Office of the Ombuds for Self-Insured Workers

2013 Annual Report

Reporting Period:
July 1, 2012 – June 30, 2013

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 30, 2013

The Honorable Jay Inslee
Honorable Members of the Legislature

I am pleased to submit the annual report for the Office of the Ombuds for Self-Insured Injured Workers. This report covers the period July 1, 2012, through June 30, 2013, along with our recommendations for changes to the system.

We just completed our fourth full year of operations, and the number of requests for assistance remains steady. We completed 505 investigations during this time period, essentially mirroring our numbers for the prior reporting period.

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

Respectfully submitted,

Denise McKay

Denise McKay
Ombuds

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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 Ombuds was appointed by the Governor on January 12, 2009. This report represents our fourth complete year of operations and covers the period July 1, 2012, through June 30, 2013.

Helping Injured Workers

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

Connecting with the Customer

Two years ago we conducted a customer survey with very favorable results. A follow-up survey is planned for the upcoming year to ensure we are continuing to meet the needs and expectations of our customers.

Our partnership with labor organizations provides an important connection to workers. We offer educational and training opportunities for their members and staff. In turn, they continue to be a significant source of referrals to this office.

Our website offers an overview of our services, information on workers' compensation, and links to helpful resources.

Investigating Complaints

During this fiscal year, we completed 505 investigations based upon complaints filed by injured workers. Last reporting period we completed 508 investigations, so our numbers remain steady.

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

Structured Settlements

Effective January 2012, the law provides an option for workers to enter into a structured settlement agreement to resolve claim issues and/or certain benefits. Injured workers of self-insured employers who are not represented by legal counsel have the option to request this office provide technical assistance or be present during negotiations. Informational materials explaining the structured settlement process and clearly identifying our role are available through our office and are posted on our website. Since the law was implemented in January, 2012, we've received fewer than 15 inquiries from workers requesting information about structured settlements.

Recommendations

Pursuant to RCW 51.14.400, this office is tasked with identifying deficiencies in the workers' compensation system, and making recommendations for improvements to the system. In making these recommendations, we recognize the great majority of self-insured employers adjudicate claims appropriately.

Enforce Payment of Benefits during Appeal

We continue to receive complaints from workers indicating the self-insured employer or TPA has refused to pay time loss and/ or medical benefits during the appeal process. RCW 51.52.050 states that an order by the department awarding benefits shall become effective and benefits due on the date issued. If the department order is appealed, the order can be stayed pending a final decision only by order of the Board of Industrial Insurance Appeals (BIIA). Absent a stay, the department or self-insured employer is required to pay those benefits. A number of employers still refuse to pay benefits as required under the statute. We recommend the legislature authorize a significant graduated penalty process for noncompliance.

Require Timely Payment of Medical Bills

As noted in the past four reporting periods, the timely payment of medical bills remains a significant concern. We continue to receive a significant 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.

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 state 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 of the Law

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

Independence

The 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 Settlements

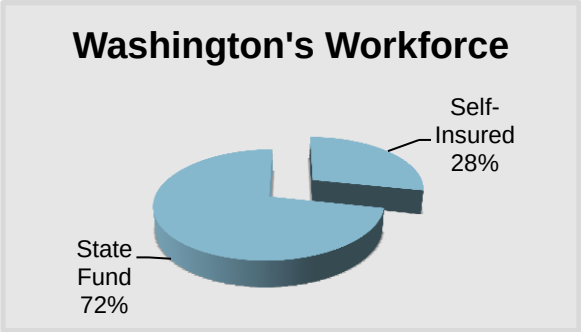
Effective January 2012, changes to workers' compensation law allow eligible workers to initiate a resolution of claim issues and/or benefits through a structured settlement process. The law also provides injured workers of self-insured employers who are not represented by legal counsel the option to request that the Ombuds provide technical assistance or be present during negotiations. Informational materials explaining the structured settlement process and clearly identifying our role are available and posted on our website. To date, we've received less than 15 calls from injured workers regarding the structured settlement process.

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

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

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

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

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

What types of businesses choose to self-insure?

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

Who manages the self-insured claims?

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

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

During 2012, over 42,000 claims were filed by self-insured injured workers. This number represents approximately 28% of all industrial insurance claims filed in Washington during calendar year 2012.

What benefits are provided to injured workers?

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

Those benefits may include:

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

What is included in an audit?

An emphasis is placed on timeliness and accuracy of benefits delivered to injured workers and on proper reporting requirements. Records are examined to ensure total claim costs and worker hours were accurately reported. Claims are reviewed for compliance with workers' compensation laws and regulations. The auditor will review 70 claims consisting of a combination of time-loss, medical only, rejected claims, and claims with reopening applications. For smaller self-insured employers, this may result in an audit of all claims filed during the audit period. For larger employers, this sample size may represent only very small percentage of total claims filed.

How often are audits conducted?

The department audits both active self-insured and inactive self-insured employers with open claims. There are 360 active self-insured employers in this state, as well as number of inactive employers who are also subject to audit. Under department rules, the goal is to audit every three years. The average audit cycle for fiscal year (FY) 2012 was 4.8 years and FY 2013 was 5.9 years. The department currently has eight auditors to complete this work.

What happens after an audit?

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

Audit Reform

2013 marked the beginning of a collaborative effort to look at the Department's current auditing practices of self-insured employers. The Ombuds Office has joined with labor, business, and the Department in a collaborative effort to begin tackling this complex, and long-standing problem. The initial phase of the process begins with an important goal; to create list of prioritized recommendations that will be developed and linked to a self-insurance scorecard.

Coupling the goals of the reform team with the goals of audit should ensure a successful reform effort.

The Audit specific mission for this reform effort is 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; focus audit efforts on the outliers
- Provide a clear path to correction with meaningful enforcement tools

Additionally, the initial phase of reform is focused on identifying the key components of audit and to maximize the efficiency and effectiveness of the audit process.

- Who is audited: Explore whether audits should include third-party administrators as well as self-insured employers
- What is audited: Ensure the audit measures support the accurate and timely payment of benefits, and the audit results provide meaningful information to resolve compliance issues
- Where audits are performed: Explore options to incorporate alternate audit methodology such as desk audits and/or data metrics to maximize the use of auditor time
- When audits are performed: Explore options to incorporate targeted audits in addition to scheduled audits

Our office is very supportive of an audit reform that places an emphasis on timely and accurate delivery of benefits, clarifies correct reporting requirements, and produces a meaningful audit report.

The Ombuds Office

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

Customer Service

Workers' compensation laws and regulations are complicated, and can be confusing to workers. An important function of this office is to provide help and guidance to workers in a clear and easy to understand manner.

We provide accurate timely responses to worker inquiries, and involve them in the investigative process.

Outreach

Labor organizations are strong supporters of the program. Almost a quarter of our customers indicate they were referred to our office by their union. Labor conferences and meetings offer a chance to meet with business staff and union members. These events provide the opportunity to interact directly with workers, provide an overview of our program and share information about worker's compensation.

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

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.

Resources

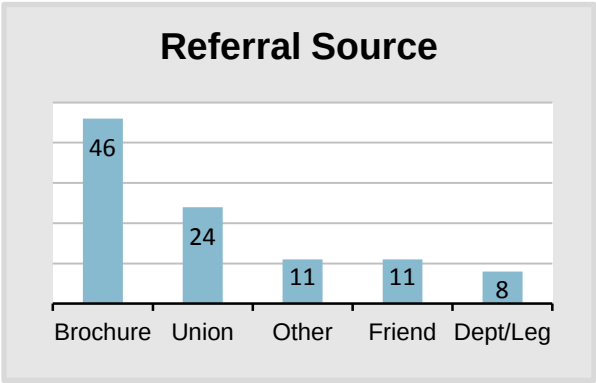
Our website offers information about the office, and provides contact information and links to other resources for workers. The *Frequently Asked Questions* section provides answers to commonly asked questions from injured workers. Our web address is: **ombudsman.selfinsured.wa.gov** .

Intake Evaluations

Workers contact this office for a variety of reasons. Some 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.

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



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

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

The Investigation Process

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

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

The Referral Process

If we are unable to resolve the worker's issues with the self-insured employer or TPA, we have the ability to make a formal referral to the department for their review and action. The department conducts a thorough review of the claim information and makes an independent adjudicative decision based upon their analysis of the claim. A summary of the action taken by the department is provided to the Ombuds Office.

Worker Confidentiality

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

RCW 51.14.370 protects the confidentiality of 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.

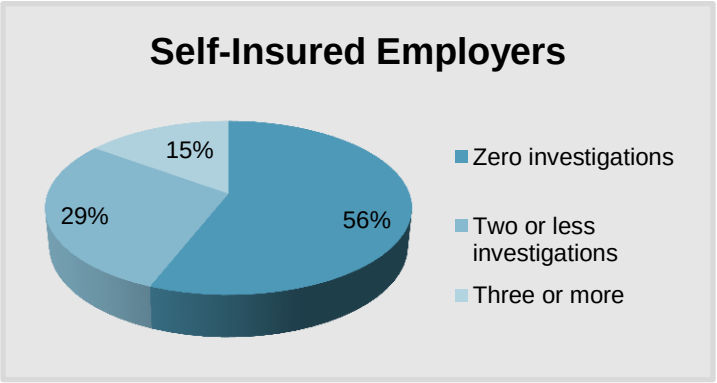
Reporting

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



During this reporting period, we completed 505 investigations from workers employed by 158 self-insured employers.

The majority, 56%, of the 360 active self-insured employers did not have any complaints filed which warranted an investigation.

Distribution of Investigations

As in 2012, the majority of investigations completed during this reporting period involved only a small percentage of the total number of self-insured employers. During this reporting period, approximately 56% of self-insured employers did not have any investigations; another 29% had one or two.

Number of Investigations	2013 (360)	2012 (362)	2011 (361)	2010 (366)
Zero investigations	202	196	233	243
1-2 investigations	104	111	86	98
3	15	19	16	9
4-5	19	17	9	7
6-9	13	11	10	4
10-16	3	4	4	3
17-19	1	1	2	0
20-25	2	0	0	2
27-29	0	2	0	0
33-40	0	1	1	0
49	1	0	0	0

Resolving Issues

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

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

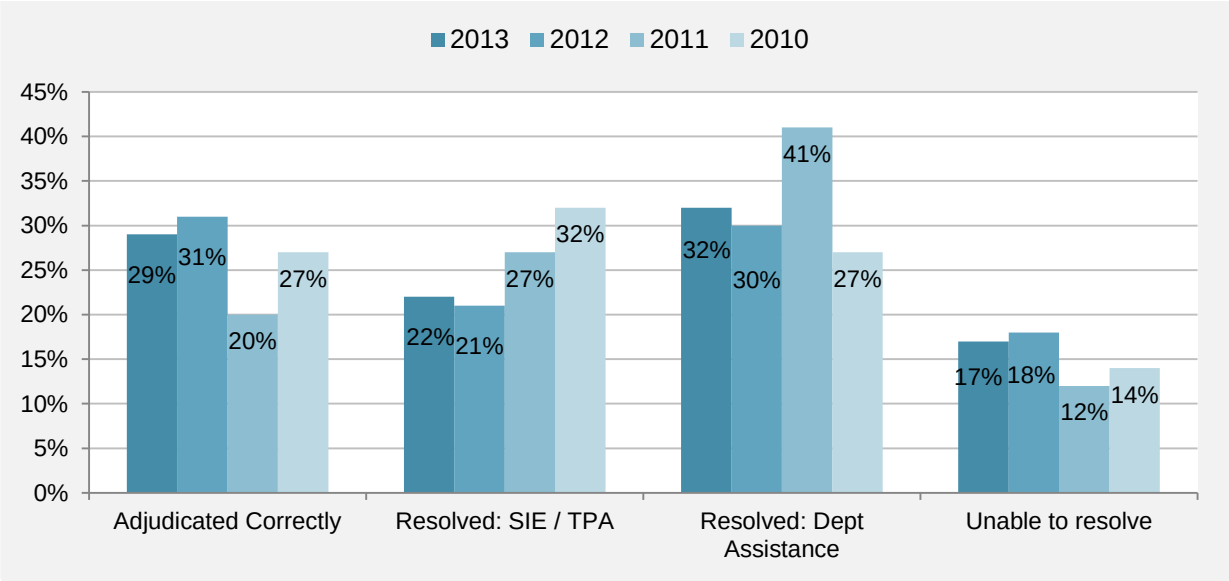
Our preferred method to resolve a complaint is to work directly with the self-insured employer or TPA. Working directly with the claims administrator allows for a quick resolution. Any changes to treatment authorization or worker benefits can be immediately implemented.

We completed 505 investigations during this reporting period. The following two charts compare the number of investigations by fiscal year, as well as the method of resolution by percentage for investigations completed during FY 2013, FY 2012, FY 2011, and FY 2010.

Resolution Profile				
	2013 (505)	**2012 (508)**	**2011 (400)**	**2010 (289)**
Claim Adjudicated Correctly	146	156	81	77
Resolved: SIE / TPA	111	108	106	92
Resolved: Department assistance	162	153	164	78
Unable to resolve	86	91	49	42

Of the 273 cases that were successfully resolved, 41% were resolved with the self-insured employer or TPA and 59% were resolved with the assistance of the department.

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



Explanation of Terms

Claim Adjudicated Correctly

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

Unable to Resolve

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.

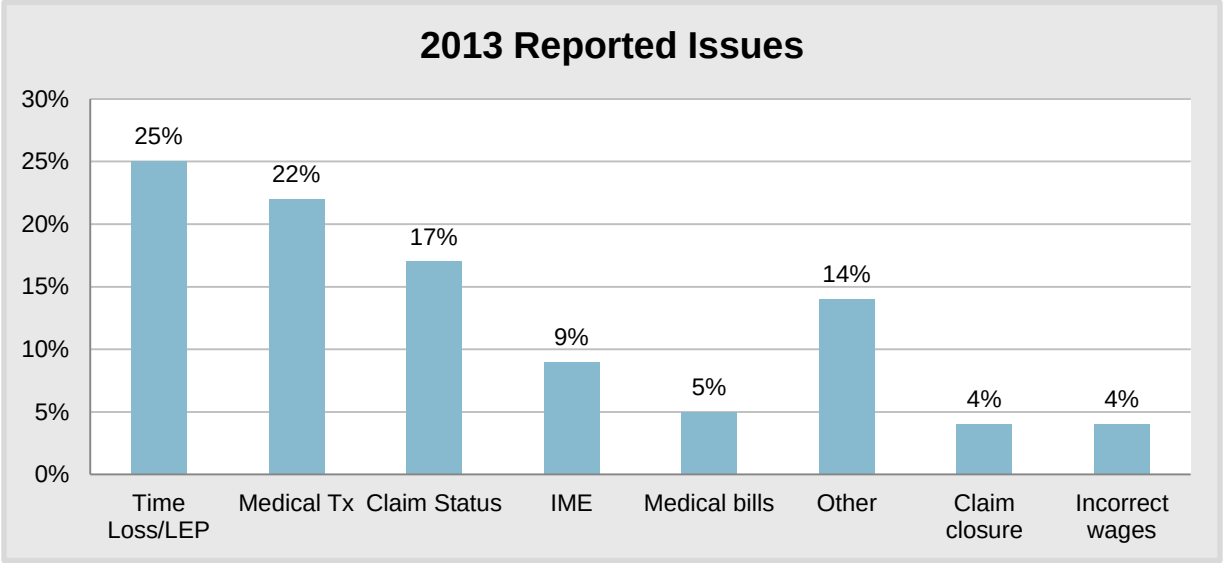
Reported Issues

Many of the complaints we receive involve more than one claims-related issue. The top five categories remain the same as last year, and represent 78% of the total number of issues reported by workers during this reporting period.

The top five categories are:

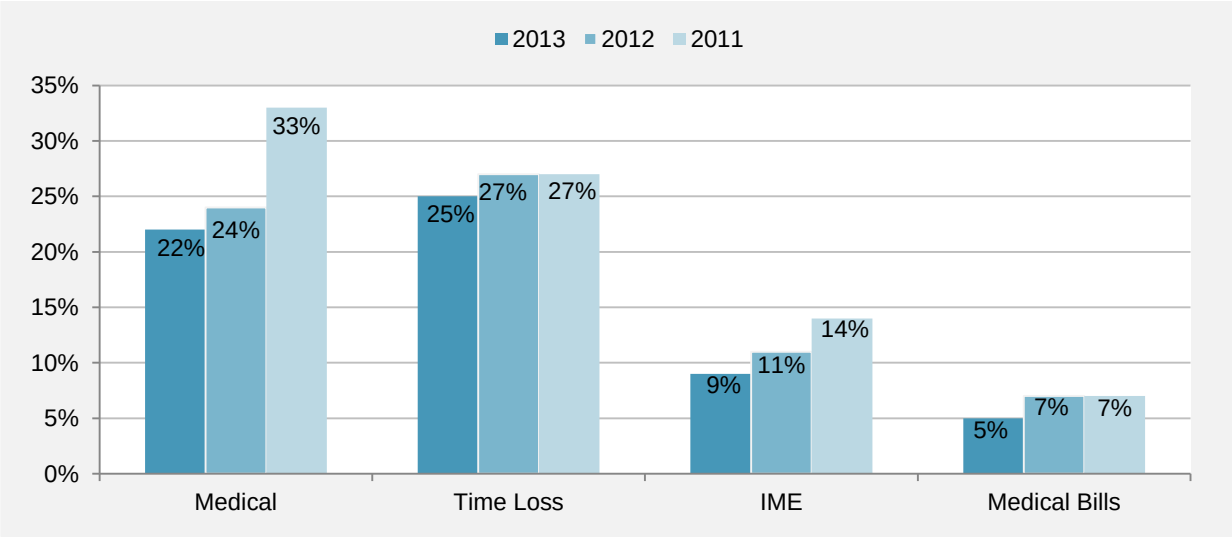
- Delayed/ denied time-loss or loss of earning power (LEP) (25%)
- Delayed or denied medical treatment (22%)
- Claims status: provisional/rejected (17%) (new in FY 2012)
- Complaints related to independent medical exams (IMEs) (9%)
- Non-payment or late payment of medical bills (5%)

The numbers in the following chart are expressed as a percentage of the total number of issues reported by workers during the fiscal year.



Comparison of Reported Issues

This table shows the comparative distribution of the top categories for the FY 2013, 2012, and 2011 reporting periods. The numbers are reflected as the percentage of the total number of issues reported during each fiscal year. As most of the investigations involved more than one issue, it is important to note there is not a 1-1 relationship between the number of reported issues and the number of completed investigations.

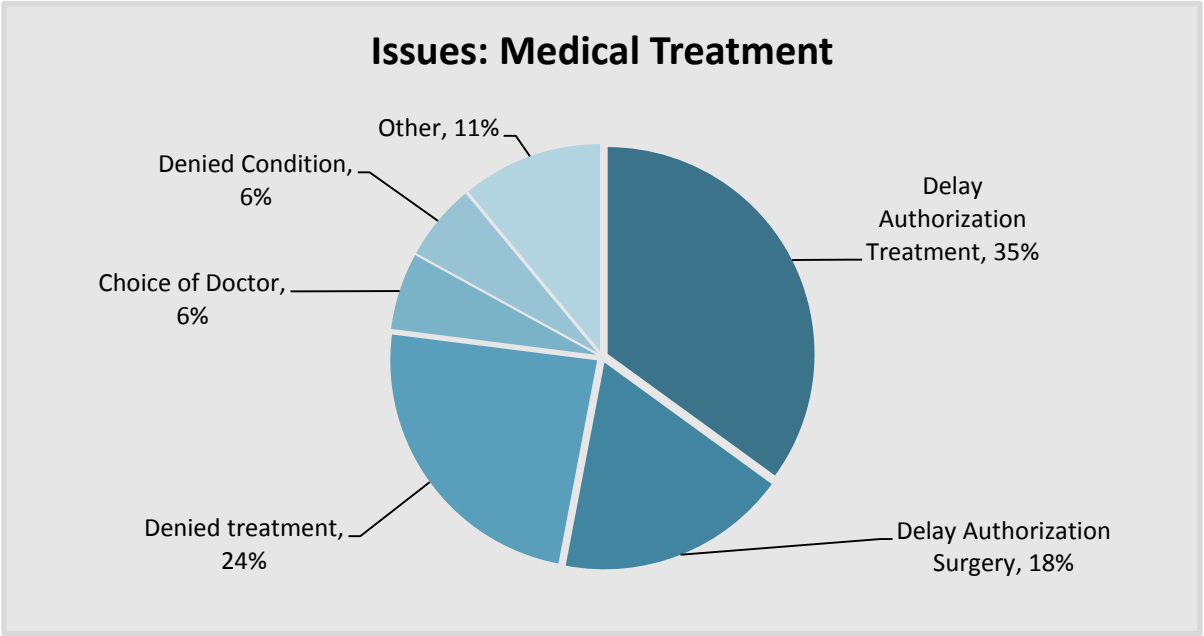


Medical Treatment

Consistent with the last several reporting periods, over half of the complaints in this category involve a delay in the authorization of medical treatment, testing, or surgery. Workers report these delays are impacting their recovery, and often delay their ability to return to work. We continue to field calls from attending physicians and other providers relaying their frustration in trying to obtain authorization to treat their patients.

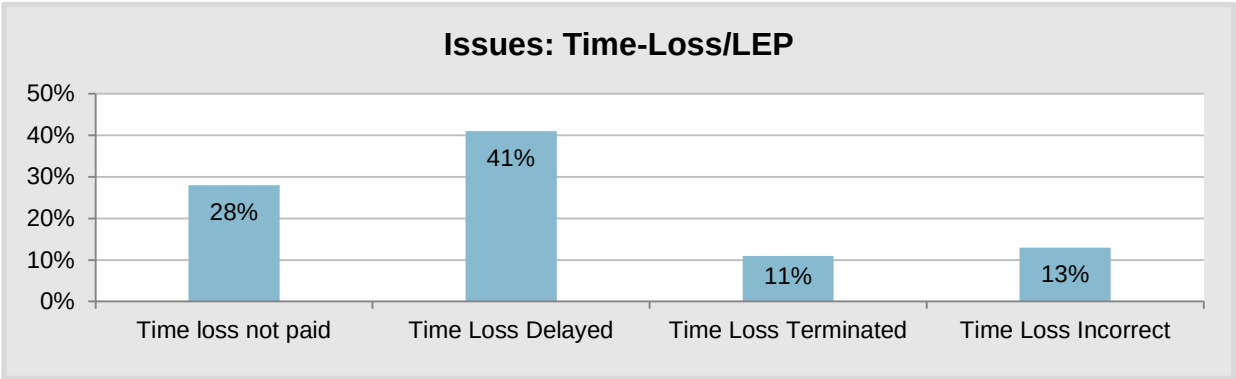
The department can issue an order directing the SIE/TPA to authorize and pay for specific treatment on a case by case basis. Currently there are no rules requiring the SIE or TPA to take action on a treatment request within a specified time period.

The chart below illustrates the breakdown of medical treatment issues by specific category.



Time-Loss

The most common complaint reported by workers involved delayed or unpaid time-loss benefits. 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.



Independent Medical Exams

Although the number of complaints involving IMEs dipped slightly from last year, from 11% to 9% of all complaints reported, the most common IME related concern remains constant over time. Workers report their SIE or TPA would not make an allowance determination on their claim until the worker attended an IME.

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

Until the claim is allowed, the self-insured employer or TPA is not required to pay for medical treatment. Many months can pass from the date the workers' compensation claim is filed and the completed IME report is received and processed by the self-insured employer or TPA. It is not unusual for the workers to report waiting more than six months for an allowance determination. During this time period, the worker is not covered for any medical treatment, and many do not have the funds to self-pay. In general, most private insurance plans will not cover injury-related treatment unless/until the claim is rejected.

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.

During this reporting period, 8 workers reported they were sent to collections for unpaid bills on allowed claims. The collections process affects their personal finances, causing undue stress and worry. In addition, it requires a considerable amount of time and effort just to rectify their credit status. Most workers do not have the ability to pay from private resources. Under most instances, their private insurance will not cover treatment for an industrial injury or disease. Our current recourse is to make a referral to the department to issue an order directing payment. Sometimes this is not enough, and even after an order is issued, the medical bills are not paid.

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. This decision overturned a prior BIIA ruling that excluded medical benefits as benefits within the meaning of that statute. The BIIA designated this decision as "significant", setting the BIIA position on future rulings. This decision was appealed to Superior Court by both the SIE and the Department of Labor and Industries. The Superior Court affirmed the BIIA ruling. The department appealed the Superior Court ruling to the Court of Appeals.

In response to *Coston,* the department indicates they will start rulemaking shortly to establish a process under which injured workers may request penalties for delays in the payment of medical bills or authorizations for the provision of medical treatment. The rules are expected to include the information needed for the department to be able to make a determination on the request.

We have complaints from workers that their claims were closed without addressing their protest to the penalty denial. If the worker wants the department to address the penalty denial, we advise them to protest the claim closure. If the closing order includes a monetary award for permanent partial disability (PPD), the award does not have to be paid if the order is under protest. Workers report feeling forced to choose between the payment of their PPD award and pursuing the delay of benefits penalty.

The department is of the opinion that the claimant does not need to protest a claim closure to preserve their penalty request, and will be issuing a letter explaining that the penalty will be addressed within thirty days of closure.

Case Scenarios

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

Authorization for Medical Treatment

We were contacted by a worker and his medical provider regarding authorization for medical treatment and testing. The worker had fallen from a ladder and suffered an injury to his back and hip. The claim was allowed. The provider reported they requested authorization for treatment repeatedly over a seven month time frame without a response from the TPA claims manager. We contacted the claims manager to determine why the treatment was not authorized, and we were able to secure the authorization.

Time Loss Not Paid

This injured worker has an open allowed claim. He had an authorized surgical procedure approximately one month earlier, but had not received any time loss payments. We contacted the TPA claims manager who issued a payment to the worker that day.

Worker Sent to Collections

We received a call from a worker who was sent to collections for an unpaid medical bill. He injured his shoulder at work and sought treatment that day at a local emergency room. The claim was allowed for medical treatment and closed. The worker was surprised to receive notice of a collections lawsuit filed in district court several years after the claim was closed. The TPA was contacted, arrangements were made to pay the billing, and with the assistance of the department the collection proceedings were stopped.

Delay of Benefits

This individual contacted our office as she was having extreme financial difficulty. She was not released to perform her job of injury, and had been working reduced hours for the past year. There was medical certification in her claim file to support the payment of loss of earning power benefits (LEP) for the past 14 months totaling in excess of $8000. The worker requested and was granted a delay of benefits penalty for over $2000 as the LEP payments were late.

Delay of Medical Treatment

This worker fell at work, suffered an injury involving both knees and her back. An order was issued by the department allowing the claim for bilateral knee injuries as well as an aggravation to a pre-existing lumbar condition. The order was not protested or appealed. The worker contacted our office stating the claims manager for the TPA refused to allow treatment for her back, stating it was not an allowed condition under her claim. The claims manager also called her doctor's office and canceled her medical appointments.

We contacted the claim manager to discuss treatment options, and ultimately the TPA agreed to authorize continued treatment. The employer changed claims administrators and unfortunately the new claims manager did not conduct a thorough file review prior to denying treatment.

Incorrect Wages

Incorrect wage calculations are a fairly common complaint. In this instance, the worker was employed by a school district during the school year, and works at other employment during the summer months. For this type of employment, the claims manager should obtain a work history from the worker showing all employment for a minimum of three years prior to the date of injury/occupational disease, and select a 12 month period that fairly represents the worker's earning history. In this case, her wages were calculated using only her wages from the school district, although the worker was employed elsewhere during the summer months.

We brought the issue to the department's attention and a wage order was issued with the correct time loss compensation rate. The TPA corrected the payments.

Unpaid Medical Bills – Worker Sent to Collections

This worker filed a medical only claim on 7/23/09. He sought initial treatment at an emergency room, and the claim was subsequently allowed and closed by the TPA on 4/12/10. In January 2013, the worker received legal notice he was being sued by a credit agency for the unpaid emergency room visit. We contacted the hospital to determine why the worker was sent to collections. The hospital reported billing the TPA twice without response and then sold the account to a collections agency. We contacted the department, which responded by sending a letter to the hospital instructing them to stop the collection process against the worker. A provider cannot bill the worker for treatment for an accepted industrial injury. Ultimately, the TPA paid the bills and the collection process was halted.

Claim Allowance

This individual filed a claim for a foot injury that occurred when a very heavy box fell onto his foot. The incident was witnessed by a customer during a delivery. The worker hoped the pain would subside and did not seek treatment right away. The pain grew worse and he sought treatment with an orthopedist who diagnosed a stress fracture that was progressively worsening due to work activities. The employer requested claim rejection, indicating they tried and were unable to recreate his injury. Ultimately, the department issued an allowance order based upon a statement of medical causality from his doctor and a witness statement which verified the incident occurred as reported by the worker.

Claim Closure

A legislator contacted our office on behalf of an injured worker. This individual was under active curative medical treatment when her claim was closed. The TPA sent a closure request to the department and did not include all the medical records and requests for treatment from the attending physician. The department acted on the incomplete claim file and issued the closing order.

We obtained a complete copy of the medical records and requested the department review the claim closure. Based upon a review of the complete medical record, the department set aside the closing order and directed the TPA to resume the payment of time loss benefits. The worker received a payment for six months of back time loss compensation.

Stay of Benefits Denied – Refusal to Pay Benefits

This worker was terminated from employment as he was unable to perform his job due to the effects of an industrial injury. After the worker was terminated, the employer refused to pay additional time loss compensation. The department issued an order directing the payment of time loss benefits. The employer appealed the order and requested a stay of benefits. The BIIA denied the employer's request for a stay of benefits on May 15, 2012. The employer continued to refuse to pay time loss compensation during the appeal process. The worker was forced to hire an attorney. On July 11, 2012, after the worker retained counsel, and prior to the BIIA hearing, the employer paid the back time loss benefits due and dropped their appeal.

Pay during Appeal

All orders issued by the department have protest and/or appeal language. Protests are under the jurisdiction of the Department of Labor and Industries. If the order is appealed, the jurisdiction over issues addressed in the order moves from the department to the BIIA. The time period from the filing of the appeal with the BIIA to a final resolution is a lengthy process, and is known to take up to two years. The average time to resolution on contested appeals for self-insured claims is over one year, with an average of 59 weeks.

Prior to June 12, 2008, during the appeal process, the worker was not entitled to receive benefits associated with the order on appeal. For example, if the order on appeal allowed the claim, no medical or time-loss would be paid. If the order was to approve time-loss or medical treatment, no time-loss or medical bills would be paid pending the final outcome of the appeal.

This created significant hardships for injured workers. The legislature recognized the impact on injured workers, passing a bill during the 2008 session to address this issue. RCW 51.52.050 states that an order issued by the department awarding benefits shall become effective and benefits due on the date issued. If the department order is appealed, the order can be stayed pending a final decision only by order of the BIIA. If the stay of benefits is denied, an employer may appeal the BIIA decision to Superior Court. Absent an order granting the stay, the employer is required to pay benefits pending the outcome of the appeal.

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

A number of workers have contacted our office to report their employer refused to pay benefits during the appeal process, even though a stay order was not granted by the BIIA. Our ability to assist those workers is limited to helping the worker request a delay of benefits penalty.

The following are a few typical examples of the complaints we receive.

Refusal to Pay during Appeal – No Stay of Benefits Requested

This injured worker was employed by the same employer for over 20 years. He worked full time, plus overtime, on a year round basis. Following a significant injury, he was unable to

return to his job of injury. An alternate job was offered by the employer; however, the work pattern for the new job was not full time. The new job was subject to a lay-off period of approximately 10-11 weeks during the winter. As the worker was earning less than 95% of his pre-injury wages, he was entitled to loss of earning power benefits (LEP) until legal fixity (claim closure). The employer refused to pay LEP benefits.

The department issued an order on October 17, 2012, directing the payment of LEP from March 11, 2011, through October 17, 2012. The employer appealed the order. No stay of benefits was requested from the BIIA. Penalty orders were issued by the department for delay of benefits as the employer refused payment. To date, no payment has been made to the worker for either the LEP benefits or the delay of benefits penalty.

Without full time employment, the worker was unable to meet his financial obligations. He was forced to draw out his retirement money for living expenses.

Refusal to Pay during Appeal – No Stay of Benefits Requested

A SIE appealed a department order directing the employer to pay for treatment recommended by the worker's attending physician. The SIE did not request a stay of benefits from the BIIA. The BIIA upheld the department decision and ordered the SIE to pay for medical treatment as recommended by the worker's doctor. The SIE appealed the BIIA decision to Superior Court. No stay was requested through Superior Court. The SIE continues to refuse to pay for medical treatment as ordered.

Self-Insured Ombuds Workgroup

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

The current members include:

Matt Webby	Teamsters #174
Jeff Johnson	President – Washington State Labor Council
Kelly Early	Manager of Claims – ESD 113
Rebecca Forrestor	Risk Manager Group Health Cooperative
Liz Fischer	Sedgwick CMS
Natalee Fillinger	Dept. of Labor and Industries – Program Manager – Self-Insurance
Denise McKay	Ombuds for Self-Insurance Injured Workers

Observations and Tips

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

Recommendations for Change

Our first recommendation concerns a small number of workers whose employers refuse to pay benefits during the appeal process. RCW 51.52.050 requires benefits to be paid during the appeal process unless a stay has been granted by the BIIA. In these cases, either a stay of benefits was not requested or was denied by the BIIA. In all but one case, the workers filing a complaint were pro se.

The second recommendation, requiring timely payment of medical benefits, is based upon complaints received by this office over the past four reporting periods. Similar recommendations concerning medical bill payments were also included in our 2012, 2011, and 2010 annual reports.

Require Self-Insured Employers to Pay Medical and Time-Loss Benefits during an Appeal

RCW 51.52.050 states that an order by the department awarding benefits shall become effective and benefits due on the date issued. If the department order is appealed, the order shall not be stayed pending a final decision on the merits unless ordered by the BIIA.

The vast majority of SIE's comply with this statute, and pay benefits during the appeal process. A few employers refuse to comply. In those instances, the department can issue penalties for delay of benefits. Unfortunately, these few employers also elect to ignore the department penalty orders. While the number of workers affected may be small, the financial impact to those workers can be devastating. Although legislation exists to protect the worker, it lacks an effective means of enforcement.

Recommendation

We recommend adoption of a graduated penalty model with increasing penalties assessed if the employer refuses to provide benefits during an appeal where a certain number of days have elapsed and a stay of benefits is either not requested from or not granted by the BIIA. If the employer refuses to comply, they would ultimately be placed in corrective action.

Alternatively, the Legislature could require action against the employer's self-insured certificate if the employer does not pay benefits as per the order on appeal.

Establish Rules Requiring Timely Payment of Medical Bills

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

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

This year, eight workers reported to us they were sent to collections over unpaid medical bills for accepted medical conditions. Others report they were forced to pay using their personal resources or private medical insurance to avoid a collections process. We received complaints from workers stating they were unable to obtain treatment for their injuries. They were unable to find providers willing to treat or continue treatment because the bills were not paid.

Recommendation

Given the department's stated plan to establish rules to implement a process in which injured workers may request penalties for delays in the payment of medical bills or authorizations for the provision of medical treatment, we defer any recommendations at this time.

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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