

# NOTICE OF CONTROVERSY

## THIS IS A DENIAL OF YOUR BENEFITS

(Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.)

1. WCB FILE # (if known):  
**DN5**

EMPLOYEE					
2. EMPLOYEE LAST NAME: <b>DN43 &amp; DN255</b>		3. FIRST NAME: <b>DN44</b>		4. MI: <b>DN45</b>	5. EMPLOYEE ID: TYPE: <b>DN270</b> #: <b>DN(42/152/153/154/156)</b>
6. STREET/P.O. BOX MAILING ADDRESS: <b>NA - DN46</b> <small>(will print all NA boxes with data from FRO)</small>		7. CITY: <b>NA - DN48</b>	8. STATE: <b>NA - DN49</b>	9. ZIP: <b>NA - DN50</b>	10. HOME PHONE #: <b>NA - 51</b>
11. DATE OF INJURY: <b>DN31</b> ___/___/___		12. SPECIFIC INJURY OR ILLNESS: <b>NA-DN35</b>		1. BODY PART(S) AFFECTED: <b>NA - DN36</b>	

EMPLOYER	
14. INSURER/CLAIM ADMIN FILE #: <b>DN15</b>	15. EMPLOYER NAME: <b>NA - DN18</b>
16. EMPLOYER MAILING ADDRESS AND PHONE #: <b>NA - DN168, 165, 170, 167, and 159</b>	
17. INSURER/CLAIM ADMIN NAME AND ADDRESS: <b>DN188, NA - DN10, 12, 13, and 14</b>	18. INSURER/CLAIM ADMIN FEIN: <b>DN187</b>

**19. NOTICE TO EMPLOYEE**  
YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW. IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW.

<p>19a. <b>FULL DENIAL REASON</b></p> <p style="text-align: center;"><b>DN198</b></p> <p>FULL DENIAL EFFECTIVE DATE ___/___/___ <b>DN199</b> / ___</p>	<p>19b. <b>PARTIAL DENIAL REASON</b></p> <p style="text-align: center;"><b>DN294</b></p> <p>20a. DATE OF INITIAL INCAPACITY ___/___/___ <b>DN56</b> / ___ CURRENT DATE OF INCAPACITY ___/___/___ <b>DN144</b> / ___</p> <p>20b. DATE EMPLOYER NOTIFIED ___/___/___ <b>DN281</b> / ___</p>
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\*NOTE: Reasons identified in boxes 19a or 19b will not preclude a party from raising additional issues at a later date.

21. **COMMENTS:**

**DN197**

**22. IF THIS DENIAL NOTICE IS NOT TIMELY PURSUANT TO RULE 1.1**, the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with 39-A M.R.S.A. § 205(2) and in compliance with 39-A M.R.S.A. § 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a Notice of Controversy and the payment of any accrued benefits. Payment under Rule 1.1 requires filing of a Memorandum of Payment.

**ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES**

<b>AUGUSTA</b> 24 STONE ST. SUITE 2 AUGUSTA, ME 04330-5220 (207)287-2308 (Voice) 1-800-400-6854 (Voice) TTY 1-877-832-5525	<b>BANGOR</b> 106 HOGAN ROAD BANGOR, ME 04401-5638 (207)941-4550 1-800-400-6856	<b>CARIBOU</b> 43 HATCH DRIVE SUITE 110 CARIBOU, ME 04736-2347 (207)498-6428 1-800-400-6855	<b>LEWISTON</b> 36 MOLLISON WAY LEWISTON, ME 04240-5811 (207)753-7700 1-800-400-6857	<b>PORTLAND</b> 62 ELM ST. PORTLAND, ME 04101-3061 (207)822-0840 1-800-400-6858
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23. NAME (TYPE OR PRINT): <b>DN140</b>		24. TELEPHONE #: (       ) <b>DN137</b>	25. DATE SENT TO WCB: ___/___/___ <b>DN100</b> / ___
E-MAIL ADDRESS: <b>DN138</b>			26. DATE RCVD AT THE WCB (WCB use only): ___/___/___

**WCB-9 (1/12/06)** The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services, or activities. This form is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone: 1-888-801-9087 or TTY (877) 832-5525.  
DISTRIBUTION: COPY (1) EMPLOYEE, (2) EMPLOYER

# NOTICE OF CONTROVERSY (DENIAL), WCB-9

## **General Reporting Requirements**

The claims administrator (CA) must file\* a Notice of Controversy (NOC) with the Board to report the denial of a claim for incapacity (disability), death and/or medical benefit(s).

Denial of Incapacity (disability) Benefits: Where the claim for incapacity (disability) benefits is in dispute, a NOC must be filed\* on or before the 14th day payment is due under §205(2).

Denial of Death Benefits: Where the claim for death benefits is in dispute, a NOC must be filed\* on or before the 14th day payment is due under §205(2).

Denial of Medical Benefits: Where the employee's claim is only for medical benefits, a NOC shall be filed\* on or before the 30th day after notice or knowledge of the claim for medical benefits. See Rule 8.2 for exceptions and further instructions.

## **EDI Reporting Requirements**

Unless a waiver has been granted, effective July 1, 2006, all NOCs and all MTC "CO" corrections to NOCs (that are the result of a "TE" transaction error) shall be filed\* using the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Release 3 format. See Board Rule 3.4. Following is a general overview. More detailed information can be found at: <http://www.state.me.us/wcb/departments/technology/electronic.htm>.

Each transaction requires a Maintenance Type Code (MTC). The MTC is a code that identifies the type of transaction:

### **MTC Code**

### **Definition**

CO

Correction: Correct transaction reported on the AKC as "TE" (see below). This transaction must contain the Maintenance Type Correction Code (MTCC) and Maintenance Type Correction Code Date (MTCC Date) fields. These fields communicate which report is being corrected. The jurisdiction claim number/WCBN is mandatory for this transaction.

04

Full Denial: A FROI 04 transaction indicates an original/new FROI and the filing of a Full Denial simultaneously. This MTC can only be used if the FROI has never been filed with the Board.

04

Full Denial: A SROI 04 transaction indicates a Full Denial on a FROI that has been previously filed with the Board. The jurisdiction claim number/WCBN is mandatory for this transaction.

PD

Partial Denial: A SROI PD transaction indicates a Partial Denial. The jurisdiction claim number/WCBN is mandatory for this transaction.

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\* accepted EDI transaction, with or without errors ("TE" or "TA" only)

If the claim is being denied in part, the FROI must be filed\* prior to the submission of the Partial Denial. If the claim is being denied in full, the CA may file\* a FROI 04, submitting the original FROI and Full Denial in one transaction.

Each transaction is acknowledged with an Application Acknowledgement Code (DN0111) used to identify the accepted/rejected status of the transaction being acknowledged:

<b><u>DN0111</u></b>	<b><u>Definition</u></b>
HD	Batch Rejected: Batch rejected in its entirety.
TA	Transaction Accepted: The transaction was accepted without errors.
TE	Transaction Accepted with Error: An error was found on an expected data element. A CO (Correction) must be submitted to resolve the error(s).
TN	Transaction Rejected by Service Provider: The transaction fails mandatory requirements.
TR	Transaction Rejected: The transaction was not accepted. An error was found on a mandatory or mandatory conditional data element. A review of the error(s) must take place to determine if the transaction should be resubmitted with the same MTC – correcting the error. If an error of duplicate transaction, invalid event sequence, etc. then resubmission may not be required.

It is the CA's responsibility to maintain the Acknowledgment (AKC) for every batch of EDI transactions sent to the Board. A NOC is not considered filed with the Board until it receives a "TA" or "TE" code on the AKC.

### **Corrections**

Changes to NOCs filed prior to July 1, 2006 using a paper WCB-9 (10/98) must be made by sending an amended paper WCB-9 (10/98) to the Board via e-mail, via fax (207-287-5895), or via standard mail at the following address:

Workers' Compensation Board  
27 State House Station  
Augusta, ME 04333-0027

**PLEASE ENSURE THAT THE FORM IS CLEARLY MARKED AS AN AMENDMENT AND CIRCLE OR HIGHLIGHT THE INFORMATION TO BE CHANGED.**

A MTC "CO" EDI transaction must be sent to the Board to correct any errors that were received on a "TE" acknowledgement report.

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\* accepted EDI transaction, with or without errors ("TE" or "TA" only)

Changes/updates to NOCs that have been filed electronically (and are not the result of a “TE” transaction error) must be made by sending a paper WCB-9 (1/12/06) to the Board via e-mail, via fax (207-287-5895), or via standard mail at the following address:

Workers’ Compensation Board  
27 State House Station  
Augusta, ME 04333-0027

**PLEASE ENSURE THAT THE FORM IS CLEARLY MARKED AS AN AMENDMENT AND CIRCLE OR HIGHLIGHT THE INFORMATION TO BE CHANGED.**

**Distribution**

WCB-9 (1/12/06) shall be mailed to the employee, the employer and, if required by Rule 5.7(2) or Rule 8.2, the health care provider, within 24 hours after the NOC is transmitted to the Board.

**Closure**

Closure of the NOC is required. Closure occurs when one of the following actions is taken:

- 1) The employer or carrier withdraws the NOC. This requires the filing of a Memorandum of Payment, WCB-3, when indemnity payments are made.
- 2) Denied benefit(s) are not pursued.
- 3) The parties reach agreement outside of the litigation process. This requires the filing of a Memorandum of Payment, WCB-3, or a Consent Between Employer and Employee form, WCB-4A, when the agreement includes indemnity payments.
- 4) The parties reach agreement at Mediation. This requires the filing of a Memorandum of Payment, WCB-3, when the agreement includes indemnity payments.
- 5) A petition is filed by the denied party after unsuccessful Mediation.

**Form Filing Violations**

Failure to file any Board-prescribed forms within established time frames is a violation under §360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

**Other Violations**

Failure to file\* a NOC or pay benefits on or before the 14th day payment is due under §205(2) is a violation of Rule 1.1(1). This violation requires payment of benefits to the injured employee as set forth in Rule 1.1(2), which must be reported on a Memorandum of Payment, WCB-3, as required by Rule 1.1(3). Failure to file\* a NOC or pay benefits on or before 30 days after the 14th day payment is due under §205(2) requires a penalty payment to the injured employee, as set forth in §205(3). Failure to file\* a NOC or pay medical benefits within 30 days after receipt of notice of nonpayment by certified mail requires a penalty payment to the provider of the medical or health care services or the employee who paid for the medical or health care services, as set forth in §205(4).

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\* accepted EDI transaction, with or without errors (“TE” or “TA” only)

## INSTRUCTIONS FOR COMPLETING NOTICE OF CONTROVERSY, WCB-9

For instructional purposes, this Forms Manual indicates the WCB-9 Box # and description as listed on the paper form, the IAIABC Data Element Number (DN) and the data requirements of each field to assist CAs with electronic filing and paper distribution of NOCs. Specific technical questions can be answered by reviewing the Element Requirement Tables that are available at: <http://www.state.me.us/wcb/departments/technology/edirule.htm>.

Certain fields are mandatory at the time of the EDI transaction. If any “mandatory” fields are missing, incomplete or incorrect, the EDI transaction will completely reject, resulting in a “TR” on the AKC. A “TR” on the AKC means that the EDI transaction was completely rejected. The fatal error(s) that caused the rejection must be corrected and a new EDI transaction must be sent as if it had never sent it in before. Other fields are given an expected rating which indicates that the data in those fields is expected by the Board. If any “expected” fields are missing, incomplete or incorrect, the NOC will be accepted (filed) with errors. The error(s) must be corrected by submitting a MTC “CO” using the jurisdiction claim number/WCBN provided in the acknowledgement report.

1. WCB File # (if known): **(Assigned for FROI 04; Mandatory for SROI CO, SROI 04 and SROI PD) (DN5 – JURISDICTION CLAIM NUMBER)**

Enter the file number assigned by the State of Maine to identify this claim.

2. Employee Last Name:  
**(DN43 – EMPLOYEE LAST NAME) (Mandatory)**  
**(DN255- EMPLOYEE LAST NAME SUFFIX) (If Available)**

Enter the employee’s legally recognized last name and last name suffix.

3. First Name: **(Mandatory) (DN44 – EMPLOYEE FIRST NAME)**

Enter the employee’s first name.

4. MI: **(If Available) (DN45 – EMPLOYEE MIDDLE NAME/INITIAL)**

Enter the employee’s middle initial.

5. Employee ID: **(Mandatory)**

Enter the employee’s ID type **(DN270 – EMPLOYEE ID TYPE QUALIFIER)**

Values:      A= Employee ID Assigned by Jurisdiction (DN154)  
                  E= Employee Employment Visa (DN152)  
                  G=Employee Green Card (DN153)  
                  P=Employee Passport Number (DN156)  
                  S=Employee Social Security Number (DN42)

Enter the employee’s ID #: **(Expected)**

DN042 – EMPLOYEE SSN  
DN152 – EMPLOYEE EMPLOYMENT VISA  
DN153 – EMPLOYEE GREEN CARD  
DN154 – EMPLOYEE ID ASSIGNED BY JURISDICTION  
DN156 – EMPLOYEE PASSPORT NUMBER

6. Street/P.O. Box Mailing Address: **(Expected on FROI 04)**  
**(DN46 – EMPLOYEE MAILING PRIMARY ADDRESS)**  
Enter the employee's mailing address.
7. City: **(Expected on FROI 04)** **(DN48 – EMPLOYEE MAILING CITY)**  
Enter the city of the employee's mailing address.
8. State: **(Expected on FROI 04)** **(DN49 – EMPLOYEE MAILING STATE CODE)**  
Enter the state of the employee's mailing address.
9. Zip: **(Expected on FROI 04)** **(DN50 – EMPLOYEE MAILING POSTAL CODE)**  
Enter the postal code of the employee's mailing address.
10. Home Phone #: **(If Available)** **(DN51 – EMPLOYEE PHONE NUMBER)**  
Enter the employee's home telephone number, including area code.
11. Date of Injury: **(Mandatory)** **(DN31 – DATE OF INJURY)**  
Enter the date of the employee's injury (MM/DD/YYYY).
12. Specific Injury or Illness: **(Expected on FROI 04)** **(DN35 – NATURE OF INJURY CODE)**  
Enter the title corresponding to the Nature of Injury Code.  
Values: see <http://www.iaabc.org/>
13. Body Part(s) Affected: **(Expected on FROI 04)** **(DN36 – PART OF BODY INJURED CODE)**  
Enter the title corresponding to the Part of Body Injured Code.  
Values: see <http://www.iaabc.org/>
14. Insurer/Claim Admin File #: **(Mandatory)** **(DN15 – CLAIM ADMINISTRATOR CLAIM NUMBER)**  
Enter an identifier for a specific claim within the CA's processing system.
15. Employer Name: **(Mandatory on FROI 04)** **(DN18 – EMPLOYER NAME)**  
Enter the legal name of the employer.
16. Employer Mailing Address and Phone #:  
**DN168 – EMPLOYER MAILING PRIMARY ADDRESS (Expected on FROI 04)**  
**DN165 – EMPLOYER MAILING CITY (Expected on FROI 04)**  
**DN170 – EMPLOYER MAILING STATE CODE (Expected on FROI 04)**  
**DN167 – EMPLOYER MAILING POSTAL CODE (Expected on FROI 04)**  
**DN159 – EMPLOYER CONTACT BUSINESS PHONE NUMBER (If Available)**  
Enter the primary mailing address, city, state, postal code, and phone number of the employer.

17. Insurer/Claim Admin Name: **(Expected) (DN188 – CLAIM ADMINISTRATOR NAME)**  
Enter the legal name of the entity adjusting the claim.

Insurer/Claim Admin Address:

**DN10 – CLAIM ADMINISTRATOR PRIMARY ADDRESS (Expected on FROI 04)**

**DN12 – CLAIM ADMINISTRATOR CITY (Expected on FROI 04)**

**DN13 – CLAIM ADMINISTRATOR STATE CODE (Expected on FROI 04)**

**DN14 – CLAIM ADMINISTRATOR POSTAL CODE (Mandatory)**

Enter the address, city, state, and postal code of the claim adjusting office handling the claim.

18. Insurer/Claim Admin FEIN: **(Mandatory) (DN187 – CA FEIN)**

Enter the Federal Employer Identification Number of the entity licensed or allowed by a jurisdiction to adjust a claim.

19a. Full Denial Reason **(Mandatory on FROI 04 and SROI 04) (DN198 – FULL DENIAL REASON CODE)**

Enter the code(s) used to identify the reasons for denying a claim in its entirety.

Values (Enter no more than five):

1=No Compensable Accident (A,B,C,D,E,F,G or H)

2=No Causal Relationship (A,B,C,D,E or F)

3=No Coverage (A,B,C,D,E,F,G,or H)

4=Substance Use/Abuse (A)

5=Other (not elsewhere classified) (A or C)

Full Denial Effective Date **(Mandatory on FROI 04 and SROI 04) (DN199 – FULL DENIAL EFFECTIVE DATE)**

Enter the date (MM/DD/YYYY) from which the claim administrator is denying all benefits for the claim.

19b. Partial Denial Reason **(Mandatory on SROI PD) (DN294 – PARTIAL DENIAL CODE)**

Enter a code identifying which portion of the claim is being denied.

Values:

A=Denying Indemnity in Whole, not Medical

B=Denying Indemnity in Part, not Medical

C=Denying Medical in Whole, Not Indemnity

D=Denying Medical in Part, Not Indemnity

E=Denying Indemnity in Whole, Medical in Part

F=Denying Medical in Whole, Indemnity in Part

G=Denying Both Indemnity & Medical in Part

20a. Date of Initial Incapacity **(Expected for Lost Time Claims) (DN56 – INITIAL DATE DISABILITY BEGAN)**

Enter the first day qualifying as a day of disability in the first period of disability (MM/DD/YYYY). If the period of disability has been intermittent or sporadic, please include comments in Box 21 (DN197).

**Current Date of Incapacity (If Applicable) (DN144 – CURRENT DATE DISABILITY BEGAN)**

Enter the first qualifying day of disability in the current period of disability being denied (MM/DD/YYYY). If this date is the same as DN56, leave blank.

If the period of disability has been intermittent or sporadic, please include comments in Box 21 (DN197).

**20b. Date Employer Notified (Mandatory for Lost Time Claims) (DN281 – DATE EMPLOYER HAD KNOWLEDGE OF DATE OF DISABILITY)**

Enter the date that the employer was notified or had knowledge of the employee's work-related disability/incapacity (DN56 or DN 144 as applicable to this transaction).

**21. Comments: (If Applicable) (DN197 – DENIAL REASON NARRATIVE)**

Use this area to enter any additional information, explanations or clarifications.

**PLEASE INCLUDE THE NAME AND CONTACT INFORMATION OF THE HEALTH CARE PROVIDER IF THE NOC IS CONTROVERTING WHETHER A HEALTH CARE PROVIDER'S BILL IS REASONABLE AND PROPER UNDER 39-A M.R.S.A. SEC. 206.**

**22. IF THIS DENIAL NOTICE IS NOT TIMELY PURSUANT TO RULE 1.1,** the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with 39-A M.R.S.A. Sec. 205(2) and in compliance with 39-A M.R.S.A. Sec. 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a NOC and the payment of any accrued benefits.

**23. Name: (Expected on SROI 04 and SROI PD) (DN140 – CA CLAIM REPRESENTATIVE NAME)**

Enter the name of the individual working for the claim administrator that is responsible for handling the claim.

**E-Mail Address: (If Available) (DN138 – CA CLAIM REPRESENTATIVE E-MAIL ADDRESS)**

Enter the internet E-mail address of the individual responsible for handling the claim.

**24. Telephone #: (If Available) (DN137 – CA CLAIM REPRESENTATIVE BUSINESS PHONE NUMBER)**

Enter the telephone number of the individual responsible for handling the claim.

**25. Date Sent to WCB: (Mandatory) (DN100 – DATE TRANSMISSION SENT)**

Enter the actual date (MM/DD/YYYY) the batch of data was sent via EDI to the Board.