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State of North Dakota

WSI Claims Process Review

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I Executive Summary

Introduction

On December 4, 2007, the State of North Dakota, on the recommendation of Governor John Hoeven, issued a Request for Proposal (RFP) for an independent outside review of Workforce Safety and Insurance's (WSI) workers' compensation claims processing to ensure that management is clearly focused on the agency's mission of servicing North Dakota's workforce.

On January 8, 2008 Marsh USA Inc. (Marsh) was awarded a contract to review WSI's claims processing procedures and a sampling of claims in order to identify problems, develop recommendations and outline a plan to ensure those recommendations are implemented by WSI in an expeditious and orderly manner.

Marsh assembled a diverse team of professionals with extensive experience in workers' compensation, claims administration, process analysis and auditing to assist with the following project steps:

- review of documents related to WSI's workers' compensation claims processing procedures and challenges;
- development of guides to focus our interviews and a claims audit template to ensure relevance and consistency in our assessment of the claims files;
- review of 475 wage-loss and medical-only claims, with dates of loss from January 1, 2005 to January 1, 2008; and
- interviews with WSI staff with claims management related responsibilities in order to clarify our understanding of procedures and how they are implemented.

On January 16, 2008, Marsh conducted a meeting at WSI's Bismarck offices to review the scope of the project with claims handlers, supervisors, and management. At that time we also began the interview process. We returned with the entire team on January 28th to continue the interviews and begin the claims file audit. By February 1 we had collected the necessary data and returned to the Marsh offices to complete our analysis.

Scope and Methodology

Review of Claims Processing Procedures

We began with a review of the workers' compensation statute and administrative rules, previously conducted surveys and studies related to WSI claims processing procedures, and numerous WSI policies and procedures and documents available on WSI's website.

Based on WSI's organizational chart and our initial understanding of roles and responsibilities we developed a preliminary list of interviewees. We refined this list based on our review of job descriptions and our continued review of WSI's policies and procedures. With input from WSI, we developed a "final" list; adding a few more while onsite. Ultimately, interviewees included personnel directly responsible for implementing claims processing procedures and their managers and/or department directors. The complete lists of the documents reviewed and interviewees by title, is included in Appendix A.

This report includes our assessment of current claims processing procedures as documented and implemented relative to the requirements of North Dakota's Century Code, Title 65 and administrative rules, article 92-01; and industry standards.

Review of Claims Files

Marsh selected a random sample of 475 workers' compensation files including wage-loss and medical-only; open, closed and denied, to achieve a 95% +/- 5% confidence level that the sample is an accurate reflection of all claims handled by WSI.

Marsh created an audit template consisting of 34 industry practice objectives and 19 WSI claims processing objectives. The objectives were used to create 14 categories of claims management criteria that we would evaluate through the audit relative to claims management "industry standards" and WSI performance guidelines.

Marsh's definition of "industry standards" is based upon hundreds of previous audits and reviews of the largest insurance carriers and third party administrators countrywide. We would expect to see a compliance score of 85% to 90% compared to these standards. Results greater than 90% exceed industry standards, while scores below 85% represent an improvement opportunity for the claims handling operation.

Marsh's proprietary audit technology platform, STARS Compliance, was used to organize the audit template and house all of the data. The audit team conducted a comprehensive review of the selected claims files using WSI's electronic claims management system to review claims handler notes, medical bills, and financial information.

Only activities captured in the electronic files were noted and evaluated. Claims handling industry practices consistently instruct claims handlers to document the claims files

appropriately, or the claims management activity “didn’t happen” from a supervisory and audit standpoint.

Marsh successfully audited 475 claims with dates of loss from January 1, 2005 to January 1, 2008. The audit sample had total incurred of approximately $6.2 million dollars.

Overall Findings

Marsh assessed WSI’s workers’ compensation claims processing practices from two perspectives.

1. Does WSI have documented claims processing procedures that
   - are consistent with statutory requirements, administrative rules and industry practices;
   - are clearly and consistently understood by WSI staff; and
   - can be implemented as intended given the organizational structure, staff expertise, technical resources and support for continuous education?
2. How consistently is WSI’s claims management staff implementing the documented claims processing procedures on individual claims files at a level that meets industry standards?

Review of Claims Processing Procedures

Relative to the first question, overall WSI has the essential components of an effective workers’ compensation claims management organization – including significant strengths that it can build on and opportunities to be more effective and efficient. The tables below summarize the results of this assessment.

Table A. addresses the broader organization, administration and staffing issues that have an impact on how easily and effectively WSI can fulfill its mission. Table B. focuses on the claims management process itself.

Table A

Area of Focus	Strengths	Opportunities
Documentation		
Policies and procedures	Extensive documentation covering all relevant areas	Organize manual for better access. Separate guidelines from policies to emphasize mandatory requirements for consistent execution Link manual to claims management system to ensure only current policies/forms are used.
Claims file documentation	Meets industry standards	
Staffing		
Roles and responsibilities	Routine time-consuming tasks assigned to support staff; frees up adjuster time	Consider adjuster experience when assigning claims (i.e. new adjusters are assigned medical-only)
Adjuster caseloads		Re-evaluate caseloads based on new system for assigning claims
Education and Training	Extensive initial adjuster training	Strengthen ongoing training including education regarding rationale for policies Strengthen professional continuing education opportunities

Of the areas addressed in Table A, above, the opportunities related to “Documentation” and “Education and Training”, though requiring time and resources, are modifications of strong programs WSI already has in place and activities WSI regularly undertakes.

Relative to staffing, establishing a different system for assigning claims will take time and training to implement but, more importantly, will require detailed assessment and creativity to build the best system for North Dakota. This recommendation has potential for high impact due to the gains in claims management efficiency that should result. At the same time, because this is a significant change in the way claims are assigned, WSI’s new management team should be in place and involved in deciding how this recommendation will be implemented.

Table B

Area of Focus	Strengths	Opportunities
Intake	Website is user friendly	Do not establish a claim based on medical provider report alone.
Compensability Investigation	Support for catastrophic claims Automatic referral for return-to-work case management	Review medical provider contact policy. Utilize external investigations and recorded statements for questionable claims. Improve lag times for compensability decisions. Improve guidelines for making decisions regarding prior work injuries.
Reserving	Official Disability Guidelines are used to help set reserves	Update Reserving Handbook with current costs. Track non-medical reserves separately from medical.
Action Planning, Implementation and Closure	Multi-disciplinary "triage" discussions on all wage-loss claims	Clarify communication policies when the return-to-work case manager is assigned to a claim to ensure adjuster continues to control the file.
Managed Care	*Official Disability Guidelines* are used for treatment and duration guidelines Significant medical staff and consultant resources available to adjusters	Better utilize available medical staff resources and increase library of guidelines. Assess impact of physician choice. Enhance adjuster/medical collaboration. Clarify use of body part vs. ICD-9 for utilization review. Review policy of addressing utilization review only on accepted claims. Utilize benchmarks. Ensure appropriate use of Independent Medical Evaluations (IMEs).
Legal	Onsite legal resources Fraud warning reviewed when claims reported	Resume regular training. Increase adjuster involvement on litigated claims. Enhance fraud investigations, increasing focus on employers and medical providers.

Of the areas addressed in Table B, above, the highest priorities that should be addressed now are:

- Improve lag times for making compensability decisions – this is vital because of the impact it has on the entire claims management timeline. WSI will need to begin to address this with an assessment to determine the root cause.

- Improve guidelines for making decisions regarding prior work injuries – this process requires that the adjusters make decisions related to medical issues and liability which are not always clear and are subject to interpretation. The fact that the workforce is aging and degenerative and cumulative diagnoses are likely to become more common will only add to the challenge of this requirement.
- Review policy of addressing utilization review only on accepted claims – this is not an unusual workers' compensation practice, but since its implementation the average timeframe for deciding compensability has also increased, possibly delaying medical care.

Finally, there is one area in which WSI excels and has a significant opportunity – Unit 7 is a pilot "injury management" claims team with a dedicated nurse and regular input from the Medical Director and Pharmacy Benefits Director. Because of its structure the team is able to actualize a proactive, collaborative philosophy for maximum effectiveness. WSI should continue to explore how to replicate this structure with the other claims units.

Review of Claims Files

As with the operational analysis, the audit findings included a range of results. For example, the WSI claims handlers exceeded industry standards in four of the criteria, met the goal in five of the criteria, and have opportunities for improvement in five of the criteria. The WSI claims handlers overall performance for all 14 criteria was 80 percent. In comparison to industry standards, a score of 85 to 90 percent would be expected. The majority of insurance carriers and third party administrators strive to achieve an overall score above 90% to be considered an industry leader.

The following table highlights the overall scores for all 14 criteria.

New Claims Processing	85 to 90 percent	97 percent	Exceeded
Timeliness of Payments	85 to 90 percent	93 percent	Exceeded
Medical Cost Containment	85 to 90 percent	91 percent	Exceeded
Communication	85 to 90 percent	93 percent	Exceeded
Medical Only Claims Processing	85 to 90 percent	90 percent	Met Standards
Investigation	85 to 90 percent	86 percent	Met Standards
Denied or Withdrawn Claims	85 to 90 percent	89 percent	Met Standards
Disability Management	85 to 90 percent	87 percent	Met Standards
Reserving	85 to 90 percent	86 percent	Met Standards
Three-Point Contacts	85 to 90 percent	75 percent	Opportunity
Subrogation/Recoveries	85 to 90 percent	35 percent	Opportunity
Action Plans	85 to 90 percent	77 percent	Opportunity
Supervision	85 to 90 percent	82 percent	Opportunity

In addition, Marsh took a closer look at WSI's combined overall score in relationship to the 2005 accident dates versus the 2006/2007 accident dates. WSI had some statutory claims management process changes which took place in 2006 for those claims with dates of loss from January 1, 2006 to January 2008. Marsh examined the overall score for claims with accident dates of 2005 versus those with accident dates of 2006 and 2007 for any noteworthy trends. The overall score for the 2005 claims was 79% in comparison to the 2006/2007 claims which had an overall score of 81%. Any significant trends noted in comparison to the 2005 accident dates versus the 2006/2007 losses are noted in the detail findings of the report.

WSI Exceeds Industry Standards in the Following Categories

New Claims Processing

The claims handlers performed very well in the categories of new claims processing, timeliness of statutory payments/overpayments, medical cost containment and communications. The WSI technicians did an excellent job of processing new claims by consistently completing the appropriate employer, injured worker and medical forms. The accurate completion of new claims forms is one of the first steps in validating the compensability of a claim.

Timeliness of Payments

The claims handlers performed very well in the category of timeliness of payments and overpayments. They had good results in effectively paying disability benefits after the required 5 days had elapsed and minimum overpayments were discovered with medical and indemnity benefits. The processing of statutory benefits timely prevents fines and additional costs from occurring and cultivates positive employee relations. By eliminating overpayments of indemnity and medical benefits the claims handler gains a clearer picture of the liabilities associated with each claim and reduces any likelihood of an employer being inappropriately assessed for paid losses.

Medical Cost Containment

The claims handlers demonstrated effective medical cost containment and this is arguably one of the most important aspects of solid claims handling. Nationally, medical costs are rising at more than twice the consumer price index and success in managing this cost component pays positive benefits. The claims handlers executed appropriate utilization reviews for inpatient hospital, physical therapy, and chiropractic treatment. These activities successfully managed medical costs in conjunction with the diagnosed injury. The claims handlers consistently relied on appropriate medical documentation prior to paying medical bills. However, improvement is required to ensure approved medical bills are paid within

30 days or less. The claims handlers should establish a daily diary to process appropriate medical bills within the required time frames.

Communication

The claims handlers consistently communicated with the employer and injured employee throughout the claims handling process. With consistent communication the likelihood that an injured employee's claim is consistently managed and appropriate benefits will be paid is greatly improved. The claims handler's ongoing communication with the employer kept stakeholders abreast of the injured employee's disability, medical treatment, and return-to-work options.

WSI Met Industry Standards in the Following Categories

Medical Only Claims Processing

The claims handlers successfully reviewed new medical-only claims to determine if the injured employee's claims history involved any prior or duplicate claims. There were 31 files which were automatically adjudicated. However, there is room for improvement to ensure the notepad (WSI's file notation system) is appropriately updated within 30 days of receipt of the claim to reflect the decision reached on the medical only claims.

Investigation

The claims handlers demonstrated good overall investigation practices, with appropriate documentation to reflect the rationale behind compensability decisions. However, for those claims in which a compensability decision was not reached timely, the claims handler should consistently complete an action plan to resolve open issues. Also, WSI has room for improvement in its assignment of field investigation involving complex and serious claims. With the utilization of field investigators WSI can obtain appropriate recorded statements from the injured employee, employer, and witnesses to expedite a compensability determination.

There were several missed opportunities for the claims handler to obtain a recorded statement from the employer, injured employee and/or witness to confirm a questionable accident was work related. When a witness was noted in the first report of injury, the file notes in most instances did not reflect the person was contacted for a possible statement.

The claims handlers relied on summaries of their discussions with the injured employee and/or employer and this can cause key information to be missed when investigating a questionable accident. The lack of recorded statements may be impacted by the turnover in the SIU investigation department, as one of their roles is to secure recorded statements for the claims handlers.

Denied or Withdrawn Claims

WSI performed well in its handling of denied claims. The majority of claims were well investigated and denied based on the applicable state statutes.

The appropriate FL205, FL724 and FL206 forms were consistently used by the claims handlers when a decision was made to deny a claim. However, there were a small number of claims in which the denial of the claims was questionable, based on the lack of documentation, interpretation of “arising out of and in the course of employment”, medical documentation, pre-existing injury triggers, and/or possible fraud interpretations.

The North Dakota workers’ compensation statute in some instances is open to interpretation as to whether a claim is work related or an aggravation of a pre-existing injury has occurred. Marsh recommends periodic training sessions conducted by outside defense counsel to review what is and is not considered a compensable claim for consistency purposes among all claims handlers.

Disability Management

WSI performed well in its efforts to manage the disability of the injured employee. There was good collaboration by the claims handler, employer, medical provider, telephonic nurse case manager, onsite nurse case management, and return-to-work specialist in getting the appropriate treatment for the injured employee and returning him/her to work accordingly. WSI consistently applied effective disability case management to return the injured employee to work timely and appropriately. The use of the return-to-work specialists at the designated medical facilities has been effective in addressing return-to-work opportunities for WSI, and should be continued. WSI should obtain quarterly or semi-annual reports from the medical facilities with which they contract to track the disability duration results of each operation and confirm the cost benefit.

One of the concerns in this category rests with the poor results in using independent medical exams when an injured employee’s disability duration exceeded the Occupational Disability Guidelines (ODG). It is understood a treating medical provider has examined and treated the injured employee, but there has to be some oversight in place when an injured employee’s disability duration exceeds the guidelines. An independent medical exam (including a physical exam versus a review of records only) by a specialist in the appropriate field allows a second set of eyes and objectivity. If independent medical exams have proven to not be effective in the State of North Dakota, another option would be for the State to explore the creation of a medical review board to determine if the ongoing disability and treatment of an injured employee is appropriate. However, this option has the potential to lead to backlogs if not properly staffed and organized.

Reserving

WSI consistently reserved for the total probable exposure on each file and the majority of the cases were reserved appropriately. The State of North Dakota statute regarding benefits under medical, temporary total disability, total permanent disability, permanent partial disability (amputations, and schedule of benefits), has proven to be very effective in managing workers' compensation indemnity benefits. The rationale support the reserves displayed on the majority of files as the claims handlers relied upon the ODG to determine the number of weeks of expected disability based on type of job and anticipated medical treatment.

A modest number of claims audited included permanent partial or total permanent disability benefits. (For a permanent partial disability benefit to be paid the injured employee must have a disability rating of greater than 16%.) WSI consistently applied the state statutes in compensating injured employees based on temporary total disability, permanent partial disability, total permanent disability, death benefits, medical benefits, or schedule of benefits.

Although WSI scored well regarding its reserving practices, there is room for improvement. For example, a small number of files included excessive medical reserves, primarily due to reserves not being reduced when the injured employee had been back to work for a considerable period of time and was no longer treating. WSI should revisit the medical reserves timely when an injured employee has been back to work for at least 90 days and is no longer treating for his/her injuries. In those instances, the medical reserves should be reduced considerably or closed out based on no further payments being anticipated.

In addition, we observed limited instances of "stair stepping" of reserves with medical reserves being increased frequently over a six month period. The claims handler needs to be addressing reserves whenever new developments take place on the file and subsequent action plans are updated. This is also an area where the ongoing review by the supervisor can identify reserving issues. However, the claims handler is not the only person adjusting the reserves, as others can also adjust the reserves and this may have led to the frequent reserve changes.

Another important observation is that medical and expense reserves are combined which can impact the ongoing reserve level when medical bills and legal expenses are being paid from one source. The combined medical and expense reserve procedure should be studied to determine if the benefits of keeping these allocations together is still appropriate. From an industry standpoint, the medical and legal expense reserves should be kept separate to effectively track the allocations and determine if the medical costs and legal expenses are appropriate for each file based on the severity of the injury and any open litigation issues.

WSI Has Room for Improvement in the Following Categories

Three-Point Contact

WSI should improve its ability to contact the injured employee, employer, and medical provider within 24 hours of a wage-loss claims being assigned or converted from a medical only claim. Typically, WSI made contact within 72 hours or less of the claim being assigned. Unfortunately, in several instances the claim file did not reflect contact attempts with the injured employee, employer or medical provider. Many of the claims handlers appeared to rely on written correspondence, instead of verbally attempting to contact the pertinent parties to begin investigation and explain the workers' compensation process. However, per WSI standards, the claims handlers do not have to contact the medical provider if the claim file had appropriate return-to-work documentation when the claim was received. (The auditors gave appropriate credit in those instances where the return to work documentation supported the claim handler not having to contact the treating medical provider in the initial three point contact phase.) WSI should improve its initial contact practices to meet the industry standard of 24 hours to begin the investigation process while the facts of the accident remain fresh.

Subrogation/Recoveries

WSI should improve its execution of addressing subrogation opportunities on the applicable claims files. WSI has standards in place which address subrogation procedures, but the claims files did not reflect consistent execution of the activities. Marsh is unclear if this is a documentation issue or a lack of execution. There were a number of files in which WSI failed to properly investigate whether subrogation or recovery was applicable against a responsible party, company, or manufacturer. WSI should consistently investigate subrogation opportunities when a claim is first reported to determine if a responsible party should be placed on notice and pursued for appropriate recoveries.

Also, there were a small number of cases involving offsets/apportionment and the claims files were not consistently documented to reflect appropriate procedures were followed. The management of subrogation and offsets allows the employer to potentially achieve a reduction in the overall value of claims which can impact the overall experience rating of an employer's workers' compensation program. WSI should address subrogation and offsets during the investigation of compensability when a claim is first reported and execute the necessary procedures when appropriate.

Action Plans

WSI should also improve its execution of action plans to assist in the management of each wage-loss file. Action plans provide the claims handler with a strategy for managing each claim to an appropriate resolution. We did observe a trend regarding initial action plans

involving the 2005, 2006, and 2007 claims. The initial action plans completed within 90 days of assignment were consistently present for the 2006 and 2007 claims. However, the 2005 dates of loss claims did not consistently have initial action plans. Marsh believes the improvement is due to WSI's use of a "triage" process since 2006 to discuss the overall direction of the claims and strategies for managing next steps. With the implementation of the triage process the claims handlers have been effectively executing the initial action plans.

However, the claims handlers are not consistently completing the "C97a" form prior to entering the 90 day action plan in the notepad. In addition, after the execution of the initial action plan the claims handler is not consistently setting up a meeting within 7 days of the 90 day action plan with a claims supervisor and medical case manager to review next steps and other strategic issues. Subsequent action plans need to be improved as well, as many of the 2006/2007 claims had the initial triage action plan, but lacked subsequent action plans. When subsequent action plans were noted on the file, the claims handler responded timely to follow-up items.

Supervision

The claims supervisors have room for improvement in their direction and oversight of the claims handlers, as they attempt to move files to an appropriate resolution. If the claims supervisors have been providing ongoing direction to the claims handlers the files are not being consistently documented to reflect that supervision. Several of the complex or questionable claims would have benefited from more supervisory involvement.

The claims supervisors improved their involvement with the 2006/2007 claims in comparison to 2005, and this may be the result of the triage process, but further improvement is required. When the claims supervisors were actively involved claims handlers were more engaged in the management of each file. When the claims supervisors provided direction to the claims handlers the response to open items was improved. The claims supervisors should establish an effective diary system to review those claims not assigned to a senior claims handler for appropriateness of reserves and resolution plans.

Litigation Management

WSI's litigation management results were impacted by the small number of applicable claims (8 files) in this category and the overall results are misleading based on the sample size. The small number of applicable claims does not validate any significant trend in this category.

However, there is room for improvement to ensure the claims handlers remain actively involved in the ongoing management of outside defense counsel. The claims handlers successfully refer litigated cases to defense counsel in a timely manner and need to ensure that each assignment to defense counsel has an effective litigation plan in place.

Defense counsel should provide an effective litigation plan within 30 days of receipt, including the estimated expense costs associated with defending the designated claims. Updated litigation status reports should be provided monthly or quarterly, depending on the outstanding issues associated with the claims. The claims handlers should require defense counsel to provide a detail monthly or quarterly bill to validate the services being provided.

II Review of Claims Processing Procedures

Introduction

The Review of Claims Processing Procedures covers the following areas.

- Documentation – Documented policies and procedures support consistency, efficiency and quality in claims management. Complete documentation of the facts guides decision-making when managing claims and is necessary to successfully defend those decisions if they are challenged.
- Claims Management Staffing – How well the claims staff's abilities are matched to their responsibilities, how effectively they work with each other and how adequately they are supported are key to WSI meeting its mission of serving North Dakota's workforce.
- Education and Training – Thorough training of new staff is a vital first step. Ongoing training and continuing education must also be provided to keep staff up-to-date with regulatory changes and advances in medicine and claims management philosophy.
- Claims Management – The claims management policies and procedures must support the requirements of the workers' compensation statute and administrative rules, be accurately interpreted and consistently applied, and constantly evolve to address changing laws or newly identified issues. This section addresses the same territory as the claims audit, but from the perspective of the adequacy of the policies and procedures rather than how well they are carried out.
- Organizational Collaboration – The more effectively WSI's departments and staff work together, the more successful it will be in carrying out its mission.

Each section begins with a statement of the applicable statute or rule, followed by the accepted claims management industry practices and benchmarks, or "review standard." Our findings are based on our review of documents and interviews. We noted any areas of special strength, which either exceed industry standards or are a unique approach that others in the industry could learn from. Areas which need to be enhanced or improved to meet the requirements of the standard, statutes or rules are discussed under "Opportunities." Recommendations describe next steps or options to consider going forward.

Documentation

Statute or Rules

The organization shall adopt rules necessary to carry out this title.

65-02-08

Review Standard

Policies and Procedures

- The organization should document policies and standard procedures related to claims management from intake through closure. Documentation should:
  - reflect current regulatory requirements and mandatory and recommended practices; and
  - be organized for easy access to specific topics by the claims adjuster.
- Documented policies and procedures should cover, at a minimum:
  - reporting;
  - claims file setup;
  - investigation;
  - three-point contact;
  - compensability determination;
  - reserving;
  - diary;
  - authority levels;
  - fraud identification;
  - litigation management;
  - medical management; and
  - disability management.

File Documentation

Claims files should clearly demonstrate that the adjuster is actively directing the claim to a timely and appropriate conclusion. Documentation should be organized, consistent, accurate and complete, with needed information easy to retrieve.

- Ensure on-line data entry, adjuster notes, and diary.
- Establish standardized abbreviations.
- Capture all activities.
- Scan documents into electronic file.

Findings

Strength

WSI has extensive documented policies and procedures in the *Claims Procedure Manual* covering all relevant areas.

Opportunities

- The manual is organized by section, generally in the order in which a claim is handled, and includes an alphabetical listing of topics. It is updated to reflect regulatory or process changes as necessary.

  The rationale for the location of specific topics is not always apparent. For example, Section 200 includes three-point contact, calculating and issuing wage-loss benefits, and claims closure. Although the topics are also listed alphabetically they are only listed once, so when looking for “calculating wages for the self employed,” for example, one must know to look under ”c” rather than “s” (for self-employed) or “w” (for wages).

- The cover of the manual states that “the policies and procedures…are guidelines to be used in the processing and management of claims. They are not intended to be standards or requirements that must be strictly followed.” This was frequently repeated by interviewees discussing claims management, who stressed that they “did not worry about benchmarks, but about processing claims.”

  Although each claim is unique and it may not always be possible to accomplish the required activities in the required timeframes, adjusters should understand that these policies are not “just guidelines.” In other words, they are not optional and though exceptions will occur, they must be documented and justified.

Recommendations

- Develop an electronic, searchable version of the *Claims Procedure Manual*, so it can be easily accessed and searched by the claims adjuster as necessary. Preferably key policies, procedures and forms are directly attached to the claims management system so that the most up-to-date version appears when accessed.

  Also, consider distinguishing between "policies," which are required and "guidelines," which are merely informative or implemented totally at the adjuster's discretion, by storing these in separate files. For example, for the "Claims Procedure 100 Series" all of the supplementary questionnaires and claims status definitions would be stored with the guidelines.
- Maintain a "leading industry practices" claims management philosophy to build an understanding of the value and necessity of mandatory standards.

Claims Management Staffing

Statute or Rules

N/A

Review Standard

- Claim assignment should be made based on adjuster experience, with new adjusters handling medical-only claims and adjusters with experience handling wage-loss claims. More complex wage-loss claims should be assigned to senior adjusters, who should be given a reduced case load (100-125).
- Case loads should not exceed 175 wage-loss or 300 medical-only depending on:
  - the demands of the types of claims in the adjuster's portfolio;
  - extent of internal assistance to the adjusters; and
  - efficiency of managed care resources.
- Supervisor should have no case load.

Findings

Strengths

Support staff handles more routine time-consuming tasks related to claims handling, freeing up adjusters' time for vital claims management activities.

- Claims Service Representatives assist injured workers and other stakeholders with basic claims related questions. This provides prompt response to injured worker, employer and medical provider concerns, which helps to keep the lines of communication positive and open – essential to effective claims management.
- Technicians assist with initial file set-up and on routine administrative tasks throughout the life of a claim.

Opportunities

- All WSI adjusters are assigned employer accounts and are responsible for all claims associated with those employers, without regard for the adjuster's experience or claim complexity. Employers and injured workers reportedly appreciate the consistency of a relationship with one adjuster, which this process supports.

  According to staff who have been with the organization for some time, WSI previously assigned medical-only claims to the least experienced adjusters and wage-loss claims to more experienced adjusters based on the duration of time loss, potentially resulting in three or four adjusters for one claim. Both injured workers and employers complained and the employer-based assignment system was implemented. Wyoming has also used an employer-based process for assigning claims, and has resisted change because of the advantages this provides. (At the same time, they received an "F" in the "2004 State Report Cards for Workers' Comp.", published by the Work Loss Data Institute.)

  Assigning wage-loss claims to seasoned adjusters and medical-only claims to new adjusters is a leading practice. It allows the organization to get the most value from experienced employees who are able to effectively and efficiently investigate claims facts, quickly identify and address potential issues, and successfully manage claims to closure. It also provides a "training ground" for new adjusters to become familiar with workers' compensation concepts without expecting them to know and understand all of the nuances that can impact management of wage-loss claims.

  Many third party claims administrators, while assigning only medical-only claims to less experienced staff, also have some adjusters dedicated to specific (usually larger) employer accounts. WSI has an opportunity to benefit from such an approach that continues to support relationships, valued by its customers, while more effectively utilizing adjusters' experience.
- Average caseloads per claims adjuster for FY2007 are 63 active wage-loss claims and 212 active medical only claims[1]. This is low relative to the review standard Though the mix of medical-only and wage-loss claims will have an impact on what an appropriate standard is, the support provided by the technicians and claims service representatives would indicate that adjusters should be able to handle a higher case load.

[1] According to the *WSI Operating Report As of the Quarter Ending: September 30, 2007*

Recommendations

- Develop and phase in a system for assigning claims by employer account as well as adjuster experience. Possible approaches include:
  - Assign each employer to an adjuster team, with the least experienced adjuster assigned to medical-only claims.
  - Assign all medical-only claims to newer adjusters without regard for employer, and continue to assign employer accounts to more experienced adjusters who manage only the wage-loss claims.
  - With either of the above, limit dedicated adjusters to larger employers, or employers with a certain amount of claims.
  - Define complex claims and identify red flags indicating claims that can easily go south. Assign these claims only to senior adjusters.
- Re-evaluate caseloads for any new system of assigning claims.
- In order to minimize the possibility of a number of adjusters serially assigned to one claim, develop an expanded definition of “wage-loss” to include probable or expected wage-loss and problem claims. For example, all claims expected to reach the five-day trigger for indemnity payments should be assigned to a wage-loss adjuster. The following may also benefit from the dedicated resources and more in-depth management required of wage-loss claims:
  - surgery is scheduled or expected;
  - injured worker on modified duty (especially if originally a wage-loss claim);
  - cumulative trauma;
  - repeat claimant; etc.

Education and Training

Statute or Rules

N/A

Review Standard

- New adjusters should:
  - receive classroom and on-the-job training in workers’ compensation and claims management policies and procedures, including:
    - statutory requirements;

        - roles and responsibilities of, and interaction between, internal and external stakeholders;
        - use of the claims management system and other technology;
        - effective investigation and decision-making; and
        - effective use of resources for medical management, investigation, disability management, litigation support, etc;
    - demonstrate understanding before being allowed to work independently; and
    - be provided sufficient resources if questions or unusual situations arise.
- Ongoing training and education is viewed as an investment in valued staff, to ensure that they hone and develop new skills and are up-to-date on current legal and medical issues.

Findings

Strength

- WSI provides training which, in our experience, is more extensive in duration than many third party claims administrators. This includes.
    - Six to seven weeks of half-day book training and half-day observing working adjusters in the Resource Unit.
        - Classroom training covers the technical aspects of claims management consistent with the review standard.
        - Observing (and later partnering with) others provides new adjusters with some experience in the variety of situations and decisions that can impact a claim.
    - For approximately one month, or more as necessary, new employees work with an experienced adjuster on their assigned unit.
    - Self-assessment is completed by new adjusters when initially assigned to their own unit, and every three months for up to one year, with additional training provided as necessary.

Opportunities

- Formal training does not appear to include a discussion of the rationale for mandatory claims management procedures and timelines. As adjusters gain experience with the technical aspects of claims management, further education covering why specific procedures are important and how they can impact costs and outcomes will improve claims management efficiency and cost effectiveness
- Adjusters receive training on any new procedures or policies as they occur. There is limited formal ongoing training related to claims management.

- There is a limited budget for educational programs for professional staff. Those interviewed expressed concern that they did not know what similar organizations are doing, the rationale behind new procedures or recommendations, and what "industry practices" (often used to justify change) are based on.

Recommendations

- Determine staffing model before making changes to the adjuster training program in order to ensure that content is appropriate for the adjusters' level(s) of responsibility.
- Introduce the concept of "leading industry practices" when training adjusters on required claims management procedures in order to improve their understanding of the importance of achieving documented requirements within stated timeframes. For example,
  - Leading Practice – Contact injured worker and employer by phone within 24 hours receipt of the claim.
  - Purpose
    - to gather accurate information necessary to decide compensability and manage the claims; and
    - to provide information to stakeholders to smooth the process and open communication.
  - Rationale
    - Time lapse impedes ability to gather accurate detailed information which is necessary to make an appropriate compensability decision.
    - A timely compensability decision allows for timely issue of benefits, which reduces potential hardship for the injured worker and helps to maintain a positive relationship with all parties.
    - Delayed compensability decision may also delay medical care, which can result in a longer period of disability and ultimately higher medical costs.
    - Any delays at the beginning will lengthen the time it takes to close the claims.
    - The longer a claim is open, the more it costs. For example, in the chart below, indemnity claims lasting 19-36 months are over 2½ times as expensive as those closed in the first 12 months [2]

[2] Source: Marsh Dimensions database, 2005

Average Paid per Claim by Duration Group
2004 Closed Indemnity Claims

- Provide adjusters with regular meaningful training and continuing education specific to claims management. Conduct mandatory formal training at least annually. Also support training available through outside organizations for adjusters who want to expand their knowledge and value to WSI.
  - Training programs for claims adjusters are available through insurance companies, third party claims administrators and organizations such as the Insurance Institute of America Inc. which awards professional designations, e.g., Associate in Claims (AIC), Associate in Risk Management (ARM), and Chartered Property Casualty Underwriter (CPCU).
  - In order to ensure that the organization gets maximum value from any non-mandatory continuing education it supports, incorporate specific goals in individual adjusters' performance reviews, based on interest, readiness and job-related purpose.
- Establish relationships with professional organizations that provide resources and tools, often free to members via their websites, and sponsor educational seminars. See Appendix B for some examples.
- Support educational seminars for professional staff, to improve the organization's knowledge of the latest trends and tools and establish colleague networks which can serve as informal resources when new issues arise.

Claims Management

This section covers the following claims management processes:

- Intake and File Set-up
- Compensability Investigation
- Reserving
- Action Planning, Implementation and Claims Closure
- Managed Care
- Legal Issues

Intake and Initial File Set-up

Statute or Rules

> If a claim for compensation has not been received by the organization but the organization has received an employer's first report of notice of injury, the organization shall notify the employee that the employer's first report has been received.
>
> 65-05-01.2-3

Review Standard

- A formal, clear and easy-to-use loss reporting protocol should be established, such as a 1-800 hotline, E-mail, or comparable reporting access.
- Employer and injured worker should be notified that the claim has been received, by the next business day.
- Initial file set-up should be completed within 24 hours.

Findings

Strength

The WSI website is very user-friendly and online reporting instructions are easy to follow.

Opportunity

An injury may be reported by the employer, worker, or medical provider, via telephone, mail or on-line. The first report of injury received, regardless of originator or missing information, establishes a claim. By contrast, employees in Washington State are required to report claims only through their medical provider. A pilot project is currently underway, to determine if having employers file claims results in less disability and better return-to-work outcomes.[3]

While timely conversion of incidents to claims is a best practice, a medical provider report in lieu of an employer or injured worker report may result in "claims" that are never filed by the injured worker and therefore must be "denied" to close the file. This can waste WSI staff time on claims that should not have been made in the first place and skew statistics used for evaluating the organization and its procedures. It is unclear that there is any value in accepting the first report of injury from the provider and it may leave the injured worker with the mistaken impression that no action is necessary on his part (as is often the case with group health policies) thus increasing the time it takes to complete the investigation and decide compensability.

Recommendation

Change policy for establishing a claim based on any originator of the first report of injury, to include only the employer or injured worker.

Compensability Investigation Three- Point Contact

Statute or Rules

> Each claim must be signed by the person entitled to compensation … accompanied by a certificate of the employee's doctor stating that the employee was physically examined, stating the nature of injury and the nature and probable extent of the disability. For any reasonable cause shown, the organization may waive the provisions of this section.
>
> 65-05-02

[3] Washington State Department of Labor and Industries, Employer Reporting Pilot Project
http://www.lni.wa.gov/ClaimsIns/Insurance/Learn/Projects/EmpReport/Default.asp

> An injured employee's doctor shall certify the period of disability and …abilities and restrictions…[and]include in the report filed with the organization: the medical basis…, [if] totally disabled…able to return to any employment…restriction...limitations, length of and reason for disability…
>
> May not certify…more than 60 days before the doctor's examination
>
> 65-05-08.1

Review Standard

- For wage-loss claims, initial contact should:
  - include at least the employee (attorney), employer, and medical provider;
  - be attempted within 24 hours; and
  - be voice-to-voice.
- For questionable medical-only claims, the employer should be contacted.
- If unable to make contact, at least three attempts should be demonstrated. If unsuccessful, follow up by mail with:
  - contact card; or
  - letter of acknowledgment; and
  - statutory forms and procedures.

Findings

Opportunity

Contact must be made within 24 hours receipt of all wage-loss claims (and medical-only claims when directed by the supervisor) with the worker and employer, regardless of data in the file. Voice-to-voice contact with the medical provider may be waived if the return-to-work case manager note or first report of injury contains all of the necessary information.

89% of three-point contacts were made within 24 hours in FY2007[4], while 75% of the claims files Marsh audited met the standard.

[4] According to the *WSI Operating Report As of the Quarter Ending: September 30, 2007;* in contrast, Wyoming's Department of Employment Strategic Plan for July 1, 2004-June 30, 2008 proposes to "continue the three-point contacts completed within 15 days of receipt of report indicating lost time."

Recommendation

The following recommendation was addressed in the claims audit:

Review policy that adjuster does not need to contact medical provider if return-to-work documentation is in place.

Investigation

Statute or Rules

N/A

Review Standard

- Investigation should be initiated concurrently with initial contact in order to determine compensability without delay.
- Information should be obtained regarding
  - employee's personnel records, including employment history and wage statements; and prior medical records;
  - prior workers' compensation injuries from the Central Index Bureau and the Bureau/Board/Commission records;
  - investigative reports from Police, Fire Department, Emergency Medical Services, OSHA or other authority having jurisdiction, on-site safety department (i.e. accident investigation), and surveillance specialists; and
  - recorded statements, where applicable, from the injured worker, supervisor, co-workers, contractors and temporary workers and other witnesses.

Findings

Opportunities

- The *Claims Procedure Manual* includes an instruction to request a crash report if the claim is a motor vehicle accident, but no other investigative reports are recommended. Information contained in other reports may provide additional detail that is helpful for the adjuster in determining compensability or subrogation opportunities.
- Recorded statements from the injured worker are required for wage-loss claims meeting certain criteria (questionable injury, employer questions extent of injury, history of injuries etc.). Recorded statements from other parties (employer, witnesses, etc.) are not discussed in the *Claims Procedure Manual*.

> Missed opportunities to use recorded statements were also seen in the claims audit, "There were several missed opportunities for the claims handler to obtain a recorded statement from the employer, injured employee and/or witness to confirm a questionable accident was work related."

Recommendation

Request additional available investigative reports from external sources to assist with making compensability decisions and to strengthen the evidence in the file to support those decisions. Accident investigations conducted by the employer can be especially helpful in deciding compensability and can also highlight the potential for subrogation or potential barriers to return to work (e.g., repetitive motion claims when ergonomic hazards are evident).

The following recommendation was addressed in the claims audit:

Provide guidelines for appropriate use of recorded statements with employer, witnesses, etc.

Other Initial Investigations

Statute or Rules

Catastrophic injury

> Catastrophic injury includes:
>
> a. Paraplegia; quadriplegia; severe closed head injury; [etc]…or
> b. Those employees the organization so designates, in its sole discretion, provided that the organization finds the employee to be permanently and totally disabled…
>
> 65-05.1-06.1

The statute provides for additional benefits for "catastrophic" injuries.

Subrogation

> When an injury or death for which compensation is payable under provisions of this title shall have been sustained under circumstances creating in some person other than the organization a legal liability to pay damages in respect thereto, the injured

employee, or the employee's dependents may claim compensation under this title and proceed at law to recover damages against such other person. The organization is subrogated to the rights of the injured employee or the employee's dependents to the extent of fifty percent of the damages recovered up to a maximum of the total amount it has paid or would otherwise pay in the future in compensation and benefits for the injured employee…

If the injured employee or the injured employee's dependents do not institute suit within sixty days after date of injury, the organization may bring action in its own name and as trustee for the injured employee or the employee's dependents and retain as its subrogation interest the full amount it has paid or would otherwise pay in the future in compensation and benefits to the injured employee…

Review Standard

Catastrophic Injury

On-site investigation for catastrophic claims should be conducted within 24 hours.

Subrogation

During initial investigation, determine potential for subrogation. Potential should be considered when:

- injury occurs on another's premises;
- injury from using a machine or disease from exposure;
- Injury where there are maintenance agreements with outside vendors, or contracts with landlords;
- equipment involved was manufactured or maintained by other parties;
- motor vehicle accidents; and
- second injury fund

Timely Referral to Case Management

Protocols and triggers for referral to case management should be defined and reviewed during initial investigation; and claims should be referred as required or appropriate.

Findings

Strengths

- The adjuster is supported by two groups when a “catastrophic claim” is reported.
  - The Catastrophic Management Team assists with immediate needs such as investigation and compensability decision. Loss prevention consultants will do the onsite investigation.
  - The Catastrophic Review Committee approves the “catastrophic” designation.
- Return-to-work case management referral is automatic on all wage-loss claims treated at one of the six major medical facilities with which WSI has a contract. If the worker is treated elsewhere the adjuster decides if referral is necessary. Automatic screening is a program strength. (See the section on Managed Care for more detailed discussion of case management findings and recommendations.)

Compensability Decision

Statute or Rules

> “Compensable injury” means an injury by accident arising out of and in the course of hazardous employment which must be established by medical evidence supported by objective medical findings.
>
> 65-05-02
>
> Examples of cases that would be considered compensable and non-compensable situations are also listed.
>
> The injured employee shall ensure the required reports for any period of disability are filed.
>
> 65-05-08.1
>
> When a compensable injury combines with a non-compensable injury, disease or other condition, the organization shall award benefits on an aggravation basis, on the following terms:
>
> In cases of prior injury…known in advance of the work injury, which has caused previous restrictions or interference with physical function the progression of which is substantially accelerated by, or the severity of which substantially worsened by a compensable injury the organization shall pay benefits of the acute period in full…presumed to be sixty days

> immediately following the compensable injury…Following the period of acute care, the organization shall pay benefits on an aggravation basis.
>
> If the progression of a prior injury is substantially accelerated by, or the severity substantially worsened by a non-compensable injury…the organization shall pay benefits on an aggravation basis…. as a percentage of the benefits to which the injured worker would otherwise be entitled…presumed to be payable on a fifty percent basis.
>
> 65-05-15

Review Standard

Make and document the compensability decision within timeframes required by law, or within 14 days, whichever is sooner. Obtain reviews and approvals.

Findings

Opportunities

- In FY2007, initial determination of compensability was made on 55% of all claims within 14 days and 23% were still in pending status over 31 days. This is a marked increase over 2006, as can be seen in the table at right.[5]

Percent of Claims pending more than 31 days

FY 05	FY 06	FY 07	FY 08	Target
10%	12%	22%	26%	10%
			(projected)	

- The adjuster checks for priors during the initial investigation. If priors are identified the adjuster gets necessary medical opinion(s), and then must decide, is the preexisting condition contributing to the current condition (aggravation)? and, if yes, has work:
  - substantially accelerated the progression
  - worsened the severity of the preexisting condition?

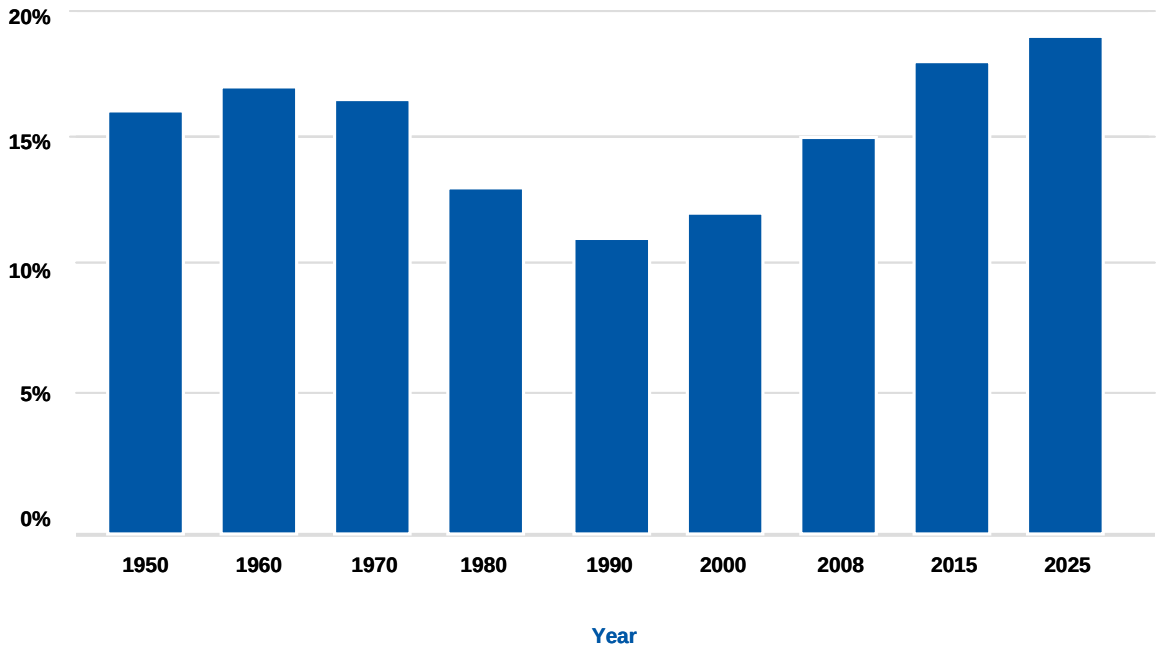
  Within the last couple of years a team with representatives from claims, legal and medical was formed for the purpose of clarifying medical/legal issues, including the process used to determine priors. As a result they made minor changes to the original priors questionnaire and developed a “subsequent investigation of priors” questionnaire.

  Although some feel that this has helped, those interviewed felt that there is still confusion over the definition and impact of “priors,” especially in regards to

[5] According to the *WSI Operating Report As of the Quarter Ending: September 30, 2007*

musculoskeletal conditions associated with aging. The importance of addressing this issue and clarifying the decision-making process is highlighted when data on the aging workforce, such as the chart below, is considered.[6]

Proportion of the Labor Force Aged 55 +
1950 to 2000 Data Projected to 2025



As can be seen in the table below, the U.S. Census Bureau[7] data shows that North Dakota will be disproportionably impacted by the aging of America relative to the country as a whole.

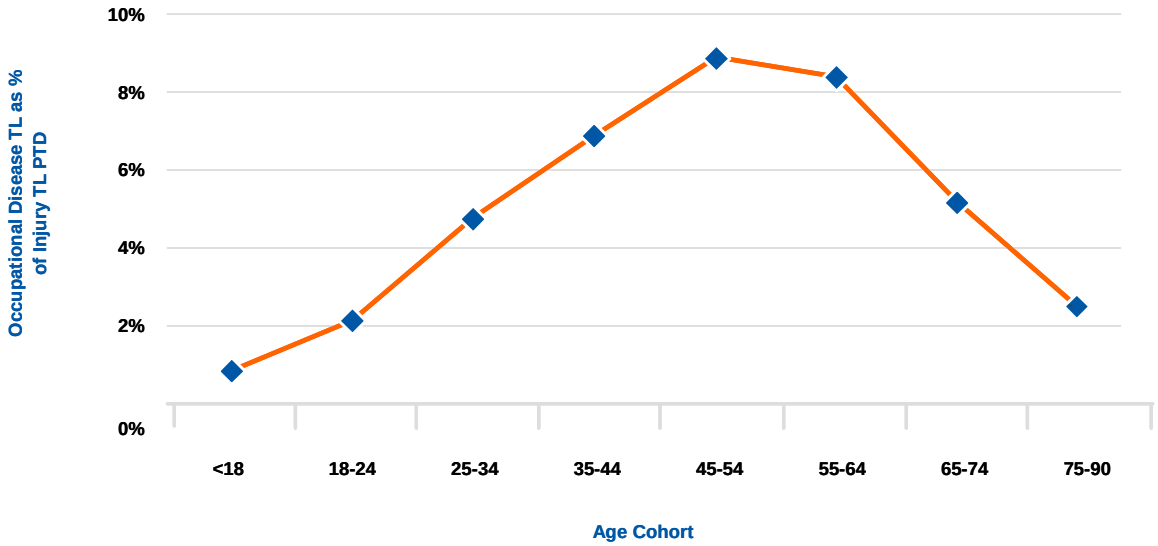
	2000		2010		2030	
	< 18	≥ 65	< 18	≥ 65	< 18	≥ 65
N.D.	25%	14.7%	22.3%	15.3%	21.2%	25.1%
U.S.	25.7%	12.4%	24.1%	13%	23.6%	19.7%

[6] Source: Fullerton 1999a and 1999b; U.S. Department of Labor 200

[7] U.S. Census Bureau, *State Interim Population Projection by Age and Sex 2004-2030*

The chart below shows how the rate of musculoskeletal claims increases with age, with the highest between ages 45 and 64[8].

Percent Occupational Disease Time-Loss Claims Paid to Date by Age



This chart is based on Washington's State Fund claims data. Note that Washington's occupational disease categories include peripheral nervous system conditions (e.g., carpal tunnel syndrome) lower musculoskeletal and upper musculoskeletal, exposure and hearing loss.

Recommendation

- Analyze data to determine why there has been an increase in lag time from receipt of claims to compensability decision and address issues identified. Possible contributors include the issues below:
  - Receipt of a claim starts the clock on measuring lag times. Accepting the physician's first report as a claim in absence of either an injured worker's or employer's report may result in increased lag times because their reports must be submitted before the adjuster can accept compensability. The worker/employer may be less responsive to attempted contacts because they had no intention of filing a claim or do not understand their obligation to do so once the physician has filed.
  - Lack of clarity regarding what constitutes a "prior" injury may have resulted in adjusters requesting more medical information before making a decision.

[8] Washington State Department of Labor and industries, *The Aging Workforce in Washington State: Impacts and Implications for Workers Compensation*, Report of Research in Progress Second Edition, Research and Data Services Information for Informed Decisions, November 9, 2007

  - Low adjuster morale may result in slower processing time.
  - Public attitudes toward the organization may result in slower responses to requests for information.
- Require that all questionable claims are triaged before the adjuster makes a denial decision to ensure that the perspectives of medical, supervision and others as necessary are considered.
- Develop further guidelines, such as an algorithm, to simplify the process for identifying a "prior" injury and determining its impact on WSI's liability for the current claim. Include definitions or more detailed guidelines covering:
  - "known in advance of the work injury"
  - "previous work restriction or interference with physical function"

  Include a requirement that adjusters detail rationale for their decisions in the claims file.
- Annually review with adjusters the statutory requirements regarding compensability decisions, including the sections on prior injuries. Consider using a defense attorney who can bring an outside perspective to do the training.

Reserving

Statute or Rules

N/A

Review Standard

- Define reserve philosophy and authority levels.
- Establish initial reserve within 72 hours.
- Complete reserve worksheets/spreadsheets.
- Review reserve appropriateness within 30 days of claim open date to ensure that information obtained through investigation or other new information is considered.
- Subsequently, adjust reserves within 24 hours of any material change and review no less than every 90 days.
- Claims reserves should be zero at claims closure.

Findings

Strengths

- WSI has adopted the Official Disability Guidelines (ODG) as standard guidelines, which the adjusters use to help set reserves.
- Adjuster uses medical costs associated with ICD-9 code according to the ODG to set medical reserves.

Opportunities

- Questions to consider when setting reserves are included in the *Claims Procedures Manual*, and the reserving handbook, which includes extensive guidelines on costs and was last updated in 2002.
- Non-medical expenses, such as fees for legal and private investigators and "miscellaneous lump sum," are captured under the medical reserve. WSI should consider tracking these components separately in order that medical cost trends can be analyzed and the value-added by other services can be measured. Accurate cost data is necessary to enable the organization to evaluate the effectiveness of its initiatives or impact of changes (e.g., to workers' compensation statute or administrative rules, state demographics, change in industry mix). This is vital for continuous improvement.

Recommendations

- Update reserving handbook with current cost guidelines.
- Break out non-medical costs and track as "expense" separate from the medical reserves. Expense costs would include legal costs, private investigators, and miscellaneous/lump sum.

Action Planning, Implementation and Claims Closure
Action Planning and Communications

Statute or Rules

N/A

Review Standard

Action Plan

- Action plans should demonstrate that the adjuster is directing the claim to a timely and appropriate conclusion.
- The adjuster should document an action plan based on investigative findings within five days of receipt of a claim. The plan should indicate that the adjuster has identified the current issues to be resolved and what steps will be taken to direct the claim through the next diary review and, at a minimum, address:
  - investigation/evaluation;
  - medical management;
  - return-to-work issues;
  - reserves;
  - if applicable,
    - benefit payments/adjustments;
    - offsets to payments;
    - subrogation;
    - legal; and
  - review for closure.
- Action plan revisions should be documented at each diary review – or a minimum of every 60 days – and within three days of material change.

Communications

- Contact the employee (or the employee's attorney):
  - every 14 days for adverse circumstances or contentious claims;
  - every 30 days for routine claims; and

  - as needed in order to:
    - demonstrate empathy to defuse the trauma of injury;
    - establish effective communications to overcome personal concerns, aggressive behavior, bi-lingual and cultural issues; and
    - promote recovery through aggressive treatment plan and early return to work.
- Typical triggers for employer contact (beyond initial contact):
  - suspected fraud;
  - litigated cases, trial dates & depositions;
  - treatment/disability durations outside the norm P&S/MMI, PD rating; and
  - employee released to return to work, transitional duty > 90 days, unable to return to job they had at time of injury, vocational rehabilitation.
- Potential triggers for physician contact (beyond initial contact):
  - suspected fraud;
  - notice of trial dates and depositions;
  - at or before medical appointment, treatment/disability durations outside the norm, need for PD rating assessment;
  - disability period extended or 30 days, whichever is shorter.

Findings

Strengths

All wage-loss claims (pending and accepted) are discussed in “triage staffings” the week after receipt and as necessary thereafter. For the first 90 days from receipt of a wage-loss claim the adjuster documents these staffings in lieu of the action plan.

The unit supervisor, adjusters and nurse regularly attend; others may attend on request. The purpose is to work as a team to develop strategies to reduce time loss. The triage staffings add value by

- encouraging a more collaborative approach to claims management;
- facilitating earlier identification of potential issues; and
- enabling more effective, proactive assignment of additional resources that can add value to the process.

Opportunity

It appears that the return-to-work case manager has primary responsibility for maintaining contact with the employer and the medical provider. It is unclear what the communication policies are when the return-to-work case manager is not assigned to a claim.

Recommendation

Specify requirements for the adjuster to communicate with the employer and medical provider when a return-to-work case manager is not assigned to the claim. The purpose of regular communication is to ensure that all parties are working together to move the claim forward to conclusion and optimum results.

Reviews and Closure

Statute or Rules

> The organization may not issue an impairment award for impairment findings due to unrelated, noncompensable, or preexisting conditions, even if these conditions were made symptomatic by the compensable work injury…
>
> 65-05-12-2
>
> A doctor evaluating permanent impairment shall include a clinical report in sufficient detail to support the percentage of ratings assigned. The organization shall adopt administrative rules governing the evaluation of permanent impairment. These rules must incorporate principles and practices of the fifth edition of the AMA's "Guides to the Evaluation of Permanent Impairment" …
>
> 65-05-12-2
>
> For one to fifteen percent impairment permanent impairment multiplier [is] 0.
>
> 65-05-12-2
>
> All permanent impairment reports must include the opinion of the doctor on the cause of the impairment and must contain an apportionment if the impairment is caused by both work-related and non-work-related injuries or conditions.

> The organization shall establish a list of medical specialists within the state who have the training and experience necessary to conduct an evaluation of permanent impairment. The organization may include in the list medical specialists from other states if there is an insufficient number of specialists in a particular specialty within the state who agree to be listed….
>
> Upon receiving a permanent impairment rating report from the doctor, the organization shall audit the report and shall issue a decision awarding or denying permanent impairment benefits.
>
> 92-01-02-25

Review Standard

- Adjuster should diary case reviews for wage-loss claims every 14 days.
- Supervisor reviews should address:
  - adequacy of an adjuster's action plan strategy;
  - accuracy of reserves;
  - adherence to claims management policies and procedures; and
  - specific feedback as indicated.
- Supervisors should review the following files:
  - all files at file set-up;
  - all files at closure
  - wage-loss claims at 30 days and 90 days thereafter
  - medical only claims if open longer than 6 months
  - at the following material triggers:
    - Physician treatment referrals;
    - Injury assessed a PD rating;
    - Significant reserve changes/review of reserve worksheet;
    - Legal representatives assigned by either side;
    - Surveillance under consideration;
    - Referral to SIU;
    - Referral to case manager; and
    - Outside investigations;
- At closure, adjusters should verify as applicable:
  - settlement is full and final;

- receipt of dismissal order from the court;
- employee has successfully returned to work with no continuing medical treatment;
- permanent and partial payments have been completed;
- no continuing medical expense;
- no open diaries requiring further action;
- coding for nature, cause, and body part is correct; and
- receipt of appropriate signed releases.

Findings

Opportunity

At this time, only the WSI Impairment Auditor and a chiropractor are certified in impairment evaluation. WSI uses the chiropractor almost exclusively for permanent impairment evaluations, with exceptions including neuropsych, eyes and ears.

WSI sponsored a training program in 2005 on the evaluation of permanent impairment, conducted by a physician trainer from the American Academy of Disability Physicians. WSI sent 800 letters targeting ophthalmologists, neurosurgeons, orthopedic surgeons, physical medicine and rehabilitation specialists, chiropractors, cardiologists, and family practice physicians.

There were only 15 attendees, including specialists in physical medicine and rehabilitation, cardiology, family practice, orthopedics, hand surgery and a chiropractor (subsequently, the only one to get certified).

Recommendation

Consider a follow-up training session to increase the number of trained and certified impairment evaluators in North Dakota.

Managed Care
Overall Medical Management

Statute or Rules

The fund shall furnish to an injured employee reasonable and appropriate medical, surgical, and hospital service and supplies necessary to treat a compensable injury.

65-05-07

Every employee who sustains an injury may select a doctor of that employee's choice to render initial treatment. Upon a determination that the employee's injury is compensable, the organization may require the employee to begin treating with another doctor to better direct the medical aspects of the injured employee's claim. The organization shall provide a list of three doctors who specialize in the treatment of the type of injury the employee sustained.

65-05-28

During the first sixty days after a work injury, an employee of an employer who has selected a preferred provider may seek treatment only from the preferred provider for the injury…after sixty days the employee may make a written request…to change providers.

An employee of an employer who has selected a preferred provider may elect to be treated by a different provider provided the employee makes the election and notifies the employer in writing prior to the injury.

65-05-28-2

The organization shall establish a managed care program, including utilization review and bill review, to effect the best medical solution for an injured employee in a cost-effective manner The program shall operate according to guidelines adopted by the organization and shall provide medical management of claims within the bounds of workforce safety and insurance law.

65-02-20

Review Standard

- Channel claimants to preferred providers.
- If employee self-selects a medical provider, establish a partnership with the treating physician.
- Reference sources for treatment and duration guidelines should be identified and applied.
- Medical and disability management resources should be provided.
- Other strategic tools for medical case manager or claims adjuster to reconcile diagnosis and treatment plan discrepancies include:
  - IME
  - Functional capacity assessments (FCA)

Findings

Strengths

- WSI refers to the Official Disability Guidelines (ODG) for treatment/duration guidelines for accepted ICD-9s.
- In addition to the ODG Guidelines, resources for the adjuster include a strong team of medical and disability management resources available to support adjusters with effective claims management:
  - Return-to-Work Case Managers – WSI has contracts for RN case management at six major treating facilities. Case managers screen all wage-loss claims for case management services.
  - Medical Case Managers – RN employees of WSI manage more complex cases.
  - Medical Director – The Medical Director is available for staffings, though availability is limited because of significant other responsibilities, including utilization review and hearings.
  - Medical Consultants – Other physicians are available for claim file reviews.

Opportunities

- It is leading practice to establish early medical control on a claim, including directing medical referrals when allowed by the law, or guiding injured workers to quality, cost-effective medical care. Ideally, medical providers should be:
  - selected on the basis of quality of care and experience with work-related injuries and occupational medicine concepts;

- familiar with the workers' compensation system, laws and report requirements; and
- willing to comply with prompt scheduling and reporting requirements.

Those interviewed reported that adjusters rarely require injured workers to change treating physicians, and they voiced no concerns that quality of care is compromised. Further, adjusters feel there is value in allowing injured workers to treat with self-selected providers (when the employer does not have a preferred provider) from the standpoint of maintaining their trust and open communication.

- One study of the impact of physician choice on medical care in four states supports the adjusters' observations, but also indicates that directing or guiding provider selection may be of value. The study found that when workers selected their own providers, they had similar reported recoveries of physical health; and there was a 57-59% higher likelihood of workers reporting a high level of satisfaction with their health care.[9]

At the same time:

- medical payments were 10-21% higher and indemnity payments were 8-15% higher (in the case of indemnity payments, only 15% is statistically significant);
- time out of work was 23-32% longer;

Considering that injured workers in North Dakota commonly use one of at least two available avenues of referral to a treating physician (self-selection or employer-selected preferred provider), WSI has an opportunity to study the impact of physician choice on injured workers' medical care.

How WSI interprets any results will have to take into account physician availability, which may be an issue. North Dakota ranks 27th relative to other states for "Doctors per 100,000 Resident Population, 2003"; and North Dakota has a population density of only 7-70 people per square mile (2000) (U.S. Census Bureau) This will make it difficult to guide all injured workers to physicians specializing in workers' compensation, but guiding injured workers may still be of value where the resources are available.

- The adjusters and nurse case managers primarily rely on the ODG to guide decisions about medical care. Though widely accepted in the industry and sufficient for most acute and immediate post-operative situations, the ODG as well as other similar guidelines are inadequate for post-operative care beyond that because of the variety of issues and complications that can occur. At this stage a physician peer review is usually necessary.

  Of interest, as WSI continues to explore the use of evidence-based guidelines, a recent study conducted by the Blue Cross and Blue Shield Association found that, "80% of American consumers would want their doctors to use established best

9 Victor R, Barth P., Neumark D., *The Impact of Provider Choice on Workers Compensation Costs and Outcomes,* Workers Compensation Research Institute and Public Policy Institute of California, November, 2005.

practice guidelines for treatment and diagnosis." (from Claims Magazine, Covering the Business of Loss)

- Those interviewed indicated they often used medical consultants to review an injured workers file when there was a question about care, rather than referring for an independent medical evaluation (IME).

Recommendations

- Consider a study of the impact of physician choice on injured workers' satisfaction and outcomes. Results can be used to support future policy positions.
- Assess the availability of the Medical Director or other physicians to provide guidance and peer reviews when necessary. The assessment should include a study of how and when WSI physicians are accessed for guidance and whether or not they are consulted when appropriate.
- Continue to add to the library of guidelines available to WSI medical staff. The Medical Director and other medical personnel should study and select WSI standards from the quality evidence-based guidelines available. Some of these include:
  - Other states that support evidence-based medicine include California, which uses the American College of Occupational and Environmental Medicine (ACOEM) guidelines; and Minnesota, Colorado and Washington, which provide treatment guidelines that can be downloaded from their websites.
  - Under the Evidence-based Practice Centers (EPC) Program of the Agency for Healthcare Research and Quality (AHRQ), 5-year contracts have been awarded to institutions in the United States and Canada to serve as Evidence-based Practice Centers. The centers review all relevant scientific literature on clinical, behavioral, and organization and financing topics to produce evidence reports and technology assessments. The 700+ page *Diagnosis and Treatment of Worker-Related Musculoskeletal Disorders of the Upper Extremity*, Evidence Report/Technology Assessment: Number 62, can be found through AHRQ, (http://www.ahrq.gov/clinic/epc/), or can be accessed on-line at the National Library of Medicine (http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat1a.chapter.29294)
  - The National Guideline Clearinghouse, another AHRQ initiative, includes another 194 occupational health related guidelines developed by the Work Loss Data Institute (developers of the Official Disability Guidelines).
  - Review appropriate use of IMES with adjusters.

Nurse Case Management

Statute or Rules

"Case management" means the ongoing coordination of medical services provided to a claimant, including:

- Developing a treatment plan to provide appropriate medical services to a claimant.
- Systematically monitoring the treatment rendered and the medical progress of the claimant.
- Assessing whether alternative medical services are appropriate and delivered in a cost-effective manner based upon acceptable medical standards.
- Ensuring the claimant is following the prescribed medical plan.
- Formulating a plan for keeping the claimant safely at work, or expediting a safe return to work.

92-01-02-29

Review Standard

Triggers for Referral to Case Management

- Claims should be referred for case management evaluation when one or more triggers are present.
  - anticipated or actual lost time > 15 calendar days;
  - catastrophic claims;
  - specific injury or illness types;
  - repetitive stress injuries;
  - psychiatric issues;
  - diseases;
  - soft-tissue subjective findings;
  - multiple injuries;
  - multiple diagnoses;
  - need for surgery;
  - hospitalization;
  - multiple providers; and

  - inappropriate treatment or disability duration as compared to medical and duration treatment guidelines.
- Other factors, alone or in concert, may indicate the need for case management:
  - repeat claimant;
  - discontinuation of other benefits (STD, FMLA);
  - lack of insurance (health / medical or disability);
  - employment problems (individuals or group layoffs, pending strikes);
  - recent hire; and
  - conditions easily caused by aging or other outside factors.
- A referral form should be completed by the adjuster, detailing the scope and purpose of referral.

Medical Case Management Assessment

The medical case manager should make a written medical assessment within 5 days of assignment to determine appropriateness of:

- Treatment:
  - extent;
  - duration;
  - diagnostic testing;
  - pharmaceuticals; and
  - hospitalization;
- Medical provider:
  - current documentation of objective findings, subjective complaints, employee's abilities;
  - referral to specialists;
  - peer review; and
  - communication between medical provider and employee.
- Disability:
  - extent; and
  - duration.

Medical Case Management Follow-up

- Design a written disposition strategy and plan of action with specific time frames for completion.
- Assess outside factors affecting resolution of injury.
- Provide periodic (at least every 30-60 days) reports to the claims adjuster, including analysis of diagnosis and treatment plans:
  - objective findings;
  - accepted conditions;
  - pre-existing conditions;
  - subjective complaints and symptoms;
  - disability type and causal relation to accepted condition;
  - expected disability duration;
  - appropriateness and frequency of treatment; and
  - anticipated impairment rating, and approximate percent.

Return-to-Work Case Management

- Use disability duration guidelines in conjunction with job demands and injured workers' work capacity to facilitate the earliest return to work possible.
- Establish strategy for return to work during initial contacts, including availability of modified work with the employer.
- Following each medical visit, obtain and update information regarding work restrictions and work capacity.
- Continually re-evaluate until injured worker is released for regular work, vocational referral is appropriate or maximum medical improvement is reached.

Findings

Opportunities

Adjusters and injured workers may benefit from additional application of, and a more collaborative approach with, nurse case management.

As quoted in *Case Management Guideline 100*, according to the *Commission for Case Management Certification (CCMC),*

> "Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the

client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes."

- Currently, "mandatory" referrals for nurse case management are listed in the *Claims Procedure Manual*. Other (non-mandatory) red flags and referral criteria for medical case management are included in the *Case Management Guideline* binder, with a note that this is also a guide to be used in reviewing files for/by claims adjusters, but this is not documented in the *Claims Procedure Manual*. Adjusters should understand and appropriately apply non-mandatory triggers for nurse case management.
- "Mandatory" referrals for nurse case management are not required if the injured worker has returned to work. And return-to-work case managers are instructed to close their case once an employee has returned to work. (*The Case Management Guideline* specifies that employee must have returned to pre-injury job, with or without restrictions, but that distinction is not clear in the *Claims Procedures Manual*.) Automatically removing or not initiating case management because an injured worker has returned to work, especially if the worker has work restrictions, may not always be appropriate.

Recommendations

Implement a more collaborative approach between adjusters and nurse case managers through education and policy changes, such as:

- Review non-mandatory triggers for nurse case management and the value that a nurse case manager can provide during training, and incorporate, along with additional referral guidelines, into the *Claims Procedure Manual*.
- Modify the clams management procedure instruction to discontinue (or not initiate) nurse case management because an injured worker has returned to work, especially if the worker has work restrictions.
- Require discussion between the adjuster and the nurse case manager and the adjuster's documentation of reasons in the file, should the adjuster not agree with a recommendation for case management.

Rehabilitation and Vocational Consultation

Statute or Rules

It is the goal of vocational rehabilitation to return the disabled employee to substantial gainful employment with a minimum of retraining, as soon as possible after an injury occurs…the first appropriate option among the following, calculated to return the employee to substantial gainful employment, must be chosen for the employee:

a. Return to the same position
b. Return to the same occupation, any employer
c. Return to a modified position
d. Return to a modified or alternative position, any employer
e. Return to an occupation within the local job pool…
f. Return to an occupation in the statewide job pool

Retraining of one hundred four weeks or less.

65-05.1-01

The vocational consultant shall review all records, statements, and other pertinent information and prepare a report to the organization and employee.

1. The report must: identify the first appropriate rehabilitation option…contain findings of why a higher listed priority…is not appropriate…
2. Depending on which option…the report also must contain findings that identify jobs in the local and statewide job pool…describe an appropriate retraining program
3. The vocational consultant's report is due within sixty days …

65-05.1-02.1

Review Standard

Refer injured workers unable to return to their previous job for vocational rehabilitation to include: vocational assessment and counseling, goal setting, service planning, case management, job placement and follow-up.

Findings

WSI policies and procedures are consistent with the review standard.

Utilization Review and Bill Review

Statute or Rules

Utilization Review

- Medical service providers shall request pre-service review from the utilization review department for:
  a. all nonemergent inpatient hospital admissions or … inpatient surgery and outpatient surgical procedures…
  b. all nonemergent major surgery…
  c. magnetic resonance imaging, myelogram, discogram, bonescan, arthrogram, or computed axial tomography…
  d. physical and occupational therapy beyond the first ten treatments …
  e. electrodiagnostic studies..
  f. themography
  g. Vax-D treatment
  h. IDET," [etc through (t)]

  Chiropractic provider shall request pre-service review …treatment beyond the first twelve… (92-01-02-34).
- Providers shall request prior authorization directly from the claims analyst for
  a. durable medical equipment…
  b. biofeedback programs, pain clinics, psychotherapy, physical rehabilitation programs…chronic pain management programs, and other programs …
  c. concurrent care
  d. telemedicine (92-01-02-34)
- Concurrent review of emergency admissions is required within twenty-four hours, or the next business day, of emergency admission. (92-01-02-34).
- The organization may conduct retrospective reviews …if preservice review…
  – is requested by a provider and the claimant's claims status in the adjudication process is pending or closed…
  – is not requested by a provider …and the provider did not know that the condition was...covered under workers' compensation. (92-01-02-34).

Bill Review

- As soon as reasonable after receiving a bill, the organization shall:

- Pay the charge or any portion of the bill that is not denied;
- Deny all or a portion of the bill on the basis that the injury is not compensable, or the service or charge is excessive or not medically necessary;
- Request specific additional information to determine whether the charge or service is excessive or not medically necessary or whether the condition is compensable.

The organization shall provide written notice of nonpayment to the claimant when the claimant is personally responsible for the payment of a charge…[and/or] to the provider through a remittance advice of denial…or shall provide written notice to the provider for any request for additional information. (92-01-02-45)

Review Standard

Utilization Review

- A three-step process should be employed to determine medical necessity:
  - initial clinical review by a licensed health professional; if service/treatment cannot be approved, then
  - peer clinical review by a physician or like provider (e.g., chiropractor for chiropractor) who is available to discuss case with treating provider; if not approved, then
  - worker or medical provider may appeal, and case should be considered by clinical peer of same specialty that typically manages the condition under review.[10]
- Manage all disputes with collaboration between the clinician and the adjuster.
- Prescriptions should be covered based on formulary of effective and affordable drugs. For use beyond the formulary, provide for prior authorization for review by a licensed pharmacist.

Bill Review

- Conduct medical bill process review within 1-2 business days of receipt of bill.
- Require medical report, notes to accompany the invoice.
- Pay undisputed bills within 30 days of receipt.
- Provide the Explanation of Benefits (EOB).
- Attach a copy of the EOB electronically to the appropriate payment transaction within the claims file.

[10] URAC

Findings

Opportunities

- The Medical Director has limited time available for staffings and working with the claims management teams because of his utilization review responsibilities (all of every morning), review of disputes and preparation for hearings. He also participates once per week in triage with Unit 7, an Injury Management Pilot Team, which all participants find to be valuable. WSI will benefit from exploring ways of replicating this model with other units. (The design and value of Unit 7 will be discussed in more detail in the section "Organizational Collaboration")

  In order to accomplish this with current resources it will be necessary to redistribute work. According to Utilization Review (UR) Department statistics for calendar year 2007,

  - 8,514 reviews were conducted by the UR staff, in addition to handling approximately 1,600 requests which were not reviewed because the claim was not "accepted"
  - 1,369, or approximately 16% of actual reviews were completed by the medical director, with 7,145 reviews remaining.
  - Considering that there are three UR nurses, each does approximately 2,381 reviews, or 9.5 per day.

  Based on these numbers, assuming half of the Medical Director's URs are assigned to the nurses (giving him two extra hours per day to work with the claims management teams), each nurse would be required to do 2,610 reviews per year, which is 10.4 or approximately one more per day. A more in-depth analysis of the UR nurses' other work activities is necessary to determine if they have capacity for one more review.

- UR makes recommendations based on medical necessity and contacts the adjuster/supervisor if there is a question about relatedness to the compensable injury. Documented UR procedures state that the nurse will inform the requesting provider that a review will not be conducted if the request is "for a body part and/or ICD-9 that has not been accepted." But those interviewed stated that UR will review for necessity for treatment for the body part for which liability was accepted, not the ICD-9. This could result in confusion on the part of the injured worker, medical provider and adjuster.
- Within the last two years WSI changed its policy to conduct utilization reviews on accepted claims only. Prior to this change reviews were conducted on pending claims. This resulted in the following change in numbers, per the UR department statistics:

	2004	2005	2006	2007
Claims Adjuster Review				726
BDR				6
FL 427s (review not done because claim not accepted)			423	1504
FL 428				86
FL 428-1				14
Total UR staff reviews (exclusive of all of the above)	9,959	10,028	9,094	8,514

At the same time, the percentage of claims still in pending status over 31 days increased markedly from 12% in 2006, to a projected 26% in 2007.[11] This is a significant concern if injured workers are putting off care until compensability has been accepted. For example, certain diagnoses, such as carpal tunnel syndrome can be further aggravated and more costly if treatment is delayed.

There is some indication that delays in treatment are occurring as noted in the "Proposal for Pending Claims" being considered by the department,

> "…patient being taken off surgery schedule list, MRI not completed until approval given, procedure not being scheduled until a review can be completed, and some facilities are not submitting request for review as they know the claim is pending."

- There are currently no performance benchmarks for bills reviewed or bill turn-around time. Those interviewed voiced concern that benchmarks used in the past did not take into consideration the variety of other tasks that bill reviewers were asked to do.

Recommendations

- Consider re-balancing work loads to free up some of the Medical Director's time for other value-added activities. Currently policy requires that a physician conduct certain initial reviews. WSI should re-evaluate this list to determine if some of the reviews could be conducted by the nurses (e.g., electrodiagnostic studies). At the same time, in order to decrease the number of UR reviews required, the Medical Services Department should continue to evaluate the need for certain reviews, such as the CT scans within 30 days of the injury (which they are already exploring); or consider extending the number of treatments allowed before review is required, e.g., for physical and occupational therapy, which currently have approval ratings of 96% and 97%, respectively.

[11] According to the *WSI Operating Report As of the Quarter Ending: September 30, 2007*

- Ensure that the UR nurses are conducting reviews based on the accepted ICD-9, not the accepted body part.
- Re-evaluate the policy of conducting preservice reviews on accepted claims only, and explore options for addressing issues that have been raised. Options include resuming reviews on pending claims, conducting reviews on certain pending claims because of the test and/or treatment being requested for specific diagnoses, and evaluating and addressing the issues that have increased the time it takes to decide compensability.
- Develop realistic benchmarks for Bill Review (it is our understanding that a benchmarking project is currently underway).

Legal Issues

Statute or Rules

Disputes

The organization shall make rules providing for procedures for dispute resolution.

65-02-20

Prior to the expiration of a period of disability certified by a doctor…the organization shall send a notice to the employee of the organization's intention to discontinue benefits…

65-05-08.1

The organization may conduct a hearing on any matter within its jurisdiction by informal internal review of the information of record.

The organization may issue a notice of decision for any decision made by informal internal review and shall serve the notice of decision on the parties by regular mail. A notice of decision must include a statement of the decision, a short summary of the reason for the decision, and notice of the right to reconsideration.

A party has thirty days…in which to file a written request for reconsideration…

Within sixty days after receiving a request for reconsideration, the organization shall [send a NOD reversing the decision or an administrative order]

[At this point the party may ask for assistance from the office of independent review]

65-01-16

Fraud

> The organization shall establish a workforce safety and insurance fraud unit. The organization may employ investigators and licensed attorneys, or contract with a private investigator … to investigate and review any alleged case of fraud against the fund by employers, injured workers, or providers of medical care or other services…
>
> Money in the workforce safety and insurance fund is appropriated on a continuing basis for payment of costs associated with identifying, preventing, and investigating employer or provider fraud. (the biennial independent performance evaluation must report on the effectiveness of these expenditures)
>
> 65-02-23

Employer noncompliance specified in (65-04-33) includes:

- no WSI coverage
- misrepresent payroll
- default on premium

False claims (65-05-33) include:

- File a false claim or make a false statement
- Misrepresent physical condition
- Fail to notify WSI if receiving disability benefits and income or increased income from work.

Review Standard

Litigation Management

- The adjuster should obtain supervisor approval for legal referral.
- The adjuster should manage the legal aspects of a claim in a manner that is efficient, cost-effective and promotes teamwork between the adjuster and legal counsel.
- A litigation referral form should be completed by the adjuster, detailing the scope and purpose of referral and including:
  - description of injury;
  - compensability;
  - investigation information including, witnesses, and prior claims and medical information;

  - wage information;
  - payments including periods of disability paid and disputed or not paid;
  - second injury fund/special fund eligibility;
  - any investigations related to litigation;
  - specific instructions;
  - subrogation potential; and
  - date for next planning conference.
- The adjuster is responsible for obtaining any appropriate records and forwarding them to counsel.
- Adjusters should continue to manage the litigation, establishing ongoing diary a maximum of every 60 days to follow up on litigation activity.
- Defense Counsel should:
  - provide legal analysis of litigation as it progresses, including resolution strategies;
  - confer with the adjuster on all decisions regarding the direction of the claims;
  - report promptly, as required, on significant event depositions, motions, and provide all required documentation; and
  - promptly notify adjuster of trial dates scheduled as soon as the information is available.

Fraud

- Fraud triggers for referral to the special investigations unit should be identified for both medical-only and wage-loss claims.
- The adjuster should evaluate the file to determine if fraud triggers are present and maintain on-going follow-up with the fraud unit for status on any claims referred.

Findings

Strengths

- The WSI legal department provides advice related to legal issues at the adjuster's request, as issues develop. The adjuster may drop by with a few questions, or schedule a staffing. Legal will provide advice including what further information they need or other people they should talk to.
- If the First Report of Injury is submitted on-line, the person completing the report is required to verify that they have read the accompanying fraud warning. If the report is received telephonically, the Claims Service Representative reads the fraud warning to

the reporting party (employer, worker or medical provider) and obtains agreement/understanding.

Opportunities

- There is currently no schedule for formally training adjusters on litigation issues, but the department intends to resume this.
- When an issue escalates to actual litigation, the legal department acts as a liaison with outside counsel. The adjuster is not involved unless any information changes, at which time legal will inform the adjuster.

  Industry practice states that adjusters should maintain control of claims even when other consultants are involved, whether medical, legal, vocational, etc. Given WSI's onsite legal resources it is appropriate that they are very active when legal issues arise, but the adjusters should retain responsibility and be informed of all activity.
- The majority of referrals to the special investigations unit have always been related to the employee. This is consistant with the instructions in the *Claims Procedure Manual*, to consider fraud investigation when there is:
  - evidence worker is working;
  - evidence of a false statement/claims;
  - information on fraud hotline;
  - information that worker may be misrepresenting condition; and
  - accumulation of inconsistent/red flag information.

  Studies have shown that worker fraud is not as costly or common as previously thought – and employer or medical provider fraud can be very costly For example, a study by the New York comptroller found that employers failed to pay the state insurance fund $525 million in 1995 representing 30% of the premium collected by the fund that year.[12]

  The unit has been working on getting employer and medical provider programs going; the focus for the last couple years has been a medical provider program.

  WSI has done some research on what to do next:
  - Reviewed Ohio's program and contacted Washington; these states have well-developed programs, but had problems with referrals and were looking at other ways to identify issues;
  - Looked into developing system queries with specific criteria to identify employers and claims that should be reviewed for possible fraud

[12] Michaels, David, PhD, MPH, *Fraud in the Workers Compensation System: Origin and Magnitude*, Occupational Medicine: State of the Art Reviews, vol.13, no.2, April-June 1998.

Recommendations

- Resume regular training of adjusters on legal issues and ways in which the department scan most effectively work with each other. Consider a session on medical-legal issues, possibly in conjunction with medical staff. Review the different ways the two professions look at questions regarding diagnoses and other overlapping concerns, and how the adjusters should consider different, possibly opposing opinions.
- Formalize and increase the frequency of communications between the adjuster and legal when legal is involved on a claim.
- As staffing allows, continue to explore technology and practices to better identify fraud. Ensure that the department is focused on potential employer and medical provider fraud, in addition to worker fraud. Include red flags for employer and medical provider fraud in the *Claims Procedure manual*.

Organizational Collaboration

Leading Practices

Collaboration can be fully achieved only within a well-integrated organization. It will be evident in the claims files and in effective use of resources.

Collaborative claims management is proactive, involving claims, medical and disability management resources, legal, investigations, etc. At the same time, the claims adjuster is accountable for all components of the process, driving it forward and always maintaining control. Effective and meaningful communication between all parties (internal and external stakeholders) is evident in the claims file documentation.

> "Our entire performance management philosophy and system revolve around motivating our colleagues to achieve the goals and objectives of the clients of their specific work unit in alignment with the goals and objectives of each affiliated work unit cascading all the way to the goals and objectives of the corporation as a whole…. operating as one company/one team are the driving forces for achieving excellence for our company and our clients."
>
> (Sedgwick Claims Management Services, http://www.sedgwickcms.com/CareerResources/Claims.aspx)

Strength and Opportunity

In 2007, WSI put together a pilot claims management unit, referred to as "the injury management unit" or Unit 7. The unit is structured differently than the others in that it has a dedicated nurse case manager and the Medical Director and Pharmacy Benefits Director participate in weekly triage sessions. Because of its structure, the unit has also been able to do some activities differently. For example, the nurse completes the pre-existing injury questionnaire on wage-loss claims and the team has done some employer site visits to become familiar with the types of work and the hazards workers may be exposed to.

Because Unit 7 has only been in place for a year it is not possible to assess results, but those interviewed both with the unit and with other units felt that there is significant value in how it is organized. The multi-disciplinary team, proactive approach and more active involvement with the employer are leading practices which should result in better outcomes for the injured worker and the employer.

Recommendation

WSI should continue to explore the potential for replicating Unit 7. As recommended elsewhere, reducing some of the Medical Director's utilization review responsibilities would give him more time to participate in triage with other units. It may also be necessary to look at ways of organizing the agenda for each triage session so that the nurse, Medical Director and Pharmacy Benefits Director do not have to participate the entire time. For example, the Pharmacy Benefits Director may not be a necessary participant when discussing new claims where compensability is in question.

III Claims File Audit

The audit included 475 open and closed wage-loss and medical only claims randomly selected from WSI's claims data base of losses from January 1, 2005 to January 1, 2008. Marsh successfully audited 475 claims of which 273 were wage-loss claims, 91 denied wage-loss claims and 111 medical-only claims. Of the 111 medical only claims, 34 claims were auto adjudicated. Our audit team focused on the following 14 criteria in evaluating each claim.

New Claims Processing

Once the first report of injury is received, a claims technician should complete the employer, injured worker, and medical forms (C97, C96, C101, or C1 and C2 forms) for the initial processing of the new claims.

WSI Standard

State specific claims handling instructions should always be followed and documented in the file to reflect ongoing compliance.

Audit Score

Adherence to claims policies and procedures had a 97percent compliance rate.

Findings

WSI achieved a 94% compliance score with their 2005 dates of loss claims and scored a 99% compliance score for the 2006/2007 dates of loss claims.. The WSI technicians did an excellent job of processing new claims. They consistently completed the appropriate employer, injured worker and medical forms. Accurate completion of new claims forms is a critical first step in validating the compensability of a claim.

Recommendations

Documented Process

Continue the current work flow in which the technicians effectively address the first report of injury and complete the required forms to start the investigation process.

Medical Only Claims Processing

Processing of medical only claims to determine compensability and payment of appropriate medical bills. Medical only processing involves documentation of prior claims history, compensability decision reached, and automatic closure after 90 days of no activity.

Industry Standard

State specific claims handling instructions should always be followed and documented in the file to reflect ongoing compliance.

Audit Score

Adherence to claims policies and procedures had a 90 percent compliance rate.

Findings

Of the 91 medical-only claims randomly selected, 34 were auto adjudicated and did not have any pertinent file notes.

WSI had a 92% overall compliance rate with the 2005 dates of loss claims in comparison to the 2006/2007 claims in which they scored an 88% compliance score.

The 2006/2007 dates of loss claims medical-only processing in which prior claims history should be investigated decreased by 12% in comparison to the 2005 dates of loss claims.

Overall, the updating of the notepad outlining how the injury occurred, what body part was injured, who the employer is, and the decision reached on the claim within 30 days of receipt scored an 81% compliance score; there is room for improvement. Updating of the notepad regarding compensability decisions for 2006/2007 claims decreased by 12% in comparison to the 2005 claims.

Closure of medical only claims after 90 days of no activity scored an outstanding 99% compliance score.

Recommendations

- Continue current process of reviewing new medical only claims timely to determine if the injured employee's claims history involved any prior or duplicated claims.
- Establish a diary to ensure the notepad is consistently updated within 30 days of receipt of the claim to reflect the compensability decision.
- Continue to use the claims management system to close medical only files after 90 days of no activity.

Three-Point Contact

Three-point contact is a fundamental aspect of sound claims adjusting. Multiple studies have proved that a lack of timely contact with injured employees is a leading cause of litigation, increased costs, and additional lost time from work. Additionally, timely contact with the injured employee, medical providers and employers provides the claims handler with important information regarding the accident, the history of the employee, and any current medical treatment.

Industry Standard

The file contain documented evidence that the claims handler made actual contact or made reasonable attempts to contact the injured worker, employer, and medical provider (be it oral or written) on all wage-loss claims within 24 hours of receipt of assignment.

Audit Score

Three-point contact scored a 75 percent compliance rate.

Findings

WSI has a 76% compliance rate in the WSI claims handler contact with the injured worker, employer and medical provider within 24 hours.

There was no significant difference between the claims with dates of loss in 2005, 2006, and 2007, as the scores remained in the mid 70 percentile.

The claims handlers made the majority of their contacts within 72 hours or less of the claims being assigned. In some instances the claim handlers did not document initial three point contacts taking place.

WSI claim handlers in many instances relied on written correspondence, instead of verbally attempting to contact the parties to begin the investigation process and/or explain the workers' compensation process.

Recommendations

WSI should improve its contacting of the injured employee, employer, and medical provider with a goal of within 24 hours of a wage-loss claims being assigned or converted from a medical only claims.

Avoid relying on written correspondence to serve as contact notice to the employer and injured employee.

Establish diary system to address three point contacts within 24 hours on all new wage loss claims.

Pursuant to WSI policy, claims handlers do not have to contact the medical provider if the claims file has appropriate return to work documentation. This practice should be revisited to determine if it causes the claim handlers to rely too heavily upon correspondence to achieve contacts versus actual verbal communication which has proven to lead to superior claims investigations.

Investigation

A variety of activities are conducted during the investigation of a claim. All activities are intended to provide the claims handler with necessary information to determine compensability.

Industry Standard

Investigation involves issues of compensability, apportionments, second injury or subrogation potential, causal relationship between injury and treatment plans, etc. Investigation to determine compensability should be completed within 14 days of receipt of assignment, unless outstanding investigation is clearly documented as to why the delay is occurring. The entire investigation should be completed within 30 days of assignment if all pertinent reports (medical, police, etc) have been gathered timely

Audit Score

Investigation scored an 86 percent compliance rate.

Findings

WSI investigation improved by 4% involving claims with dates of loss in 2006/2007 versus 2005 claims, resulting in the overall compliance score of 86%.

WSI claim handlers completed the investigation during the initial three point contact or within 60 days of the file being assigned in 88% of the cases audited.

Once compensability was determined the appropriate forms were sent to the supervisor in 93% of the applicable cases. WSI improved by 6% in this area with 2006/2007 dates of loss claims in comparison to the 2005 claims.

WSI had a 94% compliance rate in reaching compensability decisions supported by the evidence in all claims managed for the 2005, 2006 and 2007 claim years. The claim handlers demonstrated good overall investigation results, as they had good documentation to reflect why a compensability decision was reached on a claim.

Pursuant to WSI's policy, for claims pending longer than 21 days an action plan is required. WSI achieved an 86% overall compliance in this area. However, the 2005 claims had only a 65% compliance rate, versus a 94% compliance rate for the 2006/2007 claims. WSI improved by 29% in this area, resulting from the 90 day or less triage taking place on the 2006/2007 claims.

WSI achieved an overall compliance score of 47% in their utilization of field investigators with complex or serious injury cases. There were 19 applicable cases included in the sample of claims audited.

The claim handlers had an overall score of 26% in appropriately using recorded statements. The WSI claim handlers did not consistently obtain appropriate recorded statements on questionable claims. The results were the same regardless of whether the claim was in 2005, 2006, or 2007. The 2006/2007 claims had 33% success rate in this area, versus a 17% success rate for the 2005 claims. There were several missed opportunities for the claim handler to obtain a recorded statement from the employer, injured worker and/or witness to confirm a questionable accident was work related. When a witness was noted in the first report of injury, the file notes in most instances did not reflect that the witness was contacted for a possible statement. The claim handlers relied on summaries of their discussions with the injured worker and/or employer and this can cause key information to be missed when investigating a questionable accident.

Recommendations

WSI has formal written procedures for determining compensability on each wage-loss claim. A review of the procedures with the claim handlers should be conducted to confirm a common understanding of the procedures and standards.

The claims handlers should implement a target date to complete investigations prior to making any initial wage-loss or medical payments. For those claims in which a compensability decision has not been reached, WSI should consistently complete an action plan to resolve open issues.

Recorded statements should be obtained from the injured employee and witnesses on all questionable claims, subrogation matters, cumulative trauma, and catastrophic cases to validate the facts of the accident, medical treatment, and current disability duration.

WSI should use field investigators in its investigation of complex and serious claims. With the use of field investigators the claims handlers can obtain appropriate recorded statements from the injured employee, employer, and witnesses to determine if a claims is compensable.

Witness Follow-up

All witnesses should be contacted and interviewed to verify the facts of the accident and if the claim is questionable, a recorded statement should be taken from the witness.

Denied or Withdrawn Claims

WSI Standard

WSI investigates wage-loss claims to determine if the accident is compensable and benefits payable. The denial of a claim should be based on a thorough investigation and appropriate execution of applicable forms. The injured worker also can withdraw his/her claim if they realize the claim is not work-related.

Thoroughly investigate all wage-loss claims to determine compensability and apply appropriate statutory laws during the investigation process.

Audit Score

Adherence to claims policies and procedures scored an 89 percent compliance rate.

Findings

WSI improved by 5% their overall results in the area of denied claims with dates of loss in 2006/2007 versus 2005 claims, resulting in the overall compliance score of 89%. WSI's overall score in this category for denied claims with dates of loss in 2006/2007 was 91%.The majority of claims were well investigated and denied based on the applicable state statures.

WSI achieved a 67% compliance score when an injured employee voluntarily withdrew his/her claim and it required an FL112 form to be filed and the claim diary for 14 days. However, there were only six applicable claims and four were successfully handled.

WSI achieved a 97% compliance score in utilizing the appropriate FL205, FL724 and FL206 forms when a decision was made to deny a claim.

However, there were a small number of claims in which the denial of a claim was questionable, based upon a lack of documentation, interpretation of “arising out of and in the course of employment”, medical documentation, pre-existing injury triggers, and/or possible fraud interpretations.

WSI achieved an 85% compliance score when a denial was determined and the C96, C97, and C101 forms were required to be routed to the supervisor for review and approval of the denial. WSI improved by 23% their results in this area with the 2006/2007 dates of loss claims versus the 2005 claims. The 2006/2007 dates of loss claims had a 93% compliance score for this objective.

WSI achieved an 86% compliance score in whether the denial of the claim by the claim handler was appropriate and this score changes by less than 2% when you look at the results by accident year.

Recommendations

Review all denied claims with the claims supervisor, claims director, medical director, and legal to come to a consensus decision on the compensability issue and whether the interpretation of the work comp law was appropriate.

Consistently document all activities regarding denial decisions reached and the appropriate state statute.

Consistently utilize appropriate forms and disburse to the supervisor for timely review and approval.

The North Dakota workers’ compensation statute in some instances is open to interpretation as to whether a claim is work related or an aggravation of a pre-existing injury. Marsh recommends periodic training sessions conducted by an outside law firm to give everyone a consistent approach as to how to address compensability and whether a case should be denied.

Timeliness of Payments

Processing payments in a timely manner meets the State’s regulatory obligations and improves the overall interaction with the injured employee. North Dakota also calls for a five day waiting period before any indemnity payment is required.

Industry Standard

Indemnity payments are made based on the statutory guidelines and time limitations. In the State of North Dakota, indemnity payments are to be issued after 5 days of disability for the first 5 days of lost time.

Audit Score

Timeliness of payments scored a 93 percent compliance rate.

Findings

WSI did a very good job of issuing indemnity payments based on the statutory guidelines. Applicable disability benefits after the required five days had elapsed were paid in 100% of the cases. WSI achieved good results in effectively paying disability benefits after the required 5 days had elapsed and minimum overpayments were discovered with medical and indemnity benefits.

WSI achieved a 64% compliance score in requesting a copy of the injured worker's three previous years of profit or loss when the person is a self-employed worker. However, there were only 11 applicable claims which involved this objective.

Recommendations

Continue to follow statutory laws in paying appropriate indemnity benefits within the required time frames.

Continue to effectively managed indemnity and medical benefits to avoid duplication of payments.

Continue to effectively obtain the require tax returns for a self employed injured worker to determine the validity of the claimant's average weekly wage.

Subrogation/Recoveries

The ability to identify and pursue potential recoveries from responsible third parties is an important process to control overall workers compensation costs. The consistent utilization of subrogation reduces the overall employer's cost of a claims and the company's claims experience.

Industry Standard

The recovery potential (subrogation, second-injury fund, and offsets/apportionments) is identified, investigated, and pursued if warranted against the responsible party.

Audit Score

Subrogation/recovery scored a 35 percent compliance rate.

Findings

WSI achieved disappointing scores in this category regardless of the age of the claim. They achieved a 26 percent success rate in their recognition and pursuit of potential subrogation opportunities.

When subrogation /recovery potential was identified and investigated WSI achieved a 42 percent compliance rate. They improved by 27 percent in this area with claims covering dates of loss in 2006 and 2007, but major improvement is needed.

The claims handlers had two applicable offset claims in 2005 and they were not successfully managed for a zero compliance score. There were eight applicable claims in 2006/2007 in which five of the claims were effectively managed for a 63 percent compliance rate. Overall, WSI achieved a 50 percent compliance score for proper identification and pursuit of offsets and/or apportionments.

WSI was inconsistent in their documentation of whether there was subrogation/recovery opportunities. If the claims handlers pursued recoveries, the electronic claim files did not consistently reflect the activities undertaken.

Additionally, there were a small number of claims involving offsets/apportionment and the claim files were not consistently documented to confirm whether the appropriate procedures were followed.

Recommendations

WSI needs to review its current subrogation/offset procedures and consistently manage for full compliance.

WSI needs to have the supervisor actively engaged in this process during the initial triage of a claim and during subsequent supervisory reviews to avoid any missed opportunities to recover from the responsible party to a work related accident.

WSI legal department is involved in the subrogation workflow and their role should be reviewed to determine where breakdowns in the process exist and what corrective actions need to be taken.

Offsets, subrogation/recovery opportunities should be addressed during the initial investigation of a claim and documented appropriately in the claims file.

WSI should coordinate with legal to conduct an initial training session on “how to recognize recovery opportunities” and hold an introductory session for new hires and refresher courses as part of normal training activities.

Medical/Cost Containment

The medical component of workers compensation is the fastest growing portion of workers compensation costs. Implementing effective controls in this area is essential to managing overall claims costs and medical treatment. .

Industry Standard

Includes but is not limited to medical bill audits, fee schedule reviews, reasonable and customary reviews, periodic receipt and review of medical reports, establishment and utilization of managed care network (PPOs, HMOs), pre-certification/pre-admission review, and utilization review.

Audit Score

Medical/cost containment scored a 91 percent compliance rate.

Findings

The claim handlers demonstrated effective medical cost containment throughout the audit process and this is arguably one of the most important aspects of solid claims handling.

WSI achieved a 99% compliance rate in their utilization review of inpatient, physical therapy and chiropractic treatment of an injured worker. These activities successfully managed medical costs in conjunction with the diagnosed injury. The claims handlers consistently relied on appropriate medical documentation prior to paying medical bills.

WSI achieved a 99% compliance rate in not paying medical bills without the appropriate medical documentation.

However, WSI has room for improvement in paying approved medical bills within 30 days of receipt, as they scored an 80% in this area.

Recommendations

Continue to follow procedures for executing utilization review and the processing of medical bills.

WSI should strive to issue payment on approved medical bills within 30 days or less. The claim handler should establish a daily diary to process appropriate medical bills within the required time frames.

Review current procedures for paying medical bills and confirm no bottlenecks exist in the process or training issues are present.

Disability Management

Returning injured employees back to work is a key goal of the WSI. While there are many variables that influence whether an injured employee can and will return to work, consistent and clear practices must be in place. Effective disability management allows the injured employee to receive the appropriate treatment and return to work in a reasonable manner based on the injury sustained.

Industry Standard

Includes but is not limited to proper and timely use of independent medical exams (IMEs), aggressive pursuit of return to work (RTW), timely assignment of nurse case managers and/or vocational managers, and aggressive pursuit of maximum medical improvement (MMI).

Audit Score

Disability management scored an 87 percent compliance rate.

Findings

WSI achieved a 91 percent compliance score in making timely referrals to a telephonic case manager (TCM) or field case manager (FCM) when the injured employee's injury dictated nurse intervention. When the TCM or FCM was assigned they consistently pursued return-to-work opportunities for the injured employee in 97% of the applicable cases.

WSI achieved a 92 percent compliance score in referring the appropriate cases for mandatory medical case management when it was determined the case was a wage-loss case.

When a case was not referred for medical case management the claims handler successfully pursued return-to-work in opportunities for the injured employee in 95% of the applicable files.

WSI performed well in its application of disability management practices with the injured worker. There was good collaboration between the claims handler, employer, medical provider, telephonic nurse case manager, onsite nurse case management, and return-to-work specialist in getting the appropriate treatment for the injured employee and returning him/her to work accordingly.

Effective use of the six major medical facilities in the coordination of return-to-work opportunities for the injured employee has proved to be a very solid process for WSI.

However, the claims files were not appropriately documented to indicate approval was given by the claims supervisor to extend return-to-work services beyond 60 days. The 2005 dates of loss claims achieved a 73 percent compliance score compared to a compliance score of only 57 percent for the 2006/2007 claims.

WSI achieved inconsistent results in utilization of independent medical exams when an injured employee's disability duration exceeded the Occupational Disability Guidelines (ODG). They achieved a 46 percent success rate in this area.

Independent Medical Exams (IMEs) were successfully used on the 2005 dates of loss claims in 88 percent of the cases, versus only 30% compliance for the 2006/2007 dates of loss claims.

Recommendations

Telephonic medical case managers should be used when the disability is expected to exceed four weeks or the severity of the injury is moderate.

The claims supervisor should instruct the claims handlers to establish a diary (to be reviewed by the Supervisor) when the return-to-work services are expected to exceed 60 days. For Senior Claim Handlers who have sole responsibility to manage these activities, files should be clearly documented with pertinent action plans.

WSI should continue the return-to-work procedures in place involving the claims handler, nurses, return-to-work specialist and the six medical facilities. WSI should obtain quarterly or semi-annual reports from the six medical facilities to track the disability duration results of each operation to confirm the cost benefit.

Field medical case management should be used when the injured worker's disability has exceeded the duration guideline and/or the severity of injury is significant. In addition, a field medical case manager can be used to meet with the treating doctor to obtain a modified duty or full duty release is appropriate.

WSI should schedule an independent medical exam for the injured worker when their disability duration period exceeds the recommended guidelines and the treating doctor has not objectively explained the rationale for the ongoing disability. If independent medical exams have proven to be ineffective in the State of North Dakota, then another option is to explore the creation of a medical review board to determine if the ongoing disability and treatment of an injured employee is appropriate. However, this option has the potential to lead to backlogs if not properly staff and organized appropriately.

Reserving

Reserving for the probable total cost of a claim allows for improved budgeting, claims handling prioritization, and appropriate escalation practices.

Industry Standard

Reserves should be set to reflect the probable outcome based on both known and reasonably foreseeable factors regarding injury, treatment, and period of disability. Reserve changes should be made when significant developments occur that could change the ultimate amount expected to be paid on the claims.

WSI Standard

The goal of WSI is to achieve and maintain adequate reserves to ensure financial stability and integrity of the fund. An adequate reserve should not be significantly overstated or understated. It should reflect the amount the claims adjuster anticipates to pay through the point of claim resolution.

Audit Score

Reserving scored an 86 percent compliance rate.

Findings

WSI consistently reserved for the total probable exposure on each file and the majority of the cases were reserved appropriately. They achieved an 87% compliance score on appropriateness of the reserves.

The rationale supported the reserves displayed on the majority of the files, as the claims handlers used the Occupational Disability Guidelines reference source to determine the number of weeks of expected disability based on type of job and anticipated medical treatment. WSI achieved an 88 percent compliance score in this area.

A small number of claims included the payment of a permanent partial or total permanent disability benefit. For a permanent partial disability benefit to be paid the injured employee must have a disability rating of greater than 16 percent. WSI consistently applied the State statute in compensating injured employees based on temporary total disability, permanent partial disability, total permanent disability, death benefits, medical benefits, or schedule of benefits.

However, occasionally medical reserves were excessive. In most instances, excessive reserves were the result of the injured employee completing his/her treatment and returning to work for a considerable period of time without the medical reserve being reduced.

We also noted the “stair stepping” of the medical reserves. In a limited number of claims the medical reserves were increased frequently over a nine month period. The claims handler does not appear to be consistently reviewing the reserves when new developments occur and during the updating of action plans.

An important note is that medical and expense reserves are combined which can impact the ongoing reserve level when medical bills and legal expenses are being paid from one source.

Recommendations

Continue to utilize ODG as a guide in the establishing of reserves, as this has been an excellent tool for the claims handlers to use in determine the number of weeks based on injury and job status.

The claims handlers should revisit the medical reserve timely when an injured worker has been back to work for at least 90 days and is no longer treating for his/her injuries. In those instances, the medical reserves should be reduced considerably or closed out based on no further payments being anticipated.

The special program coordinator adjusts the supplemental benefit reserve and more communication is required to ensure the reserves consistently reflect the current exposure of the claims to avoid stair stepping. The claims handler should be responsible for the overall management of the claim, including the reserves.

The medical and expense reserves are combined and this can impact the ongoing reserve level when medical bills and legal expenses are paid from one source. WSI should revisit the combined medical and expense reserve procedures to determine if the benefits of keeping these allocations together are still appropriate.

From an industry standpoint, the medical and legal expense reserves are kept separate to effectively track the allocations and determine if the medical costs and legal expenses are appropriate for each file based upon the severity of the injury and any open litigation

issues. Marsh recommends WSI break out the medical and expense reserves to more appropriately track medical costs and paid legal expenses on each file.

Action Plans

Action plans provide a blueprint for the claims handler to follow in moving a wage-loss claim to the appropriate resolution in a timely manner.

Industry Standard

Action plans should identify (1) all pertinent issues/barriers, (2) clear strategies for resolving those issues/barriers, and (3) the appropriate target date for resolution. The initial action plan should be posted to the file within 30 calendar days of the wage-loss claims being received. On-going actions plans should be current and a review of the plan should be completed and posted to the file every 60 calendar days from the last posed action plan.

Audit Score

Action plans scored a 77 percent compliance rate.

Findings

WSI had an overall score 33 percent higher for those claims with dates of loss in 2006/2007 versus the claims with dates of loss in 2005. WSI 2006/2007 dates of loss claims had an 87 percent overall compliance score in this category.

WSI had a 63 percent compliance score in contacting the employer and completing the C97a prior to entering the initial 90 day action plan in the notepad. Claims handlers are not consistently completing the “C97a” form prior to entering the 90 day action plan in the notepad.

After the execution of the initial action plan the claims handler is not consistently setting up the meeting within 7 days of the 90 day action plan with the claims supervisor and medical case manager. WSI achieved a 69 percent compliance score in this area.

Initial action plans within 90 days does not occur consistently for the 2005 claims. The claims with dates of loss in 2006/2007 had initial action plans on the majority of applicable files. Since 2006, WSI has been conducting a triage of each new claim to discuss the overall direction of the file and agreed next steps in managing the file. With the implementation of the triage process the claims handlers have been effectively executing the initial action plans in 90 percent of the applicable cases. Overall, WSI achieved an 80 percent compliance score in implementing the initial action plan.

WSI achieved a 67 percent compliance score in executing subsequent action plans to move cases toward an appropriate resolution based on the injured employee's injury and treatment being rendered by the treating doctor.

The use of subsequent action plans has improved by 37 percent with the newer claims in comparison to the 2005 claims, but they are still not being consistently used on each applicable claim. Subsequent action plans should be prepared every 60 days on an open wage-loss file.

When action plans were executed the claims handlers successfully addressed open items in a timely fashion. WSI achieved a 93 percent compliance score in this area and demonstrated good follow-up on open action items when the activities are documented.

Recommendations

WSI should review the "C97a" form procedure with the claims handlers to confirm a common understanding of the process and improve compliance in this area. The claims supervisors should check bi-weekly for the claims handler's compliance in using the C97 forms.

Claims handlers should document the file accordingly if within seven days a meeting has taken place with the claims supervisor and medical case manager to review the action plan.

Claim handlers should consistently update their action plans every 60 days to address open items and bring files to a timely resolution.

Claim handlers should consistently document their activities on each file and implement a manual or electronic diary to track each file for appropriate and timely resolution.

Supervision

Supervision plays an important role in the claims handling process, as the second set of eyes should be working with the claims handler to ensure appropriate claims management activities are being consistently utilized.

Industry Standard

The initial supervisor review should be completed 30 calendar days from the date the wage-loss claims was received and posted to the file. Ongoing supervisor reviews should be current and posted to the file 90 days from the last posted review. The supervisor review should provide value-added oversight and direction to the claims handler relative to the complexity of the claims.

Audit Score

Supervision scored an 82 percent compliance rate.

Findings

WSI achieved an 81 percent compliance score in documented comments reflecting ongoing direction being provided to the adjuster. Unfortunately, the files lacked consistent documentation of claims supervisors' on-going direction to the claims handlers.

The WSI claim handlers achieved a 94 percent compliance score in successfully responding to the claim supervisor's documented directions and this improved the quality of the claim management in some instances.

WSI involvement on the files was appropriate in 82 percent of the applicable cases, based on the documentation noted in the claim file. Some of the complex and serious claims did not have documented supervisor comments and this would have benefited the file with additional direction being provided to address open issues.

Recommendations

The claims supervisors should improve their direction to the designated claims handlers to move files to an appropriate resolution. If the claim supervisors have been providing ongoing direction to the claims handlers the files are not being consistently documented. Several of the complex or questionable claims would have benefited from more supervisory involvement.

The claims supervisors should establish an effective diary system to review those claims not assigned to a senior claims handler for appropriateness of reserves and resolution plans.

Communication

Consistent communication by the claims handler with the employer and injured worker ensures a consistent level of understanding of all parties regarding authorized disability and appropriate allocation of benefits.

Industry Standard

Adequate communication is to include timely telephone contact, written correspondences, and/or electronic correspondences with the employer and injured employee every 30 days until the injured employee is return to full duty status. All communications should be timely

and reflect a high level of professionalism. Necessary parties include the employer, injured worker, and defense counsel as applicable.

Audit Score

Communication scored a 93 percent compliance rate.

Findings

The WSI claim handlers did a very good job of consistently communicating with the injured worker and employer. They achieved a 91 percent compliance score in ongoing communication with the employer. WSI claim handlers achieved a 96 percent compliance score with ongoing communication with the injured worker.

The claims handlers consistently communicated with the employer and injured worker throughout the claims handling process. With consistent communication the injured worker's claim was consistently managed and appropriate benefits paid. The claims handler's ongoing communication with the injured worker, employer, and medical provider kept all parties abreast of the injured worker's disability, medical treatment, and return-to-work options.

Recommendations

Continue to consistently communicate with the employer and injured worker to investigate files timely and move cases to an appropriate resolution.

Litigation Management

Litigation management provides guidelines for defense counsel to follow in the defense of a claim to avoid unnecessary legal expenses, consistent resolution strategies, and mismanagement of resources.

Industry Standard

Claims or issues in dispute will be recognized and promptly referred to the appropriate defense counsel. Litigation referrals will clearly define the issues and clarify the roles and responsibilities. The claim file will be documented with ongoing communication between the claims handler and counsel that clearly identifies the litigation strategy and supports the timely resolution of the case.

Audit Score

Litigation management scored a 67 percent compliance rate, based on eight applicable claims files.

Findings

WSI's litigation management results were impacted by the small number of applicable claims in this category. They did a satisfactory job of litigation management and their preparing of appropriate documents for forwarding to defense attorneys.

The claims handlers successfully refer litigated cases to defense counsel in a timely manner. The claims handlers should consistently adhere to the guidelines in place to improve their results in this area and document the claims files accordingly.

Recommendations

Claims Handler should remain actively involved in the ongoing management of outside defense counsel to ensure each assignment to defense counsel has an effective litigation plan in place.

Defense counsel should prepare an effective litigation plan within 30 days of receipt, including the estimated expense costs associated with defending the designated file.

Updated litigation status reports should be provided monthly or quarterly, depending on the outstanding issues associated with the claims file. The claims handlers should require defense counsel to provide a detail quarterly bill to validate services provided.

IV Implementation Plan

The following tables summarize the recommendations included in the report. These are organized along two lines,

- Operational concerns, similar to the organization of the process review section of the report
  - Documentation, Staffing, Education and Training
  - Intake and File Set-Up, Compensability Investigation
  - Reserving, Action Planning, Implementation, Closure, Legal
  - Managed Care
- Type of recommendation
  - Maintain
  - Execute Existing Processes
  - Execute New Processes
  - Evaluate

Implementation of the recommendations should be carried out in the following order:

- All “Maintain” and “Execute Existing Processes” recommendations (shaded dark orange) can be implemented immediately. The tools and resources for these are, for the most part, already in place and will be familiar to WSI management and staff. Consistent implementation and, in some cases, more robust guidelines are all that is necessary.
- Of the remaining recommendations, those shaded red should be implemented first and as soon as possible. These either deal with significant process issues or are leading practices that should have high impact on the effectiveness and efficiency of WSI.
- Recommendations highlighted in yellow should be put on hold until new management is in place. These are recommendations that would significantly change how WSI executes processes and are based on leading industry practices, but require more study to determine the value for North Dakota. New management should be given the chance to have input on decisions related to these recommendations.
- All other recommendations can be scheduled on an extended timeline that takes into account the number of changes WSI has already been exposed to and the number of studies scheduled.

Documentation, Staffing, and Education and Training

Execute Existing Processes	Execute New Processes	Evaluate
Provide adjusters with regular meaningful training and education specific to claims management.	Develop an electronic, searchable version of the Claims Procedure Manual.	Develop and phase in a system for assigning claims by employer account as well as adjuster experience. (A)
Support educational seminars for professional staff, to improve the organization's knowledge of current issues and approaches.	Distinguish between "policies" and "guidelines," by storing these in separate files.	This recommendation should be implemented after (A) is completed. Re-evaluate caseloads for any new system of assigning claims
Update reserving handbook with current cost guidelines.	This recommendation should be implemented after (A) is completed. Develop an expanded definition of "wage-loss" to include probable or expected wage loss and problem claims to minimize adjuster handoffs.	
Resume regular training of adjusters on legal issues and ways in which the departments can most effectively work with each other.	Maintain a "leading industry practices" claims management philosophy to build an understanding of mandatory standards. Introduce the concept of "leading industry practices" when training adjusters on required claims management procedures.	
Coordinate with legal to conduct an initial training session on "how to recognize recovery opportunities" for new hires and refresher courses for current employees.	Establish relationships with professional organization that provide resources and tools	
Review the "C97a" form procedure with the claims handlers to ensure common understanding of the process and improve compliance in this area.	Annually review with adjusters the statutory requirements regarding compensability decisions, including the sections on prior injuries and what is and is not a fraudulent claim. Use an outside defense counsel to do the training, for a different perspective.	

Intake and File Set-up, Compensability Investigation

Maintain	Execute Existing Processes	Execute New Processes	Evaluate
Continue the current work flow in which the technicians effectively address the first report of injury and complete the required forms to start the investigation process.	Request available investigative reports from external sources to assist with making compensability decisions	Change policy for establishing a claim based on any originator.	Consider a study of the impact of physician choice on injured workers' satisfaction and outcomes to determine if WSI should guide injured workers to treating physicians when employers do not have preferred providers.
Continue current process of reviewing new medical only claims timely to determine if the injured employee's claim history involved any prior or duplicate claims.	Use field investigators in investigation of complex and serious claims.	Develop further guidelines, to simplify the process for identifying a "prior" injury and determining its impact on WSI's liability	Review policy that adjuster does not need to contact medical provider if return-to-work documentation is in place.
Consistently complete action plans to resolve open issues for those claims in which a compensability decision has not been reached.	Establish a diary to ensure the notepad is consistently updated within 30 days of receipt of the claim to reflect the compensability decision.	Contact and interview all witnesses to verify the facts of the accident and if the claim is questionable.	Analyze data to determine why there has been an increase in lag time from receipt of claim to compensability decision
Continue to effectively obtain the require tax returns for a self employed injured worker to determine the validity of the claimant's average weekly wage.	Provide and consistently follow guidelines for appropriate use of recorded statements with the injured worker, employer, witnesses, etc. (e.g., all questionable claims, subrogation matters, cumulative trauma, and catastrophic cases).		
	Address offsets, subrogation/recovery opportunities during the initial investigation of a claim and document appropriately in the file.		

Maintain	Execute Existing Processes	Execute New Processes	Evaluate
	Require that all questionable claims are triaged before the adjuster makes a denial decision; include claim supervisor, claim director, medical director, and legal.		

Reserving, Action Planning, Implementation, Closure, Legal

Maintain	Execute Existing Processes	Execute New Processes	Evaluate
Continue to follow statutory laws in paying appropriate indemnity benefits within the required time frames.	Specify requirements for the adjuster to communicate with the employer and medical provider when a RTW case manager is not assigned.	This recommendation should be implemented Based on findings, break out non-medical costs and track as "expense" separate from the medical reserves to clearly manage allocations after (A) is completed.	Revisit the combined medical and expense reserve procedures to determine if the benefits of keeping these allocations together are still appropriate. (A)
Continue to effectively manage indemnity and medical benefits to avoid duplication of payments.	Improve communication when the special program coordinator adjusts the supplemental benefit reserve to ensure the reserves consistently reflect the current exposure of the claim.	Revisit the medical reserve timely and reduce or close out when an injured worker has been back to work for at least 90 days and is no longer treating for his/her injuries.	Clarify the intent of the statute regarding qualifications for conducting impairment evaluations (i.e. "physicians" defined as medical doctors and doctors of osteopathy or other).
Continue to utilize ODG as a guide in the establishing of reserves	Claims supervisors should check weekly the claims handler's compliance in using C97 forms.	Formalize and increase the frequency of communications between the adjuster and legal when legal is involved on a claim.	Continue to explore technology and practices to better identify fraud, focused on employer and medical provider in addition to worker.
Continue to use the claim management system to close medical only files after 90 days of no activity.	Document within 7 days when a meeting has taken place with the claims supervisor and medical case manager to review the action plan.	Require that defense counsel prepare an effective litigation plan within 30 days of receipt, including the estimated expense costs associated with defending the designated file	Review workflow regarding when legal counsel gets involved in pursuing subrogation recovery and determine if revisions are necessary.

Maintain	Execute Existing Processes	Execute New Processes	Evaluate
Continue to consistently communicate with the employer and injured worker to investigate files timely and move cases to an appropriate resolution.	Improve claim supervisor's direction to the designated claims handlers to move files to an appropriate resolution; establish an effective diary system for reviews.	Require that defense counsel provide updates monthly or quarterly, depending on the outstanding issues associated with the claims file.	
Consistently update action plans every 60 days to address open items and bring files to a timely resolution.		Require defense counsel to provide a detailed monthly bill to validate services provided.	.
Consistently document activities on each file and implement a manual or electronic diary to track each file for appropriate and timely resolution.			

Managed Care

Maintain	Execute Existing Processes	Execute New Processes	Evaluate
Use telephonic medical case managers when the disability is expected to exceed four weeks or the severity of the injury is moderate.	Use field medical case managers when the injured employee's disability has exceeded the duration guideline and/or the severity of injury are significant; or to meet with the treating doctor to obtain a work release.	Implement a more collaborative approach between adjusters and nurse case managers through education and policy changes.	Obtain quarterly or semi-annually reports from the facilities with contracted RTW case managers to assess disability duration results to confirm cost benefit.
Continue the return-to-work procedures in place involving the claims handler and the return-to-work case managers at the 6 medical facilities.	Develop realistic benchmarks for bill review and process bills as required.	Instruct the claims handlers to establish a diary (to be reviewed by the Supervisor) when the return to work services are expected to exceed 60 days.	Review current procedures for paying medical bills and confirm no bottlenecks exist in the process and there are no training issues.
Strive to issue payment on approved medical bills within 30 days or less; establish a daily diary to process appropriate medical bills within the required time frames.	Ensure that the UR nurses are conducting reviews based on the accepted ICD-9.	Schedule independent medical exams for injured workers when their disability duration period exceeds the recommended guidelines and the treating doctor has not objectively explained the rationale for the ongoing disability.	If independent medical exams are ineffective in the State of North Dakota, explore the creation of a medical review board to determine if the ongoing disability and treatment of an injured employee is appropriate.
Continue to follow procedures for implementing utilization review and the processing of medical bills.		Consider re-balancing work loads to free up some of the Medical Director's time for other value-added activities. (A)	Re-evaluate the policy of conducting pre-service utilization reviews on accepted claims only, considering the fact that compensability decisions are taking longer.
Continue to add to the library of guidelines available to WSI medical staff.			Assess the availability of the Medical Director or other physicians to provide guidance and peer reviews when necessary. (B)
Continue to explore the potential for replicating Unit 7.			This recommendation should be implemented after (A) and (B) are completed.

Implementation Challenges

WSI faces a number of challenges in implementing the recommendations contained in this report. Some are relevant only to specific recommendations, e.g., limited medical resources state-wide will have an impact on guiding employees to the best qualified physicians; and the new claims management system that WSI was in the process of designing during our visit may not have the capacity to effectively "automate" the Claims Procedure Manual as recommended. WSI will only be able to consider and select solutions within the constraints of available resources.

Other challenges are more global and should be considered when assigning a specific timeline to the Implementation Plan. The spotlight WSI has been under has stressed the organization, and staff should be given an opportunity to "get back to normal" before implementing extensive changes. Recommendations that are not clear-cut must be evaluated and viable options may all have pros and cons that will need to be weighed carefully. These types of decisions should be postponed, as indicated in the Implementation Plan tables, until WSI management has stabilized.

At the same time, line staff should be involved in designing and implementing all of these changes—they know the processes and procedures better and have as much of a stake in success as anyone. Their buy-in is essential for real change.

Appendix A

Documents Reviewed

Document	Document Date
N.D.C.C. Title 65-01, 65-05 and 65-05.1	
N.D.A.C. Title 92	
Claims Procedure Manual	October 10, 2007
Workforce Safety and Insurance Performance Evaluation Report by Octagon Risk Services, Inc.	November 21, 2006
Performance Audit Report, Report No. 3024, Office of the State Auditor	October 26, 2006
Customer Satisfaction Survey, DH Research,	May, 2007
Workforce Safety and Insurance Quick Facts and Figures	
EOBs and Bill Processing	Cover – October, 2002
Medical Services Bill Review Guidelines	February, 2007
Utilization Review Procedures Manual	September, 2006
Bill Review Policy and Procedure Manual	April, 2007
Case Management Guidelines	May, 2007
Claims Training Program	2006
Senior Analyst Training Materials	April, 2003
CMS User Manual	June, 1999
Reserving Handbook	December, 2002
WSI Operating Report	Quarter ending: September 30, 2007
Miscellaneous documents on the WSI website	

Staff Interviewed—by Title

- Chief of Injury Services
- Claims Adjusters
- Claims Director
- Claims Policy Manager
- Claims Senior Adjusters
- Claims Unit Supervisors
- Customer Services Manager
- Impairment Auditor
- Internal Auditor
- Medical Services Director
- Medical Bill Review Nurse
- Medical Case Managers
- Medical Director
- Pharmacy Benefits Director
- Quality Assurance Director
- Registration Clerk
- Resource Unit Supervisor
- Return-to-Work Manager
- Special Investigations Manager
- Special Program Coordinator
- Staff Counsel
- Technician Supervisor
- Utilization Review Supervisor

Appendix B

Professional Organizations

Public Agency Risk Management Association

http://www.parma.com

Public Entity Risk Institute

http://www.riskinstitute.org/peri/

Public Risk Management Association

http://www.primacentral.org

Risk and Insurance Management Society, Inc.

http://www.rims.org

Claims Metrics

http://www.claimsmetrics.com

American Association of State Compensation Insurance Funds

http://www.aascif.org

International Association of Industrial Accident Boards and Commissions

http://www.iaiabc.org/

National Council on Compensation Insurance

https://www.ncci.com

Workers Compensation Research Institute

http://www.wcrinet.org/

National Underwriter

http://www.propertyandcasualtyinsurancenews.com/

Managed Care Matters (weblog)

http://www.joepaduda.com/

Workers Comp Insider (weblog)

http://www.workerscompinsider.com/

National Business Group on Health

http://www.wbgh.com/

American Institute for CPCU and Insurance Institute of America

http://www.aicpcu.org/

Appendix C

Claim Roster

State of North Dakota

Claim Roster

Audit: State of North Dakota 2008 WC Claim Audit

Carrier/TPA	Coverage Line	Date of Review
Self Administered	WC	01/28/2008

CLAIM NUMBER	CLAIMANT NAME	DATE OF LOSS
2005708530	XXX	01/03/2005
2005708651	XXX	01/04/2005
2005708903	XXX	01/05/2005
2005709018	XXX	01/11/2005
2005709089	XXX	01/10/2005
2005709099	XXX	01/11/2005
2005709128	XXX	01/11/2005
2005709518	XXX	01/05/2005
2005709605	XXX	01/14/2005
2005709748	XXX	01/22/2005
2005710155	XXX	02/01/2005
2005710183	XXX	01/11/2005
2005710294	XXX	02/02/2005
2005710396	XXX	02/03/2005
2005710561	XXX	02/04/2005
2005710854	XXX	02/11/2005
2005710916	XXX	02/12/2005
2005711335	XXX	02/01/2005
2005711745	XXX	02/22/2005
2005711797	XXX	02/16/2005
2005711895	XXX	02/16/2005
2005712100	XXX	03/02/2005
2005712321	XXX	03/08/2005
2005712362	XXX	03/04/2005
2005712477	XXX	03/14/2005
2005712620	XXX	03/15/2005
2005712842	XXX	03/15/2005
2005712965	XXX	03/17/2005
2005713096	XXX	03/08/2005
2005713168	XXX	03/29/2005
2005713282	XXX	03/29/2005
2005713407	XXX	02/23/2005
2005713507	XXX	04/04/2005
2005713632	XXX	04/04/2005
2005713653	XXX	03/31/2005
2005714043	XXX	04/13/2005
2005714102	XXX	04/04/2005
2005714293	XXX	04/01/2005
2005714495	XXX	04/18/2005
2005714553	XXX	04/22/2005

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Claim Roster

2005714831	XXX	04/27/2005
2005714877	XXX	04/27/2005
2005715027	XXX	05/03/2005
2005715031	XXX	03/28/2005
2005715321	XXX	05/07/2005
2005715516	XXX	05/03/2005
2005715605	XXX	04/30/2005
2005715633	XXX	04/15/2005
2005715947	XXX	04/26/2005
2005715969	XXX	05/17/2005
2005716080	XXX	05/11/2005
2005716270	XXX	05/22/2005
2005716436	XXX	05/26/2005
2005716786	XXX	06/01/2005
2005716874	XXX	05/16/2005
2005716939	XXX	06/03/2005
2005717119	XXX	06/09/2005
2005717161	XXX	06/09/2005
2005717333	XXX	06/10/2005
2005717352	XXX	06/08/2005
2005717466	XXX	06/09/2005
2005717711	XXX	06/20/2005
2005717810	XXX	06/13/2005
2005717819	XXX	06/21/2005
2005718047	XXX	06/16/2005
2005718238	XXX	06/28/2005
2005718301	XXX	06/29/2005
2005718335	XXX	06/20/2005
2005718559	XXX	06/03/2005
2005718780	XXX	06/09/2005
2005718817	XXX	07/08/2005
2005718853	XXX	06/30/2005
2005719100	XXX	07/14/2005
2005719255	XXX	07/12/2005
2005719293	XXX	07/18/2005
2005719555	XXX	07/20/2005
2005719568	XXX	07/20/2005
2005719737	XXX	07/23/2005
2005719976	XXX	07/20/2005
2005720207	XXX	08/01/2005
2005720209	XXX	07/29/2005
2005720272	XXX	07/21/2005
2005720321	XXX	08/02/2005
2005720543	XXX	08/02/2005
2005720694	XXX	07/25/2005
2005720766	XXX	08/03/2005
2005721166	XXX	08/12/2005

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2005721170	XXX	08/15/2005
2005721256	XXX	08/04/2005
2005721347	XXX	07/04/2005
2005721560	XXX	08/20/2005
2005721581	XXX	07/01/2005
2005721662	XXX	08/23/2005
2005721750	XXX	08/24/2005
2005721976	XXX	08/24/2005
2005722135	XXX	08/26/2005
2005722150	XXX	08/20/2005
2005722154	XXX	08/30/2005
2005722352	XXX	09/01/2005
2005722571	XXX	09/01/2005
2005722784	XXX	08/30/2005
2005723022	XXX	08/29/2005
2005723048	XXX	08/31/2005
2005723098	XXX	09/10/2005
2005723248	XXX	09/15/2005
2005723472	XXX	09/20/2005
2005723525	XXX	09/17/2005
2005723718	XXX	09/08/2005
2005723889	XXX	09/27/2005
2005724013	XXX	09/14/2005
2005724060	XXX	09/29/2005
2005724284	XXX	09/23/2005
2005724292	XXX	09/15/2005
2005724500	XXX	09/27/2005
2005724568	XXX	10/03/2005
2005724573	XXX	09/16/2005
2005725053	XXX	10/06/2005
2005725097	XXX	10/11/2005
2005725193	XXX	10/13/2005
2005725348	XXX	10/04/2005
2005725526	XXX	10/21/2005
2005725627	XXX	10/19/2005
2005725968	XXX	10/26/2005
2005725971	XXX	06/28/2005
2005726145	XXX	10/25/2005
2005726285	XXX	09/22/2005
2005726353	XXX	11/02/2005
2005726680	XXX	11/07/2005
2005726714	XXX	10/19/2005
2005726965	XXX	11/11/2005
2005727241	XXX	11/17/2005
2005727307	XXX	09/22/2005
2005727511	XXX	11/12/2005
2005727691	XXX	09/26/2005

2005727888	XXX	11/28/2005
2005728115	XXX	12/03/2005
2005728271	XXX	12/05/2005
2005728283	XXX	12/05/2005
2005728530	XXX	12/07/2005
2005728716	XXX	12/05/2005
2005728746	XXX	12/09/2005
2005728838	XXX	12/12/2005
2005728974	XXX	11/26/2005
2005729159	XXX	12/13/2005
2005729197	XXX	12/18/2005
2005729394	XXX	12/14/2005
2005729628	XXX	12/27/2005
2005729648	XXX	12/12/2005
2005729726	XXX	12/14/2005
2006729970	XXX	12/25/2005
2006730080	XXX	01/06/2006
2006730103	XXX	02/01/2005
2006730820	XXX	01/18/2006
2006730851	XXX	01/09/2006
2006730871	XXX	12/20/2005
2006730971	XXX	01/18/2006
2006731292	XXX	09/23/2005
2006731442	XXX	01/06/2006
2006731449	XXX	01/27/2006
2006731656	XXX	01/27/2006
2006731870	XXX	01/04/2006
2006732015	XXX	01/30/2006
2006732128	XXX	01/15/2006
2006732140	XXX	02/03/2006
2006732373	XXX	01/17/2006
2006732616	XXX	02/15/2006
2006732634	XXX	02/20/2006
2006732745	XXX	02/10/2006
2006732875	XXX	02/22/2006
2006733079	XXX	10/20/2005
2006733211	XXX	02/27/2006
2006733270	XXX	12/07/2005
2006733351	XXX	02/23/2006
2006733416	XXX	03/06/2006
2006733419	XXX	03/03/2006
2006733529	XXX	03/06/2006
2006733751	XXX	02/28/2006
2006733941	XXX	03/09/2006
2006733968	XXX	01/31/2006
2006734104	XXX	03/09/2006
2006734179	XXX	02/23/2006

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Claim Roster

2006734340	XXX	03/20/2006
2006734470	XXX	03/22/2006
2006734535	XXX	03/23/2006
2006734657	XXX	03/21/2006
2006734693	XXX	03/24/2006
2006734975	XXX	03/24/2006
2006735101	XXX	03/31/2006
2006735219	XXX	04/04/2006
2006735315	XXX	03/27/2006
2006735477	XXX	04/07/2006
2006735721	XXX	04/12/2006
2006735727	XXX	04/10/2006
2006735803	XXX	02/18/2006
2006735936	XXX	04/18/2006
2006736167	XXX	04/12/2006
2006736313	XXX	04/25/2006
2006736401	XXX	04/25/2006
2006736559	XXX	04/21/2006
2006736623	XXX	05/01/2006
2006736834	XXX	04/27/2006
2006736904	XXX	05/03/2006
2006736909	XXX	05/02/2006
2006737139	XXX	05/08/2006
2006737364	XXX	05/13/2006
2006737455	XXX	05/15/2006
2006737525	XXX	10/08/2005
2006737590	XXX	04/30/2006
2006737685	XXX	03/12/2006
2006737844	XXX	05/05/2006
2006738015	XXX	05/23/2006
2006738116	XXX	05/26/2006
2006738219	XXX	05/23/2006
2006738579	XXX	06/05/2006
2006738641	XXX	06/01/2006
2006738666	XXX	06/07/2006
2006738863	XXX	06/09/2006
2006739102	XXX	06/13/2006
2006739174	XXX	06/14/2006
2006739307	XXX	06/17/2006
2006739407	XXX	06/13/2006
2006739585	XXX	06/20/2006
2006739725	XXX	05/26/2006
2006739845	XXX	06/21/2006
2006740048	XXX	02/01/2006
2006740100	XXX	06/29/2006
2006740293	XXX	07/05/2006
2006740316	XXX	07/05/2006

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Claim Roster

2006740525	XXX	07/10/2006
2006740660	XXX	06/25/2006
2006740754	XXX	06/23/2006
2006740859	XXX	07/10/2006
2006741033	XXX	07/17/2006
2006741294	XXX	07/20/2006
2006741428	XXX	07/19/2006
2006741503	XXX	07/25/2006
2006741524	XXX	07/10/2006
2006741583	XXX	07/24/2006
2006741856	XXX	07/28/2006
2006741987	XXX	03/05/2006
2006742155	XXX	07/31/2006
2006742393	XXX	08/07/2006
2006742477	XXX	08/08/2006
2006742543	XXX	08/04/2006
2006742620	XXX	08/04/2006
2006742892	XXX	02/21/2006
2006742935	XXX	03/24/2005
2006742967	XXX	08/13/2006
2006743121	XXX	08/01/2006
2006743129	XXX	08/16/2006
2006743352	XXX	08/21/2006
2006743582	XXX	08/24/2006
2006743699	XXX	08/17/2006
2006743702	XXX	08/26/2006
2006743753	XXX	08/31/2006
2006743780	XXX	08/27/2006
2006744196	XXX	08/31/2006
2006744282	XXX	08/23/2006
2006744395	XXX	01/01/2005
2006744405	XXX	08/30/2006
2006744625	XXX	09/06/2006
2006744663	XXX	09/13/2006
2006744847	XXX	08/30/2006
2006744895	XXX	09/13/2006
2006745080	XXX	09/15/2006
2006745251	XXX	09/19/2006
2006745294	XXX	09/22/2006
2006745443	XXX	09/21/2006
2006745507	XXX	09/15/2006
2006745673	XXX	08/29/2006
2006745751	XXX	09/30/2006
2006745986	XXX	10/02/2006
2006746068	XXX	10/05/2006
2006746198	XXX	09/26/2006
2006746264	XXX	10/09/2006

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Claim Roster

2006746512	XXX	10/11/2006
2006746588	XXX	10/12/2006
2006746607	XXX	10/13/2006
2006746716	XXX	10/16/2006
2006746858	XXX	10/19/2006
2006747117	XXX	10/23/2006
2006747178	XXX	10/20/2006
2006747282	XXX	09/08/2006
2006747297	XXX	10/02/2006
2006747565	XXX	10/31/2006
2006747719	XXX	11/02/2006
2006747772	XXX	10/29/2006
2006747874	XXX	10/21/2006
2006747928	XXX	11/06/2006
2006748118	XXX	11/02/2006
2006748255	XXX	11/07/2006
2006748324	XXX	11/06/2006
2006748370	XXX	11/13/2006
2006748630	XXX	11/02/2006
2006748842	XXX	11/17/2006
2006748952	XXX	11/15/2006
2006749008	XXX	11/27/2006
2006749052	XXX	11/03/2006
2006749192	XXX	11/17/2006
2006749405	XXX	12/01/2006
2006749553	XXX	12/05/2006
2006749559	XXX	12/05/2006
2006749795	XXX	12/05/2006
2006750030	XXX	11/30/2006
2006750140	XXX	12/12/2006
2006750480	XXX	12/21/2006
2006750500	XXX	12/18/2006
2006750695	XXX	12/18/2006
2006750714	XXX	12/19/2006
2007750837	XXX	01/02/2007
2007750907	XXX	12/06/2006
2007750939	XXX	12/13/2006
2007751096	XXX	01/04/2007
2007751319	XXX	01/09/2007
2007751436	XXX	12/10/2006
2007751489	XXX	01/11/2007
2007751564	XXX	01/03/2007
2007751739	XXX	12/28/2006
2007751883	XXX	01/16/2007
2007752103	XXX	01/23/2007
2007752157	XXX	01/22/2007
2007752301	XXX	01/04/2007

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Claim Roster

2007752500	XXX	01/28/2007
2007752706	XXX	01/31/2007
2007752736	XXX	01/31/2007
2007752917	XXX	02/06/2007
2007753180	XXX	02/06/2007
2007753239	XXX	02/11/2007
2007753400	XXX	02/08/2007
2007753583	XXX	02/20/2007
2007753778	XXX	02/13/2007
2007753805	XXX	02/21/2007
2007753966	XXX	02/16/2007
2007754170	XXX	02/27/2007
2007754286	XXX	02/16/2007
2007754359	XXX	03/05/2007
2007754377	XXX	02/28/2007
2007754473	XXX	12/16/2006
2007754539	XXX	03/05/2007
2007754604	XXX	02/28/2007
2007754795	XXX	02/12/2007
2007754898	XXX	03/01/2007
2007754954	XXX	03/13/2007
2007754979	XXX	10/02/2006
2007755251	XXX	03/15/2007
2007755386	XXX	03/20/2007
2007755437	XXX	03/21/2007
2007755713	XXX	03/26/2007
2007755802	XXX	03/05/2007
2007755831	XXX	03/27/2007
2007755976	XXX	03/18/2007
2007755980	XXX	02/23/2007
2007756026	XXX	03/25/2007
2007756228	XXX	04/02/2007
2007756482	XXX	04/09/2007
2007756499	XXX	04/08/2007
2007756567	XXX	03/31/2007
2007756746	XXX	04/10/2007
2007756961	XXX	10/25/2006
2007757006	XXX	04/16/2007
2007757025	XXX	04/17/2007
2007757098	XXX	04/17/2007
2007757192	XXX	04/02/2007
2007757378	XXX	04/23/2007
2007757409	XXX	04/06/2007
2007757521	XXX	04/26/2007
2007757547	XXX	03/15/2007
2007757715	XXX	04/27/2007
2007757837	XXX	04/27/2007

2007757939	XXX	05/02/2007
2007758059	XXX	05/02/2007
2007758080	XXX	04/02/2007
2007758201	XXX	05/04/2007
2007758395	XXX	04/14/2007
2007758423	XXX	05/10/2007
2007758627	XXX	05/04/2007
2007758635	XXX	05/15/2007
2007758843	XXX	05/16/2007
2007758978	XXX	05/17/2007
2007759116	XXX	05/07/2007
2007759234	XXX	05/18/2007
2007759298	XXX	05/18/2007
2007759486	XXX	05/28/2007
2007759694	XXX	01/05/2007
2007759701	XXX	05/31/2007
2007759753	XXX	03/20/2007
2007759824	XXX	06/03/2007
2007759989	XXX	05/30/2007
2007760170	XXX	06/11/2007
2007760200	XXX	06/11/2007
2007760232	XXX	05/29/2007
2007760342	XXX	06/07/2007
2007760579	XXX	06/17/2007
2007760686	XXX	06/13/2007
2007760825	XXX	06/06/2007
2007760883	XXX	06/13/2007
2007761058	XXX	06/18/2007
2007761194	XXX	06/24/2007
2007761232	XXX	06/25/2007
2007761316	XXX	06/27/2007
2007761535	XXX	06/14/2007
2007761650	XXX	06/25/2007
2007761739	XXX	07/05/2007
2007761832	XXX	07/02/2007
2007761851	XXX	06/19/2007
2007762035	XXX	07/02/2007
2007762175	XXX	07/11/2007
2007762256	XXX	07/15/2007
2007762364	XXX	07/15/2007
2007762366	XXX	07/16/2007
2007762511	XXX	06/28/2007
2007762713	XXX	07/19/2007
2007762781	XXX	07/23/2007
2007762906	XXX	07/20/2007
2007763114	XXX	07/11/2007
2007763187	XXX	07/25/2007

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Claim Roster

2007763384	XXX	07/30/2007
2007763462	XXX	08/01/2007
2007763609	XXX	08/02/2007
2007763622	XXX	07/22/2007
2007763746	XXX	07/31/2007
2007763844	XXX	08/04/2007
2007763852	XXX	08/07/2007
2007764136	XXX	08/08/2007
2007764177	XXX	01/15/2007
2007764286	XXX	08/01/2007
2007764487	XXX	08/17/2007
2007764608	XXX	08/10/2007
2007764658	XXX	08/21/2007
2007764828	XXX	08/05/2007
2007764894	XXX	08/22/2007
2007764948	XXX	08/24/2007
2007765164	XXX	08/27/2007
2007765240	XXX	08/01/2007
2007765335	XXX	08/30/2007
2007765638	XXX	08/16/2007
2007765658	XXX	09/04/2007
2007765841	XXX	09/06/2007
2007765964	XXX	08/23/2007
2007766013	XXX	08/29/2007
2007766081	XXX	09/12/2007
2007766189	XXX	09/11/2007
2007766206	XXX	09/12/2007
2007766488	XXX	09/17/2007
2007766673	XXX	09/13/2007
2007766831	XXX	09/18/2007
2007766839	XXX	09/18/2007
2007767029	XXX	09/26/2007
2007767184	XXX	09/28/2007
2007767264	XXX	10/02/2007
2007767513	XXX	09/24/2007
2007767639	XXX	06/14/2007
2007767706	XXX	10/09/2007
2007767754	XXX	10/08/2007
2007767970	XXX	10/09/2007
2007768149	XXX	09/24/2007
2007768258	XXX	10/16/2007
2007768273	XXX	10/02/2007
2007768449	XXX	10/12/2007
2007768550	XXX	10/19/2007
2007768836	XXX	10/25/2007
2007768917	XXX	10/23/2007
2007769071	XXX	10/22/2007

2007769115	XXX	10/30/2007
2007769371	XXX	11/02/2007
2007769394	XXX	11/02/2007
2007769571	XXX	10/30/2007
2007769818	XXX	11/10/2007
2007769970	XXX	11/13/2007
2007770104	XXX	11/16/2007
2007770440	XXX	11/20/2007
2007770574	XXX	11/25/2007
2007770690	XXX	11/28/2007
2007770875	XXX	11/29/2007
2007772162	XXX	12/17/2007

Number of claims reviewed: **475**

Appendix D

2008 Overall Combined Score Report

Audit Scoring by Category

Audit State of North Dakota 2008 WC Claim Audit

Carrier/TPA Self Administered

Coverage Line WC

Date of Review 01/28/2008

Audit Category	No. of Answers	Score
New Claim Processing	361	97.23
Medical Only Claim Processing	77	89.61
Three-Point Contact	360	75.29
Investigation	364	86.02
Denied or Withdrawn Claim	91	89.01
Timeliness of Payments/Overpayments	275	93.39
Subrogation/Recoveries	42	34.92
Medical/Cost Containment	345	91.40
Disability Management	238	87.00
Reserving	273	85.62
Action Plan	315	77.26
Supervision	285	81.75
Communication	339	92.53
Litigation Management	8	66.67
Claims in Audit: 475	Audit Total:	80.16

Note: Any non-scoring questions (those with an assigned question weight of 0) are not included in this report. A claim section score is the average of all the applicable questions within the section for a single claim. The audit section score shown in this report is the average of all the claim section scores

Appendix E

2006/2007—Overall Score Totals

Audit Scoring by Category

Audit State of North Dakota 2008 WC Claim Audit (2006/2007 Losses Only)

Carrier/TPA Self Administered

Coverage Line WC

Date of Review 01/28/2008

Audit Category	No. of Answers	Score
New Claim Processing	241	98.76
Medical Only Claim Processing	49	87.76
Three-Point Contact	240	74.81
Investigation	243	88.56
Denied or Withdrawn Claim	61	91.26
Timeliness of Payments/Overpayments	187	93.09
Subrogation/Recoveries	28	41.67
Medical/Cost Containment	231	93.65
Disability Management	160	86.08
Reserving	182	86.72
Action Plan	222	87.11
Supervision	186	82.44
Communication	228	93.35
Litigation Management	7	78.57
Claims in Audit: 317	Audit Total:	80.93

Note: Any non-scoring questions (those with an assigned question weight of 0) are not included in this report. A claim section score is the average of all the applicable questions within the section for a single claim. The audit section score shown in this report is the average of all the claim section scores

Appendix F

2005—Overall Score Totals

Audit Scoring by Category

Audit State of North Dakota 2008 WC Claim Audit (2005 losses only)

Carrier/TPA Self Administered

Coverage Line WC

Date of Review 01/28/2008

Audit Category	No. of Answers	Score
New Claim Processing	120	94.17
Medical Only Claim Processing	28	92.86
Three-Point Contact	120	76.25
Investigation	121	80.92
Denied or Withdrawn Claim	30	85.56
Timeliness of Payments/Overpayments	88	94.03
Subrogation/Recoveries	14	21.43
Medical/Cost Containment	114	86.84
Disability Management	78	88.89
Reserving	91	83.42
Action Plan	93	53.75
Supervision	99	80.47
Communication	111	90.84
Litigation Management	2	41.67
Claims in Audit: 158	Audit Total:	78.65

Note: Any non-scoring questions (those with an assigned question weight of 0) are not included in this report. A claim section score is the average of all the applicable questions within the section for a single claim. The audit section score shown in this report is the average of all the claim section scores

Appendix G

2008 Overall Combined Scores by Question

Audit Scoring by Question

Audit State of North Dakota 2008 WC Claim Audit

Carrier/TPA Self Administered

Coverage Line WC

Date of Review 01/28/2008

Category/Question	No. of Answers	% Score
New Claim Processing		
Once the first report of injury was received, did the claim handler complete the employer, worker and medical forms (C97, C96, and C101)?	361	97.23
Medical Only Claim Processing		
When the medical only claim was received, did the claim handler document there searching of previous claim history to identify any prior claims and locate any possible duplicate claims?	75	92.00
Did the claim handler enter a notepad outlining how the injury occurred, what body part was injured, who the employer is, and outlined the decision reached on the claim within 30 days of receipt by the claim analyst?	75	81.33
If this medical only claim had no activity for a period of 90 days was it automatically closed?	75	98.67
Three-Point Contact		
WSI claim handler made actual contact or reasonable attempts to contact the injured worker within:	358	76.33
WSI claim handler made actual contact or reasonable attempts to contact the employer within:	359	75.97
WSI claim handler made actual contact or reasonable attempts to contact the medical provider (contact with the medical provider can be waived if medical data is in the claim folder and return to work date established). If there is medical information in the f...	279	75.54
Investigation		
Investigation was...	364	88.46
Once the claim handler determined the claim was compensable, did he/she clearly explain why the claim was compensable and routed the C96, C97 and C101 forms to the claim supervisor for review?	259	93.05
The compensability decision reached by the WSI claim handler was supported by evidence that addressed all issues and documented in the claim file.	322	93.79
If the claim was still pending at 21 days, did the claim handler complete an action plan on the status of investigation and a plan to determine compensability? (A claim supervisor may waive this requirement for a Senior Claims Handler III and Claim ...	91	85.71

Category/Question	No. of Answers	% Score
Field investigation may be warranted in complex /serious injury cases. If a field investigation was warranted, one was completed.	19	47.37
If statements were warranted, they were secured. Statements should be obtained from the employee, the employee's supervisor, and witnesses on: Questionable Claims, history of work related injuries, history of similar injuries/health conditions,	82	25.61
Denied or Withdrawn Claim		
If an injured worker withdrew his/her claim in writing or verbally, did the WSI claim handler send a FL112 and diary the claim for 14 days? If the worker has not reconsidered the claim withdrawal at that time the claim handler will change the status...	6	66.67
Did the WSI claim handler send a FL205 (Not eligible wage loss, less than 5 days of wage), FL206 (Not eligible wage loss, Dr. has not Verified wage loss), or FL 724 (Deny Disability, narrative), when the decision to deny the wage loss claim was made?	67	97.01
Once the claim handler determined the claim should be denied, did he/she clearly explain why the claim is not compensable and routed the C96, C97, and C101 forms to the claim supervisor for review and approval?	72	84.72
Was the denial of this claim by the WSI claim handler appropriate?	84	85.71
Timeliness of Payments/Overpayments		
For a self employed worker, did the WSI claim handler request a copy of the injured worker's three previous year profit or loss tax forms to determine the average weekly wage.	11	63.64
Per North Dakota state law, was the injured employee off work 5 consecutive days before receiving his/her initial temporary total disability benefits for the first five days of disability?	260	100.00
Did an indemnity overpayment take place on this file and if so, how many? (Place in the comments section the number of overpayments if applicable).	225	91.11
Did the WSI claim handler discontinue the wage loss benefits to the injured worker confined (jailed) in excess of seventy two consecutive hours?	5	80.00
Did a medical overpayment take place on the file and if so, how many? (Place in the comments section the number of overpayments if applicable).	234	93.16
Subrogation/Recoveries		
Subrogation/Recovery potential was recognized and pursued.	34	26.47
Subrogation/Recovery Potential was identified and proper investigation initiated within:	31	41.94
Offsets and/or Apportionments were identified and properly pursued.	10	50.00
Medical/Cost Containment		

Category/Question	No. of Answers	% Score
The WSI claim handler utilized appropriate utilization review for inpatient hospital, physical therapy and chiropractic treatment?	205	98.54
Appropriate supporting medical documentation was consistently secured prior to bill payment.	343	99.13
Were medical bills paid by the claim handler within 30 days of receipt of the bill?	342	80.41
Disability Management		
When appropriate, did the WSI clam handler make a timely referral to a TCM/FCM?	123	91.06
Did the claim handler refer to this case for mandatory medical case management when it was determined this was a wage loss claim?	12	91.67
If the file was not referred to TCM/FCM did the adjuster pursue a release to full/modified duty as soon as appropriate?	131	95.42
If TCM/FCM was assigned, did the claim file reflect appropriate activity was performed to return the injured worker to full/modified duty?	116	97.41
The claim handler appropriately requested and utilized Independent Medical Examinations.	28	46.43
Did the on-site case manager under contract with WSI complete an initial return to work investigation with the employer of injury, provider, and claims analyst within 24 hours of the referral (normal business days)?	100	76.00
Did the claim supervisor approve continued RTW services which exceeded 60 days?	41	60.98
Reserving		
Reserves on this lost time case adequately reflect the current exposure in the file.	179	86.59
Current Reserving is	178	77.53
There is evidence of reserve stair stepping during the life of the file.	268	89.55
Reserve rationale was adequately and consistently documented in the file.	269	87.73
Action Plan		
Prior to entering the initial 90 day action plan in the notepad, did the WSI claim handler contact the employer and complete the C97a.	212	62.74
After the initial 90 day action plan was entered, did the claim handler set up a meeting within 7 days of the 90 day action plan event with the claim supervisor and MCM to review the action plan?	157	69.43
Did the claim handler execute an initial action plan for this wage loss claim at 90 days or less?	272	80.15
The subsequent action plans were continually updated every 60 days to reflect current status of the file.	147	66.67
The notes reflect follow up on open action items by the WSI claim handler?	212	93.40
Supervision		

Category/Question	No. of Answers	% Score
Did the Claim Supervisor's documented comments reflect ongoing direction being provided to the adjuster?	270	80.74
Does the claim file reflect evidence of the adjuster's response to the Claim Supervisor's direction?	207	93.72
Has the supervisor's involvement on this file been appropriate?	282	82.27
Communication		
The claim handler maintained adequate communications with the employer?	327	91.44
The claim handler maintained adequate communications with the injured employee.	335	96.12
The WSI claim handler phoned the injured worker at least every 28 days while wage loss payments were being issued to inquire about his/her current medical condition and any return to work issues.	140	87.86
Litigation Management		
The claim handler maintained control, conducted necessary investigation and directed defense counsel activity at the appropriate life of the file.	6	50.00
When warranted the claim handler referred the case, with guidelines, to counsel in a timely fashion.	8	87.50
The claim handler solicited, reviewed, and appropriately acted upon, periodic status reports from defense counsel.	5	80.00
Claims in Audit: 475	Audit Total Score:	80.16

Note: Any non-scoring questions (those with an assigned question weight of 0) are not included in this report. The score for each question is the average of all the claim-by-claim scores for that question.

Appendix H

2006/2007 Overall Score by Question

Audit Scoring by Question

Audit State of North Dakota 2008 WC Claim Audit (2006/2007 Losses Only)

Carrier/TPA Self Administered

Coverage Line WC

Date of Review 01/28/2008

Category/Question	No. of Answers	% Score
New Claim Processing		
Once the first report of injury was received, did the claim handler complete the employer, worker and medical forms (C97, C96, and C101)?	241	98.76
Medical Only Claim Processing		
When the medical only claim was received, did the claim handler document there searching of previous claim history to identify any prior claims and locate any possible duplicate claims?	48	87.50
Did the claim handler enter a notepad outlining how the injury occurred, what body part was injured, who the employer is, and outlined the decision reached on the claim within 30 days of receipt by the claim analyst?	48	77.08
If this medical only claim had no activity for a period of 90 days was it automatically closed?	47	100.00
Three-Point Contact		
WSI claim handler made actual contact or reasonable attempts to contact the injured worker within:	239	75.52
WSI claim handler made actual contact or reasonable attempts to contact the employer within:	239	76.05
WSI claim handler made actual contact or reasonable attempts to contact the medical provider (contact with the medical provider can be waived if medical data is in the claim folder and return to work date established). If there is medical information in the f...	203	75.00
Investigation		
Investigation was...	243	90.53
Once the claim handler determined the claim was compensable, did he/she clearly explain why the claim was compensable and routed the C96, C97 and C101 forms to the claim supervisor for review?	179	94.97
The compensability decision reached by the WSI claim handler was supported by evidence that addressed all issues and documented in the claim file.	204	93.63
If the claim was still pending at 21 days, did the claim handler complete an action plan on the status of investigation and a plan to determine compensability? (A claim supervisor may waive this requirement for a Senior Claims Handler III and Claim ...	65	93.85

Category/Question	No. of Answers	% Score
Field investigation may be warranted in complex /serious injury cases. If a field investigation was warranted, one was completed.	12	41.67
If statements were warranted, they were secured. Statements should be obtained from the employee, the employee's supervisor, and witnesses on: Questionable Claims, history of work related injuries, history of similar injuries/health conditions,	46	32.61
Denied or Withdrawn Claim		
If an injured worker withdrew his/her claim in writing or verbally, did the WSI claim handler send a FL112 and diary the claim for 14 days? If the worker has not reconsidered the claim withdrawal at that time the claim handler will change the status...	4	75.00
Did the WSI claim handler send a FL205 (Not eligible wage loss, less than 5 days of wage), FL206 (Not eligible wage loss, Dr. has not Verified wage loss), or FL 724 (Deny Disability, narrative), when the decision to deny the wage loss claim was made?	38	94.74
Once the claim handler determined the claim should be denied, did he/she clearly explain why the claim is not compensable and routed the C96, C97, and C101 forms to the claim supervisor for review and approval?	45	93.33
Was the denial of this claim by the WSI claim handler appropriate?	56	87.50
Timeliness of Payments/Overpayments		
For a self employed worker, did the WSI claim handler request a copy of the injured worker's three previous year profit or loss tax forms to determine the average weekly wage.	10	70.00
Per North Dakota state law, was the injured employee off work 5 consecutive days before receiving his/her initial temporary total disability benefits for the first five days of disability?	174	100.00
Did an indemnity overpayment take place on this file and if so, how many? (Place in the comments section the number of overpayments if applicable).	147	91.84
Did the WSI claim handler discontinue the wage loss benefits to the injured worker confined (jailed) in excess of seventy two consecutive hours?	2	50.00
Did a medical overpayment take place on the file and if so, how many? (Place in the comments section the number of overpayments if applicable).	154	93.51
Subrogation/Recoveries		
Subrogation/Recovery potential was recognized and pursued.	22	27.27
Subrogation/Recovery Potential was identified and proper investigation initiated within:	19	52.63
Offsets and/or Apportionments were identified and properly pursued.	8	62.50
Medical/Cost Containment		

Category/Question	No. of Answers	% Score
The WSI claim handler utilized appropriate utilization review for inpatient hospital, physical therapy and chiropractic treatment?	153	100.00
Appropriate supporting medical documentation was consistently secured prior to bill payment.	230	98.70
Were medical bills paid by the claim handler within 30 days of receipt of the bill?	229	84.72
Disability Management		
When appropriate, did the WSI clam handler make a timely referral to a TCM/FCM?	89	93.26
Did the claim handler refer to this case for mandatory medical case management when it was determined this was a wage loss claim?	8	87.50
If the file was not referred to TCM/FCM did the adjuster pursue a release to full/modified duty as soon as appropriate?	81	96.30
If TCM/FCM was assigned, did the claim file reflect appropriate activity was performed to return the injured worker to full/modified duty?	84	97.62
The claim handler appropriately requested and utilized Independent Medical Examinations.	20	30.00
Did the on-site case manager under contract with WSI complete an initial return to work investigation with the employer of injury, provider, and claims analyst within 24 hours of the referral (normal business days)?	66	75.76
Did the claim supervisor approve continued RTW services which exceeded 60 days?	30	56.67
Reserving		
Reserves on this lost time case adequately reflect the current exposure in the file.	160	85.00
Current Reserving is	162	75.93
There is evidence of reserve stair stepping during the life of the file.	180	93.89
Reserve rationale was adequately and consistently documented in the file.	181	90.06
Action Plan		
Prior to entering the initial 90 day action plan in the notepad, did the WSI claim handler contact the employer and complete the C97a.	147	76.87
After the initial 90 day action plan was entered, did the claim handler set up a meeting within 7 days of the 90 day action plan event with the claim supervisor and MCM to review the action plan?	104	81.73
Did the claim handler execute an initial action plan for this wage loss claim at 90 days or less?	197	89.85
The subsequent action plans were continually updated every 60 days to reflect current status of the file.	103	77.67
The notes reflect follow up on open action items by the WSI claim handler?	157	95.54
Supervision		

Category/Question	No. of Answers	% Score
Did the Claim Supervisor's documented comments reflect ongoing direction being provided to the adjuster?	177	81.92
Does the claim file reflect evidence of the adjuster's response to the Claim Supervisor's direction?	137	95.62
Has the supervisor's involvement on this file been appropriate?	185	82.16
Communication		
The claim handler maintained adequate communications with the employer?	220	91.82
The claim handler maintained adequate communications with the injured employee.	226	97.35
The WSI claim handler phoned the injured worker at least every 28 days while wage loss payments were being issued to inquire about his/her current medical condition and any return to work issues.	98	85.71
Litigation Management		
The claim handler maintained control, conducted necessary investigation and directed defense counsel activity at the appropriate life of the file.	4	75.00
When warranted the claim handler referred the case, with guidelines, to counsel in a timely fashion.	6	83.33
The claim handler solicited, reviewed, and appropriately acted upon, periodic status reports from defense counsel.	5	100.00
Claims in Audit 317	Audit Total Score:	80.93

Note: Any non-scoring questions (those with an assigned question weight of 0) are not included in this report. The score for each question is the average of all the claim-by-claim scores for that question.

Appendix I

2005 Overall Score by Question

Audit Scoring by Question

Audit State of North Dakota 2008 WC Claim Audit (2005 Losses Only)

Carrier/TPA Self Administered

Coverage Line WC

Date of Review 01/28/2008

Category/Question	No. of Answers	% Score
New Claim Processing		
Once the first report of injury was received, did the claim handler complete the employer, worker and medical forms (C97, C96, and C101)?	120	94.17
Medical Only Claim Processing		
When the medical only claim was received, did the claim handler document there searching of previous claim history to identify any prior claims and locate any possible duplicate claims?	27	100.00
Did the claim handler enter a notepad outlining how the injury occurred, what body part was injured, who the employer is, and outlined the decision reached on the claim within 30 days of receipt by the claim analyst?	27	88.89
If this medical only claim had no activity for a period of 90 days was it automatically closed?	28	96.43
Three-Point Contact		
WSI claim handler made actual contact or reasonable attempts to contact the injured worker within:	119	77.94
WSI claim handler made actual contact or reasonable attempts to contact the employer within:	120	75.83
WSI claim handler made actual contact or reasonable attempts to contact the medical provider (contact with the medical provider can be waived if medical data is in the claim folder and rtw date established) . If there is medical information in the f...	76	76.97
Investigation		
Investigation was...	121	84.30
Once the claim handler determined the claim was compensable, did he/she clearly explain why the claim was compensable and routed the C96, C97 and C101 forms to the claim supervisor for review?	80	88.75
The compensability decision reached by the WSI claim handler was supported by evidence that addressed all issues and documented in the claim file.	118	94.07
If the claim was still pending at 21 days, did the claim handler complete an action plan on the status of investigation and a plan to determine compensability. (A claim supervisor may waive this requirement for a Senior Claims Handler III and Claim ...	26	65.38

Category/Question	No. of Answers	% Score
Field investigation may be warranted in complex /serious injury cases. If a field investigation was warranted, one was completed.	7	57.14
If statements were warranted, they were secured. Statements should be obtained from the employee, the employee's supervisor, and witnesses on: Questionable Claims, history of work related injuries, history of similar injuries/health conditions, emp...	36	16.67
Denied or Withdrawn Claim		
If an injured worker withdrew his/her claim in writing or verbally, did the WSI claim handler send a FL112 and diary the claim for 14 days? If the worker has not reconsidered the claim withdrawl at that time the claim handler will change the status...	2	50.00
Did the WSI claim handler send a FL205 (Not eligible wage loss, less than 5 days of wage), FL206 (Not eligiible wage loss, Dr. has not Verified wage loss), or FL 724 (Deny Disability, narrative), when the decision to deny the wage loss claim was made?	29	100.00
Once the claim handler determined the claim should be denied, did he/she clearly explain why the claim is not compensable and routed the C96, C97, and C101 forms to the claim supervisor for review and approval?	27	70.37
Was the denial of this claim by the WSI claim handler appropriate?	28	85.71
Timeliness of Payments/Overpayments		
For a self employed worker, did the WSI claim handler request a copy of the injured worker's three previous year profit or loss tax forms to determine the average weekly wage.	1	0.00
Per North Dakota state law, was the injured employee off work 5 consecutive days before receiving his/her initial temporary total disability benefits for the first five days of disability?	86	100.00
Did an indemnity overpayment take place on this file and if so, how many? (Place in the comments section the number of overpayments if applicable).	78	89.74
Did the WSI claim handler discontinue the wage loss benefits to the injured worker confined (jailed) in excess of seventy two consecutive hours?	3	100.00
Did a medical overpayment take place on the file and if so, how many? (Place in the comments section the number of overpayments if applicable).	80	92.50
Subrogation/Recoveries		
Subrogation/Recovery potential was recognized and pursued.	12	25.00
Subrogation/Recovery Potential was identified and proper investigation initiated within:	12	25.00
Offsets and/or Apportionments were identified and properly pursued.	2	0.00
Medical/Cost Containment		

Category/Question	No. of Answers	% Score
The WSI claim handler utilized appropriate utilization review for inpatient hospital, physical therapy and chiropractic treatment?	52	94.23
Appropriate supporting medical documentation was consistently secured prior to bill payment.	113	100.00
Were medical bills paid by the claim handler within 30 days of receipt of the bill?	113	71.68
Disability Management		
When appropriate, did the WSI clam handler make a timely referral to a TCM/FCM?	34	85.29
Did the claim handler refer to this case for mandatory medical case management when it was determined this was a wage loss claim?	4	100.00
If the file was not referred to TCM/FCM did the adjuster pursue a release to full/modified duty as soon as appropriate.	50	94.00
If TCM/FCM was assigned, did the claim file reflect appropriate activity was performed to return the injured worker to full/modified duty?	32	96.88
The claim handler appropriately requested and utilized Independent Medical Examinations.	8	87.50
Did the on-site case manager under contract with WSI complete an initial return to work investigation with the employer of injury, provider, and claims analyst within 24 hours of the referral (normal business days)?	34	76.47
Did the claim supervisor approve continued RTW services which exceeded 60 days?	11	72.73
Reserving		
Reserves on this lost time case adequately reflect the current exposure in the file.	19	100.00
Current Reserving is	16	93.75
There is evidence of reserve stair stepping during the life of the file.	88	80.68
Reserve rationale was adequately and consistently documented in the file.	88	82.95
Action Plan		
Prior to entering the initial 90 day action plan in the notepad, did the WSI claim handler contact the employer and complete the C97a.	65	30.77
After the initial 90 day action plan was entered, did the claim handler set up a meeting within 7 days of the 90 day action plan event with the claim supervisor and MCM to review the action plan?	53	45.28
Did the claim handler execute an initial action plan for this wage loss claim at 90 days or less?	75	54.67
The subsequent action plans were continually updated every 60 days to reflect current status of the file.	44	40.91
The notes reflect follow up on open action items by the WSI claim handler?	55	87.27
Supervision		

Category/Question	No. of Answers	% Score
Did the Claim Supervisor's documented comments reflect ongoing direction being provided to the adjuster?	93	78.49
Does the claim file reflect evidence of the adjuster's response to the Claim Supervisor's direction?	70	90.00
Has the supervisor's involvement on this file been appropriate?	97	82.47
Communication		
The claim handler maintained adequate communications with the employer?	107	90.65
The claim handler maintained adequate communications with the injured employee.	109	93.58
The WSI claim handler phoned the injured worker at least every 28 days while wage loss payments were being issued to inquired about his/her current medical condition and any return to work issues.	42	92.86
Litigation Management		
The claim handler maintained control, conducted necessary investigation and directed defense counsel activity at the appropriate life of the file.	2	0.00
When warranted the claim handler referred the case, with guidelines, to counsel in a timely fashion.	2	100.00
The claim handler solicited, reviewed, and appropriately acted upon, periodic status reports from defense counsel.	1	0.00
Claims in Audit 158	Audit Total Score:	78.65

Note: Any non-scoring questions (those with an assigned question weight of 0) are not included in this report. The score for each question is the average of all the claim-by-claim scores for that question.

Appendix J

Combined Answers Summary

State of North Dakota

Answer Summary Report

Audit: State of North Dakota 2008 WC Claim Audit

Carrier/TPA	Coverage Line	Date of Review
Self Administered	WC	01/28/2008

New Claim Processing

	Yes	No	NA	Total Responses
Once the first report of injury was received, did the claim handler complete the employer, worker and medical forms (C97, C96, and C101)?	351	10	0	**361**

State of North Dakota

Answer Summary Report

Medical Only Claim Processing

When the medical only claim was received, did the claim handler document there searching of previous claim history to identify any prior claims and locate any possible duplicate claims?	Yes	No	Not Applicable	**Total Responses**
	69	6	0	**75**
Did the claim handler enter a notepad outlining how the injury occurred, what body part was injured, who the employer is, and outlined the decision reached on the claim within 30 days of receipt by the claim analysist?	Yes	No	Not Applicable	**Total Responses**
	61	14	0	**75**
If this medical only claim had no activity for a period of 90 days was it automatically closed?	Yes,	No	NA	**Total Responses**
	74	1	0	**75**

State of North Dakota

Answer Summary Report

Three-Point Contact

	0-24 hours	24-48 hours	48-72 hours	over 72 hours	Contact not made	Contact not required	Total Responses
WSI claim handler made actual contact or reasonable attempts to contact the injured worker within:	237	37	17	60	7	0	**358**

	0-24 hours	24-48 hours	48-72 hours	over 72 hours	Contact not made	Contact not required	Total Responses
WSI claim handler made actual contact or reasonable attempts to contact the employer within:	242	29	18	62	8	0	**359**

	0-24 hours	24-48 hours	48-72 hours	over 72 hours	Contact not made	Contact not required	Total Responses
WSI claim handler made actual contact or reasonable attempts to contact the medical provider (contact with the medical provider can be waived if medical data is in the claim folder and rtw date established) . If there is medical information in the f...	184	25	16	44	10	0	**279**

State of North Dakota

Answer Summary Report

Investigation

Investigation was...	Completed during 3-point contact phase	Necessary beyond 3-point contact phase	Insufficient / Inadequate	No evidence of investigation	Med only	Total Responses
	223	99	40	2	0	**364**

Once the claim handler determined the claim was compensable, did he/she clearly explain why the claim was compensable and routed the C96, C97 and C101 forms to the claim supervisor for review?	Yes	No	NA	Total Responses
	241	18	0	**259**

The compensability decision reached by the WSI claim handler was supported by evidence that addressed all issues and documented in the claim file.	Yes	No	Not Applicable	Total Responses
	302	20	0	**322**

If the claim was still pending at 21 days, did the claim handler complete an action plan on the status of investigation and a plan to determine compensability. (A claim supervisor may waive this requirement for a Senior Claims Handler III and Claim ...	Yes	No	Not Applicable	Total Responses
	78	13	0	**91**

Field investigation may be warranted in complex /serious injury cases. If a field investigation was warranted, one was completed.	Yes	No	Not Warranted	Total Responses
	9	10	0	**19**

If statements were warranted, they were secured. Statements should be obtained from the employee, the employee's supervisor, and witnesses on: Questionable Claims, history of work related injuries, history of similar injuries/health conditions, emp...	Yes	No	Not Warranted	Total Responses
	21	61	0	**82**

State of North Dakota

Answer Summary Report

Denied or Withdrawn Claim

If an injured worker withdrew his/her claim in writing or verbally, did the WSI claim handler send a FL112 and diary the claim for 14 days? If the worker has not reconsidered the claim withdrawl at that time the claim handler will change the status...	Yes	No	Not Applicable	**Total Responses**
	4	2	0	**6**
Did the WSI claim handler send a FL205 (Not eligible wage loss, less than 5 days of wage), FL206 (Not eligiible wage loss, Dr. has not Verified wage loss), or FL 724 (Deny Disability, narrative), when the decision to deny the wage loss claim was made?	Yes,	No	NA	**Total Responses**
	65	2	0	**67**
Once the claim handler determined the claim should be denied, did he/she clearly explain why the claim is not compensable and routed the C96, C97, and C101 forms to the claim supervisor for review and approval?	Yes	No	NA	**Total Responses**
	61	11	0	**72**
Was the denial of this claim by the WSI claim handler appropriate?	Yes	No	Not Applicable	**Total Responses**
	72	12	0	**84**

State of North Dakota

Answer Summary Report

Timeliness of Payments/Overpayments

	Yes	No	Not Applicable	Total Responses
For a self employed worker, did the WSI claim handler request a copy of the injured worker's three previous year profit or loss tax forms to determine the average weekly wage.	7	4	0	**11**
Per North Dakota state law, was the injured employee off work 5 consecutive days before receiving his/her initial temporary total disability benefits for the first five days of disability?	260	0	0	**260**
Did an indemnity overpayment take place on this file and if so, how many? (Place in the comments section the number of overpayments if applicable).	20	205	0	**225**
	Yes,	No	NA	Total Responses
Did the WSI claim handler discontinued the wage loss benefits to the injured worker confined (jailed) in excess of seventy two consecutive hours?	4	1	0	**5**
	Yes	No	Not Applicable	Total Responses
Did a medical overpayment take place on the file and if so, how many? (Place in the comments section the number of overpayments if applicable).	16	218	0	**234**

State of North Dakota

Answer Summary Report

Subrogation / Recoveries

Subrogation / Recovery potential was recognized and pursued.	Yes	No	Not Applicable			**Total Responses**
	9	25	0			**34**
Subrogation / Recovery Potential was identified and proper investigation initiated within:	0 - 14 days	15 - 30 days	31 - 60 days	Greater than 60 days	Subrogation Not Applicable	**Total Responses**
	13	0	0	18	0	**31**
Offsets and/or Apportionments were identified and properly pursued.	Yes	No	Not Applicable			**Total Responses**
	5	5	0			**10**

State of North Dakota

Answer Summary Report

Medical / Cost Containment

	Yes	No	Not Applicable	Total Responses
The WSI claim handler utilized appropriate utilization review for inpatient hospital, physical therapy and chiropractic treatment?	202	3	0	**205**
Appropriate supporting medical documentation was consistently secured prior to bill payment.	340	3	0	**343**
Were medical bills paid by the claim handler within 30 days of receipt of the bill?	275	67	0	**342**

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Answer Summary Report

Disability Management

	Yes	No	Not Applicable	Total Responses
When appropriate, did the WSI clam handler make a timely referral to a TCM/FCM?	112	11	0	**123**
Did the claim handler refer to this case for mandatory medical case management when it was determined this was a wage loss claim?	11	1	0	**12**
If the file was not referred to TCM/FCM did the adjuster pursue a release to full/modified duty as soon as appropriate.	125	6	0	**131**
If TCM/FCM was assigned, did the claim file reflect appropriate activity was performed to return the injured worker to full/modified duty?	113	3	0	**116**
The claim handler appropriately requested and utilized Independent Medical Examinations.	13	15	0	**28**
Did the on-site case manager under contract with WSI complete an initial return to work investigation with the employer of injury, provider, and claims analyst within 24 hours of the referral (normal business days)?	76	24	0	**100**
Did the claim supervisor approved continued RTW services which exceeded 60 days?	25	16	0	**41**

	Yes	No	Not Applicable (med only)	Total Responses
If the file was not referred to TCM/FCM did the adjuster pursue a release to full/modified duty as soon as appropriate.	125	6	0	**131**

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Answer Summary Report

Reserving

Reserves on this lost time case adequately reflect the current exposure in the file.	Yes	No	Not Applicable			Total Responses
	155	24	0			**179**

Current Reserving is	Appropriate	Excessive	Insufficient to resolve the claim	Too early to assess	Not Applicable	Total Responses
	138	34	6	0	0	**178**

There is evidence of reserve stair stepping during the life of the file.	Yes	No	Too early to assess	NA		Total Responses
	28	240	0	0		**268**

Reserve rationale was adequately and consistently documented in the file.	Yes	No	Too early to assess	NA		Total Responses
	236	33	0	0		**269**

State of North Dakota

Answer Summary Report

Prior to entering the initial 90 day action plan in the notepad, did the WSI claim handler contact the employer and complete the C97a.	Yes,	No	NA	**Total Responses**
	133	79	0	**212**
After the initial 90 day action plan was entered, did the claim handler set up a meeting within 7 days of the 90 day action plan event with the claim supervisor and MCM to review the action plan?	Yes,	No	NA	**Total Responses**
	109	48	0	**157**
Did the claim handler execute an initial action plan for this wage loss claim at 90 days or less?	Yes	No	Not Applicable	**Total Responses**
	218	54	0	**272**
The subsequent action plans were continually updated every 60 days to reflect current status of the file.	Yes,	No	NA	**Total Responses**
	98	49	0	**147**
The notes reflect follow up on open action items by the WSI claim handler?	Yes	No	Not Applicable	**Total Responses**
	198	14	0	**212**

State of North Dakota

Answer Summary Report

Supervision

	Yes	No	Not Applicable	Total Responses
Did the Claim Supervisor's documented comments reflect ongoing direction being provided to the adjuster?	218	52	0	**270**

	Yes	No	Not Applicable	Total Responses
Does the claim file reflect evidence of the adjuster's response to the Claim Supervisor's direction?	194	13	0	**207**

	Yes	No	NA	Total Responses
Has the supervisor's involvement on this file been appropriate?	232	50	0	**282**

State of North Dakota

Answer Summary Report

Communication

The claim handler maintained adequate communications with the employer?	Yes	No	No communication necessary	**Total Responses**
	299	28	0	**327**
The claim handler maintained adequate communications with the injured employee.	Yes	No	No communication necessary	**Total Responses**
	322	13	0	**335**
The WSI claim handler phoned the injured worker at least every 28 days while wage loss payments were being issued to inquired about his/her current medical condition and any return to work issues.	Yes,	No	No communication necessary	**Total Responses**
	123	17	0	**140**

State of North Dakota

Answer Summary Report

Litigation Management

The claim handler maintained control, conducted necessary investigation and directed defense counsel activity at the appropriate life of the file.	Yes	No	Not Applicable	**Total Responses**
	3	3	0	**6**
When warranted the claim handler referred the case, with guidelines, to counsel in a timely fashion.	Yes	No	Not Applicable	**Total Responses**
	7	1	0	**8**
The claim handler solicited, reviewed, and appropriately acted upon, periodic status reports from defense counsel.	Yes	No	Not Applicable	**Total Responses**
	4	1	0	**5**

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