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CITY OF HOUSTON
2011 WORKERS COMPENSATION AUDIT

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NARRATIVE REPORT

Introduction/Overview

ESIS ProClaim was asked by the City of Houston (City) to conduct a claims audit of their Workers Compensation claims covering claims with occurrence dates between April 1, 2010 and April 1, 2011. The City is contracted with Cambridge Integrated Services Group, Inc., a Third Party Administrator (TPA) that is responsible for the administration and management of these claims. The purpose of the review was to evaluate the performance of the TPA and, specifically, test and validate the performance on certain Performance Standards contained in the Third Party Administrator Agreement.

In order to accomplish the purpose of the review, an audit sheet was prepared and approved by the City which measured performance of the key elements of the claim process and the Performance Standards. These included:

- Claim Investigation (including intake function)
- Claim Evaluation/Reserving
- Claim Management
- Medical Management
- Legal Management
- Claim Resolution Plan
- Recovery/Contribution
- Supervision
- Documentation
- Service and Responsibilities

Included in these areas covering the key elements of the claim handling process were questions designed to measure the performance on the Performance Standards.

Methodology

We were supplied with a loss run valued at April 28, 2011 listing all claims with occurrence dates between April 1, 2010 and April 1, 2011. The total number of claims contained on the loss run was 2,164 of which 1,871 were closed and 293 were open/reopened. From that list we selected a random sample of 80 open claims and 71 closed claims for review. It should be noted that by the time we conducted the review, a number of the open claims had been closed. The ultimate mix between open and closed claims was 70 open and 81 closed. Of the total number of claims contained on the list, 822 were classified as Lost Time (LT) claims and 1,342 were classified as Medical Only

(MO) claims. We reviewed 110 LT claims (approximately 13.4% of the total number of LT claims) and 41 MO claims (about 3.1% of all MO claims on the loss run). Overall, we reviewed approximately 7% of all the claims in the annual period which we feel is a representative sample for purposes of evaluating the overall performance of the handling.

We also attempted to select a sample of files that was representative of all of the adjusters in the unit. Cambridge provides the COH with a dedicated unit that now consists of 2 supervisors and 7 adjusters. The unit is managed by Lisa Webster, an experienced workers compensation claims professional. For the first three months of the measured period, the unit consisted of two additional MO adjusters. The COH then requested that the unit be downsized and the MO claims were distributed among the remaining LT adjusters. All adjusters now handle both LT and MO claims. The breakdown of claims reviewed by adjuster was as follows:

<u>Adjuster</u>	<u>LT Claims</u>	<u>MO Claims</u>	<u>Total Claims</u>
Adams	18	9	27
Bible	4	2	6
Brown	25	2	27
Davila	1	1	2
Knight	13	11	24
Mitchell	0	1	1
Sollock	10	6	16
Starcher	27	3	30
Taylor	12	6	18
Total	110	41	151

The audit was conducted during the week of May 16, 2011. The physical files were provided at that time along with a print out copy of the adjuster claim notes and the file financials which provide a reserve and payment history for the file. Review of the file and the print out documents provided us with all of the documentation we needed to evaluate the performance on the files. An audit sheet was completed for each of the files reviewed.

Arrangements for the audit and receipt of supporting documentation were done through Luann Sonoski, Senior Account Executive for the TPA, and Lisa Webster, Claim Manager. During the audit, our point of contact was Jeff Ladwig and Leann Dargavell from the TPA's Internal Quality Team. Ms Webster and Tim Lott, claim supervisor, were also available. In addition, Lynne Polk, Head of Production for the TPA also was available during the week of the audit. Present, representing the COH during the course of the audit, was Angel Barnhart. Through Ms Barnhart, the TPA was kept advised of our findings as the audit progressed and eventually, all of the audit sheets were duplicated for the TPA to use in possible rebuttal to our findings. The rebuttals were received and

responded to during the week following the file review. We received rebuttals on 31 of the files reviewed. Some of the files had more than one finding rebutted so the actual total of rebutted findings was 44. In consideration of the rebuttals, we reviewed the audit sheets along with the file notes for the particular file. After reviewing the necessary documents, we resolved/agreed on 22 of the rebuttals and revised our findings on the audit sheet. The other 22 rebuttals were rejected based on the required action of the performance standard involved and our findings on review. The rebuttals and our responses are provided as Exhibit A to this report. A wrap up session was held at the end of the audit at which the general findings were discussed. The schedule for future dates of activity was also discussed.

Following are our findings from the audit.

Audit Results

As indicated previously, the purpose of the audit was to evaluate the TPA's overall performance and to specifically measure compliance with certain Performance Standards established in the TPA services agreement. Compliance with the Performance Standards is mandatory and if compliance is lacking there are financial risks established by the agreement. Each Performance Standard has an amount at risk associated with it and if there is a failure to comply with the Standard, the amount at risk is pro-rated according to the following sliding scale:

Amount at Risk charged to TPA:

98% Compliance:	0% of Amount at Risk
96% - 97% Compliance:	25% of Amount at Risk
94% - 95% Compliance:	50% of Amount at Risk
92% - 93% Compliance:	75% of Amount at Risk
90% - 91% Compliance:	100% of Amount at Risk

The following is a brief description of each of the Performance Standards and the Amount at Risk associated with each of the Standards. The full Performance Standard as described in the Agreement is provided in the next section when the scores are provided.

<u>Standard</u>	<u>Description</u>	<u>Amount at Risk</u>
Staffing 1	COH involvement in staffing	\$0.00
Staffing 2	Manageable work loads	\$50,000
Administration 1	Timely initiation of benefits	\$20,000
Administration 2	Contractual Reporting Required	\$10,000
Administration 3	Processing Child Support Liens	\$5,000
Administration 4	Reimbursement of Overpayments	\$0.00
Administration 5	Timely posting of Recoveries	\$10,000
Administration 6	Posting expenses to COH	\$10,000
Claims Mgmt 1	LT initial contacts	\$15,000

Claims Mgmt 2	MO initial contacts	\$10,000
Claims Mgmt 3	Prior Claims History Documentation	\$10,000
Claims Mgmt 4	Recorded Statements on LT Claims	\$15,000
Claims Mgmt 5	Injured Worker Contact on TIBS	\$15,000
Claims Mgmt 6	Adjuster Diary	\$20,000
Claims Mgmt 7	Initial Plan of Action	\$20,000
Claims Mgmt 8	Supervisor Review	\$5,000
Claims Mgmt 9	Captioned Reports \$25,000 incurred	\$5,000
Claims Mgmt 10	Direction of Private Investigators	\$5,000
Claims Mgmt 11	Law Firm assignment in 24 hrs.	\$5,000
Medical Mgmt 1	Mgmt of Case Mgrs and Voc Rehab	\$5,000
Medical Mgmt 2	Timely payment of medical bills	\$10,000
Medical Mgmt 3	Utilization of nurse case management	\$5,000

Each of these Performance Standards is now described in more detail along with the results of the file review for compliance with the particular Standard.

PERFORMANCE STANDARD: Staffing 1

Description:

The City will interview all proposed dedicated Adjusters should a change in the staff (Adjuster or Supervisor) servicing the City occur. Prior written notice to the City Claims Manager, or their designee is required, along with a two-week transition-orientation training. Candidate should have the equivalent experience as the existing staff.

Results:

There have been some staffing changes in the dedicated unit during the year of service from April 1, 2010 to April 1, 2011. According to personnel at the TPA, there were 9 people in the unit at the start of the period. At the end of June, the COH requested that the TPA reduce the size of the staff and the 2 MO adjusters were eliminated. Thereafter, the remaining adjusters received both LT and MO claim assignments. In addition, one of the other adjusters terminated and the COH took part in the hiring process of the replacement. The COH was involved in the interview process and the decision to hire the replacement.

The TPA is in compliance with this Performance Standard.

PERFORMANCE STANDARD: Staffing 2

Description:

Maintaining a manageable workload of one hundred ten (110) active Lost Time Claims. If the Adjuster's caseload exceeds one hundred twenty-five (125) active Lost Time Claims for 30 days, the TPA agrees to reduce same within thirty (30) days. If the average pending City files reaches 110, TPA will notify the City. TPA and the City will reach a mutually agreeable solution to make adjustments were needed, i.e., either an increase in headcount, or status quo. If TPA does not follow through on the mutually agreeable solution and Adjuster's caseload exceeds 125 Lost Time Claims for three (3) consecutive months, the penalty will be assessed.

Results:

The TPA provided us with a report listing end of month active claims, both LT and MO, for each adjuster for each month during the annual period being measured. We have attached that report as Exhibit B. We have summarized the information on that report into a spreadsheet showing the monthly pending for each adjuster. That spreadsheet is attached as Exhibit C. The average active LT workload per adjuster never rises above 96.9 files per adjuster. It ranges from 96.9 to 74.1 at the end of March 2011. While two adjusters show more than 125 LT claims for consecutive months, both of these adjusters were at the time overseeing inactive LT cases open for medical maintenance. This accounts for the pendings in excess of 125 cases.

Consequently, we believe the TPA is in compliance with this Standard.

PERFORMANCE STANDARD: Administration 1

Description:

Initiating weekly benefits within the statutory time constraints. A standardized process will be established for all payment calculations to ensure payments are made accurately and timely. Mandatory training will be provided to all adjusters and supervisors – City files DWC-6 notice within 3 days of lost time beginning date rule 120.3 & 129.4.

Results:

This standard refers to claims that are classified as indemnity files where actual TIB payments were made. The files considered as N/A are Medical Only files and some files classified as Lost Time but where no TIBS were actually paid. The total results were as follows:

Not Applicable	57	
Did not meet the standard	1	(1.0% of applicable files)
Successfully met standard	93	(99.0% of applicable files)

PERFORMANCE STANDARD: **Administration 2**

Description:

Complying with Contractual Report Requirements set out in Exhibit J – the reports will be delivered to the City on the 10th day of each month.

Results:

The reports are provided in Exhibit J from the contract between the Coty and TPA. The results are as follows:

The TPA provides the required reports on a monthly (or as required) basis and retains CD's containing all of the reports supplied to the City as documentation. Therefore, we feel they are in compliance with the performance standard.

PERFORMANCE STANDARD: Administration 3

Description:

The TPA shall, within one payment processing cycle, correctly process child support liens received from the City Payroll Office.

Results:

This standard applies to only those cases on which the TPA is notified by the City of a child support lien to be considered in issuing TIB payments. The results were as follows:

Not Applicable	141	
Did not meet standard	0	(0% of applicable files)
Successfully met standard	10	(100% of applicable files)

PERFORMANCE STANDARD: Administration 4

Description:

The City will be reimbursed for any overpayments or duplicate payments that cannot be recovered within 90 days.

Results:

This standard refers to those claims on which overpayment or duplicate payments are made by the TPA. In those cases, the file must reflect reimbursement to the City within 90 days. There are a large number of not applicable files in this category since an overpayment must be recognized before the standard applies. There is some question regarding the process in making recoveries and whether it is being followed by the TPA. We were supplied with an exhibit which is titled "Overpayment and Duplicate Payment Log" and is reported to contain all overpayments and duplicate payments for the April 1, 2010 to April 1, 2011 period. There are three payments noted on the spreadsheet. The two cases reviewed that apply to this standard were not listed on the spreadsheet. It appears that not all overpayments and duplicate payments are being placed on the spreadsheet and being tracked per the procedure. The results are as follows:

Not applicable	149	
Did not meet standard	2	(100% of applicable files)
Successfully met standard	0	(0% of applicable files)

PERFORMANCE STANDARD: Administration 5

Description:

Posting subrogation recoveries within the month received unless received within the last five (5) working days of the month. If received within 5 working days of month's end then recovery must be posted in the following month.

Results:

It is our understanding that the TPA does not handle any of the subrogation attempts for the City and that they refer all claims to designated counsel for determination of subrogation potential and actual pursuit of recovery. Our review in this regard was to determine if the TPA was notified of any actual recovery and, if so, did the TPA properly and timely post those recoveries to the file. The review indicated that none of the files reflect any notification of recovery and consequently, all files were not applicable.

Not applicable	151	
Did not meet standard	0	(0% of applicable files)
Successfully met standard	0	(0% of applicable files)

PERFORMANCE STANDARD: Administration 6

Description:

Properly posting Injured Workers expense activity to the City budgetary organizational structure as provided by the Director. (Properly posting GL accounting data as provided).

Results:

The TPA provides a monthly feed to the COH of all posted activity on the claims and the COH runs a query to compare the coding on the feed to their internal accounting structure. There are no significant on-going problems with the coding being done and the query usually confirms the data and allocations. There are occasions where an incorrect cost center is used but the TPA will usually contact the COH and resolve the issue prior to month end so that the month end feed is accurate. There are occasions when the information regarding the cost center is provided incorrectly by the COH due to changes that have not been made in their internal records. There appears to be no problem with this standard and we find the TPA compliant.

PERFORMANCE STANDARD: **Claims Management 1**

Description:

Completing and documenting facts pertaining to three (3) or four (4) point contacts for each Lost Time Claim. Namely, Injured Workers, the Director, medical provider, and witnesses, if applicable, within twenty-four (24) hours of receipt of the Claim by the Adjuster. (Three efforts will be made for voice to voice contact with the Injured Worker and Witnesses, if applicable. If unsuccessful after the third attempt, a contact letter will be sent.)

Results:

This standard pertains to all Lost Time Claims. The not applicable files are Medical Only. In order to be in compliance, initial contact with **all** applicable parties must be made within 24 hours of receipt of the claim by the adjuster. The results are as follows:

Not Applicable	41	
Did not meet standard	45	(41% of applicable files)
Successfully met standard	65	(59% of applicable files)

PERFORMANCE STANDARD: **Claims Management 2**

Description:

Medical Only claims shall have a 3 point contacts required with documentation in the claim notes within two business days. The employee and the supervisor shall be contacted within 24 hours of the claim and Treating Doctor within 2 days. Medical Only claims will become a Lost Time Claim when they reach the threshold of \$2,500.00. (Three efforts will be made for voice to voice three point contacts. If unsuccessful after the third attempt, a contact letter will be sent).

Results:

This standard pertains to all Medical Only Claims. The not applicable files are Lost Time Claims. In order to be in compliance, initial contact with **all** applicable parties must be made within the specified time of receipt of the claim by the adjuster. The results are as follows:

Not Applicable	112	
Did not meet standard	13	(33% of applicable files)
Successfully met standard	26	(67% of applicable files)

PERFORMANCE STANDARD: Claims Management 3

Description:

Documenting claim file notes within 3 business days of Claim receipt regarding Prior Claims History of Injured Workers from City historical claims and other sources and evidencing awareness of contribution applicability to subject claim.

Results:

The standard refers to all claim files. There were a few files not applicable due to the initial circumstances determined when the claim was assigned (i.e., there was no treatment or claim being made). The CSR runs a manual check of the TPA Claim System by name and Social Security Number to determine if there have been previous claims for the employee. An ISO Index Bureau check is also run. The results of these checks are posted in the Claim Notes and the adjuster is responsible for commenting if the previous injury and any permanent disability may have an effect on the current claim. The results are as follows:

Not applicable	2	
Did not meet standard	1	(1% of applicable files)
Successfully met standard	148	(99% of applicable files)

PERFORMANCE STANDARD: Claims Management 4

Description:

Taking recorded statements, documenting daily attempts, or reasons a recorded statement cannot be taken on all Lost Time Claims within 2 business days of receipt of the claim.

Results:

This standard refers to files classified as Lost Time Claims as defined by the Statute. To meet the standard, the recorded statement must be taken or the attempts to take the statement must be documented and explanation given as to why there is a delay or why a statement is not necessary. The results are as follows:

Not applicable	65	
Did not meet standard	27	(31% of applicable files)
Successfully met standard	59	(69% of applicable files)

PERFORMANCE STANDARD: Claims Management 5

Description:

Contacting and documenting Claim File notes regarding contact with Injured Workers (on a weekly but no less than bi-weekly basis) who are receiving Temporary Income Benefits.

Results:

This standard refers to claims classified as Lost Time Claims. There are a good number of not applicable files which are Medical Only or on which only a minimal amount of TIBS were paid. The results are as follows:

Not Applicable	71	
Did not meet standard	6	(9% of the applicable files)
Successfully met standard	74	(91% of the applicable files)

PERFORMANCE STANDARD: Claims Management 6

Description:

Every 30 days (90 days for inactive files only paying out mandatory impairment benefits or lifetime medical) the Adjusters must document under the proper code 1) Plan of Action or File Review. This should state when the file will be reviewed again. 2) Reserve Review which should address current reserves as outlined in written guidelines.

Results:

The standard relates to all files. It calls for adjusters to maintain a working diary that mandates that the adjuster be in the file every 30 days. There are some cases that may not be applicable if they were not open for 30 days. The results are as follows:

Not applicable	15	
Did not meet standard	30	(22% of the applicable files)
Successfully met standard	106	(78% of the applicable files)

PERFORMANCE STANDARD: **Claims Management 7**

Description:

All open cases will be maintained on an open diary and all diaries must be reviewed every 30 days. Unless clearly documented, no file is to go more than 30 days without being seen. Each open indemnity case must have a plan of action with a time-line, which provides adequate information to demonstrate how the adjuster intends to move the claim to closure. An initial action plan will be documented within 14 days of receipt of claim. (If for any reason a diary date is expected to exceed 30 days, the adjuster must document with supervisor acknowledgement).

Results:

The results are as follows:

Not Applicable	0	
Did not meet standard	18	(12% of the applicable files)
Successfully met standard	133	(88% of the applicable files)

PERFORMANCE STANDARD: Claims Management 8

Description:

The Supervisor must review all Lost Time Claim files after the adjuster has completed their three point contact, investigation, reserves and POA. The supervisor must document the initial review within 14 days of receipt of the claim. Subsequent supervisor reviews will be documented every 60 days until file closure.

Results:

The results are as follows:

Not Applicable	55	
Did not meet standard	65	(68% of applicable files)
Successfully met standard	31	(32% of applicable files)

PERFORMANCE STANDARD: Claims Management 9

Description:

Providing on-line captioned reports of Claim status within thirty (30) days of reserves reaching the threshold amount and periodic update memos to the claim file regarding status on Claims where the combined included loss reserve exceeds Twenty-Five Thousand Dollars (\$25,000.00) and continuous ninety (90) day memo to file notes.

Results:

The threshold is defined as an incurred of \$25,000.00 for Indemnity, Medical and Expense combined. The not applicable files are those with combined incurred of less than \$25,000. The results are as follows:

Not Applicable	128	
Did not meet standard	16	(70% of the applicable files)
Successfully met standard	7	(30% of the applicable files)

PERFORMANCE STANDARD: Claims Management 10

Description:

Documenting and directing the scope of services sought and rendered in retaining private investigating firms. Report should be documented in Claim file notes within 7 days of receipt.

Results:

This standard applies only if outside investigators are utilized. None of the files reviewed utilized independent investigators.

Not Applicable	151	
Did not meet standard	0	(0% of the applicable files)
Successfully met standard	0	(0% of the applicable files)

PERFORMANCE STANDARD: Claims Management 11

Description:

Notifying Law Firms within twenty-four (24) hours of receipt of notice of Benefit Review Conference and Benefit Contested Case Hearing.

Results:

This standard applies only when a Benefit Review Conference or Benefit Contested Hearing is noticed and the file needs to be assigned to Counsel. None of the files reviewed contained any such notices.

Not Applicable	151	
Did not meet standard	0	(0% of the applicable files)
Successfully met standard	0	(0% of the applicable files)

PERFORMANCE STANDARD: Medical Management 1

Description:

Documenting scope and management of case managers and vocational rehabilitation professionals with clear directives and time frames for goal completion.

Results:

The standard applies only when case managers or vocational rehabilitation professionals are utilized. These services all require approval by the City of Houston. The results are as follows:

Not Applicable	143	
Did not meet standard	0	(0% of the applicable files)
Successfully met standard	8	(100% of the applicable files)

PERFORMANCE STANDARD: Medical Management 2

Description:

All medical and reconsideration bills should be paid within an average of 14 days upon receipt. Hospital bills and Reconsideration bills to be paid within statutory guideline requirements.

Results:

We reviewed all of the medical payment documentation on the files reviewed. Each entry has an "Invoice Receipt Date", "Check Date", "Service Date", "Check Number", and "Payee". In order to confirm the accuracy of the "Invoice Receipt Date" (since the invoices were not included on the file) we asked IMO to provide copies of a random number of invoices associated with payments on the reviewed files. The sampling included payments from each month during the year of service being reviewed. We reviewed the invoice copies supplied by IMO. They were clearly stamped with a "CISGI" Received date and an "IMO" Received date. From our review of the random sample (about 2.5% of the number of payments) we are satisfied that the "invoice Receipt Date" on the file financial sheet is accurate. The results are as follows:

The average number of days from the receipt of the invoice by the TPA to the date the check was issued is 18.5 days. The TPA was not in compliance with this standard.

PERFORMANCE STANDARD: Medical Management 3

Description:

Properly utilizing nurse case management to facilitate obtaining light duty or return to work authorization. Measurement criteria will be determined by the City and the TPA.

Results:

Case Management used in this capacity is done on a limited basis in conjunction with discussion and approval from the City. It is generally reserved for situations when the Injured Worker cannot be ordinarily contacted and additional information is required concerning the Injured Worker's status. For example, if the Injured Worker is hospitalized due to his injuries. The results are as follows:

Not Applicable	133	
Did not meet standard	0	(0% of the applicable files)
Successfully met standard	18	(100% of the applicable files)

The following Table provides a Score Card of the measured compliance with the Performance Standards established in the service agreement. It provides the degree of compliance, the amount at risk for each standard, and the penalty.

CITY OF HOUSTON
2011 XCHANGING/CAMBRIDGE AUDIT

**PERFORMANCE STANDARDS
 SCORE CARD**

Performance Standard	Description	At Risk	Score	Penalty
Staffing 1	The City will interview all proposed dedicated Adjusters should a change in the staff (Adjuster or Supervisor) servicing the City occur. Prior written notice to the City Claims Manager, or their designee is required, along with a two-week transition-orientation training. Candidate should have the equivalent experience as the existing staff.	\$0.00	100%	\$0.00
Staffing 2	Maintaining a manageable workload of one hundred ten (110) active Lost Time Claims. If the Adjuster's caseload exceeds one hundred twenty-five (125) active Lost Time Claims for 30 days, the TPA agrees to reduce same within thirty (30) days. If the average pending City files reaches 110, TPA will notify the City. TPA and the City will reach a mutually agreeable solution to make adjustments were needed, i.e., either an increase in headcount, or status quo. If TPA does not follow through on the mutually agreeable solution and Adjuster's caseload exceeds 125 Lost Time Claims for three (3) consecutive months, the penalty will be assessed.	\$50,000	100%	\$0.00

Administration 1	Initiating weekly benefits within the statutory time constraints. A standardized process will be established for all payment calculations to ensure payments are made accurately and timely. Mandatory training will be provided to all adjusters and supervisors – City files DWC-6 notice within 3 days of lost time beginning date rule 120.3 & 129.4.	\$20,000	99%	\$0.00
Administration 2	Complying with Contractual Report Requirements set out in Exhibit J – the reports will be delivered to the City on the 10 th day of each month.	\$10,000	100%	\$0.00
Administration 3	The TPA shall, within one payment processing cycle, correctly process child support liens received from the City Payroll Office.	\$5,000	100%	\$0.00
Administration 4	The City will be reimbursed for any overpayments or duplicate payments that cannot be recovered within 90 days.	\$0.00	0%	\$0.00
Administration 5	Posting subrogation recoveries within the month received unless received within the last five (5) working days of the month. If received within 5 working days of month's end then recovery must be posted in the following month.	\$10,000	N/A	\$0.00
Administration 6	Properly posting Injured Workers expense activity to the City budgetary organizational structure as provided by the Director. (Properly posting GL accounting data as provided).	\$10,000	100%	\$0.00

Claims Mgmt 1	Completing and documenting facts pertaining to three (3) or four (4) point contacts for each Lost Time Claim. Namely, Injured Workers, the Director, medical provider, and witnesses, if applicable, within twenty-four (24) hours of receipt of the Claim by the Adjuster. (Three efforts will be made for voice to voice contact with the Injured Worker and Witnesses, if applicable. If unsuccessful after the third attempt, a contact letter will be sent.)	\$15,000	59%	\$15,000
Claims Mgmt 2	Medical Only claims shall have a 3 point contacts required with documentation in the claim notes within two business days. The employee and the supervisor shall be contacted within 24 hours of the claim and Treating Doctor within 2 days. Medical Only claims will become a Lost Time Claim when they reach the threshold of \$2,500.00. (Three efforts will be made for voice to voice three point contacts. If unsuccessful after the third attempt, a contact letter will be sent).	\$10,000	67%	\$10,000
Claims Mgmt 3	Documenting claim file notes within 3 business days of Claim receipt regarding Prior Claims History of Injured Workers from City historical claims and other sources and evidencing awareness of contribution applicability to subject claim.	\$10,000	99%	\$0.00
Claims Mgmt 4	Taking recorded statements, documenting daily attempts, or reasons a recorded statement cannot be taken on all Lost Time Claims within 2 business days of receipt of the claim.	\$15,000	69%	\$15,000

Claims Mgmt 5	Contacting and documenting Claim File notes regarding contact with Injured Workers (on a weekly but no less than bi-weekly basis) who are receiving Temporary Income Benefits.	\$15,000	93%	\$11,250
Claims Mgmt 6	Every 30 days (90 days for inactive files only paying out mandatory impairment benefits or lifetime medical) the Adjusters must document under the proper code 1) Plan of Action or File Review. This should state when the file will be reviewed again. 2) Reserve Review which should address current reserves as outlined in written guidelines.	\$20,000	78%	\$20,000
Claims Mgmt 7	All open cases will be maintained on an open diary and all diaries must be reviewed every 30 days. Unless clearly documented, no file is to go more than 30 days without being seen. Each open indemnity case must have a plan of action with a time-line, which provides adequate information to demonstrate how the adjuster intends to move the claim to closure. An initial action plan will be documented within 14 days of receipt of claim. (If for any reason a diary date is expected to exceed 30 days, the adjuster must document with supervisor acknowledgement).	\$20,000	88%	\$20,000
Claims Mgmt 8	The Supervisor must review all Lost Time Claim files after the adjuster has completed their three point contact, investigation, reserves and POA. The supervisor must document the initial review within 14 days of receipt of the claim. Subsequent supervisor reviews will be documented every 60 days until file closure.	\$5,000	32%	\$5,000

Claims Mgmt 9	Providing on-line captioned reports of Claim status within thirty (30) days of reserves reaching the threshold amount and periodic update memos to the claim file regarding status on Claims where the combined included loss reserve exceeds Twenty-Five Thousand Dollars (\$25,000.00) and continuous ninety (90) day memo to file notes.	\$5,000	30%	\$5,000
Claims Mgmt 10	Documenting and directing the scope of services sought and rendered in retaining private investigating firms. Report should be documented in Claim file notes within 7 days of receipt.	\$5,000	N/A	\$0.00
Claims Mgmt 11	Notifying Law Firms within twenty-four (24) hours of receipt of notice of Benefit Review Conference and Benefit Contested Case Hearing.	\$5,000	N/A	\$0.00
Medical Mgmt 1	Documenting scope and management of case managers and vocational rehabilitation professionals with clear directives and time frames for goal completion.	\$5,000	100%	\$0.00
Medical Mgmt 2	All medical and reconsideration bills should be paid within an average of 14 days upon receipt. Hospital bills and Reconsideration bills to be paid within statutory guideline requirements.	\$10,000	18.5 Days	\$10,000
Medical Mgmt 3	Properly utilizing nurse case management to facilitate obtaining light duty or return to work authorization. Measurement criteria will be determined by the City and the TPA	\$5,000	100%	\$0.00
Grand Total		\$250,000		\$111,250

Despite some problems with compliance with the Performance Standards, the overall handling of the files and the claim outcomes appear appropriate. The files were reviewed with an eye toward evaluating the overall handling, reserving/evaluations, outcomes, etc. We looked at the key elements of the claim handling process as described earlier. It is generally felt that compliance with these critical components will result in the highest level of service and performance, and assures optimum efficiency and control in effectively handling and resolving claims in an equitable manner. Following is our analysis of the TPA's performance in these areas.

Compensability

The foundation of any workers' compensation claim is the obligation of the employer based on the Workers' Compensation Act for the state involved. Compensability must be verified accurately and timely.

Our review of the files found prompt initial consideration of the compensability issue and where questions existed as to the scope of the activity being performed at the time of the incident, there was careful consideration of whether the matter was compensable. The files always reflected the adjuster's opinion of compensability and we found no decisions that were questionable.

Investigation

Timely investigation and development of the factual circumstances of each claim submitted is critical to effective claim management. The quality of the investigation determines the ability of the claim handler to verify compensability, evaluate the claim, and develop a reasonable resolution plan.

We saw that contact requirements were not met in all instances but sufficient information was obtained to make informed decisions on compensability and to initiate TIB payments on a timely basis. Improvement is needed in the three and four point contact performance standard and in obtaining recorded statements on Lost Time cases. Again, we saw no inappropriate decisions or outcomes.

Claim Evaluation/Reserving

It is the claim handler's responsibility to evaluate every claim file. The evaluation process begins with the receipt of the first notice of loss and continues as factors involving compensability and damages develop. The claim handler should reevaluate the claim every time the file is handled. The evaluation process includes a determination of the projected length of disability and any permanence, as well as projected future medical expenses. The evaluation is then used in establishing a reserve on the file. The evaluation is a professional judgment based on many factors including the facts of the

case, the applicable statutory and case law, the jurisdiction, the impression of the insured and other key witnesses, the involvement of third parties, and other intangibles that must be considered. This requires a complete and timely investigation.

The TPA's reserve philosophy is to reserve for the known exposure. We reviewed each file looking at reserve history and timeliness of reserve adjustments. We found the evaluations to be both appropriate and timely. We had no disagreements with any of the reserves currently posted on open files. The TPA does not use a reserve worksheet but their thought process was generally clear from the adjuster notes.

However, they did not adhere in all cases to the requirement that a captioned report be completed when the total incurred on a file reached or exceeded \$25,000. The threshold incurred signifies a case of significant value and the adjuster's documentation of the facts of the case, the injury description and treatment, and the adjuster's evaluation and analysis of the value of the case is essential for others reviewing the case that will benefit from a complete analysis by the adjuster.

Claim Management

This component measures the claim handler's management of the claims in terms of their proactive approach to controlling the various aspects of the claim that will eventually lead to more efficient and effective resolution.

The TPA did an excellent job in initiating TIB's on a timely basis and generally kept sufficient contact with the employees to ensure that they were still off work and continuing with any required treatment. This eliminates duplicate payments and overpayments. The adjusters also maintained control over the disability notices through the medical providers and by working with the COH, were able to return employees to active service appropriately.

Medical Management

The TPA generally performed well in this area. There was proactive involvement in the management of the course of treatment and prompt and beneficial use of the peer review process with positive results from the pre-certification process. There were examples of disallowed services, alternative treatment regimens, and overall reduced medical cost. When the use of nurse case management was approved, there was evidence of control and specific task assignments by the adjuster.

There is a bill review process in place through Injury Management Organization (IMO). All medical bills are reviewed for appropriateness and then sent to IMO for review and determination of reasonableness. They are then returned for payment. While the initial receipt and transfer to IMO seem to be done quickly, there is a delay in the average time taken to make actual payment. It is not clear where the delay takes place and we could not determine the problem within the scope of our review.

Legal Management

The claim handler is responsible for the management of every aspect of a claim extending to legal management if required due to contested claims or defense obligations. An initial assignment letter should be directed to assigned counsel by the claim handler in which there is authorization of specific assignments or activities consistent with the documented strategy and evaluation of the claim. This initial letter should also lay out the agreed hourly rates, reporting requirements, and various responsibilities.

The claim handler's job is to direct litigation, conduct settlement negotiations whenever possible, and control litigation expenses. Defense counsel is to provide the insured and the claim handler with a sound economic return on legal work performed. Generally, the claim handler must view their role as the owner of the claim utilizing those resources needed. The effectiveness of controlling the attorney, and thus costs, depends largely on the ability, experience, and efforts of the claim handler.

None of the files we reviewed had any litigation involvement. Further, there were no notices received for Benefit Review so we cannot comment on the timeliness of any assignments to counsel.

Claim Resolution Plan

The claim handler is responsible for the development of a claim resolution plan. This plan should be formulated as soon as the necessary compensability decision is made and the investigation and evaluation are completed. The claim resolution plan can, and should, be reviewed and revised, as claim development requires.

The COH requires that the Claim Resolution Plan, or Action Plan, be documented within 14 days of assignment of the claim to the adjuster. On indemnity claims the POA must include a time-line providing information on how the adjuster plans to move the claim toward resolution and at what points various activities are expected to take place. After the initial POA, the file must be updated every thirty days with a continuing POA, File Review, or Reserve Review coded adjuster note with the appropriate documentation called for by the particular type of review being done.

The files reflect a good effort by the adjusters to stay in the files. The files are not abandoned and there is an effort to stay on calendar but the initial POA's have not all been timely and there are some gaps in follow up review that are not explained or justified.

Nevertheless, we did not encounter any claims where the end result was unacceptable and the outcomes all seemed to be appropriate and reasonable.

Recovery/Contribution

There must be a consistent and efficient recognition of every claim that involves the possibility of recovery and/or contribution. These possibilities must be recognized, investigated and properly pursued. Sufficient facts should be established during the investigation to successfully identify, prove and pursue recovery and/or contribution. Consideration must also be given to the cost/benefit of the potential recovery/contribution.

We were advised that the TPA staff is not involved in the subrogation efforts. Rather, they refer each case to a designated law firm for recovery evaluation and pursuit, if appropriate. If assistance is required of the adjuster, the law firm will make the appropriate request. So, the adjuster should make sure that the initial investigation is thorough with respect not only to the compensable issues, but should also touch on any issues that might support recovery attempts.

If a recovery is made, the law firm will advise the adjuster accordingly and a recovery should be posted to the file in a timely fashion. None of the files reviewed had any recovery notices so we cannot comment on whether the TPA is in compliance in this area.

Supervision

A claim supervision process is necessary to provide the proper guidance needed throughout the life of the claim file, in order to efficiently channel the claim toward an effective resolution. This process allows for the ongoing periodic monitoring of cases that, by virtue of the severity, complexity, or other threshold issue, will warrant review at the supervisory, management level. Additionally, the process allows for the periodic review of the claim handler's files to assure compliance with established guidelines, procedures, roles, and obligations.

The supervision process should include a formal written authority system. The system should establish levels of reserving and settlement authorities and the authority levels should be based on the individual's position, experience, and ability. The supervisor/manager should document the granting of authority and document the file when providing supervisory input.

The COH requires that on LT Claims, the supervisor review the file within 14 days of receipt of the claim. On LT Claims, the supervisor must then review the file every 60 days until closure. It appears that the supervisory diary is not being set for 14 days as the compliance on this requirement was only on about one third of the applicable files reviewed. Follow up review by the Supervisor was timelier. Where there was supervisory input, the suggestions and remarks were appropriate and offered sound advice and direction.

We discovered no inappropriate payments made by any of the adjusters that would be considered beyond their authority. The authority system for reserving and payments is built into the system and will not allow financial transactions beyond the user's authority. The function is "kicked" to the user's supervisor for approval.

Documentation

In order to assure the proper level of supervision and accountability, which will facilitate and enhance the achievement of the optimum claim results, there must be the appropriate level of documentation. It is the responsibility of the claim handler and supervisor to document the required information. It is a record of the decision-making process for the claim handler and should allow subsequent claim personnel to understand prior activity and direction on the claim. The file notes and other documentation should provide the development of information, including prior and current activity. Every file should speak for itself and provide a clear history of the development of the claim and the claim handler's activity.

The files reviewed were well documented and the notes were easy to follow. They provided an accurate history of the file activity. The only area of poor documentation relates to the requirement to prepare an electronic captioned report on those files where the total incurred is \$25,000 or greater. The report must be prepared within 30 days of the threshold incurred being posted. These are more significant claims by virtue of the amount of money that will be spent and they are subject to additional scrutiny and review by people whose interest is triggered by the threshold level of incurred. Consequently, the captioned report which summarizes the case should be completed with a thorough discussion of the compensability, investigation, injuries, treatment, and projected disability. It serves as support for the amount of paid and reserved dollars.

Service and Responsibilities

The claim handler has the ultimate responsibility for producing a quality work product on behalf of the company, in order to ensure the achievement of results oriented objectives. The claim handler is responsible for meeting these objectives by providing service in a manner consistent with the quality and timing guidelines set forth in the claim handling procedures.

The efforts on this account include timely response to notification by the COH of obligations to include child support in TIB payments. They must be processed within one payment processing cycle. There was 100% compliance on this issue as the TPA did an excellent job in processing these liens.

The TPA must also make sure that they are filing all required statutory forms and notices to the employee and employer. We found the TPA to be compliant in this area as well.

Summary and Recommendations

ESIS ProClaim reviewed a representative sample of approximately 7% of the total number of claims with occurrence dates between the targeted period of April 1, 2010 to April 1, 2011. The 151 files reviewed included 110 Lost Time Claims and 41 Medical Only Claims. The purpose of the review was to evaluate overall performance by the TPA and to measure compliance with Performance Standards as dictated in the TPA Service Agreement.

Our review found that the files are generally well handled and the outcomes are appropriate. Initial attention to the reported claims is prompt and there is an effort being made to meet initial contact requirements, although compliance with the standard in this area needs improvement. There are times when the adjuster meets obstacles in making these contacts as some of the supervisors with the Fire and Police Departments can be difficult to get on the phone. The adjusters need to document their efforts and continue attempts at contact. We saw some files where the effort was abandoned and no contact was ever made. Investigations generally are adequate and compensability issues are resolved. The files always contain a statement as to compensability. Some improvement is needed in obtaining the recorded statements of employees on Lost Time Claims. Generally, the investigations are thorough enough and prompt enough to allow the adjuster to initiate timely TIB's, make a prompt accurate evaluation for reserving purposes, and to prepare a timely initial Plan of Action.

Reserving is accurate and timely and we had no disagreement with any of the reserves on the currently open files. While there is no reserve worksheet utilized, the adjuster's thought process in arriving at the reserve amount is clear from the file notes.

There was appropriate and successful utilization of medical management in the form of nurse case managers, pre-certification, peer review, and the adjusters' management of the course of treatment and disability. A bill review process is in place but despite prompt initial attention to the medical bills upon receipt, there is a delay occurring which caused the average paid time on medical invoices to extend beyond the 14 days required in the Performance Guaranties.

While the files are generally handled well, there needs to be further attention paid to meeting the standards prescribed in the TPA Handling Agreement. The files clearly demonstrate that these standards are not just simply being ignored. There is an effort to comply but a more focused approach is needed as once the initial contact period is past or the time is passed to obtain a recorded statement, the standard cannot be met. The work loads are manageable and the standards are attainable. Likewise, further attention needs to be paid to follow up diary by the adjuster and the supervisors' involvement in the files. The supervisor must review the file within 14 days on Lost Time Claims. When the supervisors do provide input, we found that they provide sound advice and direction.

In general, we feel that increased focus needs to be placed on compliance with several of the Performance Standards:

- Three and Four point contact on Lost Time and Medical Only Claims.
- Recorded Statements within 48 hours on Lost Time Claims
- Completion of initial POA within 14 days assignment.
- Consistent follow up diary on cases by the adjuster.
- Supervisor review on Lost Time Claims within 14 days of assignment.
- Timely completion of captioned reports on files with incurred amounts of \$25,000 or more.

In addition, we have the following recommendations:

1. Consider revising Performance Standard “Staffing 2” since adjusters are now handling both Lost Time and Medical Only Claims. The effort required to handle the MO Claims should be considered when determining a manageable work load. The TPA advises that a manageable work load of all MO Claims is between 200 and 250. Using the 200 target for MO Claims and 110 for LT Claims, the current work loads can be used to determine what per cent of a whole adjuster is required to handle each of the current pending file amounts. Based on end of March 2011 pending file counts, none of the adjusters has more work than can be handled by one person. The counts call for a range between .55 of a person and .79 of a person. For the previous month (February 2011), the range was .68 to .94. We would suggest that the combined work load not exceed 1.00 of a person.
2. The process for tracking overpayments and duplicate payments should be reviewed. The Log for tracking these payments provided during the audit did not include the two claims on which we found overpayments/duplicate payment. So not all of these payments appear to be making the list.
3. Review the medical bill payment process and determine where the delay is occurring in paying medical bills. Initial attention seems to be prompt but there should be a quicker turn-around time for payment.
4. Consider expanded use of medical case management on problematic cases such as chronic back or repeated back injuries and other chronic pain cases to provide increased focused attention on getting proper treatment and increased motivation to return to work.