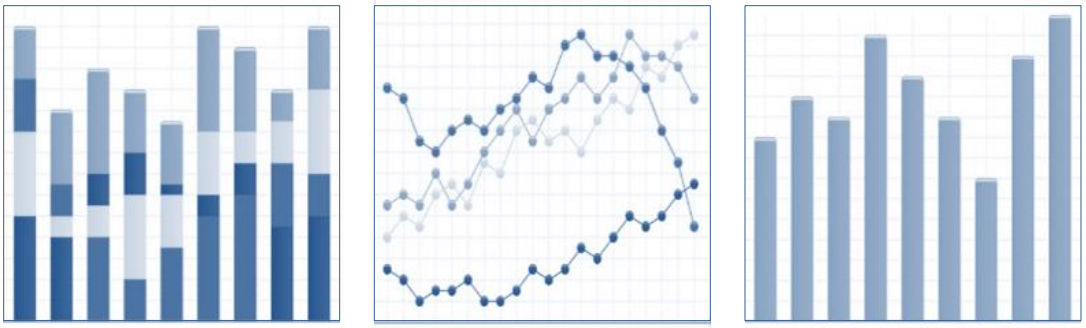
Workers' Compensation Insurance Rating Bureau of California®



WCIRB Medical Transaction Data Quality Program

January 2019

WCIRB California®
Objective. Trusted. Integral.

Notice

This *WCIRB Medical Transaction Data Quality Program* was developed by the Workers' Compensation Insurance Rating Bureau of California for the convenience and guidance of its members. It does not bear the official approval of the California Department of Insurance and is not a regulation.

Table of Contents

Our Mission

The WCIRB is California's trusted, objective provider of actuarially-based information and research, advisory pure premium rates, and educational services integral to a healthy workers' compensation system.

1221 Broadway
Suite 900
Oakland, CA
94612

Voice 415.777.0777
Fax 415.778.7007

www.wcirb.com
medicaldata@wcirb.com

I. Introduction

In order to meet the WCIRB's ratemaking needs and respond to California Department of Insurance directives, the Workers' Compensation Insurance Rating Bureau of California (WCIRB) has facilitated the collection of medical transaction data in California. The *WCIRB Medical Data Call Reporting Guide* (Guide) outlines the general rules, medical data call structure, record layouts, data dictionary, reporting rules, editing and other validation procedures pertaining to the reporting of California medical transaction data to the WCIRB.

This *WCIRB Medical Transaction Data Quality Program* (Program) is intended to promote the timely, complete and accurate submission of California medical transaction data (Medical Data Call) information to the WCIRB inasmuch as this data will be used for research and medical cost trend analysis and to enhance pure premium ratemaking. Analogous to other WCIRB data quality programs, insurers are subject to monetary fines and other administrative action for failure to submit data or for failure to address documented data quality reporting issues in a timely manner.

II. Program Administration

A. Eligibility

The Program is administered on a calendar quarter basis and applies to production Medical Data Call submissions made in accordance with the rules in the Guide.

The Guide defines the eligibility and reporting requirements for submission of medical transaction data. Eligibility to report the Medical Data Call is determined based on the insurer group structure designated by the National Association of Insurance Commissioners (NAIC). These NAIC groups may elect to report the data in separate sub-groupings, referred to in this Program as "Insurer Groups." All NAIC Groups that are required to report the Medical Data Call are subject to this Program.

An Insurer Group must complete testing and receive certification approval from the WCIRB to submit Medical Data Call production files no later than one year from the date of notification of eligibility. If the Insurer Group fails to meet this deadline, or if the Insurer Group is not on track to meet this deadline, the Insurer Group must meet with the WCIRB to detail the specific reasons for the delay and receive WCIRB approval of a written plan and time frames by which certification testing will be completed and the submission of Medical Data Call production files will commence. If the Insurer Group fails to timely meet with the WCIRB and obtain approval of a written plan, or if the time frames in the written plan approved by the WCIRB are not met and the Insurer Group's Medical Data Call submissions are not provided as detailed in the approved plan, the Insurer Group will be subject to fines as described in Section III, Part D, *Timeliness of Submissions Fines and Credits*.

B. Insurer Group Results

The WCIRB will provide Insurer Groups with a quarterly Medical Transaction Data Quality Notice that summarizes the submission timeliness for the reporting quarter as outlined in Section III, *Timeliness of Submissions.* This Notice also includes a summary of any open Medical Data Inquiries as outlined in Section IV, *Quality of Data*.

One month following the issue date of the Medical Transaction Data Quality Notice, each Insurer Group will receive a Fine and Credit Notice showing any quarterly fine imposed or incentive credit given for submission timeliness as outlined in Section III, Part D, *Timeliness of Submissions Fines and Credits*, and any fines for Medical Data Inquiry response timeliness as outlined in Section IV, Part C, *Medical Data Inquiry Fines*, subject to the annual maximum fine amount as outlined in Section V, *Maximum Annual Fines*. Fines are levied against, and incentive credits are applied to, the Insurer Group as a whole and not the individual insurers within the Insurer Group.

III. Timeliness of Submissions

A. Expected Files

The Due Date for quarterly Medical Data Call submissions is the last calendar day of the following quarter. The timeliness of an Insurer Group's submissions is evaluated based on the WCIRB's expectation of the minimum number of files, referred to herein as Expected Files, to be submitted by the Due Date each calendar quarter.

In order for the WCIRB to be certain that all of the data for a quarter has been received, Insurer Groups are expected to maintain a consistent file submission frequency and to advise the WCIRB if they are changing their submission frequency (e.g., from quarterly to monthly). An Insurer Group meets the criteria for timeliness if all of the Expected Files are received and successfully processed on or before the Due Date. A file is considered successfully processed if it completes the File Acceptance stage of editing, as described in Section 7 of the Guide and in the California Medical Data Call Edit Matrix (Edit Matrix).[1] If a file does not pass the File Acceptance editing stage, an email notification is sent to the designated Insurer Group and/or Medical Data Submitter (Submitter). If a file completes the File Acceptance stage, a File Submission Report is provided to the designated Insurer Group and/or Submitter.

A Submitter is a unique data reporting entity authorized by means of a "Consent to Use Third Party Entity and Agreement to Indemnify" to send Medical Data Call information to the WCIRB on behalf of an Insurer Group. Insurer Groups may have one or more Submitters, and each Submitter must elect to report the data with either a monthly or quarterly frequency. This means that monthly Submitters submit a minimum of three files per quarter and quarterly Submitters submit a minimum of one file per quarter. Submitters may also segregate the data into separate files based on data source — by insurer, network vendor, billing system, third party claims administrator or any other identifiable data source. However, the number of files submitted should be consistent over time; any changes to the expected number of files should be promptly communicated to the WCIRB.

Example

ABC Insurer Group has only one approved Submitter and has elected a monthly reporting frequency. For the 1st Quarter reporting period, the Submitter creates a file containing January transaction data and submits the file in early February. One month later, the Submitter creates a file containing February transaction data and submits it in early March. One month after that, the Submitter creates a file containing the March transaction data and submits it in early April. The WCIRB records the total number of Expected Files for this Insurer Group as three.

[1] File Acceptance stage edits determine if the basic structure and format of the file are correct and all required fields that are necessary for the WCIRB to be able to process the file have been reported. These edits also verify the record length is correct and that the Electronic Transmittal Record and File Control Record are in the proper positions in the file. Relational edits check that the values reported for the required fields are acceptable and will reject records that do not meet the criteria. If the percentage of records in the file does not meet a minimum standard of edit failures as outlined in the Guide, the entire file is rejected and does not pass the File Acceptance stage, and the Insurer Group will receive an email notification that the file is rejected. If this minimum standard is met, records with invalid key fields will still be returned, but the file will be accepted and the Insurer Group will receive an email notification with a File Submission Report. All files that complete the File Acceptance stage of editing will be considered accepted, regardless of the results of the edits included in the File Submission Report.

B. Exception Files

Insurer Groups may have valid business reasons to submit more than the minimum number of Expected Files each quarter. These files may not follow the same monthly or quarterly submission frequency as an Insurer Group's Expected Files. When these files, referred to herein as Exception Files, are received, they are not counted toward fulfilling the corresponding Insurer Group's expected quarterly file count to evaluate the timeliness of submissions. Examples of Exception Files include:

- Replacement files; File Control Record's File Type = 'R'
- Deleted files
- Files only containing Replacement and/or Cancellation transactions to correct data reporting errors
- Files only containing previously rejected records that have been corrected for resubmission
- Rejected files
- Clearly erroneous data submitted for the purpose of meeting the scheduled Due Date
- Other files the WCIRB determines are not expected based on the Insurer Group's historical submissions or based on information received from the Insurer Group

C. Insurer Group Notifications

Approximately two weeks prior to the Due Date, the WCIRB will notify an Insurer Group if any Expected Files have not been received and successfully processed. The notification will include a timeliness summary that indicates the total number of Expected Files for the quarter, the number of files that have been received and successfully processed to date, and the outstanding number of files the WCIRB expects to receive by the Due Date.

The quarterly Medical Transaction Data Quality Notice prepared after the Due Date will be sent to all Insurer Groups whether or not all Expected Files have been received. This Notice will provide the submission timeliness information available to date and indicate if an Insurer Group may be subject to fines pursuant to Part D, *Timeliness of Submissions Fines and Credits*.

D. Timeliness of Submissions Fines and Credits

1. Fines

Fines for Timeliness of Submissions will be $250 per business day, beginning on the sixth business day following the Due Date, until all Expected Files are received and successfully processed.[2] (Fines for failure to respond to a Medical Data Inquiry on a timely basis, as described in Section IV, Part B, Medical Data Inquiries, will be incurred in addition to any fines for failure to adhere to the Timeliness of Submissions criteria.)

If all Expected Files are not received and successfully processed within 90 calendar days from the Due Date and the Insurer Group has not made a good faith effort to request an extension from the WCIRB, the Insurer Group may be subject to administrative action – up to and including citation to the WCIRB Classification and Rating Committee.

Fines for Insurer Groups that fail to obtain certification approval from the WCIRB to submit production data within one year from the date of notification of eligibility, as described in Section II, *Program Administration*, Part A, *Eligibility*, are as follows:

[2] A brief extension to the Due Date may be granted under special, limited circumstances, provided the request for an extension is made in writing by the insurer to the WCIRB on or before the Due Date and the extension does not have a significant impact on the WCIRB's research needs. All extensions are subject to written pre-approval by WCIRB staff. If an approved extended Due Date is not adhered to, the Insurer Group will be subject to fines accruing from the original Due Date.

(a) Fines for failure to obtain WCIRB approval of a written plan within 45 calendar days from the later of: (i) the one-year deadline, or (ii) the WCIRB's request for a written plan, will be $250 per business day, beginning on the first business day following the 45 calendar day deadline, and will continue until the Insurer Group obtains the WCIRB's approval of a written plan.

(b) Fines for not meeting the plan's approved time frames will be $250 per business day, beginning on the first business day after the missed deadline, and will continue until the Insurer Group completes certification testing and Medical Data Call production files are received and successfully processed by the WCIRB.

2. Credits

For each calendar quarter, if the WCIRB receives all Expected Files and they are successfully processed on or before the Timeliness Incentive Credit Submission Deadline (see below), the Insurer Group shall receive a Timeliness Incentive Credit of $1,000. Timeliness Incentive Credits are subject to a non-refundable maximum accumulated credit balance of $7,500 that can be used only to offset fines levied pursuant to this Program.

Timeliness Incentive Credit (Per Quarter)	Timeliness Incentive Maximum Credit Balance
$1,000	$7,500

To receive the Timeliness Incentive Credit, an Insurer Group must submit all Expected Files for the calendar quarter by the quarterly deadline listed in the following table. The Timeliness Incentive Credit Submission Deadlines are calendar days and are not adjusted for weekends or holidays.

Quarter	Timeliness Incentive Credit Submission Deadline
1	May 15
2	August 15
3	November 15
4	February 15

The Timeliness Incentive Credit is not applicable if the WCIRB determines that the Insurer Group's data for the quarter was not complete or accurate pursuant to Section IV, Part A, *Data Evaluation*.

IV. Quality of Data

A. Data Evaluation

An Insurer Group's submissions are evaluated for completeness and accuracy based on the WCIRB's analysis of the Insurer Group's data as compared to industry averages or to the Insurer Group's previously reported data. If an Insurer Group's data indicates that a potential data quality issue exists and the WCIRB has not previously received an explanation from the Insurer Group, the WCIRB may send the Insurer Group a Medical Data Inquiry as described in Part B, *Medical Data Inquiries*.

1. Evaluating Data Completeness

Medical Data Call submissions are evaluated to determine if various categories of data have been reported in their entirety. The quarterly data can be analyzed to validate, for example, that transactions have been reported for all insurers within an Insurer Group or that transactions have been reported for all Paid Procedure Code types listed in Section 5 of the Guide. Before determining if a potential data completeness issue exists, the WCIRB's evaluation will include an analysis of data previously reported by the Insurer Group as well as a review of previous communications from the Insurer Group to determine if the issue has already been addressed.

2. Evaluating Data Accuracy

Medical Data Call submissions are evaluated for accuracy by analyzing fluctuations in the pattern of an Insurer Group's historical reported data as well as comparing with industry averages. The quarterly data can be analyzed to validate, for example, that there is a reasonable distribution of transactions amongst all of the Paid Procedure Code types or that there are reasonable distributions of transactions reported for each accident year with open claims. The WCIRB may also compare the reported medical transaction data with data reported on WCIRB aggregate financial data calls to look for anomalies in the data reported. The WCIRB will analyze the Insurer Group's historical data reported and any previous communications from the Insurer Group to determine if further information from the Insurer Group is needed.

B. Medical Data Inquiries

A Medical Data Inquiry (Inquiry) will be sent to an Insurer Group if a potential data quality issue is identified that may have a significant impact on the WCIRB's ability to conduct research using the medical transaction data submitted. (Inquiries will not be sent for data quality issues that are able to be addressed or resolved expeditiously through informal and routine communication with the WCIRB Medical Data Call team.) Inquiries will include a description of the potential data quality issue, the evaluation criteria used to identify the issue, and the WCIRB's expectations for submitting corrections to the data, if necessary.

Insurer Groups must provide a timely, complete and satisfactory response to an Inquiry. In order to be considered timely, the response must be received within 60 calendar days of the date of Inquiry.[3] A complete and satisfactory response must include (a) identification and submission of any potential

[3] If necessary, Insurer Groups may request additional time to prepare a response, provided the request is received prior to the due date for the response to the Inquiry. All extensions are subject to written pre-approval by WCIRB based on the specific circumstances as well as the significance of the data issues. If an approved extended response due date is not adhered to, the Insurer Group will be subject to fines accruing from the original response due date.

missing data, (b) a valid, fully documented business reason that the Insurer Group's data is complete and accurate as reported, or (c) a written plan to address any significant data reporting deficiency identified in the Inquiry that includes a schedule for remediation.[4]

The WCIRB may also request that an Insurer Group provide additional supporting documentation, if necessary, to substantiate the response. The WCIRB will review the response based on the validity and reasonableness of the information provided by the Insurer Group. If a response is submitted timely and approved as complete and satisfactory by the WCIRB and any applicable remediation efforts outlined in the response to the Inquiry are satisfactorily completed, the data quality issue will be closed and no further action will be required by the Insurer Group.

C. Medical Data Inquiry Fines

Insurer Groups that fail to provide a complete and satisfactory response to an Inquiry, as outlined in Part B, within 60 calendar days of the date of Inquiry shall be subject to a fine of $2,500. At that time, the WCIRB will send the Insurer Group a Fine and Credit Notice indicating that additional fines may be imposed, beginning 30 calendar days after the Fine and Credit Notice, if the Insurer Group does not provide the previously requested response.

If the missing data or a complete and satisfactory response is not received within 30 calendar days after issuance of the Fine and Credit Notice or the Insurer Group fails to resolve the identified data reporting deficiency within the timeframes specified in the response to the Medical Data Inquiry,[5] the Insurer Group shall be subject to an additional fine of $100 per business day until a complete and satisfactory response is received.

The WCIRB may request an Insurer Group with significant medical transaction data reporting deficiencies to meet with the president of the WCIRB or his/her designated WCIRB staff representative to outline remedial measures to resolve the data reporting deficiencies.

V. Maximum Annual Fines

The total fines levied pursuant to this Program will be limited to a maximum of $100,000 per calendar year.

[4] An Insurer Group may later revise the schedule for remediation indicated in a response to an Inquiry subject to the approval of WCIRB staff if they are demonstrating a good faith effort to address the data quality issues and the nature of the data issues is not having a significant impact on the WCIRB's research efforts.

[5] Requests to extend the scheduled date to complete the resolution of data reporting deficiencies stated in the Insurer Group's response to the Inquiry are subject to WCIRB approval based on the progress being made by the Insurer Group as well as the criticality of the data issues for WCIRB research purposes.

VI. Appeal Procedures

An Insurer Group may file an appeal with the WCIRB regarding fines or other administrative actions imposed pursuant to this Program, provided that such appeal is submitted, in writing, with a detailed explanation as to the reason the Insurer Group believes the fines imposed or other administrative action taken by the WCIRB is not appropriate. An appeal of a fine must be filed with the WCIRB within 45 calendar days from the date of the Fine and Credit Notice which imposes the fine. An appeal of an administrative action must be filed with the WCIRB within 45 calendar days of the date of notification of the action.

All appeals, including all appropriate documentation supporting each appeal, must be emailed to medicaldata@wcirb.com. Specify "Appeal of WCIRB Medical Transaction Data Quality Program Fines" in the subject line.

The WCIRB will acknowledge an appeal within 15 calendar days of receipt of the appeal and will have 30 calendar days from receipt of a timely-filed appeal to respond. If the Insurer Group disagrees with the WCIRB's response to the appeal, the Insurer Group may appeal the WCIRB's response to the WCIRB Classification and Rating Committee. All appeals to the WCIRB Classification and Rating Committee must be submitted within 45 calendar days of the WCIRB's response to the initial appeal.

WCIRB California®
Objective. Trusted. Integral.

1221 Broadway, Suite 900
Oakland, CA 94612

Voice 415.777.0777
Fax 415.778.7007

www.wcirb.com
wcirb@wcirb.com