

Chapter One: Claims Management Organization

INTRODUCTION

In Chapter I of the report, Claims Management Organization, Washington’s claims management organization will be analyzed and recommendations presented in three sections:

1. [Background](#) – provides an overview of Washington workers’ compensation insurance, and covers the three main insurance “types” that formed the focus of the audit.
2. [Structure of the L&I Claims Management Program](#) – examines the claims management program with an eye towards efficiency.
3. [Claims Management Differences Based on Insurance “Type”](#) – analyzes the differences between the three types of insurance.

1 BACKGROUND

1.1 WORKERS’ COMPENSATION INSURANCE

First, we will provide a general description of the system used in Washington for workers’ compensation insurance. There are essentially three “types”: Self-Insured, Insured, and then within the Insured type, Retrospective Rated.

We will start with an overview of the “Insured” type, which is the traditional form of workers’ compensation insurance and is the default requirement in Washington. Over the past 100 years, state workers’ compensation systems in the United States have tended to converge on a few design and administrative principles. They typically involve some form of “no fault” insurance purchased by employers that provides statutory benefits to workers who suffer workplace injuries.

Workers’ compensation insurance is mandatory in Washington. However, as in other states, there are some exclusions, the result of which is that approximately 2.5% of Washington workers are not covered.¹ Certain domestic employees working in private homes, persons hired for gardening or maintenance at private homes, horse-racing jockeys, newspaper carriers, children under 18 years of age working on a family farm, and barbers who lease booth space are examples of employments that are excluded. Additionally, business owners are generally excluded, but can opt to purchase coverage. Finally, employments covered by other programs, such as the Federal Employees’ Compensation Act, the Jones Act, or the Longshore and Harbor Workers Act are not required to have Washington workers’ compensation insurance.

¹ Table 3 and Table A, Workers’ Compensation: Benefits, Coverage, and Costs 2012, National Academy of Social Insurance, Aug. 2014 (available at http://www.nasi.org/sites/default/files/research/NASI_Work_Comp_Year_2014.pdf) (reporting 2.75 million Washington workers covered by workers’ compensation).

Washington's workers' compensation insurance system is administered by the Department of Labor and Industries (L&I), which manages and pays claims out of a pooled fund called the Washington State Fund (State Fund.) The State Fund is the exclusive insurance mechanism for workers' compensation in Washington. Besides Washington, in the United States this relatively unique structure is in place in Wyoming, North Dakota, and Ohio.² In other states, most workers' compensation insurance is purchased from private insurance carriers or a competitive state fund. Canadian jurisdictions utilize the exclusive insurance structure.

Washington workers' compensation premiums are paid by both employers and workers.

- Employer premiums fund the "Accident Fund," which pays non-medical claim costs, such as income-replacement benefits.
- Both employer and worker premiums fund the remaining three funds: Medical Aid, which pays for medical care; Stay-at-Work, which partially reimburses employers for wages and other expenses from bringing injured workers back to light-duty or transitional jobs; and Supplemental Pension, which provides cost-of-living increases to workers with extended disabilities.

Employers are responsible for payment to L&I of the entire premium. For the three funds where employee contributions are allowed, the rate for each fund is split 50/50 between employers and employees. In 2014, the workers' share of premium was \$343 million while employers paid \$1,514 million. Worker-funded premiums are atypical among workers' compensation systems. Employers may collect the employee share through payroll deductions, based on a rate for each risk class assigned to a business and authorized by L&I. L&I reports that some employers choose not to make payroll deductions, but fund the premium without employee contributions.

1.2 SELF-INSURANCE

Washington also provides for self-insurance, as set forth in RCW 51.14.010 and WAC 296-15-021. Approximately one-quarter of Washington employees work for approximately 360 self-insured employers.³

An employer that meets certain eligibility criteria, primarily involving financial stability and solvency, is able to apply to L&I for certification as a self-insured employer. Certified employers are required to post security to ensure that losses can be paid in case of insolvency. Typically, self-insured employers are larger employers with sophisticated business practices, such as well-developed benefits programs and multi-state operations. To qualify, employers must:

- Be in business for at least 3 years
- Possess total assets of at least \$25 million as verified by fully audited financial statements
- Submit 3 years' worth of fully audited financial statements in the name of the applicant with the application
- Meet all of the following financial standards
 - A current liquidity ratio of at least 1.3 to 1
 - Positive debt-to-net-worth ratio of not greater than 4 to 1

² This structure is often referred to as a "monopolistic" or "exclusive" state-fund program. In contrast, many states utilize a state fund to provide workers' compensation insurance, but the funds either insure select groups of employers, such as state agencies or higher-risk, difficult-to-insure employers, or they compete with private insurers and are simply another option for securing workers' compensation insurance.

³ Fiscal Year 2014. From L&I Facts and Figures, available at <http://www.lni.wa.gov/News/files/LNIFactsAndFigures.pdf>.

- Positive earnings in the current year and in 2 of the last 3 years
- Overall positive earnings for the period.

Additionally, self-insured employers must have an L&I-approved accident-prevention program. L&I can require the self-insurer to supply a surety bond of a sufficient amount to secure claims payment in the event of bankruptcy by the employer.

1.3 RETROSPECTIVE RATING PROGRAM

Three-quarters of Washington employees work for employers that purchase workers' compensation insurance from the State Fund, a significant portion of which elect to participate in L&I's Retrospective Rating Program (Retro).⁴ Retro employers are given financial incentives to reduce their workers' compensation claims and claim costs. They face the risk of paying more than standard premium if their losses are unusually high in exchange for potential premium savings if they have losses that are lower than the actuarial target for an employer of their size and risk classification. The following is an excerpt from the "Employers' Guide to Workers' Compensation Insurance in Washington State":

If you are committed to operating a safe workplace, preventing accidents and managing workers' compensation claims effectively, you may be interested in L&I's Retrospective Rating Program (Retro).

Retro is an optional financial incentive program offered by Labor & Industries to help qualifying employers reduce their workers' compensation costs. Employers can enroll on their own or in a group plan sponsored by a trade association or professional organization. Employers may receive premium refunds or they may be assessed additional premium based on their performance.

*Enrollment in this program occurs four times each year. Coverage runs for one year, beginning January 1, April 1, July 1 or October 1.*⁵

About one-quarter of Washington workers are employed by State Fund employers who are part of the Retro program; about one-half of Washington workers are employed by State Fund employers that are not part of the Retro program.⁶ Total premiums paid by Retro employers in 2013 was \$725 million; for non-Retro employers total premium for the same period was \$1,066 million.⁷

Premiums for any insured employer – Retro or not – are based on the risk class of the employment and on the particular experience of the insured employer. Premiums are based on actual hours worked, whereas most workers' compensation systems use payroll as the basis for insurance premiums. Rates for particular risk classes (e.g. clerical) are based on actuarial analysis of the entire risk class. Experience, on the other hand, is based on the individual losses (or not) of a particular employer. The Retro program makes the premiums paid by Retro participants in any given coverage year sensitive to the experience or losses incurred by participating employers. Within plan limits, premiums paid by Retro participants

⁴ Ibid.

⁵ See <http://www.lni.wa.gov/IPUB/101-002-000.pdf>, p. 23.

⁶ Source: L&I actuarial report, based on total reported hours, used to determine premium, and derived using full-time employment hours of 1,920 annually (reporting that among State Fund workers, which comprise 75% of the total WA workforce covered by workers' compensation, 35% are with Retro employers and 65% are with non-retro employers).

⁷ See <http://www.lni.wa.gov/ClaimsIns/Files/Retro/FinInfo/marketshare/2013RetroMarketShareAnalysis.pdf>.

(after assessments for additional premium or refunds) are tied to the actual losses in the year of coverage. By contrast, premiums paid by non-Retro employers are fixed for the coverage year, though they will be adjusted in future years based on actual loss experience. Employers are able to participate in the Retro program either individually, or as a member of a Retro group. The following table highlights the distinction between the two:

Exhibit 1-1: Group vs. Individual Retro Participation

Group vs. Individual Retro Participation		
	Group	Individual
Minimum premium amount	There is no minimum annual premium for you to enroll in Retro as part of a group.	Your standard premium (accident and medical aid fund premium) must be at least \$5,850.
Fees	You must be a member of the association that sponsors the group, which will have membership dues. Most groups also charge their members a fee in return for administering the Retro group. This may be: <ul style="list-style-type: none"> • A flat fee. • A percentage of refunds. • A percentage of premiums. • A combination of these. 	No extra fees.
Services	Many groups offer services to improve the group's Retro performance. These also often help members' experience factor and rates improve over time. Services may include accident prevention training, and direct claim management help from the association or a third-party administrator.	No extra services.
Refund potential	Groups typically have better refund potential because they have a larger premium total. Retro is "premium sensitive," meaning the larger the premium, the greater the percentage refund for a given amount of risk. A large group risking 10% might realize a 20-40% refund.	If you're a small premium payer, your potential refund is lower than large groups. For example, if you are risking 10% on your own, you might realize a 3-15% refund.
Choice	The association managing the group selects the Retro plan type, minimum and maximum loss ratios, and single loss limits. This means less control for you, but less to research and decide.	You choose the plan type, minimum and maximum loss ratios, and single loss limits.
Risk	Risk is spread within the group. If you have a bad claim year, you might still get a refund if the group has done well overall. However, if you have a good claim year, you may end up with an assessment (paying more premium) if the group didn't do well.	Your refund or assessment is based entirely on your own performance.
How to enroll	<u>Contact an association that sponsors a group.</u>	<u>Contact us.</u>

Source: L&I, <http://www.lni.wa.gov/ClaimsIns/Insurance/Reduce/Qualify/About/GroupOrIndiv.asp>. Note that as indicated in the chart, there is no minimum premium for an employer to join a Retro group, but to be enrolled as a new group, the group itself is subject to a minimum: "The standard premiums for the group members for the four quarters prior to enrollment total at least one million five hundred thousand dollars." WAC 296-17B-220(6).

2 STRUCTURE OF THE L&I CLAIMS MANAGEMENT PROGRAM

In this section, we will address the State Fund claims management structure. In the next section we will address structural differences in how claims are processed for the State Fund (Retro and non-Retro) and self-insured employers.

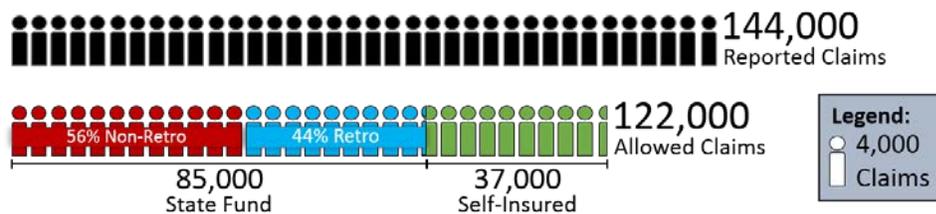
As general context, claims of workers of employers with State Fund provided insurance are managed by claims managers (CMs) at L&I. For self-insured employers, claims are handled directly by the employer or, more commonly, by private third party administrators (TPAs), with administrative oversight and some specific decisions made by a separate section called the L&I Self-insurance Division. Claims of Retro participants are handled by L&I CMs in the same manner as all State Fund claims. Adjudication of disputes (protests) brought by employers & workers, regardless of State Fund or self-insured status, are initially handled by L&I and can be appealed (directly or after protest) to the Bureau of Industrial Insurance Appeals (BIIA).

2.1 STATE FUND CLAIM MANAGEMENT

In Washington, there are roughly 144,000 reported workplace accidents each year; about 22% involve lost time, and the rest involve only medical treatment.⁸ Of all reported claims, roughly 85% are accepted, or “allowed”; thus there are approximately 122,000 accepted claims each year. The vast majority of claims (over 95%) are categorized as “injury” claims, as opposed to “illness” claims, e.g. occupational-disease claims.

Among the approximate 122,000 claims accepted annually, 85,000 involve State Fund employers, and 37,000 involve Self-Insured employers. Among State Fund allowed claims, the Retro/Non-Retro split is roughly 44%/56%. The 85,000 State Fund claims require hundreds of thousands of decisions and actions annually by the Department. The following graphic presents an approximate, conceptual representation of these volumes.

Exhibit 1-2: L&I Claim Volume by Type



Source: WorkComp Strategies

L&I has 28 units designated for managing State Fund claims. Each unit has between 9 and 14 staff members and supervisors; in 2013, units began being staffed with “claim processors,” who provide support to CMs for claim management activities. The formal CM job title is “Workers’ Compensation

⁸ These figures are general approximations, based on L&I data from 2010-2013, as of December 31, 2013. In 2010 there were 144,037 reported claims, 31,681 reported time-loss claims, 126,458 accepted claims (86,929 State Fund, 39,529 self-insured), and 121,170 accepted injury claims; statistics for other years are provided in Appendix 3 – Methodology.

Adjudicator,” or “WCA.” CMs advance from an entry level (level 1) up to level 4. There is a formal apprentice program that lasts 22 months; after completion of the program, the CM reaches “Journey” level. A level 3 CM has on average 6.5 years of service. As of October 2014, there were a total of 408 staff members in the claims section, distributed as follows:

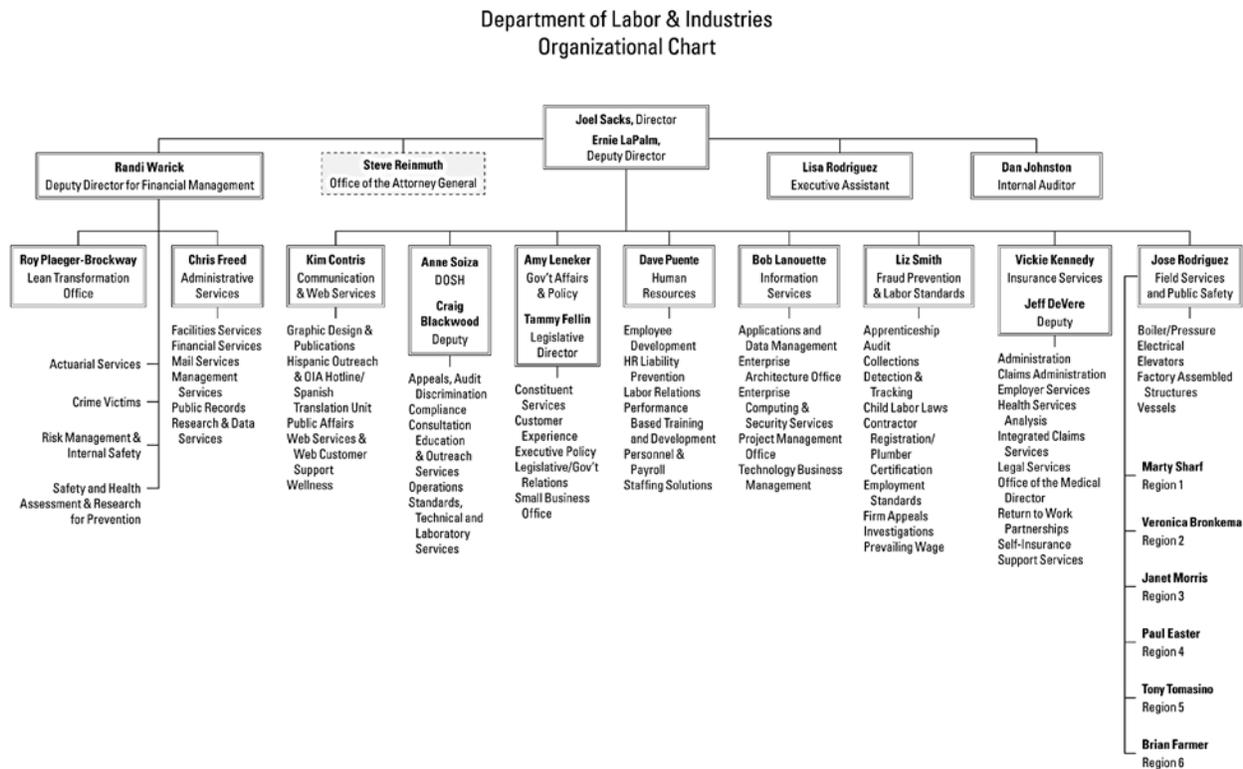
Exhibit 1-3: Claims Section Staffing

Position	Staff Members
Office Assistant 3	40
Office Assistant Lead	04
Program Coordinator	09
Data Complier	01
Claim Processors	27
WCA 1	10
WCA 2 Apprentice	33
WCA 2	90
Option 2 Specialist (WCA 2)	01
WCA 3	85
WCA 4 (includes trainers & coaches)	49
Program Support Supervisor 2	04
Industrial Insurance Supervisor	31
Management Analyst 3	02
Management Analyst 4	03
Administrative Assistant 3	08
Administrative Assistant 5	01
Senior Project Manager	01
Business Project Manager	01
Program Manager	01
Operations Manager	06
Chief of Claims	01
Total	408

Source: L&I, October 2014

Note that the regulatory scope of L&I is much broader than claims management. Exhibit 1-4 is an organizational chart shows the many functions of L&I. The claims management function is within the Insurance Services Division.

Exhibit 1-4 L&I Organizational Chart



Source: L&I Website (March 2015)

L&I utilized sequential claim assignment across the work groups for most claims for several years, but as of July 2014, has transitioned back to geographic assignment of claims. There are five “employer-based” units, which are responsible for managing claims for certain types of employers, e.g., home health care, state agencies, restaurants, retail, auto dealerships and school districts. There are two units that have a somewhat broader “industry base”: one unit handles trucking and taxi companies and one unit handles logging industry claims. Within these employer-based units there are CMs who are assigned to particular employers. There are two other specialized units: one for handling bilingual claims and the other for handling “Out of State” claims. There is also one unit specializing in claims without any lost time from work, involving only medical treatment. Another unit handles most chemical exposure and hearing loss disease claims; other occupational-disease claims, such as claims involving carpal tunnel syndrome or other repetitive activity conditions, are not handled by a separate unit, but distributed throughout the units according to the various characteristics just described.

The FileFast unit is a specialized unit created to provide for more prompt and thorough accident reporting by telephone or online and uses the Early Claims Solution (ECS) computer application. ECS is a set of screens, set up in a questionnaire format, which provides a web-based, “e form” style of data entry. L&I rolled out the ECS system to all State Fund claim units in February 2015.

Staff utilize two primary claims management software systems: LINIIS and ORION. CMs also have access to a highly detailed online reference system, containing regulations, statutes, and claim-handling reference material and guidance. The online reference system is scheduled to be upgraded.

- The LINIIS system is a mainframe system, requiring prompts to access and view information.

- The ORION web-based system provides a view of images, and also allows a view of some information contained in LINIIS. ORION also provides a task management view to users of the work that is due for all cases.

The LINIIS mainframe system is not a familiar, modern system, and the combination of the various systems creates information-system inter-connections that are not “user friendly” to beginners; once fully acquainted with the required prompts and what is available to be accessed, however, the LINIIS system is fast and responsive. The ORION system has slower processing times than LINIIS, but is easier to navigate, and being able to view images is helpful. Not all information is available without using both systems; moreover, the ECS and online reference systems mentioned above are not integrated. LINIIS and ORION have undergone many patches and fixes since they were introduced many years ago. L&I recently made a budget request of \$9.8 million to retire LINIIS.⁹

External users who have statutory authorization can access claim information using the online Claim and Account Center. The information available includes all notes input by L&I staff, including sensitive information obtained during investigation. L&I reports that the information obtained during the investigation is placed into the record once the investigation is complete and has been reviewed for release to the claim. The audit team heard that some external users were reluctant to provide information about cases that would be input into the system, because it would then be available to all users. For example, a supervisor for an employer might question whether an accident was work related, but does not want to potentially create a negative environment for the injured worker by questioning a claim. Another example is a witness may be reluctant to provide information about a claim for fear of retaliation from an employer, who would be able to view the information.

The Claim and Account Center also provides a mechanism for “secure messages,” pursuant to which a party to the claim can exchange secure, electronic messages with a claim manager. The Claim and Account Center is one of the most frequently visited web pages in the L&I web domain; in August 2014, it received almost 3 million “information requests.” The Claim and Account Center handles more than just claims; it also handles insurance account services. Employers are the highest percentage of registered users, followed by workers. As of August 2014, there were just under 160,000 registered employers, and a little over 75,000 workers. Next is “authorized delegate” at a little over 28,000; this would include employer representatives. There were just over 1,600 registered legal counsel; L&I reports that these latter registered users primarily represent workers.

In the course of file reviews the audit team observed heavy use of secure messages by employer representatives. An example would be an employer representative sending a message to a claim manager that a medical examination was just completed and the provider gave a permanency rating, and requesting that the CM review the record, issue an order of permanency benefits, and close the claim. We heard reports from some CMs that they spent a relatively large portion of their workdays responding to secure messages; in some instances this was perceived as a barrage of “too easy to send” communications that might be serving to prevent more substantive case engagement.¹⁰ We did not observe this to be a problem requiring correction, other than perhaps additional training on time

⁹ Vickie Kennedy, presentation to WA Workers’ Compensation Advisory Committee, Sept. 22, 2014.

¹⁰ Note that this is likely a symptom of the larger societal phenomenon of being “too connected” and not a shortcoming of the L&I secure message system. See generally Boussem, “Are We Too Connected to Connect,” Mar. 28, 2010, Huffington Post, at http://www.huffingtonpost.com/jasmine-boussem/are-we-too-connected-to-c_b_410959.html.

management, specifically tips on when to stop performing certain actions to respond to secure messages, and when to use a message as part of a diary entry for later review.

In the [next section](#), we will discuss structural differences between State Fund claims and claims for other insurance “types,” namely Retro and self-insured claims. As a preview, we did not observe any structural differences between Retro and non-Retro claims management. Thus, in this section, which discusses State Fund claims management organization, it would include all claims of insured employers, both Retro and non-Retro. Self-insured claims are handled quite differently, as will be discussed below.

2.2 STATE FUND CLAIMS MANAGEMENT PROCESSES

Washington’s State Fund claims management processes can be viewed as involving six primary activity groups:

1. Reporting
2. Investigation (includes claim assignment, determination, payment, caseloads, and contacts)
3. Management of Medical Treatment
4. Management of Disability (includes vocational and return-to-work services)
5. Disputes
6. Claim Closure (including permanent loss)

Our analysis will be organized around these six core claim management activities.

2.2.1 Reporting

Reporting is an essential aspect to effective and efficient claim management. Accurate and thorough reporting helps create a claim record and initiate services, including medical treatment and lost income benefit payments. Prompt reporting is essential to ensuring that services are delivered promptly.

In Washington, claims are reported primarily by medical treatment providers, which is atypical among workers’ compensation systems in other states. Most private insurance programs involved the insured – in this case, the employer – reporting a loss to its insurance carrier. The carrier then assigns an adjuster to initiate services on the claim.

From a statutory perspective, workers are required to “forthwith” report accidents to their employers, who are then required to “at once” report the accident to L&I.¹¹ In practice, however, most claims are reported to L&I by the medical treatment provider; this is by design, as claim forms and other reporting mechanisms, such as FileFast, establish and expect provider participation. A 1998 JLARC audit recognized this fact, and resulting legislation asserted that “one of the most significant causes for delayed benefit payments to workers and lack of employer involvement in claims was the manner in

¹¹ RCW 51.28.010.

which claims were reported.¹² Under this system of reporting, the worker generally reports the injury to a physician who, in turn, reports the injury to the department.”¹³

The standard process after L&I receipt of a claim is that the claim is first processed by Account Services, which checks to see if the employer is covered and verifies on the employment status, i.e. employer and employee relationship, as well as verifies the proper risk classification.

We observed performance deficits, in terms of timely decisions, that are likely connected to delayed reporting; these are examined in Chapter 2 of this report. In 2010, L&I began deploying the FileFast unit to address accident-reporting issues regarding timeliness and thoroughness. The unit handles approximately one fifth of L&I accident reports with a specialized computer application; accident reports to the unit are made via telephone or online.

2.2.2 Investigation

2.2.2.1 Initial prioritization

Once reported, accident reports are data-entered; the software system performs an automated procedure to determine if a claim is “priority” or not. In general, claims not involving more than 3 days of lost time, as indicated by a provider on an accident report, are considered “non-priority.” Otherwise, they are given higher priority and assigned and routed to a CM for immediate attention. Claims that are not priority claims also are routed for CM attention, but service level expectations are different: Time-loss (TL) claims with fewer than 3 days of lost time and those involving only medical treatment (“medical only” or MO) are scheduled for follow-up in 14 days. Some MO claims are spread throughout all claim units but most MO claims are routed to a specialized MO unit.

2.2.2.2 Claim determination

The CM investigates the validity of a claim. The essential criteria are whether there was a work incident, causing a specific, diagnosed condition that is supported by objective medical evidence. The accident report provides a series of questions that providers can complete that relay this information. Another “checkbox” on the form is whether the provider believes that the condition is “more likely than not” caused by the accident. Assuming the form is complete, the CM typically can make a prompt determination about validity. Some types of claims require more investigation; for example, some require inquiry concerning where the accident occurred, the relation between the accident and the work, and the contribution of work to a disease condition.

L&I reports that approximately 40% of claims coming into the department are processed through an auto adjudication process. These claims run through a predictive model that determines if all elements of for claim allowance have been met, the claim is not for an occupational disease, and there is no indication of time loss. If these criteria are met, the system automatically sends an allowance determination to the parties with a letter of explanation and sets the future closure date based on historical data. This process is intended to ensure quick access to treatment for the injured worker and

¹² <http://www.lni.wa.gov/ClaimsIns/Files/DataStatistics/DataAnalysis/EmployerAssistedInjuryReporting.pdf>. In response to the 1998 JLARC audit, L&I presented a December 2007 report to the Legislature about employer-assisted reporting of claims. In the report, L&I summarized results from a pilot program to encourage claim reporting by workers through their employers, with a stated goal of increasing the speed of initial payment; L&I reported that the results of the pilot did not indicate speedier payments, but also noted some limitations with the pilot that may have impacted the results. The report did not directly address the goal of increasing employer participation in the claims process.

¹³ RCW 51.28.015(1)(a).

allow claim managers to focus on more complex claims that need direct intervention. If a claim that has been allowed by the auto adjudication system ultimately needs intervention (e.g., an employer questions validity, time loss is contended, or the medical condition is more serious than originally noted), the CM can remove the future closure and manage the claim to resolution.

Employers are encouraged to complete an employers' accident report, in which they can assert their view of the accident, verify wage and benefit information, and give contact information for the claimant. Employers receive this request from the CM via mail. Despite L&I's encouragement to employers to submit employer reports, in our file review we observed many cases where an employer's accident report simply was not provided to the department. L&I reports that roughly 50% of employers now complete requested accident reports.

One aspect of initial claim analysis that is missing in Washington, and that is present in most other insurance systems, is case reserving by the adjuster, which is a practice by which the claim adjuster estimates the expected cost of the claim. In Washington, an automated system establishes initial reserves, as opposed to the CM establishing reserves. L&I reports that a separate case-reserving unit of Level 3 CMs performs reserving activities of claims that continue to be open at 8 – 9 months. It may well be that automated reserving is as accurate as "manual" reserving. Regardless, reserving in theory requires gaining enough information about a case that supports an assessment of how much potential financial loss will be involved. Again, in theory, this activity is useful in establishing a foundation for case management actions. Reserving is not a substitute for case planning; as will be discussed below, in the file review the audit team observed inadequate documented action plans, but in private insurance companies, the individual case reserve is based on the CM's action plan to resolve the claim, the expected disability and the cost of medical treatment expected for the particular injury involved.

2.2.2.3 Payment

After investigation, the CM will determine if the claim should be "allowed" or "denied" and enter an appropriate order of this decision. In almost all cases the order is accompanied by a letter; in some cases the letter explains and describes the condition that is being "allowed" or "denied." In other cases the letter simply states that the "accident of [particular date] is being allowed/denied." If denied, typically the CM will communicate the statutory exclusion being applied. (More about the effectiveness of communications is provided in Chapter 4 of this report.) In either the allowance or denial scenario, the order will outline how to "protest" or appeal the decision; more about the effectiveness of that protests is provided in Chapter 3 of this report.

A TL claim is one in which the worker is disabled by the accident and loses paid employment for more than three days after the day of injury.¹⁴ An MO claim is one involving only medical treatment, and not resulting in three days of uncompensated time away from work. Another scenario is called Kept-on-Salary (KOS), where the employer continues to pay an injured worker's salary despite absence from work. Thus a KOS claim is technically a TL claim without the payment of TL benefits. The audit team observed many cases where CMs did not document close attention to KOS claims. In such situations we did not observe overpayments, i.e., a worker being both paid salary and paid TL benefits; rather we observed failure to closely manage the KOS claim to ensure that medical care was appropriate and that functional limitations were being respected if the injured worker was performing modified duty.

¹⁴ This "waiting period" is a common feature in workers' compensation systems, and ranges among U.S. states from 3 to 7 days; in Canadian jurisdictions the range is 0 to 3 days.

In TL claims, after the initial investigation, the CM will establish a wage order, which is used to calculate the amount of benefits to be paid. Wage order calculations generally are complicated, and the Washington system is equally, if not more complex than other systems. Wage orders involve several factors, and the amount of compensation ranges from 60 – 75% of pre-injury wages. In performing these calculations, a common approach among workers' compensation systems is to use the "average weekly wage" (AWW), which is typically an average of earnings over the year preceding the accident. Washington, however, uses a monthly approach. Performing these calculations can be complex, particularly when wages vary over time. Washington has additional complexities. When wages are not "fixed by the month," the calculation involves a multiplier that is based upon the daily wage and depends upon how many days per week the worker was "normally employed." RCW 51.08.178. In Washington, wages also include employer-paid health care benefits, which is not typical. Finally, the amount of compensation depends upon the marital status and number of dependents. In summary, although wage calculations are generally complicated, the Washington approach arguably is more complicated than most other states.

2.2.2.4 Claim Manager caseloads

In analyzing CM performance it is important to understand the workloads, or caseloads, borne by L&I CMs, and how it compares to similar organizations. The audit team queried a panel of experts through a "Best Practice Survey" on industry standards for a wide range of processes and organizational conditions pertaining to workers' compensation claims handling. Workloads reported by the expert panel were an average of 105 TL claims or 203 MO claims, or for total caseloads if TL and MO claims were handled by a single adjuster, the average was 141. While maintaining continuity on a claim often requires CMs to handle both types of claims and some MO claims can require high level expertise, experts in our survey, and in the general literature, recommended that CMs specialize in particular claim types. For example, one respondent commented as follows:

"I would recommend not having an adjuster handle both lost time and routine medical only claims. There should be a dedicated medical only adjuster and a dedicated lost time adjuster. The lost time adjuster may have a small number of complex/severe medical only claims assigned to them (including claims with no compensable lost time because the employer has provided light-duty modified work) but these claims should be counted in their inventory as if it was a lost time claim."

Our review of CM workloads at L&I finds that the agency uses best practice in having CMs largely specialize by claim type. Generally three divisions are used: Level 1, which are mostly medical only, but also some relatively minor TL claim; Level 2, which are low-relatively low-complexity TL claims; and Level 3, which are higher complexity TL claims.¹⁵

Generally level 1 complexity claims are handled by level 1 CMs, level 2 complexity by level 2 CMs, and level 3 complexity by level 3 CMs. However, level 2 CMs handle wage payments for the level 1 TL claims, as well as some level 3 claims. Level 3 CMs handle most level 3 claims, but can handle some level 1 and 2 claims. Level 1 CMs handle only level 1 claims. All CMs handle protests related to the claims under their management. Generally, as noted, most TL claims are handled by Level 2 and 3 CMs and most MO claims by Level 1 CMs. There are exceptions, however, and L&I reports that 28% of the level 2 CM-

¹⁵ There are some employer-based units where individual CMs handle both TL and MO claims for their assigned employers.

assigned claims are MO claims; for level 3 CMs the figure is 15%. L&I reports that across the agency, 29% of claims are level 1, 43% are level 2, and 28% are level 3.

Most respondents in our survey of claims experts agreed, however, that as a general rule case complexity is an important criterion in setting caseload expectations; additionally, more respondents agreed that lost-time and medical-only cases were so different in character that they should be handled by different adjusters.

Measured by the caseload standards proposed by the expert panel, L&I caseloads appear to be higher than industry norms. L&I reported a two-year (April 2013 – March 2014) average total caseload for Level 2 CMs of 266; for Level 3 CMs it was 247. These averages are based on 78 Level 2 CM positions and 92 Level 3 positions. Using the reported TL/MO breakdown described above, this would result in the averages in Exhibit 1-5 below.

Exhibit 1-5 L&I CM Average Total Caseloads (2013 – 2014)

	Avg Total Caseload	TL (Complexity Level 3)	TL (Complexity Level 2)	Total TL (Complexity Levels 2 and 3)	Total MO (Complexity Level 1)
Level 2 CM	266	9	183	192	74
Level 3 CM	247	142	68	210	37

Source: L&I, from May 2015 caseload responses and Monthly Caseload Analysis report (Sept 2014); assumes complexity level 1 claims are predominantly MO claims

In reviewing L&I’s complexity guidelines, it appears that complexity level 2 is a “standard” level of complexity. Level 2 CMs have 73% of such claims and a very small number of level 3 complexity claims. Level 3 CMs have the vast bulk of level 3 complexity claims (94%), and a fair number of level 2 claims. If level 3 claims were weighted, at say 10% more complex, then applying this weighting would be the equivalent of 224 “standard” claims.¹⁶ Thus, using this analysis, standard TL caseloads for CM Levels 2 and 3 averaged between approximately 180 and 225 for 2013-14.

When evaluating the impact of caseloads on service delivery, understanding the experience of the CM, as well as the complexity of claims, is essential to proper analysis.¹⁷ Some CMs undoubtedly are more experienced than others. Moreover, not all claims are equally complex: some involve workers with several co-morbidities and limited education, skills, and experience; some involve employers with limited ability to provide light-duty work and no return-to-work program; some involve complex causation issues; some involve medical providers who are not skilled or experienced in occupational

¹⁶ Calculated as follows: 142 level 3 complexity, adding a weighting of 10%, yields 156 claims, plus 68 level 2 complexity claims, equals 224. For level 2 CMs, this weighting yields an average of 193 “standard” TL claims. Based on 78 level 2 CM positions and 92 level 3 CM positions, this yields an overall average of 210.

¹⁷ See “Study and Recommendations Relating to Workers’ Compensation Adjuster Performance Standards,” Report presented to the Vermont General Assembly (2005) (available at http://www.dfr.vermont.gov/sites/default/files/WC_report_adjusters_perfstandards.pdf) (“An adjuster’s ability to handle a certain caseload depends on a wide variety of factors relating to the individual (experience, education, training, work habits) [and] the type of claims involved (medical-only, routine indemnity, catastrophic loss) . . .”).

medicine; some involve all of these factors. Other claims are far less complex: the worker is fully engaged in recovery and return to work; the employer has a mature return-to-work program, including ample light-duty opportunities; causation is straightforward; and the medical provider is well-equipped to support sound occupational medicine practices.

As noted above, L&I grades complexity generally by MO vs. TL, with an additional grade within TL based on the type of injury. An additional method that L&I uses to understand the nature of its claims is the duration that a claim is open and active. An “active TL” means a TL claim in active pay status. When a claim has no payments for 60 days, it is categorized as “inactive.” L&I reports that some inactive TL claims can also be complex, including claims that are under protest or on appeal, under consideration for adding new conditions or for re-opening, and those where payment has been suspended for non-cooperation. L&I data shows that claims open and active for 5 years or greater make up 31% of all active TL claims. Some inactive TL claims are not acted upon for long periods, for example while an appeal is pending at the BIIA; at other times, they can have a flurry of activity, for example after the appeal concludes and additional work is required. Similarly, claims that are open for long periods are not necessarily complex, but require only routine maintenance. In understanding the time requirements per claim, it would be helpful if additional precision were available about the relative complexity of a claim.

It is also important, in gauging caseloads, to take into account the steps required of the adjudicator. We have identified several areas where the duties of a CM in Washington are relatively complex and time consuming, e.g., wage calculation and vocational service management, including application of the “employability” standard. On the other hand, we have identified areas in which the workload of the CM is relieved of some burdens confronting claim adjudicators elsewhere, including the availability of supporting staff to assist with certain activities. L&I utilizes a specialized unit called “Early Return To Work” to manage employer contacts to discuss RTW options. L&I also recently added a unit of claims processors to assist with certain claims management contacts and handle routine tasks. Appropriateness of medical treatment (utilization review) is generally outsourced. There are also aspects of claims management structure that are somewhat unique to L&I; for example, L&I CMs do not conduct initial claims reserving, do not handle litigation, and many TL cases are “auto adjudicated.” Moreover, in many insurance organizations claims adjudicators manage claims in several jurisdictions, requiring them to apply varying legal requirements. Regardless, a caseload of between 192 and 210 TL claims (Exhibit 1.5a) in need of varying levels of attention, at first blush, appears high; our best practice survey had an average TL caseload of 105, with responses of up to 150. North Dakota’s Workforce Safety and Insurance agency has in recent years maintained caseloads per adjuster in the range of 207 to 229 claims (a mix of MO and TL).¹⁸

Without additional in-depth study of the factors just discussed it is difficult to render a firm assessment as to whether current L&I caseloads are impeding the claims process. Likewise, we cannot say whether current caseloads are unreasonably higher than the total caseload figure indicated by our best practices survey and indications of typical workloads in other insurance organizations. Addressing some of the

¹⁸ The 2014 audit report of WSI by Sedgwick looked at adjuster workloads and commented: “. . . if we were to look at average caseloads around the industry, WSI would at an average of around 220 cases appear high. But in other operations, indemnity claims examiners may have caseloads around 130–150 while those servicing medical only desks could have around 300 claims.” They noted several unique aspects of the WSI system, such as all claims from particular employers being assigned to the same adjuster, the large number of out of state claims, and a number of streamlining processes. See: http://www.nd.gov/auditor/reports/wsi_pe_14.pdf.

issues discussed in this audit, however, may call for increased work from CMs, at least in the short run. This would create pressure on the existing body of CMs to keep up with the flow of new claims. However, over time, the average caseloads should decrease if addressing the issues discussed in this report and continued pursuit of initiatives already started by L&I are successful in closing claims faster.

2.2.2.5 Initial contact with parties

A critical aspect of claim investigation is direct contact with parties. As will be discussed in detail in Chapter 2, there were observed departures from what we considered standard claims practices with respect to making direct stakeholder contact. From an organizational standpoint, as observed in file reviews of claims from 2010 – 2013, there was not a sufficiently clear expectation of what contact is expected, when, and by whom. In 2014, a new procedure was implemented to have supporting staff known as “Claims Processors” follow up on any failed attempts by a CM to reach an injured worker. Two more attempts are made and if contact is made, the Claims Processor records routine information and then transfers the call to the CM.

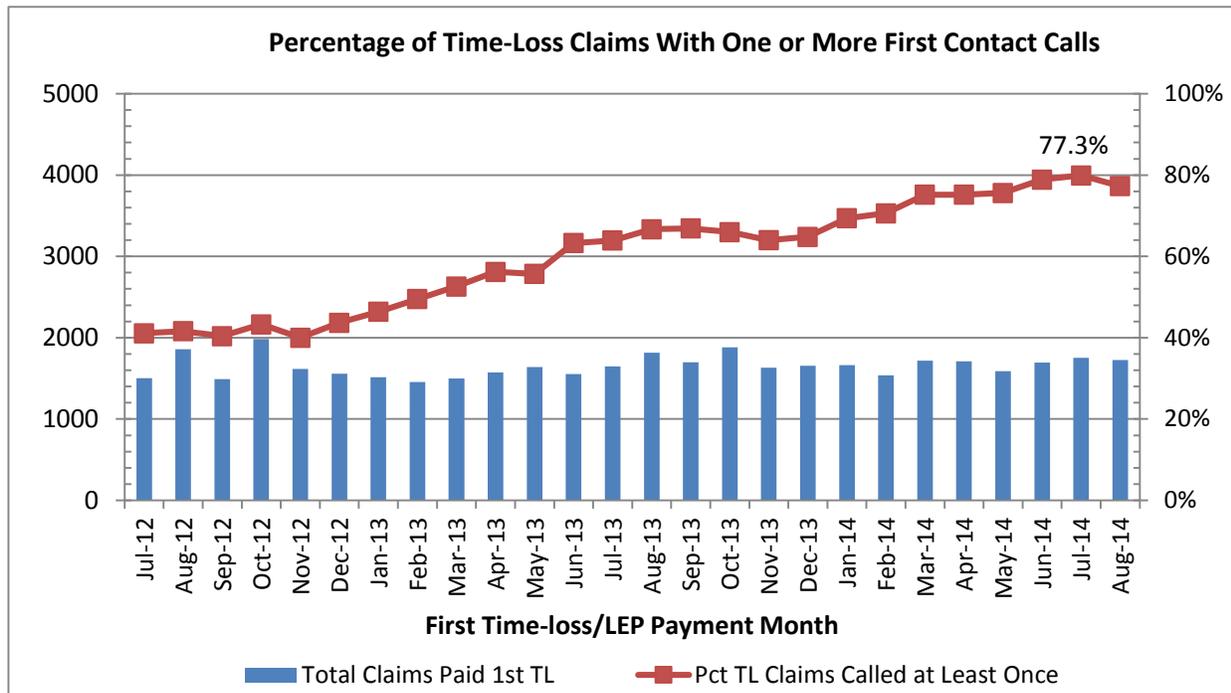
The overwhelmingly large share of contacts with parties to a claim are via letter. Some contacts are made by support staff. Many contacts are in response to incoming calls and emails. The “Early Return to Work” staff contacts employers when lost-time claims eclipse a certain number of days. This is an excellent way to begin return-to-work discussions with an employer, but it is not a substitute for a CM establishing a working relationship with an employer,¹⁹ made in connection with creating expectations in a case about desired outcomes. This is an “ownership” and accountability issue; in other words, it is unclear who ultimately “owns” a claim, in terms of being responsible for making contacts, building relationships, and planning and taking actions that are designed to lead to good outcomes.

During file reviews, the audit team observed very little documented actions that would be evidence of establishing a plan with clear, measurable goals of case activities that are designed to lead to desired outcomes. To use the example of case contact, there were virtually no observed examples of “3 point contact,” and just a few observed examples of even a single, prompt direct voice contact. This performance will be discussed in Chapter 2.

Many things have changed since the period of our file review (2011-2013), but from an organizational standpoint, it does not seem that there is a clear and enforced standard for immediate actual contact with the claimant, within a certain specified timeframe, let alone with the employer. In interviews with L&I staff and management, there is a stated goal of prompt CM contact with the worker and the employer in all TL cases; contact with the treating physician is not a priority, except in cases where contact is determined to be needed. In the best-practice survey, the number of days for “actual voice contact” with an injured worker had an average of less than one business day; for contacting the employer of injury the results were the same. CM contact with the injured worker is measured, but L&I tracks both attempts and actual voice contact in the same way, but is unable to differentiate between whether an attempt resulted in actual contact. CM supervisor interviews indicated that the quality of the contact varies widely as well. Exhibit 1-6 shows attempts at initial phone contact with injured workers; this figure does not show the timing of the attempted contacts.

¹⁹ In some cases there is a very good ongoing relationship between CMs and employers assigned to their unit. In such cases, where the employer is well acquainted with the system and the receptivity to early RTW is proven, a call may not be necessary.

Exhibit 1-6: Attempted First Contacts (2012 – 2014)



Source: L&I Research and Data Services, 2014

Challenges in making initial contacts likely result from an organizational or structural problem; in other words, it is not a performance problem per se, but a problem of rule setting, namely, L&I’s operating procedures with respect to 3-point contact is not clearly defined or enforced. It is important to note that casework is not rote and does not fit conveniently within narrow or rigid workflows; rather, contacting people, reacting to medical conditions and treatment protocols, and interjecting plans into typically complicated, personal, individual lives requires flexibility. One clear standard that is common in workers’ compensation claim handling, however, is prompt contact with injured workers, employers, and providers. This lack of contact often results in the CMs inability to timely adjudicate the claim or establish an early plan for prompt claim resolution that takes into consideration any unusual aspects of the claim.

A previous JLARC performance audit recognized the lack of immediate contact as being a departure from best practices and recommended more timely contact with workers and employers. L&I reports that they tried this but found that it was “not well-received” because many of the contacts were unnecessary. The practice was discontinued.²⁰ Surely, contact is not always necessary because most claims tend to close within a few weeks without direct personal contact. The payoff, however, is in detecting issues that might “blow up” and severely complicate the end of disability as well as add considerable, and perhaps unnecessary cost to the system. Since this is industry “best practice,” clearly private insurers’ have found a cost benefit to this practice as it helps identify problems that will affect successful return to work for those claims that will be most costly and for those workers who need assistance in reducing these barriers early in the life of a claim.

²⁰JLARC, Follow up: 1998 Workers Compensation Performance Audit, Report 03-10, September 17, 2003.

Contact is often difficult, e.g., lack of correct phone number or repeated no answers. Yet, L&I recognizes that personal contact is important and has tried various means of contacting employers and injured workers. As part of the “First 100 Days” project, which has a goal of identifying those actions within the first 100 days of the life of a claim that lead to the best outcomes, management has modified the process of contact with the injured worker to use Claims Processors to make initial contact, gather necessary facts, and pass the call on to the CM on the claim. When voice contact is actually made, CMs need to be as effective as possible in the conversation with the injured worker and gather all the information necessary to identify problems and establish a plan to mitigate or eliminate them. L&I has announced to the Workers’ Compensation Advisory Committee training in techniques to help motivate a worker, how to build a relationship with them, and how to identify case specific barriers to return to work. L&I reported that it has contracted with a disability management consultant to train evidenced based skills and strategies specific to assessing return to work (RTW) motivation and determining risks and predictive factors of prolonged duration. The training of existing staff was broken down into 8 phases and is underway, and is planned to be built into training for all newly hired staff starting August 2015. The training is designed to train staff on identified factors regarding RTW motivation and teach skills and strategies, including more effective communications, to improve outcomes.

2.2.3 Medical Treatment

Medical case management is vital to ensuring appropriate and well-timed treatment. There are standard tools available to support such activities, the primary of which are treatment guidelines. Washington was a pioneer in establishing the use of treatment guidelines in informing case management. Treatment guidelines establish what to expect in terms of overall timing and treatment practices for a particular diagnosis. Other factors, such as age and co-morbidities, provide additional helpful context.

A particularly successful program pioneered by Washington is the “Center for Occupational Health Excellence” (COHE), which has shown clear evidence of greater success in disability management than non-COHE providers. COHEs are community-based centers that undertake a more collaborative and integrated approach to occupational medicine. COHEs receive certain support from L&I and are recognized for their success. There are currently six COHEs across Washington. The State, in close cooperation with the medical community, continues to refine and strengthen ways to promote good occupational medicine.

Medical treatment is primarily managed through letter contact by the CM with treating providers and “fill-in forms” asking about treatment and disability. Consults with internal specialists are available in complex situations. For example, at present, CMs contact Occupational Nurse Consultants (ONCs) when internal guidelines so indicate or when they are perplexed by some medical situation. ONCs are not part of the claims units per se, but are assigned to particular units to provide consultative services. CMs can also request an Independent Medical Examination (IME) to obtain a second medical opinion of appropriate medical care, usual and necessary treatment, current disability status, etc. We observed that communication with IME physicians by letter is effective because these providers are well experienced in their roles and easily understand the instructions given by the CM.

In file reviews covering claims from 2011 – 2013, the audit team did not observe, at the individual CM level, efficient use of tools available to manage treatment. This is likely the result of deficient planning; for example, if a clear, documented plan with expected medical outcomes were required, this should lead to review and use of medical management tools like treatment guidelines; requesting ONC assistance for file reviews on issues of unusual or prolonged treatment or disability, and second medical opinions when needed. Often observed was the use of “Qualis,” which is the contract utilization-review

(UR) vendor. UR is a process by which certain requests for medical treatment are compared with approved treatment guidelines. Qualis makes a recommendation to the CM as to the appropriateness of requested treatment. This is an important tool to managing case costs, but it was often seen later in cases, after lengthy periods of treatment (as opposed to earlier in the cases before patterns of treatment were established) and in relatively serious interventions, like surgeries and advanced imaging.

What was not observed was routine CM utilization of medical treatment planning and advice of internal or external medical consultants. L&I reports that the Office of the Medical Director contracts with 23 specialized medical consultants. During calendar year 2014, these consultants completed approximately 860 referrals. Common reasons for a referral to a medical consultant are questions concerning causation, impairment ratings, treatment or reopening. An internal medical consultant commonly utilized is the Occupation Nurse Consultant (ONC). In recent months additional ONC efforts have been planned and initiated by L&I. Between July 2013 and May 2014, 11 new ONCs were hired. L&I reports that in 2014, ONCs completed over 40,000 requests for assistance on medical issues from about 250 claim managers in 28 claims units. L&I further reports that ONCs are charged with review of claims with 14 days of time loss, to identify expected length of claim duration, opioid use, risk factors and pre-existing conditions. The audit file review covered a sample of claims from 2011 – 2013, before some of the above measures were in place. In our file review we saw little evidence of CMs working from their documented plans to influence the providers' treatment plans or obtaining additional information as to reasons and documentation for outlier medical treatment. The causes for this gap in the documentation are clearly multifactorial, and the changes underway at L&I in this regard should improve outcomes if properly designed and implemented.

One important aspect of managing medical treatment involves limiting treatment to those conditions caused by the accident. This occurs by the use of "segregation orders," which is an order that limits treatment to a particular condition, or conversely, excludes a particular condition or treatment. File reviews indicated that segregation orders did not follow an established workflow. In other words, there were no apparent triggers in cases that resulted in a segregation order. Rather the audit team observed more reactive workflows, where treatment of a particular condition was noted in a treatment record, and then the CM would either deny treatment for the new condition or pursue additional information, and often not address the issue before claim closure.

2.2.4 Disability

Helping injured workers and employers properly manage time away from work caused by workers' compensation injuries is vital to good case outcomes. In Washington, this occurs without documented deliberate planning and coordination by the CM. In other words, the information systems do not document plans or actions, which are designed or taken to achieve prompt return to work (RTW), in a logical and coherent way. This is not to say that L&I does not have a vigorous RTW emphasis. Numerous initiatives and programs are designed to assist and provide incentives to achieve prompt RTW. For example, resources are applied to Kept-on-Salary, the Early Return to Work (ERTW) Program, the Stay at Work (SAW) program, the Preferred Worker Program, and many vocational services to assist employers in job modifications. In terms of vocational services, it appears L&I employs a lot of services, but it is less clear how the use of such services is positively affecting case outcomes.

The audit team observed, primarily in file reviews, that CMs seldom act to facilitate agreement on an early return to work strategy acceptable to the injured worker, employer, and treating physician. Nor is there much documented interchange between the CM and other L&I staff trying to promote RTW, such as the ERTW program or SAW program. We observed notes like "ERTW contacted employer/no

modified duty available,” but no documented efforts of CM interaction and engagement to pursue a different strategy to attempt to reach an agreement on return to work with the pre-injury employer.²¹ Claim managers in any state know that as the worker’s time away from work stretches out to months, resuming the relationship with the employer of injury becomes less and less likely. In Chapter 5 we will describe in detail the negative impacts both on the livelihood of injured workers and also the costs of claims caused by prolonged time away from work.

There may have been more planning than we detected, from our file reviews. Given the lack of user “friendliness” of the computerized information systems, it could be true that pro-active planning and actions were being undertaken, and not documented. Additionally, most records and notes are fully open to all parties through the Claim and Account Center, which we believe has a negative effect on documenting and measuring planning activity. Regardless, claims manager performance will be described in Chapter 2 of this report, and overall performance in Chapter 5, and there are noted deficiencies. From an organizational perspective, this appears to be the result, at least in part, of a reactive approach to disability management by the CM. Receptive employers can get abundant assistance from L&I through job analysis and assistance from the RTW and Stay at Work program. However, if the employer is skeptical or reluctant to engage in modified duty, the opportunity may be lost. Likewise, some CMs may accept without challenge overly restrictive functional limitations prescribed by the treating physician, e.g., “no work for 7 days.” The path of least resistance is to continue to pay indemnity and medical bills as long as there is paperwork to justify it.

Effective claim management involves initiating and managing a large number of integrated services, most of which are focused on effective medical treatment and early return to work. Disability Management is a concept that has gained broad acceptance in the field of workers’ compensation.²² It seeks to provide proactive and coordinated medical and vocational services directed at efficiently returning an injured worker to as close to their pre-injury condition, including employment status, as possible as quickly as possible. Washington’s Stay-at-Work program directly subsidizes workplace modifications and wages to help workers stay on the job while recovering. “Early Return to Work,” a core component of disability management, is a well-accepted public policy throughout workers’ compensation systems. Washington invests heavily in vocational and rehabilitation services, as well as specialized return-to-work experts that are meant to intervene early, although timing is not always optimal for maximizing success. Additionally, major legislative reforms were enacted in recent years, and several management initiatives are ongoing, with a targeted emphasis on improving outcomes through RTW related interventions.

In some ways, it appears that L&I fully embraces sound disability management principles, e.g., the Stay at Work Program, the Preferred Worker Program, the use of claims free discounts, and the Early Return to Work program.²³ Recent efforts by management to incorporate a “culture” of proactive, outcome-based actions designed minimize unnecessary time away from work appear to be taking hold, as demonstrated during interviews with CMs and supervisors.

²¹ L&I reports that the ERTW staff would be primarily responsible for follow-up in such situations.

²² Disability management best practices are reviewed more thoroughly in Appendix 2.

²³ We noted that Return-to-Work Services Program staff have set out very sensible process improvement studies: 1) identify the claims that most need ERTW assistance and those that need intensive services, 2) continue to develop standard vocational work parameters, 3) strengthen the partnership with claims staff, and 4) evaluate how the new COHE referral process is working.

The mantra of early RTW is clearly engrained in the culture of L&I.²⁴ But, as mentioned above and discussed in detail in Chapter 2 and in Appendix 4, certain steps in the claims process, during the time period we studied, deviated from best practices and norms for other workers' compensation systems. While L&I has constructed an efficient and well-disciplined process, there are deviations from practices that are common in other systems that seem to be contributing to very high proportions of very long-term disability; as will be discussed in detail in Chapter 5, the rate of "pensions," involving claims of "permanent and total disability," is extremely high in Washington.²⁵ L&I has recognized the importance of return to work but so far there is no evidence that the agency is reducing the number of very long-term disability cases.

As we have noted, L&I has instituted several procedural changes in the past two years that appear to be making a difference in disability duration and return to work. There have been improvements in the timing of vocational services delivery, as well as in better management of treatment involving opioids, to name two examples; we discuss performance of these and other efforts in Chapter 2. Also, in Chapter 6, Summary of Recommendations, we offer additional ways to respond to weaknesses in the claims process. Launching new initiatives is not enough. Performance matters. That is why we have recommended that L&I publish a broad set of rigorously developed performance metrics.

As just mentioned, a critical aspect of medical management involves opioid use. Opioid prescriptions for workplace injuries grew rapidly in the 1990s and early 2000s. Washington medical authorities, as well as others nationally, have taken the position that the risks of opioid use for chronic pain outweigh the benefits for the injured worker.²⁶ In file reviews (2010-2013), the audit team frequently observed prescriptions for opioids for less complex conditions like sprains and strains, as well as frequent renewals of prescriptions for extended periods without sufficient discussion of clinical evidence supporting the continued use.

Washington has been a national leader in altering the medical-management landscape regarding the use of opioids. In terms of how the claim management process is organized, there are now clear guidelines for physicians and directives to claims managers on the use of opioids for chronic pain.²⁷ A CM's role is to ensure that payment for opioids will be discontinued if all the expected clinical reports and patient agreement are not satisfactory. During the period of our file review, guidelines were less strict and there was evidence that long-term use of opioids seemed to be tolerated without any showing of clinical improvement in pain or function. We will discuss performance with respect to opioid management in more detail in Chapter 2.

²⁴ L&I presentations before the Workers' Compensation Advisory Council have frequently referenced the importance of building a culture of early return to work in the agency, among counselors, and in the employer community.

²⁵ Barth, Peter S., Heather Grob, Henry George Harder, H. Allan Hunt, and Michael Silverstein. 2008. "Washington Pension System Review." Upjohn Institute Technical Report No. 08-025. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research. http://research.upjohn.org/up_technicalreports/25 ("The number of pensions awarded per 100,000 covered employees is very high in Washington compared with other states; roughly four to eight times the 36-state average, and about two to four times as high as any other jurisdiction.")

²⁶ "In a paper published Sept. 30, 2014 by the American Academy of Neurology, the authors conclude that the risk of dependence with long-term use, combined with the poor understanding of best practices by physicians, makes the overall risk of opioid use vastly outweigh the potential benefit for many patients. The lead author on the paper was Dr. Gary Franklin, Medical Director at L&I. See: <http://www.neurology.org/content/83/14/1277>.

²⁷ Medical Treatment Guidelines: Guideline for Prescribing Opioids to Treat Pain in Injured Workers, Office of the Medical Director, July 2013.

2.2.5 Disputes

The dispute system is organized around the formal “protest” of orders. CM decisions typically take the form of an order, which contains language outlining the process to contest the order. A more generic complaint can be handled like a protest, but generally protests follow orders. The CM responsible for the case handles the protest, and after review issues a new order either affirming or modifying the original order.

In lieu of a protest, an aggrieved party (worker, employer, or provider) can appeal to the BIIA; in such cases, the BIIA offers L&I the opportunity to re-assume jurisdiction of the case, and if re-assumed, a select L&I unit of senior CMs will handle the review. After review, a new order is issued either affirmed or modifying the underlying decision. The new order can be appealed to the BIIA. We discuss performance of the dispute process in detail in Chapter 3.

2.2.6 Claim Closure

The final step in the claim management process is moving a claim to closure. The actions and steps include ending medical interventions, i.e., achieving a “fixed and stable” medical condition; processing benefits for permanent loss, if any; and making a determination about “employability.”

A clearly established goal of a worker’s compensation system is to restore as much as possible an injured workers’ work capacity: “One of the primary purposes of this title is to enable the injured worker to become employable at gainful employment. To this end, the department or self-insurers shall utilize the services of individuals and organizations . . . as may be reasonable to make the worker employable consistent with his or her physical and mental status.”²⁸ Thus, the CM is required to manage a case to closure by identifying barriers to “employability” and addressing them.

A related aspect of this set of activities is awarding one-time benefits for permanent loss. This is referred to as a “permanent partial disability (PPD) rating,” which is a percentage of loss that an injured worker retains as a result of the workplace accident. Under certain circumstances the payment may be made in a single lump sum; for larger amounts, payments are spread over time. The goal of such policies is to recognize that workers’ compensation injuries sometimes result in physical impairments that are permanent, and warrant financial compensation. Workers’ compensation systems vary in how permanent loss is handled; studies have established basic groupings of the various approaches that are

²⁸ RCW 51.32.095. The statute further describes this public policy as follows:

When in the sole discretion of the supervisor or the supervisor's designee vocational rehabilitation is both necessary and likely to make the worker employable at gainful employment, then the following order of priorities shall be used:

- (a) Return to the previous job with the same employer;
- (b) Modification of the previous job with the same employer including transitional return to work;
- (c) A new job with the same employer in keeping with any limitations or restrictions;
- (d) Modification of a new job with the same employer including transitional return to work;
- (e) Modification of the previous job with a new employer;
- (f) A new job with a new employer or self-employment based upon transferable skills;
- (g) Modification of a new job with a new employer;
- (h) A new job with a new employer or self-employment involving on-the-job training;
- (i) Short-term retraining and job placement.

RCW 51.32.095(2). Note that this statute is effective only through June 30, 2016, but was made permanent in the 2015 legislative session.

used, including in a publication by John F. Burton, Jr., which set forth six types of PPD benefits.²⁹ The approach used by Washington falls within the “impairment” approach, which was noted by Burton to appear to be the most common, and according to which PPD benefits are paid based on the extent of the impairment.³⁰ The Washington approach is to award PPD benefits, after a medical condition is fixed and stable, based on the percentage of “whole body impairment” caused by the injury (as determined by a physician).

Another related issue is “permanent and total” incapacity, meaning that the worker is not capable of any gainful employment. Known in Washington as a “pension” claim, CMs will prepare a file for review by a specialized adjudicator, to determine if the worker meets the specified standard and should be awarded a pension. As will be discussed in detail in Chapter 5, Washington has a very high rate of pension claims.³¹

A claim progresses to closure as treatment concludes. Before a claim can be closed, however, the CM must have evidence of the employment prospects of the injured worker. Obviously, employability is affirmed if the injured worker returns to work at or before the time healing is completed. But if the worker has not returned to work, or the treating physician has not given an unrestricted return to work finding, the CM seeks objective evidence on the worker’s “ability to work.” This can be a complex, costly and contentious part of the claim process. Vocational specialists assist CMs in the determination of employability; performance for these activities will be discussed in detail in Chapter 2.

- If the worker is found to be employable, they are paid permanent partial disability based on a physician’s rating of “whole body impairment” and the file closed after payments are complete.
- If, as a result of this process, the injured worker is found to be unemployable, the CM would manage development and delivery of vocational services designed to maximize work capacity and secure employment.
- If these services are not successful, and the non-employable determination is considered permanent, then the CM will prepare the claim for review by an L&I pension adjudicator, to determine whether to accept the claim as involving a pension.

Impacts, on both economic and non-economic costs, from the application of this standard, which results in a high rate of pensions, will be discussed in detail in Chapter 5.

There is a consensus of vocational experts that the optimal outcome is returning to pre-injury employment, with or without the need for job modification. The least desirable outcome is to try to retrain a worker for a new career. This is clearly recognized by the Washington State Legislature in legislation setting up the Vocational Improvement Pilot (discussed below), in which the least desirable

²⁹ Burton, John F., Jr., “Permanent Partial Disability Benefits,” published in “Workplace Injuries and Diseases: Prevention and Compensation: Essays in Honor of Terry Thomason (Upjohn 2005) (available at http://research.upjohn.org/up_bookchapters/287/).

³⁰ Other models attempt to compensate for loss of earning capacity, and others attempt to compensate for actual loss of wages. See Burton, id., p. 94.

³¹ See Barth et al., op cit. (“The number of pensions awarded per 100,000 covered employees is very high in Washington compared with other states; roughly four to eight times the 36-state average (depending on the measure), and about two to four times as high as any other jurisdiction.”)

outcome of delivering vocational services is engaging in re-training for a new job.³² This is particularly undesirable if the injured worker lacks the skills, aptitudes and motivation for formal retraining.

In managing such situations, work context is obviously vital. For example, a small employer without many staff positions likely will have far less flexibility in establishing permanent job modifications than a larger employer with a broader set of staff positions. The age, experience, education level, primary language and work history of the injured worker is also important context. Some of this context is outside the control of the CM, but this entire context is essential to the understanding of and making a determination about “employability.”

The problem with the employability standard, however, is that it creates a much more rigorous standard for claim closure than in other jurisdictions. It seems logical that when most injured workers reach maximum medical improvement (MMI), often also called “fixed and stable,” they are no longer temporarily totally disabled since additional treatment will not help them recover any more. In most states, benefits change to permanent partial disability or permanent total disability. In Washington, temporary benefits continue to be paid after maximum recovery until a determination of “employability” is made. One would assume that a rebuttable presumption should be that they are employable and permanent partial disability (PPD) should be started. After all, they were employable before the injury, and if they do not have serious impairments why wouldn’t they be employable after MMI?³³ Of course the strength of this logic is strongest with workers having a good job history and transferable skills, and weakest for workers with very limited and tenuous job histories and few if any transferable skills.

In most other jurisdictions, when an injured worker reaches MMI, temporary disability benefits stop. If the worker cannot immediately find employment, PPD benefits help supply income during the transition from MMI to full labor force participation. PPD systems vary widely across the US. The different systems are the result of individual state policy decisions to balance the equities to workers with differing personal characteristics and degrees of injury.³⁴

The Washington statute (RCW 51.32.090(3)) provides as follows: “As soon as recovery is so complete that the present earning power of the worker, at any kind of work, is restored to that existing at the time of the occurrence of the injury, the payments shall cease.” An example of how this can be interpreted is from the L&I Self-Insurance Claim Manual, which provides in relevant part as follows:

Once the payment of time-loss benefits has begun, the benefits must be continued until one of the following occurs:

- **Released for Full Duty** - When a worker is given a full release to the job of injury, time-loss benefits may be terminated. Note: If a worker is released for work on the same day they see their provider, time-loss is payable through the end of that day (i.e., worker has an appointment with their provider on January 17th, at the appointment the provider signs a release for work as

³² RCW 51.32.095(2).

³³ Admittedly, RTW after injury may be complicated by “soft” impairments not ratable by a physician, such as loss of self-confidence or muscle deconditioning. Also, the state of the economy controls employment options.

³⁴ See Welch, E., “Permanent Partial Disability Benefits” (Michigan State Univ. 2008) (available at http://hrlr.msu.edu/hr_executive_education/documents/PPD20Discussion2008-02.pdf) for a detailed analysis of PPD system types and policy implications; see also Barth and Niss, *Permanent Partial Disability Benefits: Interstate Differences*, Workers Compensation Research Institute, September 1999, page 6 (discussion of the public policy purposes of PPD which includes earnings losses, other economic losses, non-economic losses, and pain and suffering) (available for purchase at www.wcrinet.org).

of January 17th, the same day as their appointment, the worker is eligible for time-loss through the 17th).

- **Found Employable** – When a vocational assessment is conducted and a worker is determined to be employable, time-loss may be terminated after the determination of employability is made.
- **Returns to Work** – When a worker returns to work, they are not eligible for time-loss benefits. If the worker’s earning capacity has decreased as a result of the injury or occupational disease they may be entitled to loss of earning power benefits.³⁵

From file reviews and interviews with L&I staff and others on this subject, it appears that the approach to employability is as follows:

- If the doctor has not released the worker to the job of injury (based on objective medical findings) the CM must determine whether the worker can return to some type of work before beginning the process of stopping time loss and closing the claim — it can be either the job of injury or a vocational evaluation to determine whether the worker has skills from prior employment that would transfer to other types of employment and a supportive labor market.
- If the injured worker is not rehired after injury (employer of injury or other) and if they do not have an unrestricted return to work from their doctor, the CM seeks to determine if they have “transferable job skills” that would enable them to find gainful employment.
- The CM, with the assistance of vocational rehabilitation counselors, who are independent experts retained by L&I, also must establish a “labor market.” This means that considering the particular situation of the worker, including factors such as experience, background, work history, and work capacity, there are jobs in the area where the worker lives. These factors are not outlined by statute, although some have been established by administrative rule.³⁶ An L&I report, “Labor Market Surveys in a Challenging Economy,” notes that a labor market is established “if it shows enough job opportunities in the worker’s relevant labor market to enable the injured worker (IW) to become employable.”³⁷ What are “enough job opportunities?” Applying this standard involves subjective aspects. In some instances, counselors will interview the employers to inquire whether they would have hired the worker if given the chance. In one interview, the CM’s role was described as being required to establish every aspect of re-employment short of actually placing the worker in the new job.

This is different from most other states, which allow termination of temporary disability benefits once maximum medical improvement is attained, regardless of “full” employability. In such states, only if there is “zero” employability would permanent and total disability (PTD) benefits be warranted. Between “zero” and “full” it is essentially up to the injured worker to maximize job opportunities while being paid any permanent partial disability to which they may be entitled.

Most states allow vocational services to be sought by a worker, but these would be applied for and determined by various standards for eligibility. Thus, it would appear that Washington’s structure and approach to claim closure is more complex in that L&I is required to manage a case to “employability”

³⁵ L&I Self-Insurance Claims Adjudication Guidelines, “Time-Loss Compensation – January 2015,” p. 19. Loss of earning power benefits would be paid until MMI is reached and the case is closed.

³⁶ WAC 296-19A-070; labor market factors are described in WAC 296-19A-140.

³⁷ Available at <http://www.lni.wa.gov/ClaimsIns/Voc/BackToWork/LaborMarket/Default.asp>.

which generally means a full-duty medical release, a full-duty “vocational” release, meaning a vocational assessment that supports full employability, actual return to work, or a finding of no employability.

Most states award PTD for serious impairments defined by statute, regardless of residual work capacity, such as 100% loss of use of two limbs or total blindness. Washington and most other states do not require such cases to show lack of employability or deny benefits if there are future earnings of any amount. Apart from these statutory permanent total cases, states typically do not provide PTD benefits even for serious impairments if there is a significant residual work capacity or actual post-PTD earnings. For example, in Oregon, PTD is awarded when a worker proves that he or she is incapacitated “from regularly performing work at a gainful and suitable occupation.” A “gainful” occupation means one that pays the lesser of: (i) two-thirds of the worker’s average weekly earnings; or (ii) federal poverty guidelines for a family of three. Additionally, the worker is required to show that he or she has made reasonable efforts to obtain employment. Benefits cease if there is return to work and the post-injury earnings plus the permanent and total benefit exceeds a worker’s pre-injury wage.³⁸ As outlined above, Washington’s “employability” standard is relatively less clear than the Oregon standard, regarding both what level of incapacity qualifies a worker for PTD and also what amount of post-PTD earnings disqualify a worker from benefits, and appears to be more complicated to put into practice by L&I CMs.

Other states face some of the same difficulties as Washington in determining the gainful employment potential of a worker. But these states may have fewer problems in resolving the ambiguity of gainful employment potential because the parties often reach agreement to settle the claim with a lump-sum benefit. This particular issue was examined in the Upjohn Institute study of pensions in Washington.³⁹

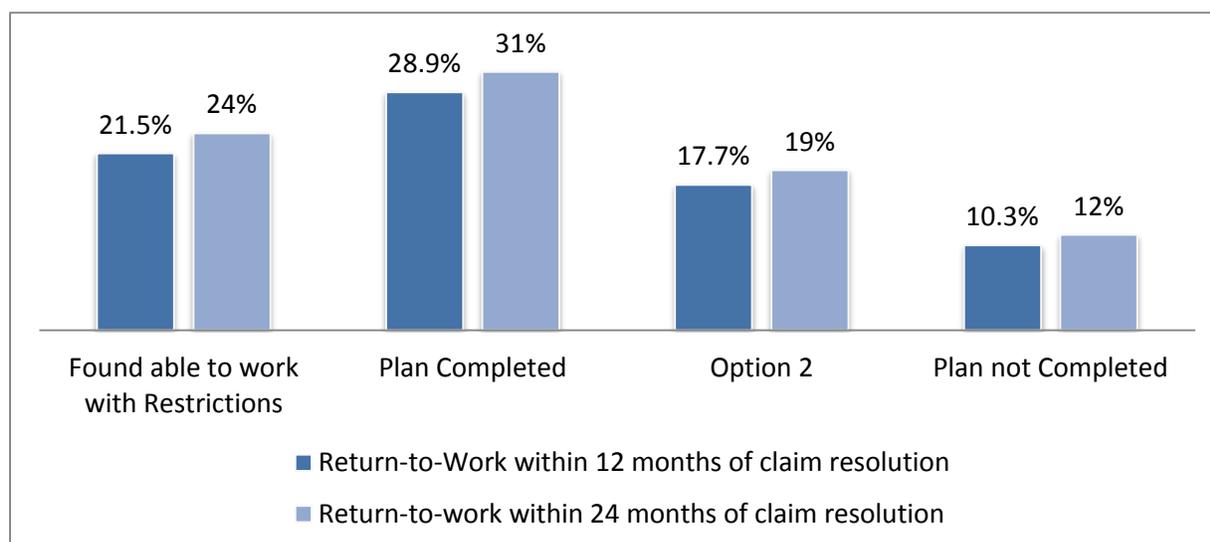
Retraining injured workers has been an important feature of Washington’s system since at least the 1970s. But retraining seemed to have chronic problems. The greatest problem was the failure of many plans to be completed as written; for various reasons the worker abandons the plan. Other problems included: inefficiency in the plan development, over reliance on formal training versus on the job training, and poor RTW. In response to these problems, the Washington legislature initiated a multifaceted reform package called the Vocational Improvement Pilot (VIP),⁴⁰ implemented January 2008. Among its many features, VIP allows an individual eligible for retraining to take a lump sum equivalent to 6 months of time-loss benefits in exchange for closing their claim. This election to opt-out of retraining is called “Option 2.” Option 2 has been popular.

Exhibit 1-7 shows the RTW outcomes computed by L&I for four classes of workers: 1) those choosing Option 1 and completing training, 2) those choosing Option 1 and failing to complete training, 3) those choosing Option 2; and 4) for comparison, those found ineligible for retraining because they could return to work. The best RTW outcome shown is those completing their retraining, who had a 31% RTW rate two years after plan completion. Those failing to complete their plans had the lowest RTW rates. Rates of RTW for those electing Option 2 is midway between the rates of RTW for workers that have failed retraining plans and those who complete retraining.

³⁸ Oregon Revised Statutes 656.206.

³⁹ Barth, Peter S., Heather Grob, Henry George Harder, H. Allan Hunt, and Michael Silverstein. 2008. "Washington Pension System Review." Upjohn Institute Technical Report No. 08-025. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research. http://research.upjohn.org/up_technicalreports/25.

⁴⁰ RCW 51.32.099(1)(a).

Exhibit 1-7: Evaluation of Vocational Rehabilitation RTW Outcomes by Class of Injured Worker

Source: L&I Research and Data Services, Fall 2014

A three-part assessment of the reforms completed in 2011 by the University of Washington⁴¹ reached generally positive findings of the so-called Vocational Improvement Pilot (VIP) program. On the positive side, Option 2 seemed to be a desirable choice for nearly a third of those eligible for retraining; the return to work rate and percentage of pre-injury income regained stood midway between the outcomes of those completing training and those with failed training plans. Efficiency of plan development was unambiguously improved. On the negative side, RTW for all plan outcomes was worse and the failure rate of retraining had not improved. Many elements of the pilot could not be judged for lack of sufficient time or data. Additionally, the Great Recession clearly had significant impacts on job availability in general, as well as significant impacts on the VIP program, particularly for those injured workers with restrictions. Studying the pilot reforms taught lessons about system enhancements:

- **Efficiency.** The timeliness and satisfactory conclusion of vocational plans can be improved, as shown by the average time to complete plans and the number of plans successful approved.
- **On the Job Training.** Despite the difficulties of arranging On the Job Training (OJT), its advantages, in terms of lower costs and shorter delivery timeframes, suggest that it be pursued. OJT only makes up 3% of job training plans from 2011 to the present.
- **Option 2.** Those electing Option 2 achieve success with RTW and income restoration better than those entering into a retraining plan but failing to complete it.
- **Failed Plans.** Slightly less than 45% of retraining plans fail to complete their planned goals suggesting either that retraining is not appropriate for some and that too many people are incorrectly steered into the formal retraining route, or that plans are ill conceived, improperly managed, or inappropriate for a worker's particular situation, such as lengthy retraining plans for some adult learners. There are other miscellaneous reasons for plan failures.
- **Poor Perceptions by Workers.** The opinions of workers that enter into retraining show a significant negative shift in evaluations from before to after retraining of L&I, vocational counselors, and the

⁴¹Jeanne Sears and Thomas Wickizer, Evaluation of the Vocational Rehabilitation Pilot Program, University of Washington, Dec. 2012 (p. xviii), available at <http://www.lni.wa.gov/ClaimsIns/Files/Vocational/VocPilotProgEval.pdf>.

retraining process.

L&I supported legislation to make the VIP reforms permanent. In 2015, the Washington State Legislature enacted a significant enhancement of Option 2, among other vocational-service related changes (2015 substitute HB 1496).⁴²

Survey evidence on the opinions of injured workers toward the vocational system comes from Sears and Wickizer in their evaluation of VIP. They found that 50.1% of those workers electing retraining said their vocational counselor has a positive effect on RTW, and 42.6% said that the Claims Manager had a positive effect.⁴³ But the overall satisfaction with the vocational retraining process was low before retraining began, and even lower after their claim was closed; 69% said they were “satisfied” or “very satisfied” before retraining, and only 48% said the same after closure.

The audit team also surveyed injured workers about vocational services. A more negative evaluation of an injured worker’s vocational counselor was indicated, relative to the aforementioned survey by Sears and Wickizer. For example, only 9.5% of respondents gave their vocational counselor a “helpful” or “very helpful” rating in the RTW process. The Claims Manager received 10.5% helpful ratings. The L&I RTW specialist received only 3.2% of the two helpful ratings. This evidence is disparate in method and result from the University of Washington study, but it does signal the importance of stakeholder evaluations. L&I sponsors regular worker surveys, and results show higher worker satisfaction levels with vocational services than found in our worker survey. Sampling methods may account for this difference. Our survey sampled more serious claims, and also included claims involving attorney representation. Given the importance of and significant investment in terms of time and money for vocational services, and the difficulty of setting and maintaining objective performance standards for this type of service, ongoing surveys of recipients of services are a good way to verify that the vocational process is functioning properly.

Our team observed that L&I demonstrated a disciplined management approach to vocational service delivery. On a typical month over 350 different service providers are performing assessments and engaged in retraining planning and implementation. L&I defines the scope of services and reporting mechanisms. A review by an L&I Vocational Service Specialist is required before assessments or plans are accepted and fees paid to the provider. All these components to the system are reviewed by a technical advisory committee and changes are made when there appears to be a broad agreement among stakeholders. Management reports document the performance of Vocational Service Specialists in reviewing plans and assessments; their reviews uniformly come in under the desired time limits.

There is naturally tension between the goals and expectations of the injured worker, the vocational service provider, and L&I’s overall system objectives. Providers want to have a streamlined system with standard work expectations, cooperation from the client, and adequate compensation for their services. Injured workers present a wide range of cooperation and expectations; they want a plan personalized to their needs and interests (which may be unrealistic). L&I would of course like to see services provided timely and with uniformly high quality by a stable pool of providers. Ideally, all three interest groups

⁴² L&I, Workers Compensation Vocational Rehabilitation System, Annual Report to the Legislature, Dec. 2014. It states: “...the subcommittee along with L&I, recommends that some aspects of the VIP be changed to increase efficiencies, accountability and worker choice; and that the VIP, with these changes, become a permanent part of Washington’s workers’ compensation system.” See: <http://www.lni.wa.gov/Main/AboutLNI/Legislature/PDFs/Reports/2014/WorkCompVocRehabSys.pdf>

⁴³ Sears and Wickizer, op. cit., pp 78-80.

would like to see RTW as the typical outcome of the vocational process. L&I must balance the interests of all parties, which to date has meant a very drawn out and expensive process. Vocational services might include an AWA, followed by Retraining Plan Development, followed by Plan Implementation. Vocational professional fees averaged \$2,500 for completing an AWA and \$3,700 for developing a plan in FY14. On top of this, TL benefits are paid until the retraining is completed. There are long lag times in completing each step of the vocational process, discussed at length in Chapter 2.

To advance these goals, L&I has instituted a host of measures to improve the claim process and RTW success, including:

- Washington Stay at Work program (financial incentives to keep workers at pre-injury employers)
- Preferred Worker Program (encourages and incents hiring of disabled workers)⁴⁴
- Specialized Early Return to Work staff in regions (these vocational experts appear to be more successful than private counselors and achieve good evaluations from clients)
- A general review of claim manager training (this training teaches apprentice and experienced CMs how to communicate with stakeholders about RTW and how to overcome resistance)
- Medical provider training on their role in return to work (expansion of COHE and rigorously building a qualified Preferred Provider Network)
- Promoting Kept-on-Salary (KOS) (allows employers that are in jeopardy of losing their “claim free” discounted rate)
- “Claims Evolution” initiative (an umbrella term for systematic changes to the training and role of CMs, e.g., adding claims processors to assist CMs with routine tasks and revamped CM apprentice training; Claims Evolution consists of six projects: Medical Management; Return to Work Coordination; Claims Technology; Claims Leadership; Claims Handling; and Claims Training)
- Early AWA (a pilot program that seeks to more effectively target early vocational assessments)
- Re-Employment Specialists co-located with State Fund claim managers; L&I is also piloting co-location of WorkSource (the Washington State re-employment program) specialists at L&I, on contract specifically to support injured workers.

We will comment further on some of these measures in Appendix 2 covering disability management and in the recommendations to follow.

In addition to the above process improvements, L&I is planning or implementing significant changes in its IT systems that will make substantial improvements in claims processing. Some examples:

- L&I is currently working to allow Health Information Exchange (HIE) data to be entered in the new Occupational Health Management System (OHMS) utilized by the COHE providers. Management believes that when this is accomplished, 80% of all Reports of Accident (ROAs) should be filed electronically (either by FileFast’s web-based application or HIE).
- Management has requested \$9.8 million in the 2015/17 budget process to implement a replacement for the legacy LINIIS system.⁴⁵

Other states have recognized the need to create structural incentives for RTW. For example, California, Tennessee, and other states have created financial incentives for employers to accept disabled workers

⁴⁴ Note that in the 2015 legislative session, the incentives for the Preferred Worker Program were increased. Substitute HB 1496.

⁴⁵ Presentation to the WA Workers’ Compensation Advisory Committee, Sept. 22, 2014.

back in order to lower the amount of PPD paid. At least 10 states cap temporary disability benefits at limits ranging from 110 days to 500 days (regardless of the date of MMI); in such situations, the carrier must continue to pay temporary benefits until “employability,” but it is capped. Some states, like Oregon, Montana, and Washington, offer financial incentives to promote employer receptivity to RTW.

Even if the statutory requirements are roughly similar in some states, case law can make dramatic differences in how disability must be managed. The term “gainful employment,” which appears in the statutes of most states, has generated both very broad and very narrow court interpretations of that term.

As indicated, the law in Washington is different than in most other states. In the majority are those states that permit TL benefits to be terminated upon a medical finding of maximum medical improvement, the equivalent of “fixed and stable” in Washington. This, of course, will create a major difference in the responsibility of the insurance carrier to provide or guarantee vocational services. Naturally, the rights of injured workers are more limited in those states that allow cut off of TL without any evidence of employability. Labor advocates in Washington have portrayed the employability standard as being too prone to find employability for minimum wage jobs far below the work history of the injured worker. This is clearly a very charged issue that pits some business interests against advocates of worker rights.

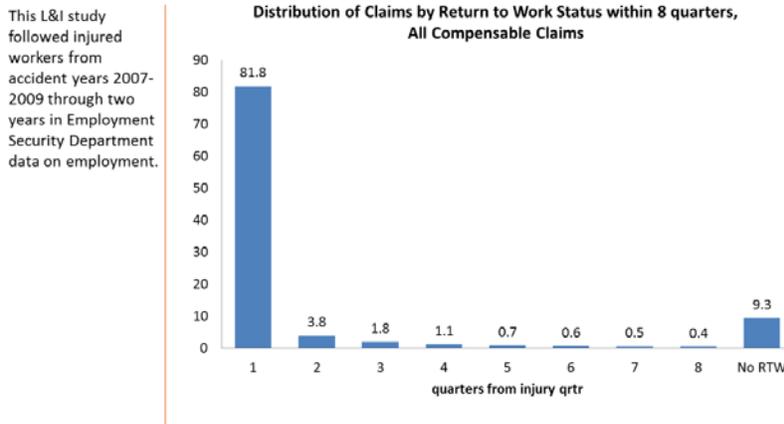
Even without arbitrary cutoffs or other means of curtailing TL, well-focused disability management will help keep the number of long-term disability cases to a very small fraction of claims. In Chapter 5 of this report we present statistics on disability duration in Washington, which show that Washington unique in the degree to which it has extremely long periods of paid disability payments. As discussed further in Chapter 5 and Appendix 2 – Disability Management, data from the analysis of Washington’s workers’ compensation system indicate a departure from outcomes noted in other jurisdictions for longer-term temporary disability claims. This signifies that disability management, in its broadest sense, in Washington suffers serious shortcomings, at least for the period under study. This is a multifactorial issue, encompassing not just the claims process but also factors such as the underlying laws defining benefits, the employer and worker response to RTW, medical provider facilitation of RTW, and disputes and attorney involvement, It is also true that just because another state has relatively lower rates of long-term disability, it does not necessarily follow that it is utilizing more effective disability-management practices. However, the impact of the delivery of certain claims handling services is clear, and compensation systems that excel in disability management are characterized by specific practices that facilitate early, safe, and durable return-to-work outcomes for injured workers. Recent initiatives by the agency are designed to identify and address several of these concerns, including a significant focus on the timing and nature of RTW and vocational rehabilitation services. Such efforts should be carefully studied and expanded as success is shown.

Exhibit 1-8 illustrates the nature of claims management in Washington: Good outcomes for 80-85% of claims while 15-20% are on a path that runs the risk of never returning to work. These long-term disability and pension cases are very expensive: 9.3% of all claims generate 85% of the system cost.⁴⁶ This general pattern of a small fraction of claims representing a huge share of costs is common in workers’ compensation. However, there is an unusually large fraction of extremely long disability in Washington (2 or more years in duration); more discussion of the impact on overall performance is provided further in Chapter 5 of this report.

⁴⁶ Kirsta Glenn, April 30, 2013 statement to Washington Workers’ Compensation Advisory Committee.

Exhibit 1-8: RTW outcomes 2007 – 2009

Most injured workers either return to work quickly or stay in the system a long-time



Source: L&I Kirsta Glenn Workers' Compensation Advisory Committee presentation, April 2013; note that "compensable" in the sub-title of this chart refers to TL claims

3 CLAIMS MANAGEMENT DIFFERENCES BASED ON INSURANCE "TYPE"

Next, we will provide an analysis of the differences between State Fund and claims for the different insurance "types," namely Retro claims and self-insured claims.

3.1 RETRO EMPLOYERS

From a structural standpoint, our investigation revealed no distinction in organization or claims management, intended by L&I or observed by the audit team, between Retro and non-Retro claims. Actual performance measurements were done for Retro versus non-Retro participation, and will be presented in Chapters 2 and 3 of this report.

The big difference between Retro and non-Retro employers is not found in L&I but rather in the way Retro employers engage in the claims management process. Retro employers, both those participating as an individual employer and as part of a group, often utilize representatives to assist with their program, help control costs, and assist with improving overall outcomes. The claims "experience" of an employer is a key component of the amount of premium an employer is required to pay. Experience is based primarily on the severity of claims, which would lead to payments by L&I on the claims. To avoid loss experience, employers can "invest" in safety initiatives and programs to prevent accidents in the first place; similar investments include expenditures to minimize the loss of a claim through, for example, returning a worker to work or keeping a worker on salary during periods of missed work. There are other "friction" costs of claims, including paperwork and decisions involved in the course of a claim, that are borne directly by employers. The services of representatives, which as just indicated are often used by Retro employers, are aimed at, among other things, managing these costs: investments in preventing accidents and in keeping claims experience and friction costs low.

Depending on the success of this loss control activity, an employer's premium is affected. We analyzed four specific scenarios, using varying levels of claims loss experience and what their premiums (and in

the case of Retro employers their refunds or additional assessments) would be based on L&I calculations, to compare premium results of similarly situated Retro and non-Retro employers. The results showed that as experience increased, both Retro and non-Retro employers' base premiums increased in an equivalent manner. In the case of minimal loss experience, the more risk a Retro employer accepted (the employer has several risk levels to choose from), the greater the refund. Conversely, in the case of significant loss experience, and the more risk a Retro employer accepted, the greater the assessment owed. For the non-Retro employer, premiums were equivalent to the similarly situated Retro employer, but no refunds were received, and no assessments owed. As loss experience varied it hit the premium charge of both Retro and non-Retro employers in future years. Our analysis showed that the "investments," described above, which are borne directly by the Retro employer and not by L&I or non-Retro employers, were correlated with the refunds or additional assessments. In other words, the more successful an employer at preventing accidents and controlling losses, the bigger the refund; the less successful, the bigger the additional assessment. Similarly, a non-Retro employer could make similar investments and theoretically achieve better financial outcomes, through lower premiums, but would not receive a refund in the coverage year, but only a better experience rating in future years. In conclusion, Retro employers, by taking on the risk of a potential assessment, and through the effective use of cost-control measures, such as safety and return-to-work programs, can not only benefit from reduced premium but also benefit from a premium refund. The degree of risk retained, and the effectiveness of the cost-control measure utilized, determines the amount of any refund; the refund is not determined by L&I claim management or non-Retro employers' claims experience, and thus is not borne by L&I or non-Retro employers.

It is important to note that a highly effective CM will help control claim costs. Thus, if there were a pattern of organizing CMs according to Retro or non-Retro, where more effective CMs were placed with particular groups, then such a scenario could result in bias. Our investigation did not reveal such structural bias, however. In other words, claims of Retro and non-Retro employers were distributed and worked according to standard, "blind" methods. Similarly, as will be shown in Chapters 2 and 3, we did not observe performance outcomes that would indicate biased selection.

We did observe evidence of participation by employer representatives in claim management. An example would be an employer representative sending a message to a CM that a medical examination had been completed and requesting review of the record and closure of the claim. We did not observe biased adherence to (or avoidance of) such advice by the CM. To the extent such interventions improved claim outcomes, the costs were borne by the employer hiring the representative, and not by L&I or other employers in general.

3.2 SELF-INSURED EMPLOYERS

Next we will discuss difference between State Fund and self-insured employer claims management organization. For self-insured employers, primary responsibility for claims management rests with the self-insured employers; L&I's role in many practical respects is secondary, involving auditing and reviewing reports of claim activities engaged in by self-insured employers. L&I does issue formal orders and is involved in protests of such orders. Self-insured employers, or their third-party administrator (TPA), do the detailed work of claims management, starting with an initial decision on compensability⁴⁷;

⁴⁷ Note that a self-insured employer may choose to administer its own claims, although interviews indicated that most utilized third-party administrators. If self-administered, the self-insured employer in essence serves as its own third-party administrator, and the reference to "TPA" would include the self-administered claims management function of the

Continued next page

this initial decision is submitted to L&I for approval. If the TPA approves or “allows” the claim, L&I’s role is to issue an allowance order; if the TPA wants the claim denied, L&I’s role is to request a complete copy of the file and review the case and either issue an allowance or rejection order. Our file reviews showed that the allowance order was most often issued by L&I clerical staff and often the elements of a prima facie case were not submitted by the employer so L&I could not have made an informed decision. L&I reports that it gives a self-insured employer the prerogative to allow claims as it deems appropriate, and L&I would not typically deny a claim for which a self-insured employer is requesting allowance. A CM rather than clerical staff would issue determinations that deny claims. This differs significantly from the elements required to be present in the State Fund claims. In terms of disputed decisions, if L&I overturns the denial, the employer (TPA) may file a protest, and if L&I upholds the denial, the worker may file a protest.

In contrast, the State Fund process is more streamlined: The initial decision on compensability is made by the State Fund; the State Fund submits the decision to both the employer and the worker; in terms of appeal, if the State Fund approves or “allows” the claim, the employer may protest; if the State Fund denies compensability, the worker may protest.

L&I organizes its operations for performing its role in self-insured claims in a separate section of its Insurance Services unit; the Self- Insurance section is housed in a separate building from the State Fund operations. The Self-Insurance claim section is broken into two units, both of which are “employer based,” meaning that they handle claims from certain types of employers. Each unit has 13 employees, and distributes claims within the units sequentially. The WCAs who staff the units are level 2 and 3 WCAs; the average tenure of the level 3 WCAs is 7.5 years. In early 2014, a new workload tracking system, known as “SICAM,” was implemented. Management reports are now available at the program, unit, and individual adjudicator level. Management identified 6 key areas for performance goals, which are now included in each adjudicator’s performance review process. Self-Insurance data is also reported periodically to L&I via the “SIEDRS” system.⁴⁸ At certain points in a claim, the TPA file is required to be provided to L&I, e.g., when requesting a denial or requesting closure. This data is added to and made available in the LINIIS and ORION systems. In general, these files are poorly organized in the L&I system; during file reviews we saw many instances of duplicates, large, unwieldy files, and files where the key documents were hard to locate.

As mentioned earlier, workers’ compensation self-insurance regulation covers two functions: regulating the self-insurer’s financial ability to pay claims as they come due, and regulating the self-insurer’s performance in managing claims. The structure of self-insurance regulation in Washington has many features common to all states that permit self-insurance for workers’ compensation.⁴⁹ It also has some features that are unique to Washington’s system.

self-insured employer.

⁴⁸ See WAC 296-15-231. Our interviews with self-insured employers and L&I staff indicated that there were many unreliable aspects of the data provided through SIEDRS, including delay, inconsistent coding, and missing fields.

⁴⁹ Two states, North Dakota and Wyoming, do not permit self-insurance, and coverage is provided only through a state fund. Ohio and Washington permit self-insurance; all other employers must insure through the State Fund.

To widely varying degrees, states monitor claim processing to assure that standards for claim processing performance are met by self-insurers. As in all states, self-insurers are obligated to pay the same benefits to injured workers as other insurers, for the same set of covered conditions and circumstances. Washington has a unique approach to payment of workers' compensation insurance premiums. In almost all states, the employer pays the full premium cost. As discussed above, in Washington, half of the cost for the Medical Aid Fund, as well as for the Stay and Work and the Supplemental Pension funds, is paid by workers. This is not true for self-insurance, where the entire risk is self-insured and paid by the employer. This would seem to be a substantial disincentive to self-insure, on the order of 25% of claim costs, yet a significant portion of the Washington workers' compensation market uses self-insurance. This seems to imply that self-insured employers believe that they can be substantially more cost-effective than L&I even with the full payment of medical costs, and the full burden of claims administration.⁵⁰

In most states, self-insurers are generally subject to the same regulatory standards for claim processing as other types of insurers. As there are only two states (Washington and Ohio) that use an exclusive state fund and permit self-insurance, it is less meaningful to say what is typical in most states. Nevertheless some comparisons are useful. We focus on Ohio as the most comparable jurisdiction to Washington from the perspective of its insurance and self-insurance regulatory model.

Some unusual features in the Washington system involve the necessity for Labor & Industries to perform certain claim processing functions instead of (or in addition to) the self-insurers or their TPAs. These functions include adjudication of compensability (both acceptance and denial), after receiving the recommended decision from the self-insurer. Another area with L&I involvement, where there is typically none in similar states, is claim closure. Still another is the requirement that employers submit pension recommendations to L&I for approval. Presumably, these functions have been placed within L&I because it is perceived as a neutral body that has no financial interest in the outcome. Nevertheless, these extra steps come at a cost in both time and staff effort. These added steps tend to slow down claim processing and in some cases may delay benefits.

Where data was available for comparison, aspects of claim processing for self-insured employers showed better performance than for State Fund claims. Examples were: 1) timeliness of first payment of TTD; 2) shorter duration of TTD; 3) faster use of first vocational service; 4) faster retraining plan completion; and 5) faster closure of the claim. These performance advantages naturally come from the very large size of most self-insured organizations. Size allows for more RTW options and for greater sophistication in claims management than for smaller organizations. Larger organizations are better able to provide modified duty than smaller organizations and also possess more resources to afford keeping workers on salary despite absence. They also can employ more specialized human resources staff to manage safety and return-to-work programs.

For most claims decisions, all jurisdictions allow parties to appeal adverse decisions in some manner, although this mechanism typically involves delays, adversarial proceedings, attorneys, and other frictional costs. The typical avenues of self-insurance claim-processing regulation attempt to minimize disputes through a combination of features which can involve monitoring processing through reporting

⁵⁰ Cost is one consideration for an employer seeking to be authorized to self-insure. Other considerations would include a corporate desire to be more closely involved with managing safety, injuries, work disability, and wellness. Also, there is a tendency for multi-state corporations that prefer self-insurance to use this mechanism for all the states in which they have employees; thus the decision to self-insure in Washington is not independent of self-insurance status in other states.

of key events to the regulatory agency, feedback on processing performance statistics in relation to the industry as a whole, audit for accurate and timely processing performance, and sanctions when standards are not met.

For injured workers, most of whom have no experience with workers' compensation claims, the process is very confusing. For some workers, information sent by the state or a claims administrator is hard to assimilate and use. Many states provide some form of free ombudsman service to injured workers, typically from an independent or quasi-independent office that is empowered to provide advice to injured workers, resolve some disputes, and provide some degree of investigation and monitoring of system trends affecting injured workers. These offices differ across states in a variety of dimensions: statutory role, degree of funding and staffing, and means of interaction with various parties in the system to resolve disputes. In most cases these offices do not provide legal advice.⁵¹

Washington does not have an agency-wide ombuds. Project Help, however, which is a cooperative effort between L&I and the Washington State Labor Council (AFL-CIO), provides general assistance with navigating the claims process.⁵² Assistance is available with both State Fund and self-insured claims. Performance related observations involving Project Help will be discussed in Chapter 2.

One relatively new program in the Washington system is the Office of the Ombuds for Self-Insured Injured Workers.⁵³ Unlike most similar state programs, this office assists those injured workers whose employers are self-insured. The office was designed to be operated independently of the L&I Insurance Services Division. The office was authorized by the 2007 legislature, and the Ombudsman was first appointed by the Governor of Washington on January 12, 2009. Thus the first full year of data on the office's operation was Fiscal Year 2010. As we might expect, there was an increase in workload over the initial years of the office, with counts of resolutions growing by 76 percent from FY2010 to FY2012. These counts have been roughly flat in FY2013 and FY2014.

Most cases reported on by the Office of the SI Ombuds involve those where the worker contacted the office with a "complaint" and an investigation was opened. Reported statistics do not fairly represent the full spectrum of claims in a year, only the ones contacting the Office of the SI Ombuds.⁵⁴ Nevertheless some insight is provided by the trends observed. In 2014 there were 486 completed investigations, involving 136 employers; 62% of all Washington self-insurers had "zero" investigations. Of the investigations, 190 (39%) were reported to be resolved with the assistance of the Ombuds; 183 (38%) involved a "correct adjudication" and did not require resolution; 65 (13%) were resolved by the TPA; and 48 (10%) were unable to be resolved. Appendix 1 provides additional detail about Washington's self-insurance program, how it compares with key states, and the Office of the SI Ombuds.

A substantial portion of the [Office of the SI Ombuds Annual Report](#) is dedicated to the discussion of recommendations for rule and regulation changes. The 2014 report discusses ongoing efforts at audit reform (audits had been suspended during process review) and makes some recommendations concerning reform proposals. Audit reform in Washington is ongoing, and more information is available

⁵¹ At least two states are exceptions; Nevada and Texas have state-funded, attorney-staffed offices that can provide legal assistance to injured workers in some circumstances.

⁵² See <http://www.lni.wa.gov/ClaimsIns/Claims/Benefits/MedBenefits/default.asp>.

⁵³ The original term for this function was "Ombudsman"; it was later changed to "Ombuds."

⁵⁴ Annual reports available at <http://ombudsman.selfinsured.wa.gov/resources/>.

in Appendix 1. In general, stakeholders were unhappy with several aspects of the audit process; during interviews we heard complaints of a focus on inconsequential or “picky” findings, and a lengthy, cumbersome process. L&I assembled a task force of internal and external experts to review and make reform recommendations, which outlined a “three-tier” process for performance-based audits, whereby all self-insured employers receive a review annually on a specific aspect of workers' compensation benefits (in the first year, the aspect under review is the calculation of worker wages). Based on whether the employer achieves an appropriate score they may be moved to Tier 2 (the topic of this review is still under consideration); for a smaller number of employers, a full claims management audit at Tier 3 would be conducted, based on Tiers 1 and 2 results. The audit reform will also support complaint-based audits (primarily triggered by worker complaints) and issue-based audits (using data trends).⁵⁵ Tier 1 audits will be made of all self-insured employers in 2015; Tier 2 and 3 level audits are under development.⁵⁶

In many important ways, Ohio is the most comparable jurisdiction to Washington from the perspective of its insurance and self-insurance regulatory model. A number of features have proven effective in regulating self-insurance in Ohio, similar in size to Washington. The Ohio state insurance fund agency responsible for self-insurance administration is the Ohio Bureau of Workers' Compensation (BWC). The BWC monitors financial solvency, claim reserving practices, and payments of various assessments for dedicated funds and administration costs. Unlike the Washington system, BWC does not generally get involved in processing claims except in rare events; rather it monitors and audits for performance periodically, to ensure SI adherence to statutory requirements. The BWC also publishes a detailed claims administration *Procedural Guide*.⁵⁷ BWC audits consist of two levels of periodic audits on at least a 3-year cycle, with a third more comprehensive level if certain trigger deficiencies are found.

Recent changes to the Ohio audit process have allowed audits to proceed much more efficiently. BWC auditors get remote login access to SI claims systems, and thus have the ability to do audit work remotely as needed. According to BWC documents, since implementation of this new process, the number of audits increased by over 155% by the end of 2013. Per agency status reports, only about 3 to 4 percent of audited employers fail to receive a satisfactory rating.

Approaches to self-insurance regulation vary among states. In Appendix 1 we describe approaches used in neighboring jurisdictions, as well as additional detail about the Washington and Ohio programs.

⁵⁵ Source: Vickie Kennedy presentation to Workers' Compensation Advisory Committee presentation, “Self-Insurance Risk Analysis System, Dec. 2014.

⁵⁶ L&I presentation “Self-Insurance Audit Reform (last modified Dec. 1, 2014),” found at: <http://www.lni.wa.gov/ClaimsIns/Files/SelfIns/SIAuditReformPPT.pdf>

⁵⁷ The Ohio Procedural Guide for Self-insured Claims Administration can be found at <https://www.bwc.ohio.gov/downloads/blankpdf/SIClmsProcedureGuide.pdf>. Washington publishes a similar guide, the [L&I Self-Insurance Claims Adjudication Guidelines](http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/Claims/Guidelines/Default.asp), available at <http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/Claims/Guidelines/Default.asp>.