Element 6: Claims

Element Six required an in-depth review of various aspects of the WSI claims process, and encompassed a total of six distinct areas of evaluation:

1) Denied claims;
2) Claims involving Independent Medical Exams (IME's);
3) Appropriateness and effectiveness of disability guideline integration into the claims management process;
4) "Routine processes" that claims and benefits follow from beginning to end, and claims involving Permanent Partial Impairments (PPI's);
5) Claims regarding degenerative conditions; and
6) Changes in WSI's claims management philosophy between fiscal years 2004 and 2006/2007.

This section addresses each aspect of the evaluation in sequence.

Evaluation of Denied Claims

Objective

Review WSI's denied claims to determine the rationale behind the denials and explain any trends in denials from 2003-2007. Evaluate the appropriateness of denials based on state law, administrative code and WSI policies and procedures. Provide a comparison to other claims payers' denial rates/trends.

Key Activities

To conduct these evaluations, BDMP undertook the following activities:

- Conducted interviews with the following WSI staff:
  - Chief of Injury Services
  - Medical Services Director
  - Claims Director
  - Medical Director

- Provider Relations Manager
- Claim Supervisors (2)
- Claim Adjusters (6)
- Case Managers (2)
- Utilization Review Supervisor
- Return to Work Supervisor
- Quality Assurance Manager
- PPI Auditor
- Constituent Liaison

- Reviewed the North Dakota statute and rules pertaining to the claims handling process along with the WSI Claims Procedure Manual, and selected a random sample of WSI claims for evaluation.

- Obtained a data extract file from WSI technical staff listing all new claims from July 1, 2002 through December 31, 2007, as well as Microsoft Excel files used to track acceptance rates (CL0961 Acceptance Rates FYXX.xls). From these files, BDMP selected a total of 100 random claims that had been denied.

- Logged into the WSI claim and document management system to evaluate the selected claims for compliance with North Dakota state law, administrative code and WSI policies and procedures.

- Reviewed state forms, claim notes, medical reports/notes, formal correspondence as well as WSI attorney work product (where applicable).

- Entered evaluation results into web-based survey software for tabulation and summarization.

- Reviewed relevant published reports addressing various aspects of WSI's operations, including:

  - Historical WSI Operating Reports
  - Prior Performance Evaluation Reports
  - The Marsh Claims Process Review (3/4/2008)
  - The Connolly & Associates Report to the Board of Directors (3/5/2008)
  - The Independent Medical Examination Audit Report conducted by DA Dronen Consulting (2/1/2007).

- Conducted interviews with other monopolistic state funds and large workers' compensation claims payers.

Observations & Findings

Of the 100 denied claims reviewed by BDMP:

- 60 were from 2007 injuries, 40 were from 2006.
- Each initial claim denial decision reviewed appeared appropriate based on state law, administrative code and WSI policies.
- The sample included one claim that was incorrectly categorized as a denial and had not actually been denied.

Of the remaining 99 denied claims reviewed:

- Only five were from injured workers who requested a reconsideration of the denial decision.
- Four of the reconsiderations resulted in a reversal of the initial decision and an acceptance of the claim, whereas the initial decision of the fifth reconsideration was upheld and the claim was denied without further legal action.
- Only 1 of 100 denied claims evaluated resulted in a referral to the Office of Independent Review (OIR) and in that instance, the denial was upheld.

All reviewed denials appeared to follow the process outlined in the WSI Claims Procedure Manual, with the adjuster documenting the denial reason and issuing the required Notification of Decision (NOD) document. We noted:

- Standard claims handling processes also were followed for reconsiderations as documentation in the files confirmed that claim supervisors and in-house legal were engaged whenever injured workers submitted written requests for reconsiderations.

- Four denial reasons—No signed C1 form (C1 form is the Injured Workers signed First Report of Injury), Claim Comment (utilized when the decision to deny does not fit the categories already established and needs explanation noted in the claim notes with an event to the supervisor), No Medical Treatment (an incident that did not require medical treatment) and Uncooperative—accounted for 81% of all denials within the evaluated population of claims. Those same four reasons were also the top four reasons cited among all denials from 2006 to 2007 and accounted for more than 85% of all denials over that period, as illustrated in Table 6-1 below.

Table: 6-1: Percent of Initial Denials by Reason, FY2006-07

	% of Evaluated Denials	% of All Denials 2006-07
No Signed C1	28.0%	26.5%
Claim Comment/Active	24.0%	35.9%
No Medical Treatment	16.0%	12.5%
Uncooperative	13.0%	10.3%
Not Covered by WSI	9.0%	2.2%
Injury due to Alcohol/Drugs	4.0%	0.5%
No Medical Records	2.0%	2.8%
Treatment not by DMP	2.0%	1.8%
Claim Withdrawn	1.0%	4.0%
Not Timely Filed	1.0%	0.8%
All Other Reasons	0.0%	2.7%
Grand Total	**100.0%**	**100.0%**

- It should be noted that of the evaluated denials, 61% were for purely "administrative" reasons including:
    - No signed C1 form filed by the injured worker;
    - Failure to seek medical treatment;
    - Claim outside North Dakota's jurisdiction (not covered by WSI);
    - Alcohol/drug involvement;
    - Claim withdrawn or not filed within the required timeframe; and
    - Treatment not by DMP.

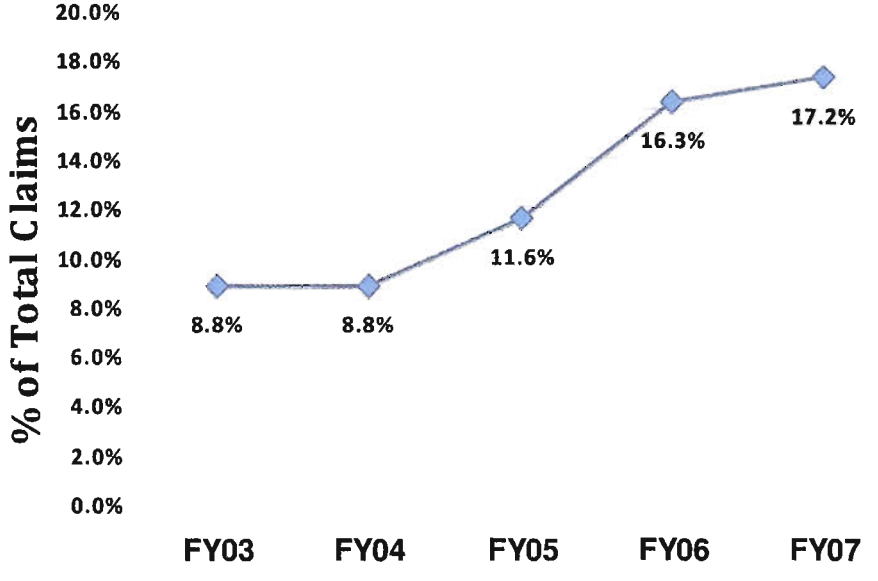
- An additional 13% of the denied claims were denied due to lack of cooperation (Uncooperative) where the adjuster had requested additional information or documentation from the injured worker to support the compensability determination but never received the additional documents or forms.

- Similarly, 2% of the claims were denied due to lack of medical records from the treating provider. Typically, claims that fell into these last two categories of denials were merely the result of following state law and WSI policies, and did not require any additional adjuster judgment or decision-making.

- The remaining evaluated denials were for reasons documented in claim comments, which did typically involve adjuster judgment or interpretation.
    - 20 of the 24 claims denied with "Claim Comment" as the reason were denied because the adjuster believed that the reported injury was not work-related or was an aggravation/trigger of a pre-existing condition.
    - Injured workers requested reconsiderations in writing on only 2 of the 24 "Claim Comment" denials, and only one of those reconsiderations resulted in a reversal of the initial denial.

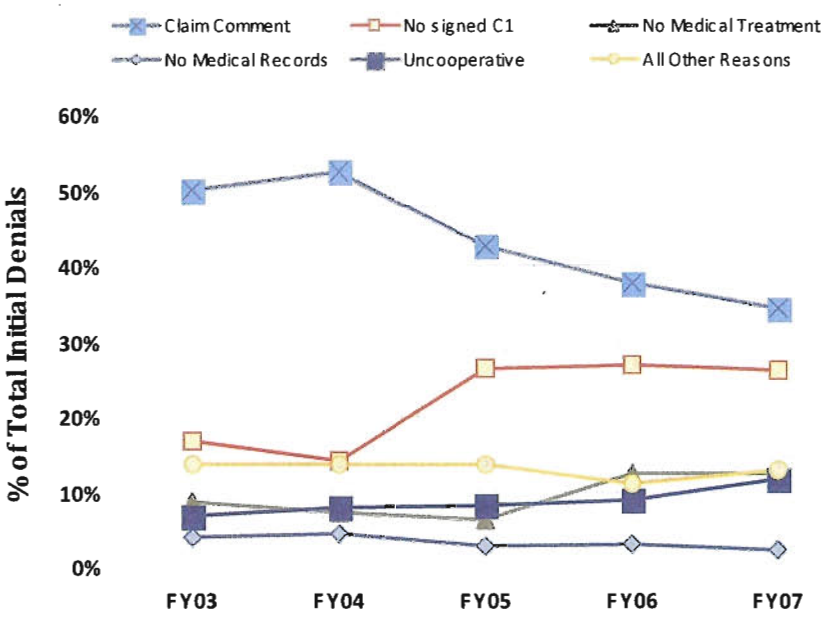
When the historical WSI data was analyzed, there was a notable increase in the percent of new claims denied after the initial adjuster investigation beginning in fiscal year 2005. The unadjusted denial rate had consistently run between 8.5% and 8.8% of all new claims in each fiscal year from 2000 to 2004, but as Figure 6-1 demonstrates, the rate began to climb dramatically in FY2005.

Figure 6-1: Unadjusted Percent of New Claims Denied at Initial Determination



By fiscal year 2007, the unadjusted denial rate had nearly doubled to 17.2%. However, more than 80% of all denials were due to just five reason codes as illustrated if Figure 6-2.

Figure 6-2: Percent of Total Initial Denials, FY2003-07



- While the percent of all denials due to "Claim Comment" reasons actually *decreased* from fiscal year 2005 to 2007, three denial reasons accounted for the majority of the overall increase in the denial rate:
    - 1) No signed C1;
    - 2) No medical treatment; and
    - 3) Uncooperative.

Interviews with WSI staff provided additional insight into the reasons behind the growth of denials due to these three reason codes.

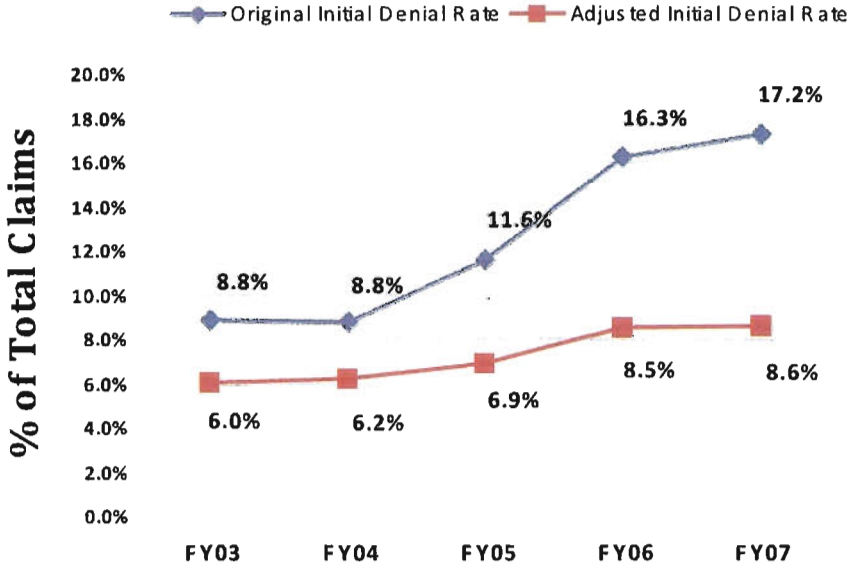
In fiscal year 2005, WSI initiated a new program designed to improve the timeliness of employers' submissions of first reports of injury forms. Prior to the new program, employers were automatically assessed a $250 fee for each new claim reported. The Early Claim Reporting Incentive program, instituted for all incidents after July 1, 2005, offered to waive the $250 fee assessment if the claim notice was received by WSI by midnight of the next WSI business day following the injury date. If WSI received notice of an incident within 2-14 calendar days of the injury date, employers would be assessed the "standard" $250 fee. However, if WSI did not receive notice of the claim until more than 14 calendar days from the date of injury, the fee assessment would increase to $350.

As a result of this new policy, employers began to report more incident-only events, many of which never resulted in an injured worker's submitting a corresponding C1 first report of injury form or even seeking any relevant medical treatment. At the end of the initial investigation period, adjusters would close these "claims" using one of the three reason codes outlined above. In most instances, these incidents would not have even been reported as claims prior to the fee policy change, but employers trying to avoid the $250 or $350 assessment began proactively reporting incidents which were ultimately closed as denied claims. It is common in the industry for employers to report these types of minor injuries as incidents but not count them in their "claim" count totals.

As a result of these unintended consequences of the fee policy change, WSI modified the denial rate calculation on quarterly Operating Reports to exclude denial reasons that could be associated with the change in employer behavior. This is called the "adjusted denial rate" as noted in the previous section. BDMP obtained a detailed spreadsheet of all of the WSI denials and reasons for denial and re-calculated the "adjusted rates" for the 2003-2007 timeframe. BDMP results matched the WSI adjusted denial rates in the operating report.

If the historical denial rate is adjusted to remove the denial reasons that could be attributed to the change in the fee assessment policy, it is clear that while the growth is not nearly as dramatic as the unadjusted numbers, the denial rate did indeed increase in FY2006 and FY2007. (Figure 6-3)

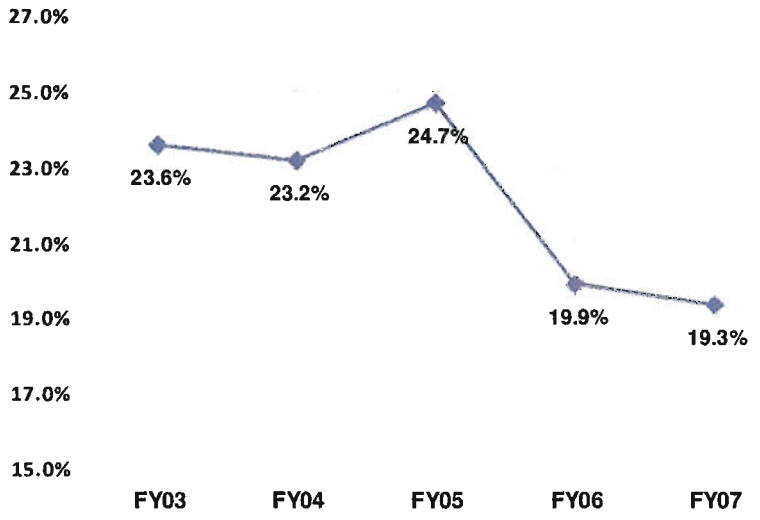
Figure 6-3: Adjusted Initial Denial Rate



As described by every claims staff member interviewed and as evidenced in the claim evaluations, the more intensive investigation prompted by the leadership change at WSI identified additional information on claims relating to prior injuries and pre-existing or degenerative conditions creating additional but appropriate denials according to the North Dakota statute.

Figure 6-4 shows that while the initial denial rate has increased since FY2004, the percent of initial denials that were ultimately reversed has actually decreased over the same time period.

Figure 6-4: Percent of Initial Denial Decisions Reversed

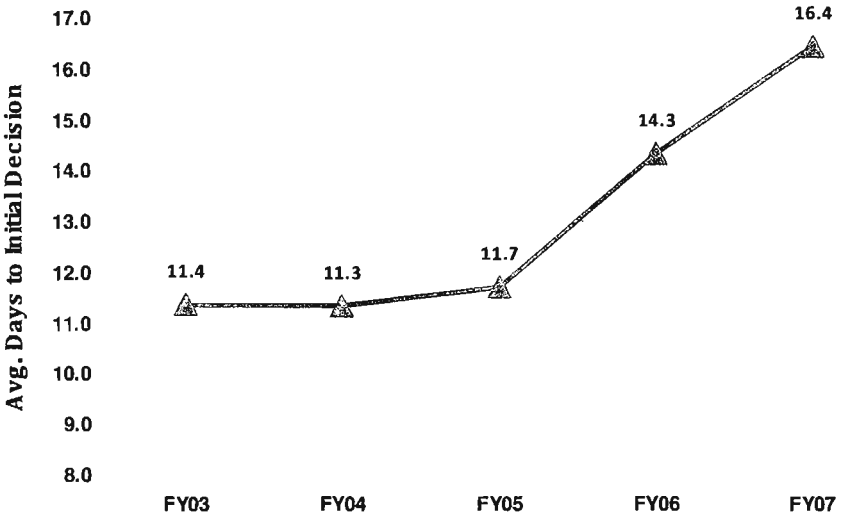


Again, based on the claim evaluations as well as the interviews conducted with staff in the Claims Department, it appears that the initial investigations regarding prior injuries/pre-existing and degenerative conditions became more rigorous 2005-2007 enabling better decision making in regards to acceptance/denial resulting in a smaller percentage of reversals.

In conjunction with analyzing the trends in claim denials, BDMP also reviewed WSI's trends in the timeliness of the initial adjudication decision (i.e. how long it took WSI staff to make the initial determination of whether to accept or deny a claim).

Figure 6-5 shows that from F72003 through FY2005, the average number of days required to make an initial compensability decision remained relatively constant between 11.3 and 11.7 days. As illustrated below, the average number of days began to rise in fiscal year 2006 and continued to rise in FY2007.

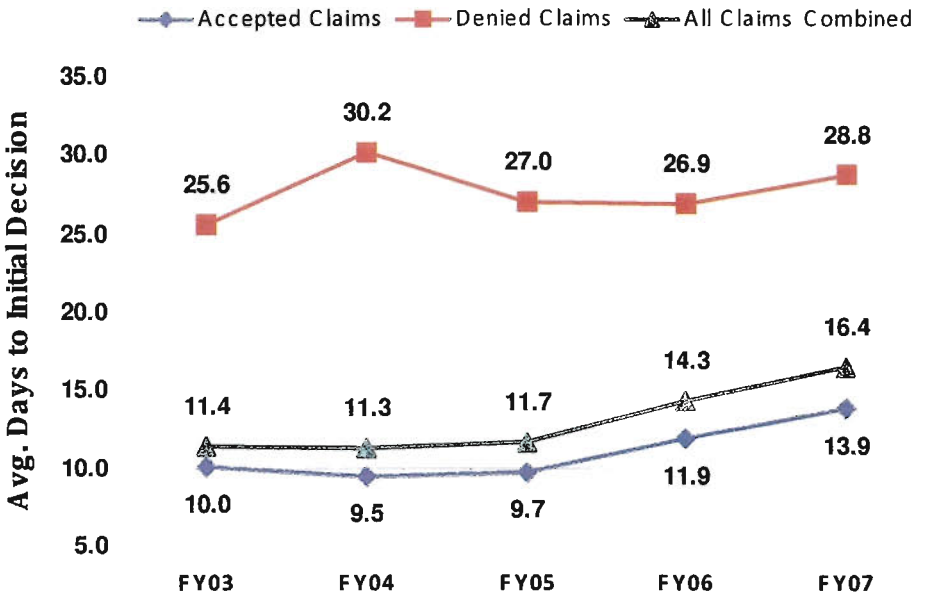
Figure 6-5: Average Days to Initial Compensability Decision, All Claims



Denied claims took nearly twice as long as accepted claims to reach an initial compensability decision, most likely because the standard WSI workflow requires that injured workers, employers and medical providers be given up to 30 days to supply additional information or missing forms before a claim can be administratively denied. In addition, a portion of the overall increase in average time to a compensability decision is clearly attributable to the increase in the number of denied claims in FY2006 and FY2007, and to those denied claims averaging twice as long as accepted claims to reach a compensability decision.

The average time to reach the compensability decision on claims initially denied did not increase as dramatically as that for claims initially accepted. (Figure 6-6)

Figure 6-6: Average Days to Initial Compensability Decision by Claim Type



For fiscal year 2007, the average time to the initial compensability decision on denied claims was 28.8 days, which was only 4% above the FY03-05 average of 27.6 days. By comparison, the average time to the initial compensability decision on claims that were accepted in FY2007 was 13.9 days, which was 42% higher than the FY03-05 average of 9.8 days. The increase in the average time required on accepted claims for FY2006 and FY2007 is consistent with feedback gathered during WSI interviews; during that timeframe, claims adjusters were being encouraged to be much more thorough in their initial investigations and to look for prior injuries or pre-existing conditions before accepting a claim as compensable. On average it appears that they were taking an additional 4-5 days to complete that additional investigation work.

The trend data suggests that even if the denial rates are adjusted to exclude claim denials that could be related to the administrative change in the $250 fee assessment policy, the overall claim denial rate did increase during FY2006 and FY2007. Likewise, the average time taken to reach an initial compensability decision clearly increased over the same time period. Our claim evaluation of 250 claims identified that adjusters were being very thorough in their initial claims investigations during that time period. Our analysis of 250 claims indicated that adjustments as a result of a change in management and a subsequent shift in philosophy – were encouraged during this time period to be very vigorous in conducting their initial investigations. This was born out during interviews with a variety of the claims staff.

Conclusions

BDMP's evaluations of denied claims uncovered no evidence of inappropriate claims handling processes or decisions inconsistent with state law or WSI claim policies. In our analysis of this element we concluded the following:

- When compared to other jurisdictions, the North Dakota statute is aggressive in empowering the claims payer to deny claims based on prior injuries or pre-existing conditions. None of the claims evaluated appeared to have been denied inappropriately based on what appears to BDMP to be a conservative state law, administrative code and supporting WSI claim policies as related to the definition of "compensability". (See Recommendation 6.5.)

- An analysis of historical WSI data revealed an increase in the percent of new claims denied after the initial adjuster's investigation, beginning in fiscal year 2005. However, the majority of this increase appeared to be related to a new program designed to improve the timeliness of first reports of injury rather than to any major shift in organizational philosophy.

- The amount of time it takes WSI to reach an initial adjudication decision increased to 16.4 days in FY2007, up from 11.4 days in FY2003. The management and philosophy change during the time period evaluated required adjusters to perform a more rigorous investigation as it related to prior injuries and pre-existing or degenerative conditions. In order to give the injured employee and the medical provider time to respond to the requested forms and letters, this investigation added time to the initial adjudication decision making.

- WSI staff consistently reported experiencing a change in philosophy surrounding the investigation of prior injuries, pre-existing or degenerative conditions during the 2006-2007 period of time. They described:

    - Being encouraged by management to become "more focused" on their investigations; and

    - Being more likely to be asked to request or review medical reports on these claims and/or to review them with the Medical Director before making a compensability decision.

  Although, WSI staff described how this change in philosophy changed their overall claims handling processes and delayed their initial adjudication decision, according to the interviews with claims personnel, it did *not* affect their ultimate decisions regarding claims compensability. However, BDMP noted in the claims evaluations that a more rigorous investigation clearly led to more information on previous injuries or pre-

existing or degenerative conditions with which to make a claim compensability decision. The denial trend supports the fact that the increased rigor of the initial investigations resulted in additional denials.

Evaluation of Independent Medical Exam (IME) Program

Objective

This component of Element Six required an evaluation of claims involving Independent Medical Exams (IME's), to determine the efficiency and efficacy of IME practices and to assess whether WSI was doing enough to encourage North Dakota physicians to participate in the IME program.

Observations & Findings

BDMP reviewed 50 random claims that had IMEs scheduled during the 2006/2007 calendar years.

- Forty-eight of the claims evaluated (96%) followed the appropriate IME referral process outlined in the WSI Claims Procedure Manual.

- The two instances that deviated from the standard referral process were appropriate IMEs however they did not have form C54—Prep Form Claims Assessment completed in a timely manner. This is an administrative form to be completed by the adjuster that instructs the claim technician to enter the IME into the Medical Events Window and generate a notice to the injured worker to attend the IME.

- The claim evaluations revealed that IMEs were utilized appropriately in the claims process and ultimately helped drive claims towards resolution 86% of the time. In other words, the claim adjuster was able to make decisions on the claim once they obtained an independent medical opinion. The remaining 14% of evaluated claims are still ongoing and have not yet been resolved. According to WSI, 0.5% of the claims are sent for IMEs. In every case BDMP examined, the adjuster chose an IME physician based on the specialty required to provide a thorough and accurate independent medical exam.

    - In many cases, rather than simply trying to match the specialty of the treating provider on record, the adjusters picked appropriate specialists based on the injured workers' injury types and the specific questions the adjusters had about the treatment/injury.

    - In every claim evaluated, the specialty of the IME physician was either the same as the treating physician or was a specialty better versed in the specific injury or treatment that was in question. The specialty of the IME physician was often

documented on the forms sent to the injured worker and on the report forwarded back to the adjuster.

- BDMP also noted that adjusters routinely worked to accommodate injured workers' schedules, assisted with travel planning and/or paid travel expenses when out-of-state trips were required for IMEs.

- Of the IME claims evaluated by BDMP with completed IME reports, 35% of the IME physicians agreed and 65% disagreed with the treating physician.

- Of the IME claims evaluated, only 18% were completed with North Dakota physicians, while 82% were scheduled with Minnesota physicians.

    - In multiple instances however, the Minnesota IME physicians traveled to North Dakota to complete the IME.

    - There was no significant difference between the IME results (agree/disagree with the treating physician) related to the location of the IME physician. 33% of the North Dakota IME physicians agreed with the treating physician compared to 35% of the Minnesota IME physicians.

    - The use of out-of-state IME physicians did not appear to significantly impact the efficiency of the claims process as IMEs performed in MN required a total of 46 days from the date the C54 Claims Assessment Worksheet was completed to the date the IME report was received. By comparison, IMEs scheduled in North Dakota required 41.4 days from the C54 to the final IME report.

During the interview phase, WSI staff charged with increasing the number of in-state IME providers outlined several significant initiatives that had been implemented in an effort to encourage North Dakota providers to participate in the IME program, but also noted that the fundamental challenge they face is the size of the North Dakota provider community. We noted:

- The most recent data from The Kaiser Family Foundation State Health Facts identifies a total of only 1,782 Non-Federal primary care physicians in North Dakota, compared to 17,295 in Minnesota and 973,524 nationally.[25]

- In addition, a significant number of the 1,782 physicians identified in North Dakota would not be appropriate for workers' compensation claims, as the Kaiser data suggests that 9% of all in state providers are Pediatricians and another 8% specialize in Obstetrics/Gynecology. If those specialties are removed from the North Dakota totals,

[25] Kaiser State Health Facts, http://www.statehealthfacts.org/profileind.jsp?ind=433&cat=8&rgn=36, (Jun 2008)

the entire universe of potential North Dakota workers' compensation primary care providers would appear to be less than 1,500 physicians.

- The most recently available data from the Bureau of Labor Statistics (BLS) summarized in Table 6-2 for relevant provider types, suggests that the North Dakota medical provider community is extremely small.

Table: 6-2: North Dakota Healthcare Practitioner & Technical Occupational Employment[26]

Occupation Code	Occupation Title	Employment
29-1011	Chiropractors	160
29-1062	Family and General Practitioners	370
29-1063	Internists	110
29-1067	Surgeons	120
29-1069	Physicians and Surgeons, All Other	350

- In a community with less than 1,500 primary care providers and only 120 surgeons, it is extremely difficult to find in-state providers who are willing to evaluate and potentially criticize the performance of their peers. Prices paid to providers for IMEs did not appear to be a deterrent as providers from MN were even willing to travel to North Dakota in multiple instances to perform examinations at the WSI rates.

Even with the paucity of physicians in North Dakota, WSI has worked to build relationships with providers and ultimately identify in-state providers for IMEs and PPI ratings:

- Added the position of WSI Provider Relations Manager in March 2005, focused solely on improving WSI's relationship with the ND medical provider community;
- Scheduled regional provider meetings in 2005 but then began regularly occurring one-on-one meetings with provider groups, their staff and appropriate association groups in Spring 2006;
- Distributed quarterly newsletter (MedProLink) to providers beginning August 2005;
- Formed a Medical Guidance Council in January 2006 that meets quarterly to discuss relevant issues, changes and suggestions;
- Implemented changes to the Provider Fee Schedule effective January 1st 2008, raising rates to levels higher than BC/BS reimbursement; and

[26] Bureau of Labor Statistics, *May 2007 State Occupational Employment and Wage Estimates*, http://www.bls.gov/oes/current/oes_nd.htm#b29-0000, (May 2007).

- Conducted an Impairment Rating training seminar for Medical Providers in November 2005.

BDMP also reviewed the February 2007 DA Dronen Consulting report which evaluated the Independent Medical Exam process in North Dakota, to determine if the results of that review could be helpful in the Performance Review. The most useful tactical recommendations from that report appear to have been implemented already or at least initiated by WSI staff as noted above. The report did not appear to offer any additional viable recommendations to address the fundamental environmental challenges inherent in the North Dakota IME situation.

The BDMP claim evaluations revealed that IMEs were utilized appropriately in the claims process and ultimately helped drive claims toward resolution. Due to the paucity of physicians with occupational specialties in North Dakota, many of the IMEs are sent out-of-state. The use of out-of-state IME physicians did not appear to significantly impact the efficiency of the claims process, as IMEs performed in MN required a total of 46 days from the date the C54 Claims Assessment Worksheet was completed to the date the IME report was received. By comparison, IMEs scheduled in North Dakota required 41.4 days from the C54 to the final IME report.

Conclusions

BDMP's review of 50 claims that had utilized IMEs during the evaluation period revealed that IMEs were utilized appropriately in the claims process and ultimately were a trigger that helped drive claims toward resolution 86% of the time (the remaining 14% of claims are still ongoing). We noted:

- WSI staff appear to be using IMEs appropriately and effectively. Referrals are being made to medical providers in appropriate clinical specialties; are being sent with specific lists of questions/issues to be addressed and are being processed in a very timely manner.

- The vast majority (96%) of the claims with IMEs that were evaluated followed the appropriate IME referral process outlined in the WSI Claims Procedure Manual. The remaining 4% (2 claims) were missing some minor administrative details noted as necessary in the Procedure Manual.

- A large portion of the IMEs are being completed by medical providers from outside North Dakota (82% of the claims evaluated). However, the use of out-of-state providers does not appear to be affecting the quality, timeliness or effectiveness of the IMEs themselves

- WSI has initiated reasonable efforts to increase the number of North Dakota medical providers willing to participate in their IME program, but the success of those programs

has been hampered by the relatively small number of appropriate providers in the state. WSI staff's perception is also that providers would be reluctant to judge or critically evaluate the work of their peers. (See Recommendation 6.3 for further ideas to potentially increase the providers for IMEs.)

Evaluation of Disability Guideline Integration

Objective

This component of Element Six required an evaluation of the appropriateness and effectiveness of disability guideline integration into the claims management process, including a comparison to disability guideline usage at other monopolistic state funds and large workers' compensation claims payers.

Observations & Findings

The nationally recognized Official Disability Guidelines (ODGs) developed by the Work Loss Data Institute were referenced consistently in interviews with all levels of WSI staff, including adjusters, supervisors, case managers, the Utilization Review manager, the Medical Director, and the Chief of Injury Services.

- Guidelines were mentioned as tools used for setting reserves, planning return-to-work targets, determining the appropriateness/necessity of medical treatment, building action plans/timelines for claim resolution and for benchmarking adjuster/unit performance.

- Only 7% of the claims in the general evaluation contained references to the ODG guidelines in the claim notes. Based on the claim reviews, it appeared that less experienced adjusters were documenting references to the guidelines in their claim or triage summaries while more tenured adjusters have become more familiar with the ODG guidelines and are not specifically documenting references to them in individual claims.

Over the past decade, the use of disability guidelines has grown dramatically in the workers' compensation industry, with "a total of 23 jurisdictions using national evidence-based guidelines (23 selecting ODG in whole or in part) and 21 considering national guidelines" according to ODG publisher, Work Loss Data Institute.

BDMP's experience and interviews with organizations that have implemented ODG protocols suggest that WSI has implemented the ODGs more comprehensively than the other monopolistic state funds and large insurance companies. Whereas other payers are more likely to utilize the ODG protocols for just medical management or utilization review, WSI staff at all

levels are more familiar with the guidelines and utilize them in the course of routine claims handling.

While their use at an individual claim level is excellent, WSI could make better use of the ODGs as a performance-benchmarking tool.

- WSI has not yet implemented higher-level reports or analyses that compare actual organizational performance against the evidence-based guidelines.
- Several WSI staff noted that this use of ODGs has been planned but has not yet been implemented.

Conclusion

After analysis of WSI's use of ODGs, BDMP determined the following:

WSI has not yet begun to evaluate actual organizational performance against the evidence-based disability duration guidelines. However, the use of the ODG at an individual claim level is notable. WSI's broad and thorough implementation of the ODG guidelines across multiple departments is more comprehensive than other monopolistic state funds and large insurance companies. As a result, this provides added value in that all members of the claims management team (medical staff, claims staff, supervisors, etc) are using the same benchmark and objective criteria to attempt to drive claims to resolution, providing added value to the process.

Evaluation of "Routine" Claims Processes & Permanent Partial Impairments (PPI)

Objective

This component of Element Six included an evaluation of the "routine processes that claims and benefits follow from beginning to end." The primary objective of this evaluation was to determine whether the claims handling process was efficient, timely and in accordance with state law, administrative code and WSI policies and procedures.

In addition, this evaluation included an analysis of whether the treatment and/or benefits provided to claimants were provided in a timely manner and whether the WSI processes placed any unnecessary or unreasonable burdens on injured workers.

Finally, this component of Element 6 required an evaluation specific to claims with PPI to determine whether those claims were processed in accordance with state laws/regulations and WSI policies and procedures.

Observations & Findings

The WSI staff interviews together with a review of the Claims Procedure Manual provided a detailed description of the standard WSI claims process from beginning to end, including the routine process for managing claims with PPI awards.

- The 100 claim evaluations completed for general claims processing (including 10 claims with PPI awards and 25 claims with degenerative condition diagnoses) followed the claims handling guidelines outlined by the interviews and the process specified in the claims manual very closely.

- Taken as a whole, the claims handling displayed in the evaluated files appeared proactive and timely.

- Most WSI adjusters displayed very dynamic management of their claims, in contrast to the reactive management style that often characterizes similar organizations facing similar rises in caseloads.

- WSI caseloads appear to remain very manageable and the staff interviews suggested that all of the available additional WSI resources (Nurse Case Managers, Return-to-Work specialists, the Medical Director, etc.) are well-publicized and leveraged appropriately to help resolve claims more efficiently.

Injury Management Model

The "Injury Management" model in particular provides an excellent example of industry best practices and teamwork. This model, which is currently in place with 2 claim units out of the 7 total claims units, essentially embeds the Medical Director as a key member into the claims team.

- By dedicating time each week to the case staffings and triage process for these units, the Medical Director dramatically improves the clinical expertise of the unit and helps speed the overall "velocity" of the claims handling process.

- Most of the claims staff with whom we spoke mentioned the increased speed and aggressiveness of the claim handling in this "Injury Management" unit. Decisions regarding treatment were made quickly and cooperatively rather than combatively.

- In this model, treatment does not have to go to the Utilization Review unit for pre-certification as the unit's nurse case manager has more authority to authorize treatment that they believe will help bring the claim to resolution. If the nurse case manager or adjuster has questions regarding proposed treatment, they can simply discuss the requests with the Medical Director during triage. This process is more representative of

what other claims payers in the industry are doing in that if there is a nurse case manager involved with a claim, and that nurse typically makes the utilization review decisions rather than forcing the treating provider to deal with a separate unit and process.

- The Injury Management model also helps adjusters identify potentially challenging claims before they escalate, set more appropriate goals and milestones for individual claims, and interact more effectively with treating providers. While many claims payers have attempted to inject more clinical expertise and/or injury management into their claims process, very few have succeeded as well as WSI. BDMP believes additional Injury Management rollout will result in improved outcomes. (See Recommendation 6.2.)

- During the interview process, staff identified the availability of the Medical Director as the primary obstacle prohibiting the rollout of this model to all of the WSI claims units. The WSI Medical Director currently serves less than half-time on the Utilization Review unit, reviewing the appropriateness of individual treatment requests for procedures such as physical therapy, CT/MRI scans, outpatient surgery, spinal injections, etc.

- According to UR management reports for calendar year 2007, the WSI utilization review unit actually only denied 7% of all treatment requests received. In fact, pre-certification requests for most types of care were approved more than 96% of the time, other than in several targeted areas such as chiropractic care, chronic pain evaluation, durable medical equipment, injections and palliative care. Given the tremendous value of the Injury Management model and the relatively low denial rates achieved via utilization review, the amount of the Medical Director's time dedicated to the utilization process may need to be re-evaluated in order to allow the rollout of the Injury Management model to the other 5 units. (See Recommendations 6.2 & 6.3.)

Claim Compensability

In terms of claim compensability, acceptance or denial decisions were well documented in 85% of the reviewed claims. The other 15% were simple, medical-only claims (e.g. foreign body in the eye, cuts, etc.) where there were few claim notes and the documentation was the NOD (Notice of Decision) in the imaged documents section of the file. Of the claims with more than 5 days of lost time, only 47% contained documentation indicating the 3-point contact was completed within 24 hours; however the contacts were eventually made and documented on 100% of wage loss claims.

- As noted above, there were compensability decision delays (30-50 days) in initial investigations when adjusters were researching pre-existing conditions or prior injuries. These delays were typically due to adjusters' waiting for requested medical reports related to the prior conditions.

- In the evaluated claims, there were instances where the injured worker was treated extensively prior to the adjuster's issuing a compensability decision. In several of these instances, the adjuster ultimately issued a denial. However, none of those claims resulted in the injured worker requesting a reconsideration in writing. Although the decisions on these claims were appropriate based on state law, administrative code and WSI policies and procedures, the research into potential pre-existing conditions did cause delays in the compensability decisions.

Permanent Partial Impairments

Claims with permanent impairments were managed appropriately.

- Of the 10 claims evaluated, four had permanent impairments of greater than 16% and an additional two had scheduled amputations that generated PPI payments and four had impairment ratings below 16% and therefore did not receive a PPI payment.

- All claims that had PPI awards were processed in a timely fashion. The average time from the date the PPI evaluation was completed to the date the PPI remittance was issued was 12.5 days. The average number of days from the AS35 order awarding permanent impairment to the date the PPI remittance was issued was only 5.5 days.

- Although a comparison to other jurisdictions of the 16% impairment rating needed in North Dakota to receive an award was not within scope of the biennial performance evaluation conducted by BDMP, it was noted that prior evaluations had suggested such a review. Since BDMP has recommended a review of other jurisdictional statutes for comparison of definitions of compensability, it is suggested that impairment ratings be added to the list of topics for the study group. (See Recommendation 6.5.)

Administrative Burdens Placed on Injured Workers

Administrative requirements placed on the injured worker in the process did not appear to differ significantly in North Dakota from what is commonplace throughout the rest of the industry.

- Requiring injured workers to return critical claim forms, attend medical appointments, adhere to work restrictions, return phone calls, etc. are a normal part of the workers' compensation claims process in most jurisdictions, although the North Dakota statute is somewhat more aggressive in terms of permitting the claims payer to deny benefits for injured worker non-compliance.

- WSI staff appeared to attempt to minimize administrative burdens for injured workers whenever possible, as evidenced in both the interviews and claim evaluations. Most administrative denials due to late or unsigned claim forms or lack of cooperation were

immediately reversed once the injured worker actually completed his or her responsibilities.

- In fact, the decision to deny one claim due to a positive drug test was reversed by the adjuster and accepted as soon as their investigation revealed that the injury was not related to the drug use. In similar circumstances, many claims payers would have placed the burden on the injured worker to prove that their drug use was not the cause of their injury and forced them to appeal the initial denial.

Vocational Rehabilitation

Unlike many other states, the Vocational Rehabilitation Program in North Dakota, as described in the WSI staff interviews, is extremely "injured worker-friendly" and very generous in both process and benefits. The Return to Work Supervisor shared that "this is the most 'emotional' program and one that requires a great deal of communication."

- BDMP learned that the cases going through Vocational Rehabilitation are generally the "toughest claims" since many of them are in industries and/or geographic locations where there is little opportunity for light duty or alternative employment. They often have to relocate injured employees to more populated areas in order for them to obtain employment.

- These employees go through a vocational assessment and a transferrable skills analysis, and often need upgrading to at least a GED. Employees who are unable to obtain employment that's provides a wage within a certain percent of their previous earnings are eligible for retraining. The 2005 law gave the injured worker two years to complete retraining as well as flexibility around the income test, i.e. even if they fail the income test they can still be recommended for retraining if they qualify.

- By comparison, in the state of Washington an injured worker who cannot return to his previous employment must accept any job available to him, no matter how menial and even if the wage is significantly lower than his injury wage.

While WSI staff consistently displayed a clear understanding of the needs of injured workers, the adjusters and supervisors interviewed by BDMP struggled to articulate how their performance was evaluated.

- Adjusters almost uniformly said that their primary goal was "to get injured workers the medical care they needed and then help them return to work as quickly as possible."

- Adjusters were unsure, however, how many active claims they currently were managing, how many of their claims were medical only versus time loss, or how the performance of their claim unit compared to others within WSI.

Conclusions

The 100 claim evaluations completed for general claims processing (including 10 claims with PPI awards and 25 claims with degenerative condition diagnoses) followed the claims handling guidelines outlined by the interviews and the process specified in the claims manual. We noted:

- The Injury Management Model being piloted by several of the claims teams delivers true "industry best practice" performance. However, constraints on the WSI Medical Director's time imposed by the Utilization Review unit have limited attempts to expand this innovative approach to all claim teams. Reviews of the relatively unimpressive Utilization Review results would appear to suggest that WSI would achieve better overall outcomes by investing more of the Medical Director's time in the Injury Management Model. (See Recommendation 6.2.)

- Claim compensability decisions were generally very well documented yet there were often delays in reaching the initial decision, based on the thoroughness of the research being conducted into pre-existing conditions or prior injuries(in order to address compensability as defined by state statute and procedural requirements as addressed by WSI Policies and Procedures.)

- Claims with Permanent Partial Impairments were managed appropriately according to state regulations and WSI operating guidelines. PPI award decisions appeared to be made in an objective and consistent manner. Once an award was approved, payments were processed very quickly. Since the 16% threshold for PPI awards seems rather high to BDMP and has been mentioned as high by other performance evaluations, it seems that review of other jurisdictional impairment rating percentages may be appropriate. (See Recommendation 6.5.)

- The administrative burdens placed on the injured worker did not differ significantly from the requirements placed by other jurisdictions. However, the North Dakota statute is somewhat more aggressive than most jurisdictions in permitting the claims payer to deny benefits in cases of injured worker non-compliance. In most instances reviewed, WSI staff appeared to work consciously to minimize administrative burdens on injured workers.

- The Vocational Rehabilitation benefit in North Dakota could be considered more "worker-friendly" than many comparable states and appears to be utilized appropriately by injured workers.

- While overall claims handling performance was clearly above average, WSI staff at multiple levels throughout the organization struggled to articulate their performance goals or how their individual performance was measured.

Evaluation of Claims with Degenerative Conditions

Objective

This component of Element Six entailed evaluating WSI's decisions regarding claims with degenerative conditions to determine whether they reflect industry norms.

Observations & Findings

BDMP identified a total of 72 claims from fiscal years 2006 and 2007 that had degenerative diseases/conditions according to ICD-9 diagnosis codes submitted by treating providers on medical bills for the relevant injured workers. Of those 72 claims with degenerative conditions, a random sample of 25 was selected for evaluation purposes. We found:

- The claims evaluated for this section showed consistent efforts by adjusters to identify and understand prior medical history.

- Rather than relying upon the First Report of Injury notation from the Injured Worker on whether or not he/she had a prior injury or pre-existing condition, 84% of the degenerative disease claims evaluated contained file documentation suggesting that claim history and/or index bureau services were searched for potential prior claims, indicating that adjusters were thoroughly investigating claims before making compensability decisions.

- Adjusters sent the C96a (Prior Injury Questionnaire) to the injured worker for completion on 44% of the claims with degenerative conditions and requested prior medical records via the FL304 form from medical providers on 56% of the evaluated claims, again indicating that the investigations on these claims were rigorous.

- Largely as a result of these efforts, adjusters documented prior injuries/pre-existing conditions in 56% of the claims identified as having degenerative conditions. On 31% of these claims with prior injuries or pre-existing conditions adjusters (using the FL332 form) communicated in writing to treating providers in an effort to determine if prior conditions were significant and if employment substantially accelerated or worsened an underlying condition.

- Ultimately, adjusters identified 18% of the claims with degenerative conditions as aggravations of prior injuries.

As a whole, the degenerative condition claims demonstrated a significantly higher level of documented involvement of the claims supervisors and/or the WSI Medical Director when compared against the population of general claims evaluated.

- Sixty percent (60%) of the claims with degenerative conditions contained documentation suggesting the claim was staffed with a supervisor versus only 15% of the claims in the general evaluation population.

- Similarly, 38% of the claims with degenerative conditions had documented referrals to and/or staffings with the WSI Medical Director before an initial compensability decision was made versus only 8% of the claims in the general evaluation population.

At the end of the initial claim investigation process, a total of 44% of the claims with degenerative conditions were accepted as compensable workers' compensation claims, while nearly double that figure (83%) of the general population of WSI claims were accepted after the initial investigation.

All of the degenerative disease claims evaluated did contain documentation of the acceptance/denial rationale and all of those decisions appeared appropriate per state law, administrative code and WSI policies. Adjusters documented their search for prior injuries or pre-existing conditions on every evaluated degenerative claim, and the WSI Medical Director also reviewed nearly 40% of the claims before an initial compensability decision was made.

While all claims followed the required investigation and documentation process, there was some variability in how the compensability decisions were applied to the evaluated degenerative condition claims.

- In some instances, when the adjuster's investigation revealed a pre-existing or degenerative condition, the adjuster would accept compensability for just the medical treatment relating to the new, specific injury, while explicitly excluding any treatment required by the underlying pre-existing condition.

    - For example, in one claim in which an injured worker slipped on the ice and bruised their knee, subsequent diagnostic imaging revealed a pre-existing degenerative knee condition that was likely to require a knee replacement surgery.

    - The adjuster accepted compensability for the knee contusion as work-related and agreed to pay for the associated medical treatment (ice packs and limited physical therapy), but explicitly denied compensability for a future knee replacement.

- In other instances, once it was determined that a prior injury or a pre-existing, degenerative condition existed, the entire claim was denied due to lack of clear evidence that the injury was work related.

- Results in each of these instances still appeared to conform to state law, administrative code and WSI policies, as the language of the existing North Dakota statute and the complexity of determining causality in cases with prior injuries or pre-existing degenerative conditions leave significant room for interpretation up to the individual adjusters.

These results point to the challenges inherent in determining compensability on claims with pre-existing conditions, particularly those that relate to degenerative conditions. While many jurisdictions have begun to try to address the issue of the compensability of claims with pre-existing injuries and/or conditions related to the aging process, few have gone as far as the North Dakota statute, which explicitly excludes as non-compensable:

> *Injuries attributable to a pre-existing injury, disease, or other condition, including when the employment acts as a trigger to produce symptoms in the pre-existing injury, disease, or other condition unless the employment substantially accelerates its progression or substantially worsens its severity.*[27]

This language, together with the additional explicit exclusion of "ordinary diseases of life to which the general public outside of employment is exposed,"[28] in the North Dakota Workers' Compensation Century Code, provides WSI adjusters with a clear ability to deny claims that they determine are either a trigger/aggravation of a prior injury or are due to pre-existing/degenerative conditions. However, the WSI Claims Procedure Manual does require the adjuster to clearly document the rationale for their denial and include any evidence, such as medical records, suggesting that an injury was related to a pre-existing or degenerative condition. (See Recommendations 6.1 & 6.5.)

Comparison to Others on Degenerative Disease Claims

BDMP interviewed a variety of industry experts and staff at other monopolistic funds/large payers in an attempt to determine whether WSI's treatment of claims with degenerative conditions was consistent with current best practices in workers' compensation.

- The Vice President at the Property Casualty Insurers Association (PCIA) reported that the handling of degenerative condition claims is dictated by the jurisdictional statutes in place within each state and that many states' statutes support the acceptance of the injured employee "the way the employer found him/her." If a work injury magnified the

[27] N.D.C.C. § 65-01-02(10)(b)(7)
[28] N.D.C.C. § 65-01-02(10)(b)(1)

symptoms of an underlying condition, the employer is typically responsible for the entire medical/disability claim. The fight for limiting a payer's liability or apportionment then typically only occurs if/when the issue of permanent disability is raised, not during the initial claim compensability investigation.

- The Vice President of Risk Management and Workers' Compensation for Safeway, Inc. and an active participant in workers' compensation reform initiatives across multiple jurisdictions, noted that "there are wide variances in how states define compensability." He used the example of a work-related orthopedic injury that exacerbates an underlying debilitating chronic disease such as AIDS or diabetes. In California and many other states, medical care associated with the underlying pre-existing condition would typically be paid for as the intent of the workers' compensation system would be to return the injured employee to work and pre-injury status. He agreed with PCIA that in most instances "the medical care would be covered, but any permanency would be apportioned."

  He went on to point out that there are typically also statutory differences in the language used to define compensable injuries as either arising out of employment (AOE) or in the course of employment (COE). In most cases, statutes that utilize "AOE" language focus primarily on whether an injury occurred while an employee was at a location relevant to their employment while "COE" statutes tend to focus on whether the activity being performed by the employee at the time of the injury was related to their job rather than just a routine "activity of daily living." For example, if an injured worker strained their back while lifting a box of parts on a loading dock, that would be considered a compensable injury in both types of jurisdictions. If that employee suffered the same back strain while bending over to pick up a pencil off the floor in the hallway, it might be considered a compensable injury in an AOE state, but would likely be deemed an activity of daily living in a COE state and judged non-compensable. The North Dakota statute actually includes both requirements in its definition of compensability:

  > *"Compensable injury" means an injury by accident arising out of and in the course of hazardous employment, which must be established by medical evidence supported by objective medical findings.*[29]

- In the monopolistic state of Washington, even if there was a pre-existing/degenerative condition, the state fund is typically forced to accept full liability for the whole claim so long as the injury occurred at work.

  - According to the Deputy Director of the Washington Department of Labor & Industry, there are very few instances where the fund would not accept a claim

[29] N.D.C.C. § 65-01-02(10)

that was determined to occur while the employee was working; even a broken tooth while chewing is an accepted claim for a salaried employee.

- In Washington, the standard claims process is to check for priors/pre-existing conditions generally only if subrogation is involved as the Deputy Director noted, "since the statute in the state of Washington is relatively liberal relative to pre-existing conditions, the Department does not take much action on pre-existing conditions and generally just accepts the claims." He previously led the Illinois Workers Compensation Commission and he shared that the Illinois statute is very similar to the Washington statute, as it relates to pre-existing/degenerative condition claims and claims payers do not typically challenge at intake.

- The Louisiana Workers' Compensation State Fund (LWCC) told BDMP, *". . . the way we handle it [claims with pre-existing conditions] is to work with the physician to determine at what point they are treating the pre-existing condition versus the aggravating injury. Those lines are often not clear. The bottom line is if they [workers] are injured we would probably even pay for the pre-existing situation until it is established that the physician is only treating the back problem that existed prior to the injury."*

  - Louisiana also has a Second Injury Fund, established to encourage employers to hire workers with pre-existing conditions. Each claims payer in the state is assessed an amount that is contributed to the fund.

  - If an injured worker's injury is exacerbated or complicated due to a pre-existing condition, the workers' compensation payer pays for any necessary medical treatment but can apply to the Fund for reimbursement of care that was attributable to the pre-existing condition. This process is designed to help ensure that employers do not discriminate against potential workers with pre-existing conditions in the hiring process and that if an injury does occur the injured worker receives the appropriate medical care they require.

- A study commissioned in 2000 by the Workers' Compensation Division of the Oregon Department of Consumer and Business Services in which researchers conducted a comprehensive analysis of the statutory compensability standards for workers' compensation injuries found that:

  - The actual statutory language is often critical to a clear understanding of compensability standards. The danger in not looking at the precise language is that different standards may be incorrectly lumped together and variations may

not be understood. In addition, states sometimes have different standards depending on the particular physical or mental condition involved.[30]

- In addition, their review found that some states "have specifically eliminated compensability for the natural aging process, conditions caused by daily living, the ordinary diseases of life, or degenerative conditions."[31]

All of the industry experts and other claims payers contacted by BDMP regarding the question of pre-existing injuries or degenerative conditions commented that decisions regarding pre-existing/degenerative conditions are dictated by the state statute and the interpretation of that statute by the courts within that state. (See Recommendation 6.5.)They made a point of saying that due to the different nature of both the statutes and the interpretations of each statute, there is currently no industry-wide norm for dealing with degenerative condition claims.

Conclusions

During the interview phase of BDMP's evaluation, WSI staff consistently noted a change in claims philosophy that occurred during FY2006-2007 in which adjusters were encouraged to investigate all new claims for prior injuries or pre-existing conditions much more thoroughly. In addition:

- BDMP's claim evaluations suggest that there was additional scrutiny applied to new claims in this regard, but at the same time, BDMP did not find any inappropriate denials given the definition of "compensability" in the state law, administrative code and WSI policies. The claims evaluation and trending analysis did however suggest that there was a push to have adjusters follow the statute regarding the investigation into the compensability of pre-existing or degenerative conditions more rigorously than had previously been the norm.

- While all claims followed the required investigation and documentation process, there was some variability in how the compensability decisions were applied to claims with pre-existing and/or degenerative conditions. (See Recommendation 6.1.)

The way compensability decisions are made at other state funds and large payers regarding pre-existing or degenerative conditions is driven almost entirely by the language of the statute(s) in which they administer claims. The North Dakota statute is conservative and it provides adjusters with direction to deny claims with pre-existing injuries and/or degenerative conditions than most other jurisdictions. (See Recommendation 6.5.)

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[30] Edward M. Welch, Workers' Compensation Center Michigan State University, *Oregon Major Contributing Cause Study,* http://www.cbs.state.or.us/wcd/administration/finalmcc.pdf, (Oct, 2000), p. 106

[31] Welch, *Oregon Major Contributing Cause Study,* p. 109

Evaluation of WSI Claim Philosophy

Objective

This component of Element Six directed that BDMP determine whether there had been a change in the organization's claims management philosophy between fiscal year 2004 and fiscal year 2007. We also were asked to provide a comparison of WSI's claims management "philosophies" to those of other monopolistic funds and large workers' compensation payers.

Observations & Findings

Each WSI employee BDMP interviewed was asked about changes in the claims handling philosophy and the timeliness of adjudicating a claim. We found:

- Employees consistently commented on the shift in management focus to a more aggressive and in- depth search for prior injuries or pre-existing/degenerative conditions, which could possibly reduce WSI liability for the injury.

- According to the interviews and the data included in this report, this change in philosophy did lengthen the initial investigation process with new claims and helped drive a 25% increase in the adjusted denial rate from fiscal year 2005-fiscal year 2007. The Chief of Injury Services said, "We were losing focus on the test of compensability. We need to go back to our basics and make the call based on our training and get the claim accepted or denied without all the extensive analysis," and reported that the extent of the analysis spent on priors/pre-existing conditions was keeping claims pending for longer periods of time.

Claim evaluations suggest that, despite these philosophical changes, overall claims handling remained extremely strong during the period and there was no evidence that claims were being denied inappropriately.

Investigation of prior injuries and pre-existing conditions including obtaining and reviewing all previous relevant medical records is "best practice" in Workers' Compensation claims handling, although many state statutes support apportionment only as it relates to permanency. Given the unusual but explicit direction given by the North Dakota statute to deny compensability based on a work-related injury acting as a trigger for a prior injury or pre-existing condition, the denials reviewed by BDMP appeared reasonable.

Conclusions

As noted elsewhere, WSI staff consistently referenced experiencing a change in claims philosophy during FY2006-2007. They reported that adjusters were more frequently encouraged to investigate all new claims for prior injuries or pre-existing conditions much more thoroughly. Of note were the following:

- The philosophical change within WSI appears to have been real. However, this shift appears to have been motivated by a desire to follow the language of the statute more closely and to leverage the power it provides the claims organization to reduce WSI's liability for a specific subset of claims with prior injuries or pre-existing conditions. The North Dakota statute is conservative in its definition of "compensability" as compared to other jurisdictions. (See Recommendation 6.5.)

- There was evidence of some variability in adjuster judgment in relation to the compensability of those claims, yet all decisions appeared to be well within the scope of state law, administrative code and WSI procedures. (See Recommendation 6.1.)

Recommendations

Recommendation 6.1: Revise the WSI Claim Procedure Manual to standardize "best practices" and train claims adjusters on new practices. (High)

> WSI should clarify claims handling processes and procedures regarding the acceptance or denial of claims with prior injuries and/or pre-existing/degenerative conditions and train or re-train all existing claims adjusters on these new practices.

WSI Response: CONCUR
Adjudicating claims involving prior injuries, diseases and conditions has, and remains a challenge within North Dakota. Establishing training on this issue is extremely important to ensure consistency. Claims training has been conducted and is scheduled on an ongoing basis. Updating the claims procedure manual is an ongoing process as well.

Recommendation 6.2: Implement the Injury Management pilot program across all 7 claim units by ensuring better utilization of the WSI Medical Director. (High)

WSI Response: CONCUR
Currently, the Medical Director, Pharmacy Benefit Director, Return to Work Manager, and Claims Director are involved in the Triage for Units 2, 6, and 7. Plans are being developed for implementation of Injury Management into the remaining units. Additionally, WSI has hired three new nurse case managers to imbed within each unit.

Recommendation 6.3: Decrease the amount of time the WSI Medical Director dedicates to the Utilization Review unit. (High)

Suggestions on how this may be accomplished include:

- Limiting the procedures/treatments that require pre-authorization to those where utilization review appears to be having an impact (e.g. chiropractic care, chronic pain evaluation, etc); and,

- Utilizing external physician advisor services, rather than the Medical Director, to assist the utilization review process.

WSI Response: CONCUR

Effectively using the Medical Director's time is a challenge and requires balance. WSI has begun altering his assignments with the intention of increasing availability. Since Jan. 05 through June 06 the average monthly UR requests completed by the medical director was 303. From Jan. 07 through May 08, the average monthly UR requests completed by the medical director were 122. This was a reduction of 60%. Long term goal is to reduce the number by approximately another 20 to 30%.

We have also trained and started having the UR Nurses conduct some of the reviews that were previously completed by the Medical Director. Expansion of allowing Medical Case Managers to conduct Utilization Review on the claims they are assigned is planned. Initial training has been completed.

On July 1, 2008, a pilot program was established that CT scans done in the first 30 days from the date of injury will no longer require pre-authorization from WSI.

Recommendation 6.4: Investigate additional sources for North Dakota IME providers and peer review. (Low)

This may be accomplished by publishing a request for information to determine the ability of the new national Peer Review/IME firms to provide Peer Review/IME services utilizing providers in North Dakota.

WSI Response: CONCUR

The Service Requisition for IME services has been signed and approved accordingly by WSI staff. This requisition is the first step in the process of developing a Request for Proposal (rather than a Request for Information) for IME services. Plans are to include many of the current IME needs but to also take into account the proposed recommendations from the 2007 IME audit.

Recommendation 6.5: Enhance WSI's knowledge of industry best practices through staff attendance at appropriate industry conferences. (Medium)

Regular attendance at workers' compensation industry trade events is an important means for WSI management and staff to stay informed on industry benchmark standards, new processes and procedures, current and future trends, and general industry dynamics. Examples of these learning opportunities include:

- Workers' Compensation Research Institute Conference
- National Workers' Compensation & Disability Conference
- Annual National Workers' Compensation & Occupational Medicine Conference

WSI Response: CONCUR

North Dakota is a monopolistic insurer. In order to continue performance at the highest levels, WSI recognizes the need for continual training of staff at all levels. Due to WSI's monopolistic nature, these training opportunities often occur outside of the state of North Dakota. This increases the expense of training due to travel costs but resources have been, and will continue to be focused on this area. Historically staff has participated in various AASCIF workshops, NCCI conferences, and the National Workers' Compensation & Disability Conference and will continue to do so.

Recommendation 6.6: Review the North Dakota Statute in relation to other jurisdictions. (High)

In our work, BDMP observed that the North Dakota statute is more conservative than most other jurisdictions as it relates to prior injuries, pre-existing or degenerative conditions, triggers and aggravations and impairment rating percentages. BDMP recommends that a study group formed of all the stakeholder groups be brought together to review how other jurisdictions' statutes handle these important Workers' Compensation issues. Suggested sources of information for this study group include:

- Edward M. Welch, Workers' Compensation Center Michigan State University, *Oregon Major Contributing Cause Study,* http://www.cbs.state.or.us/wcd/administration/finalmcc.pdf, (Oct, 2000)
- Clayton, Ann, *Inventory of Workers' Compensation Laws - Beta Version, March 2007,* Workers' Compensation Research Institute, Cambridge, MA : Only available to members of WCRI and/or IAIABC.

WSI Response: CONCUR

WSI will undertake a study of the adequacy of the current law in these areas. Currently, this issue is being reviewed with WSI by the North Dakota Industry Business & Labor interim committee. Whether any legislative changes will occur as a result of insights gained is not known but WSI will continue to monitor.

BDMP Concluding Remarks

While it is beneficial that the WSI and IB&L committee consider this, we re-iterate the importance and benefit to the State of North Dakota that a multi-perspective stakeholder group be assembled to specifically study this issue.