

Managing Workers' Compensation Claims

**Philip E. Goldsmith, CSP, ARM
Deputy Chief for Risk Management
Office of Protection Services, National Gallery of Art
Washington, DC**

Overview - The Workers' Compensation System

Each of the states, territories and Canadian provinces has its own Workers' Compensation (WC) Law, and its own level of benefits, but all include some level of the following five benefit types:

- Indemnity payments, to reimburse the employee for (part of) his or her lost wages.
- Payments to medical providers for services rendered.
- Scheduled benefits to the employee for loss of a limb, disfigurement, etc.
- Payments to rehabilitation providers to assist in rehabilitation and return to work.
- Survivors' benefits for burial and some replacement of income.

Covered losses include:

- Accidental injuries
- Occupational disease
- Cumulative trauma injuries
- Mental injuries

Injuries not covered by workers' compensation include:

- Intentionally self-inflicted (all but 3 states)
- Sustained while attempting to injure another person
- Caused by employee's intoxication (all but 6 states)
- Caused by employee's willful misconduct
- Caused by willful failure to use a safety device (but not if employer failed to enforce) (a few states)

Claim Management

The Wrong Ways

Some managers or organizations adopt a posture of benign neglect. They see a problem and hope it gets better. These managers often abandon responsibility for the active management of the claim to the injured employee, the insurer, or the physician/health care provider.

Others take an aggressive approach. They believe that there are no “legitimate” comp cases. They often adopt an “Us vs. Them” philosophy, and believe that the WC system automatically benefits the employee.

Oftentimes, organizations fall into a combination of first two. They ignore the problem until it’s a high value claim, and then blame the employee. The result is often a high-cost, lump-sum settlement.

The Right Way - A Managed Approach

The right way to manage claims requires management attention to seven basic actions:

- Report and investigate claims promptly
- Focus on the problem claims
- Select appropriate medical care
- Keep communications open
- Implement a return-to-work program
- Manage contested claims
- Manage your insurance carrier or TPA

Report and Investigate Claims Promptly

There are statutory limits on the filing of claims by employees - 60 days to 2 years, but many states include language that says “as soon as practical” or “excusable.” More important, there are tighter requirements on reporting by the employer. States vary in what types of accidents/injuries must be reported to the state (e.g., deaths, disability of more than 3 days). Time limits on reporting vary (typically 2-10 days), and there are fines for nonreporting/late reporting. Regardless of state reporting though, all claims should be reported to the insurance carrier.

In the employer’s/supervisor’s section of the First Report of Injury, give full details on the accident and allegations as you know them, but don’t speculate on the diagnosis or prognosis. Follow the insurer’s recommendations on transmitting the claim – fax is preferred over mail. Studies have proven that quicker reporting results in lower overall cost.

Focus on the Problem Claims

Some claims, because of the nature of the injury, need to be watched:

- Back injuries
- Vascular injuries
- Serious traumatic injuries

Some current or preexisting medical situations introduce an element of uncertainty that requires attention:

- An unclear medical diagnosis or prognosis
- Other pre-existing medical problems
- Alcohol/drug dependency
- Personal/family problems

Some factors involving the reserve or timing of a claim also bear watching:

- High initial reserves
- Compensation approaching net earnings
- Disability near retirement

Suspect and Fraudulent Claims

Not every claim is bogus, and not every claimant is a malingerer. However, look at each claim for any of the following signs of a fraudulent claim:

- The accident was unwitnessed.
- Co-workers suggest the claimant is involved sports, other jobs, etc.
- The accident occurred on Monday morning or Friday afternoon (but wasn't reported until Monday).
- The accident occurred just before or after a layoff, strike, the end of season, or the end of the project.
- The same lawyers and doctors are used by many injured employees.
- The employee seems to be doctor shopping.
- The description of accident to the doctor contradicts the first report of injury.
- The employee has a history of suspicious or litigated claims.
- The employee refuses an independent medical exam.
- You can't contact the employee at home or the employee address shows only a PO Box.
- There are high medical expenses but low disability.
- The claimant has moved out of town.
- The claimant has a history of self-employment or has the potential to work for cash (in trades).

Loss Runs and RMISs

Every carrier and TPA provides its clients some form of loss run, with detailed claim status. Traditionally, these have been in the form of monthly paper reports, but for clients of reasonable size (and therefore expected claim frequency), loss runs are now being offered in on-line form. While some are still in dial-up format, most have gone to web-based format.

Loss run formats vary, but typically each claim shows the name, the date of the accident, a brief description of the accident, and the following four costs:

- **Incurred value** = Total expected cost
- **Paid-to-date value** = Losses paid to *the claimant* so far
- **Reserve** = Remainder expected to be paid
- **Expenses** = Amounts paid to *other than the claimant*, such as for an investigator, IME, etc.

$$\text{Incurred Losses} = \text{PTD} + \text{Reserve}$$

Paper loss runs should be provided monthly, in order to be relatively current. They are normally sorted by facility, then by date of accident, but any sort is usually available upon request. A valuable second report shows only open claims, which provides the "critical few" that need action to manage them.

On-line claims systems contain information that is likely to be more up-to-date than paper loss runs. In many cases you'll also have access to the adjuster's notes to see the actual status, rather than just the dollar amounts.

True Risk Management Information Systems (RMIS) take loss runs and expand them into comprehensive information systems, combining exposure data and providing the user the opportunity to manipulate *data* to provide many forms of useful *information*.

Select Appropriate Medical Care

The medical provider, of course, is primarily responsible for applying the most appropriate clinical care to treat the injury or illness. However, the provider is often the key to minimizing the time away from work as well.

About half of the states allow the employer to select at least the first medical provider for an injured employee. Regardless, it's important to at least offer a choice of a medical facility that understands occupational medicine.

Select a nearby occupational health facility and reserve the emergency room for traumatic or off-hours injuries. Use the same facility for pre-placement exams if you do them. Invite the medical staff to your facility (especially if it has unique operations or processes).

Keep Communications Open

Workers' Compensation (WC) should not be a mystery to your employees. Educate them in what they should legitimately know. Have a written handbook or policy addressing the following points:

- What is WC?
- When am I entitled to benefits?
- What are my responsibilities?

Most state WC Commissions publish employee information booklets, and you can also ask your insurer for help.

Some other communication strategies:

- Assure that the insurer or TPA makes its first contact with the employee within 24 hours.
- Be fair and reasonable; make sure employees get what they're entitled to.
- Continue periodic contact with the employee and health care provider.
- Identify "alternative duty" jobs for the employee.
- Create a return-to-work expectation.

Implement a Return-to-Work Program

Perhaps the single most important part of claims management is actually bringing the injured employee back to work in a timely manner. Doing so has a huge impact on reducing indemnity costs.

- Identify a limited number of positions that lend themselves to alternate work.
- Pick good candidates: those who are in generally good health and who exhibit a willingness to return to work.
- Get written clearance from the employee's physician.
- Keep the employee's supervisor in the loop.
- Set time limits for alternative work.
- Develop a target schedule to increase function.
- Consider a formal work hardening program to increase the employee's strength and stamina.

The more alternative work assignments you have, the more likely you'll be successful in bringing the employee back. First, have a detailed written position description for his or her job. Then consider some alternatives to simply bringing the employee back to the job he/she held:

- Returning to the old position with no modifications.
- Returning to the old position with modifications.
- Returning to a new position, using transferable skills.
- Returning to a new position, requiring a new skill set.
- Using vocational rehabilitation.
- Permanent part-time return.
- Temporary part-time return.

Not everyone is a likely candidate for a return-to-work program. Those most likely to return exhibit a positive attitude, are not hampered by a negative environment (family, community, co-workers urging the employee to stay home), those in generally good physical health, and those with wages well above their indemnity payment.

Position Descriptions should include:

- A concise description of the job and its requirements.
- A description of the working environment, including heat/cold, fumes/dusts/gases, chemicals, machinery, noise.
- Physical demands (include frequency/weight), including requirements for standing/walking/sitting, lifting/carrying/pushing, moving fingers/hand, climbing stairs/ladders, balancing/kneeling/squatting.
- PPE required to be used.

The supervisor is an important aspect of the return-to-work (RTW) process; keep him or her in the loop. They can provide valuable perspective on alternative jobs or modifications to the old job. They can maintain the supervisor/employee relationship. Send a card or make a call to the employee.

Target a return-to-work schedule: Set short and long-term target dates. Encourage increasing demands (with medical concurrence). Explore the potential benefits of rehabilitation, including physical, vocational and psychological, in every potential return-to-work situation.

Manage Contested Claims

States vary, but each has a hierarchy of processes by which contested claims are heard. Most states assign WC claims to a system of Administrative Law Judges.

In a typical system (Massachusetts), the first step is an informal meeting with WC Commission representative called Conciliation. This step is primarily to assure the employee understands his or her rights and is attended by the employee and his/her attorney.

The next step is a Conference, before an Administrative Law Judge, and is attended by the claimant, both attorneys, and the employer's representative.

The Hearing, where most contests are decided, is before same Administrative Law Judge. The Hearing is a more formal procedure; rules of evidence apply, and the decision is final, subject only to an appeal to a Review Board and the State Court of Appeals/Supreme Judicial Court.

Attending WC Hearings

An employee representative is a critical part of the WC hearing. The employee is there with his or her attorney: Why shouldn't the employer be likewise represented?

Prepare for the hearing by understanding the employee's job requirements and be prepared to offer alternative work assignment *in writing*.

At the hearing, sit at defense table; you're part of the team, and should be ready to consult with your attorney. Make notes of inconsistencies, but leave strategy to your attorney. Expect pressure from both sides to settle, but be prepared to accept it.

Surveillance

Surveillance is not always appropriate, but when it is, it can document the ability to work and demonstrate a full or partial earning capacity. Hire a pro, and do it soon after the injury, well before the hearing. Have reasonable expectations; many investigations are inconclusive. Aim to show inconsistency with statements, but maintain the claimant's right of privacy.

Video surveillance can be extremely powerful. However, some care needs to be taken in preserving the "evidence" and chain-of-custody. Don't tamper with the original; let the investigator keep it. Editing is OK to show it to others. It's especially helpful to show it to the employee's physician, and during an independent medical exam. It can also be used as a tool for negotiating settlement.

Manage Your Insurance Carrier or TPA

Claims are received and processed in substantively the same way by most insurance carriers and Third Party Administrators. The claim is received, checked and data entered into a claims management system, usually proprietary to the carrier/TPA. The claim is then assigned to a representative, based on initial reserve/complexity. Simple, medical-only claims are assigned to

processing staff that follow narrow guidelines to assure that payment is made to the appropriate providers. More complex claims, those involving lost time, are assigned to claims adjusters, who have more latitude in assigning reserves and managing the progress of the claim.

You should determine the best way of reporting claims: by mail, fax or on-line, and where the reports should be directed. Require that the insurer contact the employee within 24 hours (or the next business day) of their receipt of the claim.

If your organization has multiple locations, get consistent service by developing a set of account service instructions, defining contacts, philosophies of claims settlement, settlement authorities, etc. Require consistent staffing with the same claims adjusters on your account.

Get to know your claims adjuster; the personal touch can go a long way in keeping your claims at the “top of the pile.”

Your new facilities or operations should receive at least a basic claims kit, so that the facility management knows what to do when the first claim hits.

Establishing and Monitoring Reserves

As discussed above, the Claim Reserve is the insurer’s estimate of what’s *yet to be paid* on a claim. What’s paid (PTD) is already gone!

Claims Reserve Reviews should be conducted at insurer’s office. Give the adjuster or the account coordinator an advance list of claims in question (just a week or two). Conduct the review 4-6 weeks before mid-year, so that the results can be implemented before the date used to calculate the Experience Modification Factor (mod) and Retrospective Rating Plan (retro) adjustments. Consider the effect on experience mod and retro adjustment (e.g.: 4-year-old claims don’t affect the mod, but do affect that year’s retro). Most important, for each claim, leave with a disposition strategy!

Questions to ask include:

- What kind of investigation took place?
- Do reserves reflect exposure?
- Has there been medical management?
- Has alternative duty been considered?
- Is the reserve adjusted regularly (up or down)?
- When did supervisor last review the file?
- Was subrogation considered?
- Can the claim be closed now? When?
- Is there consistent handling of the claim by the staff (to avoid handoffs)?

Summary

- Get reports from your employees quickly and pass them on to your insurer quickly and accurately.
- Focus on the meaningful claims, the ones that have the most potential to impact your future cost.
- Provide appropriate medical care by an occupational medical clinic.
- Communicate well and constantly with the employee, the medical provider, the insurer, the attorney, and others involved in the claim.
- Aggressively manage the return-to-work process.
- Form a team with your insurer to manage contested claims.
- Know how your insurer's claim function operates and participate in the process.