REPORT OF

THE

STATE AUDITOR

Division of Workers' Compensation
Department of Labor and Employment

Performance Audit
August 2004

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August 10, 2004

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Division of Workers' Compensation. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The report presents our findings, conclusions, and recommendations, and the responses of the Division of Workers' Compensation and the Division of Administrative Hearings.

TABLE OF CONTENTS

STATE OF COLORADO
OFFICE OF THE STATE AUDITOR **REPORT SUMMARY**

JOANNE HILL, CPA
State Auditor

Division of Workers' Compensation
Performance Audit, August 2004

Authority, Purpose, and Scope

This performance audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the Office of the State Auditor to conduct performance audits of all departments, institutions, and agencies of the state government. The audit work, performed between December 2003 and July 2004, was conducted in accordance with generally accepted governmental auditing standards.

Our audit focused on the Division of Workers' Compensation's oversight of employers, insurance carriers, self-insured employers, and physicians. We evaluated the Division's methods for (1) ensuring that Colorado employers comply with workers' compensation insurance coverage requirements, (2) minimizing and resolving disputes within the workers' compensation system, (3) monitoring of insurance carriers and self-insured employers, and (4) containing costs through expanding electronic data collection. We did not evaluate the Division's handling of claims paid from the Major Medical Insurance Fund and the Subsequent Injury Fund.

Overview

The Division of Workers' Compensation, located within the Colorado Department of Labor and Employment, administers and enforces the Workers' Compensation Act of Colorado (Articles 40 to 47 of Title 8, C.R.S.). Statutes require employers to report to the Division any workplace injuries that result in an employee's missing more than three days or shifts of work. According to Division data, about 36,000 injury claims are filed each year.

The Division's operations are entirely cash-funded, primarily from semiannual assessments paid by insurance carriers. Employers pay premiums to their insurance carriers to maintain workers' compensation insurance, and the carriers pay the Division surcharges based on the total premiums received. For self-insured employers, the Division calculates a premium-equivalent and assesses the surcharges on the equivalent. In addition to covering the Division's administrative costs, the surcharges are used to fund the Major Medical Insurance Fund, which covers catastrophic injuries that occurred from July 1, 1971, through June 30, 1981; the Subsequent Injury Fund, which covers injuries occurring before July 1, 1993, and occupational diseases whose onset occurred prior to April 1, 1994; and the Medical Disaster Fund, which provides limited benefits to workers with catastrophic injuries that occurred before July 1, 1971. For Fiscal Year 2003 the Division collected about $64 million in revenues from the surcharges and other fees.

For further information on this report, contact the Office of the State Auditor at 303.869.2800.

Summary of Audit Comments

Insurance Coverage

We found the Division needs to improve compliance with laws requiring employers to carry workers' compensation insurance. Employers who do not maintain required insurance place their employees at risk in case of injury and have a competitive advantage over employers that do maintain insurance. We reviewed Division data for the period July 2001 through May 2004 and identified about 1,400 employers that received at least one notification from the Division regarding possible noncompliance, and then, after providing the Division with proof of insurance or exemption, received notification of apparent lack of insurance at a later date. We also found that, of 265 employers referred to the Attorney General's Office between November 1999 and April 2004 for not providing proof of insurance, 47 obtained insurance and subsequently dropped their coverage. The Division has not collected penalties from any employers for failure to maintain required insurance.

We also found that employers who violate workers' compensation insurance laws are not identified and notified in a timely manner. The Division does not track and analyze data to identify employers that are consistently or repeatedly out of compliance with insurance requirements. Additionally, it may take up to six months or more from the time an employer first hires employees to the time the Division notifies the employer that it has no record of insurance.

Dispute Management

The Division has several mechanisms to minimize litigation and resolve disputes. We reviewed these mechanisms, which include oversight of physicians who participate in the system, and found:

- **The Accreditation Program needs to be strengthened.** Physicians must be accredited by the Division to perform impairment ratings, which indicate the degree of physical impairment resulting from an injury and provide the basis for determining an injured worker's benefits. Physicians must be reaccredited every three years. As part of the accreditation and reaccreditation process, physicians complete impairment rating case studies. The Division has an informal policy that physicians who score below 65 percent on their accreditation case studies or 56 percent on their reaccreditation case studies are expected to attend tutoring. We found that only 21 of the 77 physicians in our sample who were identified as needing tutoring actually received it. Also, once tutoring sessions are completed, the Division does not review the physicians' impairment ratings to determine if the quality of the ratings has improved. Further, between Calendar Years 1999 and 2002, physicians did not receive feedback on their reaccreditation case studies for an average of almost eight months. Lastly, the Division does not maintain complete records on physicians' accreditation scores and is therefore unable to link scores to other evidence of physician performance.

- **Physician monitoring needs improvement.** Once accredited, physicians do not always rate impairments using the appropriate methodology or adhere to the treatment guidelines. A 2002 consultant's review of Colorado impairment ratings revealed opportunities for improvement with most physicians' rating reports.

- **Corrective action is needed for physicians who submit incomplete or late Independent Medical Examinations (DIMEs).** The Division coordinates independent medical examinations (called DIMEs) to resolve disputes over medical issues in workers' compensation cases. Either a claimant or an insurance carrier may request a DIME after the claimant's authorized treating physician has declared that a patient's condition is unlikely to improve. Late DIME reports often delay the expedient closure of claims, which can result in over- or underpayments to claimants for the period of delay. Between January 1, 2000, and December 31, 2003, about 33 percent of DIME reports were not filed within the 20-day regulatory deadline and 9 percent were not complete when submitted.

- **Comprehensive data to analyze litigation trends is lacking.** The Division is responsible for minimizing litigation in the workers' compensation system. However, data collected on workers' compensation hearings are insufficient for determining trends in litigation.

- **Assistance available to pro se claimants is insufficient.** Workers' compensation claimants who do not have legal representation (referred to as pro se claimants) face substantial difficulties in negotiating the complex laws and processes of the workers' compensation system. The workers' compensation hearing process mirrors a judicial court case, and pro se parties are expected to know and follow procedural and evidential rules, substantive law, and an extensive body of case law. Despite the complicated litigation process, only limited published material explaining the hearing process is available, virtually all of which is in English, and the Division does not assist pro se parties with many confusing elements of the process.

Claims Oversight

The Division oversees approximately 360 companies (primarily insurance carriers) that adjust workers' compensation claims in Colorado. The Division performs periodic reviews of carriers to determine compliance with the State's claims adjusting requirements. We reviewed the Division's oversight processes and found:

- **Adequate regulatory mechanisms to promote compliance with claims handling requirements are lacking.** The Division believes it does not have clear statutory authority to issue penalties against carriers for general noncompliance with claims handling requirements. The Division does impose penalties when carriers violate requirements in adjusting a specific claim. The Division has only assessed 11 such penalties, totaling about $102,000, since the beginning of Fiscal Year 2000. Further, the Division has no incentives,

such as discounts on the surcharges that carriers pay to fund the Division's operations, to reward carriers for compliance.

- **Acceptable rates of compliance with state laws and regulations have not been defined.** The Division's carrier reviews calculate an overall percentage to indicate a carrier's compliance level with applicable state laws and regulations. Staff indicated that it considers an overall score of 95 percent to represent reasonable compliance. However, we found that this 95 percent standard is informal, has not been set in statute or rules, and has not been consistently communicated to carriers.

- **A systematic risk-based approach for reviewing carriers and self-insured employers is needed.** The Division's Carrier Practices and Self-Insurance units both perform periodic carrier compliance reviews. Carrier Practices has compiled a list of 122 carriers it has reviewed in the past and/or is planning to review in the future. We analyzed the compliance review histories of the carriers on the list and concluded that, on the basis of risk factors, it was unclear why 21 of them were selected for review while another 8 that appeared to meet the Division's criteria were not. Self-Insurance's standard is to review self-insured employers on a three-year cycle. We found that Self-Insurance did not conduct 24 percent of its planned reviews during Fiscal Years 2000 to 2003.

- **Compliance reviews do not ensure that all affected employees receive unpaid benefits.** Claimants may receive additional benefits as a result of the Division's compliance reviews if the reviews find inaccuracies in benefit payments. Specifically, the Division requires carriers to fix any errors found in the sample of claims examined during its reviews but does not ask carriers to review all other claims covered by the review period and correct all additional errors. As a result, claimants whose files happen to be part of the review sample receive all benefits due to them, while those not included in the sample may not.

- **Oversight efforts are not well-coordinated.** We found considerable overlap between the Division's four units that perform oversight of carriers (Carrier Practices, Claims Management, Document Entry, and Self-Insurance). For example, all units review whether carriers are submitting correct and complete forms. In addition, three units are responsible for determining whether the carrier has provided the required documentation to support termination of benefits or final admissions on a claim. Finally, two units perform compliance reviews of self-insured employers. The duplication of effort not only uses the Division's resources inefficiently but also causes carriers to sometimes receive contradictory information from the Division about their levels of compliance because the various units sometimes look at different data to evaluate compliance.

Division Administration

In addition to the oversight issues mentioned previously, we reviewed the Division's administration of the Workers' Compensation Act and identified the following:

- **Controls over collections need improvement.** Carriers and self-insured employers pay the Division a semiannual surcharge based on the amount of insurance premiums (and premium-equivalents for self-insured employers) they collect each year. The Division's process for reviewing surcharge payments does not ensure that payments are correct, and documentation of the reviews is inadequate. By comparing data on insurance premiums reported to the Division of Insurance with data reported to the Division of Workers' Compensation, we found 15 inconsistencies totaling $4.2 million in premiums that could mean some carriers underpaid their surcharges owed to the Division. We estimate the total of such underpayments would be about $160,000.

- **The collection of workers' compensation data should be expanded.** We noted several areas in which the Division's data collection efforts are deficient, impairing its ability to provide effective oversight of the workers' compensation system. For example, the Division does not have adequate information about the issues addressed in workers' compensation hearings. As a result, it is unable to identify ways to reduce litigation and associated costs in the system.

- **Electronic filing is not maximized.** The Division receives about 133,000 claims-related forms each year. Currently, carriers submit about 18 percent of all forms electronically. We estimate that the Division could achieve long-term savings of about 7.6 FTE at a cost of $249,000 annually if it expanded the number of documents that can be submitted electronically and mandated the use of electronic filing.

Our recommendations and the Division's responses can be found in the Recommendation Locator on pages 7 through 10 of this report.

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	24	Seek a formal opinion from the Attorney General's Office regarding the authority to apply penalties when an employer does not comply with insurance requirements and propose statutory changes as appropriate.	Division of Workers' Compensation	Agree	January 2005
2	25	Analyze data to identify employers who repeatedly violate workers' compensation laws and rules and shorten the notification process.	Division of Workers' Compensation	Agree	January 2005
3	30	Ensure surcharge payments are adequately reviewed and verified.	Division of Workers' Compensation	Agree	December 2004
4	34	Follow up with physicians recommended for tutoring, provide feedback in a timely manner, and link data on physician performance from various sources.	Division of Workers' Compensation	Agree	July 2005
5	38	Review and automate physician performance data, create and enforce written policies, and modify automated systems to aggregate information.	Division of Workers' Compensation	Partially Agree	December 2005
6	43	Establish standards to ensure timely and complete Independent Medical Exam reports and consider options for corrective action.	Division of Workers' Compensation	Partially Agree	July 2005

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
7	46	Work with the Division of Administrative Hearings (DOAH) on the development of a searchable database of hearing orders.	Division of Workers' Compensation	Agree	Summer 2005
			Division of Administrative Hearings	Agree	Summer 2005
8	49	Investigate options for improving guidance provided to pro se claimants and employers in the litigation process.	Division of Workers' Compensation	Agree	July 2005
9	55	Clarify authority to penalize carriers for overall noncompliance with the State's claims adjusting requirements and develop criteria for assessing penalties.	Division of Workers' Compensation	Partially Agree	December 2005
10	56	Consider adopting incentives, such as surcharge discounts, to promote carrier compliance with the State's claims adjusting requirements.	Division of Workers' Compensation	Partially Agree	July 2005
11	58	Develop weighted standards that define what constitutes reasonable compliance with the State's claims adjusting requirements.	Division of Workers' Compensation	Agree	December 2005
12	60	Develop and use risk-based criteria for selecting carriers and self-insured employers for reviews.	Division of Workers' Compensation	Agree	December 2004

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
13	62	Revise compliance review procedures to ensure that insurance carriers correct deficiencies involving the payment of benefits in all claims covered by the review period.	Division of Workers' Compensation	Agree	July 2005
14	64	Test all areas of required compliance, treat all deficiencies consistently, make specific recommendations, and report results accurately and consistently.	Division of Workers' Compensation	Agree	December 2005
15	66	Increase the effectiveness of the sampling approach for reviewing admissions of liability.	Division of Workers' Compensation	Agree	January 2005
16	70	Reduce duplication of oversight functions, develop procedures to provide consistent feedback to carriers, and ensure that units communicate the results of their oversight efforts with each other.	Division of Workers' Compensation	Agree	December 2005
17	73	Perform a cost/benefit analysis of options for upgrading the computer system, determine the most viable option, and develop a plan for implementing the new system.	Division of Workers' Compensation	Agree	December 2005
18	75	Maximize the use of electronic filing of documents by carriers.	Division of Workers' Compensation	Partially Agree	December 2005

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
19	77	Obtain an estimate for making the necessary programming changes to reduce or eliminate invalid error letters and proceed with the changes, if they are cost-effective.	Division of Workers' Compensation	Agree	July 2005
20	79	Clarify statutory requirements regarding the reporting of workplace injuries.	Division of Workers' Compensation	Partially Agree	July 2005

Overview of the Division of Workers' Compensation

In accordance with state statute (Section 8-44-101, C.R.S.), most employers in Colorado must maintain workers' compensation insurance to provide for workers who are injured on the job. Employers can purchase this insurance from an insurance carrier or, if they meet certain requirements, they can be self-insured. Some employers, such as those hiring persons to do part-time maintenance or domestic work, are exempt from the requirement to have workers' compensation insurance. According to information from the Unemployment Insurance (UI) Program within the Department of Labor and Employment, there were about 134,000 employers in Colorado with one or more employees as of December 2003.

In general, workers' compensation insurance coverage pays for medical costs associated with work-related injuries and provides indemnity (lost-wage) benefits to injured workers. Indemnity benefits are provided on either a temporary or permanent basis and vary depending on the degree of disability caused by the injury, as described below:

- Temporary Disability benefits compensate for lost wages while a worker is receiving medical treatment for an injury. Workers who are completely unable to work while recovering receive **Temporary Total Disability (TTD)** benefits. TTD benefits generally provide the worker with about two-thirds of his or her average weekly wage prior to the injury. **Temporary Partial Disability (TPD)** benefits are provided when a worker can work part-time or at modified duty while recovering from an injury. TPD benefit amounts are similar to TTD but with reductions equal to the amount the worker earns while on modified duty.

- Permanent Disability benefits are provided when an injured worker has recovered as much as possible yet suffers a permanent impairment. **Permanent Total Disability (PTD)** benefits are generally paid at the rate of about two-thirds of the worker's average weekly wage prior to the injury if the worker is unable to work at all. **Permanent Partial Disability (PPD)** benefits are paid if the impairment is partial. Generally, multiple injuries or injuries to core systems of the body (e.g., the back) result in PPD benefits calculated as a percentage of the whole body; single injuries to the extremities (e.g., hands or feet) result in benefits that are based on a statutory schedule that assigns a dollar value for the loss of particular body parts or functions. According to the Division, whole-body benefits typically provide

more money than scheduled benefits and are consequently the subject of more dispute.

Whenever a worker in Colorado is injured in the workplace, the employer is required to notify the workers' compensation insurance carrier of the injury. The carrier evaluates information about the injury to determine if it was a legitimate workplace injury that the carrier will cover. According to the National Council on Compensation Insurance (NCCI), a national workers' compensation trade organization, Colorado carriers paid the following amounts in medical and indemnity benefits to workers' compensation claimants during Calendar Years 2000 through 2002 (the most recent years available).

Total Workers' Compensation Benefits Paid by Colorado Carriers Calendar Years 2000-2002

Calendar Year	Total Benefits Paid*	Change From Prior Year
2000	$477,000,000	-
2001	$560,000,000	17.4%
2002	$615,000,000	9.8%

Source: 2004 NCCI Statistical Bulletin.
***** Does not include benefits paid by self-insured employers.

The Division of Workers' Compensation

Section 8-43-101, C.R.S., requires employers to report any workplace injuries that result in an employee's missing more than three days or shifts of work to Colorado's Division of Workers' Compensation (Division) within the Department of Labor and Employment. According to Division data, about 36,000 injury claims are filed each year.

The Division is responsible for administering and enforcing the Workers' Compensation Act of Colorado (Articles 40 to 47 of Title 8, C.R.S.). According to Section 8-40-102(1), C.R.S., it is the intent of the General Assembly that the Act "be interpreted so as to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. . . ." To fulfill this intent, the Division carries out a variety of functions, including the following:

- **Overseeing Insurance Carriers.** The Division reviews individual claims for compliance with requirements relating to medical care, cost containment, and timeliness of benefit payments; maintains electronic and hard-copy files of all claims filed; and conducts on-site compliance reviews to evaluate

whether insurance carriers handle workers' compensation claims in accordance with applicable laws and regulations.

- **Overseeing Employers.** The Division monitors Colorado employers on an ongoing basis to ensure they maintain workers' compensation insurance and has the authority to penalize employers that do not maintain the required insurance. The Division also issues permits for certain employers to be self-insured; conducts reviews of self-insured employers for compliance with claims handling requirements and adequacy of reserves; and grants certificates to employers with documented safety programs and decreasing accident frequency, which reduces the cost of their workers' compensation insurance premiums by up to 10 percent.

- **Overseeing Physicians.** The Division accredits physicians to allow them to rate permanent impairments and to provide independent medical examinations when disputes arise related to individual workers' compensation claims. The Division also coordinates the assignment of accredited physicians to conduct these exams.

- **Conducting Pre-Hearings and Settlement Conferences.** The Division has a group of pre-hearing Administrative Law Judges who conduct pre-hearings and settlement conferences in an effort to resolve any disputes regarding workers' compensation claims.

- **Administering Special Funds.** The Division administers three funds that provide benefits to injured workers meeting specific criteria, as described below, and manages any workers' compensation claims paid out of these funds.

Funding

Division operations are entirely cash-funded, primarily from a semiannual assessment paid by insurance carriers. Specifically, employers pay premiums to their insurance carriers to maintain workers' compensation insurance and the carriers pay the Division surcharges based on the total premiums they receive. For self-insured employers, the Division calculates a premium-equivalent (which approximates the premium the employer would pay a carrier for insurance) and assesses the surcharges on the equivalent.

The largest surcharges provide funds to pay benefits for certain types of workers' compensation claims. Specifically, a 2.888 percent annual surcharge on all premiums paid by employers (or premium-equivalents for self-insured employers)

generates revenues for the Major Medical Insurance (MMIF), Subsequent Injury (SIF), and Medical Disaster funds. The MMIF covers catastrophic injuries that occurred from July 1, 1971 through June 30, 1981. The SIF covers injuries occurring before July 1, 1993, and occupational diseases occurring prior to April 1, 1994. The Medical Disaster Fund provides limited benefits to workers with catastrophic injuries that occurred before July 1, 1971. According to statute, the surcharges for the MMIF and SIF are intended to be discontinued once the funds achieve a sufficient balance to pay all future claims.

The surcharges and fees collected by the Division and the funds they support are described in the table below.

Funding Sources for the Division of Workers' Compensation

Who Pays	Type of Fee/Charge	Fund and Purpose	FY 2003 Revenue
Insurance Carriers and Self-Insured Employers	0.9% surcharge on insurance premiums	Workers' Compensation Cash Fund [1] - Pays for the Division's general administrative activities.	$21,580,661
	2.888% assessment on insurance premiums	Subsequent Injury Fund (SIF) [1,2] - Provides benefits to workers permanently and totally disabled from more than one industrial accident. Closed to injuries occurring after July 1, 1993 and occupational diseases after April 1, 1994.	$18,741,967
	Shares 2.888% assessment with Subsequent Injury Fund	Major Medical Insurance Fund (MMIF) [1,2] - Provides benefits for workers sustaining catastrophic injuries between July 1, 1971 and June 30, 1981.	$22,599,469
	From MMIF - amounts transferred as needed	Medical Disaster Fund - Provides limited benefits to workers sustaining catastrophic injuries before July 1, 1971.	$2,231
	0.03% surcharge on insurance premiums	Premium Cost Containment Fund - Pays for the Division's cost containment program.	$362,200
	$2,000/self-insurance permit or annual renewal	Workers' Compensation Self-Insurance Fund - Pays for Division oversight of self-insured employers.	$214,000
	Interest and assessments on self-insurers	Workers' Compensation Immediate Payment Fund - Provides immediate payment to injured workers if their self-insured employer declares bankruptcy.	$22,418
Requesting Party	$1,250 per request for a utilization review	Utilization Review Fund - Covers the cost of an additional medical opinion on a workers' compensation case as requested by the claimant or insurer.	$50,589
Physicians Seeking Accreditation	$150 to $400 per accreditation, depending on level	Physicians' Accreditation Fund - Pays for the Division's Physician Accreditation program.	$83,625

Source: Colorado Department of Labor and Employment Budget Request for Fiscal Year 2005.

[1] In May 2004, the Division approved changes to the surcharge rates that fund the Workers' Compensation, SIF, and MMIF funds. Beginning July 1, 2004, the surcharge for the Workers' Compensation Cash Fund decreased from 1.47% to 0.9%; the surcharge that funds the SIF and MMIF increased from 2.318% to 2.888%.

[2] According to the Division, revenues from the 2.888% assessment are first deposited into the SIF. Most of the revenue is then transferred into the MMIF. In making the transfer, the Division ensures that enough revenues will remain in SIF to fund its current-year benefits.

The Division's revenues increased almost 30 percent between Fiscal Years 1999 and 2003. According to the Division, the increase is due primarily to increases in the amount of insurance premiums paid by employers. Over the same period, overall spending levels increased about 6 percent, the number of claims filed decreased about 8 percent, and the Division's appropriated FTE figures remained essentially level. Detailed information for the last five years is shown in the following table.

Division of Workers' Compensation Statistics, Fiscal Years 1999-2003

	1999	2000	2001	2002	2003	%Change
Revenues	$49,734,263	$52,334,709	$53,221,996	$68,526,571	$64,347,429	29.4%
Expenditures	$24,183,519	$26,226,746	$25,478,637	$26,235,941	$25,511,909	5.5%
Claims Filed	40,250	40,167	40,618	38,875	36,922	-8.3%
FTE	129.4	129.4	128.4	128.4	128.4	-0.8%

Source: Office of the State Auditor analysis of revenue and expenditure data from COFRS, claims data from the Division of Workers' Compensation, and appropriations data from Colorado's 1999-2003 Session Laws.

In recent fiscal years the Legislature has transferred funds from various workers' compensation funds to the State's General Fund and disaster funds due to shortfalls in the State's General Fund. Transfers out of and into the funds are shown in the following table.

Transfers Affecting Workers' Compensation Cash Funds
Fiscal Years 2002 Through 2004

Fiscal Year	Transfer Type	Fund			
		MMIF	SIF	Workers' Comp. Cash	Total
2002	Out	($211,481,539)	($11,000,000)	$0	($222,481,539)
	In	$0	$0	$0	$0
	Net	($211,481,539)	($11,000,000)	$0	($222,481,539)
2003	Out	($225,000,000)	($20,000,000)	($6,000,000)	($251,000,000)
	In	$211,481,539	$0	$0	$211,481,539
	Net	($13,518,461)	($20,000,000)	($6,000,000)	($39,518,461)
2004	Out	$0	$0	$0	$0
	In	$10,000,000	$0	$0	$10,000,000
	Net	$10,000,000	$0	$0	$10,000,000
2002 - 2004	Net	($215,000,000)	($31,000,000)	($6,000,000)	($252,000,000)

Source: Office of the State Auditor analysis of data from the Division of Workers' Compensation.
Note: House Bill 04-1422 names the MMIF, SIF, and Workers' Compensations Cash Fund as part of the state emergency reserve fund for Fiscal Year 2005. This designation allows transfers of up to $24 million from the MMIF, $20 million from the SIF, and $12 million from the Workers' Compensation Cash Fund.

The main effect of these transfers is that the surcharges on insurance carriers and self-insured employers for the MMIF and SIF will remain in place longer than expected. As noted above, these surcharges are intended to be discontinued once the funds achieve a sufficient balance to pay all future claims. Before the transfers, the surcharges were expected to end in 2004 or 2005. The Division's most recent actuarial analysis (completed in January 2004) indicates the surcharges will continue until at least 2012 and perhaps until 2019.

Other Entities in the Workers' Compensation System

In addition to the Division of Workers' Compensation, the following state agencies carry out certain functions related to Colorado's workers' compensation system:

- The **Division of Insurance (DOI)** in the Department of Regulatory Agencies is responsible for licensing insurance carriers and for collecting information from all insurance companies in Colorado on the amount of workers' compensation insurance premiums paid by employers. DOI also conducts examinations of carriers to assess their underwriting, rating, and claims practices.

- The **Division of Administrative Hearings (DOAH)** in the Department of Personnel and Administration employs Administrative Law Judges who conduct hearings on workers' compensation claim disputes that are not settled through the dispute resolution processes available at the Division of Workers' Compensation. For example, if a claimant disputes the indemnity benefit amount a carrier agrees to pay, the dispute may first be handled by the Division of Workers' Compensation through means such as a settlement conference or pre-hearing meeting. If the dispute is not resolved at that level, it will go to a formal hearing at DOAH.

- The **Industrial Claims Appeals Office** in the Department of Labor and Employment and the appellate court system act as final decision makers on disputed workers' compensation issues that are appealed after being heard by the DOAH.

Audit Scope

Our audit focused on the Division of Workers' Compensation's oversight of employers, insurance carriers, self-insured employers, and physicians. In particular, we evaluated the Division's methods for ensuring that Colorado employers comply with workers' compensation insurance coverage requirements; minimizing and

resolving disputes within the workers' compensation system; monitoring of insurance carriers and self-insured employers; and containing costs through expanding electronic data collection. We did not evaluate the Division's handling of claims paid from the MMIF and SIF, which are described above.

Insurance Coverage

Chapter 1

Background

Colorado statutes require most employers to obtain workers' compensation insurance. Specifically, Section 8-44-101, C.R.S., requires employers to secure workers' compensation for all employees by obtaining insurance through an insurance carrier or by obtaining a permit to self-insure from the Department of Labor and Employment. The statutes also include exemptions from the coverage requirements for certain employers such as those who hire domestic, maintenance, or repair labor on a part-time basis.

Once an employer obtains workers' compensation insurance, it is important that the coverage be maintained without interruption as long as the employer is subject to the insurance requirements. Continual coverage not only protects employees from bearing the costs of any injuries sustained while working, but ensures a level playing field among employers. Premium rates for workers' compensation insurance (i.e., the amount that employers pay for every $100 of payroll) vary depending on the type of business the employer transacts. For example, an employer who hires roofers may pay over $17 in workers' compensation insurance for every $100 in payroll, whereas an employer who hires clerical staff may pay about $0.30 per every $100 in payroll. When these employers fail to obtain workers' compensation insurance, or allow required coverage to lapse, they obtain an economic advantage over employers that follow the law.

The Division is responsible for ensuring that Colorado employers obtain and maintain workers' compensation insurance coverage. The Division's two primary methods for fulfilling this responsibility include: (1) a periodic match of data from a national workers' compensation insurance database and the State's Unemployment Insurance database; and (2) reviewing applications and issuing permits for employers who self-insure. These two methods are described in more detail below.

- **Data match.** Division of Workers' Compensation rules require insurance carriers to report insurance coverage to the National Council on Compensation Insurance (NCCI), which manages the nation's largest database of workers' compensation insurance information, within 30 calendar days of the effective date of coverage. All Colorado employers, unless exempt, are required to report employee wage information to the

Unemployment Insurance (UI) Program within the Department of Labor and Employment. The Division of Workers' Compensation matches these data on a periodic basis to identify employers who may not be maintaining coverage as required. The data match is not a fail-safe method for identifying employers that are out of compliance because (1) some of the employers identified in the match are exempt from the insurance requirements; (2) some carriers may not report insurance policy information to NCCI immediately, so some employers may appear uninsured; and (3) some employers may report incorrect employee information to UI. To verify whether employers identified by the match are required to be insured and whether they do, in fact, have coverage, the Division sends a series of letters to the employer requesting information on its insurance status. If the employer does not respond to the series of letters, the Division issues a penalty order.

- **Permitting self-insured employers.** The Division issues permits to employers who wish to be self-insured after analyzing factors such as the employer's solvency and profitability, internal policies to protect workers against injuries, and compensation losses over the past five years. The Division requires self-insured employers to obtain security such as a surety bond to cover outstanding and future losses in the event of a bankruptcy. The Division reviews self-insured employers annually to ensure that the amount of the bond remains sufficient. The Division also audits self-insured employers about every three years to ensure they comply with self-insurance requirements.

Uninsured Employers

Our audit evaluated whether Colorado employers are maintaining workers' compensation insurance in accordance with law. We found evidence that some Colorado employers have not maintained workers' compensation insurance for at least some period when they were required to do so. Specifically:

- The Division had 350 claims filed from June 2001 to December 2003 against approximately 345 employers who were not insured at the time the worker's injury occurred.

- Between November 1999 and April 2004 the Division referred 265 employers to the Attorney General's Office for not providing proof of insurance. Of these, 154 were not insured as required and ultimately obtained insurance. Another 34 employers were still under investigation as of April 2004. Of the remaining 77 employers, 27 had obtained insurance

prior to being referred to the Attorney General but had not provided proof of coverage; the remaining 50 were not required to have workers' compensation insurance because they had either ceased operations or had no employees.

In some cases, employers may not be insured because they are unaware of requirements to maintain workers' compensation insurance. However, there is evidence that, despite awareness of insurance requirements and notification from the Division, some employers repeatedly violate requirements to maintain workers' compensation insurance. Specifically:

- We reviewed cross-match data for the period of July 2001 through May 2004 and identified about 1,400 employers that received at least one notification from the Division regarding possible noncompliance, and then, after providing the Division with proof of insurance or exemption, received notification of apparent lack of insurance at a later date. This statistic could indicate that these employers provided proof of insurance and then dropped their insurance or allowed it to expire on multiple occasions.

- We reviewed information on 265 employers who were referred to the Attorney General's Office between November 1999 and April 2004 for not providing proof of insurance. We found that 25 of these employers obtained insurance, subsequently dropped their coverage, and later reinstated it, and another 22 obtained insurance and dropped it but had not renewed again as of April 2004. These cases indicate a possible pattern of noncompliance.

Employers who repeatedly and consistently violate insurance requirements–including those who do not obtain insurance despite repeated contact by the Division and those who obtain insurance and subsequently allow it to lapse–are particularly concerning.

We also reviewed the Division's practices for monitoring employers who fail to maintain workers' compensation insurance in accordance with the law, and more specifically, the Division's practices for regulating and sanctioning willful, repeated violators. We found the Division needs to seek clarification of statutes to ensure it has sufficient authority and remedies available to sanction such employers. Additionally, we found the Division needs to improve its regulation of uninsured employers by strengthening its identification and notification practices. We discuss each of these issues in the following two sections.

Sanctions

Statutes authorize the Division to penalize uninsured employers. Statutes state:

> Upon receiving information . . . that an employer is in default of its insurance obligations, the Director [of the Division of Workers' Compensation] shall . . . either: (a) Order the employer in default to cease and desist immediately from continuing its business operations during any period such default continues; or (b)(I) Impose a fine of not more than five hundred dollars for every day that the employer fails or has failed to insure or to keep the insurance [required] . . . except that the Director shall not impose a fine that exceeds the annual cost of the insurance premium that would have been charged for such employer. (Section 8-43-409 (1), C.R.S.)

Statutes limit any penalties imposed by the Division to the period *after* an employer has been contacted by the Division regarding lack of insurance. In other words, statutes do not permit penalties to be imposed for time periods prior to Division notification, even if the employer was required to maintain insurance during that time period. Statutes also state that the Division Director, when imposing penalties, "shall suspend any fine imposed . . . if the employer provides proof suitable to the Director that the employer has in force insurance for so long as the employer has any obligation under articles 40 to 47 of this title, and is not otherwise in violation of articles 40 to 47." The Division has interpreted this provision to mean that once an employer provides proof of insurance, any fine that has been assessed must be dismissed, regardless of how long the employer operated without insurance.

Our audit reviewed the Division's imposition of penalties on uninsured employers for Calendar Years 2002 and 2003. We found that the Division issued penalty orders to 1,600 employers for failing to provide proof of workers' compensation insurance and did not collect penalties from any of them. Further, we found that the Division has only issued one cease and desist order to an employer for failure to carry the required workers' compensation insurance since June 1993 when the Division was granted such authority. According to the Division, no penalties were collected because, in accordance with its interpretation of statutes, all penalties were suspended once the employer provided proof of insurance, even if the proof of insurance was only for prospective periods of coverage, and not for all periods when an employer was required to have insurance coverage but did not.

We contacted the Office of Legislative Legal Services (OLLS) to obtain an interpretation of the Division's statutes authorizing sanctions. According to OLLS staff, the statute could reasonably be interpreted in more than one way. The statute could be interpreted to mean that the Division should only suspend a penalty if the

employer provides proof of insurance for all periods when coverage was required. Alternatively, the statute could be interpreted in accordance with the Division's practice, which is to suspend the penalty, even for periods when the employer did not maintain the required insurance, if the employer provides proof of insurance prospectively. This interpretation does not provide the Division with sufficient remedies to address employers who repeatedly violate workers' compensation insurance requirements.

According to the Division, imposing penalties for retrospective periods when an employer did not maintain required coverage, once proof of prospective insurance is provided, would subject the employer to possible double penalties. The Division noted that, if an employee of an uninsured employer is injured, the employer will be required to pay higher benefits. Statutes stipulate that the compensation and benefits provided to an injured employee of an uninsured employer are to be increased by 50 percent.

Although this statutory requirement provides some amount of sanction for an uninsured employer whose employee sustains an injury, it does not provide sufficient remedy for employers who repeatedly violate insurance requirements, and, thus, obtain a competitive advantage over other employers who maintain insurance in accordance with the law. Additionally, it does not sufficiently remedy the increased burden on employees, taxpayers, and employers. Employees of uninsured employers must file their own workers' compensation claims with the Division and negotiate the claims process without the assistance of the insurance carrier. Taxpayers shoulder the increased costs of treatment when an uninsured worker seeks medical treatment from a government-funded facility. Employers who comply with the law pay, through their insurance premiums, for the Division's increased operating costs when the Division must constantly communicate and notify those uninsured employers who repeatedly violate workers' compensation insurance laws.

We contacted five states that have authority to impose penalties on uninsured employers. We found that all of these states impose penalties on employers for the full time period the employer lacks the required insurance.

The Division needs to strengthen its ability to enforce laws requiring employers to maintain workers' compensation insurance. The Division should seek a formal opinion from the Attorney General's Office regarding the intent of the penalty statutes. On the basis of the opinion, the Division should consider seeking statutory change to clarify when penalties are to be imposed and to allow penalties for any period when an employer is out of compliance as well as to specify how funds from penalties will be used. Currently, fines collected for failure to maintain insurance go into the Workers' Compensation Cash Fund and are intended to offset the surcharges

paid by carriers to fund the Division's operations. One alternative would be to deposit all or a portion of the fines into the State's General Fund.

Recommendation No. 1:

The Division of Workers' Compensation should improve its regulation of employers by seeking a formal opinion from the Attorney General's Office regarding its statutory authority to apply penalties during periods when an employer is out of compliance with the insurance requirements. Depending on the result of the formal opinion, the Division should consider proposing statutory changes to strengthen the Division's authority to collect penalties from employers who repeatedly and wilfully violate requirements to maintain workers' compensation insurance and applying penalties for all periods when an employer is out of compliance with the insurance requirements. The proposed legislation should specify where penalty revenues will be deposited.

Division of Workers' Compensation Response:

Agree. Implementation date: January 2005. The Division believes, based upon informal advice from the Attorney General's office, that its enforcement actions are in compliance with the current statute. Any changes to the statute are a matter of policy for determination by the General Assembly.

Identification and Notification

As discussed in the previous section, the Division's cross-match data indicate that some employers fail to maintain workers' compensation insurance and others repeatedly allow their coverage to lapse. We found that the Division does not consistently identify these noncompliant employers for increased monitoring and follow up. Specifically, the Division does not analyze data to determine which employers have had repeated violations and the frequency and duration of periods when they did not maintain required coverage. If this information was available, the Division could monitor these employers more closely, provide shorter notification periods for proof of insurance, and obtain evidence to support imposition of penalties and sanctions.

We also found that the Division does not notify employers who may be in violation of workers' compensation laws on a timely basis. Delays in notification can lead to employers being uninsured for lengthy periods. We reviewed a sample of 26

employers that received penalty orders from the Division in December of 2003 and identified 9 (about 35 percent) that were uninsured for more than six months before obtaining insurance. Notification delays occurred for the following reasons:

- **Notification letters.** The Division sends three separate notification letters, at intervals of about 30 to 40 days, before issuing a penalty order. On average, a total of about 100 days elapses from the date of the first notification letter to the date when the penalty order is issued.

- **Data timeliness.** About six months elapse from the time the Unemployment Insurance (UI) Program receives employer data and the time it is provided to the Division of Workers' Compensation for use in the cross-match. This delay occurs because the data are edited and the number of reported employees is checked for reasonableness before the data go to the Division. Since the Division is primarily concerned with whether the employer has employees, and not whether the number of reported employees is reasonable, the Division does not need to wait for verification before performing a data match.

- **Cross-match delays.** Once the Division receives the data from UI, the Division does not always perform the cross-match timely. For the period of December 2001 to September 2003, we found the Division delayed performing the cross-match for an average of 40 days after receiving the UI data. This practice delays the issuance of the first notification letter to potentially uninsured employers.

Division practices for identifying uninsured employers, and particularly those employers who violate the law repeatedly, need improvement. To address these issues, the Division should analyze data from its notification system and identify employers who repeatedly are out of compliance with workers' compensation requirements. The Division should consider decreasing the number of notifications sent out before issuing a penalty order, particularly for repeated violators. The Division should also request UI data as soon as possible after receipt and conduct the data cross-match promptly.

Recommendation No. 2:

The Division of Workers' Compensation should expedite contact with potentially uninsured employers by analyzing data to identify those employers who repeatedly violate worker's compensation laws, increasing its monitoring of and follow up with repeated violators, eliminating one or more of the notification letters and shortening

the time periods between notification letters, and using more current data from the Unemployment Insurance Program to identify potentially uninsured employers.

Division of Workers' Compensation Response:

Agree. Implementation date: January 2005. As stated in the narrative, over a two-year period the Division issued 1,600 penalty orders to employers, reflecting that those employers did not respond to Division letters and potentially did not have required workers' compensation insurance. This is out of approximately 139,000 employers for which the Division performs a cross-match. Computed on an annual basis, this reflects that just over one-half of one percent of employers received a penalty order. The Division agrees to utilize data from Unemployment Insurance more expeditiously, and will investigate whether eliminating a notification letter or other actions would improve the process.

Review of Surcharge Tax Assessments

Carriers and self-insured employers pay semiannual fees to the Division that are deposited into the following funds: the Workers' Compensation Cash Fund (which covers the Division's operations); the Major Medical Insurance Fund (which covers catastrophic injuries to workers that occurred from July 1, 1971 through June 30, 1981); the Subsequent Injury Fund (which covers injuries to workers occurring before July 1, 1993 and occupational diseases occurring prior to April 1, 1994); and the Cost Containment Fund (which covers costs for certifying employers who promote health and safety programs). For insurance carriers, the fees are in the form of surcharges totaling 3.818 percent of the premiums they collect each year from employers for providing workers' compensation insurance. For self-insured employers, the fees total 3.788 percent of their premium equivalents (i.e., the approximate premium the employer would have paid had it purchased insurance from a carrier). The carrier surcharge is 0.03 percent higher than the self-insured employer surcharge because carriers support the Cost Containment Fund, which funds a program intended to increase safety and reduce workplace injuries. Self-insured employers do not participate in the Cost Containment Fund.

To calculate the surcharges, the Division relies on self-reported information, specifically:

- Carriers submit a record of the total amount of premiums written during the past six months on a Division form, calculate the surcharge owed based on the premiums, and remit the calculated fees every six months. To verify the

premiums, the Division compares them to premiums reported by carriers to the Division of Insurance (DOI) at the end of every calendar year. The Division then manually recalculates the amount of surcharge to be paid based on submitted information.

- Self-insured employers submit a Division form listing the number of employees in each workers' compensation classification code and the associated payroll for these employees. These codes have been developed by the National Council on Compensation Insurance (NCCI) and are related to the types of job duties performed by the employee and associated risk of injury. Each code has an associated rate that is multiplied by the employers' payroll for all employees falling under each code, and the result is the premium equivalent. There are several additional adjustments made to the premium equivalent so that it mirrors the premium written by carriers, including a modification factor that reflects the self-insured employers' loss experience. Finally, the net premium-equivalent is multiplied by the surcharge to determine the payment, which is sent to the Division. The Division confirms that the correct NCCI rates were used and manually recalculates the premium equivalent. To verify that the employer correctly reported the number of workers in each classification code, the Division conducts periodic on-site payroll audits.

We reviewed a sample of 20 of the 292 payments received (about 7 percent) on premiums and premium-equivalents for the period July to December 2003. Our sample included $17.5 million, or about 69 percent of all payments made. We also reviewed a sample of 5 of the 36 payroll audits (about 14 percent) conducted by the Division from August to December 2003. We found problems in several areas as discussed below.

Adequacy of reviews and audits. We found errors relating to the calculation of surcharge payments, as follows:

- One self-insured employer used an outdated modification factor (a factor assigned by NCCI that reflects the employers' experience with workers' compensation losses) and three self-insured employers did not provide required documentation for the modification factor used so it was not possible to determine if the factor was correct. The modification factor affects the amount of the surcharge.

- One carrier added canceled premiums that should have been subtracted because the Division does not assess the surcharge on canceled premiums. As a result, the carrier overpaid its surcharge about $2,800.

Because of a substantial lack of documentation, we could not determine in all cases whether the Division identified and corrected the errors we noted. In addition, two of five payroll audits we reviewed had no documentation of the audit work that had been conducted and one had a single sheet of paper with a few numbers and notations, but no explanation of their meaning. Further, there is no management review of either the payroll audit files or the surcharge assessment reviews. Because relatively few staff members (1.4 FTE) perform both of these tasks, management review is important as a fraud prevention procedure and to ensure that work is accurate.

Due to the significant amount of money the Division receives from surcharges (about $52 million annually), we believe documentation of reviews of the surcharge payments and payroll audits is a necessary control to ensure accuracy and the appropriate handling of any errors. Payroll audits should be documented to ensure the Division has a record of the audit and to support any adjustments.

Frequency of payroll audits. The Division believes that on-site payroll audits of self-insured employers should be conducted every three years. For the period April 2000 through April 2004, we reviewed the frequency of audits of the 99 employers who held self-insurance permits throughout the entire period reviewed and found about half are not being audited this frequently. Specifically, 31 self-insured employers should have been audited twice during this period but were only audited once, and 21 were not audited at all.

Currently the Division focuses its audits on large employers and those that have had errors in calculating their surcharge payments. However, the Division has not established specific criteria for selecting employers to audit. For example, the Division has not specifically defined what a "large" employer is or determined that a certain number of calculation errors will lead to an audit. We believe the Division should develop a more formalized risk-based audit approach. The approach should include defining specific criteria for selecting employers for audits such as the severity of problems found during the Division's review of the surcharge calculations or during prior audits. The Division should also establish an audit plan so that all employers are audited on a routine frequency in accordance with the risk-based criteria.

Reconciliation of data reported to the Division of Workers' Compensation and the Division of Insurance. As mentioned previously, one way the Division verifies that insurance carriers are reporting the total amount of premiums they receive from employers is by comparing the premium amounts reported to the Division of Workers' Compensation with those reported to the Division of Insurance (DOI). If carriers report different premium amounts to the Division and DOI, this could mean that carriers either underpaid the Division's surcharge or underpaid DOI's tax, both

of which are assessed on the amount of premiums paid by employers. We reviewed the premium amounts carriers reported to both Divisions for Calendar Year 2002 (most recent data available). In 30 cases, the carrier reported more premiums to DOI than to the Division of Workers' Compensation, totaling about $8.2 million. The Division has been able to explain 15 of the 30 differences and is still investigating the remaining 15 differences totaling about $4.2 million in premiums. Premiums are the basis on which the surcharge is calculated. These 15 differences could indicate that carriers underpaid their surcharges to the Division. We estimate the total of such underpayments would be about $160,400. In 96 cases, the carrier reported more premiums to the Division of Workers' Compensation than to DOI. The Division believes that in most cases this is due to differences in how the data are required to be reported to the two Divisions. However, it could also mean that the carriers underpaid their taxes to DOI. Division of Workers' Compensation staff reported that they discuss discrepancies with DOI.

According to the Division, if a significant difference (defined by the Division as 7 percent) is found, further research is conducted. According to Division staff, no significant differences were found for Calendar Year 2002 . However, when we conducted the comparison, we found 21 of the 30 differences exceeded the 7 percent threshold. The Division should clear all existing discrepancies and request additional payments if necessary. For all future years (beginning with Calendar Year 2003), the Division should document its reconciliation and follow up with carriers when it appears premiums are underreported.

In addition, the fixed 7 percent threshold for investigating differences may not be reasonable for all premiums. For example, the Division would investigate a $350 discrepancy for a carrier that writes $5,000 in premiums in a year but would disregard a discrepancy of this amount if the carrier wrote $50,000 in premiums. Instead, the Division should consider a fixed-dollar threshold for investigating differences. The threshold should be determined based on the cost of investigating differences versus the effect on revenue from over- or underpayments on both the Division and the carrier.

As mentioned, the Division needs to make several improvements to its process for reviewing surcharge payments. These improvements are essential because the surcharge revenue provides a majority of the Division's funding. Without better controls for ensuring that carriers and self-insured employers are accurately reporting their premiums and premium-equivalents, the Division cannot ensure it receives all of the funds due.

Recommendation No. 3:

The Division of Workers' Compensation should ensure that surcharge payments are adequately reviewed and verified by:

a. Documenting and retaining staff recalculations of the surcharge payments and the audit work related to the payroll audits and implementing a management review of staff recalculations and audit work.

b. Implementing a payroll audit schedule to ensure all self-insured employers are audited every three years, including using a risk-based approach to select employers for audits.

c. Changing the threshold for investigating discrepancies between the amount of premiums reported to the Division of Workers' Compensation and to the Division of Insurance, and reconciling all reporting differences that exceed the threshold.

Division of Workers' Compensation Response:

Agree. Implementation date: December 2004.

Dispute Management

Chapter 2

Introduction

The legislative declaration of the 1991 Workers' Compensation Act states that it is the intent of the General Assembly that the act "be interpreted so as to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation . . . ." The Division of Workers' Compensation, which is responsible for enforcing and administering the provisions of the act, has several mechanisms to minimize litigation and resolve disputes, including:

- Providing assistance to ensure timely submissions of claims-related documents, clarify requirements, and locate missing information.

- Conducting pre-hearings and settlement conferences to resolve procedural issues and reach settlements when possible.

- Coordinating reviews of physicians' medical treatment decisions to help settle disputes over the appropriateness of care.

- Offering independent medical examinations that provide second opinions about other disputed medical issues on a workers' compensation claim.

If none of these mechanisms result in resolution of the dispute, either party to a claim can request a formal hearing in front of an Administrative Law Judge (ALJ) at the Division of Administrative Hearings (DOAH) within the Department of Personnel and Administration. The Division of Workers' Compensation pays the DOAH about $2.2 million annually for hearings resulting from workers' compensation disputes.

The Division also seeks to prevent disputes from occurring by ensuring that medical care and wage benefits are consistent and in compliance with statute. To encourage consistency, the Division publishes Medical Treatment Guidelines (detailing acceptable treatment for common occupational injuries) and a Medical Fee Schedule (capping the fees for this treatment) that physicians are required by statute to follow. Additionally, physicians must follow the *AMA Guides to the Evaluation of Permanent Impairment, 3rd Edition, Revised* when assigning an impairment rating, which is the basis for determining an injured worker's wage benefits. Wage benefits

based on these impairment ratings totaled about $124 million annually as of Fiscal Year 2001 (the most recent data available). Physician compliance with these statutes and rules is an important component of minimizing litigation, and containing costs in the workers' compensation system. We reviewed the Division's oversight of physicians, as well as other efforts to resolve disputes and minimize litigation, as discussed in the comments below.

Physician Accreditation

Physicians who choose to rate the impairments of injured workers are required by Section 8-42-101, C.R.S., to earn Level II accreditation. These physicians attend an accreditation seminar or complete a home-study course that provides detailed instruction on how to rate an impairment according to the *AMA Guides to the Evaluation of Permanent Impairment, 3rd Edition, Revised.* At the end of the seminar or home-study, the physicians must pass a two-part exam that includes an objective portion and a set of case studies for which the physicians provide thorough impairment ratings. In order to become accredited, physicians must score a minimum of 56 percent on the impairment rating case studies, which, according to the Division, represents the basic knowledge necessary to apply the proper methodology to provide valid ratings. After passing the original accreditation exam, physicians are required to reaccredit every three years through a similar process, including studying the curriculum or attending a seminar followed by completing impairment rating case studies. Although reaccreditation is earned simply through the completion of these case studies, the Division grades them and provides feedback to reaccrediting physicians as a quality control measure. The Level II accreditation process is intended to educate physicians to provide consistent, high-quality impairment ratings to ensure equitable benefits and minimize litigation. Accreditation is not required for a physician to treat injured workers or to determine that there is no impairment.

We reviewed the accreditation process and noted several problems. First, the Division does not follow up adequately with physicians who perform poorly on their accreditation or reaccreditation case studies. The Division has an informal policy that physicians who pass the impairment rating portion of the accreditation exam but score 65 percent or lower, as well as physicians who score below 56 percent on their reaccreditation case studies, should receive tutoring to improve their ability to rate impairments.

According to information from the Division, 39 out of 330 physicians (12 percent) who took the Level II accreditation exam between January 1, 1999, and December 31, 2003 scored between 56 and 65 percent on the exam and therefore should have received tutoring. We reviewed files for 23 of these and found that only 13 had been

sent letters advising them they needed tutoring and only 1 of the 13 actually completed tutoring, according to Division records. We also reviewed reaccreditation records for a sample of 93 Level II physicians for the period January 1, 1999, and December 31, 2002 (the most recent reaccreditation data available), and found that while most of the physicians that the Division identified as needing tutoring did receive a tutoring request (98 percent), the overall tutoring completion rate was only 37 percent (20 of 54 sampled physicians who were asked to complete tutoring). The Division does not make any further contact with physicians to encourage them to obtain tutoring. In addition, once a tutoring session is completed, the Division does not monitor or reevaluate the quality of the physician's impairment ratings to determine if the tutoring improved his or her performance. As a result, physicians who score poorly *and* never complete tutoring can continue to perform unlimited impairment ratings without further monitoring from or contact with the Division until their next reaccreditation date three years later.

Second, the reaccreditation case study feedback provided by the Division may not promote quality improvement. After grading reaccreditation case studies, the Division sends a feedback letter to physicians explaining errors in their impairment ratings. We found that feedback for the initial accreditation exams is timely, but feedback for the reaccreditation case studies is significantly delayed. For our sample of 93 reaccrediting physicians, we found that the time elapsed between the date the case studies were completed and the date feedback was provided has grown significantly, reaching more than a year in 2002, as shown in the table below.

Average Number of Days From Reaccreditation Case Study to Division Feedback Calendar Years 1999-2002*

	1999	2000	2001	2002	1999-2002 Average
Average number of days elapsed	76	105	288	378	234.5

Source: Office of the State Auditor analysis of Physician Accreditation files.
* Data for 2003 is unavailable because, as of July 2004, about two-thirds of sampled case studies completed in 2003 had not yet been graded.

Since physicians do not receive a copy of the original case study for reference and in 2001 and 2002 did not receive feedback until more than nine months after the date the case studies were completed, it is unlikely that the Division's feedback will contribute significantly to the quality of impairment ratings. Timely feedback is particularly important for those physicians whose scores indicate a deficiency. According to the Accreditation Program's case study score logs, 12 percent of the 389 physicians whose scores have been recorded since January 1, 1999, scored below 56 percent on their reaccreditation impairment rating cases, yet did not receive timely feedback to improve their rating ability.

Finally, the Division does not have complete information on physicians' accreditation examination scores. The Division maintains an accreditation database (called PADRS) that contains information such as physicians' demographic information, accreditation application information, and exam dates. However, PADRS cannot generate score reports for individual physicians over time, and some physicians' accreditation scores from prior to 1998 are no longer accessible at all due to programming problems. To compensate for the limitations of PADRS, the unit maintains informal score spreadsheets. However, we found these spreadsheets are incomplete, containing case study scores for 283 out of 315 accrediting physicians, and only 389 scores for 784 reaccrediting physicians since the beginning of 1999. Accurate, comprehensive scoring records for the accreditation exam and the reaccreditation case studies could allow the Division to link scores to physician performance in other areas, as detailed later in this chapter, and to assess the quality of the curriculum and the effectiveness of the accreditation process.

The accreditation process currently used by the Division is not an effective mechanism for promoting quality impairment ratings nor an efficient use of Division resources. Physicians' accreditation is designed to educate physicians in the workers' compensation system on the use of treatment guidelines and the proper methodology for conducting impairment ratings. However, due to weaknesses in the accreditation process, the Division cannot be sure the intent of the program is being accomplished, nor can it substantiate cost savings or quality improvements attributable to the physicians' accreditation process.

Recommendation No. 4:

The Division of Workers' Compensation should improve the physicians' accreditation process by:

a. Following up with physicians recommended for tutoring to increase the number who complete tutoring sessions.

b. Providing feedback on reaccreditation case studies to physicians in a timely manner.

c. Monitoring physician performance in accordance with Recommendation No. 5 and linking the data gathered through this process to accreditation scores to both track ongoing performance and determine whether the accreditation curriculum and testing are effective.

Division of Workers' Compensation Response:

a. Agree. Implementation date: July 2005. The Division agrees with recommendation 4 a, but notes that once a physician is accredited any tutoring would be voluntary.

b. Agree. Implementation date: July 2005.

c. Agree. Implementation date: July 2005. The Division agrees with recommendation 4c, based on its understanding that this recommendation addresses improving the coordination of data.

Oversight of Accredited Physician Performance

As noted in the previous section, the Division provides an Accreditation Program to educate physicians in the legal, administrative, and medical aspects of the workers' compensation system. Physicians can earn either Level I or Level II accreditation, both of which include training in the use of the Medical Treatment Guidelines and the Medical Fee Schedule. Level II accreditation also includes training on how to rate the impairments of permanently injured workers. Although a physician is not required to become accredited in order to treat injured workers, Level I accreditation is required for all chiropractors who provide long-term treatment and Level II accreditation is required for all physicians who rate permanent impairments. According to the Division's medical director, the program is intended to reduce overall system costs by:

- Standardizing the permanent impairment ratings according to the *AMA Guides to the Evaluation of Permanent Impairment, 3rd Edition, Revised,* upon which permanent disability wage benefits are based.

- Promoting compliance with the Medical Treatment Guidelines and Fee Schedule.

- Emphasizing an aggressive, return-to-work, treatment philosophy.

- Clarifying the paperwork requirements and timelines for billing, filing medical reports, and making referrals.

Physician compliance with these standards is intended to ensure that medical care is reasonable, billing is timely, and impairment ratings are consistent and accurate, consequently minimizing the number of disputes and speeding the resolution of claims. However, we found several indicators that physicians, once accredited, may not always use the correct impairment rating methodology or adhere to the treatment guidelines. Specifically:

- **A 2002 review of Colorado impairment ratings (conducted by an independent consulting firm under contract with the Division) revealed problems with some ratings and reports.** This review of a sample of 250 impairment ratings performed by Level II accredited physicians found that 8 percent of the sampled ratings were incorrect. On average, physicians perform about 11,800 impairment ratings each year, so if 8 percent of them are incorrect, about 940 injured workers each year have ratings that are inaccurate, which may mean their benefit payments are incorrect. Additionally, about 5 percent of the reports physicians wrote to support their ratings were given a grade of "D" or "F" by the reviewer, indicating that they did not meet "basic standards" of quality. Overall, the report stated that there were opportunities for improvement with most physicians' rating reports.

- **About 12 percent of all physicians seeking Level II reaccreditation between January 1999 and December 2003 scored lower than 56 percent on their case studies.** A 56 percent score is the minimum passing grade for an initial Level II accreditation exam. As mentioned earlier in the chapter, reaccreditation case studies are graded only as a quality control measure, but 56 percent is used as a scoring threshold to identify physicians who need tutoring to improve their impairment rating ability.

- **Some physicians are repeatedly cited during utilization reviews (URs)**. A UR is conducted at the request of an insurance carrier and involves a panel of physicians evaluating the appropriateness of medical treatment provided to a claimant by the treating physician. If the review panel finds that treatment has been excessive, unnecessary, or out of compliance with the Medical Treatment Guidelines, the physician may be sanctioned by removal from the workers' compensation case, or if noncompliance is more egregious, by retroactive denial of payment for medical treatment already rendered. We found that some accredited physicians have been cited repeatedly by the review panel for inappropriate treatment or misuse of the Guidelines. For example, since the inception of the utilization review program in 1993, one physician has been subject to 10 URs, which resulted in his removal from five separate cases. Another physician has undergone 9 URs, resulting in seven orders for removal from a case and two orders retroactively denying payment for unreasonable medical treatment. Overall, 42 different accredited

physicians have been removed from a case by the UR panel and 21 have been retroactively denied payment. Because the Medical Treatment Guidelines provide proven treatment methods that are most likely to help claimants return to work and that are the most economically efficient, physicians who are noncompliant may increase overall system costs and pose a health risk to claimants. UR records provide a mechanism through which the Division could identify physicians who warrant additional training or monitoring.

- **Participants in the workers' compensation system report that certain physicians consistently fail to complete impairment ratings using the appropriate methodology.** We interviewed a number of attorneys from the Workers' Compensation section of the Bar Association, Administrative Law Judges, and Division staff and found consensus that certain physicians in the system consistently provide inadequate impairment rating reports, and are thus repeatedly involved in litigation over benefits. Although all parties identified the same few physicians, the Division does not maintain cumulative data on complaints, violations of statutes and rules, or poorly performed impairment ratings to evaluate the extent of these physicians' noncompliance.

We reviewed the Division's process for monitoring accredited physicians and noted several reasons for its inability to ensure physician compliance. First, there is a lack of communication among Division Units regarding physician performance. For example, the Utilization Review (UR) Unit does not inform the Accreditation Program when a physician is subject to a review of his or her medical treatment practices. UR data could provide the Accreditation Program with a history of each physician's compliance with its curriculum. Although the physicians' accreditation database includes a field to indicate when a physician has been subject to a UR, this field is not used, nor is UR data kept in a physician's individual paper file in the Accreditation Program. Staff report that the Division's current data systems are not designed to compile information from all the different units that have physician-related processes. This prevents the Division from identifying noncompliant physicians who may need further instruction, and from gathering a comprehensive understanding of physician compliance in general.

Second, the Division does not monitor impairment ratings performed by accredited physicians to evaluate the accuracy and consistency of their rating methodologies. Because the calculation of a permanently impaired worker's long-term wage benefits is based in large part on impairment ratings, it is important that the ratings be conducted using an appropriate methodology. Impairment ratings determine the benefits for about 11,800 permanent disability claims filed each year, totaling more than $124 million in wage benefits, or about 22 percent of total wage benefits paid to workers annually. The only method the Division currently uses to track a

physician's ability to rate impairments is through the accreditation process. As noted earlier in this chapter, we also identified substantive problems with the Accreditation Program.

Third, the Division has no method to compile aggregate information on the performance of individual physicians (such as their compliance with statutes and rules) and no policy on how to respond to physicians with recurring problems. For example, the Division has no standard process for maintaining information on complaints against physicians and no way to combine such information with other indicators of physician compliance to identify those with consistent problems. For a 2002 Sunset Review of the Accreditation Program, staff sorted through nearly 1,300 individual physicians' files to compile a complaint history. This cumulative complaint record has not been maintained in the years since.

Physician oversight is necessary to minimize disputes and litigation. To strengthen its oversight, the Division should systematically review physician performance for compliance with statutes and rules. This review effort should include compiling complaints to determine which physicians require sanctions; documenting the sanctions the Division imposes to identify those that are the most effective at improving performance; sampling impairment ratings for periodic review to flag physicians in need of further training; and tracking the results of utilization reviews to identify physicians with recurring problems. Although these efforts may require additional staff time, we have identified FTE savings elsewhere in the audit that could be redirected toward these activities.

In addition, the Division should develop formal written policies for responding to physicians with recurring problems. These policies should stipulate which types of problems warrant what types of actions, such as sending instructional or corrective letters, providing tutoring, removing the physician from the Division Independent Medical Exam Panel or Utilization Review panel, or ultimately revoking accreditation. Finally, the Division should consider incentives for quality performance, such as modified reaccreditation requirements or public recognition.

Recommendation No. 5:

The Division of Workers' Compensation should strengthen its oversight of accredited physicians by:

a. Instituting a regular review of physicians' performance data, including samples of impairment ratings, treatment decisions, and complaints, to identify individual physicians who warrant additional assistance, monitoring, or corrective action.

b. Creating and enforcing written policies for responding to physician noncompliance with statutes and rules.

c. Implementing changes to the Division's automated systems to aggregate information on physician performance in accordance with Recommendation No. 17 in Chapter 4.

Division of Workers' Compensation Response:

a. Partially Agree. Implementation date: December 2005. Regarding a, there are constraints on corrective actions as discussed below.

b. Partially Agree. Implementation date: December 2005. The Division believes that any written policies must allow for the application of discretion depending on the particular situation.

c. Partially Agree. Implementation date: December 2005. The Division will explore options for the better coordination of data.

As noted in the audit, the accreditation process is voluntary. About 7,500 physicians are licensed in Colorado and only 9%, or 676, are Level II accredited. To ensure a sufficient pool of physicians in a voluntary system there are constraints on corrective actions that can be taken. Some of the physicians who choose to withdraw from the accreditation program cite bureaucratic hurdles as their reason for doing so.

Decisions on medical treatment and evaluating impairment involve judgment and perspective. Two different physicians could follow the proper methodology and provide somewhat different impairment ratings. That does not necessarily mean that one physician is right and the other is wrong. Also, the workers' compensation system is set up such that anytime a party disagrees with a treatment or impairment decision there is recourse to dispute that decision. The Division cannot insert itself into the middle of such disputes. The Division will implement these recommendations as appropriate and will work to improve its administration of this program.

The Independent Medical Exam Process

The Division coordinates independent medical examinations (called DIMEs) to help resolve disputes over medical issues. Either a claimant or an insurance carrier may request a DIME after the claimant's authorized treating physician has declared that

the patient's condition is unlikely to improve even with further medical treatment. The disputing parties cooperate to select, from a panel of about 189 accredited physicians, a physician who has had no previous contact with the case. Currently Section 8-42-107.2 (5)(a), C.R.S., requires the requesting party to pay the DIME fee, set in Rule XIV at $675 per exam, 10 days prior to the examination date. Within 50 days of being selected for a case, the DIME physician should determine (1) whether the claimant has a permanent disability resulting from the injury; (2) the appropriate impairment rating for the permanent disability (which will be used to calculate the claimant's wage benefits); (3) the portion of a worker's permanent disability that can be attributed to the workplace injury; and (4) any other medical issues specified by the requesting party.

About 11,800 permanent injury claims per year involve an impairment rating, and the associated wage benefits resulting from these ratings totaled an estimated $124 million (or an average of about $10,500 per claim) in Fiscal Year 2001, which is the most current available data. Although the Division has no data on the portion of this money associated with the 2,800 permanent injury claims per year that involve a DIME, we roughly estimate that the indemnity benefits associated with these claims could exceed more than $29 million per year, based on the average dollar amount per claim figured above.

DIME physicians are required to submit their reports to the Division within 20 days of the examination date in accordance with Rule XIV of the Division's Policies and Procedures. The Division oversees the timeliness and quality of this process. If the Division has not received the physician's report within 5 days after the 20-day deadline, staff send the physician a "late notice" reminder of the deadline and request the report within 7 business days from the mailing of the notice. If there is no response to the first late notice, two subsequent letters are sent 10 days after the first, and another 10 days later. If the physician does not respond to any of the notices, the Division calls to investigate the delay and request that the physician either send the report or a refund of the DIME payment. The Division also monitors DIME reports by comparing them with a checklist of required information. If a report is incomplete or appears inaccurate, the Division sends the physician a notice asking for a revised report or other remedy within 10 business days from the mailing of the notice. Two more incomplete notices are sent out in intervals of 10 days after the original if the Division does not receive the corrected report. Additionally, if Division staff believe the DIME physician used a questionable methodology to rate an impairment, they pass the DIME report on to the Division's impairment rating expert for review. Either party to a claim may also request a review of the DIME report by the Division's impairment rating expert.

We reviewed the Division's automated records for all of the about 10,400 completed DIMEs with an examination date between January 1, 2000, and December 31, 2003,

and found that the Division has difficulty enforcing timeliness and quality of DIME physician reports. Specifically:

- **About 33 percent of DIME reports were filed late**. According to the information in the Division's IME database, we found that approximately 3,400 DIME reports filed during the period did not arrive at the Division within the 20-day deadline set out in Division Rule. Nearly 1,900 reports were submitted between 7 and 59 days after the deadline, prompting the Division to send late notices to the offending physicians. About 115 reports were 60 days late or more. In addition, some physicians repeatedly received late notices for overdue DIME reports. We found that 27 of the 272 DIME panel physicians (10 percent) who have performed a DIME since January 1, 2000, have been responsible for more than 50 percent of all late notices.

- **About 9 percent of DIME reports were not complete when submitted.** These reports had to be returned to the physician for corrections because they lacked required information and/or the physician used an incorrect rating methodology. Incomplete reports were delayed an average of 50 additional days before the corrected version was received.

- **The Division did not mail about 30 percent of notices of incomplete reports timely.** In our testing of notices sent since January 2000, we found that Division staff mailed notices an average of about 20 days following the receipt of an incomplete report. Although the majority of notices were sent in a timely manner, incomplete DIME reports that were sent to the Division's medical reviewer for more extensive examination were significantly delayed. For example, we found the Division held more than 60 incomplete reports for longer than three months.

Untimely and incomplete DIME reports often delay the expedient closure of claims. Although there is no information with which to quantify the effect of overdue DIMES, delays can result in over- or underpayments to the claimant for the period of the delay. If the carrier has admitted liability for temporary disability payments only until the anticipated DIME completion date, the claimant may not receive any benefits while waiting for the overdue report. Staff provided several examples of changes in payments resulting from delayed DIMEs, as follows:

- One carrier paid indemnity benefits based on a disputed impairment rating for 20 weeks while waiting for an overdue DIME report. The new rating provided by the DIME resulted in a lower indemnity payment. Based on the new calculation, the carrier had overpaid the injured worker more than $5,000 while waiting for the DIME report.

- One claimant went entirely without wage benefits for nearly five months while waiting for a DIME report to be filed. When the report was finally received, the carrier immediately admitted liability for benefits in accordance with the new rating. Had the report arrived on time, the claimant would have received indemnity benefits of about $850 per month based on the DIME physician's rating.

- Another claimant waited about 17 weeks for an overdue DIME report, during which time the claimant's wage benefits totaled $2,295 less than if the DIME report had been on time and a final admission filed in response.

To minimize costs to carriers and claimants, the Division should take immediate steps to address problems with poorly performing physicians. First, the Division should develop a range of responses to physicians whose reports are consistently late or incomplete. Currently, staff occasionally write letters of admonition to physicians who file untimely reports or offer tutoring to physicians with repeatedly incorrect reports. Also, in the most serious cases, the Division removes problem physicians from the DIME panel. Since January 1, 2000, the Division has removed five physicians from the DIME panel. The Division should consider more rigorous application of corrective actions, as well as other options such as discontinuing DIME referrals to physicians with outstanding reports or with a history of filing late or incomplete reports. The Division could also consider seeking a statutory change to provide for payment for the DIME only after the exam is completed and the report accurately filed.

Second, the Division should modify its threshold for imposing corrective action. Division staff report that they have recently developed a DIME performance policy that will flag physicians for corrective action if they perform 10 or more DIMEs per year and have a "late rate" of more than 25 percent (measured by the number of late notices sent). However, our analysis of the policy shows that the criteria will not account for the majority of late reports or the physicians who are most frequently noncompliant. For example, the 25 percent late rate threshold will address only 29 percent of all late notices sent. Additionally, 17 percent of all late notices since January 2000 have come from only five DIME panel physicians (2 percent), but these physicians would not qualify for sanctions under this plan.

One way the Division could address both the majority of late reports and the physicians who repeatedly submit late reports is to establish a combined fixed-number/percentage threshold for corrective action. For example, the Division could base corrective action on a standard of five late/incomplete notices or a 25 percent late/incomplete rate per year, whichever is reached first. If this standard were applied to reports filed from January 1, 2000, to December 31, 2003, by physicians who performed 10 or more DIMEs per year, the five least timely physicians

mentioned above, along with 27 other physicians who accounted for a total of 989 late notices (55 percent) during this period, would have been subject to corrective action.

Finally, the Division should regularly review aggregate data to determine why physicians submit late or incomplete reports, and to monitor the extent of delays in its own administrative process. Systematically reviewing data on DIME filings would help the Division identify performance issues that could be addressed by informational mailings or physician tutoring, by freezing DIME referrals or payments, or by removing physicians from the DIME panel.

Recommendation No. 6:

The Division should strengthen the Independent Medical Exam process by:

a. Establishing standards to ensure that DIME panel physicians submit timely and complete reports. These standards should account for the majority of noncompliant reports, as well as the most frequently noncompliant physicians.

b. Systematically reviewing individual and aggregate data on timeliness and quality of DIME reports to identify issues that could be addressed with corrective action for particular physicians or staff, or more broadly, with informational mailings or changes to the accreditation curriculum, thereby reducing the number of recurring problems.

c. Considering additional options for corrective action against physicians who consistently fail to meet the standards, including freezing DIME referrals while reports are overdue, tutoring for recurring errors, removing physicians from the DIME panel, or seeking statutory change to require postpayment of the DIME.

Division of Workers' Compensation Response:

a. Partially Agree. Implementation date: July 2005. The Division agrees to establish standards but cannot "ensure" that a doctor who is voluntarily participating in the process and who is not under the control of the Division will always provide a timely report.

b. Partially Agree. Implementation date: July 2005. The Division partially agrees with Recommendation 6b, noting that there are constraints on corrective actions that can be taken since it must ensure a sufficient pool of doctors willing to participate in the system.

c. Partially Agree. Implementation date: July 2005. The Division currently utilizes the options listed in the recommendation, and it should be noted that doctors sometimes temporarily remove themselves from the panel at the Division's suggestion without the necessity of formal action. Any changes to the statute are a matter of policy for determination by the General Assembly.

The findings of the DIME doctor are binding and can only be overcome by clear and convincing evidence. For many claimants, the DIME is a required gateway to the litigation process to dispute benefits. As such, it serves an important due process component. Therefore, while timeliness is important, quality should not be compromised.

Physician participation on the DIME panel is voluntary. As noted, a small percentage of doctors (189) are on the DIME panel. If the parties cannot agree on a DIME doctor the Division must provide a panel of 3 potential doctors. Pursuant to §8-42-107.2, those 3 doctors must be in fields of specialization authorized to rate the condition or injury at issue, and there must also be measures to prevent over-utilization of physicians or specialists. Additionally, the parties can request that the DIME be conducted in a particular region in the state, generally close to the claimant's residence. The Division's oversight must provide a balance to all these factors and ensure a sufficient pool of physicians. Finally, there is a set fee for a DIME, and the Division is concerned about taking any action that could result in the DIME fee needing to be increased.

Causes of Litigation

The Division has stated in its recent budget requests that one of its main objectives is to:

> . . . reduce litigation and/or the necessity for workers' compensation hearings before a Division of Administrative Hearings Administrative Law Judge by 5% a year by identifying areas in which the Division of Workers' Compensation can successfully intervene . . . .

Currently hearing data are collected in the Division's Claims Database, which was developed more than a decade ago. The Division of Administrative Hearings (DOAH) staff are responsible for entering codes describing the issues to be addressed at a hearing, the order issued as a result of the hearing, and which side "won" each issue. They also enter codes indicating motions, continuances, and other legal procedures. The Division of Workers' Compensation can produce reports summarizing the frequency of these codes. However, these reports cannot provide the information necessary to identify trends in litigation, for the following reasons:

- **The data contain inaccuracies**. Division staff and Bar Association representatives confirmed that attorneys often include all possible issues on a hearing application in case they might want to address them during litigation. Codes for all of these issues, even if they are not ultimately introduced in the hearing, are entered into the system. Therefore, the system may report that ALJs have heard some issues that, in actuality, they have not. Additionally, according to the Division, high administrative staff turnover at DOAH has required frequent retraining of staff on the correct use of codes. Division of Workers' Compensation staff believe this turnover results in codes' frequently being entered incorrectly, potentially rendering the data unreliable.

- **The numerical data generated by the Division's data system are not detailed enough to identify trends in litigation.** Summary reports of the issues addressed in hearings do not include narrative to explain the ALJs' orders. In the case of Division Independent Medical Examinations, for example, narrative information could help the Division determine whether more DIMEs are being overturned and are therefore no longer minimizing disputes as intended. Our interviews with Division staff, ALJs, and several workers' compensation attorneys, revealed there is no consensus on whether this is occurring, yet the Division has begun to investigate ways to restructure the DIME process to minimize litigation. If the Division does not have narrative data about if and why DIMEs are overturned, it is unlikely that policy changes will achieve this objective.

Currently the Division stores a paper copy of each hearing order, which contains the narrative information the Division needs, in the claimant's file. A systematic review of these files to determine trends would be excessively time-consuming for Division staff. Developing a searchable, electronic data system containing narrative hearing information would more cost-effectively provide useful information to the Division.

DOAH is in the process of developing a Request for Proposals for the development of a system to be completed in Calendar Year 2005 that would contain searchable narrative information about hearing orders. Because this system could provide

valuable information to help reduce litigation, the Division of Workers' Compensation and DOAH should cooperate on the system's planning through an interagency agreement.

The Division pays the DOAH approximately $2.2 million annually, or about one quarter of its administrative expenditures, for hearings related to workers' compensation claims. Without data pinpointing the most common sources of this litigation, the Division is unable to develop policies to reduce the number of hearings and thus contain costs for system participants and the Division itself.

Recommendation No. 7:

The Division of Workers' Compensation and the Division of Administrative Hearings (DOAH) should work together on the continuing development of the DOAH system through a formal interagency agreement. This effort should focus on designing the DOAH system to include a Web-based, searchable database of hearing orders. Once the system is operational, the Division of Workers' Compensation should conduct annual qualitative reviews of hearing orders to determine what policies, procedures, or outreach could minimize the frequency, length, and cost of hearings.

Division of Workers' Compensation Response:

Agree. Implementation date: Summer 2005. The Division agrees with this recommendation based on our understanding that the database will be limited to Division employees and not the public. The Division will begin annual reviews of hearing orders once the DOAH system is operational.

Division of Administrative Hearings Response:

Agree. Implementation date: Summer 2005. DOAH welcomes the opportunity to work together with the Division of Workers' Compensation to improve the integrity and reliability of data collected. DOAH is in the process of reviewing responses to our Request For Proposals regarding our new case management software system. We will begin discussions with DOWC after our vendor is selected and the new system installation is underway, not later than Summer 2005.

Pro Se Party Assistance

According to its mission statement, the Division encourages "understandable, fair, useful and efficient processes of resolution [of workers' compensation disputes] at a reasonable cost." One way to control costs for all parties is through a system in which even complex disputes can be resolved without the involvement of attorneys. However, claimants and employers who do not have legal representation (called "pro se" parties) can be at a disadvantage in Colorado's workers' compensation system.

We interviewed stakeholders from all sides of the workers' compensation system, including attorneys for both claimants and carriers, Division staff at all levels, and ALJs, about pro se parties. All interviewees agreed that a party without legal representation will generally not be as successful in the litigation process as a party with an attorney. Additionally, attorneys reported that claimants with particular types of injuries will find it nearly impossible to secure legal representation. For example, attorneys often refuse claimants with injuries whose related benefits are limited by the statutory fee schedule because there is no financial incentive to represent them.

Although there have been no studies specifically on the outcomes of hearings involving pro se parties versus represented parties, the Division published a report in 2004 entitled *Work-Related Injuries in Colorado* which includes some information on the issue. The report notes that for claims where a settlement was agreed upon between the claimant and the carrier in 2001, the average settlement negotiated by claimants' attorneys was about $26,000, while the amount negotiated by pro se claimants was about $13,600. One reason a claimant with an attorney may receive a higher settlement amount than a pro se claimant is that claimants with more serious injuries may be more likely to hire an attorney. Alternately, represented claimants may have better success in negotiations because their attorneys have knowledge of negotiation strategies, statutory benefit levels, and the benefit levels likely to be granted in a hearing. Pro se claimants are unlikely to have similar expertise.

Division staff provided several examples of pro se claimants who suffered negative effects because of their lack of legal representation, including:

- **Delays.** In August of 2003, an insurance carrier denied liability for a back injury that left a worker entirely disabled. Statute allows claimants to file for an expedited hearing to determine compensability, in which case the hearing shall be held within 40 days of the application. This particular claimant filed for an expedited hearing, but the application was returned to the claimant by DOAH several times over a period of eight months because it was completed incorrectly. In total, nine months elapsed before the hearing was held to

determine the compensability of the claimant's injury, during which time the claimant had no income and received no reimbursement for medical care.

- **Case Closures or Dismissals.** In March of 2003, a claimant's attorney filed an application for a hearing with the Division of Administrative Hearings. When the claimant moved out of state, the attorney withdrew from the case. The carrier then filed a Motion to Dismiss the application for a hearing that the claimant's attorney had filed prior to withdrawing. According to staff, the motion was granted because the claimant did not know how to argue the case and could not afford to hire a new attorney. The claimant is now without recourse for medical care or wage benefits. In a similar case from May 2004, a claimant filed for a hearing to reopen his closed claim because his medical condition had worsened. The carrier filed a Motion to Strike the application for hearing, and when the claimant did not respond quickly enough, the hearing was cancelled and the case remained closed.

The difficulties faced by pro se claimants are apparent. First, statutes and rules regarding rightful benefits and compensability of injuries are complicated and detailed, with more than two dozen deadlines relating to the timely resolution or challenge of benefits. Additionally, the hearing process mirrors a judicial court case, involving factors such as discovery, depositions, serving of documents, and motions. The ALJs who conduct pre-hearings and hearings for workers' compensation claims report that they are required to hold pro se litigants to the same standards as attorneys. When arguing their cases, pro se parties are expected to know and follow procedural rules, rules of evidence, and substantive law in addition to an extensive body of case law that sets precedence for the interpretation of unclear workers' compensation statutes.

Despite the complicated litigation process, there is little assistance available to pro se parties. The Division of Administrative Hearings (DOAH) provides the public with limited published material explaining the hearing process or benefits set forth in statute. Although an instructional pamphlet is available in Spanish, other statutory guidelines and rules are not, leaving non-English speakers or illiterate pro se parties particularly vulnerable. Division of Workers' Compensation staff report that they receive about 40 calls per week from pro se claimants solely on the issue of completing the application for hearing. From July 2003 through May 2004, nearly 700 applications for a hearing were returned by DOAH to applicants because they were incomplete or incorrectly filled out. Further, DOAH and the Division of Workers' Compensation do not assist pro se parties with many of the confusing elements of the process in order to avoid crossing the line between providing assistance and offering legal advice, which has not been clearly defined.

In light of the concern for pro se parties expressed by all participants in the workers' compensation system, we believe the Division should investigate options for a pro se party advisor to assist them in navigating the dispute processes, understanding relevant laws and rules, and preparing for hearings. Several other states, such as Texas and Oregon, have a claimant advocate or ombudsman (some housed in their Workers' Compensation agencies, others housed in a related department). Examples of the duties of these advisors include:

- Communicating with employers, employees, carriers, and health care providers on the pro se party's behalf.

- Showing the pro se party how to gather and prepare facts and evidence for dispute resolution proceedings.

- Helping the pro se party present facts and evidence, prepare questions for witnesses, and raise questions about evidence at dispute resolution proceedings.

- Providing information about how to appeal a dispute resolution decision.

The Division expects that such a function in Colorado would require statutory change. We believe the Division should investigate the need for this service, as well as options for its implementation. Meanwhile, the Division should create materials that more clearly explain the pre-hearing and hearing processes and that better accommodate a variety of non-English-speaking or illiterate populations.

Recommendation No. 8:

The Division should investigate options for improving guidance for pro se claimants and employers in the litigation process, including:

a. Identifying key areas of difficulty for pro se participants in the hearing process.

b. Considering options for an ombudsman or pro se advisor function for both claimants and employers. Special consideration should be given to striking a balanced protection of the legal vulnerabilities of pro se system participants and of the Division.

c. Improving published and audio/visual material to accommodate lay people, non-English speakers, and illiterate claimants.

Division of Workers' Compensation Response:

a. Agree. Implementation date: July 2005.

b. Agree. Implementation date: July 2005. The Division agrees to consider options relative to an ombudsman or pro se advisor. However, given the complexities of the litigation process the Division has concerns that an ombudsman will foster a false sense of competency in pro se litigants.

c. Agree. Implementation date: July 2005.

Claims Oversight

Chapter 3

Introduction

The Division of Workers' Compensation oversees the approximately 360 companies that currently adjust workers' compensation claims in Colorado. These companies include insurance carriers, self-insured employers that assume the risks for their workers' compensation costs, and third-party administrators (that insurance carriers and self-insured employers hire to adjust claims on their behalf). These entities are referred to as "carriers" throughout this chapter.

The purpose of the Division's oversight is to determine whether claims are adjusted in accordance with the Workers' Compensation Act and the Division's Rules of Procedure. According to the Act, the Division has a mandate to ensure that carriers adjust claims properly. Specifically, Section 8-43-217, C.R.S., states:

> The general assembly hereby finds, determines, and declares that active management of workers' compensation claims should be practiced in order to expedite and simplify the processing of claims, reduce litigation, and better serve the public.

Carriers file about 36,000 claims with the Division annually. The Division's oversight helps ensure the accuracy and timeliness of claims by identifying and correcting claims adjusting mistakes. Accurate and timely claims adjusting is important so that claimants quickly receive the benefits necessary to treat their injuries and return to work, costs to carriers and employers remain reasonable, and minimal litigation within the workers' compensation system occurs.

During the audit we noted that some carriers are not adjusting claims in an accurate and timely manner. For example, carrier compliance reviews conducted by the Division from Fiscal Years 2000 through 2003 found that 29 percent of disability benefit payments to claimants were late. Such delays have a negative impact on claimants who depend on these payments to replace their paychecks while their injuries prevent them from working full-time. In addition, miscalculations in claimant benefits have steadily risen. Specifically, the amount of errors (either over- or underpayments to claimants) detected by the Division has increased steadily from $2.5 million in Fiscal Year 2001 to $3.5 million in Fiscal Year 2003 and was on pace at the time of our audit to reach $3.2 million in Fiscal Year 2004. Most of the

miscalculations involved potential underpayments to claimants. In Fiscal Year 2003, for example, the Division detected about $3.0 million in underpayments involving about 1,700 claimants and about $500,000 in overpayments to about 130 claimants.

We reviewed the Division's oversight efforts and found weaknesses that limit its effectiveness in ensuring compliance with the State's claims adjusting requirements. This chapter discusses ways the Division can improve its carrier oversight functions to make them more effective and promote compliance by carriers.

Compliance Reviews

The Division performs periodic reviews to determine compliance with the State's claims adjusting requirements. The Division also evaluates whether self-insured employers have enough reserves to cover the costs of their outstanding claims. The main purpose of the compliance reviews is to ensure that carriers are calculating benefits accurately, paying them timely, and are otherwise adjusting claims in accordance with the State's laws and regulations. For each review, the Division selects a sample of claims (usually about 40) and tests compliance in categories related to timeliness and accuracy of benefit payments and the proper filing of claims documents. The Division's evaluation of timeliness includes whether the carrier has admitted or contested liability for a claim and made payments to claimants and health care providers within statutory time limits. Its evaluation of accuracy includes whether the carrier's benefit calculations are correct and whether the carrier has paid benefits for the proper time period. For documentation, the Division determines whether the carrier's filings comply with state laws and regulations. The Division calculates an overall compliance percentage for each carrier reviewed by averaging the percentages for all categories evaluated. If a carrier scores low on its review, the Division may provide training to correct the noted problems, schedule a follow-up review, or both.

The Division focuses its efforts on the largest carriers operating in the State and on any carriers that it has identified as making a large number of claims adjusting errors. We analyzed the results of the reviews conducted by the Division from Fiscal Years 2000 through 2003 and noted a number of concerns about carriers' overall compliance. We found:

- **Subsequent reviews do not consistently reflect improved carrier compliance.** We reviewed all carriers that were subject to multiple compliance reviews from Fiscal Years 2000 through 2003 and found that for 33 percent of the carriers (9 of 27), compliance rates declined between the initial and subsequent review. On average, the compliance rates decreased by eight percentage points. When considering only the categories associated

with timely benefit payments, compliance rates declined for 48 percent of carriers (13 of 27) between the initial and subsequent review. The average decline for these compliance rates was 11 percentage points.

- **Few carriers exhibit high levels of compliance.** Division staff report that they consider an overall compliance review average of 95 percent to represent satisfactory compliance with the State's claims handling requirements. For the 107 reviews conducted from Fiscal Years 2000 through 2003, we found that only one carrier achieved the 95 percent standard and only one other carrier achieved an average score of at least 90 percent. Overall, carriers attained an average compliance percentage of 69 percent for all categories reviewed, while average compliance in categories specifically related to making timely payments to claimants and health providers was 71 percent. The table below shows the distribution of compliance averages for all categories and for those associated with timeliness of payments for reviews conducted during Fiscal Years 2000 through 2003.

Compliance Averages for the Division Compliance Reviews
Fiscal Years 2000-2003

	Overall[1]		Timeliness	
Compliance Average	**# of Reviews Within Range**	**% of Reviews Within Range**	**# of Reviews Within Range**	**% of Reviews Within Range**
90-100%	2	2%	4	4%
80-89%	15	14%	28	26%
70-79%	37	35%	35	33%
60-69%	37	35%	22	21%
0-59%	16	15%	18	17%
Total	**107**	**100%[2]**	**107**	**100%[2]**

Source: Office of the State Auditor analysis of data provided by the Division of Workers' Compensation.

[1] The overall compliance percentage is an average of the compliance percentages from eight categories, four of which relate to the timeliness of benefit payments, two of which relate to the accuracy of benefit payments, and two of which relate to proper filing of documents. We did not detail the compliance rates for the two categories related directly to the accuracy of benefit amounts because the Division did not routinely calculate a compliance percentage for one of them during the period covered by the table.

[2] Percentages do not add up to 100% due to rounding.

We identified specific improvements the Division can make to increase the effectiveness of its review process and promote compliance by carriers. We discuss these in the next six sections of the report.

Claims Adjusting Penalties

One of the reasons the Division's efforts to promote compliance have suffered is that it does not have strong mechanisms to encourage compliance and penalize carriers that are repeatedly noncompliant. This is important because there are many carriers whose compliance levels appear low. As previously shown in the table on page 53, roughly half of the 107 compliance reviews conducted by the Division from Fiscal Year 2000 through 2003 found overall compliance averages of less than 70 percent. In addition, one carrier that had been reviewed three times during the period was still only making timely payments to claimants and health providers 58 percent of the time, while another carrier that had been reviewed four times still had an overall compliance average of only 64 percent.

We found that the Division rarely sanctions carriers for adjusting claims incorrectly, having issued penalties on only 11 claims totaling about $102,000 since the beginning of Fiscal Year 2000. Although the Division does not track the number of claims for which carriers could be penalized, we noted earlier that carriers over- or underpaid indemnity benefits for about 1,800 claims in Fiscal Year 2003. In addition, of the 48 carriers that scored below 70 percent overall on one of the Division's compliance reviews since the beginning of Fiscal Year 2000, we found that the Division has only penalized 4 of them for claims adjusting errors.

Although the Division is authorized to levy penalties on carriers that do not comply with the State's claims handling requirements, imposing them for general non-compliance is problematic. Specifically, Section 8-43-304(1), C.R.S., provides for a penalty of not more than $500 per day for each violation of the Workers' Compensation Act, 75 percent of which is payable to the aggrieved party and 25 percent to the Subsequent Injury Fund. Currently penalties are issued on a case-by-case basis in which the claimant is the aggrieved party who receives the 75 percent portion of the fine because the carrier mishandled his or her claim. However, if the Division intends to impose penalties on the basis of general noncompliance with the State's claims adjusting requirements, it is not clear who the aggrieved party is. Naming individual claimants as aggrieved parties would be time-consuming and costly because it would necessitate separate penalty orders and hearings for each person whose claim was adjusted improperly.

The Division's authority to assess penalties based on general noncompliance with the State's claims handling requirements is unclear. The Division should pursue specific statutory authority to allow the imposition of penalties when carriers consistently fail to comply with requirements and to deposit at least a portion of the funds collected from such penalties into the State's General Fund or the Workers' Compensation Cash Fund. The Division should also develop and use criteria to determine when to assess penalties against carriers for overall noncompliance.

Recommendation No. 9:

The Division of Workers' Compensation should expand efforts to promote carrier compliance with laws and regulations by:

a. Proposing legislation to clarify the Division's authority to penalize carriers for overall noncompliance with the State's claims adjusting requirements and to deposit at least a portion of the penalties into the State's General Fund or the Workers' Compensation Cash Fund.

b. Developing and using criteria to assess penalties against carriers for overall noncompliance.

Division of Workers' Compensation Response:

a. Partially Agree. Implementation date: December 2005. The Division agrees to review this area to see if technical assistance and/or rule changes can adequately address this situation. Currently, the Division is also working jointly with the Division of Insurance on carrier practice audits and referral by the Division of Workers' Compensation to the Division of Insurance to take penalty actions. Any changes to the statute are a matter of policy for determination by the General Assembly.

b. Partially Agree. Implementation date: December 2005. The Division agrees to work on criteria.

Compliance Incentives

In addition to penalties, another way the Division can promote compliance with laws and rules is through less punitive measures. Currently the Division has no incentives available to promote increased compliance by carriers. One incentive the Division could offer is a discount on the surcharge a carrier pays into the Workers' Compensation Cash Fund, which pays the Division's administrative expenses, if the carrier maintains a certain level of compliance as measured by the Division's reviews. One advantage of this approach is that it would provide a tangible, bottom-line reward to carriers for conscientious adjusting practices. Another advantage is that it would create a situation in which noncompliant carriers would be paying a larger proportion of the Workers' Compensation surcharge than compliant ones, which would be fair because noncompliant carriers create a disproportionate amount of work for the Division.

Another incentive the Division could consider is a reduction in the amount of oversight on more compliant carriers. For example, the Division could implement mandatory training for noncompliant carriers, at the carrier's expense. The Division would need to establish criteria that define what makes a carrier noncompliant and subject to mandatory training. Doing so would provide an incentive for carriers to improve their compliance to avoid paying for mandatory training. The Division could also establish guidelines for scheduling carriers for follow-up reviews that reward carriers for improved compliance by scheduling fewer reviews for those carriers that meet specified compliance levels. Having fewer reviews would be an advantage for carriers, who must commit resources to cooperate with the Division in completing the review and to implement recommendations that result from the review.

The Division could implement the incentive options mentioned above through its rule-making authority. For example, the Division Director sets the Workers' Compensation Cash Fund surcharge by rule and could enact a discount provision for carriers that maintain a high level of compliance. Similarly, the Division could adopt rules that link mandatory training and the frequency of compliance reviews to the results of previous reviews.

Recommendation No. 10:

The Division of Workers' Compensation should consider adopting incentives to promote carrier compliance with the State's workers' compensation laws and regulations, such as promulgating rules to reduce the premium surcharge rate paid by compliant carriers into the Workers' Compensation Cash Fund, to provide mandatory training for noncompliant carriers, and to establish guidelines for follow-up reviews that ensure that compliant carriers receive fewer reviews. For each incentive, the Division's rules should establish criteria that define the level of carrier compliance needed to receive the incentive.

Division of Workers' Compensation Response:

Partially Agree. Implementation date: July 2005. The Division agrees to consider various alternatives to promote carrier compliance. Although we disagree with providing a reduction in surcharge for certain carriers, because that could result in barriers to new carriers starting operations in Colorado and potential litigation by carriers dissatisfied with ratings, we do agree that providing fewer follow-up reviews for compliant carriers is feasible, and agree that training and assistance within our current budget and staffing can be offered.

Compliance Standards

Another factor that limits the Division's ability to promote compliance is the lack of specific criteria to define whether a carrier's claims adjusting practices reasonably meet the requirements of workers' compensation laws and regulations. As previously mentioned, the Division believes that carriers are performing satisfactorily if they achieve an average of 95 percent compliance in all categories tested during a compliance review. According to staff, they used the Division of Insurance's 95 percent standard for its insurance carrier examinations as a benchmark. However, we found that the Division of Workers' Compensation's standard is informal and has not been set in rule or statute. Moreover, staff have not consistently communicated this standard to carriers so that they know what level of compliance is expected of them.

Without formalized standards, the Division does not have a basis for making legitimate conclusions about whether a carrier is reasonably compliant with applicable laws and regulations. This is important because, as previously noted, the Division's reviews have found that carriers' average compliance rates appear low. The lack of standards also impairs the Division's ability to take corrective action. For the Division to successfully impose penalties for general noncompliance, as discussed in a previous section, it will have to establish standards to define what constitutes noncompliance. Section 8-43-218(3), C.R.S., allows the Division to impose penalties on "any party willfully refusing to cooperate or comply with claims management efforts of the division. . . ." However, the Division does not currently have any criteria to define what would constitute a willful refusal by carriers to cooperate or comply.

A related problem in this area is that the Division does not weight the factors it evaluates during its reviews, even though staff believe that some factors, such as making timely benefits payments to claimants, have more serious effects on claimants than others. For example, to compute a carrier's overall compliance percentage, all categories are averaged equally; those areas that staff consider to be more important because they affect the benefits received by the claimant are not weighted to reflect their significance. Establishing standards that emphasize those deficiencies that materially affect claimants would make the Division's oversight more effective because it would focus the carriers' attention on the most important issues.

The Division has drafted several proposals to establish compliance standards for carriers. For example, a 1999 proposal would have defined "willful failure" to cooperate or comply with the Division's claims management efforts based on a documented lack of improvement in claims adjusting practices over time or a lack of cooperation with the Division. Meanwhile, a 2003 proposal would have formally

established 95 percent as an acceptable compliance average for the Division's compliance reviews and any average below 90 percent as representing "serious" non-compliance. The 2003 proposal would also have used compliance averages to determine how often the Division would review a particular carrier (i.e., the lower the carrier's average, the more often it would be subject to review). So far, the Division has not enacted any of these proposals.

The Division should develop standards that define what constitutes reasonable compliance by carriers with the State's workers' compensation claims adjusting requirements. The standards would give carriers clear guidance on the level of compliance expected from them and define what "willful" noncompliance means.

Recommendation No. 11:

The Division of Workers' Compensation should develop weighted standards that define what constitutes reasonable compliance by carriers with the State's workers' compensation claims adjusting requirements and clearly communicate these standards to carriers adjusting workers' compensation claims involving Colorado workers. This effort should include defining what represents "willful" noncompliance by carriers.

Division of Workers' Compensation Response:

Agree. Implementation date: December 2005. The Division agrees and has already begun joint efforts with the Division of Insurance.

Risk-Based Reviews

The Division's Carrier Practices and Self-Insurance units both perform periodic carrier compliance reviews. We reviewed how the two units select carriers for review and noted a number of weaknesses, as follows.

Carrier Practices. Carrier Practices does not appear to have formalized, risk-based criteria to select carriers for compliance reviews. Generally, the unit reviews carriers based on market share, as defined by the number of claims filed annually, and previous compliance history. The unit's intent is to review large carriers once every three years and reexamine carriers within 6 to 12 months of a review in which the carrier has a low compliance average. The Division also considers other factors when selecting carriers for reviews, including complaints from stakeholders, referrals from the Division's Claims Management unit (which monitors claims information

on a daily basis), and the carriers' geographical locations. Carrier Practices has compiled a list of 122 carriers it has reviewed in the past and/or is planning on reviewing in the future. We analyzed the compliance review histories of the carriers on the list to evaluate whether Carrier Practices' review selection practices appeared reasonable, in terms of focusing its resources on those carriers that represent the greatest risk to the workers' compensation system. For 29 of them (24 percent), we concluded that it was unclear why they had or had not been selected for review. Specifically, there were:

- 17 carriers that did not appear to be large enough, in terms of the number of claims filed with the Division, to warrant reviews.
- 5 carriers that appear to be large enough to warrant regular reviews but have gone more than three years without a Division review.
- 4 carriers that either received or were scheduled for follow-up reviews, even though they exhibited above-average compliance, in relation to their peers, on their most recent reviews.
- 3 carriers that have not received or been scheduled for follow-up reviews even though their last reviews revealed below-average compliance, in relation to their peers.

Based on these results, we believe Carrier Practices should develop a formal plan that defines the criteria, in terms of risk to the system, that are most important for selecting carriers for review and then choose carriers for review accordingly. For example, Carrier Practices has not currently defined what is considered a large carrier for review purposes, other than saying that it will not review carriers who file fewer than 10 claims per year (which represents 0.02 percent of the approximately 36,000 claims filed annually). Based on a 2001 report (the most recent year available) on the number of claims submitted by carriers annually, we calculated that carriers submitting at least 100 claims per year (about 60 carriers) accounted for about 90 percent of all claims filed with the Division. Therefore, while Carrier Practices should continue to review smaller carriers periodically so that all carriers remain subject to review, defining large carriers as those submitting 100 or more claims per year would focus resources on those carriers filing the bulk of claims with the Division.

The plan should also state which carriers Carrier Practices intends to review each year, while allowing for flexibility if staff determine during the year that other carriers should be reviewed instead. Currently Carrier Practices maintains a log of projected compliance reviews. However, the log does not cover a finite period of time, such as a calendar or fiscal year. Instead, staff report that carriers are

continually added to the log "as needed." A formal review schedule would help ensure that Carrier Practices chooses carriers for review that fulfill the risk-based criteria it develops.

Self-Insurance. Self-Insurance's goal is to review self-insured employers on a three-year cycle. However, we reviewed the unit's compliance review history and found that the Division did not conduct 24 percent of its planned reviews during Calendar Years 2000 through 2003. We also found that self-insured employers are reviewed on average only once every six years. Further, we found that 37 self-insured employers (about 35 percent) were not reviewed for nine years or more. According to the Division, a number of issues, including lack of staff, changes in staff, and the priority of other projects, have prevented Self-Insurance from completing compliance reviews as planned. We also found that Self-Insurance has not formally implemented a risk-based approach to identify employers for review. Instead, it has dedicated its resources to reviewing those self-insured employers that have not been visited within the three-year review cycle.

Later in this chapter we will be recommending that the Division eliminate the duplication of effort that now occurs when both Carrier Practices and Self-Insurance evaluate self-insured employers' claims adjusting practices. Even so, Self-Insurance will still need to conduct reviews to determine if self-insured employers have adequate financial reserves. A risk-based approach for selecting carriers for review would help Self-Insurance focus them on employers that need the most attention in the area of adequate financial reserves.

Recommendation No. 12:

The Division of Workers' Compensation should ensure that its carrier compliance reviews are scheduled and conducted on a risk basis by:

a. Having Carrier Practices develop a formal plan for selecting carriers for compliance reviews. The plan should formally define the criteria the unit will use to select carriers for review and state which carriers it intends to review annually.

b. Having Self-Insurance establish and use risk-based criteria for selecting self-insured employers for review of their financial reserves.

Division of Workers' Compensation Response:

a. Agree. Implementation date: December 2004. The Division will implement more formal written criteria that will be balanced with the need to take into account carrier performance trends, stakeholder complaints, referrals from other division units, new entries into the market, and geographical concerns.

b. Agree. Implementation date: December 2004.

Unpaid Benefits

Some claimants receive additional benefits owed to them as a result of the Division's compliance reviews. Whenever the Division identifies inaccuracies in benefit payments through its compliance reviews, it requires the carrier to correct the deficiencies identified by the review and make any missed benefit payments to claimants. However, the Division does not currently ask the carrier to review all claims covered by the review period to identify and correct all errors. As a result, claimants whose files happen to be a part of the review sample are assured to receive all benefits due to them, while those not included in the sample are not.

Two of the Division's reviews we examined found that the carriers had failed to pay waiting period benefits that were owed to claimants in at least 10 percent of the claims reviewed by the Division, which may indicate a systemic problem. As a result of the reviews, the carriers had to pay these benefits to all claimants in the review's sample that should have received them but did not. We estimated these benefits to total about $2,000 for one carrier and about $800 for the other.

All workers' compensation claimants should receive all statutory benefits owed to them. In cases where Division compliance reviews find significant systemic problems in claims adjusting practices, the Division should require carriers to review claims filed during the review period but not included in the sample, correct any errors found, and modify procedures to avoid similar problems in the future, as appropriate. To accomplish this, the Division will need to establish thresholds to define what constitutes a significant systemic problem. This approach not only helps ensure that more claimants receive the benefits owed to them but also provides an incentive to the carriers to adjust their claims correctly from the outset.

Recommendation No. 13:

The Division of Workers' Compensation should revise its compliance review procedures to ensure that insurance carriers correct deficiencies involving the payment of benefits in all claims covered by the review period. To accomplish this, the Division should establish thresholds of noncompliance with respect to benefits payments that would trigger a request that the carrier go back and ensure that it has correctly paid the benefits for all claims filed during the review period.

Division of Workers' Compensation Response:

Agree. Implementation date: July 2005. The Division agrees with this recommendation but the extent to which the Division can require correction of deficiencies in individual cases will depend on whether the individual case is open or closed and its litigation status.

Quality of Compliance Reviews

Previous sections have recommended that the Division use its compliance reviews to establish standards for acceptable claims handling practices and to develop sanctions and rewards based on carriers' compliance. For these measures to work, the Division's reviews must effectively identify noncompliant carrier behavior. We reviewed a sample of compliance reviews performed by the Division's Carrier Practices and Self-Insurance units during Fiscal Years 2002, 2003, and 2004, and noted a number of weaknesses in the work papers, procedures, and reports. We believe the Division will be able to promote carrier compliance more effectively if it improves its compliance review processes to address the concerns discussed below.

Reviews are not always comprehensive. Testing by Carrier Practices was not always adequate during the reviews in several ways. First, when testing whether a carrier makes timely payments to claimants and health providers, staff only review computer printouts from the carrier to verify that checks were sent out on time rather than reviewing the carrier's actual warrants, unless the carrier's policy is to place the warrants in the claims file. The Division should consider using audit software (such as ACL) to perform a 100 percent review of large data sets like payment information. Second, the reviews did not always test every element of the carrier compliance review mandated by the Division's Rule IV. For example, 4 of the 10 reviews we sampled did not examine whether the carrier consistently exchanged documents, such as medical reports, with all parties to a claim. The consistent exchange of

documents, which is a claims adjusting requirement in addition to the categories already mentioned, is important so that everyone involved with a claim is notified of all developments related to that claim. Finally, staff did not cite all identified deficiencies as exceptions, even though the carriers failed to meet specified claims adjusting requirements. For example, the Division's Rule IV.N.1 says that carriers shall state a position on the provision of medical benefits after a claimant has reached Maximum Medical Improvement (MMI) when submitting a final admission of liability to the Division. According to staff, this statement is important because it provides closure to claims and prevents future litigation about benefits owed by carriers. The Division does not currently consider it a deficiency subject to corrective action, although it will mention the error to the carrier.

The reviews' recommendations are not specific enough. We found that Carrier Practices' recommendations to carriers for improving their compliance are vague, consisting mainly of suggestions to comply with the law. Specific recommendations are more likely to result in improved compliance because they will pinpoint particular actions that carriers must take to improve their practices. Specific recommendations are also important if the Division intends to use its reviews to penalize or reward carriers for their claims adjusting practices. For example, an informal 1994 Attorney General's opinion stated that the Division could penalize carriers for not complying with the Division's recommendations only if the recommendations were specific as to what is expected for compliance in deficient areas. The main reason for the Division's vague recommendations is that its reviews do not consistently identify the causes behind a carrier's noncompliance, which makes it difficult for the Division to recommend specific carrier actions that need to be corrected.

Lack of work paper review. We found that unit managers do not review the underlying documentation supporting the compliance reviews of self-insured employers' conclusions and recommendations. Instead, managers only review the final reports. We believe that management review is critical to ensure that the report conclusions are accurate. In addition, because only two staff members conduct self-insurance reviews, management oversight helps ensure that compliance reviews remain objective and staff are consistent in their reporting.

It is important that the Division's review procedures and reports provide accurate and complete results. The Division's current supervisory review procedures do not appear to ensure that testing is comprehensive and adequate in all areas, that recommendations are specific enough, and that results are reported accurately and consistently.

Recommendation No. 14:

The Division of Workers' Compensation should improve the effectiveness of its carrier compliance review process by establishing supervisory procedures to ensure that the reviews comprehensively test all areas of compliance required by rule, treat all deficiencies consistently, make specific recommendations to improve carrier compliance, and report the results accurately and consistently. These improvements should specifically include having managers in the Self-Insurance unit examine work papers from that unit's compliance reviews.

Division of Workers' Compensation Response:

Agree. Implementation date: December 2005. The Division agrees it will work to improve the effectiveness of its compliance reviews. However, the Division must balance its regulatory role in the workers' compensation system with the due process considerations in individual cases.

Admissions Review

The Division also tracks carrier compliance by reviewing claims information as it is submitted by carriers and compiling aggregate claims data on individual carriers. Most of these reviews involve admissions of liability, which are binding legal documents that state benefits that carriers will provide to claimants. A general admission states whether the carrier admits responsibility for the claimant's injury and what indemnity benefits it will pay. A final admission states the final amount of indemnity benefits the carrier will pay and when it will pay them.

The main purpose of the admission review is to identify claims adjusting errors made by carriers. The Division has two methods for identifying errors in general and final admissions. First, data from all admissions are entered into the Division's claims database, which has an automatic edit function to identify errors such as incorrect benefit calculations. Second, staff perform a manual review to identify errors such as lack of documentation to support the termination of benefits or the filing of the final admission. The Division receives about 82,000 admissions annually and staff manually review most of them (85 percent in Fiscal Year 2003).

We believe the Division could improve the effectiveness of the manual review because the number of adjusting errors found does not appear to warrant the amount of resources (2.0 FTE at a cost of about $119,000 annually) currently dedicated to

it. For example, in Fiscal Year 2003, the Division found incorrect benefit calculations in about 5 percent of claims filed resulting in about $3.5 million in over- and underpayments to claimants. The Division does not maintain statistics on total benefits paid to claimants, but we estimated that Colorado carriers paid about $433 million in indemnity benefits in Calendar Year 2002, based on data from the National Council on Compensation Insurance (NCCI), which manages the nation's largest database of workers' compensation insurance information. Therefore, the $3.5 million in errors found by the Division appears to represent less than 1 percent of all indemnity benefits paid to claimants.

Division staff believe that about half of these payment errors (i.e., involving 2.5 percent of all claims) are found through the manual review of admissions and the other half through the automatic computer review. However, the Division's basis for this statement is data last collected in 1995, which may no longer be relevant. Therefore, it is unclear how many calculation errors are actually found as a result of the manual review.

Our 1995 audit of the Division recommended that the Division begin reviewing admissions on a sample basis for those carriers with less risk for error, which the Division agreed to do. The rationale for our 1995 recommendation was that claims managers were devoting a large amount of time to review every admission, even though they were finding errors in only about 3 percent of them. The 1995 audit found that the Division should focus its admissions reviews on carriers with more risk for making errors.

The Division did institute sampling in Fiscal Year 2003. Currently only 3 of the approximately 360 carriers adjusting claims in Colorado have their admissions reviewed on a sample basis (including the carrier filing the most claims in the State). The Division's sampling approach involves staff's reviewing only the final admissions submitted by the carrier (which account for about 40 percent of all admissions) and those general admissions for which the computer identifies an error. Staff believe it is important to review the final admissions so that claims managers can address any errors before the claim closes. As noted above, under the current approach, the Division still reviewed 85 percent of the admissions it received in Fiscal Year 2003.

We identified several weaknesses in the Division's sampling approach, as follows:

- **No firm criteria exist for selecting carriers for sampling.** The Division reports that the three carriers currently selected for sampling were recommended by staff because of a past history of good compliance. However, staff do not use standard, objective criteria as the basis for their recommendations. As a result, it is unclear why these three carriers were chosen for sampling while others were not. For instance, we found that the

overall compliance averages for the three carriers on sampling, based on their most recent reviews, ranged from 67 to 81 percent. Currently there are 14 other carriers that scored at least 81 percent overall on their last reviews, suggesting that they might be equally good candidates for sampling.

- **The Division does not determine if sampling is still appropriate for carriers.** Staff said that they have not reevaluated the compliance levels of the three carriers on sampling to determine if sampling is still appropriate for them. The Division did track compliance for one of three sampled carriers in January 2004 and found that 23 percent of its admissions contained errors. However, tracking reports are not used to help determine if sampling is still appropriate for a carrier.

Staff believe it is important that the Division find as many errors by carriers as possible to ensure that claimants are receiving the correct amount of benefits. Staff are concerned that some claimants will not receive the benefits they are owed if the review of admissions is reduced. We agree that it is important for the Division to detect claims adjusting errors that materially affect the benefits received by claimants. However, we believe that sampling can be an effective tool to balance the costs and benefits of staff's manual reviews when they do not identify large numbers of errors. To ensure that sampling is effective, the Division should track the number of claims adjusting errors specifically found through the Division's manual admissions review for a specified period to determine how many errors are found by staff and adjust its sampling program, as needed, based on the results.

The Division should also develop criteria to select carriers for sampling. Using the criteria, the Division should systematically evaluate the larger carriers in the State to identify more prospects for sampling. Finally, the Division should establish guidelines to periodically reevaluate those carriers selected for sampling to ensure it remains appropriate for them.

Recommendation No. 15:

The Division of Workers' Compensation should increase the effectiveness of its sampling approach for reviewing admissions of liability by:

a. Developing and applying specific criteria to determine which carriers are good candidates to have their admissions reviewed on a sample basis and establishing guidelines to periodically reevaluate the carriers whose admissions are being sampled to make sure sampling is still appropriate.

b. Tracking the number of claims adjusting errors specifically found through the Division's manual admissions review for a specified period to determine how

many errors are found by staff and adjusting the sampling approach, as needed, based on the results.

Division of Workers' Compensation Response:

Agree. Implementation date: January 2005.

Coordination of Oversight Efforts

Another factor inhibiting the Division's efforts to promote better carrier compliance is a lack of coordination in overseeing carriers. Four units in the Division (Carrier Practices, Claims Management, Document Entry, and Self-Insurance) all perform oversight on carriers. The following table briefly describes each unit's oversight duties and shows where overlaps occur.

Comparison of Oversight Responsibilities of Units Within the Division

Compliance Activities	Carrier Practices	Claims Management	Document Entry	Self-Insurance[1]
Determining if First Reports of Injury (FROIs), admissions of liability, and Notices of Contest (NOCs) are complete, accurate, and submitted on current forms.	T	T	T	T
Determining if carriers have correctly figured the claimant's Average Weekly Wage when calculating indemnity benefits.	T	T		T
Determining if carriers have admitted or denied liability for a claim within statutory time limits.	T			T
Determining if carriers accurately calculated the total amount of temporary disability benefits owed to the claimant, including the proper accounting for the claimant's waiting period.	T	T		T
Determining if the carrier filed the required supporting documentation to properly terminate claimants' temporary disability benefits.	T	T		T
Determining if the carrier paid benefits through the date of termination.	T			T
Determining if carriers have correctly filed Final Admissions.	T	T		T
Determining if carriers have made initial and subsequent indemnity benefit payments to claimants within statutory time limits.	T			T
Determining if carriers have made medical bill payments to health providers within statutory time limits.	T			T

Source: Office of the State Auditor analysis of data provided by the Division.
[1] The Self-Insurance unit performs these compliance activities on self-insured employers only.

As the table above shows, there is considerable overlap between the Carrier Practices, Claims Management, and Self-Insurance units. Each of these units provides value to the oversight process by reviewing claims information at different stages in the process. However, for the Division's oversight activities to be as effective and efficient as possible, it is important that different units not perform the same tasks. We believe the Division could reduce duplication in the following areas:

- **Review of Forms.** All units review whether carriers are submitting correct and complete forms when they provide claims data to the Division. It would be more efficient for only one unit to provide this oversight, with Document Entry likely being the best candidate since it sees these documents first.

- **Review of Terminations and Final Admissions.** Three of the units, Carrier Practices, Self-Insurance, and Claims Management, have some responsibility to determine whether the carrier has provided the required documentation to support the termination of benefits or final admission on a claim. Claims Management looks at all terminations and final admissions, while Carrier Practices and Self-Insurance look at only a sample of them during their reviews - a sample taken from a group of claims that Claims Management has already reviewed in full. Reviewing the same claim twice to ensure that carriers have filed proper terminations and final admissions does not appear to add value to the Division's oversight efforts. Carrier Practices should continue to check whether the carrier has paid benefits through the date of termination by reviewing the carrier's payments records on-site. Claims Management cannot verify this because it does not have access to the carrier's records.

- **Review of Average Weekly Wage (AWW) and Temporary Benefit Calculations.** Three of the units, Carrier Practices, Self-Insurance, and Claims Management, evaluate whether carriers have correctly calculated the amount of benefits due to claimants and have properly accounted for the claimant's waiting period. We found that Claims Management may not be able to provide consistent oversight in its manual review of these areas, because it sometimes lacks the necessary data. For example, its ability to determine if carriers have properly accounted for a claimant's waiting period is often hampered by the fact that carriers generally do an inadequate job of documenting how they handled the waiting period in their admissions. In addition, Claims Management's review to determine the accuracy of the claimant's stated AWW depends upon supporting documentation from the carriers that they are not required to submit. As a result, the value of Claims Management's manual review in these areas is not clear and could potentially be discontinued.

- **Overall Compliance Review.** Both Carrier Practices and Self-Insurance perform compliance reviews of self-insured employers. We compared the factors reviewed by the two units and found them to generally be the same. The main difference is that Self-Insurance also reviews whether self-insurers' reserves are sufficient to cover the expected costs of claims for which it has liability. We found that 8 of the 104 companies that currently have self-insurance permits have been reviewed by both units since the beginning of Fiscal Year 2001. It would be more efficient if Self-Insurance continued to review the self-insured employers' reserves while Carrier Practices became the sole unit responsible for reviewing self-insured employers' claims adjusting practices.

In addition to being an ineffective use of resources, the overlap and lack of coordination among these units results in carriers' sometimes receiving contradictory information from the Division about their levels of compliance. For example, Carrier Practices may find in a review that a carrier has a poor record of terminating benefits correctly, but the carrier may have received few error letters on the subject from Claims Management. Situations like this appear to occur because the two units sometimes look at different data to evaluate compliance, as noted above in the area of terminations. As a result, carriers may not know which of the units is providing accurate feedback about their level of compliance, which diminishes the Division's ability to promote better compliance in the future.

We believe the Division needs to reevaluate the oversight processes performed by Carrier Practices, Claims Management, Document Entry, and Self-Insurance to ensure that they are all necessary. Ideally, this reevaluation would assess the value each unit brings to each task, particularly in terms of the numbers of errors found and their effect on claimant benefits. Based on the assessment, the Division should assign tasks to the units to maximize efficiencies while also ensuring that each unit communicates the results of its efforts to the others.

Representatives from Claims Management, Carrier Practices, and Document Entry began meeting in May 2004 to discuss ways to better coordinate their efforts. Specifically, the group is attempting to develop better ways to track carrier behavior and to communicate those results with each other. The Division already has established a common computer directory that links each unit's oversight results so that they can be accessed by the others. This effort could lead to the development of a comprehensive and coordinated system that ensures that oversight is efficient, non-duplicative, and consistent.

Recommendation No. 16:

The Division of Workers' Compensation should streamline its oversight efforts by:

a. Determining which unit can perform each oversight task most effectively and assigning tasks accordingly to reduce duplication while providing adequate oversight.

b. Developing procedures for ensuring consistency in the feedback provided to carriers regarding their claims adjusting deficiencies.

c. Developing procedures to ensure that each unit consistently communicates the results of its oversight to other units in the Division.

Division of Workers' Compensation Response:

a. Agree. Implementation date: December 2005. The Division agrees to determine which unit can most effectively perform oversight tasks. However, the Division disagrees that there is currently unnecessary duplication in its oversight. Each unit has a different purpose and focus for review. For example, self insurance audits review claims handling since potential penalties can effect reserving or financial status as well as indicate need for monitoring or additional training. Claims managers review documents at the time they are they submitted; Carrier Practices fully audits a portion of those claims later in the process and with the benefit of having the entire file. The Division agrees to examine this area and see if further refinement is warranted.

b. Agree. Implementation date: December 2005.

c. Agree. Implementation date: December 2005.

Division Administration

Chapter 4

Introduction

In addition to the specific oversight issues that we highlighted in the previous chapters, our audit found that the Division could make other improvements in the way it administers the State's Workers' Compensation Act. Specifically, we identified concerns with the Division's data collection, claims filing, and injury reporting. In general, the issues and recommendations in this chapter identify areas where improved efficiencies could result in savings in staff time and cost, allowing resources to be redirected to other activities as suggested in earlier sections of the report.

Data Collection

During our audit we noted a number of instances in which the Division does not collect or link important data about various aspects of the workers' compensation system. These data deficiencies impair the Division's ability to provide effective oversight of the workers' compensation system as described below.

Incomplete information about workers' compensation hearings. Currently the Division does not have adequate information about the issues addressed in workers' compensation hearings. The Division's computer system contains two-digit codes that explain why a claim has gone to hearing but does not allow the Division to add any other explanatory information about a hearing. The codes themselves are generally too broad to give meaningful information about why hearings occur. As a result, information in the system is not sufficient to allow the Division to identify ways to reduce litigation and associated costs in the State's workers' compensation system. This issue is discussed in detail in Chapter 2.

Important information on physicians not captured by or linked between different units in the Division. Currently information on physician performance that could be valuable for multiple units in the Division is not linked electronically. For example, the Division's Utilization Review unit maintains information on physicians who do not comply with the Division's Medical Treatment Guidelines, but the current computer system does not allow another unit, such as Physicians'

Accreditation, to access this information. Physicians' Accreditation could use such information to determine the effectiveness of its curriculum.

Other data limitations related to physicians include the fact that the Division's claims database does not include a field for the name of the physician. Without this data, the Division is unable to link physician performance to particular treatment decisions, disputes, or impairment ratings. Also, the Division does not maintain comprehensive scoring records for the accreditation exams it administers to physicians. This information would allow the Division to determine the effectiveness of its accreditation curriculum. These issues are discussed in detail in Chapter 2.

Claims Tracking. Each month, Division staff select up to eight carriers whose admissions of liability are specifically tracked to determine compliance with the State's claims handling requirements. Staff prepare manual reports for each carrier monitored because the current claims database does not have the capability of summarizing the results of these tracking efforts. For example, the Division cannot run a report to find out what percentage of a particular carrier's admissions contained a particular error such as failure to pay waiting period benefits. Instead, the only way the Division can identify the frequency of such an error is to manually track admissions for a given period and calculate the error rates. In addition to being time-consuming, we found the Division's manual tracking reports were not always accurate.

A related problem is that the Division cannot identify when staff discover a claims adjusting mistake through their manual review that results in an over- or underpayment of claimant benefits. As we discuss in Chapter 3, having these data would be important for the Division to determine the effectiveness of the staff's manual reviews relative to their costs.

Repeatedly noninsured employers. The Division does not consistently track those employers to which it repeatedly sends notice requesting proof of workers' compensation insurance coverage. As we discuss in Chapter 1, these data would allow the Division to expedite sanctions against these employers to improve compliance with the State's insurance requirements.

Staff indicated that the weaknesses in data collection result from limitations in its computer systems. The Division's data about workers' compensation claims and its activities are contained in a mainframe computer. According to the Division, the mainframe does not allow much programming flexibility to incorporate new data collection and reporting techniques that could improve the Division's efforts to promote compliance with workers' compensation laws and regulations.

The Division would like to upgrade its computer system to a client-server environment, which generally provides more flexibility and interoperability than a mainframe system. The Division has begun the process of developing a client-server system, using assigned staff from the Department of Labor and Employment's Information Management Office (IMO) but has only converted one unit to a client-server system to date. According to the Division, the main reason for the delay in progress is that the IMO staff with the most experience in client-server architecture are frequently assigned to other Department projects with higher priority. As a result, the IMO staff working for the Division often have to spend time training themselves in client-server systems before they can complete the Division's requests. Another reason we found for the delay in updating the Division's computer systems is that the Division has made implementing the Medical Data Warehouse (MDW) a priority for its IMO staff. This database will collect medical, claims, and loss-time information to help the Division develop more accurate fee schedules and medical treatment guidelines but will not address the issues we have raised.

An upgraded computer system would improve the Division's efficiency and effectiveness in providing oversight. For example, if the Division were able to compile reports documenting the results of its reviews of general and final admissions, it would be able to reduce some of the testing performed during carrier audits, such as the correct filing of final admissions. In addition, the Division could use the upgraded computer system to capture more meaningful information about its hearings to identify trends and determine methods to reduce the need for litigation.

Division staff report that they have begun to analyze the advantages and disadvantages of migrating to a client-server system using its IMO staff, purchasing an entirely new client-server system "off-the-shelf," or keeping the status quo. However, they have not yet performed a cost/benefit analysis on these options. We believe the Division should investigate the costs and benefits of each of these options, determine the most viable one, and then develop a plan to implement it. Although we recognize that current budgetary constraints make gaining approval for new systems difficult, a thorough cost/benefit analysis would help the Division to demonstrate that the cost of an upgraded system may be offset by increased efficiencies and reduced staff, as evidenced by the potential cost savings we have identified elsewhere in our report.

Recommendation No. 17:

The Division of Workers' Compensation should perform a cost/benefit analysis of various options for upgrading its computer system, determine the most viable option, and then develop a plan with reasonable timelines for implementing the new system.

Division of Workers' Compensation Response:

Agree. Implementation date: December 2005. The Division agrees with this recommendation; however, the Division does not believe a formal cost/benefit analysis is necessary. Due to initial successful migration of one work process, the Division believes it will be able to migrate additional portions of the computer system onto client-based servers.

Electronic Filing

The Division receives about 133,000 claims-related forms from carriers each year. Carriers can submit some of these forms, like First Reports of Injury, Notices of Contest, and Final Pay Notices, via electronic data interchange (EDI). Other forms, such as general and final admissions, are not currently set up for electronic submission. Overall, carriers submit about 18 percent of forms electronically to the Division. All forms not submitted through EDI must be manually input by Division staff into the computerized claims database.

In general, electronic document submissions are preferable because they are cheaper to process and eliminate data entry errors at the Division level and for carriers. We estimate that expanding the use of electronic filing to all submissions would result in savings of about 7.6 FTE at a cost of about $249,000 annually over the long term. Specifically, the Division could save up to 3.6 FTE (at a cost of about $132,000) annually who currently enter data from hard copy documents into the computer system and another 4 FTE (at a cost of about $117,000) annually who maintain paper documents. Even with electronic filing, it is likely that some FTE will be needed to follow up on electronic submissions that do not pass all of the Division's computer edits, although the number of staff needed for this task may decline over time as carriers become familiar with electronic filing.

Despite the potential savings, the Division has been reluctant to mandate that carriers submit forms electronically for two primary reasons. First, current procedures for electronic submissions require that carriers either purchase software or use a third-party vendor to make the submissions. These options create additional expenses for the carriers. Second, some forms include many attachments, such as medical reports or wage records, that do not necessarily lend themselves to standardization and are therefore difficult to file electronically.

We discussed the Division's concerns with the staff of the Department of Labor and Employment's Information Management Office (IMO). The IMO indicated it could establish systems that would allow all carriers to more easily submit documents

establish systems that would allow all carriers to more easily submit documents electronically. One option would use a file transfer protocol (FTP) system, which allows users to transfer batch files over the Internet. The IMO estimates it would take about 150 hours of programming time at a cost of $65 per hour ($9,750 total) to put the FTP system into place and then another 25 hours ($1,625) per carrier to set up each one on the system. In comparison, the IMO estimates it currently spends 100 to 150 hours ($6,500 - $9,750) setting up each new carrier on the EDI system. Another advantage of using FTP, versus the current EDI system, is that submissions would be free for carriers, whereas they now pay third-party vendors about $1 per EDI submission. Another option would establish an Internet-based document submission process in which carriers would submit individual forms through the Division's Web site. For example, the IMO estimates it would take about 650 hours ($42,250) to make First Report of Injury forms available for web-based submission.

With respect to filings of attachments to general and final admissions that are on non-Division forms, such as medical reports or wage records, one option would be for the Division to require carriers to file the admissions electronically (once those forms are available in an automated format) and submit the attachments separately. The Division would need to clarify whether this approach would be consistent with Section 8-43-203(2)(b)(II), C.R.S., which states, "When the final admission is predicated upon medical reports, such reports shall accompany the final admission."

Although it is possible that the Division will not realize all of the potential cost savings noted above, we believe the Division should make expanding the use of electronic filing a priority. At a minimum, we believe the Division should implement systems as soon as possible so that carriers can more easily submit forms such as FROIs and NOCs electronically and then mandate their use. In addition, the Division should develop a plan with firm timelines for bringing other forms, such as the general and final admissions of liability, online.

Recommendation No. 18:

The Division of Workers' Compensation should maximize the use of electronic filing of documents by carriers by working with the Information Management Office (IMO) to develop and implement file transfer protocol (FTP) and Internet-based document submission systems. In addition, the Division should develop a plan for making other forms, such as admissions of liability, available for electronic submission. Finally, the Division should require carriers to submit documents using the FTP or Internet-based system.

Division of Workers' Compensation Response:

Partially Agree. Implementation date: December 2005. The Division agrees with establishing a FTP system. The Division has been pursuing this issue for some time, and IMO estimates that the initial work should be completed by September 1, 2004. The Division attempts to make electronic submissions easy and inexpensive, and agrees with the auditors that establishing the FTP system should further encourage use of electronic filing, which may make the mandating of electronic filings unnecessary. The Division agrees to examine the feasibility of making other forms available for electronic submission.

Error Letter Process

As the previous section mentioned, the Division inputs information into its claims database from the admissions of liability submitted by carriers. The claims database automatically generates a potential error letter whenever an admission contains incomplete or inaccurate information, such as an incorrect benefit calculation, or information that is inconsistent with previous filings by the carrier. Staff review the letters so that they are aware of the mistakes, to determine if any modifications to the letter are necessary, and to verify that the Division needs to print and send the letters. We found that staff currently send out only about 21 percent of the error letters generated, voiding the remaining 79 percent because they do not reflect actual errors. Most of the error letters are voided because they identify changes in benefits that are not erroneous. For example, if the amount of a claimant's temporary disability benefits changes for a legitimate reason (e.g., the claimant returns to work part-time), the computer system detects the change as an error. As a result, every subsequent admission for that claim will generate an error letter because the benefit amount in the admission will not match the benefit information previously on file.

Our 1995 audit recommended that the Division take steps, such as reprogramming the computer system, to eliminate unnecessary error letters. The Division convened a task force in 1995 that recommended programming changes that have not been implemented. As a result, staff currently review about 15,300 error letters each year to determine which letters they should send to carriers and which should be voided, a process we estimate consumes about 0.64 FTE at a cost of about $38,000 annually. A representative of the IMO roughly estimated that reconfiguring the computer system so that it only produces legitimate error letters would take about 175 programming hours at a cost of $11,375. The Division should obtain a more detailed estimate and proceed as soon as possible with the programming changes, if they are cost-effective.

The Division indicated that upgrading its computer system, discussed in the previous section, would include the programming changes necessary to reduce the number of invalid error letters. However, if an immediate fix is cost-effective, the Division should not wait until it has implemented a new computer system to resolve this issue. Reducing the number of invalid letters now would allow the Division to devote additional FTE to other, more important oversight activities, or eliminate it altogether.

Recommendation No. 19:

The Division of Workers' Compensation should obtain an estimate for making the necessary programming changes to its computer system to reduce or eliminate the number of invalid error letters and proceed with the changes if they are cost-effective.

Division of Workers' Compensation Response:

Agree. Implementation date: July 2005.

Injury Reporting

According to Section 8-43-101, C.R.S., all workplace injuries that occur in Colorado are required to be reported to the Division. The reporting responsibility is divided between employers and carriers, as follows:

- **For severe injuries and occupational diseases** the statute states: "Within ten days after notice or knowledge that an employee has contracted an occupational disease, or the occurrence of a permanently physically impairing injury, or lost-time injury to an employee, or immediately in the case of a fatality, the employer shall . . . report said . . . disability, . . . injury, or fatality to the division."

- **For less severe injuries** the statute states: "Injuries to employees which result in fewer than three days' or three shifts' loss of time from work, or no permanent physical impairment, or no fatality to the employee shall be reported by the . . . insurer . . . only by monthly summary form to the division."

In our review of the Division's procedures for tracking workplace injuries that occur in Colorado, we noted the following two issues with respect to injury reporting that should be clarified to ensure the Division is fulfilling legislative intent.

The Division does not use summary injury reports submitted by carriers. According to Division staff, the summary data reported by carriers have so far not proved useful for any purpose. As a result, the Division does not actively enforce the statute, meaning that some carriers (including the State's largest) do not submit the data and the Division does not follow up to obtain the information. Also, some carriers submit data quarterly rather than monthly. To prevent carriers from spending time collecting and submitting unnecessary information, the Division should work with carriers, employer groups, and employees to determine if the reports can be improved to provide useful information. Alternatively, the Division should seek statutory change to eliminate this provision from the law.

It is unclear when occupational disease injuries must be reported to the Division. Section 8-43-101, C.R.S., as quoted above, has been interpreted in different ways with respect to whether carriers must always submit injury reports involving occupational diseases or only when the disease results in lost time from work for the claimant. The Division's position has been that carriers must report when a worker has contracted an occupational disease, regardless of whether it results in lost time. However, the Industrial Claims Appeals Panel (ICAP) within the Department of Labor and Employment's Executive Director's Office, which reviews decisions from workers' compensation hearings, has ruled (e.g., *Sanchez v. Western Forge Corp.*, May 17, 2001) that injury reports on occupational diseases must be filed only if the claimant has lost time (i.e., missing at least three days or shifts of work because of the injury). The basis for ICAP's ruling is the language at the end of Section 8-43-101(1), C.R.S., which refers to "occupational disease disability." The panel interpreted this phrase to mean that carriers should only report occupational disease injuries that involve lost time because these are the only injuries that qualify for disability benefits under Colorado's workers' compensation laws.

The Division continues to encourage carriers to submit all occupational disease injury reports and has cited the failure to report these diseases as a deficiency in its compliance reviews. The Division's rationale is that filing an injury report starts the clock on the claimant's statute of limitations for requesting compensation for the injury and that setting this limitation in motion provides greater claims stability and predictability for carriers. The Division also believes that having carriers report all occupational disease injuries ensures that injured workers receive medical treatment for those injuries that do not involve lost time from work. However, some carriers have disagreed with the Division's position and do not submit these claims unless loss time is involved, which means that the Division's oversight of these injuries is

inconsistent. One of these carriers argued that sending in all claims would greatly and unjustifiably increase its workload.

We believe the Division should seek legal clarification about the legislative intent behind the requirements for reporting occupational disease injuries. If the determination is that all occupational disease injuries should be reported, the Division should consider seeking statutory change to clarify and enforce this provision. Otherwise, the Division should no longer encourage carriers to report occupational disease injuries unless they result in lost time from work. Clarifying the requirement is important not only because the current situation may create unnecessary work for the Division to track claims that do not need to be filed but also because the Division may not be providing oversight on all claims intended by the General Assembly.

Recommendation No. 20:

The Division of Workers' Compensation should clarify statutory requirements regarding the reporting of workplace injuries by:

a. Evaluating the need for carriers to submit monthly summary data on workplace injuries that do not involve lost time. If the Division determines there is no use for the data, it should seek legislative change to remove the reporting requirement from the law.

b. Seeking legal guidance on when carriers should report occupational disease injuries. If the determination is that these should be reported at all times, the Division should consider seeking legislative change to clarify this requirement or enforce current statute. If the determination is that these injuries should only be reported when they involve lost time, the Division should discontinue encouraging carriers to report those that do not involve lost time.

Division of Workers' Compensation Response:

Partially Agree. Implementation date: July 2005. The Division agrees to evaluate these issues as outlined. Any legislative changes are a matter for the General Assembly and the Division will provide whatever assistance is requested.

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