

Workforce Safety and Insurance

Performance Evaluation Report

Prepared by
OCTAGON RISK SERVICES, INC.

Consulting Division
A Sedgwick CMS Company
November 21, 2006



TABLE OF CONTENTS

| | |
|--|-------------------|
| <u>TRANSMITTAL LETTER</u> | <u>1</u> |
| <u>EXECUTIVE SUMMARY</u> | <u>2</u> |
| <u>ELEMENT ONE – EVALUATION OF WSI PERFORMANCE MEASUREMENTS</u> | <u>9</u> |
| <u>ELEMENT TWO - EVALUATION OF SAFETY AND LOSS PREVENTION PROGRAMS</u> | <u>20</u> |
| <u>ELEMENT THREE – EVALUATION OF INFORMATION TECHNOLOGY</u> | <u>30</u> |
| <u>ELEMENT FOUR – REVIEW OF WORKFORCE SAFETY AND INSURANCE BOARD</u> | <u>50</u> |
| <u>ELEMENT FIVE – FRAUD UNIT</u> | <u>58</u> |
| <u>ELEMENT SIX - EVALUATION OF MEDICAL SERVICES (PART ONE – BILL REVIEW)</u> | <u>62</u> |
| <u>ELEMENT SIX - EVALUATION OF MEDICAL SERVICES (PART TWO – UTILIZATION REVIEW)</u> | <u>70</u> |
| <u>ELEMENT SEVEN - EVALUATION OF POLICYHOLDER SERVICE (PHS) FUNCTIONS</u> | <u>73</u> |
| <u>ELEMENT EIGHT – PRIOR RECOMMENDATIONS</u> | <u>88</u> |
| FULLY IMPLEMENTED | 90 |
| PARTIALLY IMPLEMENTED | 96 |
| NOT IMPLEMENTED | 116 |
| NOT APPLICABLE | 120 |
| <u>ATTACHMENT A</u> | <u>121</u> |
| <u>ATTACHMENT B</u> | <u>122</u> |

November 21, 2006

Governor of North Dakota
The Legislative Assembly
Chairman of the Workers' Compensation Board of Directors
Chairman of the Workers' Compensation Board Audit Committee
Executive Director of Workforce Safety and Insurance

We are pleased to submit this report summarizing the results of the 2006 performance evaluation of Workforce Safety and Insurance. The performance evaluation covered Calendar Years 2004 and 2005.

The purpose of this performance evaluation was to assess certain aspects of the functions and operations of Workforce Safety and Insurance (WSI) to determine whether the divisions of WSI are providing quality service in an efficient and cost-effective manner. Where appropriate, we were to provide recommendations for improvement, satisfying the requirements of North Dakota Century Code (NDCC) sections 65-02-03.3, 65-02-23, 65-02-30 and 65-03-04.

The performance evaluation features eight elements including WSI Performance Measures, Safety and Loss Prevention, Information Technology, WSI Board, Fraud, Medical Services, Policyholder Services, and the 2004 Performance Evaluation Recommendations. Recommendations in this evaluation were made pertaining to each of the elements where we felt opportunities existed to improve performance and/or establish greater cost efficiencies. One hundred nine recommendations were made.

The report consists of an executive summary, sections pertaining to each element, recommendations, WSI responses to the recommendations and two attachments. In some instances, we added a comment to follow up on a WSI response.

We want to thank all those at WSI who assisted us in the performance evaluation process.

OCTAGON RISK SERVICES, INC.

Oakland, California

EXECUTIVE SUMMARY

This summary provides highlights of our findings with an emphasis on areas where higher priority recommendations, if properly implemented, can lead to overall improvement in the results achieved by Workforce Safety and Insurance (WSI).

We also provide the following table that sorts the 109 recommendations by Element and priority.

| Element | High Priority | Medium Priority | Low Priority | Total |
|----------------|----------------------|------------------------|---------------------|--------------|
| One | 5 | 6 | 4 | 15 |
| Two | 2 | 7 | 1 | 10 |
| Three | 20 | 9 | 6 | 35 |
| Four | 5 | 3 | 1 | 9 |
| Five | 1 | 0 | 1 | 2 |
| Six | 8 | 7 | 0 | 15 |
| Seven | 3 | 14 | 6 | 23 |
| Eight | 0 | 0 | 0 | 0 |
| Total | 44 | 46 | 19 | 109 |

Element One – WSI Performance Measures

Our objective in this element was to assess the performance measurements developed by WSI in keeping with North Dakota Century Code (NDCC) Section 65-02-30.

Probably the most notable change in this area is that WSI has turned the Operating Report, its set of measures that receives quarterly Board review, into an evolving document. We see this as a positive development. Measures of an organization should not always be the same from year to year. Circumstances change, new trends emerge, and the organization needs to have a way of communicating those changes to itself and its Board.

Many department measures are substantial in quantity and reasonable in content. And where we felt measures were lacking or could get more visibility through inclusion in the operating report, we made such recommendations.

Key observations from Element One are:

- Meaningful cost measures for claims are needed, and we suggested one approach as seen in Attachment A.
- Defense costs need to be measured over a broader span of time to demonstrate whether WSI is successfully controlling those costs.
- Fraud by category (employer, employee and medical provider) needs to be captured in the operating report.
- Loss control measures relying on a payroll measure should be included in the operating report.

- The customer satisfaction survey should be expanded to include a wider array of claim types.
- Bi-annually at minimum, WSI should include its own assessment of its implementation of performance evaluation recommendations, and we urge this to be accomplished to coincide with the end date of each subsequent performance evaluation.
- A training document should be provided to better understand how to read the operating report (this would be particularly beneficial for new Board members).

Element Two – Safety and Loss Prevention Programs

Our objective in assessing the safety and loss prevention programs was to evaluate those programs in the context of NDCC Section 65-03-04.

We noted two significant developments during the performance evaluation that bear mention here. First, the Loss Prevention and Policyholder Services groups were grouped within the same organization. This grouping has the effect of merging that portion of the organization that assesses risk and premium requirements with the group that is charged with employer safety. As such, the organization may now be better positioned to assist employers in lowering their costs through the implementation of safety initiatives that achieve better results.

Second (and these changes occurred close to the conclusion of the performance evaluation period), WSI instituted two new programs. One is the Safety Outreach Program and the other is the Risk Management Program Plus. As these programs were new at the time of our review, we can only comment that the focus of these programs seems sound and may lead to better outcomes than the programs being replaced. In that context, it is worth noting that WSI already enjoys a desirable frequency of time loss claims. That is, only about 3 in every 20 claims results in time loss benefits being paid. This is a rate that is generally much lower than the results achieved in other jurisdictions.

Key observations from Element Two are:

- WSI will want to assess the results of its new programs when data is sufficiently aged to measure outcomes.
- WSI will want to tie incentives for premium discounts to actual results rather than an employer's documentation that it has implemented new safety approaches.
- Ongoing professional development is important for the loss prevention staff who would benefit by seeking certification in their chosen specialty, receiving greater ergonomics training, and who following certification may be rewarded with a higher compensation package.

Element Three – Information Technology

The objective in this part of the report was to assess whether WSI's Information Technology team is being managed in an effective, cost efficient and proactive manner. We also sought to assess whether maintenance costs are being monitored effectively, and we were to determine whether policies and procedures were effective and being followed.

It should not go unnoticed that nearly one-third of all recommendations made in our report pertain to the Information Technology (IT) area. Further, nearly half our high priority recommendations are made in this area.

We found that the department had during parts of the Performance Evaluation period functioned in a less than cooperative manner. One example of this lack of cooperation led to the development of different web platforms, leading to a greater resource drain and inefficiencies that would not have occurred had the department managed web development consistently.

Having said that, WSI was at the time of the performance evaluation implementing a change management process to prioritize work. A key feature of the change management process is that the business units have accepted accountability and responsibility for determining business priorities. Additionally, a project management methodology is newly implemented, and a tracking system exists for change requests. These steps lay a good foundation for creating a high-performing IT department.

Key observations from Element Three are:

- Communication needs to be consistently better within the department and philosophical disagreements cannot be allowed to impact the department's overall performance.
- Business analysts need to focus on the business need and process flow, not the technical solution. That is a task for developers.
- WSI has to complete its Data Integrity project to upgrade all currently "mediocre" or "bad" data to "good" data. Eliminating sub-standard data has the effect of eliminating workarounds to accommodate information demands that would otherwise result in inaccuracies.
- As part of the Data Integrity project, reserve errors need to be resolved.
- An IT architect should be used to review major development and enhancement projects.
- A single web platform is needed.
- There were security issues with the OAI/JBoss server, and we urge WSI to work with ITD to be certain that this server is at no greater risk than any other application.
- WSI should have management reports from HEAT.
- IT staff should be available at least during the same hours as the customers they support.
- WSI needs to have a method to track maintenance costs, which is essential to determine when it is better to maintain a system or replace it with something better.
- Formal project management should exist for all IT projects.
- WSI should have a formal testing methodology so it assures that a "fix" accomplishes its intentions without disrupting some other functionality.

Element Four – WSI Board

Our objective here was to determine if the Board is operating in accordance with NDCC Sections 65-02-03.1 – 65-02-03.3 and within the Board's bylaws.

As part of this Element, we benefited by being able to review all Board minutes and also had the opportunity to speak with the Board Chair, the Board Audit Committee Chair and one other Board member. We appreciate the participation of these various Board members in our evaluation.

In November 2004, the Board established six outcomes that it believes should drive WSI in its efforts to maintain financial integrity, enhance service and the knowledge base of its staff, and

promote safe work environments among policyholders. These outcomes were then supplemented by a substantial strategic planning effort undertaken by WSI's leadership and its employees leading to multi-point initiatives overseen primarily by the chiefs of Employer Services, Injury and Medical Services, and Support Services. These initiatives are broad-based and well defined, and they demonstrate that the organization has committed on paper to achieving Board outcomes.

One area of significance that warrants consideration by the legislature is the make-up of the Board. We discovered that the WSI Board includes one member who is considered by WSI to satisfy both the labor and injured worker representation. It was our impression from a review of the statute that one representative should be from organized labor and another from the pool of injured workers. Parenthetically, we wonder if the legislature might wish to establish a time frame for the injury. For instance, how relevant might it be if an injured worker is appointed to the Board in 2005 but has not had an industrial accident in the past twenty-five years? It probably makes some sense to select someone who has had an injury in the fairly recent past (e.g., over the past two to four years).

As part of our consideration of this point, the State Auditor's Office sought an opinion from the Attorney General on board representation, and the Attorney General's office agrees with our assessment.

Other key observations from Element Four are:

- We encourage the labor representative to be a standing member of the legislative committee. We think it is healthy for the organization that if it is considering statutory changes that Labor participate in the formative discussions that occur in those committee meetings.
- Department chiefs need to sign off with certainty when audit recommendations are considered fully implemented. This creates ownership and accountability for the recommendations.
- The Board Governance document should be timely updated and it should be clear from the Board's review of the document that it meets Board objectives.
- Due to issues that WSI has had with reserving, we encourage this topic to be a standing topic at Board meetings.
- Emerging trends should be considered as part of the standing topic of Board education at each quarterly Board meeting.

Element Five – Fraud

For this Element, we evaluated the effectiveness of expenditures occurred by WSI's fraud unit, in accordance with NDCC Section 65-02-23.

It is noteworthy that the Fraud Unit (more commonly referred to as the Special Investigations Unit), was the subject of an extensive review in the 2004 Performance Evaluation. As such, there was some overlap in our work between this element and Element Eight (prior recommendations).

What we observed, in general, is that WSI has taken a major step forward in its control of costs associated with fraud investigations, reducing costs by a substantial margin since the last performance evaluation period. Specifically, external investigative costs averaged more than

\$800,000 for fiscal years 2003 and 2004. For Fiscal Year 2005, the cost dropped to a little more than \$500,000 and for fiscal year 2006, the projection was about \$150,000. These drops have occurred at a time when SIU's operating expenses have grown by only about 7% between 2003 and 2006.

The principal area of weakness that remains for the SIU is in the area of medical provider fraud. We have made an extensive recommendation about that subject, and it is one of only two recommendations in this section of the report. As you may recall, we made a similar (although less detailed) recommendation in 2004. WSI may need to consider external training resources to successfully implement an effective medical provider fraud program.

Element Six – Medical Services

In this section, we evaluated both the bill review and utilization review services provided by WSI. As with other sections, we sought to determine whether these operations worked efficiently and effectively.

As an initial step, we conducted an extensive review of document flow (including scanning) and the layers of services provided by bill review and utilization review staff.

Key observations in Element Six are:

- System upgrades would assist WSI in merging the work of bill review and utilization review staff. Upgrades in the scanning area could also lead to more effective links between submitted bills and reports associated with those bills.
- In the latter part of 2005 and into early 2006, WSI experienced a major growth in its backlog of medical bills. This backlog was resolved through an auto-adjudication process that could have been better devised.
- A training manual is needed for bill reviewers. Currently, no such document exists.
- Bill payers should not set up new payees in the system as this violates sound separation of duty principles. This function should shift to the Finance Department.
- Utilization Review staff should assist bill review staff in establishing routing rules, particularly for more complex diagnosis bills and those involving questionable procedures.

Element Seven – Policyholder Services (PHS)

In Element Seven, we reviewed the PHS collections function, the premium audit function, the premium billing process, the overall effectiveness of WSI's Experience Rating plan and the existing rate classification manual.

While this section of the report led to the second highest number of recommendations, only three of the twenty-three recommendations for this department were considered high priority.

We observed that since 2001, PHS has improved its collections and write-off statistics significantly with the amounts in collections declining by 37% and write-offs declining by 65% during that time frame. We should also note that the collections amount has slightly increased (slightly more than 5%) when comparing 2005 to 2003 and 2004.

The premium audit function adequately evaluates employers for classification, correct payroll, and headcount.

Generally, we observed that WSI collects premium in ways that it believes are appropriate for its customer base, but may be different from what we observe in the industry in general. Our recommendations are made in the context of industry standard.

Key observations about Element Seven are:

- WSI should require its customers to make an advance deposit and a quarterly premium deposit. At minimum, it should have a policy requiring advance deposits for new employers and those with poor payment histories.
- WSI should integrate the collection process with its PICS database.
- Premium auditors should be included in the review of employee classifications to ensure that clear objective criteria exist for classifying employees.
- Annual and five-year rotational plans are needed to audit employers.
- Employer self-billing should be instituted.
- WSI should set targets for moving customers to an online payroll reporting system.
- WSI should consider with its actuary whether the large cap level on losses at \$250,000 should be lowered. Typically, large cap levels run between \$100,000 and \$150,000.
- To help ensure that employers keep workers' compensation safety at the forefront of their decision-making, the experience modification cap should be eliminated.

Element Eight – Prior Recommendations

In our review of prior recommendations, we assessed whether those recommendations had been fully implemented, partially implemented, not implemented or not applicable.

We found that about four of every five recommendations from the previous performance evaluation had been fully or partially implemented. A summary table is provided below that shows the recommendations by category and by priority (high, medium or low).

| Recommendation Priority Level | Fully Implemented | Partially Implemented | Not Implemented | Not Applicable |
|--|------------------------------|----------------------------------|----------------------------|-----------------------|
| High | 10 | 11 | 3 | 2 |
| Medium | 9 | 14 | 5 | 0 |
| Low | 1 | 3 | 0 | 1 |
| Total | 20 | 28 | 8 | 3 |

WSI's own summary of these recommendations differed from our assessment in 24 of the 59 recommendations. The primary reason for these differences has to do with the degree of implementation of the 29 recommendations made in the Claims Department in 2004. Of the 29 recommendations, we disagreed with WSI's assessment in 17 instances. For most of those differences, WSI considered a recommendation fully implemented while we viewed implementation as partial. Since the completion of our fieldwork, WSI has purportedly completed the implementation of several claim recommendations. You will notice many instances within their status responses that recommendations were fully implemented as of September 2006. We can't validate implementation as of that date given the timing of our work, but it is encouraging that additional efforts were made to fully implement recommendations that were seen as incomplete as of approximately May 1, 2006. We should also point out that WSI's Claims Department did not

appear to start its implementation plans concerning recommendations until approximately May 2005, and it is likely that this tardiness in implementation efforts contributed to the overall result.

For other department results, WSI and Octagon agreed on the degree of implementation in approximately 80% of the recommendations.

We also want to single out two prior recommendations for additional comment.

Recommendation #42 called for WSI to retain additional legal and paralegal staff to take on legal work that is currently outsourced. WSI took a different approach to legal cost containment and also indicated that a limited amount of previously outsourced work is now serviced internally. We feel WSI is still in a position to retain staff to further control costs and manage litigation.

Recommendation #56 asked WSI in part to consider the retention of a second firm to support its chiropractic cost containment efforts. This recommendation was made because the return on investment with the current provider has consistently been below the break-even point. While not having implemented the recommendation during the performance evaluation period, WSI has expressed its intent to evaluate these options when it re-bids these services in 2007.

ELEMENT ONE – EVALUATION OF WSI PERFORMANCE MEASUREMENTS

Objective

In this section, we evaluated the performance measurements developed by Workforce Safety and Insurance (WSI) in accordance with North Dakota Century Code (NDCC) Section 65-02-30. To accomplish this review, we undertook the following tasks:

- A review of WSI operating reports
- A review of department reports
- Interviews of WSI department staff and internal audit staff to clarify our understanding of various measures
- A review of the 2002 Performance Evaluation as it was the last comprehensive review of performance measures conducted as part of the biennial performance evaluation process
- A review of the 2004 Performance Evaluation as it contained numerous recommendations for modifying performance measures, notably in the Claims Department

By way of background, the 2002 Performance Evaluation contained 19 recommendations relating to performance measures. During the 2004 Performance Evaluation, we were able to confirm that 14 of these recommendations had been fully implemented and that one of those recommendations was no longer applicable. That left four recommendations pending from the 2002 Performance Evaluation.

Of these four recommendations, two were in the Safety and Loss Prevention area. Both recommendations were predicated on WSI developing measures tied to the number of fulltime equivalents within policyholder industry. WSI has been unable to adequately develop these measures, but has developed measures in their place that rely upon payroll. These alternative measures satisfy the 2002 recommendations.

The other two recommendations were tied to the Claims Department. One of them pertained to the development of incentives and penalties to encourage timely initial claim reporting. Since the 2004 Performance Evaluation, WSI has implemented an incentive program for employers who report within 24 hours of notice of injury. This practice satisfies the recommendation.

The other remaining recommendation pertaining to performance measures had not been implemented at the time of our 2006 Performance Evaluation. This recommendation encouraged WSI to measure the paid and incurred values of time loss claims over a five-year window to assess how these claims develop over time. As the recommendation had not been implemented as of this evaluation, we provided WSI staff a sample report based on actual WSI data during our exit interview in July 2006 that will satisfy this recommendation.

Performance measure recommendations that pertained to the 2004 Performance Evaluation will be addressed in the Element Eight section of this report, so we make no further comments regarding those recommendations here.

Overview and Analysis

N.D.C.C. Section 65-02-30 states in part that WSI, “shall develop and maintain comprehensive, objective performance measurements,” and that, “these measurements must be evaluated as part of the independent performance evaluation.” We also understand that this evaluation must include any recommendations for enhancement of the existing system and identification of any additional areas of measurement to be utilized.

As noted above, we reviewed quarterly operating reports as well as department measures to evaluate the adequacy of WSI's performance measurements. Quarterly operating reports are compiled by relying on key data elements that are captured in the department measures. The department measures generally contain not only the data elements that are included in the operating report, but they also include measures of performance at a more detailed level. As an example, the quarterly operating report contains a measure of pending claim counts exceeding 31 days. The department measures in this area break the pending claim counts down into different time parameters and sort the data by Claims Analyst. The level of detail in the department measures is appropriate for day-to-day management of the Claims Department, but the operating report is limited to a key data element amidst the detail.

The quarterly operating report is reviewed by the Board Audit Committee at its quarterly meetings and then reviewed by the full Board in summary fashion. Thus, the report is intended to capture key measures that adequately inform the Board of WSI performance.

Over the course of the performance evaluation time frame of January 1, 2004 – December 31, 2005, the quarterly operating report underwent content and format changes. For instance, in December 2004, the operating report was 31 pages long, reported in quarterly increments, did not provide totals by fiscal year and had some fairly short-term measures in certain areas.

In March 2005, the report was condensed to about six pages, data was captured by fiscal year, and some data targets were established. This report had no department headings nor did it provide annualized projections.

By September 2005, the report added department headings and annualized projections. It also offered up a color-coded trend analysis showing whether a projection or target represented a positive development, tended to be neutral, or warranted a classification as an item to "watch."

We view these modifications of the operating report over the performance evaluation timeframe as positive developments.

As the quarterly operating report is currently configured, it sorts measures into the following components:

- Injury and Medical Services
- Legal/Special Investigations Unit
- Employer Services
- Support Services
- Finance
- Paid Cost Data
- Customer Satisfaction
- Financials

Injury and Medical Services

The injury and medical services measures track the performance of claims, bill review, utilization review, case management and return-to-work. Nearly all of the measures for this department track process. There are a handful of measures that track counts (e.g., total claims filed, indemnity claims filed) or outcomes (e.g., percent of preferred worker program participants who have found employment). None of the injury and medical services measures track cost. One caveat to this statement is that the Paid Cost Data that is summarized in another section of the operating report contains a summary of paid losses by benefit type (e.g., indemnity benefits paid, medical benefits paid).

The report also contains no information on the utilization review program, nor does it contain any information on vocational rehabilitation other than the preferred worker program. Regarding cost measures, we had the benefit of being able to participate in a portion of the WSI Legal Summit that took place on April 21, 2006. During one portion of that summit, information was presented by WSI showing that time loss claims had an average fully developed value of more than \$40,000 for the most recent accident years. We also were able to obtain information from WSI showing that average incurred estimates of time loss claims amounted to substantially less, generally at an estimated level that might represent one-fourth to one-third of the fully developed liability. Given this disparity, we have developed (see Attachment A) a measure for undeveloped time loss claims over the most recent five-year time frame.

Recommendation #1

We recommend WSI further develop the measure captured in Attachment A so it includes a developed loss measure in conjunction with undeveloped losses.

Priority Level: High

Recommendation #1 Additional Information: For information purposes, developed costs represent the actuarial forecast for a book of losses. Undeveloped loss costs are reserve estimates as established by claims staff. WSI has expressed an interest to us in the past at trying to provide meaningful methods to assist its staff in addressing reserve shortcomings, and this measure may assist WSI in accomplishing that objective.

WSI Response: CONCUR

Analogous information is currently contained in our annual Reserve Review. We will work with our actuary to develop this loss measure.

Recommendation #2

We recommend WSI implement a measure of time loss costs that combines the information in Attachment A with actuarial time loss projections. Include this measure in the operating report as an annual measure tied to fiscal year end data points (i.e., 12 months, 24 months, etc.) For purposes of the actuarial projection, we are assuming a confidence factor of 50%.

Priority Level: High

WSI Response: CONCUR

Analogous information is currently contained in our annual Reserve Review. We will work with our actuary to develop this loss measure.

Octagon Reply to WSI Response:

As WSI knows the value of this information is not only in trending but also in working with claims staff to enhance their reserving practices independent of any reserving aids they may also utilize to improve reserving adequacy. Remember that one of the reasons for the recommendation grows out of the disparity between undeveloped losses as reported by claims and developed losses as reported by the actuary. Additionally, Attachment A demonstrates that time loss claims are becoming more expensive in the most recent years, and it would be good for the Claims organization to understand the reasons for these trends.

Ongoing Overview and Analysis

HB 1171 created changes to the way in which certain indemnity benefit provisions were to be managed by WSI for claims occurring on or after 1/1/06. Among other provisions, the definition of permanent total disability (PTD) was changed, a cap of 104 weeks of temporary total disability was enacted, and the plan approaches for satisfying vocational rehabilitation obligations were redefined.

For permanent total disability claims, WSI has data that shows the number of new awards each quarter. PTD frequency assumptions have been made in actuarial forecasting.

For vocational rehabilitation, WSI has long maintained data in its department measures that identifies the types of plans that have been pursued to assist injured workers in returning to work. This data documents vocational participation by plan type.

Given the nature of these statutory changes, we think measures should be developed to identify how permanent total disability frequency and vocational rehabilitation plan type may change over time. Tracking such data by the fiscal year in which the injuries occurred would provide helpful information on trends.

Recommendation #3

Part A: WSI should report in its operating report the number of PTD claims by quarter.

Part B: WSI should show in its operating report vocational plans by plan type distinguishing non-schooling plans from schooling plans. As noted in Part A above, data should be tracked according to the fiscal year in which the injuries occurred.

Priority Level: Low. We are placing a low priority on this recommendation because it may be a few years before meaningful data develops on PTD or vocational losses with injury dates after 1/1/06.

WSI Response: CONCUR

WSI will prepare the measures and present them as the information is developed.

Ongoing Overview and Analysis

We observed in the December 2005 operating report that a backlog in bill review materialized. This backlog was identified in the performance measures and singled out as a “watch” item within the report. The operating report showed a fairly consistent result, that through the third quarter of calendar year 2005, the percentage of bills that was more than 30 days old amounted to 4%. Historically, this percentage has been in the 4% to 5% range. In December 2005, that number jumped to 18%. (The growth in outstanding bills more than 30 days old from September to December 2005 changed from a few hundred to a few thousand.) In short, the report identified an area requiring attention. The subject of this shortcoming is covered in greater detail in Element Six.

While the bill review measure of bills that are more than 30 days old is a reasonable one, we encourage WSI to rely on its measure of bill review adjudication at 21 days as its most meaningful measure of bill review timeliness. If bills can be paid in 21 days, it likely means that providers will not have to submit duplicate bills for services rendered. The fewer duplicates the better both for providers and WSI staff.

We don't believe bill adjudication measures are necessary for other time increments. (Currently, WSI also tracks bill adjudication at seven and fourteen day increments.)

Recommendation #4

We recommend WSI establish a 90% target for bill adjudication within 21 days within the operating report. The current target is 95% and applies to a 31-day measure. We encourage WSI to keep both the current and recommended targets.

Priority Level: Medium

WSI Response: CONCUR

The target for the 21 day measure was added to the June 30, 2006 Operating Report. In the September 30, 2006, issue of the operating report, we will remove the other time measures so we are just reflecting the 21 and 31 day measures.

Legal/Special Investigations Unit (SIU)

The Legal Department measures are principally limited to process steps. No financial measures are included in the Legal Department measures within the quarterly operating report. For the Special Investigations Unit, all measures are financial measures.

One of the areas of interest for the Legal Department is to shorten the amount of time cases are in the hands of the Office of Administrative Hearings (OAH). Currently, the operating report identifies the average number of days cases are in the hands of OAH. The report shows that from FY 2004 through FY 2006 (year to date as of 12/05) the average has declined from 172 days to 143 days. The report currently shows no target to be reached that would satisfy WSI about the time cases should be with OAH.

Another missing item from the Legal Department measure is defense costs associated with litigation.

For the SIU measures, no data is captured in the operating report that shows the proportion of cases being pursued by SIU into its three fundamental categories (employee, employer, medical provider). Further, WSI has had nearly zero provider fraud investigations through calendar year 2005, and it would be good for the Board to see what progress is being made in this area.

Recommendation #5

We recommend that the Legal Department identify a target measure for hearing time with OAH. While this measure is not within the control of WSI, it would be worth capturing given the stated interest of WSI in reducing the time OAH takes to manage its role in the litigation process.

Priority Level: Low

WSI Response: CONCUR

WSI began discussing an appropriate target with OAH approximately two years ago and placed guideline language in the contract approximately one year ago. In the contract for hearing officer services executed in September 2005, it was formally agreed that OAH would follow case processing guidelines for WSI cases. The most recent guidelines, established in May 2006, outline a 160-day guideline for the entire administrative hearings process. These guidelines became effective July 1, 2006.

Recommendation #6

We recommend WSI add a line of information in the operating report showing defense litigation costs by fiscal year. Cost controls have been developed in this area, and it would be good for WSI and the Board to see the effects of these controls from year to year.

Priority Level: Medium

WSI Response: CONCUR

WSI external counsel costs have been tracked and monitored by the legal department for several years.

Octagon Reply to WSI Response:

While WSI external defense costs have been tracked and monitored by the Legal Department for years, this does not address the fact that they are not included in the operating report and this is why we are making the recommendation. The intent behind capturing this data within the operating report is that it will allow WSI and the Board to consider how effectively defense costs are managed (both internally and externally) over several years and in the context of Recommendation #42 in the 2004 Performance Evaluation.

Recommendation #7

We recommend WSI show in its operating report the percentage of employee, employer and medical provider fraud cases that it has pursued by fiscal year. Showing data starting with FY 2004 would be a good starting point.

Priority Level: High

WSI Response: CONCUR

Prior data beginning with fiscal year 2004 will be reported.

Employer Services

The Employer Services Department includes Safety and Loss Prevention and Policyholder Services. One of the measures contained in the operating report identifies the lag time between a date of injury and the date of the initial report. WSI has recently provided incentives to employers who report within 24 hours, and the operating report demonstrates the success of this program. In FY 2005, only 10% of injuries were reported within 24 hours. In FY 2006, that number has grown to 37%. Other benchmark measures also show recent employer reporting to have improved.

Industry data with which WSI is familiar consistently demonstrates the importance of timely reporting in controlling workers' compensation claims costs. So, the incentive program rewards employers for immediate reporting and allows WSI to manage claims more expediently and efficiently.

WSI established an ambitious target for the number of employer audits it expected to complete in FY 2006. The number was about 18% higher than its results in FY 2004 and FY 2005, and the audits themselves have become somewhat more detailed. Wisely, WSI plans to develop a less ambitious target in this area.

WSI has also generally not developed incident rate reporting that is tied to full time equivalents. While it relies on data from Job Service for aggregate data, it is easier for WSI to derive loss prevention measures keying off payroll.

The operating report also tracks delinquent premium as a percent of in-force premium and that number has generally hovered at around 2%. The report also shows total delinquent premium in dollars as well as those with delinquent premium who are not making payments. In examining the operating report for December 2005, the total delinquent premiums for accounts not making payments for FY 2006

represents about 76% of the total delinquent premium. For FY 2005, the percentage was only 62%. The actual dollar difference between the two years is approximately \$550,000.

Recommendation #8

In that measures by fulltime equivalent are difficult to develop, we recommend that WSI add two measures to the operating report that track a.) average cost/a dollar payroll measure by industry, and b.) a similar comparative measure for special safety and loss prevention programs against those who are not participating in those programs as well as measures of program participants over time. This second set of measures should also be developed in such a way that comparisons can be made within industry.

Priority Level: Medium

WSI Response: PARTIALLY CONCUR

With respect to item (a) WSI publishes rate sheets annually, separate from the operating report, indicating costs per \$100 payroll by rate classification and will continue to do so. With respect to item (b), WSI agrees and fully intends to monitor the progress of SOP participants compared to the non-participants. Claim and severity rate indicators have been established and programs will be monitored for both groups at annual intervals. WSI will continue to review for other appropriate measure(s) as well.

Octagon Reply to WSI Response:

As we noted in Recommendation #6, these measures should be included in the operating report.

Recommendation #9

Given the variance in accounts not paying delinquent premium between FY 2005 and FY 2006, it may be appropriate to explain in the operating report via footnote why the non-paying delinquent premium has grown. It would be good for the Board to know if the growth is due to a more aggressive collections policy (i.e., fewer write-offs) or if the growth is due to higher interest and penalties or some combination of the two.

Priority Level: Low

WSI Response: CONCUR

Footnotes will be added in future reports.

Support Services

The Support Services Department includes facility management, human resources, office services, finance, information technology, quality assurance and special projects. Of these functions, the operating report contains limited measures relating to human resources, office services and information technology. Stand-alone measures pertaining to Finance are separated within the operating report and covered in the next section of this Element. No reporting is provided reflecting the work of facility management, quality assurance or special projects.

The Human Resources measures pertain to absenteeism and turnover rate. WSI reported the turnover rate has been in the 5% to 6% range and reported the turnover rate in 2005 was slightly higher than 8%. Industry averages tend to run higher than WSI's turnover rate. WSI's reported absenteeism rate runs about 3% to 4%.

The only IT measure that is captured in the operating report is system availability during core business hours. The only office services measure captured is the number of documents indexed in the imaging system.

Finance

The Finance measures are a combination of aggregate and average measures that assess various cost, premium and staff allocations. The measures are reasonable for this department. It probably makes sense for WSI to move one of the Finance measures (return on investment) to the section of the operating report called Financials, as the Financials section of the report addresses WSI's overall investment picture.

Paid Cost Data

This section of the operating report contains a chart that tracks paid losses by benefit type over the past four fiscal years. The measure amounts to a cash flow report, something that should be standard in an insurance organization. The measure is a good one and does not need to be amended.

Customer Satisfaction

WSI tracks two measures of customer satisfaction. One is an annual measure of employer satisfaction while the other tracks employee satisfaction.

In discussing these measures with Board and WSI staff, it became apparent that not everyone who reviewed these measures understood how employees were identified to sample in the satisfaction survey. The current employee sample is limited to relatively new, accepted lost time claims. That is, the claims are fairly new so no long-term claims management issues would have arisen. Further, cases in the sample have been accepted, meaning there is no general compensability dispute in the case mix. WSI is evaluating the approach it takes to the employee satisfaction survey because the current sample is taken from a group of claims where one would expect favorable responses. The sample would become more valuable as a management tool if it assessed performance by relying on a wider array of claim characteristics. As things stand right now, the measure tells WSI nothing about customer satisfaction for employees with chronic conditions.

Recommendation #10

We recommend that the satisfaction survey ultimately include a sample of cases that have been open for at least a year. Further, we recommend that a small sample of denied claims (less than 5% of the overall sample) be included in the sample. We also recommend that litigated claims not be included in the sample.

Priority Level: Medium

WSI Response: CONCUR

WSI will incorporate these requirements into the customer satisfaction survey services Request for Proposal (RFP).

Financials

The Financials Section of the operating report contains a broad spectrum of information showing the overall financial health of the organization. The information provided is an appropriate summary of key financial measures.

Recommendation #11

We recommend WSI add to the Financials section a pie chart that shows the proportionate share of WSI's portfolio mix. This information is already available in department measures and should just be added to the report. The pie chart approach is a common method of expressing investment mix.

Priority Level: Low

WSI Response: CONCUR

The chart was added to the June 30, 2006 Operating Report.

General Comments and Recommendations

Since approximately 2005, the Quality Assurance department took the place of the Internal Audit Department insofar as tracking recommendations made in the previous Performance Evaluation. WSI's tracking of the implementation of prior recommendations had been a standard part of the operating report but it was not part of the 2005 Operating Report.

Recommendation #12

We recommend WSI add a section in the operating report to track implementation of the prior performance evaluation recommendations. The recommendations should be tracked in the four standard categories (Fully Implemented, Partially Implemented, Not Implemented and Not Applicable). If the Quality Assurance department will continue to track implementation, then the data should be captured in the Support Services segment of the operating report.

Priority Level: Medium

WSI Response: DO NOT CONCUR

Since its inception, Quality Assurance has tracked and reported the implementation of the prior performance evaluation recommendations to Board of Directors. The report is standardized and does delineate between Fully Implemented, Partially Implemented, Not Implemented and Not Applicable. Additionally, Quality Assurance has recently expanded the audit and evaluation monitoring reports to include the status of recommendations from all audit reports, internally and externally. WSI feels that the manner in which it is currently reporting the performance evaluation recommendations is the most appropriate. WSI will consult with the Board Audit Committee to determine whether a snapshot of the biennial performance evaluation should be included within the operating report the fourth quarter of each year immediately preceding the next performance evaluation.

Octagon Reply to WSI Response:

A biannual calendar year fourth quarter snapshot of the status of performance evaluation recommendations in the operating report would satisfy this recommendation.

The operating report is an evolving document, as the changes over the last year and a half attest. New readers of the report, such as new Board members, may have less understanding of the report contents than is desirable. For example, and as noted above, not everyone reviewing the report had a good idea of what was being measured in the customer satisfaction employee survey.

Recommendation #13

For the operating report, we recommend that WSI should have training information that provides context for the data contained therein. This training information should provide a general description of the

material presented in the report including projections and targets, the purpose for each measure, and an explanation as to how each data point is derived.

Priority Level: High

WSI Response: CONCUR

WSI will create a support/training document that provides detailed information regarding the performance measures contained in the Operating Report.

As we noted earlier in this section, certain business segments have few or no measures that are captured in the operating report. This does not mean measures for those departments are not available elsewhere. For instance, significant utilization review (UR) statistics are captured regarding that department's performance but no UR measures are included in the operating report.

Recommendation #14

In the event such a process is not already in place, we recommend WSI managers review their measures carefully to notice trends, and that where significant progress or adverse trends emerge that they alert senior managers.

Priority Level: High

WSI Response: CONCUR

WSI will continue to work with the department managers and encourage them to set time aside in their regular department meetings to review measures including a review of trends and to bring these items to senior management.

We noticed a few errors in some of the operating reports. For instance, some of the legal projections in the December 2005 operating report had not been updated when compared to the September 2005 report. We don't believe a recommendation is necessary for this finding, but would encourage WSI staff responsible for each segment of the operating report to validate carefully its contents before the report is published.

In looking at other measures and data collection that is accomplished by WSI, we observed the following:

- PPI benefits paid in 2005 were the lowest over the last eleven years
- A measure exists to identify how much WSI receives in third party recoveries
- Prescription costs are tracked to examine cost containment progress made with the pharmacy benefits manager program
- Pending counts on claims rose in the first quarter of calendar year 2006, likely because of the need to identify ICD9 codes as part of the case set-up
- The Utilization Review reports generally show a return on investment measure
- The Preferred Worker Program is a valuable program available to employers
- Data on the costs paid to private investigators is somewhat misleading due to changes made in the way investigations are assigned and managed. Private investigations are now defined as costs strictly related to potential fraud. The previous distribution of work with private investigators did not make this distinction as effectively.

Recommendation #15

We recommend the following actions with department measures:

- a) A third party recovery measure will be of greater value if WSI also provides third party recovery potential as part of its analysis. On an ongoing basis, WSI would then know what percentage of recovery potential is actually being recovered.
- b) For prescription costs, provide footnotes to identify when coding changes occurred such that pharmacy costs paid in hospital settings were added to the paid pharmacy total. Some of the growth in pharmacy expense as captured in department measures is simply the result of a coding change, not an actual increase in pharmacy costs.
- c) For measures that graphically show a return on investment, add a line of demarcation at the \$1.00 level. Anything above the line would show a positive return, while anything below would show a net loss.
- d) Develop a measure within the return to work department that identifies, as a result of the preferred worker program, the salaries reimbursed, the premium saved and the worksite modification costs. As these measures are developed, consider them for inclusion in the operating report, particularly in light of the vocational changes that have occurred due to HB 1171.
- e) In addition to capturing the cost of private investigations, also capture the cost of field investigations in the operating report. This information approach will then give a better picture of how investigations and costs associated with those investigations are not only declining but also shifting. The current depiction of investigations expenses distorts the savings that have been achieved.

Priority Level: Medium

WSI Response: **PARTIALLY CONCUR**

- a) **DO NOT CONCUR** -- Potential recovery is based on multiple factors, which are too speculative to accurately quantify. What adds complexity is that when a third party settlement is reached, WSI's subrogated interest is 50% of the settlement amount. However, if the amount expended to date is less than that amount, WSI only recovers what it has expended to date. The balance is set up in the form of suspended benefits. Future benefit payments are then offset against this amount until it has expired. Thus, the organization has credit rights in certain instances. To the extent a claim has additional payment activity future recoveries will be made. On the contrary, absent further payment activity, there are no additional amounts to recover.
- b) **CONCUR** -- Footnote will be added.
- c) **CONCUR** -- A \$1 demarcation line will be added.
- d) **CONCUR** -- The salaries reimbursed data is currently captured by Preferred Worker staff; the premium saved data is available from the Employer Services unit; and the worksite modification costs data is currently captured by Preferred Worker staff.
- e) **CONCUR** -- WSI will include field investigation expenses and associated savings in the Quarterly Operating Report.

ELEMENT TWO - EVALUATION OF SAFETY AND LOSS PREVENTION PROGRAMS

Objective

WSI operates a work safety and loss prevention program for its covered employers. As described in NDCC § 65-03-04, its goal is “to protect the health of covered employees and the financial integrity of the fund, including programs promoting safety practices by employers and employees through education, training, consultation, grants, or incentives.” Our objective was to evaluate the administration of WSI’s work safety and loss prevention programs. To achieve this objective we reviewed the purposes of the programs to ensure that the programs are being completed as defined and that these programs are effective in supporting WSI’s overall work safety and loss prevention efforts, as defined in NDCC 65-03-04.

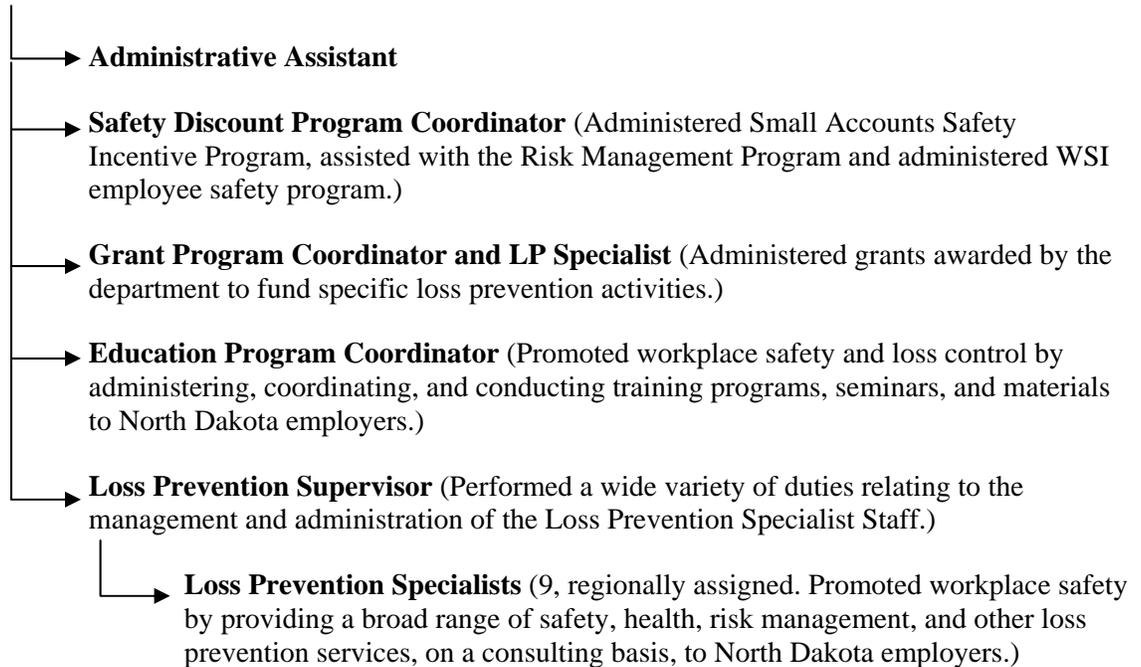
As noted, this evaluation covers the Loss Prevention activities from 1/1/2004 through 12/31/2005. However, significant changes for both the organizational design and work practices were being planned during 2005. Much of the groundwork for these changes was laid between July 2005 and December 2005, with the major changes in programs beginning in January 2006. It would be misleading and inaccurate to only comment on the two-year period without also including mention of the significant changes that were planned and are in progress of being implemented. Therefore, much of the discussion will focus on the state of the program during the two-year evaluation period, the appropriate next steps given that state, and then the new changes that are already addressing the areas for improvement. The suggestions that are provided are intended to build on the work that is already in progress since January 2006.

Overview and Analysis

The Employees of Loss Prevention Department

In 2004, the Director of the Loss Prevention/Risk Management Department reported to the VP/Underwriting/Research and Development. The department was organized in the following fashion:

Director of Loss Prevention/Risk Management



The nine Loss Prevention Specialists served employers in the region to which they were assigned. During the initial year of employment with WSI, every Loss Prevention Specialist was required to attend the following training courses:

- OSHA 500 – 30 hour General Industry Train-the-Trainer,
- OSHA 501 – 30 hour Construction Industry Train-the-Trainer,
- National Safety Council’s Supervisory Development Course, and the
- National Safety Council’s Defensive Driving Course

They were also required to spend a minimum of three days of internal training with LP Education Coordinator, the LP Supervisor, and the Vice-President of Loss Prevention and a minimum of one week on-the-job training with a current Loss Prevention Specialist.

After the initial year of employment, each Loss Prevention Specialist was required to complete a minimum of 40 hours of training/education per year and a maximum of 80 hours of training/education per year (unless prior approval was given by the LP Supervisor or Vice-President of Loss Prevention).

The Loss Prevention Department’s Activities

Until approximately halfway through 2005, the Loss Prevention Specialists were expected to spend their time as depicted in the table below.

| Activity: | % of Time: |
|--|-------------------|
| RMP Activity – For employers who were participating in the RMP (Risk Management Program), specialists provided assistance with program audits and/or miscellaneous consultations. | 50-60% |

| | |
|---|-----------|
| Service Plan Activity – Specialists also were assigned five “service plan accounts.” These were generally either high-risk or high volume accounts that called for special loss prevention efforts. At the beginning of the year, the specialist drafted a customized plan to address this account and followed up during the year. | 15-20% |
| Safety Inspections – Specialists toured and inspected facilities for the purpose of identifying potential hazards for correction. | 10-15% |
| Training Activity – Specialists provided training on a variety of topics. The audience may have been a specific company, an association, or even a conference. | 5-10% |
| RMP Recruitment – Recruited participants for the RMP program. | 5-10% |
| SASIP Activity – A specialist could recruit employers to participate in the SASIP (Small Account Safety Incentive Program). SASIP offered an 8% discount to participants who implement four program elements. To employers who participated in the program, specialists might have provided consultation or assistance with running their program. | As Needed |
| Accident Investigation – Specialists provided assistance with collecting the information surrounding the occurrence of an accident. | As Needed |
| Loss Control Activity – Specialists provided general loss prevention consultation to employers not participating in the SASIP or RMP. Such services may have included activities with specific employers, or it may have included participation in general safety associations, WSI seminars, or trade shows. | As Needed |

As is evident from the table above, most of the Specialists’ efforts were to be focused around customers who were RMP participants.

In addition to the efforts of the Loss Prevention Specialists, the Education Program Coordinator planned 78 different safety-related seminars in 2004 (34 of them were SASIP seminars) and 101 in 2005 (39 of them were SASIP seminars).

The Loss Prevention Department also administered the grant program. Several contracts or grants managed by the department are the result of the Safety Partnership Initiative. The purpose of the partnership was to enlist specific loss prevention expertise, targeted to high-risk industries to reduce the incidence of workplace injuries. At the time of our last review in April 2004, the Grant Program Coordinator was managing 12 active grants, only three of which were used for the salary and benefits of a full time professional targeted to a specific area (such as the Associated General Contractors (AGC) or the ND Association of Counties). The rest of the grants were applied toward smaller, more specialized projects. An example of this type of contract would be the one awarded to ND Metro Fire Chiefs Association to enhance fitness programs and establish an incentive award program.

Changes in the Loss Prevention Department

In 2005, WSI was reorganized to combine Loss Prevention Services and Policy Holder Services under the same heading of Employer Services. The Chief of Employer Services was hired in March 2005, and one of his first activities was to evaluate the department and the services they provide. Some of his conclusions were:

1. Although loss prevention activities being accomplished by the department were numerous, they were not as focused as they could be, nor were they achieving the results in reducing claims. Specialists tended to service as many companies as possible, rather than focusing on the high injury/high premium accounts.

2. The safety discount programs they were managing were “paper programs.” It was unclear if the customers were actually implementing the programs, but as long as their documentation was clear and complete, then their discount was always approved.
3. Loss Prevention Specialists tended to do safety for their customers instead of teaching them how to become self-sufficient.
4. The Loss Prevention Specialists weren’t as technically knowledgeable as they should be and none of them were certified.
5. Teamwork between departments, such as between Loss Prevention and Policy Holder Services, seemed to be missing. He noticed that employees tended to work in “silos” while not necessarily partnering with other departments of the agency.
6. The focus on ergonomic solutions with the customers was not as strong as it should be, as many of the claims were ergonomic related.

So, given these conclusions, many departmental changes were implemented beginning in January 2006. To evaluate the safety and loss prevention programs of 2004 – 2005, and to determine whether they are now moving in an appropriate direction, we interviewed the Chief of Employer Services, the Director of Loss Prevention, the Director of Research & Technical Support, the Director of Loss Control, two Loss Prevention Specialists, the PHS Technical Advisor, the Grant Program Coordinator, the Program Evaluator, the Loss Control Specialist, and one of the Employer Services Education Coordinators. We collected written policies and procedures, job descriptions, forms, training materials, descriptions of the two incentive programs – the Safety Outreach Program (SOP) and the Risk Management Program Plus (RMP+), and a description of the Hazard Elimination Learning Program (HELP). We reviewed the activity files of approximately 20 high premium/high injury frequency employers. Finally, we also looked at a number of safety consultation services offered by other states.

Compliance with North Dakota State Law (NDCC § 65-03-04).

This section of the code states WSI “shall create and operate work safety and loss prevention programs to protect the health of covered employees and the financial integrity of the fund, including programs promoting safety practices by employers and employees through education, training, consultation, grants, or incentives.” Our finding is that WSI does indeed comply with this law, as it provides:

- Consultation with employers on health and safety matters
- Grants available for funding engineering controls
- An incentive program for employers to implement effective health and safety programs.
- Employer education in various forms.

Comparison with Other State Programs

In a cursory review of the loss prevention consultation services offered by nine other state workers’ compensation bureaus/state funds (namely, California, Minnesota, Montana, New York, Ohio, Texas, Utah, Washington, and Wyoming), we find the services and programs offered by WSI to be comparable. Most of these other states provide some sort of health and safety consultation program (free to participating employers), and training to employers/employees. Most also offer a video library and several on-line resources. However, only three of the above states (Wyoming, Ohio, and California) offer a financial incentive for participating in a program that consists of implementing safety programs/practices. The North Dakota safety incentive program is similar to those required by other states in that they all are results-driven. For example, the number and/or the severity of injuries must be reduced in order to qualify for the discount.

Focus Shift to High-Risk Employers

As mentioned previously, the loss prevention activities being accomplished by the department during 2004-2005 were numerous, but they were not necessarily focused. Specialists tended to service as many companies as possible, rather than focusing on the high injury/ high-risk accounts. To confirm this, we pulled the records for 20 employers that had some of the most severe and most numerous claims. In reviewing both the notes on the PICS system and in the paper files, we found that many employers were not visited beyond the annual RMP review. For those employers who were visited more than once per year, it generally only consisted of an additional accident investigation or a safety inspection. As this group of employers accounted for the most frequent and most expensive injuries in the state, more prevention efforts could have been focused here.

Recommendation #16

We recommend WSI focus the majority of loss prevention efforts on high-risk employers rather than spending significant amounts of time on employers that are not.

Priority Level: Low

WSI Response: CONCUR

Three primary high-risk industries (nursing homes, hospitals and equipment manufacturing) were identified that drive 40% of the claims filed. WSI implemented a new safety consulting effort titled "Safety Outreach Program" effective January 2006 to assist these high-risk industries. The purpose of the program is to teach high-risk employers how to effectively implement safety management systems.

Recommendation #17

We recommend WSI consider a thorough evaluation of the Safety Outreach Program (SOP) after it has been in place a year to determine if there are ways it could be enhanced. For example, how many employers chose to participate in the program vs. how many were invited but chose not to participate? Of those who chose to participate, how many are beginning to experience lower claim severity (even if their frequency has slightly increased)? Can employers be surveyed for their feedback regarding the program? Did the Loss Prevention Specialists have the technical expertise to assist with the specialized issues that came up within their SOP accounts? If the number of SOP accounts per Specialist is increased in the next year or two, will they still be able to have a maximum impact on the high-risk claims?

Priority Level: Medium

WSI Response: CONCUR

An annual analysis of the Safety Outreach Program to determine areas of enhancement was planned during its design.

We are pleased to see that plans are being made to enhance WSI's website so that employers, such as those who are not participating in the SOP, will find many more self-help resources online. However, consider how the employers of North Dakota will accept the change to going "high tech, low touch." This is a significant paradigm shift for many, as they are used to having the personal interaction with their Loss Prevention Specialist. Consider ways to ease the transition to "high tech, low touch."

Recommendation #18

We recommend WSI ensure that the website is well designed, easy to navigate, and widely publicized. Also, consider providing some sort of in-person technical assistance, especially when the website is new,

which might consist of providing a few training classes in various locations around the state or being available to answer questions by phone.

Priority Level: Medium

WSI Response: CONCUR

WSI will provide enhanced web products that are well designed, easy to navigate, and that include a built in support system. WSI will partner with recognized professional vendors in the development of these applications. It is also WSI's intent to utilize the internal resources available to coordinate a statewide marketing campaign to introduce the new learning initiative.

Ergonomics

The focus on ergonomic solutions with the customers is not as strong as it should be, as many of the claims among employers are ergonomic related.

Recommendation #19

We recommend WSI consider whether there is a need for the Loss Prevention Specialists to attend specialized ergonomics training, particularly training that is focused on the high-risk industries such as health care or manufacturing. Further, we understand there is a possibility that WSI might hire a Safety Technical Advisor that specializes in Ergonomics. If this hasn't been done already, we recommend WSI pursue this option.

Priority Level: High

WSI Response: CONCUR

Ergonomics education for all Loss Prevention Staff will continue with further education for the staff in FY 2007. Additionally, WSI will continue its efforts to recruit a Certified Ergonomist.

Results-Driven Incentives

During the interviews, it was mentioned that the safety discount programs managed during 2004-2005 were simply "paper programs," and that often Loss Prevention Specialists only looked into whether employers had complete documentation before approving a program for a discount. It was felt that discounts were too easily given and they were not earned by truly implementing a successful safety program. Whether this holds true for all employers who participated in the original RMP discount program is difficult to verify. However, since a sizable discount in premium is on the line for those who do comply, it is very reasonable to expect to hold an employer accountable by measuring the results of their program before automatically giving a discount.

Recommendation #20

We recommend WSI reward employers with discounts only if they achieve certain results, not if they just have the appropriate documentation.

Priority Level: High

WSI Response: CONCUR

The SOP and RMP+ programs created in 2005 both address this recommendation. The SOP provides employers with potential premium discounts for:

1. completing actions aimed at reducing injuries,
2. reducing the frequency rate of claims,

3. reducing the severity rate of claims, and
4. a bonus discount for achieving a reduction in both frequency and severity rates.

The RMP + program is similar to the SOP, with potential premium discounts for the following performance measures:

1. reducing the frequency rate of claims,
2. reducing the severity rate of claims, and
3. a bonus discount for achieving a reduction in both frequency and severity of claims.

Note: We are pleased with the recent direction of the new RMP+ discount program, which requires reductions in claim frequency and/or claim severity before receiving any premium discounts. Similarly, the SOP requires the employer fully commit to follow through with a completely customized plan to reduce injuries. The implementation of these two programs essentially satisfies this recommendation.

Links and Teamwork Between Loss Prevention and Policy Holder Services

As determined by Chief of Employer Services' evaluation, teamwork between departments, such as between Loss Prevention and Policy Holder Services (PHS), seems to be lacking. Employees tend to work alone, without partnering with other departments of the agency. Even though the departments were reorganized at the beginning of this year so that Loss Prevention and PHS are within the same organization, most employees when interviewed could not describe practical examples of linkages between PHS and Loss Prevention. As such, teamwork within the group seemed lacking.

Recommendation #21

We recommend WSI continue to foster teamwork between departments in inter-department meetings (at more than just the Director level), in-services training, and by identifying situations where teamwork has been or could have proven helpful. In cases where teamwork proves helpful, publish the case studies internally. And, where possible, assign appropriate projects to several departments, so that they can work together.

Priority Level: Medium

WSI Response: CONCUR

In an effort to foster communication and provide up-to-date knowledge of the activities, the Employer Services Group will continue to hold cross-functional meetings. Monthly staff meetings have also been reorganized to allow for internal department growth. The focus is on education for all employees of Employer Services, to include inter-department education, as well as professional development training. Additionally, cross-functional teams have been formed to implement the various outcome strategies.

Expertise of the Loss Prevention Specialists

As with any occupation, the Loss Prevention Specialists should have the tools and expertise they need to accomplish their job. It appears that many of the Loss Prevention Specialists don't currently have a formal education in employee health and safety (such as a Bachelor's degree in Safety or a Certified Safety Professional designation). Instead, they have learned their trade on the job. As a result, ensuring that these individuals receive continuing education is crucial.

We recognize that WSI has recently taken a more pro-active approach to train Loss Prevention Specialists to be effective consultants, and that this training will be customized according to the needs of each Loss Prevention Specialist, instead of each specialist having the same training.

Many of the Loss Prevention Specialists seem a bit unsure of how to compose specialized action plans for their clients as they are used to the old way of doing things (i.e., auditing a paper program is very different from assisting with an ergonomic assessment). For example, the Director of Loss Prevention might consider partnering with each of the Loss Prevention Specialists as they compose their initial action plans with the SOP employers, meet with the employers, etc., until the specialists are comfortable with this high-level type of planning.

Recommendation #22

To ensure that each Loss Prevention Specialist receives adequate continuing education, we recommend WSI include in the annual performance review a certain number of personal educational hours for each specialist, ensuring that a variety of topics are covered from year to year.

Priority Level: Medium

WSI Response: CONCUR

The Loss Prevention Specialists (now titled Safety Consultants I and II) have a measurement/goal to seek professional development, with a goal of 10% of their time allocated to professional development. Additionally, the new Employee Performance Management System offers a feature for Development Plans for each employee. The Loss Prevention Team will be utilizing this element to guide each team member in the successful completion of goals, as well as continued professional development initiatives.

Recommendation #23

We recommend WSI consider offering employees an incentive for becoming certified, whether it be in the form of salary, job title and duties, or both.

Priority Level: Medium

WSI Response: CONCUR

The Loss Prevention Department has created a second level classification (Safety Consultant II) and increased the salary range. This position requires additional education, knowledge, responsibilities, and certification in the field of safety and health from a recognized organization (CSP, CIH, OHST, etc.).

Note: We understand that the implementation of this recommendation is already in progress, working in conjunction with the Human Resources Department.

Recommendation #24

We recommend WSI consider providing additional staff development/guidance concerning safety consulting (in their new role).

Priority Level: Medium

WSI Response: CONCUR

WSI is committed to providing external resources for staff development/guidance in the safety consulting arena. WSI's proposed FY 2007/2009 biennial budget includes an increased request for training dollars for the agency.

Loss Prevention Specialist Performance Evaluations

The Director of Loss Prevention indicated that Loss Prevention Specialists would likely be evaluated based on the following criteria:

- Did the Department reduce overall claims by 10%?
- Did the Department reduce the frequency rate of all the SOP participants by 15-20%?
- Did the Department reduce the severity rate of all the SOP participants by 15-20%?
- Did the Loss Prevention Specialist reduce the frequency rate of his/her SOP participants by 15-20%?
- Did the Loss Prevention Specialist reduce the severity rate of his/her SOP participants by 15-20%?
- Did the Loss Prevention Specialist spend 5-10% of his/her time in professional development?
- Did the Loss Prevention Specialist spend 35-45% of his/her time onsite with policyholders?
- Did the Loss Prevention Specialist meet his/her personal goal(s), (e.g., improving technical writing capabilities)?

Performance based measures, such as the reduction of claim severity or frequency, can be helpful to determine whether a specialist is effective. However, frequency and severity reductions are not the only measure of performance. These numbers also need to be interpreted carefully, as there are *many* factors that can contribute to the number or severity of claims being reported at a particular facility, and many of these factors will not be within the control of the Loss Prevention Specialist.

If performance-based measures are to be used, consider those related to the severity of claims. Also, consider how the claims department and the employer may have a greater impact on severity than may the loss prevention specialist.

If frequency is measured, then consider incidence rates (such as the number of claims per a specific payroll measure) rather than a simple frequency. Consider measures over longer periods of time (such as annual), rather than those over a shorter period of time (such as monthly) that could fluctuate easily.

For example, if the criteria listed above are to be used, we might suggest lowering the required percent reduction of overall claims, or perhaps applying a smaller weight to this measure. This measure applies to employers of all types – both high and low risk employers. For low risk employers, it may be very difficult to achieve a reduction in claims, since the number of claims is so low in the first place. Other measures might be more appropriate to apply to low-risk employers, such as the proactive measures they have taken.

Recommendation #25

We recommend WSI develop performance measures that reflect the client mix of a loss prevention specialist, that as suggested above, take into account different performance expectations that may exist for high v. low risk employers, that consider the extent to which loss prevention specialists control severity, and that examine how loss prevention specialists have worked with employers to implement effective safety programs.

Priority Level: Medium

WSI Response: CONCUR

WSI adopted a new employee performance management system that was introduced in August 2006. The new system will allow for new goals in November 2006, which will be measurements for the Safety Consultants in 2006-2007. The goals of the Loss Prevention Staff will be closely aligned with the established Outcomes and strategies of WSI. The primary focus areas will be:

1. Reduce employer claim frequency rates by 10%
2. Ongoing Staff Development

ELEMENT THREE – EVALUATION OF INFORMATION TECHNOLOGY

Objective

The objective of Element Three of the WSI Performance Evaluation was to evaluate the following components of the Information Technology department:

1. Determine whether the Information Technology (IT) section of WSI is being managed in an effective, efficient, and proactive manner.
2. Are on-going maintenance costs being monitored and compared against the cost of replacing ineffective or inefficient systems?
3. Are the policies and procedures used for IT project management effective and being followed?

Key Activities

Our approach to address these three topics utilized a combination of existing process, procedure, and work product documentation review and face-to-face interviews with IT management, IT staff, and internal IT customers to build an analysis of current operations and make recommendations for future enhancements.

Throughout our review of Element Three, you may see commentary that addresses the current state of the IT operation in addition to our observations about the way the IT operation functioned during the performance evaluation period. We are providing this commentary as a way of differentiating circumstances where recommendations are needed from those where sufficient progress has been made in an area, thereby negating the need for a recommendation.

Overview and Analysis

Information Technology – Organization Structure

The Information Technology (IT) department of WSI consists of three functional units led by a single Director. Each of the three functional units, Application Services, Business Services, and Technology Services, are led by a Supervisor. Together, the Director and Supervisors make up the IT management team. Overall, WSI IT efforts are largely allocated to “keeping the lights on” (i.e., maintenance) and doing minimal enhancements, or upgrades to functionality; however, this conclusion is based on anecdotes as costs are not formally tracked nor allocated toward the type of work done. A summary of the focus of each functional section follows below.

Application Services – Software and application development experts: This area is responsible for software and application development and maintenance to existing systems and applications, including technical design, code development, and code testing. The roles in this area are:

- Supervisor (1)
- Software Engineer (9)

Business Services – Technical liaisons with business customers: This area is responsible for prioritizing IT’s work with business customers, applying project management structure to large projects, and working with business customers to translate their needs into detailed business requirements, which can be understood by technical developers (i.e., Software Engineers). The roles in this area are:

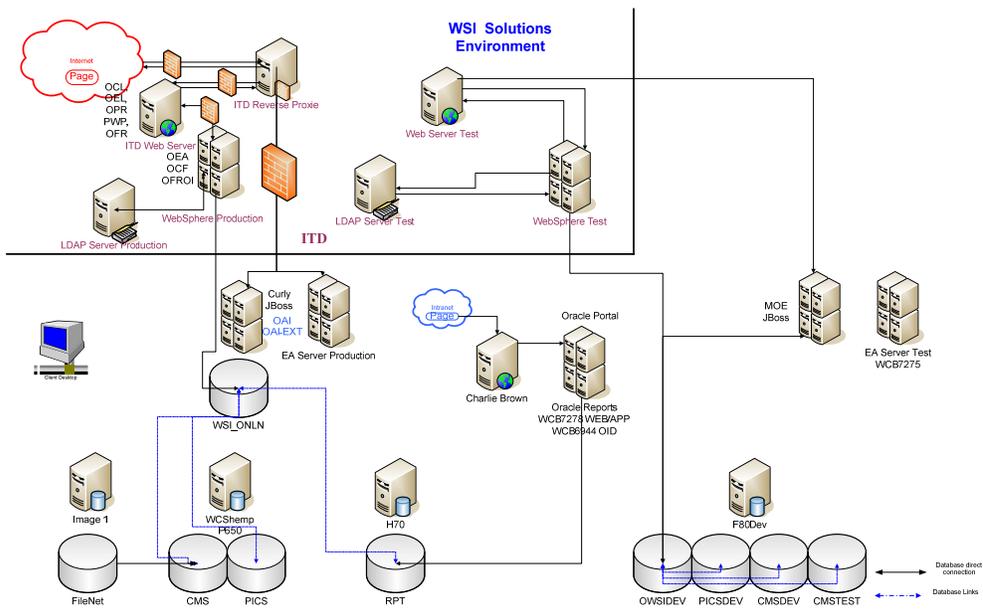
- Supervisor (1)
- Project Manager (1)
- Business Analyst (3)

Technology Services – Data and ongoing technical operations support: Typically, the responsibilities of a group like Technical Services are invisible to the average end user with the exception of the Help Desk. This group is responsible for such things as database administration (ensuring the security and integrity of WSI’s internal and customer data), system administration (ensuring the proper functioning of servers, security of the IT environment, and desktop security of the end user), and user support (referred to as the Help Desk). The roles in this area are:

- Supervisor (1)
- Database Administrator (DBA) (1)
- Systems Administrator (1)
- Systems Analyst (1)
- Help Desk Technician (1)
- IT Technician (1)

Together, the three IT units support WSI’s systems and applications. The core systems and applications referred to in this report, as well as a brief description of each, is below followed by a complete system diagram outlining all of WSI’s systems, applications, and servers. This review focused on how well IT supports WSI through its processes, procedures, and practices, not how well the specific systems and applications perform. The system diagram below provides some insight into the scope of IT’s responsibilities, but it is not necessary to understand the diagram in order to understand the recommendations in this report.

- *Claims Management System (CMS)* – Used by Injury and Medical Services to process claims and claims related information
- *Policy Holder Information Computer System (PICS)* – Used by Employer Services to maintain policy holder information
- *Oracle* – Used to store data and generate reports by IT staff and business customers
- *HEAT* – Used by IT to track Help Desk calls (i.e., “tickets”) and all requests for IT work



Face-to-face interviews were conducted with several individuals and groups:

- The IT Director and Supervisors were interviewed to get an understanding of the overall operational performance of IT including: communication, vision, planning, standards and measures, and performance.
- Software Engineers (6) were interviewed either individually or in small groups with a goal of understanding the process and standards by which IT creates, tests, and documents systems and applications. Information was also sought to confirm the extent these processes and standards are practiced. The staff interviewed represented all of WSI's supported applications and systems. Schedules and time constraints did not enable three Software Engineers to participate in the interview process.
- The Business Services (4) interviews focused on understanding the change management and project management processes and the extent to which they are practiced. Questions also centered on the extent to which Business Services knows, understands, and supports its business customers.
- All Technology Services staff (4) participated in interviews focused on understanding the data and system security and maintenance processes and procedures and the extent to which they are practiced. Additional questions focused on the Help Desk policies, procedures, and practices. Questions for the Database Administrator focused on understanding how applications or systems, once development is completed by Application Services, get moved into a "production" environment, or implemented for use by the intended audience.
- Lastly, representatives (6) from each of the key customer areas supported by IT were interviewed to assess the effectiveness and efficiency of the support IT provides. Those customer areas were: Injury and Medical Services, Employer Services, Support Services, and Legal. Questions focused on results as compared to business need, communication and responsiveness, and overall satisfaction with IT's services.
- The CFO was also interviewed to more fully understand the IT budgeting process.

Effective and Efficient Management of the Information Technology (IT) Section of WSI

Critical elements of effective, efficient, and proactive management of IT operations include:

- A cohesive and communicative management and organizational structure
- Strict control over data and the platforms, systems, applications, and tools to manage the data
- Ability to understand, assign and distribute, and predict work
- Staff that understand their roles and their operational policies and procedures
- Deep knowledge of the customers being supported.

WSI IT is successful because of its dedicated, mostly tenured staff. Management, staff, and customers all agree that the staff is dedicated and hard working and come together effectively in a crisis to solve problems.

Challenges arise in managing efficient, effective, and proactive day-to-day operations. WSI IT has made many improvements during the performance evaluation period of January 1, 2004 through December 31, 2005. Namely, three current initiatives are core components of future success in ongoing effective, efficient, and proactive IT operations management.

First, WSI IT is on the cusp of implementing a change management process to prioritize work. A critical component of this Change Management process is that the business units have accepted accountability and responsibility for determining business priorities. Second, a project management methodology is also newly implemented within the IT department. Third, all customer requests must be logged into HEAT, a

tracking system for change requests. The combination of these three initiatives provides a solid foundation for creating a high-performing IT department.

A Cohesive and Communicative Structure

Communication is the biggest issue faced by WSI's IT department. IT Director and Supervisors disagree philosophically on the direction and operations of the IT department (e.g., business driven or development driven). Their disagreements are evident both to the IT staff and internal customers and are negatively impacting productivity. The root cause dates back to 2004 over the disagreement on which web development platform to pursue. An agreement was reached; however, the developers did not agree with management and purchased a separate web development product. Today there are several web development products used by WSI causing a drain on IT resources and limited success of the web applications.

On some occasions when the IT management agree on something (e.g., the recent new organization structure), they do not share the information or agreement with their staffs; however, staff know very well when the management team disagrees on an issue.

Organization roles and responsibility division is generally good since the late 2005 organizational realignment with some improvement needed on controls that safeguard data. Further separation of some roles and clarity between others would improve those controls (see Recommendation #29). Due to the small scale of the IT operations, supervisors also play an active role in the core IT functions leaving little time for proactive management of the operations. Some of the role and responsibility sharing is done due to operating a small shop with many different systems and platforms to support.

In contrast, there is confusion, misunderstanding, and overlap between the Business Analysis and Development functions causing duplicate efforts, productivity drains, and friction among the staff. Business Analysts must be well versed in the business customer's processes and goals and are typically responsible for creating *business* process flows, soliciting and documenting *business* needs, and translating those needs into *business* requirements documents. They need to think like the customer. Business Analysts bring a strong technical understanding to their role in order to help them ask good questions of their customers and to help them respond to questions from the Developers.

Developers (Software Engineers) should be focused on *how* to *technically* implement the business needs using the business requirements as their guide. They typically develop *technical* requirements from the business requirements to provide a plan for developing the solution. In the information technology industry, Developers are also responsible for creating a system flow – a diagram that shows how data is displayed, stored, changed, and reported. At WSI, Developers tend to take on a lot of business analysis functions and Business Analysts tend to take on some development functions, given their strong technical backgrounds.

For an organization this size, it is critical for WSI IT to get the most out of its human capital and should therefore make it a priority to get the most out of its testing, monitoring, and other automated tools in addition to more clearly defining some of the roles and responsibilities. By enabling the staff to handle more work through automation, it will free up the supervisors to focus on more proactive management

Recommendation #26

We recommend the management team fix their communication issues, agree philosophically on being a business-driven IT department instead of a development-driven IT department, and keep their disagreements among the management only. To implement this recommendation, WSI should consider focused directives from senior staff up to and including the CEO. Note that this recommendation does not mean we expect the CEO and non-IT senior staff to direct technical issues, only strategic ones. WSI

should also consider the development, approval and implementation of policies and procedures that aim to prevent actions that run counter to the strategic intent of the organization.

Priority Level: High

WSI Response: CONCUR

Addressing the communication issue is a top priority. The IT Director has initiated bi-weekly leadership meetings with the Leadership and Organization executive. He has facilitated discussions to assist the leadership team in addressing communications and leadership issues. The IT Director has also initiated monthly meetings with this executive and the entire IT team to openly discuss issues with the team. From a corporate standpoint, the CEO has had an agency philosophy since 2004 that the business units drive the information technology decisions rather than the converse. WSI believes that the information system replacement initiative best exemplifies the incorporation of this philosophy. More than 80 business unit representatives worked on cross-functional teams to outline the business needs based on WSI's strategic plan. The replacement system(s) that will be selected will be based first on business needs and then on the technology used to fulfill those needs. To the extent that this philosophy may still require clarification, the CEO and the agency's senior management team will do so.

Recommendation #27

We recommend WSI focus Business Analysts on identifying the business need and business process flow vs. focusing on the technical solution.

Priority Level: High

WSI Response: CONCUR

WSI believes this recommendation is currently being met. The primary, focus of the Business Analysts is on defining and documenting business needs. Over the past few months, it has become a common practice to involve Business Analysts, System Engineers, and Business Representatives in meetings to discuss business requirements first and possible technical solutions to satisfy those requirements second. This enhanced level of involvement has proved to be an effective method of communicating and addressing business needs.

Recommendation #28

We recommend WSI expand the use of existing technical tools (such as automated system monitoring and application testing tools) on more applications and systems.

Priority Level: Medium

WSI Response: CONCUR

WSI currently has some automated application testing tools. WSI will investigate the implementation of additional system monitoring and application testing tools that may be available and beneficial to the agency for the next three to four years. WSI is in the process of a major system replacement project that will replace the majority of its core applications. Once the vendor is selected, WSI will be in a better position to make better longer-term implementation acquisitions associated with this recommendation.

Octagon Reply to WSI Response:

While purchasing additional tools for future system monitoring and testing may be helpful, this recommendation intends to make expanded use of existing tools already owned by WSI. Feedback gathered during the interviews indicated that there are existing tools that are either not being used or being used within a fraction of their capabilities.

Recommendation #29

We recommend WSI ensure there is a staff level resource cross-trained on the Database Administrator's functions to provide backup.

Priority Level: Low

WSI Response: CONCUR

WSI has hired an additional DBA, effective November 1, 2006, who will assist in maintaining the production database. Additionally, WSI has a multi-level backup plan in place.

Strict Control Over Data and Systems

WSI handles highly sensitive personal data for its customers. Virus protection, password access, and firewall security are in place and functioning well to protect WSI's data from external threats. Access to the data center is limited and secure. However, some of the practices internal to the organization, such as developers changing production data, put WSI's customer data at risk of corruption and hacking. Additionally, because of the small size of the IT staff often root-cause problems are not solved, but rather only the symptoms are treated. Examples of these practices are detailed below:

- Developers, with the approval of Injury and Medical Services, change reserves in the system when financial auditors are in and if the report does not match the system. No audit trail, or clear documentation showing what the reserve change was, when it was made, or who made it is reflected in the file.
- For two and a half years, about five bills per month are inexplicably not paid from the auto-adjudication process (process by which bills totaling up to \$1,500 automatically get paid according to the fee schedule). These bills are not caught as missed until they appear on the 60-day aging report. They are then fixed on a bill-by-bill basis. For example, bill number 12785470 in the amount of \$492.07 from March 2005 and bill number 12828231 from August 2005 in the amount of \$49.00 were not automatically paid through the auto-adjudication process even though they met criteria. IT cannot identify the underlying problem.
- While Visual SourceSafe, an automated tracking tool, does some tracking of code changes, not all code changes are documented or tracked.
- JBoss, one of the web development tools, has been installed on the root account for the Online Application for Insurance (OAI) project, which could provide full read/write/delete access to servers. Information Technology Department (ITD), the state of North Dakota's IT department, has insulated itself from WSI on this risk. WSI has hidden the screen that would provide access to this information. However, the access is not safe from hackers. The existing web developers have reached the extent of their JBoss knowledge in trying to resolve this security risk.
- System security options are limited on the two largest applications, CMS and PICS, and do not enable the optimum security configuration or set up.

The need for much of the in-production data changes is due to a poor mainframe data conversion several years ago. Data is grouped into "good", "mediocre", and "bad". WSI should not have any "mediocre" or "bad" data. These are not industry terms, but rather terms WSI has assigned to their data. No new system or application will ever fix the "bad" and "mediocre" data. If bad data is put into a system, bad data will come out of a system. This problem will persist until the data itself is cleansed.

Another result of poor data conversion was a decision by the business to write checks in advance of the system being ready. These checks were never tied back to any system for accounting. The impacts are still affecting account balances and current payments on some current accounts.

Recommendation #30

We recommend WSI complete the Data Integrity project and upgrade all “mediocre” and “bad” data to “good data” to increase the integrity of WSI data; eliminate the need for developers to change production data; and, free up business resources from efforts spent on manual workarounds.

Priority Level: High

WSI Response: CONCUR

In 2005, WSI established a cross-functional team that worked to identify, categorize and prioritize all data integrity issues. A multi-phased action plan was developed and implemented to address system deficiencies. In 2006, WSI implemented a new change management process. This process utilizes representatives from the major business units at WSI to prioritize all remaining data integrity issues from in 2005. WSI continues to actively work on its Data Integrity Project. All related tasks have been prioritized and scheduled into future releases of the core applications. An effort within the preparation phase of WSI’s System Replacement Project focuses specifically on data cleansing. WSI will ensure that all data is cleaned with a level of integrity sufficient for migration into the system.

Recommendation #31

We recommend WSI immediately cease the practice of developers moving code to production and changing production data. The Database Administrator (DBA) should be the only one who performs these functions.

Priority Level: High

WSI Response: CONCUR

WSI currently does not allow developers to move code to production. The process for moving application code to the production environment is done exclusively by the DBA. WSI will eliminate any potential future need for developers to change production data by hiring an additional database administrator. It will also be an expectation that when the new applications from the major system replacement project are placed into production, the DBA will be the only role allowed access to change production data.

Recommendation #32

We recommend WSI investigate and correct the problem for why reserves on a report do not always match what is in the system.

Priority Level: High

WSI Response: CONCUR

This recommendation will be completed as part of the Data Integrity Project. A new application for CMS will be deployed that uses the same logic for the calculation as the logic in the report.

Platform, system, application, and tool purchase or development decisions are often made without a formal analysis of the costs and benefits. Tools (such as testing tool SilkTest) are purchased to solve a specific business need v. analyzing the overall impact of a platform, system, application, or tool to the long-term goals of the IT organization. As a result, IT manages far too many systems, applications, and platforms for a business the size of WSI.

This is especially true of the web development platforms. There are three different web development platforms: Java, OpJ (OJ Tool), and JBoss (OJ Tool currently not in production because of instability). ITD can only help support Java. Further, the one dedicated web developer is self-taught on these platforms and needs to know a lot of information to be effective.

WSI's internal and external customers are moving towards more electronic commerce and it is critical that WSI IT can support this evolution on a unified web development platform. The web applications currently do not support a lot of WSI transactions, but the business would like much more of their activity and transactions to be supported on the web. Decisions to purchase these tools were not supported by a strong analysis of the on-going costs anticipated to support such a variety of platforms. While WSI's size and structure probably do not warrant a full-time architect, a contractual or shared architect resource with the state would provide a critical function to the IT department.

Recommendation #33

We recommend WSI employ the services of an IT architect to review major development and enhancement projects and the associated hardware and software associated with those activities. It would not be unreasonable for some assistance in this area to come through the state's ITD staff.

Priority Level: High

WSI Response: CONCUR

WSI has partnered with ITD on the system replacement project for architect services and will continue to partner with ITD and/or private consultants where appropriate. WSI agrees that an IT architect should have a role for the review of major hardware and software purchases associated with development and enhancement projects.

Recommendation #34

With the assistance of an IT architect, we recommend WSI determine a single web platform as WSI's standard and develop an actionable plan to migrate existing web applications to this platform.

Priority Level: High

WSI Response: CONCUR

WSI is currently in the process of planning for the replacement all core business applications --including web-based applications. Once the main system platform is identified, the most appropriate web platform will be selected.

Recommendation #35

We recommend WSI provide formal training to the web developers on the chosen platform.

Priority Level: High

WSI Response: CONCUR

Based upon the responses received on the System Replacement RFP, WSI will train its developers on the chosen platform. WSI's proposed FY 2007/2009 biennial budget includes an increased request for training dollars for the agency.

Recommendation #36

We recommend WSI hire technical development resources to secure the OAI/JBoss server or shut down the application until the data can be secured. This is critical from a security perspective.

Priority Level: High

WSI Response: DO NOT CONCUR

During the development and deployment of OAI/JBoss, WSI worked with ITD to secure this application and its data from outside risks. WSI recognizes that there is a potential security risk in any application; however, WSI believes that by working with ITD, the risk has been minimized. The JBoss application server has been installed under the JBoss user ID in the JBoss system environment, thereby mitigating the risk of full read/write/delete access to the servers. WSI will continue to work with ITD to further lockdown access to the server where possible. NOTE: Currently, WSI receives 50 percent of all insurance applications on-line. The potential business impact of removing this application at this time would not be in the best interests of the customers of WSI.

Octagon Reply to WSI Response:

Given the cost/benefit analysis done on this recommendation, we concur with WSI's response with the following proviso. Our assumption in the WSI response is that with the assistance of ITD, this application is now at no greater security risk than other similar applications. If that is not the case, then we strongly urge WSI to take additional security precautions to secure the application.

Back up procedures are documented and followed; however, the biggest data related issue is with the back up process. Back up data tapes are secured in a fireproof safe in a locked room in the basement of the WSI building. This does not meet industry standard disaster planning criteria – one of the largest natural disaster risks in North Dakota is flooding, which would impact the basement first. According to industry standards, data back-up tapes must be stored at a “distant” off-site location from the original data. The appropriate distant varies by state and location. In recent years the required distance has been growing due to disasters such as 9/11 and Hurricanes Katrina and Rita. Off-site storage can also be accomplished via online mechanisms eliminating the need for WSI to create physical back-up tapes.

Recommendation #37

We recommend WSI store its back-up data storage tapes off-site, not in the fire-proof safe in the basement of WSI.

Priority Level: Medium

WSI Response: CONCUR

WSI believes this recommendation is complete. WSI has completed negotiations with AllState Vault Services to provide off-site storage capability and the ability to ship backup media to our disaster recover site if the Business Continuity Plan is activated. WSI began shipping media to AllState during the week of August 21st, 2006. Allstate Vault provides a storage facility in Patterson, NJ, located 1600 miles from WSI. The facility is a 700,000 square foot structure with reinforced concrete construction designed to withstand catastrophic forces. Doors are guarded by keypad access, and walls are reinforced with a thick steel plate. In addition, Allstate has installed an array of central-station monitored security devices, including door contacts, infrared sensors, motion detectors, and photo beams. Backup tapes are shipped

in containers manufactured by Perm-A-Store, Incorporated the worlds leading manufacturer of permanent storage cases for vital computer backup tapes, brand name "Turtle." The "Turtle" containers have a hard shell on the outside that protects vital information on the inside. The "Turtle" cases are designed to protect tape edge damage from shock/impact, debris from foreign contaminants, and temperature/humidity extremes. NOTE: At no time was the basement safe either expected or planned to be a permanent solution. Prior to the purchase of the safe, the tapes we simply placed in an unsecured, closet off site. Placing the data in the safe designed to store electronic media until WSI could work out the permanent solution noted above was a significantly better temporary solution.

Work Distribution

The IT department has made excellent strides in its work tracking and management by requiring that all requests be entered into HEAT. This will give IT a single source to understand its work volume and make-up, source of work requests, the basis for cost analysis, and building blocks for historical reporting and proactive planning. It also provides a history and evidence of work performed.

Currently, only the Help Desk staff has authority to enter work requests into HEAT. Often, this means that other IT staff who receive the request directly have to hand off the entry to the Help Desk staff. Alternatively, some of those requests may never get tracked. Any time there is an unnecessary hand off, the risk of mis-communicating important pieces of information or delaying the entry increases. By allowing additional staff access to enter HEAT requests, there is still a central repository of work, yet the Help Desk staff is not unduly burdened.

Recommendation #38

We recommend WSI expand the entry of HEAT requests to Software Engineers, Business Analysts, Project Managers, and Business Representatives.

Priority Level: Low

WSI Response: PARTIALLY CONCUR

Current WSI procedures allow software engineers, business analysts, and project managers to enter HEAT requests. A decision was made and supported by the business representatives, that they would not enter HEAT requests. The business representatives have access to reporting and query functions within HEAT.

Octagon Reply to WSI Response:

We believe that expanding entry of HEAT requests to all IT staff yet limiting business representatives access to reporting and query functions is a good alternative. As the process evolves and matures, we encourage IT to consider having business representatives, on a limited basis, enter requests directly to streamline the entry process.

However, having all HEAT requests reviewed by Business Analysis prior to being assigned is creating a bottleneck and will create a growing backlog of requests. IT is planning to identify "cookie cutter" work that can be immediately assigned to certain IT staff without going through the prioritization process. The practice of streamlining the distribution and execution of work that can be done quickly without impact to existing priorities is in line with industry standards. Items with limited work effort such as table updates, security access requests, employee separations, data fixes, and data entry errors can and should be directly routed to assigned individuals and bypass the prioritization process.

Recommendation #39

We recommend WSI identify the types of work that can be directly routed to the assigned individual.

Priority Level: High

WSI Response: CONCUR

WSI believes this recommendation has been implemented with the IT Change Management process. In July 2006, WSI reassessed and refined the process of direct routing of HEAT calls as part of the IT Change Management Process. This process identifies the types of work that can be directly routed to an individual. This process has been documented as part of the IT Change Management Process.

Also integral to effectively, efficiently, and proactively managing IT's workload is the ongoing implementation of the change management (prioritization) and project management processes. Most every IT organization struggles with prioritization, and especially recognizing the need for the business to have the ultimate accountability in making prioritization decisions. WSI has achieved the realization that the ownership over prioritization lies with the business. IT can help the business make intelligent choices by describing the relative technical impact of one decision over another. Or, for example, IT can provide insight when waiting for a system upgrade makes sense before implementing a functional enhancement.

Once implemented, the change management process will be the most important procedural improvement IT makes over the 2004 – 2005 review period, where work prioritization was based on the relationship with the individual developers or the requestor's status within the organization. In other words, who you were drove the priority of the request versus the real business value of the work driving the priority. Appropriate prioritization ensures that the work IT does holds value for its individual customers and the enterprise.

Once a project is prioritized with business and IT, customers want IT to use more rigorous project management and they like that it enforces accountability. A strong project management discipline combined with a review of regular IT management reports will aid in the early identification of project and IT resource risks which will contribute to the ability to proactively and effectively manage IT work.

Recommendation #40

We recommend WSI create and regularly (weekly, monthly, quarterly, and annually) review management reports from HEAT, including at the most basic level:

- Total number by type of request
- Total number of new, open, closed requests and time to resolve
- Total number of Requests per Customer by type of request

Priority Level: High

WSI Response: CONCUR

IT management will evaluate the reporting options available from the HEAT system and produce regular reports.

In the time frame of 2004 – 2005, it was commonplace for system fixes and enhancements to be moved into production as soon as development was completed. These practices created prioritization challenges, led to limited ability to proactively manage work, and provided little evidence that fixes or enhancements produced the desired result without impacting existing data and functionality. IT is moving toward a

release schedule for its two primary systems CMS and PICS which will help in the proactive management and prioritization of technical changes, quality control, and efficient use of IT resources.

As discussed earlier in the report, defining IT priorities is one of the biggest challenges organizations face and so many of those priorities are listed as “high”. It is a common mistake to have too many “high” priorities; however, as with all organizations, WSI has limited financial and human resources and can only focus on a limited number of priorities at any given time. The more requests that have a “high” priority assigned to them, the less meaning the priority levels have and the less efficient IT can manage their time and resources. Priority levels must have real meaning in an organization to be effective. All IT staff and Business Representatives should be aware of the definitions and their meanings.

Recommendation #41

We recommend WSI default priority type in HEAT to Low instead of High to force staff to look at the priority level and attach real meaning to it. Update the definitions of High, Medium, and Low, and synch them with the project management methodology.

Priority Level: Medium

WSI Response: DO NOT CONCUR

The HEAT system has a field that can be used to identify priority. WSI IT has decided to not use this field. Every request that comes to the help desk goes through a triage process that was developed when the change management process was implemented. As part of the triage process, the help desk gathers information from the customer, including the urgency and date needed. Large projects and items identified to the help desk, which require analysis and scheduling, are assigned to a business analyst, prioritized by the business representatives and the change management team and then scheduled accordingly. Items with limited work effort are directly routed to assigned individuals and bypass the prioritization process.

Octagon Reply to WSI Response:

HEAT should be updated to reflect the prioritization methodology identified through the change management process. The new prioritization definitions should also be incorporated into project management methodology documentation and practice. We recommend that the default priority either be blank or labeled “to be prioritized” so that all requests don’t end up being of the highest priority. From the prioritizing process, there should then be reporting capability to assess the importance and the number of outstanding projects, their deadlines, and the workload of the staff assigned to complete the projects.

Deep Customer Knowledge

IT knows their business customers well on an individual basis – personal relationships are strong and customers are empathetic to IT’s efforts to accomplish what they do. However, IT is not well versed in the strategic goals of the business units they support, nor do the Business units formally share business strategy with IT.

Recommendation #42

On a quarterly or annual basis, We recommend IT and business unit management share formal business strategy and vision to enable IT to make more cohesive and cost effective decisions aligned with the strategic goals of WSI.

Priority Level: High

WSI Response: CONCUR

A long range strategic IT plan based on organizational and business needs has been developed to support WSI's strategic direction for the next 8 to 10 years. This plan will be reviewed on a routine basis with the applicable business units to assure adherence to expectations.

Customers are frustrated with the speed and fit of solutions, the availability of IT staff, and that they cannot get good business intelligence from their existing systems. Support was noted to be lacking particularly in the late afternoons and on Fridays when many IT staff take advantage of flexible work hours. Even though cell phones and pager contact information is provided to customers as a backup, they do not feel remote support meets their needs. The Help Desk did receive high marks from internal IT staff and customers noting an increase in responsiveness from IT. However, there are times when the Help Desk is unmanned, which is frustrating to customers who have grown to depend on the Help Desk. A Help Desk should never be unattended during business hours.

The Help Desk is good at ensuring items are logged, responding to individual callers, and being pleasant and communicative. Customers appreciate acknowledgement that their requests have been logged into HEAT yet they are frustrated when they do not know the status of their requests.

Recommendation #43

We recommend WSI determine a back-up protocol for the Help Desk for emergencies and mandatory staff meetings.

Priority Level: Medium

WSI Response: CONCUR

A back-up protocol and guidelines for maintaining help desk support have been developed.

Customers perceive that they must follow up and prod IT to get their requests resolved. They are often frustrated at not being able to reach IT staff for questions. Further, their perception is that IT does not maintain the same hours as the customers they support putting the burden on the customers instead of the service unit.

Recommendation #44

We recommend WSI acknowledge customer requests with the name of the assigned individual and an estimate of when the request might be resolved or when they may hear from someone with a status update.

Priority Level: Medium

WSI Response: CONCUR

The customer is given a single contact for each issue; however, the customer may not be given the name of the actual developer addressing the issue. To the extent possible, an estimated completion date will be given. On certain calls, though, it may not be possible to provide an estimate of request resolution until further analysis is completed.

Recommendation #45

We recommend IT staff maintain the same hours as the customers they support.

Priority Level: Medium

WSI Response: CONCUR

WSI IT will work with the business units to determine the exact core business hours and business functions that they expect to be supported. If after this review staffing changes are required, adjustments will be made where applicable.

Maintenance Cost Monitoring and Comparisons Against the Cost of Replacing Ineffective or Inefficient Systems

In our review, we found no evidence that formal tracking of on-going maintenance costs (such as, maintenance costs per system, cost of upgrades, cost of problem fixes, development versus maintenance costs) is accomplished other than by estimating the time spent on maintenance and multiplying that percentage by the cost of the IT resources.

While an independent study performed by Gartner estimated maintenance costs, there was no documentation justifying or sourcing those numbers. The maintenance costs in the Gartner study reflect a percentage of IT costs and do not attribute costs to any particular system, application, project, or business unit.

In addition to the lack of on-going maintenance cost tracking, there is very little performance metric tracking or standards in IT. There is manual calculation, tracking, and reporting of available hours, scheduled down time, and unscheduled down time for four core systems (PICS, CMS, Great Plains, and FileNet) and three core applications (Active Directory, Outlook, and the WAN). The three core applications are supported by ITD, not by WSI IT.

Further, customers do not have a concept of what IT has provided for them over any period of time nor the relative costs of those services.

Recommendation #46

At a minimum, We recommend WSI's IT department provide quarterly and annually reporting to customers outlining the number of requests by type and status and the percentage of IT costs attributed to a business unit (based on number, type, and time spent on requests).

Priority Level: High

WSI Response: CONCUR

WSI does not charge back costs to specific departments or business units, so this data has not been measured. WSI will review the possible development of a simple reporting tool to track basic cost drivers per unit.

Octagon Reply to WSI Response:

The intent of this recommendation is not necessarily to charge back the costs to the business units, but rather for IT to have good business intelligence on how to manage their costs more effectively.

Recommendation #47

We recommend WSI establish service level agreements for customer requests and performance reporting related to those service levels.

Priority Level: Low

WSI Response: CONCUR

WSI implemented a new IT Change Management Process, which includes basic Service Level Agreements. WSI will be evaluating the process in early 2007 and will make decisions on additional SLA's.

Time tracking systems are widely used in IT departments. HEAT could potentially serve this function for WSI with minimal modifications. Time tracking is critical information to have to make cost/benefit driven decisions because IT must first understand the costs of maintaining and enhancing their current environment. Time tracking should be done at least to the quarter-hour, be allocated to specific systems or projects, and signify the type of activity done (e.g., maintenance, problem fix, enhancement, new development, testing, etc.).

Recommendation #48

We recommend WSI implement a simple time tracking system.

Priority Level: Medium

WSI Response: CONCUR

Policies and procedures used for IT project management

Policies and procedures were looked at in several different areas of IT operations: Project Management; Development and Testing; and Data Center. Each area is discussed below.

Project Management

Project management is a relatively new practice within WSI. For purposes of this report of findings and recommendations, the WSI term of "change management" is considered as part of the project management function. Currently, formal project management is only used on projects with budgets over \$250,000.

Project management increases the cost-benefit driven discipline within an IT and business organization. It also fosters communication within an IT organization and with its customers as well as increases the overall amount of documentation supporting and explaining the technical environment. The benefit for all the documentation is the ability to more quickly develop future enhancements, track errors, and troubleshoot problems. It also helps bring new staff and contractors up to speed on the systems environment. A good project management methodology should be scalable for projects of all size.

Recommendation #49

We recommend all IT staff, led by Business Analysis staff and supported by the IT Director, should implement formal project management for *all* IT projects.

Priority Level: High

WSI Response: PARTIALLY CONCUR

As part of the Information Technology Transformation Program (ITTP) system replacement project, expanded project management methodologies were developed. These project management methodologies will be applied to additional projects where appropriate.

Octagon Reply to WSI Response:

We recommend not waiting to expand project management utility to existing projects. There are strong elements of the project management methodology that can be quickly and easily implemented for a big impact to existing projects, such as minimum documentation and communication standards.

Recommendation #50

We recommend Business Analysis staff make the project management methodology scalable by clearly identifying the level of project management rigor required for each size and type of project.

Priority Level: High

WSI Response: CONCUR

Refer to the response to recommendation #49.

Octagon Reply to WSI Response:

Refer to the Octagon Reply to recommendation #49.

The ownership for rolling out project management methodology is concentrated on the Project Manager. All methodology and template updates are channeled through this one person, which exemplifies good change control. However, there is only one Project Manager, who works part time. Rolling out a project management methodology is a huge undertaking and will take the deep understanding and buy-in of the entire IT organization before it can take hold throughout WSI. Executive support of this is critical.

Currently there are Business Representatives for the three main customer areas: Injury and Medical Services, Employer Services, and Support Services. However, there are segments of business within the departments that are not adequately represented for prioritization according to customers. As change management takes hold in the organization, prioritization bottlenecks are possible with a limited number of Business Representatives for the customer departments and not all units within the departments will have a voice in the prioritization process.

Recommendation #51

We recommend WSI define formal, active roles for all Business Analysis staff in the project management roll out.

Priority Level: High

WSI Response: CONCUR

Refer to the response to recommendation #49. Roll out of the project management methodology is included in this plan and will include all relevant resources, not just Business Analysis staff. WSI views project management as an agency-wide effort and not just an IT or Business Analysis function.

Recommendation #52

We recommend WSI formalize the project management methodology roll out including formal training and measurement of adherence to the process in individual performance goals.

Priority Level: High

WSI Response: CONCUR

WSI will develop a scalable project management methodology that assures roll out methodology, formal training and measurement. Adherence to standard processes, including project management is already documented and will continue to be documented in individual performance goals where applicable.

Recommendation #53

We recommend WSI identify additional Business Representatives for each department so that all units within departments have a voice to reduce prioritization bottlenecks.

Priority Level: Low

WSI Response: DO NOT CONCUR

The role of the Business Representative is to coordinate requests for service and the prioritization of requests within respective business units. As such, all units have a voice in the prioritization and bottlenecks should not occur. All outstanding requests have been prioritized and scheduled with the current number of Business Representatives. On an ongoing basis, WSI will evaluate the need for additional Business Representatives.

Octagon Reply to WSI Response:

We agree that the need to streamline the request process is important to making this process effective for IT. However, the source of this recommendation was from a customer who felt underrepresented in the new process. Given that the Business Representative role was new at the time of the audit, Octagon concurs that the ongoing evaluation of the need for additional business representatives will address the concern. Documentation of this consideration should be provided to the Quality Assurance Manager.

Development and Testing

The development staff love what they do and are hard working – that is the key to their current success. It is because they developed WSI's core systems that they are so critical to WSI's IT department because system documentation is either not well maintained or is non-existent. If there was documentation provided for the existing systems such as CMS/Work Manager, it was minimal or at least it is no longer available at WSI. On a positive note, IT does use the TOAD tool that automatically formats code by applying a standard. That is the extent of formal development standards.

The development methodology at WSI is unique among IT operations in the industry; it does not follow a standard System Development Life Cycle (SDLC) methodology. It is a one page, high-level diagram of the life of a project. Further, "testing" is referred to only in the context of user testing. Industry standards of unit, integration, regression, and user testing are not appropriately applied at WSI. Most evidence shows that if testing is done, it is only end user testing, which is often referred to as integration or regression testing. Industry standard testing methodologies apply to all systems and include unit, integration, and regression testing (done by the developers) and user acceptance testing (done by end users) and are scalable for all system changes. Testing environments and the use of testing tools are typically part of a testing strategy.

The development supervisor prefers creating little to no documentation and using a RAD (Rapid Application Development) methodology where the developers work directly with the end-users. This is in direct conflict with the positive changes in motion – project management and change management. Release notes are not published explaining the functionality changes made to a system. Currently, if this is maintained at all, it is through the independent efforts of a customer. The formal project management process will help increase the required amount of documentation from IT. Having formal documentation to refer to will lessen the need to rely on individuals' memories and expertise and put the emphasis on the documented facts.

During the performance evaluation, we discovered an example of a testing and documentation issue. A December 2005 example that proved problematic for not having been tracked was a request to correct claim file charges for non-chargeable fraud investigation costs. The request was not tracked, what was done to fix the solution was not tracked, and the user tests, if any were done, were not documented. As a result, the charges continued to be accounted incorrectly and because there was no documentation to refer to, the development team needed to re-investigate the problem and the fix to correct the problem.

Customer and other IT staff perceive IT decisions to be driven by the want to develop versus the actual business need. Customers are also concerned that they are not getting the most effective solution for their business, but rather whatever the developer tells them. Customers feel if they question developers, their work will automatically move to low priority.

Recommendation #54

We recommend WSI increase the level of testing by implementing a formal testing methodology.

Priority Level: High

WSI Response: CONCUR

WSI is in the process of a major system replacement project that will replace the majority of its core applications. One of the preparation phases is an effort for identifying effective Methodologies and Processes. One of the anticipated deliverables for this effort will be a standard recommended testing methodology for all applications.

Recommendation #55

We recommend WSI increase the use of existing, automated testing tools to maximize the efficient use of human IT capital and increase the quality of work produced by IT.

Priority Level: High

WSI Response: CONCUR

WSI agrees that the use of automated testing tools will have a major benefit for the IT department. WSI anticipates implementing the use of automated testing tools as part of the system replacement initiative.

Recommendation #56

We recommend WSI implement a formal system development life cycle (SDLC) methodology to integrate with the project management methodology.

Priority Level: Medium

WSI Response: CONCUR

WSI is in the process of a major system replacement project that will replace the majority of its core applications. Part of the preparation phase of this project is the establishment of a system development lifecycle process.

Octagon Reply to WSI Response:

The system development life cycle is a methodology that guides an IT department's development process. It seems logical to adopt a system development life cycle methodology first so that it can be used in the major system replacement project.

Recommendation #57

We recommend WSI increase the overall level of requirement, coding, and testing documentation in IT.

Priority Level: High

WSI Response: CONCUR

WSI developers currently document all code that is developed. WSI will increase the level of documentation in the requirements gathering phase through the use of business analysts and the change management process. WSI will continue to review and improve the process.

Recommendation #58

We recommend Software Engineers publish release notes for each release.

Priority Level: Medium

WSI Response: PARTIALLY CONCUR

When a new application version is placed into production, release notes should be published. WSI has made the decision that business analysts (not software engineers) should have the responsibility to publish the release notes and coordinate the communication. WSI believes that this recommendation on communicating application release information has been completed.

Octagon Reply to WSI Response:

This alternative is good as long as the software engineers, or the people responsible for making the technical changes, approve the content of the release notes to ensure the consistency and accuracy.

Data Center

Data Center Operations are well documented and followed and overall security procedures are strong. Desktop security is evident throughout the organization, new password protocol has gone into effect, and contractors and vendors are given limited or view only access to systems, network files, and data.

Server monitoring, making sure the technical “lights stay on” for the organization, is done consistently well, albeit manually. Tracking and reporting of server and system availability is also done manually.

Recommendation #59

We recommend WSI set log-in IDs for temporary staff and consultants to automatically expire after their expected tenure.

Priority Level: Low

WSI Response: CONCUR

Recommendation #60

We recommend WSI consider investing in automated server monitoring and reporting tools to offer more flexibility in the Data Center resource capabilities.

Priority Level: Low

WSI Response: CONCUR

WSI currently has some automated monitoring tools. WSI is in the process of a major system replacement project that will replace the majority of its core applications. Once the vendor is selected, WSI will be in a better position to make better longer-term implementation acquisitions associated with this recommendation. At that time, WSI will investigate the implementation of additional system monitoring and application testing tools that may be available and beneficial to the agency for the next three to four years.

In summary, an IT organization should operate as a support organization, enabling the core business of a company to continuously operate efficiently, effectively, and in a quality manner. An ideal IT organization is completely aligned with the business vision and goals and IT work priorities are driven by IT. IT should consult with business customers on *how* to accomplish their goals, rather than *what* their goals should be.

WSI's IT department tends to drive technology decisions and priorities that do not necessarily support the business vision and goals of the organization as a whole. WSI's IT processes and procedures typically follow a completely unique approach rather than following industry standards. While some of these things are changing, WSI's IT department must:

- Improve the communication and teamwork among the management staff;
- Adopt industry standard methodologies for system development, testing, and documentation;
- Track where IT time and resources are spent; and,
- Continue the implementation of the change management and project management processes.

Finally, we acknowledge review of the September 2005 report of Eide Bailly where various recommendations were made relating to overall IT function. To the extent those recommendations do not overlap with the ones we have made herein, we view those as additional areas of consideration for WSI and its IT operations.

ELEMENT FOUR – REVIEW OF WORKFORCE SAFETY AND INSURANCE BOARD

Objective

The objective of this element is to determine whether the Workforce Safety and Insurance Board is operating in accordance with NDCC Section 65-02-03.1 – 65-02-03.3, and within the Board’s bylaws. The review of the Board is required by statute (NDCC Section 65-02-30) every other biennium. The last review of the Board occurred in the 2002 Performance Evaluation.

Key Activities

To accomplish this objective, we undertook the following activities:

- Reviewed all Board meeting minutes from 2004 and 2005
- Conducted a limited review of some of the minutes of the Audit Committee
- Reviewed the relevant statutes
- Reviewed strategic planning documents
- Reviewed bylaws
- Reviewed Board Governance policies
- Interviewed three Board members
- Consulted with various WSI staff on Board activities
- Reviewed other documentation pertaining to Board activities
- Reviewed the 2002 Performance Evaluation pertaining to the Board

Overview and Analysis

NDCC Section 65-02-03.1 spells out how the Board is to be comprised, that the Board will have six employer representatives, three employee representatives, one at large member, and one member of the North Dakota medical association.

Within the employer representation, Board members are to be selected based on premium size. For instance, the Board has to have at least two members whose companies pay workers’ compensation insurance premium of at least \$25,000. Insofar as employer representation is concerned, the Board make-up is consistent with the statutory requirement pertaining to premium.

One employer representative is also supposed to be a participant in the risk management program, and the Board is in compliance with this requirement. However, the statute needs to be amended slightly to reflect that this program is now referred to by WSI as “risk management plus,” and *it is expected in the upcoming legislative session that this minor language change will be made.*

In our review of employee representation on the Board, we were unable to validate that the Board makeup is comprised of membership in keeping with legislative intent. The statute states in part that, “at least one member must have received workforce safety and insurance benefits; and at least one member must represent organized labor.” In our reading of the statute, there is no clear indication that the legislature believes that the recipient of benefits and the representative of organized labor can be one and the same person, but this is the way WSI has interpreted this statute. In discussions with WSI staff, they acknowledged that the labor representative also received workers’ compensation benefits.

It is our own observation that the legislature went to some length in its description of employer representatives to distinguish one representative from another, and we assume the legislature may also

have intended for employee representation to be similarly distinguished in its definition of Board membership. Further, the legislature gave no time constraint on when the workers' compensation benefits should have been provided. But we note from documentation provided by WSI that the labor representative who received workers' compensation benefits received them many, many years ago.

In addition to our own review of the statute, the Attorney General's office, at the request of the State Auditor, has also authored an opinion about Board makeup. The Attorney General office's opinion (see Appendix B) is that state law "requires one employee member to have received workforce safety and insurance benefits, and another separate employee member to represent organized labor." Therefore, WSI's Board is not in compliance with Board membership requirements in state law at this time.

We observed that the Board follows appropriate statutory protocol via its Nominating Committee when a Board vacancy is imminent or has occurred.

Recommendation #61

Employee representation on the Board should be modified to reflect legislative intent. We also recommend WSI undertake research of the statute and determine a time frame that the legislature believes receipt of workers' compensation benefits could be a factor in Board membership. For example, given the substantial workers' compensation reform that has occurred since the mid-1990s, the legislature may want an injured worker to have received benefits at a time that is reasonably representative of the benefits available at the time of the Board appointment, rather than the 1980's or even earlier.

Priority Level: High

WSI Board Response: CONCUR

This recommendation has been reviewed by the North Dakota Attorney General and he has issued an opinion clarifying that the labor representative and the injured representative must be separate appointments. If approved by the Board, WSI will seek clarification regarding this statute from the Legislative Assembly to eliminate any perceived ambiguities.

Octagon Reply to WSI Board Response:

We expect that approval by the Board to seek clarification will be a formality. Further, when WSI seeks clarification regarding the meaning of the statute, it should also assess the other part of the recommendation; namely, the time frame within which the age of an injury may be relevant for Board participation.

Ongoing Overview and Analysis

NDCC Section 65-02-03.3 describes the powers and duties of the Board. Those powers and duties include:

- Appoint a director on a nonpartisan, merit basis
- Set the compensation of the director
- Ensure a proper response to any audit recommendations
- Present an annual report to the legislative audit and fiscal review committee. The report must be presented by the chairman of the board and the director
- Prepare with the assistance of WSI an operating budget and submit this budget within the state-mandated deadline

- Assist the organization in formulating policies and discussing problems related to the administration of the organization, while ensuring impartiality and freedom from political influence
- Incorporate principles of continuous improvement goal setting, a procedure for implementing team-oriented continuous improvement program throughout all operations of the organization. The program must include a number of challenging, measurable goals to ensure the organization maintains focus on improving those areas most important to its primary mission
- Adopt internal management rules creating bylaws for the board and relating to the election of a board chairman, formation of committees, replacement of departing members, voting procedures and other procedural matters

Certain of these powers and duties can be addressed in our report quickly. For instance, the Board did appoint a director on a nonpartisan, merit basis and sets his compensation. Board minutes document the outcomes of their work to appoint a director in the early part of 2004 and subsequent minutes address the compensation of the director showing that director salary is reviewed periodically.

The Board also presents an annual report as required by statute, and it appears to participate in the preparation of WSI's biennial budget request.

The Board also operates from bylaws it has established, forms committees and conducts other procedural matters as expected.

In our discussion with the Board chair, we learned that the representative of labor has consistently been a member of the Legislative Committee. The Legislative Committee is an ad hoc committee that meets in preparation to discuss various legislative proposals WSI may wish to make at each biennial session of the legislature. Over the last decade, reform efforts have changed the way workers' compensation benefits are awarded in North Dakota. Further, the media have reported (whether accurate or otherwise) that certain injured workers have not received adequate compensation or care for the effects of their injuries. This type of reporting is not unique to North Dakota, nor is it unique that some injured workers may not be compensated adequately for the effects of their injuries.

Recommendation #62

From a strategic perspective, we recommend that the labor representative be a permanent member of the Legislative Committee. If legislation is to be proposed by WSI that influences the benefits to be provided to injured workers, we think it advisable that labor has a voice in the discussion about the legislation in its formative stages.

Priority Level: High

WSI Board Response: CONCUR

It has been a practice of the current and former Board Chair to place the Labor Representative on the legislative committee specifically to ensure he/she has a voice in legislative matters. The issue will be brought before the Board of Directors for a vote of support to permanently place the Labor Representative on the Legislative Committee. If approved by the whole Board, the appropriate Board Governance documents will be modified.

Other Board powers and duties will be discussed below in greater detail. The sub-sections that follow include audit recommendations, policy formulation and problem discussion, and continuous improvement.

Audit Recommendations

Another of the Board's duties is to ensure a proper response to any audit recommendations. We could see from a review of various minutes that the Quality Assurance Manager regularly provided updates to the Audit Committee regarding the status of the 2004 Performance Evaluation recommendations.

The position of Quality Assurance Manager is relatively new to WSI. One of the responsibilities of this position is to document the implementation strategies employed by WSI to respond to performance evaluation recommendations. This is a function that had previously been the responsibility of the Internal Audit Manager. The Internal Audit Manager functioned more as an information repository than a quality control check. We observed in the work of the Quality Assurance Manager greater attentiveness to the details of each recommendation, but we also know that the Quality Assurance Manager did not have subject area expertise for most of the recommendations.

During our fieldwork in April 2006, we were also provided with a copy of the Eide Bailly report documenting their audit of the financial statements for the year ending June 30, 2005. This report contained numerous recommendations, notably those relating to Information Systems (documentation, security, monitoring and disaster recovery). The report also included a claims-related recommendation in the area of reserving. We did not observe any documentation either from the last Board or Audit Committee meeting of 2005, which is when we would have expected discussion to occur on this report. By contrast, we observed a review of the 2003-2004 financial audit in the November 2004 Board minutes.

Recommendation #63

Before the Quality Assurance Manager reports to the Audit Committee on prior recommendations, we recommend that the appropriate department chief sign off to his/her satisfaction that a recommendation has been fully implemented. The intent of this recommendation is to make sure that a subject area expert has signed off on the implementation. This should then lead to a greater likelihood that subsequent performance evaluations will come away with the same implementation results as reported to the Board.

Priority Level: High

WSI Board Response: CONCUR

WSI's Quality Assurance Department has created an "Initial Evaluation/Audit Recommendation Form" which includes an area for the signature of the appropriate Section Chief or Executive. Once the recommendation owner has indicated that the recommendation is complete, Quality Assurance will audit the new system and/or supporting documentation. If the recommendation is validated, Quality Assurance will request a signature from the appropriate Chief or Executive prior to reporting the information to the Board Audit Committee.

Recommendation #64

When an audit issues, documentation should exist in the Board minutes immediately following the audit publication date that either summarizes the findings and WSI's planned response to the audit, or identifies a reasonable date when the audit is to be discussed by the Board.

Priority Level: Medium

WSI Board Response: DO NOT CONCUR

WSI Board believes that this recommendation is not applicable. The Board Audit Committee already reviews the audit findings and WSI responses following each audit. If a Board Audit Committee meeting

is scheduled such that there is limited time to review WSI responses, the committee will set a date to review responses to the audit issue at their next scheduled meeting or hold a special meeting. All Board Audit Committee minutes reviewed reflect either a full review of the responses or future scheduled date for the review has been conducted.

Octagon Reply to WSI Response:

The reason for this recommendation had to do with a perceived delay on our part in the presentation of the 2005 financial audit to the WSI Board. Subsequent to our initial review of this report, WSI provided additional information showing that the financial audit had been a timely but tentative agenda item for the November 2005 Board meeting. As it turned out, the financial audit could not be presented at that time due to scheduling conflicts as well as a clarification about the report that was not resolved until too late.

Policy Formulation and Problem Discussions and Continuous Improvement

Policy formulation, problem discussions and continuous improvement are the remaining Board powers and duties to address in this section, and we discuss them jointly due to the overlapping strategic nature of these duties.

To assess these areas, we read all the Board minutes over the past two years. We considered the strategic planning processes in which the Board has been involved. We considered the way in which the Board has or has not responded to problems within the organization. And we evaluated Board bylaws and Board Governance Policy documents.

Board members participated in an offsite strategic planning session in November 2004. The purpose of this meeting was to set overall goals or outcomes for the organization. Board members broke off into two work groups and independently developed goals for the organization. When the groups reconvened, the goals were consolidated. These goals include the following:

- Develop and Expand Proactive Safety Program
- Streamline Reporting/Processing
- Improve Communication with North Dakota's Workforce, Employers, Medical Providers and WSI Employees
- Achieve/Guarantee the Integrity of WSI Data/Data Systems
- Assure Fund Solvency with Integrity
- Enhance WSI Staff Development

For each of these outcomes, WSI staff developed action items with target dates for completion. Each department developed action items tied to each outcome, as well although it is fair to say that one department (Employer Services) is further along with that process than other departments.

In light of these goals, the Board also made changes in its Board Governance Policy. Where goals in the Board Governance Policy had previously been department driven, the Board's outcomes as identified in November 2004 crossed traditional department boundaries. For example, while the first goal pertains to safety programs, some of the sub-objectives within that goal are tied to events related to claims, such as return to work programs.

While the Board established outcomes in late-2004, the Board Governance Policy was not updated until early 2006, a delay for which we found no supporting information. When it was, some department

outcomes or goals were retained while others were not. In addition, while outcomes may have changed, measures tied to some of those outcomes did not. For example, safety, human resources, customer relations and financial measures in the 2003 Board Governance Policy are the same (with a few exceptions) as the safety, staff development, improve communication and fund solvency measures in the 2006 revision. Board Governance Policy goals and measures for Claims, Legal, Special Investigations Unit and Policyholder Services no longer exist in the 2006 revision. Subject areas with unchanged goals and measures include Internal Audit, the Office of Independent Review, and Independent Performance Audit Response.

Recommendation #65

Given that the Board outcomes have undergone cosmetic changes in some places and deletions in other areas, we recommend that the Board a.) confirm its desire to delete certain departments from its outcomes measures, b.) if it does wish to do this, that the strategic plan implementation grid covers these areas in sufficient detail to satisfy the Board that pursuant to Item #7 of the Board's Powers and Duties that it "incorporates principles of continuous improvement goal setting, a procedure for implementing a team-oriented continuous improvement program throughout **all** (emphasis added) operations of the organization," and c.) confirm that the cosmetic changes made in certain of the measures are sufficient to meet the overall outcomes established by the Board.

Priority Level: High

WSI Board Response: DO NOT CONCUR

After seeking clarification from Octagon on the intent of this recommendation, WSI submits it has accomplished this recommendation through the mandated approval process for bylaw and governance process changes. The reviewer further notes, "While the Board established outcomes in late-2004, the Board Governance Policy was not updated until early 2006, a delay for which we found no supporting information." The timetable of events has been outlined below:

Following the November 2004 Board retreat and subsequent to the legislative session, which ended in April 2005, WSI undertook a number of necessary preliminary steps to properly lay the foundation for the successful implementation of a strategic plan. Based on the Board developed outcomes, WSI Executive Management conducted a strategic visioning and planning session in September 2005 wherein the elements of the draft structural framework were created. In October 2005, WSI staff then validated the outcomes, business plan, and structural framework document and formulated strategies to comprise a strategic plan. In November 2005, a strategic core team was ultimately developed to facilitate strategy implementation and monitor progress of the strategic plan. During its next regularly scheduled meeting in February 2006, the Board directed staff to align the governance manual with the six outcomes. The proposed changes to the bylaws and governance process were initially presented and distributed to the Board Audit Committee and the full Board of Directors during their May 16 and May 17, 2006 meetings, respectively. The proposed amendments were again presented and formally approved by the Board at the June 15, 2006 Board of Director's meeting.

Octagon Reply to WSI Response:

At the time of our fieldwork, we reviewed a draft of segments of the governance manual that had been developed by WSI staff in January 2006 and this draft appeared to be aligned with the six outcomes. It was from that draft that we drew the conclusions referenced above pertaining to cosmetic changes and deletions. We would have to review the amendments as approved by the Board in June against that draft to assess how the Board may have modified it to reflect its strategic intent.

As we noted in Element One when discussing measures relating to Claims, all the measures in the Operating Report are tied to process. It is for that reason that we recommended that a time loss claim measure be developed that merges paid, incurred and forecast values to assist WSI and the Board in

looking at cost and reserving trends. In discussions with the Board chair, he acknowledged that reserving competency on the part of the Claims organization has been lacking. As such, the organization has to place substantially more reliance on its external actuary for loss estimates than it does on its claims organization.

We are aware that WSI is looking at the MIRA loss reserving tool as an adjunct to claim reserving, and we encourage its use with the same caveat as that suggested by WSI's actuary. Namely, the tool is a good guide, but it needs to be supplemented with sound judgment on the part of claims professionals.

Recommendation #66

Either through the regular report of the CEO to the Board or through the Audit Committee, we recommend that reserving within the Claims organization be included as a quarterly discussion point.

Priority Level: High

WSI Board Response: CONCUR

The Board Audit Committee will make reserving a topic for their quarterly meetings.

WSI has benefited financially over the past decade through sound investment strategies that have contributed greatly to the health of the organization. Ten or so years ago, WSI showed a liability deficit of approximately \$250 million. As of 11/05, the organization reported total assets of more than \$1.5 billion and net assets of nearly \$500 million. Because of its favorable financial position, the organization has been able to pay more robust dividends and provide incentive programs designed to reduce employer costs. Numbers have a way of getting bandied about. There is an old adage about statistics that they are just a bunch of numbers looking for an argument. An easy to access summary of the organization's financial position may assist those interested in WSI's financial standing. For instance, a website posting could include how much of the organization's assets are earmarked for claim liabilities, how much is held in surplus (and why a surplus is necessary), and how other assets may be offset by other liabilities. The Board may choose to add other financial information in its posting, as well.

Recommendation #67

Due to the favorable position in which the organization finds itself, we recommend that the Board authorize a semi-annual posting on the WSI website that explains in layman's terms what the financial position is of WSI.

Priority Level: Low

WSI Board Response: CONCUR

Board authorization for a semi-annual posting is not necessary. A simplified exhibit outlining WSI's financial position will be placed on the website semi-annually.

During our review of Board minutes for November 2005, we noted that there was a discussion of anonymous letters. This is not the first time that the Board has dealt with anonymous letters, but in response to such letters this time the Board and WSI Legal have worked to develop a policy of managing anonymous letters. Our understanding is that the policy has been approved by the Attorney General's office. We viewed this subject as a problem worthy of discussion by the Board, and its approach to resolving the problem seemed reasonable.

It is important to distinguish the Attorney General's office's approval of a records retention policy from how the Board may respond to anonymous letters. The Attorney General's approval had to do with

WSI's records retentions policy only. The substance of anonymous letters is a different matter altogether. It will still be up to the Board to manage the substance of anonymous letters.

We also noted that when reviewing Board minutes that electronic copies of attachments were not always available.

Recommendation #68

We recommend that all documents presented at the Board meetings be available electronically. If for security or privacy reasons, WSI needs to maintain documentation related to executive sessions separately, it may do so.

Priority Level: Medium

WSI Board Response: CONCUR

Board Meeting material will be made available in an electronic format and archived in a folder based on the date of the Board Meeting.

While several of the Board members have been on the Board for many years, we view the segment of each quarterly meeting pertaining to Board education as particularly important. By background, Board members are not workers' compensation experts so ongoing education is a key factor in the decisions the Board may make. Examples of Board education topics included reserving, bill review, investment mix, extraterritorial and other states coverage, the role of the Office of Administrative Hearings, and review of compensation and performance management methods. In short, the topics represented a broad blend of topics and ones that were appropriate for the Board.

Recommendation #69

We recommend the Board also consider the establishment of education topics predicated on performance as revealed in the quarterly operating report. This report identifies key trends of the organization, and when results are either positive or adverse, the Board may benefit from knowing how these results were actually achieved.

Priority Level: Medium

WSI Board Response: CONCUR

WSI staff will survey the board members in order to identify any specific items or trends within the operating report that they feel would be most beneficial to review.

ELEMENT FIVE – FRAUD UNIT

Objective

The objective of this element was to evaluate the effectiveness of expenditures incurred by WSI's fraud unit, in accordance with NDCC Section 65-02-23.

Key Activities

To achieve the above objective, the following activities were undertaken:

- Review of fraud-related statistical information provided by WSI for the performance evaluation period
- Review of fraud cost-related information both before and during the performance evaluation period
- Interviews of WSI staff from the Legal/Fraud, Policyholder and Claims departments
- Review of some workers compensation claims files on which investigations were assigned
- Review Element One of the 2004 Performance Evaluation, which also addressed the effectiveness and efficiency of the Fraud Unit

Overview and Analysis

The Fraud Unit, or Special Investigations Unit (SIU), is part of the Legal Department in WSI's organizational framework. The SIU Manager reports to General Counsel. A senior special investigator, a special investigator, two administrative investigators and a paralegal report to the SIU Manager.

By statute, the SIU may contract with a private investigator whenever feasible or cost effective to investigate and review any alleged case of fraud against WSI by employers, injured workers, or providers of medical or other services. The statute also specifically references employers who do not secure workers' compensation insurance coverage as well as those who may file a false claim or make false statements.

In the 2004 Performance Evaluation, an extensive review was accomplished of the SIU. Following the evaluation, various recommendations were made to improve the efficiency and effectiveness of the SIU. Those recommendations are specifically addressed in Element Eight. However, in response to those recommendations, WSI retained as an employee the consultant who made the recommendations to provide training, redesign work flows, establish best practices criteria for private investigators, differentiate fraud investigations from routine claims investigations, and develop cost controls.

Primarily during 2005, the consultant/employee conducted numerous training sessions for staff in the Claims, Policyholder Services and SIU departments. For instance, the training provided to the Claims Department covered the fundamentals of the investigative process, but also included training segments on compensability, apportionment, subrogation, return-to-work, surveillance, background investigations and depositions. The intent of the training was to provide claims staff with the right investigative tools to manage claims and mitigate exposure. In addition, a series of "red flags" pertaining to all manner of potential fraud was provided to claims personnel.

The consultant/employee also worked with other SIU staff and private investigators to explain the revamped investigative approach. This consisted of a revised approach to reporting, and it also included controls on investigative hours to assist WSI in managing the costs associated with investigations.

One aspect of the redesign of the department was that Claims was to assume the lead role on routine investigations, thereby allowing SIU staff to focus on fraud. This had the positive effect of WSI not needing to retain additional staff to manage investigations referrals, as the majority of all investigations are not potential fraud cases.

In the area of cost control, the SIU has shown a dramatic reduction in the fees paid to private investigators when comparing the 2004 Performance Evaluation period to the current cycle. For instance, as reported in the December 2005 Operating Report, fees paid to private investigators in fiscal years 2003 and 2004 amounted to \$1,614,584, or an annual average of \$807,292. In FY 2005, that number declined to \$516,703. The projection for FY 2006 is that private investigator fees will amount to approximately \$150,000. One of the controls placed on private investigators over the past 18 months or so has been a limitation of ten hours for them to complete their assigned tasks. This control has had a favorable impact.

During the time frame between FY 2003 and FY 2006, the operating budget for the SIU has increased a modest 7% (from \$329,954 in 2003 to a projected figure of \$353,244 for FY 2006). With the redistribution of the workload and the training provided, SIU investigators are now positioned to accomplish a wider array of investigative tasks including supporting the claims department through certain routine investigations, such as compensability determinations. In short, the staff now functions more efficiently at approximately the same cost when compared to other fairly recent fiscal years.

Recommendation #70

Given that there is a 10-hour control on private investigations, we recommend that WSI maintain a report on private investigations that, with the prior authorization of WSI, extend beyond the 10-hour control. This list should be reviewed for time trends to determine what the reasons are for investigations extensions and develop other process or cost controls after evaluating the trends.

Priority Level: Low

WSI Response: CONCUR

Electronic reports will be made available for review of possible trends.

Ongoing Overview and Analysis

As we noted in Element One at Recommendation 14e (where we urge WSI to more accurately report its investigation service costs), there are two types of investigations services that are tracked by WSI. The tracking is accomplished by pay code with pay code 009 signifying a payment made to a private investigator. Pay code 116 is used to pay the cost of field investigations, and it is this group of investigations that is managed principally through the Claims Department.

Investigators used for either of these services may be from the same firm. The coding simply allows WSI to differentiate what it sees as potential fraud from what it considers routine investigations.

At the time of the 2004 performance evaluation, fraud referral data was artificially inflated because many of the cases showing up in the fraud case counts consisted of what are today captured correctly as routine investigations. To illustrate this difference, there were 763 “fraud” cases in 2002 and 2003. In 2005, there were 62 such cases.

More significantly, we observed a continuing trend that potential medical fraud is not pursued. Of the 62 cases identified as fraud referrals for 2005, only one of them was for a medical provider. Of the remaining 61 cases, 44 were employee fraud cases and 17 were employer fraud cases.

Within the employer fraud category, we learned that common themes for employer fraud cases are misclassification and under-reporting. Employees may be misclassified as independent contractors by certain employers who then assert no obligation to insure these workers and pay premium. Employees may also be coded to a different, lower premium job classification, or payroll may be understated. WSI case examples show that SIU, working with Policyholder Services, displays a balanced approach to the collections process; that is, payment plans are developed for those who acknowledge their under-reporting or misclassification, while legal proceedings are appropriately pursued against employers who fail to cooperate.

Observations about Medical Provider Fraud

While the consultant/employee provided some training regarding medical provider fraud, WSI has not pursued this area in a significant way, at least not during the performance evaluation period. This finding appears to grow out of a lack of certainty on the part of the organization as to how to identify possible medical abuse or medical fraud.

Medical provider fraud ultimately turns up in the medical bills. Bills may be submitted for services that have not been provided. Or the services that are described on the bill may represent an embellishment of the services actually provided. For instance, routine initial and follow-up office visits are billed based on codes that define the level of service actually provided. The codes range in complexity. A common term used in the industry that reflects the process of over-billing is upcoding. That is, a provider selects a service level that suggests a higher degree of complexity in the office visit than what might actually have been provided. Another type of over-billing practice is unbundling, where services are billed according to component elements rather than under one global fee that accurately reflects the service provided. Also, fraudulent billing occurs when providers charge for services that were never provided.

As well as certain billing practices, medical fraud can occur through deliberately inaccurate diagnoses where the services required to manage more complex diagnoses are broader in scope. As such, one place to examine fraud is through an assessment of diagnostic accuracy. And once a diagnosis is made, treatment should be assessed to make sure the treatment provided constitutes the usual standard of care for that diagnosis.

Medical fraud may also surface in situations where providers have a financial interest in ancillary medical services. For example, some physicians may share ownership in diagnostic facilities. In such situations, might the physicians be inclined to refer proportionately more patients for diagnostic services? Practice patterns can be investigated to understand this issue in greater detail.

In a related matter, we observed in 2005 in an analysis of data relating to disability management programs that the cost of a medical only claim (that is, a claim not involving time loss) was substantially higher when an injured worker was treated at a facility providing a disability management service than medical only claims where no disability management service was provided. While we did not delve more deeply into this cost anomaly as it was outside our scope of work, it would be an area worthy of greater analysis on the part of WSI. A question to ask would be this: Did the disability managers and the treating providers with whom they worked appear to encourage greater utilization of services before releasing injured workers from care? If so, then WSI might like to know why.

Recommendation #71

We recommend WSI investigate medical provider fraud more thoroughly, and we have several components to this recommendation, which are:

- a) Make sure SIU investigators are thoroughly trained in medical fraud

- b) Expand training for medical bill reviewers so they are more adept at identifying bill coding irregularities
- c) Once billing irregularities are identified on a consistent basis with certain providers, meet with the identified providers on their billing patterns and provide constructive alternatives for the providers so they may accurately bill for services in the future
- d) Work with claims staff to spot-check whether services billed are actually provided. This may include periodically calling injured workers about their care.
- e) Where certain medical providers may have a known financial interest in ancillary medical services, compare costs to other providers. If such ancillary services are provided more frequently, consider education of the provider and continue to measure cost outcomes
- f) Evaluate diagnostic accuracy. For instance, are there certain providers who seem to come up with multiple diagnoses for many of the patients they see? Do injuries seem to migrate? Are multiple surgeries performed? Does the diagnosis seem reasonable given the mechanics of injury? (For this component of the recommendation, SIU should work with WSI medical staff for assistance in implementing protocols to assess diagnostic accuracy.)
- g) Unless medical fraud appears to be an absolute certainty, we encourage WSI to work with identified providers on their anomalous results. Then continue to review performance of these providers.

Priority Level: High

WSI Response: CONCUR

Budget constraints in the current biennium have hampered expanding the medical fraud specialty. The investigation of provider fraud is extremely technical in nature and requires highly skilled and trained personnel. Additionally, the key to an effective provider fraud program hinges on technological resources that are currently not in existence at WSI. Obtaining the necessary skills and resources is an evolving process and WSI expects the provider fraud program to significantly develop as these resources are obtained. Nevertheless, SIU has taken steps within its current capabilities to develop provider fraud detection and awareness. These efforts include: provider fraud training for WSI Injury Services staff and members of the North Dakota medical community; the development of computer generated queries to ascertain and review certain “red flag” activity; and various SIU staff training sessions on provider fraud from internal and external medical and investigative resources.

Octagon Response to WSI Reply:

Prioritizing resources appears to be an important consideration to satisfy this recommendation, and we urge WSI to do that.

In summary, the SIU has made favorable strides in improving performance and streamlining process and the associated costs. The department works much more efficiently with other departments at WSI. The primary area for process development was and continues to be medical provider fraud.

ELEMENT SIX - EVALUATION OF MEDICAL SERVICES (PART ONE – BILL REVIEW)

This element contains two components. One pertains to medical bill review and the other to utilization review. The element is divided into those two components.

Objective

In this section, we review the medical services area to ensure it is functioning properly. Our objective was to provide an evaluation of the overall efficiencies and effectiveness of WSI's Medical Bill Review and Audit program including a review of the relevant policies, procedures, and processes.

Key Activities

To achieve the above objectives, the following activities were undertaken:

- Review of the Mail Area and Scanning Areas and processes
- Review of Bill Imaging and processes
- Review of Bill Input Area and processes
- Review of Medical Bill Review Processes
- Review of Provider Appeal Process
- Interviews with numerous staff within Injury and Medical Services

Overview and Analysis: Medical Bill Review

Several departments are involved in the processing of medical bills.

Support Services

The initial process begins in the mailroom where the mail is managed daily by the imaging team. The imaging team receives medical records, legal correspondence, vocational rehabilitation correspondence, medical bills, form letters, and communication from the injured worker. Paper correspondence is date stamped (each page) and electronically stamped for electronic bills (Optical Character Recognition, or OCR) and EDI bills.

The mailroom receives approximately 4000 – 4250 pieces of mail per day. Of that amount 600 – 700 paper bills are received per day. Paper Medical Bills and reports are then checked for claim number and then written on the bills and reports by the imaging team. If there is no claim number on the bill or reports, the imaging staff will search the claims system for the claim number. If the imaging staff cannot identify the bill it is placed in an unidentified mail area, which is held for two weeks in this area. If not able to identify within this two-week period it will be moved to another mail holding area where it will be held for a one year.

Paper bills that are ready to be processed are then scanned into work manager system. The bills that are received by EDI and OCR are also in a work queue in the Work Manager system. Hard copy bills that are received without any medical documentation are marked with "X" so the system will not look to auto attach any medical notes.

The auto attaching of medical notes is taking place in three phases, two of which are operational.

Phase 1 (already implemented): For any bill received without notes, a standard form (C45) is sent to the provider to request medical notes. A unique bill ID is assigned to be able to match the bill to the notes when received. Once received the notes are linked to the medical bill electronically.

Phase 2 (current phase): match medical notes with medical bills by date of service. This link is created automatically by using the date of service as the key. The link does not consider provider in this linkage so multiple services performed by different providers on the same date of service will be linked to medical notes not necessarily pertaining to the bill in question.

Phase 3 (not implemented yet): will look at defining the linkage of medical bills to medical notes and reports not only by date of service but by provider type as well.

Bills that are received via EDI can be auto adjudicated as the bills are in the accepted format. These bills still need to be linked to the medical reports or progress notes in the system. In the current EDI system the provider is not able to submit medical documentation so the provider must either fax or mail the medical documentation.

Recommendation #72

We recommend WSI work with the current scanning vendor to determine if an upgrade to the scanning software is available to allow for the scanning of multiple page HCFA forms, UB 92's, as well as the scanning of black and white HCFA forms.

Priority Level: High

WSI Response: CONCUR

WSI upgraded their Optical Character Recognition software (Cardiff) software in September of 2006. Cardiff allows for the processing of multiple-page HCFA and UB92's; however, due to system limitations (software separating the multiple page bill into single page bills and putting pages together that did not belong together) WSI has chosen to not process multiple-page HCFA and UB92's. WSI will continue to discuss multiple-page bill processing with the software vendor. WSI currently scans black and white HCFA's through the Cardiff software.

Octagon Response to WSI Reply:

We encourage WSI to work with its software vendor to work out the bugs in the processing of multiple page bills.

Recommendation #73

We also recommend WSI work with the current scanning vendor to determine if an upgrade is available to scanning software to allow medical reports and notes to be attached to medical bills through the scanning process. Other alternatives to consider would be to cross reference bills to corresponding reports with some type of unique ID. A short-term solution may be to cross reference bills to reports with unique identifiers prior to bills and reports being scanned so the medical bills can be linked to the appropriate report.

Priority Level: High

WSI Response: CONCUR

As noted in recommendation #72, WSI upgraded their Optical Character Recognition software (Cardiff) software in September of 2006. WSI's current OCR software does allow for the scanning of bills and medical notes at the same time; however, due to the inability to store the information as multiple document types, WSI chose not to move forward with this option. WSI does have an established process

to auto-attach medical correspondence to medical bills based on the date of service. A unique identifier would assist in that the potential exists to have multiple pieces of correspondence on a single medical bill.

Recommendation #74

We recommend WSI work with the current EDI vendor to explore the ability of medical providers to submit medical reports via EDI along with the electronic bills. This lack of ability has discouraged medical providers from utilizing the EDI process, which for much of the performance evaluation period hovers around 13%.

Priority Level: Medium

WSI Response: CONCUR

WSI's third-party EDI vendor cannot support this recommendation. WSI is currently piloting a program with another vendor to allow for receipt of electronic bills and medical records. As noted during the audit, WSI is open to any recommendations of software vendors who are capable of meeting the recommended functionality.

Bill Input

The bill input area then completes the data entry process for the OCR bills and the bills that cannot be scanned. The bills that cannot be scanned are bills greater than one page in length, black and white HCFA's, and also bills that are not billed in the accepted format.

The bill input staff will data enter all bills that can not be scanned as well as validate claim number and will assign the UPIN number of the provider to the bill. If no UPIN can be assigned to the provider, a generic number will be assigned. If a paper bill is received, the bill input staff also checks to see if the bill is a duplicate

Once the bills are validated for correct data, the batch is committed by the bill input staff and it is batched to CMS windows work queue.

The mail room, the scanning and bill input area all report to Office Services. Office Services also maintains the vendor file and is responsible for updating the W9 information.

Recommendation #75

We recommend WSI allow Bill Input staff to complete the processing of lower level bills. Defined criteria could be applied, which would allow bills to be completed at the time they are entered in the system.

Priority Level: High

WSI Response: CONCUR

The bill input staff is now handling some lower level non-medical bills. Additionally, WSI is in the process of developing an automated bill payment that will require limited human intervention.

Octagon Reply to WSI Response:

We recommend the automation that is proposed is fully tested prior to implementation and that the process is routinely validated through a quality assurance audit process no less frequently than monthly.

Recommendation #76

We recommend Vendor File and W9 information be maintained by the Finance Department. This process needs to be accurate to ensure payments are only being made to providers with accurate W9 information on file.

Priority Level: High

WSI Response: CONCUR

WSI will develop an action-plan to migrate the Vendor File and W9 information to the Finance Department. Along with the migration of W9s, WSI will transfer the responsibility for ensuring a process of verifying and updating legal entity information associated with these forms.

Ongoing Overview and Analysis: Medical Bill Review

The medical bill review staff consists of three nurse reviewers and two medical bill reviewers. This staff is to review medical bills for payment and apply the state fee schedule. Nurse reviewers are reviewing HCFA 1500 forms as well as UB92's.

The bill review staff pulls bills up in their work queues and validates the provider, service dates, procedure or service codes, medical notes that have been auto attached to bills and utilization review (UR) services if required. Medical bill review staff will also attach any UR letter if applicable, review body part and diagnosis code (ICD9), and validate if the claim is accepted.

To complete the bill, the reviewer must change the audit status on the bill to audit and then release. If the reviewer is denying the charges, he or she would need to set the dollar amount to \$0.00, put the correct reason code under the reduction reason, and then attach a note on the bill either at line level or bill level with appropriate explanation.

If questioning liability, the reviewer needs to write a notepad entry, change the status of the bill to one pending analyst decision, and route the bill to an adjuster for recommendation.

The process for the UB92 bills is the same with the exception that ambulatory surgery center bills also need payment status indicators.

Eight screens need to be reviewed for completion of a medical bill review. These screens are both in the claims and bill review systems.

In July 2005, a batch bill release process was instituted. The process calls for bills to be automatically cleared through the bill review system if they meet pre-defined criteria. Further, a process change that also occurred in 2005 called for bill reviewers to take the lead role in bill processing rather than claims staff, who previously were responsible for bill payment approvals.

With these changes and with other circumstances influencing inventory management in the bill review department, outstanding medical bills of greater than 30 days duration grew from about 4% of all bills as of September 2005 to about 18% as of December 2005. While various factors seem to have contributed to this increase in backlog, including staff changes and staff training, incoming bills do not appear to be a factor. Medical bills over the eight quarters of the performance evaluation generally amounted to around 45,000 to 47,000 per quarter, and there was relatively little volatility in bill volume.

Recommendation #77

A consistent inventory tracking mechanism needs to be developed to manage and track incoming inventory of bills at WSI.

Priority Level: Medium

WSI Response: CONCUR

A consistent inventory tracking mechanism exists and it will be further refined. The observed report contained both medical and non-medical bills.

Octagon Reply to WSI Response:

As WSI is aware, Octagon reviewed a report showing outstanding bills in approximately March 2006. This report seemed to show that certain medical bills might have been counted twice in the outstanding inventory. We simply want to insure that bills don't get counted twice on outstanding inventory reports. Distinguishing medical from non-medical bills on the inventory report also will help WSI as non-medical bills are not processed in the same manner as medical bills.

Ongoing Overview and Analysis: Medical Bill Review

Duplicate logic has been introduced recently in the bill review system and questionable bills are routed to the nurse reviewer to determine if a duplicate exists. We discovered that the duplicate logic has not eliminated the entry of total duplicates in the bill review system. We audited medical overpayments identified by WSI that had been paid to providers and determined that duplicate payments to medical providers have been made in the system.

We reviewed several auditing reference documents, although these did not appear to have been updated in some time. We also reviewed claims procedures for processing of medical bills and also reprocessing of medical bills. We did not find a procedure manual available to the medical bill review staff, which clearly documented the step-by-step process on how to process different types of medical bills in the current system.

We also reviewed some bills where a provider filed for a binding dispute resolution for payment denials. It appeared the bills had been denied appropriately up front. Frequently, bills of this type are resolved in the provider's favor. The reasons for this could include that the provider was able to substantiate they did not realize the injured worker was being treated under workers' compensation or they were able to document they were an out of state provider who did not realize North Dakota requirements.

Provider reconsideration requests are handled by a nurse reviewer. The nurse will review the provider's request for reconsideration and make additional payment if necessary.

In the future, a provider will be able to complete a M6 form to request reconsideration of the prior payment. This form should be implemented by 09-01-06, which would be available to the provider to use when submitting requests for additional allowance. Once this process is instituted, an Explanation of Benefits message code will need to be developed to identify to providers that the payments they are receiving are actually additional allowances to prior payments.

Of particular concern to us during the performance evaluation was the growth in aged medical bills between September and December 2005. Data was also available at the time of our fieldwork that indicated that the percentage of outstanding bills of more than thirty days had again increased as of March 2006 well beyond the December 2005 figure. At our exit interview in early July 2006, we learned that this inventory had been reduced substantially during the second quarter due at least in part to the expansion of auto-payment criteria, a list of bill circumstances or bill types that are thought by WSI to

have a high likelihood that these bills (subject to fee schedule considerations) can be paid without question or closer examination.

Recommendation #78

- a) We recommend that the auto-payment process be reviewed to determine if the process is adequate to validate the legitimacy of the bill, to determine if there are certain procedure codes (e.g., 99204, 99214 and 99284) that are in the auto-payment criteria that may indicate a problem with up-coding, and to confirm that liability has been satisfactorily addressed.
- b) Further, we recommend that once this process is complete that WSI again review its payment approval workflows. It is possible that either additional bill review staff will need to be hired or the approval process should return to the claims staff.
- c) We also recommend that Medical Services management staff fully understand how to process bills so they can pitch in if backlogs arise that can only be addressed with additional manpower. This is an essential requirement that also ties into the next recommendation.

Priority Level: High

WSI Response: PARTIALLY CONCUR

- a) **CONCUR** -- An updated ICD-9 mapping and flowchart automation process will replace the current automated bill release process. The process will kick-out, for example, 99204, 99214 and 99284. These complicated codes will be routed to RN bill reviewers.
- b) **PARTIALLY CONCUR** -- Once mapping and flowchart automated process is implemented, WSI will re-evaluate. The purpose of automating the process is to reduce human intervention.
- c) **CONCUR** -- Bill Review Supervisor, Bill Review Team leader, Claim Supervisors & Claim Adjuster are all trained to process medical bills. All of the mentioned can assist in processing bills if needed.

NOTE: The statements in the narrative preceding audit recommendation #78 prompted WSI to do further research. There appears to be a misunderstanding concerning a WSI bill payment report. The report lists all medical & dental bill payments, pharmacy bill payments, and vouchers (injured worker travel reimbursements). The bill payment system was purposely set up to identify *potential* duplicate medical & dental payments. Any potential duplicates identified are routed to the senior bill reviewer for duplicate determination. The potential duplicate bills --not bill payments-- identified by the system are usually bills in which an injured worker (IW) has more than one claim number and the physician treated the IW for both injuries during the same appointment and then billed WSI for two office visits on the same day. The system currently catches these bills before payment is made. It was these “potential duplicate bills” that were brought to the Octagon team’s attention.

Octagon Reply to WSI Response (Part b only):

We agree as long as the process can be achieved in such a way that it minimizes the risk of any error. Further, and as regards the Note above, duplicate payments do occur that are not necessarily tied to companion files. Tracking the reasons for these duplicate payments should lead to fewer duplicate payments in the future.

During our assessment of the bill review process, we felt the process was not clearly defined, something that could be remedied with a good manual. User manuals typically show screen prints at the appropriate intervals with clear documentation of the bill review process from start to finish.

Recommendation #79

We recommend a bill review procedure manual be developed by the manager to assist bill review staff in documentation of a step-by-step process on how to complete a review of medical bills. In order to

accurately document all policies and procedures the author (i.e., the manager) will have to be familiar with all bill review systems and processes.

Priority Level: High

WSI Response: CONCUR

A procedure manual is in the process of being developed by the medical services department.

Bill review systems need to integrate both UR and Bill Review areas to allow for more automation of the medical bill process. A system should be able to route bills to appropriate reviewers, apply state fee schedules, provide the ability for utilization review to complete treatment plans, and have those treatment plans automatically apply to medical bills which would speed up the processing time of medical bills. A good bill review system should also be able to produce reports for current inventory and determine which bills are truly not yet reviewed and which bills are currently being held for another reason. The system will also need to be able to produce letters and forms currently required by the state for bill review purposes.

Recommendation #80

We recommend WSI upgrade the current bill review system to a more robust system.

Priority Level: High

WSI Response: CONCUR

WSI hired an automated bill specialist nearly two years ago to review how best to upgrade and automate the bill review functions. As a result of this review, the entire IS structure was evaluated and is now being planned for replacement.

Octagon Reply to WSI Response:

We are unsure based on WSI's response how the replacement of the current IS structure with a new one is responsive to our recommendation. We are also unsure what the automated bill specialist may have recommended insofar as bill review system upgrades.

Recommendation #81

We recommend nurse reviewers complete higher-level hospital, surgery and facility type reviews while Medical Bill reviewers should complete routine bill review. This will allow the nurses to utilize their expertise on the reviews demanding more clinical review. Ultimately, this change in bill mix could lead to a need to modify the current staffing model.

Priority Level: Medium

WSI Response: CONCUR

This has been WSI's procedure -- nurses review the UB 92s and higher-level bills.

Octagon Reply to WSI Response:

We know that WSI has the nurses processing UB 92s and high-level bills, but they are also involved in the processing of other bills, as well. The recommendation was made with consideration to how resources may be retained and utilized in the future.

Recommendation #82

We recommend all bill review staff obtain Certified Professional Coding Designation. This would provide the same quality and consistency of application of CPT codes being utilized by the department as a whole.

Priority Level: Medium

WSI Response: CONCUR

Of the six members of the bill review staff (including management), only one newly hired RN is not certified. The certified staff received notice of certification in March of 2006. The new bill review RN will be given the opportunity to participate in the next class offered.

Recommendation #83

Random Quality Assurance audits need to be completed by management staff to ensure accuracy of reviews being completed by bill review staff.

Priority Level: Medium

WSI Response: CONCUR

Random quality assurance audits are currently completed in the auto-adjudication process. With the implementation of the ICD-9 mapping and flowchart automation process noted in recommendation #78, new reports and data will be developed to facilitate and promote quality assurance audits in the automated process and manual bill review.

ELEMENT SIX - EVALUATION OF MEDICAL SERVICES (PART TWO – UTILIZATION REVIEW)

Objective: Utilization Review

In this section, we reviewed the utilization review area to ensure it is functioning properly. Our objective is to perform an evaluation of the overall efficiencies and effectiveness of WSI's Utilization Review program including a review of the relevant policies, procedures, and processes.

Key Activities

To achieve the above objective, the following activities were undertaken:

- Review of Intake Area
- Review of Utilization Review Area
- Review of Utilization Review Policies and Procedures
- Review of Utilization Review Appeals Process
- Interviews with numerous staff within Injury and Medical Services

Overview and Analysis: Utilization Review (UR)

The Utilization Review Area consists of two Intake Coordinators, three Nurse Reviewers, a part time Medical Director in the Fargo Office and at the time of this review it was planned for a full time Medical Director to reside in the WSI office in Bismarck. It is the role of the Utilization Review Department to review requests for treatment from providers on a Prospective, Concurrent, Retrospective and an Appealed basis.

UR receives requests for utilization review from a medical provider office either by fax or by phone. The Intake Coordinator will complete the UR 1 form and will get all of the information on the injured worker as well as the doctor recommending the service and the facility in which services are to be performed. The Intake Coordinator will also note the notepad entry documenting how the request was received as well as the nurse to whom the task will be assigned. The Intake Coordinator will also request any pertinent medical information from the provider if not included in the request. Intake Coordinators receive approximately 40 requests per day for two Intake Coordinators.

Once the utilization review nurse receives the request for treatment, a determination is made by the nurse if the service requires pre-certification, concurrent review, or if the request is from a provider disputing the recommendation made by UR. For a retrospective review, the claims adjuster must first approve the request.

Prior authorization must include a statement of condition diagnosed, relationship to compensable injury, medical documentation supporting medical necessity, an outline of the proposed treatment plan including duration and services, and the expected prognosis.

The Utilization Review Nurse is responsible for reviewing all acute inpatient medical surgical requests, all continued hospital stays at acute inpatient settings with length of admission greater than 14 days, non-emergency major surgery, concurrent reviews (required within 24 hours of employee entering the facility or the next business day which ever occurs first), outpatient surgery with exceptions clearly documented, therapeutic injections, most CT scans, MRI's as well as other diagnostic procedures.

Physical Therapy has an initial window period of 10 visits or 30 days of care whichever comes first. Services exceeding that amount require prior authorization. If the nurse determines additional review is necessary these will be forwarded to the North Dakota Physical Therapy Association (NDPTA) for review.

Occupational Therapy has an initial window period of 10 visits or 30 days of care whichever comes first. Services exceeding that amount require prior authorization. If the nurse determines additional review is necessary these will be forwarded to North Dakota Occupational Therapy Association (NDOTA) for review.

Chiropractic has an initial window period of 12 visits or 90 days of treatment. Services exceeding that amount require prior authorization. If the nurse determines additional review is necessary the request for treatment will be forwarded to Orthopedic Chiropractic Consultants for review.

Claims adjusters must approve chronic pain programs, chemical dependency programs, detoxification programs, health club memberships, specialized rehab, biofeedback, FCA and FCE, pool therapy, independent exercise programs and DME with the exception of TENS units which is managed by utilization review department.

The Utilization Review Department receives approximately 800 – 900 reviews per month or about 15 reviews per day per nurse.

In reviewing other broad UR department statistics, if the provider complies with pre-certification requirements services are certified 85% of the time, partially certified 6% of the time and denied in entirety 9% of the time.

Providers who appeal UR denials receive a full reversal 63% of the time, a partial reversal 7% of the time, and a denial of the appeal 30% of the time. As we noted earlier, the most frequent reasons for reversals are that the provider can substantiate they did not have knowledge that they were treating a work related injury or if the provider is an out of state provider unfamiliar with North Dakota processes.

In reviewing statistics for retrospective reviews, services are approved 93% of the time, partially approved 3% of the time, and denied 4% of the time.

A random review of approximately 25 utilization review claims documented the consistent application of utilization review procedures as well as application and documentation of the UR criteria utilized to perform review.

Reviews requiring medical director review were sent timely with timely response by the medical director.

Once a UR review is completed the nurse completes the review request by documenting the injured worker information, review detail, procedure, review type, cost savings, UR criteria utilized, claim number, case type, status (approved, deny, partial), MD involved, which RN performed the review, and the date completed.

A letter to the provider is sent indicating whether or not services were authorized as requested, partially authorized or denied. This letter also indicates the authorization is not a guarantee of payment as liability decisions are made by the claims adjuster. Once completed the UR nurse will return the packet to the Intake Coordinator. The Intake Coordinator will then update UR data entry form and separate medical reports and send to imaging to be scanned to the system.

The Utilization Review Department policies and procedures were documented thoroughly. All Utilization Review letters sent out by UR staff were audited. The audit revealed less than a 1% error rate, nearly all of which were address errors.

Recommendation #84

We recommend WSI have its utilization review nurses work on a platform, which is integrated into the bill review system. This will allow the nurses to have the decisions applied in an automated fashion, which takes the guesswork out of processing a bill on the bill review side. The treatment plan can enforce utilization review decisions by only allowing services, which have been prior authorized (if required) and prior approved to be paid. (See also Recommendation #80, as it overlaps with this one.)

Priority Level: High

WSI Response: CONCUR

A software change was implemented which will allow for automatic payment of routine office visits, physical therapy, and occupational therapy bills that fall within specified criteria. This was one of the phases of the auto bill payment process that began in late 2005.

Octagon Reply to WSI Response:

WSI will benefit from a system in which treatment plans are actually integrated into the bill review processing system. This will allow the reviewer to have access to current and prior treatment recommendations when processing medical bills and provider appeals. This integration process should be considered when building out the Utilization Review interface.

Recommendation #85

We recommend UR staff assist in developing routing rules for bill review staff. UR nurses can assist in making sure that higher level bills, surgeries, complex diagnosis bills and questionable procedures are routed to bill reviewers with higher level skill sets.

Priority Level: Medium

WSI Response: CONCUR

WSI will use the UR nurses to help create the routing rules and design the automated bill process for the “new” claims management system, which is targeted for implementation in the next three to four years.

Recommendation #86

We recommend WSI discontinue the process of auditing 100% of the UR letters being sent out by UR staff. This area appears to be functioning well within the expected error rate. We would suggest the UR supervisor do random audits to ensure that UR letters continue to be within the 1% error rate.

Priority Level: Medium

WSI Response: CONCUR

The practice of auditing 100% of the UR letters was discontinued in August of 2006. The system generated event to the UR supervisor was discontinued in September of 2006.

ELEMENT SEVEN - EVALUATION OF POLICYHOLDER SERVICE (PHS) FUNCTIONS

Objective

In conjunction with a comprehensive review of the Workforce Safety & Insurance Employer Services, we were asked to evaluate Policyholder Service functions, including:

- The PHS collections function
- The premium audit function
- The premium billing process
- A review of the overall effectiveness of WSI's Experience Rating Plan, and
- A review of the existing rate classification manual

Pursuant to these objectives, we were asked to limit our scope of procedures to gain an understanding and specifically as stated in our proposal.

We understand that Workforce Safety & Insurance was interested in efficiencies in the conduct of this review. As such, this was not to be a formal internal control audit or performance audit as described under the Government Audit Standards (Yellow Book) but an agreed upon procedure review of the system. The principle difference is that an internal control audit would render an opinion on the control procedures and the effectiveness. To render such an opinion control testing would have to be performed to determine if we can render an opinion that the described procedures are in place and are effective. To provide for efficiency we reviewed the control processing environment and procedures and performed a walk-through on critical functions.

Key Activities

To accomplish these tasks, we performed the following (specifically related to the PHS collection and audit functions and the billing process):

- Conducted interviews with key contacts to gain a basic understanding of processes
- Obtained copies of control policies and procedures
- Reviewed the control environment; policies and procedures
- Obtained an understanding of the related statutes, administrative rulings external and internal factors
- Reviewed the significant transaction cycles, the collections policies and procedures and the billing process including a complete walk-through of the transaction cycle while on-site

As a result of these activities, we assessed the overall effectiveness of the policies and procedures in place.

For the review of the overall effectiveness of WSI's Experience Rating plan, and a review of the existing rate classification manual, we:

- Obtained a copy of the rating plan
- Interviewed program staff regarding objectives relating to the rating plan
- Reviewed with WSI's actuary the rating plan goals and objectives.
- Discussed principle assumptions and characteristics of the rating plan including:
 1. Identification of separate rated groups and their characteristics

2. Scope of developed loss data included in the rating plan
3. Limiting of loss assumptions
4. Excess loss assumptions
5. Inherent credibility of loss information as a predictor of future loss experience
6. How the plan accounts for the multiple variables that arise from evaluating the primary and excess loss components implicit in a rating plan
7. Discussed with WSI's staff and actuary and evaluated principle assumptions and credibility effect the rating factors may have on the plan
8. Discussed with WSI's staff and actuary the characteristics of the plan that may make it responsive or not responsive to changes in loss trends; for example, precipitous increase in medical cost components
9. Identified comparable plan to compare basic assumptions
10. Reviewed with staff and actuary a sample of historical loss experience for a selection of rate classifications as compared to the indicated rating to assess the predictive nature of the plan
11. Reviewed the responsiveness of WSI's application of the plan
12. Reviewed the existing rate classification manual as it relates to the goals and objectives above to determine if the manual is consistent
13. Reviewed the control environment related to plan assumptions

Overview and Analysis:

The Policyholder Services (PHS) is comprised of three major functions:

1. Underwriting: this is a unit of four staff and one supervisor
2. Collections: this is a unit of five staff and one supervisor
3. Audits: this is a unit of six auditors and one supervisor

There is one Director overseeing PHS.

The PHS Collections Function

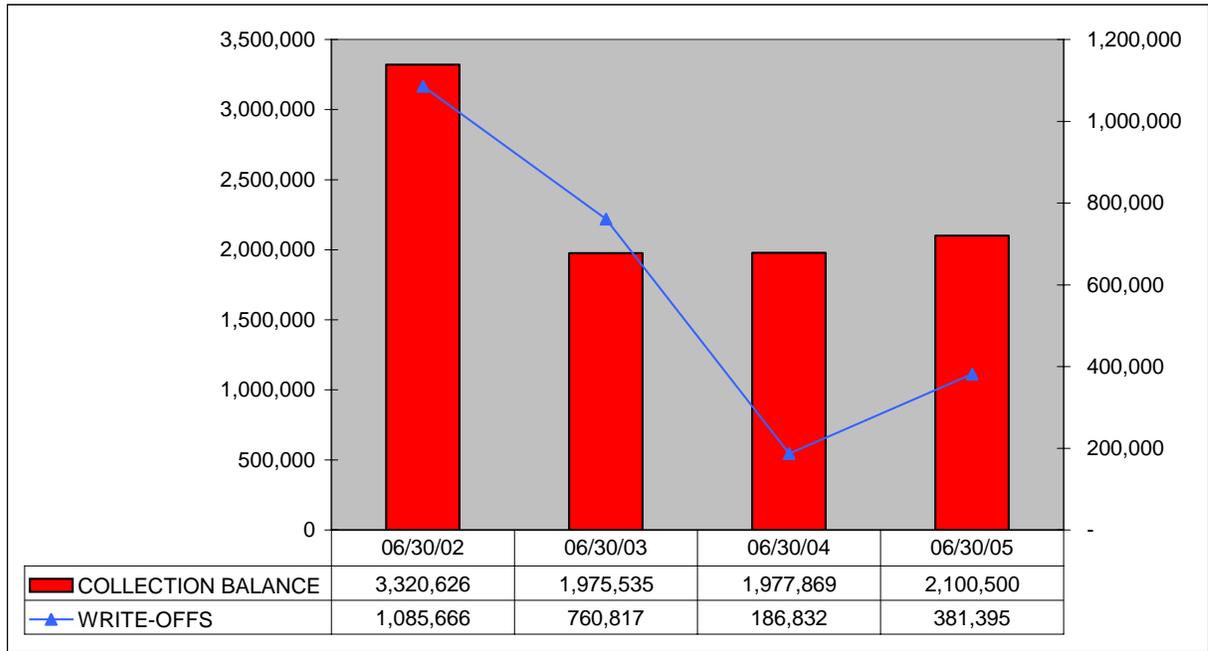
The principle activity of collections is working with employers to collect delinquent workers compensation billing and excess medical billing. Collections are assigned accounts that have received the third notice and are at least thirty-days past due. In addition to collections issues, independent contractor disputes are currently referred to the Collections Unit to issue a decision.

As of June 30, 2005 collection aging is as follows:

| Aging | Premium Balance | Interest Balance | Penalty Balance | Total Balance |
|------------------------|------------------------|-------------------------|------------------------|----------------------|
| Less than 12 Months | \$ 1,168,812 | \$ 123,645 | \$ 33,610 | \$ 1,326,067 |
| 12 to 24 Months | 302,686 | 80,034 | 35,010 | 417,730 |
| Greater than 24 Months | 259,712 | 86,311 | 10,681 | 356,704 |
| Grand Total | \$ 1,731,209 | \$ 289,989 | \$ 79,301 | \$ 2,100,500 |

PHS has improved collections and write-off statistics significantly since 2001. These results are due to a combination of improved billing and collection processes. The average amount in collections has reduced by \$1.2 million dollars or 37%. The write-offs have reduced by \$704,271 or 65%.

Collection / Write-off Amounts
July 1, 2001 through June 30, 2005



Motivating employers to keep payments current. The principle characteristic of an account that goes delinquent is that the employer is a construction contractor or truck driver employer. Typically these employers will pay two months of premium and after year-end not make payment on the annual balance. Essentially, once these employers receive the certificate of valid workers compensation insurance, which is valid for one year, they stop making payments on their account.

Deposits may serve a useful purpose, and deposit amounts could be adjusted depending on credit worthiness. In keeping with a deposit plan, it might also be appropriate to issue certificates of insurance only through the quarter beyond which premiums have been paid.

Recommendation #87

To improve the stability of workers' compensation funding and collections, we recommend WSI require employers to make an advance deposit and a quarterly premium deposit.

Priority Level: Medium

WSI Response: DO NOT CONCUR

The current billing process is structured to request the future month's premiums within the minimum amount due --indirectly securing a deposit amount. The current billing process permits additional flexibility through the calculation of installment amounts on a *monthly* rather than a quarterly basis. WSI does not intend to require all employers to provide an advance deposit beyond the current process.

Octagon Reply to WSI Response:

A monthly deposit increases the number of deposits by a factor of three over a quarterly payment. Transitioning to a quarterly payment process would reduce administration for both WSI and its employers. Management should weigh the benefits of this efficiency with the flexibility it is offering its employers.

Employer Deposit. Having employers maintain a workers' compensation deposit is the general rule in the industry. While WSI is required to cover all employers, this shouldn't mean that WSI and the rest of the employers that participate in the group funded program should be at risk for other employers that do not make their required payments.

Recommendation #88

To ensure payment and program funding security, WSI should have deposit requirements for all employers, or develop a policy to have a deposit for new employers and those with poor payment history.

Priority Level: Medium

WSI Response: PARTIALLY CONCUR

WSI will review incorporating a deposit policy for employers with a poor payment history.

Octagon Reply to WSI Response:

This can be problematic unless WSI institutes the deposit policy for all new employers and then evaluates how they do over the first two years or so. Otherwise, if WSI policy waits to determine which new employers are poor payers it could already be in a situation where it creates unrecoverable billings.

Employer pre-funding a deposit for their workers' compensation coverage is customary in the industry. The WSI is an enterprise fund where the goal is that the program funds itself. Policies that ensure that each employer funds their premium and provides adequate security on an employer-by-employer basis is ordinary and customary.

Analyzing Poor Paying Employers. As discussed above, we noted some characteristics of employers that tend to have problems in making payments. The PHS manager should evaluate whether additional training or information be provided to these employers including the implementation of policies and procedures to reduce late and non-payment of required premiums.

Recommendation #89

To support the PHS in its identification and analysis of poor paying employers, we recommend the Research and Technology Unit review the characteristics of employers that have poor payment history and write-offs of premium and determine if there is information that can be developed to aid the premium billing and collections department.

Priority Level: Medium

WSI Response: CONCUR

WSI will review past payment history for delinquent policyholders; attempting to identify characteristics of collection and write-off accounts. This information will be shared with collection staff to aid in the identification and collection of past due amounts.

Integration of the collections process with the PICS database: Daily, a technician will query the system and print out all third notice billings that became due since the last printing. This is about 200 billing statements per month. These billings are alphabetized and then handed over to collections specialists for collection. In addition, a separate Excel spreadsheet is maintained for collection specialists to document collection activities.

The PICS database contains employer and billing information. As such, collection screens can be designed to track through the collections process and to provide for documentation. In addition,

collections reports can be generated to list accounts that are in collections status and the collections manager could assign the bills to the collection specialists without printing bills.

Recommendation #90

We recommend WSI integrate the collections process with the PICS database.

Priority Level: Medium

WSI Response: CONCUR

Due to system limitations, PICS does not currently integrate with the collection process. This functionality has been included in the system replacement RFP.

PHS Manager Monitoring of Billing. Monitoring an aged accounts receivable report is a customary management tool for billing and collections for businesses. These reports can provide a stratification by date of the outstanding billings and help management and staff focus efforts and monitor balances.

Recommendation #91

To provide for improved collections monitoring and management, we recommend the PHS manager review monthly an aging report that shows aged accounts receivable that shows amounts, 30, 60, 90, and 120 days and beyond. This information should be used in evaluation of the performance of the billing and collections process.

Priority Level: Medium

WSI Response: CONCUR

The Collections Supervisor will conduct monthly briefings with the PHS Director, Audit Supervisor and Underwriter Supervisor.

The Premium Audit Function

The premium audit function is designed to be a process to ensure that employers are properly calculating and reporting payroll and employee classifications. There are about 20,000 covered employers and seven auditors. The auditors conduct approximately 1,800 phone and physical audits per year. Audit subjects are selected based on a variety of criteria including: premium size, number of classifications, variances, and industry or classification focus. There are two types of audits: telephone audits and physical site visit audits.

In order for WSI to collect sufficient premiums to cover claims and administrative costs, it is imperative that an employer be properly classified. Proper classification not only provides the correct premium for the risk, but it also ensures that the proper rate is being charged for each classification. Each classification must maintain a level of income equal to claims costs. WSI accomplishes this goal by auditing employer accounts to determine proper classification, correct payroll reported, correct number of employees, and correct reporting of optional coverage.

Aside from the random audit selection, insureds may also be selected because they:

- Have negative loss ratios
- Are accounts with last audit date of three years or older
- Pay the minimum premium accounts

Audits may also be determined during the claims edit function due to significant payroll changes or other indicators. Telephone audits for out-of-state employers will be accomplished to determine if site visits are required. New accounts or employers with four or more rate classifications may also garner more attention in the audit process.

The objectives of the audit are:

1. To determine the correct basis of premium charged for the period audited
2. To furnish guidance and counsel to the employer for payroll reporting and matters of coverage
3. To obtain information regarding the nature and extent of the employer's operation and submit factual information with regard to any need to amend coverage
4. To assure consistency, equity, and accuracy in the application of the same rate classifications to similarly situated businesses
5. To maintain good public relations and equity among employers

Interpretation of classifications. The items reviewed are payroll amounts (covered payroll) and employee classifications. Covered payroll can typically be compared to the Job Services database and can be verified through this and comparable federal forms 941. Employee classifications are sometimes problematic because there are differing opinions on what is included in some job classifications. This can cause differences among staff and confusion for employers. PHS is planning on a full review of the employee classifications to resolve these differences. Once this review is complete training should be prepared for necessary WSI staff to ensure consistent implementation.

Recommendation #92

We recommend the auditors be included in the review of the employee classifications to help ensure clear objective criteria exist for classifying employees.

Priority Level: Medium

WSI Response: CONCUR

In March of 2006, a cross-functional committee was formed to review the classification manual. The auditors have been and will continue to be an integral part of this process due to their expertise.

Interaction with other units. Employers to be audited are selected based on a variety of factors and with input from Underwriting, Claims, Audit, Billing, SIU (Special Investigations Unit), Research and Technical Support and, Loss Control / Loss Prevention. It is important that these departments establish internal criteria that are formalized to refer employers that are indicated audit candidates to the PHS manager. In addition, these other units may need the auditor to observe other conditions at the employer site or identify information to the other units for further follow-up.

Recommendation #93

We recommend the audit department report quarterly on their findings and observations to the management team and other units. The audit paperwork could include other potential areas for follow-up, such as safety and loss control, either as a result of the audit or because of specific requests of the policyholder.

Priority Level: Medium

WSI Response: CONCUR

The Audit Supervisor currently produces a monthly premium audit report detailing audit findings. WSI can supplement the monthly report with a quarterly report. The quarterly report would be an overall synopsis of completed audits and the needed follow-up required by other WSI units.

Billing in a sense is doing a phone audit when reviewing edit differences and contacting employers and if these practices were reviewed and well understood, they might help the Audit Unit streamline its own audits, redirect audit efforts and/or eliminate some of its potential audit assignments altogether.

Recommendation #94

To streamline phone audit activities, we recommend the PHS manager have the Audit Unit review what the Premium Billing Unit is doing during its employer contacts.

Priority Level: Low

WSI Response: CONCUR

The premium auditors will review system notes prior to conducting an audit and review any findings that require additional follow-up with the applicable staff.

Structured approach to audit selection. Audit staff rotates employers to review and uses a variety of selection criteria; however, in the past there have been large employers or certain employer types that escaped regular review. The audit selection approach should include a formalized stratification by payroll and key characteristics such that it can be monitored and managed to ensure that the long-term employer audit coverage goals are met. For example, employers with payroll of \$100,000 or greater should be audited every three years.

Recommendation #95

We recommend WSI establish, in conjunction with Research and Technical Support, a structure that documents the rotational plan for audit of employers. Other components of this recommendation include:

- The PICS system can be used as a resource to manage this process.
- An annual and a five-year plan should be developed.
- Regular statistics should be compared to this plan to measure results and help plan for the future audits or if modifications should be made due to risks identified by the Audit Unit and the Research and Technology Unit.

Priority Level: Medium

WSI Response: CONCUR

Research & Technical Support in conjunction with PHS management will develop a plan for the auditing of policyholders for a one and five year period. To the extent that it is feasible, WSI will utilize the PICS and replacement system to manage this process.

Audit differences (NDCC Section 65-04-32 Decisions by organization – Disputed decisions): Under the workers' compensation law there is a formal process for addressing audit adjustments or other disputed decisions. Based on our inquiry, there have been times when employers use outside political contacts to put pressure on staff and management to change or influence decisions.

Recommendation #96

To ensure integrity about the process, we recommend to WSI that when staff and management are faced with outside pressure to revise audit findings, WSI should ensure that the processes as described under NDCC section 65-04-32 are followed and staff and employers are assured that policies, classifications and adjustments are objectively applied.

Priority Level: High

WSI Response: CONCUR

It should be noted that this is an anecdotal and best practices reference to avoid external pressures. No proof of acquiescence to such pressure was presented. While the potential exists in any organization for such pressures, it is important to have a formal process in place to assist with disputes. Historically, the organization sought to handle disagreements on a more informal basis. The employer appeal process will be more formalized and documented.

Auditor training: The auditors meet quarterly to discuss the audits and their process. The audit supervisor or, as deemed necessary, audit staff should attend national organization training events for workers' compensation payroll auditing. Following attendance at such training events, summary information can be provided to appropriate staff. The summary information can include audit process, procedures, rules and regulations and insights and materials gained from national associations.

Recommendation #97

To help tune the skills of auditors, we recommend WSI have an internal formal training process for outcomes related to attendance at national training sessions.

Priority Level: Medium

WSI Response: CONCUR

Appropriate courses and training will be made available including the acquisition and maintenance of professional certifications. WSI's proposed FY 2007/2009 biennial budget includes an increased request for training dollars for the agency.

Computer resources: The auditors travel extensively and are highly dependent on their laptop computers and the data saved. If the laptop fails the ability of the auditor to be effective is seriously impaired.

To maximize efficiency, staff can backup audit data daily to prevent a loss if their computer is stolen or fails. Auditors can be trained to maintain their computers through regular system error checks and disk scans. This process along with an up-to-date virus scan should help ensure an optimal operating condition. In addition, an older spare laptop could be configured to serve as a temporary replacement when the auditors' computers need to be serviced.

Recommendation #98

For field auditors, to provide backups, we recommend that each auditor be provided with a USB storage "thumb drive," and that virus scans be a routine activity for the computers used by field audit staff.

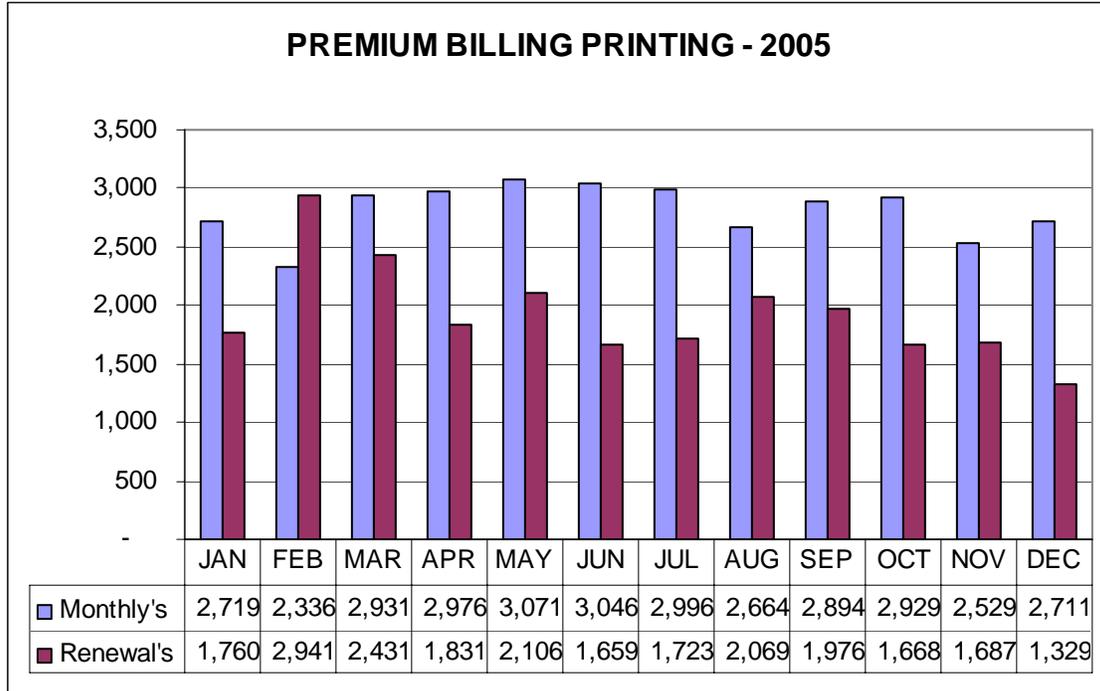
Priority Level: Low

WSI Response: CONCUR

WSI laptops continue to be maintained on an on-going basis with support from information technology. "Thumb drives" were given to the auditors on 05/25/06.

The Premium Billing Process

Underwriting (Billing). The principle activities of the underwriting department involve applying actuarially determined base rates modified by employer loss experience to arrive at a rate for the workers' compensation premium as a function of \$100 of payroll. The underwriting department prepares billing based on payroll and loss data for the employer. In addition, underwriting has significant interaction with employers to explain billing and to collect necessary billing information. Billing volume is depicted as follows:



We reviewed how the payroll information of the employer is validated. Reported payroll can be compared to the payroll reported to Job Service to verify accuracy. When the staff is verifying the payroll it can be difficult to match and outside calculations may have to be made to adjust to the billing period and to exclude certain payroll.

Employers Self Bill. Currently a payroll estimate request is sent to the employer thirty days prior to the end of the policy period. Once this information is received, it is reviewed to determine if the amounts appear reasonable. If they appear reasonable a bill is processed and sent. If it does not appear reasonable, the billing technician will contact the employer to resolve. In the best case scenario the payment will be received within fifteen days after the beginning of the policy period. If research is needed the payment may not be received until forty-five days after the beginning of the new policy period. It is typical in the workers' compensation industry for employers to self-bill based on set employee classifications and payroll reports. The employer can include the estimated payroll, calculate, and pay the estimated premium.

Recommendation #99

To streamline the billing process, employers should self-bill with a premium billing worksheet that is customized for the employer that includes the billing codes based on the prior year and the current rates. In addition, employers that submit reports that are questioned can be followed up over the next quarter, while WSI has at least an initial premium.

Priority Level: High

WSI Response: CONCUR

WSI will review a phased approach to self-billing starting with minimum premium employers and then expanding to other than minimum premium employers.

Quarterly Billing. Currently employer payroll information is verified against the Job Service database. This database collects information on a quarterly basis. Comparisons of payroll can only be estimated for billing that doesn't align with the Job Service data. Staff must perform hand calculations to try to compare the payroll information submitted to the Job Service database. Based on service to 20,000 employers, streamlining the process should be a priority.

Recommendation #100

To improve the billing and payroll verification process, we recommend that billing be prepared on the quarterly basis. This will enable direct comparison to the Job Service database. This would also eliminate some of the hand calculations being performed.

Priority Level: Medium

WSI Response: DO NOT CONCUR

A significant number of policyholders utilize fiscal year reporting periods, which would not coincide with quarter end dates. In addition, there are differences between WSI and Job Service payroll amounts resulting from (i.e.: coverage requirements, payroll caps, reporting periods), which prevent a direct comparison of payroll amounts.

Octagon Reply to WSI Response:

WSI may wish to consider the quarterly process as described above anyway if it can validate that employers already have to gather and report employee payroll information to the federal government on a quarterly basis.

Integration of Job Service Database. WSI depends on data from the Job Service database to verify payrolls for billing but this can be a difficult process when two systems must be opened up and hand calculations must be made to make data comparable.

Recommendation #101

We recommend the Job Service database be integrated with the Policyholder Information Computer System (PICS). The database could then be used to create reconciliation reports that adjust out non-covered payroll items such as officer pay and to limit payroll to the payroll cap.

Priority Level: Low

WSI Response: PARTIALLY CONCUR

Due to differences in wage cap, coverage requirements, and payroll reporting periods this is similar to the response in recommendation #100. However, to the extent exchange of data benefits WSI, information systems will be integrated where appropriate.

Octagon Reply to WSI Response:

The wage cap differences should be something that can be objectively evaluated and as a result programmed into the system. A critical barrier appears to be comparability of the payroll data submitted from different payroll reporting periods for each employer. Perhaps, greater consideration should then be given to Recommendation #100.

PICS database should be able to print payroll formatted reports: Employers can submit their workers' compensation payroll report online. Currently, billing specialists must print this report to maintain the report format. This data flows into the PICS database.

Recommendation #102

We recommend WSI create a report that enables the payroll report to be recreated in the same format from the PICS database. This would eliminate the need to print and maintain a hard copy of this report.

Priority Level: Low

WSI Response: CONCUR

To the extent possible, the report will be recreated within PICS.

Online Payroll Submission. Currently there are about 40% of the employers submitting online payroll information. This leaves 60% of employer data or 12,000 to be entered manually. Many have multiple billings per year. Increasing online submission should be a priority to improve efficiency of the unit.

Recommendation #103

To improve participation in the online payroll submission, we recommend,

1. The billing technician spends time with employers when contacting them on other issues to walk them through the online payment reporting (OPR) and ask them to report this way.
2. The billing staff should put together an online power point presentation that walks the user through the steps to complete the online report. In addition, this presentation should describe and show examples of how data can be sent and used to report the required information and what information formats cannot be used. This presentation should be posted on the WSI website as a resource for the OPR system.
3. The PHS manager should establish targets for moving manual reported employers to the online system. The PHS manager and the billing staff should review with the Research and Technology manager the PICS database to determine:
 - a. What are the characteristics of the employers that submit electronically
 - b. What are the characteristics of the employers that do not participate in the online reporting program
 - c. Develop a marketing and educational program to move these employers to online reporting.
4. Requiring employers with more than a given number of employees be required to submit payroll information online.
5. Also WSI could offer a first-time incentive for submitting the payroll information online.
6. Some employers elect not to submit information online because WSI staff advises them there is not "a secure line" for submitting the data. There is always a security risk when e-mailing data. Employers that are concerned should be encouraged to use the online form.
7. Some employers report that they cannot attach their data to the online payroll report. The billing technician should identify these employers and the PHS manager should have IT staff review the characteristics of these employer systems or data to arrive at possible solutions to enable online reporting and data submission.

Priority Level: Medium

WSI Response: PARTIALLY CONCUR

- 1) **CONCUR** -- Staff will continue to encourage the policyholders to submit their payrolls through the On-line Payroll Reporting (OPR) system.
- 2) **CONCUR** -- A PowerPoint presentation will be prepared and placed on the WSI website for policyholders.
- 3) **PARTIALLY CONCUR** -- Utilization has increased since the inception of OPR. Staff will continue to market this tool to policyholders with the emphasis on increasing overall participation. WSI will review setting an appropriate target, but will not commit to establishing a firm target.
- 4) **DO NOT CONCUR** -- WSI will recommend that the policyholders utilize this system, but will not direct customers on how they must do business with the agency.
- 5) **CONCUR** -- WSI will explore the feasibility of offering an incentive to increase OPR usage.
- 6) **PARTIALLY CONCUR** -- While some employees have noted to employers who wanted to e-mail information to WSI that this would not be secure transmission, there is no evidence that employers were advised that filing through the website portal is not secure. To the extent that this issue may exist, WSI will provide additional training.
- 7) **DO NOT CONCUR** -- These issues are very infrequent and are usually resolved by telephonic communication with the policyholder and PHS staff without IT intervention.

Octagon Reply to WSI Response:

(Part 3) – A business would set targets for moving customers to an online system. WSI should be no different.

(Part 4) – A strong customer services attitude is important and WSI demonstrates this in its response. But even the IRS and the Social Security Administration have identified larger employers and certain administrators capable of submitting information electronically and have required this for years. WSI should not be hesitant. WSI can make a similar commitment and structure a plan as described in the recommendation.

A Review of the Overall Effectiveness of WSI's Experience Rating Plan, and a Review of the Existing Rate Classification Manual

Experience Rating Plan. The experience rating plan is designed to provide a rate modifier for employers based on past loss experience. The WSI experience rating formula is an actuarially based method of determining if a specific risk's loss experience is better than expected or worse than expected. Similar to formulas used in nearly all other states, WSI's formula compares the losses that actually occurred to the losses that were expected. The period used for comparison is referred to as the experience rating period – it consists of five policy periods excluding the most recently completed period. A unity modification factor (1.00) indicates an average risk. A factor greater than 1.00 indicates a risk with greater than expected loss experience. A factor less than 1.00 indicates a risk with better than expected loss experience. Experience rate modification factors can be translated to surcharges or discounts. Modification factors of 1.00 or greater reflect a premium surcharge; factors less than 1.00 reflect discounts to premium (e.g., .97 = 3% discount or -3%).

The Mod Formula

| | | | | | |
|---------------------------------------|-----------------------------------|-----------------------|--|---------------------------|-----------------------|
| Actual Primary y Losses | + x Actual Excess Losses | Credibility Factor | + x Expected Excess Losses | 1 - Credibility Factor | + Ballast Value |
| <hr/> | | | | | |
| Total Expected Losses + Ballast Value | | | | | |

Rate Classification Manual. The rate classification manual assigns premium rates to different work classifications. These assignments are made in recognition of the differences in loss experience and loss exposure for types of work and industries. Standard industry classifications as maintained by National Council on Compensation Insurance, Inc. (NCCI) to help employers, insurance companies and governments compare relevant loss data.

Basic changes in the rate plan are allocated among the twelve major groups of rate categories and then among the classifications within the groups. Based on our review we found that the effectiveness of the Experience Rating Plan for distributing the losses among classifications and among employers can be improved by the following:

Consider lowering the large cap loss amount. The experience rating plan uses a large loss cap of \$250,000. This amount may be considered on the high side as large cap loss limits may be typically run between \$100,000 to \$150,000. The effect of this may be to place more emphasis or impact of a large loss on the experience formula. This may tend to extenuate the swings due to large losses rather than to moderate them.

Recommendation #104

We recommend WSI consider and discuss with its actuary whether this large cap level should be reduced to limit the swings it may cause on employer rates.

Priority Level: Medium

WSI Response: CONCUR

WSI will reevaluate with its actuary the possibility of lowering the \$250,000 loss cap in conjunction with its 2007 legislative proposal to eliminate the 1.75 experience modification cap.

Credibility Factors. We considered the inherent credibility of loss information as a predictor. The covered workforce in the state is about 350,000 and there are 141 rate classifications (NCCI has 640). The smaller classifications may not have enough creditable data as a basis. In the past, the actuary used NCCI pure premium data. Since North Dakota has a salary cap and its classifications do not directly feed into the NCCI classifications, direct comparison has not been done in more recent years.

We discussed the elements of credibility. The goal has been to improve credibility and simplicity. The factors that have been used were based on an averaging of California and NCCI factors.

Recommendation #105

We recommend the actuary and WSI revisit the credibility factors used in the class ratemaking plan as it has been sometime since they were selected.

Priority Level: Low

WSI Response: CONCUR

WSI will work with its actuary to revisit the credibility factors used in the state's experience rating formula.

We discussed with the WSI's staff and actuary the characteristics of the plan that may make it responsive or not responsive to changes in loss trends. The experience rated plan is formula driven. The losses presented in the loss data are be translated into modifications in the experience allocations; however, many rate classifications may have too little data or may need comparable date to be more credible. As the loss data is included in the plan calculations, the formula allocates the loss experience among the classifications.

Recommendation #106

We recommend WSI consider including NCCI loss data to supplement the credibility of loss information.

Priority Level: Low

WSI Response: CONCUR

WSI will consider and review. Significant technical issues exist in carrying out this recommendation. WSI will explore the costs of obtaining this information from NCCI and look at this from a cost-benefit position. If done, a mapping of the North Dakota class plan to the NCCI class plan will need to be completed.

We considered comparability of the plan and its basic assumptions, and California and NCCI are the plans that are most comparable. The plan includes the same basic considerations and elements in the experience formula. The actuary used NCCI pure premiums in some past studies; however, since the classifications are not all comparable a cross indexing to them has not been possible at this point. In discussion with the actuary national pure premium rates from others were used in the class rate plan in the past.

Recommendation #107

We recommend WSI consider developing a database that would make comparisons of North Dakota loss information to NCCI loss information possible in the future.

Priority Level: Medium

WSI Response: CONCUR

WSI sees this recommendation as an extension of recommendation #106 and will consider additional study in this area.

The WSI currently has a payroll cap or limited payroll at 70% of the average annual wage in North Dakota. The vast majority of other workers' compensations systems calculate premium on a gross payroll basis. The full compensation benefit is paid regardless of wages when an injury occurs; however,

premium is being collected on a restricted basis because of the payroll cap. This tends to increase the rate per class. In addition, this creates certain inequities among employers and hinders comparability to other plans. We understand this would take legislative action.

Recommendation #108

We recommend the executive director review the benefits of calculating payroll rates on a gross payroll instead of capped payroll and make recommendations to the legislature.

Priority Level: Medium

WSI Response: DO NOT CONCUR

The issue was considered by the 2001 Legislative Assembly (HB 1429 do not pass 85-7) as well as by the 2003 Legislative Assembly in which the issue was amended into a study bill which ultimately received a do not pass vote of 44-1. There are no indications that overall reception to this proposal has improved since this issue was last visited by the Legislature.

Octagon Reply to WSI Response:

Changing the payroll cap should not affect the overall premiums collected from employers. However, there are certain inequities that can occur among employers. This is why similar caps are uncommon.

WSI's goals include workforce safety and protection. Pursuant to these goals WSI has many employer outreach and training programs. Employer participation varies. The realities of the economic effect of employee safety are translated to the employer via the overall rate by classification and employer experience as calculated by the experience modification factors. Currently the experience modification factor component is capped at 1.75. Typically, an experience modification factor of 1.00 would be no rate effect, .75 would impact the rate with a 25% reduction and 1.75 would be 75% greater than the base rate.

Typically in the industry there are no caps. The experience rate cap limits the amount by which an employer's experience will impact their individual rate. The total effect of the capped premium versus the uncapped premium for the 2004-05 fiscal year is \$223,228. There were only fifty-nine employers that exceeded the 1.75 cap. The experience for some employers is as high as 3.95, a factored experience of nearly four times the expected.

Recommendation #109

To help ensure that employers keep workers' compensation safety at the forefront of their decision-making, we recommend elimination of the experience modification cap. This will help employers focus attention on how employee safety affects their rates.

Priority Level: High

WSI Response: CONCUR

The issue had already been included as an item in the 2007 legislative agenda.

The above procedures were accomplished pursuant to specific goals and objectives and constitute agreed upon procedures and not an audit in accordance with *Generally Accepted Auditing Standards*, nor are they intended to be a comprehensive internal control audit. Instead the intent is to evaluate specific areas to provide the WSI assistance in evaluating performance improvement opportunities.

ELEMENT EIGHT – PRIOR RECOMMENDATIONS

Objective

In this section, the objective is to review the prior recommendations made during the 2004 performance evaluation to determine the extent to which WSI has implemented each of the fifty-nine recommendations that were made.

Each prior recommendation is categorized in one of four groupings, which are:

- Implemented
- Partially Implemented
- Not Implemented
- Not Applicable

Key Activities

To assess the status of the recommendations, several approaches were taken. These included:

- Interviews with WSI staff
- Reviews of various reports and performance measures
- Reviews of correspondence
- Reviews of ad hoc reports created specifically to address one recommendation or another
- Review of claim files

A resolution comment is provided on those recommendations that have been implemented or no longer apply. A status comment is provided on recommendations that were either partially or not implemented.

The table below sorts the prior recommendations by priority level and by degree of implementation.

| Recommendation Priority Level | Implemented | Partially Implemented | Not Implemented | Not Applicable |
|--|--------------------|----------------------------------|------------------------|-----------------------|
| High | 10 | 11 | 3 | 2 |
| Medium | 9 | 14 | 5 | 0 |
| Low | 1 | 3 | 0 | 1 |
| Total | 20 | 28 | 8 | 3 |

Overview and Analysis

As part of its management of 2004 Performance Evaluation recommendations, WSI tracked implementation in a more detailed fashion than had been the case following the 2002 Performance Evaluation. Working with department personnel, the Quality Assurance Manager (QAM) had tracking responsibility. This led to situations where department personnel may have believed that a recommendation was fully implemented but the QAM determined otherwise, and the department would then have to re-evaluate its response.

The recommendations made in the 2004 performance evaluation occurred in six categories. These categories (with the number of recommendations in parentheses) included Fraud (11), Claims (29), Legal (3), Pharmacy (7), the Office of Independent Review (4) and Prior Recommendations (5).

Our assessment of WSI's implementation is that departments made a conscientious effort to respond; however, we note that the Claims department fell short of expectations. Our assessment of their implementation success shows disagreement on seventeen of the twenty-nine prior recommendations. We believe this occurred because no significant efforts at implementing recommendations occurred until Spring 2005, and there were also misunderstandings between Claims Department staff and the content of our prior recommendations. These misunderstandings were identified during our on-site work in April 2006 and during our exit interview approximately two months later.

As Claims made up roughly half of the recommendations, the overall impact of this result could be seen as significant when viewing compliance on all recommendations. However, for the rest of the recommendations, disagreements existed in only seven of thirty. In one of those seven, WSI felt a recommendation had only been partially implemented, but we viewed it as complete (see Recommendation 44, which simply pertained to pharmacy coding).

We view the addition of the position of Quality Assurance Manager as an important one and an indication that WSI moved constructively to manage prior recommendations in a more thorough manner. We simply encourage staff in the future to contact us should there be any lack of clarity or full understanding of the content of a recommendation.

Details of our assessment of prior recommendations follow.

FULLY IMPLEMENTED

2004 Performance Evaluation - Recommendation #1

We recommend that claim personnel be allowed to work directly with the approved private investigators for their surveillance needs on activity checks. If during the investigation it is determined potential fraud exists, then the case can be referred to the Special Investigations Unit for further investigation.

This recommendation was classified as a medium priority.

Resolution:

Claim and SIU practices were modified during the performance evaluation period to fully comply with this recommendation.

2004 Performance Evaluation - Recommendation #2

We recommend cross-training be performed in the Claim and SIU departments. It is necessary for the Special Investigations Unit investigators to clearly understand the responsibilities of the Claim Analysts and vice versa.

This recommendation was classified as a high priority.

Resolution:

Cross training was accomplished, and we reviewed documentation to that effect.

2004 Performance Evaluation - Recommendation #3

In addition to the cross training, there needs to be routine formal Special Investigations Unit training held for the Claim Department and Policyholder Services. The cross-training should minimally include an understanding of how to perform self audits on claim files to identify potential fraudulent activity early, an understanding of exactly how the referral process works, an understanding of the investigative measures utilized to prove or disprove the case, and an understanding of the legal remedies utilized in pursuing the violators.

This recommendation was classified as a high priority.

Resolution:

We reviewed training materials and sign-in sheets to confirm that this recommendation had been fully implemented.

2004 Performance Evaluation - Recommendation #4

We recommend the suspected fraud referral process become paperless.

This recommendation was classified as a high priority.

Resolution:

An electronic fraud referral process is in place.

2004 Performance Evaluation - Recommendation #5

In addition to the referral timelines, we recommend:

- Requirements be placed on the private investigators to report on their assignments by e-mail every 14 days

- Target dates should be established such that each investigation is completed within 21 days
- Each status report received by the Special Investigations Unit should be documented in the claim system and forwarded to the respective Claim Analysts
- If a file is open longer than 60 days, it should be formally addressed with the Claim Analysts, Claim Supervisor, and Special Investigations Unit Director for consideration of closure. No Special Investigations Unit case should be open longer than 90 days without some type of conclusion or clear explanation as to why the investigation needs to extend beyond that period. (The same process can be applied to employer and provider fraud cases as well.)

This recommendation was classified as a medium priority.

Resolution:

Files were reviewed on a random basis to confirm that these requirements were met. Files also were generally assigned with specific tasks in mind such that sampled cases did not remain open longer than 60 days.

2004 Performance Evaluation - Recommendation #6

The Special Investigations Unit should be receiving a product, which thoroughly documents the observations of the investigator and what they have captured on videotape.

This recommendation was classified as a high priority.

Resolution:

Training was accomplished to achieve this result, and summary reports thoroughly document the observations of investigators.

2004 Performance Evaluation - Recommendation #7

We recommend a clear and decisive reporting format be provided to the private investigations firms including a surveillance log, which lists their observations of the activities from the video. This log must be prepared in a way where the document can be used in both civil and criminal prosecution as documentary evidence.

This recommendation was classified as a medium priority.

Resolution:

Logs were reviewed in case files that confirmed that this recommendation had been fully implemented.

2004 Performance Evaluation – Recommendation #11

The Special Investigator should prepare a written report, which can be utilized by the paralegal to prepare the appropriate legal documents. The rationale for this approach is that it should be the goal of the Special Investigations Unit to increase the number of criminal prosecutions, thereby creating a need for Special Investigators to become direct witnesses in their cases. As such, the Special Investigator's report will become a crucial document for review by the prosecutor and utilization in the prosecutorial process. The Special Investigator should therefore be a firsthand participant in the creation of the report.

This recommendation was classified as a medium priority.

Resolution:

This process has been implemented, and we observed examples of written reports that show compliance with this recommendation.

2004 Performance Evaluation - Recommendation #12

The claims units should train analysts and support staff in the area of compensability determination. Specific training in how to complete and document a thorough and objective claims investigation should be accomplished, beginning with techniques already documented in the WSI Claims Procedure Manual. The training should highlight the importance of three-point contact, the evaluation of injury histories to make sure they are consistent, and the limitation of liability throughout the life of the claim. We observed a number of cases where injuries migrated to body parts that were not originally a part of the industrial injury and the claims staff did not adequately assess causation in many of those circumstances.

The recommendation was classified as a high priority.

Resolution:

The SIU manager conducted several in-service units for the claims department in July 2005 that included training on how to perform 3-point contacts, how to interview and take recorded statements and fraud recognition. The WSI Claims Procedure Manual was expanded to include information provided during the SIU training sessions. Supervisors were trained on how to manage injury migration and were advised about the updates to the repetitive motion questionnaire in December 2005. The supervisors were tasked with sharing the additional information on injury migration and procedure manual updates, but were not able to accomplish this by 12/31/05.

Comment: While we categorize this recommendation as fully implemented in that the training initiatives were met, we still observed a number of cases where the same investigative processes were employed in 2005 claims that were found in the 2004 review period. Follow up review of the claims adjusters' work product to determine that the training was effective and that the new process is in use is a logical endpoint to the training.

2004 Performance Evaluation - Recommendation #20

A more cohesive organization structure is needed that blends the activities of claims, case management, utilization review, disability management, vocational rehabilitation and legal so that overall, quality claims management approaches are the rule. When that structure comes into play, all parties should have a voice in the direction that more serious claims need to go, but the authority and responsibility for that direction should ultimately reside with the claims staff.

The recommendation was classified as a high priority.

Resolution:

WSI has restructured its operations to create a team-based claims management approach termed "triage". This multi-disciplinary approach is used to manage disability. The SIU assists the claims units with field and fraud investigations, discussing the case with the claims adjusters personally to ensure their understanding of the claim facts and the issues. The Return to Work manager is a part of the medical case management team and the injury migration team, leading regular case triage staffings to ensure that cases that have been referred for assistance are managed timely and appropriately.

2004 Performance Evaluation - Recommendation #28

WSI should work with CorVel (the vocational vendor) to streamline reporting. As this facet of vocational services comprises a healthy portion of payments made to CorVel, streamlining will reduce costs.

The recommendation was classified as a medium priority.

Resolution:

The team observed claims adjusters using the CareMC website to obtain CorVel reporting information. It is working effectively and the adjusters use it regularly. One analyst was not aware that the data contained in the website could be cut and pasted into their own notes, functionality that could reduce claim notepad documentation time.

2004 Performance Evaluation - Recommendation #30

WSI should work with the provider community to identify and train more providers to conduct PPI evaluations. PPI providers are needed, especially in the evaluation of musculoskeletal disabilities. Adding a few orthopedists and neurosurgeons would create a broader resource base for this service, and this should be an objective of WSI.

The recommendation was classified as a medium priority.

Resolution:

Three new doctors have been added to the list of providers eligible to perform PPI evaluations. They include one orthopedic surgeon, one neurosurgeon and one chiropractor.

2004 Performance Evaluation – Recommendation #41

We recommend that all legal bills be sent to an outside legal firm for review in keeping with the published Legal Services Guidelines that are summarized later on in this section. In part, the Guidelines specifically state that, “WSI has the right to audit all bills using either WSI in-house auditors or the services of an independent auditor.”

This recommendation was classified as a high priority.

Resolution:

Through a combination of initiatives (including training, an assessment of prior legal billings, appropriate internal controls and tighter billing guidelines with legal firms), this recommendation has been implemented.

2004 Performance Evaluation - Recommendation #43

Best practices in the claim industry suggest that claims staff should accomplish the scheduling of independent medical legal evaluations, and they should also prepare any written communication required to the independent medical evaluator or the injured worker concerning the appointment. Alternatively, staff counsel can prepare these documents. Whoever prepares the letter to the independent medical evaluator needs to have a full understanding of the matters to be assessed by the evaluator, and the communication should reflect that understanding.

This recommendation was classified as a medium priority.

Resolution:

Based on a review of statistical documentation provided by WSI, we concur that this recommendation has been fully implemented, and that the use of outside counsel to draft IME letters is minimized.

2004 Performance Evaluation - Recommendation #44

WSI needs to implement a consistent data capture process.

The recommendation was classified as a high priority.

Resolution:

All pharmacy costs are now captured as expense code 10. During the prior performance evaluation, we discovered that pharmacy costs appeared for a time as either expense code 06 or expense code 10. The consistent use of one code allows WSI to track accurately its pharmacy costs.

2004 Performance Evaluation - Recommendation #45

WSI should be careful on the classification of the “rebate”. Oftentimes, when a PBM agrees to share rebates, they may reclassify some of their rebates as “administrative fees” in order to share less.

The recommendation was classified as a medium priority.

Resolution:

WSI has carefully tracked rebates and also instituted a pharmacy and therapeutics committee to create a more restrictive formulary that should enhance rebates to WSI.

2004 Performance Evaluation - Recommendation #51

The job description should be changed to accurately reflect the correct reporting relationship. A dotted line reporting relationship with the WSI CEO would provide OIR with leadership that will link them more closely with the rest of the organization, create an opportunity to participate in strategic planning that will improve the claim dispute resolution process, and foster communication of issues and trends to the WSI identified by OIR in the dispute resolution process.

The recommendation was classified as a low priority.

Resolution:

OIR’s reporting structure was revised in accordance with the prior recommendation. The WSI Administration Organization chart confirms OIR’s reporting relationship to WSI’s Board Audit Committee, with a dotted line reporting relationship to WSI’s CEO.

2004 Performance Evaluation - Recommendation #53

The Audit Committee and WSI CEO should give consideration to moving the PPI Auditor out of OIR and into the WSI claims department. The modest number of OIR related hours worked by the PPI Auditor may either be absorbed by current OIR staff or the contract employee for advocate services.

The recommendation was classified as a medium priority.

Resolution:

While not moved into the WSI claims department, the PPI Auditor was moved out of OIR and into the WSI Medical Services Department. This is confirmed in the WSI Utilization Review Organization chart. The Impairment Auditor (PPI Auditor's new title) now reports to the Medical Services Director, under the direct supervision of the Utilization Review Supervisor. The Medical Services Department and the Claims Department are both under the leadership of the Chief of Injury Services.

2004 Performance Evaluation - Recommendation #57

We recommend that the organization structure be revamped to create broad operational areas of authority within WSI. In its current configuration, there are eight vice presidents. Operational control should be vested in a more limited group in the absence of a CEO. A restructuring that accomplishes this objective will put the organization in a better position to continue to develop strategic initiatives and staff goals on a timely basis. We understand this is an objective of the new CEO.

This recommendation was classified as a high priority.

Resolution:

A new organization structure was developed to satisfy this recommendation. Principally, control of the operational areas was consolidated into three groups (Injury and Medical Services, Employer Services and Support Services). The make-up of these groups has previously been reported in Element One.

2004 Performance Evaluation - Recommendation #59

Until staff is retained in-house, WSI should also evaluate why so much money is paid to disability management vendors on claims involving no time loss. WSI should seek to minimize the fees paid to disability management vendors on claims that result in no time loss. For instance, we don't believe anything more than a screening fee should be paid in such cases. This already appears to be the practice of at least one of the disability management firms (Trinity Hospitals).

This recommendation was classified as a high priority.

Resolution:

Contractual requirements in the new agreements with disability management firms limit their involvement to claims involving time loss and those with restrictions that last longer than 90 days.

PARTIALLY IMPLEMENTED

2004 Performance Evaluation - Recommendation #8

We recommend increased emphasis should be made to develop a proactive provider fraud and employer fraud program. This needs to be accomplished in conjunction with the Claim Department and Policyholder Services.

This recommendation was classified as a high priority.

Status:

As we reported in Element Five, medical provider fraud has barely been pursued. Some hotline calls were documented in late 2005 and early 2006, and some training in this area was accomplished, but the knowledge base on medical provider fraud within SIU is lacking. A recommendation has been made in Element Five to address this matter.

2004 Performance Evaluation - Recommendation #13

To determine if the training is effective, claims analysts and supervisors should track time loss claims to determine if injury migration issues have been appropriately investigated. Claims analyst and supervisor performance should be assessed in this area. Injury migration will be better addressed if claim analysts are more careful to document and manage the original extent of injuries and the Utilization Review staff has a role in assessing not only the need for care but also its relevance to the industrial accident.

The recommendation was classified as a high priority.

Status:

An injury migration form was created for tracking and trending purposes in 2005. Claim supervisors were trained regarding its purpose and intended use in December 2005. Additional WSI staff training was not accomplished by 12/31/05. Claim analyst and supervisor performance was not tracked in this area during the performance evaluation period.

2004 Performance Evaluation - Recommendation #14

Annual claims analyst training on reserving, utilizing the Reserving Handbook training guidelines and cost projections should be accomplished. More supervisory guidance needs to be provided to prevent analyst stair-step reserving. Where the analyst is not applying sound judgment and is not utilizing the handbook for guidance, the supervisor must step in and provide guidance and training, altering the reserve at mandatory supervisory claim review timeframes. Claims analyst and supervisor performance should be tied to compliance in this area.

The recommendation was classified as a high priority.

Status:

Claim unit staff training was conducted on updated WSI reserving policy and procedure in March, June and July 2005. The claim unit reserve manual and the ODG guidelines are to be used to establish initial reserves. Additional supervisor reserve training took place in November 2005. Supervisors receive reports to help them monitor claims with reserve changes greater than \$25,000 and claims with more than four reserve adjustments in one year.

A review of a group of claims filed in 2005 and early 2006 found that the staff is still not consistently using WSI procedures requiring use of the reserve manual to reserve a case, do not consistently document the reserving rationale, and supervisors are not yet taking corrective action

when the process is not followed. Most claims have no documented rationale for reserving, and reactive stair-stepping in the first 90 days of the claim is still occurring as analysts increase medical reserves to cover provider billings as submitted. Cases reviewed still included 2, 3 and even 4 reserve changes in calendar year 2005. Analyst and Supervisor performance was not tied to compliance in this area by 12/31/2005.

2004 Performance Evaluation - Recommendation #15

Require mandatory case management assignment for all cases that meet the consideration criteria outlined in Claim Procedure #602 of the WSI Claims Procedure Manual. Claim Analysts and Supervisors must discuss the current activity on the individual claim at least quarterly with the case manager (internal or external) to discuss issues, case strategy and create updated action plans for moving the claim toward resolution. Discussions and action items with completion dates must be documented in the claim notepad.

The recommendation was classified as a high priority.

Status:

Claim Procedure #602 was updated to include mandatory medical case management assignment on chronic pain program and potential catastrophic injury claims only. The claim procedure is worded in such a manner that allows the claims analyst an option of assigning wage loss cases medical care management; in other words, it is not mandatory. The types of cases open to analyst decision for referral include wage loss claims with conditions that have historically created high value claims, (e.g., spinal cord injury, amputations, non-healing wounds, severe burns, chronic pain, etc.) These types of cases should be referred early for medical management to ensure a strategic approach to coordination of benefits and services, early return to productivity and reduced overall claim costs.

Where cases have been referred to case management, the procedure calls for quarterly staffings as long as the case remains open, or until the injured worker returns to work. Members of the review team observed one of the medical case management staffings. Case issues were discussed amongst the team of claims analysts, the return to work manager and the medical case manager. Appropriate interaction and strategic action planning was accomplished when a case is assigned to the medical case management staffings.

WSI Response: Octagon indicates Partially Implemented as of December 31, 2005. WSI indicates Fully Implemented as of September 2006. Claim Procedure 602 has since been updated to remove the option of mandatory assignment for wage loss claims. Training was held on September 6, 2006.

2004 Performance Evaluation - Recommendation #16

WSI also needs to have a fully engaged plan for managing temporary disability cases that reach 90 days duration. Elsewhere in this report, we document the need to identify via standard report any claim on which TTD benefits have reached 90 days. Relying on this report, a staffing should occur involving case management staff, the claims analyst and supervisor assigned to the case so that a cogent medical and disability strategy emerges. To the extent that more frequent communication is needed with employers, injured workers and treating physicians to affect these strategies, this should be accomplished.

The recommendation was classified as a high priority.

Status:

Reports of open time loss cases with greater than 90 days of time loss are generated to the supervisors weekly. A CMS system generated diary is sent to the claim analysts notifying them when more than 90 days of disability have been paid. However, there is no documented policy or procedure to provide direction on what to do with these cases. Some of the cases are staffed based upon claim procedure 602, but again, this is at the claims analyst's discretion.

WSI Response: Octagon indicates this recommendation Partially Implemented as of December 31, 2005. WSI indicates it is Fully Implemented as of September 2006. Claims Procedure 602 outlines the need for a staffing every 90 days for claims with medical case management assigned. This policy was recently updated to link to Claims Policy 906 to outline the criteria to consider for the staffing. Training was held on September 6, 2006 for this update.

2004 Performance Evaluation - Recommendation #17

WSI needs to have a firm target of issuing the first temporary disability benefit within the first 14 days following notice of lost time. This goal is a reasonable one that can be met with timely and thorough investigations coupled with a willingness either to issue indemnity benefit checks more than once a week or to issue manual checks where delays beyond the fourteen days would otherwise result.

The recommendation was classified as a medium priority.

Status:

WSI now has the ability to issue manual checks to help them reduce payment delays. At the direction of the CEO and Chief of Injury Services, WSI has targeted a goal of issuing 85% of all wage payments within 14 days of notice of time loss. The goal was communicated to all WSI staff at quarterly employee meetings, is documented in the monthly progress reports, in the Quarterly Operating Report, and is available for viewing on the WSI intranet. Although the goal has been fully communicated, the results over calendar year 2005 have run between 65% and 70% compliance, and are not materially different from the results achieved in calendar year 2004.

We agree with the Quality Assurance Director's finding "that one cannot see any real change in the philosophy or payment processing patterns of the claims unit regarding this new target". The claims unit advises that it has plans to readdress the issue in the summer of 2006.

WSI Response: Based on additional discussions with Octagon, WSI will reassess this measurement to ensure it is capturing the information as intended in the recommendation.

Octagon Reply to WSI Response:

WSI had considered a measure based on notice of injury to first time loss benefit delivery date as opposed to notice of time loss to first time loss benefit delivery date. It is the latter measure that should be pursued.

2004 Performance Evaluation - Recommendation # 18

Require mandatory internal case management for cases where treatment is occurring outside state of North Dakota. Cases should be assigned within two days of claim registration.

The recommendation was classified as a medium priority.

Status:

Claims procedure #602 was revised in 2005 to include injuries where treatment is occurring outside North Dakota. Claim analysts are to “consider” them for mandatory medical case management within two days of claim registration. The criteria are not mandatory; therefore, the medical case management staffings are not mandatory.

The review team requested an available report listing “Out of State Injured Workers” for the period 6/1/05-9/30/05 to attempt to determine if cases with medical treatment outside state were being identified appropriately and staffed post-process revision. The report did not fit the unit’s need, as the majority of injured workers on the list were injured outside the state of North Dakota, but were treated in the state. The two cases on the report where treatment was being obtained outside the state of North Dakota were not referred for medical case management staffing.

WSI Response: Octagon indicates Partially Implemented as of December 31, 2005. WSI indicates Fully Implemented as of September 2006. Claims Procedure 602 was updated to remove the option of mandatory case management assignment for wage loss claims. Training was held on September 6, 2006. The claim adjusters are to review claims for mandatory medical case management if the claim is a wage loss and the worker is treating out of state. The claim supervisors verify this during the CSE and 21-day audit. Treatment out of state is also reviewed during triage staffings. The “Out of State Injured Workers” report is the 4th checks and balance. This report is used due to the limitations in capturing information on treatment outside the state.

2004 Performance Evaluation - Recommendation #19

Action plans should be strategic as well as reflect history. Therefore, the plan should spell out what the analyst expects on the case, and subsequent action plans should reflect that the analyst is managing cases to those expectations. When changes in expected outcomes appear likely, the plans need to reflect that. To that end, when plans go awry the analysts should be determining why and seeing what can be done to mitigate reduced expectations. And as a backdrop to all this, the claim reserve should reflect the strategic intent on claims. In short, changes in reserves should be the result of changes in strategy.

The recommendation was classified as a high priority.

Status:

Ninety-day action plan training was conducted in July 2005. Reserve training was conducted in March, June and July 2005. Claim procedure 1001 requires reserves to be updated simultaneously with the creation of the 90-day TTD action plan. Most of the ninety-day action plans reviewed were completed timely. The procedure requires that the Claims Director is responsible for reviewing all claims with outstanding reserves greater than \$200,000. There is no documentation to support that this occurred on a consistent basis during the review period.

Ninety percent of the cases reviewed by the team had supervisor “rubber stamp” approvals of action plans and reserves. Analyst action plan comments such as “I need to review the file further” or “I do not anticipate any RTW options, but I have not reviewed that entirely” or “I will continue to monitor medical progress and pay disability, reserves are fine” were reviewed by supervisors with the documented response of “Agree with action plan at this time”.

Action plans are still not viewed as long-term strategic planning tools, and there is a lack of follow up to ensure compliance with WSI’s internal procedures.

2004 Performance Evaluation - Recommendation #21

PTD cases should be reserved for their full value. This means taking into account inflationary factors relating to supplementary benefit increases, life expectancy tables and/or the retirement presumption in those cases where it may apply.

The recommendation was classified as a high priority.

Status:

Policy 211, dated May 2004, outlines the requirement for PTD claims to be reserved for the life of the claim. The reserve is set up at the time of PTD designation and then a diary is created to review for accuracy every 2 years. The Finance and Claims Department worked with WSI's actuary to develop a PTD model that estimates reserves for the lifetime of the PTD claim to include an inflationary factor. WSI reports that this spreadsheet model was implemented in June 2005. We were provided with copies of the "WSI Supp & ABP Cal 2001-Now Law" form completed for 2 claims, but there was no reserving documentation in the claim file notes. Reserves in 2005 on three other PTD cases were still set for approximately 1-2 years of benefits at a time.

While it is not confirmed that all open PTD cases are currently accurately reserved, WSI has implemented a process for doing so, and we encourage WSI to ensure that all PTD cases have been reviewed for reserve adequacy by calendar year end.

WSI Response: Octagon indicates Partially Implemented as of December 31, 2005. WSI indicates Fully Implemented as of September 2006. Previously, WSI provided examples of claims where the reserves were reviewed at least every 2 years for PTD claims. A recent sample audit was also conducted on PTD claims to verify when the last reserve was created and that a diary exists for a reserve review at least every 2 years.

2004 Performance Evaluation - Recommendation #22

WSI should track the dates that claim analysts prepare C64s and make sure they are timely addressed both by supervisors and the committee. We are categorizing this recommendation as a low priority because the claim list used by the committee should suffice, but claim analysts should also be in a position to tell injured workers what is going on with their claims, and injured workers should be able to expect that decisions affecting their benefits will occur within a reasonable time frame.

The recommendation was classified as a low priority.

Status:

WSI indicated that they would not notify the injured worker at the time the case is initially referred for PTD review, so the recommendation will only be implemented partially. The claim unit's rationale is that changing the status from TTD to PTD does not change the amount of the benefit check until the worker is eligible for supplemental benefits. While the review is pending, the worker is still receiving all the indemnity and medical benefits for which they are eligible.

The team found many instances where the PTD review process has stalled, for one reason or another.

Claims procedure 211 surrounding the PTD review committee process was put into place May 2004. The claims analysts are responsible for monitoring the PTD process, or the status of the

C64 request. The PTD review committee does not set target dates for resolution, nor do they have a follow up process to ensure that they receive the information they requested in a timely manner. The claims unit indicates it began tracking C64's in September 2005, and that timeliness would be measured by ensuring completion prior to eligibility for supplemental benefits, a process to be monitored by the Claim Director. There is no documentation available to support monitoring of the C64 request process at any level of WSI.

2004 Performance Evaluation - Recommendation #23

Obtain copies of the current regulations regarding eligibility for Social Security Retirement benefits. Maintain current information by contacting the SSA at least annually. Alter the FL805 addressed to the Social Security Administration to request the date that the injured worker became or will become eligible for SSR if they are not currently receiving benefits.

The recommendation was classified as a medium priority.

Status:

The claims department has designated responsibility to a WSI claim staff member to annually seek regulatory updates from the Social Security Administration regarding Social Security Retirement eligibility. The FL805 request form now used to request information from the Social Security Administration was updated 4/26/05. No Social Security Administration updates were solicited or received as of 12/31/05.

2004 Performance Evaluation - Recommendation #24

Use the event trigger system in CMS to automate the identification of claims where injured workers have attained the minimum age of eligibility for SSR benefits based upon the most current information from the Social Security Administration. Claims Analysts or Assistants should make contact with the Social Security Administration via form letter regarding eligibility at least quarterly when the injured worker is receiving disability benefits, rehabilitation benefits, supplementary benefits and/or a social security offset to reduce the potential for overpaid indemnity benefits.

The recommendation was classified as a medium priority.

Status:

Event trigger diaries for the claims unit staff were included in the May 2005 update of CMS based upon appropriate criteria. There is no supervisor or claims analyst training documentation to support the frequency with which the Social Security agency should be queried regarding eligibility. The Special Program Coordinator still manages the ancillary indemnity benefits.

2004 Performance Evaluation - Recommendation #25

Automate the calculation of the ABP benefit to reduce benefit calculation error. Reserve the claim for the full liability of the ABP. Claims Analysts should manage this benefit along with the other indemnity benefits, with Supervisory oversight, to avoid overpayment of indemnity benefits. Training in this area should be provided to all Supervisors and Analysts immediately. The Special Programs Coordinator should audit the process and provide oversight.

The recommendation was classified as a high priority.

Status:

The ABP calculation function has been automated within the claim system, and is functional. Claims supervisors and analysts have not been trained to manage this benefit. The Special Programs Coordinator is still handling all ABP cases.

2004 Performance Evaluation - Recommendation #26

Seek a legal opinion regarding the WSI's statutory obligation to recover overpayments under all benefit statutes, and implement it.

The recommendation was classified as a high priority.

Status:

The claims unit has received conflicting information from the WSI Legal Department regarding WSI's obligation to recover overpayments under all benefits. In 2004, the Claims Manager reported that the Legal Department stated that all overpayments were to be recovered. In September 2005, the Legal Department stated that the "may" language included in the statute gives WSI flexibility in how to structure collections policies.

Overpayments due to injured worker fraud should be reported to the SIU, and recovery efforts swift. Overpayments due to WSI error should be communicated carefully and arrangements made for recovery over a reasonable period of time.

The team reviewed a number of cases where disability benefits had been overpaid. Where injured worker fraud was suspected, full recovery was requested and pursued for the most part. Not all cases were reported to the SIU. Where the overpayment was due to WSI error, there was no consistent process in place regarding recovery. Some cases were closed without recovery efforts. In some instances, the injured worker was required to reimburse WSI the full amount. In others, there is documentation in the claim notes that the injured workers were intentionally paid additional sums after the error was identified, with no request for reimbursement. It does not appear that the Claims Department has yet settled upon a formal policy and procedure that is fully communicated to staff, is implemented and administered evenly.

WSI Response: At this time, without specific examples of inconsistent application, WSI cannot confirm Octagon's research. Nonetheless, it is a fluid, fact-driven analysis each time an overpayment issue is addressed. As of September 2006, the Claims updated its formal indemnity overpayment procedure to include a provision that allows for an Overpayment Committee review of unique overpayment issues in order to foster consistent application. In any event, WSI will continue to review and monitor this issue.

Octagon Reply to WSI Response: WSI counsel reviewed the pertinent statutory language pertaining to WSI's management of overpayments. The statute does require reimbursement by an injured worker who has been overpaid. The discretion provided to WSI is in its method of recoupment, whether from future benefits or by direct reimbursement.

2004 Performance Evaluation - Recommendation #27

WSI should manage better the Vocational Rehabilitation referral process so that premature referrals are minimized. Premature referrals add needless claims costs.

The recommendation was classified as a low priority.

Status:

2005 HB 1171 restructured the disability system effective 1/1/2006. While some cases have been viewed in the new triage staffing procedure, all planning with regard to the vocational rehabilitation referral process accomplished by the claims unit on this recommendation has been aimed at addressing vocational rehabilitation issues on claims filed with dates of injury on or after 1/1/2006.

WSI Response: Octagon indicates Partially Implemented as of 12/31/05. WSI indicates Fully Implemented as of September 2006. All referrals for vocational rehabilitation are reviewed by the Return to Work Manager before assigned for a determination that the referral is appropriate. Triage staffing includes discussion on the appropriate time for vocational rehabilitation referral.

2004 Performance Evaluation - Recommendation #29

WSI notices should be written in plain language. One notice we observed read, "Partial benefits are subject to the provisions of the NDCC 65-05-10." While it is appropriate to cite applicable Century codes, it also makes sense to state what that code section says. While we make this recommendation in this section, the recommendation applies to notices in general that are sent to injured workers including those notices that are sent by OIR.

The recommendation was classified as a medium priority.

Status:

WSI established a permanent committee to review all communications, including forms, for accuracy and customer-friendliness. The review team did see evidence of some forms that were changed within the review period. Those changed utilized more customer-friendly language. WSI comments that it will take years to review/revise every form letter. No documentation exists regarding the goals of the review committee in terms of which letters are to be reviewed first, or how many will be revised on an annual basis.

WSI Response: The committee will continue to review communications every week until this recommendation is completed; however, this will always be an on-going continuous improvement process. WSI began the review process by looking at the most processed letters first. As policies and procedures were updated, WSI deferred from this plan as appropriate. The claim technician supervisor's log which shows the last date each letter was updated was sent to Octagon. At that time, approximately 2/3 of the correspondence had been updated. Estimated completion date is December 2007.

2004 Performance Evaluation - Recommendation #33

The recommendation was classified as a medium priority.

This recommendation has multiple components, which include:

- Claim analysts need to manage disability. This means completing full three-point contacts on all time loss claims and working with employers to bring injured workers back to work as soon as that is practical.

Status: While the claim unit's 3-point contact goal of 98% has not yet been met, significant improvement has been made since the prior review period. Calendar

year end 2005 reports document 96% of three point contacts were made within 24 hours from the date the case was assigned to an adjuster.

While 3-point contacts are being made, this does not address the issue of managing lost time. An important tool in avoiding protracted time loss and lost productivity is in efforts expended to control and reduce the first 90 days of lost time. There must be a consistent effort made by every claims analyst to work with employers to locate transitional work for injured workers early – day one of disability period is not too soon.

There is evidence of the effectiveness of the return-to-work collaboration when the case has been referred to the triage team, but this does not usually occur until the case is 90 days old. Analysts are to be cautioned that they hold the ultimate responsibility for managing disability on their caseload, not the triage team.

WSI Response: There is a consistent effort made in contacting employers to set up transitional work for injured workers. All lost time claims are staffed at two weeks. The 90 day mark is used to trigger “mandatory assignment” if the IW has not yet returned to work.

- In the case of protracted time loss claims (those with disability beyond 90 days), analysts should meet with in-house disability management staff to develop strategies to address return to work. To the extent employers need to be included in these discussions, this should be accomplished.

Status: Where injured workers are required to be off work for longer disability durations, mandatory case management is useful to brainstorm possibilities for a return to productivity. As discussed earlier, the mandatory processes in place do not require mandatory assignment. The collaborative triage process began late 2005; it is showing much promise when utilized appropriately.

- Training of the claims analyst staff must continue with an emphasis on overall goal setting for each claim. This training must include an emphasis on reserving claims in keeping with the standard promulgated in the Claim Manual.

Status: Claims analysts were provided with reserve training during the review period. Analysts are still not consistently using WSI procedure to document reserving rationale, and reserve stair-stepping is still a prevalent practice in the claims unit.

- The Claims Department needs to assume some of the duties that have previously been undertaken by the Legal Department. See Exhibit One (note correction: Exhibit Two) for more details about that role.

Status: Claim analysts now perform 2 of the Legal Department’s former duties; collecting prior claims information, and handling phone calls from injured workers and employers regarding the appeal of legal orders. WSI declines to change ownership for the remaining 6 items “in order to maintain a consistent process to ensure all rules are met.”

- Because of the limited number of cases that generate truly high costs in the workers’ compensation program, claims that meet various financial criteria cited elsewhere in this report need to be emphasized by the claims analysts and appropriate resources assigned to those claims to mitigate costs.

Status: No implementation plan was developed for this performance recommendation. WSI's response to their implementation is that they provide ongoing training of claims analysts and supervisors in claim management that will result in cost mitigation, and that caseload shifting occurred in November 2005 to create more a equitable distribution of PTD, time loss, new claims, etc.

Several policies document the requirement of the supervisor or Claim Director to review claims with higher outstanding reserve values, however we have determined that this did not occur with any degree of regularity. There are limited instances where the claims were reviewed and documented during the review period, signifying a process that was not yet fully implemented during the review period.

- Claims analysts need to pursue vocational rehabilitation options with the current VR and RTW staff at WSI, because rehabilitation tends to be the last stop in the life of many claims that ultimately become permanent total disability claims. It should be the objective of the Claims Department to minimize the number of claims that qualify for PTD benefits.

Status: While there are case management staffings that address some cases reported by claims analysts, the claims unit still lacks a strategic objective of returning injured workers to gainful employment to preclude claims that qualify for PTD; particularly where claims were filed prior to 1/1/06. All recent implementation efforts made in this area have been related to the relatively new HB 1171 affecting claims with dates of injury 1/1/06 and beyond.

WSI Response: Significant efforts continue to be made to return injured workers to gainful employment. It should be noted that this also requires support from the treating physician.

- Claims analysts need to work closely with the UR staff not only on the issue of medical necessity but also to address relatedness to the industrial accident. Some costs have been borne by WSI that grew out of UR decisions to authorize services on a medical necessity basis, when the services had nothing to do with the original industrial accident.

Status: The UR staff generally communicates with the individual claims analysts via claim events (diaries). The UR staff raised concerns during our interview process that often the claims staff is not able to respond to the questions/issues raised in the events within a reasonable time frame. The UR staff produced a report that identified a large number of unattended events that the claims unit had not yet responded to. UR does not have a follow up event/process to ensure their questions are answered timely. Additional leadership review of the process is warranted to ensure that the teams can begin to work together effectively.

WSI advises that a UR representative is involved in triage sessions to provide input on liability. The team could not determine if this is occurring with any degree of regularity, as there are no minutes of those meetings, and the claims are not documented with the attendee names.

WSI Response: Octagon indicates Partially Implemented as of 12/31/05. WSI indicates Fully Implemented as of September 2006. Beginning September 1, 2006, UR staff reviews open claims only; a review is not conducted on a closed

or a pending claim. This has created a secondary process for communication on closed or pending claims.

2004 Performance Evaluation - Recommendation #34

The recommendation was classified as a high priority.

This recommendation has multiple components, which include:

- Supervisors need to emphasize reserving adequacy in each of their action plan reviews. This means looking at the overall likely value of a claim, not just what it might cost over the next six months or year.

Status: As reported earlier, a sampling of cases identifies the continuing lack of meaningful supervision in action plan review. More consistent use of the reserve manual and life expectancy reserves is indicated. Where action plans are insufficient, where the case status information is not current, or there is a failure to provide a plan to move the case toward resolution, the supervisor should provide guidance and help the analyst create a more meaningful action plan that will result in more meaningful reserving.

WSI Response: Octagon indicates Partially Implemented as of December 31, 2005. WSI indicates Fully Implemented as of September 2006. Claims Procedure 906 has been updated to instruct the supervisors to only accept complete action plans. Training was held in September of 2006.

Action plan frequency should be flexible. The lower the claim value, the less frequent reviews should occur. By contrast, active time loss claims with incurred loss values greater than a certain dollar threshold (e.g., \$25,000) should be seen more frequently.

Status: If an action plan does not require 90 day follow up due to legitimate reason(s), the supervisor should so note, and an appropriate diary date for the analyst should be documented to avoid unnecessary claims activity. Conversely, active claims valued at more than \$50,000 should have multiple level and more frequent reviews by many members of the claims organization, often resulting in additional action items or changes to strategy; particularly as the active case value reaches the \$200,000 level. The higher the claim value, the greater the need to bring to bear expertise and collaborative effort to effect claim resolution.

WSI Response: Octagon indicates Partially Implemented as of December 31, 2005. WSI indicates Fully Implemented as of this response. Triage staffings have provided us with increased action plan flexibility.

- Reporting needs to be updated so large claim exposures are known and more aggressively managed. Chiefly, these reports will include claims of long-term TTD benefits, high payment frequency and high outstanding exposure.

Status: No additional reports were developed, more specifically claims with long-term TTD benefits and high payment frequency. Data is available in the claim system to meet the parameters necessary.

WSI Response: Octagon indicates Partially Implemented as of December 31, 2005. WSI indicates Fully Implemented as of September 2006. An additional report for claims with outstanding reserves greater than \$200,000 was created. Claims on this report are reviewed for an appropriate action plan and documentation. This report is run quarterly.

- Supervisors should always be looking at cases to make sure that analysts adequately document and understand medical treatment plans and that injury migration does not occur.

Status: Injury migration training took place in December 2005. Supervisors have not had an opportunity to fully train their staff or implement new process.

WSI Response: WSI indicates this as Partially Implemented as of 12/31/2005. WSI indicates Fully Implemented (including training) as of September 2006.

- Place emphasis on the existing reports that get at high cost claims. Examples of those are the reports dealing with \$25,000 reserve changes and the chronic pain program cases.

Status: Standard reports are available that get at high cost claims. These reports are available for supervisory use and are produced monthly and on an as needed basis. There is no documentation regarding training on how to use these reports in an effective manner.

- Develop a set of performance measures for supervisors that create accountabilities for reserve adequacy, disability management and high cost claim management. For instance, measure the number of claims by unit on which reserve changes occur more frequently than four times a year. The goal should be to reduce the incidence of these types of claims over time. Require the supervisor to staff all cases on which TTD benefits exceed 90 days and measure that this is accomplished. Measure the success of action plans developing out of these meetings by determining if there is a reduction in the number of claims that reach 180 days of TTD. And have the Vice President of Claims review the supervisor's role in action plans on cases where the outstanding reserve exceeds \$50,000 and critique that performance.

Status: Performance measures were not fully established for the supervisors in all these areas by 12/31/05. There is no process in place to measure the success of action plans developed out of the triage meetings. The accountability of the former Vice President of Claims position has been transitioned to the Claims Manager. There is no consistent documentation to support the Claims Manager review of supervisor's roles in action plans where case reserves exceed \$50,000.

2004 Performance Evaluation - Recommendation #35

Limit the pending claim data capture to pending claims by unit and pending claims of more than 30 days. Link the 30-day pending report to a department goal. For instance, the department might establish a goal of having no more than 50 pending claims of greater than 30-day duration. The goal should be stated on the monthly progress report, and some consideration should be given to how losses are reported by unit. For instance, over the past year the two alpha units have had significantly fewer reported losses than the other three units, so the pending goal for those two

units should be less. The alpha units might have a goal of no more than seven claims while the other three might have a goal of no more than twelve claims.

The recommendation was classified as a medium priority.

Status:

The claims department established a claim department goal of fewer than 29 pending claims open more than 30 days. The goal is measured and reported on the monthly claims progress report. Benchmarks have not been set at the unit/analyst level, although reports are available at the claim unit, supervisor and analyst levels measuring pending claims from 22-31 days and 32-60 days.

2004 Performance Evaluation - Recommendation #37

Within the quarterly reports, many measures are taken multiple times. We would recommend that a single measure be established for each performance area measured and that the remaining measures be eliminated. Five reports should suffice and they would include (measures are captured in parentheses after each report type):

- Time loss claims accepted/denied within fourteen days (80%)
- Time loss denial rate (10%)
- MO claims accepted/denied within fourteen days (90%)
- MO denial rate (6%)
- Percentage of payments made within twenty-one days (90%)

The recommendation was classified as a medium priority.

Status:

The Claims Department has established goals that differ from the recommendation. The goals established are to be reported on the Board's Quarterly Operating Report and Claims monthly/quarterly progress reports. Data is found on the December 2005 quarter end Board report, but is not contained in any of the claims monthly reports:

- 80% of time loss claims accepted/denied within 14 days of receipt – target is missing
- 90% of medical only claims accepted/denied within 14 days of receipt – target is missing
- Total Claims decision target of 90% within 14 days of receipt – target is listed
- Initial acceptance rates are being monitored, but targets will not be developed (the lack of a target is reasonable, but trends in initial acceptance rates can be monitored for changes in the rates)
- 85% of initial time-loss payments made within 14 days of registration - target is listed
- 98% of medical bills will be paid in less than 30 days – target is listed at 95%

2004 Performance Evaluation - Recommendation #38

As part of its goal setting in future years, the claim department should identify two or three areas of claim management specifically targeted to cost. A focused process on cost containment will likely include the integration of services with claim support departments such as nurse case management, utilization review and return-to-work services. The types of claims referenced above would be a good place to start. Claim analysts and their supervisors should approach these claims seeking to successfully address the questions raised above.

The recommendation was classified as a medium priority.

Status:

The claims department is relying upon its new team-oriented triage process to proactively address the issues raised within individual claims. Management reports are available to identify the specific claim types listed in prior recommendation #37, and certain reserve reports have been developed and overseen by supervisors to assess reserving trends. More can be done in this area.

2004 Performance Evaluation – Recommendation #42

By using the data above, WSI is in a position to assess the cost benefit of bringing in-house the defense firm services that it currently out-sources. We believe that consideration should be given to hiring an attorney and a paralegal to work from its Fargo office and one additional attorney and paralegal in Bismarck. We think with the addition of these positions along with better utilization of the current staff that WSI could effectively manage litigation on its own. We think the cost of adding four positions would be modest in comparison to the cost of outside defense fees. Should WSI commit to this process, it should systematically reclaim the defense service responsibilities of claims currently serviced by outside counsel. Given the number of outstanding claims, we think this process could be completed within six months of making the commitment to take claims in house.

This recommendation was classified as a high priority.

Status:

WSI is assessing its capabilities to bring certain legal services in-house through a three-year business plan. It has thus far determined that certain cases (e.g., PPI disputes) that might previously have been outsourced can be managed with in-house counsel. We have placed this recommendation in the partially implemented section only because some work on completing the recommendation has been accomplished. Much more remains to be done, and it should not take three years to complete the assessment.

WSI Response: WSI does not concur with this status. WSI agrees it does not take three years to complete an assessment and it has not. In 2004, WSI was in fundamental disagreement with this recommendation. The initial response to this recommendation provided that WSI would “consider this recommendation along with a more detailed analysis of the most effective and cost-containing legal services structure for the organization.” WSI made no assurances that it would migrate legal services in-house; only that it would be considered. During the 2005-2007 biennium, WSI has implemented numerous cost control measures which included: Caps on WSI defense counsel fees; management level audit of WSI defense counsel bills; the negotiation of a competitive legal services contract with one primary defense firm; and more efficient litigation case management guidelines. Although WSI has reviewed the migration of certain legal services in-house, WSI believes the above-described efforts have resulted in a litigation structure that is appropriate and cost-effective and will continue to implement additional measures as operationally appropriate.

Octagon Reply to WSI Response:

Some cost controls that WSI has achieved have derived from its implementation of Recommendation #41. Further, the intent of this recommendation was for WSI to assess seriously the potential advantages of managing more litigation in house than it currently accomplishes. Over the years, the Legal Department has had a significant role in the oversight of the Claims operation insofar as legal matters are concerned. Our expectation is that the Claims

department can assume greater responsibilities (e.g., with Notices of Decision) thereby freeing up legal staff to manage more of the litigation work in house. As we observed during the litigation summit in April 2006, WSI legal staff is well qualified to manage litigation given their role in training external litigators around the state.

2004 Performance Evaluation - Recommendation #47

Paying bills with an ICD 9 relatedness edit will allow WSI to make payment for prescription drugs only in accordance with the allowed diagnosis in the claim. This functionality should be audited on a frequent basis to ensure that proper edit controls are in place according to the term of the contract. Additional edits should be developed in the process of paying bills. For example, all prescription drugs that would never be reimbursed by WSI should be reviewed systematically and denied for payment. Currently, WSI cannot detect early fills. US Script should also build this into their editing process.

The recommendation was classified as a medium priority.

Status:

US Script has indicated that they are capable of receiving ICD-9 codes for claims and further mapping medications for ICD-9 code relatedness. WSI began a process of assigning ICD-9 codes for all claims filed since January 1, 2006. Until such time as all active claims can be reviewed and the appropriate ICD-9 codes applied, a medication prior authorization program is in place to ensure that only those medications which are appropriate for the work injury are being paid by WSI.

2004 Performance Evaluation - Recommendation #48

WSI may want to consider the implementation of a card program with US Script.

The recommendation was classified as a medium priority.

Status:

WSI implemented a card program for all out-of-state injured workers. US Script mailed the cards on May 24, 2006. The impetus for this was feedback from some of the major pharmacy chains that indicated that their policy is to continue to use a third party billing company for workers' compensation pharmacy claims in the absence of a pharmacy card. CVS Pharmacy signed a contract with US Script on June 13, 2006. This includes the six Osco Drug stores in the North Dakota. These account for almost 75% of the remaining paper claims. WSI continues to encourage US Script to pursue contracting with the major pharmacy chains to eliminate paper bills. Octagon does recognize some of the work on this performance measure was completed after the review period, which ended December 31, 2005.

WSI is not pursuing a pharmacy card program for in-state injured workers, although we believe value exists in such a program. For instance, pharmacy services can be denied at the outset if the card program does not substantiate the relationship between a work-related accident and the medication prescribed.

WSI Response: In 2004, WSI was in fundamental disagreement with this recommendation. WSI still does not intend to globally expand the pharmacy card program to in-state injured workers. The most significant solution is a stronger, seamless data network with pharmacies.

2004 Performance Evaluation - Recommendation #50

Several components exist to this recommendation, and they include (note that this recommendation was classified as a low priority):

- Consider a threshold of pharmacy cost at \$500.00 when the threshold is penetrated, a case manager and/or the medical director should review the claim to determine if the prescribed medicines are necessary.

Resolution:

Fully implemented. WSI currently requires a prior authorization review for any medication, which exceeds \$1000 in cost. WSI agrees that a more extensive review would be accomplished if the process were altered to include all claims in which a cumulative monthly expenditure breached that dollar cost.

WSI Response:

This was listed by Octagon as fully implemented since prior authorization is required on all prescriptions, which exceed \$1000 in cost. A more thorough case review is being considered at the lower threshold and should be in place by 12/07.

- Focus on medications that tend to cause addiction problems and attempt to find alternative pharmacotherapy solutions.

Status:

Partially implemented. WSI concurs that more needs to be done in identifying potential problems with addictive medications. The state has applied for a Harold Rogers grant, which would fund the implementation of a prescription drug-monitoring program. WSI is named as one of the agencies, which would have access to the information contained in the database.

WSI Response: The state has secured a Harold Rogers grant and will have a prescription drug monitoring program for all controlled prescriptions by November of 2006. WSI is listed by statute as one of the agencies, which will have access to this information. Policies will be developed outlining when and who may access this information at WSI.

- Consider utilization review criteria requiring pre-authorization for narcotic medications, particularly the need for narcotics extending beyond 90 days. Consider that of the top 25 drugs reimbursed in 2003, ten of them were narcotic analgesics or opiates (Pain Meds.). \$2.7 million was paid on the top 25 drugs in 2003. Of that, over \$700,000 was paid on Oxycontin. We identified that continues use of Oxycontin occurred in some claims for more than two years, where diagnoses of unspecified back pain were made. In short, a narcotic was being dispensed when an exact diagnosis had not been made to substantiate the need for such medication.

Status:

Partially implemented. WSI has begun to look at specific narcotic medications, which have the potential for misuse or abuse. A more complete strategy for dealing with long-term narcotic use needs to be developed.

WSI Response: The issue continues to be actively reviewed by the Pharmacy and Therapeutics Committee. Strategies will be developed to address long-term narcotic prescribing and usage.

- Utilize drug therapy programs for more injured workers. In the active claim group, 26 injured workers were referred and treated in a drug therapy program in 2003. Of the 26, 11 were repeats from 2002.

Status:

Partially implemented. This is related to item B (the second bullet) above. WSI agrees with the recommendation, unfortunately access to drug therapy programs has become more limited with the closure of one of the primary programs in Minneapolis. WSI will continue to work to identify those injured workers who would benefit from such programs.

WSI Response: The prescription drug monitoring program cited above will help identify injured workers who demonstrate addictive behaviors such as doctor or pharmacy shopping.

- Make certain there is a tie between the medication being dispensed and the accepted injury. This means that the ICD-9 codes should be current in the system.

Status:

Partially implemented. This part of the recommendation overlaps with our response to Recommendation # 47.

- Make sure generic medications are being dispensed when they are a safe alternative to a brand name.

Resolution:

Fully implemented. Generic medications are the rule of thumb in the pharmacy benefits management program.

2004 Performance Evaluation - Recommendation #52

A regular meeting for OIR staff to present claim management recommendations to the Claims Vice President and Claims Supervisors should occur. Meeting minutes should be shared with the Audit Committee and the WSI Executive Director. The purpose of the meeting should be to identify trends that may emerge out of OIR reviews, and training can then be provided to analysts on claim service issues that need to be addressed.

The recommendation was classified as a medium priority.

Status:

OIR proposed that it would be more advantageous to meet directly with the WSI CEO to avoid the potentially unhealthy dynamic of OIR acting as a claims oversight function in addition to its daily claims dispute role. Documentation was reviewed confirming OIR presence at Board meetings where individual high profile claim situations were discussed with the CEO. WSI 2/3/05 meeting minutes confirm WSI CEO's support for OIR's quality assurance role in the organization. Documentation regarding further discussion between the CEO and the claims unit is not generally available, however there are notes regarding some type of mediation on a few cases supporting CEO discussions with the claims manager.

A 2/15/05 meeting further discussed the role between Claims, Legal and OIR. A focus group was created, and the group met regularly during 2005 to discuss dispute resolution efforts involving OIR. The outcome of that meeting was a recommendation to provide OIR with some limited settlement authority to resolve claims situations. There is no documented evidence that any trends were identified or raised by OIR during this review period.

While the lines of communication are open between the OIR and the CEO, and between the CEO and the Claims Manager or Chief of Injury Services at this time, it is on a case-by-case basis. The current dynamic has not fostered an atmosphere of collaboration between OIR and the claims department. The intent of the recommendation was that OIR would be another set of eyes to the organization, improving its timeliness and accuracy in benefit delivery, as well as further reducing litigation. OIR would attempt to discover the root cause(s) of the issue(s) that result in disputes between the injured worker/employer and the claims unit. As trends were identified where the claims unit was not following its internal processes/procedures, (i.e. lack of appropriate claim investigation leading to claim denial or benefit restriction, under/overpaid benefits, lack of clarity in communication, etc.) and where training needs or improvement in claims unit processes could be identified, those trends would be communicated effectively such that the claims organization, and WSI as a whole, has an opportunity to improve overall performance.

WSI Response: WSI considers this to be Fully Implemented. The CEO meets on a routine basis with OIR and does bring issues and corrections back to WSI as appropriate. Additionally, OIR is a standard agenda item at the quarterly Audit Committee meeting. At each quarterly meeting, OIR presents the trends including referrals, closures, claim disposition and other OIR measures. To the extent there are common recurring concerns or issues, they can and will continue to be presented in this forum as well.

Octagon Reply to WSI Response: This recommendation (#52) spoke to a need for more communication between OIR and the Claims Unit. The intent was to facilitate and improve Claim Unit staff performance by using trends gleaned from claim issues brought to light during the OIR resolution process. WSI chose to utilize a different approach to satisfy the meeting requirement. However, it is not evident that meetings between the CEO and OIR, and the information/trends discussed therein, are used by the organization (more specifically, the Claims Unit) to improve overall claims management performance.

2004 Performance Evaluation - Recommendation #54

The job descriptions of the OIR Advocates should be modified to contain qualifications that include at least one year of claims management experience, a thorough review of NDCC (Title 65), and training that includes the implementation of the NDCC (Title 65) and the Administrative rules of procedure. Initial training, as well as periodic training updates, should be provided by the WSI legal staff in conjunction with the WSI claims department.

The recommendation was classified as a medium priority.

Status:

The OIR Advocate job description was updated March 2005. Qualifications include a Bachelor's degree or equivalent in business, health care, legal or related field, at least one year claims management experience, and education/training or experience in dispute resolution processes. It does not include the Title 65 NDCC review qualifications.

The WSI Training and Development Director developed a "New Worker Advocate Training Plan" that includes a review of Title 65 of the North Dakota Century Code and the Administrative rules of procedure. There is no mention of collaborative training efforts in conjunction with WSI legal staff.

2004 Performance Evaluation - Recommendation #55

To create an accurate implementation compliance approach, WSI staff should familiarize themselves thoroughly with each recommendation made during the draft report process. To the

extent they need to validate their understanding of each recommendation, they should communicate with members of the performance evaluation team. Their response to each recommendation can then clearly articulate how they will satisfactorily implement a recommendation. Once a recommendation has been implemented following the performance evaluation, documentation sufficient to demonstrate full implementation should be provided to the Internal Audit Manager. Only when the Internal Audit Manager and/or CEO are satisfied that a recommendation has been fully implemented should it be so categorized in WSI publications. (One good example of a recommendation having been implemented and fully documented can be found in the way WSI responded to Recommendation 16 in the 2002 Performance Evaluation.)

This recommendation was classified as a medium priority.

Status:

A Quality Assurance Manager position was created with one function of this position being to oversee implementation of prior performance evaluation recommendations. A report summarizing the status of recommendations was regularly updated during the performance evaluation period.

WSI has a process in place whereby the CEO, Chiefs, Managers and Supervisors take responsibility for recommendations that are made in a performance evaluation. For the 2004 performance evaluation review, WSI staff reported prior recommendation implementation results to the Quality Assurance Director; however, the obligation for accurate and complete reporting remained with the WSI staff.

The Quality Assurance Director compiled the information and provided the performance evaluation review team with the documented results. We were able to determine that the Quality Assurance Director made legitimate attempts to validate results reported.

We observed that WSI has reported in its documentation that as of 4/06 36 of the 59 recommendations were fully implemented. In summarizing compliance, we considered recommendations partially implemented according to WSI if they had less than a 100% completion percentage but greater than 0%. See the summary table at the outset of this Element to see how our results differ from WSI's assessment.

In some instances, we know recommendations were not fully implemented because of a misunderstanding on the part of WSI relating to the intent of the recommendation. As a general comment, WSI prepared more accurate implementation information for the 2006 Performance Evaluation than it had in 2004. This is particularly true in the SIU, Legal, Pharmacy and OIR areas.

WSI Response: Partially Implemented as of December of 2005. WSI considers this recommendation to be Fully Implemented as of September of 2006. WSI has a process where once draft audit report is issued; Internal Audit takes the lead in coordinating responses to each recommendation. Internal Audit corresponds with the CEO, Chiefs, Managers, Supervisors and staff along with the performance evaluation team to address any misunderstandings as to the intent of the recommendation. Once the final report is issued, Quality Assurance oversees the implementation of the recommendation by first meeting with the recommendation owner, outlining the plan of action and assigning a timeline for completion. Quality Assurance then schedules quarterly progress reviews, validates completed recommendations, assembles supporting documents and requests signoff signatures. This newly expanded process assures that there are checks in the system to confirm the intent of the recommendation prior to its final

issuance. In addition, this new process provides validation of progress from inception to implementation.

NOT IMPLEMENTED

2004 Performance Evaluation - Recommendation #9

We recommend the Special Investigations Unit begins keeping injured worker statistical information in the claim system.

This recommendation was classified as a medium priority.

Status:

This recommendation was placed on hold pending implementation of an IT strategy to address systems upgrades and capabilities.

2004 Performance Evaluation - Recommendation #31

A performance measure for the claim department should be developed that assesses the timeliness of PPI benefit delivery. We observed a number of cases where PPI benefits were paid more than a month following the completion of the review by OIR staff. A fourteen-day measure would be reasonable. The fourteen days should be measured from the OIR completion date to the first issuance of the PPI benefit.

The recommendation was classified as a medium priority.

Status:

WSI states it changed its internal policies in July 2004 to begin issuing the PPI payment immediately after issuance of the order. The benchmark for measurement is questionable, as “immediately” is impossible to quantify and measure. The review team reviewed cases with PPI awards between 6/20/05 and 9/30/05 with at least 16% whole person impairment. 50% of the cases reviewed by the team had payments more than 14 days from the date the PPI audit was completed. The orders were issued anywhere from 5-14 days from the date the PPI audit was completed. There is no documented training to support a change in the process. Timeliness of PPI payments was not a part of the claim department’s performance measurements as of 12/31/05.

WSI Response: Octagon indicates Not Implemented. WSI indicates Partially Implemented. Staff met July 7, 2006, regarding this measure and defined the data elements that will be gathered to measure the timeliness of PPI benefit delivery. The target to be added to the Operating Report will be 85% of the PPI payments issued within 14 days.

Octagon Reply to WSI Response: We categorized this recommendation as not implemented due to our evaluation of work accomplished through the performance evaluation period, as well as our awareness of work that had not yet been accomplished as of the time frame of our fieldwork (April 2006). This comment could just as easily apply to other WSI responses where implementation efforts continued after April 2006.

2004 Performance Evaluation - Recommendation #32

With the assistance of WSI’s actuary, the threshold should be reconsidered. Four years ago, some consideration was given to reducing the threshold to 10% or 11%. However, no change in the law occurred. We think this threshold should be dropped to 10% in conjunction with the provision of other indemnity benefits as explained further in our comment below.

The recommendation was classified as a medium priority.

Resolution:

WSI did not concur with this recommendation and did not seek any legislative initiatives to change the PPI threshold. Their response is that a review of the legislation results showed that in 1994 the total awards issued were \$8,090,479 to 1,231 people at an average of \$6,572 per award. In 2004 the total awards issued were \$1,640,206 to 103 people at an average of \$15,924 per award. This is an indication that the intent of the legislation is working.

If this issue is to be pursued in the future, it likely will be the responsibility of organized labor or other groups seeking to create a benefit entitlement for injured workers with PPI below the current threshold.

2004 Performance Evaluation - Recommendation #39

WSI should develop a team of managers and other staff from various departments who are charged with reviewing key data differences as they develop. This team should make sure that payments are captured and reported in such a way that trends can be appropriately identified. Once trends are identified, the causes need to be investigated and understood.

The recommendation was classified as a high priority.

Status:

WSI is relying upon its new team-oriented triage process to proactively address the issues raised within individual claims. There was no team or process in place to seek, monitor or address trends as of 12/31/05.

WSI Response: WSI believes the status provided is not relevant to this recommendation and that this recommendation should be listed as Partially Implemented. WSI's Research & Development Department produces a number of key reports (i.e. quarterly operating report, paid cost by expense code report, etc.) that trend payments and other costs. The quarterly operating report is reviewed at quarterly intervals by senior management as well as the Board of Directors. Consistent with WSI's response to 2006 Recommendation #14, WSI will continue to work with department managers to set time aside in their regular department meetings to review payment trends.

2004 Performance Evaluation - Recommendation #40

Once the team understands the reasons for changes in payment patterns, it should develop suitable internal standards to improve cost management. For instance, the data on physical therapy is suspect because of the splitting out of out patient physical therapy that commenced in earnest in 2003. But in the years leading up to 2003, physical therapy costs increased at a significant rate. Specifically, from 1998 to 2002, physical therapy and occupational therapy costs climbed by about 187%. Upon finding information like this, the team might recommend that WSI's utilization review staff manage physical therapy more closely. Or, they might suggest the development of a managed care statute that limits the number of allowable visits for physical therapy services. (The team should also investigate why physician costs climbed in 2004 and understand the reason for hospital cost increases in 2001.) The gist of this recommendation is that once an anomalous trend is observed, the organization should endeavor to evaluate how to manage that change.

The recommendation was classified as a high priority.

Status:

Again, WSI is relying upon its new team-oriented triage process to proactively address the issues raised within individual claims. There was no team or process in place to seek, monitor or address trends identified as of 12/31/05.

WSI Response: As in Prior Recommendation #39, WSI believes the status provided is not relevant to this recommendation and that this recommendation should be listed as Partially Implemented since it can never be Fully Implemented as written. Over the years, there have been numerous program changes initiated as a result of trend monitoring. For example, in response to escalating medical costs some of the initiatives implemented include, but are not limited to: the implementation of a home health care fee schedule; the implementation of an ambulance fee schedule; the hiring of a Doctor of Pharmacy; the implementation of a Pharmacy Benefit Administrator (PBA); the implementation of MAC pricing for generic medications; and modifications to the hospital inpatient and outpatient reimbursement methodologies. In response to escalating legal cost trends, WSI has revamped its defense counsel contracts and processes. In response to escalating SIU cost trends, WSI streamlined SIU processes and operations.

Octagon Reply to WSI Response (#s 39 and 40): When Octagon met with WSI staff concerning the implementation of these two recommendations, the conversation focused on the triage process. Admittedly, the triage process is not responsive to these recommendations, but it represents the substance of the discussion with various WSI staff regarding how trends are evaluated to create initiatives designed to bring greater efficiencies to the organization. This response is also why recommendations 39 and 40 are in the not implemented section. We acknowledge that WSI's response to Recommendation #40 is indicative of responsiveness to trends, some of which were identified through its own analysis and some from the 2004 performance evaluation. What we were unable to evaluate was the extent to which middle managers were involved in this process, and it was for that reason that we made Recommendation #14 in this performance evaluation.

2004 Performance Evaluation - Recommendation #46

We recommend that US Script assume the cost of prescriptions that are filled for the first time and the claim is subsequently denied. Currently, WSI assumes this cost. It is completely appropriate that the contracted PBM take on this risk.

The recommendation was classified as a medium priority.

Status:

WSI indicated that its initial contract renewal in 2005 with US Script was an evergreen renewal. As such, the contract was renewed without addressing this recommendation. It will need to be addressed prior to the 2007 contract renewal.

2004 Performance Evaluation - Recommendation #49

Because so much of the pharmacy expense occurs on claims that are more than four years old, one way to contain costs is to allow prescriptions to be filled through a mail order program. Mail order programs work well for injured workers who need medicines on a continual basis, and this is the case for those with aged injuries. WSI can realize an immediate reduction in cost for continued prescription drug services. It is not uncommon to see mail order prescription prices at (AWP – 53%). This is significantly lower than WSI's current retail price.

The recommendation was classified as a medium priority.

Status:

WSI did not wish to implement this program due, at least in part, to the fact that the organization felt that a mail order program could disrupt the relationships it currently has with pharmacies in the state. WSI indicated it would look at other cost containment efforts. One alternative that has not been explored is to obtain a price list for commonly prescribed drugs from mail order programs and see whether or not local pharmacies can be or are price-competitive. The intent of this recommendation was to help WSI contain pharmacy costs, an issue that was a significant concern to WSI during the time of the last performance evaluation.

WSI Response: In 2004, WSI was in fundamental disagreement with this recommendation. WSI still does not intend to implement a mail order program at this time. There continue to be other more significant ways to reduce costs.

2004 Performance Evaluation - Recommendation #56

WSI's medical director and Medical Services Vice President should meet with OCC to determine the causes for the adverse results achieved in the chiropractic utilization review program. Once those causes are known, WSI and OCC should agree on approaches that will lead to a favorable overall savings result. The ongoing measurement of UR results will allow WSI to determine if the new approaches are working. WSI should simultaneously consider its options for alternative chiropractic utilization review services. Such services may be provided by another chiropractic group within North Dakota or could be offered by many of the national bill review organizations.

This recommendation was classified as a high priority.

Status:

WSI indicated in its updated response to this recommendation that during the 2004 performance evaluation we were given inaccurate data to derive the conclusions we reached. We disagree.

We referenced "adverse results" in the 2004 recommendation relating to OCC, and we did so because the return on investment for the program was achieving a negative return on investment (less than \$1.00 saved for each \$1.00 spent). In reviewing utilization review measures over the past two calendar years, OCC achieved a favorable return in only one of eight quarters.

It is likely true that WSI derives some cost savings as a result of the sentinel effect; that is, chiropractors in the state know there is a program in place that tracks utilization so they control their treatment patterns to a certain extent. Nonetheless, OCC is the only UR provider, who according to WSI's own reporting, achieves a consistently unfavorable return. It was for this reason in the prior performance evaluation that we encouraged WSI to examine a second source for chiropractic UR.

WSI Response: WSI will take this recommendation into consideration when it rebids for these services.

NOT APPLICABLE

2004 Performance Evaluation - Recommendation #10

Given the high cost of private investigations, we recommend more SIU investigators be hired and trained to perform most if not all of the work currently being provided by private investigation firms. We specifically recommend that five additional Special Investigators be retained to accomplish this work. SIU staff should be housed geographically around the state to improve expense efficiencies and the timeliness of investigations. (We estimate the cost for staff salaries and benefits to be \$237,600. This amount is based on a \$36,000 annual salary and a 32% benefits load.)

This recommendation was classified as a high priority.

Resolution:

Once the work of investigation management became a shared responsibility between SIU for fraud and Claims for routine investigations, this recommendation was no longer necessary.

2004 Performance Evaluation - Recommendation #36

For the nine-quarter measures, the report should be current through the valuation date. If this means that this portion of the report should be delayed slightly to allow for data capture to occur through the valuation date, then this approach should be taken.

The recommendation was classified as a low priority.

Resolution:

WSI declares that the monthly progress report reflects the most current data available. We understand the only instances where data is not provided through quarter end date are those cases where data may come from a source outside WSI.

2004 Performance Evaluation - Recommendation #58

WSI should bring disability management services in house. WSI claims and return-to-work staff should determine how many FTE's are needed given the increased role claims analysts should assume in the management of time loss claims.

This recommendation was classified as a high priority.

Resolution:

With our participation in a review of the disability management programs by the Internal Audit Department, we developed an alternative set of recommendations in 2005 to address recommendations 58 and 59. The process consisted of a detailed analysis of disability management data, a review of disability management claims, meetings with five of the six disability management firms, a presentation of findings to the Board's Audit Committee, and the implementation of those recommendations starting in late 2005 and early 2006. Anticipated savings as a result of the revisions to the disability management programs amount to approximately \$150,000/year.

ATTACHMENT A

Time loss claim volume:

| Fiscal Year | 12 Months | 24 Months | 36 Months | 48 Months | 60 Months |
|-------------|-----------|-----------|-----------|-----------|-----------|
| 2001 | 2,636 | 3,036 | 3,088 | 3,099 | 3,104 |
| 2002 | 2,656 | 3,055 | 3,098 | 3,122 | |
| 2003 | 2,554 | 2,931 | 2,961 | | |
| 2004 | 2,616 | 2,982 | | | |
| 2005 | 2,649 | | | | |

Time loss total paid:

| Fiscal Year | 12 Months | 24 Months | 36 Months | 48 Months | 60 Months |
|-------------|--------------|--------------|--------------|--------------|--------------|
| 2001 | \$10,849,074 | \$20,204,853 | \$25,692,420 | \$29,925,884 | \$32,674,151 |
| 2002 | \$11,569,183 | \$21,805,499 | \$28,300,734 | \$32,151,970 | |
| 2003 | \$12,537,692 | \$24,081,982 | \$28,917,664 | | |
| 2004 | \$13,532,188 | \$26,911,570 | | | |
| 2005 | \$15,054,096 | | | | |

Time loss average paid:

| Fiscal Year | 12 Months | 24 Months | 36 Months | 48 Months | 60 Months |
|-------------|-----------|-----------|-----------|-----------|-----------|
| 2001 | \$4,116 | \$6,655 | \$8,320 | \$9,657 | \$10,526 |
| 2002 | \$4,355 | \$7,138 | \$9,135 | \$10,299 | |
| 2003 | \$4,909 | \$8,216 | \$9,766 | | |
| 2004 | \$5,173 | \$9,025 | | | |
| 2005 | \$5,683 | | | | |

Time loss total incurred:

| Fiscal Year | 12 Months | 24 Months | 36 Months | 48 Months | 60 Months |
|-------------|--------------|--------------|--------------|--------------|--------------|
| 2001 | \$17,172,626 | \$25,652,409 | \$33,086,219 | \$37,435,438 | \$42,863,902 |
| 2002 | \$23,500,584 | \$33,840,652 | \$39,994,198 | \$42,335,229 | |
| 2003 | \$22,684,441 | \$31,293,758 | \$35,861,664 | | |
| 2004 | \$24,712,444 | \$34,843,963 | | | |
| 2005 | \$25,180,347 | | | | |

Time loss average incurred:

| Fiscal Year | 12 Months | 24 Months | 36 Months | 48 Months | 60 Months |
|-------------|-----------|-----------|-----------|-----------|-----------|
| 2001 | \$6,515 | \$8,449 | \$10,714 | \$12,080 | \$13,809 |
| 2002 | \$8,848 | \$11,077 | \$12,910 | \$13,560 | |
| 2003 | \$8,882 | \$10,677 | \$12,111 | | |
| 2004 | \$9,447 | \$11,685 | | | |
| 2005 | \$9,506 | | | | |

Time loss paid to incurred ratio:

| Fiscal Year | 12 Months | 24 Months | 36 Months | 48 Months | 60 Months |
|-------------|-----------|-----------|-----------|-----------|-----------|
| 2001 | .63 | .79 | .78 | .80 | .76 |
| 2002 | .49 | .64 | .71 | .76 | |
| 2003 | .55 | .77 | .81 | | |
| 2004 | .55 | .77 | | | |
| 2005 | .60 | | | | |

ATTACHMENT B

**LETTER OPINION
2006-L-28**

September 6, 2006

The Honorable Robert R. Peterson
State Auditor
600 E Boulevard Ave Dept 117
Bismarck, ND 58505

Dear Mr. Peterson:

Thank you for your letter asking whether one person on the Workforce Safety & Insurance (WSI) Board of Directors may serve as the employee who has received WSI benefits and also as the employee representative for organized labor. For the reasons stated below, it is my opinion that one person may not serve as the employee representative who has received WSI benefits and as the employee representative for organized labor.

ANALYSIS

The WSI Board consists of 11 members.¹ The appointment and replacement of the members must insure that "[t]hree members represent employees; at least one member must have received workforce safety and insurance benefits; and at least one member must represent organized labor."² You ask whether this statute permits a single board member to be both the employee member who has received benefits and the employee member who represents organized labor.

When statutory language is clear and unambiguous, that language cannot be disregarded under the pretext of pursuing the legislative intent because the intent is presumed to be clear from the face of the statute.³ "The Legislature must be presumed to have meant what it has plainly expressed."⁴ The language in N.D.C.C. § 65-02-03.1(1)(b) is clear and unambiguous. The plain language indicates that the Legislature wanted one employee

¹ N.D.C.C. § 65-02-03.1.

² N.D.C.C. § 65-02-03.1(1)(b).

³ District One Republican Committee v. District One Democrat Committee, 466 N.W.2d 820, 824-25 (N.D. 1991); N.D.A.G. 2005-L-46.

⁴ Little v. Tracy, 497 N.W.2d 700, 705 (N.D. 1983), quoting City of Dickinson v. Thress, 290 N.W. 653, 657 (N.D. 1940).

LETTER OPINION 2006-L-28
September 6, 2006
Page 2

member to represent the perspective of an employee who had received benefits and one member to represent the perspective of organized labor.

That this is the Legislature's intent can be discerned from the statutory language itself. The Legislature was specific in determining the board's membership. The board is comprised of eleven members. Six of the members are employer representatives, and the class from which each of these board members must be selected is specifically set forth in the statute.⁵ Likewise, another member is a member of the North Dakota Medical Association,⁶ and another is a member at large who must be over the age of twenty-one.⁷ The remaining three are the employee representatives.⁸ It is clear that the Legislature intended that there would always be at least one board member who would be an organized labor employee representative, selected by the Governor from a list of three names submitted by a statewide labor organization.⁹ And it is equally clear that the Legislature intended that there would always be at least one board member who had received benefits, selected by the Governor.¹⁰

If the statute were read to allow the board member who has received WSI benefits and the organized labor representative to be the same person, an anomalous situation could arise. If a board member who served the dual purpose were to resign, leaving the Board without at least one member who represented labor and at least one member who had received WSI benefits, it would force the labor organization to nominate as that member's replacement only a person who had received benefits. The statute does not require that the labor organization limit its potential nominees in that manner. In such a case, if the labor organization did not submit among its three nominees to the Governor the name of at least one person who had received benefits, it would force the resignation of a sitting board member in order to fulfill the requirement of the statute. Likewise, if the labor organization submitted three names, only one of which was a person who had received benefits, it would require the Governor to name that person, and not one of the others, to the board. This would render the requirement of the submission of three names an idle act.¹¹ Statutes must be construed in a practical manner so that they do not produce an absurd or ludicrous result.¹² I do not believe this result is what the Legislature intended.

⁵ N.D.C.C. § 65-02-03.1(1)(a).

⁶ N.D.C.C. § 65-02-03.1(1)(c).

⁷ N.D.C.C. § 65-02-03.1(1)(d).

⁸ N.D.C.C. § 65-02-03.1(1)(b).

⁹ N.D.C.C. § 65-02-03.1(2)

¹⁰ *Id.*

¹¹ N.D.C.C. § 31-11-05(23) (the law neither does nor requires idle acts).

¹² *Huber v. Oliver County*, 602 N.W.2d 710, 716 (N.D. 1999).

LETTER OPINION 2006-L-28
September 6, 2006
Page 3

Thus, it is my opinion that N.D.C.C. § 65-02-03.1(1)(b) requires one employee member to have received workforce safety and insurance benefits,¹³ and another separate employee member to represent organized labor.

Sincerely,

Wayne Stenehjem
Attorney General

jak/vkk

This opinion is issued pursuant to N.D.C.C. § 54-12-01. It governs the actions of public officials until such time as the question presented is decided by the courts.¹⁴

¹³ The statutory requirement that one board member must have received WSI benefits does not imply that the other board members may not have received benefits. This requirement exists to insure that at least one board member represents workers who have received or may receive benefits, and that this member does not have a competing or different purpose for serving on the board.

¹⁴ See State ex rel. Johnson v. Baker, 21 N.W.2d 355 (N.D. 1946).