

The Institute thanks the Division staff for its excellent work on these new regulations and the improvements made following the 1st Forum, and offers the following recommendations and comments.

Recommended specific modifications are indicated by underline and ~~strikethrough~~, and discussion in *italics*.

§9705. Administrative Penalty Schedule for Labor Code Section 138.6

(b) If the failure by the claims administrator to comply with WCIS reporting requirements is due to a system failure caused by or affecting the Department of Industrial Relations, the Administrative Director shall waive all or part of administrative penalties assessed pursuant to this section. For the purpose of this section, "system failure" is defined as a WCIS human error, hardware or software malfunction that prevents the timely transmission or proper validation of otherwise valid data elements.

Modify the definition of "system failure" to include WCIS human error. Human error by DIR or WCIS Unit staff can and has caused error messages to occur that now may result in penalties that are not the fault of claims administrators. For example rejection or error messages occur when data is submitted to WCIS in the correct order, but is processed out of order by WCIS Unit staff.

(c) For each of the violations listed below, the penalty amount shall be \$100.00:

(1) For failure to submit on a claim, when if required, an electronic report (maintenance type code MTC = 00, 04 or AU) under section 9702(b), hereinafter referred to as the "First Report of Occupational Injury."

(2) For failure to submit on an indemnity claim, **when if** required, an electronic report (MTC = IP or AP) under section 9702(d), hereinafter referred to as the “Subsequent Report of Occupational Injury.”

(3) For failure to submit on a claim, **when if** required, an electronic, subsequent report of injury (MTC=AN) under section 9702(g), hereinafter referred to as the “Annual Report.”

(6) For failure to submit on a claim, **when if** required, an electronic report under section 9702(e), hereinafter referred to as a “Medical Bill Payment Record.”

Replace “when” with “if” where indicated. The penalties in this section (c) are intended to apply if a report was required, but was not submitted. The penalties in the next section, (e) are intended to apply if a report is required, but is submitted late. Because “when” connotes timing, substituting “if” will more clearly communicate the intended meaning.

(d)(1) Each electronic report identified in subdivision (c) that is rejected by the WCIS electronic reporting edits **and** identified **as mandatory/fatal or conditional/fatal** in the California EDI Implementation Guide for First and Subsequent Reports of Injury, as defined in section 9701(b), or **mandatory or conditional in** the California EDI Implementation Guide for Medical Bill Payment Records, as defined in section 9701(c), will be considered not filed. For such reports, the claims administrator will receive an acknowledgement with a “TR” (transaction rejected) code.

Clarify that the rejected reports, those acknowledged with the TR (transaction rejected) code, apply to data elements identified as mandatory/fatal or conditional/fatal (if condition is met) in the FROI/SROI Guides or as mandatory or conditional (if condition is met) in the Medical Bill Payment Guide. This will help users understand the requirements, and is consistent with the “data quality criteria” described in section G of the WCIS FROI/SROI Implementation Guide.

(2) If an electronic report initially rejected under subdivision (d)(1) is required to be resubmitted under section 9702, but remains rejected and is not corrected and resubmitted into WCIS within **30 60** calendar days after receipt of the original acknowledgement rejection message, an administrative penalty shall be assessed in the amount of \$100.00 for each such report.

Allowing up to 60 calendar days instead of 30 calendar days is consistent with the time allowed in section G of the WCIS FROI/SROI Implementation Guide, and in section 9702(b) for updating data elements omitted from first reports because they were not known.

(e) For each of the violations listed below, the penalty amount shall be \$50.00:

(1) For failure to timely submit on a claim, **if required**, the First Report of Occupational Injury.

(2) For failure to timely submit on a claim, **when if** required, a Medical Bill Payment Record.

(3) For failure to timely submit on a claim, **when if** required, an Annual Report.

Add “if required and replace “when” with “if” where indicated. The penalties in this section (e) are intended to apply if a report was required, and was submitted, but was not submitted timely. If a report was not required, for example on an optional data element, but was submitted “late” no penalty should be issued. The recommended change will clarify that no late penalty applies if the report was voluntarily submitted.

(4) For failure to correct and resubmit to WCIS within 30 calendar days after receipt of the original acknowledgement message, the following error codes on a First Report of Occupational Injury or a Subsequent Report of Occupational Injury on an acknowledgement with a transaction accepted with (“TE”) error code:

(A) Mandatory Field not Present: Error code 001;

(B) Code Invalid: Error codes 006, 007, 008, 009, 011, 012, 014, 015, 016, 017, 020, 032 (with reported United States address), 042;

(C) Date Invalid: Error code 029;

(D) Format Error: Error code 028, 031;

(E) Required Segment not Present: Error code 062;

(5) For failure to correct and resubmit to WCIS within 60 calendar days after receipt of the acknowledgement message, the following error codes on a Medical Bill Payment Record with a date of injury on or after March 1, 2000 and a transaction accepted with (“TE”) error **(“TE”)** code: No Match on Database; Error code 039 **;**

Clarify that the reports accepted with a “TE” error code, apply to data elements listed in section 9702 and identified as mandatory/serious or conditional/serious (with met conditions) in the

FROI/SROI Guides or where error code 39 applies to data elements listed in section 9702 and identified as mandatory or conditional (with met conditions) data elements in the Medical Bill Payment Guide. This is consistent with the “data quality criteria” described in section G of the WCIS FROI/SROI Implementation Guide.

Consider clarifying how this “no match on database” error for a medical bill payment record must be corrected. If the medical report is accurate, the error that must be corrected is actually the absent FROI/SROI report(s), and it would be helpful to clarify whether or not the medical report must be re-submitted after submitting the appropriate FROI/SROI report(s).

§9705.1 Investigation and Assessment of Administrative Penalty Issued Pursuant to Labor Code section 138.6.

(a) **On a periodic basis, no less than two times but no more than four times per year,** WCIS will provide ~~to~~ claims administrators **and trading partners with quarterly a** data quality reports, which will identify data reporting errors that are subject to ~~an~~ assessments of administrative penalties under section 9705. The data quality reports shall identify the electronic report or reports that are subject to an assessment and indicate the specific violations in section 9705 that are associated with the reports.

Provide quarterly data quality reports to claims administrators and trading partners. Providing data quality reports to claims administrators and trading partners quarterly will educate submitters and claims administrators, and will accelerate and improve compliance.

(g) On or before October 1 of each calendar year, the Administrative Director shall issue a Notice of Penalty Assessment to claims administrators with identified violations of section 9705 during the previous calendar year. The Notice of Penalty Assessment shall consist of:

(8) The information that the Administrative Director plans to post on the DWC web site.

Identify on the notice the information that the Administrative Director plans to post on the DWC web site so that the claims administrator has the opportunity to challenge or correct that information.

(i) A conference to discuss the Notice of Penalty Assessment shall be scheduled, if necessary requested, within twenty-one calendar days from the issuance of the notice.

Replace “necessary” with “requested.” If a conference is not requested, it will not be necessary. If this change is not adopted, language is needed to describe how to determine whether or not a conference is necessary.

(k) After the time for making payment or requesting reconsideration, and after final determination of any request(s) for reconsideration, The the Administrative Director shall post on the website for the Division of Workers' Compensation an annual report disclosing the compliance rates of claims administrators for the previous calendar year.

Clarify that the report will be posted after the time for payment or requests has ended and after final determination of any requests for reconsideration.

Consider also including information on where to send payment.

California EDI Implementation Guide for First and Subsequent Reports of Injury (FROI/SROI) Version 3.1

Section A

Section E – Legal Authorities references the WCIS regulations.

Delete this verbiage from page 3. It appears to be inadvertently misplaced.

Section D

Retain the Labor Code language as it is a convenient reference for users and will help ensure compliance.

Section G

Revise the standards in the second bullet on page 38 in the Data Quality Criteria section so that it conforms to standards in section 9705.1, or vice versa.

WCIS automatically monitors the quality of data received from Trading Partners during the Pilot and Production phases. The system tracks all outstanding errors and produces

automated data quality reports. The Division provides ~~annual~~ **quarterly** data quality reports to each Trading Partner and claims administrator ~~upon request~~.

Revise on page 44 the frequency of data quality reports from annual to quarterly, and remove “upon request.” This will educate submitters and claims administrators, on the requirements and will accelerate and improve compliance.

Section K (and subsequent sections)

Retain the conditional status for DN 5 – Jurisdiction/Agency Claim Number. Claims administrators utilize the claim number as their primary identifier. The WCIS Unit can continue to crosswalk from the claims administrator’s claim number and other identifiers except when this information is missing. Requiring claims administrators to report a 22-digit number assigned by the DWC for its own purposes is unnecessary and contrary to specific commitments not to do so made by DWC management representatives.

Section N

Retain the FROI and SROI alphabetical data element tables as they are helpful and convenient for users and will help ensure compliance.

Section N

Retain the code lists as they are convenient references for users and will help ensure compliance.

Peggy Thill, Claims Operations Manager
State Compensation Insurance Fund

April 29, 2013

9705 Administrative Penalty Schedule for LC Sec. 138.6

Section 9705 (d) (2)

Comment: Allowing up to 60 calendar days instead of 30 calendar days is consistent with the time allowed in section G of the WCIS FROI/SROI Implementation Guide.

Recommendation: Increase the time frame to sixty (60) calendar days as adequate time to correct and resubmit a previously rejected report.

Steven Suchil, Assistant Vice President
American Insurance Association

April 29, 2013

Introduction

We are in general agreement with the proposed regulations and concur with the Division's goal of increasing compliance in mandated reporting to the Workers' Compensation Information System. We do have several concerns with some of the specific language of the proposal, as provided below.

Suggestions for added language are highlighted and shown with underline and deletion with ~~strikethrough~~.

Section 9705

Section 9705 (b) provides that penalties will be waived, in whole or in part, if the reporting failure is due to a system failure caused by, or affecting, the Division of Industrial Relations.

It is unclear how these failures will be reported to the Trading Partner, and we are concerned that some less sophisticated systems may be unable to track these instances. Section 9705.2 (b) (1) includes WCIS failure, in whole or in part, as a qualification for reconsideration of a penalty. We believe there needs to be an addition here, or in Section 9705.2 (b) (1), as to how this failure will be reported to the Trading Partner so that any necessary documentation can be presented, if necessary.

Section 9705.1

Section 9705.1 (a) states that WCIS will provide data quality reports to Claims Administrators two to four times per year.

We suggest that the regulation require WCIS to transmit these reports four times per year. We see these reports as potential training tools that may speed compliance and the provision of more reliable data to the WCIS.

In subdivision (c) we are somewhat concerned about the disparate sources the Division is planning to use to determine if all claims have been reported. It seems that this could lead to greater error than choosing a single checkpoint.

Section 9705.2

Subdivision (b) (4) states

A clear showing that the violation or violations for which administrative penalties are assessed under section 9705 was based on the reporting of a data element that was not available to the claims administrator.

We ask that a description of what “a clear showing” would constitute be added in the proposed rule. This would provide clarity regarding the information Trading Partners must collect.

Subdivision (b) (8) provides:

A clear showing that the claims administrator experienced an unexpected, unintended system failure that prevented the submission of timely and accurate electronic reporting to WCIS.

As above, we ask that a description of what “a clear showing” would constitute be added in the proposed rule to provide clarity regarding the information Trading Partners must collect.

California EDI Implementation Guide for First and Subsequent Reports of Injury (FROI/SROI) Version 3.0 3.1

We recommend the following change under Data Quality Criteria, on page 38:

Of the accepted reports ($\geq 95\%$ of transmitted reports), no more than ~~10~~5% contain errors (Application Acknowledgment Code = TE or “accepted with errors”). This is the same as saying that at least ~~90%–95%~~ of the accepted reports are free of any errors in mandatory/serious or conditional/serious data elements.

Under Data Quality Reports, on page 44:

WCIS automatically monitors the quality of data received from Trading Partners during the Pilot and Production phases. The system tracks all outstanding errors and produces automated data quality reports. The Division provides annual data quality reports to each Trading Partner and claims administrator upon request.

We recommend that the word annual be changed to conform with the proposed two to four times per year reporting found in the regulation.

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

April 29, 2013

Due to the volume of medical bills that we process, we routinely receive bills that do not conform properly to Division reporting requirements. In the past, when we have submitted such bills to the state, they have likewise routinely been rejected on the WCIS side. Seeing as the new rules may now subject us to a penalty, we are questioning which bills may **legitimately** be excluded from California reporting that will **not** result in a penalty being incurred.

Examples of such bills include:

- i. Bills submitted to us by the providers that are *incomplete* (missing key data elements, *etc.*)
- ii. Bills submitted to us that contain *invalid information*
- iii. Bills that are submitted to us on the *incorrect billing forms*

While we are aware that subsection (b) of proposed Section 9705 does contain exception language for failure to comply "...due to a system failure caused by or affecting the [DIR]...", we would request that the rules be amended to specify situations, such as those outlined above, where either (1) exclusion is deemed proper, and/or (2) due consideration is given for payers who, through no fault of their own, are submitting bills that are lacking the required data elements as specified by the Division.

Please advise if DIR will commit to a 24-48 hour turn around time for medical bill file processing. Timely and reliable file processing is a critical step in the reject correction/resubmission process.

FROI vendors and medical bill vendors are not typically the same entity. Please clarify expectations re: TE errors. CA documentation currently says that bills with ack record of TE are "transaction accepted with errors".

Is CA expecting the MBR vendor to coordinate TEs with client/third party in order to resolve? MBR vendors do not have any control over FROIs.

Is CA expecting MBR vendors to resubmit medical bill records with ack record of TE until they have an ack record of "TA"? Or will CA resolve the error internally once the FROI is sent?

Please provide clarification on medical bill reporting timelines.

CA code of regulations (<http://www.dir.ca.gov/t8/9702.html>)states that *"The claims administrator shall submit the data within **ninety (90) calendar days** of the medical bill payment."*

However, the penalty document references two other timelines for rejected bills - 30 days (for bills with ack code TR) and 60 days (for bills with ack code TE).

Does this mean the claims administrator has the full 90 days referenced in the CA code of regulations, plus another 30 (or 60) days, to successfully submit a bill?

Or does the timeline for bills with ack code TR(30 days) or TE(60 days) supercede the timeline referenced in the CA code of regulations (90 days)?

Janice Bell, Asst. Vice President, Corporate Claims – EDI
Zenith Insurance Company

April 26, 2013

- Section 9705-(c)(3) imposes a \$100 penalty for failure to timely submit, on a claim, an electronic subsequent report of injury (MTC=AN) under Section 9702(g) or what is otherwise referred to as an Annual Report. This item appears to be a new addition to the proposed penalty regulations. We would like the DWC to consider extending the deadline for submission of Annual Reports from January 31 to February 28 of each year if the submission of an Annual Report is to be the basis for a violation subject to penalty. Based on past years' experience, the WCIS has limited the number of transactions that can be submitted in one day, requiring submitters to parse their files and submit multiple files over a period of about two weeks for large volume filers. Additionally, January is a month requiring many insurers to produce large reports and files for year-end reporting, placing a strain on IT resources.
- Section 9705-(e)(5) imposes a \$50 penalty for failure to correct and resubmit to WCIS within 60 calendar days after receipt of an acknowledgement message, the following error codes on a Medical Bill Payment Record with a date of injury on or after March 1, 2000, and a transaction accepted with ("TE") error ("TE") code: No Match on Database; Error code 039.. This item appears to be a new addition to the proposed penalty

regulations. We would like to point out that receipt of an error code of “No Match on Database” for a Medical Bill Payment Record with a date of injury on or after March 1, 2000, is more often than not attributable to a deficiency in the DWC database and not as a result of a reporting error.

- Section 9705.1-(f)(1)(C) and (D) should be revised to take into account that reports are often resubmitted and errors corrected. See suggested language below.

C) Electronic reports that are submitted but rejected (acknowledgement code “TR”) during the previous calendar year and **are not timely resubmitted** are exempted from resubmission in section 9705(d)(2)(A)

D) Electronic reports that are accepted with an error (acknowledgement code “TE”) during the previous calendar year and **are not timely resubmitted or corrected.**

Malia Burrow, EDI System Analyst
Nordstrom Risk Management

April 25, 2013

A handful questions/concerns...

1. Can you provide more information on how the Annual Report of Inventory will be used to determine whether a claims administrator has failed to submit a mandatory electronic report, submitted a mandatory electronic report that was not accepted, or failed to timely and accurately submit a mandatory electronic report?

There's known differences in ARI's vs. WCIS (EDI) Ind & Med counts, so I'm curious as to which/how/when the ARI counts will be used.

2. Can you confirm that the annual report disclosing the compliance rates, will **ONLY** be posted **AFTER** the claims administrators have had the opportunity to **review & resolve** any errors with the report?
3. In the regulations, on the first page (138.6. (b)), it says (sum up) all or part of penalties assessed due to a system failure on the State's end, will be waived. How will these reports be identified/logged?

Will any late reason codes (DN0077) exclude the FROI/SROI from the penalty review?

I.e. E4-Error(s) from State; L4-Late Notification, State; or L8-Technical Processing Delay/Computer Failure

4. In the EDI Implementation Guide, it says the FROI & SROIs are due within 10 or 15 business days. Are the holidays posted by DLSE (<http://www.dir.ca.gov/dlse/StateHolidays.html>) **ALL** considered non-business days?

Char Wilber, Workers' Compensation Analyst III
Shasta County Risk Management

April 24, 2013

I realize there are carriers still out there who are not reporting. There is no training provided on how to report or what to do in certain circumstances except to read the manual, yet the state proposes to impose penalties for reporting errors. The EDI manual can be a bit confusing and each computer system is different to know what field is causing the error. Certain fields need to be populated or it will create an error when transmitted. I can understand imposing penalties to those entities who are not reporting, but for those of us who are reporting and have been reporting since 2000, there should be a grace period for everyone and there should be training available on an annual basis where people can get hands on training and ask questions.

George Poulin, Manager
Systems Regulatory Data Management
Liberty Mutual Insurance Company

April 24, 2013

Penalty Regulation:

Question #1) Penalty Regulation reads in part: "The total amount of penalties assessed against a claims administrator in a calendar year shall not exceed \$5,000.00. "

What's the DWC definition of a Claim Administrator for the purposes of this penalty regulation? Does the definition apply equally to WC Carriers, Third Party Administrators and Self-Insured/Self-Administered Employers?

WC Carriers underwrite business with different underwriting company Insurer Names and FEINs and may report EDI with that underwriting company Insurer Name/Insurer FEIN. Is the overall parent Insurance Company of all these underwriting companies considered as 'one' Claim Administrator for the purposes of this penalty regulation with a maximum penalty

exposure of \$5000.00 per year vs. each individual underwriting company exposure of \$5000.00 per year?

Third Party Administrators handle claims for other insurance companies with many underwriting companies and for self-insured employers. Are the penalties applied to the Third Party Administrator as the 'one' Claim Administrator for the purposes of this penalty regulation or assessed against each underwriting carrier/self-insured employer individually handled by the Third Party Administrator?

Question #2) §9705.1 Investigation and Assessment of Administrative Penalty Issued Pursuant to Labor Code section 138.6.

(a) On a periodic basis, no less than two times but no more than four times per year, WCIS will provide to claims administrators a data quality report, which will identify data reporting errors that are subject to an assessment of administrative penalties under section 9705. The data quality report shall identify the electronic report or reports that are subject to an assessment and indicate the specific violations in section 9705 that are associated with the reports.

In my opinion this regulation should spell out the specific criteria, logic, data fields, measurements for each individual EDI Report Type, if the criteria changes by Report Type, the DWC will use to identify and assess a penalty on those EDI reports. We should have the opportunity to review and provide feedback.

Question #3) (f) (1) Administrative penalties under section 9705 will not be assessed against a claims administrator on the first 5% of each of the following types of violations:

- (A) Electronic reports that are not submitted.
- (B) Electronic reports that are not submitted within the timeframes established in section 9702.
- (C) Electronic reports that are submitted but rejected (acknowledgment code "TR") during the previous calendar year and are not exempted from resubmission in section 9705(d)(2)(A).
- (D) Electronic reports that are accepted with an error (acknowledgment code "TE") during the previous calendar year.

Seeking clarification – is the 5% the total number violations of A,B,C,D combined or 5% applied to each category individually (A,B,C,D)?

Question #3a) (D) Electronic reports that are accepted with an error (acknowledgment code "TE") during the previous calendar year.

Reports with a “TE” should not be included as a violation or a measurement criteria for a violation – TE means Transaction (i.e. Report) Accepted with errors. A report with a TE has met the statutory reg for submission. I am in EDI production with 30 other jurisdictions and I am not aware of any of those jurisdictions assessing fines/penalties for reports with TE error codes.

Version 3.1 Implementation Guide:

DN 39 Initial Treatment: This is being changed from “O” – Optional to “M/S” Mandatory/Serious– why? In my opinion the quality and accuracy of this data field will be poor if claim administrators are required to provide it on the FROI. For most newly reported claims we have little or mostly no medical information to accurately report this data field.

What does the DWC intent to use this data field for exactly? The WCIS already receives millions of medical bill records from the carriers today why can’t the DWC access whatever medical drivers its looking to review internally from the WCIS medical bill database?

DN 56 Initial Date Disability Began: In Release One there’s only one data element for Date Disability Began – its used for the “Initial” Date Disability Began on the claim and never changes over the life of the claim. DWC correctly defines the FROI Date Disability Began but requires a “moving” Date Disability Began for the SROI – this is inconsistent. If the DWC wants the Date Disability Began to re-set for each new/subsequent disability period it must adopt IAIABC Release 3 which has both the Initial Date Disability Began and the Current Date Disability Began which is intended to change for each subsequent period of disability.

For Release One our claim systems capture one and only one Date Disability Began – and it doesn’t change for subsequent period of disability. Another side note – what kind of havoc would a single ‘moving’ Date Disability Began have on all our/DWC date logic edits?

FROI:

SROI:

DN 74 Claim Type: Why is this being changed from “O” – Optional to “M/F” Mandatory/Fatal? What is the DWC plans for this data field?

Cindy Hall
Compliance Manager
Aon eSolutions, Inc.

April 22, 2013

I've reviewed the proposed penalty regulations and EDI Implementation Guide changes.

I have no comments on the penalties regulations.

I noted a discrepancy related to SROI MTC FN in the EDI Guide. The SROI MTC list on page 52 indicated

FN#	Claim is closed. <u>Required on all claims, indemnity and non-indemnity.</u>	<u>Within 15 business days of event</u>
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And also noted FN required for ALL claims at

California EDI Implementation Guide for First and Subsequent Reports of Injury (FROI/SROI)

Appendix A

Differences Between Version 3.0 and Version 3.1 of WCIS

14. The FN is now required for all closed claims, indemnity and non-indemnity.

HOWEVER~~~Section M, page 97 states FN is **not** required on non-indemnity claims

MTC Code	MTC Name
AN	Annual

For non-indemnity claims, i.e., claims without indemnity payments, a sufficient final report would be the Annual transaction (AN) with the Claim Status (DN73) set to “closed”. A Final transaction (FN) need not be sent.

Jeffrey Gaines

April 17, 2013

If you read the Audit reports, the carriers are underpaying indemnity to the tune of \$176,000,000. Yet you want to take it easy on the carriers and limit the fines to \$5000.00 per adjuster.

Explain this.
