Appendix 4: Highlights from File Reviews

INTRODUCTION

In the review of claim files we covered a broad set of questions designed to cover several performance areas, and to answer specific questions set forth for this audit. The scope of the review and methodology are reviewed in Appendix 3: Methodology.

In the course of the review there were some recurrent performance themes, which we highlight here for analysis. The themes are as follows:

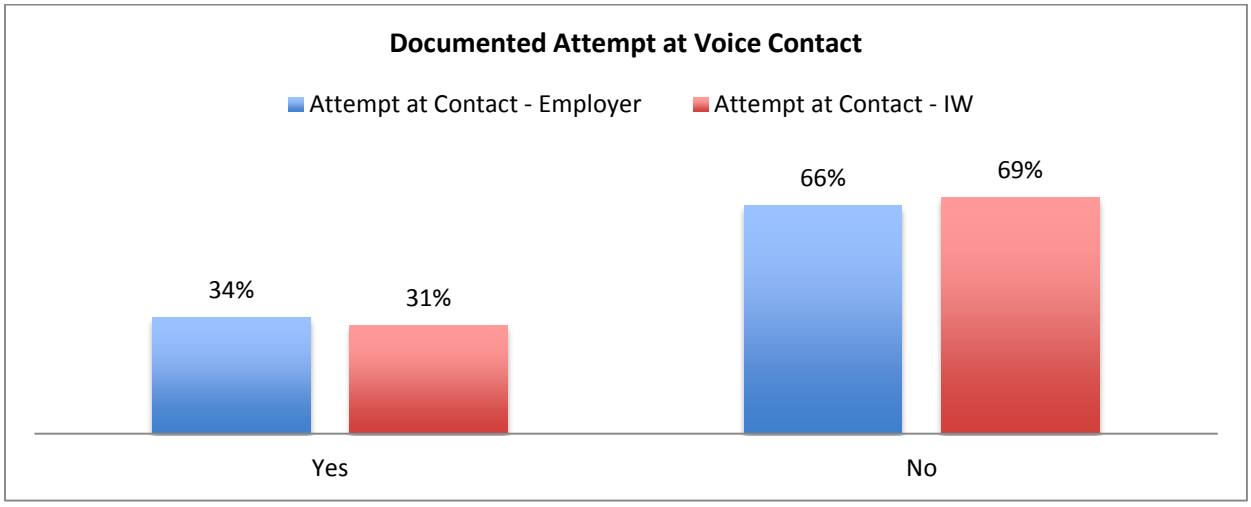
1. Voice contact
2. Allowance review
3. Denial review
4. Case management planning.

1 VOICE CONTACT

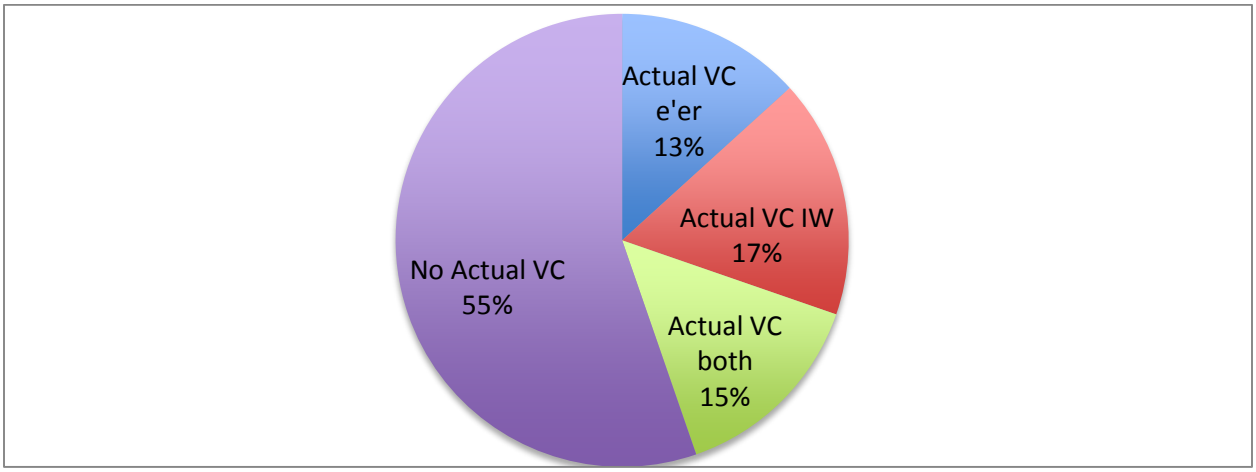
Here, we looked for actual and attempted voice contact within 30 days of claim receipt. (n=264; State Fund claims)

1.1 ACTUAL AND ATTEMPTED VOICE CONTACT

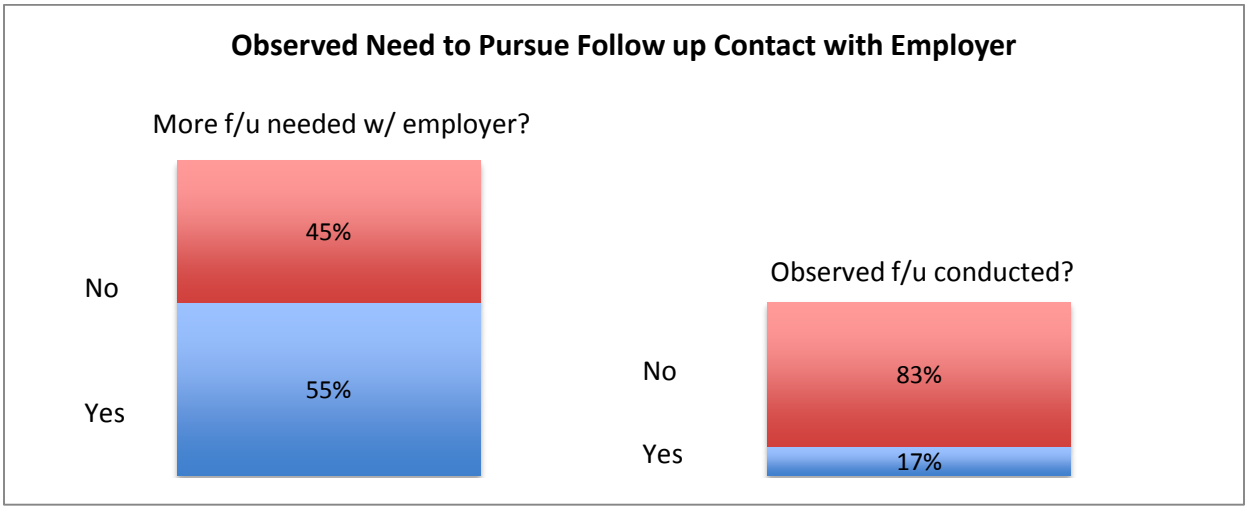
Only about a third of the files reviewed contained evidence of an attempt to contact the employer and the injured worker. The observation of whether follow up was needed was based on observed issues that present in the file for which follow up would help provide resolution. These included straightforward items, such as a stated desire for follow up, to what appeared to be an injury for which at least light-duty RTW would be appropriate, but there was no documented explanation of why light-duty RTW was not being pursued. In the opinion of the reviewers documentation of such follow up would have provided clarity and insight to managing the claim.



Voice Contact within 30 Days



Observed Need to Pursue Follow up Contact with Employer

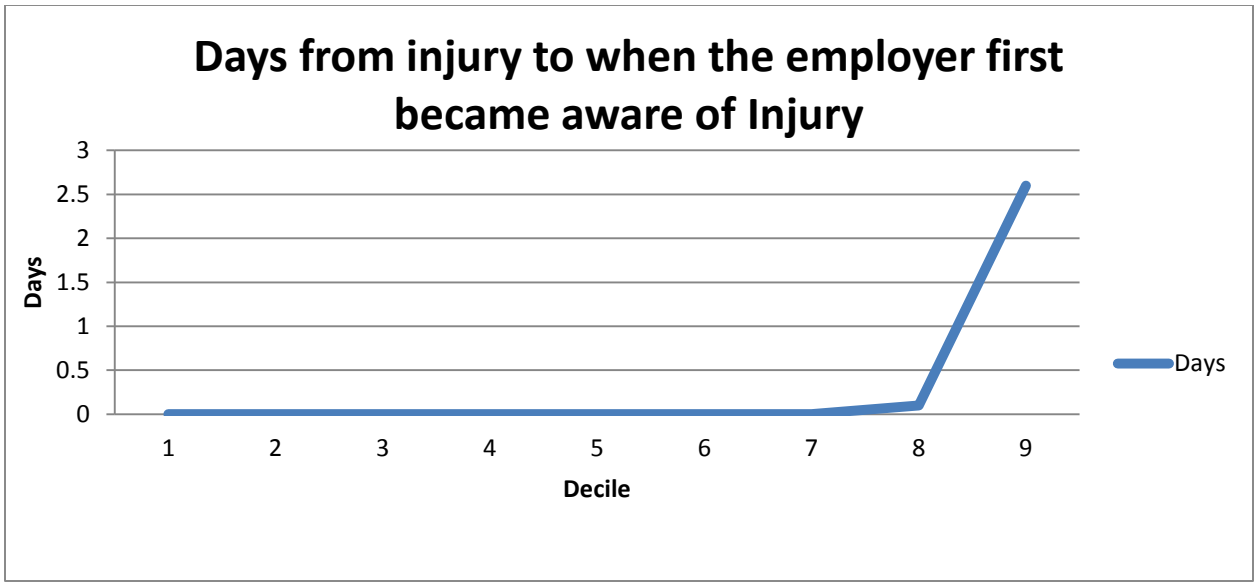


2 ALLOWANCE REVIEW

This covers various steps taken by the CM to verify that the reported injury was covered under the law and should be "allowed."

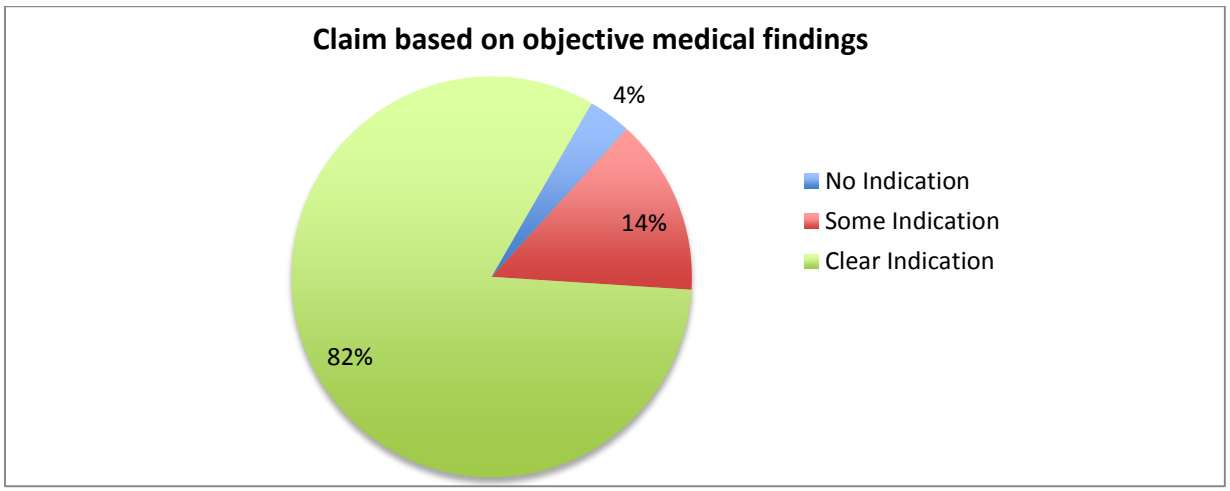
2.1 TIME FROM DATE OF INJURY TO APPARENT DATE OF EMPLOYER NOTICE

From injury to L&I receipt, median = 7 days; average = 18.8 days. Removing 2 x SD outliers, median = 7 days; average = 12.3 days. To process the risk class assignment, it takes an average of 0.7 days; median is same day (zero days) (n=262). The file reviewer identified the date that the employer was aware of the injury from the ROA or other documentation.

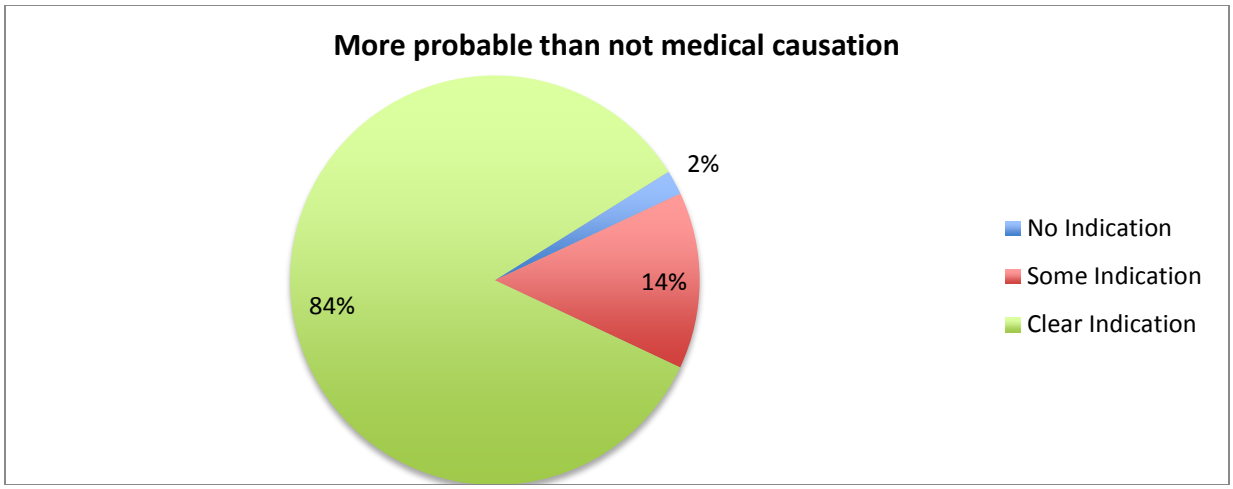


2.2 Review of Allowed Claims, State Fund (264 files reviewed)

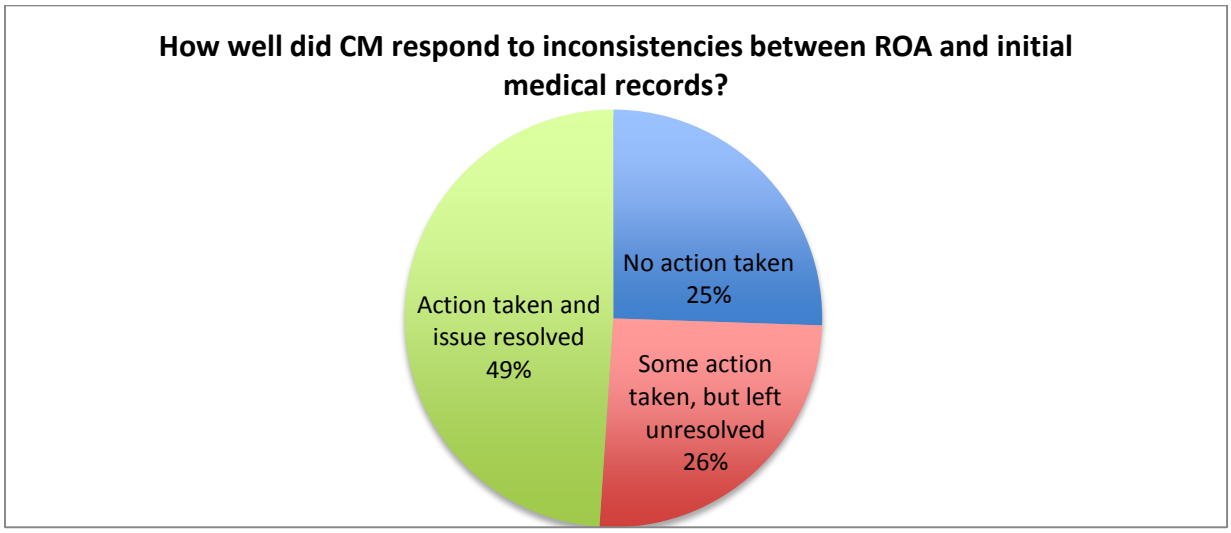
This review step examined the file to see if there were objective medical findings in the report of injury, or in follow up materials received by the CM. In 4% of the files there was no indication; in the remainder there were varying degrees of findings. Clear indication only meant that the doctor's statement was unambiguous and filled the necessary conditions, not that it was necessarily correct or thorough.



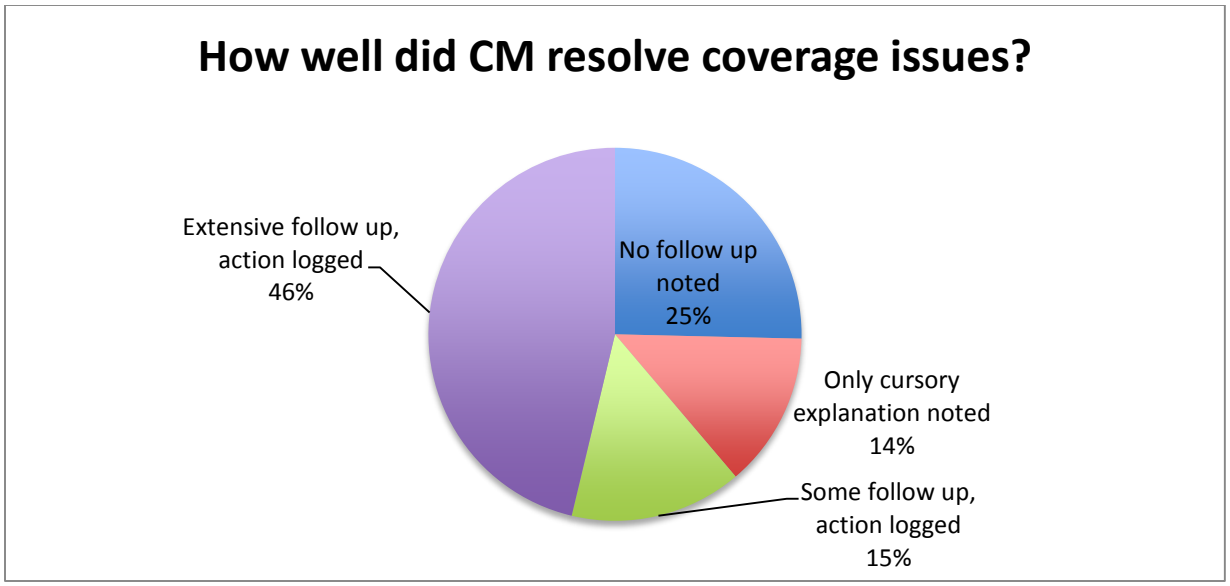
Another test for the validity of a claim is whether the treating physician opined that the injury was "more probably than not" related to work. In 2% of the files there was no such indication.



In 75% of the files the CM took varying degrees of action to resolve gaps or inconsistencies between the report of injury and other medical records. In a quarter of the cases the reviewers thought that there was no action taken to resolve an apparent inconsistency.



CM reaction of coverage problems and uncertainties was extremely varied. In 46% of the files there was extensive follow up shown. At the other extreme, in 25% of the files there was no follow up noted for issues that the review thought should have been pursued.

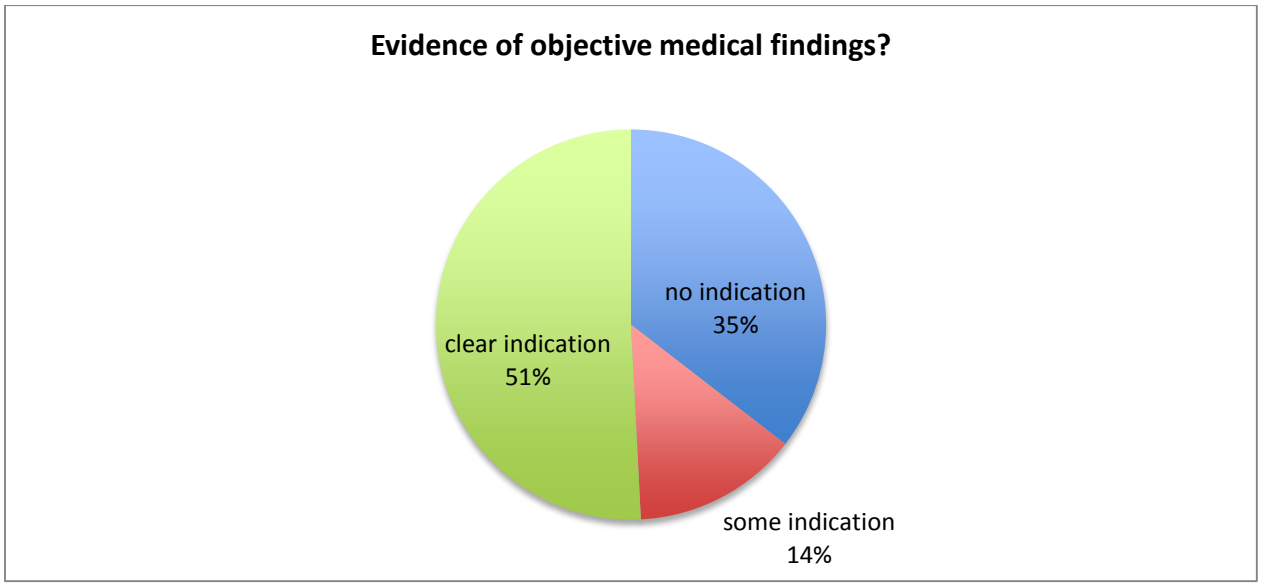


2.3 Review of Allowed Claims, Self Insured (144 files reviewed)

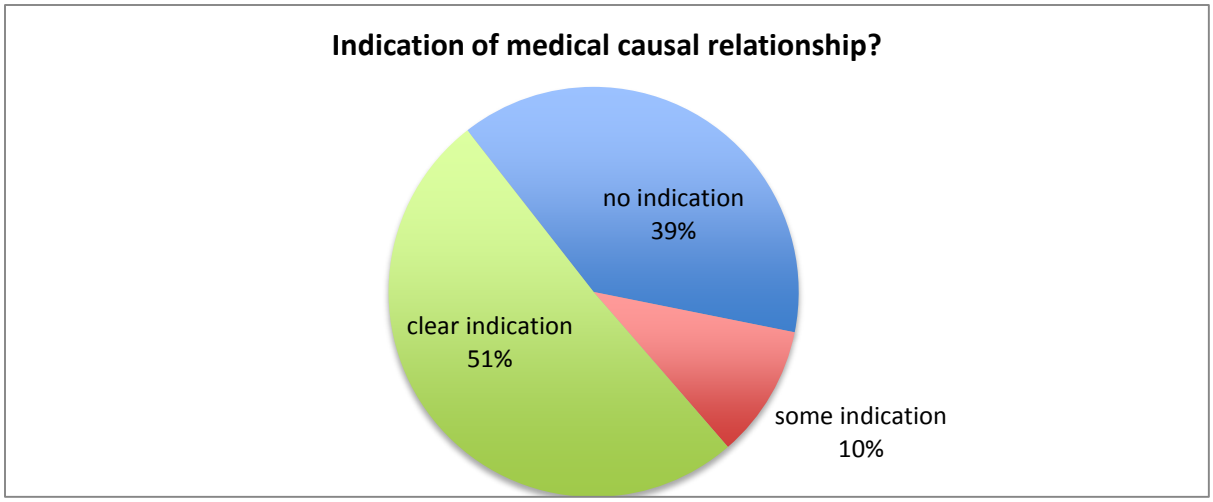
This review point explored the quality of the information provided by the physician on the first report of injury.

In nearly half the files there was some information missing that the reviewer thought was necessary to make a solid decision. Additionally, in nearly half the files reviewed there was no statement by the doctor that the injury was work related. This is a surprising breach in claim reporting.

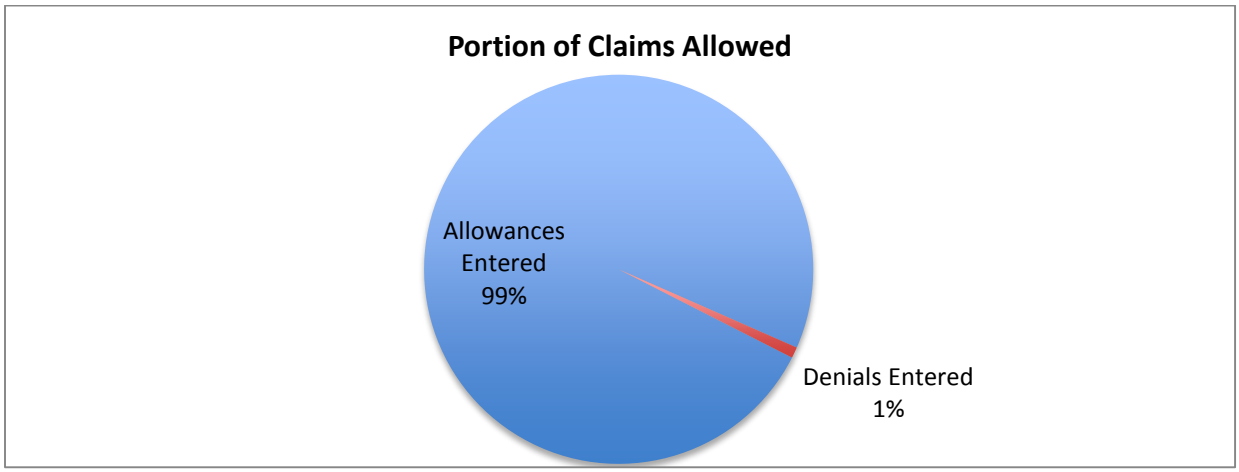
The first reports contained a wide range of statements by the doctor regarding the findings from the patient encounter. In just over a third of the files the reviewer saw no indication of any objective clinical evaluation of the injury.



In 39% of the self-insured files there was no indication shown of a medical causal relationship for the injury being claimed.



Despite what the reviewers saw as some rather clear gaps in the physician's report of injury, only 1% of the self-insured files reviewed were denied.



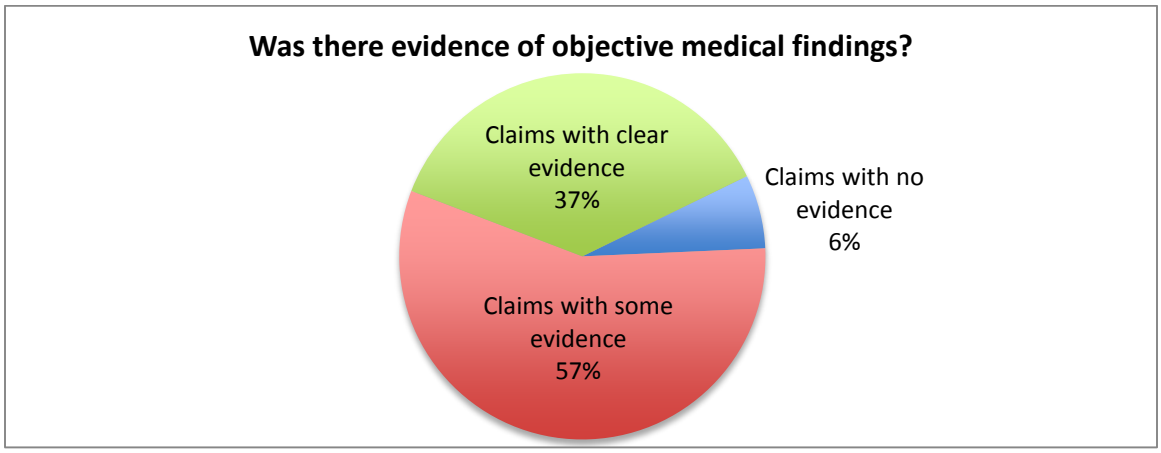
Note: In our reviewed files, there were 110 allowances entered by L&I, and 1 denial, which was later overturned. L&I sometimes enters an allowance, although the TPA does not specifically request it. In other cases, the TPA specifically requests allowance. In our review files, there were 72 specific TPA allowance requests, of which 66 were granted by L&I; the balance (72 – 66 = 6) were not yet acted upon by L&I.

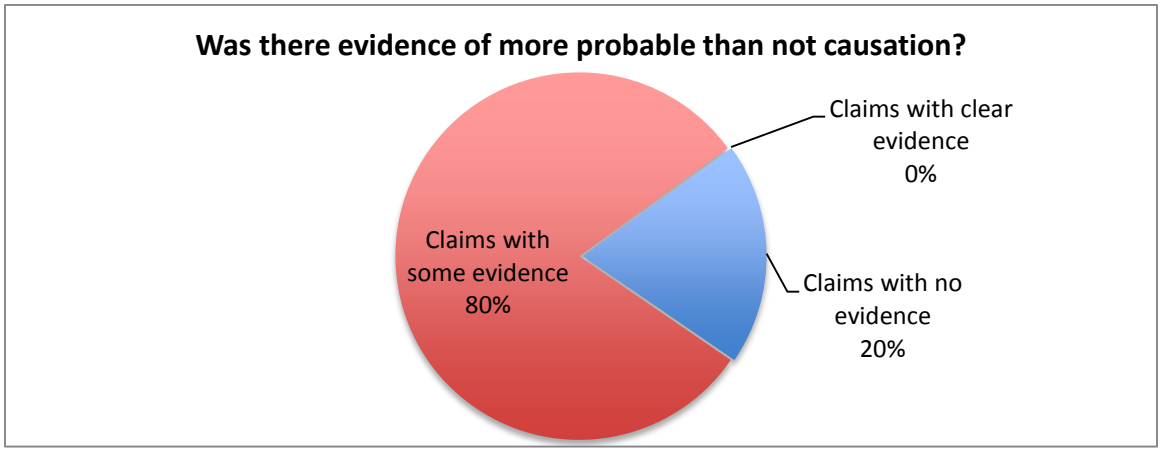
3 Review of Denials

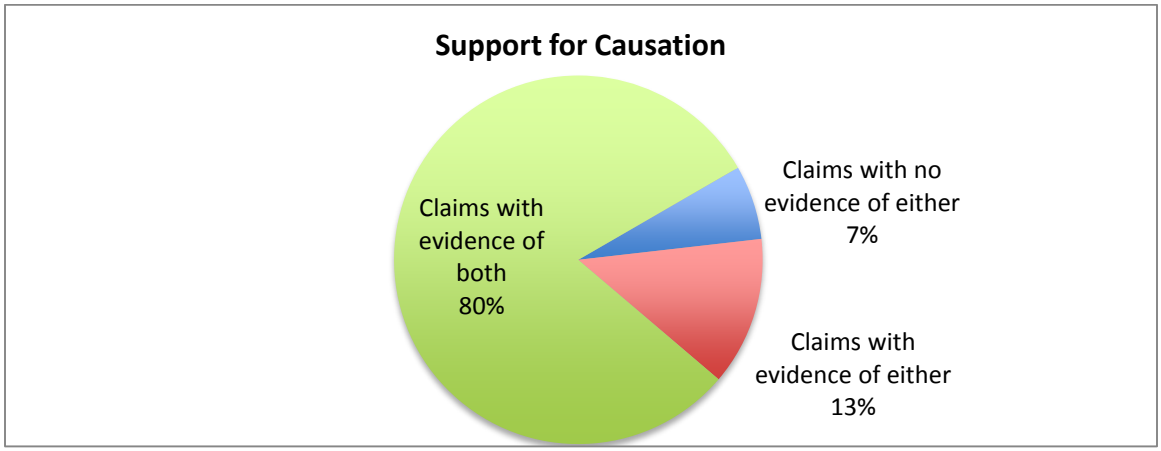
Here we looked at three aspects of the evidence presented to support denials by State Fund and self-insurance. Ninety two files were reviewed with an even split between State Fund and self-insurance.

3.1 STATE FUND

We looked for documented medical legal evidence important to addressing causation. The absence of such evidence does not mean that the claim should be denied; rather some degree of such evidence is likely present in most workers' compensation reported accidents. We calculated these results primarily for comparison purposes with self-insured files.

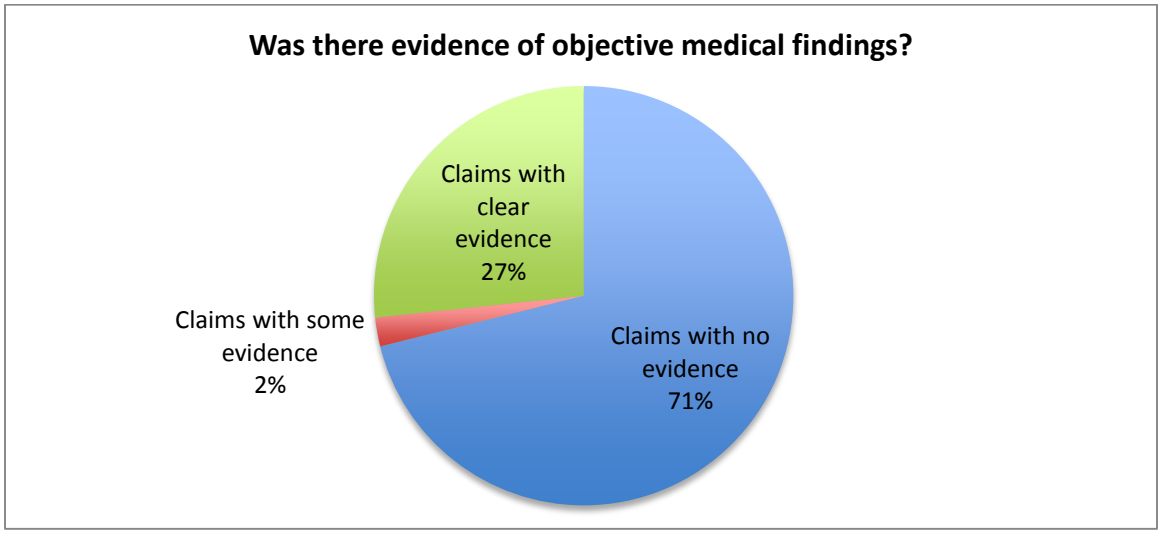


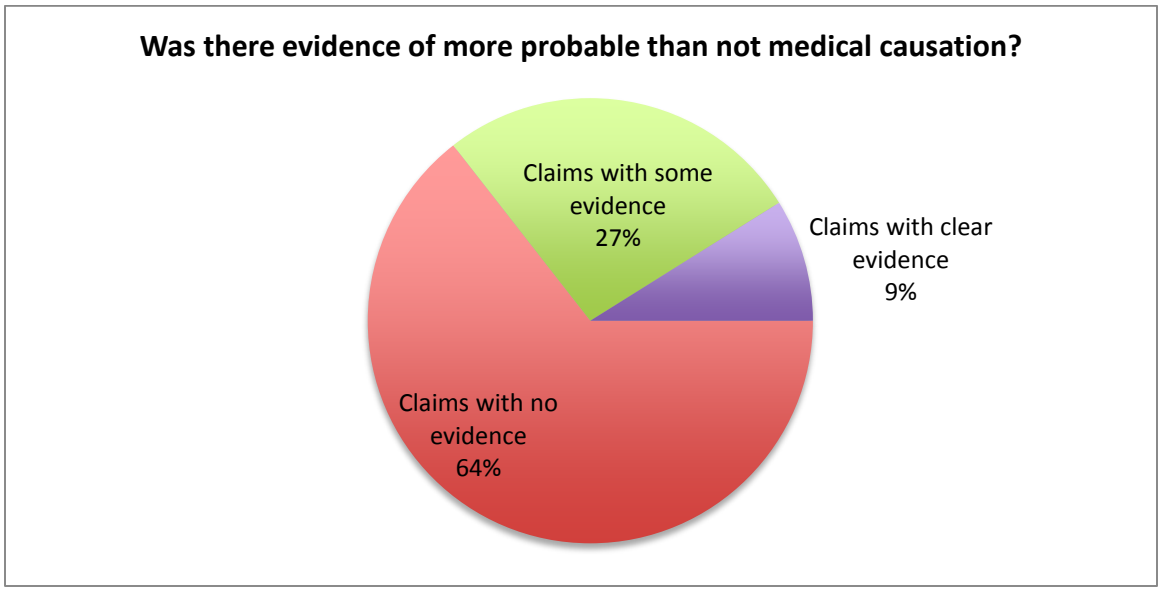


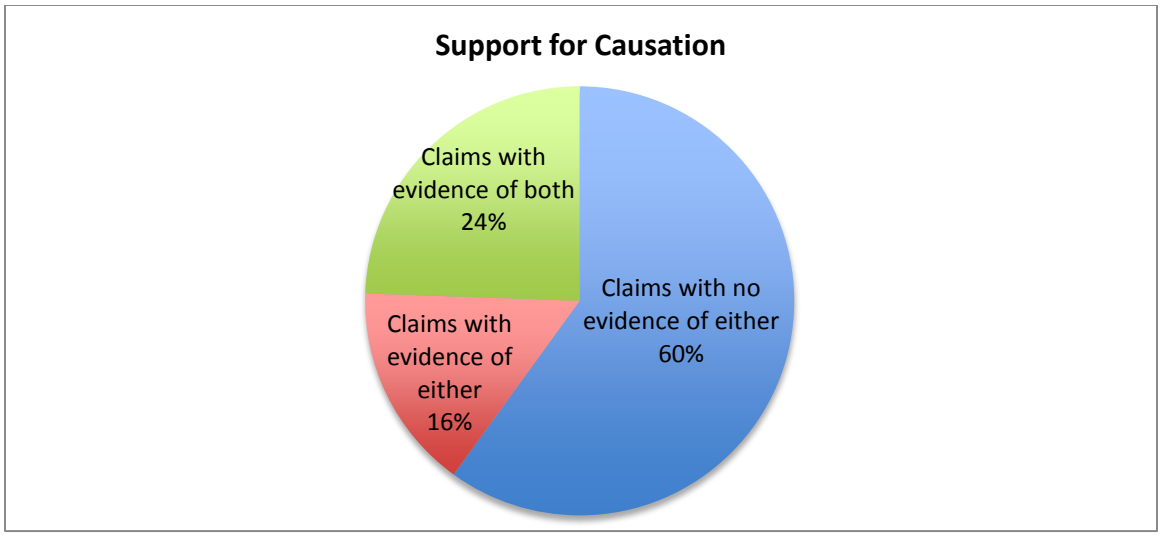


3.2 SELF INSURED

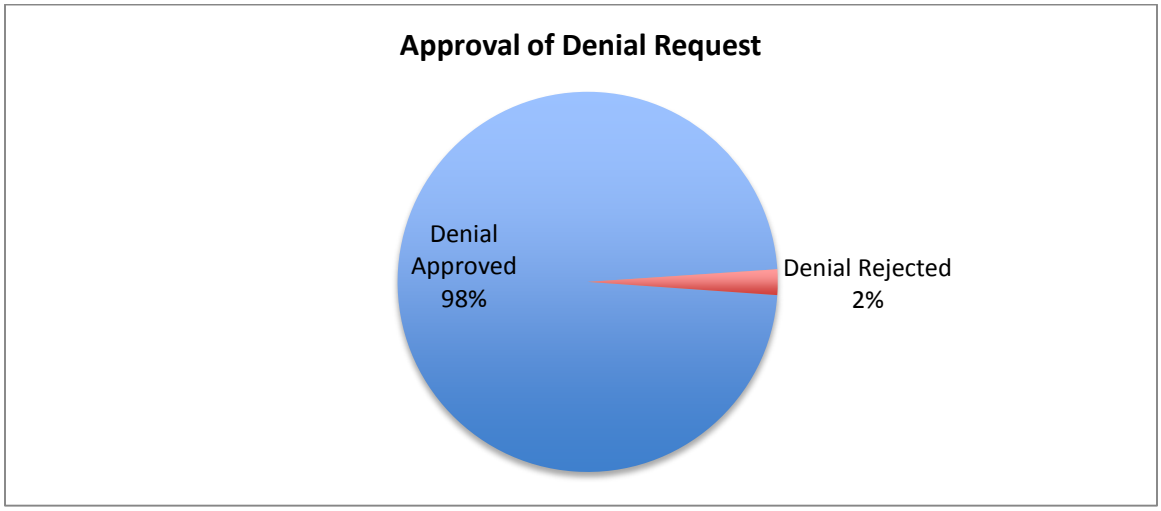
As for State Fund claims, we looked at the supporting evidence of record. The absence of evidence, e.g. objective medical findings, is not equivalent to proof that objective medical findings were missing, and thus the denial was appropriate. Rather, most reported injuries have some degree of evidence of medical causation. Solely for comparison with State Fund claims, we looked at the portion of self-insured claims where this evidence was present. We expected a similar portion of claims where there would be at least some supporting evidence of causation. What we found, however, was that there was far less documented evidence in self-insured claims. We believe that this is likely the result of simply not supplying the information to L&I, and provides at least some support for the conclusion that L&I is not conducting an in-depth review of denied claims.







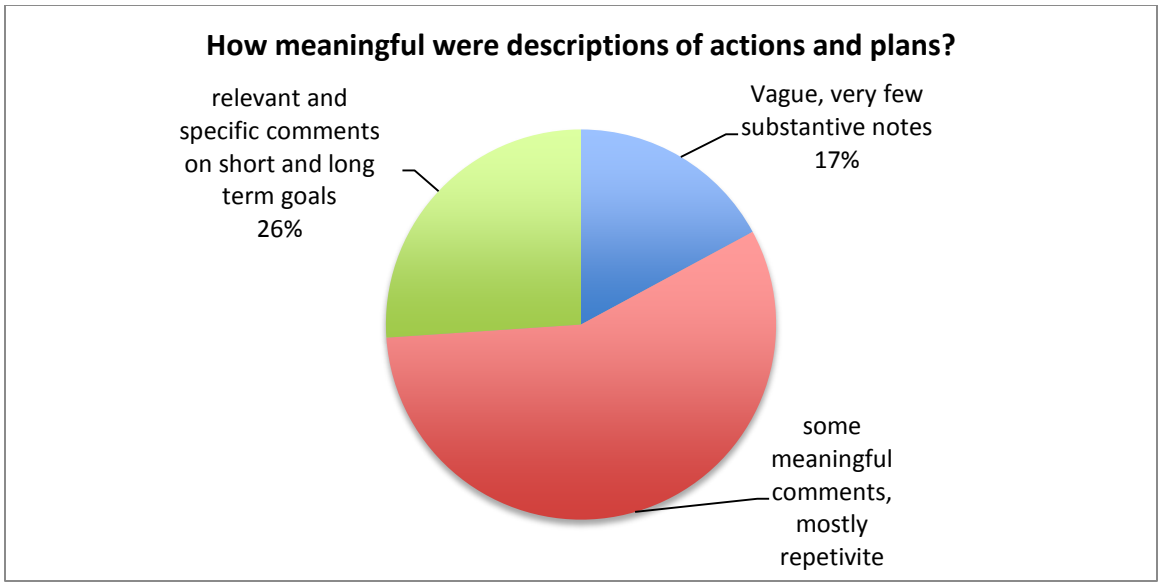
Importantly, only 2% of the denials recommended by the self-insurer were rejected by the L&I reviewer. This fraction may have gone down even further to the extent the self-insurer successfully protested the initial denial.



4 Case Management Planning

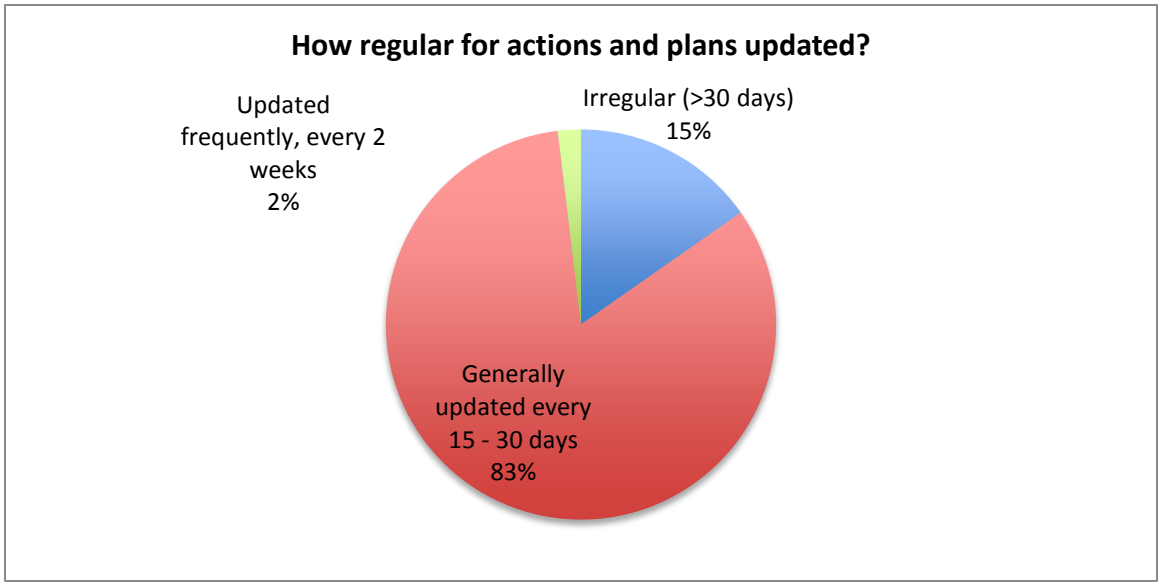
4.1 Documented Action Plans (257 statistically relevant files our of 264 reviewed)

This step of the file review rated the descriptions recorded in the actions and plans notations inserted in the file by the CM. It was rare to find more than a few words that hinted at potential problems, and there was very little documentation of potential solutions or plans to overcome or prevent problems. In some cases, in LINIIS single words were used to document actions or plans, such as: “opioids?” “close?” and in ORION, the detail and action field often were blank. Hence the degrees of documentation shown below are based on short and sometimes cryptic notes. L&I reports that recent system changes (March 2015) have increased the character space available in the information system for documentation to 650 characters in the Claim Details Action field and the Claim Details Plan field.



4.2 DOCUMENTED UPDATES (262 STATISTICALLY RELEVANT FILES OUT OF 264 REVIEWED)

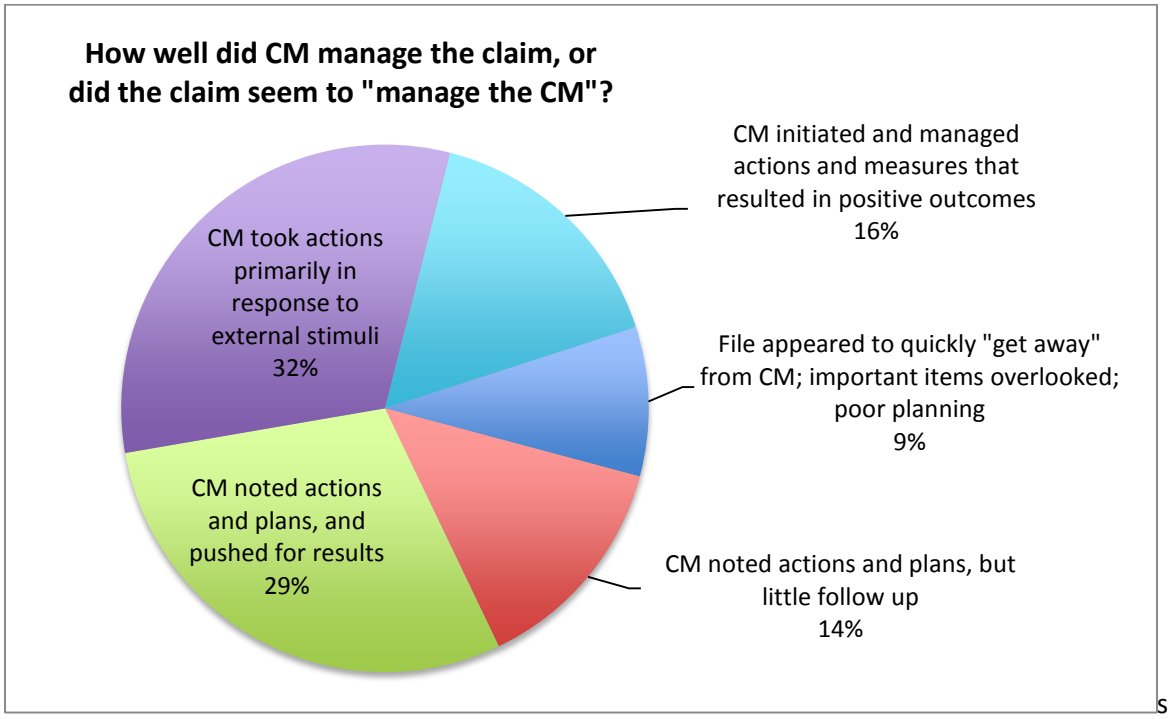
L&I claim management software demands that the files contain updates on the actions and plans periodically. We tended to see updates that were done every 2-4 weeks. Most of these were rather minor alterations of the previous actions and plans.



4.3 OVERALL DOCUMENTED PLANNING EFFECTIVENESS (262 STATISTICALLY RELEVANT FILES OUT OF 264 REVIEWED)

This critique is strictly based on what was recorded in the file. Ranked in order of the quality of file management: 16% of the files displayed a robust record of actions and planning by the CM that evidence proactive behavior to achieve positive results; 29% noted somewhat less proactive or actions

to move the file to a positive outcome; and in 32% of the files the reviewers saw CMs recording actions that were more passive reactions to the parties to the claim (claimant, doctor, employer, ERTW).



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