Employee Insurance Division
Workers' Compensation Program

Work Plan and Standards

For Fiscal Year 1993 and Beyond

Department of Employee Relations
November 1992

Employee Insurance Division
Workers' Compensation Program

Table of Contents

Introduction	1
Mission and Value Statement	3
Philosophy and Long-term Goal	4
Priorities	5
Quality Assurance Plan	11
Outcome Measures	16

Workers' Compensation Program

Introduction

The state's self-insured Workers' Compensation Program is administered by the Department of Employee Relations (DOER) through its Employee Insurance Division. In the last two years, the program has been under close scrutiny by state managers and policy makers who have demanded more responsive service, improved quality and greater ability to control costs.

Since January 1992, the staff and managers in charge of the program have engaged in a concerted effort to revitalize the operation and examine both the internal and external environment in a search for cost effectiveness.

Within DOER, the Workers' Compensation operation merged with the Benefits operation to create the Employee Insurance Division to decrease the isolation of the Workers' Compensation Program by opening up opportunities to share resources and expand the options available. Additionally, we restructured the program to encourage teamwork among claims specialists and accounting staff, as well as to build the base on which to implement our quality improvements.

Worker's Compensation Program staff have researched the external environment to identify alternatives to administer the program. These alternatives include varying degrees of involvement with private sector partners. In July 1992, DOER published a Request for Proposal (RFP) soliciting bids from qualified vendors to administer all or parts of the self-insured Workers' Compensation Program. From the responses to the RFP, we will gain valuable insight about the range of available choices. Once the responses, which are due November 2, 1992, are in, we will make a decision regarding this public/private partnership by the end of January.

Within this context, the Workers' Compensation staff has developed this document which contains the work plans and standards pertaining to the operation of the program. The plans reveal our commitment to the development of a strong contractual partnership with a managed care organization which meets the requirements of the new workers' compensation law mandated by the legislature in Minnesota Laws 1992, Chapter 510. As you will read in this document, we are dedicated to quality, efficiency, prevention and cost containment.

These are fluid plans, as all plans should be in a changing environment. We will review them at least quarterly to measure the progress and confirm their validity. In addition, we will measure quality assurance indicators regularly as stated in the *Quality Assurance Plan* included in this document.

Maria Gomez
Manager of Workers' Compensation Program
Minnesota Department of Employee Relations

Employee Insurance Division

Mission and Value Statement

Innovation and Excellence in Employee Insurance

Our primary customer is the executive branch as a single employer, with the primary goal of providing a uniform and cost-effective statewide employee insurance program.

As a division, we will

- seek progressive and innovative ways to meet the challenges of administering the employee insurance programs,
- promote employee and family health and wellness, and
- build customer confidence by
  - providing superior service and expertise,
  - providing service in a fair and ethical manner, and
  - treating our customers and stakeholders with dignity and respect.

Workers' Compensation Program

Philosophy and Long-term Goal

Philosophy

The Workers' Compensation Program's philosophy is to treat injured employees with dignity and respect while managing their claims. Working in close coordination with state agencies, we strive to provide the highest standard of services to injured employees to guarantee their quick recovery.

We strive for superior, efficient, and equitable evaluation and payment for legitimate claims. Whether investigating claims, paying benefits, ensuring medical care or providing for vocational rehabilitation services, we do so in a fair, prompt and equitable manner.

We enter into partnerships with state agencies to reduce costs by focusing on job modifications, accident prevention and early return-to-work programs.

We make unbiased, legally-based decisions which center on the facts of each case. We follow the laws of the state and the policies of the Workers' Compensation Program to ensure that all parties are treated fairly.

Long-term Goal

To design and implement structural and policy changes in the state's self-insured Workers' Compensation Program so that the performance achieved meets or exceeds the standards established by the Department of Labor and Industry, and excels among other self-insured employers.

Workers' Compensation Program

Priorities

Contain increases in workers' compensation per claim average expenditures to no more than 9 percent per year during the 1994-1995 biennium.

Tasks

- Develop a set of management reports to monitor claim expenditures, use of services, incidence of injuries, lost time and other critical measures on a monthly, quarterly and annual basis.

  Responsible: Mark Haupt
  Due: December 31, 1992; on schedule thereafter

- Analyze all management reports and provide specific recommendations to reduce expenditures based on analysis. Compare results to industry-wide indicators.

  Responsible: Liz Houlding and Allison Huiras
  Due: April 1, 1993; on schedule thereafter

- Communicate recommendations to appropriate levels within the Department of Employee Relations and other agencies.

  Responsible: Liz Houlding and Allison Huiras
  Due: April 1, 1993; on schedule thereafter

- Measure implementation of recommendations and effect on performance.

  Responsible: Liz Houlding and Allison Huiras
  Due: June 30, 1993; on schedule thereafter

- Develop and implement a far-reaching contract with a managed care organization to perform utilization reviews, medical care management and medical bill payment.

  Responsible: Maria Gomez
  Due: March 1, 1993

- Organize and staff an interagency work group to identify cost containment opportunities and recommendations for implementation.

  Responsible: Maria Gomez
  Due: March 1, 1993

Reduce the incidence of work-related injuries from 9 percent to 8.8 percent among state employees by July 1, 1995.

Tasks

- Develop guidelines for state agencies to incorporate safety objectives into supervisors' and managers' position descriptions and training.

  Responsible: Gary Caple and Elaine Dixen
  Due: December 31, 1992

- Develop guidelines and training to assist state agencies in developing appropriate pre-placement physicals for high risk occupations; and research the feasibility of establishing a state-wide network of physicians for agencies to use. The guidelines must comply with the Americans with Disabilities Act requirements.

  Responsible: Gary Caple and Elaine Dixen
  Due: December 31, 1992

- Complete and distribute an assessment (which will include source, injury, agency and division information) of the incidence of injuries among state employees, and which will identify higher risk agencies and/or occupations.

  Responsible: Gary Caple and Maria Gomez
  Due: January 31, 1993

- Assist agencies that are most affected with developing plans to address issues identified in the above assessment.

  Responsible: Gary Caple and Maria Gomez
  Due: January 31, 1993

- Coordinate and enhance the activities of safety personnel in state agencies; develop mechanisms to allow small state agencies access to safety expertise in large state agencies.

  Responsible: Gary Caple
  Due: January 31, 1993

Develop and implement an effective return-to-work program which reduces the number of work days lost because of temporary-total and temporary-partial disability.

Tasks

- Establish criteria and standards, which include methods of securing a second opinion if necessary, to insure that return-to-work restrictions placed on injured workers are appropriate and consistent with established medical practice. This must be coordinated with any action to secure independent medical examinations.

  Responsible: Elaine Dixen and Liz Houlding
  Due: January 31, 1993

- Develop procedures and implement new rehabilitation rules, including training state agencies on new rule procedures, and research the feasibility of establishing an outside network of qualified rehabilitation consultants.

  Responsible: Elaine Dixen
  Due: November 30, 1992

- Develop and implement referral criteria and standards to ensure early contact among state agencies' workers' compensation coordinators, qualified rehabilitation consultants and specialists so that early return-to-work and disability management plans are developed and implemented expeditiously.

  Responsible: Elaine Dixen and Cindy Storelee
  Due: November 30, 1992

- Develop and implement monitoring and intervention mechanisms to ensure that outside vendors and qualified rehabilitation consultants meet acceptable standards.

  Responsible: Elaine Dixen
  Due: April 1, 1993

- Within two weeks of referral by a specialist to the state placement coordinator, assess the injured worker's qualifications and abilities and develop a plan with the respective agency to place the employee in a position within the agency, in other state agencies or in outside employment.

  Responsible: Cindy Storelee
  Due: November 30, 1992; ongoing

- Assist the Consultive Services unit in the Department of Employee Relations in developing appropriate training and other interventions to prevent work-related injuries and illnesses.

  Responsible: Return-to-work staff
  Due: Ongoing

- Maintain clearly written, up-to-date manuals to guide state agencies on disability management and return-to-work methods.

Responsible: Return-to-work staff
Due: Ongoing

- Develop standards regarding case load management for in-house qualified rehabilitation consultants.

  Responsible: Elaine Dixen and Maria Gomez
  Due: January 30, 1993

Develop and implement mechanisms to improve the quality and efficiency of the Workers' Compensation operation.

Tasks

- Develop and implement a quality assurance plan and corrective action mechanisms in Workers' Compensation.

  Responsible: Maria Gomez
  Due: November 15, 1992

- Develop a set of monthly management reports to monitor penalties, recoveries, overpayments, underpayments, and compliance with timelines.

  Responsible: Allison Huiras
  Due: December 31, 1992; ongoing

- Analyze all monthly management reports and provide specific recommendations for corrective action.

  Responsible: Allison Huiras
  Due: December 31, 1992; ongoing

- Monitor the administrative budget to ensure appropriate expenditures.

  Responsible: Allison Huiras
  Due: November 15, 1992; ongoing

- Evaluate the efficiency and effectiveness of the Workers' Compensation computer system, and provide recommendations for improvement if necessary.

  Responsible: Mark Haupt and Allison Huiras, in coordination with consultant
  Due: December 15, 1992

- Document and analyze current work flow to eliminate duplication, identify and strengthen procedures to reduce risk of errors, and evaluate automation potential. Analyze mail and faxing procedures; develop procedures to simplify and increase the accuracy of computation of weekly benefits and back-to-work status; and develop a process to log and monitor all essential communication.

Responsible: Mark Haupt and supervisors
Due: November 30, 1992; ongoing

- Develop and implement a training plan, which includes the content and frequency of in-service training, and professional and personal development, for all levels of staff.

  Responsible: Supervisors
  Due: December 31, 1992

- Reduce legal case loads by appropriately referring cases to outside attorneys and by closing legal cases.

  Responsible: Maria Gomez
  Due: October 31, 1992

- Develop standards to manage legal case load; develop and implement an audit program to monitor adherence by legal staff to the Workers' Compensation quality assurance plan.

  Responsible: Maria Gomez and Liz Houlding
  Due: November 30, 1992

- Research alternative methods to charge state agencies for Workers' Compensation costs. The methods must be responsive to the needs of small- and medium-sized state agencies in terms of catastrophic losses.

  Responsible: Maria Gomez
  Due: June 1, 1993

Develop and implement a communications plan to ensure that agencies, injured workers, vendors and others have easy access to services provided by the Workers' Compensation Program, and that relevant program information is communicated rapidly.

Tasks

- Implement changes in telephone equipment so that Workers's Compensation employees can handle incoming calls more efficiently and effectively.

  Responsible: Maria Gomez and supervisors
  Date: November 30, 1992

- As part of a corrective action plan, implement standards to return phone calls and to respond to correspondence on a timely basis.

  Responsible: Maria Gomez
  Due: November 15, 1992

- Develop regular communications through the division newsletter and *Workers' Compensation Bulletin* to transmit relevant information to stakeholders.

  Responsible: Maria Gomez and supervisors
  Due: October 15, 1992; ongoing

- Strengthen the role of the Workers' Compensation Advisory Committee.

  Responsible: Liz Houlding
  Due: November 30, 1992; ongoing

- Increase staff participation in appropriate internal or external committees or associations dealing with workers' compensation issues.

  Responsible: Liz Houlding
  Due: November 30, 1992; ongoing

- Increase face-to-face and other focused interaction between supervisory staff and the state agencies they serve.

  Responsible: Liz Houlding
  Due: November 30, 1992; ongoing

- Develop and implement a format to communicate and negotiate with state agencies about litigation strategies.

  Responsible: Maria Gomez
  Due: November 30, 1992

- Develop a "Memorandum of Understanding" with each state agency regarding our mutual roles and responsibilities.

  Responsible: Maria Gomez and Liz Houlding
  Due: April 1, 1993; updated annually thereafter

- Develop and implement a strategy to encourage state agencies to submit their data electronically so that Workers' Compensation employees can record at least 90 percent of all first reports of injury.

  Responsible: Mark Haupt and Allison Huiras
  Due: July 1, 1994

Workers' Compensation Program

Quality Assurance Plan

All properly documented vendor bills processed by the program shall be paid within 30 days. All incomplete vendor bills will be denied and returned to the vendor within 10 working days.

- Publish monthly reports depicting the percent of bills paid on time and the number of medical bills processed by the program as a whole and by each unit.

- Publish monthly reports depicting the number of payments reduced and savings achieved by application of the fee schedule and the mandated reduction on hospital bills. Report this information by unit and summarize it for the program.

Process accurate indemnity benefit payments by the program that reflect 100 percent of benefits paid within 30 days.

- Produce a monthly report on the total number of compensation payments processed by the program and by each unit, and on the percentage of them paid on time.

- Produce a monthly report depicting overpayments and underpayments in compensation payments processed by each unit.

Review a minimum of 65 claim files each month (See attached *Self-Audit Program*). The claims management supervisor reviews each file for compliance with standards in the following categories:

- *Investigations.* Investigations of routine claims are usually limited to verifying and obtaining information to properly manage the claims. Investigations on assignments other than routine claims require contact with the agency, employee and medical provider (three-point contact).

- *Reserves.* Reserves accurately project the claim's potential payments.

- *File control.* Perform all claims management activities on a timely basis; make payments within statutory requirements; respond to correspondence requiring a response within 30 days; use diaries to control claim activities.

- *Medical aspects.* Request adequate and timely medical reports verifying disabilities and work statuses to support benefits paid.

- *Rehabilitation.* Identify and refer in a timely manner claims that require rehabilitation services; monitor ongoing activities for cost effectiveness.

- *Litigation management.* Manage litigation to ensure quality legal defense services.

- *Recoveries.* Pursue reimbursements from responsible parties in a timely manner.

- *Policies and procedures.* Administer all claims in accordance with division policies and procedures.

- *Communications with agencies and injured workers.*

  - *Minimum rate.* Accept a rating of no less than 80 as the minimum rating on the Self-audit Program for acceptable performance.

  - *Error correction.* Correct errors identified through the audit process within a week, if appropriate. Supervisors must implement corrective action to avoid similar errors in the future.

Research checks received by the program and transmit them to the department's accounting staff within five days of receipt. On a monthly basis, reconcile processed checks with the program's check register.

- Develop a monthly report that will detail this activity by unit.

- Record all recoveries pertaining to a claim file in the claims management system.

The claims management system and the Statewide Accounting System must depict the exact payment record as authorized by the program.

- On a daily basis, identify and correct any errors resulting from the interaction between the two systems or from keying.

- Publish a monthly report for the program as a whole and for each unit depicting the number and type of errors.

- Make keying errors .5 percent or less of the number of transactions.

No penalties are attributable to the Workers' Compensation Program for failure to act in a timely manner.

- Claims administration supervisors maintain a logging system to ensure that deadlines are met.

- Publish a monthly report for the program as a whole and for each unit depicting the number and amount of penalties. Take corrective action immediately to avoid errors identified in the future.

Maintain and update the claims management system's data to reflect the current activity of any claim file. Guarantee the integrity of the system's data base.

- Create daily, weekly and monthly system back-ups according to existing schedules. The Claims Administration coordinator verifies information.

- Update and maintain master codes according to program policy; strictly limit the access to authorized personnel. Support Services supervisor verifies the information.

- Data entry operator reviews data entry and coding for each *First Report of Injury* to ensure consistent recording of data into the claims management system. The Support Services supervisor verifies information on a monthly basis.

- Report security issues or violations immediately to the Support Services supervisor.

Maintain timely and appropriate external and internal communications.

- Maintain a P.O. box number for faster mail delivery to the program.

- Review and direct all incoming mail to appropriate staff on a daily basis. (Mail is monitored so that correspondence is handled in a timely basis.) Respond to correspondence within 30 days or in accordance with any applicable statutory timeline. Supervisors or designated employees log and monitor any legal or regulatory correspondence to ensure 100 percent compliance with required standards.

- Workers' Compensation Program staff acknowledges phone calls within one working day. If appropriate, enter a record of the phone call and respective response in the claim's file.

- Mail outgoing mail daily.

- Provide the following information to agencies, including agencies' central office:

  - hard copy of the *First Report of Injury* if injury was reported electronically
  - copies of pertinent correspondence affecting critical aspects of the case
  - monthly, quarterly and annual reports detailing claim and liability activities
  - procedure manuals and updates as appropriate
  - training as appropriate
  - all legal information (specified on the following page)

Review a minimum of 10 legal files each month according to Legal Audit Program (to be developed by November 30, 1992). The Claims Administration coordinator reviews each file for compliance with the following standards:

- Answer all *Claim Petitions* within 20 days from date of service, except where opposing counsel has granted an extension of time in which to file a formal answer on behalf of the self-insured employer.

- At the time of the *Claim Petition,* file answer and complete a *Claim Petition* memo which includes the following:

  - nature of claims and dollar values
  - basis of claim
  - important deadlines
  - legal issues
  - actions and strategies to handle case

- Prepare a case summary and identify any informal resolutions or settlement possibilities within four months of filing the *Claim Petition Answer.* At the same time, schedule a conference with Claims Administration staff and agency representatives to discuss summary and settlement possibilities.

- Schedule Independent Medical Examinations (IMEs) if indicated by the facts of the case. Conduct the exam and file the medical report within 120 days from the date of service of the *Claim Petition* unless a written request for extension is submitted and granted. Request extensions only in unusual and exigent circumstances.

- Schedule and take depositions as the facts of the case dictate.

- Complete deposition memos within 30 days from the date of the deposition. The deposition memo must contain a summary of the deposition testimony and an analysis/impression of the witness.

- Start settlement negotiations within 30 days of the date in which the settlement authority is granted by the agency. The specialist who is the case manager must be a part of the negotiations with the agency. The legal file must contain documentation of attempts to settle and reasons for not settling. The respective agency and the specialist are kept informed of details, including any settlement conference or any other relevant discussion at least three weeks prior to the occurrence unless special circumstances and mutual agreement dictate otherwise.

- Finalize stipulations within 30 days after settlement has been reached.

- Provide copies of all pertinent information gathered during the litigation process, including claim petitions, claim petition memos, deposition memos, response from the self-insured employer, IME reports, notices, *Stipulation for Settlement* and *Stipulation for Settlement* memos, and *Award and Stipulation* to the Claims Management Unit and the respective agency's workers' compensation coordinator.

- Complete stipulation memos on all settled claims. The stipulation memos must include the following:
  - nature of claim and dollar value
  - defenses
  - settlement reached
  - reasons for settlement and name of agency contact who was involved in the settlement.
- Respond to all correspondence within 30 days or earlier if required.
- File all appeals on a timely basis (within 30 days of order).
- Respond to all requests from management on or before the due date.
- Return all phone calls within one working day.
- Adhere to established procedures to handle legal files and correspondence.

Provide training for section staff and agency staff in accordance with the Annual Training Plan (to be developed by January 31, 1993).

Workers' Compensation Program

Outcome Measures

Cost containment, prevention of work-related injuries and efficiency in administration are critical to the success of our Workers' Compensation program. The following set of outcome measures and objectives will track the program's performance in these critical areas.

Measure 1: Expenditures for workers' compensation claims

	FY 91	FY 92	FY 93 Estimated	FY 94 Projected	FY 95 Projected
Percentage increase in state workers' compensation expenditures	11.8%	11.3%	10%	9% or lower	9% or lower
Minnesota (all employees)	21.4%	11.5%	NA	NA	NA

Objective: Contain cost increases at a rate equal or below industry trends.

Measure 2: Number of work-related injuries per 100 employees

FY 91	FY 92	FY 93 Estimated	FY 94 Projected	FY 95 Projected
8.4	10.3	9.0	8.9 or lower	8.8 or lower

Objective: Decrease the number of injuries per 100 employees.

Measure 3: Percent of participating groups and individuals satisfied with services

FY 91	FY 92	FY 93 Estimated	FY 94 Projected	FY 95 Projected
NA	76%	80%	85% or higher	90% or higher

Measure 4: Management of case load size

	FY 91	FY 92	FY 93 Estimated	FY 94 Projected	FY 95 Projected
Cases re-opened	578	854	800	800	800

New cases opened	4,774	4,221	4,000	4,000	4,000
Cases closed	9,652	8,143	4,800	4,800	4,800
Case load at end of fiscal year	6,866	3,637	3,637	3,637	3,637

Objective: The number of cases closed should be greater than or equal to the number of cases opened in order to maintain a stable or declining case load. The number of cases opened includes new cases and re-opened cases.

Measure 5: Administrative cost per case closed

	FY 91	FY 92	FY 93	FY 94 Projected	FY 95 Projected
State program	$170	$243	$495	$495	$495
Industry-wide	TBD	TBD	TBD	TBD	TBD

Objective: Adjusted for inflation, the administrative cost per case closed should remain the same or decrease over time.

Measure 6: Percentage of medical and indemnity payments made within 30 days

	FY 91	FY 92	FY 93	FY 94 Projected	FY 95 Projected
Medical	56%	85%	90%	90%	90%
Indemnity	100%	100%	100%	100%	100%

Objective: Meet statutory prompt payment goals.

Measure 7: Number of penalties received and total amount paid in penalties

	FY 91	FY 92	FY 93	FY 94 Projected	FY 95 Projected
Number of late payment penalties	39	29	25	25	25
Total amount paid	$10,282	$13,679	$13,000	$13,000	$13,000
Number of transactions with penalty potential	14,200	15,700	15,700	15,700	15,700

Objective: Measure the timelines and accuracy of decisions.

State of Minnesota
Department of Employee Relations
Workers' Compensation Program

Self-Audit Program

TABLE OF CONTENTS

		Page
1.	Overview of Self-Audit Program	1
2.	Category Explanations	2
3.	Forms	
	a) Individual File Review	5
	b) Claims Quality Summary	6
	c) Three-Point Contact	7
	d) File Closing Criteria	8
4.	Medical Only Review	9

OVERVIEW OF SELF-AUDIT PROGRAM

Effective and efficient disposition of Minnesota workers' compensation claims, in accordance with applicable laws and Division policies and procedures, is the primary objective of the Claims Management Unit of the Workers' Compensation Program. Virtually all of the systems, processes, procedures, functions and activities of the Claims Management Unit are intended to achieve this goal, with the inherent objective being to serve our customers while containing costs. This demands quality claims management by our personnel.

The Self-Audit Program is the principle method used to measure the quality of claims management. It is a structured system designed to ensure that the primary objective of the Claims Management Unit of the Workers' Compensation Program is met. It is used to determine training needs and measure individual and division performance. The Self-Audit Program is comprehensive, uniform and as objective as possible considering the subjective and judgmental nature of claims management.

The Self-Audit Program uses an Individual File Review form to examine claims and evaluate applicable categories of claims activity using a "G" for Good, "A" for Acceptable and a "D" for Deficient. Marking a category with a "G" means the requirements and standards established have been met. Conversely, marking a category with a "D" means the requirements and standards have not been met. If the reviewer cannot fully support a "G" or a "D" rating, then an "A" for acceptable but marginal rating is given and the reason for the use of the "A" is explained in the comments section. The original Individual File Review form will be given to the specialist and a copy will be retained by the reviewer. The comments section of the form can also be used to expand on the category ratings and/or to make recommendations for future claims management activities.

After evaluating a representative sampling of claims, the Individual File Reviews will be summarized by using a Claims Quality Summary form on which an overall performance rating is determined. This overall rating will be used to evaluate the quality of claims management by personnel in the Workers' Compensation Program. To arrive at this rating, the "G's" and "A's" are added together and divided by the total number of applicable files to reach a percent acceptable for the claim category. This figure is then extended by a weighted factor, which reflects the importance and impact of each claim category, to determine a result. The result of the applicable claim categories are added together to reach the overall performance rating.

This rating is then compared to the minimum acceptable rating of 80. A rating under 80 is "not acceptable"; while a rating of 80 or over is "acceptable", although the goal is to strive to reach 100.

CATEGORY EXPLANATION

INVESTIGATION

The investigation of a lost time workers' compensation claim requires contact with the employee within 24 hours of assignment. The specialist will complete the three point contact by gathering additional information from the agency and the treating medical provider. When investigation beyond the three point contact is needed to properly evaluate a claim, it should be done by the most expeditious method available, taking investigative expense, factual circumstances, complexity, and loss exposure into consideration. The investigative activities must be monitored. When the investigation lags, flounders or heads in unnecessary or unproductive directions, redirection is necessary.

RESERVES

Reserves should accurately project the claim's potential; they should be based upon known facts contained in the file and conclusions reasonably drawn. The reserves should be consistent with the guidelines established by Division reserving policy.

"Step reserving" should be avoided, but reserves must be promptly adjusted to reflect newly obtained factual data which can reasonably expect to change the extent of the State of Minnesota's exposure. We reserve to exposure and do not practice "hope" reserving which anticipates the lower reserve based upon possible successful rehabilitation and/or possibility of an eventual third party recovery.

FILE CONTROL

The file should be promptly prepared. Diaries should be for a specific reason (e.g., completion of investigation, receipt of a follow-up for medical information, and reserve consideration, etc.). Average weekly wage and causal relationship of injuries to employment must be documented. Payment of compensation is based upon medical verification of any disability for initial and ongoing payments. To verify ongoing disability, bi-weekly contact will be made with the injured employee and, if appropriate, with the medical provider.

All claims must be administered in accordance with applicable workers' compensation statutes and every effort must be made to ensure compliance with the laws of the State of Minnesota. All claims must be accepted or denied on a timely basis and all required forms are to be promptly completed and filed so as not to incur penalties. Proper compliance can minimize potential disputes and/or litigation.

All files must be controlled in a timely manner. Supervisors and specialists are accountable for actively moving cases to conclusions. All files will be promptly closed pursuant to the File Closing Criteria form (22).

MEDICAL

Adequate and timely medical reports and information verifying disability and work status must be current to support benefits paid and to avoid overpayments:

(1) Medical status of the claimant must be monitored and failure to progress as anticipated should require:

- A re-examination by the treating physician
- A re-evaluation of the prescribed course of treatment
- An Independent Medical Examination should be requested if appropriate

(2) Medical bills should not be paid without benefit of a medical report and there should be evidence that medical bills are scrutinized for reasonableness and necessity of treatment.

(3) The file should reflect that a timely effort is made to obtain a "Maximum Medical Improvement" opinion and, if appropriate, a permanency evaluation.

REHABILITATION

Rehabilitation is an integral part of claims management and must be considered in every case when warranted or required by statute. Cases for rehabilitation should be identified on a timely basis and promptly referred.

There must be evidence that the specialist is monitoring rehabilitation activities to ensure that they are cost effective and appropriate.

LITIGATION CONTROL

Litigated cases represent a small number of claims but account for a substantial portion of the State of Minnesota's workers' compensation costs. The purpose of litigation control is to ensure that quality legal defense services are provided. The specialist is the claims manager and must approve of all actions to bring claims to their final disposition. This responsibility cannot be delegated to defense counsel.

RECOVERY

Potential recovery cases will be evaluated in the following categories:

A) Subrogation

The file should reflect:

(1) That potential recovery cases are identified and, if appropriate, the parties are put on notice.

(2) That prompt legal referral is made.

(3) That the recovery process is monitored.

(4) That if recovery possibilities are not pursued, the file must be documented why.

B) Second Injury Fund

The file should reflect:

(1) That all claims are investigated for registration with the Second Injury Fund.

(2) That Notice of Intention to Claim Reimbursement from the Second Injury Fund is filed timely on all potential Second Injury Fund claims.

(3) That Annual Claims for Reimbursement from the Second Injury Fund are filed on a regular basis on all claims that have been accepted by the Second Injury Fund.

(4) That all eligible injuries are promptly registered with the Second Injury Fund.

DIVISION POLICIES AND PROCEDURES

All claims are administered in accordance with division policies and procedures which are outlined in the Safety & Workers' Compensation Division's procedure manual.

All claims with a date of injury 7-1-88 forward, must be fastened in CHRONOLOGICAL ORDER (except: unpaid bills attached to blue cards, green cards and paysheets). The claim file should not contain duplicate material.

INDIVIDUAL FILE REVIEW

Claim #:	Employee:	Agency:	Specialist:

Date of Injury	Date Reported to Agency	Date Reported to S&WC

	CATEGORY	RATING G	RATING A	RATING D	COMMENTS
1	Investigation				
2	Reserve				
3	File Control				
4	Medical				
5	Rehabilitation				
6	Litigation Control				
7	Recovery				
8	Division Policies/Procedures				

G = Good A = Acceptable D = Deficient

REVIEWER:	DATE:

263/HSWC

CLAIMS QUALITY SUMMARY

Specialist:	Reviewer(s):	Date(s) of Review:

	Category	Total Applicable Files	Ratings			Percent Acceptable	x Weighted Factor	= Result
			G	A	D			
1	Investigation						20	
2	Reserve						15	
3	File Control						30	
4	Medical						10	
5	Rehabilitation						10	
6	Litigation Control						5	
7	Recovery						5	
8	Division Policies & Procedures						5	

G = Good A = Acceptable D = Deficient

Overall Performance Rating: ____

COMMENTS:

263/HSWC

MEDICAL ONLY REVIEW

Medical only (MO) files are workers' compensation claims which qualify for medical benefits only. The Workers' Compensation Claims Supervisor has the responsibility to monitor the handling of MO files.

Evaluations of MO file handling are to be recorded on an Individual File Review form. The only categories evaluated, using the classification "G" for Good, "A" for Acceptable, and "D" for Deficient, are:

(1) Investigation
(2) Reserves
(3) File Control
(4) Medical
(7) Recovery
(8) Division Policies and Procedures

These categories are explained in more detail in the Category Explanation Section.

The original of this form remains in the claim file and copies will be retained by the Specialist and the Reviewer.

Semiannually an abbreviated Claims Quality Summary Form is completed to determine if the evaluated categories are at least 80% acceptable.

HSWC/263

FILE CLOSING CRITERIA

____ 1. Do not anticipate receipt of any further medical bills.

____ 2. Do not anticipate payment of further compensation benefits and NOID has been filed showing all compensation paid.

____ 3. A. Pre-1984 claims: A final medical report addressing permanency has been received and filed with DOLI.

B. Post 1-1-84 claims: MMI has been received and served and permanency addressed.

____ 4. If supplemental benefits have been paid to employee, reimbursement for supplemental benefits has been requested.

____ 5. Reimbursement from the Second Injury fund has been requested and paid, if appropriate.

____ 6. Third party possibilities explored, approved/rejected and finalized.

____ 7. Closing letter sent to DOLI.

_____
(Signature)

_____
(Date)

22/hswc