Office of the Ombuds for Self-Insured Workers

2014 Annual Report

Reporting Period:
July 1, 2013 – June 30, 2014

The Office of the Ombuds 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, Ombuds

STATE OF WASHINGTON
Office Of The Ombuds For Self-Insured Injured Workers
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September 29, 2014

The Honorable Jay Inslee
Honorable Members of the Legislature

I am pleased to submit the 2014 Annual Report for Office of the Ombuds for Self-Insured Injured Workers. The report includes a summary of our activities for the period July 1, 2013 through June 30, 2014.

The Ombuds Office serves the self-insured worker community by providing information, education, and investigating claims related complaints. During this reporting period, we completed 486 investigations into complaints filed by self-insured injured workers.

My term as Ombuds ends January 11, 2015. I have appreciated the opportunity to serve as Washington's first Ombuds for Self-Insured Injured Workers.

Respectfully submitted,

Denise McKay

Denise McKay
Ombuds

Table of Contents

Executive Summary 1
Office of the Ombuds for Self-Insured Injured Workers 4
Self-Insurance in Washington 6
Audit Reform 8
The Ombuds Office 12
Investigations 15
Resolution Profile 16
Reported Issues 18
Case Scenarios 22
Update on Prior Recommendations 24
Contact the Ombuds Office 27

Executive Summary

The Office of the Ombuds for Self-Insured Injured Workers was established by the 2007 legislature to advocate for the rights of injured workers of self-insured employers. The first Ombuds was appointed by the Governor on January 12, 2009. This report covers the period July 1, 2013, through June 30, 2014.

Role of the Ombuds Office

The role of the Ombuds Office is to act as an advocate for injured workers of self-insured employers. Workers contact this office for information on industrial insurance and assistance in resolving issues related to their workers' compensation claims. We work together with self-insured employers (SIE), third-party administrators (TPA), and department adjudicators to ensure the worker receives the appropriate benefits under the law.

Focus on Customer Service

Workers' compensation laws and regulations are complicated and often confusing to workers. Our goal is to provide accurate timely responses to worker inquiries in a clear and easy to understand manner.

We strive to provide the highest level of services to our customers. In 2011, we conducted a customer survey to ensure we were on track to meet our customer needs. Over 90% of respondents indicated we met or exceeded their expectations. A second survey will be completed this fall to ensure we remain on target.

Investigating Complaints

Most worker inquiries do not warrant an investigation. They are informational in nature or involve issues that can be easily resolved.

This year we completed 486 investigations into complaints filed by injured workers. The number of investigations has remained fairly constant over the past three reporting periods; however the number of workers contacting our office for general information has increased significantly over the past year.

As in past years, the most common complaint received concerns the payment of time loss compensation. One in three complaints received during this reporting period related to delayed/denied time loss payments or incorrect wage calculations.

Working directly with the employer's claims administrator is the most efficient method of complaint resolution. While we prefer to resolve claims related issues directly with the SIE or TPA that is not always possible. If we are unable to resolve the dispute with the SIE or TPA, we have the authority under RCW 51.14.350 to make a referral to the department for independent review and action.

Update on Prior Recommendation for Change

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.

Department to Implement New Rules Requiring the Timely Payment of Medical Benefits

As noted in past reporting periods, the timely payment of medical bills remains a significant concern. We continue to receive a number of complaints related to either the late payment or non-payment of medical bills. When medical bills are not paid, it is very difficult for an injured worker to find a provider willing to treat them. If unpaid medical bills are referred to a collection agency, it causes undue stress to the worker's personal finances, and negatively affects their credit.

I am pleased to report the department is in the process of rulemaking to address the timely payment of medical bills and anticipates rules to be implemented by the end of this calendar year. I expect the implementation of the new rules will serve to significantly decrease the number of workers affected by unpaid medical bills.

Recommendations for Change

The department is making significant changes to the self-insured audit program. The changes include the implementation of a three tiered audit model. Employers who do not meet department standards in a Tier 1 audit are subject to a more comprehensive audit in Tier 2 or Tier 3. The tiered model is intended to focus resources and attention on those employers who do not meet set standards. The audit reform also provides for the ability to conduct complaint and issue based audits, and offers additional education and training to employers to increase compliance. The pilot for the Tier 1 audits begins January 2015.

One of the goals for audit reform was to ensure the timely and accurate payment of time loss benefits to workers. The scope of the pilot Tier 1 audits is limited only to the review of wage calculations. The audit does not review for timeliness or accuracy of benefit payments to workers. The department indicates they do not have the capacity to audit benefit payments.

I propose the department add additional audit staff to review benefit payments and ensure the reform processes meet the goal of ensuring accurate and timely payments to injured workers.

In addition, if a Tier 2 or Tier 3 audit reveals findings or additional deficiencies, I recommend the self-insured employer be required to cover all costs associated with the audit. Audit resources are scarce and compliant self-insured employers should not have to share in those additional costs.

Office of the Ombuds for Self-Insured Injured Workers

The Office of the Ombuds 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 industrial insurance law.

Authority

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

Key Features

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

Independence

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

Powers and Duties

The statute directs the Ombuds 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 ombuds 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 ombuds*

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 Settlement Agreements

Legislative changes to workers' compensation law allow eligible workers to initiate a resolution of claim issues and/or benefits through a structured settlement process. Since the law was implemented in January 2012 we've received less than 20 inquiries from self-insured workers requesting information about structured settlements.

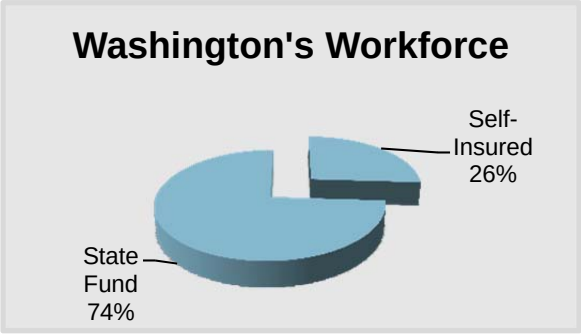
Informational materials explaining the structured settlement process and clearly identifying our role are available through our office and are posted on our website.

Staffing

The Ombuds Program is funded by self-insured employers as part of their annual administrative assessment. The 2007 enabling legislation provided for an ombuds and three additional staff, and allows for additional staffing adjustments based on workload demands. The office is currently fully staffed with an ombuds, two workers' compensation adjudicators, and a customer service specialist.

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 currently 357 active self-insured employers in Washington. Self-insured companies employed over 868,000 workers in FY2013.

Labor and Industries has regulatory authority over the provision of industrial insurance 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 ensure claims are managed in accordance with laws, rules, and policy.

Basic requirements to self-insure for workers' compensation

- 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

How many industrial insurance claims are filed by self-insured workers?

During CY2013, 42,796 claims were filed by self-insured injured workers.

Who manages the self-insured claims?

Self-insured employers may elect to self-administer their claims or contract with a TPA to manage their claims. During this reporting period, 92% of self-insured employers contracted with a TPA to manage their industrial insurance claims. There are 67 TPA office locations managing Washington claims. More than half of those offices are located outside Washington.

What benefits are provided to self-insured injured workers?

All Washington workers are entitled to the same level of workers' compensation benefits.

Those benefits may include:

- Medical benefits to cover treatment for a work-related injury or illness
- Time-loss 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
- Permanent partial disability benefits (PPD) 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 has the authority to audit self-insured employers to determine whether they are complying with laws governing workers' compensation. Regular audits were suspended October 2013 as the department began the process of audit reform.

Audit Reform

Last year the Department began a collaborative effort with representatives from business, labor, and the Ombuds to revise their audit process.

The stated goals for the reform were to:

- Ensure accurate and timely payment of benefits
- Communicate clear expectations to self-insurers
- Provide effective claim management tools coupled with consultation and training
- Detect non-compliers
- Provide a clear path to correction with meaningful enforcement tools

The change includes a move to a three tiered performance based audit system and incorporates options to conduct issue based and complaint based audits. Enforcement will be coupled with training to ensure the SIE/TPA's have the tools and knowledge to pay benefits correctly. The department plans to develop a Self-Insurance Risk Analysis System to collect data that will support the identification of specific non-compliance risks and audit priorities.

Tier 1 is a very limited scope annual audit of all active self-insured employers. Delay of benefits penalties and rule violation penalties will not be issued for Tier 1 audits during the first year pilot phase. Employers who do not perform satisfactorily in this audit may be subject to a more comprehensive audit process.

The development of the audit models for Tier 2 and Tier 3 will begin in 2015. The change to a tiered audit format will be implemented in stages, subject to review and adjustments as necessary. The department intends to develop a governance committee to review concerns and to provide advice and customer input on topics for future issue-based audits.

<u>Pilot for Tier 1 Audit</u>

Scope: Wage calculation only. All active self-insured employers
Timeline: One year period starting January 2015
Sample size: 10% of compensable claims up to a maximum of 35 claims.
Passing Rate: 70%
Remedial Actions: Audit specific training
Directives on method errors to correct and repay benefits on all open claims
Penalties: No penalties will be issued for delay of benefits or rule violations
Follow-up on Directives: None by department. Employer to self-certify compliance
Pilot Review: Ongoing and interim reviews

Concerns:

One of the original goals set by the Audit Reform Committee was to ensure accurate and timely payment of benefits. During the 2015 pilot, Tier 1 audits are limited to a review of the calculation of wages. Claims will not be audited to determine whether the benefits were paid accurately or on a timely basis.

Timeliness of the first payment of time loss is a significant performance measure for state fund claims with a 95% expectation; however this measure will not be included in the 2015 audit for self-insured employers. I am also concerned there is no planned department oversight on performance directives to ensure workers receive payments for unpaid benefits. The department intends to rely on the self-insured employer to self-certify compliance.

My concerns were met with department capacity issues. They indicated they do not have enough staff to conduct a more thorough Tier 1 audit on an annual basis, or to follow up on Tier 1 audit directives.

Proposal: Add additional audit staff to review for the timely and accurate first payment of time loss during Tier 1 audits, and spot-check audit directives to ensure compliance.

Cost: $98,800 per FTE (per department budget staff). This figure includes salary, benefits, and all ancillary costs such as training and equipment. The cost of additional staff would be borne by the 357 self-insured employers.

Propose: Cost for Tier 2 & 3 audits paid by the non-compliant self-insured employer
The self-insured employer community should not have to bear the costs for employers that are non-compliant. If a Tier 2 or Tier 3 audit results in audit findings, the individual self-insured employer should bear the costs associated with the audit.

Our office remains supportive of audit reform that places an emphasis on timely and accurate delivery of benefits, ensures compliance with audit directives, offers audit specific training, and produces a meaningful audit report.

Department Completes First Complaint Based Audit

The Ombuds Office received a number of complaints from injured workers employed by a large self-insured employer. The complaints received involved incorrect payments for time loss, loss of earning power (LEP), and incorrect wage calculations. Based upon the complaints filed, this appeared to be a systemic issue with the methodology used by the TPA to calculate and pay

benefits. This employer had a total of 728 compensable claims filed in 2012 and 2013. Method errors are of particular concern as they likely affect benefits paid on all compensable claims.

As Ombuds, I contacted the TPA several times in January 2014, in hopes to resolve this issue. As this employer's claims are managed outside of Washington, I provided links to rules, statutes, and educational information as well as contact names and numbers for the self-insured training program.

We continued to receive ongoing complaints from injured workers. As we were unable to resolve the issue with the TPA, I requested the department conduct an audit based upon the complaints received. The department agreed and an audit was conducted over a three month period beginning in March 2014.

The department auditor looked at a sample of 52 compensable claims with dates of injury from February 1, 2012 to December 11, 2013. The following is a sampling of the errors found during the audit.

Wage Calculation Errors:

Incorrect hourly rate/incorrect average hours	87% incorrect
Value of healthcare benefits (HCB) not included	92% incorrect

Payment of Benefits

Benefits underpaid: Wages incorrect	83% incorrect
Benefits underpaid: HCB not included	79% incorrect
Benefits underpaid: Time loss days not paid	42% incorrect
LEP calculated incorrectly	100% incorrect
Initial time loss payment late	48% incorrect

Corrective Action

On August 22, 2014, an order was signed by the Director of Labor and Industries placing the employer on notice of corrective action. The employer has the right to appeal the order to the Board of Industrial insurance Appeals. The order must be appealed within 60 days.

The employer is required to submit a corrective action plan to the department within 30 days. The plan must specify how the employer will address the deficiencies identified in the audit.

Directives

The department issued 46 directives requiring the employer to correct and pay the underpayments on the audited claims. Separate orders were also issued to address delay of benefits penalties on individual claims.

A separate directive was issued requiring the employer to recalculate wages and correctly pay benefits on all open claims with a date of injury after June 9, 1988 as well as all employer closed claims within the past two years. The employer is required to submit documentation of payments and corrected self-insured forms (SIF-5 and SIF-5A) to the department.

Monitoring

The department will monitor and spot-audit the employer's performance during the corrective action period. The department also identified specific training required for the employer and their TPA. The corrective action order requires the employer to identify all TPA employees that pay benefits on their claims. Those employees will be required to receive training on the calculation and payment of benefits.

Comment

I am appreciative of the department's action in conducting the audit. I was particularly pleased to see the training requirement for the employer and TPA, as well as the directive to correct the compensation paid on all open claims.

The department has offered several training opportunities over the past few years that specifically address wage calculation and payment of compensation. The training was offered at no cost. Unfortunately the training was not mandatory for SIE's or TPA's.

Every TPA location is required to have at least one certified claims administrator. I believe there is an opportunity to reduce the number of adjudication errors by requiring one certified adjudicator in each location to attend department sponsored training.

The Ombuds Office

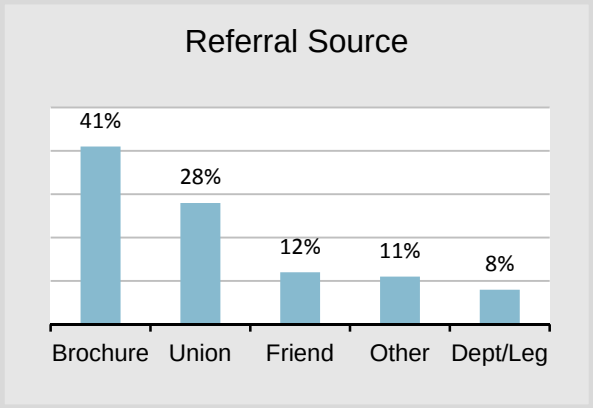
We are advocates for self-insured injured workers. We offer information, investigate worker complaints, and work collaboratively to ensure workers receive the appropriate benefits under Washington laws. We track complaints received, document outcomes, and analyze the data from a trending perspective. This information is used to make recommendations to improve to the system.

Providing Quality Service

Providing accurate timely information to workers is a key responsibility of this office. Industrial insurance laws and regulations are complicated and can be confusing to workers. We respond to worker inquiries in a clear and easy to understand manner.

In 2011, we conducted a customer survey to ensure we were on track to meet our customer needs. Over 90% of respondents indicated we met or exceeded their expectations. A second survey will begin this fall. The results will be carefully reviewed to ensure we continue to meet the needs of the workers.

How do workers hear about us?



In keeping with all prior reporting periods, the majority of workers reported they received information about our office from our brochures or they were referred by their union representative.

Other sources of referrals include friends, legislative offices, department employees, treating physicians, attorneys, and employers.

The labor community continues to be a significant source of referrals to our office. We appreciate labor's support and willingness to share information about our services. Over 28% of workers report they were referred to our office by their union representative.

We also appreciate the opportunity to attend labor conferences and meetings. These events offer a chance to interact directly with workers, provide an overview of our program, and share information about worker's compensation.

The department publication *A Guide to Workers' Compensation Benefits for Employees of Self-Insured Businesses* includes a general overview of the program and lists contact information for our office. The employer is required to provide a copy of the pamphlet, or the same information in a substantially similar format, to every injured worker.

A brochure outlining the functions of our program is available and distributed to employers and labor organizations. Mandatory worksite posters list contact information for our office.

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

How do we help?

Workers contact this office for a variety of reasons. The majority of callers are looking for general information about workers' compensation, while others need help to resolve complex claim issues.

When a worker contacts our office, we conduct an intake evaluation to identify the issues and determine the best course of action. 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 investigation. We maintain contact with the worker and involve them in both the investigation and resolution process. We encourage the worker to maintain contact with both their employer and claims administrator throughout the claims process.

Investigating Complaints

The investigation process 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.

The Referral Process

When we are unable to resolve the worker's issues with the SIE or TPA, the Ombuds office has the ability to make a formal referral to the department for review and action under RCW 51.14.350. 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 Ombuds Office.

Confidentiality

RCW 51.14.370 protects the confidentiality of Ombuds records and files. It states that all records and files of the Ombuds 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 Ombuds without the consent of any named witness or complainant unless the disclosure is made without the identity of any of these individuals being disclosed.

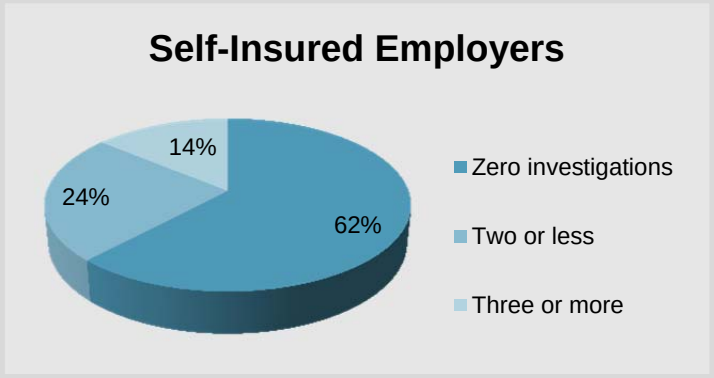
Reporting

The self-insured ombuds 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.

Investigations



Consistent with prior reporting periods, the majority (62%) of self-insured employers did not have any complaints filed which warranted an investigation.

Distribution of Investigations

The majority of investigations completed during this reporting period involved only a small percentage of the total number of self-insured employers.

Number of Investigations	2014 (357)	2013 (360)	2012 (362)	2011 (361)	2010 (366)
Zero investigations	221	202	196	233	243
1-2 investigations	85	104	111	86	98
3	22	15	19	16	9
4-5	14	19	17	9	7
6-9	8	13	11	10	4
10-16	3	3	4	4	3
17-19	0	1	1	2	0
20-25	3	2	0	0	2
27-29	0	0	2	0	0
33-40	0	0	1	1	0
48	0	1	0	0	0
74	1	0	0	0	0

Resolution Profile

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.

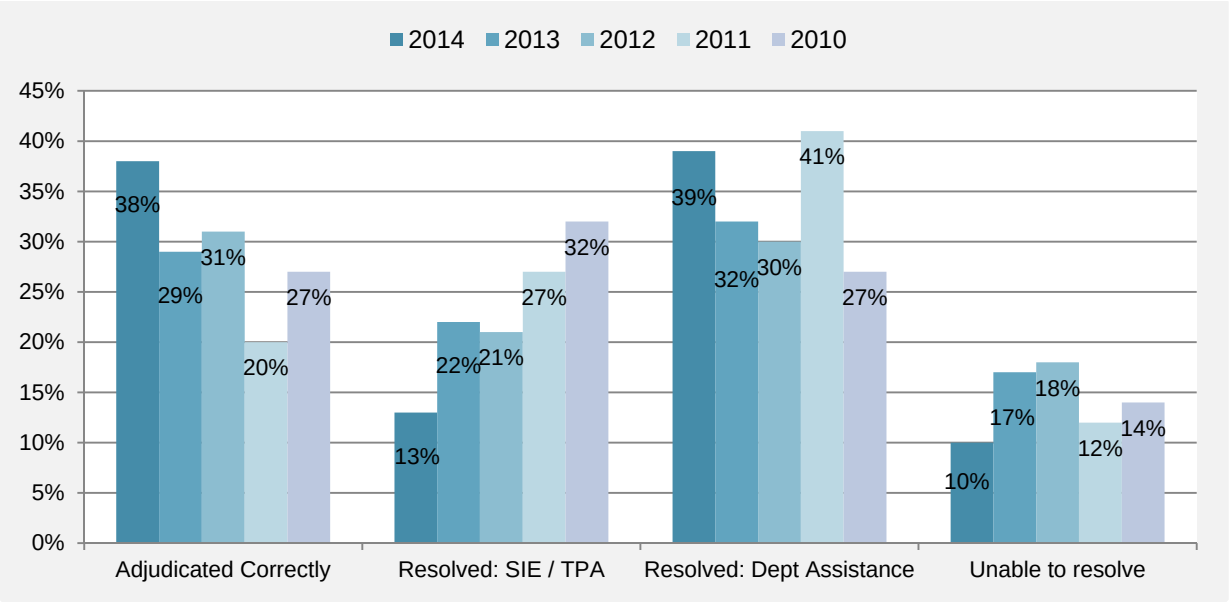
Approximately 92% of the total number of self-insured employers contract with a TPA to manage their worker' compensation claims. The Department of Labor and Industries is not currently authorized to regulate TPA's.

We completed 486 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 in prior years.

Our 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. Any changes to treatment authorization or worker benefits can be immediately implemented. Unfortunately the number of complaints we were able to resolve with the SIE/TPA has significantly diminished during this reporting period.

Resolution Profile					
	2014 (486)	**2013 (505)**	**2012 (508)**	**2011 (400)**	**2010 (289)**
Claim Adjudicated Correctly	183	146	156	81	77
Resolved: SIE / TPA	65	111	108	106	92
Resolved: Dept. Assistance	190	162	153	164	78
Unable to resolve	48	86	91	49	42

This table shows the resolution distribution by percentage for all reporting periods.



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

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.

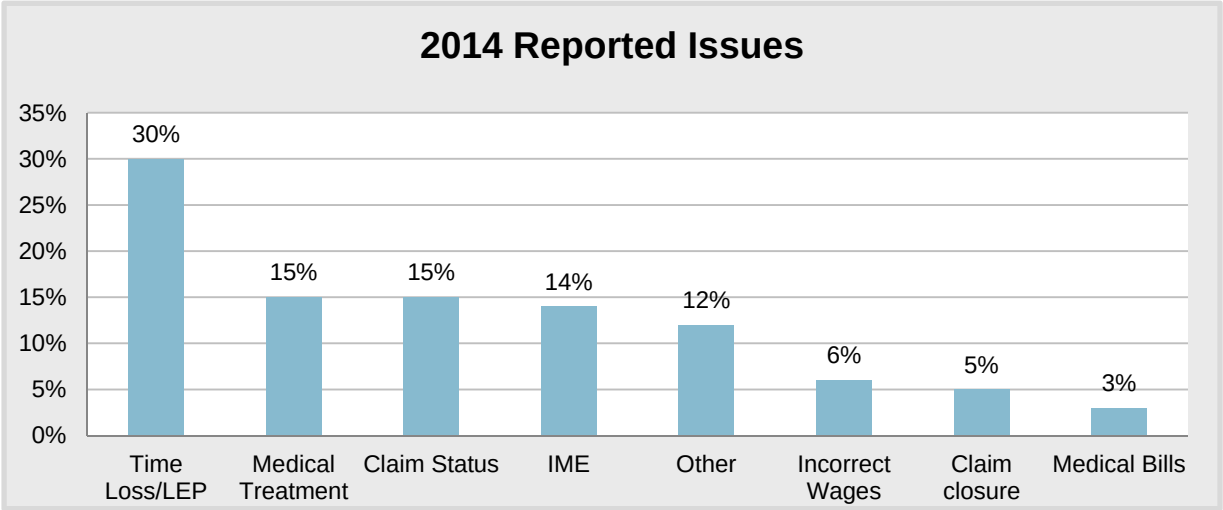
Reported Issues

A significant number of investigations involve more than one claim issue. As noted in earlier reports, the most frequent complaints involve the payment of time loss compensation.

The top categories for FY2014 are:

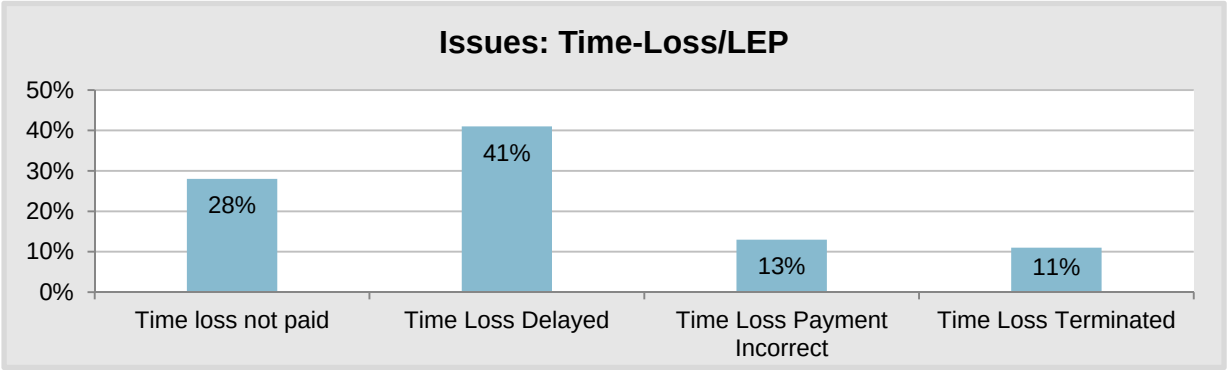
- Delayed/ denied time-loss or loss of earning power (LEP) (30%)
- Delayed or denied medical treatment (15%)
- Claims status: provisional/rejected (15%)
- Complaints related to independent medical exams (IMEs) (14%)
- Incorrect Wages (6%)
- Non-payment or late payment of medical bills (3%)

The numbers in the following chart are expressed as a percentage of the total number of issues reported by workers during the fiscal year. As a high percentage of investigations involve more than one issue there isn't a one-to-one correlation of issues to the number of completed investigations.



Delayed/Denied Time-Loss

Workers rely on time-loss compensation as partial wage replacement while they are unable to work due to an industrial injury. Any delay in the payment of time-loss or loss of earning power (LEP) can cause significant hardship for the worker. This is by far the most commonly reported issue by workers.



Incorrect Wage Calculations

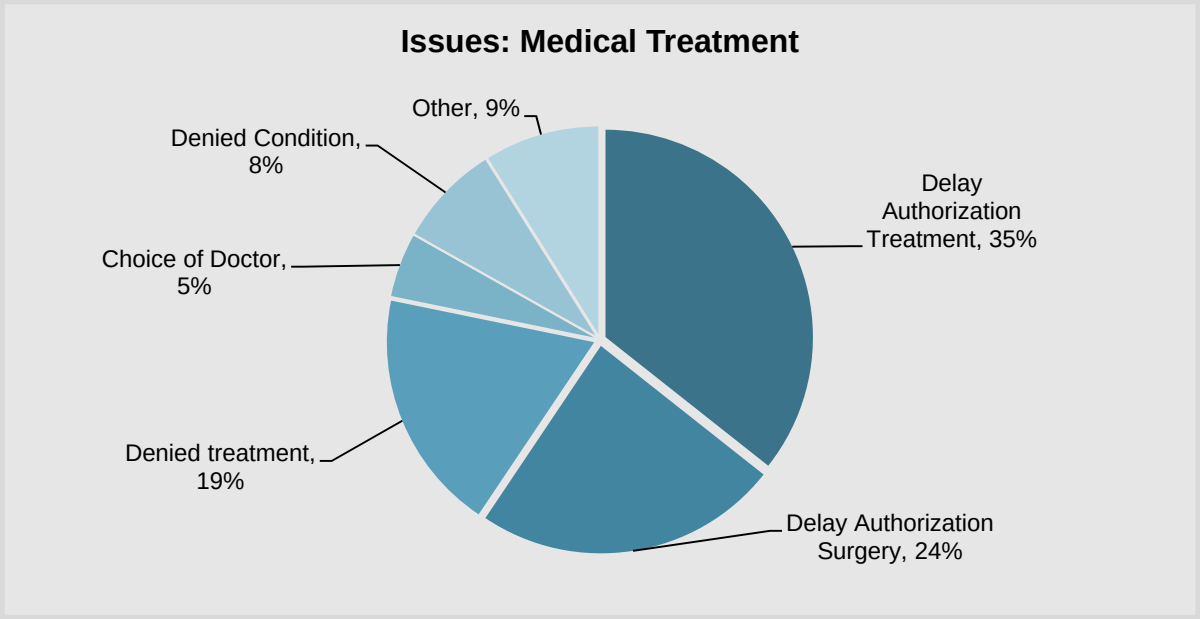
Under current Washington law, the wage calculation is complicated for certain types and/or patterns of employment. For example, determining the correct time loss rate for workers with varying hours and rates of pay requires the claims manager to examine payroll records for a representative time period, averaging worker hours at each rate of pay to determine the wage. The value of healthcare benefits, bonus, commission, housing, as well as a number of other types of remuneration must also be sourced, documented, and included in the wage calculation. Often it is difficult for workers to understand the calculations or know whether their time loss rate was calculated appropriately.

If a worker was receiving health care benefits (HCB) at the time of injury, the employer contribution to those benefits is taken into consideration when calculating the time loss rate. If the employer does not continue to contribute to the worker's healthcare at the same rate as at the time of injury, the value of the HCB must be added to the time loss rate to compensate the worker for the loss of benefit.

The Ombuds Office received a number of complaints against a large employer concerning wage calculations. The value of HCB was not included in their time loss rate. I attempted on several occasions to resolve the issue with the out-of -state third party administrator (TPA) but was not successful. I requested department intervention. The department agreed to do a complaint based audit and found the employer had a wage calculation error rate of 92%.

Medical Treatment

Almost 60% of the complaints in this category involve a delay in the authorization of medical treatment, testing, or surgery. Workers and their treating providers report these delays impact recovery and may delay their return to work.



Currently there are no rules requiring the SIE or TPA to take action on a treatment request within a specified time period. The department can issue an order directing the SIE/TPA to authorize and pay for specific treatment on a case by case basis.

Medical Bills

Non-payment or late payment of medical bills continues as a significant issue for workers. A number of workers report they cannot obtain treatment because their provider bills were not paid. This can delay the worker's recovery and affect their ability to return to work.

A recent decision from the Board of Industrial Insurance Appeals, *In re James Coston,* BIIA Dec., 11 12310 (2012) ruled that the payment of medical bills is a benefit under the industrial insurance act. If a self-insured employer unreasonably delays a benefit or refuses to pay the benefit, RCW 51.48.017 requires a penalty against the SIE. The department is in the process of rulemaking to assess penalties for late/non-payment of medical bills for claims related treatment.

Independent Medical Exams

The number of complaints involving IMEs rose from 9% to 14%. Half of those workers indicated their SIE or TPA would not make an allowance determination on their claim until the worker attended an IME. This is of particular concern to workers as the SIE or TPA is not required to pay for medical treatment until the claim is allowed. It can take a number of months to schedule, process, and review the IME report. During this time, the worker is not covered for medical treatment under the claim, and workers report they cannot afford to self-pay. In general, private insurance plans will not cover injury-related treatment unless/until the claim is rejected.

It is appropriate to schedule an IME as part of the information-gathering process if the self-insured employer or TPA does not have enough information to make an allowance determination. 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 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. If our investigation shows the requirements were met, a referral is made to the department to review for claim allowance.

Case Scenarios

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

Authorization for Medical Treatment

We received a call from an injured worker who recently underwent knee surgery. Following the surgery he had 12 physical therapy sessions. After the 12 sessions, his surgeon felt that an additional short period of physical therapy was essential to the worker's recovery. The surgeon had requested authorization however he was unable to obtain a response from the claims manager. After several weeks of waiting, the worker contacted our office. We contacted the claims manager and asked them to authorize the physical therapy. The TPA authorized the additional therapy that same day.

Claim Closure

A worker contacted our office because his claim had been closed. His doctor recommended additional treatment and certified that he was unable to return to work. The closure was reversed to allow additional treatment. The worker also wrote several letters to the TPA requesting time loss compensation. Our office placed several calls to the TPA asking for time loss to be reinstated. Medical documentation certified the worker was permanently restricted from returning to his job of injury. The TPA declined stating the worker had voluntarily retired and therefore was not eligible for time loss. During the investigation we determined the worker did not retire, his job was eliminated as part of a company downsize. We requested department intervention and the department issued an order directing the payment of time loss.

Medical Bill Payment

A worker contacted our office because he received a bill for a wrist brace. We contacted the TPA and determined the bill for the brace was never submitted for payment. We learned the provider attempted to obtain authorization for the wrist brace. At the time of the request, the wrist was not an accepted condition under the claim. The wrist condition was subsequently accepted under the claim. We contacted the provider; they submitted the bill which was promptly paid by the claims manager.

Loss of Earning Power (LEP) Not Paid

A worker may be entitled to LEP compensation when the worker's earning power has decreased as a result of an industrial injury or occupational disease, and that loss of earning is greater than 5 percent of their wages at the time of injury. A worker contacted our office as she returned to a light duty position at reduced hours and had not received payment for LEP. We contacted the TPA who indicated the worker had earned too much for the pay period in question so didn't qualify. Upon further investigation it was determined that the worker's gross earnings were not in excess of 95% of her salary. The worker elected to cash out vacation leave and the value of the leave was inadvertently included in her gross earnings. We called the TPA back to explain vacation pay is not considered as part of LEP wages. The TPA recalculated the benefits resulting in a LEP payment for the worker.

Delay of Benefits

The worker contacted our office because she had not been working or only working part-time/seasonal jobs since she was terminated from employment in 2006 following an industrial injury. Although her claim was open and she remained off work due to her injury, she had not received any time-loss or LEP benefits. The worker contacted our office last fall requesting assistance. As we were unable to successfully resolve the time loss issue with the TPA, we requested department intervention. The department ordered the SIE to pay back time-loss and loss-of- earning power benefits in excess of $124,000.00. The worker requested and was granted a delay of benefits penalty in excess of $31,000.00. The employer appealed the decision and refused to pay benefits until the BIIA denied their motion to stay benefits in July 2014.

Incorrect Wage Calculations

RCW 51.08.178 provides the basis for the calculation of wages under Title 51. It states in part that wages shall also include the employer's payment or contributions, or appropriate portions thereof, for health care benefits unless the employer continues ongoing and current payment or contributions for these benefits at the same level as provided at the time of injury.
We received a number of complaints from workers employed by the same company that the value of their health care benefit was not included in their time loss calculations. In this case, the employer, per union contract, contributed a specific amount for health care for every hour the employee worked. If the worker was off work due to the injury, the employer contributions ceased. In this instance, the value of the health care benefits should have been included in the rate and paid for the period the worker was off work. In some instances, the TPA agreed to correct individual payments however most required department intervention to correct.

Update on Prior Recommendations

Department to Establish Rules Requiring Timely Payment of Medical Benefits

Beginning in 2010, the Ombuds Office has recommended the implementation of rules or regulations to require timely authorization and payment of claim-related medical bills. Late or non-payment of medical bills remains a significant issue for workers. We continue to receive complaints from workers indicating they are unable to obtain treatment because their provider bills were not paid, or treatment was not authorized. This can delay the worker's recovery and affect their ability to return to work.

RCW 51.48.017 provides for penalties if a self-insurer delays or refuses to pay benefits when due. The Department has historically only awarded penalties to workers for a delay in the payment of monetary benefits, including time-loss compensation, loss of earning power, and permanent partial disability awards. Penalty awards have not been ordered for late/nonpayment of medical bills for claims related treatment. A recent court decision resulted in a change to the Department's current practices, determining the term "benefits" also applies to medical treatment.

RCW 51.48.017 If a self-insurer unreasonably delays or refuses to pay benefits as they become due there shall be paid by the self-insurer upon order of the director an additional amount equal to five hundred dollars or twenty-five percent of the amount then due, whichever is greater, which shall accrue for the benefit of the claimant and shall be paid to him or her with the benefits which may be assessed under this title. The director shall issue an order determining whether there was an unreasonable delay or refusal to pay benefits within thirty days upon the request of the claimant. Such an order shall conform to the requirements of RCW 51.52.050.

The Department is in the process of creating new administrative regulations to determine when a self-insured employer has unreasonably delayed the payment of medical bills. A workgroup was assembled consisting of key department personnel and representatives from the Washington State Labor Council (WSLC), Washington Self-Insurers Association (WSIA), Washington State Association for Justice (WSAJ) and the Ombuds for Self-Insured Injured Workers.

The proposed rules will:

- Define the elements needed for penalty requests;
- Establish procedures to file and respond to penalty request;
- Determine how penalties will be assessed;
- Describe when a penalty is payable to the worker;
- Address other issues, as necessary.

The rulemaking process is currently on schedule to hold public hearings this fall with a target date for rule implementation at the end of this year.

With the exception of emergent or lifesaving treatment, the proposed new rules do not specifically address the timely authorization of treatment. If a billing is denied, the proposed rules do require a written explanation to the worker, provider, and department clearly stating the reason for denial. The worker or medical provider may then file a dispute with the department.

Recommendations

Additional Staff to Support Audit Reform

One of the stated goals for audit reform is to ensure the timely and accurate payment of time loss benefits to workers. The piloted Tier 1 audits are limited to the review of wage calculations. Benefits payments to workers will not be reviewed for timeliness or accuracy. The department indicates they do not have the capacity to review benefit payments as part of the Tier 1 pilot.

Timeliness of first payment of time loss is a key performance measure for State Fund claims, with the expectation that 95% of first time loss payments are made within 14 days of contention and certification. I am concerned that self-insured workers do not receive the same level of review. I recommend the addition of audit staff to ensure the reform processes support the goal of ensuring accurate and timely payments to injured workers.

Recommendation: Add additional audit staff sufficient to audit for the timely and accurate first payment of time loss during Tier 1 audits, and to spot-check all audit directives to ensure compliance. Request the Department provide a capacity analysis to determine the number of additional staff necessary.

Cost: $98,800 per full time auditor according to estimates provided by the department budget office. This figure includes salary, benefits, and all ancillary costs such as training and equipment.

Recommendation: The costs associated with Tier 2 & 3 audits should be paid by the self-insured employer.

Employers who fail a Tier 1 audit may be subject to a more comprehensive and costly audit process designated as Tier 2 or Tier 3. If a Tier 2 or Tier 3 audit results in additional audit findings or deficiencies, the self-insured employer should bear the costs associated with the audit.

As resources are a concern for the department, I recommend that the individual self-insured employer be required to cover all costs associated with a Tier 2 or Tier 3 audit if additional deficiencies are found. Audit resources are scarce and the self-insured employer community should not have to bear the costs for employers that are non-compliant.

Contact the Ombuds 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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