggests a specific percentage of files, the AD might also state these elements in terms of a pattern of conduct pursued with such frequency as to be found prevalent, widespread, and habitually engaged in as a customary action.</p> <p>The standard definition of “pattern” is a representative sample. A representative sample of claims files managed over the period can only be established by a ratio or percentage sample. Auditors must consider the totality of the claim management process, including the total number of claims being managed within</p>			

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>the period being reviewed, in determining whether statutory violations have been knowingly committed with a frequency that indicates a general business practice.</p> <p>The goal of this audit process is compliance with the statutory obligations to promptly and fully pay the workers' compensation benefits to which the injured worker is entitled. In order to avoid an inappropriate chilling effect on permissible claims management activity, these regulations must clearly state the criteria for adherence to the statute, must establish a reasonable deterrent effect, and must include all of the statutory elements of section 129.5, or the regulations will fall beyond the authority of the statute.</p>			
10100.2(y)	<p>Commenter suggests that the language be amended as follows:</p> <p>(y) Indemnity Payment. <del>Compensation</del> <u>Payment</u> for any of the following benefits</p> <p>The term "compensation" is defined much differently in subdivision (n) than the meaning implied in this section. Substituting the word "payment" will eliminate this confusion and would be more consistent with the use of the term "payment" in subsections (s), (t), (u), and (x).</p>		Disagree. Compensation is defined under proposed subdivision (n) as "Every benefit or payment, including vocational rehabilitation, supplemental job displacement benefits, medical treatment, and medical-legal expenses, conferred by Divisions 1 and 4 of the Labor Code on an injured employee or the employee's dependents." Use of the word in proposed subdivision (y) is entirely reasonable; it does not result in confusion.	None.

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
10100.2(cc)	<p>Commenter suggests that the language be amended as follows:</p> <p>(cc) Knowingly committed. <del>Acting</del> <u>Action by a managing representative</u> with knowledge of the facts of the conduct subject to an investigation and/or audit under Labor Code sections 129 and 129.5 and <u>acting with actual knowledge that the conduct is unlawful, or done with conscious disregard for the unlawful nature of the conduct at issue.</u> <del>A corporation has knowledge of facts any employee receives while acting within the scope of his or her authority. A corporation is presumed to have has knowledge of information contained in its records and of the actions of its employees performed in the course of employment. An employer or insurer has knowledge of information contained in the records of its third party administrator and of the actions of the employees of the third party administrator performed in the scope and course of employment.</del></p> <p>The administrative director’s definition of “knowingly committed” relates only to knowledge imputed to a corporate entity. In so limiting the regulation, the definition eliminates the essential</p>		Disagree. See above response to similar comment by the American Insurance Association regarding section 10100.2(cc).	None

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>statutory requirements and exceeds the authority of the regulator. Section 129.5(e) permits the assessment of a civil fine if the audit subject “has knowingly committed or performed with sufficient frequency so as to indicate a general business practice any of the following:</p> <ul style="list-style-type: none"> <li>(1) Induced employees to accept less than compensation due, or made it necessary for employees to resort to proceedings against the employer to secure compensation.</li> <li>(2) Refused to comply with known and legally indisputable compensation obligations.</li> <li>(3) Discharged or administered compensation obligations in a dishonest manner.</li> <li>(4) Discharged or administered compensation obligations in a manner as to cause injury to the public or those dealing with the employer or insurer.”</li> </ul> <p>The statute applies enhanced deterrence based on a higher level of misconduct. The proposed regulation ignores this and would permit the application of the civil fine for negligence, inadvertence, or sloppy practice by a single claims adjuster, not the intentional, substandard business practices enumerated in the statute.</p>			

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	<p>To establish a knowing violation, an auditor must be able to provide evidence of scienter: knowledge of the nature of one's act or omission, the intent to engage in particular conduct, or the intent to deceive, manipulate, or defraud. In <u>People v. Simon</u> 9 Cal. 4th 493, the California Supreme Court noted that the term “knowingly” is a <i>mens rea</i> requirement. This proposed regulation ignores that requirement and instead creates liability for a third party’s conduct of which the employer or insurer has no actual knowledge.</p> <p>To apply the civil fine to a business practice, it must be clear that the company managers were aware of and ratified the conduct. It is therefore necessary to delete the portion of the regulation which expands employer and insurer liability to conduct by a third party administrator and to narrow the knowledge requirement to managing representatives.</p>			
10100.2(dd)	<p>Commenter suggests that the language be amended as follows:</p> <p>(dd) Lawful delay. A delay permitted by law or regulation, <del>and for which the claims administrator has given a proper and timely notice of delay when such a</del></p>		Disagree. As expressly provided in the proposed definition, if notice is required, it must be provided for a lawful delay to exist. Conversely, if notice is not required, it need not be given. DWC is unaware of a specific	None.

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	<p><del>notice is required.</del> Any other delay is an unlawful delay.</p> <p>A delay may be permitted by statute or regulation that is separate and apart from whether another regulation may require the sending of a notice within certain time constraints. This provision impermissibly restricts the scope of what is, by statute, a lawful act and exceeds the regulator's authority.</p>		scenario where a lawful delay could occur where notice is required by statute or regulation yet not provided by the claims administrator.	
10100.2(ff)	<p>Commenter suggests that the language be amended as follows:</p> <p>A work-injury claim as defined by 8 CCR 10100(p) in which no indemnity benefits have been paid <del>or would reasonably be anticipated or expected to be paid.</del></p> <p>An indemnity claim is distinguished from a medical-only claim solely by the fact that an indemnity payment has been made. This definition is a clear, bright line.</p> <p>The Workers' Compensation Insurance Rating Bureau, workers' compensation claims administrators, and researchers all understand and use this line of demarcation. Therefore, within the California workers' compensation system, there is no such thing as a medical-only</p>		Disagree. See above response to similar comment by the American Insurance Association regarding section 10100.2(ff).	None.

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>claim defined in terms of a reasonably anticipated or expected indemnity payment, nor should there be.</p> <p>A standard of “reasonable expectation” injects vagueness and invites disputes. This notion would be completely foreign to claims administrators and they would not know how to report it or collect it for the audit unit.</p> <p><u>Consistency:</u> Having inconsistent definitions for a “medical-only claim” in section 10100, 8 CCR 10100.1(t), 8 CCR 15201(z) and (bb), and proposed section 10100.2(ff) is confusing, misleading, and results in lack of clarity. It also needlessly creates inconsistencies and ambiguities in electronic data element reporting under CCR section 9702, notices under section 9812, claim log maintenance under section 10103.1, 10103.2, the annual report contents under section 10104, audit penalties under section 10111, target audit penalties under section 10111.2, aggregate annual reports under section 10203.1, individual employer annual reports under section 10103.2, loss estimates under section 15300, claim file maintenance under section 15400, and adjuster certifications under 10 CCR 2592, et seq.</p> <p>There is no rational basis for multiple</p>			

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>definitions of the same term, and no justification for the confusion that will result from this definition.</p>			
10101.1	<p>Commenter suggests that the language be amended as follows:</p> <p><del>Every claims administrator shall maintain a claim file of each work injury claim including claims which were denied. All open claim files shall be kept maintained at the adjusting location for the file responsible for administering the claim. Where the claim file is, wholly or partially, maintained electronically or “paperless”, the entire electronic or “paperless” file shall be accessible from the adjusting location responsible for administering the claim. The file shall contain but not be limited to: ...</del></p> <p>Where claims are wholly or partially maintained in an electronic format, the “claim file” is not physically at the adjusting location. Instead, the files are merely accessed electronically by staff at the adjusting location. Although subdivision 10101.1(p) recognizes the electronic format, this section fails to address that.</p>		<p>Agree. See above response to similar comment by the California Applicants’ Attorneys’ Association regarding section 10101.1</p>	<p>Amend section 10101.1 to move subdivision (p) to the introductory paragraph such that the section expressly provides that claim files may be in either hard copy or electronic form.</p>
10101.0(o)	<p>Commenter suggests that the language be amended as follows:</p>		<p>Agree. See above response to similar comment by Farmers’</p>	<p>Amend section 10101.1 such that any piece of</p>

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Notes, <u>correspondence</u>, and documentation, whether stored on paper or in electronic form and including correspondence to or from any individual or entity, describing telephone conversations relating to the claim which are of significance to claims handling, including the dates of calls, substance of calls, and identification of parties to the calls.</p> <p>Subdivisions (k), (l), (m), and (n) all refer to “notes, correspondence and documents” and the failure to do so in subdivision (o) will be confusing regarding what was intended to be omitted, particularly in light of the use of the word “correspondence” later in the subdivisions.</p>		Insurance regarding section 10101.1	correspondence that must be included in a claim file shall be either initiated or received by the claims administrator.
10101.1(p)	<p>Commenter suggests that the language be amended as follows:</p> <p><del>Files maintained in hard copy shall be in chronological order with the most recently dated documents on top, or subdivided into sections such as medical reports, benefit notices, correspondence, claim notes, and vocational rehabilitation.</del></p> <p>...</p> <p>The third sentence in subdivision (p)</p>		Disagree. In order for the Audit Unit to determine whether claims administrators are providing injured workers the full measure of compensation to which they are entitled, each claim file must contain documentation of all aspects of claim handling that affect the amount of benefits due or potentially due. The authority to audit claims inherently contains the authority to require	None.

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	<p>should be deleted because it dictates a uniform file structure that is beyond the scope of the statutory audit process. Regulations imposed (and enforced through penalties) for the sake of administrative convenience are counterproductive and not supported by the express language of the statute or the underlying philosophy of the process</p>		<p>that claim files be maintained and provided to the Audit Unit in a manner that can be readily accessed by auditors.</p> <p>The language of the proposed section is consistent with the claim file requirements for self-insurance plans. California Code of Regulations, title 8, section 15400(c) provides in pertinent part: "Files maintained in hard copy shall be in chronological order with the most recently dated documents on top, or subdivided into sections such as medical reports, benefit notices, correspondence, claim notes, and vocational rehabilitation."</p>	
10103.2	<p>Consistency: The definition of a "medical-only" claim in this section differs from that in proposed section 10100.2(ff). Please, refer to the comments and recommendations regarding section 10100.2(ff).</p>		<p>Disagree. The definition of "medical-only" claim does not differ from that in proposed section 10100.2(ff). Since only indemnity claims where a payment has been made are subject to a random audit, it is essential to distinguish between indemnity claims where a payment has been made from medical-only claims or indemnity claims where payment is anticipated yet has not been</p>	None.

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			made.	
10104	Consistency: This 45-day time period is at odds with the same subject matter covered in section 10104(d)(3) which specifies 30 days for some of these same changes. The two should be made consistent.		Agree. See above response to similar comment by American Insurance Association regarding section 10104.	Amend section 10104(d)(3) by providing that the “claims administrator shall notify the Administrative Director, by mailing written notice to the manager of the Audit Unit, of any change in the information provide in the Annual Report of Adjusting Locations.” Amend the 30-day calendar notification period to 45-days.
10104(d)(2)	There is no subdivision (c)(1) in section 10104. The reference should be corrected. The same reference is contained in subdivision (d)(4).		Agreed. The reference should be corrected to subdivision (d)(1).	Amend 10104(d)(4) by changing the reference to subdivision (c)(1) to subdivision (d)(1).
10105	<p>Commenter suggests that the language be amended as follows:</p> <p>To carry out the responsibility pursuant to Labor Code sections 129 or 129.5, the Administrative Director <del>or his/her representative</del> shall audit claims administrators' claim files and claim logs</p>		Disagree. The section has only been amended to reflect the authority of the Administrative Director, conferred by Labor Code section 129.5, to assess both administrative and civil penalties. This remaining portion of the regulation, which included	None.

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	<p>at such reasonable times as he/she deems necessary. The Administrative Director or his/her representative may also utilize the provisions of Government Code sections 11180 through 11191.</p> <p>Consistency: The use of the term “representative” is ambiguous and contradictory in light of section 10100.2(c), which defines the administrative director as including her designee or delegate. Legal principles of drafting intent would lead to the conclusion that the different language is intended to refer to different persons. A reference only to the “administrative director” will include the definition from section 10100.2(c) and resolve any potential confusion. If a “representative” is intended to refer to a different person, then that should be clarified.</p>		reference to the Administrative Director “or his/her representative”, is not being amended in this rulemaking. As such, no comment is required.	
10106.1(c)	<p>Commenter suggests that the language be amended as follows:</p> <p>Pursuant to Labor Code section 129(b) (<del>2</del>) and <del>(b)</del>(3), the Audit Unit <del>shall</del> <u>may</u> conduct a <u>targeted</u> profile <u>audit</u> review <del>audit</del> or full compliance audit of targeted audit subjects. An audit subject shall be selected for a targeted audit based on the following <u>targeted profile</u> audit <u>review</u> criteria:</p>		Agreed. The regulation should reflect the statutory language of Labor Code section 129.	Amend section 10106.1(c) to reflect the language of Labor Code section 129.

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>(1) Prior <u>full compliance</u> audit results pursuant to Labor Code section 129(b)(2) shall be used independently as factual information to support selection of a claims administrator for a return, targeted <u>profile</u> audit <u>review</u> as follows:</p> <p>(A) When a final <u>full compliance</u> audit report is issued, the report will include a final performance rating. The final performance rating will be calculated in the same manner as the performance audit review performance rating as set forth in California Code of Regulations, title 8, section 10107.1(c)(3), except that the rating shall be determined based on audit findings from all claim files randomly selected pursuant to section 10107(c)(1), (d)(1), and (e)(1), and selected additional claims files.</p> <p>For greater clarity, the regulation must mirror the language of the statute in reference to the levels of review being imposed and the regulatory criteria for the targeted profile audit reviews.</p>			
10106.1(c)(2)(A)	Commenter suggests that the language be		See response to comment by	None.

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	<p>amended as follows:</p> <p>The Division of Workers' Compensation will regularly submit to the Audit Unit copies of WCAB decisions, findings, and/or awards issued pursuant to Labor Code section 5814, <del>and reports of WCAB cases involving allegations of section 5814 violations.</del></p> <p>Allegations are meaningless in this context and should not be considered by the audit unit. Claims of unreasonable denial or delay in the payment of benefits are made for reason too numerous to list but mostly these assertions are intended to intimidate the claims administrator and leverage a settlement. Reports of cases involving allegations of section 5814 penalties are, therefore, irrelevant. The absence of an award of a section 5814 penalty is a clear indication that the allegations were unproved and evidence that no unreasonable delay occurred. The audit apparatus of the Division should not be triggered by mere allegations. The other reports contained in the proposed regulation are more than sufficient to alert the audit unit to potentially deficient performance by a claims administrator.</p> <p>Similarly, with regard to Labor Code Section 5814.6, allegations are irrelevant. That statute does not permit fines or</p>		<p>American Insurance Association to section 10106.1(c)(2)(A).</p>	

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	penalties based on assertions of unreasonable delay, but only cases in which a final award of a penalty under 5814 was awarded. Including in the audit selection process cases “involving allegations” of section 5814 violations, where none was adjudicated, is beyond the AD’s jurisdiction.			
10106.1(c)(2)(B)	<p>Commenter suggests that the language be amended as follows:</p> <p>(B) For each adjusting location, the total number of <u>final</u> decisions, findings, and/or awards <del>issued</del> <u>that issue a penalty</u> pursuant to Labor Code section 5814 ...</p> <p>Not infrequently, the Board may issue a findings and award pursuant to section 5814 indicating no section 5814 violation. As noted above, section 5814.6 does not permit fines or penalties based on anything other than a final judgment awarding a penalty under section 5814.</p>		Disagree. The section has only been amended to delete the vague phrase “approximately once per year” and to substitute “subdivision” for “subsection.” The remaining portion of the regulation is not being amended in this rulemaking. As such, no comment is required.	None.
10106.1(c)(3)	<p>Commenter suggests that the language be amended as follows:</p> <p>(3) The Audit Unit may also target audit subjects based on credible complaints and/or information received by the Division of Workers' Compensation that indicate <del>possible</del> <u>probable</u> claims</p>		Disagree. The section has only been amended to include a provision allowing the Audit Unit to request information to determine the validity of a complaint and to delete the vague phrase “approximately once per year”. The remaining portion of	None.

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	<p>handling violations, except that the Audit Unit will not target audit subjects based only on anonymous complaints unless the complaint(s) is supported by credible documentation.</p> <p>For the reasons commenter stated regarding section 10100.2(o), the AD should not trigger the targeted audit process unless there is clear evidence supported by verified, reliable information that the audit subject is engaged in conduct that is very likely contrary to Code sections 129 or 129.5.</p> <p>The AD must make it clear that the audit unit will act only on credible complaints. Anonymous complaints should be subject to an even higher standard of supporting evidence. The AD should use a validation process similar to regulation section 9792.11(e), which is used for the new utilization review standards. This must include screening and an investigation to determine if the complaints are credible and the supporting documentation is reliable.</p> <p>If the “complaint audit” is not verified and an initial determination made that there are probable violations, then the audit unit will engage in one wild goose chase after another. Without some meaningful pre-screening of complaints</p>		<p>the regulation is not being amended in this rulemaking. As such, no comment is required.</p>	

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	<p>and without any consequences for providing false information and making fraudulent complaints, the DWC audit will devolve from a quality assurance program to a means of institutional harassment.</p> <p>DWC audits are a costly exercise. Relying on verified, credible evidence will ensure that the audits are well founded and that the resources of both the Division and the regulated community are properly employed.</p>			
10106.1(c)(3)(B)	<p>Commenter suggests that the language be amended as follows:</p> <p>... In considering the potential for specific <del>poor</del> <u>unlawful claims</u> practices, ...</p> <p>The Division’s regulatory authority extends to compliance or non-compliance with the law. This subdivision should reference “unlawful claims practices”, rather than the vague assessment of “poor” practices, as that subjective evaluation is beyond the Division’s authority.</p>		Disagree. The subdivision has only been amended to account for formatting changes. There are no substantive changes to the existing provision in this rulemaking. As such, no comment is required.	None.
10106.1(d)(2)	<p>Commenter suggests that the language be amended as follows:</p> <p>... on the basis that the Audit Unit has</p>		Disagree. Section 10106.1(d) sets forth the procedure for conducting a target audit. At this point, one of the listed criteria for	None.

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>received <u>credible</u> information alleging the existence of an <del>improper</del> <u>unlawful</u> claim handling practice, and for the purpose of determining whether that practice occurred in those files.</p> <p><u>Consistency</u>: To be consistent throughout the proposed regulations and to ensure that the audit unit will not act on the basis of mere allegations, the AD must require “credible information” in order to trigger the initiation of a targeted audit. Additionally, the appropriate legal standard for an investigation is “unlawful” claim management practices; not the ambiguous, subjective standard of “improper” practices.</p>		<p>conducting a target audit under section 10106.1(c) has been satisfied; the audit subject has been provided the opportunity to appeal its selection. See section 10106.1(d)(4). The ability to select files allows the Audit Unit to investigate and determine whether the information alleging the existence of an improper claim handling practice is valid and whether corrective or other action needs to be taken. As indicated above, in certain cases the only way in which to determine the validity of the complaint is to audit the file.</p>	
10107.1(c)	<p>Commenter suggests that the language be amended as follows:</p> <p><del>Claim samples randomly selected under this subdivision shall not include claims with a single indemnity payment that cannot be classified under the profile audit review performance standards set forth in subdivision (c)(3)(A) through (C)(3)(E).</del></p> <p>Because the audit unit cannot review the entire population of claims files for a given adjusting location, a random sampling methodology is necessary. It is</p>		<p>Disagree. See response to comment by American Insurance Association to section 10107.1(c).</p>	<p>None.</p>

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	<p>essential that the files selected be representative of the population, and not biased in a systematic manner.</p> <p>Random sampling is a technique where the auditor selects a group of claim files at random from the entire population of claims. In order to meet the definition of a random sample, each file must have the same opportunity to be selected by the audit unit and the sample must be large enough to represent the entire population.</p> <p>If the random sample includes “additional files” or if files are removed based on a pre-set criterion, then the sample is no longer random, but rather a stratified sample. The utility of the audit findings that are based on a stratified sample will therefore be compromised and applicable only to that part of the population represented by that stratified sample and not applicable to the entire claim population. A true random sample should contain the proportionate volume of all claim types.</p> <p>The presumed intent of the use of a random sample is to validate the audit subject’s performance over the entire population of claim files being managed at the adjusting location. Any mix of random and non-random (stratified) files or any elimination of specific files</p>			
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AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>randomly selected will preclude the assessment of performance across the entire population, compromise the sampling methodology, and invalidate the performance measure of the audit.</p> <p>The PAR performance rating formula must be based exclusively on the random sample determined according to the table contained in section 10107.1(c).</p>			
10107.1(c)(2)	<p>Commenter suggests that the language be amended as follows:</p> <p>Claims with complaints that are randomly selected <u>pursuant to subdivision (c)(1)</u> will be audited as part of the random sample and included in the performance rating.</p> <p>The recommended clarification is necessary to explain that any complaint files selected as part of the random sample will be audited and included in the calculation of the performance rating but that other “complaint files” will not be included in the random sample.</p>		Disagree. Based on the proposed definition of “random sample”, section 10100.2( <i>ll</i> ), the suggested addition to the subdivision is unnecessary. Any complaint files selected as part of the random sample will be audited and included in the calculation of the performance rating ; other “complaint files” will not be included in the random sample.	None.
10107.1(c)(2), (d)(2), and (e)(2)	<p>Commenter suggests that the language be amended as follows:</p> <p>(2) In addition to the randomly selected indemnity claims, the Audit Unit may</p>		Disagree. See above response to similar comment by the American Insurance Association regarding section 10100.2(o). Injured workers need to be assured that	None.

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>audit any claims for which it has received a <u>credible</u> complaint or <u>reliable</u> information over the past three years that indicate a failure to pay indemnity, including any companion claim needed to ascertain the extent to which benefits have been provided. Claims with complaints that are randomly selected will be audited as part of the random sample and included in the performance rating.</p> <p>See comments regarding sections 10100.2(o) and 10106.1(c)(3) relating to the need to base all audits on credible complaints and verifiable information.</p>		<p>complaints will be reviewed and assessed during an audit. Claim files with complaints can be readily reviewed to determine whether the complaint is credible or reliable. If the complaint is not credible, then no penalties will be assessed or compensation owed.</p>	
10107.1(c)(5) and (e)	<p>Commenter suggests that the language be amended as follows:</p> <p>Unless the audit subject demonstrates that the factual basis for the Audit Unit’s calculation of the profile audit review performance rating is incorrect within <del>two</del> <u>ten</u> working days of the receipt of the rating or at the post profile audit review conference, the Audit Unit may continue and complete the full compliance audit. The audit subject may appeal the issues pursuant to California Code of Regulations, title 8, section 10115.1 following the issuance of the final audit report. Failure of the audit subject to raise factual issues related to failing to meet or</p>		<p>See response to comment by State Fund to section 10107.1(c)(5) and (e).</p>	None.

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>exceed the profile audit review performance standard within <del>two</del> <u>ten</u> working days of the receipt of the profile audit review performance rating or during the post-profile audit review conference shall constitute a waiver of appeal on those issues.</p> <p>In both of these subdivisions, the allowance of two working days to appeal an audit performance rating is unnecessary and tantamount to a denial of due process. It is simply not possible to evaluate and present arguments on the number of cases involved in such a review in that short a time. Imposing a “waiver of appeal” on the basis of a 48-hour review of what may have been a month’s long evaluation will ensure an automatic, mechanical appeal in every case and raises questions of due process. Whereas, allowing a thoughtful response to the audit will promote a better understanding of the process and will frame the issues that are necessary to fully adjudicate legitimate concerns.</p>			
10108(d)	<p>Commenter suggests that the language be amended as follows:</p> <p>However, penalties shall still be issued for violations during the period of delay for: the failure to timely pay or object to</p>		Disagree. Labor Code section 5402(c), enacted as part of Senate Bill 899’s reform package, requires a claims administrator to provide, within one working day after an employee files a claim	None.

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>medical bills for treatment authorized under Labor Code section 5402(c); <u>unless there are other threshold issues of liability or defenses, such as, but not limited to, employment, AOE/COE, independent contractor, statute of limitations, fraud, medical malpractice, initial physical aggressor, willful self-infliction, intoxication, serious and willful misconduct of the employee, and insurance coverage;...</u></p> <p>The reference to “treatment authorized under LC 5402(c)” impliedly relates to issues involving utilization review. Duplication of penalties for both utilization review enforcement regulations and full compliance audit is prohibited by law. Additionally, liability for 5402(c) payments can be disputed even though treatment meets the UR standards, as in cases involving the statute of limitations, fraud, medical malpractice, willful self-infliction of injury, intoxication, serious and willful misconduct, and insurance coverage, etc. Nothing in Labor Code section 129 or 129.5 authorizes penalties or fines under the full compliance audit based on unresolved issues yet to be fully adjudicated. Consequently, this proposed regulation is beyond the AD’s statutory grant of authority.</p>		<p>form under Labor Code section 5401, all medical treatment consistent with the Medical Treatment Utilization Schedule (Labor Code section 5307.27). Treatment must be provided until liability is accepted or denied. Until the date the claim is accepted or denied, liability for medical treatment is limited to \$10,000.00. It is unclear how the proposed amendment “impliedly relates to issues involving utilization review” or possible defenses to section 5402(c) payments. The proposed section expressly states that if section 5402(c) treatment is authorized, i.e., the claims administrator has approved the treatment, then penalties may be assessed during the period of delay for the failure to pay or object to a medical bill. A claims administrator can object to a medical bill; there is no preclusion from defenses being asserted.</p>	

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
10111.2(b)(10) &(b)(11)	<p>Commenter recommends that the reference to doubling the penalties should be deleted from these sections.</p> <p>The DWC has encouraged claims administrators to review treatment for medical necessity, even if there is an unresolved issue of compensability. Medical reviewers are, therefore, being asked to determine the appropriateness of treatment for an injury that may not be eligible for workers' compensation payments under the law. Both of these subdivisions propose a doubling of the penalty if treatment was authorized through the utilization review process. When there is an issue of compensability outstanding, no audit penalty should be imposed on the delay in payment of treatment.</p> <p>While we agree that all bills for treatment should be paid or objected to timely, the statute provides for the payment of both a penalty and interest. The audit regulations already apply an additional penalty for this failure. The question of whether or not the treatment was subject to utilization review is irrelevant, because many utilization reviews focus on the entire recommended course of medical care and utilization review looks at the efficacy and appropriateness of the recommended treatment, while proper payment is a</p>		Disagree. See response to comment by American Insurance Association to sections 10111.2(b)(10) and (b)(11).	None.

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	matter of specific coding. Doubling that penalty is unwarranted, so multiplying that audit penalty will have no increased deterrent effect.			
10111.2(b)(10)	<p>Commenter recommends deleting the reference to a doubling of the penalty.</p> <p><del>Any penalty assessed under this subdivision shall be doubled if the medical treatment provided by the physician was authorized by a reviewer, as defined by California Code of Regulations, title 8, section 9792.6(q), through a utilization review process established pursuant to Labor Code section 4610 and California Code of Regulations, title 8, section 9792.7.</del></p> <p>Or, in the alternative, add the following language to the end of the subdivision:</p> <p><u>... except where other threshold issues or defenses to liability exist which are beyond the scope of utilization review (including but not limited to, the statute of limitations, employment issues, whether the injury arose out of or occurred in the course of the employment, independent contractor status, fraud, medical malpractice, initial physical aggressor, willful self-infliction of injury, intoxication, serious and willful</u></p>		Disagree. See response to comment by American Insurance Association to sections 10111.2(b)(10) and (b)(11).	None.

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><u>misconduct of the employee, insurance coverage, etc.) ...</u></p> <p>Even where utilization review determines that the recommended treatment is consistent with the medical treatment utilization schedule for the condition, liability may still be denied on other grounds or specific affirmative legal defenses-- statute of limitations, AOE/COE, employment, independent contractor status, fraud, medical malpractice, initial physical aggressor, willful self-infliction of injury, intoxication, serious and willful misconduct of the employee, insurance coverage, etc. By law, utilization review cannot address any of those ancillary issues. As drafted, the regulation is contrary to the AD's statutory authority. Therefore, the "doubling" of the penalty on the stated basis is a penalty not authorized by law and this subdivision should be deleted. Alternatively, the AD could add the suggested clarifying language to require consideration of these statutory defenses.</p>			
10111.2(b)(13)	<p>Commenter recommends deleting the following:</p> <p><del>\$50 for each failure to distinguish on the claim log an indemnity claim that has no</del></p>		Disagree. See response to above comment regarding section 10103.2. Note that the penalties assessed under subdivision (b) are of limited application. They are	None.

AUDIT REGULATIONS	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><del>payment of indemnity from one that has indemnity payment(s).</del></p> <p>Section 10100.2(x) defines an indemnity claim as a work-injury claim that has resulted in the payment of indemnity. In accordance with that definition, there is no such thing as “an indemnity claim that has no payment of indemnity.” Every medical-only claim in the workers' compensation system would fit the description contained in Section 10111.2(b)(13), but there is no rational reason why any differentiation on the claim log would matter to the Division. This section should be deleted as it is vague and contradictory.</p>		<p>not assessed unless a claims administrator fails to meet the full compliance audit standards.</p>	