Chapter Three: Disputes

INTRODUCTION

Included in the scope of this study is an examination of the performance of L&I in managing workers' compensation disputes. This chapter is presented in five sections:

1. General description of workers' compensation dispute processes
2. Overview of Washington's dispute system
3. Timeliness, fairness, and effectiveness
4. Observations regarding informal and formal settlements
5. Conclusion

1 GENERAL DESCRIPTION OF WORKERS' COMPENSATION DISPUTE PROCESSES

Workers' compensation systems typically involve an employer purchasing coverage and reporting any claims to its insurance carrier, which then assigns an adjuster to handle the claim. The claims adjuster opens a file, contacts the parties, and determines whether the injury or disease (for simplicity "injury" hereafter will include disease) is covered. Meanwhile, the injured worker begins treatment for the injury.[1] The carrier must report the injury to the relevant state's workers' compensation administrative agency according to the state's laws, and the agency will often provide brochures and similar materials to the parties about what to expect during the course of handling the claim, including the process for resolving disputes over the claim.

One of the fundamental decisions in any workers' compensation system is whether an injury is allowed by the relevant jurisdiction's workers' compensation laws.[2] If not allowed, then the injury would be denied, or "rejected." Workers' compensation systems are administrative in nature and ideally should be, as much as possible, "self-executing," meaning that parties to a claim should be able to agree on the respective rights of the parties, including the benefits payable without the need for formal adjudicatory intervention. In most cases, the adjuster investigates the claim, determines if it is allowed, and communicates the decision to the worker, all without much oversight or intervention from a government agency. In some states, if this decision is against allowance, then this "denial" decision must also be reported to the state, which may then alert the worker to rights he or she may have to have a hearing on the merits of the claim.[3] Normally, as this process is executed, there is no formal government administrative decision; rather, the adjuster applies the law in making the decision.

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[1] States diverge on how an injured worker selects a treating provider. Some states provide for "employee choice," meaning that the worker selects a physician. Other states allow the employer to assign a treating provider. In yet other states the employer will assemble a panel from which the worker may select a provider. Washington provides for worker choice, but requires that workers select from the approved Washington Medical Provider Network. See: http://www.lni.wa.gov/ClaimsIns/Claims/FindaDoc/FAQ/.

[2] Many states use the term "compensable" to indicate that a claim is covered as a workers' compensation claim. Washington uses the term "allowed" and the process to determine coverage is called "allowance."

[3] Decisions to accept an injury, and pay, are also required to be reported by many states' laws.

The system ceases to be self-executing when a dispute arises between any of the parties to the claim. Review of the decision would be on a case-by-case basis, by a government agency, according to an adjudicatory process. State workers' compensation agencies routinely manage conflicts and disputes regarding claims. States typically have a system for first-level administrative hearings[4] on disputes, and an appeal process for the first-level hearing. Hearings are time consuming and expensive, so many states will have trained staff (customer service reps, mediators, and ombudsmen) to informally handle problems and issues with claims, prior to moving forward with a more formal hearing. Even if the claim is scheduled for a formal hearing there is often an effort by a judge to resolve problems at a pre-hearing.

As a claim progresses, other decisions are made, including whether disability benefits should be paid; the amount, or rate of payment; whether a particular type or quantity of medical treatment is allowed; and whether other benefits and services, such as vocational retraining, should be provided. All these decisions can be disputed. Less frequently, disputes can involve service providers (e.g., doctors and rehabilitation specialists) over issues such as service pricing or appropriate treatment.

Typically a state's workers' compensation laws or regulations will establish a legal standard, and an adjuster will apply the standard to a particular case. This includes consideration of how administrative law judges (ALJs) have interpreted the law, and similarly, how courts have interpreted the law in the course of appeals of ALJ decisions. If a worker is not satisfied with the adjuster's decision, he or she is able to seek redress through a state's adjudicatory process.

2 Overview of Washington's Dispute System

For our analysis, we use the term "dispute" primarily to describe formal disagreements over decisions made in handling a workers' compensation claim. Disputes in Washington can be grouped as follows: 1) "protests," which in Washington are written submissions noting formal disagreement with a decision; 2) "appeals," which are filings with the Board of Industrial Insurance Appeals (BIIA); and 3) "re-assumptions," which are formal case reviews by L&I that occur after an appeal to BIIA, but before BIIA accepts jurisdiction.[5]

Washington also uses informal dispute resolution practices, which include information services such as the L&I Self Insurance Office of the Ombuds, Project Help, and other services that function to provide information and clarify issues.[6] Often such services can have the practical force of a protest to a decision, particularly in the case of the Office of the Ombuds, which is authorized to conduct investigations into claims-related complaints on behalf of workers for self-insured employers.

Although we will discuss these in more detail below, we will provide a brief description here.

- In Washington, protests are formal, written submissions to L&I that object to a decision. A protest can be made by any party to a claim, including the worker, the employer or an employer representative, or the provider. Attorneys may represent such parties, and if so, may lodge a protest. Protests are typically made to the claims manager (CM) handling the claim, although they

[4] Administrative hearings differ from most state courts in that they impose simplified rules on procedures, discovery, and rules of evidence. They are generally faster to complete than a state court trial.

[5] Note that performance of the BIIA is not within the scope of this study.

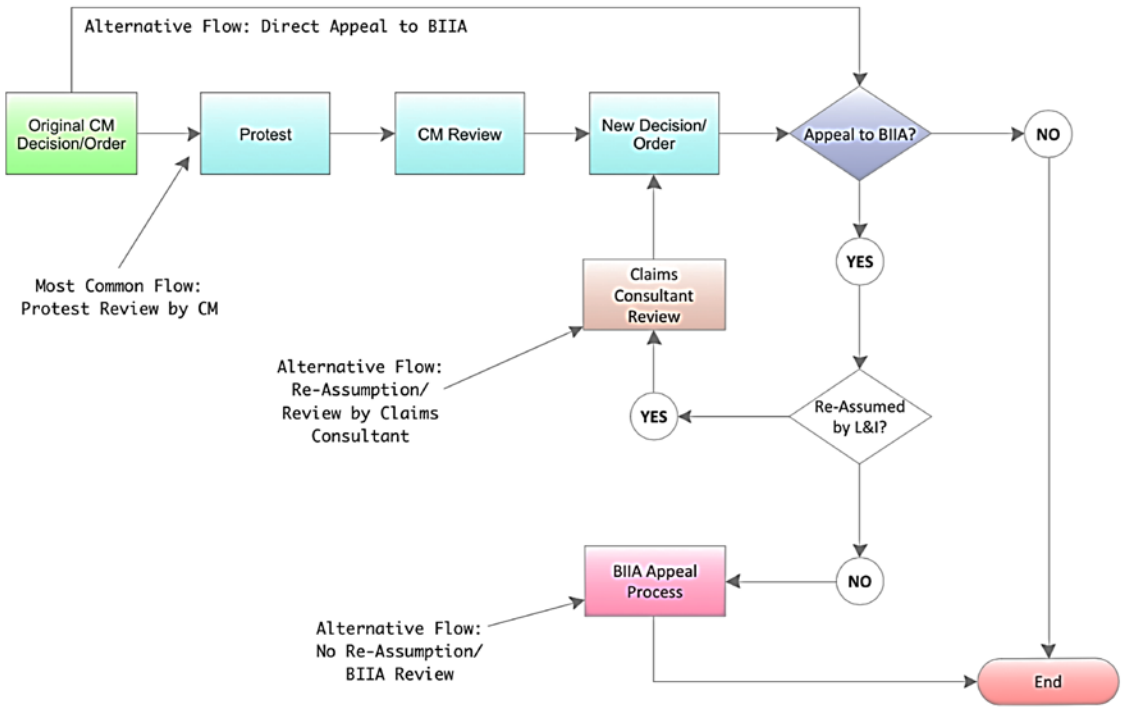
[6] The BIIA appeal process involves mandatory mediation, in an effort to resolve disputes before advancing to a formal hearing.

may be generally submitted to L&I. However submitted, the CM who made the decision that is at issue handles the protest.

- An appeal is a formal filing with the BIIA concerning an L&I written decision or order; only decisions and orders that are in writing can be appealed. Upon receipt of an appeal, L&I is provided a 30-day period to review the appeal. L&I has discretion to choose to re-assume the decision, which means that the appeal does not proceed at BIIA but is handled by L&I, with the dispute being processed as a protest. A claims consultant, rather than the CM, reviews the re-assumed claim.

Exhibit 3-1 depicts these basic alternative flows that disputes follow in Washington. Additionally, more detailed process maps for are provided in Appendix 5.

Exhibit 3-1 Alternatives for Dispute Processes in Washington



Source: WorkComp Strategies

2.1 Unique Aspects of Washington's Dispute System

Washington's dispute system is unique in several respects. First, with the exception of self-insurance, which will be discussed further below, Washington claim-related decisions become official pursuant to an "order" that is made directly by L&I staff. In other systems, the decision is made by a private insurance adjuster and becomes official only after some type of review by the state workers' compensation agency. For example, a CM issues an order when he or she makes a decision about claim validity (allowance or denial), sets the rate of compensation to be paid for lost wages, sets the rate of permanency benefits, closes a claim, or determines that certain treatment should be excluded from an

allowed claim.[7] Thus in Washington the State Fund claim manager's (CM) decision is akin to an administrative decision applied by a government official. A CM issues an order, in writing, describing the action taken, and containing a statement explaining the formal appeal process, namely that if reconsideration of the decision is not requested (protested), or the decisions is not appealed, the order will become final.[8]

Next, the first level of formal dispute in Washington is typically made to the CM who made the decision. In most other workers' compensation systems, the injured worker would first contact an insurance claims adjuster directly and request reconsideration of a decision; failing agreement with the adjuster through this informal manner, the first formal dispute by the injured worker would occur by lodging the complaint with the state workers' compensation agency. In other words, in Washington, the adjuster's (CM's) decision has the nature of a formal, official decision.

A unique feature of Washington's workers' compensation system is the use of employer attorneys. In most workers' compensation systems, an insurer will legally defend an insured employer as its policyholder. As a dispute moves through a formal adjudication process, the insurer will hire an attorney to defend its interests. Thus, an attorney client relationship between the attorney and both the employer and the insurer is established. In Washington, employer attorneys do not typically become involved in State Fund claim disputes. When they are involved, their fees are paid by the employer, not out of the State Fund. A member of the Office of the Attorney General represents L&I on appeals to the BIIA. For final orders issued by the BIIA in 2013, when workers appealed State Fund decisions, the workers were represented by counsel 66% of the time; employers who appealed State Fund decisions were represented 61% of the time. By contrast, workers who appealed decisions in self-insured cases were represented 52% of the time, whereas employers who appealed decisions in such cases were represented 98% of the time.

Another unique aspect of Washington's dispute system is that, apart from self-insurance claims, decisions are not required to be reported to the workers' compensation agency, as the agency itself is making the decisions, and the CM's records are the bulk of the official record of the case.

Finally, most state workers' compensation agencies offer both a formal administrative adjudicatory process for disputes as well as less formal interventions to address more routine case problems and concerns. In Washington, this process is bifurcated. The Board of Industrial Insurance Appeals (BIIA) is the agency charged with managing formal disputes, and L&I is the agency charged with the claims management, as well as non-judicial dispute resolution. Workers' compensation disputes can be quite complex and difficult to sort through. The BIIA is an independent, quasi-judicial agency, and focuses solely on these and other L&I program disputes.

2.2 Self-Insurance Disputes

Self-insurance dispute handling in most workers' compensation systems mirrors private-insurance dispute handling. Washington's approach to self-insurance is unique, and, therefore, self-insurance

[7] Managing medical treatment involves several types of decisions, including whether the treatment aligns with approved treatment guidelines, is related to the injury, or is otherwise covered by law. In some cases the decision to limit treatment takes the form of a "segregation" order, which excludes particular illnesses or injuries from the scope of the claim.

[8] See RCW 51.52.050 (establishing a 60-day appeal period for claims decisions by L&I).

dispute handling has some unique aspects. As described in detail in Chapter 1, Washington self-insurance involves employer management of claim decisions, which are sent to L&I for approval. L&I then "decides" the issue in question through an order, which either approves the underlying request or orders a different result. For other decisions, such as a self-insured employer decision not to provide particular medical treatment, a party aggrieved by the decision would contact L&I, which would investigate to determine if the decision was correct. L&I's order can be protested or appealed.[9]

When there is a disagreement or dispute in a claim that involves a self-insured employer, an L&I CM (typically referred to as an "adjudicator" in the L&I Self-Insurance Division) reviews the facts and determines if the order should stand as is or be modified. The self-insured employer will have made the decision, which is then submitted to L&I for issuance of a formal order, which is either in accordance with what was requested, or is not, based on a different understanding by L&I.[10] The L&I order is subject to formal protest and appeal. A similar process, as just described for State Fund claims involving re-assumption and claims consultants, is followed for self-insured employers.

Thus, in a case with a protest, regardless of whether the employer is self-insured or insured via the State Fund, the protest of an order triggers an internal review within L&I; in State Fund claims, the review is conducted by the CM who made the decision at issue. For self-insured employer claims, the review is by a CM in the L&I self-insurance unit. Following review, the CM will issue another order, either confirming or revising the underlying order. Appeal rights are re-stated on this new order. An aggrieved party may then appeal L&I's decision to the BIIA.

2.3 Direct Appeals to BIIA

In Washington, stakeholders have the option to skip L&I review, and appeal a decision directly to the BIIA. One of three options can occur after an appeal to the BIIA: the appeal can be re-assumed by L&I, it can be granted, or it can be denied. The re-assumption process involves the BIIA notifying L&I that an appeal was filed, and providing L&I the opportunity to "re-assume jurisdiction" over the appealed issue. If L&I chooses to re-assume jurisdiction, then it will process the appeal similar to a protest, issuing a further decision.[11] In such cases, when re-assumed, the review is conducted by a "Claims Consultant," a member of a specialized unit of senior adjudicators, who might gather additional information if needed, and issue a new order either reversing, affirming or modifying the order under appeal. The parties can then protest or appeal this new order to the BIIA if they choose to do so. If the order is protested, the Claims Consultant will issue the further decision, which will be accompanied by appeal rights.

If not re-assumed, then the BIIA will either grant or deny the appeal. A "granted" appeal means that the appeal proceeds through the standard appeal process, involving mandatory mediation and a formal hearing before a judge, if not resolved by mediation. An appeal can be "denied" for several reasons, including technical reasons (e.g., the appeal could be a duplicate). A denial could also occur because the appeal is not to a "written decision" (e.g., it is not valid for a party to appeal something said in a telephone conversation). Another reason for a denial could be that the appeal is based on an essential misunderstanding in terminology (e.g., a party may ask the BIIA to "award my claim" although the order

[9] Disputes regarding workers whose employers are in the Retro program are handled no differently than non-Retro disputes.

[10] In certain instances involving claim closure the self-insured employer is able to issue its own closing order.

[11] As a matter of course, in any appeal the RCW provides L&I the opportunity to re-assume jurisdiction over the appealed issue and review the underlying decision.

is an allowance order, and thus they already have the very relief they are requesting). Our interviews with BIIA staff indicated that most appeal denials occur because L&I is already processing review of the order as a protest. That is, L&I received a protest, placed the underlying order in "abeyance" pending review, and at the same time, or within 60 days of the decision being communicated, the party also appealed the decision to the BIIA. Using this analysis, a denied appeal is similar to a protest that already is being processed, i.e., duplicative of an existing protest.

Another important feature of the BIIA appeal process is that a significant amount of granted appeals are resolved prior to a BIIA hearing. Some of these are resolved via the BIIA mediation process. Some, however, are simply resolved by the parties. In other words, an appeal will be granted, only to be withdrawn by the mutual consent of the parties.[12]

2.4 VOLUMES

In each year of the study period (2010-2013), there were approximately 144,000 reported claims in Washington annually. Of these, roughly 122,000 are accepted: 85,000 involve State Fund employers and 37,000 involve Self-Insured employers.[13]

In approximate terms, L&I handles 20,000 protests annually: about 82% are submitted directly to L&I while another 18% are re-assumptions of appeals from BIIA. In addition, BIIA grants approximately 8,000 appeals annually; as discussed above, a granted appeal is one that is not re-assumed by L&I or denied. Note that the longer a claim is open, the more likely it becomes that a protest will occur. State Fund protests represent 19% of accepted State Fund claims (using annual protest count as a percentage of 2012 accepted claims), and self-insured protests represent 7%. The State Fund/self-insured accepted claim breakdown is 70/30 per 100 claims. Exhibit 3-2 shows approximate annual protest data from L&I and re-assumption data from BIIA for 2013. Exhibit 3-3 shows appeal data from BIIA for 2013 and also provides statistics based on analysis that a denied appeal is similar to a duplicate of an existing protest.

Exhibit 3-2: 2013 Annual Volume of Protests Handled by L&I

Yearly Stats	State Fund Claims		Self-Insured Claims		Total	
	Number	Percent	Number	Percent	Number	Percent
Protests[14]	**16,750***	**87%**	**2,568***	**13%**	**19,318**	**100%**
Direct to L&I	13,657	71%	2,149	11%	15,806	82%
Re-assumed from BIIA	3,093	16%	419	2%	3,512	18%

* Source: WorkComp Strategies dataset of L&I data 2010-2013; re-assumption data from BIIA CY 2013 final orders.

[12] Note that for State Fund claims that are on appeal, L&I is a "party" to the dispute. L&I is represented by the Washington State Office of the Attorney General.

[13] Actual annual claim volumes varied by year. Data measured as of December 31, 2013, and data from 2013 show lower counts due to reporting delays and shorter claim development times compared to earlier years. For additional information, see Appendix 3 – Research Methodology.

[14] Protests can be filed by many different stakeholders with an interest in the decision, including medical treatment providers, claim beneficiaries, and employer representatives. Also, there was evidence of claims with multiple protests, so the actual number of individual claims with protests is lower.

Exhibit 3-3: 2013 Annual Volumes of Appeals and Re-Assumptions

Yearly Stats[15]	State Fund Claims		Self-Insured Claims		Total	
	Number	Percent	Number	Percent	Number	Percent
All Appeals	**10,934**	**82%**	**2,356**	**18%**	**13,290**	**100%**
Granted Appeals	*6,189*	*47%*	*1,635*	*12%*	*7,824*	*59%*
Re-Assumed by L&I	*3,093*	*23%*	*419*	*3%*	*3,512*	*26%*
Denied Appeals	*1,652*	*12%*	*302*	*2%*	*1,954*	*15%*
All Appeals (excluding denied appeals as duplicative)	**9,282**	**82%**	**2,054**	**18%**	**11,336**	**100%**
Granted Appeals	*6,189*	*55%*	*1,635*	*14%*	*7,824*	*69%*
Re-Assumed by L&I	*3,093*	*27%*	*419*	*4%*	*3,512*	*31%*
BIIA Granted Appeals	**6,189**	**47%**	**1,635**	**12%**	**7,824**	**59%**
Appealed by employer	*810*	*6%*	*380*	*3%*	*1,190*	*9%*
Appealed by injured worker	*5,379*	*41%*	*1,255*	*9%*	*6,634*	*50%*
Re-Assumed by L&I	**3,093**	**23%**	**419**	**3%**	**3,512**	**26%**
Appealed by employer	*163*	*1%*	*62*	*1%*	*225*	*2%*
Appealed by injured worker	*2,930*	*22%*	*357*	*3%*	*3,287*	*25%*
BIIA Denied Appeals	**1,652**	**12%**	**302**	**2%**	**1,954**	**15%**
Appealed by employer	*181*	*1%*	*25*	*0%*	*206*	*2%*
Appealed by injured worker	*1,471*	*11%*	*277*	*2%*	*1,748*	*13%*

Source: BIIA data on CY 2013 final orders. Some columns and rows do not sum accurately due to rounding.

2.5 Informal Dispute Resolution

L&I utilizes an external service provider to assist stakeholders with claim questions or complaints. This program, called "Project Help," is funded by L&I and is currently administered by the Washington State Labor Council.[16] It appears to be well used by stakeholders. Likewise, self-insurers through their administrative assessment support a legislatively created ombuds solely for self-insurance related issues.[17]

[15] Data is from BIIA 2013 final orders in claim-related cases; the BIIA hears other types of appeals, including provider fee disputes and employer assessment disputes.

[16] See http://www.wslc.org/services/projecthelp.htm. Project Help director notes that program services are available to both State Fund and self-insured stakeholders, and participation between those two groups is roughly 50/50. Services are provided on approximately 1,000 – 1,500 claims per year.

[17] See RCW 51.14.300 et seq. The self-insurance ombuds appointed by the Governor to a six-year term, and the office is not to be "physically housed within the industrial insurance division." The duties of the office of the ombuds are as follows: (1) To act as an advocate for injured workers of self-insured employers; (2) To offer and provide information on industrial insurance as appropriate to workers of self-insured employers; (3) To identify, investigate, and facilitate resolution of industrial insurance complaints from workers of self-insured employers; (4) To maintain a statewide toll-free telephone number for the receipt of complaints and inquiries; and (5) To refer complaints to the department when appropriate. RCW 51.14.340. See also http://ombudsman.selfinsured.wa.gov.

3 TIMELINESS, FAIRNESS, AND EFFECTIVENESS

One of the primary focus areas of the performance audit of L&I's claims management involved investigation of the timeliness, fairness, and effectiveness of dispute handling.

3.1 TIMELINESS

In terms of timeliness of dispute handling, on average protests are resolved within 55 days of the protest being filed. BIIA appeals are resolved on average within 54.6 weeks for State Fund cases, although the BIIA appeal resolution process includes more formal judicial functions, including hearings and formal discovery. L&I handles nearly 20,000 protests per year, with about 60% involving cases that are "lost time" cases and 40% involving "medical only" cases. This does not mean that each of 20,000 individual claims had a protest, since a single claim can have 2 or more protests. Appeals that are not re-assumed by L&I go through a mediation process by the BIIA. If mediation is unsuccessful, BIIA conducts a formal hearing. If appealed, the general timeframe through appeal is roughly 15 months.[18]

Exhibit 3-4 provides 2013 annualized statistics on various aspects of timing of protests and appeals.

Exhibit 3-4 Time Lags of Various Aspects of Disputes

Yearly Stats[19]	State Fund Claims	Self-Insured Claims
Protests		
Average days to resolution of protest	55	52
Average days to resolution, Retro/non-Retro (L&I data 2010-2013)	Retro: 56 Non-Retro: 55	
Re-Assumptions		
Average days to decision to re-assume	17	9
Average days to decision, Retro/non-Retro (L&I data 2010-2013)	Retro: 16 Non-Retro: 17	
Appeals		
Average weeks to completion of appeal (time from the grant of an appeal to final BIIA order)	54.6	58.7

Source: WorkComp Strategies compilation of BIIA published data (Report 411) and L&I data (2010-2013)

3.1.1 Options for Review of CM Decisions

In analyzing the timeliness of dispute resolution, it is crucial to understand the varied options available to stakeholders in Washington for pursuing dispute resolution. As depicted in Exhibit 3-1, disputes over

[18] Measured as 55 days for protest, 16 days for re-assumption decision, and 379 days for BIIA decision. Assumes case was not re-assumed; if case is re-assumed, this would add an additional 55 days.

[19] Note that with the exception of Retro/non-Retro data, the source of which is L&I data from 2010 – 2013, the appeal data is from BIIA 2013 final orders in granted appeals (meaning the appeal was not re-assumed and was allowed to proceed, and not denied from the outset) in contested (i.e., not settled) claim-related cases; re-assumption data is from BIIA 2013 appeals that were re-assumed by L&I. Other stakeholders besides employers and injured workers file a very small portion of the appeals that are heard by the BIIA.

a CM decision can either be 1) protested or 2) appealed.[20] If protested, then there are four basic paths leading to a final decision:

3.1.1.1 Protest Path

1. Decision made > protest > abeyance > final decision (by original CM)
2. Decision made > protest > abeyance > further decision > appeal that is re-assumed > final decision (by Claim Consultant)
3. Decision made > protest > abeyance > further decision > appeal that is re-assumed > further decision > possible protest (handled by Claims Consultant) or further appeal > no re-assumption > final decision (by BIIA, which reviews decision of Claim Consultant)
4. Decision made > protest > appeal that is not re-assumed > final decision (by BIIA, which reviews decision of original CM)

In the first example, in cases involving State Fund claims, the CM who made the decision (unless the claim was reassigned to a different CM) will conduct the protest review, and will either affirm, reverse or modify the original decision.

In the second example, an aggrieved party files a protest, then following the decision on protest may appeal, and the RCW gives L&I the option of re-assuming jurisdiction. There is a 30-day period within which L&I reviews the case, to decide whether or not to re-assume jurisdiction. If the decision is re-assumed, a second L&I review of the underlying decision will take place, but will be managed by a Claims Consultant (CC), who is a senior Workers' Compensation Adjudicator (WCA) in a specialized unit at L&I. In this way, a more senior staff member is able to review the underlying decision with a fresh perspective and is able to consider any new information not made available to the CM. The CC also considers the potential legal implications of the decision, including how the BIIA has ruled on similar decisions.

The third and fourth examples involve the aggrieved party choosing to pursue further appeal to the BIIA. The third example is an extension of the second; following the decision by L&I after re-assumption, the aggrieved party further protests and then appeals, and BIIA performs a review and issues a decision. Here, because of the re-assumption process, the BIIA is reviewing a new order that has been issued by a Claim Consultant, and not the original order issued by the CM.

The fourth example is an extension of the first. In other words, the aggrieved party first protests a CM decision and order, then the decision is put into abeyance, and after the CM reviews new information, if any, the CM issues another order, the party appeals the order, but L&I does not re-assume jurisdiction, and the BIIA performs a review. Here, however, because no re-assumption took place, the BIIA is reviewing the original CM's decision and order. There is a 30-day window within which L&I determines if it will re-assume jurisdiction. In some cases the decision not to re-assume will not be a true decision, but is the result of the 30-day period elapsing without a decision. According to BIIA published statistics, many appeals that are granted end up being settled. In 2013-2014, 35% of orders in granted appeals involved settlements, 81% of which involved State Fund claims; of these, 88% resulted in a modification

[20] Note that only written decisions, or orders, can be appealed to the BIIA. In other words, a party cannot appeal a statement made by a CM by telephone; the statement has to be put into the form of a decision or order. Also note that final BIIA decisions can be appealed to the Superior Court, and further on up to the Washington Supreme Court.

of the L&I decision and order being appealed.[21] In other words, in these cases L&I agreed to reverse its own decision almost 9 out of every 10 times. One possible reason for this is because the aggrieved party presented new evidence at the BIIA. L&I reports that on appealed cases it is unable to present new evidence. Another possible reason is that L&I did not conduct a thorough review during the 30-day window, and only after a more thorough review on appeal, but before hearing, did it determine to reverse its position. It would beg to reason that in such situations, had L&I re-assumed the appeal, it would have reached the same conclusion, namely that the decision under appeal should be reversed. It is important to note that a reversal of a part of a decision is still recorded as a "reversal"; partial reversals are not tracked as being partial in nature, but simply as "reversals," which allows the BIIA to issue a new decision that gives effect to the settlement.

3.1.1.2 Direct Appeal Path

Exhibit 3-1 also depicts a "direct appeal" path, as opposed to first pursuing a protest. Here, there are three basic options leading to a final decision:

1. Decision made > appeal that is re-assumed > final decision (by Claim Consultant)
2. Decision made > appeal that is not re-assumed > final decision (by BIIA, which reviews decision of original CM)
3. Decision made > appeal that is re-assumed > further decision (by Claim Consultant) > further appeal > final decision (by BIIA, which reviews decision of Claim Consultant)

In the first example, instead of lodging a protest with L&I, a party aggrieved by a CM decision files an appeal with the BIIA, and L&I has the option of re-assuming jurisdiction of the case and conducting a review.[22] If re-assumed by L&I, the Claims Consultant (CC) would conduct the first review of the underlying decision that is the subject of the disagreement, and the CM involved in the original, underlying decision would not necessarily be involved unless the CC felt that the CM had information that could inform the further decision. In this example, there is one less L&I review and the review is conducted by a more senior staff member.

In the second example, in which the appeal is filed directly with BIIA and L&I declines to re-assume jurisdiction, there is no formal reconsideration of the decision in question by L&I, beyond the decision by L&I not to re-assume the case.[23] In this example, the BIIA reviews the decision by the original CM.

In the third example, L&I re-assumes jurisdiction and a Claim Consultant reviews the original decision and issues a new order. The aggrieved party then pursues protest or further appeal of this new order. In this example, the BIIA will review the decision made by the Claim Consultant.

3.1.1.3 Impact of Re-Assumption Process

The re-assumption process is somewhat unique, and merits discussion as it adds time to the overall dispute-resolution process. It also adds an additional level of review. On average, the decision adds 17

[21] BIIA Statistical Report, "Report 411" (as of June 2014, reporting 2013 and 2014 statistics; fiscal year runs from July 1 to June 30).

[22] In our interviews we learned that L&I almost always re-assumes jurisdiction over cases that are first appealed to the BIIA, although the decision is based on the individual case, and not on whether it was appealed or protested.

[23] Although we did not analyze the extent of the review conducted by L&I upon receiving a re-assumption request, L&I reports that it reviews each such request thoroughly.

days, and if re-assumed the dispute is handled as a protest. On its face, such a process adds important value when only an appeal is filed, and not a protest. As an example, if a worker were to appeal a claim denial to the BIIA, but had not first protested the decision to L&I, then without the re-assumption process the appeal process would be initiated, often unnecessarily in that L&I resolves most protests without the need for appeal.[24] On the other hand, using this same scenario, if the worker had first protested the denial to L&I, which after CM review had confirmed the underlying decision, then having L&I perform a second review of the decision, upon appeal to the BIIA and re-assumption by L&I, could be seen as redundant in that L&I is performing two reviews, instead of one. From the perspective of quality, two reviews prior to an appeal should result in a higher-quality process, particularly in that the second review is performed by a more experienced reviewer. From the perspective of time, however, conducting two reviews in a case that ultimately ends up on appeal takes longer than a single review.[25] Of course, if the second review results in review of new information, which leads to a different decision, then such a process likely would take less time than an appeal to the BIIA.

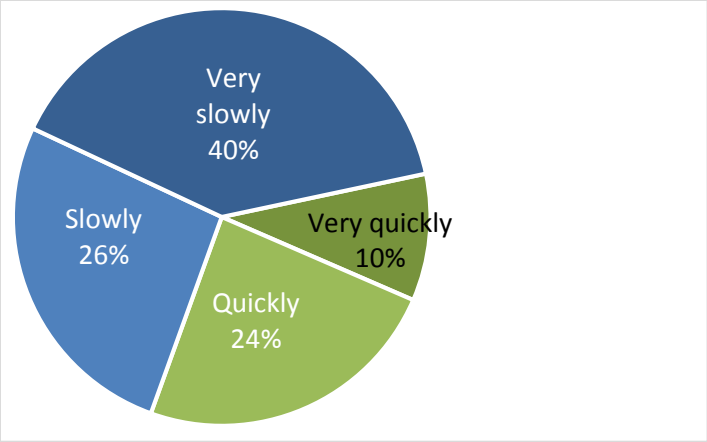
3.1.2 Stakeholder Perceptions of Timeliness

We sought input from stakeholders with respect to timeliness, and learned that timeliness was the one area of the dispute process where workers perceived the most problems. (Note that the survey of workers involved claims with relatively serious injuries and included claims in which workers were represented by an attorney.) In other areas of dispute resolution (e.g., the quality of written materials and clarity of decisions) the majority of workers gave L&I high marks. But, 66% of workers felt the dispute process was "Slow" or "Very Slow" (shown in Exhibit 3-5 below). Judicial processes typically require a number of time consuming steps, including party notification, obtaining information on which to base decisions, and appeals by parties and re-assumptions by L&I. If CMs and L&I established reasonable expectations for the timing of dispute resolution events, that could improve workers' perceptions of L&I performance and their satisfaction with the process and decisions. L&I reports that Claims Consultants, who review re-assumed appeals, communicate an expected timeframe for completing the review.

[24] Our investigation showed that approximately 70% of State Fund claim disputes are resolved by L&I; for self-insured claims this rate is 45%. This is calculated as follows: One minus the quotient of the total number of granted appeals divided by the sum of the total number of protests per year plus the total number of re-assumptions per year. This is admittedly imprecise in that an appeal could follow a protest, or could follow a decision that was not protested; in most such cases, however, L&I will re-assume such an appeal. Additionally a re-assumption can occur after a protest, but L&I can choose to decline to re-assume, though this typically occurs only when a protest has been reviewed by a Claims Consultant, and no new issues are raised in the appeal. Finally, single cases can have multiple appeals and protests.

[25] As noted above, protest reviews take on average 55 days, so in theory this second review adds on average approximately 2 months to the appeal process.

Exhibit 3-5 Workers' Perceptions of Timeliness of Dispute Resolution



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

Employer perceptions about the timeliness of dispute resolution mirrored the concerns of workers, but employers overall were more positive about the timeliness of the dispute process, with about half of employers answering that it was "Timely" or "Very Timely." However, this was much less favorable than employers' perceptions of other areas of the dispute process; see Appendix 6 for additional detail. This may be more of an issue of establishing reasonable expectations, upfront, rather than speeding up the actual dispute resolution process.

3.2 Fairness

Fairness in the dispute resolution process was tested in several ways, including the following:

1. Examining outcomes of key decisions by gender and age;
2. Examining consistency in decision-making across the three major forms of insurance (self-insurance, State Fund Retro program participant, and State Fund non-Retro program participant);
3. Surveying stakeholders on their experience with various aspects of dispute handling; and
4. Examining decision-making in terms of legal compliance.

3.2.1 Gender and Age

The protest and appeal process does not reveal any substantial differences in process or fairness 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; as noted in Exhibit 3-3 above, the proportion of appeals by injured workers is higher for State Fund claims than self-insured claims: 87% of granted appeals of State Fund claims are filed by workers; for self-insured claims it is 77%. Across the three major forms of insurance, the rates of appeals are not significantly different for Retro or non-Retro, but self-insured appeals are half the rate, based on the overall number of accepted claims. There is not a big difference in the percentage of appeals filed by workers versus employers across these types, with the possible exception of self-insured employers being more active in the appeal process.[26] We believe that these taken together – the

[26] See Chapter 1 – Claims Management Organization for a more detailed examination of differences in structure of retrospective rating program participation vs. non-participation, and Chapter 2 – Claims

lower rate of self-insured worker appeals and the higher rate of self-insured employer appeals – is largely explained by the source of the underlying decision. The self-insured employer is the underlying decision maker for its claims, which logically means that the employer is going to more vigorously defend before BIIA. 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.

3.2.2 Insurance Types

As discussed earlier in the report in Chapter 1: Claims Management Organization, for claims involving self-insured employers, the L&I oversight role appeared to be minimal. For allowance decisions, our file reviews showed L&I entered allowance orders 99% of the time, but between 35 and 40% of the files did not have evidence supporting an allowance. For denial decisions, L&I entered the requested denial orders 98% of the time. In State Fund denials in our file reviews, most claims (80%) had at least some record evidence supporting causation; i.e., the claim had some support, but after investigation the CM determined it should be denied. This is understandable, as causation can be a "toss up," involving issues requiring interpretation. In self-insured denials, however, only 40% of claims had at least some evidence supporting causation. This does not mean the evidence supporting denial was missing, but it presents a contrast with State Fund claims. There could be varying interpretations of this, including an indication that: 1) the record is not being well developed; 2) in self-insured claims there is more clarity with respect to causation; or 3) that L&I is missing importance evidence. Based on the statistic that L&I upholds virtually all denial orders requested by self-insured employers, it may be that the supporting evidence is there, but it is not being provided to or reviewed by L&I.

This does not mean, however, that self-insured claims are being inappropriately denied. If the denial order was protested or appealed there appeared to be no evidence of different outcomes for self-insured claims on appeal vs. State Fund claims. To the contrary, the evidence is strong that for all three insurance types – self-insurance, Retro, and non-Retro – and for both the dispute process at L&I and the appeals process at BIIA, the outcomes are consistent. Across insurance types they have nearly identical reversal rates of L&I decisions, regardless of whether the appeal was filed by the employer or worker. Moreover, the survey results found nearly identical perceptions of the dispute process across the different insurance types.

3.2.3 Stakeholder Perceptions

Perceptions of fairness in a judicial process can be interpreted along two dimensions: 1) the level of positive perceptions about the system; and 2) are these perceptions similar across different subgroups. On the second dimension, the audit's paramount concern was whether workers and employers reported perceptions of judicial fairness differently depending upon the insurance status of employer (self-insured, Retro, or non-Retro).

"Fairness" is in large part a perception and, as such, requires surveying participants about their opinions. However, the outcome of a judicial process, specifically whether the surveyed party prevailed in a dispute, has a large impact on overall perceptions. Therefore, we approached the question from two directions. First, we asked respondents about their perception of the decision. Next, we asked about their perception about different steps in the process. These process questions were synthesized from research on what components of a judicial process are consistent with an equitable system. Specifically,

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Management Performance for a more detailed examination of differences in outcomes of retrospective rating program participation vs. non-participation.

we asked: 1) if the steps in the judicial process were sufficiently clear; 2) if they felt they had sufficient opportunity to present their case; and 3) whether the reasoning for the ultimate decision was clearly explained**.**

As shown in Exhibit 3-6, for employers the components of the judicial process that generate the perception of equitable decisions received high marks, with 2/3^{rds} to 3/4^{ths} of employers responding favorably. Based on the authors' experience with other states' systems, these are quite positive. The overall perception of the process is lower, but as mentioned earlier, the timeliness of the process received low marks from employers and this may be intervening (along with the actual decision) to moderate employers' positive perceptions. The perception of the fairness of the final decision is also lower than perceptions of the specific qualities of the process, but again this may be heavily influenced by whether the employer prevailed in the dispute. Differences between results of Retro and non-Retro employers were minimal.

Exhibit 3-6: Employers' perceptions of dispute process

Question area	Positive response rate
L&I clear on how to pursue dispute	80%
Sufficient opportunity to present case	70%
Clear explanation of decision	64%
Overall process	49%
Decision(s)	46%

Source: WorkComp Strategies Employer Survey 2014

Workers were less positive across each aspect of the process and about the overall process and final decision (Exhibit 3-7).

Exhibit 3-7: Workers' perceptions of dispute process

Question area	Positive response rate
L&I clear on how to pursue dispute	47%
Clear written materials	60%
Sufficient opportunity to present case	54%
Clear explanation of decision	54%
Overall process	34%
Decision(s)	42%

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

We expect workers to have less positive perceptions than employers. A formal judicial process is typically arcane and complex, and as shown by the complex array of possible options for achieving resolution outlined in section 3.1.1 above, Washington is no exception. And, while employers are frequently repeat players in the dispute process, workers are most often one-time participants. Consequently, the system can be more difficult for workers to navigate.

Workers had less favorable perceptions of the fairness of the actual decision (42%) compared to employers (46%). This does not necessarily indicate a bias towards employers in the judicial process, however. The party disputing a decision usually does not prevail. For example, only about one-third of decisions are overturned on appeal. Employers, being multiple players in the dispute process have many

more decisions across which to interpret this dimension, while workers are likely relying on the outcome of a single protest or appeal. And again, the outcome of a dispute is likely critical to a party's ultimate perception of fairness.

The second dimension across which fairness can be interpreted is whether different participants are treated similarly; here, the important subgroups are employers and workers compared by the insurance status of the employer. This is particularly important because the dispute process proceeds somewhat differently depending upon if the employer is self-insured or insured by the State Fund. Also, Retro employers are substantially more aggressive about disputing L&I decisions than their non-Retro, insured counterparts.

Despite these differences, we found that perceptions of both workers and employers across the several components of the process, as well as the final decision, were very close. This is a strong endorsement of the even-handedness of L&I, as well as the BIIA, in handling disputes. The only dimension across which insurance status mattered was the employers' perception of the timeliness of dispute resolution. Self-insured employers were substantially and significantly more frustrated with the time required to complete the dispute process. It is possible that the requirement for L&I to approve orders originally issued by the self-insured employer's claims administrator contributes to this frustration. As we indicate in Chapter 1 of this report, many of these approvals are virtually automatic, but add considerable delay to the timeline. In terms of perceptions of fairness across Retro and non-Retro groups, we did not observe notable differences that would indicate bias.

3.2.4 Legal Compliance

We further examined whether the dispute process was free of bias and done in compliance with law. Our file reviews and interviews with L&I staff revealed a culture of legal compliance without any apparent favoritism toward, or prejudice against, any employer type. We did see evidence of employer representatives[27] intervening in the process to ask the CM to take some action. But, the recorded responses by the CM seemed reasonable. Sometimes it appeared that the CM took immediate action that was communicated by the employer representative, and sometimes the action was not taken, or was taken later. No clear pattern was observed. We did not observe any recommendations by employer representatives that seemed unlawful or inappropriate.

In terms of compliance, there are few statutory requirements with regard to handling disputes. One is the requirement that orders contain a statement of the 60-day time limit for appeal and the basic process for filing appeal.[28] For the re-assumption process, L&I has 90 days to issue a final decision

[27] Employer representatives are often part of a Retro program, but can also be used by employers that do not participated in the program. One non-Retro employer we interviewed had a very skilled employee handling all claims. Representatives are workers' compensation specialists who provide services to those they represent. They are hired (and paid) by a Retro group manager or individual Retro employer, or even by an insured employer that is not a participant in a Retro program. A representative's services would include advice as to the workers' compensation process in general, as well as assistance with particular issues in a claim as they arise. A major motivation of engaging a representative would be to follow a claim as it moves through the process and provide any assistance believed to be needed to improve case outcomes. An example of an intervention that was observed during file review is a representative contacting the L&I CM and communicating that an injured worker was given a permanent partial disability rating by his or her physician, and encouraging the CM to close the claim.

[28] The statute refers to a "request for reconsideration." RCW 51.52.050(1). There is a 20-day appeal period for certain decisions about repayment of fees for medical, dental, vocational, or other health services.

following re-assumption, which may be extended an additional 90 days "for good cause stated in writing."[29] Additionally, disputes *per se* can be an indication of non-compliance; for example, a high percentage of reversals of L&I decisions on a particular topic could be an indication that L&I compliance regarding the topic is inconsistent.

Our file review covered files from 2010-2013. Our review showed compliance with the provision concerning the protest and appeal statement on orders. There is no statutory timeframe for processing protests, although as just mentioned L&I is required to resolve re-assumed disputes within 90 days (180 days for good cause stated in writing). Thus, using this 90-day period as an informal benchmark, analysis of data showed that the time to decision after protest – 35 days at the median, 55 days on average – supports broad compliance.[30] L&I internal reports show that in 2014 about 80% of protests were completed within 90 days, and that about 6% took more than 180 days.

Our statistical analysis of the claims process uncovered no process differentiation across employer types. We noted in Exhibit 3-3 above that L&I re-assumes a much smaller percentage of appeals to BIIA for self-insured claims than for State Fund claims: 88% of re-assumed appeals involve State Fund claims, vs. 12% for self-insured claims. Additionally, as shown in Exhibit 3-4, the time to re-assumption decision is much quicker for self-insured (SI) claims than for State Fund (SF) claims. There are at least three ways to explain this: 1) L&I feels that the SI employer made the underlying claim decision and should defend it; 2) L&I has already reviewed the SI order, in exercising its oversight role and is comfortable with its approval; and 3) SI initiated orders are better founded than those from the State Fund and hence do not merit re-assumption as often. We have no way of determining the relative strength of these three factors, although L&I reports that self-insured employers have historically viewed an L&I decision to re-assume as re-adjudication of work already performed by the Department.

Our investigation also showed that BIIA and L&I have a good working relationship, and seek alignment on interpretation of Washington law. L&I conducts informal sessions with Claims Consultants (not CMs) to discuss recent developments in the law. The CM procedure handbook is available online to L&I staff, and contains a comprehensive set of information about both basic claim information as well as numerous exception cases. Each claim unit is managed by a senior unit supervisor, and there are designated lead CMs who are available to help with difficult decisions and situations. There is a highly qualified team of quality reviewers who conduct case reviews to ensure, among other things, legal compliance.

3.3 EFFECTIVENESS

We tested for an effective complaint resolution system in the following ways:

1. We examined the types of issues present in disputes, by stakeholder group and by appellant, to determine if there were inconsistencies present
2. We examined dispute outcomes on appeal
3. We interviewed and surveyed stakeholders as to dispute resolution effectiveness.

[29] RCW 51.52.060(3).

[30] Note that after re-assumption, the dispute is processed like a protest, followed by an order. Thus the time for re-assumed cases are contained in the overall time to protest completion, which is within compliance standard.

3.3.1 Prevalent Issues in Dispute

The most prevalent issues that are disputed, based on information from BIIA appeals,[31] include "time-loss" (21% of cases with final orders 2012-13), permanent partial disability (PPD) (16%), allowance (15%), and medical treatment (12%).[32] Together these represent approximately two-thirds of all litigated issues. This is true in both SF and SI cases.

When the employer is the appellant in State Fund cases (both retrospective rating program participant and non-participant employers), permanent partial disability (PPD) is the top issue. Retrospective rating program participants (or more likely their agents) appeal more treatment and loss of earning power (LEP) cases,[33] whereas non-participants appeal more allowance cases and time loss cases. In self-insured employer appealed cases, PPD is the top issue, but segregation is added to the list of top issues.[34]

Exhibit 3-8 shows that the dominant dispute for employers was over PPD.[35] For one of the three groups the PPD percentage is more than double the percentage of the second ranked issue, and for the other two groups PPD clearly stood above the second ranked issue. Time loss had the second highest cumulative rating and treatment was the third most frequently appealed issue. LEP was fourth in frequency overall for employer appeals. The distribution by type has a roughly consistent pattern, with the exception of retrospective rating program participant employers having the largest deviation with their relatively high ranking of treatment and LEP in the second and third place issues.

Exhibit 3-8: Employer Appeals by Type of Employer and Top Four Issues on Appeal

Employer group	1st Ranked	2nd Ranked	3rd Ranked	4th Ranked
Retro	PPD 27%	Treat 22%	LEP 22%	Allow 6%
non-Retro	PPD 28%	TL 12%	LEP 12%	Allow & Treat 11% each
Self-Insured	PPD 21%	TL 16%	Treat 13%	Seg 11%

Source: WorkComp Strategies, based on BIIA data, final orders 2012-13

[31] L&I and BIIA track "issue types" for appealed cases. Protests that are not appealed to BIIA are not tracked by issue. Our analysis uses BIIA data. BIIA records all issue types present; some cases have a single issue type noted, and others have more (up to 8 in the sample). BIIA does not track which issue was "most important." Indirect tracking occurs, however, at issuance of the final order, and thus the indicated issues likely had some bearing on the outcome of the case.

[32] "Time loss" would involve issues of temporary total disability; "PPD" would involve permanent partial disability benefits, which are paid as a percentage of functional loss; "allowance" involves a decision to accept or reject a claim as being covered by the Washington workers' compensation laws; "treatment" would involve medical treatment issues. Other issues include "LEP" or loss of earning power, which is involved when a worker returns to work at lower than pre-injury wages because of an injury; "aggravation," which involves cases that were closed, but medical condition changed such that disability returned and the case should allegedly be re-opened; and "segregation," which involves separating out medical conditions allegedly unrelated to the industrial accident.

[33] LEP is a partial income loss because of an injury, despite a return to work; for example, a return to work at modified duty, earning less pay.

[34] Note that in the self-insured employer appeal scenario, when the employer appeals, it is appealing an L&I decision to not uphold the self-insured employer's request to take a particular action. For example, a self-insured employer might request that L&I issue a denial order, but L&I disagrees with the request and issues an allowance order, which could be appealed. The worker, on the other hand, would appeal decisions by L&I to grant a self-insured employer request for a particular action, with which the worker disagreed.

[35] Our analysis is that these figures, across employer type (SI, Retro, non-Retro) are not statistically significantly different.

When the worker appeals, time loss is the dominant issue. Allowance, PPD, and treatment are second, third, and fourth most frequent issues. For State Fund claims (Retro and non-Retro), workers appeal slightly more allowance cases and slightly fewer PPD cases. Moreover, as shown in Exhibit 3-9, worker appeals are more uniform in nature, which might be an indicator of consistency of treatment across employer types.

Exhibit 3-9 Worker Appeals by Type of Employer and Top Four Issues in Appeal

Employer group	1st Ranked		2nd Ranked		3rd Ranked		4th Ranked	
Retro	TL	28%	Allow	19%	PPD	11%	Treat	10%
non-Retro	TL	21%	Allow	16%	PPD	15%	Treat	12%
Self-Insured	TL	24%	PPD	15%	Allow	15%	Treat	11%

Source: WorkComp Strategies, based on BIIA data, final orders 2012-13

3.3.2 Appeal Outcomes

We also looked at case outcomes on appeal.[36] BIIA identifies the outcome of each appeal as either "Affirming the Department," "Reversing the Department," or "Further Consideration/Abeyance." The first outcome – Affirm – indicates that a BIIA order was issued, either after a hearing or on agreement of the parties, pursuant to which the underlying decision was considered correct. The opposite is true for Reverse. The Further Consideration/Abeyance outcome means that L&I is conducting further review, and thus "Affirm" or "Reverse" is not yet applicable. The following discussion focuses on the appeals because the rate of reversal could be an indication of the quality of the L&I's claims handling leading to the appeal. An important consideration is that some appeals involve multiple issues, and a reversal on one of the issues is tracked as a "reversal"; i.e., affirmance of many issues, and reversal on a single issue, is still tracked as a reversal of the entire case.

As general background, the BIIA reports (based on FY 2013-14 final orders) that it reverses the department in 37.6% (537/1,428) of granted appeals in SF cases, and 38.5% (136/353) in SI cases, which we regard as not statistically different.[37] These counts include only final BIIA orders, in granted appeals, which are issued by a judge or the Board, in review of a judge's decision; it excludes settlements and dismissals. The BIIA "411" report publishes monthly and annual statistics of the outcomes of BIIA orders.[38] A granted appeal is one that is not re-assumed by L&I or denied. Appeals are denied for several reasons, the most common of which is that L&I is already reviewing the appealed order, and thus it already has jurisdiction; in this respect a denied appeal is similar in nature to a duplicate of an existing protest.

Our analysis of BIIA data included investigation of appeal outcomes in granted appeals, based on the type of appellant: worker or employer.[39] This analysis was based on final orders issued in 2013. Exhibit

[36] Note that the BIIA identifies and tracks each outcome, and also identifies the outcome as either "affirmed," "reversed," or "further consideration" of the L&I order at issue, thus allowing for basic identification of the outcome. L&I does not track outcome of protests in this manner, but instead characterizes the subsequent order, after review; the same characterization could apply regardless of whether the decision was determined to be correct or incorrect.

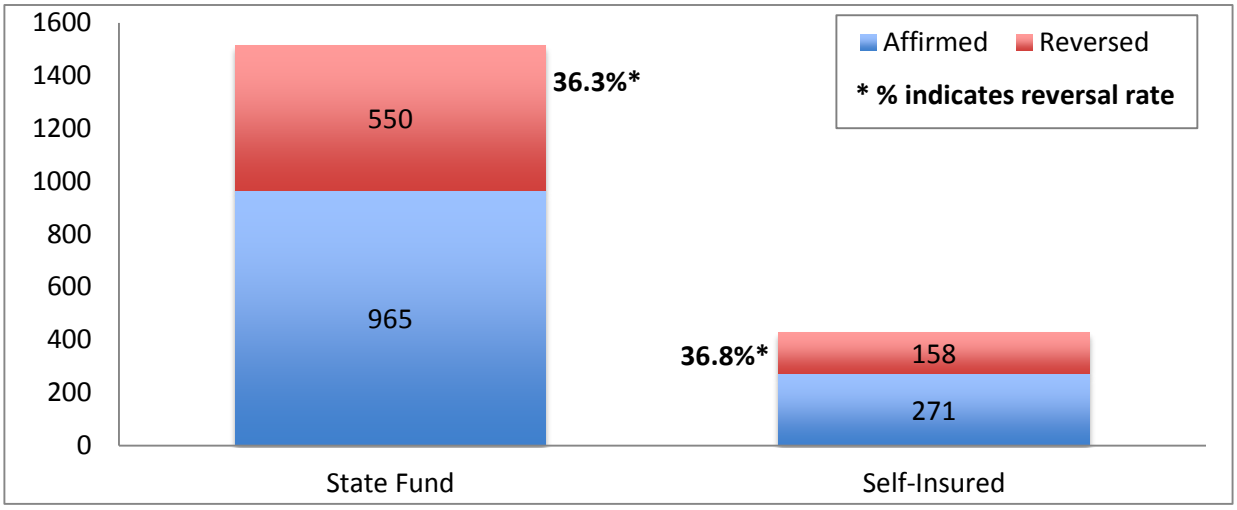
[37] BIIA Statistical Report, "Report 411" (as of June 2014, reporting 2013 and 2014 statistics; fiscal year runs from July 1 to June 30).

[38] The latest versions are available at http://www.biia.wa.gov/Reports.html.

[39] In some cases, a provider will file an appeal, for example seeking approval of particular treatment. We treated these appeals as "worker" appeals.

3-10 shows that the BIIA reverses the L&I decision in 36.3% of granted appeals in State Fund claims and 36.8% of self-insured claims. Of the appeals that were granted in State Fund claims, the BIIA reversed L&I 36.3% of the time; for self-insured claims, it was 36.8%. (In the data under analysis, 77.9% of the granted appeals involved State Fund claims, and 22.1% involved self-insured claims.[40])

Exhibit 3-10: Reversals by BIIA in Granted Appeals – State Fund vs. Self-Insured (2013 Final Orders)



Source: WorkComp Strategies, based on BIIA final orders CY 2013

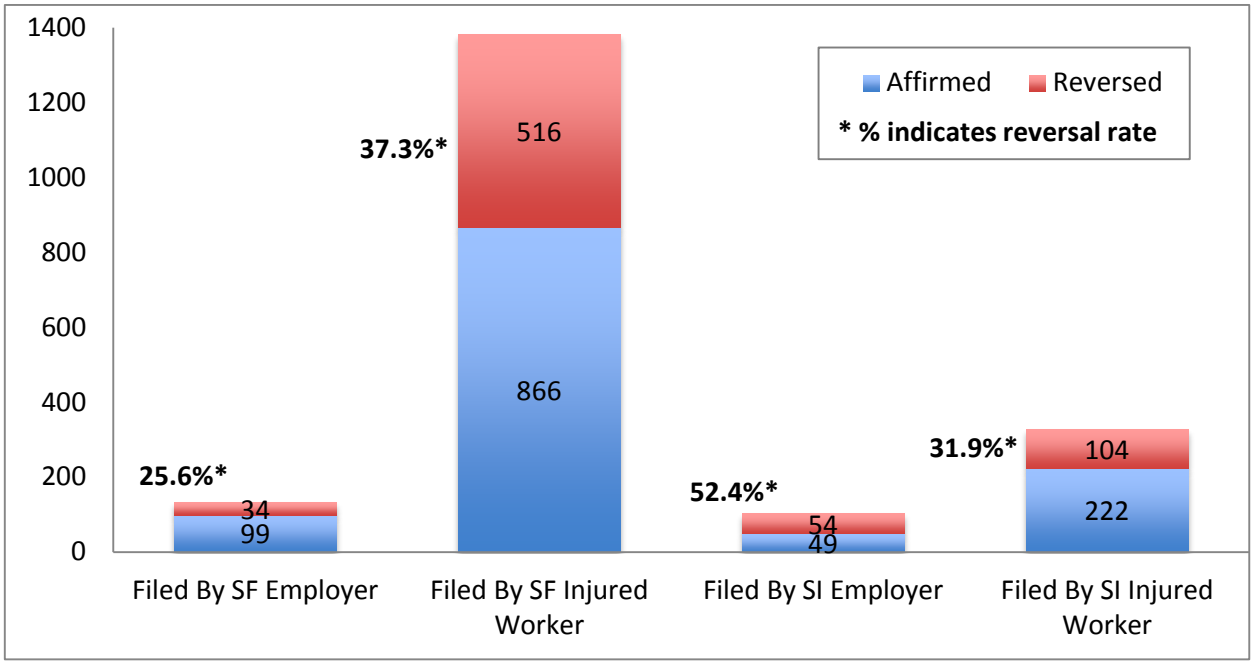
The overall rate of reversal, broken down by appellant type (worker or employer), was 36.3% when the injured worker appealed and 37.3% when the employer appealed. Although these rates are similar, when analyzed by insurance type (State Fund vs. self-insured), the results varied. The rate of reversal, when the appellant was a self-insured employer, was much higher than the overall rate. The reason for this is unclear, but could be based on a number of factors, including that self-insured employers are much more careful about which cases they choose to appeal, or that they pursue appeal litigation more aggressively than their counterparts (i.e., expend more resources gathering and developing supporting evidence). On the opposite end of the spectrum, State Fund employers that appealed had a considerably lower rate of success on appeal. The reasons behind this are not apparent. The worker reversal rates for State Fund workers were equivalent to the overall rate; for self-insured workers the rate was fairly equivalent. It is important to note that workers appeal in far greater numbers than employers, and the number of appeals by State Fund workers was much greater than self-insured.

Exhibit 3-11 shows the results when analyzing outcomes on appeal by appellant (worker or employer), and further grouped by State Fund vs. self-insured appeals. It shows that self-insured employers had over twice the proportion of their appeals result in reversals of L&I relative to State Fund employer appeals. Also, comparing reversals for employer-filed appeals to worker-filed appeals shows that self-insured employers have a much bigger reversal rate than for worker filed appeals. These reversal percentages show the opposite for State Fund reversals, i.e., worker appeals result in a higher reversal rate than employer appeals. This indicates an advantage of some sort for self-insured employers. Possible reasons include: 1) better management of claims issues and documentation by self-insureds in

[40] The overall split of accepted claims between State Fund and self-insured employers is 70% State Fund and 30% self-insured. Thus, proportionately fewer self-insured claims result in granted appeals.

the underlying claims process; and 2) stronger or more sophisticated legal defense against worker appeals.

Exhibit 3-11: Reversals by BIIA – Employer or Injured Worker, SF vs. SI (2013 Final Orders)



Source: WorkComp Strategies, based on BIIA final orders CY 2013

If the reversal cases by type matched the distribution of appeals filed, this would suggest that there is no particular issue in which the department's process was lacking in quality to sustain its judgment. When the BIIA reverses L&I, the issues differ somewhat from those appealed (Exhibit 3-12).

- For example, in non-Retro cases, where the worker appeals and BIIA reverses, the most prevalent issues are PPD (26%), time loss (19%), and allowance (12%); treatment drops off. The fourth and fifth most common issues are aggravation (defined as a case that is re-opened after final order) (11%) and segregation (11%). Together these issues represent approximately four-fifths of all issues in the reversed cases.
- When looking at Retro cases, time loss (26%), PPD (23%), and allowance (14%) are the top issues, which is very close to the overall distribution of appeals.
- In SI cases, PPD (25%), time loss (22%), and allowance (13%) are the top issues (segregation is the fourth most common issue at 11%); again, this is quite close to the overall issue distribution.

Exhibit 3-12: Worker-initiated Appeals, where BIIA Reverses L&I

Employer Group	Issue 1 (most common)	Issue 2	Issue 3 (3rd most common)
Retro	Time Loss (26%)	PPD (23%)	Allowance (14%)
non-Retro	PPD (26%)	TL (19%)	Allowance (12%)
Self-Insured	PPD (25%)	TL (22%)	Allowance (13%)

Source: WorkComp Strategies, based on BIIA data, final orders 2012-13

When the employer appeals (note that the rate of appeal of Retro employers is 24% and 76% for non-Retro) and the BIIA reverses, the sample is too small (only 14 such cases in 2012-13, compared with 363

for non-Retro) for Retro cases for meaningful analysis, but for non-Retro cases the top issues are PPD (23%), time loss (20%), allowance (13%), and segregation (10%); this, too, matches the overall distribution of issues in non-Retro employer appeals, with the possible exception of LEP issues being more prevalent on original appeal, but not in reversed cases. In SI cases where the employer appeals, the top issues in the reversed cases are again PPD (21%), time loss (21%), aggravation (13%), and segregation (11%); allowance drops out at 10%. Aggravation and allowance are not within the distribution of original appealed issues; this could be an indication that the BIIA reverses more SI employer appeals on issues of allowance and aggravation (which is essentially an allowance-type issue in a re-open application after a final order). Note that the sample is small (N=214).

Exhibit 3-13: Employer-Initiated Appeal, where BIIA Reverses L&I

Employer Group	Issue 1 (most common)	Issue 2	Issue 3	Issue 4 (4th most common)
Retro	*	*	*	*
non-Retro	PPD (23%)	TL (20%)	Allowance (13%)	Segregation (10%)
Self-Insured	PPD (21%)	TL (21%)	Aggravation (13%)	Segregation (10%)

Source: WorkComp Strategies, based on BIIA data, final orders 2012-13 * Note: sample too small

3.3.3 Stakeholder Perceptions

Our stakeholder interviews did not indicate fundamental problems with the protest or appeal process. There were comments from some self-insured stakeholders that the appeal process was required to be over-utilized, in that L&I purportedly expressed reluctance to review a decision at the protest stage, but instead "pushed" review to the appeal stage. We also heard statements that both employers and workers were reluctant to formally protest some decisions, for fear of putting the employer- worker relationship under stress. This point was made by both CMs and by the SI Ombuds. Another point was raised by CMs in connection with case file notes, which are fully opened for access by the parties (discussed in Chapter 1 of this report). The CM's contention was that they would hear from employers and workers on various points, but were reluctant to have certain items formally documented because of the public accessibility of the information.

In terms of effectiveness of the dispute process, as indicated in the discussion above, survey responses showed some issues with perceptions of the dispute process, particularly with respect to timeliness. Satisfaction with the fairness of the dispute resolution process was generally positive.

The data indicated that State Fund employers appealed a higher portion of disputes than self-insured employers, at more than three times the rate. This is expected because there are more than two times the number of State Fund claims than self-insured claims.[41] Another explanation could be that, aside from the Retro program, many State Fund employers are comparatively smaller, and have less experience with workers' compensation. They could be appealing a higher fraction of decisions simply from a lack of understanding of the system. Likewise, as shown in the notes for Exhibit 3-3, the number of protests for self-insureds is a much smaller percentage of total claims for self-insured employers relative to the percentage for State Fund insured employers (7% versus 19%, respectively). We discussed in Chapter 1 that L&I reviews self-insured claims decisions and issues an order if it agrees with the

[41] As shown in Exhibit 3-3, 2013 BIIA data showed that self-insured employers represented 21% of BIIA granted appeals whereas State Fund employers represented 79%. In general SI represents about 30% of accepted claims; SF is about 70%.

decision, which occurs most of the time. The L&I review process may lead some workers of self-insured employers to believe that the decision was indeed accurate, despite L&I's review being largely perfunctory. This might explain the lower percentage of appeals in self-insured claims. In terms of re-assumptions, a smaller percentage of self-insured appeals are re-assumed, and these re-assumption decisions are made more quickly than in State Fund claims. One reason for this could be that the decisions made by the employers were relatively more defensible. Another reason could be that, in the self-insured adjudication process, unless new evidence is presented, L&I review in essence has already been performed. The percentage of granted appeals by injured workers was less for self-insured, implying less meritorious cases filed.

4 Observations Regarding Informal and Formal Settlements

Finally, in the course of the audit, we made other observations concerning the Washington workers' compensation dispute process. These involved settlements, both informal and formal.

4.1 Informal Settlements

One area of dispute-system effectiveness that is not explicitly recognized in public discussion of the system is the mechanism of informal settlements. Known as "side bar agreements," these agreements are negotiated between the employer and worker. There are no data on the number of such agreements. Our interviews suggested that they were quite common among self-insured employers. They involve a cash payment from the employer to the worker in exchange for the worker agreeing to certain matters regarding the scope or nature of a workers' compensation claim, disability, or treatment. These agreements are not enforceable under workers' compensation law.[42]

We heard from BIIA and others that some appeals are withdrawn after such agreements are negotiated. Hence, these informal agreements are essentially another mechanism for dispute resolution. Apparently they are effective since we saw no evidence of complaints by workers over being forced to sign an agreement, or workers appealing to BIIA over what they regarded as coerced or unfair agreements.

Potentially, these side agreements to resolve claim disputes could distort the comparison with State Fund disputes. If the opinions of those we interviewed are correct, the number of disputes for self-insured employers would be much higher without the agreements and the mix of the disputes might shift. For example, the informal agreements could be heavily slanted toward causation and compensability issues, which would reduce the incidence of PPD ratings and Time Loss disputes.

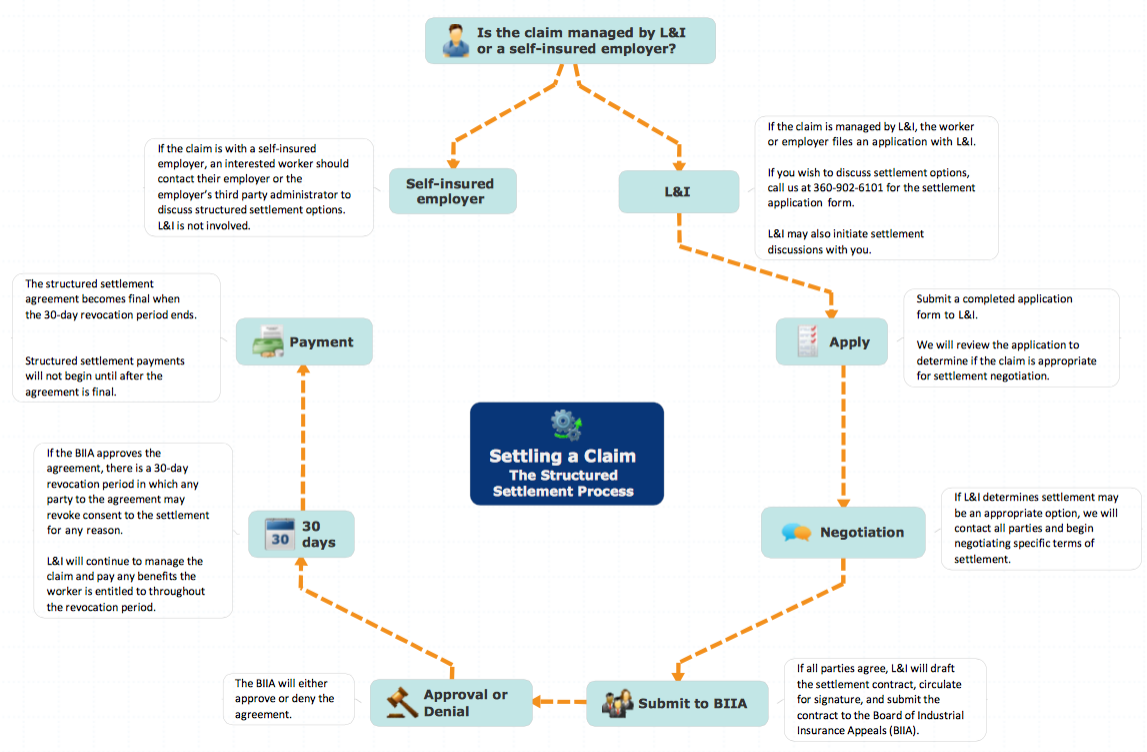
4.2 Formal Settlements

The 2011 reforms created a new optional process for formal, "structured" settlement agreements. A structured settlement is a mechanism by which the right to non-medical benefits, such as time-loss payments, in certain claims may be compromised in exchange for a lump-sum payment. It is available to both State Fund and self-insured employers. To be eligible for this option the worker must be over 53 (the age drops to 50 on January 1, 2016), the claim must be more than 180 days old, and the claim's

[42] These agreements have been in use for some time. They were mentioned in the 1998 JLARC Performance Audit done by Ed Welch.

allowance order must be final. The BIIA is required to approve all settlements. Exhibit 3-14 is an L&I diagram of the process.

Exhibit 3-14 Process for Evaluating Structured Settlements



Source: L&I website (http://lni.wa.gov/Claimsins/Files/Settlements/StructuredSettlementProcess.pdf)

There has been some controversy about the settlement program. For example, the BIIA's role in the process, namely whether the BIIA must independently decide whether the settlement is in the worker's best interest, which is a common standard in settlement programs in other states, was only relatively recently made clear.[43] Reports from L&I and the BIIA indicate that to date only a small number of claims have been processed through this process (fewer than 200 as of early 2015). Some reports indicate that the program is too restrictive to be effective.[44]

[43] The Washington Court of Appeals recently determined that the BIIA is required to apply this standard only in cases where the worker is not represented by an attorney. See BIIA v. Zimmerman, WA Ct. App. Record No. 43688-4-II (May 20, 2014) (available at http://www.courts.wa.gov/opinions/pdf/D2%2043688-4-II%20%20Published%20Opinion.pdf.)

[44] See, e.g., "Workers' Comp Settlement Program Falls Short by $242 million" Washington State Wire, June 20, 2013 (available at http://washingtonstatewire.com/blog/workers-comp-settlement-program-falls-short-by-242-million-li-announces-fuels-debate-over-reform-bill/.)

5 CONCLUSION

In summary, because it is no-fault insurance with legally defined benefits, workers' compensation should be largely free of disputes about coverage or benefits. But in all workers' compensation systems, some disputes inevitably arise because of disagreements over the facts of the claim, including causation of an injury or whether treatment is causally connected with an injury.[45] The system is complex, undoubtedly leading to misunderstanding or confusion on the part of some workers. As shown in Chapter 1, initial contact is delayed in claims; this is a missed opportunity for providing clarity to the claims management process, which would avoid some disputes born out of lack of information. For most workers, it is their one and only experience with the complex nature of workers' compensation systems, and a very stressful experience due to the injury and potential loss of income. There are several aspects of the process where they are required to act. In the dispute process, as stated on all orders, the worker is required lodge a protest or appeal, or the decision will become final.

The high re-assumption rate, in addition to the high number of settlement orders reversing the L&I decision, can be explained by several reasons, including that information needed to adjudicate the claim was needed, but not provided until the appeal. Another reason could be that the parties agreed that resolving the dispute through a mutually agreeable compromise was in their best respective interests; such resolution is quite common generally in litigation. Another potential reason could be weak decision making in the L&I claims process. Finally, the high number of settlements and re-assumptions could also point to the need to refine the dispute process itself. In 2013, the re-assumption rate was 31%.[46] Thus, L&I re-assumes approximately one-third of appeals filed with the BIIA. Re-assumptions are handled by L&I as protests, and overall L&I resolves roughly 70% of protests without further dispute. As noted above, the decision to re-assume and resolve the case is made by a specialized CM that is not a part of the ordinary claim unit. This suggests that a knowledgeable third party to the claim thought there was a correctable mishandling of the claim. This is not always an error on the part of the CM. It may be something that the CM would have corrected if the appealing party had contacted the CM to provide new information, or sent in a formal protest with their concern expressed. Thus, worker behaviors could contribute in some cases to unnecessary disputes.

[45] In Washington, disputes can be raised by any party to a claim, including a provider who disagrees with a decision, including whether to authorize treatment.

[46] Exhibit 3-3, excluding denied appeals which are similar to a duplicate of a protest already being processed.