A REPORT BY THE NEW YORK STATE OFFICE OF THE STATE COMPTROLLER

Alan G. Hevesi
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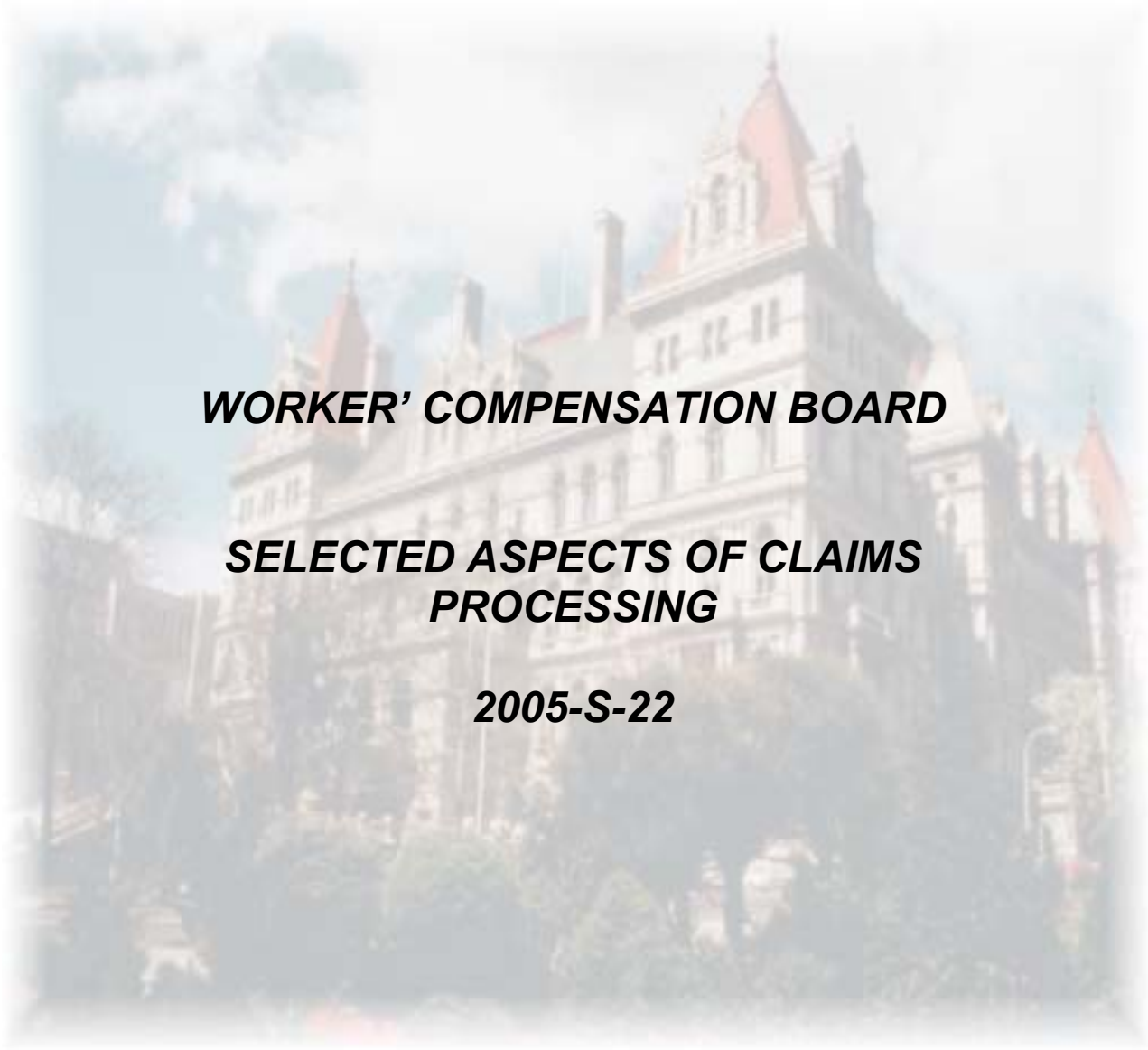

WORKER' COMPENSATION BOARD

SELECTED ASPECTS OF CLAIMS PROCESSING

2005-S-22

DIVISION OF STATE SERVICES

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Report 2005-S-22

Mr. David P. Wehner
Chairman
Workers' Compensation Board
20 Park Street
Albany, NY 12207

Dear Mr. Wehner:

The following is our audit report addressing selected aspects of claims processing of the Workers' Compensation Board.

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1, of the State Constitution; and Article II, Section 8, of the State Finance Law. Major contributors to this report are listed in Appendix A.

Office of the State Comptroller
Division of State Services

August 31, 2005

EXECUTIVE SUMMARY

WORKERS' COMPENSATION BOARD SELECTED ASPECTS OF CLAIMS PROCESSING

SCOPE OF AUDIT

Under the laws of New York State (State), employers are generally required to provide workers' compensation insurance coverage for their employees. This insurance covers eligible medical costs and payments in lieu of lost wages for employees unable to work because of a work-related injury or illness. Claims for these benefits are processed by the Workers' Compensation Board (Board), a State agency funded by assessments levied on workers' compensation insurers and self-insurers operating in New York.

During 2004, the Board opened about 318,000 cases, including both new claims it accepted and prior cases that were re-opened at the request of a claimant, carrier, or other interested party to address a possible change in the claimant's circumstances. The Board also closed out almost 330,000 cases during the same period. As a result of its efforts, the Board reduced the number of open cases by nearly 12,000 to about 138,000. Staffed with about 1,550 employees, working in a central office, 11 district offices, and 30 customer service centers, the Board relies heavily on electronic data processing systems to process claims.

Our audit addressed the following questions about the way the Board processed claims for the period of April 1, 2000 through January 31, 2005:

- Has the Board established performance parameters for measuring and monitoring selected aspects of the way it processes claims?

- Has the Board established adequate controls over its electronic data processing systems?

AUDIT OBSERVATIONS AND CONCLUSIONS

The Board uses an electronic case folder system called the Claims Information System (CIS) for tracking information on claimants. This system allows Board staff to enter electronic case notes and documents and record steps that are taken as a claim is processed, such as telephone conversations with claimants. As a result, any Board employee with access to the system may work

on a case and provide customer service. The Board has received numerous awards from state and national organizations, including *Computerworld's* Search for New Heroes Program, Aspect Communication's Customer Excellence Award, and *Network World's* 2003 User Excellence Award for its implementation of CIS and other related systems. We identified some opportunities for system improvements in the areas of case activity documentation, performance and payment monitoring, and controls over data.

We found that Board staff could make better use of the CIS case notes feature, particularly when there are delays in processing a case. We recommend that the Board remind staff of the need to document the reasons for delays in the descriptions of claims-processing activities that appear in case files. (See pp. 14-15)

Performance measures can help government agencies determine whether their resources are being deployed economically, efficiently, and effectively. The Board has developed a performance measurement system for claims processing and adjudication activities that can be used to monitor their timeliness against targets the Board has set. We found that monthly performance reports show when targets are not met, but they do not always indicate the reasons for such delays or specify the corrective actions to be taken. We recommend that the Board work with district managers to improve the way staff document both delays and corrective actions. (See pp. 16-17)

The Board needs to formally track the timeliness of initial compensation payments that employers and their insurance carriers make to claimants. Currently, the Board focuses primarily on its own claims-processing activities. However, State law both provides deadlines for the initiation of payments and specifies penalties that are to be assessed if those deadlines are not met. In our test of 24 cases in which payments were made, we found one case that was paid late, yet there was no evidence the $300 penalty called for in the Law had been assessed. We recommend that the Board electronically track the timeliness of initial compensation payments made to claimants and penalize late payers. (See pp. 17-18)

The Board maintains virtually all of its claims information in electronic data processing systems, which must be protected by strong internal controls. When we examined some of the controls in place, we found that improvements are needed. For example, the disaster recovery plan initiated in 2001 has not been completed. Without adequate backup, if any of the records were damaged or destroyed, claims processing and benefit payments could be delayed significantly. In addition, the issuance and retention of user IDs and passwords were not always handled appropriately. (See pp. 21-22)

Each month, the Board receives thousands of documents, each of which is scanned into the electronic case folder system. Most of these documents are filed in a claimant case folder. However, a small number are left in a pending

area of the system, because they cannot be filed immediately. We found several documents in this pending area that should have been either filed in an existing case folder or used to create a new case folder. When we brought this issue to their attention, Board officials developed a report that identifies these types of documents so that Board staff can assign them to the appropriate case folder. (See pp. 22-23)

COMMENTS OF BOARD OFFICIALS

A draft copy of this report was provided to Board officials for their review and comment. Their comments have been considered in preparing this report and are included as Appendix B. Officials indicated that they welcome the identification of recommendations that will assist them in achieving their mission.

CONTENTS

INTRODUCTION

Background

In New York State (State), the Workers' Compensation Law (Law) requires almost all employers to provide workers' compensation insurance coverage for their employees. Through this coverage, eligible employees who are unable to work because of a work-related injury or illness receive cash payments to replace their lost wages; and the related medical bills are paid by their employers' insurance carriers.

The workers' compensation program in New York is administered by the Workers' Compensation Board (Board), a State agency funded by assessments levied on workers' compensation insurers and self-insurers operating in the State. The Board receives and processes employees' claims for benefits, employers' reports of injury, and medical reports from health care providers. It is also responsible for adjudicating and resolving issues related to the claims.

The Board has 13 Commissioners, who are appointed by the Governor, by and with the advice and consent of the Senate, for 7-year terms. For the State's 2004-05 fiscal year, the Board had about 1,550 employees and an annual appropriation of $170.3 million for agency operations. The Board processes claims in 11 district offices: Albany, Binghamton, Brooklyn, Buffalo, Hauppauge, Hempstead, Manhattan, Peekskill, Queens, Rochester, and Syracuse. It also maintains 30 customer service centers across the State where hearings are held and where claimants may review their case files.

During 2004, the Board opened about 318,000 cases, including both new claims it accepted and prior cases that were re-opened at the request of a claimant, carrier, or other interested party to address a possible change in the claimant's circumstances. The Board also closed out almost 330,000 cases during the same period. As a result of its efforts, the Board reduced the number of open cases by nearly 12,000 to about 138,000. To handle this workload, the Board relies heavily on electronic data processing systems to process claims.

Audit Scope, Objectives, and Methodology

We audited the Board's processing of claims for the period of April 1, 2000 through January 31, 2005. Our audit covered selected aspects of the way cases are handled from receipt until resolution, the way performance is monitored, and the timeliness with which employers and insurance carriers make payments to claimants. The objectives of this performance audit were to determine whether the Board has established performance parameters for measuring and monitoring selected aspects of the way it processes claims and whether the Board has established adequate controls over its electronic data processing systems. To accomplish our objectives, we interviewed Board officials and reviewed applicable sections of State laws and regulations, as well as documents issued by the Board. We also reviewed Board records, visited district offices, and visited the Board's document conversion facility outside of Binghamton. We examined the Board's electronic case folder system, as well as the performance measurement system, reviewing random samples of forms used, cases processed, and reports produced.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to assess those operations which are included in our audit scope. Further, these standards require that we understand the Board's internal control structure and its compliance with those laws, rules, and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records, and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments, and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions, and recommendations.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally- and statutorily-mandated duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public

authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

Response of Board Officials to Audit

We provided a draft copy of this report to Board officials for their review and comment. Board officials generally agreed with our findings. Their comments have been considered in preparing this report and are included as Appendix B.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Chairman of the Workers' Compensation Board shall report to the Governor, the State Comptroller, and leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

SELECTED ASPECTS OF CLAIMS PROCESSING

According to the Law, employees who miss more than seven days of work due to work-related injury or illness are generally entitled to two-thirds of their average weekly salary times the percentage of their disability, up to a maximum of $400 per week. The Law also includes a schedule of compensation for permanent disability (total or partial) and for death benefits that are to be paid if an employee is fatally injured on the job.

When an employee is injured, the employee must notify the employer; in turn, the employer and its insurance carrier must notify the Board. A Board claims examiner is responsible for handling the case; monitoring its progress; and providing customer service to the claimant, the employer, the insurance carrier, and other interested parties.

Once a case has started, the employer or insurance carrier may controvert it (challenge the underlying claim). When liability has been established and the case goes forward, parties to a claim (employer, insurance carrier, employee, or other interested parties) may dispute the claim (challenge the facts). Generally, a case is disputed over an established fact that will affect the size of the payment to be made. At this point, the employer or insurance carrier has accepted the liability; the issue is the amount to be paid to the claimant and the period of payment.

Cases may be resolved by an administrative decision of the claims examiner, through a conciliation process, via a formal hearing, or simply without any Board intervention. Once a determination has been made and payments have begun, the claims examiner changes the case's status to "No Further Action." The Board does not close resolved cases, because cases may be reopened (due to a re-injury, for example).

During 2004, the Board resolved 330,000 cases, bringing its inventory of active cases down to about 138,000. To control so much information, the Board uses an electronic case folder system called the Claims Information System (CIS), which replaces traditional paper-based case folders with a database of

claimant information and electronic folders that can hold scanned documents. The Board has received numerous awards for CIS and related systems from state and national organizations, including *Computerworld's* Search For New Heroes Program, Aspect Communication's Customer Excellence Award, and *Network World's* 2003 User Excellence Award.

CIS was implemented in 2000 as part of the Board's Organization, Process and Technology Innovations in Customer Service initiative. Our review of CIS found some opportunities for improvement in the areas of case activity documentation, performance-monitoring, and making timely initial payments to claimants. Our findings are discussed further in the following sections.

Documentation of Case Activity

Each case folder within CIS contains all of the information related to that case, including scanned documents. Claims examiners and other Board staff can enter information such as the date and type of injury, contact information for parties involved in the case, the results of hearings, the amounts paid if benefits are awarded, and notes relating to the case. Authorized Board employees can use CIS to access cases, eliminating the need to send paper files from one location to another.

CIS has a case notes feature that allows Board employees to document pertinent actions taken and other key events. Some case notes are generated by the system when certain actions occur, such as the submission of a case to an administrative law judge for a hearing. Others are created by claims examiners and other Board staff to record case activity, such as telephone conversations with claimants, employers, medical providers, or other interested parties.

The case notes feature can be a valuable tool. When case activity is documented in case notes, the Board can use this information both for providing customer service on specific cases and for identifying problems that occur frequently. Alternatively, they may identify systematic problems and develop strategies for improving operational performance.

In January 2005, the Board provided us with a list of nearly 36,000 active cases that had been opened before January 1, 2003. (Many of them had been re-opened because the claimant's medical condition changed.) From this list, we drew a random sample of 25 and reviewed the case folder, including the case notes. Since the Board's goal is to resolve cases within 18 months, we sought to identify documented reasons that indicate why individual cases had been continued longer than that.

For 24 of the 25 cases in our sample, we found that the case notes were sufficient for determining the case history, including the reasons for delays. For example, one had a hearing in April 2004; but the next hearing was not held until December 2004, eight months later. The claims examiner noted a telephone call from the insurance carrier, requesting a specific administrative law judge for the subsequent hearing, because the case was complicated and the judge was already familiar with the issues involved; thus scheduling the next hearing took longer than usual. Another case had been resolved in 1999 and then re-opened nearly five years later, in early 2004. A revised award was made in December 2004, almost a year after the case was re-opened; but the case notes document efforts by the Board to arrange for an impartial specialist who was not a Board employee to determine the claimant's medical status. It took some time to schedule the specialist's visits with the claimant, and then to arrange for the specialist's appearance at a hearing.

Finally, one case in our sample had been re-opened in August 2004, with the first hearing held in January 2005. The claimant, who was receiving regular payments, had requested a review of the circumstances and a possible amendment of the award amount; but the claims examiner designated the case a "low priority" for scheduling a hearing. After the claimant called in October 2004 to inquire when the hearing would be held, it was scheduled for January 2005. The case notes did not sufficiently document the reason for the five-month gap between the re-opening of the case and the date of the hearing.

Supervisors should regularly review case folders to verify that staff are using the case notes, in accordance with the Board's policies and procedures. This review should include determining whether cases are progressing and whether the notes for late cases are sufficient to explain both the delays encountered and the actions taken.

Monitoring of Performance

In March 2000, the Board implemented its performance measurement system, known as the Management Information, Research, References and Operation Reports (MIRROR), for claims processing and adjudication activities. This system is used to generate about 60 different types of performance reports on various aspects of claims processing and adjudication activities by Board employees. MIRROR generates its performance reports from CIS data, such as the dates claims were received, case numbers were assigned, hearings were held before administrative law judges, and claims were resolved. The reports note how long it took to achieve the various milestones and compare those times with the targets set by the Board.

Each month, the automated MIRROR reports are sent to designated report owners (generally, district managers). The report owners review the reports and may add narrative analysis, which appear at the bottom of the report. The narrative analysis is text entered by the report owner to call attention to district and/or team accomplishments, explain why targets were not achieved, or present action plans for improving performance. Board officials told us they are currently working on boilerplate text that will be added automatically when certain targets are met. However, the Board does not plan to develop comparable text that would be used when targets are not met. Instead, report owners will be expected to enter a narrative analysis addressing the problem.

Board staff and commissioners can review these reports in detail. For example, managers can begin with a statewide report and narrow the review down to the performance in a specific district, by a certain team, and even by an individual employee. The performance measures cover the ages of cases pending, claims activity, volume of activity, etc.

From a list of the monthly reports issued at the district level, we drew a random sample of 50 of the 4,620 MIRROR reports we identified as being generated during 2004. Our sample included reports representing different months and different districts. Our objective was to determine whether the narrative analysis was being used, particularly when Board targets were not met.

Of the 50 MIRROR reports we reviewed, 35 showed that the target had been met by each team or individual on the report. Of the other 15 reports, at least 1 team or individual had failed to meet the target. We found that just 4 of these 15 provided a narrative explaining why the target was not met. The other 11 reports did not provide the information Board management would need to determine why the targets were not met and to develop strategies for addressing the problems. For example, one was a district-level report on the length of time between the receipt of a C-7 form (Notice that Right to Compensation is Controverted) and the scheduling of a hearing, which Board standards stipulate should take no longer than 30 days. However, this district took longer than 30 days to put some cases on the hearing schedule. Because the district manager had not entered a narrative analysis, Board officials could not determine whether that individual could address the failure to meet the target or if action was required by a higher level manager.

The MIRROR reports allow Board management to track performance and determine if corrective action should be taken and when it should occur. When targets are not met, the additional information entered in the narrative analysis can provide valuable assistance in those decisions. Without the narrative analysis, the MIRROR reports lose some of their usefulness as a tool for monitoring performance. As a result, management might not be able to take timely action when problems arise.

Timeliness of Initial Compensation Payments

According to the Law, unless an employer or its insurance carrier controverts a claim, the initial benefit payment to the claimant must be made no later than the 18th day of disability or the 10th day after the employer was notified of the injury, whichever is later. For controverted claims, the initial payment must be made no later than ten days after the date of the final decision. The Law requires the Board to assess a penalty if payment does not start on time. We found that the Board needs to improve its tracking of the timeliness of both initial and other payments.

Whether a claim is controverted or not, the carrier must file a Form C-669 (Notice to Chair of Carrier's Action on Claim for Benefits) with the Board indicating the amount of benefit being

paid to the claimant, the period covered, and the date of the initial payment. This form is also used when no payments to the claimant are required (e.g., when the claimant has not lost more than seven days of work time or the employer is paying regular wages during the period of disability).

The Board provided us with a list of the 10,629 cases for which a Form C-669 had been filed during October 2004. From this list, we drew a random sample of 75 cases and reviewed the C-669s in the electronic case folders. Our objective was to determine whether the initial payments to claimants had been made in a timely manner according to Board records.

We noted that 51 of the 75 were carrier notifications to the Board that no payment was required; 13 were notifications that initial payments had begun despite the possibility that the carrier or employer might dispute the claim; and 11 were notifications to the Board that the claim was not disputed and that initial payments had begun. In all but 1 of the 24 cases in which payments had already begun, the C-669s in the case folders showed that the initial payment had been made in a timely manner. The folder for that one case contained no explanation for the delayed payment; nor did it contain evidence that the carrier had been assessed the $300 penalty (paid to the claimant), as called for in the Law. In this case, the initial payment was made 32 days after the first medical examination - 14 more than the 18 days allowed by the Law.

Since the C-669 forms are part of the claimants' electronic case folders, the Board should monitor the payment dates on those documents electronically. Board officials informed us that they plan to track the timeliness of payments to claimants when additional electronic data processing resources become available.

Recommendations

1. Encourage claims examiners to use the case notes feature in the Claims Information System for documenting the reasons for delays and other issues with cases. Review that information regularly to develop strategies for improving claims processing.

Recommendations (Cont'd)

(Board officials responded that since only one case in the sample reviewed was identified as an improvement opportunity, they feel confident that management practices are consistent with the recommendation.)

2. Remind report owners to use the narrative analysis feature of MIRROR for documenting targets that are not met.

   (Board officials responded that the narrative analysis is a powerful MIRROR feature, and they will continue to encourage its use.)

3. Monitor electronically the timeliness of initial compensation payments made to claimants. Assess a penalty if payment does not start on time.

   (Board officials responded that payment data will soon become available in the CIS system. The Board will design an enhancement to CIS which will use this data to assist examiners in identifying potential late payments, and to refer those cases for consideration of a penalty.)

CONTROLS OVER DATA PROCESSING SYSTEMS

The Board's electronic databases and data processing systems enable its employees to view case folders from any terminal, regardless of which district office the case has been assigned to, expediting transfers of files from one office to another. However, the information stored on the systems is vulnerable to loss and misuse if appropriate controls are not in place. We examined some of these controls and found that improvements are needed if the Board's claims information is to be protected adequately against loss and misuse.

Disaster Recovery

The Board relies heavily on its electronic data processing systems. All claims received and all documents related to every claim are scanned into these systems. If any of them were destroyed or incapacitated for any length of time without adequate backup, claims processing and benefit payments could be delayed significantly for thousands of individuals. Therefore, it is critical that the Board implement a fully developed disaster recovery plan for its claims information.

In May 2001, the Board recognized the need for such a plan and initiated the process of developing one. It hired a consultant to assess its vulnerabilities to catastrophic information loss, received a report from the consultant, and used the findings in that report as the basis for its disaster recovery plan. However, as of December 2004, this development effort has not yet been completed. The Board should promptly complete a disaster recovery plan and test its utility on a periodic basis.

Access Controls

The information in the Board's electronic databases, much of which is confidential, is critical to the successful completion of its mission. Thus it is crucial that access to the data be restricted to authorized users and that authorization be granted

only to users who need it. Such access control is generally maintained through appropriate physical security, automated intrusion detection devices, and the assignment of appropriate user IDs and passwords. If these controls are not implemented appropriately, unauthorized individuals could gain access to confidential information, input viruses or improper data, or change claim files.

We examined the adequacy of the Board's access controls and identified a number of weaknesses. Due to the confidentiality of this information, we presented our detailed observations and recommendations to the Board in a separate document. Board officials indicated the Information Security Office has been assigned the responsibility for implementing the State's Information Security Baseline Policy, which includes all of the recommendations contained in the document we provided to the Board.

Unassigned Documents

Each month, the Board receives thousands of documents from claimants, employers, insurers, and health care providers. These documents are scanned and filed electronically within CIS. Some documents are filed in the "No-Claims" portion of CIS, either because they do not relate to a case or because incomplete or inaccurate information prevents them from being identified with a specific case. A document may have been filed initially in No-Claims, then moved later to a case folder after the case is identified or a case number is assigned.

During the audit, we noted that certain forms, such as C-7s, had been filed under No-Claims instead of being assigned to an existing or new case folder. We brought this issue to the attention of Board officials, who took corrective action and either transferred the documents to existing folders or created new ones.

In response to this issue, Board officials have developed a new procedure for reducing the number of documents filed incorrectly in No-Claims. Each week, CIS generates a "sweep report" of all forms in No-Claims that should generally not appear there. District staff review the documents identified in the sweep report and transfer them from No-Claims to the appropriate case folder.

To test the effectiveness of this new control procedure, we reviewed the weekly sweep reports for every district covering the month of November 2004, a total of 30 reports. In general, we found that most documents had remained in No-Claims for one week before being moved. A small number took longer than one week to be moved out of No-Claims, usually because they were filed close to the end of a reporting period. For a single district office, we also examined the reports for the following month, December 2004, noting the documents that had remained in No-Claims for more than one weekly report. We found that in CIS an electronic note had been attached to the documents appearing on more than one report, explaining why they had not been moved out of No-Claims.

Recommendations

4. Complete the disaster recovery plan promptly, and perform periodic tests of its utility.

   (Board officials responded that they are continuing the process of developing a formal disaster recovery program.)

5. Implement the detailed access control recommendations that were presented in a separate document.

   (Board officials responded that most of the access control recommendations have been addressed.)

6. Continue to use the No-Claims sweep report to identify and assign documents to the appropriate case folders.

   (Board officials responded that the control process is in place.)

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June 30, 2005

Honorable Alan G. Hevesi
NYS Office of the State Comptroller
Division State Services
State Audit Bureau
123 Williams Street, 21st Floor
New York, New York 10038
ATTN: Frank J. Houston

Dear Comptroller Hevesi:

As you requested, enclosed is the response to your draft audit report (2005-S-22), in accordance with Section 170 of the Executive Law.

Thank you for your attention to this matter.

Sincerely,

David P. Wehner

Enclosure

Workers' Compensation Board Response
To
OSC Draft Audit Findings
Audit Report 2005-S-22
Selected Aspects of Claims Processing

Background

The Workers' Compensation Board (the Board) is an agency that has transformed itself over the last decade, particularly in the area of Claims Processing. The Board has engaged in an enterprise-wide reengineering and modernization program that started with the claims resolution process, transforming it from a paper-intensive process characterized by enormous backlogs, and case resolution cycle times measured in years, to a paperless issue resolution process characterized by timely processing of cases, resolutions measured in weeks, and an emphasis on customer service. The Board' s mission, "To continuously improve how we serve New York's injured workers and employers" is a reflection of our dedication to continuously measuring our performance and searching for opportunities to improve our service to our customers. Therefore, the Board welcomes this opportunity to have our efforts reviewed, and welcomes the identification of recommendations that will assist us in achieving our mission.

Response to Specific Recommendations

Documentation of Case Activity		
	1. Encourage claims examiners to use the case notes feature in the Claims Information System for documenting the reasons for delays and other issues with cases. Review that information regularly to develop strategies for improving claims processing.	**As evidenced by the fact that only one case in the sample reviewed by OSC was identified as an improvement opportunity in this area, the Board feels confident that its procedures and management practices are in fact entirely consistent with this recommendation. In the instant case, the Board agrees that the examiner should have noted the reason for the delay in scheduling a hearing. Although there are many valid reasons why a hearing may not be scheduled, case notes should always reflect the reasons for action or non-action in a case.**
Monitoring of Performance		
	2. Remind report owners to use the narrative analysis feature of MIRROR for documenting targets that are not met.	**The MIRROR, the Board's award-winning Performance Measures system, provides extensive capabilities to the Board, with production CIS system data transformed into dozens of performance reports every month and no need for report owners to input or verify data. Indeed, the system is so robust, and some trends are so routine (absences at holiday and vacation time, short work months, etc), that many variations from target performance are well understood by the MIRROR audience. Likewise, if**

		there are minor deviations from the target at the individual or team level, but the district or statewide targets are still met, report owners may choose not to use the narrative feature to explain the lower level target deviation. Nevertheless, the Board agrees that the narrative analysis is a powerful feature, and should be used by report owners. This is a standing agenda item on the District Office meetings with central office staff (2 District Meetings are conducted each month), and will continue to be.
Timeliness of Compensation Payments		
	3. Monitor electronically the timeliness of initial compensation payments made to claimants. Assess a penalty if payment does not start on time.	**The Board's online procedures database, Baseline, clearly documents the examiners responsibility to look at timeliness of payment. Since only one of the cases in the OSC sample identified a late payment, the Board believes that its procedures and management practices are entirely consistent with this recommendation. The Board agrees with, and has previously identified, the need to ensure consistency in application of penalties statewide. This is an ongoing process and the Board anticipates being able to improve our performance in this area in the coming year. Further, the Board anticipated the need to be able to track timeliness of payment electronically, and included the capture of the specific data elements required for this function as a requirement in our new scanning contract. As the contract is just being implemented now (2005), this data will soon become available in the CIS system. The Board will now be able to design an enhancement to the CIS system which will use this data to assist examiners in identifying potential late payments, and to refer those cases for consideration of a penalty in accordance with Section 25 of the WCL.**
Controls over Data Processing		
	4. Complete the disaster recovery plan promptly and perform periodic tests its utility.	**The Board is continuing the process of developing a formal disaster recovery program. Many of the recommendations from our Business Continuity study have already been addressed by the Board. Completion of the plan requires contracting for various services, such as off-site storage and "hot-site" recovery facilities. The Board is attempting to take advantage of statewide contracts for these services, not all of which are in place yet. This has delayed our ability to complete and test the plan.**

Reference	OSC Recommendation	WCB Response
	5. Implement the detailed access control recommendations that were presented in a separate document.	**The Board's Information Security Office has been assigned responsibility for implementing the State's Information Security Baseline Policy, which includes, along with many other requirements, all of the recommendations articulated in the audit report. The Board is following a prioritized policy compliance program, in consultation with and at the direction of the New York State Office of Cyber Security and Critical Infrastructure Coordination. Most of the items identified in the detailed access control recommendations have been addressed as part of that ongoing Security Remediation Project.**
	6. Continue to use the No-Claims sweep report to identify and assign documents to the appropriate case folders.	**During the process of converting from paper-based to image-based processing, the Board converted its entire file of No-Claims papers from each District Office. The conversion process did not attempt to correct for misfiled documents. Therefore, any and all documents that had been placed into the No Claims file were digitized (converted to digital images) and were indexed (defined data fields like the form number, name, etc., were captured and attached to the images).** **It became apparent very early that there were documents that had been manually filed in No Claims, the C-7 for example, that one would not typically expect to find there. Consequently, in April of 1999, as the last and largest District Office, Brooklyn, was converted, the "No Claims Sweep" report was initiated. This report provided, by District, a list of all forms in No Claims, including C-7's, that would not "typically" be expected to be found in No Claims, as they are forms which normally are only filed once a case has been indexed (assembled) by the Board. This report was run periodically to continue to facilitate claims staff review to identify any potentially "misfiled" or misidentified forms. In July of 2002, we began running this monthly, and in February of 2003, the C0715 became a weekly report.** **This control process will continue as a check against case papers being misfiled.**