Chapter Two: Claim Management

INTRODUCTION

This chapter of the report is about claim management performance. This chapter is presented in four sections:

1. Timeliness
2. Fairness And Consistency
3. Disability Management
4. Summary

In the timeliness section, we review how timely certain decisions are being made. The audit design called for numerous decisions and claim events to be analyzed, and in the course of the audit hundreds of tests of timeliness were performed. In our report we will focus on two measures: 1) time to allowance decision; and 2) time to first disability payment. These two measures capture an important part of effective claim adjudication. It is essential to the process that claims handlers make prompt decisions on whether a claim merits first payment, and to communicate this to the claimants as early as possible. Delays in making these determinations cause claimants to seek help in resolving their uncertainty (e.g., union representatives, ombuds representative, or attorney). Additionally, in our discussion of disability-management performance, we will cover timing of delivery of crucial vocational services.

Next, we will review performance in terms of fairness. In other words, are decisions being made consistently and without bias? We reviewed consistency of claims handling by L&I for various stakeholder groups and also tested for observed bias in documented case actions. We examined fairness through tests of compliance with law. In addition, we surveyed stakeholders for their perceptions of L&I's claims system with respect to fairness.

Finally, we will review performance in disability management. As discussed in Chapter 1, we discovered some deficits in how L&I is organized to manage disability. These primarily concerned initial responsibility for ensuring thorough, early contact with parties involved in a claim and for establishing a plan of action that is designed to accomplish desired case outcomes. The basic steps of opening, resolving and closing a claim follow a fairly standardized process in Washington: record the claim information, investigate compensability, ensure good medical care throughout until maximum medical improvement, calculate and pay indemnity, determine permanent injury benefits (if due), keep the parties informed, and close the file. At the center of the process is the Claims Manager (CM), who discharges or oversees all the duties mentioned above. The Washington process, however, has a number of unique features, especially in the early part of the claims process:

- While CMs are required to attempt contact with the injured worker and, when needed, other parties, they are not held to the standard commonly enforced in private insurance, which is to make personal contact with the worker, employer, and medical provider ("3-point contact") within a day or two after a claim is reported to L&I.
- Claims are initially reported mainly by the treating medical provider (in recent years employer reporting has grown to about 50% of the total reported injuries); in most other systems, the standard process is for employers to report claims to the insurer.
- Much of the claim file is open to online access by the parties, and all of it is discoverable; this serves

to inhibit detailed investigation and planning as well as frank discussion of problems encountered by the CM with supervisors, external consultants (e.g., an Independent Medical Examiner), or internal consultants (e.g., expert from the L&I Medical Director's office).

Overall, our investigation finds good to very good results for L&I on most measures of timeliness and fairness. However, some measures of the disability management process indicate shortcomings, which are leaving too many workers permanently severed from jobs.

Finally, we will enumerate several aspects of Washington law that shape how disability management services are delivered. The disability management discussion integrates findings on the overall claim management process and how it meets best practices and attains positive system outcomes for both the worker and the employer.

1 TIMELINESS

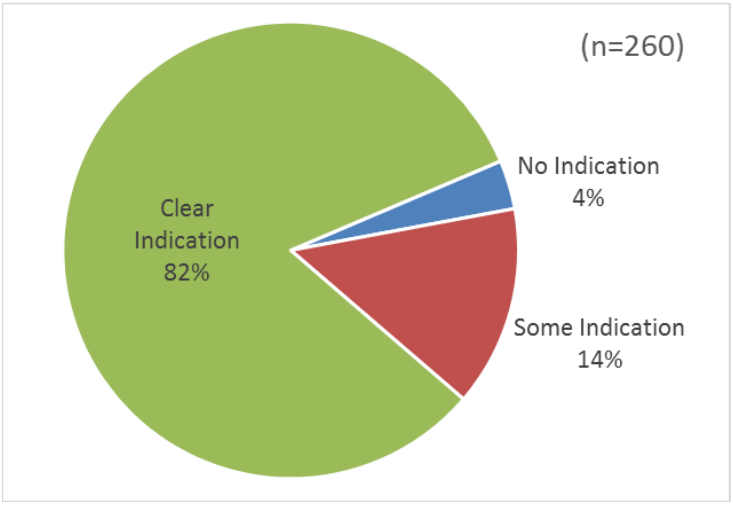
We discuss two specific aspects of timeliness: 1) time to allowance decision; and 2) time to first payment of disability. We compare these time intervals to statutory requirements, best practices, and other jurisdictional performance measures. In comparing Washington's performance with other jurisdictions we need to recognize the unique legal requirements in Washington, as well as the methodological differences in how various performance measures were developed. Timeliness was also a key aspect of our stakeholder perception surveys, and performance reviews from stakeholders will be discussed.

1.1 TIME TO ALLOWANCE

It is a principle of insurance generally that coverage decisions on claims should be made as quickly as possible. Naturally, the decision must be grounded in fact, so gathering the necessary factual information quickly is the key to a good, prompt decision. Our analysis of data from 2010 – 2013 showed that the time from the date of receipt of the claim to the date of initial determination was 5.9 days on average. In addition to timing, the accuracy of the decision is also important. Making a prompt but incorrect allowance decision can result in acceptance and payment of a claim that is not covered by the workers' compensation laws. This adds costs to the system that were not contemplated when the premiums were set. On the flip side of this issue – making a prompt denial decision that is not accurate – there can be significant negative impacts on injured workers who do not receive the benefits to which they are entitled, and for which they and their employers have paid an insurance premium. We saw evidence of what appeared to be poorly substantiated allowance decisions. We also observed decisions with only minimal documented medical support, such as a single CPT code (standard treatment coding used in billing) listed for a sprain, with no further discussion, elaboration, or medical support. Additional evidence, at a minimum, would include a description of the injury and condition from the medical provider's perspective. Some private insurers insist on receiving all clinical notes in the worker's medical record before they will pay the treating physician. We observed that some CMs would follow up on a sketchy medical report and others would not.

In terms of overall supporting documentation of allowance decisions, we observed in file reviews that evidence of "objective medical findings" to support the injury was of widely varying quality. We observed that the vast majority of allowed claims had a clear indication of supporting evidence. We noted that often this evidence was a simple "check box" from the physician, with a diagnosis code as the only objective medical finding. This we classified as "some indication" of objective medical findings.

Exhibit 2-1: Claim basis on objective medical findings

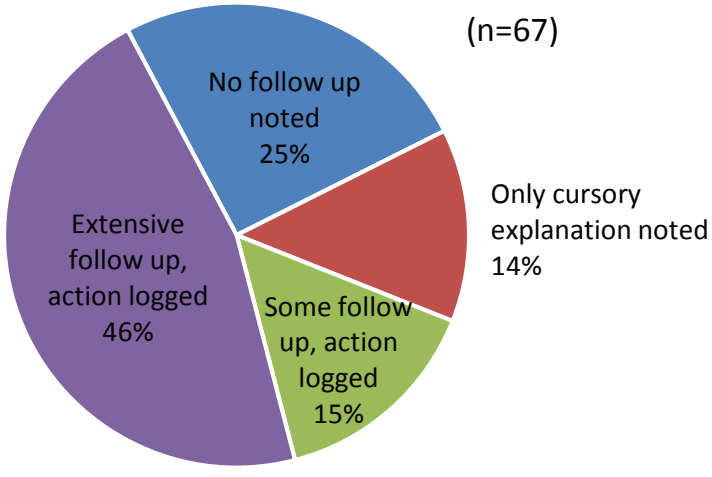


Source: WorkComp Strategies file review, 2011-13 claims (sample of claims > $5,000 in medical costs).

As shown in Exhibit 2-1, the large majority of files reviewed (82%) had a clear indication of the medical basis for the claimed injury. In the opinions of the reviewers, a small fraction (4%) had no visible indication in the physician's report.

Another aspect of allowing a claim is investigating various issues regarding "compensability," which is the standard terms used in workers' compensation to describe whether an injury is covered by a state's workers' compensation laws. Compensability issues would include items such as reports or statements from an employer or a witness concerning causation. In file reviews, where we observed compensability issues, we searched for documentation of follow up. In one quarter of reviewed files, we did not find documentation of follow up in the file comments.

Exhibit 2-2: How well did CM resolve compensability issues?



Source: WorkComp Strategies file review, 2011-13 claims (sample of claims > $5,000 in medical costs)

Exhibit 2-2 shows four degrees of follow up on the fraction of files that seemed to call for further investigation by the CM. The fractions assigned to determination of each degree of follow up are subject

to reviewer interpretation; however, in 25% of the sampled files there was no visible follow up documented in the file. Additional information concerning allowance and denial decisions is contained in Appendix 4.

If at any point in the claim investigation the CM has reason to question the compensability of a claim, these issues must be resolved with the claimant, employer, witnesses, or medical provider. The important discipline in making compensability decisions is to be prompt in investigating reasons to challenge a claim, and to make formal denials as soon as possible. With respect to L&I's timeliness of denials, we saw evidence of claims that were pended at the time of receipt for further investigation of compensability. In such situations, payments would be made pending the outcome of the investigation. Such payments are recoverable if the claim is ultimately denied, but this is inefficient and should be used as infrequently as possible.[1] About 12% of claims are ultimately denied, which falls within the range of denial rates in ten other jurisdictions from which we had reasonably comparable statistics.

1.2 Time to First Payment

Timing of first payment is a key performance metric frequently used to evaluate claim management performance. Maintaining income during periods of total disability is obviously of vital importance to injured workers. It is also a critical component to avoiding long-term disability. Issues of trust and respect shape the development of claims, and delayed payment of lost-income benefits can serve as a breach of trust and respect, and set a claim on a negative path. A related aspect is the accuracy of payments. As discussed in Chapter 1, setting the amount of compensation is a complex process. Performance with respect to accurate lost-income payments will be discussed in the Chapter 3.

Jurisdictions have long recognized that timeliness of first payment of the temporary disability benefit is extremely important; hence many states have statutory standards for timely payment. The Washington standard is fairly typical: Make the first payment within 14 days of receipt of a "payable" claim, which is interpreted by L&I as an initial Report of Accident, or a letter or some other form of initial contact, that is sufficiently full and complete to make a determination.

Confusion over what to expect and delays in payment are noted sources of complaints from injured workers in workers' compensation systems.[2] In Washington, we saw anecdotal evidence that delays in payment drove injured workers to protest to L&I and to seek help from Project HELP and from BIIA via an appeal. Payment delays were noted by the WA self-insurance Ombuds as being one of the most observed sources of worker complaints. Nationally, delays are also a leading reason why injured workers hire attorneys.[3]

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[1] During file review we did not test whether payments made prior to formal allowance or denial (known as interlocutory payments) were appropriately made, nor did we test whether interlocutory payments should have been made, but were not; this would have required sampling techniques beyond the objectives of the audit. We did not observe, however, evidence of inappropriate behavior in this regard that would compel additional investigation.

[2] Delayed or denied time loss payments were the number one source of complaints to the Self-insurance Ombuds. See 2014 Annual Report to the Governor, p 21; see also comments on disputes in workers' compensation by Richard Victor, "How to Keep Unneeded Attorneys Out of Workers' Compensation," CFO, November 27, 2012, found at: http://ww2.cfo.com/risk-management/2012/11/how-to-keep-unneeded-lawyers-out-of-workers-comp/.

[3] See also, Victor, "How to Keep Unneeded Attorneys Out of Workers' Compensation," id.

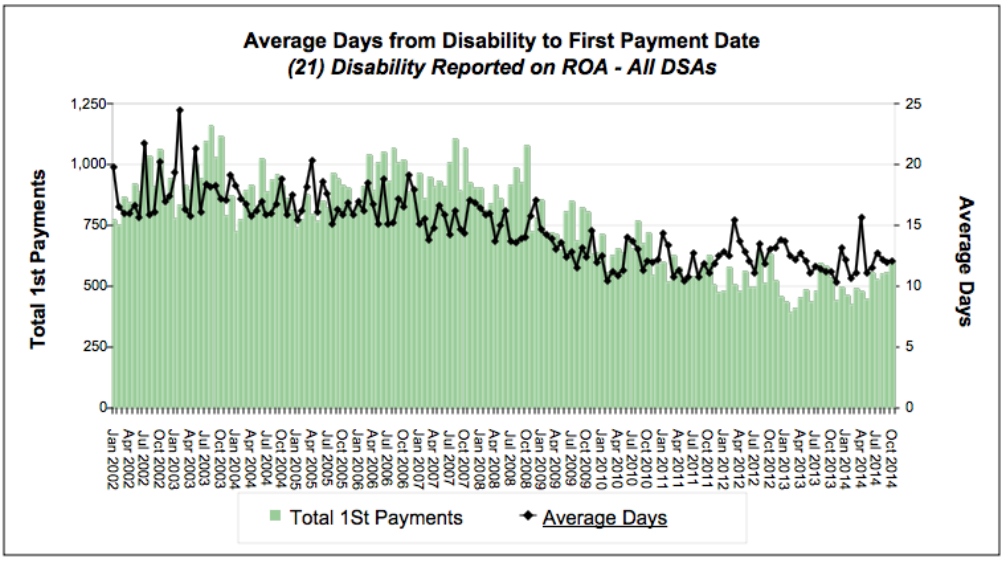
L&I measures compliance with the 14-day payment requirement by starting from the date that payment was required, and tracks various reasons why a payment might be late. We used several starting dates for our analysis. We measured the duration from date of "first notice," defined as the date a claim was received by L&I to the date of check issuance. For the sample period 2010 to 2013, we get a 60-day average duration and a 21-day median duration (both State Fund and self-insured claims). This data is not suitable for measuring compliance with the statutory 14-day payment requirement because date of "first notice" is not equivalent to date of "receipt of payable claim." L&I internally measures compliance based on the date that L&I has documentation of lost time from the injury, which explains the reason our statistical result differs from that of L&I, shown below.

The data point "first notice" is nevertheless important because it allows comparison of self-insured performance against State Fund performance on this metric; date of receipt of payable claim is not available for self-insured employers. It also allows us to more accurately compare Washington's performance on this metric with those of other states that have a 14-day payment requirement without the additional "payable" measurement screening.

Some examples of jurisdictions with similar first payment norms are given here. Virginia law requires that a payment be made within 14 days "after it becomes due," which is defined to exclude late payments made "as promptly as practicable" or those delayed by reason of "good cause outside the control of the employer for the delay." Code of Virginia 65.2-524. In Oregon, payment must be made within 14 days of notice or knowledge of the claim; insurers are subject to penalties, however, only for "unreasonable delays." Oregon Laws, Chapter 656.262(4) and (11). In Kansas, an employer or insurance carrier must pay compensation unless there is "just cause or excuse for the failure of the employer or insurance carrier to pay." K.S.A. 44-512b. Other states are stricter, however, and require an official "denial" to excuse late payment. See, for example, Maine Rev. Stat. 39-A § 205 (1) (requiring prompt payment "except in cases where there is an ongoing dispute"). One internal L&I report shows that the average days to initial payment was 27 days in 2010; during the first nine months of 2014 the average was 33 days.[4] This is measured from the "disability date," which is the date from which an injured worker was first eligible for time loss payments. This particular report covers all claims, regardless of whether they were reported late, were misreported, or had missing information that prevented a more prompt payment. In other words, this report arguably includes both "payable" and "not-yet-payable" claims; the standard is 14 days from receipt of a payable claim. A separate internal report (Exhibit 2-3 below) that purports to contain timing only of "payable" claims shows an average of less than 15 days during the first nine months of 2014. Either way, this is substantially less than our computed average, likely due to the fact that L&I's starting point (date of first eligibility of disability payments) often comes well after the starting point in our data (the date of first notice of the injury to L&I). In many cases, disability does not commence until well after the injury date; in some cases, such as occupational disease cases, this lag could be several months. In some cases the lag between injury and disability is a positive outcome, as an employer could be keeping an injured worker on light-duty employment pending surgery. This difference highlights the sensitivity of performance measures to the specifics of the measuring points. The L&I method is valid, but unlike other states. This sensitivity greatly complicates comparisons across jurisdictions.

[4] L&I "Accountability Report," last date included was August 2014.

Exhibit 2-3: Days to Initial Payment of "Payable" Claims



Source: L&I Research and Data Services, November 6, 2014.

The timeliness of payment by self-insured employers is significantly better than for the State Fund (earlier in the life of a claim), as shown in the Exhibit 2-4, which charts percentage distributions by the higher share of claims paid at each of the earlier payment time intervals (less than 7 days and less than 14 days); for the later benchmarks the performance between the two becomes more comparable. This may be due to earlier knowledge of the filing of a claim by the self-insured employer and more complete information immediately available on the wages and benefits that go into the computation of the payment. Again, keep in mind that "claim received," which means a Report of Accident or some other claim reporting an injury, is not the same as "disability." "Disability date" is not captured for self-insured claims, however.

Exhibit 2-4: Percent of First TL Payment Within Intervals by State Fund and Self-Insured, Measured from Date Claim Received (2010- 2013)

	<=7 days	<=14 days	<=21 days	<=28 days	<=90 days
Self-insured	32.4%	47.9%	55.1%	59.8%	79.5%
State Fund	20.2%	41.5%	51.1%	58.0%	79.9%

Source: WorkComp Strategies, based on L&I data 2010-2013. All results propensity matched. KOS claims not included

When comparing employers participating in the Retrospective Rating program (Retro) to non-Retro employers, the distributions show somewhat faster payment performance on average for non-Retro employers (Exhibit 2-5). As will be discussed in greater detail below, we did not observe difference in CM behavior or actions based on Retro participation. We suspect that the longer interval for Retro employers is due to the fact that many of them keep their injured workers on salary (called Kept-on-Salary or KOS) or light duty for the early part of the disability and some of these are transferred to TL payments after the disability appears to be prolonged. This would help explain why the gap between Retro and non-Retro grows as the payment interval is lengthening (i.e., from 3 days to 300 days).

Exhibit 2-5: Average days to first TL payment within intervals, Retro v. non-Retro, measured from date claim received

	10%	20%	30%	40%	50%	60%	70%	80%	90%	95%
State Fund Retro & non-Retro	**3 days**	**5 days**	**9 days**	**16 days**	**25 days**	**39 days**	**66 days**	**110 days**	**205 days**	**300 days**
Retro only	**3**	**6**	**11**	**19**	**32**	**53**	**88**	**143**	**243**	**337**
non-Retro only	**3**	**5**	**9**	**14**	**21**	**32**	**51**	**89**	**166**	**251**

Source: WorkComp Strategies, based on L&I database 2010-2013. All results propensity matched. KOS claims not included

How does this speed of first TL payment compare to other jurisdictions?

- The Workers' Compensation Research Institute (WCRI) monitors the median and mean times for first payment from notice to payer to payment. Washington's results are not totally comparable as WCRI adjusts the data for each state to attempt to eliminate any differences caused by industry mix or injury severity. Nevertheless, the WCRI statistics add perspective to the Washington results. For 2010 claims with more than 7 days of lost time, WCRI reports a mean of 51 days and median of 18 days averaged over the 16 states in the report.[5] Our computed average lag time for first payment (61 days) was only modestly higher than the WCRI average. Other jurisdictions not included in the WCRI statistics that offered publically available reports on first TTD payment with 14 days, showed the following:[6] 92% Oregon, 86% Wisconsin, 57% North Dakota, and 62% Saskatchewan. So, there are states that are accomplishing faster initial disability payments than Washington, and there appears to be opportunities for improvement.
- An internal L&I report that measures the payment within 14 days, measured from date of "disability date," or first notice of "payable" time-loss claim, shows that in 2014 about 90% of State Fund claims had on-time first payments.[7] Our analysis shows that from 2010-13, 79% of State Fund claims were first paid within 14 days of first notice of a time-loss claim. When measured from receipt of a claim, as opposed to first notice of a time-loss claim, between 30 and 40% were paid within 14 days (Exhibit 2-5 above). But, as indicated earlier, these measures would include receipt of claims that were missing information needed prior to making payment. Other states' measures may include late payments due to disputes or "just cause" for delay, and thus comparisons are complex.
- Finally, an annual report done by the Association of Workers' Compensation Boards of Canada shows a 22.9 day average time to first payment of TTD, averaged over all Canadian jurisdictions. This is surprisingly fast payment compared to US states. However, methodological differences in how the measures were made add some fuzziness to the comparisons, especially since in Washington the CM selects the date of first notification of payable claim for the department's measure of timeliness of first payments.

[5] Carol Telles, 2012 CompScope™ Benchmarks 13th Edition: The Databook, WCRI, October 2012, p 23.

[6] The way this 14-day interval was calculated is slightly different across jurisdictions, so the statistics are not perfectly comparable with each other or with Washington.

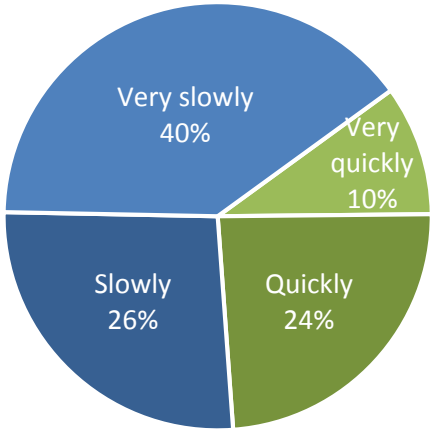
[7] L&I Accountability Report, August 2014. L&I claim-free experience and early return to work initiatives are designed to encourage keeping injured workers on appropriate light-duty work, which should generally have a positive effect on receiving complete information and improve payment timing.

1.3 Perceptions of Timeliness

In our surveys we posed questions to workers and employers concerning a few aspects of timeliness that help evaluate performance. Timeliness of first payment was a leading concern of workers, as noted above.

Dispute resolution timeliness also is an important performance measure. We analyze disputes in more detail in Chapter 3, but touch on a few perceptions here. Workers' compensation dispute resolution is ideally a streamlined, administrative law system that can resolve disputes quickly. Unfortunately, this is not the perception of surveyed workers. Two-thirds of workers (66.2%) with a dispute felt that their dispute was resolved "Slowly" or "Very slowly," with "Very slowly" dominating these two answers (Exhibit 2-6).

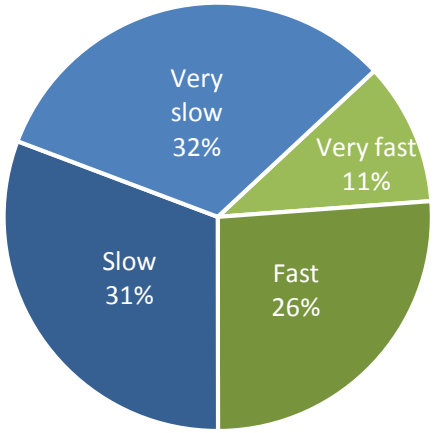
Exhibit 2-6: L&I Resolved Protest in a Timely Manner - Workers' Opinion



Source: WorkComp Strategies Survey of Workers, 2014 (sample of claims > $5,000 in medical costs)

Perceptions of workers regarding timeliness of the claim denial process (Exhibit 2-7) were consistent with the perceptions of workers filing protests on accepted claims. Each question is evidence of a negative experience on their claim. Timeliness of the legal process seems to be a general concern.

Exhibit 2-7: Workers' Evaluation of Timeliness of Claim Denial Process

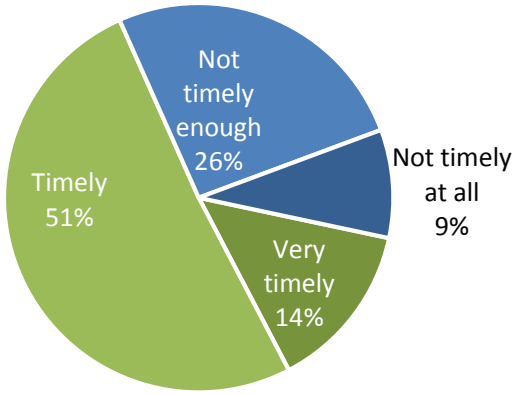


Source: WorkComp Strategies Survey of Workers, 2014 (sample of claims > $5,000 in medical costs)

Employers were generally satisfied with the quality and timeliness of information received from L&I. The employers differed from workers in having a stronger sense that L&I responded to them in a timely

manner. Almost two-thirds of employers felt that L&I was “Very timely” or “Timely” (Exhibit 2-8). This contrasts with workers where the majority was frustrated with the response time of L&I. For example, two-thirds of surveyed workers responded that their dispute was processed “Very Slowly” Or “Slowly” (Exhibit 2-6).

Exhibit 2-8: Timely in Responding to Inquires - Employers' Opinion

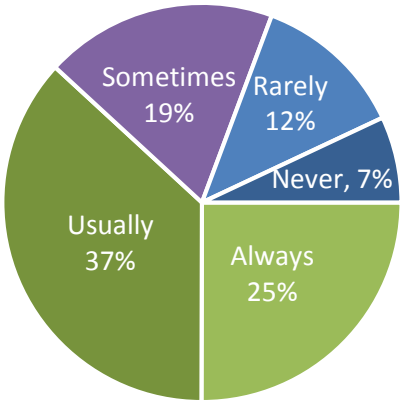


Source: WorkComp Strategies Survey of Employers, 2014

Another timeliness related question asked to employers was if L&I's information on claims was sufficiently timely to allow them to respond to decisions on their claims. There are many decisions on occupational injury claims that are easier for employers to resolve when they are informed quickly about issues. Most importantly, timely claim reporting allows employers to investigate causation and provide information to L&I on the Employer’s Report of Accident, as well as decide whether to protest a particular L&I decision. In addition, during management of the claim employer issues arise where delay can result in less than optimal outcomes, specifically regarding timely return to work.

Employers were quite positive about L&I keeping them informed. Almost 2/3rds of employers thought L&I always or usually kept them informed in a timely enough manner that they could take action on their claims (Exhibit 2-9). Given that there can be a large number of decisions made by CMs at various times in a claim, it should not be surprising that employers are not always satisfied at every point. Yet, it is worrisome that 7% of those surveyed said that L&I was never timely enough and 14% said L&I was rarely timely. This raises the question of whether there is a systemic problem or just a peculiarity of the sample of employers surveyed. It could also be that a surveyed individual was frustrated about a particular claim or claim decision and this engendered a harsh opinion on the question of timeliness. The employers surveyed are not a representative sample of all insured employers because they were selected to include only those with at least one claim during the period 2010-13 with medical costs greater than $5,000, which is in the upper 20% of claim severity. (80% or more of all employers do not have claims in a given year).

Exhibit 2-9: Informed Timely Enough for Employers to act on Claims?



Source: WorkComp Strategies Survey of Employers, 2014

2 FAIRNESS AND CONSISTENCY

This section covers the fairness portion of our analysis. This section covers fairness generally, and then explores claim-management differences between stakeholder groups.

Fairness can be gauged between groups of claimants (e.g., young versus old) or between classes of employers in the system. We evaluated fairness directly through file review and data analytics. We looked for observed bias and inconsistent treatment, as well as compliance with law. We also surveyed stakeholders on their perceptions of fairness and consistency. This audit was also to specifically address the performance of claims management service delivery and consistency between self-insured employers and state fund claims, as well as between employers who do and do not participate in the L&I Retrospective Rating Program (Retro). Our analysis shows some differences among these classes and offers reasons for the differences.

We examined fairness in several dimensions. First, did the claims process seem to be generating similar outcomes for different groups? Second, what were the perceptions of fairness by employers and workers? Third, did our file reviews and compliance reviews find any evidence of unfair discrimination? We must emphasize that differences between groups does not prove unfairness. As explained below, a difference might fully be explained by causal factors outside the control of L&I.

From file reviews, we detected no systematic bias or prejudice toward any segment of the worker or employer population. We did detect that some CMs quickly marked worker characteristics in their action plans that might indicate difficulties ahead with the file, e.g., obesity, old age, or repeated claims. But, we believe that considering these factors is prudent claims management. Similarly, our review of procedures indicated no slant or bias.

As for data analysis, some of the specific tests conducted included:

- Testing for different time lags or decision at various points in the claim process for males vs. females or for different age groups
- Testing the same differences in lags or decisions for self-insureds, Retro employers, and non-Retro

employers
- Testing for different actions by size employers and different industries.

We found some minor differences in the timeliness of some claim decisions between the genders and among claimants of different ages. For example, female claimants had slightly faster segregation orders (stating that some aspect of the claim will not be accepted, e.g., leg injury but not hip) than males, but the reverse was true for wage orders (statement of what wages and benefits were used as the basis for computing the rate of TTD compensation). Initial determinations of claims with approvals were much smaller for females, but the gender difference greatly diminished on final determination. Another example of this was the average difference in time from injury to closing order: 135 and 123 days for females and males, respectively. This difference appears to be inconsistent with NCCI countrywide data, which shows the average duration of TTD (and presumably time to closure) to be slightly higher for males than females.

Another difference is the statistically significant difference in the rate of claim denial: for males it was 11.6%, and for females it was 13.3%, but the cause for this small gap is unclear. We did not detect any sign of gender bias in decision-making by CMs in our review of claim files. The distribution by age showed a general increase in the rate of denial as age increased. In our judgment these differences arise because of the nature of the injuries, healing times required, and behaviors of the workers. We also examined other characteristics, including wage level, industry of employment, and size of the employer. Larger employers generally outperformed smaller employers in return to work, e.g., 32 days average time-loss benefits for top 25% of employers by hours worked versus 63 days for smallest 25%. The impact of this difference, in terms of overall outcome, will be discussed further in Chapter 5.

Also studied were timing differences between groups with different insurance status (self-insured, Retro, non-Retro). We also examined rates of particular decisions. A decision most tightly integrated with fairness is the decision to allow or deny a claim. Results of this and other major differences among employer groups are shown in the exhibits below.

2.1 Self-insured versus State Fund employers

Claims of self-insured employers generally demonstrated better performance on the indicators studied than those of the State Fund (Exhibit 2-10). First payment of time-loss (TL) benefits and vocational service decisions were all significantly faster for self-insured employers. The shorter duration of TL for self-insureds was especially noteworthy. The time intervals for making the allowance/denial decision and closing the file were longer for self-insured employers. We believe this is due almost completely to the L&I review process and the statutory requirement for L&I to issue an award. In terms of the rate of denial, as of 2013, for 2010 claims the denial rate for self-insured employers was 12.3% and for State Fund employers it was 12.2%; for 2011 claims the denial rate for State Fund employers was 12.6% and for self-insured employers it was 15.8%; for 2012 claims the denial rate for State Fund employers was 13.3% and for self-insured employers it was 15.1%. These differences are not statistically significant.

Exhibit 2-10 Comparison of Various Timeliness Measurements for State Fund and Self-Insured

	Average Days	
Measure	**State Fund**	**Self-insured**
Time for making allowance/denial decision from received date	5.7	66.1*
Time from received date to first TTD payment	60.5	56.1
Duration of TL	101.9	68.1
The time from the start to approval of vocational plans	153.4	114.3
Time from retraining plan approval to completion of approved plan (not propensity matched)	511	466
Time from Injury to claim closure	110.1	157.8

*We estimate that duration is increased by a 30-45 day L&I review of the self-insured's recommendation on the claim

Source: WorkComp Strategies, from L&I data 2010 – 13; unless indicated all results propensity matched; development period for Duration of TL measures as of 12/31/13. These measures used to compare SF and SI only for consistency, and not to evaluate the ultimate duration measure itself; see Chapter 5 for analysis of TL durations.

2.2 RETRO VERSUS NON-RETRO EMPLOYER

Exhibit 2-11 shows some claim decision timing differences for claims of Retro Employers versus non-Retro employers. Unless stated otherwise, the durations are means of all claims in the L&I claims database (spanning 2010 to 2013), and results are "propensity matched" to ensure comparison of similar employers. (For a description of propensity matching, see Appendix 3 – Methodology.)

Exhibit 2-11: Comparison of Various Timeliness Measurements for non-Retro and Retro Employers

	Average Days	
	non-Retro	**Retro**
Time for making allowance/denial decision from received date	6.0	5.8
Time from DOI to first TL payment	73.3	95.5
Time from Claim Received to 1st TL payment	58.5	82.5
Time to payment of first medical bill	21.1	20.7
Duration of TL	114.1	112.5

Source: WorkComp Strategies, from L&I data 2010 – 2013; all results propensity matched; development period for Duration of TL measures as of 12/31/13. These measures used to compare Retro and non-Retro only for consistency, and not to evaluate the ultimate duration measure itself; see Chapter 5 for analysis of TL durations.

For several measures, there is no meaningful difference between the two employer groups (time to initial determination of claim allowance, time to payment to medical providers, and overall TL duration). For others there was a notable observed difference. For example, the rate of denial for Retro employers was 9.0%, and for non-Retro employers it was 15.3%. When matching like employers between these groups, however, the denial rates evened out: Retro = 9.2% versus non-Retro = 10.0%, which is not a statistically significant difference. However, the difference in time to first payment of TL is large, even for propensity-matched groups.

Where there is a significant difference on some measurements, we discuss possible reasons below. First, as just demonstrated, matching like employers is important in determining true difference for some

measures; in the above example, however, it is not clear why the denial decision would be sensitive to employer size. As described in Appendix 3, Retro employers include both small and large employers, whereas non-retro employers tend to disproportionately include the smallest employers, although some low-risk class larger employers are non-Retro. The size of the employer matters very clearly on claim duration because larger employers are better able to accommodate return to work with modified duty or job transfers.

Importantly, in our file reviews and interviews we detected no L&I procedural differences between the two groups. Perhaps the slower first payment measured from date of injury for Retro is due to the fact that Retro employers are more likely to use Kept-on-Salary (KOS) and provide light-duty work early in the claim,[8] which could delay the onset of the first TL payment.

We also tested fairness by looking at differences in CM decisions at key junctures, between large versus small employers. Our analysis showed that large employers had substantially lower durations of time-loss (TL) claims. The top 25% of employers by average hours of employment had average TL durations of 32 days for accident year 2010 (accident years measure claims by the year in which the accident occurs), while the lowest 25% in average hours had durations of 63 days. This has little to do with unfair treatment by L&I; other studies have shown that larger employers have shorter durations due to many factors associated with safety practices and return to work programs.[9] Smaller employers are limited by fewer opportunities for modified duty jobs for injured workers, and less sophisticated human resource capabilities to manage disability.

One final test of fairness was to examine CM notes in the file review to detect any suggestion of bias or prejudice for or against any class of claimants or for or against employers of any type. We found no hint of inappropriate comments. However, this scrupulously clean language may be the result of concern that comments will be misinterpreted and challenged by the parties to the claim.

2.3 Stakeholder Perceptions of Fairness

Since fairness can be thought of as a subjective judgment, we can gain insights from our opinion surveys of workers and employers. We asked several questions about how they felt they were treated during the claims process; e.g., "When you contacted L&I, how often were you treated with respect?"

A surprising number of worker respondents offered negative evaluations, with 14% saying that they were "not very often" treated with respect, and 7% saying they were "never" treated with respect. This sort of customer opinion would be a disturbing wake up call for most businesses. While not quite the same as the above question, it is noteworthy that the annual injured worker survey from the North Dakota workers' compensation fund consistently finds around 92% of the respondents saying the agency treated them "politely." L&I also surveys workers on similar questions, and results are more favorable. Sampling methods, however, were different: our survey sample drew from claims with relatively serious injuries. Our sample also included claims with attorney involvement, whereas L&I surveys exclude claims with attorney involvement.

[8] KOS means that the injured worker is kept on salary to avoid paying Temporary Disability benefits. It is one of the principle tactics used in Washington to avoid higher workers' compensation premiums. Overall, KOS was used in 18.4% of compensable LT claims in 2013. Retro employers in particular use KOS as main part of their strategy to improve loss experience; using KOS for at least the immediate response to an injury is a condition of some Retro group membership.

[9] See for example, Barry Lipton, John Robertson, and Katy Porter, Workers Compensation Temporary Total Disability Indemnity Benefit Duration—2013 Update, NCCI Research Brief, August 2013.

Other questions in our survey tested the concept of fairness through examination of protests, which are formal complaints that are lodged by an injured worker or employer concerning a particular CM claim decision. Regarding protests, we posed three related questions to workers:

- Did the workers feel they had sufficient opportunity to present their case?
  - For this, 41% of the workers said they did not have sufficient opportunity.
- Were the workers satisfied with the process?
  - Here, 41% were "very dissatisfied" and 17% "somewhat dissatisfied."
- Were the workers satisfied with the outcome?
  - Here, 34% were "very dissatisfied" and 10% "somewhat dissatisfied."

Altogether, these opinions portray rather deep negative feelings from the sample of workers in the survey about the fairness of the claims process. We hasten to add that our survey sample is not a true cross section of all claimants; rather the sample included only claimants with relatively more significant medical expenditures, and who are more likely to be those workers with long-term disability and less hope for returning to prior lifestyle or employment. They are also more likely to have negative decisions made on their claim related requests. This might result in more negative opinions, especially if they experienced an unfavorable outcome in their protests.

Some stakeholder interviews suggested that employers and their representatives feel that the system as a whole tends to give advantages to the injured workers relative to employers.[10] But our survey showed a rather similar view of overall fairness by both employers and injured workers. The survey of injured workers did uncover a dissatisfied minority of respondents who were very dissatisfied with the protest process and outcome of their protests, which, among other things, could suggest a lack of fairness. Our review of disputes, however, supported the fairness of the process. First, while statistics are hard to come by on this topic, it does seem that Washington's level of disputes is not obviously out of line with other jurisdictions. Second, the rates at which protests and appeals are made against L&I decisions are only moderately higher for worker-initiated appeals versus employer-initiated appeals.

2.4 Differences in Service Delivery across Test Groups

We also tested for fairness by examining differences among the delivery of certain services. One particularly important group of services is vocational rehabilitation. The audit contained specific steps to determine if different classes of employers and their workers were treated differently in the vocational process.

Exhibit 2-12 shows that Retro employers had a statistically significant different duration of time to the first vocational assessment.[11] This does not appear to be related to CM behavior, but rather the behavior of employer representatives managing claims for Retro employers; employer representatives typically utilize and emphasize RTW programs that explore RTW options in more detail and are prone to exhaust return to work with modified duty, or KOS options. This could add time to the overall vocational services schedule.

[10] For example, this was clearly found in the survey done as part of the 1998 Performance Audit.

[11] The vocational assessment used for this analysis was Early Intervention (EI) and the Ability to Work Assessment (AWA). The AWA is the initial service upon which later services are based. Note that L&I has recently explored altering the timing of the AWA and delivery of other, more appropriate vocational services. The AWA is a relatively formal intervention, and can shift the focus of the claim away from RTW. For example, in some claims the CM determines that delaying the AWA for a certain period, and instead utilizing other RTW services, can result in earlier RTW. EI is less formal than the AWA, and thus could be viewed as improperly skewing these results. Note that this analysis does not seeking to evaluate timeliness of either AWA or EI separately, but rather consistency among matched employers in the groups under consideration.

Exhibit 2-12: Time from the received date to start of first vocational rehab service (AWA and EI)

	Duration Days	
Class of Employer	**Mean**	**Median**
Retro Employer	349.5	281
non-Retro Employer	310.5	241

Source: WorkComp Strategies, from L&I data 2010-13; results are propensity matched

In Exhibit 2-13(a), plan development times for self-insureds are much swifter than for State Fund cases. The State Fund mean is well over the 90-day target for completing plan development; over half the claims exceed 118 days (median). Results for Retro and non-Retro employers were very similar. The duration here is the time to the decision on whether to approve or reject the plan. Exhibit 2-13(b) shows this same comparison between matched Retro and non-Retro employers, and the results were very similar between these two groups, which indicates consistency of treatment. Note that these results, as are the others in this sub-section, are propensity matched, and thus for the Retro/non-Retro and State Fund/self-insured comparisons, employers are matched based on size and risk characteristics, and those for which good matches are not available are trimmed. It is extremely important to note that in using propensity matching in this section on fairness, the length of the duration measures are not being analyzed for the entire set of employers in each group. Rather, the similarity of the measures between the groups under analysis are being compared. This analysis is designed to gain understanding into consistent treatment, not to gain insight into overall timing or trends over time.

Exhibit 2-13(a): Time from the start of vocational rehab plan development to approval/rejection of plan, SF - SI

	Duration Days	
Class of Employer	**Mean**	**Median**
State Fund	153.4	118
Self-insured	114.3	91

Source: WorkComp Strategies, from L&I data 2010 – 13; results are propensity matched

Exhibit 2-13(b): Time from the start of vocational rehab plan development to approval/rejection of plan, R - NR

	Duration Days	
Class of Employer	**Mean**	**Median**
Retro Employer	183.8	155
non-Retro Employer	185.6	160

Source: WorkComp Strategies, from L&I data 2010 – 13; results are propensity matched

In Exhibit 2-14(a) below, the total length of time from plan approval to plan completion is shown for matched State Fund and self-insured employers. Note that between 2010 and 2013, there were only 14 reported retraining plans in self-insured employer claims; there were 55 such State Fund plans over the same period. In Exhibit 2-14(b), the results between Retro and non-Retro groups were fairly similar.[12]

Exhibit 2-14(a): Time from the date of vocational rehab plan approval to plan completion or closure,

[12] Note that valid propensity matching among similar State Fund Retro and non-Retro employers was not reliable for plan completion durations because of the small number of plans for the reporting period.

SF – SI, 2010- 2013

	Duration Days	
Class of Employer	**Mean**	**Median**
State Fund	473.6	421
Self-insured	459.6	468

Note: These durations are based on claims with accident years (dates of accidents causing the claim) between 2010 and 2013; hence they would tend to understate the durations for final plan completion.
Source: WorkComp Strategies, from L&I data 2010 – 13; results are propensity matched

Exhibit 2-14(b): Time from the date of vocational rehab plan approval to plan completion or closure, Retro – non-Retro, 2010- 2013

	Duration Days	
Class of Employer	**Mean**	**Median**
Retro Employer	528.4	492
non-Retro Employer	494.3	504

Note: These durations are based on claims with accident years (dates of accidents causing the claim) between 2010 and 2013; hence they would tend to understate the durations for final plan completion.
Source: WorkComp Strategies, from L&I data 2010 – 13; results are not propensity matched

Where significant differences were found, we analyzed whether this seemed to be due to the L&I procedures or other causes external to L&I. With respect to vocational services, self-insured employers employ a vocational service delivery approach that is different than for the State Fund in many ways. Most significantly, self-insured employers select and pay for vocational rehabilitation counselors—hence they have a good deal of leverage on the providers. However, the assessments and retraining plans of self-insured employers are subject to the same review as for State Fund vocational rehabilitation counselor work products.

As shown in Exhibit 2-13(a), self-insured employers appear to be faster at making decisions on whether to approve vocational plans. As noted, self-insured employers select and pay for vocational service providers without any input from L&I; hence the shorter durations for self-insureds may be due to the nature of how providers are selected and managed. Also, there may be a bias for self-insurers in the selection toward providers that develop shorter retraining plans or push for early plan completion. On average, self-insured employers appear to have a significantly lower percentage of claims with repeat Plan Development referrals and repeat Plan Implementation referrals, which would reduce the duration.[13] As shown in Exhibit 2-14(a), self-insured employers have slightly shorter times for the completion of retraining plans. However, the median times are somewhat longer. The sample size is very small and there is no statistically significance to the mean or median differences in the samples.

In examining Retro vs. non-Retro vocational service delivery we observed several areas with no significant difference. For example, as in Exhibit 2-13(b), the time to decision on a vocational retraining plan was very similar between matched Retro and non-Retro employers. We did observe some notable differences, however. In Exhibit 2-14(b), Retro employer were a little slower on average in completing plans after approval, yet the median times were a little quicker. The samples were small, however, which precluded valid propensity scoring, and we do not believe the differences are statistically

[13] Reported for the pilot evaluation period by the University of Washington evaluation of the Vocational Improvement Pilot. Jeanne Sears and Thomas Wickizer, Evaluation of the Vocational Rehabilitation Pilot Program, University of Washington, December 2012, p 32.

significant. Also, in explaining differences, we could find no part of the L&I claims process that explicitly called for any difference in the treatment of participants in the Retrospective Rating program relative to other State Fund employers. Moreover, in our interviews with L&I staff we made pointed inquiry into any differences in the treatment between Retro and non-Retro employers; the response was uniformly "there is no difference." In our file review we could not detect any recognition by the CM of the insurance status of the employer. We did, however, see frequent references to "employer representative," or the like, in file notes, for example when a representative contacted the CM to suggest that various actions be taken by the CM. Because of the above, we did expect to see some statistically significant differences in the timing and nature of services between the two groups.

Salient observations regarding Retro v. non-Retro differences in vocational services are:

- There is a somewhat longer time duration from injury to the first vocational service (EI or AWA) for Retro employers. We expect this difference is due to Retro employers utilizing additional RTW efforts before initiation of AWA services.
- For Retro and non-Retro employers there was no material difference in the time interval for vocational plan development to go from initiation to approval by L&I for matched employers.
- There is a 34-day shorter average time to complete retraining plans for non-Retro versus Retro employers claims, whereas the median time for Retro was 12 days shorter.[14] This difference does not appear to be statistically significant given the small sample of completed retraining plans.

2.5 LEGAL COMPLIANCE

Finally, we tested fairness and consistency through examination of compliance with legal standards. We observed that the Department is very scrupulous about implementing laws through careful legal analysis and procedures. Apprentice CMs are given rigorous instruction in law and procedures. However, it is not clear that CMs are given much formal legal training after apprenticeship, to keep them current in their understanding of law and procedures; post-apprenticeship continuing education and development related to claim management generally appeared to be ad hoc and without much ongoing formal instruction.[15] There is a comprehensive online reference system available to CMs, and L&I reports that it is currently implementing an improved online reference system.

Notwithstanding any formal educational program, however, our file reviews tended to show that CMs generally know and follow the law and L&I procedures; apparent errors were observed but these were individualized errors rather than systematic and conscious violations of procedures. Examples of this would include: failure to use non-English language communication when required, allowing a claim with an incomplete physician's first report, or inexplicable delay in commencing an ability-to-work assessment, ordering an independent medical examination, or closing a file.

One possible compliance issue that was observed concerned vocational services. Retraining plan development by law should be completed in 90 days or the delay excused for cause by L&I. Only about half of plans are completed in 90 days, but we did not have the data to determine how many of these

[14] Our data covered the period 2010 – 2013, and there were only 55 such plans. For the later-year claims (e.g., some in 2012 and more in 2013), there is likely not be sufficient time to fully develop the loss experience for complete analysis.

[15] A significant exception to the latter was recent training sponsored by L&I to better equip CMs with the communication skills that would minimize the root causes of some disputes through more constructive first contact with claimants.

"late" plans were excused. L&I reports that 76% of such plan developments require an extension; in FY 2014, 1,500 plans were submitted, and 1,140 late plans were excused from the statutory 90-day standard. There has been a concerted effort by L&I, since the sample period in our analysis, to modify the vocational-services delivery structure, and early results on some of these initiatives have shown success; this is discussed further in Chapter 5.

Protests and appeals also offer clues about compliance with law. While about 40% of both worker and employer sponsored appeals end up reversing the underlying L&I decision, which is discussed in Chapter 3, this seems to be attributable to the normal consequence of the parties having different interpretations of the fact situation in a claim (e.g., is a spinal stimulator "medically necessary"?). Some of the reversals undoubtedly are more general disagreements on how the law should be interpreted (e.g., BIIA saying the Director had exceeded his authority on a specific matter).

The protest and appeal process does not reveal any substantial differences across the three major forms of insurance, or by age or gender. In terms of who files appeals to the BIIA, far more injured workers file appeals than employers. The rate of appeal by injured worker is higher for State Fund claims than self-insured claims. Across the three major forms of insurance, the overall rates of appeals are not significantly different, nor is there a significant difference in the percentage of appeals filed by claimants versus employers across these types, with the possible exception of self-insured employers being more likely to initiate appeals. We believe that these taken together – the lower rate of self-insured worker appeals and the higher rate of self-insured employer appeals – is largely explained by the underlying decision at issue in the dispute being in effect the self-insured employer's decision, which is logically going to be more robustly defended by the self-insured employer. In our interviews we sensed that the TPAs handling self-insured claims had a strong sense of professional pride in their decisions and were quite willing to defend them before BIIA.

Some TPAs interviewed regarding the L&I handling of self-insured claims made negative comments about L&I's interpretation of law (allegedly making it necessary to appeal), but this was the only significant concern on the subject raised by stakeholders in interviews. We did not see any recent controversies in BIIA decisions or court appeals that suggested L&I was making arbitrary or substantively new interpretations of law in its claims handling.

3 DISABILITY MANAGEMENT

Our analysis of claim management performance is divided into three sections: Timeliness, Fairness, and Disability Management. In this section we will analyze performance in the context of disability management practices.

"Disability management" can be defined as an active process of minimizing the impact of a mental or physical impairment resulting from work related injury or disease on the injured workers' capacity to participate competitively in the work environment.[16] It was a core component of the audit. Disability management services, if well designed, target a return to pre-injury function, or a plan to address diminished functional capacity through medical and vocational interventions. The overall design of the delivery of these services can best be evaluated through analysis of the outcomes, which will be

[16] See International Labor Organization (ILO), Encyclopedia of Occupational Health and Safety, found at: http://www.ilo.org/iloenc/part-iii/disability-and-work/item/179-disability-management-at-the-workplace-overview-and-future-trends.

addressed in detail in Chapter 5 of this report. Our analysis indicated that difficulty in returning a small fraction of injured workers to gainful employment is a major performance problem in the Washington system.

Effective disability management is at the heart of a successful workers' compensation claim management program. To be sure, quick and accurate claim determination, prompt payments, and fair, unbiased, and lawful behavior and decision-making are critical to an effective program, and these issues often form the basis of stakeholder perception survey responses, both positive and negative. Performance in how well disability is managed, however, ultimately determines the overall effectiveness of a workers' compensation system.

Among the bedrock principles of disability management is the adjuster's proactive involvement in returning the injured worker to employment, using a multidisciplinary team approach when needed, and actively involving the employer and injured worker in the return to work process.[17] This principle has long been at the heart of good claim management: restoring the injured worker to their pre-injury employment status with a minimum of residual impairment. In this section we will examine L&I performance in light of these "best practices."

We include medical service management in this section because this aspect of the claim process greatly controls both successful return to work and promotes as complete a healing from injury as possible. Disability management is the systematic and proactive response to a disabling injury aimed at minimizing time away from work that is not medically necessary. The meaning of "medically necessary" time away from the jobsite is far less restrictive in modern occupational medicine than medical practices in workers' compensation 20 years ago. Absent the need for continuous immobilization or bed rest a disability manager will seek – very actively – ways of returning the injured worker to the employer of injury with temporary or permanent restrictions or job modifications, as needed.

We will evaluate disability-management performance through analysis of five critical performance measures: 1) Establishing the Claim - building relationships early in a claim; 2) Medical Management - managing medical treatment; 3) Vocational Services Delivery - identifying needed vocational services and their timely delivery; 4) Managing Return to Work; and 5) Case Management Planning. We will also discuss areas in which design is impacting performance.

3.1 Establishing the Claim

Our analysis of disability management in Washington begins with discussion of early actions in the claim. In Washington the all-important work of managing the medical and disability duration of a claim frequently gets off to a slow start. An injured worker could easily wait over a week from the time of injury before receiving a form letter from L&I, and perhaps weeks more before receiving a personal contact from an L&I representative. Great damage is done by this delayed and impersonal contact. It retards informed decisions by the CM in planning for the resolution of the claim, and it creates feelings of worry, suspicion, and animosity with the claimants. Reasons for this slow start could include: 1) late reporting by claimant; 2) delayed reporting by treating doctor; 3) underwriting review of claim; and 4) assignment of "minor" status which by design defers personal contact. Moreover, the use of mailed letters as the preferred method of initiating contact with employers, doctors, and the injured worker is

[17] Donald Shrey, "Disability Management in the Workplace: Overview and Future Trends," International Labor Organization Encyclopedia, 2011, found at: http://www.ilo.org/iloenc/part-iii/disability-and-work/item/179-disability-management-at-the-workplace-overview-and-future-trends.

inherently slow. As we will discuss in Chapter 4, written communications by L&I may be difficult to interpret, misunderstood, or just not read by a significant fraction of workers.

L&I has attempted to address the first of these delays (late reporting) by two means: 1) the FileFast initiative; and 2) enhanced use of best practices in occupational medicine (i.e., creation of Centers for Occupational Health and Education).

FileFast is a fine example of proven success in technology and service innovation. It is based on online and telephone reporting of claims by physicians and workers and entry of expanded data into a new computer application based on that information, but includes expanded capabilities for web-based reporting of injuries. The program—with considerable stakeholder input—has grown into a well-accepted tool that enhances the early reporting of claims. Just as important, the reports tend to be more complete, including more descriptive clinical information about the injury or disease. Put into production in 2011 (from earlier pilots), use has steadily grown to the point that 20-22% of first reports come in through this system. Utilization seems to have plateaued, which is unfortunate given the demonstrated value of this reporting mechanism to L&I.

As L&I notes in its website promotion of FileFast: "Online filing speeds claims processing by 5 days." Specific advantages of FileFast (FF) claims over paper reports are: Percent of claims with First Payment of Time Loss Benefits within 14 Days (56.5% FF vs. 53.8% paper); Percent of Claims in Undetermined Status on Initial Review by CMs (16.2% FF vs. 21.6% paper); Percent of Wage Orders Issued within Six Days of Allowance Decision (15.5% FF vs. 10.6% paper).

Part of this improved performance appears to relate to the prompt first contact made by the FileFast unit; in 2014 the four dedicated FileFast CMs tended to make early personal contact on 100% of the claims.[18] More significantly, L&I in describing the FileFast unit reports as follows: "Our phone conversations involve coaching the worker or employer about return to work and controlling costs of the claim," which is exactly what all CMs ought to do.

The second initiative to address timeliness of reporting is the creation of Centers for Occupational Health and Education (COHE). COHEs are designed to apply best practices in occupational medicine; they have gradually expanded throughout the state since 2002. In 2013, 38.5% of initiated claims came from COHE providers.[19] COHE providers have a much better record than non-COHE providers in timely reporting of claims and related reports (e.g. the Activity Prescription Form, or APF) on functional restrictions for the claimant during healing (using FileFast). For example, in a study of COHE applicability to the Oregon system, the study's authors reported on Washington experience and found that accident reporting and APF were superior for COHE versus non-COHE providers. Apropos to the issue of timeliness, they found that it takes L&I about two weeks to make the claim determination after receiving the report of accident (ROA) for COHE claims. For non-COHE claims it takes L&I about a week longer for the determination. In addition, non-COHE providers tend to take longer to submit the ROA.[20] This demonstrates that good occupational medicine practices are effective at speeding up claim processing.

[18] L&I internal reports (files named "JLARC FileFast Structure" and "First Contact Rpt") supplied by L&I in September and October 2014.

[19] Presentation by Vickie Kennedy to Workers' Compensation Advisory Committee, April 2014.

[20] Michael Buck and W. Kent Anger, "Developing a Methodology for Conducting a Feasibility Study of Washington State's Centers for Occupational Health and Education (COHE) Model," Center for Research on

Why is timely accident reporting important? The most important reason for timely reporting is to quickly begin discussion with the parties to the claim to allow CMs to detect problems and gain control of the claim. Delayed contact hinders investigation into the validity of a claim, getting proper medical care started, and facilitating three way discussions (employer, medical provider, and worker) on return to work. In Washington, there is a permitted reporting lag of 5 days on the physician's report of injury, which seems lax, particularly since many reports exceed this target and online reporting tools have been shown to be quick and easy. As the International Labor Organization notes, "Perhaps the most important principle of disability management is early intervention."[21] More needs to be done as early as possible in the life of a claim to identify issues that will complicate claim management and prolong disability.

One of the first steps in disability management is to make prompt contact with the parties to the claim. This serves the purpose of instilling confidence or trust in the process. Personal contact with the injured worker and employer is invaluable in uncovering issues that may inhibit progress in managing the disability. It is widely accepted as a "best practice" among private insurers to make 3-point contact (injured worker, employer, and treating physician) within a day or two of the receipt of the claim. This practice was confirmed in our survey of expert claim managers.[22]

The 1998 Performance Audit addressed prompt contact and recommended that "There should be a personal contact with the three key parties involved in a claim as soon as possible and no later than 48 hours after a report is received."[23] In response, L&I made some adjustments but later abandoned routine contacts with employers, reportedly because of unwelcome reception by employers who felt no need to be contacted unless the claim turned problematic. With respect to the injured worker, L&I nominally makes immediate personal contact a priority, but the actual practice is less than desirable. According to L&I internal reports, 70.5% of workers with claims in the period June 2013 to August 2014 received at least one "first contact" phone call.[24] The percentage of TL claims with first contact has been trending upward; in August 2014 it rose to 84.5%. A large share of the claims received two or more contacts. Many of these are by claims assistants, not the CM. By design, calls to CMs can be routed to support units if the CM is not available, and the support unit staff provide assistance to the caller, or create a referral to the CM if they are unable to provide the appropriate assistance. According to an internal L&I report 19% of external calls received for claims were answered by the CM.[25] L&I reports this as being close to its target level of 20%.

L&I survey data from September 2013,[26] however, shows that 48% of injured workers reported receiving calls initiated by the CM, up from the previous year (Exhibit 2-15). Surprisingly, nearly a fifth of the

Occupational and Environmental Toxicology, Oregon Health & Science University, available at http://www.oregon.gov/DCBS/MLAC/docs/support_docs/2012%20docs/10-26-12_Full/COHE%20Report%20FINAL%20DRAFT-10-22-12.pdf.

[21] International Labor Organization, op. cit.

[22] See also "Best Practices in Return to Work for Federal Employees Who Sustain Job Injuries: A Guide to Agencies" published by the Dept. of Labor, Office of Workers' Compensation, found at: http://www.dol.gov/owcp/dfec/power/Best_Practices_FECA_Return_to_Work.pdf.

[23] Ed Welch, Workers' Compensation System Performance Audit of the Washington State System, JLARC, Report 98-9, 1998.

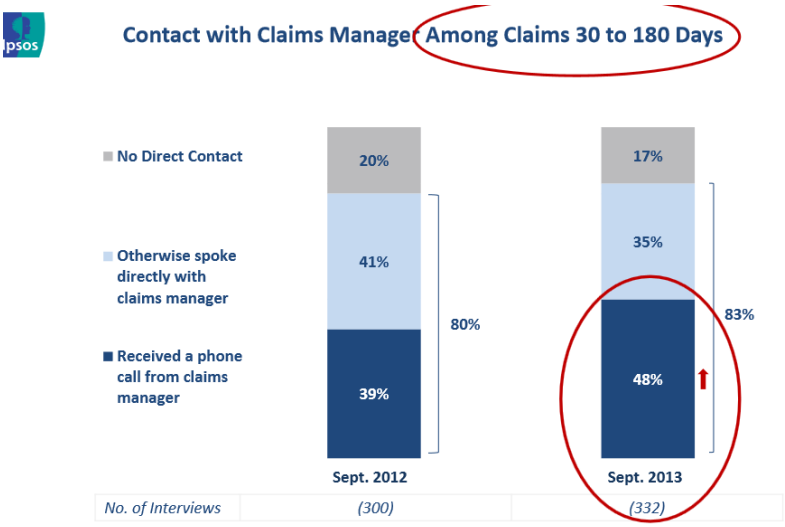
[24] L&I internal spreadsheet "Time Loss Claims with First Contact." (last modified 1/14/15).

[25] L&I internal spreadsheet "2014 Vol ACD Phone Stats."

[26] L&I commissioned surveys in fall 2011 ("Baseline"), and in fall 2012 (Wave 1), fall 2013 (Wave 2), spring 2014 (Wave 3), and fall 2014 (Wave 4).

survey respondents with claims aged 30-180 days reported not getting a direct contact initiated by the CM. This underscores the letter-based management of claims.

Exhibit 2-15: L&I Surveys of Injured Workers: Question on Phone Contact

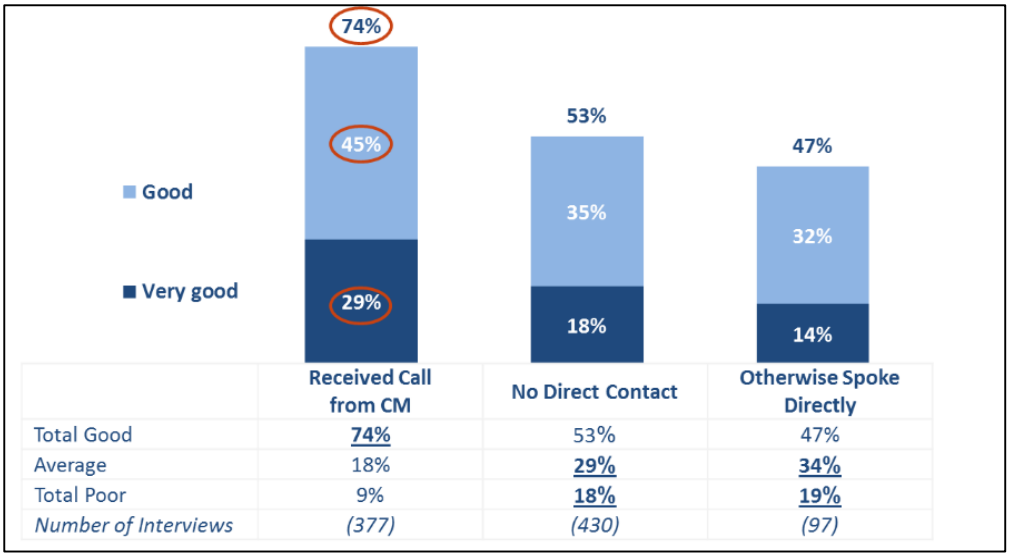


Source: Ron Langley presentation to Workers' Compensation Advisory Committee, December 2013.

Our file reviews (2011-13) confirmed this perception, namely that a small minority of claims had documented direct contact with the injured worker initiated by the CM, and fewer still recorded the substance of any discussion. The benefits of early personal contact are born out in the evaluations of workers on the overall experience with L&I.[27] As shown in Exhibit 2-16, the category "received a call from the CM" halved the poor ratings from "no contact" or "otherwise spoke directly," and increased the "very good" ratings substantially.

[27] Survey done by Ipsos-Reed, Sept/Oct 2013.

Exhibit 2-16: Worker Satisfaction Ratings for Different Contact Points



	Received Call from CM	No Direct Contact	Otherwise Spoke Directly
Total Good	**74%**	53%	47%
Average	18%	**29%**	**34%**
Total Poor	9%	**18%**	**19%**
Number of Interviews	*(377)*	*(430)*	*(97)*

Source: Source: Ron Langley presentation to Workers' Compensation Advisory Committee, December 2013.

There may be hybrid models to bridge the gap between "best practices" and L&I's historic difficulty in making immediate 3-point contact. Intermediate strategies, which L&I seems to be working toward, would segregate the claims that seem to be easily and swiftly resolved for one level of contact, and those that are at-risk of long disability and complications for more proactive contact. For example, contacting the employer immediately may not be necessary if the accident report indicates immediate return to work and contact with the worker offers a realistic indication of early return to work.

Personal contact with physicians, while desirable in principle, is fraught with difficulty. CMs will be kept on hold for extended periods and when a staff member answers they may be incapable of responding to the problem at hand. Personal contacts with physicians or their offices might be reserved for instances in which the doctor's reports are very late, incomplete, or offer dubious opinions or conclusions. In such problem situations the CM might call the office staff with a simple message to jog action from the provider in reference to a previous letter request.

3.2 Medical Management

Next, in our discussion of disability management in Washington, we turn to performance with respect to managing the medical aspects of a claim. Effective medical management of claims includes how well medical treatment is managed and how well medical restrictions on return-to-work are managed. The role of medical management in the efficiency of the claims management process and effect on outcomes is indisputable. Medical management greatly influences the timeliness of claim decisions, efficiency in the use of medical resources, and perceptions of fairness in the claim process.

Actions involving medical providers[28] control three aspects of a claim: 1) investigation and "allowance" of a claim as connected to work; 2) the conditions under which the worker can return to employment; and 3)

[28] Note that the term "medical provider" includes not only physicians, but also physician office staff, nurses, and other medical clinicians.

the duration of medical treatment required for maximum healing. Most often all three functions will be performed by a medical doctor, but other clinical disciplines sometimes enter into medical decisions. It is beyond the scope of this study to discuss the cost and effectiveness of medical treatment. Rather, we confine ourselves to CM and clinician interactions that guide the CM in managing the progress of the claim. In our review of claim files we saw examples of medical providers falling far below "best practices" for reporting and communication as accepted by occupational medicine providers.[29] Delays and incomplete reports complicate the work of the CM and delay claim resolution. Additionally, we observed in our file review that when confronted with practices that may deviate from good occupational medicine (e.g., incomplete or unsupported diagnoses, protocols, or plans) some CMs react ineffectively or delay action. Examples:

- Some doctor's reports of injury are extremely sketchy on the nature of the injury and its connection to work. For example, the report might simply show an ICD-9 code 724.5 (unspecified backache). It was our observation that some CMs write to the provider to ask for more details; others might let it pass.[30] A provider might not supply an Activity Prescription Form (APF) and the CM will then send a letter asking for an update. The APF may come back vaguely worded or incomplete, requiring another round of letters from the CM. Given the absolute importance of this information to returning the injured worker to employment, it seems that using more proactive measures to get the APF to the employer and any vocational expert involved is appropriate. Phoning the provider's office to request the information, as opposed to defaulting to slow letter exchanges would enormously speed the process. Poor medical reports become a barrier to the CM's ability to pay timely benefits and make informed decisions about timely RTW services.
- Suppose a claim showed a substantial period with no treatment; depending on previous information in the file an alert CM might follow up with a letter asking if treatment had been concluded and maximum medical improvement reached. Here again is a potential breakdown in communication between the CM and treating clinician. Resolving the treatment issues with one or more providers by letter could take weeks. Again, the vigor of the CM response should be appropriate to the fact situation and need for information.[31]
- The provider may not initiate a report declaring that there is a permanent impairment that should be rated. This requires the CM to write a letter to ask about the existence of permanent impairment and to ask if the treating provider wishes to make the rating. The rating certainly needs to be in writing, but the process could be jump-started in most cases through a phone call to the provider's office. There is a benefit to having a letter, namely that it is a formal record that the request was made; however, the relationship here between CM and provider is not one where "proof of contact" would appear to be required. The urgency of the situation – to complete the rating and return the injured worker to employment as expeditiously as possible – compels taking those steps that are most efficient, which would appear to be a phone call to the provider's office.

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[29] The best practices for COHE providers are the basis of for effective claim management: submitting a complete ROA in two business days or less; completing Activity Prescription Form on first visit or when restrictions change; contacting employer when worker has restrictions; and documenting barriers to return to work and plan.

[30] We observed that in one quarter of the reviewed files there was no documented follow up to compensability issues. See Appendix 4 for more information concerning file review results regarding allowance and denial decisions.

[31] L&I appears to be addressing these communication gaps between CMs and providers via a pilot program with The Everett Clinic. Among its goals, this initiative seeks to identify barriers, speed occupational disease adjudications, and education of providers. It is being tested with one claim unit with the intention of making it common to all claims units.

A key aspect of medical management involves opioid use, which has become one of the hottest issues in workers' compensation. Opioid prescriptions for work injuries grew rapidly in the 1990s and early 2000s. Medical authorities inside Washington and nationally have said that the risks of opioid use from chronic pain outweigh the benefits for the injured worker.[32] In our file review, which covered claims from 2010-2013 we observed very frequent prescriptions for opioids for sprains and strains, and frequent renewals of prescriptions for extended periods without any discussion in the claim file of clinical evidence supporting the continued use.

Washington has been a leader in combating abusive and potentially lethal over-prescription of opioids. In July 2013 the L&I Medical Director issued new directives on the use of opioids for chronic pain.[33] Ideally, the CM's role in managing these treatment issues includes active engagement and prompt, regular, and thorough inquiry and exchange of information. We were pleased to see that the percentage of claims with opioid use 6-12 weeks after injury declined from 4.93% in 2012 to 1.2% or less in late 2013 and early 2014.[34] This, we believe, will exert a desirable effect on claims outcomes. Despite the progress, vigilance is needed by CMs in enforcing L&I's medical guidelines.

Clinicians play an enormously influential role in the progress and outcome of a claim, especially for serious injuries. As discussed above, some practices make the work of the CM much more difficult by lax reporting or treatment protocols that deviate from accepted occupational medicine guidelines. Clinicians that substantially and frequently deviate from standard practices place a tremendous burden on the system. The ability of chronically poor performers to remain in the Medical Provider Network ought to be subject to corrective action or removal from the Network; L&I reports that the Medical Provider Network has been an effective tool for L&I to remove many of these clinicians. Recently, L&I has begun using data on chronically poor performance. In addition, L&I reports that it is using a data driven analysis to identify those clinicians who have a pattern of low quality care that results in harm or risk of harm, as defined by rule, and currently is analyzing data on repeat surgical rates and opioid overprescribing. Depending on the severity and frequency of the situation, corrective action includes education and remediation assistance by a medical director, monitoring of cases by the medical director or other clinician, transfer of cases, or removal from the Network.

3.3 Vocational Service Delivery

Next, we turn to analysis of performance in the delivery of vocational services. Effective performance in delivering appropriate vocational services involves delivering the right service at the right time. Our analysis included the timeliness of the provision of basic vocational services by L&I.[35] These services are provided to injured workers that have recovered as much as medically possible from their injuries, but have no clear job prospects. These services have been the object of many recent process improvements

[32] 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.

[33] Medical Treatment Guidelines: Guideline for Prescribing Opioids to Treat Pain in Injured Workers, Office of the Medical Director, effective July 1, 2013, found at: http://lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/FINALOpioidGuideline010713.pdf.

[34] Vickie Kennedy presentation to Workers' Compensation Advisory Committee, June 2014.

[35] We exclude from this discussion some services provided by vocational experts to investigate compensability (Forensic Study) or to facilitate job modification and modified duty return to work (Stand Alone Job Analysis).

by L&I. After covering some measuring points for vocational services, we provide a general assessment of L&I's performance in targeting, delivering, and evaluating vocational services.

3.3.1 Timing of First Vocational Service.

Early in the claim process, L&I uses staff to promote return to work with the employer of injury. L&I routinely uses Early Return to Work field staff in all claims with 14 days of disability, or for manual referrals made by the CM. These specialists perform job analysis, functional capacity examinations, and interact with the treating physician about modified duty during the healing period. This is a good example of the interdisciplinary teamwork that is useful in disability management.

The first vocational services considered here are either the "Ability to Work Assessment," (AWA) which is used to determine if the injured worker is employable in the open job market, or the "Early Intervention," (EI) which is used to attempt to restore an employment relationship with the employer of injury. EI services are generally provided by L&I field staff in the Early Return to Work (ERTW) unit; private vocational counselors are used when ERTW staff have insufficient capacity to provide the services. AWA services are provided by private vocational counselors. Either of these services is the necessary first step to determining if the injured worker is eligible for further vocational services. These assessments determine if the injured worker has transferable job skills to their relevant labor market. Historically, these assessments have been typically ordered by the CM when the injured worker's medical condition is stable and permanent functional limitations can be measured by a physician. This "wait and see" caution has been eclipsed by a far more aggressive policy on triggering AWAs; more will be said about this policy shift.

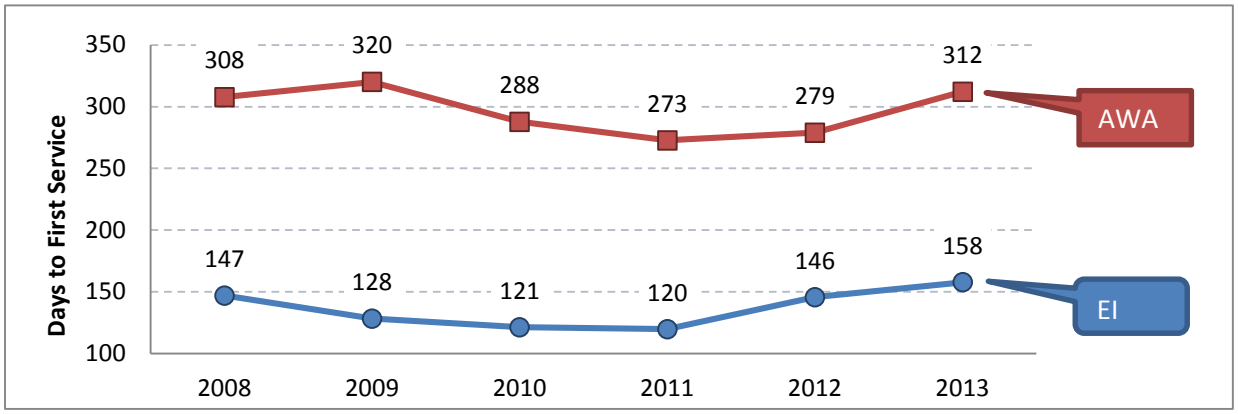
Below, we discuss in detail three major problems with the Ability to Work Assessment process—as measured during file sample period for this study (2010-13):

1. The extremely long delay in commencing the first AWA means that the injured worker's extended disability has already put him at substantial risk of never going back to work;
2. The very long time it takes to complete an AWA further hardens the psychological and vocational barriers to returning the worker to employment;
3. Up to a quarter of AWA are restarted, further reducing the odds of employment and probably discouraging the injured worker.

Internal management reports from L&I show the following trends in the provision of Ability to Work Assessment (AWA) and Early Intervention (EI). Exhibit 2-17 below shows the median duration from injury to the CM's initiation of the first EI and AWA service.

Exhibit 2-17 shows long delays in the timeliness of initiating both EI and AWA. As the figure shows, there is a seemingly random pattern of change in EI times. AWA also have erratic year-to-year changes, but median times appear to show a slight increase in 2012 and 2013. At least half the claims will go longer than three-quarters of a year (312 median days in 2013) before the first AWA is initiated by the CM.

Exhibit 2-17: Median Days for CM to Initiate Vocational Services (State Fund Only)



Source: Data from L&I internal report (Accountability Report) (Oct. 2014); graph by WorkComp Strategies

Many claims adjusters would agree that they should typically have a good idea of the probability of an injured worker going back to work at the pre-injury job within a month or so of lost time, particularly for non-surgical cases. Thus, the delay of 8 months or more to trigger a vocational assessment seems excessively long. From our staff interviews and public actions by the Department it is clear that L&I agrees strongly with the need to bring down the lag time for commencing the first AWA. Additionally, L&I has launched initiatives aimed at re-structuring the vocational services processes generally, including the timing and components of the AWA. For example, L&I has recently co-located Re-employment Services specialists with claim management units, and CMs are encouraged to utilize such services as necessary throughout the claim process. Reports from L&I are that early results are positive.

Exhibit 2-18 compares the speed of ordering this first assessment for different employers. Size and nature of the industry do not seem to have any systematic bearing on the speed to start the first vocational assessment. Exhibit 2-18 does not show any significant pattern by size quartile. The mean times for various industry class codes show inexplicable variation, e.g., building construction was 316 days and miscellaneous professional/clerical was 338 days. Note that using claim "received date" as the start date can result in longer times than, say, the date that the worker was first disabled; using "received date" allows for better comparisons between groups.[36]

[36] For example, L&I does not capture data from self-insured employers regarding "disability date." Regardless, the purpose of Exhibit 2-18 is to show results between employer industries and types, not to show overall, absolute durations or trends over time.

Exhibit 2-18: Time from received date to first vocational rehab service (AWA and EI) by employer industry (sample) and size

		Days to Start of First Assessment	
		Mean	Median
Employer Industry	Building Construction	316	237
	Health Care	352	299
	Misc. Prof. and Clerical	338	277
	Misc. Services	317	246
Employer Size	Top Quartile in Size (>996,000 hours)	360	294
	3rd Quartile	364	287
	2nd Quartile	344	266
	Smallest size quartile (<2,200 hours)	351	266

Source: WorkComp Strategies, using L&I database 2010 to 2013

Surprisingly, there is no material difference in the delay between Retro and non-Retro employers. One might have expected a notable difference because Retro employers are very likely to promote RTW via job modification, light duty, or kept-on-salary.

The system for vocational services is complex and multifaceted. It is not suited to applying absolute norms like "3-point contact within 2 days" or "first TL payments within 14 days of receipt of claim." Yet, there is one widely accepted principle in vocational services, which is to commence vocational services as soon as the claim manager can reasonably predict difficulty in the injured worker returning to the job of injury, provided that the injured worker is medically stable enough to participate in such services. This principle seems to be understood by L&I management, and recently AWAs are being initiated much faster.[37]

This practice principle of expeditious referral is well stated in the American College of Occupational and Environmental Medicine Guide, which in several places advises that the physician refer the worker to the CM as a candidate for vocational services as soon as it becomes reasonably certain that the worker will not return to their job of injury and the worker is physically able to participate in the assessment. As L&I management has noted, waiting for the worker to be medically fixed and stable is often unwarranted. Delay runs the risk of fostering significant psychological conditions (e.g., clinical depression) and a general withdrawal of the worker from the workforce.

A related trigger condition is to anticipate the need for vocational services if a permanent impairment is reasonably predictable and likely to interfere with performance of previous work. This is articulated in the federal Office of Workers' Compensation Programs guide to agencies: "Initiate vocational rehabilitation and employment action as soon as it appears that permanent impairment may result or a change of job duties may be required due to the work-related injury."[38]

During the focus period of our claim reviews, the start of AWA was seemingly delayed until all hope of RTW at the job of injury is abandoned and there is possible interference between medical treatment and

[37] Recent changes by L&I to vocational service delivery processes include the Early AWA and other RTW-focused initiatives that are designed to address better timing of appropriate services and improvement of performance of private counselors.

[38] Federal Office of Workers' Compensation, "Best Practices" op. cit., p 26.

counseling services. However, good judgment, fortified by analytical decision models, should be able to improve the targeting of early vocational interventions, even if some ongoing medical treatments need to be accommodated. L&I is currently in the process of implementing predictive analytics.

3.3.2 Speed to Complete Ability to Work Assessment

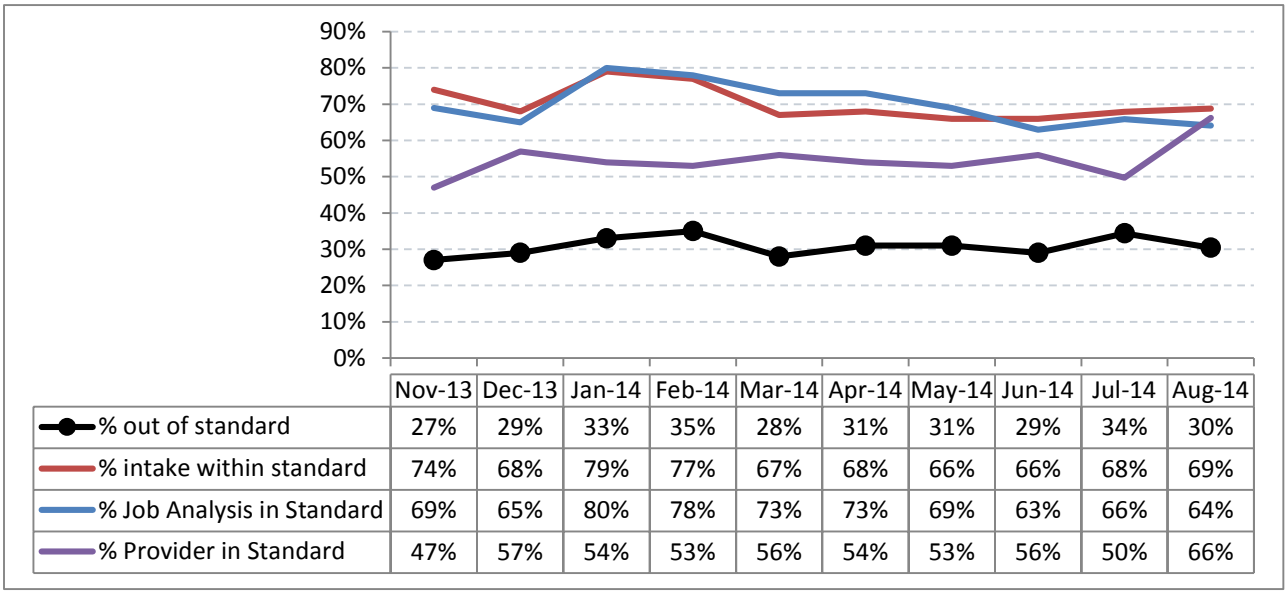
Once initiated, completion of an AWA is an important metric in evaluating overall timeliness of vocational service delivery. AWAs during the data sample period took over 200 days from start to completion; it was not unusual for AWAs to remain open for a year or more. Recently the Department dropped its informal target of completing the average AWA in 90 days or less. The reasoning seems to be that a rigid standard is not useful, e.g., cases were unforeseen medical issues require an interruption in the counselor's AWA efforts, or other, less formal RTW efforts, such as collaboration with a co-located WorkSource specialist, are more appropriate. Overall, the current emphasis seems to be in standardizing work processes. With input from the Vocational Rehabilitation Counselor (VRC) community, the agency has focused on standardizing and measuring work done by VRCs.

There are three decision points in the AWA process that L&I takes good measures of: initial contact by the counselor with the client, completion of job analysis by the counselor, and obtaining the treating physician sign off on the capacity to perform alternative jobs.

As shown in Exhibit 2-19, all three standards show considerable fractions of AWAs that are out of compliance. Data supplied by L&I for November 2013 to August 2014 showed that:

- About 30% of all AWAs were "Out of Standard" (black line) for the overall period shown
- Focusing on August 2014, about 70% of the vocational counselors were within standard work specifications for initial contact with the client (red line)
- Roughly 65% were within standard for completing job analysis (green line).
- The treating physician is expected to respond to the job analysis in 45 days; about 68% were within standard in the above time interval. (purple line)

Exhibit 2-19: Standard Work Measures for AWA



	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14
% out of standard	27%	29%	33%	35%	28%	31%	31%	29%	34%	30%
% intake within standard	74%	68%	79%	77%	67%	68%	66%	66%	68%	69%
% Job Analysis in Standard	69%	65%	80%	78%	73%	73%	69%	63%	66%	64%
% Provider in Standard	47%	57%	54%	53%	56%	54%	53%	56%	50%	66%

Source: data from L&I internal spreadsheet "Durations for AWA Completion"; graph by WorkComp Strategies.

If every case were on standard, the AWA could be completed in 90 days, but clearly there is slippage in compliance. Interviews with L&I staff identified many possible reasons for the delays, with delayed physician sign off on job analysis being mentioned most often.

In our interviews, we heard frequently about claim units participating in "Gemba Walks." This is a term used in "Lean Management" parlance, meaning to "go and see" the barriers to completing AWA referrals and to focus on more consistent application of work standards. Despite the application of sophisticated management tools AWAs were taking between 150-160 days to complete in early 2014.[39] L&I reports that it initially had targeted completion of 50% of AWA plans within 90 days, but has since determined that it is better to not use a 90-day goal, but retain the case longer, in appropriate cases, to encourage RTW before finalizing the more formal AWA plan.

During the period 2010-13 the majority of injured workers needing AWAs were over a year on TL, some perhaps even two years, before a decision was reached on their employability, which is the key to determining entitlement to continuing time-loss benefits.

Why this emphasis on speed of making vocational interventions? There is a widely quoted statistics in workers' compensation claims management: There is only a 50% chance that an injured worker will return to work after a six month absence; this decline to a 25% chance following a one year absence and is further reduced to a 1% chance after a two year absence. [40] If such odds are at all applicable to

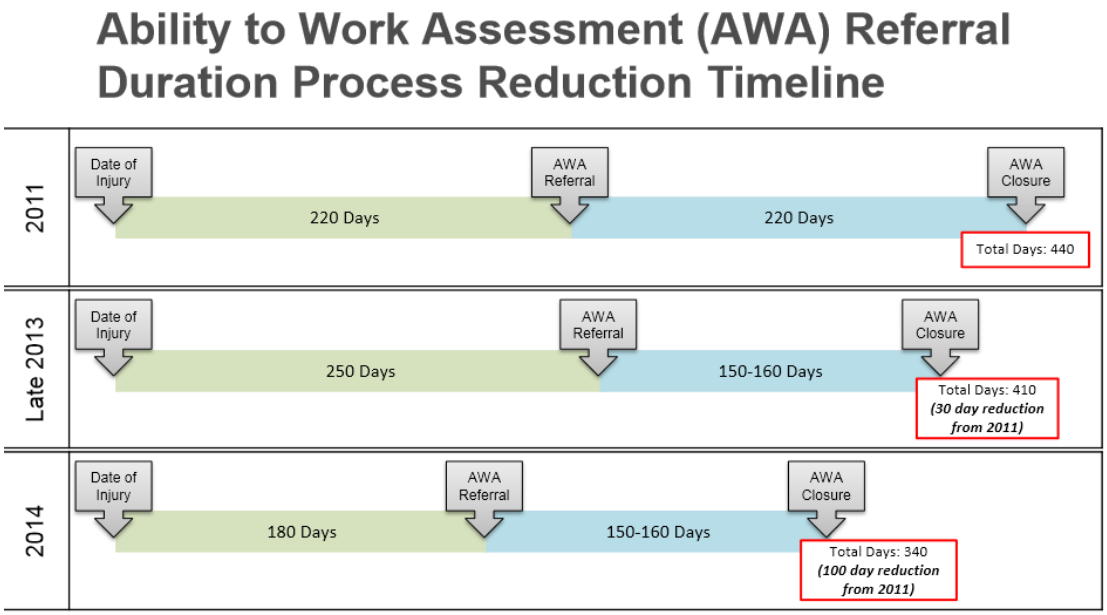
[39] Pat Delaney, Minutes, Vocational Technical Stakeholder Group, March 17, 2014, Tukwila, WA.

[40] ACOEM puts the danger point for permanent disability even earlier: "Studies have shown that the odds for return to full employment drop to 50-50 after six months of absence. Even less encouraging is the finding that the odds of a worker ever returning to work drop 50 percent by just the 12th week." See ACOEM, "Preventing Needless Work Disability by Helping People Stay Employed," Journal of Environmental and Occupational Medicine, 2006, found at: http://www.acoem.org/PreventingNeedlessWorkDisability.aspx. See also, Gregory

Washington, then by the time vocational services are begun the injured worker is already at substantial risk of never returning to work, regardless of how much effort L&I puts into retraining or other services.

L&I has made significant progress since our review period in both the first referral for an AWA and the length of time to complete the AWA. Exhibit 2-20 below shows a 100 day overall reduction from date of injury to AWA closer from 2011 to 2014.

Exhibit 2-20: Trend in AWA Process Times 2011-2014



Source: Presentation by Ryan Guppy to Workers' Compensation Advisory Committee, December 2014

Exhibit 2-21 is a segment from the recently created L&I report, referred to by L&I by the acronym "CBOB+," and shows results from January 2015, which show a typical distribution of AWA open cases for a representative claim unit. This claim unit is typical of those in the report, with over half of the AWAs open more than 90 days. As mentioned above, L&I no longer has a goal of completion of the AWA within 90 days.

Exhibit 2-21: Current Range of Open AWA Referrals

	AWA Referrals Open
0 to 90 Days	329
91 to 180 Days	186
Over 180 Days	221

Source: L&I internal report, "CBOB+, DSA 1" (2015)

J. Crabb, of Hartford Life Insurance Co., who said that after six weeks of disability there is only a 50 percent chance that injured workers will return to work. When disabled for a full year, there is only a 1 to 2 percent chance that injured workers will ever return to work." in "Hartford's Return to Work Program Proves Can-Do Approach Works," *BestWire,* April 10, 2003, found at: http://www3.ambest.com/ambv/bestnews/newscontent.aspx?altsrc=108&refnum=56974.

3.3.3 Speed to Submit Complete Retraining Plan

In some cases, the outcome of an AWA process is the recommendation of a retraining plan. Completion of a retraining plan is an important measure because it adds to the overall disability duration of a claim, and precedes actually starting retraining, or implementing the plan, which is itself often a lengthy process. The measured service was the time interval from notification of the counselor to begin plan development to the submission of the plan. As shown in Exhibit 2-22 below, the average and median times to complete plan development has been creeping upward between 2009 and 2013. Likewise, the number of referrals to counselors has been increasing over this period. In 2013 it took an average of 140 days to submit a completed plan to L&I for approval.

Exhibit 2-22: Length of Time from Referral for Plan Development to Submission of Plan for Approval

Referral Completion Year	Median duration by year	Average duration by year	Referral Count
2013	127	140	1515
2012	124	135	1635
2011	120	133	1508
2010	120	133	1423
2009	104	120	1286

Note: from time of notification to service provider; State Fund only
Source: L&I data, (spreadsheet (2014), supplied by Ryan Guppy)

As shown in Exhibit 2-23, our analysis indicated that self-insurers that refer for AWAs plans have a much shorter plan duration to submit plan for approval than in State Fund claims (i.e., 153.4 days on average for State Fund and 114.3 days for self-insured). This gap might be due to better selection and management of private counselors by self-insured employers or that their expectations of private counselors are clearer and monitored stringently. This measure of differences between State Fund and self-insured outcomes differs somewhat from Exhibit 2-22 for plan implementation durations.

Exhibit 2-23: Length of Time from Referral for Plan Development to Submission of Plan for Approval

Class of Employer	Time from Start to Submission of Plan	
	Mean	Median
State Fund	153.4	118
Self-insured	114.3	91

Source: WorkComp Strategies, L&I data 2010 – 13, results are propensity matched

In terms of statutory compliance, RCW 51-32-099(3)(c) states: "The vocational plan for an individual worker must be completed and submitted to the department within ninety days of the day the worker commences vocational plan development. The department may extend the ninety days for good cause." L&I has a maximum of 15 days to approve or reject the plan and notify all parties. Well over half the plans for 2010-13 claims appear to be out of compliance with the completion standard. Granted, many of these length-to-completion times may be excused for cause, as allowed by the statute. But the long durations suggest that the process is encumbered by obstacles, such as delays in physician responses and claimant non-cooperation. Also, after review L&I may return a portion of the plans for further work, or transfer it to a new counselor.

3.3.4 Time to Complete Plan Implementation

Another key measure in the vocational service process is the time required to complete or implement a vocational retraining plan.

- For the State Fund overall, it takes nearly one and one-half years on average to go from start to finish for approved training plans (Exhibit 2-14).
- The time for completion is somewhat lower for self-insured employer claims. For State Fund claims it was 474 days on average versus 460 days for Self-Insured cases. (Exhibit 2-14)
- The time to completion for Retro employers is 34 days longer than for non-Retro employers: 528 days v. 494 days. (L&I data 2010-2013; results not propensity matched).

No evidence was found of differences in L&I procedures to explain the Retro and non-Retro difference; rather it seems to be related to the difference in the mix of worker characteristics and management of the vocational service providers between the two groups of employers.

According to L&I data shown in Exhibit 2-24, the average time for successful completion is nearly one and one-half years. There is a slight upward trend in the duration of completed plans. The number of plans completing successfully has remained steadily in the range of 531 to 540. RCW 51.32.110 and 51.32.99 cover the reasons for failure to meet the plan's original target duration. As shown in Exhibit 2-24, only a small fraction of plans with successful completions have gone longer than two years, which is the legal limit for compensated retraining.

Exhibit 2-24: Duration of Time to Successfully Completed Plans – State Fund

Plan Completion Year	Median duration	Average duration	Plan Count	Plans Over 2 Years	% Of Plans over 2 years
2013	624 days	532 days	533	14	3%
2012	618 days	530 days	540	4	1%
2011	606 days	524 days	531	2	0%

Source: L&I 2014 spreadsheet: "Analysis of Overall Performance of Vocational Service Delivery"

The prior discussion has focused on the timing of certain services involved in the vocational services delivery process. We now turn to analyzing L&I's performance in delivering vocational services generally, beyond measuring the time required to undertake or complete certain vocational services. We confine our attention to analyzing performance in those vocational services aimed at determining if an injured worker is entitled to retraining and, if so entitled, the services for planning and implementing vocational retraining. Retraining is only one of many types of vocational services commonly used in Washington.

According to L&I,[41] about 2 percent of all injured workers and 6 percent of those injuries involving lost time are determined to have a retraining entitlement. In FY2014 this was 1700 claimants from the State Fund and a slightly fewer than 200 from self-insured employers.[42] This is a significant workflow for the agency.

[41] These data come from the 2014 Annual Report to the Legislature on the Vocational Improvement Pilot., December 2014, found at:
http://www.lni.wa.gov/Main/AboutLNI/Legislature/PDFs/Reports/2014/WorkCompVocRehabSys.pdf

[42] While direct statistical comparison data is not published, the WCRI CompScope™ data indicates that the 16 CompScope™ states spend much less than Washington on vocational service providers. In the 2012 CompScope™ report, the median percentage of lost time claims with greater than 7 days of lost time that involved any vocational services was only 4%. Even allowing for some upward development in this percentage, it is far less than Washington's 6% of all lost time claims with a retraining entitlement (as opposed to all services in the WCRI data). Note that retraining is only one of many vocational services used in Washington.

In most other states, such services are provided only when it is clear that an injured worker will face problems in returning to work, or in doing so at an acceptable level of pre-injury income. An unusual feature of the Washington system is the way claims are handled at the end of the healing period. RCW 51.32.090(3) provides that 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 that "Once the payment of time-loss benefits has begun, the benefits must be continued" until the worker has been released for full duty, returns to work, or is "found employable." This is different from the majority of states that terminate temporary disability benefits once maximum medical improvement is attained, regardless of "full" employability; if there is "zero" employability, then permanent and total disability benefits would be warranted. This difference, at least in large measure, helps explain the longer average time-loss durations in Washington (discussed at length in Chapter 5).

In Washington, a CM must manage a determination of "employability." A major weakness in disability management is the long delay in making these determinations. Absent return to work or a full and unconditional medical release, the CM must get an objective determination on employability. This is done by ordering an Ability to Work Assessment (AWA). As shown in Exhibit 2-17, in 2011 the median duration of time to first referral by a CM for an AWA from date of injury was 273 days; the exhibit shows an increase from 2012-2013. The percentage of AWA referrals by CMs made in 90 days of claims receipt were only 6.3% in 2012, and about 6% in 2013.[43] After reviewing the AWA Referral Guidelines, it is difficult to see why it should take 273 days to meet the conditions for triggering an AWA. The main criteria for an AWA should generally be known within 90 days of claim receipt, specifically: Is the injured worker physically able to interact with a Vocational Rehabilitation Counselor and is it clear that returning to the job of injury is very unlikely? Reports from L&I are that focused attention to this process has had positive results in shortening the duration, and Exhibit 2-20 shows a recent positive trend.

Given the long time between injury and first AWA and the length of time to complete an AWA (some workers have multiple AWAs), it could easily be that a year has gone with the injured worker having only an inconclusive and frustrating experience with L&I and the vocational experts. The odds for such a person in prolonged disability status ever returning to employment are not good-- with or without further vocational assistance.

If it is determined that an injured worker is not "employable," then a vocational retraining plan is an option. RCW 51.32.099. The poor outcomes of vocational retraining are well known by policymakers. In response, the Washington State Legislature instituted a Vocational Improvement Pilot, implemented in 2008, to reform the retraining process, including new options for workers. This pilot is discussed further below. L&I data on vocational retraining outcomes shows it to be a weak solution to address long-term disability; over the last several years 35-45% of those successfully completing retraining are back at work in two years. Yet, despite its shortcomings it seems to be an irreplaceable option for appropriately selected injured workers.

Historically, vocational retraining has suffered from inefficiency and poor return to work success. However, since the 2008 VIP reforms, L&I has made substantial improvements, and has recommended

[43] Vickie Kennedy presentation to Workers' Compensation Advisory Committee, April 2013.

legislation to further the successful aspects of VIP.[44] Some parts of the retraining process can be managed at L&I to better the odds of RTW. In our recommendations we cover improvements, completing retraining plans on time, and managing the quality of provider interaction with injured workers and plan development.

The performance problems that inhibit vocational retraining begin with the long lag time from injury to the start of retraining. After a year or more of disability, a psychological mindset hostile to RTW has begun to harden.

Another process problem is the selection of candidates for retraining. In practice many of those found eligible for retraining appear to be unsuited for formal education/training. The difficulty of screening candidates for, as evidenced by the high "failure" rates of retraining. Of 9,000 plans submitted since 2008 only 55% of those who commenced retraining completed it.[45] The difficult of retraining adults is widely recognized by vocational experts and similar failure rates in other vocational programs have been found by the Washington Workforce Board.[46]

Timelines of plan development is also problematic. As shown in Exhibit 2-22, development of an average retraining plan has gone up slightly from 120 in 2009 to 140 days in 2013. Twenty-four percent of plans are submitted within the required 90-day maximum allowed time period set by Vocational Improvement Pilot.

The final problem is the quality of interaction between the vocational expert and the client:

- The 1998 JLARC Performance Audit reported lower client disapproval for rehabilitation providers than for CMs, IMEs, and BIIA on such matters as ethics, courtesy, listening skills, and quality of explanations.[47]
- However, the University of Washington survey of vocational clients showed that a large fraction were displeased with their interaction with the counselor.
- Our survey of employers found that private vocational counselors were rated better than state counselors (ERTW), but much more poorly than Third Party Administrators in regard to their assistance in the Return to Work (RTW) process. Our survey sampled claims with relatively serious injuries, and also included workers who had attorney representation.
- In sharp contrast, workers gave both state counselors and private counselors very low ratings for their helpfulness in the RTW process (see Exhibit 2-25).[48] Again, the sampling methods are not the

[44] In May 2015, legislation to make the 2008 VIP reforms permanent was enacted. HB 1496/SB 5451 & SB 5468 (2015).

[45] L&I, Workers' Compensation Vocational Rehabilitation System, 2014 Annual Report to the Legislature., December 2014, found at: http://www.lni.wa.gov/Main/AboutLNI/Legislature/PDFs/Reports/2014/WorkCompVocRehabSys.pdf These success rates are comparable to programs serving similar populations: 1) Washington Division of Vocational Rehabilitation 55% completion rate; and 2) Workforce Investment Act - dislocated workers 53% completion rate. Source Workforce Training and Education Coordinating Board found at: http://wtb.wa.gov/WorkforceTrainingResults.asp

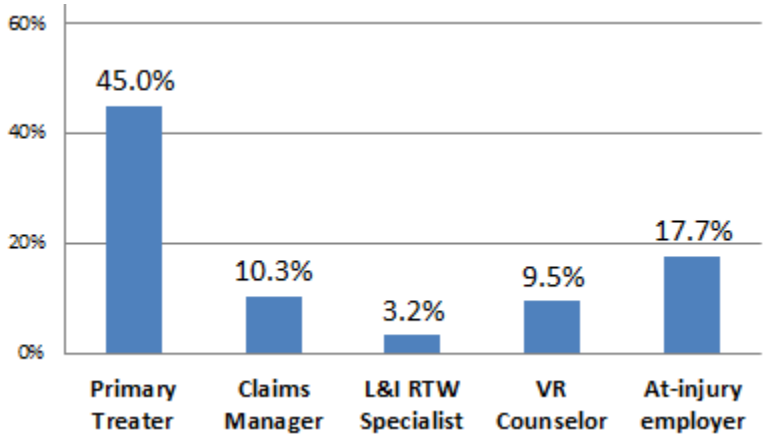
[46] See Workforce Training and Education Coordinating Board at: http://wtb.wa.gov/WorkforceTrainingResults.asp.

[47] Ed Welch, op cit, p 73.

[48] We note that our survey findings on L&I service evaluation by workers are quite different than L&I sponsored survey results. This is probably due to the wording or questions and the fact that L&I excluded attorney represented claims (probably more serious). Both surveys tried to select more serious injuries but used different screening criteria.

same as those used by L&I.

Exhibit 2-25: Percent of Workers Responding Vocational Services Provider was Helpful or Very Helpful



Source: WorkComp Strategies Worker Survey, 2014 (sample of claims > $5,000 in medical costs)

There is no doubt that developing a retraining plan is a complex challenge for counselors. As L&I noted in its 2014 Report to the Legislature, "the plan must address the worker's medical conditions and restrictions (both those caused by the injury and those that are unrelated or pre-existing) and resolve all barriers to returning to work – such as lack of education and experience, lack of skills, language difficulties and unavailability of employment in the worker's labor market." According to L&I internal reports, only 45% of plan completers (2005-2011) had returned to work within two years of closure. These poor RTW outcomes together with poor client evaluations both suggest that new direction is needed for plan development.

Finally, our review of claim files showed the following performance problems with the management of vocational services. First, for reasons discussed above, the worker may have missed the opportunity to return to work with the pre-injury employer under modified duty during the healing period. RTW with the employer of injury is universally recognized as the ideal objective of disability management. Second, medical treatment may have been unnecessarily drawn out, possibly due to opioid use or overuse of physical medicine. In our claim review, we saw scant evidence of CMs investigating the need for protracted treatments.[49] Nor did we see consistently prompt attention in confirming MMI was reached. Likewise, there were cases of delayed determination that a permanency rating was needed and selecting the physician to do the rating. Thus, some claims could be 6 months into TL before there was confirmation of MMI.[50] At this juncture RTW is compromised; the longer it takes to make vocational determinations on the ability to work the longer the TL payment period. Third, we believe CMs often waited too long to commence an AWA even though it was clear that RTW was going to be difficult.

[49] Several initiatives involving medical interventions are underway at L&I, including auto-review of certain claims by Occupational Nurse Consultants based on certain timeframes, such as a 14-day review of TL claim, as well as team-based review of certain claims identified by predictive modeling.

[50] L&I reported a number of recent initiatives to monitor treatment duration, e.g., requiring an occupational nurse to review claims with "red flag" indicators and have the CM document follow up and mandatory review of nurses for claims at the point of 40 days of disability. These and other initiatives described by L&I are very good conceptually. Implementation must also be done well.

These three observations from file review are bolstered by data of extremely long average TL payment duration, as well as data of lengthy delays before initiating AWAs or EIs.

As discussed in Chapter 1, senior management in L&I has advocated building a culture of RTW.[51] One example of this commitment to improve vocational services is the creation of a senior management position (2013) for a "Return to Work Partnerships Chief," whose job is to coordinate resources applied to improving RTW outcomes. With invigorated leadership during the past two years, a number of process improvements have been made. Many are quite minor (e.g., the change of an outcome code or design of a computer screen) while others have substantial and widely visible impacts. An example of the latter is the acceleration of the first vocational assessment for targeted claims. An indiscriminate acceleration of AWA would be a waste of time and money because some injured workers have a high likelihood of returning to work in the foreseeable future and some are medically unstable and could not participate easily in the assessment. The "Early AWA" pilot, begun in January 2014, is a careful attempt to accelerate the process by using consensus-based criteria for targeting claims for earlier initiation of AWA. After only 11 months in practice, the preliminary results on return to work are encouraging.[52]

3.4 Managing Return to Work

Next, in our analysis of performance with respect to disability management, we discuss management of returning injured workers to work. The "gold standard" for measuring claim management performance is the speed of getting the claimant back to gainful employment, often referred to as "return to work" or simply "RTW." RTW happens almost automatically for most claims. The typical injury requires simple medical treatment and resuming work quickly is favored by both worker and employer. L&I greatly facilitates this early return to work very actively promoting the economic advantage of Kept-on-Salary to preserve the employers' claims free discounts by the Stay at Work Program.

However, a significant fraction of claims have barriers to RTW that must be removed through diligent efforts by the CM, working with the injured worker, the employer of injury, medical providers, and, when needed, vocational service specialists. Granted, some conditions make successful return to work quite difficult.[53] Moreover, as discussed in the organizational section in Chapter 1, the laws of a state either hinder or help the adjusters' efforts. As indicated in that discussion, Washington's laws differ from other states' and might be serving to hinder effective RTW efforts. The weak links in the claims process seem to appear in three stages of the claim process.

3.4.1 Early stage (approximately the first few weeks)

- Avoidable lost time comes from some claims in which the worker eventually returns to his job of injury, but after weeks of delay that were not medically necessary. This is due to a combination of

[51] Vickie Kennedy presentation to Workers' Compensation Advisory Council, Dec. 2013.

[52] Presentation by Ryan Guppy to WCAC, Sept. 22, 2014.

[53] Among the factors universally associated with difficult return to work are nature of injury, size of employer, poor educational attainment, language barriers, history of work at physically demanding jobs, co-morbidity, and use of opioids for chronic pain. When these factors combine, they can create extreme problems for successful return to work. The relative importance of certain factors in prolonging disability was quantified in an L&I research finding labeled "40 Day Report," which ranked opioid use for chronic pain, pre-existing conditions, back and neck injuries, and employment by a small employer as the top ranked warning indicators of prolonged TTD. Source was an email from Rachel Aarts, December 30, 2013. See also the application of the Menniger Return to Work Scale found in John Tooson, "Evaluating Ohio's Injured Workers For Vocational Rehabilitation Utilizing The Menninger Return To Work Scale," Ohio State University, at https://etd.ohiolink.edu/!etd.send_file?accession=osu1050615058&disposition=inline.

vague, unrealistic, or delayed duty restrictions and employer reluctance to consider modified duty.

- Immediate contact by CM would overcome some of these obstacles. In the Fall 2013 L&I survey, only 41% of all worker respondents reported receiving a direct contact initiated by the CM, up from 36% two years earlier. For those workers with claims aged 30 to 180 days, 48% reported direct contact initiated by the CM. This reinforces the notion that passive letter writing has historically governed the early stages of the majority of claims. This lack of early personal contact with the claimant and employer runs contrary to best practices and we believe allows certain claims to start on a path of difficult claims management issues and excessively long disability. We were told by claims personnel that TPAs are sometimes barriers to the CM in direct contact by CMs and ERTW staff; they are said to resist direct contact with what they regard as their clients. We have no first-hand evidence of this from interviews or file reviews.
- There may be reasons outside the control of a CM as to why certain parties cannot be directly contacted. Employers may be hard to reach and not return call. Another problem represented to us was that employer representative and worker attorneys can prefer CM communications be directed not to the parties, but to them. However, we did not see in our file reviews of claims evidence of a pattern of CMs being prevented from making direct contact with parties. We are encouraged to see L&I data showing that the percentage of injured workers called by someone in a claim unit (not necessarily the CM on the claim) has been steadily increasing; in mid-2014 nearly 80% of all TL claimants had received a call. [54]
- Initial, preliminary planning with targeted dates for follow up on RTW and treatment should be recorded in the file. . In our file reviews we found poorly documented planning and follow up.

3.4.2 Mid-stage (approximately 30-160 days of lost time).

- Vocational services are commenced too late in the claim.[55] We found that the average time elapsed from the receipt of a claim to the start of the first true vocational services was 287 days (median days 216). This is a very long delay. Making matters worse, the vocational reports take too long to complete; it took 146 days from the start of plan development to approval by L&I.[56]
- The L&I approval process does not materially worsen this delay. By statute, retraining plans must be reviewed and acted on within 15 days or they are deemed approved. The L&I internal target for acting on both retraining plans and for assessment reports (AWA) is 10 days. The average L&I review time for retraining plans is 8 days and for AWA is 7 days.[57] Out of more than 9,000 plans submitted between January 2008 and July 2013, only 15 have been so long delayed by L&I that they were "deemed" approved by rule.[58] This review process seems to add value in modifying plans and

[54] L&I internal spreadsheet "First Contact Report" (2015)

[55] This was a major motivation behind the recent Vocation Services Pilot implemented in 2008. It is clearly accepted by L&I, which, as noted above, has recently taken several measures to expedite the start of vocational services.

[56] Not all steps to facilitate lasting RTW are vocational services. Facilitators to RTW and staying at work include a variety of actions that go beyond removing barriers. They include steps to address psychosocial problems that hold the injured work back from successful reintegration to the job of injury, or any new type of job.

[57] L&I internal spreadsheet "VSS activities" (2015), supplied by Richard Wilson

[58] RCW 51.32.099 requires that the vocational retraining plan must be completed and submitted to the department within 90 days of the day the worker commences vocational plan development. The department may extend the 90 days for good cause. For state fund claims, the department must review and approve the vocational plan before implementation may begin. If the department takes no action within fifteen days, the plan is deemed approved.

assessments that the reviewer finds defective.

- Only 3% of retraining plans use on-the-job training (OJT), in preference to formal education programs. However, formal educational programs to retrain workers have less satisfactory RTW outcomes than OJT.[59] L&I has recognized the failure to increase OJT since VIP was implemented.[60] One problem appears to be the greater time and effort required for the counselor to arrange OJT. Counselors are already hard pressed to meet the 90-day plan development time limit. We will recommend an option for process improvement.
- Poor management of medical care that falls short of occupational medicine norms, which promotes excess disability and higher costs.[61]
- Lack of an RTW plan, documented by the CM, describing the planned interventions, targeted outcomes, planned dates to evaluate progress, and discussion of the plan with the injured worker and other stakeholders, such as the employer and medical provider. Developing and communicating this plan helps set expectations about desired outcomes and identifying barriers to success.

3.4.3 End stage (year or more of lost time)

Too much planning is being delayed to far too late in the claim. After a year or more of TL and one or more AWA describing poor or no transferable job skills, most injured workers likely have developed what experts call a "disability mentality," meaning they have grave reservations and fears about leaving disability status for employment.[62] This should not be stereotyped as malingering because this issue has been widely recognized by practitioners as a serious—but treatable—psychological barrier. Our analysis shows, however, that many claims involve decision making that this end stage of the claim. At this stage, many injured workers are almost irrevocably resistant to RTW. Special resources are needed to respond to behavior problems, opioid addiction, and realistic vocational counseling.

As discussed in detail in Chapter 1 and earlier here, these weak links have been publicly acknowledged by management of L&I and resulted in starting and planning numerous initiatives.

3.5 Case Management Planning

Finally, in our analysis of Washington performance with respect to disability management, we discuss case management planning. In our file review we noted that the content of "*actions*" and "*plans*" in

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[59] Expanding the range of retraining options was one of the objectives of the Vocational Pilot program. The University of Washington evaluation of the pilot showed that OJT was more effective than formal retraining at RTW and income recovery, but rarely used (3% of the plans); see also L&I internal report showing percentage of OJT. Source: L&I internal spreadsheet "VIP Facts" (2015).

[60] L&I, Workers' Compensation Vocational Rehabilitation System: Annual Report to the Legislature, December 2014., found at: http://www.lni.wa.gov/Main/AboutLNI/Legislature/PDFs/Reports/2014/WorkCompVocRehabSys.pdf.

[61] By substandard we mean below the accepted standards recognized as essential in occupational medicine. Leah Hole-Marshall, L&I Medical Administrator, in her June 2014 presentation to WCAC noted that providers in the lowest zones of quality of care produce "very poor health and disability outcomes" and "high medical and disability costs." The solution was to eliminate them from the Preferred Provider Panel.

[62] A Washington attorney that advises injured workers on vocational issues described the fears of some of his clients: "By the time a worker is found eligible for vocational assistance in the form of retraining they are years into their claim. Their lives have been a revolving door of physicians, surgery, therapy, testing, medical evaluations and endless appointments. Being disconnected from the workforce for such an extended period of time makes imagining a return very overwhelming." Terri Herring-Puz, WorkComp Central, June 12, 2009, found at: https://ww3.workcompcentral.com/columns/show/id/ef7c7ccc926d1d960407aa03e37b898fg.

claim files is usually quite general and uses stock phrases. Much of the content is redundant from prior "*plan*" to current "*plan.*" We noted behavior by some CMs to satisfy the diary/tickler within LINIIS/ORION software by making only single word changes from the previous plans. Our interviews with CM and supervisor staff revealed a requirement to "read between the lines" when it came to case review of CM actions and plans.

Documentation was so perfunctory in some cases that it was impossible to capture a sense of the general direction of the claim. It was common to see flat words or phrases like "opioids?" "closure?" or "permanency?" in the plan section, presumably serving as some reminder to the CM; we expected to see actual planned activities. Not only would this serve as useful a reminder to the CM in when and how additional actions should be taken to manage the case, it would also help supervisors evaluate the pattern of steps taken by CMs and assist a new CM to whom the claim might be reassigned. We saw and heard evidence of frequent case reassignment,[63] or "transfers," so this aid to continuity of claim management has utility in these reassignments. A new claim "review template" has been implemented in the past year; this was designed to allow any CM to become familiar with a transferred claim quickly.

Sketchy and incomplete documentation might require a CM to whom the file is transferred to reconstruct the case by an independent review of correspondence. Typically, there is no insight or impression in the file of negative attitudes or behavioral difficulties that might complicate the handling of the claim, e.g., worker hostility toward the employer or strident insistence on the need for more opioids. As discussed in Chapter 1, we discovered that many statement or documents appended to the claim file are available to the parties to the claim and their representatives. This is highly unusual. In our judgment, this serves to inhibit full and frank documentation in the file. We detected a tendency for CMs to be very constrained in making notes and plans, and some CMs mentioned their hesitancy to record facts to which the injured worker might formally object.

Plan documentation serves another important objective, namely to establish expectations with the injured worker and employer about desired outcomes. For example, if a plan were for a worker to remain off work for one week, followed by two weeks of modified duty and then a return to full duty, it would serve to establish a boundary to work within and a case management goal. This is not unlike setting financial reserves in a case. It encourages establishing targets and working towards meeting those targets. The stakeholders understand what is expected, and if there is disagreement, problems can be identified early. It also provides a supervisory tool in discussing claims handling deficiencies, namely why a particularly lengthy or overly conservative RTW goal was set.

In the past year or so, L&I has introduced the "Gemba walk" exercise to track the progress of AWA plan development involve significant staff time. Our interviews revealed that this process, involving a unit meeting with vocational specialists, the unit supervisor and service-area head, and all unit CMs, was effective at eliciting and outlining plans and actions designed to overcome obstacles leading to prompt conclusion of the AWA. Additionally, these sessions would often involve discussion of general case problems. Such planning, however, was documented only informally, and follow-up or outcome review at subsequent sessions was based on informal note taking, or simply recollection. Admittedly, not all planning and coaching is amenable to a rigid, formal process. Significant investment of staff resources, however, in a particular case-management tool, such as Gemba walks for AWAs, should be subject to sufficient documentation to at least evaluate the effectiveness of the tool, if not to evaluate the

[63] The January 2015 CBOB+ reports show between 3-5% of total caseload being transferred in that month.

effectiveness of the action in changing case outcomes. Moreover, informal documentation impairs effective and seamless case transfers between CMs.

4 SUMMARY

The Washington claim service performance exhibits many good features, and a few that we propose as being idiosyncratic and counterproductive. On the positive side, the claims delivery system is efficient and disciplined; the claims staff appears to be well trained and guided by detailed, logical procedures. On the surface, CMs appear to have a high average total caseload, but the nature of the CM's job in Washington and the resources provided could offer at least some support for the current workloads. (This is discussed further in Chapter 1 – Claims Management Organization).

On the negative side, the CM's work seems to be rule driven rather than by seeking desired outcomes, including return to work and speedy claim closure. This same concern was raised in the 1998 Performance Audit[64] and in the Risk Navigation study of 2010.[65] Some CMs are adept at using the system to drive outcomes, but we saw evidence that others allowed problems to remain unresolved for too long. We saw evidence of inconsistence performance by CMs, which if able to be more uniform would likely boost performance measures. We suspect that part of this inconsistency stems from the failure to follow the venerable management slogan: "What gets measured gets done." Metrics can be a powerful supervisory tool for identifying work units and individuals that need more direction and coaching (more on this in Chapter 5).

This part of the report has identified strengths and weaknesses of performance in the L&I claims process. Our findings on the performance of CMs in processing claims can be summarized as follows:

1. CMs are efficient and timely in some key areas, and inefficient and untimely in others.
2. CMs are generally handling cases fairly and in compliance with law.
3. CMs are generally too detached from case outcomes and instead focus on following procedures.
4. Defects in managing disability appear in four principle areas:
    a. Making voice contact with workers and employers promptly after receipt of claim
    b. Early return to work, especially with the employer of injury, could be enhanced;
    c. Vocational and rehabilitation services suffer from poor timing and inefficient delivery; and
    d. Medical services are not being managed as effectively as they might be.
5. Case management is impaired by poor case documentation of planning.

Finally, it is important to bear in mind that the data analysis and file reviews for this study generally focused on the period 2010-13. Many of the findings pointing to performance deficiencies have been addressed by Departmental initiatives. In particular, the FileFast expansion, COHE expansion, Early AWA, and standardized work for AWAs seem to have produced apparent improvements in performance. In

[64] That report summarized its findings: "We found that, in general, the system was very formal and legalistic." Ed Welch, Workers Compensation System Performance Audit, Report 98-9, JLARC, Olympia, WA, December 11, 1998.

[65] Risk Navigation Group, Washington State Department of Labor and Industries Claims Assessment, Draft 2012 states: "Claim orientation that is task-based/activity-driven versus comprehensive and outcome-focused."

addition, L&I has proposed legislative changes to further enhance the Preferred Worker Program and the Option 2 alternative to vocational retraining.[66] Many other initiatives are in varying stages of development, but most of these have not yet produced credible data on their effectiveness. There are nagging problem areas, however, that do not seem to have ready corrections in process, including lack of early phone contact with parties to a claim, passive management of medical treatment, poor outcomes on retraining and the excessive numbers of multiyear duration TTD claims, most of which end up in pension status.

[66] In May 2015, legislation advancing these proposals was enacted. HB 1496/SB 5451 & SB 5468 (2015).