Office of the Ombudsman for Self-Insured Workers

2012 Annual Report

Reporting Period:
July 1, 2011 – June 30, 2012

The Office of the Ombudsman advocates for the rights of injured workers of self-insured employers by providing information, investigating complaints, and taking action to ensure the worker receives the appropriate benefits under industrial insurance law.

Denise McKay, Ombudsman

State of Washington
Office of the Ombudsman for Self Insured Injured Workers
Department of Labor and Industries
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September 25, 2012

The Honorable Chris O. Gregoire
Honorable Members of the Legislature

I am pleased to submit our annual report for the Office of the Ombudsman for Self-Insured Injured Workers. This report provides an accounting of our activities for the period July 1, 2011, through June 30, 2012, along with our recommendations for changes to the system.

We just completed our third full year of operations, and the number of requests for assistance continues to rise. We completed 508 investigations during this time period, a 25 percent increase from the prior fiscal year.

We appreciate the opportunity to serve as advocates for self-insured workers of Washington State.

Respectfully submitted,

Denise McKay

Denise McKay
Ombudsman

Table of Contents

Executive Summary

The Office of the Ombudsman for Self-Insured Injured Workers was established by the 2007 legislature to advocate for the rights of injured workers of self-insured employers. The Ombudsman was appointed by the Governor on January 12, 2009. This report represents our third complete year of operations and covers the period July 1, 2011, through June 30, 2012.

Our Role

The Office of the Ombudsman was created to provide assistance to injured workers of self-insured employers. Through this office, workers have the support and assistance of knowledgeable and effective advocates. Workers contact this office for information on industrial insurance and assistance in resolving issues related to their workers' compensation claims. We work in partnership with self-insured employers, third-party administrators (TPAs), and department adjudicators to ensure the worker receives the appropriate benefits under the law.

Marketing and Outreach

We continue our partnership with labor organizations. We offer educational and training opportunities for their members and staff. In turn, they continue to be a significant source of referrals to this office. Our website offers an overview of our services as well as information on workers' compensation.

Investigating Complaints

During this fiscal year, we completed 508 investigations into complaints filed by injured workers. This number represents a 27% increase as compared to the 2011 reporting period.

We prefer to address worker complaints directly with the self-insured employer or TPA. Working to resolve issues at the lowest possible level, without need for action or intervention by the department, is the most efficient method of complaint resolution. Pursuant to Revised Code of Washington (RCW) 51.14.350, if a resolution cannot be achieved with the employer or TPA, a referral is made to the department for independent review and action.

Structured Settlements

Effective January 2012, the law provides an option for workers to enter into a structured settlement agreement to resolve claim issues and/or certain benefits. Injured workers of self-insured employers who are not represented by legal counsel have the option to request this

office provide technical assistance or be present during negotiations. Informational materials explaining the structured settlement process and clearly identifying our role are available through our office and are posted on our website. We anticipated a number of questions or request for assistance; however, that was not the case. Since the law was implemented in January, we've received fewer than 10 inquiries from workers requesting information about structured settlements.

Stay of Benefits

RCW 51.52.050 states that an order by the department awarding benefits shall become effective and benefits due on the date issued. If the department order is appealed, the order can be stayed pending a final decision only by order of the Board of Industrial Insurance Appeals (BIIA). Absent a stay, the department or self-insured employer is required to pay those benefits.

Several workers contacted our office to report the self-insured employer or TPA refused to pay benefits after a stay was denied by the BIIA. We will continue to track and report all complaints reported through our office; however, the total number of workers affected is unknown.

Recommendations

Pursuant to RCW 51.14.400, this office is tasked with identifying deficiencies in the workers' compensation system, and making recommendations for improvements to the system. In making these recommendations, we recognize the great majority of self-insured employers adjudicate claims appropriately. Our role is to ensure all injured workers receive the appropriate benefits, and make recommendations based upon our findings.

Our previous annual reports noted late payment or non-payment of medical bills as a significant concern for workers. When medical bills are not paid, it can be very difficult for an injured worker to find a provider willing to treat them. When unpaid medical bills are referred to a collection agency, it causes undue stress to the worker's personal finances, and negatively affects their credit.

We continued to receive the same complaints from workers. One in 10 investigations continues to involve complaints related to late payment or non-payment of medical bills. Based upon the number of complaints reported over the past three years, we recommend changes to the law or rule to require the timely payment of injury-related medical bills.

Office of the Ombudsman for Self-Insured Injured Workers

The Office of the Ombudsman advocates for the rights of injured workers of self-insured employers by providing information, investigating complaints, and taking action to ensure the worker receives the appropriate benefits under Washington state industrial insurance law.

Authority

RCWs 51.14.300 through 51.14.400 provide the authority and govern actions of the Office of the Ombudsman for Self-Insured Injured Workers. The current Ombudsman was appointed by the Governor on January 12, 2009, and serves a six-year appointment.

Key Features of the Law

The following components of the law guide our actions, grant our authority to act, and protect the confidentiality of workers.

Independence

The Ombudsman reports to the Director of Labor and Industries; however, the office operates independently from the agency.

Powers and Duties

The statute directs the Ombudsman to advocate for injured workers by:

- Providing information on industrial insurance
- Investigating complaints
- Facilitating resolution
- Referring complaints to the department when appropriate

Confidentiality

The legislature recognized the importance of worker confidentiality. Under the protection of RCW 51.14.370, workers may contact our office for help with the understanding that their information will not be disclosed without their consent.

RCW 51.14.370 *All records and files of the ombudsman relating to any complaint or investigation made pursuant to carrying out its duties and the identities of complainants, witnesses, or injured workers shall remain confidential unless disclosure is authorized by the complainant or injured worker or his or her guardian or legal representative. No disclosures may*

be made outside the office of the ombudsman without the consent of any named witness or complainant unless the disclosure is made without the identity of any of these individuals being disclosed.

Structured Settlements

Effective January 2012, changes to workers' compensation law allow eligible workers to initiate a resolution of claim issues and/or benefits through a structured settlement process. The law also provides injured workers of self-insured employers who are not represented by legal counsel the option to request that the Ombudsman provide technical assistance or be present during negotiations. Informational materials were developed to explain the structured settlement process and clearly identify our role. This information is also available on our website.

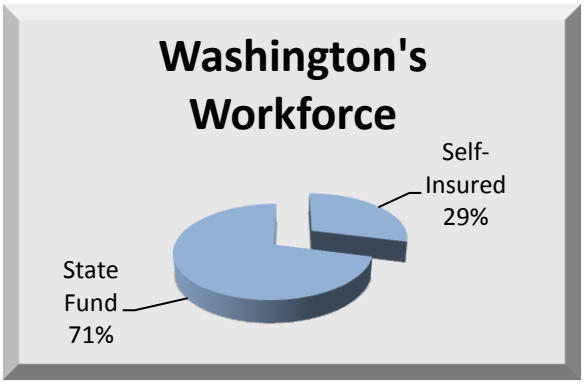
To date, we've received less than 10 calls from injured workers regarding the structured settlement process.

Staffing

The Ombudsman Program is funded by self-insured employers as part of their annual administrative assessment. The 2007 enabling legislation provided for an ombudsman and three additional staff, and allows for additional staffing adjustments based on workload demands. The office is currently fully staffed with an ombudsman, two workers' compensation adjudicators, and a customer service specialist. Even though we experienced a significant increase in the number of investigations, this staffing level is currently adequate to respond to the needs of our customers in a timely manner.

Self-Insurance in Washington

Self-insurance is an alternative method of providing workers' compensation coverage for some of Washington's largest employers. Under this option, the employer provides industrial insurance benefits to the injured worker.



There are 362 active self-insured employers in Washington. Self-insured companies employed over 854,000 workers in 2011. Self-insured employers provide workers' compensation benefits to approximately three out of every 10 workers in this state.

Labor and Industries has regulatory authority over the provision of benefits. The department is responsible to ensure compliance with the law and reviews the financial strength of the self-insurer to ensure that workers' compensation obligations can be met.

L&I's self-insurance staff assists and trains self-insured employers on the application of Washington's workers' compensation laws. The department provides policy and performs audits to determine if claims are managed in accordance with laws, rules, and policy.

What are the basic requirements to qualify for self-insurance?

- Firm must be in business for at least three years
- Firm must have total assets of at least $25 million
- Firm must have a written accident prevention program that has been in place in Washington for six months prior to applying to self-insurance
- Current financial ratio (current assets divided by current liabilities) must be at least 1.3 to one
- Debt to net worth ratio cannot be greater than four to one
- Firm must have positive earnings in two of the last three years (including current year being positive) and overall positive earnings for the three-year period

What types of businesses choose to self-insure?

Self-insured employers represent all major industry groups, and include some of the largest public and private employers in this state. These employers do business in approximately 15,000 locations throughout Washington.

Who manages the self-insured claims?

Self-insured employers may elect to self-administer their claims or contract with a TPA to manage the claims. During this reporting period, 93% of the active self-insurers contracted with a TPA to manage their industrial insurance claims. Approximately 55% of self-insured employers use a TPA with an out-of-state location to manage Washington claims.

What percentages of industrial insurance claims are filed by self-insured workers?

During 2011, 44,515 claims were filed by self-insured injured workers. This number represents approximately one-third of all industrial insurance claims filed in Washington during calendar year 2011.

What benefits are provided to injured workers?

Whether a company is self-insured or covered through the State Fund, all Washington workers are entitled to the same level of workers' compensation benefits.

Those benefits may include:

- Treatment for a work-related injury or illness paid for by the workers' compensation system.
- Benefits to partially replace lost wages if the injury or occupational disease prevents the worker from working.
- Vocational assistance if the worker qualifies to be retrained in order to be employable.
- Partial disability benefits to compensate for the permanent loss of bodily function.
- A disability pension if the worker is permanently disabled from any gainful employment.
- Death benefits for survivors if the worker dies as the result of an industrial injury or disease.

How does the department ensure self-insured employers are in compliance with industrial insurance law, rules and regulations?

L&I's Self-Insurance Section conducts audits of all self-insured employers to determine whether they are complying with laws governing workers' compensation. Employers may be subject to penalties for non-compliance.

What is included in an audit?

An emphasis is placed on timeliness and accuracy of benefits delivered to injured workers and on proper reporting requirements. Records are examined to ensure total claim costs and worker hours were accurately reported. Claims are reviewed for compliance with workers' compensation laws and regulations. The auditor will review 70 claims consisting of a combination of time-loss, medical only,

rejected claims, and claims with reopening applications. For smaller self-insured employers, this may result in an audit of all claims filed during the audit period. For larger employers, this sample size may represent a very small percentage of total claims filed.

How often are audits conducted?

The department audits both active self-insured and inactive self-insured employer with open claims. There are 362 active self-insured employers in this state, as well as 67 inactive employers subject to audit. Under department rules, the goal is to audit every three years. The average audit cycle for fiscal year (FY) 2011 was 5.2 and FY 2012 was 4.8 years. The department currently has nine auditors to complete this work.

What happens after an audit?

The employer is provided a report of the auditor's findings. If compliance issues were identified, the employer is given directives to bring the areas into compliance. The employer is given 60 days to provide a written response to the auditor's report. The department may issue penalty violations for the delay of benefits to injured workers or violations of the WAC.

The Ombudsman's Office

The Office of the Ombudsman is an advocate for the rights of injured workers of self-insured employers. We provide information, investigate complaints, and take action to ensure workers receive the appropriate benefits under Washington's industrial insurance laws. We track complaints received, document outcomes, and analyze the data from a trending perspective. This information is used to make recommendations to improve to the system.

Putting the Customer First

This office seeks to provide a high level of service to self-insured workers in this state. Providing a timely response to worker inquiries is a top priority. Workers' compensation laws and regulations are complicated, and often confusing to workers. We strive to ensure workers understand the process.

Outreach

A brochure outlining the functions of the program is available and distributed to employers and labor organizations. Information about our program is included in the worker's *Guide to Industrial Insurance Benefits,* and our contact information is printed on worksite posters.

Labor organizations are strong supporters of the program. In fact, 30% of workers contacting our office indicate they were referred by their union.

We are often invited to attend labor conferences and meetings. Attendance at these events offers the opportunity to meet with their business staff and union members, provide an overview of our program, and share information about worker's compensation.

Resources for workers

Our website offers information about the office, and provides contact information and links to other resources for workers. Our *Frequently Asked Questions* section provides answers to commonly asked questions from injured workers. Our web address is: ombudsman.selfinsured.wa.gov.

Responding to Worker Issues

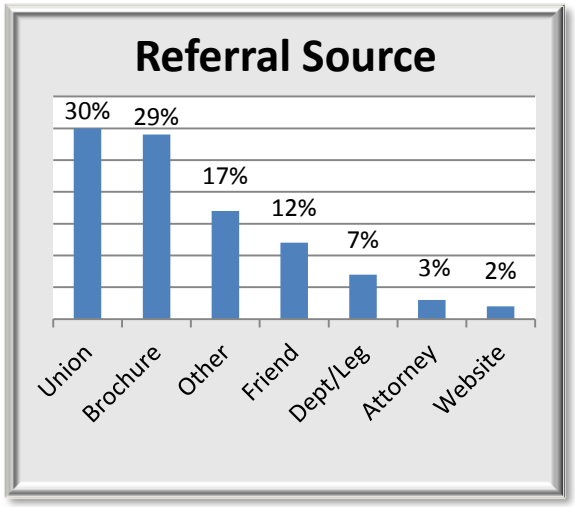
The chart to the right shows the breakdown by referral source for workers contacting our office during the past fiscal year.

Referrals from unions and our brochure continue to be the most frequent source of referrals to this office. The chart reflects the distribution of reported referral sources only.

Workers contact this office for a variety of reasons. Some are looking or for general information about workers' compensation, while others need help with to resolve claim issues.

When a worker contacts our office, we conduct an intake evaluation to identify the issues and determine the best course of action.

Our goal is to resolve their complaint as quickly as possible. While some issues can be resolved with a simple explanation or phone call, others require further investigation. It is important the worker understands the process and knows what to expect during the process. We maintain contact with the worker and involve them in both the investigation and resolution process.



The Investigation Process

The time it takes to complete an investigation can vary from a few days to several months, depending on the complexity of the issues and the time it takes to obtain and review the necessary claim file information. Claim files are maintained by the self-insured employer or TPA. By law, they have 10 working days from the date they receive a written request to provide a copy of the claim file.

The best method to resolve a worker inquiry or complaint is directly with the self-insured employer or TPA. Issues are resolved much faster as they have the authority to pay time-loss benefits and authorize medical treatment. We encourage the worker to maintain communication with their employer and self-insured claims manager throughout the claims process.

The Referral Process

We first attempt to resolve the worker's issues with the self-insured employer or TPA; however, we are not always successful. In those instances, we make a formal referral to the department for their review and action. The department conducts a thorough review of the claim information and makes an independent adjudicative decision based upon their analysis of the claim. A summary of the action taken by the department is provided to the Ombudsman's Office.

Worker Confidentiality

Workers rely on the confidentiality of this office. Some workers are reluctant to ask for help and express concerns of retaliation if it were known they contacted our office for assistance.

RCW 51.14.370 protects the confidentiality of Ombudsman records and files. It states that all records and files of the Ombudsman relating to any complaint or investigation made pursuant to carrying out its duties and the identities of complainants, witnesses, or injured workers shall remain confidential unless disclosure is authorized by the complainant or injured worker or his or her guardian or legal representative. No disclosures may be made outside the Office of the Ombudsman without the consent of any named witness or complainant unless the disclosure is made without the identity of any of these individuals being disclosed.

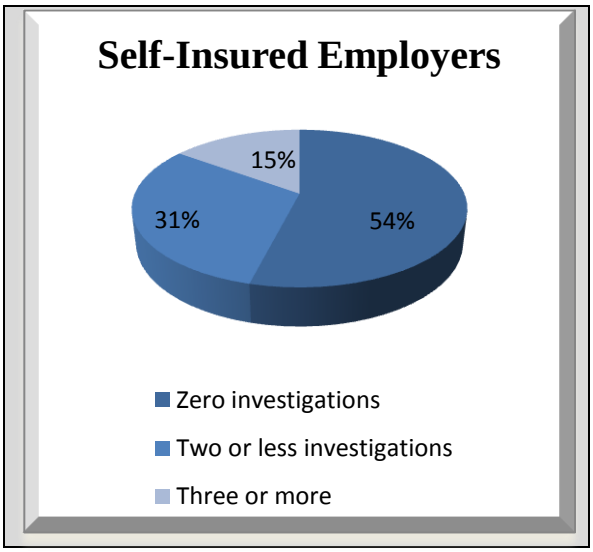
Reporting

The self-insured ombudsman data system is used to capture and report information on investigations. The system tracks investigations by:

- Employer
- TPA
- Referral source
- Issues
- Resolution

This information is used to identify trends or patterns in complaints filed by injured workers.

Completed Investigations



During this reporting period, we completed 508 investigations from workers employed by 166 self-insured employers.

The majority, 54%, of the 362 active self-insured employers did not have any complaints filed which warranted an investigation.

Distribution of Investigations

As in 2011, the majority of investigations completed during this reporting period involved only a small percentage of the total number of self-insured employers. During this reporting period, approximately 54% of self-insured employers did not have any investigations; another 31% had one or two.

Number of Investigations	2012 (362)	2011 (361)	2010 (366)
Zero investigations	196	233	243
1-2 investigations	111	86	98
3	19	16	9
4-5	17	9	7
6-9	11	10	4
10-14	4	4	3
17-19	1	2	0
23-25	0	0	2
27-29	2	0	0
33	0	1	0
40	1	0	0

Resolving Complaints

A self-insured employer may elect to self administer their industrial insurance claims or contract with a TPA to manage their industrial insurance claims. In either case, it is the self-insured employer that holds the self-insured certificate and is held responsible to ensure claims are managed in accordance with Washington's industrial insurance laws.

Approximately 93% of the total number of self-insured employers contract with a TPA to manage their worker' compensation claims. The Department of Labor and Industries is not authorized to regulate TPAs. Self-insured employers are held responsible for the management of their claims.

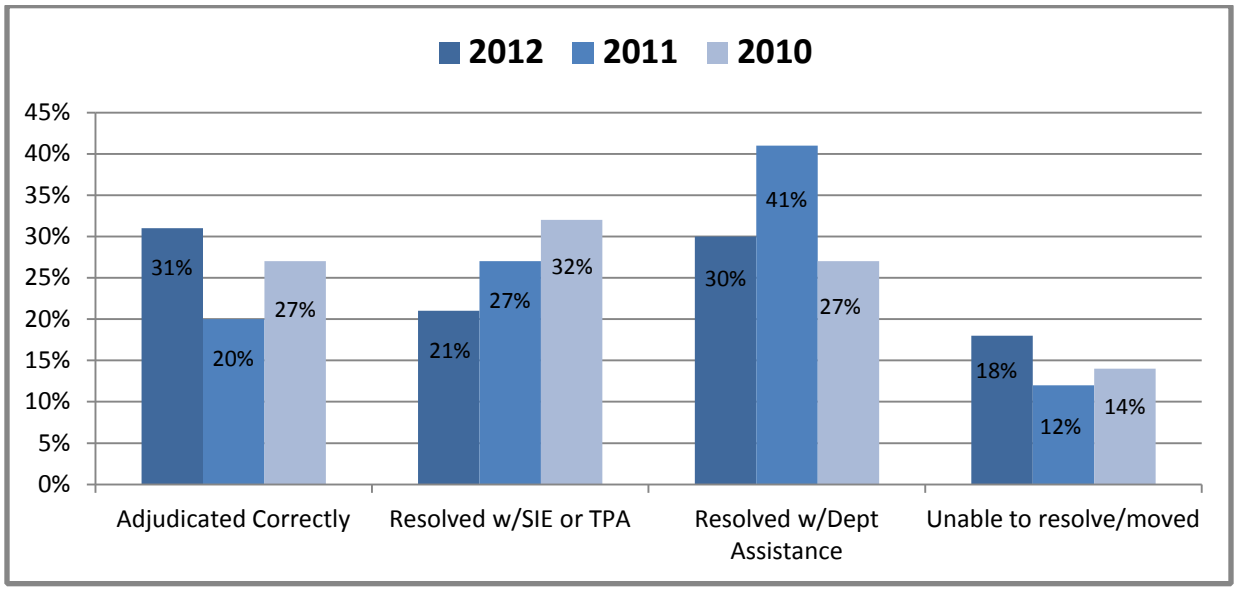
The preferred method to resolve a complaint is to work directly with the self-insured employer or TPA. Working directly with the claims administrator allows for a quick resolution. Necessary changes to worker benefits or treatment authorizations can be immediately implemented.

We completed 508 investigations during this reporting period. The following two charts compare the number of investigations by fiscal year, as well as the method of resolution by percentage for investigations completed during FY 2012, FY 2011, and FY 2010.

Resolution Profile			
	2012 (508)	**2011 (400)**	**2010 (289)**
Claim Adjudicated Correctly	156	81	77
Resolved with Employer / TPA	108	106	92
Resolved with the assistance of the Department	153	164	78
Unable to resolve or moved out of our jurisdiction	91	49	42

Of the 261 cases that were successfully resolved, 41% were resolved with the self-insured employer or TPA and 59% were resolved with the assistance of the department.

This table compares the outcomes for all completed investigations over the past three fiscal years.



Explanation of Terms

Claim Adjudicated Correctly

Based upon the results of our investigation, we felt the claim was adjudicated correctly. The percentage of complaints this office determined to be adjudicated correctly is based upon the number of complaints we investigated. This data should not be used to make general assumptions or interpretations as to the accuracy of self-insured claims adjudication as a whole.

Unable to Resolve/Out of Jurisdiction

This represents the percentage of complaints we are unable to successfully resolve. This category also includes claims in which a final order was issued or an appeal filed with the BIIA. If a final order has been issued or an appeal filed at the BIIA or through the court system, the department no longer has jurisdiction over that issue.

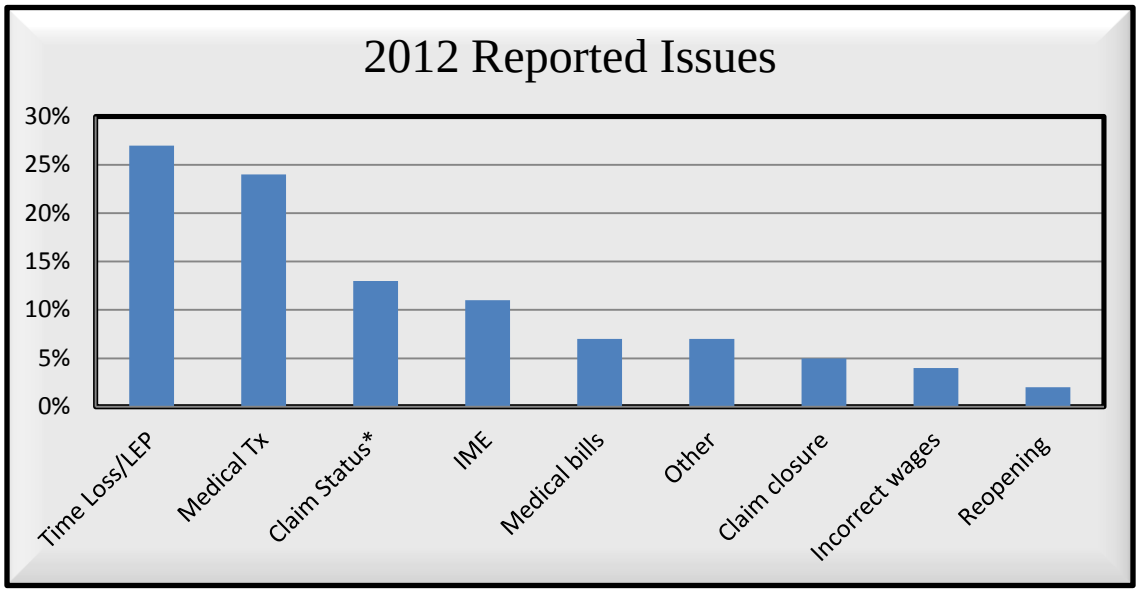
Issues

Frequently Reported Issues

The majority of complaints we receive involve more than one claims-related issue. The numbers in the following chart are expressed as a percentage of the total number of issues reported by workers during the fiscal year. Four of the top five categories remain the same as reported during the past two years. The top five categories represent 82% of the total number of issues reported by workers during the past fiscal year.

The top five categories are:

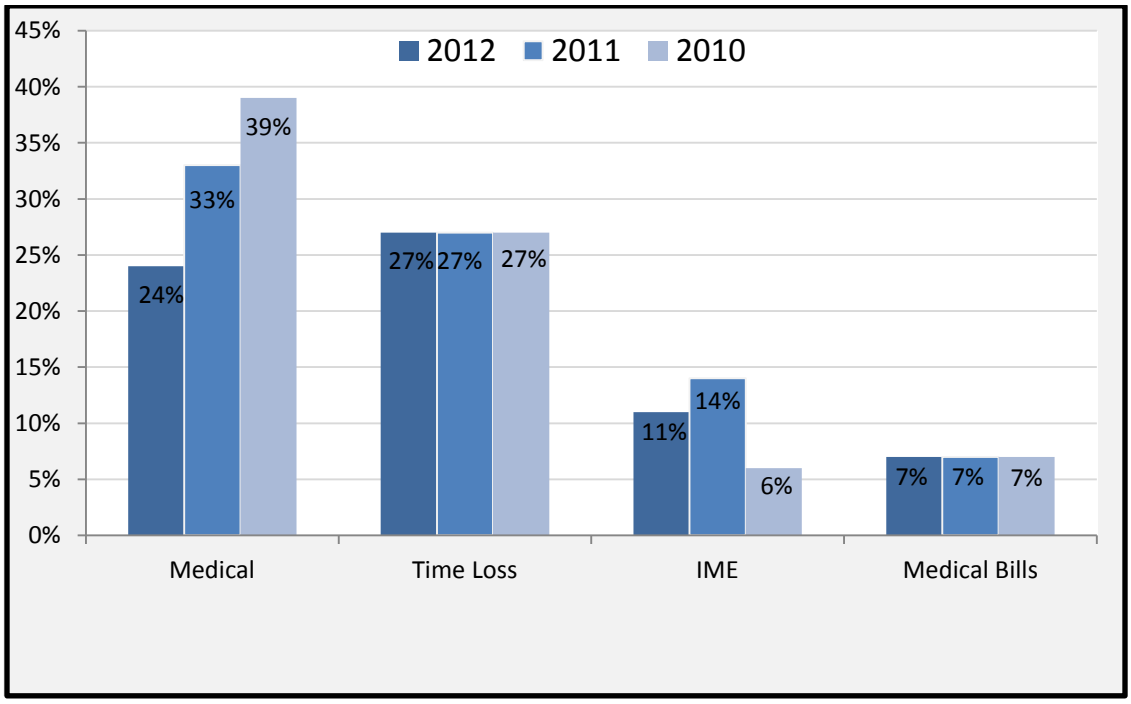
- Delayed or denied time-loss or loss of earning power (LEP) (27%)
- Delayed or denied medical treatment (24%)
- Claims status: provisional/rejected (13%) * new
- Complaints related to independent medical exams (IMEs) (11%)
- Non-payment or late payment of medical bills (7%)



Comparison of Reported Issues

This table shows the comparative distribution of the top categories for the 2012, 2011, and 2010 reporting periods. The numbers are reflected as the percentage of the total number of issues reported during each fiscal year. As most of the investigations involved more than one issue, it is important to note there is not a 1-1 relationship between the number of reported issues and the number of completed investigations.

The relative percentage of issues in the medical category decreased while issues relating to time-loss and medical bills remained constant over the three reporting periods.

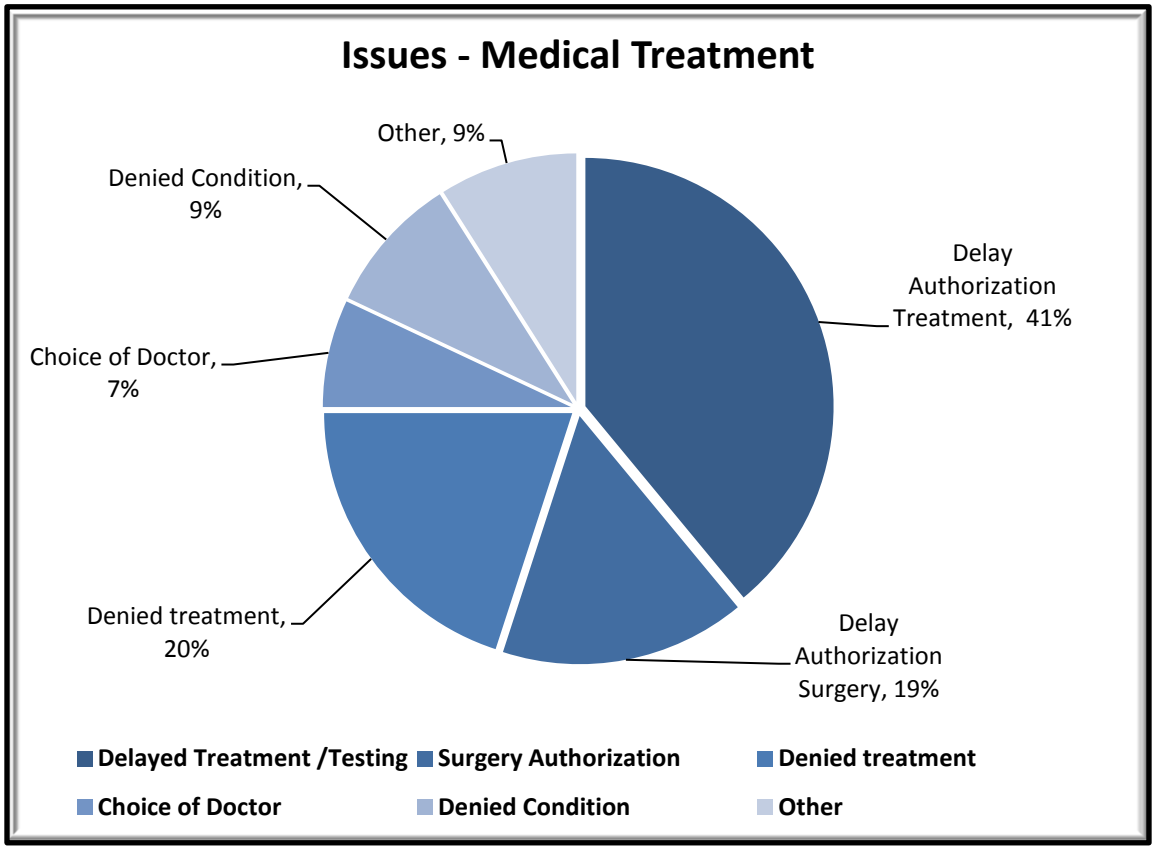


Medical Treatment: Frequently Reported Issues

In the two prior reporting periods, this was the most commonly reported general issue category. This year, it falls to second behind time-loss compensation as the most common complaint reported by injured workers.

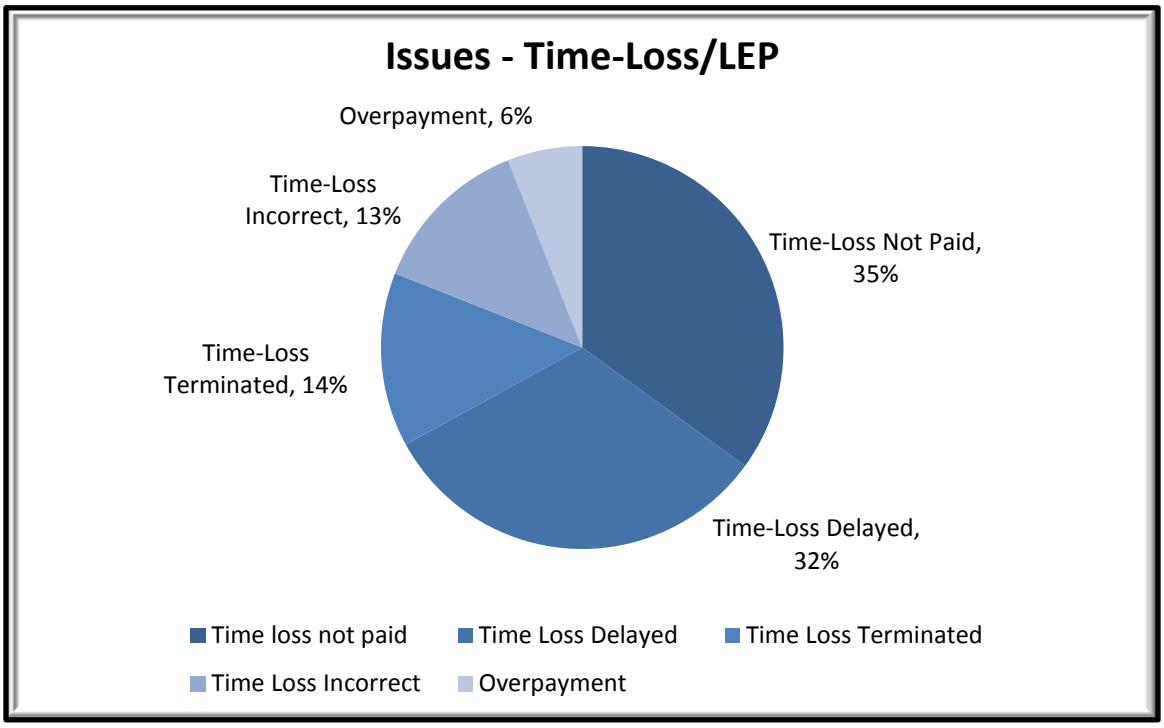
Issues relating to medical treatment are broken down and tracked by more specific complaints within the category. A breakdown of those complaints is reflected in the chart below.

The most common issue in the medical treatment category involved a delay in the authorization of medical treatment, testing, or surgery. Workers express both frustration and concern, reporting these delays are hindering their recovery, resulting in a less than optimal outcome. This year we had a significant increase in the number of calls from attending physicians and other providers relaying their frustration in trying to obtain authorization to treat their patients.



Time-Loss/LEP: Frequently Reported Issues

This year, time-loss issues were the most commonly reported complaint reported by workers. Workers rely on time-loss compensation as partial wage replacement while they are unable to work due to an industrial injury. Any delay in payment can cause significant hardship for the worker.



IMEs: Frequently Reported Issues

The number of complaints involving IMEs rose during FY 2011 to 14% of the complaints. It decreased slightly this year to 11%.

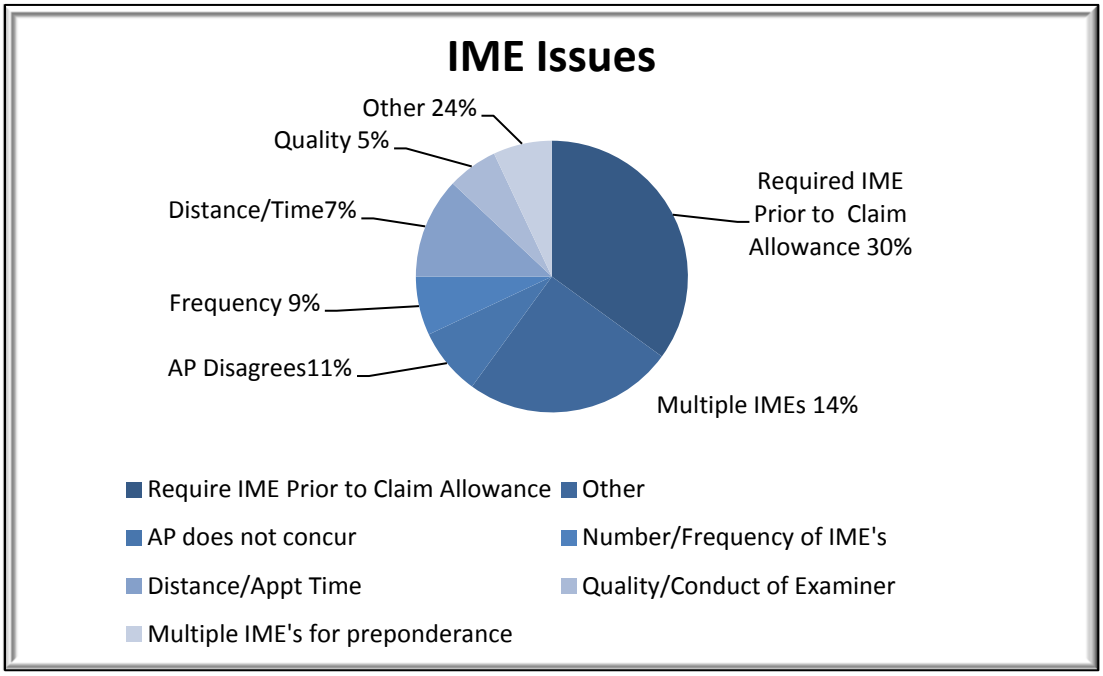
The most commonly reported complaint remains constant over both time periods. Workers are reporting their self-insured employer or TPA would not make an allowance determination on their claim until the worker attended an IME.

Until the claim is allowed, the self-insured employer or TPA is not required to pay for medical treatment. Many months can pass from the date the workers' compensation claim is filed and the completed IME report is received and processed by the self-insured employer or TPA. It is not unusual for the workers to report waiting more than six months for an allowance determination. During this time period, the worker is not covered for any treatment, and many

do not have the funds to self-pay. In general, most private insurance plans will not cover injury-related treatment unless/until the claim is rejected.

In cases where the self-insured employer or TPA does not have enough information to make an allowance determination, it is appropriate to schedule an IME as part of the information-gathering process. If the claim was filed with sufficient evidence to support that the worker's medical condition was caused by the workplace incident or exposure, the claim should be allowed. Three requirements establish a case for injury claim allowance: a descriptive statement that satisfies the legal definition of an injury, the worker must have been acting in the course of employment, and a medical opinion must relate the condition diagnosed to the incident or exposure on a more probable than not basis.

If our investigation shows the requirements were met, a referral is made to the department for to review for claim allowance.



Medical Bills

Non-payment or late payment of medical bills is a continual source of concern and complaint from workers. Although these complaints represent only 7% of the total number of issues reported, approximately one in 10 of our investigations involved complaints relating to the payment of medical bills.

Issues-Medical Bills	2012	2011
Bills sent to collections	14	9
Medical bills denied	19	17
Medical bills not paid within 60 days	16	23
Total	49	49

During this reporting period, 14 workers reported they were sent to collections for unpaid bills on allowed claims. The stress it causes the worker, in addition to the time and effort required to rectify their credit status, is significant. Most workers do not have the ability to pay from private resources. Their private insurance will not cover treatment for an industrial injury or disease. A number of workers report they cannot obtain treatment because their provider bills were not paid. This delays recovery and can affect their ability to return to work.

We also received a number of contacts from providers who expressed frustration in trying to collect their billings. They were referred to the department's Self-Insurance Program for assistance.

Our current recourse is to make a referral to the department to issue an order directing payment. Sometimes this is not enough. There are no statutory provisions or regulations to enforce compliance or assess specific penalties against an employer for non-payment of late payment of medical bills.

Case Scenarios

The following case scenarios are representative of common issues reported by injured workers during the past year.

Authorization for diagnostic testing

A worker contacted our office indicating he had a frozen shoulder and was very concerned as his condition was worsening. His attending doctor felt a MRI was necessary. Despite numerous calls and faxes to the claims manager, the doctor was unable to secure a response to their request for authorization. We facilitated a conference call with the doctor's office and the TPA which resulted in the authorization of the testing procedure.

Authorization for Surgery

The IW called our office indicating her claims manager would not authorize surgery. Her doctor diagnosed a ligament tear in her wrist caused by a lifting injury and requested an arthroscopy March 2012. The worker contacted our office the end of April 2012 as the TPA had not responded to the doctor's request for the surgery. The injured worker wanted to have the surgery as soon as possible so she could go back to work. Our office contacted the TPA claims manager. After a discussion about the claim and the need for the surgery, the claims manager agreed to authorize the surgery. This was a successful resolution as the worker was able to proceed with the surgery and return to work.

Delay of Benefits

This worker suffered an injury to his back in July while lifting a heavy piece of equipment. The injury was witnessed and reported timely. His employer hires workers and then contracts their services to other employers. As a temporary employee, he was not offered any further jobs. When the worker inquired about filing a claim, he was told he did not have workers' compensation coverage. He continued to question coverage, and after several months and many calls to the employer's out-of-state headquarters, he finally reached someone who gave him a claim form. The claim was filed five months after the injury because he was unable to obtain a claim form from the employer. This employer contracts with a TPA to manage their claims. The TPA refused to pay time-loss or allow the claim because it was filed late. We requested department intervention. The department issued orders to allow the claim, ordered the TPA to pay time-loss, and penalized the employer for a delay in paying time-loss. The employer waited until the last possible day to protest those orders, while still refusing to pay

benefits. Fourteen months after the date of injury, no time-loss or medical benefits have been paid on this claim. This is financially devastating to the family. He was forced to seek financial and medical assistance from other state agencies.

Worker Sent to Collections

A call from a collections agency prompted this worker to contact our office for assistance. A medical bill was not paid by the TPA and the provider referred the bill to a collection agency for payment. Calls to the provider and the TPA resulted in the payment of the medical bills, and removal of the collection action.

Delay of Medical Treatment

During the January snowstorm, this individual slipped and fell injuring her low back. She was able to continue working at modified duty. The claim was allowed and her attending doctor prescribed physical therapy for her low back injury. The physical therapist contacted the TPA and was told the treatment was not authorized. The physical therapist would not provide treatment after learning the bill would not be paid. According to medical aid rules, the first 12 physical therapy treatments do not require authorization. The treatment should be covered. This worker did not have other insurance coverage or the financial ability to pay for this treatment on her own. After several unsuccessful attempts to work with the TPA, a referral was made to the department for assistance. Two separate orders were issued directing the authorization for the treatment. Eight months after the injury, and only after department intervention, was the worker was finally able to start treatment. The worker is extremely upset at this unreasonable delay in treatment. She feels her injury would have resolved months ago if she was able to proceed with recommended treatment. Unfortunately, this injury has had a significant impact on her personal life and her ability to perform normal daily activities, including ability to adequately care for her home.

Incorrect Wages

This worker called for general information about time-loss calculations. In discussing his claim, it was noted he regularly worked in excess of 40 hours per week. His time-loss compensation rate did not include his overtime hours, and he had a significant underpayment for a period of time. A call was made to his claims manager. After a brief discussion, the compensation rate was corrected and an adjustment payment was promptly mailed to the worker.

Denied Medical Condition - Worker Sent to Collections

This individual was long-term, award-winning salesperson for a major retailer. She injured her hip twisting and moving a heavy item. She filed a claim for the injury and continued to work, but experienced steadily increasing pain in her hip. She had a cortisone injection into the hip to relieve the pain. This had the opposite effect and soon she was ill and in excruciating pain. Her inability to bear weight on that hip caused her to fall, shattering her wrist and elbow. She was rushed to the emergency room where it was determined she was also septic from a necrotic infection in her hip. Due to the infection, they were unable to adequately treat the fractured wrist. Ultimately, it was determined the necrosis was a result of the steroid injection. She spent the next four months in and out of the hospital and nursing homes. She was so ill from the infection she was unable to walk or care for herself. She called our office after she was sent to collections. The self-insured employer refused payment for any treatment or medical bills, despite the medical evidence and requests from numerous medical specialists. No contrary medical evidence was ever presented. We made a referral to the department, who responded by issuing orders to pay for her treatment. Months after the orders were issued; the SIE began paying the medical bills.

We also worked with her to contact her providers to halt the numerous collections processes against her. While she has not fully recovered, and will require additional surgery, she has returned to work on a part-time basis.

Unpaid Medical Bills

A physician on his way to care for a patient fell into an uncovered/unmarked utilities access panel in a hallway floor. The doctor fell into the 44-inch deep hole, landing across a beam, injuring his knee and back. The knee injury demanded immediate attention and required the physician to undergo a total knee replacement. He continued to experience worsening back symptoms and eventually required two surgical interventions for a herniated disc. The TPA refused to pay for any treatment for his back, despite the fact there was medical opinion supporting the causal relationship and need for surgery to his fall. Fortunately, this injured worker had the personal resources to proceed with the necessary surgery to avoid long-term neurological damage. The TPA refused to pay for the treatment, so a referral was made to the department for assistance. In response, the department issued an order in March 2012 directing the TPA to accept the back injury and pay for the surgeries. That order is final. The TPA made only partial payments and a second order was issued by the department to pay for the surgeries and interest on the unpaid balances. The neurosurgeon submitted the bill for payment on three separate occasions. As of August 2012, the TPA still had not paid the bills for all of the ordered treatment.

If an injury is caused by the actions of a person or entity other than the employer, a third-party claim can be filed. The self-insured employer will recoup their expenses paid on a claim from monies awarded to the worker on the third-party recovery. In this case, the utilities access hole was left uncovered by a contractor. The worker filed a third-party action against the contractor for damages, and an award is pending. The employer's failure to pay the bills has held up the resolution of the third-party claim as the action cannot be finalized until the claim costs to date are known.

Pay During Appeal

All orders issued by the department have protest and/or appeal language. Protests are under the jurisdiction of the Department of Labor and Industries. If the order is appealed, the jurisdiction over issues addressed in the order moves from the department to the BIIA. The time period from the filing of the appeal with the BIIA to a final resolution is a lengthy process, and is known to take up to two years. The average time to resolution on contested appeals for self-insured claims is over one year, with an average of 60 weeks.

Prior to June 12, 2008, during the appeal process, the worker was not entitled to receive benefits associated with the order on appeal. For example, if the order on appeal allowed the claim, no medical or time-loss would be paid. If the order was to approve time-loss or medical treatment, no time-loss or medical bills would be paid pending the final outcome of the appeal.
This created significant hardships for injured workers. The legislature recognized the impact on injured workers, passing a bill during the 2008 session to address this issue. RCW 51.52.050 states that an order issued by the department awarding benefits shall become effective and benefits due on the date issued. If the department order is appealed, the order can be stayed pending a final decision only by order of the BIIA. If the stay of benefits is denied, an employer may appeal the BIIA decision to Superior Court. Absent an order granting the stay, the employer is required to pay benefits pending the outcome of the appeal.

If the employer prevails on appeal, they can seek reimbursement from the worker. Any financial risk to the self-insured employer is mitigated, as in the event the employer is unable to collect from the worker, they can be reimbursed from a fund created specifically for this purpose. RCW 51.44.142 established a self-insured employer overpayment reimbursement fund. This fund was paid for entirely by self-insured injured workers, not self-insured employers. Expenditures from this fund can be used to reimburse self-insured employers for benefits overpaid during the BIIA or court appeal process. To date, this fund has not been tapped.

Several workers contacted our office to report their employer refused to pay benefits during the appeal process, even though a stay order was not granted by the BIIA. Our ability to assist those workers is limited to helping the worker request a delay of benefits penalty.
During an appeal, the employer is represented by legal counsel, and we cannot contact the employer directly.

Stay of Benefits Denied- Refusal to Pay Benefits

This worker was a delivery driver for the same employer for 22 years. He injured his knee in March 2011, and the department issued an order allowing the claim. Over the next several months it was a continual battle to obtain authorization for medical treatment. On November 23, 2011, the worker was examined by an IME doctor who indicated he had no restrictions from this injury and could return to his job. Contrary to the opinion of his attending doctor, time-loss benefits were terminated November 23, 2011, by the TPA. Following this action, his employer terminated his employment because he could not perform his job without restrictions. The department issued an order directing the self-insured employer to pay time-loss from November 24, 2011, forward. The employer appealed the order, and requested a stay of benefits from the BIIA. The stay was denied by the BIIA. The self-insured employer still refused to pay benefits to the worker. We helped the worker request an order for a delay of benefits penalty. Even after the penalty was issued, the employer continued to refuse to pay benefits.

During the mediation process at the BIIA, the worker hired an attorney and only after doing so did the self-insured employer pay the benefits due. A worker should not have to hire an attorney to receive ordered benefits. This individual was without benefits for seven months. When benefits were finally paid, the worker reported that 30% of the amount paid went to legal fees. The pay during appeal legislation was specifically implemented to avoid financial hardship to the worker during the appeal process.

Stay of Benefits Denied- Refusal to Pay Benefits

The self-insured employer appealed an order canceling the closure of a claim. The department issued two orders directing the employer to pay a significant period of back time-loss and to reinstate time-loss. The employer appealed the department orders. The employer's request for a stay of benefits was denied on January 9, 2012, by the BIIA. The employer did not appeal the denial to Superior Court. As the stay of benefits was denied, the self-insured employer is required by statute to continue benefits as ordered.

The employer, through their legal counsel, refused to pay benefits. In June 2012, an attorney from the Office of the Attorney General convinced the self-insured employer to follow the stay order and pay the back time-loss. A check was issued paying time-loss for the period January 2011 through June 2012. This worker was without income for almost a year and a half, resulting in extreme hardship for him and his family.

The worker contacted our office in June 2012. We assisted the worker in filing a request for a delay of benefits penalty. The department issued a penalty order against the employer for delay of benefits in the amount of $15,626.

Self-Insured Ombudsman Workgroup

The Ombudsman Workgroup meets twice annually to talk about issues reported to the Ombudsman's office by injured workers and discuss potential solutions. The membership consists of two representatives from the labor community, two representatives from the self-insured employer community, the program manager for the department Self-Insurance Program, and the Ombudsman.

The current members include:

Matt Webby	Teamsters #174
Rebecca Johnson	Governmental Affairs Director - Washington State Labor Council
Kelly Early	Manager of Claims - ESD 113
Rebecca Forrestor	Risk Manager Group Health Cooperative
Natalee Fillinger	Dept. of Labor and Industries - Program Manager - Self-Insurance
Denise McKay	Ombudsman for Self-Insurance Injured Workers

Observations and Tips

If the Ombudsman's Office notes an increase in a specific issue or concern reported by workers, we want to share this information with the self-insured community. If those concerns involve a breach of rule or policy, we partner with the Self-Insurance Program to develop a news-alert to share the concern with the self-insured community. The news alert titled "Observations from the Ombudsman" and "Tips from Self-Insurance" couples the reported issues/concerns with regulatory and policy guidelines from the Self-Insurance Program. The news-alert is distributed to the self-insured community via the department listserv.

The idea for the alerts came from the workgroup, with the intent that they serve as educational opportunities for self-insured employers and TPA's, and that they will review current claims practices and implement changes as appropriate.

Recommendations for Change

In making these recommendations we acknowledge that the majority self-insured claims are managed appropriately, with the workers receiving medical and time-loss benefits as provided by law. The first recommendation for change is based upon complaints received by this office over the past three reporting periods. Similar recommendations concerning medical bill payments were also included in the 2011 and 2010 annual reports.

The second recommendation concerns a very small numbers of workers whose employers who refuse to pay benefits during the appeal process. According to RCW 51.52.050, benefits should be paid during the appeal process. In these cases, either a stay of benefits was not requested or was denied by the BIIA. All but one of the cases reported to this office were from pro se or unrepresented workers.

Establish Rules Requiring Timely Payment of Medical Bills

RCW 51.36.085 requires all fees and medical charges shall be paid within 60 days of receipt by the self-insured employer of a proper billing or 60 days after the claim is allowed by final order or judgment. Interest at the rate of 1% per month can be assessed whenever the payment period exceeds the applicable 60-day period on all proper fees and medical charges.

As in the prior reporting periods, we continue to receive a significant number of complaints concerning payment of medical bills for treatment of accepted medical conditions. One in 10 investigations completed during the past two years involved issues related to the payment of medical bills.

This year, 14 workers reported to us they were sent to collections over unpaid medical bills for accepted medical conditions. Others report they were forced to pay using their personal resources or private medical insurance to avoid a collections process. We had reports from workers stating they were unable to obtain treatment for their injuries. They were unable to find providers willing to treat or continue treatment without payments for service.

Recommendation

Establish legislation to provide for a penalty assessment to be levied against the self-insured employers for late or non-payment of medical bills for accepted medical conditions, and that this penalty be greater than the $500 penalty for rule violations.

We recommend the Legislature consider authorizing a graduated penalty model to include a increase in the amount of penalty levied with each additional occurrence.

Require Self-Insured Employers to Pay Medical and Time-Loss Benefits after Stay is Denied

RCW 51.52.050 states that an order by the department awarding benefits shall become effective and benefits due on the date issued. If the department order is appealed, the order shall not be stayed pending a final decision on the merits unless ordered by the BIIA. All workers covered under the State Fund receive benefits unless a stay is granted, as do the vast majority of self-insured injured workers. While the number of workers affected may be small, the impact to those workers is significant. For those self-insured workers that do not receive benefits, there is no current recourse.

Recommendation

We recommend the Legislature require action against the employer's self-insured certificate if the employer refuses to provide benefits during an appeal where a certain number of days has elapsed and a stay of benefits is either not requested from or not granted by the BIIA. Alternatively, a graduated penalty model could be considered with increasing penalties assessed if the employer does not pay benefits as per the order on appeal.

Contact the Ombudsman's Office

If you or someone you know works for a self-insured employer and needs help with a workers' compensation issue, we are available to help.

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