

Executive Summary:

Washington Labor and Industries Claims Management Performance Audit

1 LEGISLATIVE CHARGE AND SUMMARY OBSERVATIONS

EHB 2123HB (2011) directed the Joint Legislative Audit and Review Committee (JLARC) to conduct a performance audit of the state’s workers’ compensation claims management system. Six topics were covered in this charge:

1. Fair, timely, and effective decisions and complaint resolutions
2. Timely, responsive, and accurate communication
3. Efficient organization and service delivery models
4. Practices that may affect retrospective rating plan refunds
5. Current Initiatives
6. Recommendations

It is important for the reader to note that the formal review of claims management in this audit focused on the years 2010-13. In many areas, the claims management process we reviewed has been modified through a large group of process changes within L&I since the end of 2013. These changes involve many operational aspects, but importantly for the purpose of this audit, include, but are not limited to changes to vocational services generally as well as the timing and quality of service delivery, medical management support for L&I claim adjusters (known as “Claim Managers” or “CMs”), support for CMs with administrative claims management tasks, and CM training. We have described the most important of these initiatives. While these process changes may have a very salutary effect, and early indicators of some changes already are showing some positive results, it is too early to measure their effectiveness on the claims process.

Further, the audit team conducted a performance audit of the L&I claims management function, as opposed to compiling a general descriptive report on L&I claims management. The team tested for compliance with certain standards, as well as an investigation into certain specifically named practices and activities. Thus, in many respects, the report presents review and analysis of observations that, in the opinion of the audit team, merit further investigation. However, there were many areas under review that demonstrated effective compliance and control, and the authors have attempted to present these observations as well.

1.1 FAIR, TIMELY, AND EFFECTIVE DECISIONS AND COMPLAINT RESOLUTIONS

Legislative Charge

“Evaluate the extent to which the Department makes fair and timely decisions, and resolves complaints and disputes in a timely, fair, and effective manner....”

Major Observations

- A review of the dispute process, individual file reviews, worker and employer survey results and data analysis do not reveal any substantial differences indicating bias in process or unfairness of dispute resolution across the three different forms of insurance coverage or by age or gender of injured worker.¹ Some substantial differences across test groups were observed, but these were generally related to the nature of the groups, e.g., the types of injuries sustained or typical healing times. Where differences existed no unfair discrimination by L&I was observed. (Chapter 3)
- More timely medical management interventions and vocational rehabilitation services could improve overall claim outcomes for both workers and employers. (Chapters 2, 5, and 6)
- Perceptions of both workers and employers across the components of the dispute resolution process, as well as the final decision in a dispute, were generally similar. This is a strong endorsement of the even-handedness and consistency 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 a self-insured employer's claims administrator contributes to this frustration as many of these approvals are virtually automatic, but add considerable delay to the timeline. (Chapters 1 and 3)
- Analysis of data showed that the time to decision after protest was 35 days at the median and 55 days on average. There is no required time to complete a protest; however, there is a 90-day requirement for reviewing a re-assumed claim, and thus the 35-day median/55-day average is substantially compliant with this 90-day review period. L&I internal reports show that in 2014 about 80% of protests were completed within 90 days; however about 6% took greater than 180 days. A significant percentage of employers (52%) and workers (66%) surveyed felt that resolving protests took too long, but it should be noted that our surveys covered relatively serious claims. (Chapter 3 and Appendices 3, 6, and 7)
- The protest and appeal process was fairly and evenhandedly applied; however, in some respects it was unnecessarily cumbersome, and sometimes required redundant consideration of disputed issues. In our review of appeals we discovered a large number of appeals re-assumed by L&I and a large number of cases where L&I settles the granted appeal before hearing. There are a few possible explanations for this, but it raises the possibility that a large number of indefensible decisions are being made by CMs or that information was missing when the underlying decision was made. A few modifications to the dispute resolution process could make it more efficient and timely for both workers and employers and result in more consistent decisions. (Chapters 3 and 6)

1.2 TIMELY, RESPONSIVE, AND ACCURATE COMMUNICATION

Legislative Charge

“ . . . communicates with employer and workers in a timely, responsive and accurate manner, including communication about review and appeal rights, and including the use of plain language and sufficient opportunities for face to face meetings . . . ”

¹ Note that L&I processing and organization for self-insurance claims is different from that of State Fund claims as explained in Chapter 1, but the dispute resolution systems for the two is fairly similar.

Major Observations

- Letters, by a wide margin, are the tool of choice for L&I to initiate and maintain contact with parties to a claim. Our file review found a few relatively minor recurring lapses from the “plain talk” guidelines in Executive Order 05-03. These included using words that were not in most customers’ vocabulary; using the passive voice; and not using personal pronouns. (Chapter 4)
- English language letters were found to be used in some cases even though the claim file showed a non-English language preference. File reviews showed language translation assistance was not always offered to help workers with treating provider or independent medical examination encounters. (Chapter 4)
- L&I has made significant strides in using online tools. Survey results show that 61.1% of workers and 76.5% of employers who used the Online Account system found it "easy" or "very easy" to use. Spanish speaking workers (and by implication other non-English speakers) rarely (4.4%) used the system to track their claims. The web-based tools are provided only in English. (Chapter 4 and Appendix 7)
- Prompt initial telephone contact upon receipt of a claim with the worker, employer, and provider (industry best practice) is not being accomplished in the majority of cases reviewed (Chapters 1 and 2). The value of prompt contact is shown by an L&I survey, which found claimants who received a phone contact initiated by the CM were much more satisfied with communication overall than those who did not have such a CM contact. (Chapter 4)
- Form letters sent following an L&I order always contained appropriate and prominently placed information on how to file a protest or appeal; however, 43% of surveyed workers with denied claims said the explanation on how to protest was “unclear” or “very unclear,” thus further illustrating the difficulty with letter communications (Chapter 4 and Appendix 4).
- Our surveys found divided opinions on the speed and quality of L&I communications. It appears that communication channels should be customized to the language and comprehension needs of the workers. Early phone contact by the CM to the worker would allow an assessment of the communication barriers and lead to customized and likely more effective approaches. (Chapter 4)

1.3 EFFICIENT ORGANIZATION AND SERVICE DELIVERY MODELS

Legislative Charge

“... determine if current claims management organization and service delivery models are the most efficient available . . .”

Major Observations

- L&I’s claims management functions are organized similar to most insurance claims organizations with a few significant differences: self-insurance claim decisions are monitored and approved by a separate unit within L&I; separate units also exist for certain claim functions such as case reserving, determining usual and customary medical treatment, determining pensions, and nurse case management. (Chapter 1)
- L&I’s State Fund CMs are efficient and timely in some key areas, and inefficient and untimely in others. (Chapter 2)

- With few exceptions, State Fund claim managers are handling cases fairly and in accordance with law. (Chapters 2 and 3)
- Service delivery is organized around detailed policies and procedures and utilizes automated reminders and warnings. The high rate of re-assumed or settled appeals made to BIIA, discussed above in 1.1, could potentially be a sign of defects in CM decision-making. However, some of these re-assumptions are due to later developments in the claim from the time the disputed CM order was issued. It could also show that a large degree of unnecessary friction and delay is present in the system. The efficiency, quality, and timeliness of a number of State Fund claims management functions can be improved, and L&I has taken significant strides to address delivery of certain claims management services in the months following the period under review (2010 – 2013). Some opportunities for process improvements include:
 - **Timely receipt of the report of injury:** For sampled claims it takes L&I an average of 12.3 days (7 days at the median) to receive notice of a claim. (Appendix 4)
 - **Initial contact with the parties to a claim:** In 15% of sampled claims were both workers and employers successfully contacted by phone within 30 days of receipt of the claim; 55% received no actual phone contact. (Chapter 2 and Appendix 4) Most sampled claims were TL claims; 15% were auto-adjudicated, meaning that based on certain criteria the claim was reviewed by computer for an allowance determination.
 - **Timely and regular use of available medical management and disability management tools:** A comparison of claims against generally accepted treatment guidelines showed longer than normal duration of disability and medical treatment for a sample of conditions. File reviews revealed that when confronted with medical practices that may deviate from good occupational medicine (such as incomplete or unsupported diagnoses, protocols, or plans) CMs too often react ineffectively or delay action; and use of vocational alternatives such as on the job training and vocational placement while still within the healing period do not seem to be used regularly. (Chapter 2 and Appendix 4)
 - **Effective vocational rehabilitation service delivery:** During the primary review period (2010 – 2013) vocational rehabilitation services were not being effectively applied, as shown by poor timing (in 2011 the median time elapsed from the date of injury to the start of the first AWA vocational services was 220 days; and it took another 220 days for AWA completion); poor client evaluations (9.5% of injured workers in our survey thought the VR counselor was “helpful” or “very helpful” in their return to work, although our sample involved relatively serious claims); and inefficiency (45% of vocational plans fail to complete and between 34% and 43% of workers completing retraining plans returned to work within two years following claim closure. (Chapters 2 and 5)
 - **Documentation of plans:** Records of documented plans and actions designed to help resolve the claim and overcome barriers to return to work were lacking in the majority of claims reviewed. (Chapter 2 and Appendix 4) Some statutory changes or new administrative policies may be needed to allow L&I to accomplish this. (Chapter 6)
 - **Claim manager’s accountability for overall claim outcomes:** Performance evaluation of CMs needs to better track to department goals and overall medical and disability management best practices; based on file reviews and interviews as well as statistics on length of disability and the poor results of vocational services, CMs are generally too detached from case outcomes and instead focus on following procedures. (Chapters 2, 5, and 6)

1.4 PRACTICES THAT MAY AFFECT RETROSPECTIVE RATING PLAN REFUNDS

Legislative Charge

“ . . . analyze organization and delivery for retrospective rating plan participants as compared to nonparticipants to identify differences and how those differences influence retrospective rating plan refunds . . . ”

Major Observations

- Retrospective Rating refunds appear to be consistently applied and are driven by a strict formula, and are not influenced by differences in claim handling at L&I. The Department does not organize its claim handling functions differently for retrospectively rated and non-retrospectively rated employers. (Chapters 1 and 2)
- Retrospective rating plan refunds are directly tied by claim outcomes, but such refunds do not come at the cost of non-retrospective employers. Instead, refunds are earned by retrospective rating plan employers who reduce their losses below actuarial expectations and also take on more risk (and pay more) if they do not control their losses. (Chapter 1)
- Outside audits have found that L&I carefully observes the legal requirement that both retrospective and non-retrospective employers pay the same percentage of losses from premium. Overall loss ratios are the same for both groups. Retrospective rating plan refunds are not required to be distributed to employers in group plans. Nor are refunds shared with employees even though they pay about 25% of the premium. (Chapter 1)

1.5 CURRENT INITIATIVES

Legislative Charge

“ . . . determine whether current initiatives improve service delivery, meet the needs of current and future workers and employers, improve public education and outreach, and are otherwise measurable . . . ”

Major Observations

- One initiative implemented in recent years is the FileFast system, which speeds reporting of injuries and aids in timely contact with some of the parties. As L&I notes in its website promotion of FileFast: “Online filing speeds claims processing by 5 days.” Specific advantages of FileFast claims over paper reports are:
 - Claims with First Payment of Time Loss Benefits within 14 Days (56.5% FF vs. 53.8% paper);
 - Claims in Undetermined Status on Initial Review by CMs (16.2% FF vs. 21.6% paper);
 - Wage Orders Issued within Six Days of Allowance Decision (15.5% FF vs. 10.6% paper).

FileFast should be strongly promoted and available to all employers and applicable care providers. (Chapters 1 and 6)

- Earlier evaluations for return to work at the same employer are a priority for L&I, as shown by the Stay at Work Program and consulting help to employers on creating light duty work and job

modifications for injured workers. This effort seems to be working as evidenced by the 70-80% of workers who are able to return to work in the first 12 weeks of disability.

- However, for those workers who do not return to work in three months or cannot return to the employer at injury, temporary disability often tends to be lengthy. Claims at the 70th, 80th and 90th percentiles of duration of TTD were about 60, 160 and 520 days longer, respectively, than claims at the same percentiles in either Oregon or British Columbia. In Washington, it is not unusual to have claims with 2-6 years of temporary disability, which would be extremely rare in other states. (Chapters 2 and 5) L&I has recently addressed long-term disability with efforts to improve the timing and quality of vocational services, particularly the Early AWA initiative. Another related recent initiative is co-locating WorkSource specialists with CMs, which is designed to provide more timely vocational services in appropriate cases. In 2015, L&I-sponsored legislation passed that expanded the Preferred Worker Program and increased Option 2 benefits; these changes are designed to promote effective RTW outcomes. Standardizing RTW and vocational service practices and outcome-based measurement according to such standards should improve overall duration results. (Chapters 1, 2, 5, and 6)
- Another initiative that addresses timeliness of reporting and higher quality and timely medical treatment is the creation of Centers for Occupational Health and Education (COHE). COHEs are designed to apply best practices in occupational medicine; they have been gradually expanding throughout the state since 2002. In 2013, 38.5% of initiated claims came from COHE providers. 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 report of accident. This demonstrates how effective good occupational medicine practices are at speeding up claim processing. (Chapter 1)
- L&I has recently added staff and consultants to assist CMs in provide more targeted services. Claims processors, in addition to other assistance, help CMs field incoming calls and quickly respond to service requests. Additional Occupational Nurse Consultants have been deployed to help CMs better address medically complex issues in the course of managing claims. (Chapter 1)
- L&I has several other initiatives in planning or early stages, such as incentives for "Top Tier" providers to demonstrate best practices in occupational medicine, qualifying providers to be in the approved Medical Provider Network, based on performance, and further enhancements to COHEs. These all have great promise for improving outcomes and should be vigorously pursued. (Chapters 1 and 2)

1.6 OPPORTUNITIES FOR IMPROVEMENT

Legislative Charge

“ . . . make recommendations regarding administrative changes that should be made to improve efficiency while maintaining high levels of quality service to help address system costs, and any needed legislative changes to implement the recommendations.”

Major Observations

The following observations are offered to address prolonged disability durations, provide for more effective measurement of performance towards desired claim outcomes, and address other areas for service and efficiency gains.

- **CM Performance and Administrative Opportunities:** The following opportunities should help address long-term claim durations:
 - **Prioritize phone contact and deliver prompt calls to workers and employers:** prompt contact with workers and employers helps build relationships, promotes better case investigation, provides insight into case risks and issues, improves stakeholder communications, and sets expectations regarding RTW; prompt contact serves as the foundation for the claim management plan; provider contacts are essential when gaps exist in treatment records and provider RTW involvement.
 - **Prioritize claim management planning:** A documented claim management plan should be promptly recorded in the claim file, typically just after completion of stakeholder contacts and claim investigation. Effective planning would include documentation of contacts, actions taken and needed, risks, options, planned interventions, and consults. Planning should be supported by system tools and alerts of claims at higher risk of poor outcomes, as well as standard actions, including vocational referrals and medical consults, to address such issues. The CM should be responsible for overall coordination of such planning, and the effectiveness of its implementation.
 - **Connect RTW training with performance management:** Recent efforts at CM training on improved stakeholder communications and effective RTW practices should be continued and expanded into an ongoing program. It is critical to incorporate outcome-oriented practices in training, e.g., role-play training on making calls and “team triage” on selected claims. Such training should be connected with performance measurement, data systems and analytics, and remediation training and coaching.
 - **Standardize claim file documentation:** Standard claim file documentation practices should be implemented across all TL claims, especially developing and documenting a claim management plan that allows quick access to information necessary to perform and monitor effective claims management activities and interventions. This would include documentation of contacts, actions taken and needed, risks, options, planned interventions and consults. There is a need for clear expectations on items to be documented and tying such documentation to performance measurement and coaching.
 - **Integrate predictive analytics into claims management processes:** Predictive analytics would apply to two areas: 1) “At-risk” claim identification (claims that are statistically at risk of

prolonged duration); and 2) statistical identification of “interventions that matter.” Such insight should be provided to CMs through system tools, such as alerts and dashboards, and be an integral part of daily CM claims management practices.

- **Clarify claim file confidentiality practices:** A lack of clarity about the confidential aspect of file documentation results in abbreviated plans and documentation that impacts CM performance and effective CM supervision. There is a need to adopt clear policies and training on how to utilize confidential areas of file, while maintaining appropriate stakeholder access to all non-confidential information.
- **Implement RTW standard practices:** Some vocational service practices need to be tailored to be more effectively utilized in appropriate claims. For example, the AWA is being used as an “adjudicative” tool, but the adjudicative approach is not an effective RTW tool. New practices and interventions need to be defined and put into use, which can become part of a standard RTW practice used to manage claims towards desired outcomes. Re-training plans are another example of vocational services that should be reserved for claims identified as appropriate for such interventions. The selection criteria for re-training plans should be more realistic about the ability to succeed in formal academic training, and alternative to formal training developed for delivery at various points in the life of a claim.
- **Improved information system:** The current set of information systems and applications are not integrated in a way that supports a streamlined flow of and access to critical claim information and need replacement with a more integrated system. CMs need outcome-based triggers, dashboards, and alerts to assist with effective claims management practices. The L&I core information system should incorporate analytical and claims management tools for CM utilization.
- **Statutory Implementation Challenges**
 - **“Employability” standard is subjective:** CMs, in conjunction with vocational providers, are required to apply a complex analysis of labor market factors, individual worker factors including medical and vocational circumstances, and RCW standards and case-law interpretation. Application of the standard is challenging and causes delays, and objective criteria would assist CMs to better identify claims for closure or additional vocational services.
- **Performance Measurement**
 - **Unit and CM level performance indicators:** Outcome-based measurements that are tied to claims unit performance evaluation are needed to support effective performance measurement, and that tie CM measurement with performance goals, e.g., RTW success rate by CM. Such measurements should be used to help identify actions, interventions that lead to better outcomes.
 - **Publish annual performance report:** Publication of an annual performance report would provide highlights and track key performance indicators, trends, and strategic initiatives. Such a report should be broadly available to stakeholders via the website.
- **Areas for Service and Efficiency Gains**

- **Adherence to expectations set by L&I regarding occupational medicine and vocational services (e.g., contacts, timeliness, plan submission):** This would lead to better customer service; improved RTW outcomes; and reduction of unnecessary CM activities.
- **Expanded ombuds services to all injured workers:** A more unified ombuds role would support improved customer service, reduce friction costs in the system, promote simpler procedures and better understanding of claims management practices, and help prevent disputes and unnecessary attorney involvement in claims. If properly structured it would provide an important feedback loop to L&I management on systemic issues and areas for improvement.
- **Relaxed L&I role in certain SI decisions:** The L&I approval role should be relaxed in certain SI decisions. This would result in efficiency gains and should be relatively easy to implement; worker protections against improper claim decisions are strong (right of appeal, SI ombuds, and audits). A statutory modification would be likely to implement such changes.
- **Increased use of FileFast:** This early reporting program has been effective at speeding claim reporting and capturing more complete claim information, which is essential to effective management. The FileFast model should be moved forward throughout all claims units and heavily promoted among stakeholders (L&I currently uses financial incentives for providers to use FileFast).
- **More protest review by Claim Consultants:** CM protest review should be reserved for claims involving missing information or straightforward error correction. For more substantive disputes in all claims, whether protested or re-assumed, the review process should provide for more senior review of claim disputes. This would improve efficiency and provide for more consistent results on review of claim decisions.
- **Shift to employer reporting:** Primary responsibility for alerting L&I to the existence of an injury should rest with employers. Provider reporting, which is current standard practice for receipt of initial reports, is effective at gaining certain aspects of a claim; but employer reporting is superior for providing earlier reports and a more complete set of information regarding the claim. With the employer's report in hand, the CM's conversation with the employer would be simplified and focused on open issues.
- **Online provider communications:** Efficiency gains would be realized by successfully promoting the use of online communication tools by medical providers. Letters are slower and require a back-and-forth exchange that causes delays in resolution of claim issues.
- **Establish standard dispute response times:** Upon receipt of protests, standard resolution response times should be communicated to stakeholders, especially the timing of the next step in the process. Establishing such expectations would result in better understanding of dispute processes and likely improve customer satisfaction with overall dispute resolution results. It would also provide an effective benchmark for measuring performance in such services.

2 METHODS USED TO GATHER DATA

Numerous methods were used to gather the information that went into the analysis for this claim management evaluation.

2.1 INTERVIEWS

WorkComp Strategies conducted interviews with the following:

- At least 40 L&I employees from multiple units (also did written interrogatories).
- At least 25 employees from State Fund and self-insured employers and their representatives.
- 7 workers representatives, including Project HELP and the Self-Insurance Ombuds.
- Self-insured system managers in Idaho, Ohio and Oregon.

2.2 FILE REVIEW

WorkComp Strategies reviewed individual claim files for timeliness of actions, signs of bias, claims management documentation, appropriate evaluation of compensability, handling of disputed claims, medical management and disability management. Files examined were for accidents in the period 2010-13. (Appendix 4)

2.3 SURVEYS

WorkComp Strategies surveyed the following (see Appendix 3 for a discussion of the survey methodology, and Appendices 6 and 7 for summaries of the worker and employer survey results):

- Employers having at least one claim with \$5,000 or more in medical cost.
- Injured workers having a claim with at least \$5,000 in medical cost.
- 14 private claim managers with an average of 33 years' experience in workers' compensation claims were conducted to determine current best claim handling practices.
- The team also reviewed results of surveys from other jurisdictions, as well as results of L&I surveys of employers and workers.

2.4 REVIEW OF L&I REPORTS, DATA, AND PROCEDURES

- Detailed claim data was obtained from systems at L&I and analyzed for numbers of timely actions during the claims process from accident years 2010 through 2013.
- Similar statistics on claims processes were also obtained from multiple US and Canadian jurisdictions for comparison purposes.
- Reviewed dozens of L&I internal procedures (e.g., governing the use of AWA and opioid management).
- Requested a wide sample of internal management reports used by L&I (current and past).
- Examined reports made by L&I management to the Workers' Compensation Advisory Committee and the Vocational Technical Services Group over 2014 and 2013.
- Reviewed all published audits and studies related to L&I claims management going back to the 1998 JLARC Performance Audit.

3 SUMMARY OF CLAIMS FLOW

Of the approximately 144,000 claims received by L&I each year, approximately 122,000 claims are accepted. Of these, about 85,000 involve State-Fund employers, and 37,000 involve Self-Insured employers. Among State-Fund claims, the Retrospective/Non-Retrospective plan claims are split roughly 44%/56%. Thus, of the 85,000 State-Fund claims, which are managed by L&I Claim Managers, thousands of lost-time claims are managed and literally hundreds of thousands of decisions are made and recorded.