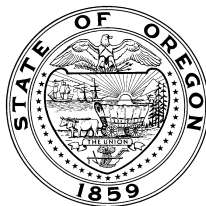


Workers' Compensation Division

Pilot Audit of Permanent Partial Disability



Final Report
November 2000



Oregon Workers' Compensation Division

350 Winter St. NE, Salem, OR 97301-3879

www.cbs.state.or.us/wcd

John L. Shilts, Administrator

Permanent Partial Disability Pilot Audit

Final Report

November 2000

Contents

- Introduction** 1
- Highlights** 1
- Objectives of Pilot Audit**..... 2
- Methodology** 2
- Summary of Findings** 3
 - Insurer authority to issue a Notice of Closure..... 3
 - Application of Disability Rating Standards (Division 035) 4
 - Updated Notices of Acceptance 4
 - Bulletin 239 Information 4
- Observations** 5
- Recommendations** 6
- Statistical Summary** 7
 - Authority to issue NOC 7
 - Application of Division 035 Disability Rating Standards 8
 - Updated Notice of Acceptance 8
 - Bulletin 239 — Closing report information not provided..... 9
 - Participants 10

Introduction

In March of 1999, the Workers' Compensation Division (WCD) began developing a proposal for a permanent partial disability (PPD) pilot audit. WCD formed focus groups with representation from insurers, self-insured employers, third-party administrators, private claim closure contractors, the Oregon AFL-CIO and department staff. The meetings took place in July 1999 and all input received was considered in the development of the PPD pilot audit procedures.

The PPD pilot audit methodology and procedures were approved in April 2000. Onsite review of claim files began April 24th and was completed August 3rd. The PPD pilot audit was conducted to develop methods by which WCD will assess insurer performance in rating disability. This report summarizes the pilot audit objectives and parameters, and the audit findings.

Highlights

- The audit sample of 600 closures represented insurers, self-insureds, and service companies.
- Of the 600 closures reviewed, 536 closures were considered accurate and 66 closures were deviated;* thus an overall accuracy rate of 89%.
- Most common deviations (42, or 7% of the sample) resulted from the insurer not establishing a proper medically stationary date, failing to request the attending physician's concurrence, prematurely closing non-medically stationary claims, and not having sufficient information to rate permanent partial disability.
- The remaining deviations (27, or 4.5% of the sample) resulted from errors in applying the established rating standards (Division 035).
- Findings from the pilot audit identified the need for continuing audit review, determining the required elements of Bulletin 239 to use for claim closure, and for on-going training specific to claim closure.

*Note: The term "deviation" used in this report refers to the number of times in a claim closure the rules were not followed or there were processing errors found.

Objectives of Pilot Audit

- Test the feasibility and appropriateness of the proposed audit approach as a permanent component in the existing compliance performance audit process.
- Assess compliance with statutory and administrative requirements addressing the rating of permanent partial disability.
- Gather statistical information regarding insurer rating of permanent partial disability for department decision makers, affected parties and policymakers, including the Management-Labor Advisory Committee and legislators.
- Identify industry training needs and possible revisions to administrative rules that would improve understanding of, and accuracy in, disability rating.

Methodology

Information Management Division (IMD) prepared a random sample of 600 closures that resulted in 56 insurers and 46 self-insured employers participating in the PPD pilot audit. The sample was composed of Notices of Closure (NOC) prior to October 1999. Rather than examine claims that were involved in some stage of litigation, the audit focused exclusively on NOCs that had not been challenged within the statutory appeal period, and had become final by law. Any conclusions drawn from the audit findings must therefore be limited to non-litigated closures. This sample size fell within the range sufficient to assure within a 95% confidence level that the estimated error rate was correct within $\pm 4\%$.

The sample consisted of 300 NOCs that awarded permanent partial disability and 300 that awarded time-loss only. The latter sample was reviewed to determine whether PPD should have been rated. It was determined that the following areas would be reviewed for each file in the sample:

- Authority to issue a Notice of Closure
- Application of disability rating standards
- Accuracy of Notices of Acceptance
- Complete Closing Reports

As this pilot was intended to focus on the accuracy of rating permanent disability, the audit team did not review the accuracy of the temporary disability periods, or review claims that were classified as non-disabling. Both of these areas are reviewed as a portion of the existing compliance audit.

Each company was notified in advance of the audit's purpose and provided a list of files to be reviewed. The review of files was based on the information insurers had available at the time they issued their closure notice, and not what appeared in the file (if anything) after closure.

Summary of Findings

Based on the sample of 600 cases, 66 claims had one or more deviations; (a deviation occurs when there has been a departure from a standard established by the statutes and rules). This computes to an 89% accurate “rating” of permanent disability.

A detailed statistical summary is included in this report (pages 7 through 10). Some claim files had more than one deviation in a finding category (a pre-determined area to be audited); therefore, the percentages for individual finding areas may exceed the total percentage of deviations for the primary finding category.

The statistics shown in the summary are explained by finding areas

Insurer authority to issue a Notice of Closure

The insurer has authority to close a claim when the worker becomes medically stationary; when the worker fails to treat or attend a closing examination; or when a major contributing cause denial has been issued.

A worker’s condition is determined to be medically stationary when the attending physician or a preponderance of medical opinion declares the worker either “medically stationary,” “medically stable,” or uses other language meaning the same thing. Medically stationary means that no further material improvement would reasonably be expected from the medical treatment or the passage of time. Medically stationary status cannot be projected.

A non-medically stationary claim may be closed if a worker fails to seek medical treatment for a period of 30 days; fails to attend a closing examination; or when a major contributing cause denial has been issued. The insurer is required to notify the worker and attending physician prior to issuing the closure.

Insufficient information to close a claim is when the medical record is incomplete or the closing examination report does not describe all applicable medical findings sufficient to evaluate and rate disability as required by Bulletin 239.

Forty-two claims (7%) were deviated in this finding area due to:

Medically Stationary closures

- worker not medically stationary
- use of a projected medically stationary date
- attending physician clarification/concurrence not requested

Non-Medically Stationary closures

- closure issued prior to expiration of 30-day waiting period
- warning letter not appropriate or not sent certified
- treatment letter not sent to worker and attending physician
- no documentation of 14 day treatment letter in file

Insufficient information to rate PPD

- closing exam not scheduled
- attending physician clarification/concurrence not requested

Application of Disability Rating Standards (Division 035)

Incorrect application of the disability rating standards is indicated when the rules are misapplied in the claim closure process. A worker is entitled to a disability rating under these rules only for those findings of impairment that are permanent and were caused by the accepted conditions as cited on the Updated Notice of Acceptance.

Only closures with sufficient information to rate permanent disability were reviewed for accurate application of the rating standards. There were 27 claims (4.5%) that deviated in this finding area. Disability ratings on 18 claims were underrated and 9 claims were overrated. Specific deviations included:

- ranges of motion
- strength loss/weakness
- sensory loss/numbness
- contralateral comparisons
- loss of member/amputation
- repetitive use (chronic)
- work status of worker
- pre-existing condition/apportionment of disability
- additional PPD granted in error
- compression fracture/surgery not rated
- rated condition not accepted

Updated Notices of Acceptance

Since Updated Notices of Acceptance (UNOA) reflect an insurer's compensability decisions, and it is not the role of WCD to evaluate the accuracy or appropriateness of decisions in this area. However, the intent was to compare the UNOA to the Notice of Closure, medical documentation in file, and any litigation to assess consistency. The UNOA's were reviewed in all 600 claims with inaccuracies found in only 6 of the claims.

Bulletin 239 Information

In 143 claims, the closing reports were found lacking elements required by Bulletin 239.

Observations

The audit team's review of the findings indicate an overall deviation rate of 11% for all claims reviewed. A deviation rate of 12% was found for both private insurers and self-insured employers. SAIF Corporation's deviation rate was 10%.

The "authority to issue" category is periodically audited by the Compliance Section in the course of regular performance audits. The pilot audit deviations, although minimal (7%), were slightly higher than previous performance audit findings in this area.

In reviewing the application of the disability rating standards, the few deviations (4.5%) were found for a variety of reasons — the most common one for not rating objective findings of range-of-motion loss. It was noted that twice as many claims were underrated as were overrated.

Of the 300 time-loss claims audited, only 3 (1%) were found where PPD should have been rated.

Concerns had been expressed that the Updated Notices of Acceptance (UNOA) were not consistent with medical documentation. Our review found inaccuracies in only 6 claims (1%).

Bulletin 239 outlines the requirements of a closing report. Although we found 143 claims did not provide complete documentation as required by Bulletin 239, in all but 11 claims there was "sufficient information" to rate disability. This raises questions about the need or requirement for all the elements outlined in Bulletin 239.

The audit methodology produced adequate data to evaluate the accurate rating of permanent partial disability. With the pilot audit paralleling the components of our established compliance audit, it would be feasible to combine the two audits.

Recommendations

- It is recommended that the pilot audit methodology to assess the accurate rating of permanent disability be incorporated into the existing Compliance Section performance audits. This process would provide the means of obtaining consistent statistical data to assess compliance with the application of the disability rating standards.
- Since the majority of the claims could be rated without all the requirements contained in Bulletin 239 (closing exam elements, e.g. medical history), it is recommended that WCD review the bulletin and assess the need for all of the requirements.

However, OAR 436-035-0007(23) regarding contralateral comparisons should remain in the rules. WCD provides the standards for rating disability based on the average individual. Even with the “perfect devices” for measuring objective findings of impairment, human variability remains with such factors as age, gender and weight. Objective findings that may be ratable under the standards may not be due to the job injury or disease and may be normal for this individual. Without a contralateral comparison, there is the possibility of the payment of PPD when none was due. The implementation of continued audit review, refining the required elements for claim closure, and on-going training specific to claim closure would benefit all parties by achieving and maintaining an acceptable level of accuracy and consistency.

- On-going training for insurers and medical providers specific to claim closure would benefit all parties by achieving and maintaining an acceptable level of accuracy and consistency. Internal and external training resources would need to be identified.
- With the pilot audit findings establishing a baseline for insurer closure performance prior to October 1999 (89% accuracy), it is recommended that an “acceptable performance” standard be established. Based on future audit findings, corrective action would be taken for substandard performance.

Statistical Summary

Sample size: 600 claims

300 claims, “1222” orders — Time loss only

300 claims, “1832” orders — PPD rated

Total number of claims deviated:

66 or 11.0%

Authority to issue

NOC deviations

42 or 7.0%

Application of Division 35

Rules deviations

27 or 4.5%

(3 claims were deviated under both categories)

Authority to issue NOC — 42 claims deviated

Areas of deviations	# of deviations
Medically Stationary closures	
<i>Specific areas of deviations:</i>	
No medically stationary status	11
Projected medically stationary date	12
Insurer failed to request either clarification or concurrence from A/P	11
Non-Medically Stationary closures	
<i>Specific areas of deviations:</i>	
Insurer failed to wait the 30-day period prior to issuing warning letter to worker	2
Insurer’s warning letter not appropriate/certified	2
Insurer failed to send treatment letter to worker and A/P	1
Could not produce 14 day treatment letter in file (new)	2
Sufficient information to rate PPD	
<i>Specific areas of deviations:</i>	
Insurer did not schedule closing exam	2
Insurer failed to request either clarification or concurrence from attending physician	9

■ Permanent Partial Disability Pilot Audit Final Report

Application of Division 035 Disability Rating Standards — 27 claims deviated

Areas of deviations		# of deviations
Application of Division 035 rating standards		
<i>Specific areas of deviations:</i>		
Range of motion		8
Strength loss/weakness		3
Sensory loss/numbness		3
Contralateral comparisons		1
Loss of member/amputation		2
Repetitive use (chronic)		3
Total		20
Computation process(es) — i.e., conversion, combining, adding		
<i>Specific areas of deviations:</i>		
Work status of worker (U/D injury)		2
Pre-existing condition/estimating		1
Additional PPD granted in error		1
Total		4
Unscheduled disability factors		
<i>Specific areas of deviations:</i>		
Compression Fx/Surgery not rated		2
Total		2
Other		
<i>Specific areas of deviations:</i>		
Rated unaccepted condition		1
Total		1
Overrated/Underrated amounts	Amounts	Claims
Overrated	\$9,710.23	9
Underrated	\$32,652.40	18

UNOA inaccuracies found — 6 claims noted

Inaccuracies found	# of inaccuracies
Compared to NOC	7
Compared to medical documentation	6
Compared to litigation	1

Bulletin 239 — Closing report information not provided — 143 claims noted

Closing report information not provided	# of B239 elements missing
Medical history Pursuant to OAR 436-010-0280(7), the Director may prescribe by bulletin what comprises a complete closing exam. B239 states a medical history is to be provided.	108
Treatment description Pursuant to OAR 436-010-0280(7), the Director may prescribe by bulletin what comprises a complete closing exam. B239 states a medical history is to be provided.	104
Medically Stationary Statement Statement not provided or unclear as to stationary status	9
Range of Motion (ROM) Not provided in degrees; ROM findings ratable under Division 35 Standards with statement of “no PPD” or “full ROM”; Not provided in all planes of a given body part (adduction of the shoulder was the largest omission); Passive (not Active) ROMs provided; ROMs measured using different vertebra levels (ex-L-1 bilaterally).	87
Strength Loss/Weakness Not provided using the 5/5 method	21
Sensory Loss/Numbness Not provided using the 2-point discrimination method	12
Contralateral Comparisons Not provided for contralateral side	9
Vascular/Dermatological Restrictions Complete information not provided for rating purposes	1
Repetitive Use Restrictions (chronic) Restrictions not provided	1
Work Status of Worker (w/ injury to U/D body part or function) Residual Functional Capacity (RFC) not provided	3

■ Permanent Partial Disability Pilot Audit Final Report

Participants

	Number of claims	PPD claims	T/L only claims	Authority to issue NOC deviation	Application of Division 035 rules deviations
Self-administered	25	10	15	4	3
Self-insured at TPAs	91	38	53	4	3
Insurers	182	69	113	19	7
Liberty Northwest	64	61	3	0	3
SAIF	238	122	116	15	11
Totals	600	300	300	42	27

