

Washington Department of Labor and Industries Claims Management Performance Audit

Completed by WorkComp Strategies LLC

For the Joint Legislative Audit and Review Committee

June 2015

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Finally, it should be understood that while the aforementioned persons made many important contributions to this report, the authors exercised control over the writing of the report. Any errors that we may not have detected remain our sole responsibility.

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Gregory Krohm
Wilmette, Illinois
Matthew Bryant
Richmond, Virginia



Organization of Report

The Washington workers' compensation system and the resulting claim management by L&I is complex and involves hundreds of decisions and actions on the approximate 144,000 reported claims for medical and lost wage benefits per year. Organizing the results of the review of these decisions and actions is challenging to present in a manner that helps readers understand both the system and also the procedures and resulting outcomes for employers and their injured workers. The results of this evaluation and the data to support the findings and recommendations are contained in 6 chapters that contain both an explanation of the topics covered and the results found; and 9 appendices that add more detail for those wanting to review the data collected and analyzed.

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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.

Glossary of Abbreviations and Terms

Abbreviation	Term
AWA	Ability to Work Assessment
APF	Activity Prescription Form
AWCBC	Association of Workers' Compensation Boards of Canada
BIIA	Board of Industrial Insurance Appeals
CAC	Claim and Account Center
CM	Claim Manager
EI	Early Intervention
IME	Independent Medical Examination
KOS	Kept-on-Salary
L&I	Department of Labor and Industries
LEP	Loss of Earning Power
MMI	Maximum Medical Improvement
NASI	National Academy of Social Insurance
NCCI	National Council on Workers' Compensation Insurance
PPD	Permanent Partial Disability
ROA	Report of Accident
RTW	Return to Work
TL	Time Loss (often "TTD," short for "Temporary Total Disability" is a substitute for TL)
TPD	Total and Permanent Disability
VIP	Vocational Improvement Pilot
VRC	Vocational Rehabilitation Counselor
WCAC	Workers' Compensation Advisory Committee
WCRI	Workers' Compensation Research Council

Term	Definition
Ability to Work Assessment (AWA)	A vocational-rehabilitation service that provides L&I information to make an appropriate determination regarding workers employability or eligibility for vocational rehab services. It may also help injured workers plan for the future by identifying their return-to-work options. These assessments are done by private vocational counselors, under the direction of the CM. AWAs must be reviewed and approved by a vocational specialist on staff at L&I.
Accident Year	Method for grouping claims for analysis that all happen to have the same year of accident causing injury or disease. Useful for grouping similar types of claims for comparisons.
Account Services	A section within L&I that supports employers and confirms basic insurance policy information for those insured by the State Fund.
Accident Fund	The portion of workers' compensation premium that pays for time-loss compensation, Permanent Partial Disability (PPD) and pension benefits. Employers pay 100% of the premium for this fund.

Term	Definition
Activity Prescription Form (APF)	Form used by the treating physician to describe the limits of physical activity that should be observed by the injured worker during the healing process. An APF is required to be sent by the physician immediately after the first office visit and periodically during treatment as the patient's condition changes.
Adjudicator	Another term for a Claim Manager. Often used specifically to refer to the L&I personnel who manage claims of self-insured employers.
Appeal	An application to the BIIA for review of an L&I decision.
Association of Workers' Compensation Boards of Canada (AWCBC)	A non-profit organization founded in 1919 to facilitate the exchange of information among Canadian Workers' Compensation Boards and Commissions.
Board of Industrial Insurance Appeals (BIIA)	The Board of Industrial Insurance Appeals is a court-like agency that hears appeals of workers' compensation disputes; other appeals are also processed, such as crime-victim benefits. The BIIA handles all aspects of workers' compensation disputes, including disputes over, among other things, claims decisions, premiums, and medical fee amounts and payments.
Claim	A general term that refers to the rights and benefits owing as a result of a workers' compensation injury that is covered by Washington's workers' compensation laws.
Claim and Account Center (CAC)	Online services that are available through secure access provided to registered users by My Secure L&I. Services include: checking the status of claims; sending information to L&I, such as a secure message to a CM; checking the status of an employer account; and viewing information about retro participants. Available to L&I stakeholders including: injured workers and their authorized delegates; legal representatives; health care providers; employers; third-party administrators; retro participants; and vocational counselors.
Claim Consultant	A senior CM who works on a team dedicated to handling reviews of claims that are appealed to BIIA. This position determines if the appeal will be re-assumed after appeal and handles the disposition of the re-assumed case. Consultants also provide general information concerning workers' compensation to CM units, upon individual request.
Claim Manager (CM)	A staff member of L&I, more formally known as a "Workers' Compensation Adjudicator," or "WCA," with responsibility for managing claims for benefits under Washington's workers' compensation laws. Most often, "Claims Manager" or "CM" refers to the manager of a State-Fund claim; the L&I staff member who manages a Self-Insured claim is typically referred to as an "Adjudicator."
COHE	The Centers of Occupational Health and Education work with medical providers, employers, and injured workers in a community-based program. COHEs seek to improve injured worker outcomes and reduce disability by training providers on occupational medicine principles and coordinating RTW and other aspects of cases. There are currently 6 COHEs in Washington.
Department	Another term for L&I.

Term	Definition
Director	The head of the Washington Department of Labor and Industries. In addition to Washington's workers' compensation system, the Director is responsible for, among other things, administering the Washington Industrial Safety and Health Act (WISHA) and enforcing Washington's child labor and wage and hour laws.
Disability	As commonly used in workers' compensation, this refers to the inability to perform certain jobs, and is typically the basis for the payment of lost-time compensation benefits. The degree of the physical impairment and the disability it causes for an individual are not always closely related. For example, a small impairment (tip of finger amputated) may destroy a career for one person, while a major impairment (leg amputated) may not have any effect on the career of another person. Other laws, such as the Americans with Disabilities Act, or Social Security Disability Insurance, use other specialized meanings.
Disability Management	Used to refer to the panoply of services and interventions designed to minimize disability caused by a workers' compensation injury. Compensation systems that excel in disability management are characterized by specific practices that facilitate early, safe, and durable return-to-work outcomes for injured workers.
Early Intervention (EI)	Early intervention is a vocational service that is used to help an injured worker return to work, or continue to work for the employer of injury or their current employer. It is used when there is an immediate and specific opportunity for return to work.
Employability	The standard used to determine a worker's eligibility for certain vocational services, specifically a Retraining Plan. (See "Retraining Plan.") Also used in determining eligibility for a pension (see "Pension").
Employer Representative	A workers' compensation specialist who assists employers with their workers' compensation programs, including disability management and resolving process issues with CMs. Typically, Employer Representatives work for Retro Groups, Individual Retro Employers, or independent firms that provide services to such stakeholders.
FileFast	FileFast is an L&I system for workers and medical providers to report worker's compensation claims online 24 hours a day. The FileFast unit also accepts phoned-in accident reports. FileFast is available to workers, health-care providers, and employers through the Claim and Account Center to users that have registered accounts with My Secure L&I.
Fixed and Stable	See "Maximum Medical Improvement."
Indemnity Payments	Payments of benefits designed to compensate for the loss of earnings due to missing work caused by a workers' compensation injury or death.
Independent Medical Examination (IME)	This is an examination by a doctor selected by the CM and instructed to provide certain medical opinions regarding a particular claimant. Typical opinions involve the need for further treatment, whether MMI has been reached, or whether an impairment rating should be given. Complying with an IME is compulsory for the injured worker.

Term	Definition
Individual Retro Employer	A single employer who participates alone in the L&I Retro Program. An Individual Retro Employer will use either a skilled employee or a third party expert to monitor and intervene on its claims.
Insurance Services Division	The division within L&I responsible for administering the Washington system of workers' compensation insurance. Headed by L&I Assistant Director.
International Association of Industrial Accident Boards and Commissions (IAIABC)	A not-for-profit trade association representing government agencies charged with the administration of workers' compensation systems throughout the United States, Canada, and other nations and territories. Founded in 1914, the stated mission of the IAIABC is to advance the efficiency and effectiveness of workers' compensation systems throughout the world.
Kept-on-Salary (KOS)	Situation in which an employer voluntarily continues to pay wages and benefits after an injury even though the worker is unable to perform normal duties. This continuation of wages avoids triggering time loss benefit payments by the State Fund, which in turn saves the employer insurance premium expenses. This practice is encouraged by L&I.
L&I	The Washington Department of Labor and Industries, which is generally responsible for administering Washington's workers' compensation laws. Among other things, L&I has responsibility for processing workers' compensation claims against the State Fund; authorizing certain employers who elect to self-insure their workers' compensation losses; and monitoring and managing workers' compensation claims of employees who work for self-insured employers.
LINIIS	The core claims management information system used by L&I CMs in day-to-day activities. LINIIS is a mainframe system accessed through pre-defined prompts.
Loss of Earning Power (LEP)	Earning power is defined as the worker's ability to earn income as a result of labor. RCW 51.32.090 provides for compensation to a worker for loss of earning power when the worker's earning capacity has decreased as a result of the industrial injury or occupational disease. Refers to a partial loss; a total loss would be compensated as Time Loss.
Maximum Medical Improvement (MMI)	This is a term of art used throughout the US to describe the condition in which no further healing or recovery from an injury is likely through continued treatment. In Washington, this is referred to legally as "fixed and stable."
Medical Aid Fund	Provides for medical care and vocational rehabilitation counselor services for injured workers. Half the premiums for the Medical Aid Fund are paid by the workers and half are paid by the employers.
Medical Only Claim	A workers' compensation claim that involves only medical treatment expense, no allowed (compensable) lost time.
My Secure L&I	An online registration portal that provides stakeholders with secure access to information at L&I and allows them to take advantage of L&I's secure online services.
National Academy of Social Insurance (NASI)	A nonprofit member organization made up of specialists on social insurance. Its stated mission is to advance solutions to challenges facing the nation by increasing public understanding of how social insurance contributes to economic security.

Term	Definition
National Council on Workers' Compensation Insurance (NCCI)	An insurance funded trade organization that gathers data, analyzes trends, and prepares insurance rating rules, and files loss cost recommendations with states in which it is licensed.
Office of the Self-Insured Ombuds	A state agency function designed to assist workers of self-insured employers with workers' compensation issues. It is housed within L&I but is independent of the Insurance Services Division, which is the L&I division that is responsible for management workers' compensation claims. The Ombuds is appointed by the Governor.
Order	A writing that formalizes an L&I claim manager decision. An order carries the right to protest or appeal.
ORION	The web-based information system at L&I used by claim managers to access imaged documents and other information involved in managing claims. Some updates from the LINIIS system are automatically posted to ORION.
Pension	The term used in Washington to describe Total and Permanent Disability. Those who qualify receive a monthly payment for their lifetime, regardless of the age at injury. Survivor's benefits are possible. The benefit level is adjusted annual for cost of living increases. Eligibility is determined based upon whether the worker is employable in gainful employment.
Pension Adjudicator	A senior claim manager who serves on a team dedicated to review and management of pension claims.
Permanent Partial Disability (PPD)	This is a benefit to compensate for the permanent loss, or significant limitation, of a body part or system due to a work injury. It is usually awarded after the worker has reached fixed and stable condition and a doctor has rated the permanent impairment to the injured worker.
Project Help	Program funded by L&I to offer one-on-one assistance regarding Washington workers' compensation claims. Staff assist workers by answering questions or interpreting correspondence from L&I. Program is operating under contract with the State Labor Council.
Protest	A formal complaint to L&I regarding an L&I decision made in the course of managing a claim. The claim manager who made the decision under protest initiates and manages an internal review of the decision upon receipt of a protest.
Re-assumption	A decision by L&I to review an L&I decision following the filing of an appeal with the BIIA. After the filing of an appeal, the BIIA will offer L&I the opportunity to re-assume jurisdiction over a claim for the purposes of reviewing the decision prior to formal processing of the appeal. If re-assumed, the appeal will be dismissed, and the dispute is handled as if a protest, subsequent to which, if still un-resolved, litigants may choose to pursue appeal.
Report of Accident (ROA)	The first official report of the claim for compensation sent to L&I. Usually provided by the physician that treated the injured worker, but can also be initiated by the injured worker. The report has certain mandatory medical findings that must be supplied by the physician to determine if the claim is valid

Term	Definition
Retraining Plan	In the context of vocational and rehabilitation services, a retraining plan is done by a private counselor at the selection of the claim manager. It is supposed to involve the injured worker and consider the aptitudes, work history, and personal limitations of the client. By law the plan must be developed in 90 days, unless delays are authorized by L&I.
Retro Program	A program administered by L&I, available to Washington employers who maintain insurance policies with the State Fund. The program involves a mechanism whereby participants retain a specified targeted level of risk of workers' compensation related losses. If actual losses end up below the specified target then L&I refunds a portion of premium; if losses exceed the target, then the participant is assessed additional premium. Employers may participate as a member of a Retro Group or as an Individual Retro Employer.
Retro Group	A group of employers with certain shared characteristics that self-organizes and participates in the L&I Retro Program. Premiums are distributed among the group, as are any refunds or assessments; refunds and assessments are distributed or charged to individual group members according to the group charter agreement. A Retro Group will employ a Retro Group Manager to manage its interaction with L&I and the claims of its members. Retro Group. Members of a Retro Group elect to have group retrospective premium calculated, based on the combined premium and incurred loss data of participants. Members must comply with eligibility requirements for the group association they seek to join.
Return to Work (RTW)	The return to employment by a worker following a workers' compensation injury. Refers to either returning to the pre-injury employer or with a new employer. One of the primary goals of L&I's strategic plan is to "help injured workers heal and return to work."
State Fund	The workers' compensation insurance pool that is funded by premiums, part of which are paid by employers and part by employees, and that pays losses of claims managed by the Washington Department of Labor and Industries.
Self-Insured Employer	An employer that applies for and is authorized by L&I to pay for its workers' compensation claims directly. A self-insured employer is required to post security, at a level determined by L&I, to ensure that it is able to cover its losses. Self-insured employers often utilize third-party administrators, or TPAs, to manage claims.
Stay at Work Fund	Provides partial reimbursement for wages, training, and equipment to employers who provide light duty or transitional work for injured workers. Half the premiums for the Stay at Work Fund are paid by the workers and half are paid by the employers
Stay at Work Program	Stay at Work is a financial incentive that encourages employers to bring their injured workers quickly and safely back to light-duty or transitional work by reimbursing them for some of their costs. Eligible employers can be reimbursed for: 50% of the base wages they pay to the injured worker; and some of the cost of training, tools or clothing the worker needs to do the light-duty or transitional work.

Term	Definition
Supplemental Pension Fund	The Supplemental Pension Fund premiums cover the annual cost of living increases in pension and time-loss benefits that are paid during the rating year. The same rate is paid by all risk classifications and is also paid by self-insured employers and workers. Half the premiums are paid by the workers and half are paid by the employers.
Third-Party Administrator (TPA)	In Washington, a business organized to provide workers' compensation claims management services to self-insured employers, or in some cases to insured employers that want professional assistance to improve L&I handling of their claims.
Time Loss (TL) Claim	A claim involving an indemnity payment for lost wages during recovery from an injury or disease. It is based on a formula that considers previous earnings and some employer provided benefits, and has a cap on maximum weekly benefits. Atypically, the Washington formula also considers the number of dependents. In many jurisdictions, and in most comparative data studies, "Temporary Total Disability," abbreviated as "TTD," is used instead of "TL." These terms are generally interchangeable.
Total and Permanent Disability (TPD)	Another term for "pension."
Vocational Improvement Pilot (VIP)	A comprehensive set of reforms for vocational retraining that was first implemented in 2008 as a pilot program, and has since been made permanent. VIP set goals for improving the efficiency and effectiveness of retraining and return to work.
Vocational Rehabilitation Counselor (VRC)	A Vocational Rehabilitation Counselor is a person with training, experience, and/or certification (WAC296-19A-210) to identify return to work options. Most VRCs are privately employed. L&I contracts with VRC to perform well defined services related to work injuries and claims for benefits. VRC have reporting requirements to the CM that hired them.
Workers' Compensation Advisory Committee (WCAC)	Created by the Washington State Legislature in 1971 (RCW 51.04.110). The WCAC members advise and serve as a sounding board for the Director of L&I and the Assistant Director for Insurance Services on matters pertaining to the state's workers' compensation system. Members include representatives from business, organized labor, self-insured employers and the Board of Industrial Insurance Appeals (BIIA). The WCAC meets at least every quarter. Meeting topics include: Budget issues; Policy changes; New programs; and Insurance rates.
Workers' Compensation Research Council (WCRI)	A not-for-profit research organization providing information about public policy issues involving workers' compensation systems. Organized in late 1983, the Institute provides information obtained through studies and data collection efforts.

Introduction

1 BACKGROUND

As part of workers' compensation reform legislation passed in 2011, the Washington Legislature directed the Joint Legislative Audit and Review Committee (JLARC) to conduct a performance audit of the state's workers' compensation claims management system.

Engrossed House Bill 2123 (EHB 2123), included the following directive:

The audit shall: (a) evaluate the extent to which the Department makes fair and timely decisions, and resolves complaints and disputes in a timely, fair, and effective manner; and 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; (b) determine if current claims management organization and service delivery models are the most efficient available; 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; and 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; and (c) 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.

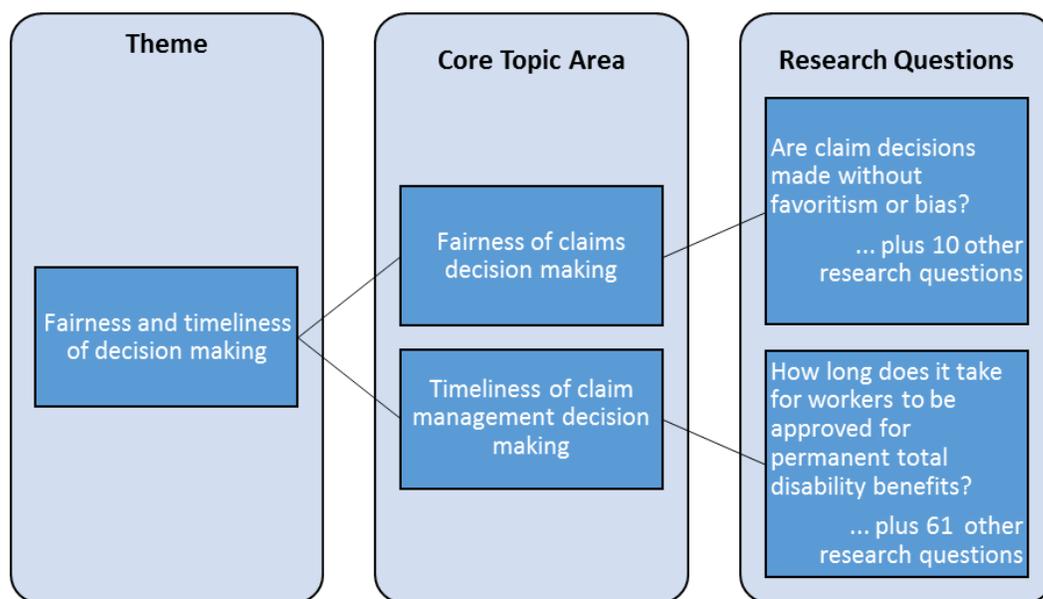
JLARC conducted an audit design, and in August 2013 issued a request for proposals to complete the audit. WorkComp Strategies LLC, a consulting firm with particular expertise evaluating workers' compensation programs, submitted a proposal and was awarded a contract to conduct the audit, and work began in November 2013. An audit team was assembled consisting of staff members from JLARC, the consultant hired by JLARC to design the audit, and the WorkComp Strategies team. The Department of Labor and Industries (L&I) provided a project manager to assist with making personnel and information available to the audit team, and numerous meetings with L&I personnel took place. Additional meetings were conducted with L&I executive staff to discuss the progress of the project.

2 AUDIT DESIGN AND SCOPE

The essential scope of the audit involved the timeliness, fairness, and efficiency of L&I's claims management function. The audit was designed to address the focus areas outlined in the 2011 legislation by answering specific questions within each of seven themes:

1. Fairness and timeliness of decision making
2. Fairness, timeliness, and effectiveness of dispute resolution
3. Timeliness, responsiveness, and accuracy of communications
4. Efficiency of claims management organization
5. Difference of organization between Retro and non-Retro employers
6. Impacts of Retro and non-Retro premium setting differences on Retro plan refunds
7. Analysis of current initiatives

These themes were divided into 15 core topic areas, which together contained 325 individual research



questions. An example of these interconnected tasks is shown in the following exhibit:

The work to address these questions involved seven research methods:

1. Stakeholder and staff interviews
2. Documentation research and review
3. Review of claim files
4. Customer opinion survey
5. Best practices survey of panel of claims management experts
6. Data analysis of L&I claims data
7. Comparative data analysis of data from other jurisdictions.

The Summary of Methodology and Appendix 3 describe these methods in additional detail. The approach included investigating not only the administrative structure, but also compiling metrics designed to address several aspects of claims management performance. A small selection of the metrics we examined: How long does it take for claims to be accepted? What portion of claims end up being denied? How long do claims stay open?

We also compared results by certain basic categories of interest, including gender, age, industry type, and employer size, as well as among three key programs involved in the Washington workers' compensation system: State Fund claims; State Fund claims where the employer was a member of the Retrospective Rating program; and claims where the employer was self-insured. We will discuss in detail how these three programs are organized for claims management purposes, and outline performance results. We examined how L&I's performance compares with the following standards: existing statutory and regulatory compliance; best practices generally utilized in workers' compensation programs; performance from other state and provincial programs; and established benchmarks for workers' compensation claims. We analyzed several recent performance improvement initiatives regarding the

Washington workers' compensation system. Finally, as a result of this analysis, the audit addresses opportunities for improvements.

3 RECENT INITIATIVES

This audit reviewed L&I claims management performance primarily between 2010 and 2013. In 2013, L&I launched a comprehensive "Claims Evolution" project designed to "improve claims and medical management operations." (Workers' Compensation Advisory Committee Presentation, April 2013). One of the primary focus areas of the effort was to collaborate across programs to promote prompt and safe return to work. L&I has undertaken several initiatives and changes in connection with this effort, including the following listed below. Additionally, in 2015 the Washington State Legislature enacted changes that are designed to improve RTW results. Note that these are not presented in any particular order; they are in various stages of development and implementation, ranging from conceptual design, to limited pilot testing, to partial implementation, to final and full implementation. Some of the initial results indicate that these efforts are promising, but we have not fully evaluated their effectiveness and performance.

- 2015 Washington State Legislature updates:
 - Additional financial incentives added to the Preferred Worker Program; this program encourages employers to hire workers with permanent disabilities, unable to return to their employer of injury. The new employers receive assistance similar to the Stay at Work program, as well as workers' compensation premium assistance and financial bonuses for keeping such workers employed
 - Making the VIP (vocational improvement pilot) changes from 2008 permanent, and making changes to the "Option 2" payment and increasing it from 6 months to 9 months and allowing additional time (up to three months) for those choosing Option 1 to revert to Option 2
- Development of the RTW program:
 - Hiring of an "RTW Partnerships Chief" to manage reform and improvement of the L&I RTW program
 - Pilot implementation of the "Early AWA" initiative, to seek to identify earlier in the claim those workers most likely in need of an AWA determination; early results have been publically discussed
 - Changes to timing in the ERTW program, where the ERTW team contacts employers in claims identified through predictive analytics as being most at risk of not returning to work
 - Development of "standard work" for AWA timing, and use of the GEMBA walk process to monitor this
 - Co-location of WorkSource specialists in some units to assist with helping workers explore available work
 - RTW ToolKit training curriculum, focusing on effective communications and strategies for encouraging early RTW; provided across claims floor, as well as ERTW and ONC staff
 - Many activities done in conjunction with the Vocational Technical Services Group, such as:
 - Process changes made to the Vocational Dispute Resolution Office program including the addition of a new evaluation form that standardized the work and allowed for quality review

- Investigating promoting retraining plans that involve work place learning
 - Re-formatting the Ability to Work Assessment progress report to include new prompts to assist CMs in managing referrals
- Medical management:
 - Additional ONCs made available to CMs; building from 10 to 20 ONCs has been going on during 2014-15
 - More standardized and issue specific timing of when ONCs would provide services on claims
 - Authority to develop list of “Top Tier” medical providers to exemplify best practices in occupational medicine and to promulgate performance metrics for this group
 - Tightened membership in the Medical Provider Network through an analysis of practice patterns so as to identify and instruct or remove poor performing providers
 - Incentives to providers to utilize FileFast
- CM support: Claims processors hired to field CM calls as needed, and attempt to resolve caller issues if appropriate
- Technology:
 - New CBOB+ report, consolidating numerous accountability reports into a smaller report; available in a web dashboard format for supervisors; this reduces the number of management reports routinely sent to claim supervisors to a more consolidated set of reports
 - Making available across the claim floor Early Claim Solution software used by the FileFast team, which allows recording and entry of additional information in investigating claims
 - Budget request (\$9.8 million in upcoming budget cycle) for replacement of core information system (LINIIS mainframe)
- Non-English language initiatives: L&I working to address appropriate operational changes regarding non-English language customers; L&I received a formal complaint from DOJ/DOL in July 2014
- Self-insurance audit reform: development of a new audit process, to include issue based audits; piloting across all SIs in 2015 for “Tier 1” on the issue of wage calculations
- Predictive analytics: Beginning use of analytics to select cases for early interventions using the in-house developed “40 day” model that predicts chances of certain claim characteristics at 40 days of LT developing into much longer term disability

Summary of Methodology

OVERVIEW

As outlined in the Introduction, the audit design involved specific questions aimed at addressing the focus areas outlined in the 2011 Washington workers' compensation reform legislation. The audit team utilized seven core research methods to address these focus areas:

1. Stakeholder and staff interviews
2. Documentation research and review
3. Review of claim files
4. Customer opinion survey
5. Best practices survey of panel of claims management experts
6. Data analysis of L&I claim data
7. Comparative data analysis of data from other jurisdictions

For the data-oriented methods (items 3, 4, 6, and 7), the general timeframe under study was 2010 – 2013. These methods are described in additional detail in Appendix 3, but we provide a brief introduction here.

1 STAKEHOLDER AND STAFF INTERVIEWS

The overall purpose of the stakeholder interviews was to gain insights about the workings of the L&I claims process. The scope of the interviews included representatives from the following groups:

- L&I personnel – management, supervisors, and front-line claim managers
- Employers and employer group managers involved in L&I's Retrospective rating program (Retro)
- L&I Retro personnel
- Non-Retro state fund employers
- Self-insured employers and TPAs
- Union representatives
- Attorneys
- Self-Insured Ombuds and Project Help management

By design, those interviewed were stakeholders who have contact with L&I through various phases and conditions of the claim process. They have much valuable information about how the process is working to advance their particular constituency's needs. Not surprisingly, the stakeholders contacted had different views of L&I because their underlying vested interests and range of experiences are different. These differing perspectives are why interviews were directed at a representative and balanced sample of experts. The team also interviewed Project Help representatives and the Self-Insurance Ombuds. Project Help is a cooperative effort between L&I and the Washington State Labor Council (AFL-CIO), designed to provide one-on-one counseling to help navigate the claims process. Project HELP provides assistance with both self-insured and state fund claims. The Self-Insurance Ombuds is a department within L&I, but managed independently from the Insurance Services Division, which is responsible for the claims management function. The Ombuds is appointed by the Governor.

2 DOCUMENTATION RESEARCH AND REVIEW

During interviews we were provided documentation and information concerning L&I performance and other relevant subjects. This was particularly true with respect to interviews of L&I personnel. The audit team also was given access to the L&I information system, which included access not only to case files, but also to reference information available to L&I personnel. Numerous written follow up questions were addressed by L&I staff, and documentation provided.

3 REVIEW OF CLAIM FILES

The audit team performed on-site review of actual claim files to analyze claim management performance and perform many of the tests required in the audit design, including testing for fairness and bias. The team utilized several approaches to reviewing files to ensure broad coverage. The audit team consisted of the two lead investigators for the project supported by two experienced claims adjusters. The audit team was trained on maneuvering through and capturing data from L&I's LINIIS and ORION information systems. LINIIS is a mainframe system that functions as the core information system used in claims management. ORION is a web-based system that displays basic claim history and actions and also stores images. There is some integration between LINIIS and ORION. L&I staff were available to answer questions as review progressed.

The review involved 500 claims, with samples from State Fund and self-insured claims. The State Fund samples included groupings of claims involving Retro and Non Retro employers. After a preliminary review of a small sample of claims, designed to validate the method and the checklist to be utilized, the team modified the checklist, and returned to L&I for additional testing in the immediate lead-up to the comprehensive file review, to finalize the checklist and prepare for training of the file-review team for maximal efficiency. The checklist that was utilized, as well as the rationale behind the sample size, is discussed in detail in Appendix 3.

It is important to note that the self-insured claim management process differs from the State Fund process in several key respects. The general difference is that third-party administrators (TPAs) are engaged by most self-insured employers to fulfill their claim management responsibilities; for State Fund claims, L&I handles this responsibility directly, within the Claims Management Section of its Insurance Services Division. For the self-insured claims, TPAs or employers themselves will apply Washington law to specific claim-related decisions, and then submit the decision for approval to the L&I Self Insurance Unit. The impact of this distinction on the file-selection and review methodology is that for self-insured claims, the audit team must rely on the documentation submitted by the TPA to analyze the rationale for the denial decision. Each TPA will use a separate information system, and utilize proprietary methods designed, for marketplace competitiveness, to ensure compliance and efficiency.

We sampled claims with total medical costs greater than \$5,000. The team determined that selecting from those files for which total medical costs exceeded \$5,000 was the best approach to including representative samples of the various required groups, as well as ensuring fair representation of other

factors, like “kept on salary,” utilization of File Fast, and complex, medical-only claims.¹ Further description of the Claim File sampling and review methodology is provided in Appendix 3.

4 CUSTOMER OPINION SURVEY

Many questions in the audit sought information on perceptions of employers and workers, which were addressed by querying the parties directly through telephone and online surveys. The complex nature of questions posed by JLARC and the desire to compare perceptions across several subgroups, particularly by insurance status (self-insured, retro, non-retro), required surveying multiple groups and attaining sufficiently large samples of completed interviews to reveal statistically valid differences, if any, between the several groups. Survey strategies and sample size decisions were designed and calculated to reliably identify differences if they are meaningful.

For the surveys, question format and wording were critical to success. To confirm the survey questions, the team utilized “focus groups” of workers and employers. For the sample used in the survey, the dates were as follows: dates of injury equally distributed among 2011, 2012, and 2013. The distribution of claims across the three injury years and the three groups of employers were carefully monitored so that the completed surveys match the targets within each subgroup. The team selected claims with total medical cost of \$5,000 or greater, for the same reasons outlined above in the description of the file-review methodology. Questions were worded, as far as practicable, to track the wording used by L&I in its prior surveys and to survey questions used in other jurisdictions to allow for comparisons.

The team surveyed injured workers and employers, using telephone and online-entry methods. Letters were mailed to the sample in advance of active outgoing calls, encouraging recipients to call or log-on and complete the survey. Letters were followed-up with post-card reminders. Callers were able to complete the survey in English or Spanish. The survey took about 15 minutes on average to complete. There were approximately 20,000 call attempts.

Exhibit M-1: Survey completion and other disposition

	Workers	Employers
Completed interviews	1,541	1,409
Refusal and mid-terminations--respondents who ended the interview before completion regardless of qualification	328	271
Respondents who do not meet the screening criteria and those respondents who would have qualified but their quota group was full	12	122
Applies to all final dispositions that do not fit any other category. For example, answering machine, wrong number, etc.	2,290	1,262
Response rate	37.2%	49.9%

Source: WorkComp Strategies

¹ “Kept on Salary” is a program that encourages employers to keep disabled employees on regular salary during periods of temporary disability, as opposed to processing a claim for temporary disability benefits. The goal of the program is to minimize financial disruption to the worker and minimize premium impacts from claims. The File Fast program is an initiative to encourage prompt, thorough reporting of workplace injuries. A “medical only” claim is one in which an injury results in medical treatment, but there is no work disability. Medical only claims are often minor in nature.

Exhibit M-2 shows the distribution of completed worker and employer responses by employer type (i.e., Retro, Non-Retro, and Self-Insured), as well as by survey instrument. The exhibit also notes that 135 of the worker responses were completed in Spanish.

Exhibit M-2: Survey completion by employer type and survey tool

	Employer Type				Survey Tool			Spanish
	State Fund: Retro	State Fund: Non-Retro	Self-Insured	Total	Phone	Online	Total	
Workers	658	454	429	1,541	1140	401	1,541	135
Employers	697	547	165	1,409	712	697	1,409	

Source: WorkComp Strategies

The completion rates met or exceeded the minimum levels that were considered necessary to establish a statistically valid sample.

5 BEST PRACTICES SURVEY

While certain practices are familiar, there is not an established set of standards for handling workers' compensation claims. To establish a benchmark for testing some of the inquiries involved in the audit, we assembled a "panel of experts" to participate in a survey, pursuant to which the participants answered general questions relating to claim management organization and performance. This panel was very helpful for informing "best practice" standards utilized for workers' compensation claims.

There were 14 respondents, all of whom had varied and lengthy careers in workers' compensation claims management; most experience was in private, non-government industry. The average professional experience for the respondents was 33 years. The survey posed 25 questions about the claim management process, including contacting parties to the claim, case workloads, investigations, allowances, denials, medical management, and vocational rehabilitation services. The survey instrument is attached to Appendix 3.

6 DATA ANALYSIS

Many of the characteristics that were analyzed in the context of claim decisions by L&I involved various aspects of timeliness. The audit design specified a number of these, which were driven by the difference between various dates available in the claim record. Where dates were in electronic files, we tested date relationships with a logic-based statistical software program. Other dates were manually collected during file reviews. The L&I database is large and complex; we were frequently assisted in better understanding the data by experts with the L&I Research and Data Services team.

6.1 LAG TIME MEASURES

For lag time measures the team looked at the distribution of lag days for each group under analysis. This included various standard measures (e.g., means, percentiles, standard deviations).

6.2 PROPORTIONS VERSUS BENCHMARKS

Some of the legal-decision questions under analysis referred to statutory measures that specified a timeliness benchmark; in such cases, the team computed the proportion of cases that met the timeliness standard and ran measures of distribution. Sometimes there was not a statutory standard, but instead the audit was designed to analyze results as compared with “best practices” or those standards that, based on the experience of the audit team, were expected. The team was flexible in utilizing those standards that are most “resonant” with stakeholders, determined through review of L&I law and policy as well as acceptable norms.

In analyzing results, the team utilized a propensity-score approach to test for differences in findings in the file review between “matched” employers (i.e., employers that are statistically comparable). The propensity scoring technique allowed for statistically robust tests of differences between the review scores between Retro/Non Retro and Self-insured/State Fund claims. The data-analytic methods are discussed in additional detail in Appendix 3.

7 COMPARATIVE DATA ANALYSIS OF DATA FROM OTHER JURISDICTIONS

For comparative analytics from other states, the team relied primarily on publicly available materials. Additionally, in terms of inter-jurisdictional experience the composition of the audit team was broad, which afforded insight into various programs across the US and Canada. The team also interviewed officials from other state workers’ compensation programs, and received program information from these and other sources. One constraint in terms of inter-jurisdictional comparisons involves the unique aspects of workers’ compensation programs in the US and Canada. Each jurisdiction has an individualized set of laws and regulations, resulting in difficulties in drawing strict comparisons. Moreover, Washington uses an exclusive state-fund model, meaning that, except for those employers who are self-insured, all workers’ compensation insurance must be purchased from the Washington State Fund. There are many procedural and legal differences that complicate particular comparisons of jurisdictions, e.g., number of permanent total disability claims or percentage of denied claims. Thus, in structuring data comparisons consideration of these differences was essential to reaching valid results. Notwithstanding these methodological challenges, we did find a large number of meaningful measures of Washington’s performance relative to other jurisdictions.

Chapter One: Claims Management Organization

INTRODUCTION

In Chapter I of the report, Claims Management Organization, Washington’s claims management organization will be analyzed and recommendations presented in three sections:

1. [Background](#) – provides an overview of Washington workers’ compensation insurance, and covers the three main insurance “types” that formed the focus of the audit.
2. [Structure of the L&I Claims Management Program](#) – examines the claims management program with an eye towards efficiency.
3. [Claims Management Differences Based on Insurance “Type”](#) – analyzes the differences between the three types of insurance.

1 BACKGROUND

1.1 WORKERS’ COMPENSATION INSURANCE

First, we will provide a general description of the system used in Washington for workers’ compensation insurance. There are essentially three “types”: Self-Insured, Insured, and then within the Insured type, Retrospective Rated.

We will start with an overview of the “Insured” type, which is the traditional form of workers’ compensation insurance and is the default requirement in Washington. Over the past 100 years, state workers’ compensation systems in the United States have tended to converge on a few design and administrative principles. They typically involve some form of “no fault” insurance purchased by employers that provides statutory benefits to workers who suffer workplace injuries.

Workers’ compensation insurance is mandatory in Washington. However, as in other states, there are some exclusions, the result of which is that approximately 2.5% of Washington workers are not covered.¹ Certain domestic employees working in private homes, persons hired for gardening or maintenance at private homes, horse-racing jockeys, newspaper carriers, children under 18 years of age working on a family farm, and barbers who lease booth space are examples of employments that are excluded. Additionally, business owners are generally excluded, but can opt to purchase coverage. Finally, employments covered by other programs, such as the Federal Employees’ Compensation Act, the Jones Act, or the Longshore and Harbor Workers Act are not required to have Washington workers’ compensation insurance.

¹ Table 3 and Table A, Workers’ Compensation: Benefits, Coverage, and Costs 2012, National Academy of Social Insurance, Aug. 2014 (available at http://www.nasi.org/sites/default/files/research/NASI_Work_Comp_Year_2014.pdf) (reporting 2.75 million Washington workers covered by workers’ compensation).

Washington's workers' compensation insurance system is administered by the Department of Labor and Industries (L&I), which manages and pays claims out of a pooled fund called the Washington State Fund (State Fund.) The State Fund is the exclusive insurance mechanism for workers' compensation in Washington. Besides Washington, in the United States this relatively unique structure is in place in Wyoming, North Dakota, and Ohio.² In other states, most workers' compensation insurance is purchased from private insurance carriers or a competitive state fund. Canadian jurisdictions utilize the exclusive insurance structure.

Washington workers' compensation premiums are paid by both employers and workers.

- Employer premiums fund the "Accident Fund," which pays non-medical claim costs, such as income-replacement benefits.
- Both employer and worker premiums fund the remaining three funds: Medical Aid, which pays for medical care; Stay-at-Work, which partially reimburses employers for wages and other expenses from bringing injured workers back to light-duty or transitional jobs; and Supplemental Pension, which provides cost-of-living increases to workers with extended disabilities.

Employers are responsible for payment to L&I of the entire premium. For the three funds where employee contributions are allowed, the rate for each fund is split 50/50 between employers and employees. In 2014, the workers' share of premium was \$343 million while employers paid \$1,514 million. Worker-funded premiums are atypical among workers' compensation systems. Employers may collect the employee share through payroll deductions, based on a rate for each risk class assigned to a business and authorized by L&I. L&I reports that some employers choose not to make payroll deductions, but fund the premium without employee contributions.

1.2 SELF-INSURANCE

Washington also provides for self-insurance, as set forth in RCW 51.14.010 and WAC 296-15-021. Approximately one-quarter of Washington employees work for approximately 360 self-insured employers.³

An employer that meets certain eligibility criteria, primarily involving financial stability and solvency, is able to apply to L&I for certification as a self-insured employer. Certified employers are required to post security to ensure that losses can be paid in case of insolvency. Typically, self-insured employers are larger employers with sophisticated business practices, such as well-developed benefits programs and multi-state operations. To qualify, employers must:

- Be in business for at least 3 years
- Possess total assets of at least \$25 million as verified by fully audited financial statements
- Submit 3 years' worth of fully audited financial statements in the name of the applicant with the application
- Meet all of the following financial standards
 - A current liquidity ratio of at least 1.3 to 1
 - Positive debt-to-net-worth ratio of not greater than 4 to 1

² This structure is often referred to as a "monopolistic" or "exclusive" state-fund program. In contrast, many states utilize a state fund to provide workers' compensation insurance, but the funds either insure select groups of employers, such as state agencies or higher-risk, difficult-to-insure employers, or they compete with private insurers and are simply another option for securing workers' compensation insurance.

³ Fiscal Year 2014. From L&I Facts and Figures, available at <http://www.lni.wa.gov/News/files/LNIFactsAndFigures.pdf>.

- Positive earnings in the current year and in 2 of the last 3 years
- Overall positive earnings for the period.

Additionally, self-insured employers must have an L&I-approved accident-prevention program. L&I can require the self-insurer to supply a surety bond of a sufficient amount to secure claims payment in the event of bankruptcy by the employer.

1.3 RETROSPECTIVE RATING PROGRAM

Three-quarters of Washington employees work for employers that purchase workers' compensation insurance from the State Fund, a significant portion of which elect to participate in L&I's Retrospective Rating Program (Retro).⁴ Retro employers are given financial incentives to reduce their workers' compensation claims and claim costs. They face the risk of paying more than standard premium if their losses are unusually high in exchange for potential premium savings if they have losses that are lower than the actuarial target for an employer of their size and risk classification. The following is an excerpt from the "Employers' Guide to Workers' Compensation Insurance in Washington State":

If you are committed to operating a safe workplace, preventing accidents and managing workers' compensation claims effectively, you may be interested in L&I's Retrospective Rating Program (Retro).

Retro is an optional financial incentive program offered by Labor & Industries to help qualifying employers reduce their workers' compensation costs. Employers can enroll on their own or in a group plan sponsored by a trade association or professional organization. Employers may receive premium refunds or they may be assessed additional premium based on their performance.

Enrollment in this program occurs four times each year. Coverage runs for one year, beginning January 1, April 1, July 1 or October 1.⁵

About one-quarter of Washington workers are employed by State Fund employers who are part of the Retro program; about one-half of Washington workers are employed by State Fund employers that are not part of the Retro program.⁶ Total premiums paid by Retro employers in 2013 was \$725 million; for non-Retro employers total premium for the same period was \$1,066 million.⁷

Premiums for any insured employer – Retro or not – are based on the risk class of the employment and on the particular experience of the insured employer. Premiums are based on actual hours worked, whereas most workers' compensation systems use payroll as the basis for insurance premiums. Rates for particular risk classes (e.g. clerical) are based on actuarial analysis of the entire risk class. Experience, on the other hand, is based on the individual losses (or not) of a particular employer. The Retro program makes the premiums paid by Retro participants in any given coverage year sensitive to the experience or losses incurred by participating employers. Within plan limits, premiums paid by Retro participants

⁴ Ibid.

⁵ See <http://www.lni.wa.gov/IPUB/101-002-000.pdf>, p. 23.

⁶ Source: L&I actuarial report, based on total reported hours, used to determine premium, and derived using full-time employment hours of 1,920 annually (reporting that among State Fund workers, which comprise 75% of the total WA workforce covered by workers' compensation, 35% are with Retro employers and 65% are with non-retro employers).

⁷ See <http://www.lni.wa.gov/ClaimsIns/Files/Retro/FinInfo/marketshare/2013RetroMarketShareAnalysis.pdf>.

(after assessments for additional premium or refunds) are tied to the actual losses in the year of coverage. By contrast, premiums paid by non-Retro employers are fixed for the coverage year, though they will be adjusted in future years based on actual loss experience. Employers are able to participate in the Retro program either individually, or as a member of a Retro group. The following table highlights the distinction between the two:

Exhibit 1-1: Group vs. Individual Retro Participation

Group vs. Individual Retro Participation		
	Group	Individual
Minimum premium amount	There is no minimum annual premium for you to enroll in Retro as part of a group.	Your standard premium (accident and medical aid fund premium) must be at least \$5,850.
Fees	You must be a member of the association that sponsors the group, which will have membership dues. Most groups also charge their members a fee in return for administering the Retro group. This may be: <ul style="list-style-type: none"> • A flat fee. • A percentage of refunds. • A percentage of premiums. • A combination of these. 	No extra fees.
Services	Many groups offer services to improve the group's Retro performance. These also often help members' experience factor and rates improve over time. Services may include accident prevention training, and direct claim management help from the association or a third-party administrator.	No extra services.
Refund potential	Groups typically have better refund potential because they have a larger premium total. Retro is "premium sensitive," meaning the larger the premium, the greater the percentage refund for a given amount of risk. A large group risking 10% might realize a 20-40% refund.	If you're a small premium payer, your potential refund is lower than large groups. For example, if you are risking 10% on your own, you might realize a 3-15% refund.
Choice	The association managing the group selects the Retro plan type, minimum and maximum loss ratios, and single loss limits. This means less control for you, but less to research and decide.	You choose the plan type, minimum and maximum loss ratios, and single loss limits.
Risk	Risk is spread within the group. If you have a bad claim year, you might still get a refund if the group has done well overall. However, if you have a good claim year, you may end up with an assessment (paying more premium) if the group didn't do well.	Your refund or assessment is based entirely on your own performance.
How to enroll	Contact an association that sponsors a group.	Contact us.

Source: L&I, <http://www.lni.wa.gov/ClaimsIns/Insurance/Reduce/Qualify/About/GroupOrIndiv.asp>. Note that as indicated in the chart, there is no minimum premium for an employer to join a Retro group, but to be enrolled as a new group, the group itself is subject to a minimum: "The standard premiums for the group members for the four quarters prior to enrollment total at least one million five hundred thousand dollars." WAC 296-17B-220(6).

2 STRUCTURE OF THE L&I CLAIMS MANAGEMENT PROGRAM

In this section, we will address the State Fund claims management structure. In the next section we will address structural differences in how claims are processed for the State Fund (Retro and non-Retro) and self-insured employers.

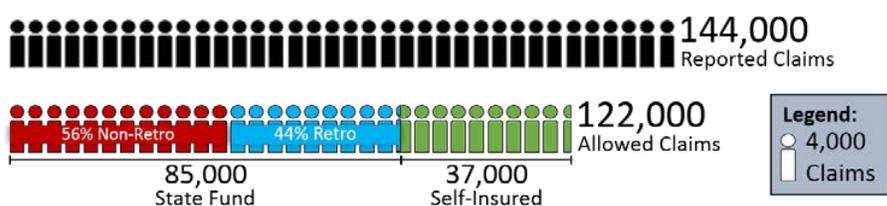
As general context, claims of workers of employers with State Fund provided insurance are managed by claims managers (CMs) at L&I. For self-insured employers, claims are handled directly by the employer or, more commonly, by private third party administrators (TPAs), with administrative oversight and some specific decisions made by a separate section called the L&I Self-insurance Division. Claims of Retro participants are handled by L&I CMs in the same manner as all State Fund claims. Adjudication of disputes (protests) brought by employers & workers, regardless of State Fund or self-insured status, are initially handled by L&I and can be appealed (directly or after protest) to the Bureau of Industrial Insurance Appeals (BIIA).

2.1 STATE FUND CLAIM MANAGEMENT

In Washington, there are roughly 144,000 reported workplace accidents each year; about 22% involve lost time, and the rest involve only medical treatment.⁸ Of all reported claims, roughly 85% are accepted, or “allowed”; thus there are approximately 122,000 accepted claims each year. The vast majority of claims (over 95%) are categorized as “injury” claims, as opposed to “illness” claims, e.g. occupational-disease claims.

Among the approximate 122,000 claims accepted annually, 85,000 involve State Fund employers, and 37,000 involve Self-Insured employers. Among State Fund allowed claims, the Retro/Non-Retro split is roughly 44%/56%. The 85,000 State Fund claims require hundreds of thousands of decisions and actions annually by the Department. The following graphic presents an approximate, conceptual representation of these volumes.

Exhibit 1-2: L&I Claim Volume by Type



Source: WorkComp Strategies

L&I has 28 units designated for managing State Fund claims. Each unit has between 9 and 14 staff members and supervisors; in 2013, units began being staffed with “claim processors,” who provide support to CMs for claim management activities. The formal CM job title is “Workers’ Compensation

⁸ These figures are general approximations, based on L&I data from 2010-2013, as of December 31, 2013. In 2010 there were 144,037 reported claims, 31,681 reported time-loss claims, 126,458 accepted claims (86,929 State Fund, 39,529 self-insured), and 121,170 accepted injury claims; statistics for other years are provided in Appendix 3 – Methodology.

Adjudicator,” or “WCA.” CMs advance from an entry level (level 1) up to level 4. There is a formal apprentice program that lasts 22 months; after completion of the program, the CM reaches “Journey” level. A level 3 CM has on average 6.5 years of service. As of October 2014, there were a total of 408 staff members in the claims section, distributed as follows:

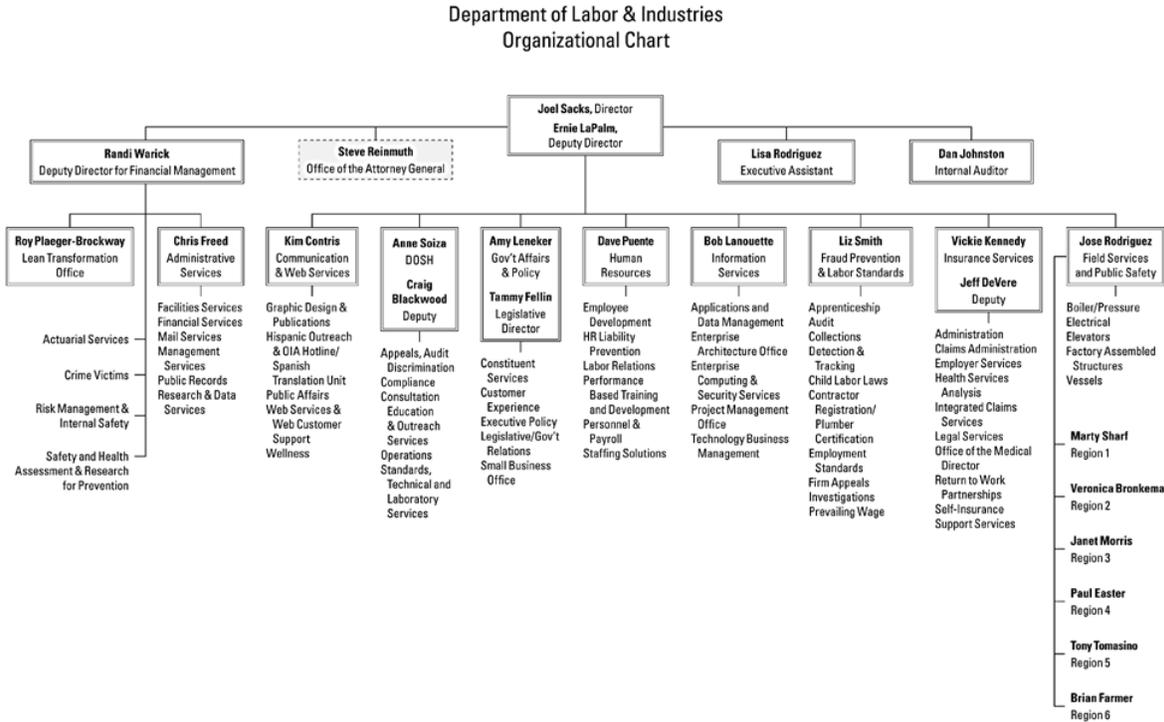
Exhibit 1-3: Claims Section Staffing

Position	Staff Members
Office Assistant 3	40
Office Assistant Lead	04
Program Coordinator	09
Data Complier	01
Claim Processors	27
WCA 1	10
WCA 2 Apprentice	33
WCA 2	90
Option 2 Specialist (WCA 2)	01
WCA 3	85
WCA 4 (includes trainers & coaches)	49
Program Support Supervisor 2	04
Industrial Insurance Supervisor	31
Management Analyst 3	02
Management Analyst 4	03
Administrative Assistant 3	08
Administrative Assistant 5	01
Senior Project Manager	01
Business Project Manager	01
Program Manager	01
Operations Manager	06
Chief of Claims	01
Total	408

Source: L&I, October 2014

Note that the regulatory scope of L&I is much broader than claims management. Exhibit 1-4 is an organizational chart shows the many functions of L&I. The claims management function is within the Insurance Services Division.

Exhibit 1-4 L&I Organizational Chart



Source: L&I Website (March 2015)

L&I utilized sequential claim assignment across the work groups for most claims for several years, but as of July 2014, has transitioned back to geographic assignment of claims. There are five “employer-based” units, which are responsible for managing claims for certain types of employers, e.g., home health care, state agencies, restaurants, retail, auto dealerships and school districts. There are two units that have a somewhat broader “industry base”: one unit handles trucking and taxi companies and one unit handles logging industry claims. Within these employer-based units there are CMs who are assigned to particular employers. There are two other specialized units: one for handling bilingual claims and the other for handling “Out of State” claims. There is also one unit specializing in claims without any lost time from work, involving only medical treatment. Another unit handles most chemical exposure and hearing loss disease claims; other occupational-disease claims, such as claims involving carpal tunnel syndrome or other repetitive activity conditions, are not handled by a separate unit, but distributed throughout the units according to the various characteristics just described.

The FileFast unit is a specialized unit created to provide for more prompt and thorough accident reporting by telephone or online and uses the Early Claims Solution (ECS) computer application. ECS is a set of screens, set up in a questionnaire format, which provides a web-based, “e form” style of data entry. L&I rolled out the ECS system to all State Fund claim units in February 2015.

Staff utilize two primary claims management software systems: LINIIS and ORION. CMs also have access to a highly detailed online reference system, containing regulations, statutes, and claim-handling reference material and guidance. The online reference system is scheduled to be upgraded.

- The LINIIS system is a mainframe system, requiring prompts to access and view information.

- The ORION web-based system provides a view of images, and also allows a view of some information contained in LINIIS. ORION also provides a task management view to users of the work that is due for all cases.

The LINIIS mainframe system is not a familiar, modern system, and the combination of the various systems creates information-system inter-connections that are not “user friendly” to beginners; once fully acquainted with the required prompts and what is available to be accessed, however, the LINIIS system is fast and responsive. The ORION system has slower processing times than LINIIS, but is easier to navigate, and being able to view images is helpful. Not all information is available without using both systems; moreover, the ECS and online reference systems mentioned above are not integrated. LINIIS and ORION have undergone many patches and fixes since they were introduced many years ago. L&I recently made a budget request of \$9.8 million to retire LINIIS.⁹

External users who have statutory authorization can access claim information using the online Claim and Account Center. The information available includes all notes input by L&I staff, including sensitive information obtained during investigation. L&I reports that the information obtained during the investigation is placed into the record once the investigation is complete and has been reviewed for release to the claim. The audit team heard that some external users were reluctant to provide information about cases that would be input into the system, because it would then be available to all users. For example, a supervisor for an employer might question whether an accident was work related, but does not want to potentially create a negative environment for the injured worker by questioning a claim. Another example is a witness may be reluctant to provide information about a claim for fear of retaliation from an employer, who would be able to view the information.

The Claim and Account Center also provides a mechanism for “secure messages,” pursuant to which a party to the claim can exchange secure, electronic messages with a claim manager. The Claim and Account Center is one of the most frequently visited web pages in the L&I web domain; in August 2014, it received almost 3 million “information requests.” The Claim and Account Center handles more than just claims; it also handles insurance account services. Employers are the highest percentage of registered users, followed by workers. As of August 2014, there were just under 160,000 registered employers, and a little over 75,000 workers. Next is “authorized delegate” at a little over 28,000; this would include employer representatives. There were just over 1,600 registered legal counsel; L&I reports that these latter registered users primarily represent workers.

In the course of file reviews the audit team observed heavy use of secure messages by employer representatives. An example would be an employer representative sending a message to a claim manager that a medical examination was just completed and the provider gave a permanency rating, and requesting that the CM review the record, issue an order of permanency benefits, and close the claim. We heard reports from some CMs that they spent a relatively large portion of their workdays responding to secure messages; in some instances this was perceived as a barrage of “too easy to send” communications that might be serving to prevent more substantive case engagement.¹⁰ We did not observe this to be a problem requiring correction, other than perhaps additional training on time

⁹ Vickie Kennedy, presentation to WA Workers’ Compensation Advisory Committee, Sept. 22, 2014.

¹⁰ Note that this is likely a symptom of the larger societal phenomenon of being “too connected” and not a shortcoming of the L&I secure message system. See generally Boussem, “Are We Too Connected to Connect,” Mar. 28, 2010, Huffington Post, at http://www.huffingtonpost.com/jasmine-boussem/are-we-too-connected-to-c_b_410959.html.

management, specifically tips on when to stop performing certain actions to respond to secure messages, and when to use a message as part of a diary entry for later review.

In the [next section](#), we will discuss structural differences between State Fund claims and claims for other insurance “types,” namely Retro and self-insured claims. As a preview, we did not observe any structural differences between Retro and non-Retro claims management. Thus, in this section, which discusses State Fund claims management organization, it would include all claims of insured employers, both Retro and non-Retro. Self-insured claims are handled quite differently, as will be discussed below.

2.2 STATE FUND CLAIMS MANAGEMENT PROCESSES

Washington’s State Fund claims management processes can be viewed as involving six primary activity groups:

1. Reporting
2. Investigation (includes claim assignment, determination, payment, caseloads, and contacts)
3. Management of Medical Treatment
4. Management of Disability (includes vocational and return-to-work services)
5. Disputes
6. Claim Closure (including permanent loss)

Our analysis will be organized around these six core claim management activities.

2.2.1 Reporting

Reporting is an essential aspect to effective and efficient claim management. Accurate and thorough reporting helps create a claim record and initiate services, including medical treatment and lost income benefit payments. Prompt reporting is essential to ensuring that services are delivered promptly.

In Washington, claims are reported primarily by medical treatment providers, which is atypical among workers’ compensation systems in other states. Most private insurance programs involved the insured – in this case, the employer – reporting a loss to its insurance carrier. The carrier then assigns an adjuster to initiate services on the claim.

From a statutory perspective, workers are required to “forthwith” report accidents to their employers, who are then required to “at once” report the accident to L&I.¹¹ In practice, however, most claims are reported to L&I by the medical treatment provider; this is by design, as claim forms and other reporting mechanisms, such as FileFast, establish and expect provider participation. A 1998 JLARC audit recognized this fact, and resulting legislation asserted that “one of the most significant causes for delayed benefit payments to workers and lack of employer involvement in claims was the manner in

¹¹ RCW 51.28.010.

which claims were reported.¹² Under this system of reporting, the worker generally reports the injury to a physician who, in turn, reports the injury to the department.”¹³

The standard process after L&I receipt of a claim is that the claim is first processed by Account Services, which checks to see if the employer is covered and verifies on the employment status, i.e. employer and employee relationship, as well as verifies the proper risk classification.

We observed performance deficits, in terms of timely decisions, that are likely connected to delayed reporting; these are examined in Chapter 2 of this report. In 2010, L&I began deploying the FileFast unit to address accident-reporting issues regarding timeliness and thoroughness. The unit handles approximately one fifth of L&I accident reports with a specialized computer application; accident reports to the unit are made via telephone or online.

2.2.2 Investigation

2.2.2.1 Initial prioritization

Once reported, accident reports are data-entered; the software system performs an automated procedure to determine if a claim is “priority” or not. In general, claims not involving more than 3 days of lost time, as indicated by a provider on an accident report, are considered “non-priority.” Otherwise, they are given higher priority and assigned and routed to a CM for immediate attention. Claims that are not priority claims also are routed for CM attention, but service level expectations are different: Time-loss (TL) claims with fewer than 3 days of lost time and those involving only medical treatment (“medical only” or MO) are scheduled for follow-up in 14 days. Some MO claims are spread throughout all claim units but most MO claims are routed to a specialized MO unit.

2.2.2.2 Claim determination

The CM investigates the validity of a claim. The essential criteria are whether there was a work incident, causing a specific, diagnosed condition that is supported by objective medical evidence. The accident report provides a series of questions that providers can complete that relay this information. Another “checkbox” on the form is whether the provider believes that the condition is “more likely than not” caused by the accident. Assuming the form is complete, the CM typically can make a prompt determination about validity. Some types of claims require more investigation; for example, some require inquiry concerning where the accident occurred, the relation between the accident and the work, and the contribution of work to a disease condition.

L&I reports that approximately 40% of claims coming into the department are processed through an auto adjudication process. These claims run through a predictive model that determines if all elements of for claim allowance have been met, the claim is not for an occupational disease, and there is no indication of time loss. If these criteria are met, the system automatically sends an allowance determination to the parties with a letter of explanation and sets the future closure date based on historical data. This process is intended to ensure quick access to treatment for the injured worker and

¹² <http://www.lni.wa.gov/ClaimsIns/Files/DataStatistics/DataAnalysis/EmployerAssistedInjuryReporting.pdf>. In response to the 1998 JLARC audit, L&I presented a December 2007 report to the Legislature about employer-assisted reporting of claims. In the report, L&I summarized results from a pilot program to encourage claim reporting by workers through their employers, with a stated goal of increasing the speed of initial payment; L&I reported that the results of the pilot did not indicate speedier payments, but also noted some limitations with the pilot that may have impacted the results. The report did not directly address the goal of increasing employer participation in the claims process.

¹³ RCW 51.28.015(1)(a).

allow claim managers to focus on more complex claims that need direct intervention. If a claim that has been allowed by the auto adjudication system ultimately needs intervention (e.g., an employer questions validity, time loss is contended, or the medical condition is more serious than originally noted), the CM can remove the future closure and manage the claim to resolution.

Employers are encouraged to complete an employers' accident report, in which they can assert their view of the accident, verify wage and benefit information, and give contact information for the claimant. Employers receive this request from the CM via mail. Despite L&I's encouragement to employers to submit employer reports, in our file review we observed many cases where an employer's accident report simply was not provided to the department. L&I reports that roughly 50% of employers now complete requested accident reports.

One aspect of initial claim analysis that is missing in Washington, and that is present in most other insurance systems, is case reserving by the adjuster, which is a practice by which the claim adjuster estimates the expected cost of the claim. In Washington, an automated system establishes initial reserves, as opposed to the CM establishing reserves. L&I reports that a separate case-reserving unit of Level 3 CMs performs reserving activities of claims that continue to be open at 8 – 9 months. It may well be that automated reserving is as accurate as "manual" reserving. Regardless, reserving in theory requires gaining enough information about a case that supports an assessment of how much potential financial loss will be involved. Again, in theory, this activity is useful in establishing a foundation for case management actions. Reserving is not a substitute for case planning; as will be discussed below, in the file review the audit team observed inadequate documented action plans, but in private insurance companies, the individual case reserve is based on the CM's action plan to resolve the claim, the expected disability and the cost of medical treatment expected for the particular injury involved.

2.2.2.3 Payment

After investigation, the CM will determine if the claim should be "allowed" or "denied" and enter an appropriate order of this decision. In almost all cases the order is accompanied by a letter; in some cases the letter explains and describes the condition that is being "allowed" or "denied." In other cases the letter simply states that the "accident of [particular date] is being allowed/denied." If denied, typically the CM will communicate the statutory exclusion being applied. (More about the effectiveness of communications is provided in Chapter 4 of this report.) In either the allowance or denial scenario, the order will outline how to "protest" or appeal the decision; more about the effectiveness of that protests is provided in Chapter 3 of this report.

A TL claim is one in which the worker is disabled by the accident and loses paid employment for more than three days after the day of injury.¹⁴ An MO claim is one involving only medical treatment, and not resulting in three days of uncompensated time away from work. Another scenario is called Kept-on-Salary (KOS), where the employer continues to pay an injured worker's salary despite absence from work. Thus a KOS claim is technically a TL claim without the payment of TL benefits. The audit team observed many cases where CMs did not document close attention to KOS claims. In such situations we did not observe overpayments, i.e., a worker being both paid salary and paid TL benefits; rather we observed failure to closely manage the KOS claim to ensure that medical care was appropriate and that functional limitations were being respected if the injured worker was performing modified duty.

¹⁴ This "waiting period" is a common feature in workers' compensation systems, and ranges among U.S. states from 3 to 7 days; in Canadian jurisdictions the range is 0 to 3 days.

In TL claims, after the initial investigation, the CM will establish a wage order, which is used to calculate the amount of benefits to be paid. Wage order calculations generally are complicated, and the Washington system is equally, if not more complex than other systems. Wage orders involve several factors, and the amount of compensation ranges from 60 – 75% of pre-injury wages. In performing these calculations, a common approach among workers' compensation systems is to use the "average weekly wage" (AWW), which is typically an average of earnings over the year preceding the accident. Washington, however, uses a monthly approach. Performing these calculations can be complex, particularly when wages vary over time. Washington has additional complexities. When wages are not "fixed by the month," the calculation involves a multiplier that is based upon the daily wage and depends upon how many days per week the worker was "normally employed." RCW 51.08.178. In Washington, wages also include employer-paid health care benefits, which is not typical. Finally, the amount of compensation depends upon the marital status and number of dependents. In summary, although wage calculations are generally complicated, the Washington approach arguably is more complicated than most other states.

2.2.2.4 Claim Manager caseloads

In analyzing CM performance it is important to understand the workloads, or caseloads, borne by L&I CMs, and how it compares to similar organizations. The audit team queried a panel of experts through a "Best Practice Survey" on industry standards for a wide range of processes and organizational conditions pertaining to workers' compensation claims handling. Workloads reported by the expert panel were an average of 105 TL claims or 203 MO claims, or for total caseloads if TL and MO claims were handled by a single adjuster, the average was 141. While maintaining continuity on a claim often requires CMs to handle both types of claims and some MO claims can require high level expertise, experts in our survey, and in the general literature, recommended that CMs specialize in particular claim types. For example, one respondent commented as follows:

"I would recommend not having an adjuster handle both lost time and routine medical only claims. There should be a dedicated medical only adjuster and a dedicated lost time adjuster. The lost time adjuster may have a small number of complex/severe medical only claims assigned to them (including claims with no compensable lost time because the employer has provided light-duty modified work) but these claims should be counted in their inventory as if it was a lost time claim."

Our review of CM workloads at L&I finds that the agency uses best practice in having CMs largely specialize by claim type. Generally three divisions are used: Level 1, which are mostly medical only, but also some relatively minor TL claim; Level 2, which are low-relatively low-complexity TL claims; and Level 3, which are higher complexity TL claims.¹⁵

Generally level 1 complexity claims are handled by level 1 CMs, level 2 complexity by level 2 CMs, and level 3 complexity by level 3 CMs. However, level 2 CMs handle wage payments for the level 1 TL claims, as well as some level 3 claims. Level 3 CMs handle most level 3 claims, but can handle some level 1 and 2 claims. Level 1 CMs handle only level 1 claims. All CMs handle protests related to the claims under their management. Generally, as noted, most TL claims are handled by Level 2 and 3 CMs and most MO claims by Level 1 CMs. There are exceptions, however, and L&I reports that 28% of the level 2 CM-

¹⁵ There are some employer-based units where individual CMs handle both TL and MO claims for their assigned employers.

assigned claims are MO claims; for level 3 CMs the figure is 15%. L&I reports that across the agency, 29% of claims are level 1, 43% are level 2, and 28% are level 3.

Most respondents in our survey of claims experts agreed, however, that as a general rule case complexity is an important criterion in setting caseload expectations; additionally, more respondents agreed that lost-time and medical-only cases were so different in character that they should be handled by different adjusters.

Measured by the caseload standards proposed by the expert panel, L&I caseloads appear to be higher than industry norms. L&I reported a two-year (April 2013 – March 2014) average total caseload for Level 2 CMs of 266; for Level 3 CMs it was 247. These averages are based on 78 Level 2 CM positions and 92 Level 3 positions. Using the reported TL/MO breakdown described above, this would result in the averages in Exhibit 1-5 below.

Exhibit 1-5 L&I CM Average Total Caseloads (2013 – 2014)

	Avg Total Caseload	TL (Complexity Level 3)	TL (Complexity Level 2)	Total TL (Complexity Levels 2 and 3)	Total MO (Complexity Level 1)
Level 2 CM	266	9	183	192	74
Level 3 CM	247	142	68	210	37

Source: L&I, from May 2015 caseload responses and Monthly Caseload Analysis report (Sept 2014); assumes complexity level 1 claims are predominantly MO claims

In reviewing L&I’s complexity guidelines, it appears that complexity level 2 is a “standard” level of complexity. Level 2 CMs have 73% of such claims and a very small number of level 3 complexity claims. Level 3 CMs have the vast bulk of level 3 complexity claims (94%), and a fair number of level 2 claims. If level 3 claims were weighted, at say 10% more complex, then applying this weighting would be the equivalent of 224 “standard” claims.¹⁶ Thus, using this analysis, standard TL caseloads for CM Levels 2 and 3 averaged between approximately 180 and 225 for 2013-14.

When evaluating the impact of caseloads on service delivery, understanding the experience of the CM, as well as the complexity of claims, is essential to proper analysis.¹⁷ Some CMs undoubtedly are more experienced than others. Moreover, not all claims are equally complex: some involve workers with several co-morbidities and limited education, skills, and experience; some involve employers with limited ability to provide light-duty work and no return-to-work program; some involve complex causation issues; some involve medical providers who are not skilled or experienced in occupational

¹⁶ Calculated as follows: 142 level 3 complexity, adding a weighting of 10%, yields 156 claims, plus 68 level 2 complexity claims, equals 224. For level 2 CMs, this weighting yields an average of 193 “standard” TL claims. Based on 78 level 2 CM positions and 92 level 3 CM positions, this yields an overall average of 210.

¹⁷ See “Study and Recommendations Relating to Workers’ Compensation Adjuster Performance Standards,” Report presented to the Vermont General Assembly (2005) (available at http://www.dfr.vermont.gov/sites/default/files/WC_report_adjusters_perfstandards.pdf) (“An adjuster’s ability to handle a certain caseload depends on a wide variety of factors relating to the individual (experience, education, training, work habits) [and] the type of claims involved (medical-only, routine indemnity, catastrophic loss) . . .”).

medicine; some involve all of these factors. Other claims are far less complex: the worker is fully engaged in recovery and return to work; the employer has a mature return-to-work program, including ample light-duty opportunities; causation is straightforward; and the medical provider is well-equipped to support sound occupational medicine practices.

As noted above, L&I grades complexity generally by MO vs. TL, with an additional grade within TL based on the type of injury. An additional method that L&I uses to understand the nature of its claims is the duration that a claim is open and active. An “active TL” means a TL claim in active pay status. When a claim has no payments for 60 days, it is categorized as “inactive.” L&I reports that some inactive TL claims can also be complex, including claims that are under protest or on appeal, under consideration for adding new conditions or for re-opening, and those where payment has been suspended for non-cooperation. L&I data shows that claims open and active for 5 years or greater make up 31% of all active TL claims. Some inactive TL claims are not acted upon for long periods, for example while an appeal is pending at the BIIA; at other times, they can have a flurry of activity, for example after the appeal concludes and additional work is required. Similarly, claims that are open for long periods are not necessarily complex, but require only routine maintenance. In understanding the time requirements per claim, it would be helpful if additional precision were available about the relative complexity of a claim.

It is also important, in gauging caseloads, to take into account the steps required of the adjudicator. We have identified several areas where the duties of a CM in Washington are relatively complex and time consuming, e.g., wage calculation and vocational service management, including application of the “employability” standard. On the other hand, we have identified areas in which the workload of the CM is relieved of some burdens confronting claim adjudicators elsewhere, including the availability of supporting staff to assist with certain activities. L&I utilizes a specialized unit called “Early Return To Work” to manage employer contacts to discuss RTW options. L&I also recently added a unit of claims processors to assist with certain claims management contacts and handle routine tasks. Appropriateness of medical treatment (utilization review) is generally outsourced. There are also aspects of claims management structure that are somewhat unique to L&I; for example, L&I CMs do not conduct initial claims reserving, do not handle litigation, and many TL cases are “auto adjudicated.” Moreover, in many insurance organizations claims adjudicators manage claims in several jurisdictions, requiring them to apply varying legal requirements. Regardless, a caseload of between 192 and 210 TL claims (Exhibit 1.5a) in need of varying levels of attention, at first blush, appears high; our best practice survey had an average TL caseload of 105, with responses of up to 150. North Dakota’s Workforce Safety and Insurance agency has in recent years maintained caseloads per adjuster in the range of 207 to 229 claims (a mix of MO and TL).¹⁸

Without additional in-depth study of the factors just discussed it is difficult to render a firm assessment as to whether current L&I caseloads are impeding the claims process. Likewise, we cannot say whether current caseloads are unreasonably higher than the total caseload figure indicated by our best practices survey and indications of typical workloads in other insurance organizations. Addressing some of the

¹⁸ The 2014 audit report of WSI by Sedgwick looked at adjuster workloads and commented: “. . . if we were to look at average caseloads around the industry, WSI would at an average of around 220 cases appear high. But in other operations, indemnity claims examiners may have caseloads around 130–150 while those servicing medical only desks could have around 300 claims.” They noted several unique aspects of the WSI system, such as all claims from particular employers being assigned to the same adjuster, the large number of out of state claims, and a number of streamlining processes. See: http://www.nd.gov/auditor/reports/wsi_pe_14.pdf.

issues discussed in this audit, however, may call for increased work from CMs, at least in the short run. This would create pressure on the existing body of CMs to keep up with the flow of new claims. However, over time, the average caseloads should decrease if addressing the issues discussed in this report and continued pursuit of initiatives already started by L&I are successful in closing claims faster.

2.2.2.5 Initial contact with parties

A critical aspect of claim investigation is direct contact with parties. As will be discussed in detail in Chapter 2, there were observed departures from what we considered standard claims practices with respect to making direct stakeholder contact. From an organizational standpoint, as observed in file reviews of claims from 2010 – 2013, there was not a sufficiently clear expectation of what contact is expected, when, and by whom. In 2014, a new procedure was implemented to have supporting staff known as “Claims Processors” follow up on any failed attempts by a CM to reach an injured worker. Two more attempts are made and if contact is made, the Claims Processor records routine information and then transfers the call to the CM.

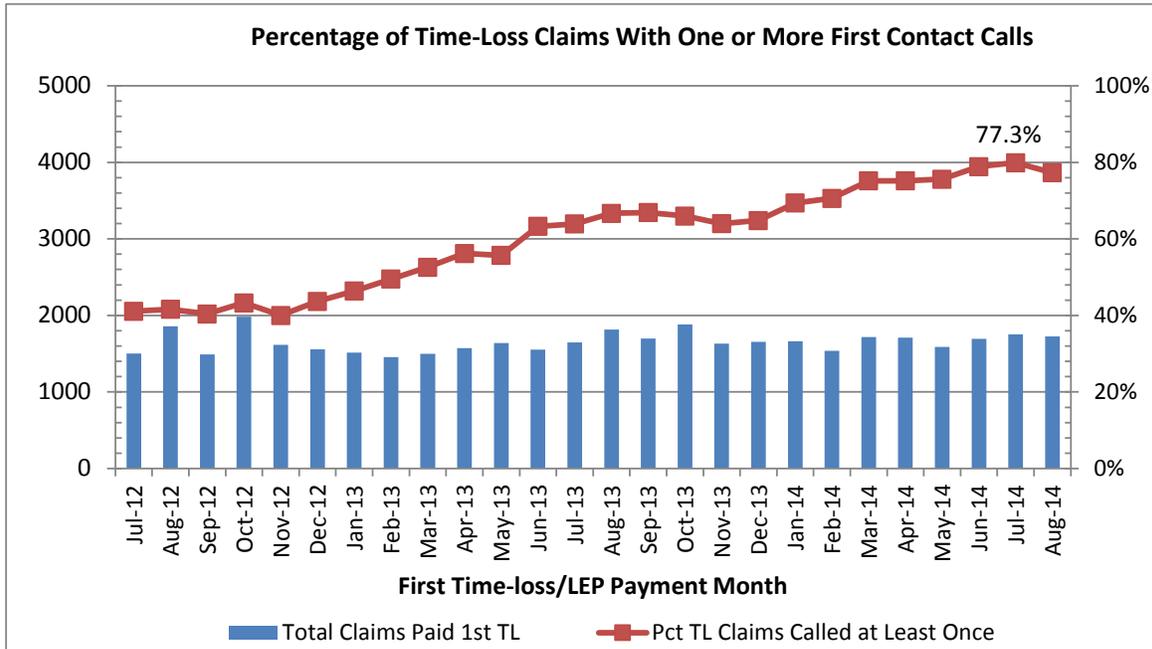
The overwhelmingly large share of contacts with parties to a claim are via letter. Some contacts are made by support staff. Many contacts are in response to incoming calls and emails. The “Early Return to Work” staff contacts employers when lost-time claims eclipse a certain number of days. This is an excellent way to begin return-to-work discussions with an employer, but it is not a substitute for a CM establishing a working relationship with an employer,¹⁹ made in connection with creating expectations in a case about desired outcomes. This is an “ownership” and accountability issue; in other words, it is unclear who ultimately “owns” a claim, in terms of being responsible for making contacts, building relationships, and planning and taking actions that are designed to lead to good outcomes.

During file reviews, the audit team observed very little documented actions that would be evidence of establishing a plan with clear, measurable goals of case activities that are designed to lead to desired outcomes. To use the example of case contact, there were virtually no observed examples of “3 point contact,” and just a few observed examples of even a single, prompt direct voice contact. This performance will be discussed in Chapter 2.

Many things have changed since the period of our file review (2011-2013), but from an organizational standpoint, it does not seem that there is a clear and enforced standard for immediate actual contact with the claimant, within a certain specified timeframe, let alone with the employer. In interviews with L&I staff and management, there is a stated goal of prompt CM contact with the worker and the employer in all TL cases; contact with the treating physician is not a priority, except in cases where contact is determined to be needed. In the best-practice survey, the number of days for “actual voice contact” with an injured worker had an average of less than one business day; for contacting the employer of injury the results were the same. CM contact with the injured worker is measured, but L&I tracks both attempts and actual voice contact in the same way, but is unable to differentiate between whether an attempt resulted in actual contact. CM supervisor interviews indicated that the quality of the contact varies widely as well. Exhibit 1-6 shows attempts at initial phone contact with injured workers; this figure does not show the timing of the attempted contacts.

¹⁹ In some cases there is a very good ongoing relationship between CMs and employers assigned to their unit. In such cases, where the employer is well acquainted with the system and the receptivity to early RTW is proven, a call may not be necessary.

Exhibit 1-6: Attempted First Contacts (2012 – 2014)



Source: L&I Research and Data Services, 2014

Challenges in making initial contacts likely result from an organizational or structural problem; in other words, it is not a performance problem per se, but a problem of rule setting, namely, L&I’s operating procedures with respect to 3-point contact is not clearly defined or enforced. It is important to note that casework is not rote and does not fit conveniently within narrow or rigid workflows; rather, contacting people, reacting to medical conditions and treatment protocols, and interjecting plans into typically complicated, personal, individual lives requires flexibility. One clear standard that is common in workers’ compensation claim handling, however, is prompt contact with injured workers, employers, and providers. This lack of contact often results in the CMs inability to timely adjudicate the claim or establish an early plan for prompt claim resolution that takes into consideration any unusual aspects of the claim.

A previous JLARC performance audit recognized the lack of immediate contact as being a departure from best practices and recommended more timely contact with workers and employers. L&I reports that they tried this but found that it was “not well-received” because many of the contacts were unnecessary. The practice was discontinued.²⁰ Surely, contact is not always necessary because most claims tend to close within a few weeks without direct personal contact. The payoff, however, is in detecting issues that might “blow up” and severely complicate the end of disability as well as add considerable, and perhaps unnecessary cost to the system. Since this is industry “best practice,” clearly private insurers’ have found a cost benefit to this practice as it helps identify problems that will affect successful return to work for those claims that will be most costly and for those workers who need assistance in reducing these barriers early in the life of a claim.

²⁰JLARC, Follow up: 1998 Workers Compensation Performance Audit, Report 03-10, September 17, 2003.

Contact is often difficult, e.g., lack of correct phone number or repeated no answers. Yet, L&I recognizes that personal contact is important and has tried various means of contacting employers and injured workers. As part of the “First 100 Days” project, which has a goal of identifying those actions within the first 100 days of the life of a claim that lead to the best outcomes, management has modified the process of contact with the injured worker to use Claims Processors to make initial contact, gather necessary facts, and pass the call on to the CM on the claim. When voice contact is actually made, CMs need to be as effective as possible in the conversation with the injured worker and gather all the information necessary to identify problems and establish a plan to mitigate or eliminate them. L&I has announced to the Workers’ Compensation Advisory Committee training in techniques to help motivate a worker, how to build a relationship with them, and how to identify case specific barriers to return to work. L&I reported that it has contracted with a disability management consultant to train evidenced based skills and strategies specific to assessing return to work (RTW) motivation and determining risks and predictive factors of prolonged duration. The training of existing staff was broken down into 8 phases and is underway, and is planned to be built into training for all newly hired staff starting August 2015. The training is designed to train staff on identified factors regarding RTW motivation and teach skills and strategies, including more effective communications, to improve outcomes.

2.2.3 Medical Treatment

Medical case management is vital to ensuring appropriate and well-timed treatment. There are standard tools available to support such activities, the primary of which are treatment guidelines. Washington was a pioneer in establishing the use of treatment guidelines in informing case management. Treatment guidelines establish what to expect in terms of overall timing and treatment practices for a particular diagnosis. Other factors, such as age and co-morbidities, provide additional helpful context.

A particularly successful program pioneered by Washington is the “Center for Occupational Health Excellence” (COHE), which has shown clear evidence of greater success in disability management than non-COHE providers. COHEs are community-based centers that undertake a more collaborative and integrated approach to occupational medicine. COHEs receive certain support from L&I and are recognized for their success. There are currently six COHEs across Washington. The State, in close cooperation with the medical community, continues to refine and strengthen ways to promote good occupational medicine.

Medical treatment is primarily managed through letter contact by the CM with treating providers and “fill-in forms” asking about treatment and disability. Consults with internal specialists are available in complex situations. For example, at present, CMs contact Occupational Nurse Consultants (ONCs) when internal guidelines so indicate or when they are perplexed by some medical situation. ONCs are not part of the claims units per se, but are assigned to particular units to provide consultative services. CMs can also request an Independent Medical Examination (IME) to obtain a second medical opinion of appropriate medical care, usual and necessary treatment, current disability status, etc. We observed that communication with IME physicians by letter is effective because these providers are well experienced in their roles and easily understand the instructions given by the CM.

In file reviews covering claims from 2011 – 2013, the audit team did not observe, at the individual CM level, efficient use of tools available to manage treatment. This is likely the result of deficient planning; for example, if a clear, documented plan with expected medical outcomes were required, this should lead to review and use of medical management tools like treatment guidelines; requesting ONC assistance for file reviews on issues of unusual or prolonged treatment or disability, and second medical opinions when needed. Often observed was the use of “Qualis,” which is the contract utilization-review

(UR) vendor. UR is a process by which certain requests for medical treatment are compared with approved treatment guidelines. Qualis makes a recommendation to the CM as to the appropriateness of requested treatment. This is an important tool to managing case costs, but it was often seen later in cases, after lengthy periods of treatment (as opposed to earlier in the cases before patterns of treatment were established) and in relatively serious interventions, like surgeries and advanced imaging.

What was not observed was routine CM utilization of medical treatment planning and advice of internal or external medical consultants. L&I reports that the Office of the Medical Director contracts with 23 specialized medical consultants. During calendar year 2014, these consultants completed approximately 860 referrals. Common reasons for a referral to a medical consultant are questions concerning causation, impairment ratings, treatment or reopening. An internal medical consultant commonly utilized is the Occupation Nurse Consultant (ONC). In recent months additional ONC efforts have been planned and initiated by L&I. Between July 2013 and May 2014, 11 new ONCs were hired. L&I reports that in 2014, ONCs completed over 40,000 requests for assistance on medical issues from about 250 claim managers in 28 claims units. L&I further reports that ONCs are charged with review of claims with 14 days of time loss, to identify expected length of claim duration, opioid use, risk factors and pre-existing conditions. The audit file review covered a sample of claims from 2011 – 2013, before some of the above measures were in place. In our file review we saw little evidence of CMs working from their documented plans to influence the providers' treatment plans or obtaining additional information as to reasons and documentation for outlier medical treatment. The causes for this gap in the documentation are clearly multifactorial, and the changes underway at L&I in this regard should improve outcomes if properly designed and implemented.

One important aspect of managing medical treatment involves limiting treatment to those conditions caused by the accident. This occurs by the use of "segregation orders," which is an order that limits treatment to a particular condition, or conversely, excludes a particular condition or treatment. File reviews indicated that segregation orders did not follow an established workflow. In other words, there were no apparent triggers in cases that resulted in a segregation order. Rather the audit team observed more reactive workflows, where treatment of a particular condition was noted in a treatment record, and then the CM would either deny treatment for the new condition or pursue additional information, and often not address the issue before claim closure.

2.2.4 Disability

Helping injured workers and employers properly manage time away from work caused by workers' compensation injuries is vital to good case outcomes. In Washington, this occurs without documented deliberate planning and coordination by the CM. In other words, the information systems do not document plans or actions, which are designed or taken to achieve prompt return to work (RTW), in a logical and coherent way. This is not to say that L&I does not have a vigorous RTW emphasis. Numerous initiatives and programs are designed to assist and provide incentives to achieve prompt RTW. For example, resources are applied to Kept-on-Salary, the Early Return to Work (ERTW) Program, the Stay at Work (SAW) program, the Preferred Worker Program, and many vocational services to assist employers in job modifications. In terms of vocational services, it appears L&I employs a lot of services, but it is less clear how the use of such services is positively affecting case outcomes.

The audit team observed, primarily in file reviews, that CMs seldom act to facilitate agreement on an early return to work strategy acceptable to the injured worker, employer, and treating physician. Nor is there much documented interchange between the CM and other L&I staff trying to promote RTW, such as the ERTW program or SAW program. We observed notes like "ERTW contacted employer/no

modified duty available,” but no documented efforts of CM interaction and engagement to pursue a different strategy to attempt to reach an agreement on return to work with the pre-injury employer.²¹ Claim managers in any state know that as the worker’s time away from work stretches out to months, resuming the relationship with the employer of injury becomes less and less likely. In Chapter 5 we will describe in detail the negative impacts both on the livelihood of injured workers and also the costs of claims caused by prolonged time away from work.

There may have been more planning than we detected, from our file reviews. Given the lack of user “friendliness” of the computerized information systems, it could be true that pro-active planning and actions were being undertaken, and not documented. Additionally, most records and notes are fully open to all parties through the Claim and Account Center, which we believe has a negative effect on documenting and measuring planning activity. Regardless, claims manager performance will be described in Chapter 2 of this report, and overall performance in Chapter 5, and there are noted deficiencies. From an organizational perspective, this appears to be the result, at least in part, of a reactive approach to disability management by the CM. Receptive employers can get abundant assistance from L&I through job analysis and assistance from the RTW and Stay at Work program. However, if the employer is skeptical or reluctant to engage in modified duty, the opportunity may be lost. Likewise, some CMs may accept without challenge overly restrictive functional limitations prescribed by the treating physician, e.g., “no work for 7 days.” The path of least resistance is to continue to pay indemnity and medical bills as long as there is paperwork to justify it.

Effective claim management involves initiating and managing a large number of integrated services, most of which are focused on effective medical treatment and early return to work. Disability Management is a concept that has gained broad acceptance in the field of workers’ compensation.²² It seeks to provide proactive and coordinated medical and vocational services directed at efficiently returning an injured worker to as close to their pre-injury condition, including employment status, as possible as quickly as possible. Washington’s Stay-at-Work program directly subsidizes workplace modifications and wages to help workers stay on the job while recovering. “Early Return to Work,” a core component of disability management, is a well-accepted public policy throughout workers’ compensation systems. Washington invests heavily in vocational and rehabilitation services, as well as specialized return-to-work experts that are meant to intervene early, although timing is not always optimal for maximizing success. Additionally, major legislative reforms were enacted in recent years, and several management initiatives are ongoing, with a targeted emphasis on improving outcomes through RTW related interventions.

In some ways, it appears that L&I fully embraces sound disability management principles, e.g., the Stay at Work Program, the Preferred Worker Program, the use of claims free discounts, and the Early Return to Work program.²³ Recent efforts by management to incorporate a “culture” of proactive, outcome-based actions designed minimize unnecessary time away from work appear to be taking hold, as demonstrated during interviews with CMs and supervisors.

²¹ L&I reports that the ERTW staff would be primarily responsible for follow-up in such situations.

²² Disability management best practices are reviewed more thoroughly in Appendix 2.

²³ We noted that Return-to-Work Services Program staff have set out very sensible process improvement studies: 1) identify the claims that most need ERTW assistance and those that need intensive services, 2) continue to develop standard vocational work parameters, 3) strengthen the partnership with claims staff, and 4) evaluate how the new COHE referral process is working.

The mantra of early RTW is clearly engrained in the culture of L&I.²⁴ But, as mentioned above and discussed in detail in Chapter 2 and in Appendix 4, certain steps in the claims process, during the time period we studied, deviated from best practices and norms for other workers' compensation systems. While L&I has constructed an efficient and well-disciplined process, there are deviations from practices that are common in other systems that seem to be contributing to very high proportions of very long-term disability; as will be discussed in detail in Chapter 5, the rate of "pensions," involving claims of "permanent and total disability," is extremely high in Washington.²⁵ L&I has recognized the importance of return to work but so far there is no evidence that the agency is reducing the number of very long-term disability cases.

As we have noted, L&I has instituted several procedural changes in the past two years that appear to be making a difference in disability duration and return to work. There have been improvements in the timing of vocational services delivery, as well as in better management of treatment involving opioids, to name two examples; we discuss performance of these and other efforts in Chapter 2. Also, in Chapter 6, Summary of Recommendations, we offer additional ways to respond to weaknesses in the claims process. Launching new initiatives is not enough. Performance matters. That is why we have recommended that L&I publish a broad set of rigorously developed performance metrics.

As just mentioned, a critical aspect of medical management involves opioid use. Opioid prescriptions for workplace injuries grew rapidly in the 1990s and early 2000s. Washington medical authorities, as well as others nationally, have taken the position that the risks of opioid use for chronic pain outweigh the benefits for the injured worker.²⁶ In file reviews (2010-2013), the audit team frequently observed prescriptions for opioids for less complex conditions like sprains and strains, as well as frequent renewals of prescriptions for extended periods without sufficient discussion of clinical evidence supporting the continued use.

Washington has been a national leader in altering the medical-management landscape regarding the use of opioids. In terms of how the claim management process is organized, there are now clear guidelines for physicians and directives to claims managers on the use of opioids for chronic pain.²⁷ A CM's role is to ensure that payment for opioids will be discontinued if all the expected clinical reports and patient agreement are not satisfactory. During the period of our file review, guidelines were less strict and there was evidence that long-term use of opioids seemed to be tolerated without any showing of clinical improvement in pain or function. We will discuss performance with respect to opioid management in more detail in Chapter 2.

²⁴ L&I presentations before the Workers' Compensation Advisory Council have frequently referenced the importance of building a culture of early return to work in the agency, among counselors, and in the employer community.

²⁵ Barth, Peter S., Heather Grob, Henry George Harder, H. Allan Hunt, and Michael Silverstein. 2008. "Washington Pension System Review." Upjohn Institute Technical Report No. 08-025. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research. http://research.upjohn.org/up_technicalreports/25 ("The number of pensions awarded per 100,000 covered employees is very high in Washington compared with other states; roughly four to eight times the 36-state average, and about two to four times as high as any other jurisdiction.")

²⁶ "In a paper published Sept. 30, 2014 by the American Academy of Neurology, the authors conclude that the risk of dependence with long-term use, combined with the poor understanding of best practices by physicians, makes the overall risk of opioid use vastly outweigh the potential benefit for many patients. The lead author on the paper was Dr. Gary Franklin, Medical Director at L&I. See: <http://www.neurology.org/content/83/14/1277>.

²⁷ Medical Treatment Guidelines: Guideline for Prescribing Opioids to Treat Pain in Injured Workers, Office of the Medical Director, July 2013.

2.2.5 Disputes

The dispute system is organized around the formal “protest” of orders. CM decisions typically take the form of an order, which contains language outlining the process to contest the order. A more generic complaint can be handled like a protest, but generally protests follow orders. The CM responsible for the case handles the protest, and after review issues a new order either affirming or modifying the original order.

In lieu of a protest, an aggrieved party (worker, employer, or provider) can appeal to the BIIA; in such cases, the BIIA offers L&I the opportunity to re-assume jurisdiction of the case, and if re-assumed, a select L&I unit of senior CMs will handle the review. After review, a new order is issued either affirmed or modifying the underlying decision. The new order can be appealed to the BIIA. We discuss performance of the dispute process in detail in Chapter 3.

2.2.6 Claim Closure

The final step in the claim management process is moving a claim to closure. The actions and steps include ending medical interventions, i.e., achieving a “fixed and stable” medical condition; processing benefits for permanent loss, if any; and making a determination about “employability.”

A clearly established goal of a worker’s compensation system is to restore as much as possible an injured workers’ work capacity: “One of the primary purposes of this title is to enable the injured worker to become employable at gainful employment. To this end, the department or self-insurers shall utilize the services of individuals and organizations . . . as may be reasonable to make the worker employable consistent with his or her physical and mental status.”²⁸ Thus, the CM is required to manage a case to closure by identifying barriers to “employability” and addressing them.

A related aspect of this set of activities is awarding one-time benefits for permanent loss. This is referred to as a “permanent partial disability (PPD) rating,” which is a percentage of loss that an injured worker retains as a result of the workplace accident. Under certain circumstances the payment may be made in a single lump sum; for larger amounts, payments are spread over time. The goal of such policies is to recognize that workers’ compensation injuries sometimes result in physical impairments that are permanent, and warrant financial compensation. Workers’ compensation systems vary in how permanent loss is handled; studies have established basic groupings of the various approaches that are

²⁸ RCW 51.32.095. The statute further describes this public policy as follows:

When in the sole discretion of the supervisor or the supervisor's designee vocational rehabilitation is both necessary and likely to make the worker employable at gainful employment, then the following order of priorities shall be used:

- (a) Return to the previous job with the same employer;
- (b) Modification of the previous job with the same employer including transitional return to work;
- (c) A new job with the same employer in keeping with any limitations or restrictions;
- (d) Modification of a new job with the same employer including transitional return to work;
- (e) Modification of the previous job with a new employer;
- (f) A new job with a new employer or self-employment based upon transferable skills;
- (g) Modification of a new job with a new employer;
- (h) A new job with a new employer or self-employment involving on-the-job training;
- (i) Short-term retraining and job placement.

RCW 51.32.095(2). Note that this statute is effective only through June 30, 2016, but was made permanent in the 2015 legislative session.

used, including in a publication by John F. Burton, Jr., which set forth six types of PPD benefits.²⁹ The approach used by Washington falls within the “impairment” approach, which was noted by Burton to appear to be the most common, and according to which PPD benefits are paid based on the extent of the impairment.³⁰ The Washington approach is to award PPD benefits, after a medical condition is fixed and stable, based on the percentage of “whole body impairment” caused by the injury (as determined by a physician).

Another related issue is “permanent and total” incapacity, meaning that the worker is not capable of any gainful employment. Known in Washington as a “pension” claim, CMs will prepare a file for review by a specialized adjudicator, to determine if the worker meets the specified standard and should be awarded a pension. As will be discussed in detail in Chapter 5, Washington has a very high rate of pension claims.³¹

A claim progresses to closure as treatment concludes. Before a claim can be closed, however, the CM must have evidence of the employment prospects of the injured worker. Obviously, employability is affirmed if the injured worker returns to work at or before the time healing is completed. But if the worker has not returned to work, or the treating physician has not given an unrestricted return to work finding, the CM seeks objective evidence on the worker’s “ability to work.” This can be a complex, costly and contentious part of the claim process. Vocational specialists assist CMs in the determination of employability; performance for these activities will be discussed in detail in Chapter 2.

- If the worker is found to be employable, they are paid permanent partial disability based on a physician’s rating of “whole body impairment” and the file closed after payments are complete.
- If, as a result of this process, the injured worker is found to be unemployable, the CM would manage development and delivery of vocational services designed to maximize work capacity and secure employment.
- If these services are not successful, and the non-employable determination is considered permanent, then the CM will prepare the claim for review by an L&I pension adjudicator, to determine whether to accept the claim as involving a pension.

Impacts, on both economic and non-economic costs, from the application of this standard, which results in a high rate of pensions, will be discussed in detail in Chapter 5.

There is a consensus of vocational experts that the optimal outcome is returning to pre-injury employment, with or without the need for job modification. The least desirable outcome is to try to retrain a worker for a new career. This is clearly recognized by the Washington State Legislature in legislation setting up the Vocational Improvement Pilot (discussed below), in which the least desirable

²⁹ Burton, John F., Jr., “Permanent Partial Disability Benefits,” published in “Workplace Injuries and Diseases: Prevention and Compensation: Essays in Honor of Terry Thomason (Upjohn 2005) (available at http://research.upjohn.org/up_bookchapters/287/).

³⁰ Other models attempt to compensate for loss of earning capacity, and others attempt to compensate for actual loss of wages. See Burton, id., p. 94.

³¹ See Barth et al., op cit. (“The number of pensions awarded per 100,000 covered employees is very high in Washington compared with other states; roughly four to eight times the 36-state average (depending on the measure), and about two to four times as high as any other jurisdiction.”)

outcome of delivering vocational services is engaging in re-training for a new job.³² This is particularly undesirable if the injured worker lacks the skills, aptitudes and motivation for formal retraining.

In managing such situations, work context is obviously vital. For example, a small employer without many staff positions likely will have far less flexibility in establishing permanent job modifications than a larger employer with a broader set of staff positions. The age, experience, education level, primary language and work history of the injured worker is also important context. Some of this context is outside the control of the CM, but this entire context is essential to the understanding of and making a determination about “employability.”

The problem with the employability standard, however, is that it creates a much more rigorous standard for claim closure than in other jurisdictions. It seems logical that when most injured workers reach maximum medical improvement (MMI), often also called “fixed and stable,” they are no longer temporarily totally disabled since additional treatment will not help them recover any more. In most states, benefits change to permanent partial disability or permanent total disability. In Washington, temporary benefits continue to be paid after maximum recovery until a determination of “employability” is made. One would assume that a rebuttable presumption should be that they are employable and permanent partial disability (PPD) should be started. After all, they were employable before the injury, and if they do not have serious impairments why wouldn’t they be employable after MMI?³³ Of course the strength of this logic is strongest with workers having a good job history and transferable skills, and weakest for workers with very limited and tenuous job histories and few if any transferable skills.

In most other jurisdictions, when an injured worker reaches MMI, temporary disability benefits stop. If the worker cannot immediately find employment, PPD benefits help supply income during the transition from MMI to full labor force participation. PPD systems vary widely across the US. The different systems are the result of individual state policy decisions to balance the equities to workers with differing personal characteristics and degrees of injury.³⁴

The Washington statute (RCW 51.32.090(3)) provides as follows: “As soon as recovery is so complete that the present earning power of the worker, at any kind of work, is restored to that existing at the time of the occurrence of the injury, the payments shall cease.” An example of how this can be interpreted is from the L&I Self-Insurance Claim Manual, which provides in relevant part as follows:

Once the payment of time-loss benefits has begun, the benefits must be continued until one of the following occurs:

- **Released for Full Duty** - When a worker is given a full release to the job of injury, time-loss benefits may be terminated. Note: If a worker is released for work on the same day they see their provider, time-loss is payable through the end of that day (i.e., worker has an appointment with their provider on January 17th, at the appointment the provider signs a release for work as

³² RCW 51.32.095(2).

³³ Admittedly, RTW after injury may be complicated by “soft” impairments not ratable by a physician, such as loss of self-confidence or muscle deconditioning. Also, the state of the economy controls employment options.

³⁴ See Welch, E., “Permanent Partial Disability Benefits” (Michigan State Univ. 2008) (available at http://hrlr.msu.edu/hr_executive_education/documents/PPD20Discussion2008-02.pdf) for a detailed analysis of PPD system types and policy implications; see also Barth and Niss, *Permanent Partial Disability Benefits: Interstate Differences*, Workers Compensation Research Institute, September 1999, page 6 (discussion of the public policy purposes of PPD which includes earnings losses, other economic losses, non-economic losses, and pain and suffering) (available for purchase at www.wcrinet.org).

of January 17th, the same day as their appointment, the worker is eligible for time-loss through the 17th).

- **Found Employable** – When a vocational assessment is conducted and a worker is determined to be employable, time-loss may be terminated after the determination of employability is made.
- **Returns to Work** – When a worker returns to work, they are not eligible for time-loss benefits. If the worker’s earning capacity has decreased as a result of the injury or occupational disease they may be entitled to loss of earning power benefits.³⁵

From file reviews and interviews with L&I staff and others on this subject, it appears that the approach to employability is as follows:

- If the doctor has not released the worker to the job of injury (based on objective medical findings) the CM must determine whether the worker can return to some type of work before beginning the process of stopping time loss and closing the claim — it can be either the job of injury or a vocational evaluation to determine whether the worker has skills from prior employment that would transfer to other types of employment and a supportive labor market.
- If the injured worker is not rehired after injury (employer of injury or other) and if they do not have an unrestricted return to work from their doctor, the CM seeks to determine if they have “transferable job skills” that would enable them to find gainful employment.
- The CM, with the assistance of vocational rehabilitation counselors, who are independent experts retained by L&I, also must establish a “labor market.” This means that considering the particular situation of the worker, including factors such as experience, background, work history, and work capacity, there are jobs in the area where the worker lives. These factors are not outlined by statute, although some have been established by administrative rule.³⁶ An L&I report, “Labor Market Surveys in a Challenging Economy,” notes that a labor market is established “if it shows enough job opportunities in the worker’s relevant labor market to enable the injured worker (IW) to become employable.”³⁷ What are “enough job opportunities?” Applying this standard involves subjective aspects. In some instances, counselors will interview the employers to inquire whether they would have hired the worker if given the chance. In one interview, the CM’s role was described as being required to establish every aspect of re-employment short of actually placing the worker in the new job.

This is different from most other states, which allow termination of temporary disability benefits once maximum medical improvement is attained, regardless of “full” employability. In such states, only if there is “zero” employability would permanent and total disability (PTD) benefits be warranted. Between “zero” and “full” it is essentially up to the injured worker to maximize job opportunities while being paid any permanent partial disability to which they may be entitled.

Most states allow vocational services to be sought by a worker, but these would be applied for and determined by various standards for eligibility. Thus, it would appear that Washington’s structure and approach to claim closure is more complex in that L&I is required to manage a case to “employability”

³⁵ L&I Self-Insurance Claims Adjudication Guidelines, “Time-Loss Compensation – January 2015,” p. 19. Loss of earning power benefits would be paid until MMI is reached and the case is closed.

³⁶ WAC 296-19A-070; labor market factors are described in WAC 296-19A-140.

³⁷ Available at <http://www.lni.wa.gov/ClaimsIns/Voc/BackToWork/LaborMarket/Default.asp>.

which generally means a full-duty medical release, a full-duty “vocational” release, meaning a vocational assessment that supports full employability, actual return to work, or a finding of no employability.

Most states award PTD for serious impairments defined by statute, regardless of residual work capacity, such as 100% loss of use of two limbs or total blindness. Washington and most other states do not require such cases to show lack of employability or deny benefits if there are future earnings of any amount. Apart from these statutory permanent total cases, states typically do not provide PTD benefits even for serious impairments if there is a significant residual work capacity or actual post-PTD earnings. For example, in Oregon, PTD is awarded when a worker proves that he or she is incapacitated “from regularly performing work at a gainful and suitable occupation.” A “gainful” occupation means one that pays the lesser of: (i) two-thirds of the worker’s average weekly earnings; or (ii) federal poverty guidelines for a family of three. Additionally, the worker is required to show that he or she has made reasonable efforts to obtain employment. Benefits cease if there is return to work and the post-injury earnings plus the permanent and total benefit exceeds a worker’s pre-injury wage.³⁸ As outlined above, Washington’s “employability” standard is relatively less clear than the Oregon standard, regarding both what level of incapacity qualifies a worker for PTD and also what amount of post-PTD earnings disqualify a worker from benefits, and appears to be more complicated to put into practice by L&I CMs.

Other states face some of the same difficulties as Washington in determining the gainful employment potential of a worker. But these states may have fewer problems in resolving the ambiguity of gainful employment potential because the parties often reach agreement to settle the claim with a lump-sum benefit. This particular issue was examined in the Upjohn Institute study of pensions in Washington.³⁹

Retraining injured workers has been an important feature of Washington’s system since at least the 1970s. But retraining seemed to have chronic problems. The greatest problem was the failure of many plans to be completed as written; for various reasons the worker abandons the plan. Other problems included: inefficiency in the plan development, over reliance on formal training versus on the job training, and poor RTW. In response to these problems, the Washington legislature initiated a multifaceted reform package called the Vocational Improvement Pilot (VIP),⁴⁰ implemented January 2008. Among its many features, VIP allows an individual eligible for retraining to take a lump sum equivalent to 6 months of time-loss benefits in exchange for closing their claim. This election to opt-out of retraining is called “Option 2.” Option 2 has been popular.

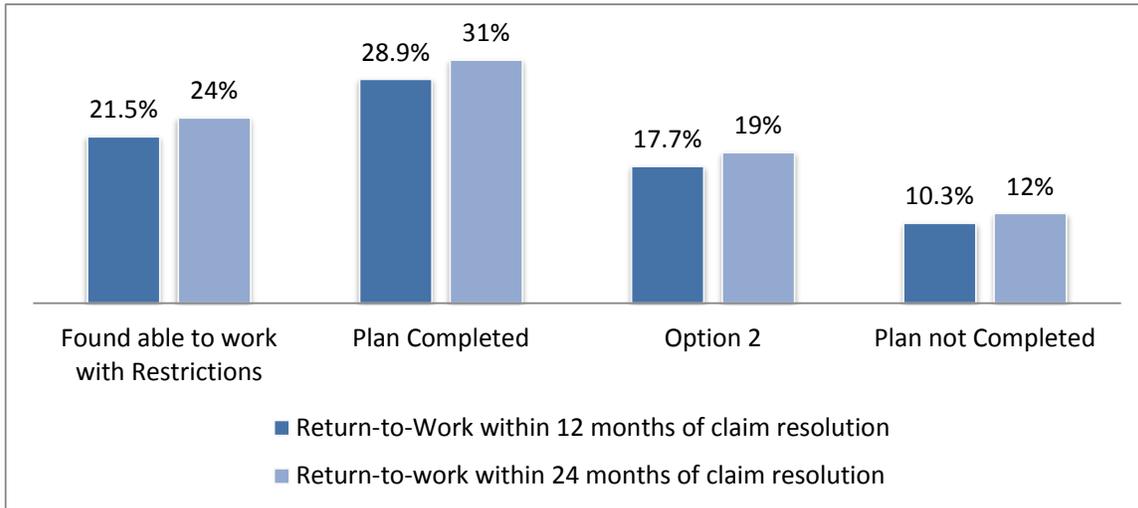
Exhibit 1-7 shows the RTW outcomes computed by L&I for four classes of workers: 1) those choosing Option 1 and completing training, 2) those choosing Option 1 and failing to complete training, 3) those choosing Option 2; and 4) for comparison, those found ineligible for retraining because they could return to work. The best RTW outcome shown is those completing their retraining, who had a 31% RTW rate two years after plan completion. Those failing to complete their plans had the lowest RTW rates. Rates of RTW for those electing Option 2 is midway between the rates of RTW for workers that have failed retraining plans and those who complete retraining.

³⁸ Oregon Revised Statutes 656.206.

³⁹ Barth, Peter S., Heather Grob, Henry George Harder, H. Allan Hunt, and Michael Silverstein. 2008. "Washington Pension System Review." Upjohn Institute Technical Report No. 08-025. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research. http://research.upjohn.org/up_technicalreports/25.

⁴⁰ RCW 51.32.099(1)(a).

Exhibit 1-7: Evaluation of Vocational Rehabilitation RTW Outcomes by Class of Injured Worker



Source: L&I Research and Data Services, Fall 2014

A three-part assessment of the reforms completed in 2011 by the University of Washington⁴¹ reached generally positive findings of the so-called Vocational Improvement Pilot (VIP) program. On the positive side, Option 2 seemed to be a desirable choice for nearly a third of those eligible for retraining; the return to work rate and percentage of pre-injury income regained stood midway between the outcomes of those completing training and those with failed training plans. Efficiency of plan development was unambiguously improved. On the negative side, RTW for all plan outcomes was worse and the failure rate of retraining had not improved. Many elements of the pilot could not be judged for lack of sufficient time or data. Additionally, the Great Recession clearly had significant impacts on job availability in general, as well as significant impacts on the VIP program, particularly for those injured workers with restrictions. Studying the pilot reforms taught lessons about system enhancements:

- **Efficiency.** The timeliness and satisfactory conclusion of vocational plans can be improved, as shown by the average time to complete plans and the number of plans successful approved.
- **On the Job Training.** Despite the difficulties of arranging On the Job Training (OJT), its advantages, in terms of lower costs and shorter delivery timeframes, suggest that it be pursued. OJT only makes up 3% of job training plans from 2011 to the present.
- **Option 2.** Those electing Option 2 achieve success with RTW and income restoration better than those entering into a retraining plan but failing to complete it.
- **Failed Plans.** Slightly less than 45% of retraining plans fail to complete their planned goals suggesting either that retraining is not appropriate for some and that too many people are incorrectly steered into the formal retraining route, or that plans are ill conceived, improperly managed, or inappropriate for a worker's particular situation, such as lengthy retraining plans for some adult learners. There are other miscellaneous reasons for plan failures.
- **Poor Perceptions by Workers.** The opinions of workers that enter into retraining show a significant negative shift in evaluations from before to after retraining of L&I, vocational counselors, and the

⁴¹Jeanne Sears and Thomas Wickizer, Evaluation of the Vocational Rehabilitation Pilot Program, University of Washington, Dec. 2012 (p. xviii), available at <http://www.lni.wa.gov/ClaimsIns/Files/Vocational/VocPilotProgEval.pdf>.

retraining process.

L&I supported legislation to make the VIP reforms permanent. In 2015, the Washington State Legislature enacted a significant enhancement of Option 2, among other vocational-service related changes (2015 substitute HB 1496).⁴²

Survey evidence on the opinions of injured workers toward the vocational system comes from Sears and Wickizer in their evaluation of VIP. They found that 50.1% of those workers electing retraining said their vocational counselor has a positive effect on RTW, and 42.6% said that the Claims Manager had a positive effect.⁴³ But the overall satisfaction with the vocational retraining process was low before retraining began, and even lower after their claim was closed; 69% said they were “satisfied” or “very satisfied” before retraining, and only 48% said the same after closure.

The audit team also surveyed injured workers about vocational services. A more negative evaluation of an injured worker’s vocational counselor was indicated, relative to the aforementioned survey by Sears and Wickizer. For example, only 9.5% of respondents gave their vocational counselor a “helpful” or “very helpful” rating in the RTW process. The Claims Manager received 10.5% helpful ratings. The L&I RTW specialist received only 3.2% of the two helpful ratings. This evidence is disparate in method and result from the University of Washington study, but it does signal the importance of stakeholder evaluations. L&I sponsors regular worker surveys, and results show higher worker satisfaction levels with vocational services than found in our worker survey. Sampling methods may account for this difference. Our survey sampled more serious claims, and also included claims involving attorney representation. Given the importance of and significant investment in terms of time and money for vocational services, and the difficulty of setting and maintaining objective performance standards for this type of service, ongoing surveys of recipients of services are a good way to verify that the vocational process is functioning properly.

Our team observed that L&I demonstrated a disciplined management approach to vocational service delivery. On a typical month over 350 different service providers are performing assessments and engaged in retraining planning and implementation. L&I defines the scope of services and reporting mechanisms. A review by an L&I Vocational Service Specialist is required before assessments or plans are accepted and fees paid to the provider. All these components to the system are reviewed by a technical advisory committee and changes are made when there appears to be a broad agreement among stakeholders. Management reports document the performance of Vocational Service Specialists in reviewing plans and assessments; their reviews uniformly come in under the desired time limits.

There is naturally tension between the goals and expectations of the injured worker, the vocational service provider, and L&I’s overall system objectives. Providers want to have a streamlined system with standard work expectations, cooperation from the client, and adequate compensation for their services. Injured workers present a wide range of cooperation and expectations; they want a plan personalized to their needs and interests (which may be unrealistic). L&I would of course like to see services provided timely and with uniformly high quality by a stable pool of providers. Ideally, all three interest groups

⁴² L&I, Workers Compensation Vocational Rehabilitation System, Annual Report to the Legislature, Dec. 2014. It states: “...the subcommittee along with L&I, recommends that some aspects of the VIP be changed to increase efficiencies, accountability and worker choice; and that the VIP, with these changes, become a permanent part of Washington’s workers’ compensation system.” See: <http://www.lni.wa.gov/Main/AboutLNI/Legislature/PDFs/Reports/2014/WorkCompVocRehabSys.pdf>

⁴³ Sears and Wickizer, op. cit., pp 78-80.

would like to see RTW as the typical outcome of the vocational process. L&I must balance the interests of all parties, which to date has meant a very drawn out and expensive process. Vocational services might include an AWA, followed by Retraining Plan Development, followed by Plan Implementation. Vocational professional fees averaged \$2,500 for completing an AWA and \$3,700 for developing a plan in FY14. On top of this, TL benefits are paid until the retraining is completed. There are long lag times in completing each step of the vocational process, discussed at length in Chapter 2.

To advance these goals, L&I has instituted a host of measures to improve the claim process and RTW success, including:

- Washington Stay at Work program (financial incentives to keep workers at pre-injury employers)
- Preferred Worker Program (encourages and incents hiring of disabled workers)⁴⁴
- Specialized Early Return to Work staff in regions (these vocational experts appear to be more successful than private counselors and achieve good evaluations from clients)
- A general review of claim manager training (this training teaches apprentice and experienced CMs how to communicate with stakeholders about RTW and how to overcome resistance)
- Medical provider training on their role in return to work (expansion of COHE and rigorously building a qualified Preferred Provider Network)
- Promoting Kept-on-Salary (KOS) (allows employers that are in jeopardy of losing their “claim free” discounted rate)
- “Claims Evolution” initiative (an umbrella term for systematic changes to the training and role of CMs, e.g., adding claims processors to assist CMs with routine tasks and revamped CM apprentice training; Claims Evolution consists of six projects: Medical Management; Return to Work Coordination; Claims Technology; Claims Leadership; Claims Handling; and Claims Training)
- Early AWA (a pilot program that seeks to more effectively target early vocational assessments)
- Re-Employment Specialists co-located with State Fund claim managers; L&I is also piloting co-location of WorkSource (the Washington State re-employment program) specialists at L&I, on contract specifically to support injured workers.

We will comment further on some of these measures in Appendix 2 covering disability management and in the recommendations to follow.

In addition to the above process improvements, L&I is planning or implementing significant changes in its IT systems that will make substantial improvements in claims processing. Some examples:

- L&I is currently working to allow Health Information Exchange (HIE) data to be entered in the new Occupational Health Management System (OHMS) utilized by the COHE providers. Management believes that when this is accomplished, 80% of all Reports of Accident (ROAs) should be filed electronically (either by FileFast’s web-based application or HIE).
- Management has requested \$9.8 million in the 2015/17 budget process to implement a replacement for the legacy LINIIS system.⁴⁵

Other states have recognized the need to create structural incentives for RTW. For example, California, Tennessee, and other states have created financial incentives for employers to accept disabled workers

⁴⁴ Note that in the 2015 legislative session, the incentives for the Preferred Worker Program were increased. Substitute HB 1496.

⁴⁵ Presentation to the WA Workers’ Compensation Advisory Committee, Sept. 22, 2014.

back in order to lower the amount of PPD paid. At least 10 states cap temporary disability benefits at limits ranging from 110 days to 500 days (regardless of the date of MMI); in such situations, the carrier must continue to pay temporary benefits until “employability,” but it is capped. Some states, like Oregon, Montana, and Washington, offer financial incentives to promote employer receptivity to RTW.

Even if the statutory requirements are roughly similar in some states, case law can make dramatic differences in how disability must be managed. The term “gainful employment,” which appears in the statutes of most states, has generated both very broad and very narrow court interpretations of that term.

As indicated, the law in Washington is different than in most other states. In the majority are those states that permit TL benefits to be terminated upon a medical finding of maximum medical improvement, the equivalent of “fixed and stable” in Washington. This, of course, will create a major difference in the responsibility of the insurance carrier to provide or guarantee vocational services. Naturally, the rights of injured workers are more limited in those states that allow cut off of TL without any evidence of employability. Labor advocates in Washington have portrayed the employability standard as being too prone to find employability for minimum wage jobs far below the work history of the injured worker. This is clearly a very charged issue that pits some business interests against advocates of worker rights.

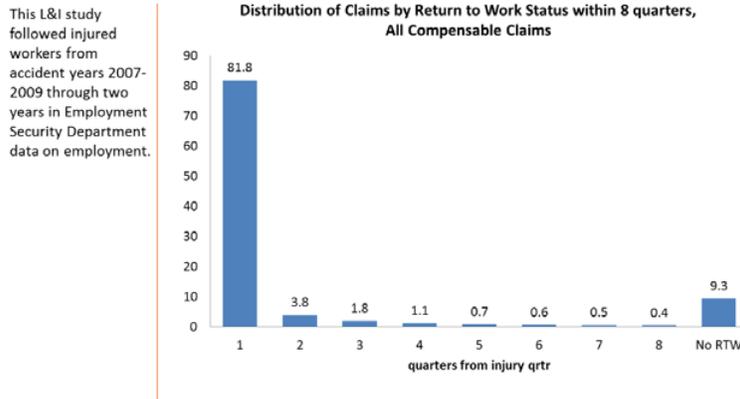
Even without arbitrary cutoffs or other means of curtailing TL, well-focused disability management will help keep the number of long-term disability cases to a very small fraction of claims. In Chapter 5 of this report we present statistics on disability duration in Washington, which show that Washington unique in the degree to which it has extremely long periods of paid disability payments. As discussed further in Chapter 5 and Appendix 2 – Disability Management, data from the analysis of Washington’s workers’ compensation system indicate a departure from outcomes noted in other jurisdictions for longer-term temporary disability claims. This signifies that disability management, in its broadest sense, in Washington suffers serious shortcomings, at least for the period under study. This is a multifactorial issue, encompassing not just the claims process but also factors such as the underlying laws defining benefits, the employer and worker response to RTW, medical provider facilitation of RTW, and disputes and attorney involvement, It is also true that just because another state has relatively lower rates of long-term disability, it does not necessarily follow that it is utilizing more effective disability-management practices. However, the impact of the delivery of certain claims handling services is clear, and compensation systems that excel in disability management are characterized by specific practices that facilitate early, safe, and durable return-to-work outcomes for injured workers. Recent initiatives by the agency are designed to identify and address several of these concerns, including a significant focus on the timing and nature of RTW and vocational rehabilitation services. Such efforts should be carefully studied and expanded as success is shown.

Exhibit 1-8 illustrates the nature of claims management in Washington: Good outcomes for 80-85% of claims while 15-20% are on a path that runs the risk of never returning to work. These long-term disability and pension cases are very expensive: 9.3% of all claims generate 85% of the system cost.⁴⁶ This general pattern of a small fraction of claims representing a huge share of costs is common in workers’ compensation. However, there is an unusually large fraction of extremely long disability in Washington (2 or more years in duration); more discussion of the impact on overall performance is provided further in Chapter 5 of this report.

⁴⁶ Kirsta Glenn, April 30, 2013 statement to Washington Workers’ Compensation Advisory Committee.

Exhibit 1-8: RTW outcomes 2007 – 2009

Most injured workers either return to work quickly or stay in the system a long-time



Source: L&I Kirsta Glenn Workers' Compensation Advisory Committee presentation, April 2013; note that "compensable" in the sub-title of this chart refers to TL claims

3 CLAIMS MANAGEMENT DIFFERENCES BASED ON INSURANCE "TYPE"

Next, we will provide an analysis of the differences between State Fund and claims for the different insurance "types," namely Retro claims and self-insured claims.

3.1 RETRO EMPLOYERS

From a structural standpoint, our investigation revealed no distinction in organization or claims management, intended by L&I or observed by the audit team, between Retro and non-Retro claims. Actual performance measurements were done for Retro versus non-Retro participation, and will be presented in Chapters 2 and 3 of this report.

The big difference between Retro and non-Retro employers is not found in L&I but rather in the way Retro employers engage in the claims management process. Retro employers, both those participating as an individual employer and as part of a group, often utilize representatives to assist with their program, help control costs, and assist with improving overall outcomes. The claims "experience" of an employer is a key component of the amount of premium an employer is required to pay. Experience is based primarily on the severity of claims, which would lead to payments by L&I on the claims. To avoid loss experience, employers can "invest" in safety initiatives and programs to prevent accidents in the first place; similar investments include expenditures to minimize the loss of a claim through, for example, returning a worker to work or keeping a worker on salary during periods of missed work. There are other "friction" costs of claims, including paperwork and decisions involved in the course of a claim, that are borne directly by employers. The services of representatives, which as just indicated are often used by Retro employers, are aimed at, among other things, managing these costs: investments in preventing accidents and in keeping claims experience and friction costs low.

Depending on the success of this loss control activity, an employer's premium is affected. We analyzed four specific scenarios, using varying levels of claims loss experience and what their premiums (and in

the case of Retro employers their refunds or additional assessments) would be based on L&I calculations, to compare premium results of similarly situated Retro and non-Retro employers. The results showed that as experience increased, both Retro and non-Retro employers' base premiums increased in an equivalent manner. In the case of minimal loss experience, the more risk a Retro employer accepted (the employer has several risk levels to choose from), the greater the refund. Conversely, in the case of significant loss experience, and the more risk a Retro employer accepted, the greater the assessment owed. For the non-Retro employer, premiums were equivalent to the similarly situated Retro employer, but no refunds were received, and no assessments owed. As loss experience varied it hit the premium charge of both Retro and non-Retro employers in future years. Our analysis showed that the "investments," described above, which are borne directly by the Retro employer and not by L&I or non-Retro employers, were correlated with the refunds or additional assessments. In other words, the more successful an employer at preventing accidents and controlling losses, the bigger the refund; the less successful, the bigger the additional assessment. Similarly, a non-Retro employer could make similar investments and theoretically achieve better financial outcomes, through lower premiums, but would not receive a refund in the coverage year, but only a better experience rating in future years. In conclusion, Retro employers, by taking on the risk of a potential assessment, and through the effective use of cost-control measures, such as safety and return-to-work programs, can not only benefit from reduced premium but also benefit from a premium refund. The degree of risk retained, and the effectiveness of the cost-control measure utilized, determines the amount of any refund; the refund is not determined by L&I claim management or non-Retro employers' claims experience, and thus is not borne by L&I or non-Retro employers.

It is important to note that a highly effective CM will help control claim costs. Thus, if there were a pattern of organizing CMs according to Retro or non-Retro, where more effective CMs were placed with particular groups, then such a scenario could result in bias. Our investigation did not reveal such structural bias, however. In other words, claims of Retro and non-Retro employers were distributed and worked according to standard, "blind" methods. Similarly, as will be shown in Chapters 2 and 3, we did not observe performance outcomes that would indicate biased selection.

We did observe evidence of participation by employer representatives in claim management. An example would be an employer representative sending a message to a CM that a medical examination had been completed and requesting review of the record and closure of the claim. We did not observe biased adherence to (or avoidance of) such advice by the CM. To the extent such interventions improved claim outcomes, the costs were borne by the employer hiring the representative, and not by L&I or other employers in general.

3.2 SELF-INSURED EMPLOYERS

Next we will discuss difference between State Fund and self-insured employer claims management organization. For self-insured employers, primary responsibility for claims management rests with the self-insured employers; L&I's role in many practical respects is secondary, involving auditing and reviewing reports of claim activities engaged in by self-insured employers. L&I does issue formal orders and is involved in protests of such orders. Self-insured employers, or their third-party administrator (TPA), do the detailed work of claims management, starting with an initial decision on compensability⁴⁷;

⁴⁷ Note that a self-insured employer may choose to administer its own claims, although interviews indicated that most utilized third-party administrators. If self-administered, the self-insured employer in essence serves as its own third-party administrator, and the reference to "TPA" would include the self-administered claims management function of the Continued next page

this initial decision is submitted to L&I for approval. If the TPA approves or “allows” the claim, L&I’s role is to issue an allowance order; if the TPA wants the claim denied, L&I’s role is to request a complete copy of the file and review the case and either issue an allowance or rejection order. Our file reviews showed that the allowance order was most often issued by L&I clerical staff and often the elements of a prima facie case were not submitted by the employer so L&I could not have made an informed decision. L&I reports that it gives a self-insured employer the prerogative to allow claims as it deems appropriate, and L&I would not typically deny a claim for which a self-insured employer is requesting allowance. A CM rather than clerical staff would issue determinations that deny claims. This differs significantly from the elements required to be present in the State Fund claims. In terms of disputed decisions, if L&I overturns the denial, the employer (TPA) may file a protest, and if L&I upholds the denial, the worker may file a protest.

In contrast, the State Fund process is more streamlined: The initial decision on compensability is made by the State Fund; the State Fund submits the decision to both the employer and the worker; in terms of appeal, if the State Fund approves or “allows” the claim, the employer may protest; if the State Fund denies compensability, the worker may protest.

L&I organizes its operations for performing its role in self-insured claims in a separate section of its Insurance Services unit; the Self- Insurance section is housed in a separate building from the State Fund operations. The Self-Insurance claim section is broken into two units, both of which are “employer based,” meaning that they handle claims from certain types of employers. Each unit has 13 employees, and distributes claims within the units sequentially. The WCAs who staff the units are level 2 and 3 WCAs; the average tenure of the level 3 WCAs is 7.5 years. In early 2014, a new workload tracking system, known as “SICAM,” was implemented. Management reports are now available at the program, unit, and individual adjudicator level. Management identified 6 key areas for performance goals, which are now included in each adjudicator’s performance review process. Self-Insurance data is also reported periodically to L&I via the “SIEDRS” system.⁴⁸ At certain points in a claim, the TPA file is required to be provided to L&I, e.g., when requesting a denial or requesting closure. This data is added to and made available in the LINIIS and ORION systems. In general, these files are poorly organized in the L&I system; during file reviews we saw many instances of duplicates, large, unwieldy files, and files where the key documents were hard to locate.

As mentioned earlier, workers’ compensation self-insurance regulation covers two functions: regulating the self-insurer’s financial ability to pay claims as they come due, and regulating the self-insurer’s performance in managing claims. The structure of self-insurance regulation in Washington has many features common to all states that permit self-insurance for workers’ compensation.⁴⁹ It also has some features that are unique to Washington’s system.

self-insured employer.

⁴⁸ See WAC 296-15-231. Our interviews with self-insured employers and L&I staff indicated that there were many unreliable aspects of the data provided through SIEDRS, including delay, inconsistent coding, and missing fields.

⁴⁹ Two states, North Dakota and Wyoming, do not permit self-insurance, and coverage is provided only through a state fund. Ohio and Washington permit self-insurance; all other employers must insure through the State Fund.

To widely varying degrees, states monitor claim processing to assure that standards for claim processing performance are met by self-insurers. As in all states, self-insurers are obligated to pay the same benefits to injured workers as other insurers, for the same set of covered conditions and circumstances. Washington has a unique approach to payment of workers' compensation insurance premiums. In almost all states, the employer pays the full premium cost. As discussed above, in Washington, half of the cost for the Medical Aid Fund, as well as for the Stay and Work and the Supplemental Pension funds, is paid by workers. This is not true for self-insurance, where the entire risk is self-insured and paid by the employer. This would seem to be a substantial disincentive to self-insure, on the order of 25% of claim costs, yet a significant portion of the Washington workers' compensation market uses self-insurance. This seems to imply that self-insured employers believe that they can be substantially more cost-effective than L&I even with the full payment of medical costs, and the full burden of claims administration.⁵⁰

In most states, self-insurers are generally subject to the same regulatory standards for claim processing as other types of insurers. As there are only two states (Washington and Ohio) that use an exclusive state fund and permit self-insurance, it is less meaningful to say what is typical in most states. Nevertheless some comparisons are useful. We focus on Ohio as the most comparable jurisdiction to Washington from the perspective of its insurance and self-insurance regulatory model.

Some unusual features in the Washington system involve the necessity for Labor & Industries to perform certain claim processing functions instead of (or in addition to) the self-insurers or their TPAs. These functions include adjudication of compensability (both acceptance and denial), after receiving the recommended decision from the self-insurer. Another area with L&I involvement, where there is typically none in similar states, is claim closure. Still another is the requirement that employers submit pension recommendations to L&I for approval. Presumably, these functions have been placed within L&I because it is perceived as a neutral body that has no financial interest in the outcome. Nevertheless, these extra steps come at a cost in both time and staff effort. These added steps tend to slow down claim processing and in some cases may delay benefits.

Where data was available for comparison, aspects of claim processing for self-insured employers showed better performance than for State Fund claims. Examples were: 1) timeliness of first payment of TTD; 2) shorter duration of TTD; 3) faster use of first vocational service; 4) faster retraining plan completion; and 5) faster closure of the claim. These performance advantages naturally come from the very large size of most self-insured organizations. Size allows for more RTW options and for greater sophistication in claims management than for smaller organizations. Larger organizations are better able to provide modified duty than smaller organizations and also possess more resources to afford keeping workers on salary despite absence. They also can employ more specialized human resources staff to manage safety and return-to-work programs.

For most claims decisions, all jurisdictions allow parties to appeal adverse decisions in some manner, although this mechanism typically involves delays, adversarial proceedings, attorneys, and other frictional costs. The typical avenues of self-insurance claim-processing regulation attempt to minimize disputes through a combination of features which can involve monitoring processing through reporting

⁵⁰ Cost is one consideration for an employer seeking to be authorized to self-insure. Other considerations would include a corporate desire to be more closely involved with managing safety, injuries, work disability, and wellness. Also, there is a tendency for multi-state corporations that prefer self-insurance to use this mechanism for all the states in which they have employees; thus the decision to self-insure in Washington is not independent of self-insurance status in other states.

of key events to the regulatory agency, feedback on processing performance statistics in relation to the industry as a whole, audit for accurate and timely processing performance, and sanctions when standards are not met.

For injured workers, most of whom have no experience with workers' compensation claims, the process is very confusing. For some workers, information sent by the state or a claims administrator is hard to assimilate and use. Many states provide some form of free ombudsman service to injured workers, typically from an independent or quasi-independent office that is empowered to provide advice to injured workers, resolve some disputes, and provide some degree of investigation and monitoring of system trends affecting injured workers. These offices differ across states in a variety of dimensions: statutory role, degree of funding and staffing, and means of interaction with various parties in the system to resolve disputes. In most cases these offices do not provide legal advice.⁵¹

Washington does not have an agency-wide ombuds. Project Help, however, which is a cooperative effort between L&I and the Washington State Labor Council (AFL-CIO), provides general assistance with navigating the claims process.⁵² Assistance is available with both State Fund and self-insured claims. Performance related observations involving Project Help will be discussed in Chapter 2.

One relatively new program in the Washington system is the Office of the Ombuds for Self-Insured Injured Workers.⁵³ Unlike most similar state programs, this office assists those injured workers whose employers are self-insured. The office was designed to be operated independently of the L&I Insurance Services Division. The office was authorized by the 2007 legislature, and the Ombudsman was first appointed by the Governor of Washington on January 12, 2009. Thus the first full year of data on the office's operation was Fiscal Year 2010. As we might expect, there was an increase in workload over the initial years of the office, with counts of resolutions growing by 76 percent from FY2010 to FY2012. These counts have been roughly flat in FY2013 and FY2014.

Most cases reported on by the Office of the SI Ombuds involve those where the worker contacted the office with a "complaint" and an investigation was opened. Reported statistics do not fairly represent the full spectrum of claims in a year, only the ones contacting the Office of the SI Ombuds.⁵⁴ Nevertheless some insight is provided by the trends observed. In 2014 there were 486 completed investigations, involving 136 employers; 62% of all Washington self-insurers had "zero" investigations. Of the investigations, 190 (39%) were reported to be resolved with the assistance of the Ombuds; 183 (38%) involved a "correct adjudication" and did not require resolution; 65 (13%) were resolved by the TPA; and 48 (10%) were unable to be resolved. Appendix 1 provides additional detail about Washington's self-insurance program, how it compares with key states, and the Office of the SI Ombuds.

A substantial portion of the [Office of the SI Ombuds Annual Report](#) is dedicated to the discussion of recommendations for rule and regulation changes. The 2014 report discusses ongoing efforts at audit reform (audits had been suspended during process review) and makes some recommendations concerning reform proposals. Audit reform in Washington is ongoing, and more information is available

⁵¹ At least two states are exceptions; Nevada and Texas have state-funded, attorney-staffed offices that can provide legal assistance to injured workers in some circumstances.

⁵² See <http://www.lni.wa.gov/ClaimsIns/Claims/Benefits/MedBenefits/default.asp>.

⁵³ The original term for this function was "Ombudsman"; it was later changed to "Ombuds."

⁵⁴ Annual reports available at <http://ombudsman.selfinsured.wa.gov/resources/>.

in Appendix 1. In general, stakeholders were unhappy with several aspects of the audit process; during interviews we heard complaints of a focus on inconsequential or “picky” findings, and a lengthy, cumbersome process. L&I assembled a task force of internal and external experts to review and make reform recommendations, which outlined a “three-tier” process for performance-based audits, whereby all self-insured employers receive a review annually on a specific aspect of workers' compensation benefits (in the first year, the aspect under review is the calculation of worker wages). Based on whether the employer achieves an appropriate score they may be moved to Tier 2 (the topic of this review is still under consideration); for a smaller number of employers, a full claims management audit at Tier 3 would be conducted, based on Tiers 1 and 2 results. The audit reform will also support complaint-based audits (primarily triggered by worker complaints) and issue-based audits (using data trends).⁵⁵ Tier 1 audits will be made of all self-insured employers in 2015; Tier 2 and 3 level audits are under development.⁵⁶

In many important ways, Ohio is the most comparable jurisdiction to Washington from the perspective of its insurance and self-insurance regulatory model. A number of features have proven effective in regulating self-insurance in Ohio, similar in size to Washington. The Ohio state insurance fund agency responsible for self-insurance administration is the Ohio Bureau of Workers' Compensation (BWC). The BWC monitors financial solvency, claim reserving practices, and payments of various assessments for dedicated funds and administration costs. Unlike the Washington system, BWC does not generally get involved in processing claims except in rare events; rather it monitors and audits for performance periodically, to ensure SI adherence to statutory requirements. The BWC also publishes a detailed claims administration *Procedural Guide*.⁵⁷ BWC audits consist of two levels of periodic audits on at least a 3-year cycle, with a third more comprehensive level if certain trigger deficiencies are found.

Recent changes to the Ohio audit process have allowed audits to proceed much more efficiently. BWC auditors get remote login access to SI claims systems, and thus have the ability to do audit work remotely as needed. According to BWC documents, since implementation of this new process, the number of audits increased by over 155% by the end of 2013. Per agency status reports, only about 3 to 4 percent of audited employers fail to receive a satisfactory rating.

Approaches to self-insurance regulation vary among states. In Appendix 1 we describe approaches used in neighboring jurisdictions, as well as additional detail about the Washington and Ohio programs.

⁵⁵ Source: Vickie Kennedy presentation to Workers' Compensation Advisory Committee presentation, “Self-Insurance Risk Analysis System, Dec. 2014.

⁵⁶ L&I presentation “Self-Insurance Audit Reform (last modified Dec. 1, 2014),” found at: <http://www.lni.wa.gov/ClaimsIns/Files/SelfIns/SIAuditReformPPT.pdf>

⁵⁷ The Ohio Procedural Guide for Self-insured Claims Administration can be found at <https://www.bwc.ohio.gov/downloads/blankpdf/SIClmsProcedureGuide.pdf>. Washington publishes a similar guide, the [L&I Self-Insurance Claims Adjudication Guidelines](http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/Claims/Guidelines/Default.asp), available at <http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/Claims/Guidelines/Default.asp>.

Chapter Two: Claim Management

INTRODUCTION

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

1. [Timeliness](#)
2. [Fairness And Consistency](#)
3. [Disability Management](#)
4. [Summary](#)

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

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

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

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

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

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

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

1 TIMELINESS

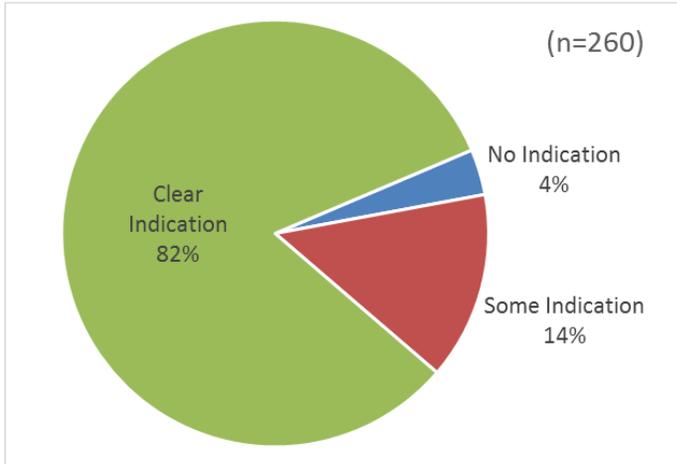
We discuss two specific aspects of timeliness: 1) time to allowance decision; and 2) time to first payment of disability. We compare these time intervals to statutory requirements, best practices, and other jurisdictional performance measures. In comparing Washington's performance with other jurisdictions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

1.1 TIME TO ALLOWANCE

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

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

Exhibit 2-1: Claim basis on objective medical findings

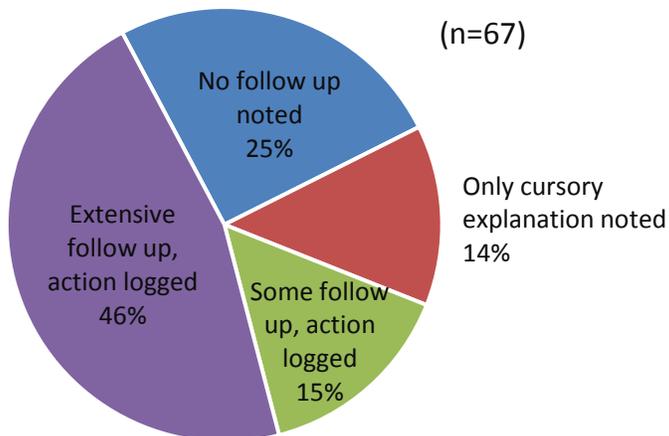


Source: WorkComp Strategies file review, 2011-13 claims (sample of claims > \$5,000 in medical costs).

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

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

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



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

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

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

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

1.2 TIME TO FIRST PAYMENT

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

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

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

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

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

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

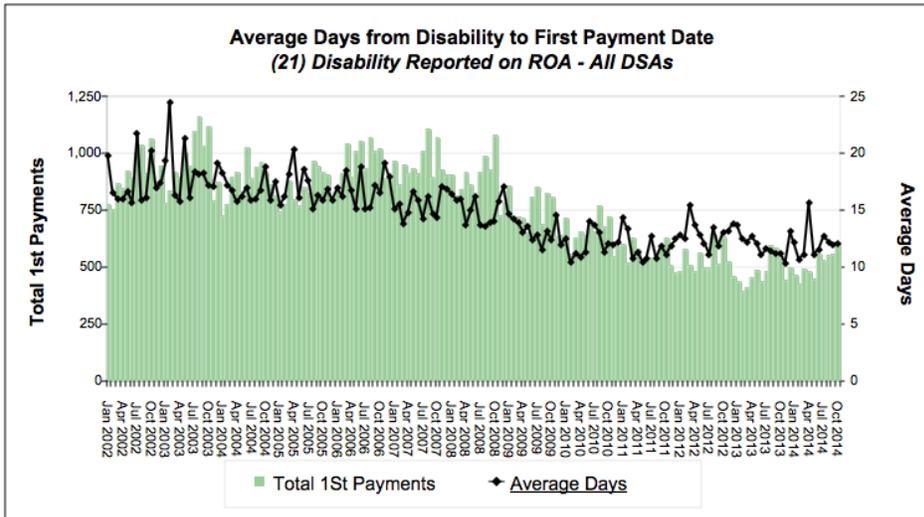
L&I measures compliance with the 14-day payment requirement by starting from the date that payment was required, and tracks various reasons why a payment might be late. We used several starting dates for our analysis. We measured the duration from date of “first notice,” defined as the date a claim was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

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

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

⁴ L&I “Accountability Report,” last date included was August 2014.

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



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

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

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

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

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

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

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

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

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

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

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

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

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

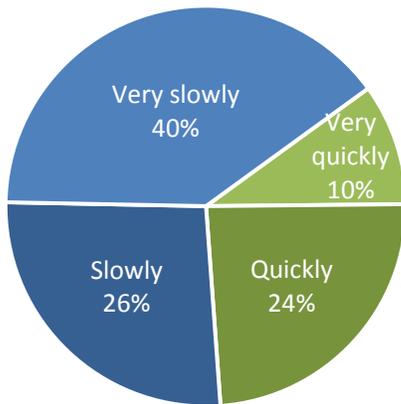
⁷ L&I Accountability Report, August 2014. L&I claim-free experience and early return to work initiatives are designed to encourage keeping injured workers on appropriate light-duty work, which should generally have a positive effect on receiving complete information and improve payment timing.

1.3 PERCEPTIONS OF TIMELINESS

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

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

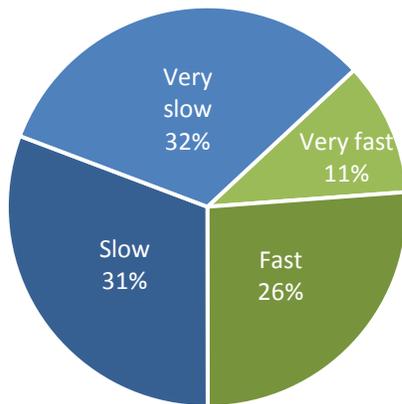
Exhibit 2-6: L&I Resolved Protest in a Timely Manner - Workers' Opinion



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

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

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

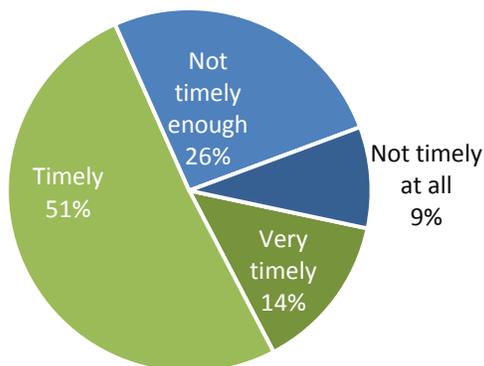


Source: WorkComp Strategies Survey of Workers, 2014 (sample of claims > \$5,000 in medical costs)

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

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

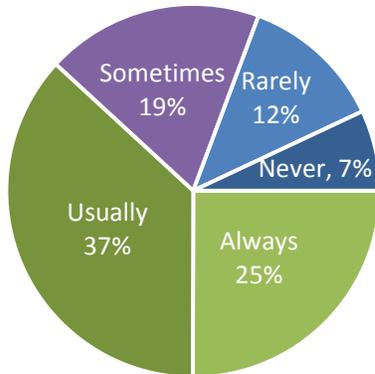
Exhibit 2-8: Timely in Responding to Inquires - Employers' Opinion



Source: WorkComp Strategies Survey of Employers, 2014

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

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

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

Source: WorkComp Strategies Survey of Employers, 2014

2 FAIRNESS AND CONSISTENCY

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

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

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

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

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

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

employers

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

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

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

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

2.1 SELF-INSURED VERSUS STATE FUND EMPLOYERS

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

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

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

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

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

2.2 RETRO VERSUS NON-RETRO EMPLOYER

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

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

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

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

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

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

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

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

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

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

2.3 STAKEHOLDER PERCEPTIONS OF FAIRNESS

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

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

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

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

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

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

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

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

2.4 DIFFERENCES IN SERVICE DELIVERY ACROSS TEST GROUPS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SF – SI, 2010- 2013

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

Note: These durations are based on claims with accident years (dates of accidents causing the claim) between 2010 and 2013; hence they would tend to understate the durations for final plan completion.

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

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

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

Note: These durations are based on claims with accident years (dates of accidents causing the claim) between 2010 and 2013; hence they would tend to understate the durations for final plan completion.

Source: WorkComp Strategies, from L&I data 2010 – 13; results are not propensity matched

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

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

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

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

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

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

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

2.5 LEGAL COMPLIANCE

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

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

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

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

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

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

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

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

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

3 DISABILITY MANAGEMENT

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

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

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

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

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

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

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

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

3.1 ESTABLISHING THE CLAIM

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

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

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

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

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

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

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

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

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

¹⁹ Presentation by Vickie Kennedy to Workers’ Compensation Advisory Committee, April 2014.

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

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

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

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

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

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

²¹ International Labor Organization, op. cit.

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

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

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

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

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

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

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

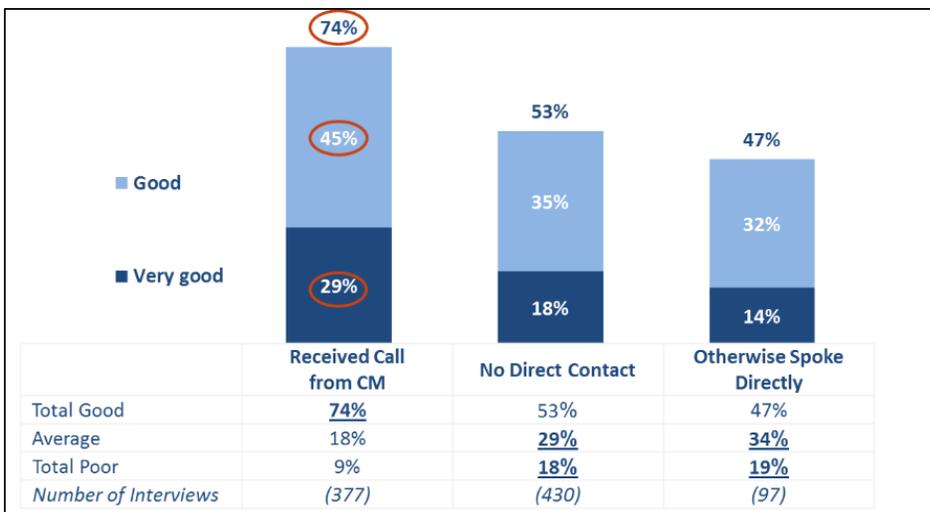


Source: Ron Langley presentation to Workers’ Compensation Advisory Committee, December 2013.

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

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

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



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

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

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

3.2 MEDICAL MANAGEMENT

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

Actions involving medical providers²⁸ control three aspects of a claim: 1) investigation and “allowance” of a claim as connected to work; 2) the conditions under which the worker can return to employment; and 3)

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

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

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

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

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

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

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

Washington has been a leader in combating abusive and potentially lethal over-prescription of opioids. In July 2013 the L&I Medical Director issued new directives on the use of opioids for chronic pain.³³ Ideally, the CM's role in managing these treatment issues includes active engagement and prompt, regular, and thorough inquiry and exchange of information. We were pleased to see that the percentage of claims with opioid use 6-12 weeks after injury declined from 4.93% in 2012 to 1.2% or less in late 2013 and early 2014.³⁴ This, we believe, will exert a desirable effect on claims outcomes. Despite the progress, vigilance is needed by CMs in enforcing L&I's medical guidelines.

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

3.3 VOCATIONAL SERVICE DELIVERY

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

³² In a paper published Sept. 30, 2014 by the American Academy of Neurology, the authors conclude that the risk of dependence with long-term use, combined with the poor understanding of best practices by physicians, makes the overall risk of opioid use vastly outweigh the potential benefit for many patients. The lead author on the paper was Dr. Gary Franklin, Medical Director at L&I. See: <http://www.neurology.org/content/83/14/1277>.

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

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

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

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

3.3.1 Timing of First Vocational Service.

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

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

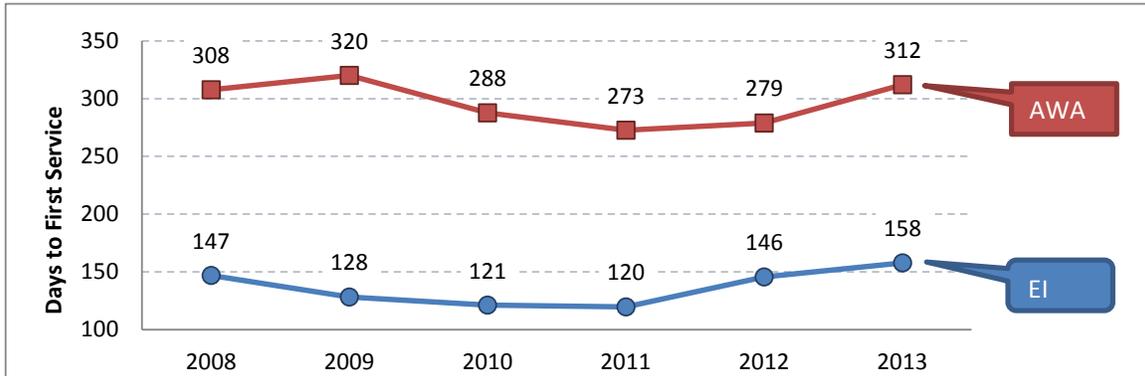
Below, we discuss in detail three major problems with the Ability to Work Assessment process—as measured during file sample period for this study (2010-13):

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

³⁸ Federal Office of Workers’ Compensation, “Best Practices” op. cit., p 26.

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

3.3.2 Speed to Complete Ability to Work Assessment

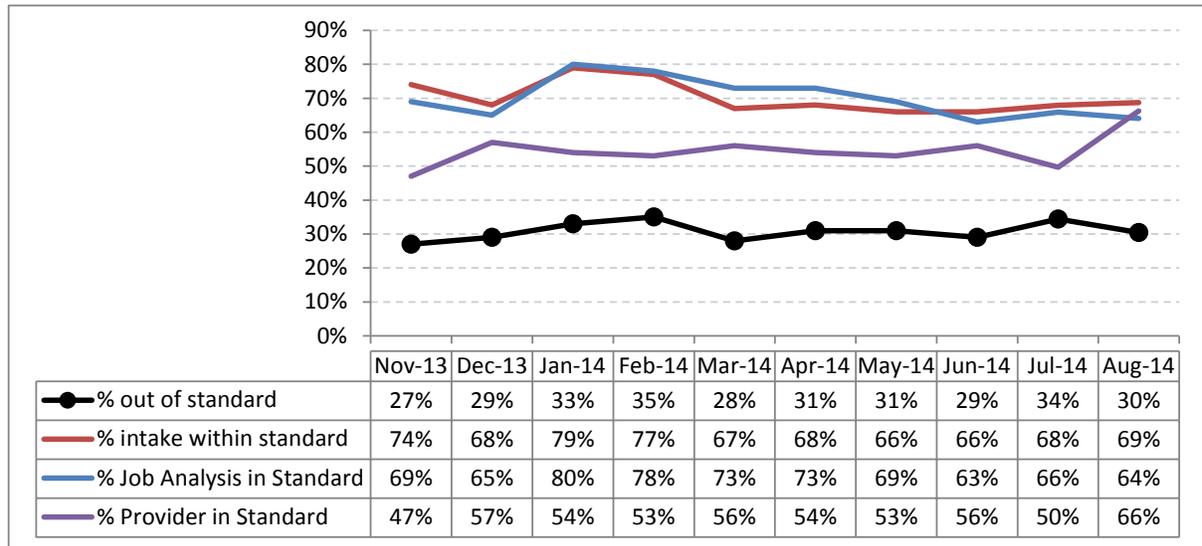
Once initiated, completion of an AWA is an important metric in evaluating overall timeliness of vocational service delivery. AWAs during the data sample period took over 200 days from start to completion; it was not unusual for AWAs to remain open for a year or more. Recently the Department dropped its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

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

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

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

Exhibit 2-19: Standard Work Measures for AWA



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

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

In our interviews, we heard frequently about claim units participating in “Gemba Walks.” This is a term used in “Lean Management” parlance, meaning to “go and see” the barriers to completing AWA referrals and to focus on more consistent application of work standards. Despite the application of sophisticated management tools AWAs were taking between 150-160 days to complete in early 2014.³⁹ L&I reports that it initially had targeted completion of 50% of AWA plans within 90 days, but has since determined that it is better to not use a 90-day goal, but retain the case longer, in appropriate cases, to encourage RTW before finalizing the more formal AWA plan.

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

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

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

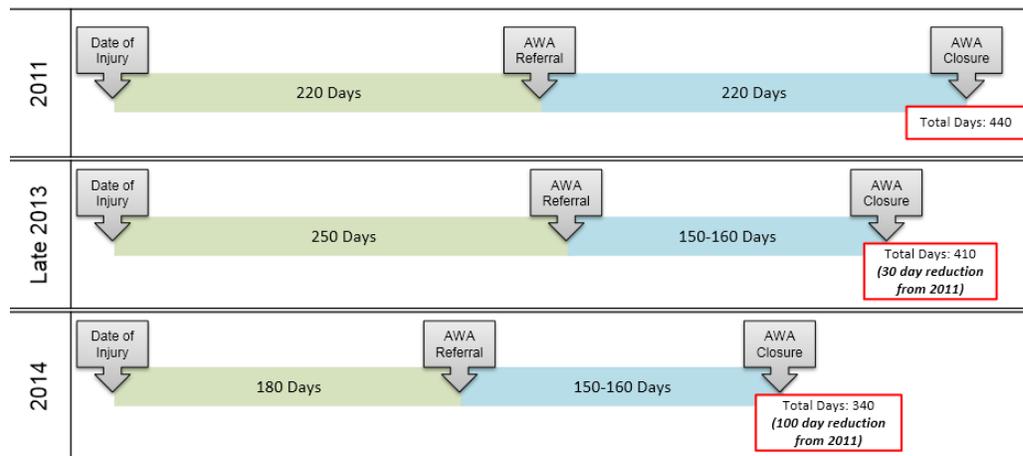
⁴⁰ ACOEM puts the danger point for permanent disability even earlier: “Studies have shown that the odds for return to full employment drop to 50-50 after six months of absence. Even less encouraging is the finding that the odds of a worker ever returning to work drop 50 percent by just the 12th week.”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

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

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

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

Ability to Work Assessment (AWA) Referral Duration Process Reduction Timeline



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

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

Exhibit 2-21: Current Range of Open AWA Referrals

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

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

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

3.3.3 Speed to Submit Complete Retraining Plan

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

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

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

Note: from time of notification to service provider; State Fund only

Source: L&I data, (spreadsheet (2014), supplied by Ryan Guppy)

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

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

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

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

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

3.3.4 Time to Complete Plan Implementation

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

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

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

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

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

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

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

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

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

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

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

In most other states, such services are provided only when it is clear that an injured worker will face problems in returning to work, or in doing so at an acceptable level of pre-injury income. An unusual feature of the Washington system is the way claims are handled at the end of the healing period. RCW 51.32.090(3) provides that as “soon as recovery is so complete that the present earning power of the worker, at any kind of work, is restored to that existing at the time of the occurrence of the injury, the payments shall cease.” An example of how this can be interpreted is from the L&I Self-Insurance Claim Manual, which provides in relevant part that “Once the payment of time-loss benefits has begun, the benefits must be continued” until the worker has been released for full duty, returns to work, or is “found employable.” This is different from the majority of states that terminate temporary disability benefits once maximum medical improvement is attained, regardless of “full” employability; if there is “zero” employability, then permanent and total disability benefits would be warranted. This difference, at least in large measure, helps explain the longer average time-loss durations in Washington (discussed at length in Chapter 5).

In Washington, a CM must manage a determination of “employability.” A major weakness in disability management is the long delay in making these determinations. Absent return to work or a full and unconditional medical release, the CM must get an objective determination on employability. This is done by ordering an Ability to Work Assessment (AWA). As shown in [Exhibit 2-17](#), in 2011 the median duration of time to first referral by a CM for an AWA from date of injury was 273 days; the exhibit shows an increase from 2012-2013. The percentage of AWA referrals by CMs made in 90 days of claims receipt were only 6.3% in 2012, and about 6% in 2013.⁴³ After reviewing the AWA Referral Guidelines, it is difficult to see why it should take 273 days to meet the conditions for triggering an AWA. The main criteria for an AWA should generally be known within 90 days of claim receipt, specifically: Is the injured worker physically able to interact with a Vocational Rehabilitation Counselor and is it clear that returning to the job of injury is very unlikely? Reports from L&I are that focused attention to this process has had positive results in shortening the duration, and [Exhibit 2-20](#) shows a recent positive trend.

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

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

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

⁴³ Vickie Kennedy presentation to Workers’ Compensation Advisory Committee, April 2013.

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

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

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

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

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

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

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

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

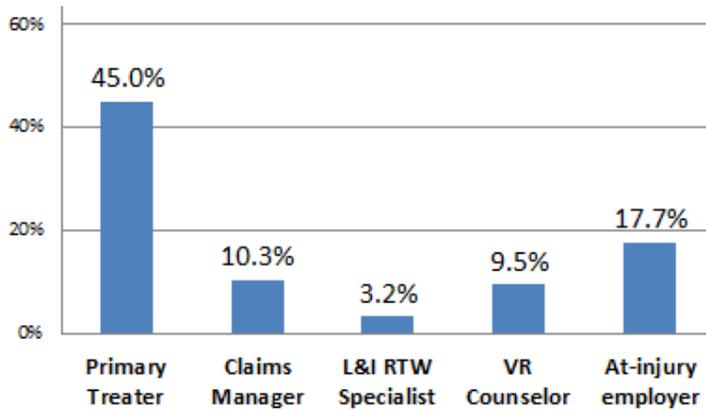
⁴⁶ See Workforce Training and Education Coordinating Board at: <http://wtb.wa.gov/WorkforceTrainingResults.asp>.

⁴⁷ Ed Welch, op cit, p 73.

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

same as those used by L&I.

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



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

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

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

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

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

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

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

3.4 MANAGING RETURN TO WORK

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

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

3.4.1 Early stage (approximately the first few weeks)

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

⁵¹ Vickie Kennedy presentation to Workers’ Compensation Advisory Council, Dec. 2013.

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

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

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

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

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

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

⁵⁴ L&I internal spreadsheet “First Contact Report” (2015)

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

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

⁵⁷ L&I internal spreadsheet “VSS activities” (2015), supplied by Richard Wilson

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

assessments that the reviewer finds defective.

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

3.4.3 End stage (year or more of lost time)

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

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

3.5 CASE MANAGEMENT PLANNING

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

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

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

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

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

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

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

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

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

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

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

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

4 SUMMARY

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

On the negative side, the CM's work seems to be rule driven rather than by seeking desired outcomes, including return to work and speedy claim closure. This same concern was raised in the 1998 Performance Audit⁶⁴ and in the Risk Navigation study of 2010.⁶⁵ Some CMs are adept at using the system to drive outcomes, but we saw evidence that others allowed problems to remain unresolved for too long. We saw evidence of inconsistent performance by CMs, which if able to be more uniform would likely boost performance measures. We suspect that part of this inconsistency stems from the failure to follow the venerable management slogan: "What gets measured gets done." Metrics can be a powerful supervisory tool for identifying work units and individuals that need more direction and coaching (more on this in Chapter 5).

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

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

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

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

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

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

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

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.

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 hearings⁴ 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-assessments," 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.

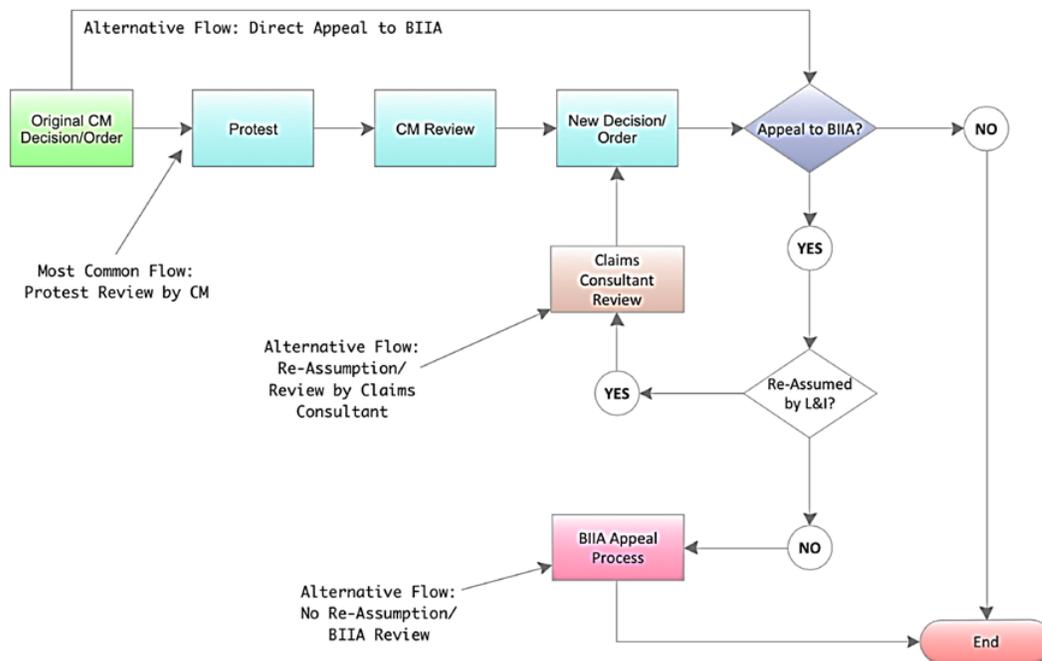
⁶ The BIIA appeal process involves mandatory mediation, in an effort to resolve disputes before advancing to a formal hearing.

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 decision 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
Protests¹⁴	16,750*	87%	2,568*	13%	19,318	100%
<i>Direct to L&I</i>	13,657	71%	2,149	11%	15,806	82%
<i>Re-assumed from BIIA</i>	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%
<i>Granted Appeals</i>	6,189	47%	1,635	12%	7,824	59%
<i>Re-Assumed by L&I</i>	3,093	23%	419	3%	3,512	26%
<i>Denied Appeals</i>	1,652	12%	302	2%	1,954	15%
All Appeals (excluding denied appeals as duplicative)	9,282	82%	2,054	18%	11,336	100%
<i>Granted Appeals</i>	6,189	55%	1,635	14%	7,824	69%
<i>Re-Assumed by L&I</i>	3,093	27%	419	4%	3,512	31%
BIIA Granted Appeals	6,189	47%	1,635	12%	7,824	59%
<i>Appealed by employer</i>	810	6%	380	3%	1,190	9%
<i>Appealed by injured worker</i>	5,379	41%	1,255	9%	6,634	50%
Re-Assumed by L&I	3,093	23%	419	3%	3,512	26%
<i>Appealed by employer</i>	163	1%	62	1%	225	2%
<i>Appealed by injured worker</i>	2,930	22%	357	3%	3,287	25%
BIIA Denied Appeals	1,652	12%	302	2%	1,954	15%
<i>Appealed by employer</i>	181	1%	25	0%	206	2%
<i>Appealed by injured worker</i>	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 Stats¹⁹	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.

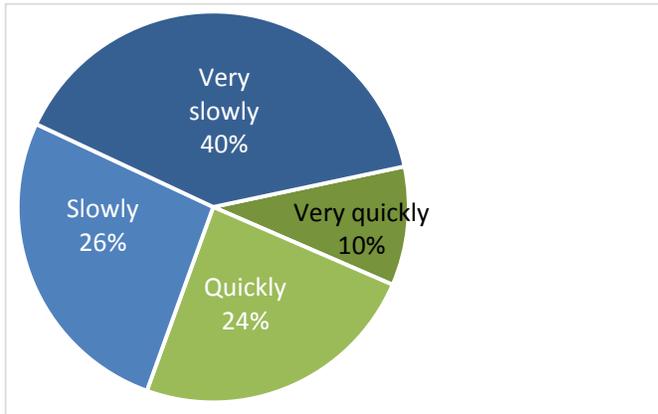
days, and if re-assumed the dispute is handled as a protest. On its face, such a process adds important value when only an appeal is filed, and not a protest. As an example, if a worker were to appeal a claim denial to the BIIA, but had not first protested the decision to L&I, then without the re-assumption 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,

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 2/3rds to 3/4ths 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 representatives²⁷ 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	1 st Ranked	2 nd Ranked	3 rd Ranked	4 th 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	1 st Ranked		2 nd Ranked		3 rd Ranked		4 th 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., affirmation 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.

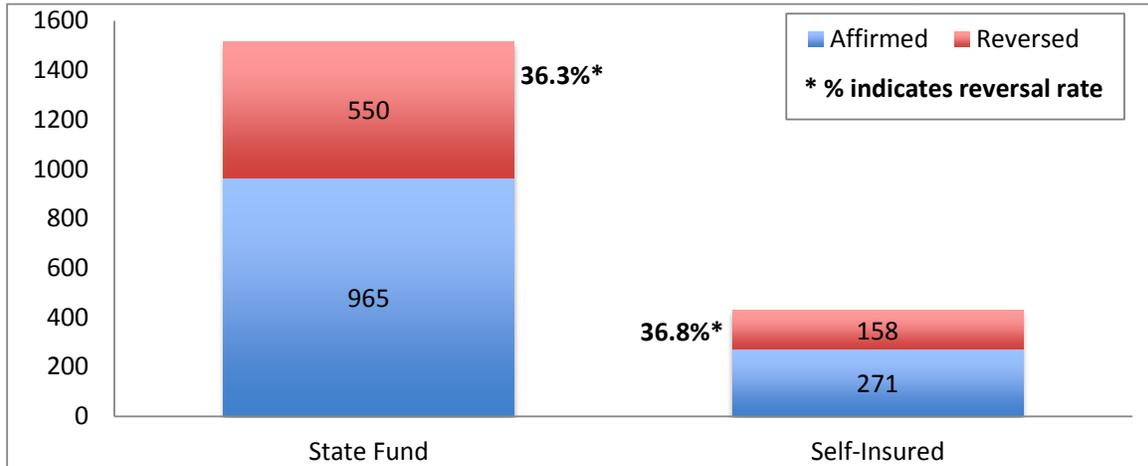
³⁷ BIIA Statistical Report, “Report 411” (as of June 2014, reporting 2013 and 2014 statistics; fiscal year runs from July 1 to June 30).

³⁸ The latest versions are available at <http://www.bija.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

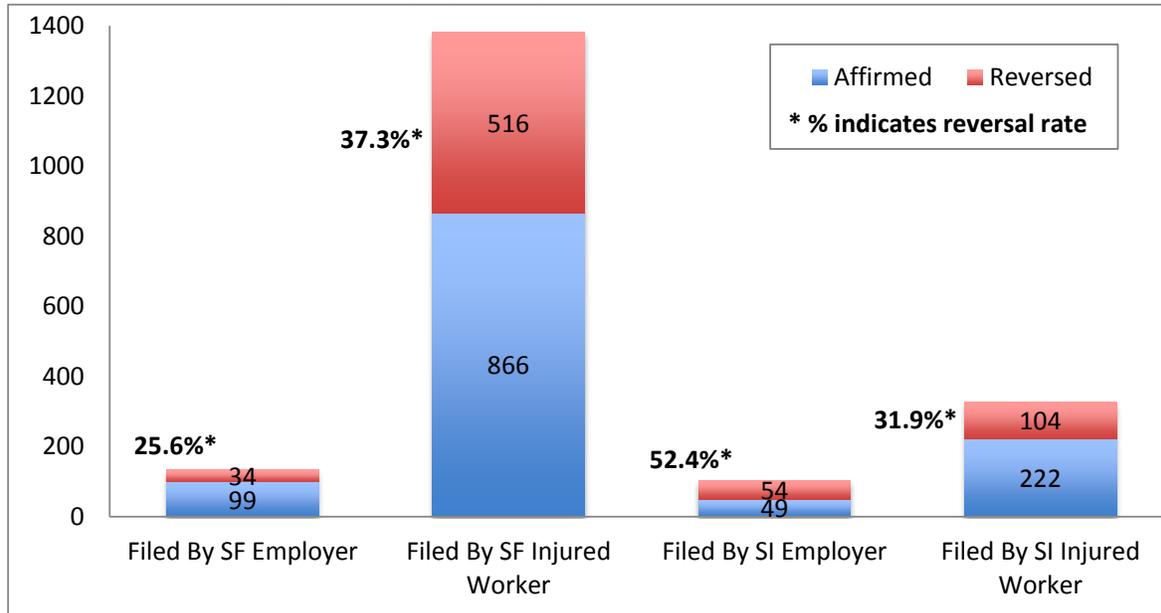
The overall rate of reversal, broken down by appellant type (worker or employer), was 36.3% when the injured worker appealed and 37.3% when the employer appealed. Although these rates are similar, when analyzed by insurance type (State Fund vs. self-insured), the results varied. The rate of reversal, 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 (3 rd 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 (4 th 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.

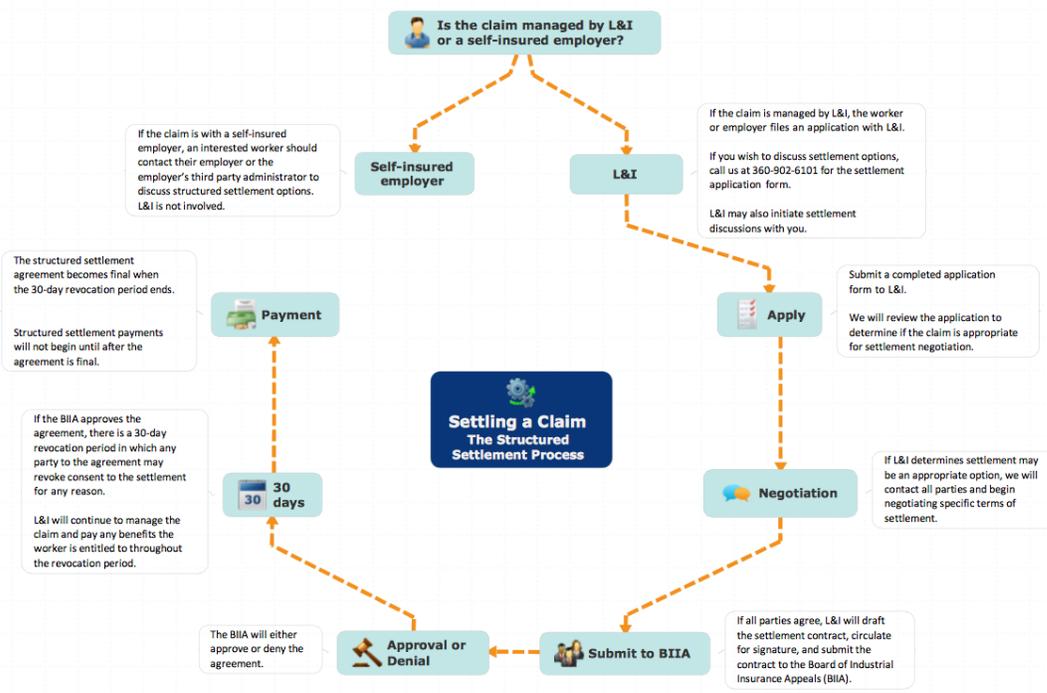
4.2 FORMAL SETTLEMENTS

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.

Chapter Four: Communications

INTRODUCTION

This part of the report addresses four communication related areas identified in the JLARC research agenda for analysis. It is presented in five sections:

1. [Timeliness](#) of communications
2. Use of “[plain talk](#)” standards
3. [Responsiveness](#) and accuracy of communications
4. Opportunity for [face to face](#) or personal interaction with L&I
5. [Online communications and the clarity of materials](#).

Timely and purposeful two-way communications are the essence of effective claim management. Good communication not only brings claims to a speedy and beneficial conclusion, it also has indirect benefits. It reduces the number of disputes that consume resources. To the extent communication can avoid misunderstandings that lead to suspicion and negative attitudes the number of protests, appeals, and attorney involvement is reduced.¹ Handling disputes consumes time from state employees and other parties to a claim. Finally, better communication builds confidence in the fairness of the workers’ compensation system among stakeholders.

L&I makes efforts to communicate well with parties to a claim, using several channels for this facilitate the flow of information.

Letters. L&I sends thousands of letters each work day to the parties involved in claims. Employers and workers are alerted to new claims received by the department. Workers and employers are notified as to the next steps in the claim process. Both groups are copied on all orders, acknowledgements of protests, and many other steps in the claim process. Treating medical providers receive a large volume of correspondence requesting information pertinent to the claim.

Letters, by a wide margin, are the tool of choice for L&I to initiate and maintaining contact with parties to a claim. Confirming significant steps in the life of a claim in writing is conventional and useful. Without this official record, parties could maintain that they were never informed about decisions or their rights. Dated letters supply defensible starting points for measuring elapsed time for the recipient to respond or exercise legal rights. While letters are helpful to some, they contain language and concepts that are difficult for the general public to understand. The simple phrase “arising out of employment” has been the subject of much policy debate and litigation.

¹ As the L&I Manager for Customer Communication put it: “State officials report that short, simple customer messages tend to result in fewer mistakes, fewer hotline calls and customers who are less frustrated with their government.” See: <http://www.plainlanguage.gov/examples/government/WARules.cfm>. According to a major report by WCRI on attorney involvement in workers’ compensation disputes, workers were more likely to seek attorneys when they felt “threatened.” The report discusses constructive and counterproductive examples of attorney involvement. See Workers Compensation Research Institute, *Avoiding Litigation: What Can Employers, Insurers, and State Workers’ Compensation Agencies Do?* WC-10-18. July 2010.

On line. There are many ways L&I uses online tools to provide or collect information and data from stakeholders, e.g., “Find a Doctor,” FileFast report of injury, e-Correspondence, Download Forms, and file Quarterly Report of hours for insurance purposes.

Educational Venues. L&I engages various stakeholder groups through face-to-face training and educational events. For example, L&I makes frequent presentations to employer associations to promote ways for them to minimize their insurance costs, make workplaces safer, and gain by using the Stay at Work Program.

Advisory Bodies. Advisory bodies meet regularly to hear from L&I and to provide feedback the agency’s policies and performance (Workers Compensation Advisory Committee, Retro Advisory Committee, Industrial Insurance Medical Advisory Committee, Advisory Committee on Healthcare Innovation and Evaluation and at least a dozen other advisory bodies).

Phone calls. A topic emphasized in this report is the placement of direct phone contacts by L&I with parties to a claim. Establishing contact is very often needed to reassure the worker, encourage early return to work with the worker and employer, and clarify the next steps in the process.

1 TIMELINESS

Timely communication with the parties to the claim is a key subject of claims adjusters' training. Private insurance companies commonly hold adjusters responsible for personally contacting the worker, the employer, and treating provider (called “3-point contact”), usually within a day or two of claim receipt. Why so quickly? Experience across the industry has demonstrated the benefits of swift contact: more accurate perceptions of the nature of the injury, clearer understanding of the attitudes of employer and worker about the injury, and—most importantly--identifying what needs to be done to get the worker back to work as soon as medically possible.

Unfortunately, this conversation with the parties to the claim is sometimes delayed because of delays in reporting claims to L&I. In the majority of claims the “First Report of Injury” comes from the provider that first treats the injured worker. There can be a delay of days or even weeks before L&I gets the first report. This could be caused by: 1) a lengthy delay between injury and when the worker obtains treatment for the injury, 2) failure of the worker and/or provider to recognize the occupational connection to the injury or illness, and 3) the lack of priority given by some providers’ offices in sending in paper reports or doing an electronic report.² These lags are likely most pronounced when a patient is initially treated by a provider unfamiliar with workers’ compensation. Providers and their office staff that are accustomed to workers’ compensation cases are increasingly using FileFast to send the initial claim report to L&I. The superiority of occupational medicine oriented clinics is seen by the fact that COHE providers have as a performance goal filing complete first reports of injury within two days of patient encounter.³

² Elsewhere we recommend that employers be able to file first reports of injury, as they do in almost all states. This change in reporting was previously tried and failed to pass into law.

³Advisory Committee on Healthcare Innovations and Evaluations, COHE Metrics &Oversight, April 24, 2014.

Employer reporting is the norm in most states, and was recommended in the 1998 JLARC Performance Audit. While employer reporting in Washington is only permissive, not mandated, L&I reports that the proportion of claims where the employer files an accident report is slightly less than 50% of all claims.⁴

The initial response from L&I depends on whether the claim appears to be a Medical Only or a Time Loss claim. This classification is based on a "check box" on the provider's Report of Accident (ROA) indicating whether he/she thinks the worker will be away from work more than three days, from certain diagnosis codes, or when the worker's portion of the ROA indicates no return to work. A Medical Only claim will usually get no personal contact and be handled as much as possible by correspondence and a great proportion are handled through auto-adjudication.

Lost-time claims trigger several communication flows. First, Account Services contacts, by phone, any employer that is in jeopardy of losing their "claim free" premium discount and advises them of options to avoid recording a lost time claim against their record. Second, claim notices are mailed to the employer and injured worker. Simple notices stating that a claim for compensation had been filed on a certain date are automatically generated and mailed to the employer and worker within a day or so of the claim being released to the CM.

After this initial, typically quick communication, things can slow down. A host of form letters and forms are mailed out at various times to the worker, employer, and treating provider. The timeliness of these letters often depends on the skill of the particular claims manager handling the claim.

An important performance measure of communications is the speed with which allowance (claim acceptance) decisions are made on claims. For the period 2010-2013, initial allowance decisions in State Fund claims have gone out an average of 5.9 days (5 days at the median) after receipt of the claim. There is no set standard in the industry for making allowance decisions. Rather it is assumed that if the immediate claim investigation suggests that it is a valid claim, the adjuster should proceed in the normal processing of benefits, unless counter-indicated by new information. In our survey of experienced adjusters, the most typical opinion was that seven days from receipt of the claim was enough time to be reasonably certain that a claim was allowable.

A final piece of information on the timeliness of the claims process comes from our survey question on timely resolution of protests. Two-thirds of workers (66.2%) surveyed with a protest felt that it was resolved "Slowly" or "Very slowly," with "Very slowly" dominating these two answers. (Note that the survey was directed at workers with claims with more than \$5,000 in medical payments.) L&I data from 2010-2013 show that the average protest is resolved in 55 days (see Chapter 3). From a sample of internal L&I reports for January 2015, about 38% of all open protests were open for more than 90 days, some more than 180 days. So what appears to be happening is that many protests are quickly resolved (well under 55 days) while a smaller fraction takes a much longer timeframe. This could be the root cause of the negative survey opinions regarding timeliness, which is discussed in Chapters 2 and 3.

2 PLAIN TALK

Executive Order 05-03 by Governor Chris Gregoire requires Washington agencies to follow "plain talk" guidelines when writing to customers. L&I has been a leading agency in the adoption of these guidelines

⁴ In Washington the employer accident report is used to help complete the information in the file; the accident report that is used to initiate a claim is filed by the medical provider.

for forms and correspondence. Our file review found only a few recurring lapses from the guidelines. Some examples are shown in Exhibit 4-1, below.

Exhibit 4-1: Summary of Plain Talk Issues Detected

Guideline	Examples of Breaches
Use Words that Your Customers Use	Words and phrases like “permanent impairment,” “order and notice,” “prognosis,” and “traumatic event” not in most customers’ vocabulary.
Use Active Voice	Sentences frequently use the passive voice.
Use Personal Pronouns	“We” should be used instead of “The Department” and “I will deny” instead of “requests will be denied.”

Source: WorkComp Strategies File Review, Sample of claims 2010-13 with medical costs > \$5,000

In addition to the above examples, we found many letters with customized language inserted by the CM that had grammatical mistakes, albeit usually very minor ones. There is a wide list of readability formulae in common use today (e.g., SMOG, [Flesch-Kincaid](#), and Dale-Chall) and it might be a good practice to test L&I documents intended for injured workers against one or more of these formulae. These formulae are not perfect measures of readability for the intended audience. Best practice would be testing reactions of the actual audience.

In spite of the above difficulties, the greatest problem is not that L&I sends poorly worded letters or forms. Most are written with care and are comprehensible to literate recipients. Rather, it is an inherent difficulty in explaining workers’ compensation. No matter how well worded, letters will often be a poor method for communicating many claims processes and important decision points to most persons unfamiliar with the workers’ compensation system. While parsimony is a virtue in most writing, there are no good, short statements about some concepts in workers’ compensation. A prime example is the causation standard: Denial letters often quote the Washington statutes at length as the explanation for why the claim is denied. These excerpts from RCW 51.08.100 and 51.08.140 highlight the legalistic nature of such quotes:

"Injury" means a sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result, and occurring from without, and such physical conditions as result therefrom. (RCW 51.08.100)

"Occupational disease" means such disease or infection as arises naturally and proximately out of employment under the mandatory or elective adoption provisions of this title. (RCW 51.08.140)

This dense legalese is very difficult to understand, even for many college-educated readers. This was borne out by our worker survey in which 32% of the respondents whose claims were denied said the reasons given were “very unclear.” Another 23% said the reasoning was “unclear.” Not surprisingly, a high fraction of survey respondents who had their claim denied hired an attorney. Note that our survey or workers involved claims with relatively serious injuries.

The tone of letters to employers, workers, and medical providers often comes across as cold and uncaring. While most letters do use the minimum courtesy of “please” and “thank you,” there are some additional opportunities to express appreciation to the recipient for their cooperation. In certain

situations it would be beneficial to give the injured worker modest encouragement for a successful healing process and return to work.

Compounding the problem with letters is the strong possibility that the recipient is illiterate, or functionally so. A large share of U.S. workers have limited education and regardless of schooling struggle with understanding written documents.⁵ The problem is particularly acute for immigrants that may be illiterate in English as well as their native language, and those with an especially low educational attainment.

3 RESPONSIVENESS TO USERS AND ACCURACY OF MESSAGE

L&I reaches out to its constituents with a variety of publications and rich website information. Our review of these outreach methods showed that they were uniformly written in an accurate and professional way. Naturally, some of the documents are written for specialists and use terminology suitable to this audience. For example, the documents and web content directed at providers and vocational service providers is fairly technical, but not unsuitable for this audience. We saw no example of forms or publications that had grammar or substantive errors.

Responsiveness must inevitably match resource limits. Stakeholders would ideally want to have their questions answered by a conversation with an expert that speaks their language in ways they can understand. But very few companies or government agencies can afford the costs of personal reception at the main phone line, or department phone lines. Also, individually customized instructions on forms and letters would be impossibly expensive. L&I seems to be paying attention to the types of queries it gets and the specific information being sought. They use this insight to produce answers to frequent questions, as least to those with minimal competency in English.

L&I's survey data shows that the satisfaction of workers and employers with L&I and the claims process is related to the level and type of contact. At the start, some claims need extensive communication to clarify the facts of the case, determine causation and the level of wage payments. The process for resolving issues and determining payment needs to be explained intelligibly to the worker. Personal contact is best for difficult communication issues. Letters are a poor substitute.

In our survey of workers, we detected an anomalous lack of recollection of L&I communication by a significant fraction of the respondents. About 21% of the worker respondents reported that they were unaware of a protest that was filed on their claim. It seems implausible that that such a high fraction of workers did not receive written notice of a protest.⁶ Other potential causes for this high failure to recall

⁵ The US Government's National Assessment of Adult Literacy done in 2003 found: 14% of U.S. adults are "below basic" in "prose literacy," or only able to perform "no more than the most simple and concrete literacy skills." 12% of adults are below basic in the "document literacy" category and 22% are below basic in the "quantitative literacy" category." <http://nces.ed.gov/pubs2009/2009481.pdf> The "document literacy" category is defined as the "knowledge and skills needed to perform document tasks, (i.e., to search, comprehend, and use non-continuous texts in various formats). Examples include job applications, payroll forms, transportation schedules, maps, tables, and drug or food labels." The estimate for Washington was 10% of the population lacked "basic prose literary skills." See: <http://nces.ed.gov/naal/estimates/StateEstimates.aspx>. More specifically related to employed individuals, the National Center for Education Statistics, in *Adult Literacy in America, 2002*, states: "... some 30 percent of the individuals in Level 1 and nearly 45 percent of those in Level 2 had full-time employment..." See: <https://nces.ed.gov/pubs93/93275.pdf>

⁶ We confirmed that L&I sends both employer and worker copies of all protests received on the claim to which they are parties.

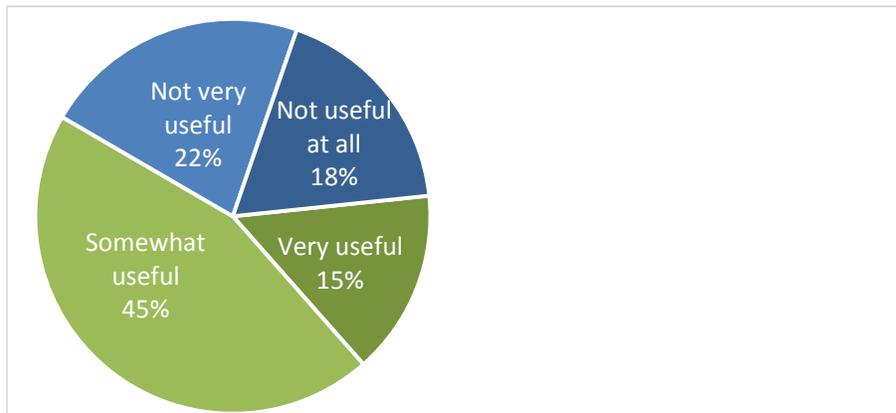
the protest notification could include: 1) the workers received so many letters that particular ones lost emphasis; and 2) workers did not recall or understand the term “protest” or did not recall getting the letter. This lack of recollection supports the value of confirming many of the actions in a claim via letter, even though some of these letters will be poorly understood. Evidence of the letter being sent may refresh the memory of the worker, and defend the department in a dispute before BIA.

The communications regarding the protest process seems to have shortcomings, especially for injured worker. We asked workers that were party to a protest, "How well did L&I explain your options when you disagreed with a decision on your claim." More than half (53.2%) reported that L&I's explanation was "Unclear" or "Very unclear." This is puzzling because the notice describing the opportunity to protest appears at the bottom of all letters containing orders and appears reasonably worded. However, there is room for improvement in how important legal notices are phrased and how they are formatted. For example, the text box with the protest information at the bottom of the letter could be more clearly set off and captioned “**IMPORTANT LEGAL NOTICE.**”

Another survey question asked about the clarity of L&I written communications during protests. 43% of workers with protests said the explanation was “unclear” or “very unclear.” In both these examples, the implication is that the L&I communications are unclear to at least a substantial fraction of workers. This may point to the helpfulness of a personal contact at certain points in the claim that are more critical, such as denied claim decisions and decisions about protests. A direct contact in such situations may help prevent disputes.

We also asked workers about the “usefulness” of the written materials provided in the dispute process. The written materials supplied by L&I to workers filing a protest appear to have been more useful than the overall clarity of the process as described just above. As shown in Exhibit 4-2, 60% of workers found the written materials “Somewhat” or “Very useful.” Only a small portion (18%) did not find them useful at all.

Exhibit 4-2: Usefulness of Written Materials on Dispute Process



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

In our survey, we did not have detailed coding on the type of issue or issues in dispute. It is possible that certain types of disputes are more difficult for workers to understand and manage. It could be useful to model the nature of the issues in dispute and track this in the electronic data, because if certain issues were especially problematic, special emphasis could be placed on redesigning materials or extra attention and time focused on these workers in their interactions with L&I.

4 PERSONAL “FACE TO FACE” COMMUNICATION

In our survey of workers, respondents fell into three nearly equally groups, those who 1) needed no direct contact with L&I, 2) needed contact other than face-to-face, and 3) needed face-to-face contact.

The JLARC research agenda asked: **Does L&I offer sufficient opportunity for face-to-face communication?** We put this question in our worker survey. The answer seems to be no. 84% of workers that said they needed face-to-face contact and felt they were given insufficient opportunity for this option. Should L&I try to satisfy this need?

We know of no private or public workers’ compensation insurer in any other state that invites face-to-face contact in the process of adjudicating claims. Most have centralized claims units covering a whole state or multiple states, much like L&I. There are compelling reasons for this:

1. There is ample evidence that the essential requirements of claim processing can be handled online, by printed correspondence and/or by phone contact;
2. Face-to-face meetings are resource intensive, requiring scheduling, travel, and meeting room;
3. Scheduling face-to-face meetings might slow down the flow of some information necessary to resolve a claim; and
4. Security would be needed to protect the agency personal from aggressive behavior that has been known to occur in insurance and legal settings.

Neither the Self-Insurance Ombuds program nor Project HELP invites interested parties to arrange for a face-to-face meeting, relying instead on phone, letter or electronic communication.

How do injured workers feel about the quality of phone contacts? In our worker survey, 79% of the respondents said they were “usually” or “always” treated with respect when they had occasion to contact L&I. That 7% said they were “never” treated with respect is worrisome, but it might be the result of irreconcilable disagreement over aspects of their claim.⁷ Another take on this issue is from L&I surveys of injured workers and employers. In their September 2013 surveys, 61% of both employers and workers rated their overall experience working with L&I as “good” or “very good.” That same survey wave found that 74% of workers who got a direct call from their CM rated their overall experience with L&I as “good” or “very good.” This compares to 53% for those that did not have direct contact.

But as the survey drilled down into the types of communication with the CM, one finds some specific weakness on the part of some CMs. The September 2013 L&I survey⁸ identified three types of information exchange that received much lower satisfaction scores:

⁷ The only other survey we could find that had a similar question was done by the North Dakota workers’ compensation agency. Question: “Did WSI staff understand your needs and provide polite assistance with your Claim?” 92% of respondent said that agency staff was polite with them (percentage is similar to previous surveys).

⁸ L&I staff member Ron Langley’s presentation to Workers’ Compensation Advisory Council, December 2013.

- Asking about concerns about RTW
- Letting the worker know what would happen next
- Actively involving the worker in discussion about next steps.

The percentage of respondents that rated the above three CM attributes as “poor” was between 2 and 3 times higher than the percentage of “poor” ratings on “friendliness” and “answering questions.” What this says is that CMs are maintaining a friendly helpful demeanor with workers, but being perceived by workers as failing to fulfill important needs. L&I already recognizes that CMs need to be properly trained in using effective techniques to communicate with injured workers, for example, asking the worker if they have any suggestions. These efforts should continue to improve the effectiveness of CMs in the limited amount of time they can spend with any one worker.

Another very important target for personal communication should be the treating provider. In our file reviews we saw that by far the dominant form of communication between the CM and treating provider was form letters (see Chapter 2 for discussion of reporting procedures). For workers’ compensation savvy providers, letter reminders and requests might be effective. But for a provider who treats only an occasional work injury, L&I’s requirements may be unclear and the response incomplete or ambiguous.⁹ This slows down important decisions and leads to incomplete understanding of what is needed by the CM. Examples of practices that potentially contribute to claim delays:

1. The first Activity Prescription Form (APF), which defines the worker’s capacity to work, is sent by the treating provider, but despite months of follow up treatments no further APFs are sent.
2. The provider is unclear as to when the functional restrictions might be modified, the need for future treatment, or the ultimate prognosis.
3. The provider answers the CMs question about whether MMI had been attained, but does not answer the CM’s question about the possibility of a permanent impairment.

Each of the above situations can require a lengthy letter exchange.

Granted, it would be difficult for CMs to make personal contact with busy providers (see discussion in Chapter 2). As a second best route, CMs could explain the reporting problems with the provider’s staff. For many providers, secure, electronic messaging would provide a faster, more direct, and interactive communication than letters or phone messages. As will be discussed next, better utilization of online communications would help alleviate these issues. Communication with some providers could be affected by the efficiency of a clinic in taking advantage of electronic communication tools. Small, independent providers’ offices, in particular, may not be set up to facilitate physicians in using electronic messaging.

5 OTHER COMMUNICATION ISSUES

As noted above, L&I offers a wide array of tools to workers and employers so that they can find information online and communicate by email or web-based forms. L&I is following a clear trend in other workers’ compensation systems. The department has made good use of online claim filing and has developed a solid and growing base of support among providers in filing injury reports through FileFast. The Claim & Account Center (CAC) is a web-based tool that allows registered workers, employers, and

⁹ L&I reports that a 2011 project, named “SmartDoc,” was designed to modify letter templates to make them simpler for medical providers to understand and respond to.

their respective representatives to access the details of a claim. These are excellent tools for those who are online savvy, but of no use those who are adverse to, or unable to, use online tools.

5.1 ONLINE COMMUNICATION

An important sign of the success of L&I's efforts to advance online communication is the increase in use by workers of the Claim and Account Center (CAC) to track their claims. The percentage of workers using the CAC nearly doubled from 18% (Gilmore survey in 2009) to 33% in the 2014 survey. Over half (57%) of employers in the 2014 survey that handle their own claims used the Online Account system. This compares with 29% of employers indicating they used the Online Account system when surveyed by Gilmore in 2009. In the recent survey, 61.1% of workers and 76.5% of employers who used the CAC system found it "easy" or "very easy" to use.

Secure, electronic correspondence is a service that could be particularly helpful on one of the weakest links in the communication chain—between CMs and treating providers. Filling out routine insurance forms is one of the most objectionable duties of a provider. Simplifying ways of providing essential information would be welcome. Paper reports add days, coming and going, to the communication lag. Simple questions about the meaning or intent of a message could be easily resolved. In our file reviews we did not detect a great deal of CM/Provider electronic communication.

The CAC seems to provide a gain for the busy clinician and for the CM. "My Secure L&I" (the online portal providing registered users with access to the CAC) provides a good vehicle for providers to accomplish a number of claim related tasks, including filing accident reports, transferring care to another provider, and billing for services. Through My Secure L&I, the provider can see all the messages to him/her regarding claims before L&I, and can respond electronically to questions and requests for more information or documents. The medical provider can create a customized dashboard highlighting all the most relevant services.

Considering the importance of clear, accurate, and timely medical information, perhaps a more robust set of tools could resolve the above difficulties in the communication flow between providers and L&I. At a minimum, a provider should be able to: 1) fill out a First Report of Injury, 2) fill out an Activity Prescription Form, 3) see any position descriptions or job analysis available for the worker, and 4) respond in a secure, electronic manner to questions from the CM or vocational service provider. For example, it would have an amazing result on the speed of claim closure if the treating provider could easily send a secure electronic message to the CM confirming that no further treatment is needed, or that another provider should be scheduled to provide a permanency rating. Unfortunately, the same set of providers who are likely to send in deficient or late reports probably greatly overlaps with those providers who are resistant to electronic communication tools. Perhaps, over several years, improved selection of providers for the treatment panel based on performance metrics will alleviate this problem.

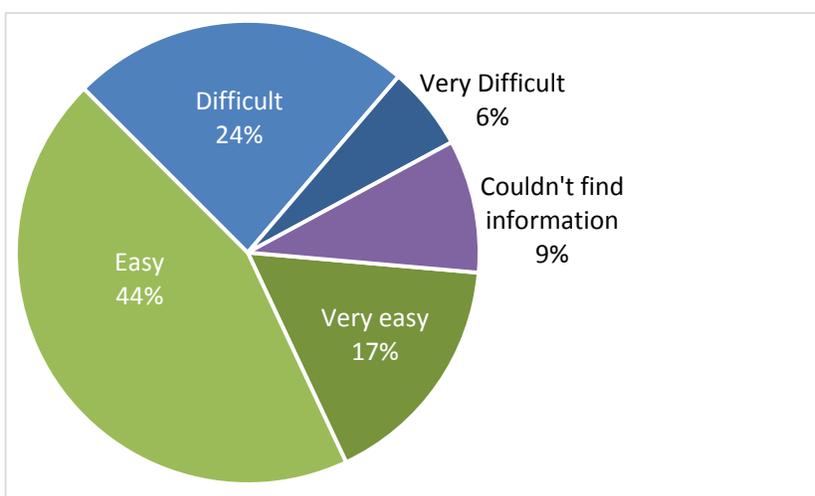
Online tools are growing in popularity. As of July 2014 there were 280,675 registered users for CAC, 2.7 million Internet information requests, and 54,266 unique users in the month of July. Medical and vocational service providers made 30% of the contacts on claims, followed by claimants that made 16% of the claims related contacts.

Online services are for the most part positively received, as confirmed in L&I surveys and our own worker survey. Yet, 30% of those responding in our worker survey who said they used online tools thought they were complex or difficult. Our testing of online tools suggests that they are not materially more complex or difficult than Amazon.com, Walmart.com, USPS.com or other highly used commercial

and government websites. My Secure L&I, for example, offers a great deal of functionality to the user, but this comes at the cost to the user of learning the range of functions and discriminating between service choices. There may be no practical remedy for making online encounters more user-friendly to the 20-30% or so of L&I stakeholders that are uncomfortable with this technology.¹⁰

In our survey, one-third of workers indicated that they used the CAC to track their claim. Both employers and workers had a positive perception of how well the system worked. Exhibit 4-3 shows that 60% of workers reported the system “very easy” or “easy” to use. While a substantial fraction of workers still find it difficult to use, the difference between the focus group (older claims) and the survey (relatively more recent claims) suggests that L&I is making substantial progress on improving the interface of the on-line system.

Exhibit 4-3: How Easy is the On-line Account System to use?



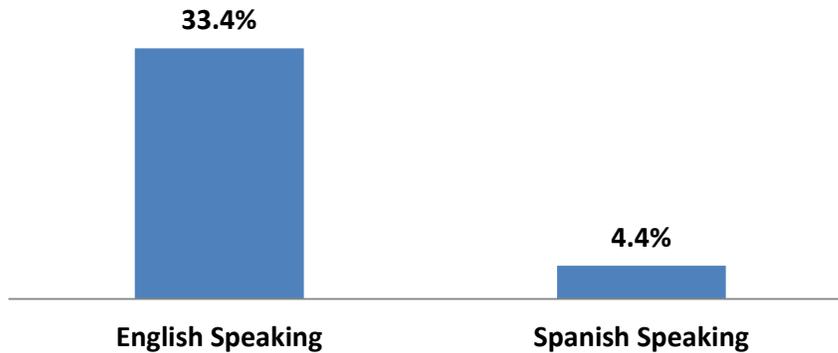
Source: WorkComp Strategy Worker Survey, 2014 (sample of claims > \$5,000 in medical costs)

There was one area of major concern about online services: few Spanish-speaking workers (4.4%) used the system to track their claims (Exhibit 4-4). There can be several reasons for this lack of use, such as lack of access to computers and the Internet, or a lack of familiarity with the Internet. The most obvious barrier is that My Secure L&I and the CAC are published only in English. Though not always a flawless translation tool, some government agencies use Google Translate to assist non-English speakers.¹¹

¹⁰ According to a 2013 household census, about 74.4% of US households have Internet access. The number is relatively low for households in which English is not spoken, households with older residents, and Hispanic households. See: <http://www.census.gov/content/dam/Census/library/publications/2014/acs/acs-28.pdf>.

¹¹ According to L&I, federal guidelines seem to discourage the use of online translator tools, presumably because they do not always capture the correct technical or idiomatic meaning of an English expression. But, online translators (like Google's) are not prohibited, particularly for Spanish. Notwithstanding this difficulty, it seems that offering English-only information and online communication tools is a disservice to some workers with profound English language deficits. One alternative is to put more prominent notices in Spanish and other frequently encountered languages on English language only web pages/tools that English translation is available from L&I upon request, and how to make such a request.

Exhibit 4-4: Percent of Respondents Reporting That They Used On-line Account System



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

This percentage of usage of online services in Washington is higher than in North Dakota, where 54% reported being aware of online services, and about 26% reported using the services.

5.2 CLARITY OF MATERIALS

A segment of workers do not understand the basics of the claims process. In our interviews with stakeholders we heard several worker representatives say that many recipients of L&I letters are left confused and need to have a third party explain what is being told them by L&I. Our worker survey found that 18% of respondents thought that L&I written communication in disputed cases was “very unclear” and another 22% thought it was “somewhat unclear.” We also heard this comprehension problem emphasized in some stakeholder interviews. Project Help is a fall back for helping bewildered workers, but the best approach is to try to customize the type of communication to the worker’s needs at the start of the claim process.

Customization means being able to determine when it would be appropriate to use letters and when a worker seems particularly confused or upset about his or her claim. The latter would get a larger share of the personal contacts by the CM, who may need training on recognizing and communicating with these injured workers. In extremely difficult cases, it might be useful to allow a referral to specialized resources to assist with communications issues that are complicating the management of the claim.

As already stated, worker opinion is widely divided on the speed and quality of communication. Also noted are the barriers to communicating with a large fraction of workers (non-English speaking, functionally illiterate), and the difficulty of explaining complex workers’ compensation rules and procedures. We believe that a more flexible and individualistic approach to communication is worthy of development.¹² Whether through decision modeling or perceptive skill training the CM ought to be able to detect early in a claim that managing the claim is going to need special communication techniques or referral to specialized resources for assistance.

¹² Recognizing this, L&I has initiated special communication skills training for all CMs. While a major step to more skillful communication, honing these communication skills should be an ongoing process and not just the subject of a one-time training program. CM turnover and unsatisfactory assimilation of the training by some CMs requires close monitoring of effective use of methods covered in the training, and repeated training as needed.

The Federal agencies cite Census data to estimate that 8% of the resident Washington population is “Limited English Proficient” and requires special handling. The investigators cited several cases in which L&I had not consistently used forms and letters in Spanish, despite the fact that the worker identified a preference for Spanish.¹³ This is consistent with our findings in file reviews, where we saw several cases of English language letters being used despite the fact that the record showed a Spanish language preference. Language assistance was not always offered for treating provider or IME encounters.¹⁴

Our review of L&I letters and forms written in English, discussed above, found some shortcomings in clarity, comprehensibility, and grammar. It may be impractical for L&I to impose sufficient quality control on translating a host of letters into Korean, Serbian, Cambodian, and dozens of other languages. Given the large number of different languages involved, and the intricacies of writing about workers’ compensation laws and procedures in any language, we think that the letter and form dependent system is particularly inappropriate for workers with limited English proficiency. Personal contact with the worker using a qualified translator, or multi-lingual CM, would seem to be best suited for these special populations.

Under some circumstances it makes sense for a party that disagrees with L&I to hire an attorney. In mediation sessions or at pre-hearings, adjudicators sometimes advise workers filing appeals to seek legal counsel before proceeding with the appeal. The fact that an attorney is willing to take a case is in some sense a confirmation of a problem in the claim. Acceptance is a demonstration that the attorney thinks there is a sufficiently good chance of winning the dispute and earning a fee relative to the effort invested. The fact that between roughly 20-30% of injured workers¹⁵ whom we surveyed either hired or considered hiring an attorney is a sign of problems with communication, if not the decision process itself.

In our survey of injured workers we found the following as the most recurrent reasons for workers to hire attorneys:

- **Confusion about the process.** Most commonly workers mentioned they consulted an attorney because they were confused about the claims process or the benefits they were entitled to. Closely related to confusion about the claims process, workers often mentioned consulting an attorney to clarify the extent of their rights to benefits.

¹³After investigation of complaints of Washington residents with limited English proficiency, the US Dept. of Justice (DOJ) and US Dept. of Labor jointly determined that L&I, Insurance Services Division, was in violation of Title VI, sec 188 of the Workforce Investment Act for not providing meaningful access to information in a language that the worker can understand, including steps to: “(1) develop, monitor, and assess the effectiveness of its language access program; (2) effectively identify the number or proportion of LEP individuals served or encountered and the frequency with which they come into contact with ISD and the language needs of LEP workers ‘compensation workers; (3) ensure that LEP workers’ compensation workers are provided timely language assistance services at no cost, including oral interpretation services and vital documents and information in the workers’ preferred language; (4) require testing procedures that assess the competency of all bilingual job applicants and employees who serve as interpreters and translators; (5) provide adequate training to staff on civil rights and language access obligations; and (6) provide LEP individuals appropriate notice of language assistance services.”

¹⁴ L&I reports that this issue is currently being addressed in a new project to address limited English proficiency communication issues.

¹⁵ Our survey of injured workers found 17.5% of the respondents reporting that they hired an attorney. An additional 13.1% of workers consulted an attorney but did not become represented. WCRI estimated that in 1995 26% of lost time claims in Washington involved a worker attorney. See: *Revisiting Workers’ Compensation in Washington: Administrative Inventory*. Carol A. Telles and Dr. Sharon E. Fox. December 1996. WC-96-10.

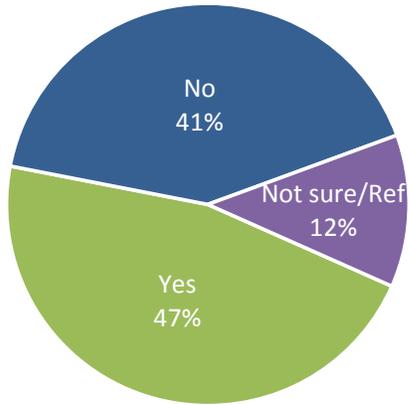
- **Termination of TL benefits.** The termination of TL benefits seems to be a trigger for seeking an attorney. There may be confusion about how and why benefits end or transition to a different type of benefit. L&I might consider a proactive, direct contact with workers when benefits are going to end. To be efficient, these contacts might be limited to claims where the benefits have had durations greater than some threshold (e.g., 30 days) or some other claim characteristic or characteristics predict a higher probability of a dispute.
- **Delay and denial of medical treatment.** This is a very important trigger. Many workers seeking an attorney indicated they were frustrated with the length of time it took to get approval for medical treatment. Another group sought an attorney after medical treatment was terminated and (in their perception) the claim closed. Ending medical treatment is not as easy a place to intervene, proactively, as the ending of a particular benefit. The ending of medical treatment tends to be much less precise. But, it might be important for CMs to contact the worker directly when a decision is made to terminate medical treatment.
- **Additional body part not allowed.** There were a number of cases where the worker consulted an attorney because a 2nd body part was not allowed to be added to the claim. These appeared to be cases where the second body part was added after the claim had been open for some time. This might be another opportunity for the CM to proactively contact the worker and explain why the additional body part is not being approved for treatment.
- **Denial of time loss payments.** Not surprisingly, a high fraction of workers who had their claim denied hired an attorney. Unlike workers that hire an attorney because of medical treatment issues, termination of benefits, or in hopes of speeding up the process, these workers are at risk of losing all, not just a fraction, of their benefits.

In our survey of injured workers (note that those surveyed had claims with relatively serious injuries) we detected strong minority opinion that L&I was not fair in how it handled the respondent's claim. Fairness is a tricky concept to query workers about. The challenge is that "fairness" is a vague concept, or more precisely, it can be inexact, understood differently by different respondents, or both. In addition, the perception of fairness can be colored by the outcome of the dispute process. We get at the issue of fairness by asking a series of three questions:

- Did the workers feel they had sufficient opportunity to present their case?
- Were the workers satisfied with the process?
- Were the workers satisfied with the outcome?

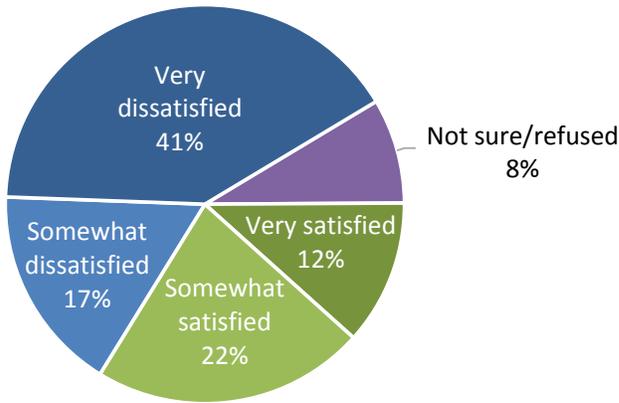
The concept of fairness should be considered in light of the answers to all three questions, shown in Exhibits 5, 6, and 7 below. The answers to the three questions are consistently negative. A large percentage (41%) did not believe they had a sufficient opportunity to present their case, 41% were "very dissatisfied" with the process, and 34% were "very dissatisfied" with the decision. Note here that in most of these figures we include the fraction of workers answering "Don't know" or "Not sure." We do this here because unlike nearly all of the other questions, the fraction answering "Don't know" or "Not sure" is not trivial. This might be an indication of how difficult it is for workers to answer questions about the concepts.

Exhibit 4-5: Workers with Protests: Sufficient Opportunity to Present Case?



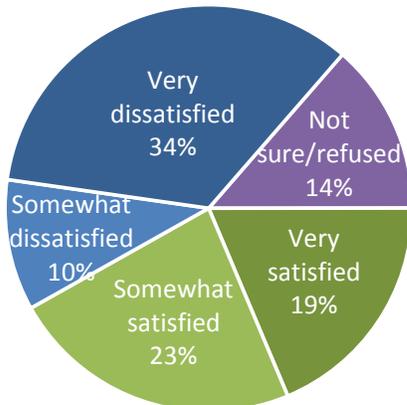
Source: WorkComp Strategies Worker Survey, 2014 (sample of claims > \$5,000 in medical costs)

Exhibit 4-6: Workers with Protests: Satisfied with Process?



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

Exhibit 4-7: Workers with Protests: Satisfied with Decision?



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

In summary, we believe that L&I can mitigate such perceptions of bias through better communication. This would include more:

- Early, personal contact by the CM.
- Understandable written communications explaining why their claim or medical treatment was denied.
- Careful assistance with non-English speakers who appear to be challenged by letters and online information.
- Improved letter communications, and less reliance on form letters.

Chapter Five: Overall System Performance

INTRODUCTION

Previous parts of this report covered specific features of the design and operation of the Washington workers' compensation system. This part of the report discusses "the big picture," that is, how these features together contribute to overall system performance. We present some common and not so common measures of how well the system is meeting stakeholder needs. Some of these measurements can be meaningfully compared to other jurisdictions, others cannot. L&I produces a large number of performance measures, some of which are internally used by management and some of which are presented to the public.

This section of the report is organized as follows.

1. Performance from the [non-economic costs](#). Our focus is on length of disability, both "temporary" disability and total and permanent disability, or "pension"
2. Performance by examining the [overall cost of insurance, and three critical insurance cost drivers](#): disability durations, multi-year disability, and pensions
3. Discussion of a related key performance indicator: [Time to closure](#)
4. Review of [overall satisfaction gauged by stakeholder surveys](#)
5. Review of [performance metrics](#)

1 NON-ECONOMIC COSTS

In discussing system performance it is common to begin with, and emphasize, insurance costs to stakeholders; in other words, emphasis on the "cost drivers" for the system.¹ Instead, we begin with a discussion of the often-neglected non-economic performance features of the system. These are defined as the effects of workplace injuries on the lives of the injured workers and their families, employers, and society at large.² A work injury can cause intense hardship not easily measured in monetary terms; chiefly pain, anxiety over income and ability to pay bills, feelings of bewilderment over the claim process, and uncertainty about what to do in reaction to the demands of the system.³

Below are a number of candidates for measures that could cast light on system costs of injured workers not subject to straightforward monetary calculations (some of these are already reported):

1. How long are workers receiving disability payments?
2. What percentage of time loss claims is receiving wage-loss benefits at the end of the 2nd and 6th year after the injury year?

¹ Such costs typically are borne by employers; Washington is unique in that workers share, along with employers, in the cost of premiums that cover workers' compensation medical treatment.

² Kirsta Glenn, WCAC Presentation, April 2013: "This cost [long term disability] is not only for employers who are paying the premiums, but it is a tragedy for injured workers and a cost in productivity for society of millions of dollars for every person that becomes a long-term disabled person."

³ See generally "Mom's Off Work 'Cause She Got Hurt: The Economic Impact of Workplace Injuries and Illnesses in the U.S.'s Growing Low-Wage Workforce," Borkowski and Monforton (Dec 2012) (available at http://defendingscience.org/sites/default/files/Borkowski_Monforton_Low-wage_Workforce.pdf).

3. How soon are workers returned to gainful employment?
4. How long do workers stay employed after returning from a work injury?
5. How many workers never return to work (within some long term limit)?
6. How many claims involve one or more independent medical examinations (potentially a sign of inefficiency and friction⁴)?
7. How is the frequency and severity of permanent impairment trending over time?
8. What level of pre-injury earnings are workers achieving by RTW?
9. How many workers are declared to be totally and permanently disabled?
10. How quickly and successfully are injuries healed by medical treatment?

Measures such as these are seldom reported by US jurisdictions, although many are commonly reported in Canada. A few can be found in one time academic studies. Some of these would require new research or annual studies by L&I (Numbers 3, 4, 5, 8 and 10), some would require more effort to publish annual trends (Numbers 1 and 2), but others (Numbers 1, 2, 6, 7, and 9) could be found in existing data. It would be desirable to report a balanced and comprehensive set of performance indicators to stakeholders. Such “Key Performance Indicators” would help provide a more complete picture of system performance and its broader effects. Appendix 2 contains examples of such indicators developed and used by all Canadian workers’ compensation agencies, and by the Australian Heads of Workers’ Compensation Authorities.

Under the heading of “Insurance Services Performance Metrics Dashboard” L&I has begun to report (since 2013) an expanding set of metrics on claims activity, e.g., duration of temporary disability (known in Washington as “Time Loss” or “TL”) and return-to-work (RTW) during the first 6 months of a claim. To enhance these reports the Department has shown a specific baseline value for both long duration TL and RTW at a particular stage of the process, and has declared target values for these metrics. Also useful are clear symbols for movement toward goals each quarter of the year: unchanged, progress, or negative change. The December 2014 report to the Workers’ Compensation Advisory Committee (WCAC) shows steady values for the 3rd quarter on: 1) number of disability cases at 1 year or longer; 2) percentage of TL cases with RTW within 6 months; and 3) the persistence of lost time from 3 months to 6 months. While these metrics are consistently collected and discussed with WCAC,⁵ they present only a small slice of the process. A fuller and more complete set would be beneficial. For example, the definition used in the RTW metric mentioned above states that it measures: “For every 1,000 new time-loss claims, the number that are off time-loss for at least a 30 consecutive day period during their first six months.”⁶ As a companion to this metric, it would also be useful to measure the number of cases that moved from TL, to no TL, and reverted back to TL. This would provide insight into re-injury or unsuitable modified duty.

⁴ In many respects the duties involved in an IME can be quite appropriate, particularly doing a PPD rating if the treating physician declines the task. But, the need to hire a doctor to offer a competing opinion to the treating physician is inherently less efficient than if the treating physician rendered a reasonably acceptable decision in the first place, e.g., whether MMI has been reached, return-to-work restrictions, or treatment plans. In a recent study of the North Dakota workers’ compensation system, the authors reviewed ND results in scheduling IMEs; between 2011 and 2013, 1.4% - 2.1% of lost time claims involved IMEs. “Performance Evaluation of North Dakota Workforce Safety and Insurance,” p. 21-22 (2014) (available at http://www.nd.gov/auditor/reports/wsi_pe_14.pdf).

⁵ Meetings are open to the public; presentations for prior WCAC meetings available at <http://www.lni.wa.gov/ClaimsIns/Insurance/Learn/Wcac/WcacMtgMin/Default.asp>.

⁶ Vickie Kennedy, presentation to the WCAC, September 22, 2014, p 46.

Another aspect of RTW that should be measured is the RTW and stay at work success of all workers who cease getting TL payments at MMI. Did they RTW? If returned to work, was the return durable (e.g., more than 90 days)? Were those who were declared “employable” by an AWA but without employment at the time back to work within a reasonable time after TTD was discontinued? For those employed, what did they earn compared to their pre-injury wage? These measures would cast light on the adequacy of RTW efforts for those without job restrictions after injury. They would also show the number of workers’ that seem to be ‘falling through the cracks’ of the vocational system.

A seldom-recognized consequence of prolonged TL is the increased likelihood of secondary injury. L&I CMs and ONCs we interviewed described the phenomenon of “diagnosis creep” in long-term claims. This means that over time secondary illnesses occur as a result of being out of work. High on the list of such secondary conditions are clinical depression, substance abuse, prescription opioid addiction, and obesity. General deconditioning of muscle strength and weight gain also accompany long periods of time away from work.⁷ Occupational medicine recognizes that prolonged disability is detrimental to overall good mental and physical health. Another cause of secondary injury is premature or inappropriate RTW with restrictions. How many workers reinjure themselves after RTW before MMI?

Some injuries are rated by physicians as leaving permanent effect on general bodily function. This can be measured in many ways. Essentially, impairment means a loss of some particular body function, e.g., an amputation of a limb or range of motion limitation on bending or lifting. More and more, workers’ compensation measures impairment by its “whole body” impacts, i.e., how the particular loss of function affects overall bodily function. Either way, impairment does not equate with disability.

Disability (as used in workers’ compensation) measures the loss of capacity to work at the pre-injury job or other jobs. One can have a tiny impairment but be 100% incapacitated from performing certain work, e.g., loss of range of motion in an index finger could ruin a professional musician. Workers’ compensation in Washington does not measure or compensate directly for “disability.” Rather, the Washington approach is based upon using impairment ratings to set compensation for permanent injuries as a proxy for non-economic loss and future wage losses.⁸ Impairment ratings are converted to indemnity payments that compensate in some way for the non-economic damage of the loss of body function; they also serve as compensation for the loss of the power to earn wages, caused by the impairment. Both of these are only rough approximations of the effects on individual workers. As previously mentioned, metrics could be developed to show how completely workers with various impairment ratings recovered their pre-injury income. We could not find any public presentations by L&I of the number of workers that have some permanent impairment as a result of their injury has varied or showing of the distribution of impairment severity. Such metrics could be directly compared to the

⁷ University of Kansas, Research and Training Center on Independent Living, Deconditioning and Weight Gain, B Series, No. 3, 1996, found at: <http://www.rtcil.org/products/RTCIL%20publications/Health%20Issues/SCI%20Deconditioning.pdf>

⁸ For discussion of differing PPD approaches and related public-policy implications, including replacement of earnings losses, other economic losses, non-economic losses, and pain and suffering, see generally Barth, Peter S., “Compensating Workers for Permanent Partial Disabilities,” Social Security Bulletin Vol. 65, No. 4 (2003/2004) (available at <http://www.ssa.gov/policy/docs/ssb/v65n4/v65n4p16.pdf>); Barth, Peter S. and Niss, Michael, “Permanent Partial Disability Benefits: Interstate Differences,” Workers Compensation Research Institute, September 1999, p. 6 (available for purchase at www.wcrinet.org); Burton, John F., Jr., “Permanent Partial Disability Benefits,” p. 94, published in “Workplace Injuries and Diseases: Prevention and Compensation: Essays in Honor of Terry Thomason (Upjohn 2005) (available at http://research.upjohn.org/up_bookchapters/287/); Welch, E., “Permanent Partial Disability Benefits,” Michigan State Univ. 2008 (available at http://hrlr.msu.edu/hr_executive_education/documents/PPD20Discussion2008-02.pdf).

Canadian Key Performance Indicators, shown in Appendix 2. This comparison could open up consideration of the underlying causes of differences in permanent disability (i.e., is it in how the concept is measured or are differences in the severity of accidents causing the differences?).

Many useful indicators of the quality of medical care could be published and used to evaluate the quality of care given by physicians in the provider network. Examples of these would include: case adjusted time to reach fixed and stable condition; degree of permanent injury; speed to RTW; and secondary injuries after RTW. The above metrics would need careful and consistent definitions and qualifications to maximize the insight into system performance. For example, the medical treatment measures would need to be carefully “case adjusted” to compare reasonably similar mixes of injuries.

As shown in Exhibit 1-8, in Washington, approximately 80% of all time loss claims are resolved within the first three months after injury.⁹ Claims with relatively minor injuries that do not impose long-term barriers to job performance are resolved quickly without significant effort by the CM. But the remaining claims are those at risk of expanding into catastrophic levels of disability. These at-risk claims are generally those which reach maximum medical improvement with some job restrictions from the injury and with no return to work prospects. If the claimant is judged to be non-employable, the stage is set for years of TL followed by a recognition of total and permanent disability, known as “TPD” or “pension” cases. Clearly, there is a large cost to the insurance system from such claims, but as discussed, the “human” cost is also significant.

The ultimate defeat of disability management is being forced to declare a worker to be permanently and totally disabled. Ideally such declarations should be limited to cases in which, despite best effort of the workers and case managers, the workers are found to be without any reasonable prospects of performing gainful employment. As preliminary context, in Washington, this threshold (no reasonable prospects of performing gainful employment) is very difficult to apply, and is sometimes crossed, and pensions awarded, despite residual capacity to work. The statute provides that a pension is appropriate in the case of, among other things, a “condition permanently incapacitating the worker from performing any gainful occupation.” This is known as an “administrative pension,” as opposed to a “statutory pension,” which is defined by statute and is awarded without regard to the ability to perform gainful employment.¹⁰ Similarly, after being awarded an administrative pension, L&I is authorized to suspend or terminate the pension if the worker “returns to gainful employment for wages.”¹¹

Case law interpretations of “gainful” vary, and are beyond the scope of this discussion. In brief, however, a worker can be able to perform work, and still continue to be eligible to receive a pension, provided the work is not “gainful.” The statute does not authorize a range of “gainful”; in other words, there is no partial eligibility. Additionally, “employability,” which is a related standard that is applied in pension cases and is discussed in detail in Chapter 2, requires establishing the residual work capacity of the worker and proving that a labor market exists for such capacity. These determinations are connected with the particular situation of the worker, e.g., education, work experience, and unemployment rates in the location of residence. The result of applying these standards – employability and gainful employment – is that workers are found eligible for pensions despite having work capacity,

⁹ Estimates for FY 2014 put pure TL claims more than 90 days at 70% of the total, ref BV 3.

¹⁰ “Statutory pensions” are determined by statute and include loss of both legs, both arms, one leg and one arm, total loss of eyesight, or paralysis. RCW 51.08.160.

¹¹ RCW 51.32.160(2).

and in some cases despite actually earning wages, and these eligibility determinations do not follow clearly defined standards. The outcome is a high number of pension recipients.

While there are arguably positive public-policy aspects of long-term support of unemployed workers with lengthy TL payments followed by permanent pensions, the downside of such prolonged time away from work include the loss of self-esteem, domestic friction, poor health, and even shorter longevity.¹² Thus, it is a human tragedy as well as a system failure each time a worker's life is transformed from productive employment to permanent disability as the result of a workplace accident.¹³

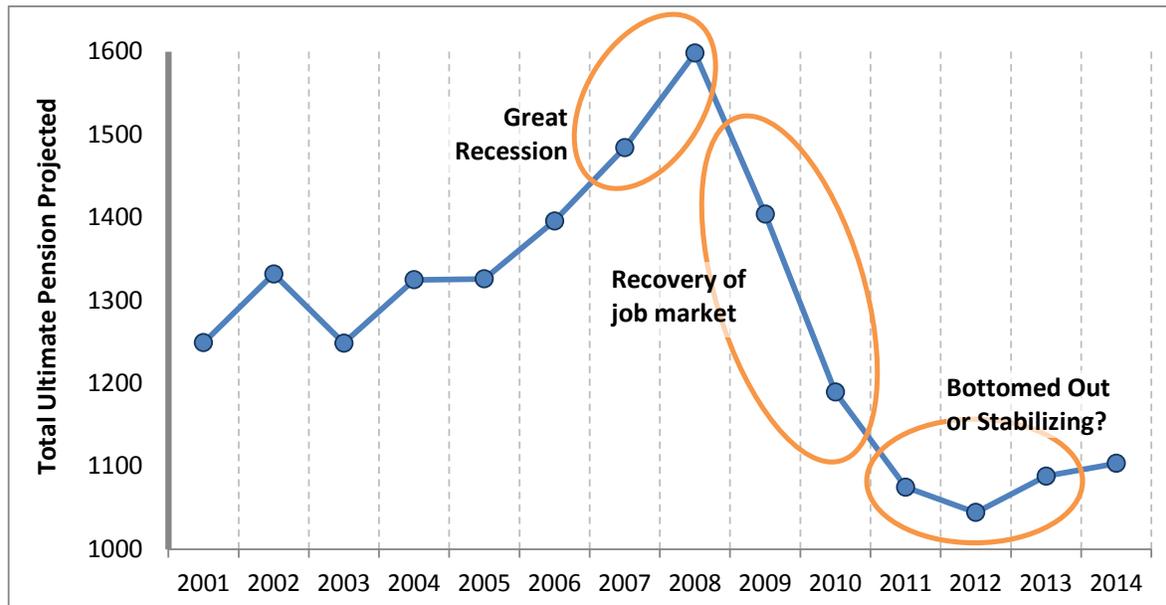
The injury rate is extremely important to system costs, both economic and human. It is beyond the scope of this study to consider safety regulation by Washington. L&I administers the delegated state OSHA program, which engages in educational and regulatory means of injury prevention. But, all of the direct and indirect costs of accidents at work can be spared through the prevention of injury in the first place. We note that L&I's number one strategic objective is to make workplaces safer.

In Washington, the number of persons expected to ultimately be declared to be permanently and totally disabled is shown in Exhibit 5-1. These are actuarial projections, which have historically developed to higher than expected levels, which is another way of saying that these may be underestimated. The reason for indicating the recession and job market on Exhibit 5-1 is that the job market is very influential in getting injured workers back to work and impacts a CM's efforts in this regard. Poor economic conditions mean fewer jobs; and fewer workers are therefore accepted back to their employer of injury, and fewer find work after retraining. The volatility in the number of pensions in a given year can also be affected by administrative policy in pushing closure of files with a pension award. This is a critical aspect of evaluating the performance of claims management efforts, as well as overall performance of a claims management program, because the longer an injured worker stays on disability, the less likely the chance that they will ever return to work.

¹² Years of lower life expectancy were found among workers compensation cases with permanent impairments, especially those permanently and totally disabled, see [Ho I-J, Hwang I-S, Wang I-D](#), Life-expectancy estimations and the determinants of survival after 15 years of follow-up for 81 249 workers with permanent occupational disabilities," *Scandinavian J Work Environ Health*, 2006;32(2):91-99; Railroad retirement workers on disability have much shorter life expectancies than non-disabled retirees of the same age; see: http://www.rrb.gov/opa/qa/pub_1212.asp.

¹³ For a good description of the human costs of injury see: OSHA, "Adding Inequality to Injury: The Costs of Failing to Protect Workers on the Job," 2015, found at: <http://www.dol.gov/osha/report/20150304-inequality.pdf>

Exhibit 5-1: Estimated Projections of Ultimate Pensions Allowed by Fiscal Year



Source: Data from L&I Actuarial Services, communication with actuary staff, 2014; graph by WorkComp Strategies

One of the performance features of the Washington system that most glaringly sets it apart from other workers' compensation systems in the US and Canada is the relatively large number of pensions in Washington. Because of sharp increases in the number of pensions awarded starting in the late 1990s, the Department contracted with the Upjohn Institute in 2007 to study the Washington pension system.¹⁴ The Upjohn authors did a comprehensive review of possible causes for the relatively large number of pensions and their rapid growth rate. They ruled out the nature of injuries, industry mix, standards for impairment awards, and demographics. The principle causes identified were backlogs of claims needing closure, the nature of the pension system, and the lack of settlement opportunities. Appendix 2 updates this review of environmental conditions that might explain the very high pension rate in Washington; it too finds little basis in explaining Washington pension by the number and severity of accidents, demographics of the workforce, or nature of the macro economy.

The Upjohn authors observed that the likelihood of pensions in Washington seems inextricably linked to the incidence of time-loss claims.¹⁵ As the Upjohn authors note, TL claims of very long durations are the "raw material" for pensions. The numbers of very long-term time-loss claims, discussed below, is a good predictor of the future of pensions.¹⁶

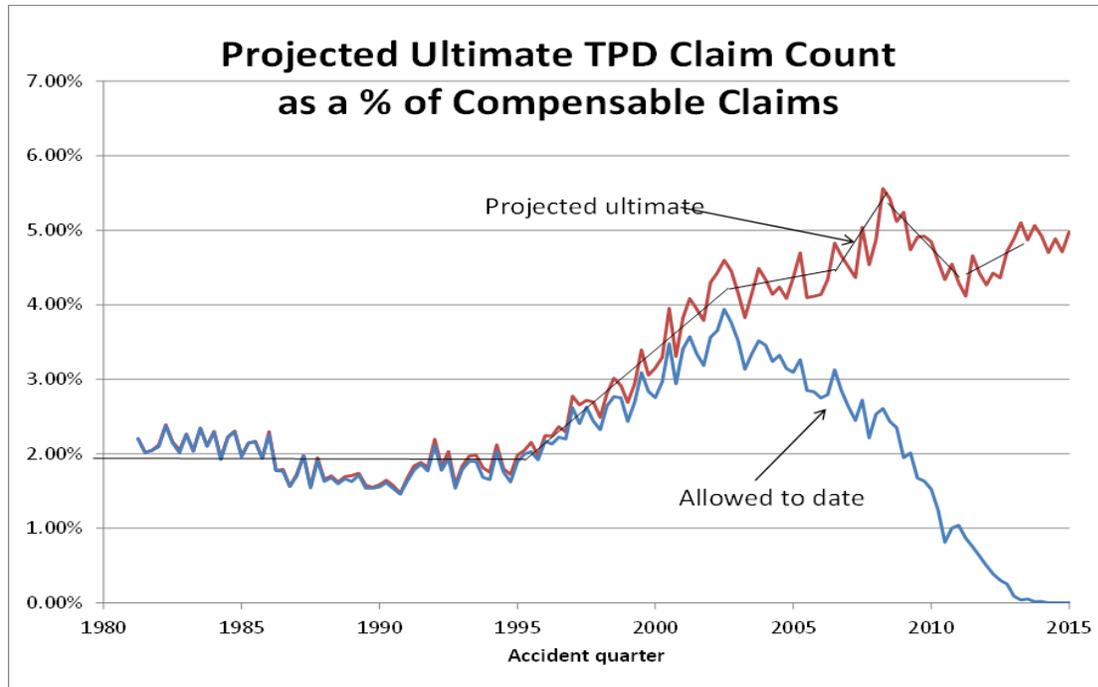
¹⁴ Barth, Peter S., Heather Grob, Henry George Harder, H. Allan Hunt, and Michael Silverstein. 2008. "Washington Pension System Review." Upjohn Institute Technical Report No. 08-025. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research. http://research.upjohn.org/up_technicalreports/25/

¹⁵ As Upjohn notes: "That the number of pensions is correlated with the number of time-loss cases with a lag of six to 10 years is both intuitive and indisputable." Op. cit. While this is a historical fact in Washington, the strength of the correlation with loss time injuries is not fixed, but can be improved by better disability management.

¹⁶ Barth, Peter and H. Allan Hunt, 2010, Workers' Compensation Reemployment Programs Options, Final Report, L&I Contract K1817.

In one sense, the situation today is improved compared to when Upjohn completed their assessment. The absolute number of pensions peaked in 2008, at 1,598 projected ultimate pensions. As Exhibit 5-1 shows, the number of pensions plummeted between 2008 and 2012, but then began to increase slightly. This sharp drop may be plausibly associated, at least in part, with the improvement in the job market. As shown in Exhibit 5-2, the percentage of pensions per time loss claim has fluctuated at or slight below 5% for the last few years, which is about the same as the percentage of TL claims at the conclusion of the Upjohn study.

Exhibit 5-2—Relationship between Pensions and Allowed (Compensable) Time Loss Claims



Source: L&I Actuarial Services, communication with actuary staff, 2014

Upjohn compared the Washington rate of pensions with national data. The report found Washington to have the highest rate of pensions per 100,000 covered employees. This was much higher than the second highest state, among all states studied by the National Council on Compensation Insurance. They reported that “The number of pensions awarded per 100,000 covered employees is very high in Washington compared with other states; roughly four to eight times the 36-state average, and about two to four times as high as any other jurisdiction.”¹⁷ The most recent estimates put Washington at 2.4 times the highest NCCI state in the study and 19 times the countrywide average. This is a glaring difference that demands attention.

Another perspective “closer to home” on the relative rate of pensions is to compare Washington with Oregon and British Columbia. British Columbia is the better of the two jurisdictions to match with Washington because it is an exclusive fund system and because it does not allow settlements.¹⁸

¹⁷ Barth, *op. cit.*, p 13.

¹⁸ Note that in 2011 the Washington State Legislature adopted statutory changes allowing structured settlements, but to date only a small number of cases have been settled through this new process.

However, the British Columbia standard for a pension is a bit different than Washington and Oregon; the closest thing to a pension case in British Columbia is a person that accrues a 100% impairment rating. Despite the fact that Oregon allows settlements, the Oregon pension rate is still instructive because it has a similar economic, demographic, and benefit level profile to Washington.¹⁹

In Exhibit 5-3 below, the ratio of pensions to covered workers was computed for each jurisdiction. The ratio of Total Permanent Disability (TPD) in Washington to Oregon was nearly a hundred times higher in FY 2012 and 66.5 times higher in FY 2013. This means that in 2013 there were just over 66 TPD claims in Washington for every 1 such claim in Oregon. The pension rates for British Columbia and Washington were much closer than in the case of Oregon. Washington was 3.7 and 3.1 times the BC rate in 2012 and 2013, respectively. BC does not have a benefit category that closely matches Total Permanent Disability as used in Washington, so the comparison is based on a “best approximation.”

Exhibit 5-3: TPD cases per 100,000 covered workers

FY Year	Washington	Oregon	Ratio WA/OR	British Columbia	Ratio WA/BC
2012	53.9	0.54	99.8	14.57	3.7
2013	54.5	0.82	66.5	17.35	3.1

Source: WorkComp Strategies computation, using these sources:

1. Washington: L&I actuarial projection spreadsheet “Total pensions by accident year”; includes both SF and SI.
2. Oregon: Dept. of Consumer and Business Services: Various Characteristics of the Oregon WC System.
3. British Columbia: special analysis supplied by WorkSafeBC, through Terry Bogyo, February 2015.

2 OVERALL COST OF INSURANCE AND CRITICAL INSURANCE COST DRIVERS

Here we will describe commonly used measures of costs, including so-called “cost drivers” and overall insurance costs. Note that we exclude from these economic costs the considerable indirect burden of accidents to both employers and workers.

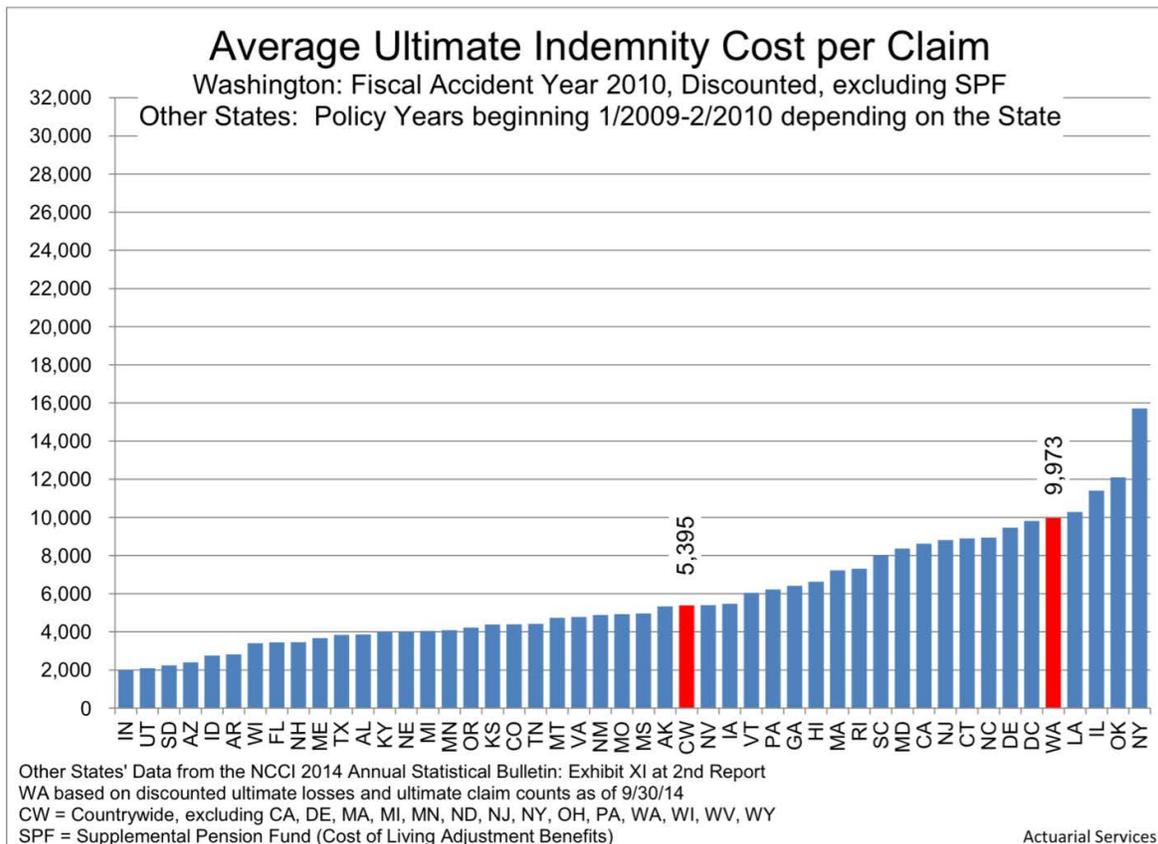
2.1 BACKGROUND

Total insurance costs are typically studied in terms of average “indemnity” cost per claim and average medical cost per claim. The average cost per indemnity claim in Washington for Accident Year 2010 is compared to other states in Exhibit 5-4. Washington is 5th from the highest of the states included, and about 85% above the countrywide average. (Note that the Washington cost excludes the Supplemental Pension Fund, which pays for cost-of-living increases for pension cases, and also discounts the indemnity payments, both of which tend to deflate Washington costs.) Washington is sometimes characterized as a high benefit state. Business interests often cite the fact that the National Academy of Social Insurance (NASI) has regularly ranked Washington highest of all states on total benefit payments per covered

¹⁹ Briefly, the Oregon standard is based on incapacity “from regularly performing work at a gainful and suitable occupation,” “regularly performing” means the “ability of the worker to discharge the essential functions of the job,” and a “suitable” occupation means one that “the worker has the ability and the training or experience to perform, or an occupation that the worker is able to perform after rehabilitation.” A “gainful” occupation means one is the lesser of (i) two-thirds of the worker’s average weekly earnings; or (ii) federal poverty guidelines for a family of three. The worker is required to prove permanent and total disability, including that the worker has made reasonable efforts to obtain employment. Benefits cease if there is return to work and the post-injury earnings plus the permanent and total benefit exceeds a worker’s pre-injury wage. See Oregon Revised Statutes section 656.206

worker.²⁰ This statistic should be interpreted with caution. Both the benefits paid and the number of covered workers are estimates. Our studies show that the statutory level of indemnity paid for TL and PPD is not particularly unusual or generous compared to other states. Two exceptions to this are the relatively generous benefits paid for workers with dependents and the inclusion of employer paid health insurance as part of lost wage. What drives up average indemnity cost in Washington the most is not average weekly benefit levels but benefit duration.

Exhibit 5-4: Comparison of Average Indemnity per Claim Countrywide

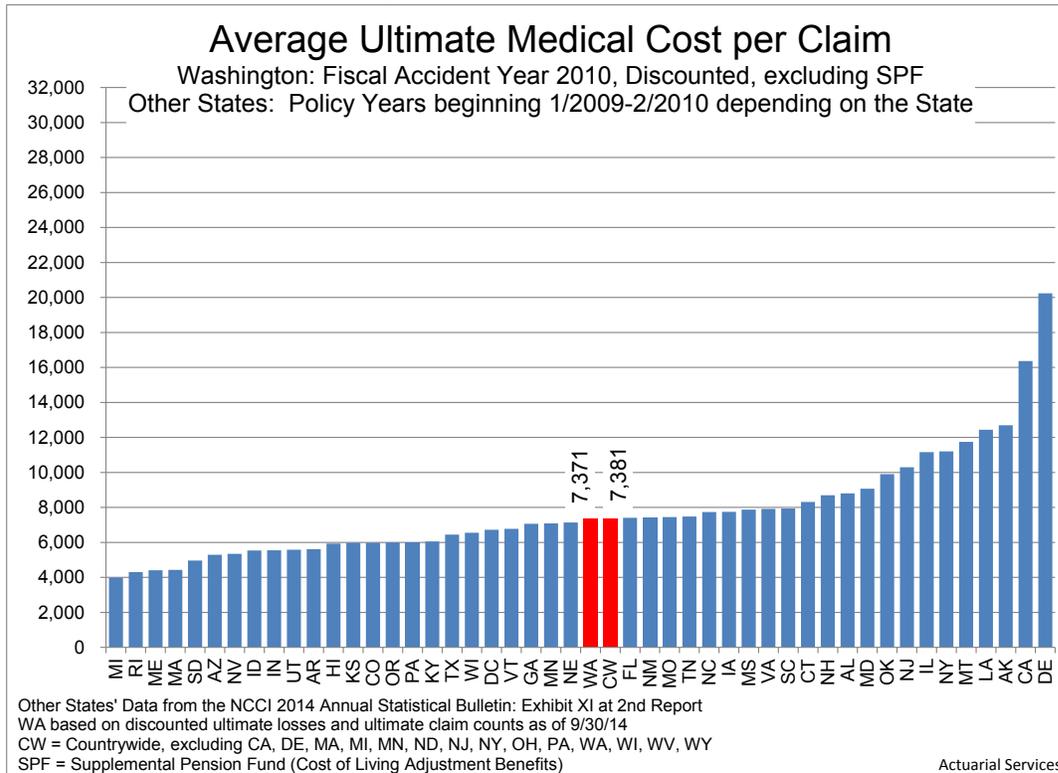


Source: L&I Actuarial Services, communication with actuary staff, 2014

The average medical cost per claim in Accident Year 2010 is shown in Exhibit 5-5. For average medical, Washington is very close to the expenditure countrywide. This appears to show that Washington has done fairly typical in managing such costs compared to other states. The quality of medical care can be measured on many scales. In Washington, injured workers choose their treating physician, as opposed to some states where employers select treating physicians. The provider network in Washington offers a wide range of choice and access to care. But the relatively long durations of TL in Washington suggest that treatment plans from some providers may unnecessarily prolong disability status.

²⁰ See for example: "Employment Cost Drivers in Washington State: The Case for Workers' Compensation and Unemployment Insurance Reform" Washington Roundtable and Washington Research Council, April 2011; and "The Best Interest of Washington Workers' Compensation System," Washington Research Council, PB 14-01, January 7, 2014. However, the relatively high benefits per covered worker is not seen in a negative light by worker advocates.

Exhibit 5-5: Comparison of Average Medical Cost per Claim Countrywide



Source: L&I Actuarial Services, communication with actuary staff, 2014

Exhibit 5-6 below shows recent trends in average medical cost per lost time claim and average indemnity cost per claim. “Incurred indemnity cost per claim,” which is the estimated ultimate cost of all indemnity obligations divided by the number of LT claims, went down substantially between 2009 and 2013. The 1.5% rise between 2012 and 2013 should not be taken as a clear reversal of this trend. These incurred costs are subject to change as they are developed by actuaries given new claims experience. Medical cost per claim is trending upward at an average rate of less than 2.9%/year. This is a favorable trend compared to other states. Furthermore, initiatives like the 2013 pain guidelines, expansion of the COHE network, tightening of the preferred provider network, and the future implementation of the Top Tier provider network promise to maintain a relatively low growth in medical costs.

Exhibit 5-6: Trends in Average Indemnity and Medical Cost per Claim

Fiscal Year	Indemnity		Medical	
	Incurred Cost/LT Claim	% change from previous year	Incurred Cost/MO Claim	% change from previous year
2009	\$21,677		\$1,103	
2010	21,352	-1.5%	1,200	8.7%
2011	20,861	-2.3	1,232	2.6
2012	18,892	-9.4	1,257	2.0
2013	19,168	1.5	1,235	-1.8

Source: Data from L&I, website found at:

<http://lni.wa.gov/ClaimsIns/Insurance/DataStatistics/WorkersCompData/default.asp>. Calculations of annual changes by WorkComp Strategies

Washington's cost of administration of insurance is much lower than in private insurance systems. Administration encompasses the insurance agreement, rating and premium collection, loss adjusting, medical and vocational services, and all other benefit administration costs. This has been shown by L&I data and by outside studies.²¹ There has not been a significant change in administrative expense as a fraction of premium charges to employers in the past few years.

The cost components of average indemnity, average medical, and administrative cost combine to set the overall cost of insurance. According to the authoritative source on comparisons of premium costs across states, the 2014 Oregon Premium Rate Comparison,²² Washington was in a three-way tie for 17th from the top in average adjusted insurance rates. This is improved from the 13th place rank in the 2012 report. Washington's position in the 2014 Oregon study was 8% above the national median; there were 21 states in the study clustered within 10%, plus or minus, of the nationwide median.

Together the above indicators suggest that Washington's insurance cost is somewhat above average on cost per covered worker and as a percentage of payroll. However, recent improvements in cost drivers have improved Washington's relative insurance cost ranking in recent years.

The principle cost driver in most jurisdictions is medical cost, but in Washington the principle cost driver is the duration of disability, i.e., how long an injured worker is disabled and receives disability benefits, together with the extremely high fraction of cases getting total and permanent disability pensions. We now discuss these cost drivers in more detail, focusing on three measures of disability:

1. The average and median days of TL paid.
2. The fraction of TL claims with multi-year durations of disability benefits.
3. The number of permanent total Injury awards ("pensions") in Washington.

²¹ The 1998 JLARC performance audit praised the administrative efficiency of L&I.

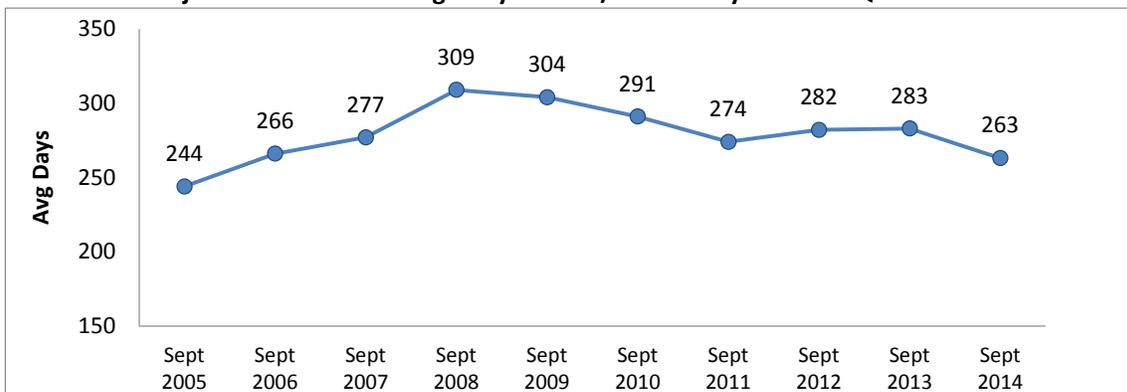
²² 2014 Oregon Workers' Compensation Premium Rate Ranking Summary, Dept. of Consumer and Business Affairs, October 2014, found at: http://www.cbs.state.or.us/external/dir/wc_cost/files/report_summary.pdf.

2.2 AVERAGE AND MEDIAN DURATION OF TIME LOSS CASES

In this section we pay particular attention to the duration of TL benefits. This is an indirect indicator of human costs of disability, discussed earlier; TL durations also serve as a major cost driver in Washington. The payment of indemnity for lost wages is a basic component of workers' compensation. Although the time and reasons why an injured worker stays on indemnity payments is highly variable from state to state, it is considered a strong indicator of the performance of a system. Shorter durations of TL usually mean faster healing from the injury, less time away from work, and lower costs for workers' compensation insurance.

In Exhibit 5-7 we show an actuarial projection of the average days of TL duration when all claims for each year are fully resolved. (The selection of the third quarter of every year has no significance). It is apparent that the average duration climbed sharply during the "Great Recession." The reason for this is that the RTW opportunities are negatively related to the number of jobs available and the employers' outlook for sales. Economic activity sharply declined in 2008 and only gradually improving for the next three years, which probably deterred many employers from finding work for their injured employees.²³ Average durations since 2011 start to resemble levels just before the onset of the recession. This is roughly similar to the pattern of pensions (Exhibit 5-1), the exception being that pension levels fell to below their pre-recession levels, while average TL is slightly above pre-recession levels (2005). While there has been improvement since the nadir point of the Great Recession, it is puzzling that average temporary total disability has not dropped more in light of the very favorable change in the labor market of 2014. It may well be that the effects of several recent L&I initiatives have yet had a chance to speed early RTW.

Exhibit 5-7: Projected Ultimate Average Days of TTD/TL Claim by Accident Quarter



Source: L&I Actuarial Services, communication with actuary staff, 2014; graph by WorkComp Strategies

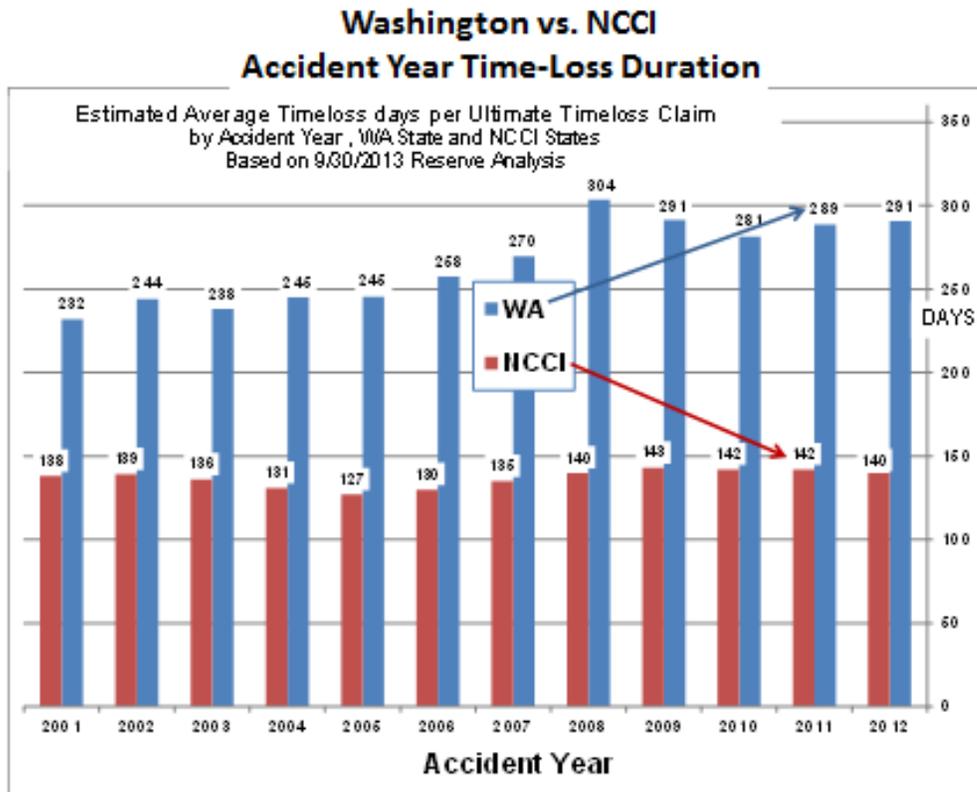
These durations can be compared to similar actuarial estimates developed by the National Council on Compensation Insurance (NCCI). NCCI's most recent published estimate of ultimate duration of TTD²⁴ averaged over 46 states is 140 days for Accident Year 2012. Washington is 102% higher than the

²³ The relationship between the unemployment rate and average duration of TTD is discussed in Lipton, B., J. Robertson, and K. Porter, "Workers Compensation Temporary Total Disability Indemnity Benefit Duration 2013 Update," NCCI, August, 2013, available on ncci.com.

²⁴ Note that workers' compensation systems commonly refer to temporary total disability benefits as "TTD"; in Washington, these same benefits are referred to as "Time-Loss Benefits", or "TL" for short. Temporary total disability benefit structures and amounts are highly variable across states.

national average, and higher than the 192-day average for highest state in the NCCI ranking²⁵ (Exhibit 5-8). Despite the fact that both were rigorous actuarial estimates, the NCCI and Washington findings have methodological differences and difference in caps on duration of TTD. Still the large difference between 291 days for Washington and 140 days for NCCI's average (AY 2012) probably would not change significantly if the methodologies were harmonized more closely.

Exhibit 5-8: Projected Ultimate Average Duration of TTD payments: WA compared to NCCI States



Note: Durations for WA shown here are estimates that were developed earlier, and with different data, than the ones in Exhibit 5-7 preceding it.

Source: L&I; Graph developed by L&I Actuarial Services, 2014

Our review (see Appendix 2) and those of others²⁶ cannot find an explanation for these relatively long temporary disability periods in the unique nature of injuries or demographics of workers in Washington. The causes for the relatively high durations in Washington seem to result from a combination of factors discussed in Chapter 2, most prominently: the need to determine “employability” status for many workers, execution and design of disability management, non-outcome based CM case ownership, and CM performance on certain key claim management activities, specifically prompt client contact and proactive medical management.

²⁵ Barry Lipton, John Robertson, and Katy Porter, Workers Compensation Temporary Total Disability Indemnity Benefit Duration—2013 Update, NCCI Research Brief, August 2013.

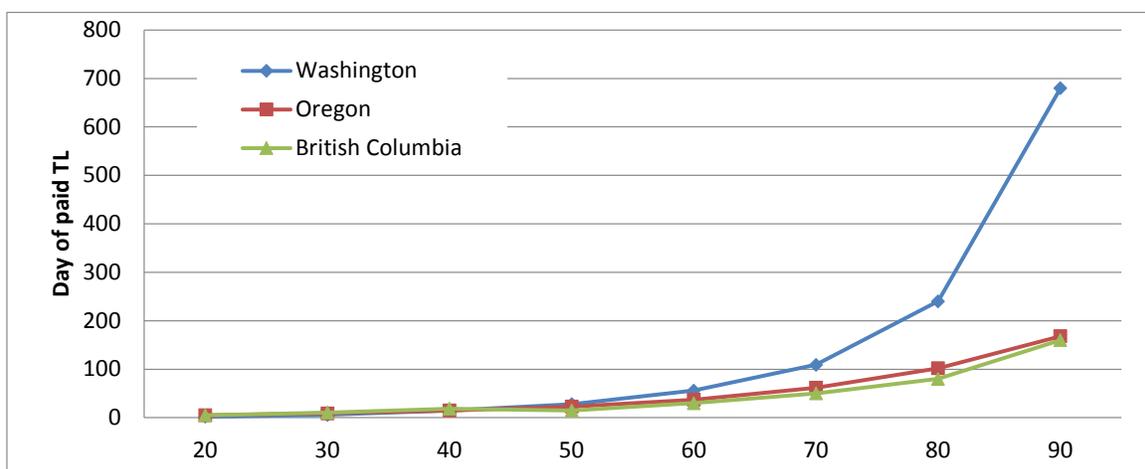
²⁶ Peter Barth, et al., Washington Pension System Review, Upjohn Institute, Technical Report 08-025, 2008.

As a final comment on durations, it is instructive to consider the large gap in TL duration between State Fund and self-insured claims. Granted, self-insured employers, because of their large employment size, have much greater return-to-work options than do smaller employers insured by the State Fund. However, the substantial difference (50% longer durations for State Fund claims than for self-insured claims, as discussed in Chapter 2) does indicate that disability duration is not pre-ordained by the nature of the injury, and can be managed. Long-term disability is remarkably cut if the opportunity for transitional or permanent modified duty is exploited by claims managers.

2.3 MULTI-YEAR DURATIONS OF WA TL CASES

One of the very unusual features of the Washington system is the high proportion of claims with multiple years of TL payments. This oddity was discussed in the 2008 Upjohn pension study.²⁷ Exhibit 5-9 shows the average days of TL in Washington, Oregon, and British Columbia at each decile of the claim distribution, i.e., the days of TL at the 50th percentile, at the 60th percentile, etc. As shown, the durations for all three are similar up to the 50th percentile; after that the durations in Washington pull away from the other two jurisdictions. At the 90th percentile (the top 10% of all claims in each jurisdiction), the Washington duration is 4.3 times that of British Columbia.

Exhibit 5-9: Days of Paid TL by Decile of Frequency Distribution



Source: WorkComp Strategies

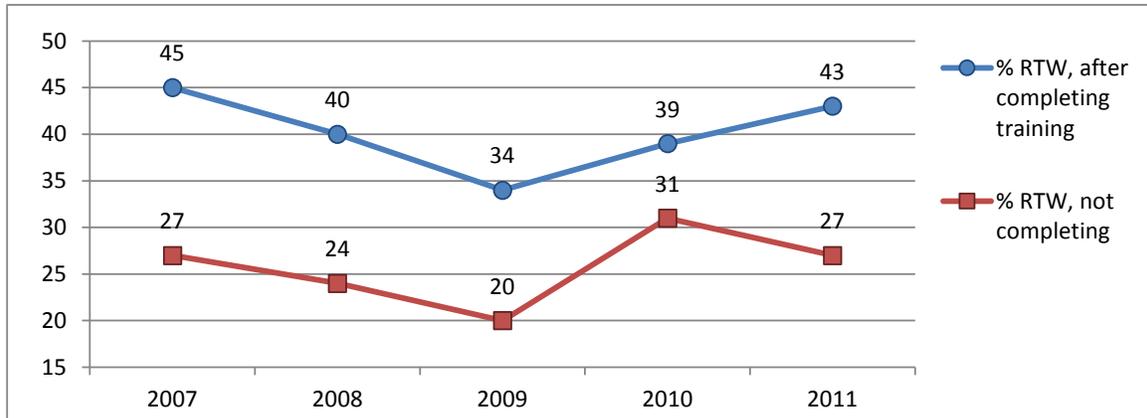
Why is this important? The odds of return to work after 6 months of disability are about 50/50; at a year they are less still. By the time one has reached two years of disability the chances of returning to work become miniscule.²⁸

²⁷ Barth, op. cit., p 3-52.

²⁸ The American College of Occupational and Environmental Medicine (ACOEM) puts the danger point for permanent disability even earlier: “Studies have shown that the odds for return to full employment drop to 50-50 after six months of absence. Even less encouraging is the finding that the odds of a worker ever returning to work drop 50 percent by just the 12th week.” See ACOEM, “Preventing Needless Work Disability by Helping People Stay Employed,” *Journal of Environmental and Occupational Medicine*, 2006, found at: <http://www.acoem.org/PreventingNeedlessWorkDisability.aspx>. See also Gregory J. Crabb, of Hartford Life Insurance Co., who said that after six weeks of disability “there is only a 50 percent chance that injured workers will return to work. When disabled for a full year, there is only a 1 to 2 percent chance that injured

The exception to these pessimistic return to work prospects are those small number of injured workers that are timely channeled into a good retraining plan that is matched to their aptitudes and interests. For these, one or two more years of TL while on retraining does not carry with it such a dismal future for work. But retraining is not a panacea for injured workers. Only 55% of those eligible workers who chose retraining (Option 1) successfully completed formal retraining; of these successful completions, only 34-45% have RTW in two years from claim closure.²⁹ About 45% do not complete retraining, and their RTW is much worse (see Exhibit 5-10).

Exhibit 5-10: % RTW in Two Years after Closure, By Training Completion Status



Source: L&I, "Claim Closure by Plan Outcome" (spreadsheet created 3/25/14)

As discussed in Chapter 1, most jurisdictions transition away from temporary disability benefits when the worker returns to work or is placed at "Maximum Medical Improvement" (MMI); in either situation the worker will receive a payment for their rated permanent partial disability (PPD). In Washington, however, MMI does not end TL automatically. For TL to end, one of three conditions needs to be met: 1) the IW returns to work, 2) the treating physician gives an unrestricted release to return to the job of injury, or 3) the worker is shown to be "employable" by a vocational assessment. Maintaining TL after MMI is a unique feature of the Washington system. The effect of this is to create a substantial demand for vocational assessments, not found in other jurisdictions. As suggested in the Upjohn pension report, if Washington offered higher PPD awards and closure at the point of Maximum Medical Improvement, and allowed settlements to be negotiated as in other states, the very long TL durations would be reduced.³⁰

Increasing the portion of claims that end with settlements may not be a necessary condition for reducing TL duration. British Columbia does not allow settlements, yet its average duration of TTD is similar to Oregon, which has a large volume of settlements. There appears to be a better approach in British Columbia and other jurisdictions to control long-term disability. One of the keys for Canadian systems is to use early vocational services directed at early return to work and not retraining.

workers will ever return to work." Located in "Hartford's Return to Work Program Proves Can-Do Approach Works," *BestWire*, April 10, 2003, found at: <http://www3.ambest.com/ambv/bestnews/newscontent.aspx?altsrc=108&refnum=56974>.

²⁹ See Chapter 2 for discussion of the choices available to a worker. In short, Option 1 involves a formal retraining plan, and Option 2 involves a lump-sum payment to the worker and claim closure, in lieu of retraining.

³⁰ Washington adopted structured settlements in 2011, but as discussed in Chapter 3 their use to date has been relatively low compared to the number of long-term disability claims.

2.4 PENSION RATES IN WASHINGTON

As discussed earlier, Washington has a very high rate of pensions. Because of this, pensions have become a major cost driver in the system. In Washington, the average total and permanent disability claim costs \$760,000 compared to the average short-term time-loss only claim cost of \$11,000.³¹ Another indirect economic cost of pensions is that the extended, multiyear period of temporary disability leading up to the pension takes time away from CMs that could be spent on managing claims to avoid total and permanent disability.³²

3 TIME TO CLOSURE

A statistic that is closely related to the length of TL payments is the time from injury to claim closure. Getting to closure as quickly as the medical and vocational factors will allow, is a cost containment measure. Claims left open without cause are more likely to generate expanded injury claims, more medical expenses, and disputes. “Finality” is a term that has positive meaning for many claimants. The popularity of Option 2, which allows workers found eligible for retraining to “cash out” their retraining plan for a payment of 6 months of indemnity and claim closure (as discussed in Chapter 2) is a good example of the desire by some to move on with their lives.

The Exhibit below shows the median days from injury to claim closure for claims with TL or PPD. There was virtually no change over the range 2011-14. However, the lack of improvement in days to closure runs contrary to the improving job market since 2013, which should have speeded up closure due to better RTW opportunities.

Exhibit 5-11: Median Length of Time from Injury Closure on a Lost Time/PPD Claim, By Year of Closure

Year	Median Days, Injury to Closure
2009	303
2010	327
2011	334
2012	336
2013	334
2014 (first 9 months)	333

Source: L&I “Accountability Report” (data on spreadsheet tracked starting October 2001 and updated monthly), received from L&I, October 2014

Time to closure is not strictly related to disability; there is also an administrative management component. For example, a claim might be left open even though the claimant was back to work with no further indemnity and no record of ongoing medical treatment. Such a scenario is not by design, but is the result of a delay in taking the administrative steps to accomplish closure. Another example is a claim kept open only because of weekly physical therapy visits; such therapy should be medically necessary to improve or stabilize a medical condition, or the claim should be closed. What the CM needs to do is

³¹ Source: Presentation by Kirsta Glenn to Workers’ Compensation Advisory Committee, L&I Research and Data Services.

³² Note that this economic cost is reduced somewhat by the Social Security Disability offset received by the State of Washington. See <http://www.ssa.gov/policy/docs/ssb/v65n4/v65n4p3.html>.

confirm the necessity of ongoing treatment, whether the claimant is in a “fixed and stable” condition, and whether there is an impairment rating requiring PPD to be paid.³³

4 OVERALL SATISFACTION, GAUGED BY STAKEHOLDER SURVEYS

The Department has several advisory groups that appear to help the Department to monitor stakeholder concerns and propose remedies. L&I seems to use these advisory groups to help shape administrative procedures. Examples of major rules developed by advisory committees include, the redevelopment of performance indicators for vocational counselors (by the Vocational Professionals Advisory Committee), audit standards for self-insurers, and pension financial accounting decisions (by sub-committees of the Workers’ Compensation Advisory Council).

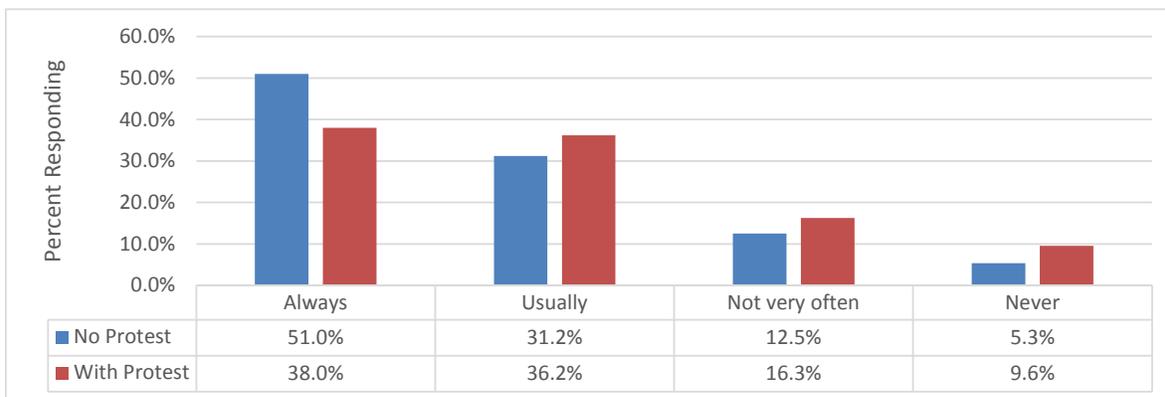
L&I reports that focus groups are used for in-depth exploration of particular subjects (no details have been published). The other feedback mechanism that seems to have received serious consideration by L&I are formal surveys. As of April 2015, L&I has sponsored four surveys of both employers and injured workers. Results tend to give L&I favorable ratings; in the 2013 survey, 61% of the respondents gave L&I a good rating overall.

In the course of the performance audit, we conducted an extensive survey of employers and injured workers. Although most of the questions targeted particular performance areas, some of the questions were designed to gauge overall performance and satisfaction, e.g., “treatment with respect” and “overall satisfaction with the protest process.” 79% of our worker respondents said that they were “always” or “usually” treated with respect by L&I. The 21% of workers who were negative about their treatment by L&I raises some concerns about the causes of this negativity. Was it just a matter of poor communication, or was there another clear cause for a grievance? Our survey of injured workers sampled those with relatively serious injuries as well as workers who were represented by attorneys. For discussion of the methodological differences, see Appendix 3.

Exhibit 5-12 groups respondents into the “protest” category, i.e., those with protests, appeals, or denials, and those without, and the “no protest” category. (Most all appeals include a protest, and almost all denials in the survey sample had protested their denial.) The results show that those without protests were a little more positive (and a little less negative) than those with protests.

³³ During file reviews, we observed in 20% of sampled claims that closure generally was needed, but not done. The reasons for this were not identified with precision, but only an observation was noted, based on factors that indicated the claim generally was a good candidate to be closed.

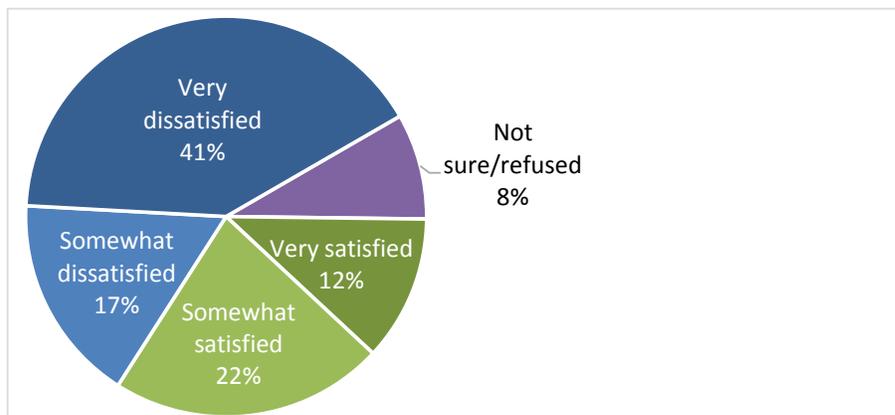
Exhibit 5-12: Treated with Respect When Contacting L&I: % Workers Responding



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

Among workers who had filed a protest, 41% were “very dissatisfied” and 17% were “somewhat dissatisfied” with the process involved in the protest (Exhibit 5-13). We suspect the very negative opinions were influenced by the outcome of the protest and perhaps the claims decision that led to the protest. Also, the length of time to resolve the protest might have been a strong contributor.

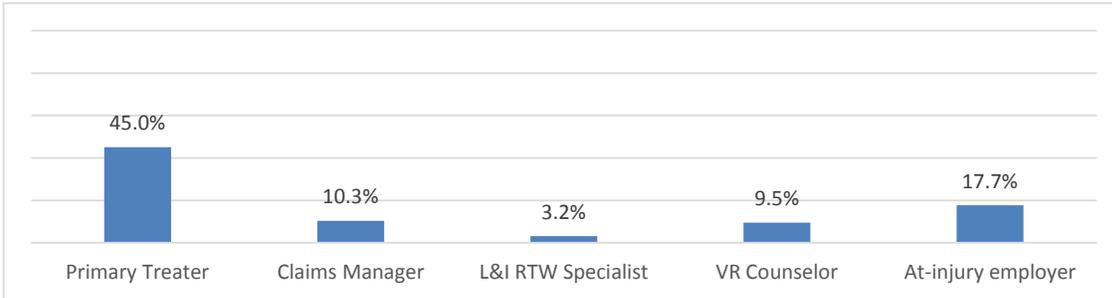
Exhibit 5-13: Workers with Protests: Satisfied with Process?



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

A key service that is closely connected with the cost drivers discussed above is delivery of vocational services. We surveyed workers on their satisfaction with those involved in the vocational services process (see Exhibit 5-14), and while 45% of workers responded that the primary treatment provider was helpful or very helpful, only 10.3% and 3.2%, respectively, of workers responded that the CM or L&I RTW specialist was helpful or very helpful. L&I survey results show higher satisfaction levels, but the samples draw from different populations. For additional explanation on methodology, see Appendix 3 – Methodology.

Exhibit 5-14: Percent of Workers Indicating That Parties to the Claim Were Helpful or Very Helpful



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

Employers' overall satisfaction with L&I was generally positive. The ratings were roughly similar for all three insurance groups (Retro, non-Retro, self-insured), although the percentage of very extreme ratings was highest for non-Retro and smallest for self-insured. Employer responses differed from worker survey responses in several significant ways. Employer responses were generally more positive toward treatment by L&I. Overall, almost two-thirds of employers (64.3%) that answered the question were "Very satisfied" (19.4%) or "Satisfied" (44.9%) with their overall experience with L&I. L&I also regularly surveys employers, and the results are similar (Exhibit 5-15). These results are discussed in further detail in Appendix 6.

Exhibit 5-15 Employers' Overall Experience Working with L&I in the Past Year

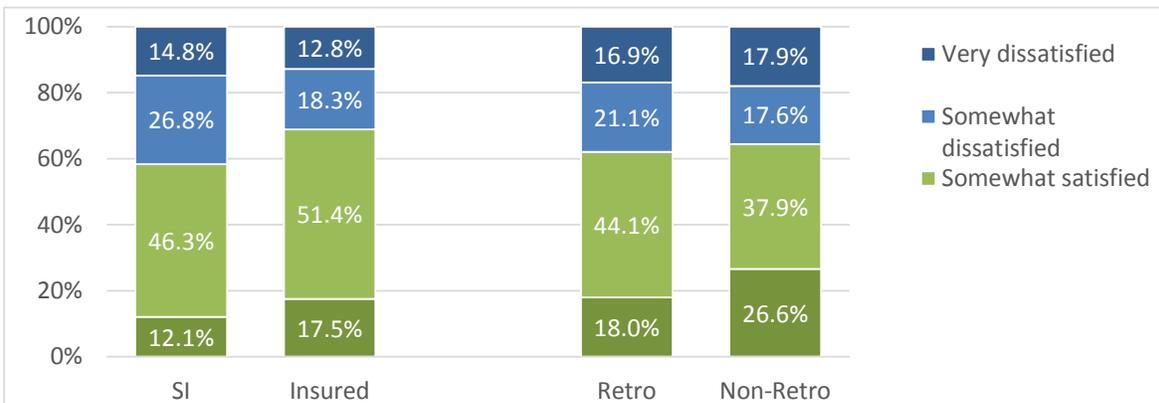


Source: L&I Employer Survey, conducted by Ipsos (November 2014).

Perceptions of overall satisfaction where an interaction takes place are highly dependent on the rating of the interaction with claims managers and staff. In the L&I survey results, respondents who had direct contact with claims managers reported relatively high levels of overall experience satisfaction. Interaction with claims managers and staff were very good/good in nearly 70% of responses. The survey supports the friendliness, helpfulness, and attentiveness (listening and understanding) of claims managers and staff. For additional discussion of these results, see Appendix 6: Employer Survey Results.

We also compared overall satisfaction levels for employers, as shown in Exhibit 5-16. Note that these results are split into separate groupings: the “SI” and “Insured” grouping compares SI employer with “matched” employers with insurance from the State Fund. This matching sought to group employers that are most similar, primarily in terms of size; the matching criteria are further described in Appendix 3. The other grouping, “Retro” and “non-Retro,” include only State Fund insured employers, but they are also matched by the same process, and in general are smaller employers.

Exhibit 5-16: Overall Satisfaction with L&I



Source: WorkComp Strategies Employer Survey, 2014

While the groupings show a close similarity for the percentage of satisfied employers, there remains an important fraction of employers in all 4 groups that are "very dissatisfied." Self-insured employers had the smallest percentage of “Very Satisfied.” and “Very Dissatisfied,” seemingly showing a generally satisfactory relationship with L&I. These results are discussed in further detail in Appendix 6.

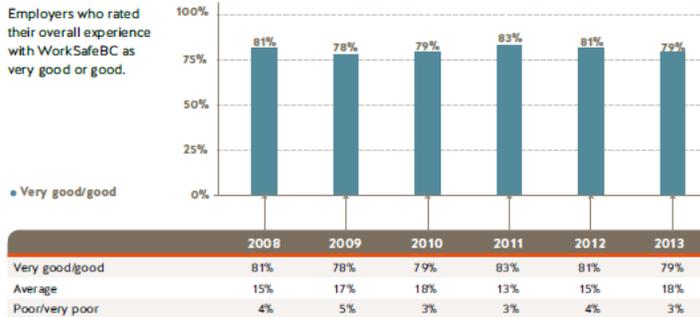
Although direct comparison between these results and those from other jurisdictions is problematic (for further discussion, see Appendix 6), L&I and the Workers’ Compensation Board of British Columbia (WorkSafeBC) have been asking similar questions with a similar general objective, and the two jurisdictions share similarities in industrial mix, economic conditions, organizational structure and legislation.³⁴ At the aggregate level, comparison of trends and some of results may provide insight into the Washington survey results.

Exhibit 5-17 reflects recent performance measurement results published by WorkSafeBC. The two measures were obtained using a similar independent survey methodology and include the time frames covered by the L&I survey results shown in Exhibit 5-15.

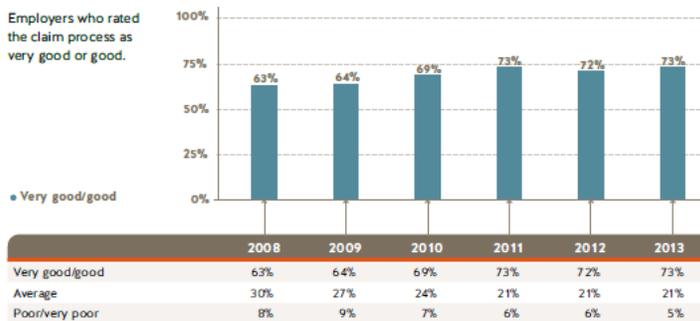
³⁴ See Appendix 2 for discussion of the similarities between Washington and British Columbia.

Exhibit 5-17 British Columbia Employer Survey Results 2008 – 2013

Employers' rating of their overall experience¹



Employers' rating of the claim process¹

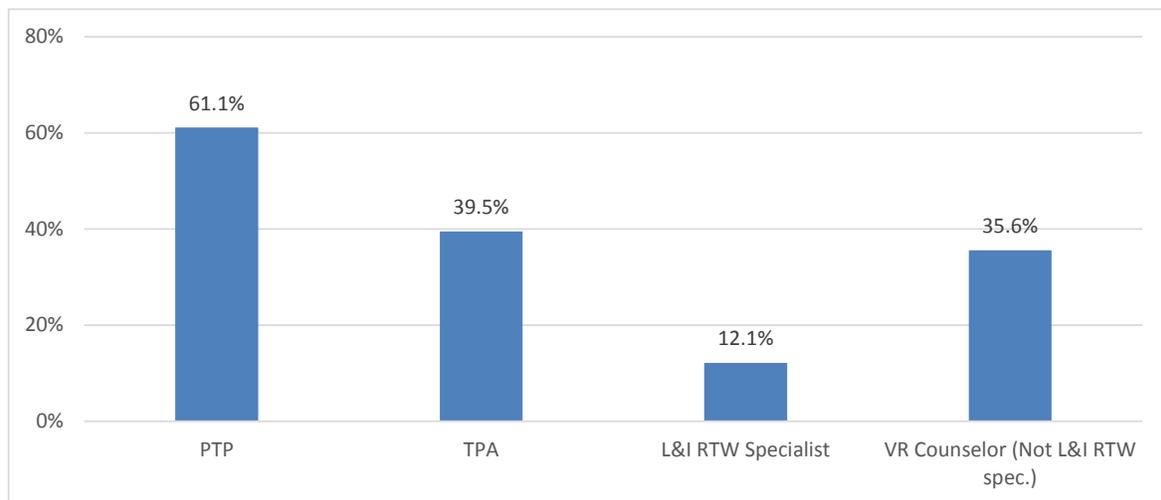


¹ Due to rounding, not all columns total 100 percent.

Source: WorkSafeBC, *2013 Statistics*, p. 97, available at http://www.worksafebc.com/publications/reports/statistics_reports/assets/pdf/stats2013.pdf.

We also surveyed employers on their perceptions of L&I's delivery of RTW services, which is closely connected with the cost drivers discussed above. Exhibit 5-18 shows that employers were considerably more positive than workers about the role of all the agents in the RTW process. As with the worker respondents (Exhibit 5-14), vocational counselors received the lowest levels of positive ratings, and L&I vocational specialists got the lowest ratings of all.

Exhibit 5-18: % Employers re Helpful RTW Services



Source: WorkComp Strategies Employer Survey, 2014

In this chart, PTP refers to “Primary Treating Physician” and TPA refers to “Third Party Administrator.” These questions were posed to both insured and self-insured employers, which explains the result that TPAs were considered helpful, as self-insured employers often hire Third Party Administrators for claims management, and specifically to assist with issues like RTW.

5 PERFORMANCE METRICS

A major part of this audit was scouring measurements of system performance from three sources: 1) L&I’s internal measurements; 2) performance measurements of other government and research related organizations; and 3) analysis of L&I claims data by the authors. Naturally, such statistical and descriptive data is useful for outsiders to evaluate performance. A number of organizations publish side-by-side comparisons of jurisdictional characteristics and performance, most prominently NCCI, WCRI, NASI, and AWCBC.

Yet another use of metrics is to manage organizational resources toward achieving management goals. We found a wealth of data used by L&I to track activities for compliance with law or internal standards. One of the important issues that repeatedly came up in our study was the use of data to measure system performance. In some areas L&I is zealous to report with detailed numbers. This is particularly true of financial and accounting information. We applaud L&I practices in this area.

However, although very much a part of internal management operations, other very important aspects of system performance rarely have the spotlight during public presentations. We have discussed the lack of non-economic indicators earlier in this section. A short list of expanded published performance reporting would include:

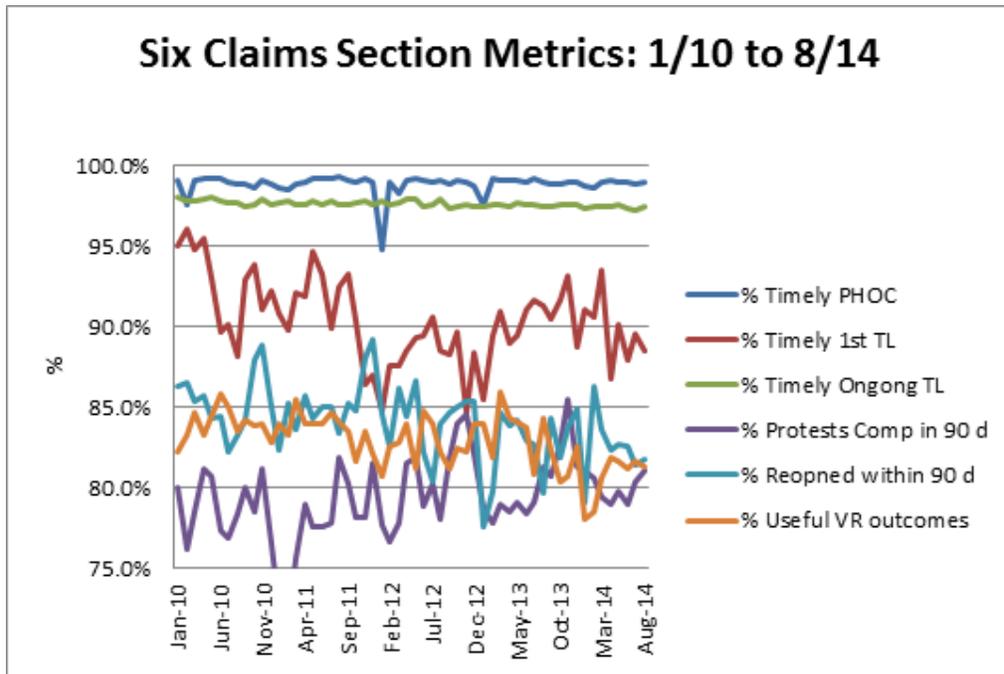
- Return to work at various time intervals after injury
- Persistence of work after return from injury
- Return to work with pre-injury employer versus other job
- Use of SAW assistance or Preferred Worker to facilitate RTW
- Recovery of pre-injury wage levels
- Percentage of claims with permanent impairments
- Average level of impairment ratings
- % claims treated by COHE providers
- Satisfaction with COHE and non-COHE medical care
- Satisfaction with IME process
- Protest filed and speed to resolution

By no means is this an exhaustive list of useful indicators. The design of performance measurement should be built on top-level management direction and stakeholder accountability.

Switching from public to internal metrics, we reviewed a cross section of L&I internal reports, covering the claims section, vocational services, medical management, self-insurance, and the Retro program. We also reviewed a variety of actuarial reports.

L&I is active in elaborating charts, tables, and reports that measure details of the workflows and functional responsibilities in the agency. The Imaging Unit, for example, measures and charts its daily workflows and processing times; the call center monitors call volumes and hold times. Likewise, the Vocational Services Specialists are closely measured for their review times. These put into practice the management dogma: “If you can’t measure it, you can’t manage it.” These and other areas represent intelligent use of metrics.

One apparent problem, at least in the 2010-13 period in which the data was collected for the performance audit, is the proliferation of metrics without clear client users. There also appeared to be “inoperative” metrics in some past reports, that is, reports that get created without any apparent serious attention or effort to control the process they purport to measure. For example, we studied a spreadsheet called an “Accountability Agency Summary” that appeared to have been consistently generated for 10 or more years with detailed measurements of about 40 particular aspects of the Claim Section workflow. The Accountability Summary report is broken down into separate reports for the claims units. Reviewing an early 2014 version of this Agency Summary report, we were struck by the fact that the values seemed to change from month to month and year to year with no apparent movement toward or away from the desired outcome. Exhibit 5-19 plots six examples of performance from Jan 2010 through August 2014. Two of the six metrics, % timely first payment of TTD and % timely ongoing payments, were relatively unchanged over the period, although the first payment line shows some surprising monthly deviations from the trend. Three of other metrics (% timely PHOC, % reopened in 90 days, and % useful VR outcomes) show a slow downward trend, with fairly substantial drops in the most recent months. Finally, one metric (% protests completed <90 days) shows a slight upward trend and a strong improvement in the latest two months. Major consolidations and refinements have been made since 2013 in management reporting, e.g., the “CBOB+” report recently initiated by L&I.

Exhibit 5-19 Sample Metrics from Accountability Agency Summary

Source: L&I Accountability Agency Summary (spreadsheet), received from L&I, Oct. 2014

After inquiry into how such metrics are used by supervisors, we found that the above report and other metrics recently were substantially re-engineered. The new report, called “CBOB+,” is much more visually attractive and logically organized. In our interviews with Claim Unit Supervisors, we got mixed reactions to the value of some of the metrics in CBOB+. The Claims Section Chief reported that the reports were used by unit supervisors for comparisons of their unit’s performance with other units, and for the evaluation of the performance of individual CMs. Our impression was that these reports were being actively used as a management tool; with respect to the Accountability Report, though, they showed no clear evidence of performance changes over time.

Another tool recently made public by L&I is a performance “dashboard” used for internal management and for reporting performance to the WCAC. This dashboard is based on the CBOB+ report and was under development as of March 2014, and the number of metrics reported to WCAC varies from meeting to meeting. An outstanding feature of the dashboard is the very clear way it shows benchmark performance, goals, and movement toward goals. To its credit, L&I reports instances where metrics are not showing progress toward goals, or even deteriorating.

Other government workers’ compensation insurance programs publish annual reports containing performance measures; the exclusive fund states of North Dakota and British Columbia are good examples. The closest thing to this in Washington is the pamphlet “Your Premium Dollars at Work.”³⁵ This document falls short of a meaningful annual report. It is written primarily for employers. The statistics it contains really do not allow the reader to gauge system performance. It could be

³⁵ 2014 version available at <http://www.lni.wa.gov/formpub/Detail.asp?DocID=2722>.

substantially expanded and enhanced. The descriptive statistics on nature and cause of injury and highly aggregated claim information, while common in jurisdiction reports, are not at all useful for research or in-depth policy analysis.

Rather, the focus in a published performance report should be on how the system is performing in meeting legal requirements, management goals, and stakeholder expectations. Some examples of statistics that stakeholders could immediately relate to would include:

- Speed to make claim determination
- First payment of TL
- Average duration of TL
- Frequency distribution of claims on TL by length of payment
- Protests filed and time to resolve protests (30, 60, 90, >120 days)
- Claims treated by COHEs
- Cost of claims within COHE versus other providers
- Speed of provider bill payment
- Number of retraining plans approved and % completion

A host of accounting reports and financial metrics are reported in detail by L&I at WCAC meetings. By contrast, much less analytical effort and attention is directed to the claims process in WCAC presentation materials. For example, meeting contingency reserve targets gets a great deal of attention at the WCAC, but movement in the average duration of TTD or pension projections receives less frequent discussion.

A fine example of integrating strategic goals with measurements of success is the recent L&I attention being paid to the excessive amount of time it has taken to initiate and complete an AWA. The AWA process is integral to meeting L&I Goal 2 (Return to Work), shown in Exhibit 5-20. System re-engineering appears to have broken through the long lag time in completing AWAs. In 2014 a new emphasis was put on early AWAs. The success of this pilot program is being measured closely and will probably result in much closer attention to the traditional reports showing no progress. In addition, the emphasis given to RTW in the new “dashboard” described above will compel the section of L&I that manages vocational services to examine how their efforts contribute to meeting departmental goals.

Performance metrics need to be linked to goals, starting with top-level goals for the Department and further broken down to work unit goals. The top-level goals for the organization must be linked logically and practically with the goals of each sub-unit in the organization. We studied the linkage of goals within L&I and how they relate to measurement.

First, three recent successive L&I strategic plans have shared a good deal of consistency, e.g., emphasis on safety and combating fraud and abuse. We found that the quantification of objectives was most pronounced in the Strategic Plan for 2014-20.³⁶ Of the five top-level goals in that plan, Goal 2 was directly related to the claims process. Although the goal’s phrasing – “Help Injured Workers Heal and Return to Work” – is too general to guide action, within Goal 2 there were 12 relevant and useful sub-goals that would help injured workers to “heal and return to work.” Exhibit 5-20 provides details from that plan.

³⁶ Available at <http://www.lni.wa.gov/IPUB/101-171-000.pdf>.

Exhibit 5-20: Detail from Goal 2 from Strategic Plan 2014-20

2.1 Create a culture of return-to-work (RTW).	Goal 2: Business Vitality and Thriving Washingtonians.	<ul style="list-style-type: none"> ▪ Number of long-term disability claims per 10,000 total claims. ▪ % of injured workers who return to work within 6 mos. after claim received. ▪ % of new claims receiving vocational services by 90 days. ▪ % of injured workers surveyed who remember discussing RTW.
2.2 Reduce preventable disability.	Goal 4: Safe People 2.5. Goal 5: Efficient, Effective Government 1.1, 1.3, 3.1.	<ul style="list-style-type: none"> ▪ % of injured workers on time-loss at 3 months who are still on time-loss 6 months after injury (persistence rate). ▪ % of injured workers being treated by COHE providers. ▪ % of injured workers on chronic opioids. ▪ % of injured workers on time loss 6 months after injury.
2.3 Reduce system delays & improve customers' experience.		<ul style="list-style-type: none"> ▪ Average # of time-loss days paid 90 days after claim received. ▪ Overall injured-worker experience. ▪ Overall employer experience. ▪ Median days of time-loss paid at first referral for vocational services.

Source: L&I Strategic Plan: 2014-2020, Goal 2, available at <http://www.lni.wa.gov/IPUB/101-171-000.pdf>.

These 12 measures related to Goal 2 have not all been reported publically, though they may be monitored within the agency. Specifically, the median days of time-lost paid at first vocational service exists as an internal metric, but was not found to have been published or discussed with WCAC. Likewise, the extent to which all of these measures are part of regular internal monitoring is not clear; for example, the percent of workers surveyed who remember a RTW discussion is not reported as part of the new dashboard.

Of course there are many other metrics and performance goals that would contribute to the success of the Department in meeting the overarching objective of Goal 2. One of these is prompt contact with employers and claimants. Another is earlier and more complete injury reports. Two of the twelve listed Goal 2 strategic-plan measures are related to medical care delivery, yet these two do not adequately cover the range of management issues connected to “healing” of injured workers. Some of these subsidiary measures were discussed above in relation to the CBOB+ report. Finally, as discussed earlier in this chapter, non-economic impacts are vital to a full evaluation of overall performance. There are some non-economic indicators covered in the 12 named in Goal 2 of the 2014-2020 Strategic Plan, but many others, as outlined and discussed above, should also be measured and monitored.

Chapter 6: Opportunities for Improvement

INTRODUCTION

In this chapter we summarize our observations and strategies to address areas that could be made more efficient, effective and produce better outcomes for Washington workers and employers. Note that many of these are inter-related and are touched on in several places. For example, we address prompt 3-point contact in connection with improving claims management performance; however, this issue also concerns more effective performance management practices, which is addressed separately.

We organize this discussion in three general headings containing many interrelated elements:

1. Claims are open too long, which impacts workers and employers
2. CMs and Units are not being effectively measured, specifically in alignment with claim outcomes
3. Other inefficiencies, which are provided to support L&I efforts at overall administrative improvements

Changes to address some of these conditions are simpler to implement than others. Additionally, some involve statutory changes, thus adding to implementation complexity. Importantly, the order of presentation does not follow that presented in the report, i.e., it does not start with Chapter 1 observed opportunities, followed by Chapter 2 observed opportunities, etc. However, references to the relevant chapter, where the particular content was discussed, are provided.

1 ADDRESS ROOT CAUSES OF PROLONGED DISABILITY

As outlined in several of the preceding chapters, and discussed in detail in Chapter 5, the extremely long durations of TL in Washington and related problem of very high rates of pensions are so unusual and are so closely connected to the overall performance of the Washington workers' compensation system that significant changes are needed. Our discussion in this regard address the entire span of the claims process, but the biggest disconnects between Washington and other jurisdictions seems to be in the handling of claims in which the worker has not returned to the workforce within a few months of injury (discussed in Chapter 2). Washington's legal standards for terminating TL and requirements for administering vocational services are much different than other state systems. The fraction of injured workers that are deemed "unemployable" is both unusual and contrary to the best interests of the workers and employers.

Washington's average duration of temporary disability is over twice the national average (NCCI data), and the rate of permanent total disability is 31 times the countrywide average rate and 3.9 times the next highest state (NCCI data). We observed several contributing causes: 1) CM

performance issues involved in delivering claims management services; 2) administrative and structural issues involving claims management services; and 3) statutory implementation challenges to effective claims management practices.

A. CM PERFORMANCE OPPORTUNITIES

1. Prioritize phone contact and deliver prompt calls to workers and employers

As discussed in detail in Chapter 1 and 2, our observations from file reviews is that actual voice contact with workers and employers by a CM within the first few days of claim receipt occurs in a minority of TL claims: 32% of reviewed files (2010-13) showed actual voice contact by CM with worker w/in 30 days. The standard tracked by L&I is actual or attempted voice contact with stakeholders within the month of receipt. Direct contact with parties, starting with the injured worker and the employer, followed by the provider as needed, is the ideal approach to initiating claim management—day one of the claim if possible. This is crucial for several reasons. First and foremost because concrete case management plans should ensue from such contacts. There is a wide acceptance in the insurance industry of the standard practice of making actual (as opposed to simply attempted) voice first contact with an employer and injured worker within one business day of the assignment of an accident report for claims identified as involving any lost time, including kept-on-salary claims, and 3 business days for medical only claims. Additionally, beyond contacting the worker and employer, a plan for contacting the provider, as needed, should be documented; in many claims early contact with the provider may not be required.

This is a pivotal aspect of effective claims management. Early contact with the worker and employer promotes better case investigation; insight into claim risks and issues; relationship building; improved communications; and sets expectations regarding RTW. In short, early contact is the foundation for effective claim management planning.

There may be techniques to balance best practices against the practical difficulty experienced by L&I in making immediate 3-point contact. Intermediate strategies, which L&I seems to be working toward, would segregate the claims that seem to be easily and swiftly resolved for one level of contact, and those that are at-risk of longer disability and complications for more proactive contact. For example, contacting the employer immediately may not be necessary if the accident report indicates immediate return to work and contact with the worker offers a realistic indication of early return to work. In principle, some claims can be auto-adjudicated (strictly by computer), but auto-adjudication rules need to be closely monitored to ensure that few of these “simple” claims morph into long-term disability. Personal contacts with physicians or their offices might be reserved for instances in which the doctor’s reports are late, incomplete, or offer dubious opinions or conclusions. In every TL case, however, the injured worker should be contacted by either a CM or Claims Assistant or Processor within a day or two of the injury receipt.

2. Prioritize claim management planning

In connection with the voice-contact observations outlined above, improved case planning, together with application of appropriate early RTW interventions, should become standardized practices. Our file reviews showed few files that documented effective case planning and application of interventions tailored to the needs presented in a particular claim. The immediate result of voice contact should be an explicit plan for returning an injured worker to work, which recognizes obstacles to RTW detected from the voice contact. The plan should be in place

promptly, following shortly after completion of contacts, claim investigation; in general, the plan should be in place within a few days of the accident.

The plan would include documentation of contacts, actions taken and needed, treatment expectations, risks, options, planned interventions, consults, and potential interventions to minimize lost time. Inputs to the plan should be provided by all staff making various stakeholder contacts, including ERTW staff contacting employers, vocational specialists consulted by the CM, and ONCs offering medical advice (discussed in Chapter 2). Importantly, overall management of these activities rests with the CM, and this management should result in a documented plan to effectively manage the claim to optimal outcomes. The plan should be communicated to the worker and employer, by voice if there are complex issues involved. The parties should be informed on next steps in the process and the target time for revisited the plan. Metrics around the timing and effectiveness of this planning should be used to monitor plans and their effectiveness.

For injured workers at risk for long-term disability, intervention must come very early in the life of the claim, before barriers to returning to work harden. Thus, tools should be available to alert the CM when a particular claim is deviating from expected norms, or at-risk for future deviation. Predictive analytics (discussed further below) should assist this activity, but CM insight into and management of the process is important. A multidisciplinary team should be used to address conditions identified by analytical models. It is well known that return to work is complicated by such factors as obesity and other co-morbidities, substance abuse, and cognitive deficits. L&I has already quantified some risk factors, e.g., showing that even a short duration of opioid use contributes significantly to claim duration. Principles of disability management recognize the need for a team of experts to manage such risk factors. For example, experts in addictive behavior or post-traumatic stress might be needed to work with the treating physician and vocational experts. The specific interventions needed are likely to be beyond the expertise and time available to CMs. But the CM should be at the center of managing this interdisciplinary team, and involving the employer and injured worker.

3. Connect RTW training with performance management

The training program for CMs on communication and RTW management skills (Return-to-Work Toolkit training) recently implemented appears to be well designed to foster activities that will lead to better claim outcomes. This training should become more standardized across the claims units and follow up training be conducted, in accordance with a strategic plan for continuous improvement related to claims management training. Included in this training should be appreciation for the usual concerns of the parties to the claim, and good listening and communication skills (discussed in Chapter 2). Methods for identifying CMs who appear to have poor early RTW success should be developed and lead to coaching to improve communication skills in this area. The techniques should become institutionalized for all new CMs and reinforced from time to time for experienced ones. The training should incorporate outcome-oriented practices: e.g., role-play training on making calls, and “team triage” on selected claims. Finally, the training should be connected with performance measurement, data systems and analytics, and remediation training and coaching.

The GEMBA-walk practice used by L&I is a model that can be developed to accomplish this enhanced collaboration and coaching. This practice is currently used in certain cases to more promptly and effectively deliver vocational rehabilitation services, and is triggered by the timing of AWA plans. Additional triggers, for example certain physician practices or treatments and complex medical conditions, could be used to highlight claims for analysis in a GEMBA walk. We recognize that claims units currently engage in collaboration on a wide variety of issues, including complex medical cases. Our discussion concerns increased, regular training and a more defined workflow in which medical management practices are better integrated with regular, timely review of CM actions and plans in targeted cases.

4. Standardize claim file documentation

As mentioned above, in file reviews we observed minimal evidence of file documentation that demonstrated effective claim management planning. The claim file should more clearly and fully document steps taken to manage the course of the claim. In our file review we saw many instances of incomplete descriptions of actions and plans. Cryptic or formulaic notations were common, e.g., “opioids?” or “PPD?”. More consistent and complete file documentation of such plans and actions is needed to assist CMs with monitoring needed actions, supervisors with review CM performance, and L&I with measuring success regarding such actions. L&I has recently introduced a new claim review template, which is designed to facilitate more straightforward creation of claim file reviews. Not all claims involve completion of such templates, however, only those selected for review. Such documentation, perhaps in more streamlined format for “everyday” use, should be implemented in all TL claims involved more than minimal time loss; there should be a clear expectation on items to be documented and this activity tied to performance measurement and coaching.

B. ADMINISTRATIVE OPPORTUNITIES

1. Integrate predictive analytics into claims management processes

Effectively addressing the observations highlighted in this Chapter hinge on continued utilization of claims management analytics. Such analytics would apply to two areas: “At-risk” claim identification, i.e., claims that are statistically at risk of prolonged duration; and statistical identification of “interventions that matter.” L&I is actively working to isolate those claims most in need of particular interventions, as well as those factors involved in claims management that are most associated with preferred outcomes. We saw ample evidence that L&I management is aware of the need to restructure the timing and delivery of vocational services. What seems to be lacking are practical and well understood rules for interventions in cases at risk of becoming extremely costly both to the State Fund and the lifetime earnings of the injured worker. One way to achieve this is modeling the claims process to find statistically robust early warning indicators of problems and trigger points for particular vocational services. This will require state of the art decision models that might require expert assistance outside of L&I to accomplish.

Such utilization of claims management analytics should be continued and expanded. Tools should be available to alert the CM when a particular claim is deviating from expected norms, or at-risk for future deviation. Additionally, analytics should be used to establish success rates for particular interventions, in order to better inform CMs which interventions are most likely to lead to preferred outcomes. We recognize that L&I is aware of the factors that contribute to long-term disability, but this insight should be integral to daily CM claims management activities.

2. Clarify claim file confidentiality practices

In connection with the performance issues outlined above, a related issue concerns the lack of clarity about whether certain internal notes, including documentation of communications among the CM, supervisors, and medical and vocational advisors as well as strategies to address identified risks and issues, can be privately recorded in a zone of the claim file that is not available for viewing by the parties to the claim. The lack of confidentiality forces the CM to use vague, stylized, and neutral statements in the file plan and actions. Uninhibited communication by the CM, e.g., regarding sensitive medical or psychological issues that impact effective claims management, should be documented for supervisors and other internal parties with a role in the claim. The case reserves should also be restricted to the protected zone. There are some aspects of current practice where notes are considered to be made in confidence, but it is not clear among management, unit supervision, and CM staff how these protocols are designed and enforced, and what is confidential, and what is not. Additionally, this data is “unstructured” and difficult to be used in creating actionable reports. This should be investigated and clearly defined, with a goal of creating the confidential “zone” while maintaining appropriate stakeholder access to all file information currently available. Statutory changes may be required to enable this change.

3. Implement RTW standard practices

Employing vocational services to achieve RTW as quickly and safely as possible and avoiding retraining except as the last resort in the disability management process are principles that L&I clearly understands. In particular, the traditional AWA process is not designed to help workers on disability with RTW. Rather it is an adjudicatory process to test for “employability,” and can be seen as moving the claim along a particular path that can often be met with resistance. L&I’s recent “Early AWA” initiative seeks to tailor delivery of vocational assessment early in the claim, in an effort to discern the appropriate level and timing of additional services. Results of the Early AWA initiative to date are promising. Such innovations should continue, including the development of even new service types and methods, but ultimately a model for service delivery should be developed and spread across the entire “claim floor” along with development of related metrics to measure success or the need for modification. In addition to developing and deploying new vocational protocols it would be beneficial to capture good data on performance and incorporate this data into performance metrics and analytical models to inform CM decisions as well as help identify high performing vocational service providers.

Additionally, the selection criteria for re-training plans should be more focused, applying only to those cases where re-training is most appropriate. Formal retraining should be reserved for candidates that have a good chance of succeeding in a formal academic setting. L&I should to apply additional focus on OTJ training and develop suitable RTW interventions for those found unsuitable for formal retraining. We believe that at the completion of early assessments, for example between 1 and 3 months of TL and no significant medical complications, a vocational rehabilitation counselor should recommend either on-the-job training (OJT) or a formal retraining referral for plan development based on the injured worker’s age, training, likely physical abilities and aptitude for formal training versus OJT. Such factors would need to be identified using developed analytical models, as well as professional experience of both CMs and VRCs. If retraining appears appropriate, the VRC could then concentrate on developing a client specific, highly tailored retraining plan. The VIP statutory language provides heavy emphasis on the timing and delivery of retraining plans. While such emphasis on measurement and accountability is crucial to success, this places an outsized focus on retraining plans. Formal

retraining provides meager returns. Recent data shows that about 45% of Option 1 retraining plans fail to complete and between 34% and 43% of workers completing retraining plans returned to work within two years following claim closure (2009 to 2011). If objective indications and the subjective judgment of the VRC and CM suggests that retraining is unlikely to be completed successfully, other options should be developed. We recognize that L&I has attempted to promote OJT; new financial incentives or other assistance appear to be needed to motivate employers to work with VRCs to develop OJT opportunities.

4. Improved information system

L&I recently pursued modernization of its claims management system, submitting a budget request (\$9.8 million) for replacement of its LINIIS claims management system. At first glance this would appear to be a significant investment. However, this is a modest sum to accomplish major redevelopment, e.g., Pennsylvania recently replaced its workers' compensation claim system at reported costs of over \$45 million; costs for a California replacement system were over \$60 million.¹ Regardless of the sufficiency of the requested budget, L&I should pursue replacement of its core information system used for claims with an integrated, more "user friendly" system. At best, working in the current information-system environment is complex, requiring highly specialized knowledge. At worst, information is going overlooked because of the requirement to "query" the system to find routine information, as opposed to it being presented to the user in an automated way. The many upgrades over the years have helped, but the system lacks the functionality needed by CMs. The need to utilize both ORION and an outdated LINIIS system, in addition to other information systems and resources, takes a significant amount of time away from CMs, time that could be better utilized in file review, action plan development, and developing timely RTW strategies – all of which affect the duration of disability and claim costs.

A related imperative is to design this technology around key case activities, integrating the claims management process with analytics and tools, such as: actions that have been identified to lead to better case outcomes; the tasks connected with those actions; and dates and performance of those tasks. Dashboards and alerts could be utilized to monitor expected outcomes, using predictive modeling. Thus, for example, claims with greater than "X" months of lost time, for certain categories of injury, could be highlighted for the CM to update planning and suggest possible interventions. Planning would require identification of specific actions to be taken and associated dates; and progress against such actions would be shown to CMs and supervisors to better identify at-risk claims and those actions being taken to manage them.

C. EMPLOYABILITY STANDARD IS SUBJECTIVE

The employability standard is difficult to apply. The standard is atypical among workers' compensation systems, and results in a relatively high number of workers being considered unemployable. Also, application of the standard is challenging and causes delays to claim resolution. Finally, CMs utilize vocational service specialists to undertake these assessments, and these services are expensive and result in high vocational service costs for the Washington system.

¹ See <http://www.lenardcohen.com/news/lenard-cohen-discusses-the-new-wcais-system>.

The employability standard should be clarified and more easily-applied criteria established. In connection with this undertaking, however, L&I would benefit from re-examining the causes of the high rate of pensions in Washington to determine why the Washington pension rate remains so high. Several contributing factors identified by the Upjohn study are discussed in Chapter 5 and Appendix 2. The principle factors identified by Upjohn should have been resolved by now, and the improving job market should be reducing the causes of pensions—lack of gainful employment opportunities. Yet, the pension rate relative to lost time injuries remains high relative to the pre-1990 experience in Washington, and in comparison to other states. In addition, the relatively stable and lower rate of pensions for self-insured employers relative to State Fund claims ought to be studied. Considering the huge cost of pensions, it would be worthwhile to revisit, as in the Upjohn study of the contributing causes to pensions, and identify legal and administrative reforms, in addition to providing more objectivity to the employability standard, in order to bring the pension rate relative to lost time claims down to the levels prior to the 1990s.

2 PERFORMANCE MEASUREMENT

A. UNIT AND CM-LEVEL PERFORMANCE INDICATORS

There is a need for outcome-based measurements tied to regular CM performance evaluation. CMs should be aware of factors, actions, and interventions, and how their management of such services, lead to better outcomes. This should also be tied to overall unit and departmental performance.

The reports given to claim supervisors regarding CM and unit performance be more focused on essential performance indicators. These should be used for reviewing the individual CM's claim files and action plans so that effective training and corrective actions for CMs can be developed to promote appropriate claims management. Any significant differences in the performance among the claim units should be traced to their causes. We note that L&I has recently begun piloting an initiative, in connection with its "First 100 days" analysis, that seeks to improve and speed up CM reviews of their files through creation of a new file review template. This assumes that the CM has provided the required action-plan and other updates to the file that could be reviewed by both the CM and their supervisor as required to address needed issues, and also assumes that the CM performs the review of each file, before there would be true benefit from this initiative. Web enablement of the CBOB+ report, which has recently been started, is a good step. Such tools, however, should not be simply expanded, but should be refined. Better, as opposed to more, metrics should be identified and developed with staff input and engrained into supervisors in each claim unit.

The most important outcome measurements to use in measuring performance include percentage of cases returning to work with the employer of injury, percentage of cases returning to work with any employer within certain timeframes, the average duration of TL, the percentage of cases meeting RTW targets, and the frequency rate of justified protests and appeals. More discussion on performance metrics is presented in Chapter 5.

B. PUBLISH ANNUAL PERFORMANCE REPORT

Any important initiatives by L&I should be accompanied by published and rigorously developed measurements of progress and success in meeting objectives (as modelled in the recent “Dashboard” reports to WCAC). Such a report would include performance highlights, e.g., key performance indicators, and report on trends in such indicators, as well as report on strategic initiatives.

Currently, there is no comprehensive set of consistently published performance metrics. Such a report should have the character of an annual corporate report to shareholders, or stakeholders for non-investor owned organizations. For public organization like L&I, such a report should include non-economic indicators of the wellbeing of injured workers, such as the degree of permanent injury, RTW including income recovery and persistence of employment. It would be desirable to make a hierarchy of measures, beginning with sub-unit indicators that roll up logically into larger unit and programmatic performance numbers. The lower level measures are useful for training and supervision; the highest-level numbers should be reported to system stakeholders. For evaluating performance against other similar systems, it would be useful to include many of those reported by the Association of WC Boards of Canada as “Key Performance Measures.”²

For example, in the 2014 – 2020 strategic plan,³ a number of useful measures were linked to the 5 top-level strategic goals for the Department. An important component for reporting on progress towards goals is an annual or other periodic report focused on system issues, management and legislative initiatives, and performance indicators. This report should be an in-depth review of L&I’s strengths and weakness, along with identifying system threats and opportunities. Establishing reasonably attainable goals along with the measures would help provide insight for readers of progress towards reaching the desired goals.

Also useful in a periodic published report would be discussion of the degree to which the identified measures were changing outcomes and impacting the goals. Specifically, identification of actions that are taken in applying the measures of success to reach the goals, along with links of the actions to targeted outcomes, would help in developing precision in reaching goals and changing outcomes. For example, the 2014 – 2020 strategic plan identifies “% of new claims receiving vocational services by 90 days” as a measure used in the RTW goals. This is a topic discussed in detail in this report. A critical aspect of meeting this goal would be to determine which vocational services help change outcomes, both positively and negatively. Tracking and reporting by service delivery, as well as the linked outcome, would help with correcting service deficits and with greater investment in the positives. We recognize that the strategic plan is just a snapshot of a much more detailed set of plans. Establishing and publishing such plans, however, in a consistent repeatable format, would help serve to track progress, define actions being taken, and ultimately reveal if the actions (and measures) were changing outcomes.

² Customized “Key Statistical Measures” reports can be created at the AWCBC website (<http://awcbc.org>), in the “statistics” section, available at http://awcbc.org/?page_id=14#KSM.

³ <http://www.lni.wa.gov/IPUB/101-171-000.pdf>.

3 ADDITIONAL AREAS FOR SERVICE AND EFFICIENCY GAINS

A. NEED BETTER ADHERENCE TO PRACTICE STANDARDS FOR OCCUPATIONAL MEDICINE, VOCATIONAL SERVICES

We observed in file reviews instances where medical providers gave vague treatment notes and out-of-work notices, such as “No work 1 week.” Vague, open-ended duty restrictions do not allow CMs to make effective evaluations of RTW, particularly whether the provider will engage in a partnership to assist with appropriate RTW options. COHEs have made excellent progress in developing a model for occupational medicine practice. Standard practices like those involved in COHEs should be advanced, and issues of poor performing providers rigorously addressed.

Additionally, there are issues regarding delivery of vocational service, including VRCs being late with developing AWA reports and, in certain cases, plans being sent back for re-work or improvement. Certainly some aspects of such issues are outside the control of VRCs, but some are the result of non-standard practice. This is an area where L&I is currently actively engaged in developing improved practices; an example is the development of “standard practice” used by VRCs to improve timing of developing AWA reports. Yet, the standards are not being routinely met. After additional standardization of the vocational service delivery process, providers should be held to more rigorous standards of compliance with plan development rules and procedures. L&I is striving to make performance-based referrals for vocational services. More enforcement of standards by sanctions may be necessary, e.g., warning a provider that they may lose their right to be on the preferred provider list if vocational reports are not promptly reviewed. The use of sanctions must be carried out with great care so as to avoid unintended consequences, such as service providers altering their practices solely to meet standards without regard to outcomes. By holding service providers to higher standards the level of worker satisfaction ought to improve.

B. EXPANDED OMBUDS ROLE (COULD REQUIRE STATUTORY CHANGE)

The Self-Insured Ombuds program is limited to workers of self-insured employers. Project Help is available to both State Fund and self-insured workers and employers, but it does not have the more formal structure of the Ombuds program. We believe that expanding into a unified Ombuds Program that covers both State Fund and self-insured claims would provide for more consistent support of workers and employers and help obviate the need for pursuing some protests and appeals. Expert information from a trusted, independent source can be very valuable for workers with concerns about workers’ compensation. The Ombuds function in Washington has proven effective over its 6-year existence, and could be extended to offer service to all workers. This model is successfully used in Ohio, Oregon, Alabama, Kansas and other states. Extending service for all workers’ compensation problems system-wide would provide a comparative source of insight into how the system functions for self-insured versus state fund workers.

If not feasible to have a single ombuds that would cover both State Fund and self-insured issues, it would still be beneficial to create an independent State-Fund Ombuds Program patterned after the self-insured Ombuds Program. The methodical approach and performance metric of the Self-Insured Ombuds program are worth imitating for State Fund interventions. Also, creating a clear feedback loop, as in the self-insured Ombuds Program, whereby

recommendations for improvement and change can be made to the Department, would help ensure that observed issues are addressed and needed changes take place.

C. RELAXED L&I ROLE IN CERTAIN SI DECISIONS (LIKELY STATUTORY CHANGE)

We observed that in some orders, e.g., issuing an allowance order, concerning decisions that are made initially by self-insurers, it appears that L&I adds little value in the decision making process of self-insurers. Moreover, L&I's role in this process and may give an incorrect perception that L&I has reviewed and endorsed the decision of the employer. In file reviews, it was clear that in the allowance order process, L&I did not perform an independent review of the supporting information, which makes sense because the self-insurer is agreeing to accept the claim. In other decisions we expect that a structure can be established to ensure appropriate action by self-insurers without the added time required to receive formal approval by L&I. In our review of denied claims, L&I approved almost all self-insurer requests (98%). This indicates either that L&I is not independently reviewing denial recommendations, or that self-insurers are presenting very clear and convincing evidence supporting their positions (our observations were that supporting evidence was not ample in such cases, however). Either way, claim processing functions such as compensability adjudication are done autonomously by self-insurers in all other jurisdictions. It is highly likely that these could also be done effectively by Washington self-insurers and their TPAs, with proper audit oversight and interventions by the Ombuds. At a minimum, L&I should clearly communicate the extent of its review of self-insurer decisions when delivering case orders.

Some L&I staff resources currently devoted to processing functions could be re-purposed into enhanced audits to more efficiently identify the problem self-insurers. These could take the form of increased sample sizes, or reviewing more claim processing areas such as timely and accurate first payments.

Note that adopting this delegation of authority to self-insured employers likely would require a statutory change. RCW 51.14.140 requires that a self-insurer "request allowance or denial of a claim" and establishes a time limit for such requests.

D. INCREASED USE OF FILEFAST (COULD IMPACT STAFFING)

We observed that most accident reports are filed by providers, and not by employers, who have first-hand knowledge of the injury. This is causing delays in claim reporting. The FileFast process is an effective measure to speed accident reporting, as well as to obtain more thorough accident and injury information. Employers should be encouraged to submit first reports of accident and physicians encouraged to submit medical reports through FileFast. Achieving a higher share of claims coming through FileFast may require marketing research, further financial incentives, and would certainly involve a major outreach to groups with the greatest identified potential for using this technology. Possible areas for consideration of expanded usage would include smaller, less sophisticated employers and promoting to them the benefits and cost savings from potential use of this system. Increased usage by both physicians and employers would speed the flow of essential information to the CM, without diminishing the role of the treating physician. These early reports would be particularly useful for uncontested traumatic injuries with lost time potential.

E. MORE PROTEST REVIEW BY CLAIM CONSULTANTS (COULD IMPACT STAFFING)

The Washington dispute process is complex and the dispute resolution path that is taken depends on a somewhat arbitrary decision, namely whether the party first filed an appeal to the BIIA or a protest to L&I. The standard protest process involves the CM who made the decision reviewing the file, which is a good design for catching simple errors. But when the protest involves a fact dispute, presumably the CM did not make an arbitrary decision and the parties simply disagree, and allowing the CM to “re-make” the same decision doesn’t seem to add much value. If the decision were arbitrary, then allowing another reviewer, the Claims Consultant (CC), with distance from the case, to perform the initial review of the decision would seem to provide a more bona fide review. We believe that limiting CM review to only simple errors and missing information, and expanding CC or senior unit CM review to disputes of a more substantive nature, would make the process more unified and consistent.

We recognize that sending all protests directly to Claims Consultants, by-passing CMs, would add significant workload to Claims Consultants. There may be an alternative approach, however, which would eliminate unnecessary re-assumption processing times and also provide a more independent review of CM decisions regarding issues that are truly in dispute, as opposed to errors or missing information. Such an alternative would involve the CM collecting file documentation of the basis for any reversal of their decision (such as the cases where information was received after the first decision) and proceed with timely resolution of that issue. However, if the CM believes their decision is correct and no known missing information is impacting the decision, the file should be sent to either the WCA4 in the unit, the unit supervisor, or possibly a Claims Consultant to request an affirmation order. This would allow a more independent review before a CM simply decides they were “right in the first place.” This would also largely eliminate the need for the re-assumption review, because such review already has occurred by the CC, except in those cases that are directly appealed without protesting to the department first.

If as a result the need for review on re-assumption is reduced, then this alternative should decrease overall protest times and result in more independent decisions, made by more experienced reviewers, and thus would be “better” decisions. If an appeal were the first formal dispute raised, then L&I would always re-assume jurisdiction and handle it as a protest, according to this same process.

We suspect that a fair number of protests arise out of decisions that are made with inadequate or missing information. It may be that the decision itself forces the issue and gets the information delivered, e.g., worker fails to supply a report so payment stops and worker then supplies the report. In such instances, the current protest process would seem to provide the simplest, most direct approach to resolving the issue. But this involves using the protest process to correct case management problems. The protest process should correct bad decisions. We recognize that this might seem simplistic; for example, if a provider does not offer an opinion on causation, despite repeated requests, and only does so after a formal denial order is issued, then perhaps the order/protest process served a valid purpose, namely to force the issue and get the needed information. In such situations, however, the CM could provide data as to why the protest process was effectively used for “case management” purposes, and this could serve to improve the overall process, and avoid such unnecessary protests.

F. SHIFT TO EMPLOYER REPORTING (MANDATE OR INCENTIVES; COULD REQUIRE REGULATORY CHANGE)

The primary mechanism for accident reporting is by providers, which is not a common feature of most systems, which utilize employer accident reporting as the primary mechanism. Employers are more familiar than providers with the nature of the job at time of injury and other circumstance of the accident. Thus getting their input early in the claim would assist with claim validation. Moreover, this would provide an excellent opportunity to gain insight into employer engagement with RTW. Reporting accidents is not equivalent to filing claims; the former is important to triggering the insurer's response, and should be made as expeditious as possible. The latter involves formally lodging a claim within a workers' compensation system. What we are discussing is prompt accident reporting, not claim filing.

The claim reporting process should be re-structured such that the primary mechanism for accident reporting is from employers, and to move away from provider responsibility for initiating the accident report. Providers cannot as easily be mandated as employers to make prompt accident reports to L&I. This would help speed up reporting to L&I, which in turn would improve timing performance of subsequent decisions. This should not serve to eliminate provider reporting to L&I; on the contrary, it is essential to effective claim management to receive prompt provider input regarding the claim and associated treatment. Such input should not delay, however, the employers' accident reporting process.

G. ONLINE PROVIDER COMMUNICATIONS

We observed that physicians and medical providers were not frequent users of online communication tools. L&I should aggressively undertake to increase acceptance and usage of online communications tools by physicians. Medical offices are increasingly equipped to use electronic records, electronic billing, and email communications with patients. COHE providers have demonstrated the ease and utility of using online tools. Increasing electronic reporting of the Activity Prescription Form would pay dividends in improving early return to work and speeding first payment of indemnity. Secure messages between the CM and the providers' offices would help resolve misunderstandings or clarify expectations. We suggest that L&I consider further financial incentives for timely and complete medical communications through My Secure L&I. This should be coupled to an educational and outreach program aimed at clinic office staff, and perhaps hospital staff who deal with emergency room billing. These staff should learn the tools and functionality (e.g., setting up a personalized dashboard) that will attract them to use online communication. Moreover, in designing the LINIIS replacement system, L&I should incorporate provider input to ensure that online communications are easy to use and the preferred communications mechanism.

H. ESTABLISH STANDARD DISPUTE RESPONSE TIMES (CM AND CC)

We observed that there are not consistently applied standards in communicating with stakeholders about what timelines to expect in resolving protests. The Department should adopt a policy, applicable to both CMs and CCs, of setting achievable standards for a substantive, clear response to a protest and a decision on re-assumption of appeals. The average protest resolution is 55 days, and this particular timeline may be acceptable. Regardless, the need for clarity in "the next steps" of the claim process was demonstrated in a 2013 L&I survey of injured workers. 27% of respondents gave L&I a poor grade in terms of "letting the worker know what

would happen next,” and 30% gave L&I a poor rating in “involving the worker in the process.” A 30-day target for closure on protests seems like a reasonable expectation unless it is clear at the time the protest was received that an IME or other external supporting documentation was needed. If the selected target date cannot be met, the parties should be kept apprised of the revised target.

Although there is obviously risk that a particular case might take more time than anticipated, leading to further frustration, we suggest that in a large portion of cases the expectation will be met or exceeded, and would likely lead to overall better satisfaction with the process and ultimately the results. We suggest that when a protest supplies all necessary information for processing, as described in the L&I information supplied to the parties with the order, that a targeted internal resolution time, e.g., 30 days, be established and that performance be monitored as to meeting this target. Compliance with such internal standards should be measured and be given management attention if the standard is routinely breached. Additionally, early personal contact with the parties to a claim, discussed in Chapter 2 of this report, would very likely eliminate some disputes and appeals, cut the number of requests for assistance from ombuds or Project HELP, cut back appeals to BIIA, and reduce attorney involvement.