

Martin Matson
Comptroller

John M. Egan, CPA
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Office of the Comptroller

October 5, 2012

To the Honorable Common Council
City of Milwaukee

Dear Council Members:

As a component of the Comptroller's comprehensive audit work plan, Jacobson and McNabb Consulting, Inc. were engaged to complete the claims management portion of the Workers' Compensation audit. The Comptroller's Office recently received the enclosed final report detailing the results of the claims management testing performed by Jacobson and McNabb in July-August 2012. The report contains findings and recommendations in order to improve the Workers Compensation function to better plan, track, and resolve Workers Compensation cases.

The consultant who performed this audit has extensive experience and subject matter expertise in best practices and industry standards for Workers Compensation claims management. The testing for claims management conducted examined seven categories including the investigation phase, recovery phase, medical management, evaluation, reserves, negotiation/disposition, and customer service. For further detail on these categories, please see the attached full-detail report from Jacobson and McNabb Consulting, Inc.

The consultant tested a total of 69 files. A system of compliance was utilized for testing; either the file was compliant with best practices for that category or not compliant. Results are shown below:

Attributes Tested	Investigation	Recovery	Medical Management	Evaluation	Reserves	Negotiation/Disposition	Customer Services
Total Files Tested	69	10	69	50	50	69	69
Total in Compliance	61	8	49	4	19	54	24
% in Compliance	88.4%	80%	71.0%	8.0%	38.0%	78.3%	34.8%

Total Average Compliance % = 56.9%

From the testing conducted, Jacobson and McNabb Consulting Inc. was able to make recommendations to improve the claims management process administered by the Workers Compensation function of the Department of Employee Relations. Within the consultant's report itself, explanations of specific findings are provided by category to give the users of this report a better idea of the current condition of claims management for these files tested.



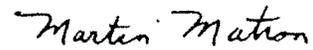
The 10 recommendations are listed below:

1. Formalized claim handling guidelines that are consistent with best practices need to be written and adhered to by the claim department.
2. A review of all open files should be done to determine which files can be closed, thereby having an accurate inventory for open claims.
3. Files need to be evaluated consistently documenting the exposure and a plan of action to move the file to conclusion.
4. Reserves should more accurately reflect full value of the case on a timely basis, avoiding stair stepping.
5. Adjuster authority levels should be more in line with industry standards which are \$50,000 for claim adjusters and \$100,000 for Senior Claim Adjusters. This allows more oversight on high exposure claims and will result in a better strategy to conclude the claim which will reduce the final cost of the claim.
6. Files above \$100,000 should be set for a strategy meeting including the Claims Manager and a Senior Adjuster, using the attached Action Initiator form to document the outcome.
7. The use of a managed care nurse should be implemented on all complex cases. Guidelines for usage include injuries with pre-existing injuries, claims that involve surgery, injuries that claimants remain off work more than 45 days and injuries that require medical treatment more than 90 days. *It is important to note that the Workers Compensation function does utilize nurse case management on rare occasions for very complex cases. In the past, the team did have a full time nurse on staff to aid in these cases, but this position was eliminated due to budgetary restrictions in 2007.*
8. All lost time claims need to be assigned to the adjuster within 24 hours and telephone contact with the claimant should be made within 24 hours of the assignment.
9. Medical only claims above \$5,000 should be reviewed by a Senior Claim Adjuster.
10. Files should be reviewed for reserve accuracy both for increases and decreases/closure on an annual reconciliation review. This will insure that the outstanding claim count and the corresponding financials are correct.

Management of the Workers' Compensation function of the Department of Employee Relations has responded to each recommendation. The response follows the consultant's detailed report.

Appreciation is expressed for the cooperation extended to the auditors by the staff of the Department of Employee Relations.

Sincerely,

A handwritten signature in cursive script that reads "Martin Matson".

Martin Matson
Comptroller

CC: Maria Monteagudo

MM:as



JACOBSON & McNABB
CONSULTING, INC.

Jeffrey J. Moerschel, CPCU, SCLA
Vice President

jmoerschel@jandmconsulting.net
262-754-5227

August 10, 2012

Ms Aycha Sirvanci, CPA
Audit Manager
City of Milwaukee
200 E. Wells Street
Milwaukee, WI 53202

RE: Workers Compensation Claim Audit

Dear Aycha,

The audit of the 69 open workers compensation files was conducted on July 26 – August 1, 2012 at the claim department's office. Individual audit sheets were completed on each file. I audited the 69 Workers Compensation claims against current Best Practices to determine if the City of Milwaukee claim department was following these practices in the management of the claims. Overall the City of Milwaukee earned a score of 56.9% (this is the combined score for all files reviewed in the seven categories discussed below), which needs improvement.

The City of Milwaukee claim department is currently comprised of a Claim Manager, a Management Services adjuster (current outstanding is 45 indemnity and 18 medical claims), two Claim Adjuster Specialists (authority level is \$300,000 per file, one has an outstanding of 134 indemnity and 19 medical claims, the other has 201 indemnity and 23 medical claims), three Claim Adjusters (authority level is \$200,000 per file, one has 99 indemnity and 19 medical claims, another has 94 indemnity and 15 medical claims, another has 115 indemnity and 25 medical claims), one Claim Representative (authority level is \$100,000 per file and has 88 indemnity and 61 medical claims), one temporary adjuster (authority level is \$50,000 per file and has 39 indemnity and 15 medical claims) and one clerical position to handle 306 medical claims.

The industry average case loads for adjusters handling indemnity claims is 150 open cases and for clerical medical only claims is 300. Authority levels within the industry vary depending on the expertise of the adjuster. Claim Adjusters typical have \$50,000 per claim authority and Senior Adjusters have \$100,000 per claim authority for the purpose of reserving and paying claims. When the reserve or payments exceed these amounts the supervisor or management needs to authorize it.

Of the 69 claims reviewed, 21 were closed after the audit was announced or need to be closed based on my review. There are 10 that should be closed that total \$126,800 outstanding reserves. The other 11 were closed in late July 2012.

The audit focused in on seven specific categories: Investigation, Recovery, Medical Management, Case Evaluation, Reserves, Negotiation/Disposition and Customer Service. Each of these categories was evaluated for compliance to Best Practices and individual scores were determined. The following is a summary of the results for each category.

Investigation

This category focuses on the discovery of the facts of the case in order to determine compensability and wage information. Timeliness and completeness of the investigation are measured. The compliance in this category was 88% (61 of 69 files). Follow up investigation was completed when needed, however, the following claims are some of the deficient files:

██████ - This is a questionable causation claim. The claim was reported on 6/16/2010. The claimant was first contacted one month later. There are numerous requests from the claimant requesting the status of the claim. The claim was finally denied on 1/11/2011.

██████ - This claim was reported on 1/4/2012. There was no investigation regarding compensability when reported. The Independent Medical Exam to determine compensability was first requested on 6/18/2012.

██████ - This is a hearing loss claim reported 10/14/2011. There is no investigation in the file, no forms sent to the claimant.

██████ - The claim was reported on 5/25/2010 and there was no initial investigation. There are several attempts to obtain medical records, however, there are medical notes in the file received 8/24/2010.

Recovery

This category determines if there is potential recovery from a third party who is legally responsible for the incident or if there are other sources of recovery. The compliance in this category was 80% (8 of 10 files). The following files were deficient:

██████ - This is a motor vehicle accident involving an emergency vehicle that was struck. There was not an investigation other than the police report which issued a citation to the at fault driver. There is mention of contact with Allstate who is the carrier, however, nothing in the file showing a lien filed. There are several comments to follow up but never done. The last entry is 5/3/2011 stating will follow up and never does. The statute of limitations ran 9/9/2011.

██████ - The accident occurred when a fiberglass ladder broke causing the claimant to fall. There is no investigation regarding the cause of the failure or inspection of the ladder.

Medical Management

This category determines if case management was needed to reduce the lost time or medical expenses. Such items as return to work, cost containment and independent medical exams are considered. The compliance was 71% (49 of 69 files). Nurse case management is not utilized at the City currently. The industry standard is to use nurse case management to work with the treating doctor to provide the best medical care and assist in returning the employee to work. This will reduce the overall cost of the claim for both medical cost and wages paid. Most employees elect to use accumulated sick leave rather than temporary total disability benefits, therefore, it is important to aggressively pursue return to work programs. The following claims are some of the deficient files:

██████ - The claimant sustained an injury to the shoulder which required surgery on 6/28/11. There was no nurse case manager assigned to assist in return to work and medical management. Claimant returned to work light duty 12/6/11 which could have been reduced. The request for the final medical report was never responded to and there should have been a request for an Independent Medical Exam.

██████ - The incident occurred three years ago and claimant had continual treatment and is now scheduled for surgery with the possibility of a second surgery. There was no nurse case manager assigned to control medical treatment and now with surgery scheduled a nurse case manager should be used.

██████ - This claim involves a torn rotator cuff injury requiring surgery. The surgery took place on 5/18/2010. The claimant was released for light duty, however, nothing available. The claimant was not released to return to work until 10/6/2010. The claimant continued to treat for the injury continuously until May 2011. A nurse case manager should have been assigned to facilitate the medical management and return to work.

██████ - This claim involves an injury to the shoulder. There are two other claims, one for the neck and one for the lower back. There was an Independent Medical Exam on 1/26/10 which is two years after the claim occurred. A nurse case manager should have been assigned when the claimant had the initial surgery to manage the treatment and assist in return to work.

Evaluation

This category determines the action plan for resolution of the case and provides the basis for determining reserve adequacy and disposition. The supervisory input into the action plan and overall file management is also considered. Compliance in this category was 8% (4 of 50 files). This is a critical portion of the claim file and improvement will result in better disposition of the claim. There is no plan of action to conclude. There were files

that were not reviewed for six months to one year. There is no ongoing supervisory input. The only evidence of supervision was when the claim representative initiated a strategy meeting. The lack of this supervisory input contributed significantly to the poor results in this area. The following claims are some of the deficient files:

██████ - This is a hearing loss claim reported on 3/8/2010. The adjuster sent the hearing loss letter on 3/18/2010 and spoke with him on 4/26/2010. This is the last note in the file until 2/12/2012, when the claimant was contacted and the claim settled. The claimant completed the form on 7/6/2010. The forms to finalize the claim were sent 7/25/2012, five months after the claim was settled. The file is off diary with no supervisory input.

██████ - There is no plan of action documented to conclude the file. The file was reassigned to the current adjuster 2/11/2011 and the only adjuster note in the last year and a half is on 7/16/2012 stating claimant to have surgery on the left elbow and probably on the right elbow later. There is no supervisory input in the file.

██████ - There is no ongoing plan of action to conclude the claim. There are several discussions with management regarding the future handling, however, not completed. The file has not been reviewed since 3/16/2012.

██████ - There is no plan of action to resolve the case. The adjuster was assigned on 11/3/2010 and first reviewed on 1/22/2012. The file is currently off diary since then.

██████ - There is no ongoing plan of action to conclude the claim. Initially sent an introductory packet to the claimant on 11/28/2011 and no further input until 7/18/2012, when the adjuster talked to the claimant and ruled out subrogation and no treatment other than the initial emergency room visit. Claim was off diary and no supervisory input.

Reserves

The financial reserves for both losses and expenses are based on the evaluation of the case from the beginning and can change throughout the life of the file. The reserve should accurately reflect the probable ultimate payment for the exposure. While reserve changes are inevitable, they should be done with a complete evaluation of the exposure and documented for the amount, thus eliminating frequent stair stepping of the reserve. Reserving additionally needs to be done timely, within 30 days of a change in exposure. The compliance in this category was 38% (19 of 50 files) mostly due to untimely reserve activity. Files need to be reviewed for closing of the file or individual reserves where the exposure is closed. The lack of management input in the reserving practices contributed greatly towards the poor results in this area. The following claims are some of the deficient files:

██████ - The initial medical reserve was established on 3/19/2010, which is more than 30 days after the claim was assigned. There are 30 reserve increases all of which

are small amounts and not for the lifetime exposure. There is no documentation for the reserves.

██████ - The medical reserve was established on 2/2/2009, one year after it was reported and there are 21 reserve increases all for minimal amounts and not the lifetime exposure. The indemnity and adjusting reserves also have multiple increases.

██████ - The claim was set up on 8/21/2009 and the medical reserve was setup on 9/21/2009. There are eight medical reserve increases all for minimal amounts and not the lifetime exposure. There is no documentation for the amount of reserve.

██████ - There are 15 medical reserve increases on the claim all of which are for minimal amounts and not for the lifetime exposure. Currently the file is open and yet it has been settled. There is no documentation explaining the reserves.

██████ - The medical reserves were increased 20 times from 3/12/2009 through 7/20/2010 when the file closed. It reopened 2/13/2012 and there have been 8 increases since then, all for minimal amounts and not the lifetime exposure.

Negotiation/disposition

Negotiations and disposition are the end result of the other categories and a documented settlement plan is critical as it forces a good evaluation and aides in resolving the case for the most cost effective amount. Settlement negotiations should be conducted timely and in most instances by the adjuster. When the city attorney's office is used, there needs to be a litigation plan to determine how the defense will proceed and an evaluation of the exposure from defense counsel. The compliance in this category was 78.3% (54 of 69 files). The following claims are some of the deficient files:

██████ - The Permanent Partial Disability rating was received on 1/17/2012 and paid on 7/18/2012 which is six months later. The file remains open with an outstanding reserve of \$45,741 which can be closed.

██████ - The medical report received on 12/12/2011 states the claimant can return to work on 12/12/2011 and Maximum Medical Improvement will be 1/12/2012. No follow up until 7/18/2012 to close file.

██████ - The claim was reported 6/23/2010 and set up. The medical was reviewed one year later and denied. The file remains open.

██████ - The permanency rating came in at 14% from the claimant's doctor and the statute calls for 10%. There was no compromise attempted and the claimant retained an attorney now looking for much more. There should have been an attempt to settle.

Customer Service

This category measures the timeliness of establishing the file upon receipt, responding to requests for information, the adherence to statutory requirements and the timeliness of issuing payments. The industry standard is to assign lost time cases to an adjuster within 24 hours from the claim being reported. The adjuster should make contact with the claimant by telephone within 24 hours to confirm the facts of the loss, the extent of the injury and what their benefits are. In this category the compliance was 34.8% (24 of 69 files). The majority of the files are not assigned promptly and no immediate contact with the claimant is made other than an introductory information packet sent in the mail. The following claims are some of the deficient files:

- ██████ - The claim was received on 12/16/2009 and first assigned on 1/7/2010. The first contact with the claimant was on 5/20/2010 after the surgery was done.
- ██████ - The claim was reported on 1/13/2011 and not assigned until 3/7/2011 as a medical only claim. The adjuster was assigned on 4/19/11 and the first contact with the claimant was 8/9/11.
- ██████ - The claim was reported on 11/24/2010 and not assigned until 1/30/2010. There was no contact with the claimant other than an information packet sent.
- ██████ - The claim was reported on 2/14/2008 and assigned on 2/25/08. There was no contact with the claimant until 6/26/2008.

Conclusion

Overall the handling of these cases needs improvement in all of the categories reviewed. Proper evaluation will result in better reserving practices and disposition of the file. The following recommendations will assist in accomplishing this.

- Formalized claim handling guidelines that are consistent with best practices need to be written and adhered to by the claim department.
- A review of all open files should be completed to determine which files can be closed, thereby having an accurate inventory for open claims.
- Files need to be evaluated consistently documenting the exposure and a plan of action to move the file to conclusion.
- Reserves should more accurately reflect full value of the case on a timely basis, avoiding stair stepping. The reserves need to be documented on all lines, indemnity, medical, and adjusting. I am including a reserve estimate sheet that can be used to achieve this.

- Adjuster authority levels should be more in line with industry standards which are \$50,000 for Claim Adjusters and \$100,000 for Senior Claim Adjusters. This allows more oversight on high exposure claims and will result in a better strategy to conclude the claim which will reduce the final cost of the claim.
- Files above \$100,000 should be set for a strategy meeting including the Claim Manager and a Senior Adjuster, using the attached Action Initiator form to document the outcome.
- The use of a managed care nurse should be implemented on all complex cases. Guidelines for usage include injuries with pre-existing injuries, claims that involve surgery, injuries that claimants remain off work more than 45 days and injuries that require medical treatment more than 90 days.
- All lost time claims need to be assigned to the adjuster within 24 hours and telephone contact with the claimant should be made within 24 hours of the assignment.
- I am including a list of industry standard Best Practices that should be considered on a going forward basis.
- Medical only claims above \$5,000 should be reviewed by a Senior Claim Adjuster.
- Files should be reviewed for reserve accuracy both for increases and decreases/closure on an annual reconciliation review. This will insure that the outstanding claim count and the corresponding financials are correct

Thank you for the opportunity to assist you with this audit. If there are any questions, please let me know. I am enclosing our invoice for services for your review.

Sincerely,



JEFFREY MOERSCHEL, CPCU, SCLA
Vice President

ATTACHMENTS

Trend sheet
Best Practices
Reserve estimate form
Action Initiator
List of files to be closed



Department of Employee Relations

October 4, 2012

Tom Barrett
Mayor

Marta Montaagudo
Director

Michael Brady
Employee Benefits Director

Martin Matson
Comptroller
City Hall, Room 404
Milwaukee, WI 53202

Dear Mr. Matson:

The Department of Employee Relations has reviewed the findings, conclusions, and recommendations presented by Jacobson & McNabb Consulting, Inc., the firm hired by the Comptroller's Office to complete the Worker's Compensation Claims Management Audit.

Before addressing specific issues raised in the audit report, this response provides an overview of factors to be considered in understanding the business environment of the worker's compensation section in the Department of Employee Relations.

Staff Reductions: Since 2004, the Worker's Compensation Section has experienced a 26.3% reduction in staff members including the elimination of a Claims Adjuster Supervisor, Occupational Health Nurse, Claims Representative, and other administrative support positions.

Migration from Mainframe Claims Management Application to New System: In 2008 DER migrated from a mainframe application to a new claim processing system. The transition to the new iVOS system has been challenging and has required numerous and complicated upgrades over the past four years. With each upgrade the system has lost key features, functions, and reports that have had to be restored and tested to ensure proper functioning after each upgrade. The Worker's Compensation and Safety Manager serves as the iVOS Coordinator and is responsible for oversight of the system and supervision of administrative functions. The Coordinator is responsible for all the system testing leading up to any upgrade both before and after the implementation and for providing ongoing and new training and to staff members.

New Centers for Medicare Services (CMS) Reporting Requirements: Effective January 1, 2010 reporting to CMS became mandatory for employers that have active employees who are injured on the job and are enrolled in Medicare or might become enrolled in Medicare. DER's Worker's Compensation and Safety Manager is the CMS Account Manager for both the City and MPS. The Worker's Compensation and Safety Manager works closely with ITMD to identify and submit reportable claims and any settlements associated with those claims. The reporting functions must adhere to a strict timeline or DER will be penalized. The Worker's Compensation and Safety Manager has to learn CMS reporting requirements and continuously manage the reporting functions in order to meet the stringent deadlines and avoid penalties.

Focus on Risk Management Initiative: In 2009, DER and the Department of Administration Budget and Management Division developed a Risk Management Program for injury prevention in order to bridge a large disconnect between workplace safety at the department level and the impact of those injuries on worker's compensation related expenditures that are budgeted in DER.

The program's accountability structure relies on department heads, safety personnel, and front line supervisors to identify, address and manage safety concerns and to focus on three main areas: understanding the cause and nature of injuries, identifying and implementing preventive measures and creating programs that expedite return to work options for injured employees.

The development and implementation of the Risk Management Program and the requirement to develop annual safety plans has contributed to a decrease of 29% in injury claims, a decrease of 30% in recordable cases, and a decrease of 37% in lost workdays since 2008. In addition, the program has facilitated the implementation of return to work programs, the development of accident investigation protocols and policies at the supervisory level, and the inclusion of safety performance measures in job descriptions and performance appraisals.

I look forward to discussing the findings of the audit with Committee members and sharing the results of action plans implemented. I also want to take the opportunity to thank the Comptroller's Office for their patience throughout this process.

Please don't hesitate to contact me at your convenience if you have additional questions/concerns.

Sincerely,



Maria Monteagudo
Employee Relations Director

cc: Aycha Sirvanci, CPA – Office of the Comptroller

DER Response to the Claims Management Audit

Recommendation 1: Formalized claim handling guidelines that are consistent with best practices need to be written and adhered to by the claim department.

DER agrees with this recommendation and the department has written guidelines available for all levels of claim processing. The guidelines are modified in accordance with changes to Worker's Compensation Law, upgrades to the iVOS system, and changes with CMS reporting.

DER will ensure that the guidelines are current and readily available to staff. DER will also continue to review any changes and reinforce established guidelines during monthly staff meetings and individual quality review sessions.

Recommendation 2: A review of all open files should be done to determine which files can be closed, thereby having an accurate inventory for open claims.

DER agrees with this recommendation. An audit of all open files has been ongoing and will be completed by December 2012. An annual reconciliation procedure is also completed in preparation for annual reports that are prepared in the first quarter of each year. A revised Quality Claim Review Process will also help pinpoint open files that may need to be closed. In addition, periodic reports will be run to monitor claim closure rates as part of metrics that are collected for the Risk Management Program.

Recommendation 3: Files need to be evaluated consistently documenting the exposure and a plan of action to move the file to conclusion.

DER agrees with this recommendation but disagrees with the report's statement about lack of consistent and regular supervisory input. There is supervisory input on a regular basis via consultations with staff, periodic strategy meetings, and through the "monitoring caseload manager" feature on the iVOS system. The Worker's Compensation and Safety Manager also reviews all payment approvals before processing and has the ability to stop, delay, or authorize a payment based on the circumstances of the case.

The Worker's Compensation and Safety Manager holds three regular weekly meeting to specifically address claims issues and claim management strategies:

- 1) Tuesday one on one meetings with staff members that focus on claim issues and performance;
- 2) Wednesday meetings that focus on litigated claims and issues pertaining to litigation for senior staff;
- 3) Thursday strategy meetings which include a mixture of litigation and regular claim issues with the adjusting staff.

To date in 2012, over 140 claims have been reviewed in the strategy meetings. This does not include incidental cases that are reviewed individually due to either customer calls or staff assists.

In addition to the on-going supervisory input, by the end of September a revised Quality Claim Review Process will be implemented in the department. This process will be conducted by the Worker's Compensation and Safety Manager and the Management Services Adjuster as a monitoring and training tool on a monthly basis. Claims will be randomly selected and reviewed for timeliness and accurate claims adjusting, meeting state requirements, pursuing return to work options, following correct reserving procedures, and providing courteous and timely customer service. Details from the reviews will be documented on the Quality Review Form and the Quality Supplement Forms.

Please reference the Quality Claim Review Process in Appendix A for additional information.

Recommendation 4: Reserves should more accurately reflect full value of the case on a timely basis, avoiding stair stepping.

DER agrees with this recommendation. The department's ability to correctly set reserves was limited by the new iVOS claims management system upon implementation because the system's reserving capacity did not meet the needs of the department. A decision was made at that time to correct some of the other critical system problems before focusing on the reserving problems.

However the recent upgrade to the system has provided improved functionality for reserving procedures. Staff will now be able to adjust protocols and entries according to new procedures which allows DER to better project expenditures for the life of the claim and utilize the information for more realistic budgeting purposes.

See the Reserving Procedures in Appendix B for more information.

While DER concurs that the stair stepping of reserves should be avoided, there are certain circumstances that warrant this practice as described below:

- 1) Clerical Support Staff are responsible for processing medical only claims and are not trained to set reserves so an initial reserve is automatically established and any payments above the initial amount must be approved by management.
- 2) Temporary Adjusting Staff are not trained in reserve procedures due to the short-term nature of the assignment and for claims that are assigned temporarily, reserves are handled as payments are made. If the claim requires long term handling it is reassigned and a permanent reserve is set.
- 3) Weekly imported files from Corvel contain payments on claims that must be added to the iVOS payment system after the reserves are met.

DER plans to provide continuous in-service and training updates for staff on reserving procedures.

Recommendation 5: Adjuster authority levels should be more in line with industry standards which are \$50,000 for claims adjusters and \$100,000 for Senior Claim Adjusters. This allows more oversight on high exposure

DER agrees with this recommendation; however the current adjuster authority levels do not follow industry standards because of issues with the reserving functionality of the iVOS claims management system.

The authority levels set at this time within the system were set in response to past system problems that prohibited payment or the input of payments by the worker's compensation staff. Most of the problems have been addressed with the upgrade to the current version. DER understands the need for oversight and is working to correct all problems with the reserving feature. When the system problems are all addressed and resolved the adjuster authority levels will be revised. In the meantime, the reserves will be monitored from the resources available on-line.

Recommendation 6: Files above \$100,000 should be set for a strategy meeting including the Claims Manager and a Senior Adjuster using the Action Initiator form to document the outcome.

DER agrees with this recommendation and already holds regular meetings each week to strategize and address complex claims and associated issues. Strategy meetings for controversial or difficult files are

conducted each Thursday morning in addition to a separate meeting for litigated files. The outcomes of these strategy meetings are documented in the iVOS claims management system on the Claim Presentation Form that is housed on the Correspondence Tab or on the Strategy Tab which is one of the individual Claim Tabs within the system.

DER plans to continue the practice of holding weekly strategy meetings and will increase the number of claims reviewed at each meeting to ensure that all critical claims are adequately addressed. DER will also continually emphasize the importance of documenting and tracking decisions that arise from the meetings and follow-up action items that need to be pursued.

In addition, see DER's response to Recommendation #3.

Recommendation 7: The use of a managed care nurse should be implemented on all complex cases.

DER agrees with this recommendation. While DER does not currently utilize Nurse Case Management as frequently as desired, these services are utilized on catastrophic cases. The City uses independent medical exams on a case by case basis and consults with Occupational Health Physicians when medical advice is needed.

DER will determine benchmarks for when to more aggressively use nurse case management resources and is planning to staff this function via a professional services contract with a qualified nurse for 20 hours per week.

Recommendation 8: All lost time claims need to be assigned to the adjuster within 24 hours and telephone contact with the claimant should be made within 24 hours of the assignment.

DER disagrees with this recommendation and the department will strive to have adjusters make telephone contact with the claimants as soon as possible within 72 hours of receipt of the claim in the Worker's Compensation section.

DER understands the importance of prompt and personal contact with claimants; however once a claim is filed multiple steps are taken to assign and verify the claim. Packets from DER containing letters of introduction, medical authorization and request for information from the injured worker are sent to claimants immediately by the claim processors. During this time, DER begins the claim information verification process which involves contacting multiple sources such as departmental payroll clerks, supervisors, and safety specialists as well as the injured workers.

Recommendation 9: Medical only claims above \$5,000 should be reviewed by a Senior Claim Adjuster.

DER agrees with this recommendation and currently all staff is directed to see management for approval any time the total charges exceeds \$5,000. DER intends to continue this practice.

Recommendation 10: Files should be reviewed for reserve accuracy both for increases and decreases/closure on an annual reconciliation review. This will ensure that the outstanding claim count and the corresponding financials are correct.

DER agrees with this recommendation and notes that the Quality Review Process (Appendix A) will help with the reconciliation process. Please also see DER's response under Recommendation #2 for information on claim closure procedures.

In addition, to improve reserve accuracy DER has a long outstanding request with Aon eSolutions to import the Work Lost Data Guidelines module directly into the iVOS system. The request for this module was made shortly after the system was implemented and AON eSolutions has yet to implement the module due to system difficulties. The module will allow adjusting staff to have direct access to data and guidelines that will assist in setting reserves and determining return to work timeframes. While this information is currently available to adjusting staff, without direct access, the process is made very labor intensive and difficult.

Appendix A: Quality Review Procedures

Quality Claim Review Procedures

The purpose of Quality Review is to as serve both a monitoring and training tool. In addition, to make sure that important claims issues are being addressed on timely basis; to meet the State of Wisconsin filing requirements; to make sure that timely and accurate claim's adjusting is occurring; to make sure that aggressive return to work case management is being pursued; that the Reserves on claims accurately reflect the total exposure to the City and MPS for the life of that claim; that courteous and timely customer service is being provided; that individual active inventories are up to date; to provide positive feedback for a job well done; to reinforce work rules and identify opportunities for training options as needed.

Quality Review will be conducted by both the Workers Compensation Manager and the Management Services Adjuster.

Quality Reviews will be conducted every third Friday of the Month in ONE in ONE sessions with each Claims Adjuster and Claims Processor in sessions that lasts no more than one hour. The claims will be pre- selected at random by someone outside of the Workers Compensation Section. The Claims Adjuster and Claims Processor will be notified in advance so that the claims that are subject to Quality review will pull before the session.

Claim Quality Review Procedure

- 1) Start the review of the "SELECTED" claims by completing the "WORKERS COMPENSATION SECTION- QUALITY CLAIM REVIEW" form for each claims reviewed. At the end of the review session, place a copy in the Claim folder and send a copy to be scanned under WORK PRODUCT-TEAM/GROWS/STRATEGY NOTES.
- 2) Check the following to be sure that all are current and up to date:
 - a) E-Vault for Medical Bills
 - b) IVOS Payment Tab for both Indemnity and Medical Payments
 - c) PD Award Tab and Scheduled Payment Tab if Indemnity payments made
 - d) Reserve Tab and Reserve Worksheet
 - e) Correspondence Tab for notification to employees
 - f) Note Pad for up to date documentation and employee interviews
 - g) Diaries- are they set and current
- 3) Go to the "CASE LOAD MANAGEMENT" Tab, select the person to be reviewed. When the inventory by "Insurer" is revealed, sort the inventory by the "Last Diary Activity". Now take a GLOBAL look. Review the "TOTAL INCURRED"; the "OLDEST DIARY"; the "LAST DIARY ACTIVITY"; review the NEXT DIARY DATE(if it is this means no date was set and possibly no diary was set. Address this with the Adjuster); the "LAST NOTEPAD entry. Show this to the Adjuster during the session
- 4) Complete the QUALITY SUPPLEMENT form. Indicate: the number of claims that are off diary or with no diaries set and the average age of the claims; other claims that have come to your attention during the month; customer service comments that have been brought to your attention; DWD results: the number of claims without Reserves; number of Medical Bills to be approved.
- 5) Complete the STRATEGY TAB. If there are recommendations and follow-up indicate these in the "Claim Strategy FU Desc field. If there is follow regarding the Medical portion of the claim, indicate the instructions in the "Medical Strategy ST Desc" field.
- 6) Finally, when follow-up is required on a Quality Review claim. An Outlook e-mail notice will be sent.

Appendix B: Adjuster Reserving Procedures

Adjuster Reserving Procedures

Setting and maintaining accurate reserves on your Workers Compensation claims is a vital part of the claims management process. Not only are reserves used to estimate the total liabilities on the claim, but the estimates are used to plan overall budgeted amounts for both the City of Milwaukee and Milwaukee Public Schools anticipated future expenses for each entity's fiscal year expenses.

The IVOS system allows Reserves to be reviewed from the Reserve Tab. Reserves can be increased and decreased as the circumstances on the claim warrant. ALL reserve entries will remain a permanent part of the claim record. A payment can not be made within the IVOS system without a sufficient reserve to cover the payment. The City of Milwaukee does have a business rule that will fire to automatically cover the following situation: CLOSED claims with Medical and Adjusting costs. See the attached exhibit # 1. The claim was closed; a payment of \$135 was added to the IVOS system on the Payment Tab for Adjusting costs, the business rule engaged to "adjust" the Reserve so that the payment would post. Otherwise the Claim must be actively open and a Reserve set by the assigned Adjuster.

On OPENED Claims:

- 1) The IVOS system will automatically set a Medical Reserve of \$3000 on ALL new data entry claims.
- 2) The Claims Adjuster must set a Reserve on the Adjusting and Indemnity costs.
- 3) To set a Reserve; the Claims Adjuster must first follow the Medical Bill Authorization guidelines:

First thoroughly review the medical bill and the accompanying documentation, in relationship to the each other. This includes the ICD9 and CPT coding. If the decision is to make a payment: Go to the Bill Review Tab and look up the pricing for the CPT code by entering the CPT code from the BILL and the Zip code (see the attached screen as an example, exhibit # 2). The ODG/WLDI (Official Disability Guidelines/Work Loss Data Institute) Guidelines are also available on each Staff members Desk top for reference. This information provides important and vital reserving information regarding: **RETURN TO WORK "BEST PRACTICE" guidelines; restricted work modifications; the average cost per claim; physical therapy guidelines; related procedures, medical treatment, possible CPT coding and post surgical treatment (see attached exhibit # 3).**

After all of this information is considered:

- A) Select Notepad Type 44
- B) Enter either of the following codes in the "OVERVIEW" that is correct for the services approved: (you may add multiple codes, see attached exhibit # 4)
 - a. DOC
 - b. HOS
 - c. PHY
 - d. SUP
 - e. WKH
 - f. PTH
 - g. HIV
 - h. CHP
 - i. HEP
 - j. IDV
- C) Enter the total amount of the bills to be paid in the "Amount " field

Appendix B: Adjuster Reserving Procedures

- D) Enter the Body part in the **BODY** of the Notepad
 - E) Itemize/List the name/s of the Medical Providers in the **BODY** of the Notepad
 - F) List the Dates of Service or Date Range. In the **BODY** of the Notepad
 - G) Stamp the Bill "OK to Pay"
- 4) Next go to the Reserve Tab and click on the **Worksheet** button. Exhibit # 5 will appear. The following information will pre-fill: "CURRENT INCURRED"; the TTD and PPD RATE; CURRENT TOTAL.
 - 5) Under **MEDICAL** Enter the CPT (ODG Medical) Estimated Amount.
 - 6) Under **INDEMNITY** Enter: the amount to Death/Burial; the amount for State Fund; Additional Indemnity; the Number of TTD; PPD weeks; the Number of PTD weeks and the amount; the number of LOE weeks and the amount; the number of RET TTD weeks and the amount. Note: After typing in each entry hit the ENTER key. The spreadsheet will calculate automatically.
 - 7) Under **EXPENSE** Enter: Adjusting costs such as IME; Mileage, Surveillance; VOC Evaluations.
 - 8) Next after all updates are entered hit the SAVE BUTTON and the totals from each of the Reserve Category will automatically update to the Reserve Tab.
 - 9) Next from the Reserve Tab (the Worksheet has been saved by Tab as an Excel document and can be viewed at any time by clicking on the Worksheet button and looking at the bottom of the page by date created), the system will ask if you want to SAVE the Reserve Worksheet? Hit OK. You will be then returned a response that indicates that "Reserve Worksheet SAVED. Click OK. The Reserve Tab screen will refresh and the new totals will appear.

The Reserve Tab

The Reserve Tab consists of the following including the button for the WORKSHEET as explained above (Exhibit # 6):

- 1) **SAVE** – Click this button to save reserve changes.
- 2) **WORKSHEET** - Click this button to access the Reserve Worksheet (see details for completion above).
- 3) **GUIDELINES** – click this button to access the Disability Guidelines and ICD 9 codes.
- 4) **VIEW** – Click this button to generate the following reports; the Reserve Face Sheet and the Reserve Listing. The Reserve Face Sheet will provide you with a summary of the case including the type of injury, cause of injury, part of the body; The Reserve Listing will provide a History of the changes to the reserves.
- 5) **SPELLCHECK** –
- 6) **RESERVE TRANSACTION** – As the Reserve Transaction is highlighted at the bottom of the Reserve Page the name of the Transaction will also appear at the TOP of the page. Each Transaction is singularly displayed with its separate details.
- 7) **PREVIOUS TOTAL INCURRED** – This is the total reserve for the selected category (**THE TOTAL INCURRED**, at the bottom of the page). This amount represents the total estimated expenses for the selected category for the current claim.
- 8) **PAYMENTS TO DATE** – This amount represent the total of all payments made on the claim for the selected reserve category (**THE PAYMENTS**, at the bottom of the page).

Appendix B: Adjuster Reserving Procedures

- 9) **CURRENT OUTSTANDING** – This amount represents the Balance of reserves (**THE OUTSTANDING**, at the bottom of the page).
- 10) **CHANGE** – This field represents place where changes are entered directly and adjustments made to the reserves either positive or negative.
- 11) **NEW TOTAL INCURRED** – Changes to the reserves can be made from this field by entering the amount either positive or negative directly. The Change will appear momentarily within the CHANGE field and populate in the new total outstanding automatically (**THE NET INCURRED**, at the bottom of the page).
- 12) **NEW TOTAL OUTSTANDING** – Changes to the reserves can be made from this field. They represent the reserve balance.
- 13) **SCHEDULE PAYMENTS** – The Payments represented here are posted from the Scheduled Payment Tab.
- 14) **RECOVERY** – Recovery payments are posted as appropriate from the payment tab.

How to Zero out an OUTSTANDING RESERVE BALANCE (Exhibit # 7):

- 1) Enter a Zero in the “NEW OUTSTANDING” field.
- 2) Hit the Tab Key
- 3) Click the “SAVE” button
- 4) Click the “OK TO SAVE CHANGES BUTTON”.
- 5) If there are more lines of “RESERVES TRANSACTIONS”, such as **MEDICAL, INDEMNITY, ADJUSTING**, highlight the next line and repeat steps 1 thru 4.
- 6) When done with all **RESERVES TRANSACTION LINES**:
 - if no payments were made on the file, you should see exhibit #4
 - if payments were made on the file, you should see exhibit #5. The **TOTAL INCURRED** and **PAYMENTS** should match.