Claims Audit Report

Trindel Insurance Authority

April 2013

Prepared by Angela Livingston Collaborations, Inc.

June 10, 2013

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EXECUTIVE SUMMARY

This section will serve as an overview of the audit findings with recommendations for moving forward. The overall audit findings, by category, are outlined below. A detailed breakdown of the individual audit categories has been included later in this report. Individual audit worksheets have been attached as a separate PDF file (due to the size of report). File handling moved from York to the Trindel Insurance Fund on April 01, 2012. As such, this is the first CSAC EIA audit.

Category	*Points Available*	*Points*	*Score*
Caseload	1	0	0.00%
Case Review Documentation	189	77	40.74%
Communication	93	88	94.62%
Fiscal Handling	83	77	92.77%
Three Point Contact	52	32	61.54%
Compensability	44	41	93.18%
Indexing	31	29	93.55%
Payments	130	93	71.54%
Medical Treatment	19	18	94.74%
Apportionment	16	15	93.75%
Disability Management	8	8	100.00%
SJDB	12	6	50.00%
Reserves	87	62	71.26%
Resolution of Claim	39	14	35.90%
Settlement Authority	11	4	36.36%
Litigated Cases	12	12	100.00%
Subrogation	0	0	N/a
Excess	3	2	66.67%
Overall Score	830	578	69.64%

After a transition from one administrator to another it is common for it to take the new administrator three to four months to come fully up to speed on the file handling. Some consideration was given for the transition within the audit scores. However, Trindel has had a difficult time getting a handle on the cases. As such, even the more recent file activity did not meet standards on a consistent basis. In our opinion the primary factor for this is staffing. The Claims Supervisor handles a full workload in addition to her supervisory responsibilities. Additionally, there are two adjusters, one who is a trainee and the other who is a mid-level adjuster. Both adjusters could benefit from a high level of oversight which the supervisor is not able to give considering her own claim workload.

their audit scores by getting "back to basics" with mail management, working the diary and file documentation. Having a supervisor that is fully dedicated to supervision would also be very beneficial. It is our opinion that they have the potential to get on track and stay on track by implementing our key recommendations.

KEY RECOMMENDATIONS

Case Review / Documentation
We strongly suggest that Lisa be relieved of her caseload so that she can provide a high level of supervisory oversight. We further suggest that a combination of mini plan of actions and CMR updates be used so that the CSAC 45/90 update standards can be met. The supervisor should look to use a similar approach, using a combination of quick targeted reviews with full supervisory audits. A project should be completed to make sure POA diaries and supervisor review diaries exist on every case.

Three Point Contact
Properly documenting all communications will naturally lead to better audit scores in a wide variety of categories, but will be particularly helpful in the three point contact category. We further suggest that Trindel use the system rules engine to set an automatic diary to for three point contact when an indemnity claim is set up. This may help them to remember to document the contacts on a timely basis.

Payments
Timely mail handling is key to improving the results in this category. If the supervisor could monitor the adjuster's mail to ensure that it is timely processed (in 3-5 business days) then this would be a secondary safety net to ensure that benefits are issued timely.

The adjusters could use some updated training on when to send permanent disability and return to work notices. Again, if the supervisor could monitor the outstanding diaries to watch for permanent disability decisions that would also help improve the scores in this area.

Reserving
By bringing the mail and diary handling current, and keeping it current, this should immediately improve the results in this category. Further, if the supervisor had more time to do comprehensive file reviews, she could assist the adjusters in identifying files that warrant a reserve increase or decrease and help them to forecast future medicals reserves consistent with OSIP standards. Each adjuster should review the OSIP website with respect to expectations with respect to file reserving.
http://www.dir.ca.gov/osip/OSIP-AuditUnit

Resolution of Claim
We would highly recommend that the supervisor review the entire open inventory to identify files ready for closure or settlement and ensure the adjuster is on diary to complete those activities. The supervisor should place an escalated supervisor diary on these cases to make sure they are timely resolved and closed. We found a handful of files that were re-opened for payment and never re-closed. An audit process should be put in place to review claims re-opened in the prior month for possible re-closure. If both of these items are put in to place there should be a permanent reduction in the overall open inventory.

CSAC EIA Training
The supervisor should meet with the adjusting team quarterly to refresh them on all handling standards.

AUDIT RESULTS

AUDIT CRITERIA

The audit criterion was formed by using the CSAC EIA standards. The file audits specifically focused on claims handling activity from April 01, 2012 through the date of the audit.

Trindel Insurance Fund provided a list of the full open inventory and a random selection of the files was pulled to gather 50 files from the open inventory. The file selection consisted of a mix of indemnity claims, future medical files and medical only claims.

Trindel Insurance Fund continues to use the York system which is completely paperless. As a result we performed the audit using the claim system.

AUDIT PROCESS

The audit was completed on site at the Trindel Insurance Fund office and via remote access. Each worksheet was provided to Lisa Mitchell for review and comment.

CATEGORY RESULTS

Caseload

Adjuster	Indemnity	Med Only	Future Med	Total
Lisa (Supervisor)	110	0	44	154
Sarah	140	0	7	147
Andrew	69	17	2	88
Total	319	17	53	389

The CSAC EIA standards indicate that Supervisory personnel should not handle a caseload, although they may handle specific issues. In that Lisa was maintaining a full workload at the time of audit this category was marked down.

Case Review & Documentation

Claims Handling Administrative	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Examiner POA updates every 45/90	1	10	39	50	49	20.41%	95%	No
Quality POA based upon case facts	1	16	33	50	49	32.65%	95%	No
Supervisor review every 120/180	7	4	39	50	43	9.30%	95%	No
MO reviewed for closure/conv @ 90	49	1	0	50	1	100.00%	95%	Yes
File contents comply with state regs	3	46	1	50	47	97.87%	95%	Yes
Category Score	61	77	112	250	189	40.74%		

The majority of the files audited did not meet the standards for plan of action or supervisor updates. This is directly related to the adjuster's not being on diary and the supervisor carrying a full workload.

MO conversion standards were met. The workflow is paperless so documents are electronically date stamped and filed in date order.

Communication

Claims Handling Administrative	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Return calls within 1 working day	23	27	0	50	27	100.00%	95%	Yes
Respond to written inquiries w/in 5 days	32	13	5	50	18	72.22%	95%	No
Comply with member requirements	47	3	0	50	3	100.00%	95%	Yes
Clearly date stamp mail	5	45	0	50	45	100.00%	95%	Yes
Category Score	107	88	5	200	93	94.62%		

There is a close working relationship between the claims unit, the members and the injured employees. The lack of response to written inquiries was solely caused by mail not being worked on a timely basis and this can be traced back to the performance issues described above.

Fiscal Handling

Claims Handling Administrative	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Balance active files 2 x per year	37	10	3	50	13	76.92%	95%	No
Proper Medicare Eligibility verified	22	28	0	50	28	100.00%	100%	Yes
Payments made on correct claim	8	39	3	50	42	92.86%	95%	No
Category Score	67	77	6	150	83	92.77%		

Although the file score did not meet standard, we did feel that Trindel did a good job with file balancing and it was evidenced in most the claims that met the criteria. They seem to have a firm understanding of the purpose of the file balancing exercise.

All cases had proper Medicare Eligibility documented in cases that were settled or in settlement posture.

There were just a few files where payments were found on the wrong claim. In all three situations the person had more than one file open.

Three Point Contact

Claim Creation	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Contact with ER within 3 days	28	18	4	50	22	81.82%	95%	No
Contact with EE within 3 days	28	13	9	50	22	59.09%	95%	No
Contact with MD within 3 days	42	1	7	50	8	12.50%	95%	No
Category Score	98	32	20	150	52	61.54%		

While the claims handling team does a very good job with communication there were a high number of cases where timely documentation of the three point contact was absent or entered late. Based upon

our observations while on-site, it seems that these communications are occurring but the documentation of the communication is not making it in to the file notes.

Compensability

Claim Creation	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Initial decision within 14 days	26	24	0	50	24	100.00%	100%	Yes
AOE/COE investigation within 3 days	45	4	1	50	5	80.00%	95%	No
Delay letter sent in compliance w/DWC	43	7	0	50	7	100.00%	100%	Yes
Final decision within 90 days	42	6	2	50	8	75.00%	100%	No
Category Score	156	41	3	200	44	93.18%		

There was one case where the AOE/COE investigation was started on day 15, rather than day 3, and did not meet the CSAC EIA standard (A-0129). On this same case, the decision date was 08/02/12 but the denial was not issued until 09/19/12.

On audit file number A-0151, when the case became litigated, the add-on body parts were not timely denied.

Indexing

Claim Creation	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Indexing done at time of set up	25	25	0	50	25	100.00%	95%	Yes
Claim reindexing annually (as needed)	44	4	2	50	6	66.67%	95%	No
Category Score	69	29	2	100	31	93.55%		

Initial indexes are routinely completed on all cases that met the criteria. Trindel has a good workflow in place for this. There were just a couple of files that we felt could benefit from re-indexing, audit file numbers A-0138 and A-0132.

Payments

Claim Handling Technical	*# of files category n/a*	*# of files meets standard*	*# of files does not meet standard*	*Total Files*	*# of files meeting criteria*	*Score*	*Standard*	*Meets Standard*
Initial TD/PD payment within 14 days	37	7	6	50	13	53.85%	100%	NO
DWC notice within 14 days	32	11	7	50	18	61.11%	100%	NO
Subsequent TD/PD payments timely	38	5	7	50	12	41.67%	100%	NO
Timely final pymt w/proper DWC notice	36	3	11	50	14	21.43%	100%	NO
SIP paid on late payments	42	6	2	50	8	75.00%	100%	NO
Overpayments identified & reimbursed	49	1	0	50	1	100.00%	95%	YES
Undisputed awards paid in 10 days	50	0	0	50	0	100.00%	95%	N/A
Copy of award to excess on excess clms	49	1	0	50	1	100.00%	95%	YES
Mileage paid in 15 days	42	7	1	50	8	87.50%	95%	NO
Medical bills paid in 60 days	12	38	0	50	38	100.00%	100%	YES
Objection letters in 30 days on disp bills	46	4	0	50	4	100.00%	100%	YES
Advance travel paid 10 days prior	43	4	3	50	7	57.14%	95%	NO
Penalties coded correctly	44	6	0	50	6	100.00%	100%	YES
Penalty reimbursement plan	50	0	0	50	0	No Score	95%	N/A
Category Score	570	93	37	700	130	71.54%		

Given the number of files involving late payments we refer you to the individual worksheets. Late payments were often driven by late handling of mail or failure to recognize what benefit notice was due and when. For the most part, self-imposed penalties were paid when the benefits were issued untimely.

Medical Treatment

Claim Handling Technical	*# of files category n/a*	*# of files meets standard*	*# of files does not meet standard*	*Total Files*	*# of files meeting criteria*	*Score*	*Standard*	*Meets Standard*
Proper use of UR	36	13	1	50	14	92.86%	100%	NO
SSSOP process used in surgery disputes	50	0	0	50	0	No Score	100%	N/A
NCM used appropriately	45	5	0	50	5	100.00%	95%	YES
Category Score	131	18	1	150	19	94.74%		

Although there one situation that did not get timely referred to UR (audit file #A-0128), the adjusters seem to have a good handle on what treatment should be approved outright and what should be sent to UR. It is our opinion that they do a good job using UR and medical case management as a tool where warranted.

Apportionment

Claim Handling Technical	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Apportionment ruled in/out	42	7	1	50	8	87.50%	100%	NO
Apportionment pursued	42	8	0	50	8	100.00%	100%	YES
Category Score	84	15	1	100	16	93.75%		

Apportionment was recognized and pursued on all but one claim that was audited. In that situation, audit file #A-0134 the employee has a long history of claims with the member. As such, each one needs to be reviewed for the body parts involved and to determine if there was any permanent disability assigned to the same body parts to identify or rule out apportionment potential.

Disability Management

Claim Handling Technical	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Proactive RTW coordination	42	8	0	50	8	100.00%	95%	YES
Member notice of perm work restric.	50	0	0	50	0	No Score	100%	N/A
20 day member f/u on perm mod/alt	50	0	0	50	0	No Score	100%	N/A
Category Score	142	8	0	150	8	100.00%		

Outstanding return to work coordination was demonstrated in the claim files with no exceptions noted. The team has a high level of communication with the member and employee which fosters timely return to work.

SJDB

Claim Handling Technical	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
SJDB concluded appropriately	44	3	3	50	6	50.00%	95%	NO
SJDB provided timely	44	3	3	50	6	50.00%	100%	NO
Category Score	88	6	6	100	12	50.00%		

Consistent with the payment section above, there does not seem to be a full understanding by the adjusters (not including Lisa) as to when these notices are due.

Reserves

Claim Handling Technical	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Initial reserves within 14 days	14	24	0	38	24	100.00%	95%	YES
Initial reserves represent probable value	26	21	3	50	24	87.50%	95%	NO
Reserves adjusted timely w/event	26	8	16	50	24	33.33%	95%	NO
TD / 4850 reserves separate	49	1	0	50	1	100.00%	100%	YES
PD exposure includes LP if applicable	49	1	0	50	1	100.00%	100%	YES
FM reserved consistent with SIP stand	37	7	6	50	13	53.85%	100%	NO
Category Score	201	62	25	288	87	71.26%		

Initial reserves were set timely and for the most part were accurate. There was a prevailing theme of reserves not being timely adjusted which directly relates to the timeliness of mail handling and addressing the diary. There were 14 claims where an increase was recommended and 3 claims where a decrease was recommended. The overall reserve variance was $370,085. There does not appear to be a consistent understanding of how to reserve future medical files consistent with OSIP standards.

Resolution of Claim

Claim Handling Technical	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Resolution pursued within 10 days	19	9	22	50	31	29.03%	95%	NO
Settlement valuation appropriate	42	5	3	50	8	62.50%	95%	NO
Category Score	61	14	25	100	39	35.90%		

Again, there was a prevailing theme of resolution and/or closure not being pursued timely which is also directly related to timely mail handling and addressing the diary. The auditor found a number of files that were ready for immediate closure or had only a small amount of work to be completed to achieve file closure.

Settlement Authority

Claim Handling Technical	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
CSAC approval of settlement	50	0	0	50	0	No Score	100%	N/A
Settlement proposal timely/accurate	42	1	7	50	8	12.50%	100%	NO
Member settlement approval	47	3	0	50	3	100.00%	95%	YES
Category Score	139	4	7	150	11	36.36%		

Member settlement approval was obtained when warranted. Consistent with the Resolution of Claim Category, claims were not timely worked up for settlement on a regular basis.

Litigated Cases

Litigation	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Initial investigation as relates to litigation	45	5	0	50	5	100.00%	95%	YES
DA from assigned panel	43	7	0	50	7	100.00%	95%	YES
Member involved for depo, trial, etc.	50	0	0	50	0	No Score	95%	N/A
Total Score	138	12	0	150	12	100.00%	95%	

Litigation was timely and appropriate addressed on all cases that met the criteria. No exceptions were noted. Despite the lags in claims handling described throughout this audit report this did not seem to trigger additional litigation. Overall, the program seems to have fairly low litigation.

Subrogation

Subrogation	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Identify & notice 3rd party in 14 days	50	0	0	50	0	No Score	95%	N/A
Periodic contact w/3rd party	50	0	0	50	0	No Score	95%	N/A
Member involved in complaint vs. lien	50	0	0	50	0	No Score	95%	N/A
Complaint or lien filed timely	50	0	0	50	0	No Score	95%	N/A
Subro pursued for max recovery	50	0	0	50	0	No Score	95%	N/A
Total Score	250	0	0	250	0	No Score	95%	

There were no files with subrogation potential within the audit sample. As a result, there is no score for this category.

Excess Coverage

Excess Coverage	# of files category n/a	# of files meets standard	# of files does not meet standard	Total Files	# of files meeting criteria	Score	Standard	Meets Standard
Report to excess 5 days from trigger	41	0	1	42	1	0.00%	100%	NO
Ongoing reports 3M0/6MO (FM)	49	1	0	50	1	100.00%	95%	YES
Reimbursement requests quarterly	49	1	0	50	1	100.00%	95%	YES
Closing report sent	50	0	0	50	0	No Score	95%	N/A
Total Score	189	2	1	192	3	66.67%	95%-100%	

With the exception of the one late initial report, excess reporting was maintained current on the files audited.

AUDIT TEAM

Angela Livingston, Owner & President

Senior Executive with 20 years claims leadership, marketing, business development, and operations experience in multi-jurisdictional workers' compensation. Recognized for developing innovative solutions to unique customer situations through the integration of technology and creative case management services.

Claim Auditing	Public Speaking
Contract Negotiation	Stewardship Reporting
Due Diligence	Strategic Planning
Operational Review	TPA Oversight & Management
Procedure Development	Training
Project Management	Vendor Management

Trindel
Insurance Fund

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A Joint Powers Authority Established in 1980
www.trindel.org

July 10, 2013

Claims Review Committee
CSAC - EIA
75 Iron Point Circle, Suite 200
Folsom, CA 95630

RE: Workers' Compensation Claims Audit 2013

Dear Committee:

On behalf of Trindel Insurance Fund, thank you for the time and effort it took to review our claims. The audit process is an important tool for us as well, as we endeavor to improve the work product and service that we provide to our members. We are not disputing any of the audit results. As you may or may not know in April 2012 Trindel built a claims department from the ground up. As mentioned in the audit we are a close working group that is very receptive to improving and values the feedback the audit provided. Providing excellent claims handling to our members and their employees is our number one priority.

What was not mentioned in the audit is how this audit compared with the previous audit. As shown below the overall audit score (2013) is in line with the 2012 audit score, with seven areas of improved performance, and Disability Management remaining at a 100%.

	2011/2012	2012/2013	Improvement ?
Case load		0%	Not Evaluated Last Time
Case Review Documentation	48%	41%	NO
Communication	73%	95%	YES
Fiscal Handling	33%	93%	YES
Three point contact	73%	62%	NO
Compensability	80%	93%	YES
Indexing	50%	94%	YES
Payment	87%	72%	NO
Medical treatment	100%	95%	NO
Apportionment	84%	94%	YES
Disability Management	100%	100%	Remains Perfect
SJDB	85%	50%	NO
Reserves	87%	71%	NO
Resolution of Claim	65%	36%	NO
Settlement Authority	100%	36%	NO
Litigation	73%	100%	YES
Subrogation	17%		Not Evaluated

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Excess	50%	67%	YES
AOE - COE and other investigations	87%		Not Evaluated
Medicare Reporting	100%		Not Evaluated
	70%	70%	

Our team is committed to excellence and is diligently working on the recommendations in the report. As Executive Director, I take the audit very seriously and will be providing the tools and resources needed to improve our product and audit score. I agree with Ms. Livingston in that having a supervisor fully dedicated to supervision would be beneficial, but given our size I don't believe that it is cost effective. We are currently in the process of decreasing the supervisor's case load, but I don't foresee eliminating the supervisor's caseload entirely.

Below you will find responses to the recommendations listed in the audit.

Case Review/Documentation:

- While we agree improvement is greatly needed in this area, there are a few factors that added to this low score. Upon receiving the files 101 cases were coded as being settled when they were not. The 101 cases were diaried for 90/180 review updates when they should have been 45/120 updates.
- As part of the exit audit in March 2012 that Trindel requested, the previous TPA was asked to update the claims status on all claims. This was done mid-March 2012. This resulted in a deluge of files needing to be reviewed by examiners and the supervisor from mid-May through July, which was not enough time to get through reviewing all the acquired files. In the meantime we were receiving new claims that needed processing.
- To improve in this category we have identified all the cases which were miscoded as being settled, and have diaried them appropriately. We have tightened our time frames for the examiner and supervisor to review claims. Indemnity claims will be reviewed every 30 days by the examiner, and every 75 days by the supervisor. Future medical claims will be reviewed every 75 days by the examiner and every 160 days by the supervisor. Medical only claims will be reviewed every 30 days.

Three-Point Contact:

- We have developed a work flow check list to ensure we are contacting all parties within 3-days, and we are utilizing a letter to the employee asking them to contact us about their claim. We are focusing on being more careful in documenting the file, and scanning our emails from the employer into the file immediately.

Payments:

- We will be utilizing a manual "Comp-Due" diary system, and training our medical-only examiner to help in monitoring and paying benefits. We will also utilize the automatic recurring payments system more than we have in the past.

Reserving:

- We acknowledge our deficiency in reserving, and have reviewed the OSIP standards. Additional training is planned in this area.

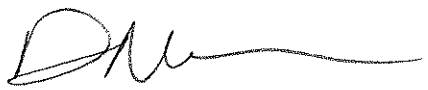
Resolution of Claim:

- The supervisor is running a monthly report to review claims for closure and settlement. A separate report is generated for re-opened claims to monitor them for closure. For medical only claims we will call the provider to make sure they have submitted all bills to us before we close the file. Our intent is to reduce the need for having to reopen claims for payment.
- We will also have a monthly "Case Strategy" meeting for examiners to bring one or two of their cases to the group that they have had difficulty getting to move forward, or settled. The group will help with ideas on bringing the claim to resolution.

Training:

- The supervisor will schedule on-going mini-trainings every two weeks for examiners to go over benefit notice requirements, SJDB rules, the CSAC Claims Handling Guidelines, and any other additional training that is needed to keep them current and on target.

Sincerely,



David Nelson, Executive Director