

BPR As-Is Assessment Report

New York State Workers' Compensation Board

Approved for distribution on January 31, 2014

Table of Contents

Sections	Page Numbers
1.0 Introduction As-Is Assessment Introduction 1.1 Purpose and Approach 1.2 Approach 1.3 Scope 1.4 Contents of Document 1.5 Common Themes Heard Across the State	4 – 11
2.0 Current State (As-Is) Assessment (Summary) 2.1 Claims Management As-Is Assessment 2.2 Adjudications and Appeals As-Is Assessment 2.3 Medical Provider Management As-Is Assessment 2.4 Compliance and Monitoring As-Is Assessment	12 – 16

1.0 Introduction

As-Is Assessment Introduction

For 70 years, the New York State Workers' Compensation Board has made periodic efforts at reform. The initiatives that have resulted have typically ranged from those focused on a single area of the claims or adjudication process, to wide ranging reform efforts such as the 1996 and 2007 reforms. While these efforts have led to changes in process, many of them good, they have also resulted in additional layers of complexity, and consequently confusion, misinformation and often, increased delays.

Established as a no fault, workers' compensation system in the state, exchanging the injured worker's right to sue for guaranteed replacement wages and medical treatment, a hundred years on the system has become ever more complicated and the process ever longer. For possibly the first time since this "great compromise" between workers and employers was reached in 1914, the whole system is under review, not only by the Board but by representatives of all system participants. Never before has the Board taken the opportunity to work in conjunction with stakeholders and other major participants to examine the entire scheme and to seek to address the issues within it and to build into the system methods and mechanisms for making it self-correcting in the future.

The Board's role within that system is only one part of the equation. The complex interactions of workers, unions, employers, insurers, attorneys and providers with the Board and with each other form the backbone of the system. Understanding these interactions is key to recreating a system to serve injured workers and yet be cost effective for employers.

This document is intended to record the current state of the system, and to identify areas that need to change. Deconstructing the system and the Board's role within the system into the component parts of Process, People and Technology, we hope that this document accurately captures the challenges of today and highlights the opportunities of tomorrow.

1.1 Purpose and Approach

Purpose

The purpose of the As-Is Assessment Report is to assess the current processes, organization and technological challenges of the New York State Workers' Compensation system and the role of the Board within that system. This assessment forms the basis for moving forward with recommendations to change the system and improve outcomes for injured workers and employers in the state.

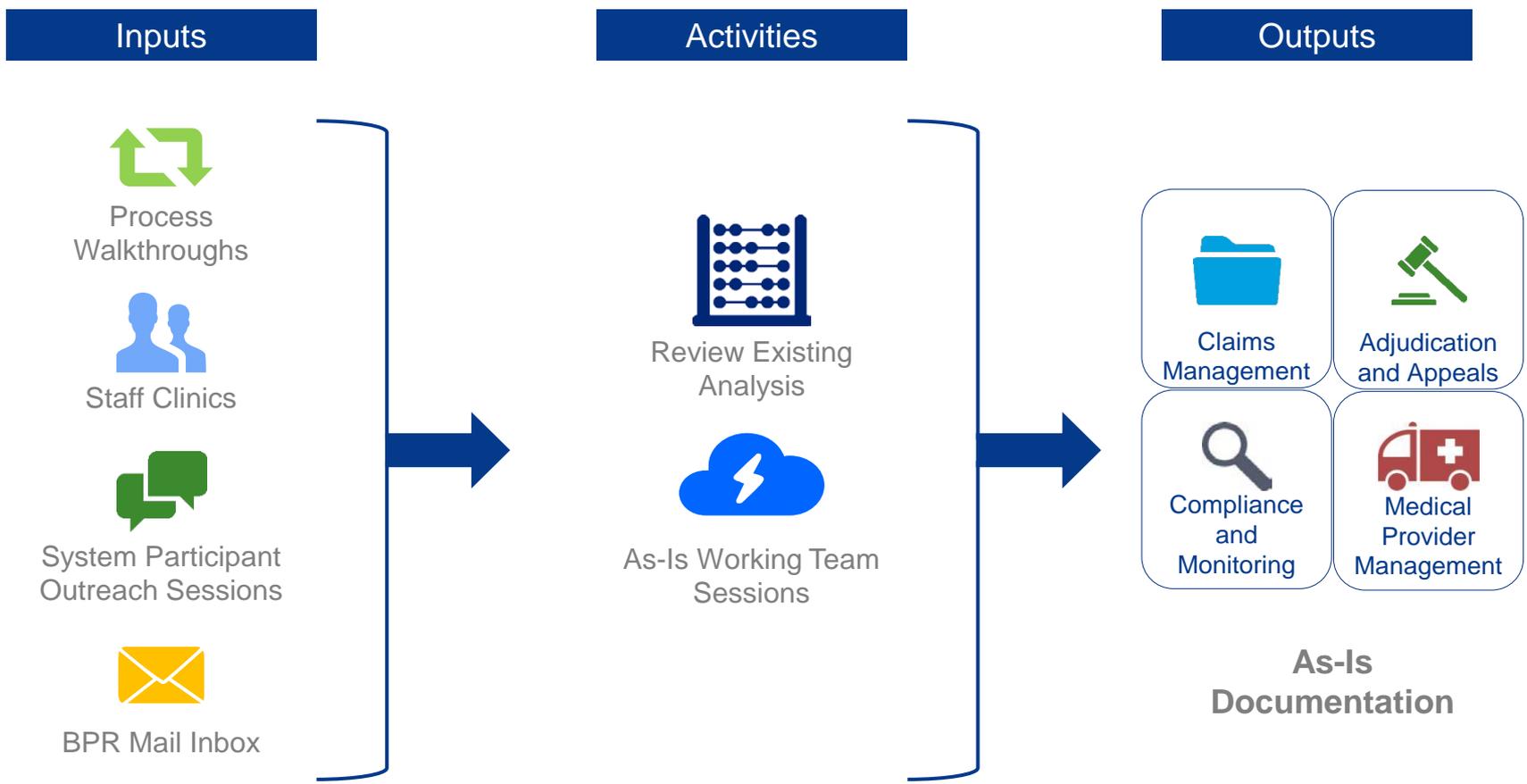
Approach

To develop the As-Is Assessment Report the team reviewed existing process documentation and conducted As-Is discussion sessions with the four working teams – Claims Management, Adjudications and Appeals, Medical Provider Management and Compliance and Monitoring. These teams were formed to provide structure to the analysis phase, but were encouraged to look beyond the boundaries of their team focus to capture overarching topics in their analysis.

The input from the working teams was supplemented and enhanced by contributions from system participants, process walkthroughs and staff clinics in addition to emails received from the BPR mail inbox. This essential input from outside the Board, provided insights from those most intimately involved in the system ranging from injured workers and worker groups, through employers, carriers/TPAs and providers, to attorneys representing the parties in the system. Many formats were used to glean this input, including surveys, in person meetings and conference calls, and webinars.

1.2 Approach

During the As-Is Assessment period, the BPR project team identified the critical challenges faced by system participants for remediation and re-engineering in the to-be development.



1.4 Contents

Contents

Below is a brief description of the sections that follow in this document:

Section 2 :Current State (As-Is) This section contains a summarized assessment of the challenges identified across processes, people and technology in the areas of Claims Management, Adjudications and Appeals, Medical Provider Management and Compliance and Monitoring.

1.5 Common Themes Being Heard Around the State

The following themes were heard in various outreach sessions around the state. Participants described how over many years the following concepts have become the norm in the system:

- Lack of trust throughout the system; participants can no longer rely on good faith
- Lack of respect and dignity for the injured worker
- Case outcomes are unpredictable and inconsistent
- Workers & employers do not have enough information to participate effectively
- Board needs to do more outreach
- The system is rife with delays for treatment, initial payments, reporting, decisions, appeals
- Lack of focus on safety & getting the worker healthy & back to work
- Cumbersome medical reporting processes & low or no payments causes doctors to leave the system
- The fundamentals of workers' compensation have been lost; the Board should get back to the mission
 - Ensure timely payment of indemnity benefits
 - Ensure receipt of appropriate medical benefits
 - Encourage return to work

1.5 Common Themes Being Heard Around the State

- Participants have no clear performance standards against which they can be measured
 - The Board's performance must be measured too
- There are many rules already in place. The Board is not using the tools it has and does not enforce those rules consistently and fairly to encourage good behavior
- The Board has contributed to the system becoming overcomplicated & confusing
- MTGs are a good concept, but the process is too complicated
- Impairment guidelines are confusing & hard to apply
 - Injuries affecting multiple body-parts are particularly problematic
- The IME process is not working
- Medical determinations should be made by medical experts not judges
- Excessive SLUs do not foster the goals of a workers' compensation system – the focus should be on payments to compensate workers

Current State Assessment (Summary)

Overall system

Overview and As-Is Challenges

Overview

The New York State Workers' Compensation system is a complicated and aged system dating back 100 years at the time of writing. Premised on a compromise between workers and employers that provides, on a no-fault basis, earnings protection and health care in exchange for no right to sue, the system's underlying goals are to protect the employee and the employer. In its current state, the system is underperforming when measured against other states, and yet is still one of the most expensive. Within that system, the Board's role has become unclear.

As-Is Challenges

Process	People	Technology
<ul style="list-style-type: none">▪ Lack of comprehensive compliance and monitoring program for system participants to promote good behavior and penalize non-performance▪ Lack of system wide performance standards promotes poor outcomes▪ Focus on “paper shuffling” and administrative tasks rather than on service to constituents▪ Process has lost sight of the underlying mission of the system and the Board▪ Hearing based monitoring results in regulation claim by claim which is ineffective and inefficient▪ Lack of regulatory authority over insurers and municipal self insured employers▪ Lack of metrics for overall system performance	<ul style="list-style-type: none">▪ Lack of outreach and engagement with participants causes frustration and a sense of alienation▪ Inefficient processes result in the need to increase staffing levels▪ Absence of trust between participants – vulnerable participants feel unsafe and devalued▪ Limited communication between the Board and participants▪ Board staff dissatisfied with the level of service they are able to provide to clients▪ High level of frustration throughout the system▪ Participants' rights, responsibilities & roles are unclear, creating uncertainty & distrust	<ul style="list-style-type: none">▪ System is 20th century technology supporting 21st century needs leading to lack of access, and incompatibility with today's standard technologies▪ High volume of paper forms causes significant administrative burden and data inaccuracies, delaying the resolution of cases for injured workers▪ Lack of role based access to data makes claims tracking and follow up manually intensive and costly▪ Lack of across the board electronic submissions and acknowledgements is inefficient and leaves participants frustrated▪ Inability to capture & mine data makes oversight & enforcement difficult.▪ Current systems inhibit ability to capture necessary data▪ Existing data capture lacks automation▪ E-Case provides a good start but needs to be enhanced.

Claims Management

Overview and As-Is Challenges



Overview

The Claims Management process creates claimants' cases, provides customer service through telephone, written correspondence and in person visits, maintains the electronic case folder, resolves uncontroverted issues relating to a case, requests necessary documentation to resolve issues in a claim, handles disputed medical bills and determines appropriate resolutions path for the claim and/or issue.

As-Is Challenges

Process	People	Technology
<ul style="list-style-type: none">▪ Pending inventories and manual processes, particularly in the absence of disputed issues, slow the system hurting injured workers and employers▪ High volume of forms required for the claims process causes a significant administrative burden and the complexity causes data inaccuracies, delaying the resolution of cases for injured workers▪ Focus on forms consolidator role as opposed to resolution-oriented role reduces Board's level of service to its constituents▪ Lack of a standardized workflow or manual process controls▪ Locating relevant information on new medical forms is difficult and affects the timeliness in which a case can be assembled▪ Lack of understanding or misapplication of medical guidelines by system participants results in frequent rework for claims staff▪ System participants confusion over case assembly and indexing processes	<ul style="list-style-type: none">▪ Inefficient and manual processes result in inadequate staffing levels▪ Uneven distribution of workload across the different offices and regions▪ Misalignment between management goals and staff expectations▪ Impersonal communication creates sense of alienation▪ Communication and training does not permeate levels of the organization resulting in lack of uniformity in practice and execution▪ Lack of succession planning to ensure continuation of good practices and knowledge transfer	<ul style="list-style-type: none">▪ System requires significant manual data entry and lacks dynamic text fields for intelligent population of data▪ System lacks basic validations and error checking▪ System needs to be accessible to more parties▪ System lacks basic workflow or prioritization and aging of items▪ Case file information is presented in a format that can be cumbersome to view or work with▪ Phone system for customer support can be confusing and cumbersome to operate▪ System lacks the ability to capture and track information for compliance for example data capture on timely payment, standard medical protocols, timely filings

Adjudications and Appeals

Overview and As-Is Challenges



Overview

The Adjudication process provides dispute resolution by formal or informal means. The Administrative Review Division (ARD) provides an administrative review of decisions rendered by a WC Law Judge and also reviews requests for reopening cases. The Full Board Review process includes the review of decisions issued by the Board Panel.

As-Is Challenges

Process

- Insufficient prioritization of rules which may cause inappropriate delays to resolution for vulnerable workers
- Lack of focus on dispute prevention because it is not viewed as one of the Board's roles by system participant groups
- Inconsistent practices with pre-hearing conference statements and at pre-hearing conferences sometimes affect the due diligence process and can result in the inefficient use of hearing time
- Inconsistent application of policies and rulings across the state are perceived as unfair
- Long and tenuous appeals process delays case resolutions that leave workers without benefits and increases frustrations of contributors to the process

People

- Lack of input from staff to changes being implemented leads to confusion and uncertainty
- Lack of empowerment of staff causes resentment and dissatisfaction which impacts delivery and thus outcomes for parties
- Inefficient and manual processes result in inadequate staffing levels
- Inability to implement new processes and guidelines due to lack of proper training and rationale behind the change.

Technology

- Lack of integration across multiple systems requiring input and extract information from multiple systems which leads to confusion and duplicate information
- Lack of sophisticated EDI to accommodate data capture and information management needs
- eCase system limitations results in limited access to documents (examples (i.e.: system times out, incompatible with certain operating systems, random shut downs, limited printing ability, close down at night)
- The Zone is not easily navigable and does not provide the most up date information for staff
- Dependency on document scanning results in high error rate and does not data-enable the information provided
- Lack of interactive online portal for questions for involved parties of interest to the overall hearing process

Medical Provider Management Overview and As-Is Challenges



Overview

The Medical Provider Management function governs the authorization of Medical Providers, determines the appropriateness of medical bills in dispute, as well as the appropriateness of many aspects of healthcare delivery in the New York State Workers' Compensation system, including but not limited to approval of medical treatment.

As-Is Challenges

Process	People	Technology
<ul style="list-style-type: none">▪ Reduced access to prompt care for injured workers due to numbers of authorized physicians reluctant to treat in the WC system▪ Downcoding, late payment and non-payment disincentivize good doctors from participating in the system▪ 'Upcoding' results in additional work for payers, friction in the system and lack of trust▪ High volume of paper forms causes significant administrative burden and data inaccuracies, delaying the resolution of cases for injured workers▪ Variance process is cumbersome and complicated▪ Poorly designed reimbursement process causes complex approval workflows and untimely bill repayments▪ Medical Fee schedules are not self-adjusting and become outdated, resulting in disincentives to treat▪ Lack of oversight for IMEs	<ul style="list-style-type: none">▪ Inefficient and manual processes result in inadequate staffing levels▪ Need for more involvement from insurance carriers in the process to educate injured workers and employers▪ Lack of consistent follow-up training for employees on new processes and procedures▪ Lack of solicitation of staff feedback has often led to problematic processes▪ Doctors and their staff are not made familiar with the system or process leading to frustration, unpaid bills and conflict	<ul style="list-style-type: none">▪ No technology solution to capture and compare data needed for performance evaluations, compliance and fraud (i.e. ICD 9 codes)▪ Current platform limits electronic billing and report submission▪ Lack of an interface or a connection to current Claims Information System▪ Lack of an interface with medical billing and reporting systems

Compliance and Monitoring Overview and As-Is Challenges



Overview

The Compliance and Monitoring function covers the employer compliance in carrying valid and appropriate insurance, payer compliance, licensing of self insurers and TPAs, UEF, business advocacy, and investigation of allegations of fraud.

As-Is Challenges

Process

- Lack of comprehensive compliance and monitoring program for system participants to promote good behavior and penalize non-performance
- Lack of procedure to prioritize and identify cases that need immediate attention
- Lack of outreach and education for employers on WC processes and safety
- Inconsistent responses to employers from Board causes confusion and lack of predictability in the system
- Board has limited authority to penalize TPAs and does not have a clear understanding of delineation of tasks among carriers and TPAs
- Cumbersome and complex procedures in getting documentation from carriers
- Lack of system wide performance standards, measurement and key performance indicators results in poor outcomes
- Lack of regulatory authority over insurers and municipal self insured employers

- Hearing based monitoring results in regulation claim by claim which is ineffective and inefficient

People

- Lack of cross training in the various processes of the Board that may likely enable staff to function more efficiently (example cross training in IC2)
- Lack of succession planning to create a structure process for knowledge transfer
- Lack of clear guidelines and procedure knowledge for staff to ensure timely delivery of first payments
- Inefficient processes results in inadequate staffing levels
- Lack of ability to retain highly qualified individuals on the team leading to backlog and inefficiencies
- Lack of delineation between Fraud and Compliance results in confusion in responsibilities

Technology

- Lack of comprehensive system in place to enforce Board policy with medical providers and carriers
- No “tickler” system in place; cases are tracked manually which requires substantial time and effort
- Lack of efficient case management to properly track ongoing and pending cases
- Lack of sophisticated internal database for the Fraud unit to manage its own information or to automate identification of potential fraud cases
- Lack of user friendly database to store and share information easily among offices.
- Limited data exchange or validation among systems. No validation of claims data (CIS) against policy data (IC)
- Lack of standardized work queue leading to untimely and improper management of cases