RON GALPERIN
CONTROLLER

June 30, 2014

Honorable Eric Garcetti, Mayor
Honorable Michael Feuer, City Attorney
Honorable Members of the Los Angeles City Council

Re: Release of Two Audits of the City's Workers' Compensation Contractors of the Personnel Department

In 2013, City employees filed more than seven thousand workers' compensation claims, costing the City $191 million. Both our workers' compensation expenses as a percentage of wages paid (6.6%) and our incident rate per 100 employees (17) were higher than those of our peer cities. The County of Los Angeles, for example, pays 4.1% of wages and has 11 incidents per 100 employees. The City of San Francisco is at 2.3% and 11.9 per 100, respectively.

Do these numbers point to a system in crisis? They certainly, among other things, raise questions of whether the City and its administrative contractors are doing the best possible job containing workers' compensation costs. To get more insight into this topic, the Office of the Controller is undertaking a series of audits of the City's workers' compensation program--two of which are being released today:

1. **Audit of Payments to Workers' Compensation Medical Providers Under the City of Los Angeles' Aon Contract.** The Personnel Department contracted with Aon eSolutions, Inc. (Aon) to review medical bills and contain costs related to employee workers' compensation claims.
2. **Performance Audit of the Workers' Compensation Claims Management for Fire and Police Personnel.** The Personnel Department contracted with Tristar Risk Management (Tristar) to process and manage workers' compensation claims filed by Fire and Police personnel.

An additional comprehensive audit of the Fire and Police Departments' efforts to prevent workers' compensation injuries and claims is currently in progress.

Background

Workers' compensation insurance provides benefits that cover lost wages, medical and other expenses when an employee is injured on the job. Temporarily injured employees are considered "Injured On Duty." They are eligible to receive their full salaries--tax-free--for up to one year. Like most public employers, the City is self-insured for workers' compensation claims.

When administered appropriately and efficiently, workers' compensation insurance can be a cost-effective way to guarantee that no worker loses his or her livelihood as a result of a job-related injury.

Claims management and medical bill reviews should be about more than just processing claims--they should be about minimizing costs through close scrutiny, aggressive oversight and careful investigation. These aspects are lacking in the current process--in some cases costing the city millions of dollars in unnecessarily high workers' compensation payments.

Roles & Responsibilities

Aon: Reviewed medical bills for approved workers' compensation claims to ensure that the City paid the correct rate for medical services (Aon's contract expired in June 2013 and Stratacare has since been handling this function).

Tristar: Responsible for approving or denying workers' compensation claims and managing approved claims, invoices and processes for Fire and Police sworn personnel (Tristar ceased serving as TPA for Fire sworn personnel in August 2013 when it transitioned to a new TPA who has since been handling this function).

Personnel Department: Has ultimate responsibility for the City's workers' compensation program. Hires outside contractors to perform services and oversees the contractors' performances.

City Attorney: Defends the City in all litigated workers' compensation claims brought before the State Workers' Compensation Appeals Board. Provides legal counsel to the Personnel Department, training and advice on workers' compensation claims matters, approves all settlements and investigates potential fraud.

Findings

Aon:

- Aon did not determine the correct amount to pay medical providers for a significant number of claims reviewed. Based on the error rate noted in the sample of bills reviewed by Moss-Adams LLP, the Controller's contracted auditor, Moss-Adams projected $1.426 million in projected over-payments by the City to

medical providers (for the audit period of July 2010-Jan 2013). Auditors further believe the errors resulted in an estimated $303,768 in additional overpayments over the life of Aon's contract (2010-2013). Aon was paid $10.6 million for its services over the life of the contract.

- Aon's performance for medical payment accuracy was lower than medical insurance industry standards. Small deviations from acceptable standards can cause errors that cost the City millions of dollars.

Tristar:

- Tristar failed to follow Claims Management processes designed to ensure that injuries and illnesses were job-related, putting the City at risk of approving invalid claims that did not arise from on-the-job injuries.
- The City failed to properly review bills processed by Tristar--instead paying bills that may have contained ineligible expenses or incorrect amounts. Also, the Personnel Department's inadequate process for reviewing Tristar's invoices means the City consistently overpaid Tristar by not deducting all applicable penalties. Unfortunately, the overpayments to Tristar could not be quantified due to unreliable penalty-coding issues and manual processes.
- Note: According to the Personnel Department, the City has implemented a new, automated claims management system since the term of our audit to correct many of the deficiencies we noted.

Recommendations

Aon:

- The City should pursue recovery of the projected $1.426 million in medical overpayments to providers--as well as the additional $303,708 auditors believe was also overpaid.
- After Aon's contract expired, the City selected Stratacare to review workers' compensation medical claims. The City should review and amend the current contact with Stratacare to ensure that it requires the contractor to perform a robust retrospective bill review process.

Tristar:

- The Personnel Department should work with Tristar and the City's other claims administration contractors to reduce the number of manual processes required to manage workers' compensation claims, which in turn can reduce the risk of fraud and incorrect payments.
- Tristar's contract will expire in FY 2015-16. We urge the Personnel Department, when issuing an RFP for any future TPA, to seek proactive solutions to the other shortcomings we found.
- The Personnel Department should examine the caseloads carried by claims administrators to ensure they meet industry standards and best practices.

My office would like to thank the Personnel Department for its cooperation with our audit process.

Respectfully Submitted,

RON | GALPERIN
Los Angeles City Controller

Attachments

RON GALPERIN
CONTROLLER

June 30, 2014

Margaret M. Whelan, General Manager
Personnel Department
700 East Temple Street
Los Angeles, CA 90012

Dear Ms. Whelan:

Enclosed is a report entitled "Performance Audit of the Workers' Compensation Claims Management for Fire and Police Personnel." A draft report was provided to your Department. Comments provided by your Department at the exit conference were evaluated and considered prior to finalizing this report.

Please review the final report and advise the Controller's Office by July 30, 2014 on planned actions you will take to implement the recommendations.

The Controller's Office is also issuing a report entitled "Audit of Payments to Workers' Compensation Medical Providers under the City of Los Angeles' Aon Contract" to your Department under a separate transmittal.

If you have any questions or comments, please contact me at farid.saffar@lacity.org or (213) 978-7392.

Sincerely,

FARID SAFFAR, CPA
Director of Auditing

Enclosure

cc: Ana Guerrero, Chief of Staff, Office of the Mayor
Miguel A. Santana, City Administrative Officer
Gerry F. Miller, Chief Legislative Analyst
Holly L. Wolcott, Interim City Clerk
Independent City Auditors

City of Los Angeles

Performance Audit of the Workers' Compensation Claims Management for Fire and Police Personnel

June 30, 2014

RON | GALPERIN
Los Angeles City Controller
controller.lacity.org

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SUMMARY

The City of Los Angeles is self-insured for its workers' compensation costs. Sixty-six percent of the City's total expenditures for workers' compensation relate to sworn personnel at the Police and Fire departments. During Fiscal Year (FY) 2012-2013, workers' compensation benefits paid for Police and Fire sworn personnel totaled approximately $138 million.

While the average number of open sworn claims during our audit period of July 2010 through June 2012 was 9,900; (6,960 for Police and 2,940 for Fire), sworn employees filed 4,464 new claims (3,182 for Police and 1,282 for Fire). At that time, there were 13,192 sworn employees (9,875 for the Police Department and 3,317 for the Fire Department).

The Office of the City Controller conducted a performance audit to evaluate the effectiveness of the City's workers' compensation claims management for Police and Fire sworn personnel, especially claims processing functions performed by the City's Third Party Administrator (TPA), Tristar Risk Management (Tristar). A prior audit had identified certain duplicate provider payments processed by the TPA. Our audit reviewed the TPA's claims management and benefits administration processes and the Personnel Department's oversight of the TPA's performance, to ensure City funds were adequately safeguarded to prevent overpayments and that workers' compensation payments were for valid claims.

This audit concluded that certain claims management practices performed by Tristar and the contract oversight performed by the Personnel Department required improvement. The City consistently spends hundreds of millions of dollars on workers' compensation costs; TPAs and the Personnel Department must ensure that costs are controlled through a more aggressive approach to claims management. Based on our audit, we found that the City may be at risk for incurring unnecessary workers' compensation costs, and questions arose whether the contractor was fully meeting the City's expectations related to claims management and managing workers' compensation costs.

The audit recommends that the Personnel Department improve its oversight and monitoring of TPAs performing claims management functions for the City to ensure workers' compensation claims are processed in accordance with contractual requirements.

While this audit focused on activities performed by the TPA and the Personnel Department, the Controller's Office has initiated other audits related to workers' compensation to determine what the City is doing to ensure costs are controlled while still delivering legally-mandated benefits. A separate audit of payments to workers' compensation medical providers, as processed by Aon eSolutions (Aon) is being released simultaneously herewith. In addition, audits examining the Fire and Police Departments' efforts in preventing workers' compensation injuries and claims, including

the promotion of safety and wellness are currently in progress. Prior related audits include: a) Investigation of Workers' Compensation Overpayments to Medical Care Providers (issued June 25, 2012); b) Audit of Salary Continuation Payments Made to Non-Sworn Employees under the City's Workers' Compensation Program (issued April 17, 2013) and c) Performance Audit of the Los Angeles City Attorney's Workers' Compensation and Subrogation Program (issued October 13, 2010).

I. Background

Like most public-sector employers,[1] the City is self-insured for workers' compensation, which provides medical treatment, temporary disability compensation for lost work time, and permanent disability compensation for future lost or diminished earnings to injured City workers. The City's Personnel Department administers civilian workers' compensation internally, but has contracted out the claims management and benefits administration function for sworn personnel to a Third Party Administrator (TPA) since 1999. In November 2007, Tristar became the City's TPA for Police and Fire sworn employees' workers' compensation claims. In May 2013, Acclamation Insurance Management Services, Inc. (AIMS) was contracted to be the TPA for Fire sworn employees' claims and Tristar remains the TPA for Police sworn employees' workers' compensation claims. The AIMS contract expires in 2016 and Tristar's contract expires in 2015.

A. Workers' Compensation Costs

In Fiscal Year 2011-12, the City spent more than $209 million in workers' compensation benefits for all departments,[2] with $150 million from the General Fund as a Citywide Human Resources Benefits appropriation administered by the Personnel Department, and salary continuation (temporary disability) payments of $59 million paid to injured employees from individual departments' budget appropriations. For FY 2012-13, the City paid approximately $205 million in workers' compensation expenditures, with more than $138 million related to sworn employees.

[1] The State of California has one of the largest workers' compensation self insurance programs in the nation. There are 360 individual public sector employers (cities, counties, school districts, etc.) and 79 Joint Powers Authorities (pools of employers with 2,905 members) that are self-insured.
[2] Includes all Offices, Council-Controlled departments, Los Angeles World Airports and the Harbor Department. The Department of Water and Power manages its own workers' compensation program.

B. Workers' Compensation Benefits

Workers' compensation benefits are comprised of the following:

- Medical expenditures;
- Expenses – amounts paid for miscellaneous and some legal expenses;
- Temporary disability – City salary continuation or Injury on Duty (IOD) pay;[3]
- Temporary disability – State Rate payments, compensation amounts determined by law;
- Permanent disability - awards for diminished earnings potential;
- Vocational rehabilitation or supplemental job displacement benefits; and
- Death benefits.

State law requires salary continuation for the first year of workers' compensation for sworn personnel, whereby sworn Police and Fire personnel are paid their regular City salary for up to one year. If the employee remains injured and unable to return to work after one year, State Rate disability compensation is paid.

Workers' compensation disability benefit payments are non-taxable. Therefore, when considering income tax effects, workers can effectively receive a higher salary by not working due to a workers' compensation claim.

II. Overall Assessment

Our audit identified certain claims management practices performed by the TPA and the contract oversight performed by Personnel required improvement. These practices put the City at risk for incurring unnecessary workers' compensation costs and raised questions whether the TPA was fully meeting the City's expectations related to claims management and managing workers' compensation costs.

[3] The City first pays temporary disability through the City's payroll system as salary continuation or IOD pay according to the Memorandum of Understanding (MOUs) negotiated by the City or per State law. IOD payments are accounted for as departmental expenditures. Subsequent year's temporary disability payments paid at the "State Rate" are paid by the Personnel Department as part of the Citywide Human Resources from the General Fund, and are accounted for separately from IOD payments. For FY 2011-12, the City paid $59 million in IOD pay to civilian and sworn employees. This is explained in more detail later in the report.

III. Key Findings

Section I: Claims Management

1. Incomplete claims management practices and inadequate supervisory oversight put the City at risk for inappropriately accepting claims as compensable and incurring unnecessary costs.

Section II: Workers' Compensation Payments

2. Inadequate bill review processes may have resulted in the City incurring unnecessary costs by paying for unauthorized medical care or paying more than mandated/discounted fees.

Section III: Personnel's Oversight of TPA's Performance

3. Personnel had not developed formal guidelines or policies regarding keyed-in transactions, which do not benefit from bill review processes, high profile claims, which may have special handling for medical expenses, and its own contract monitoring function.

4. Personnel management had not ensured that all management reports to monitor Tristar's performance could be generated, were periodically provided and included meaningful, accurate statistics.

5. Personnel's process to review and approve Tristar's invoices did not ensure all potential deductions had been considered, resulting in the City paying Tristar more than necessary. The overpayments to Tristar could not be systematically determined due to unreliable penalty coding issues and manual processes.

Section IV: Information Systems

6. The City did not have a fully integrated claims management system to help manage workers' compensation claims and disability payments.

7. System access controls did not prevent modifications to key claimant identification fields, which could have allowed unauthorized payments.

IV. Recommendations

Section I: Claims Management

Personnel Management should:

1.1 Consider the recommendations noted in this audit for applicability to the TPAs with current contracts for workers' compensation claims administration.

1.2 Ensure there are effective procedures to control workers' compensation costs through monitoring the TPA's adherence to three-point contact requirements, subrogation identification and tracking and quality assurance processes.

1.3 Ensure the new claims management system accurately tracks three-point contact timeliness.

1.4 Ensure that TPAs monitor new claims to ensure the three-point contact and initial investigation is completed timely and the compensability determination is appropriate, and completed within time limits.

1.5 Ensure TPAs track, report, and monitor subrogation referrals to the City Attorney and that referrals are made timely as required by the City's contract.

1.6 Ensure TPAs' audits and findings are documented for tracking purposes and are monitored for timely resolution. Supervisor audits should include on-going claims.

1.7 Direct TPAs to enforce their policy and procedures for claims filing and documentation.

1.8 Develop and provide training on the claims management system to ensure that all claims examiners and assistants are familiar with the proper use of all data fields, coding, and documentation requirements.

1.9 Direct TPAs to monitor, through supervisory reviews that claims examiners are documenting claims management activities accurately and completely in the claims management system.

Section II: Workers' Compensation Payments

Personnel Management should:

2.1 Ensure TPAs follow procedures for reviewing and approving invoices based on proper medical authorizations.

2.2 Direct TPAs to process bills through the bill review company unless specifically identified as acceptable keyed-in bills.

2.3 Direct TPAs to promptly and consistently communicate with new and existing claimants to have medical providers submit bills to the City and determine whether reimbursement requests for health care expenses can be rejected.

2.4 Encourage the use of the City's pharmacy/DME benefits program to help minimize costs.

2.5 Perform an analysis to determine whether the City would benefit from increased medical control and/or potentially reduce workers' compensation costs by establishing or contracting with a MPN.

Section III: Personnel's Oversight of TPA's Performance

Personnel Management should:

3.1 Establish formal guidance for keyed-in payments that may be processed by the TPA.

3.2 Establish formal guidance and criteria for processing high profile claims.

3.3 Ensure management's approval of medical treatments, medical/expense payments and explanations for procedural exceptions is clearly documented in the claims management system.

3.4 Establish formal guidance for the role of the City Monitor, including prioritizing functions and develop a procedure manual for the function**.**

4.1 Work with TPAs to review and revise, if necessary, the required statistical reports that should be provided and the frequency for providing the reports.

4.2 Include a requirement for TPAs to formally report on fraud referrals and outcomes of investigations by the City Attorney and/or Police Department.

4.3 Incorporate standard agenda items for monthly meetings to discuss the statistical reports and the TPA's performance.

5.1 Define and determine which pay codes should be used as the basis for the analysis of penalty and overpayment deductions to the TPA's invoices.

5.2 Implement procedures to reconcile penalty tracking records to a system-generated penalty report to ensure all invoice deductions have been identified.

5.3 Ensure that adjustments to the TPA invoices are calculated correctly to recover the actual cost to the City due to untimely return to work notifications for permanent disability payments and recover prior incomplete deductions.

Section IV: Information Systems

Personnel Management should:

6.1 Work with the Controller's Office to identify potential changes to PaySR to establish thresholds for IOD hours and ensure modifications to workers' compensation PaySR payroll codes are approved.

6.2 Ensure TPAs are using electronic imaging for claims file documentation.

7.1 Ensure that system controls are operational in restricting access to change data fields, especially those affecting payments.

7.2 Evaluate and monitor system controls on a regular basis.

Review of Report

A draft report was provided to the Personnel Department and the Department forwarded a copy to Tristar for its review. We held an exit conference with Personnel management to discuss the contents of the audit report. Department management indicated general agreement with the findings and recommendations and indicated that many of the recommendations have been addressed. We considered the Department's comments before finalizing this report.

Subsequent to the audit fieldwork, we learned that the City Attorney's Office and Personnel Department are modifying how the City Attorney will be involved with workers' compensation claims administration and settlements of claims. As of February 2014, the City's claims administrators (Personnel Department staff and third-party administrator staff) are now required to consult with City Attorney staff regarding presumptive illnesses/injuries and other settlement strategies and other trigger events such as disability ratings and apportionment. City Attorney staff are assigned full-time and on-site with claims administrators to determine claims acceptance for presumptive illnesses/injuries, or illnesses/injuries that occur when employees travel or are off-duty. City Attorney management indicated that legal assistance provided earlier in the claims administration process will help reduce the City's costs. Based on our understanding of the process change, earlier intervention by the City Attorney's Office should help to reduce workers' compensation costs and we encourage the City Attorney and Personnel Department to continue with these efforts and codify the process with the TPAs, as necessary. Personnel and the City Attorney should evaluate this new approach of concurrent legal assistance, to ensure its cost effectiveness.

The Fire and Police departments were not considered auditees for this review; however, the Controller's Office is in the process of conducting a separate audit of these departments' workers' compensation prevention programs.

We would like to thank the Personnel Department and acknowledge Tristar management and staff for their cooperation and assistance during the review.

BACKGROUND

Overview – Workers' Compensation

Workers' compensation insurance laws are designed to ensure that workers suffering industrial injuries and illnesses are provided prompt and appropriate medical treatment and are compensated for lost time on the job. The laws have changed over the years, so new claims may have different legal requirements than ongoing open claims. The applicability of a particular law is generally determined by the date of injury.

The City of Los Angeles is self-insured and workers' compensation claims are managed by the Personnel Department for all City departments, except the Department of Water and Power, which manages its own workers' compensation program. Personnel administers civilian workers' compensation claims internally, but has contracted out the claims management and benefits administration function for sworn personnel (Police and Fire) to a third party administrator (TPA) since 1999. The Personnel Department is ultimately responsible for the City's overall workers' compensation program, with involvement from the City Attorney's Office; IOD (Injured On Duty) coordinators throughout the City; and medical liaisons within the Police and Fire Departments.

Third Party Administrator

Since November 2007, Tristar Risk Management (Tristar) had been the City's TPA for Police and Fire sworn employees' workers' compensation claims. The contract was initiated in 2007 for an original three-year term with 2 one-year options, extending the contract through November 2012. The City subsequently executed a new three-year contract with Tristar through November 2015 as the City's TPA for Police sworn employees. Another firm was selected to administer claims for Fire sworn employees. These new contracts were not included in the audit scope.

Workers' Compensation Benefits

When an employee sustains an industrial injury or illness, the employee is eligible for workers' compensation benefits, as needed, which can be comprised of:

- Medical expenses (both evaluation and treatment);
- Expenses - miscellaneous and some legal expenses;
- Vocational rehabilitation or supplemental job displacement benefits;
- Temporary disability – City salary continuation or Injury On Duty (IOD) pay;
- Temporary disability – State Rate payments, compensation amounts determined by State law;
- Permanent disability – awards for diminished earnings potential; and
- Death benefits.

The TPA is responsible for validating the necessity of the payments and processing those invoices and payment requests accurately and timely, which are then paid by the City.

City Attorney's Office

The City Attorney's Office defends the City in all litigated workers' compensation claims brought before the State Workers' Compensation Appeals Board. The City Attorney's Office also provides legal counsel to the Personnel Department and other City departments, as well as training and advice on workers' compensation claims matters. All settlement proposals on litigated claims and matters referred for trial are reviewed and approved. The City Attorney's Office investigates cases of potential workers' compensation fraud and pursues subrogation matters.

Workers' Compensation Costs and Claims

While sworn personnel comprise 37% of City employees,[4] they incur 66% of all workers' compensation expenditures and account for 59% of all claims filed in Fiscal Year 2011-12. In Fiscal Year 2011-12, the City spent more than $209 million in workers' compensation benefits, comprised of medical expenditures, permanent disability payments, temporary disability paid at State Rate, temporary disability paid as IOD salary continuation, and miscellaneous expenses. Of the total expended for workers' compensation benefits, salary continuation payments (temporary disability IOD payments paid to employees due to lost time) for sworn individuals at both departments totaled $41 million of the $58.8 million paid to all City employees.

Exhibit 1 illustrates the total amounts and percentages paid out in total workers' compensation expenditures in Fiscal Year 2011-12 for Police and Fire sworn personnel compared to the City's civilian personnel.

[4] Per the City's Consolidated Annual Financial Report as of June 30, 2012, there were a total of 36,080 full-time equivalent employees, excluding the Department of Water and Power (DWP). Police sworn employees totaled 9,875 and Fire sworn totaled 3,317 (Fire and Police sworn totaled 13,192). All other City employees totaled 22,888, excluding DWP.

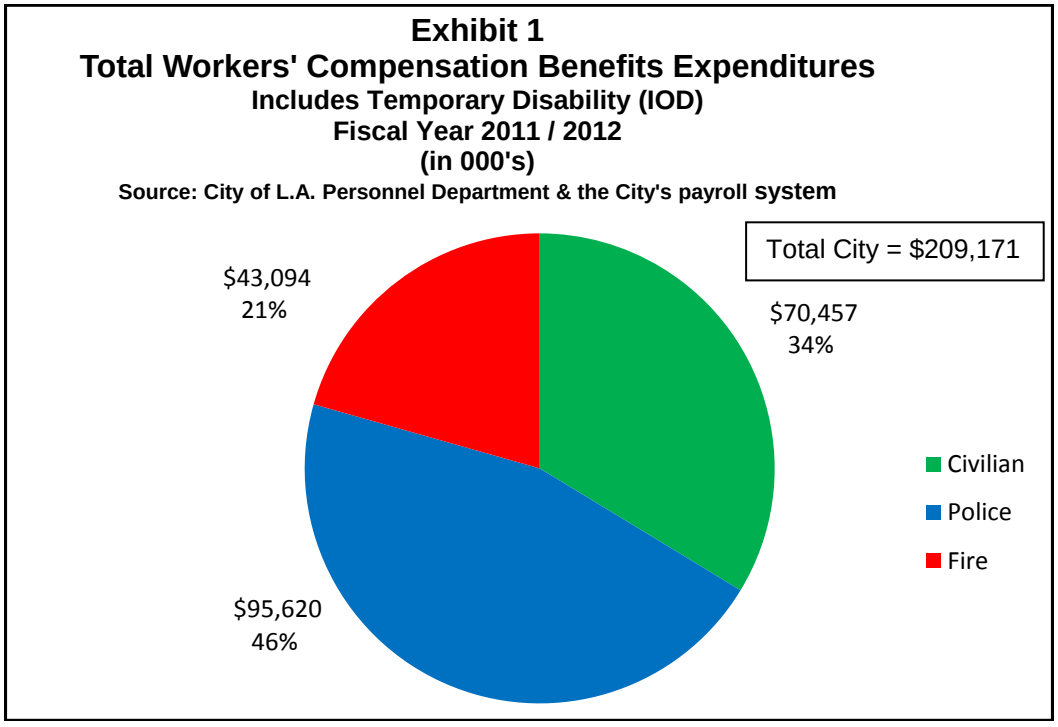


Exhibit 2 compares each of the benefit components paid out for civilian and Police and Fire sworn claimants during FY 2011-12. The expenditures include payments related to both new and existing claims, as claims expenditures may continue for years after the initial filing of the claim. The expenditures for the year were:

FY 2011-12		
Expenditure Type	Total Expenditures (in millions)	Expenditures for Police and Fire Sworn (in millions)
Medical	$97	$66
Permanent Disability Payments	$43	$28
Temporary Disability (State Rate)	$7	$2
Temporary Disability (IOD)	$59	$41
Expenses	$3	$2
Total	***$209***	***$139***

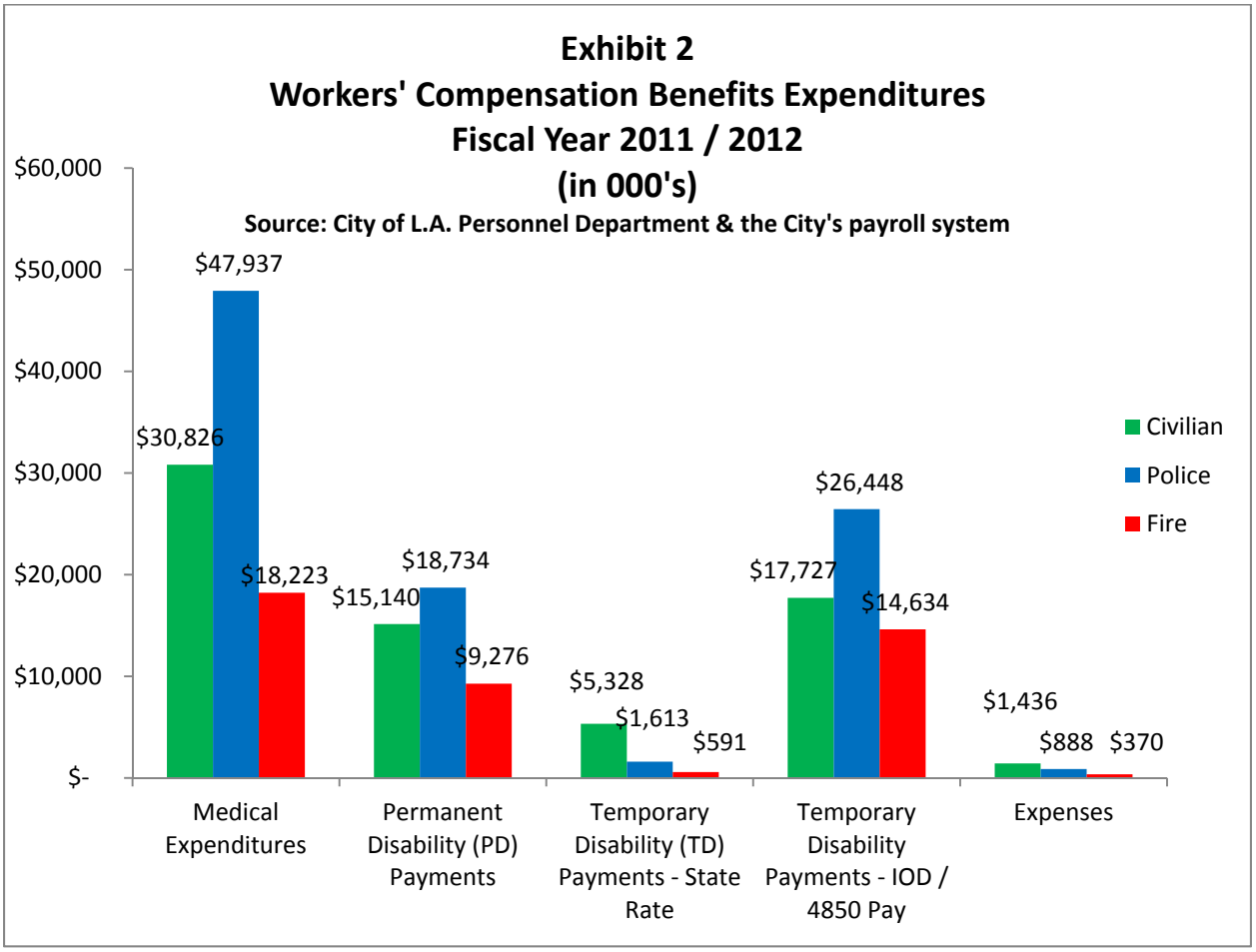
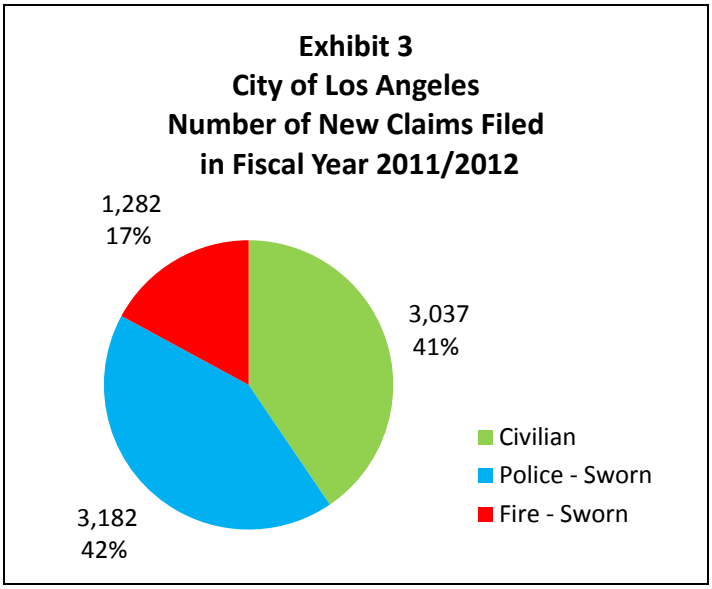


Exhibit 3 illustrates the number of ***new*** workers' compensation claims filed in FY 2011-12, and the proportion of those new claims filed by Police and Fire sworn personnel and civilian personnel. Of the 7,501 new claims filed by City employees in FY 2011-12, 59% or 4,464 claims were filed by sworn employees.

During that year, there was an average of 9,900 open sworn claims, comprised of 6,960 for the Police Department and 2,940 for the Fire Department.



Based on self-reported Workers' Compensation data,[5] as shown on the table below, the City has the highest claims incident rate and expenditures as a percentage of wages compared to other large California jurisdictions. The proportion of new sworn claims submitted by personnel was also higher for the City (59% compared to peer average of 42%).

[5] Data obtained from the State of California, Office of Self-Insured Plans (OSIP) annual reporting, with break-out between sworn and civilian obtained directly from peers by survey.

Workers' Compensation Data Fiscal Year 2011/12							
Self-Insured Employer	**New Sworn Claims**	**New Civilian Claims**	**Total New Claims**	**Total WC Exp (000's)**	**# of Employees**	**WC Exp as % of Wages**	**Incident Rate per 100 Employees**
City of Los Angeles[6]	4,505	3,129	**7,634**	$203,326	42,687	**6.60%**	**17.9**
County of Los Angeles	4,372	6,559	**10,931**	$299,634	101,095	**4.10%**	**10.8**
City & County of San Francisco	967	2,014	**2,981**	$59,464	23,340	**2.60%**	**12.8**
City of San Diego	731	810	**1,541**	$25,981	9,892	**4.10%**	**15.6**
City of Sacramento	293	332	**625**	$5,932	4,280	**2.30%**	**14.6**
City of Long Beach	N/A	N/A	**605**	$13,853	5,286	**3.70%**	**11.4**
City of San Jose	N/A	N/A	**991**	$21,164	6,560	**5.40%**	**15.1**
Average of 6 peers (excluding City of L.A.)						**3.70%**	**13.4**

Note *- Summary claims data as reported by jurisdictions. It should be noted that public services directly provided by these jurisdictions may vary (e.g., jurisdictions may have a deferred retirement option plan (DROP) or may contract out refuse collection, wastewater treatment, paramedic services, etc.) In addition, jurisdictions may account for their WC expenditures differently, and may include of any or all of the following: temporary disability payments as salary continuation; costs for Third Party Claims Administrator(s); and Utilization Review Costs.*

Medical Expenditures

A workers' compensation claim may be either a "medical only" claim or an indemnity claim (meaning that there is lost work time); however, medical expenses are a significant portion of any claim and can continue on for years even after the employee returns to work or retires.

Based on reports issued by Personnel's Workers' Compensation Division, medical costs have been almost 50% of total workers' compensation expenditures, and the City's sworn employees account for about 68% of the workers' compensation medical expenditures for the City. Multiple claims are common; and certain illnesses are presumed to be a result of the occupation. Some presumptive conditions as defined by the Labor Code include hernia, heart trouble, pneumonia, cancer, tuberculosis, and blood-borne diseases. Presumptive illnesses and injuries that occur over time are referred to as cumulative trauma, and for these, the date of injury, as stipulated by the

[6] Figures presented here are those reported by the City to the State of California, OSIP. Some differences noted from figures provided by Personnel used for our audit.

Labor Code, is the date that the employee knew or should have known that they experienced an industrial injury or illness.

During our audit period, the top three injuries for workers' compensation claims were for strains, multiple injuries and sprains. These three injury types accounted for 64% of the claims submitted.

Medical Treatment Authorization

Prior to any medical treatment being performed, the provider must have authorization for the proposed treatment. The claims examiner is responsible for reviewing medical treatment requests and invoices. Medical treatment is determined by the injured employee's treating physician in a medical report that describes the injury and the treatment plan.

There are three ways in which medical treatment for injured employees is authorized: 1) the Prior Authorization Program (PAP), 2) Utilization review (UR), and 3) Trigger Authorization Criteria List. Treatment requests for new claims are either approved by a utilization review (UR), using a sub-contractor of the City's bill review contractor, or they are included in the City's Prior Authorization Program.

The City established the Prior Authorization Program (PAP), which allows select providers to provide routine medical procedures without utilization review based on the Medical Treatment Utilization Schedule (MTUS) outlined in State regulations.[7] MTUS assists in the provision of medical treatment by indicating what treatment has been proven effective in providing the best medical outcomes. MTUS is not the only treatment for a condition or injury; other treatments can be authorized if it is "in accordance with other scientifically and evidence-based, peer reviewed, medical treatment guidelines that are nationally recognized by the medical community."

Tristar also utilized the City's Trigger Authorization Criteria List (Trigger List) that has an expanded list of treatments that could be authorized by Tristar's internal Utilization Review (UR) personnel. The Trigger List can be used for initial or continuing medical treatment. Medical treatment that is not part of the Prior Authorization Program or Trigger List must be referred to the City's contracted bill review company for UR review. Per Tristar's procedures, claims examiners must submit the request to the internal UR department for determining appropriate authorization source. If the requested treatment falls outside of preauthorized services, then the physician must submit a medical report requesting the treatment. If the physician provides a complete medical report that clearly presents his/her case, it must be presented for utilization review (UR), or by law it is deemed to be approved. The claims examiner can object to the requested

[7] California Code of Regulations, Title 8, Div. 1, Chapter 4.5, Subchapter 1, Article 5.5.2.

procedure if incomplete or unreasonable, by issuing an objection to the physician. However, fully supported treatment requests are submitted to UR because the objection or approval must come from a qualified physician, who then deems the treatment as certified, conditionally non-certified, or non-certified. Utilization review is the process wherein a neutral physician with the same specialty concurs or rejects the necessity of the procedure and issues a report to the provider and claims examiner to either certify, conditionally non-certify, or non-certify a medical treatment.

Medical Billing Reviews

All bills related to the provision of health care should be submitted to the City's contracted bill review company, which was Aon during our audit period. Aon verified health care bills have UR certifications or PAP approvals. Aon performed a bill review that matched the service to the appropriate billing code and pricing. Pricing may be determined using the State's "fee schedule" or a provider network negotiated rate for ancillary services.

Medical Payment Process

Aon tracked and identified potentially duplicate invoices and overlapping services dates for all medical services through its computer system. Aon or its subcontracted network provider applied negotiated discounts or adjusted to the State's fee schedule and generated an electronic payment file that was uploaded into LINX for payment. Aon assigned a document control number (DCN) for every bill it has reviewed and submitted for payment processing.

Tristar performed a quality review on the payment files created by Aon to give the final authorization; this included checking for potential false duplicate payments or unusual items and ensuring that the City Monitor had approved any payments greater than $10,000. Because system-identified duplicates may not be actual duplicates, Tristar examined the invoices to determine if an actual duplicate invoice/payment had been processed.

Non-Health Care Expenses

Additional approved miscellaneous expenditures related to the medical treatment plan or claim are also paid by the City (e.g. legal fees). Under the City's contract, Tristar processed non-health care expenses, such as ergonomic evaluations, medical liens, copy expenses and employee reimbursements for out of pocket expenses such as mileage incurred as related to seeking services prescribed by treatment plan. These expenses were directly "keyed in" to LINX for further processing and payment. Keyed in expenses were reviewed by both Tristar's branch manager and the City Monitor, regardless of the amount.

Temporary Disability Payments

If the primary treating physician determines that the employee is unable to work, he/she is entitled to temporary disability payments to compensate the employee for lost time away from the job. For the City of Los Angeles, this benefit is referred to as salary continuation or IOD (Injured On Duty) pay. The treating physician determines when an employee is able to return to work, at either full or modified duty.

The State Labor Code determines the requirements and establishes the amounts paid to the sworn Police and Fire personnel for temporary disability payments, which differs from non-public safety employees. For current claims, sworn employees who are temporarily disabled and unable to work are entitled to their base salary less pension contributions and other allowable deductions for up to one year (261 working days/2088 hours). For that first year, sworn employees on temporary disability are paid through the City's payroll system, PaySR. If the employee remains temporarily disabled and cannot return to work after one year, he/she is entitled to receive disability compensation at the State Rate (the maximum payment is based on the average weekly earnings, which was $1,010.50 in 2012). State Rate payments were processed by Personnel through LINX.

Workers' compensation disability benefit payments are non-taxable. Therefore, when considering income tax effects, workers can effectively receive a higher salary by not working due to a workers' compensation claim.

During our audit period, the three most common injury types (sprains, multiple injuries and strains) accounted for 80% of the total IOD hours incurred due to workers' compensation injuries. IOD hours for these injury types totaled more than 857,000 hours, the equivalent of 412 staff working for one year.

Permanent Disability

A claimant's physician may determine permanent disability after the employee reaches a "permanent and stationary" state, which is when an employee has achieved the maximum medical improvement (MMI). The doctor determines the degree of disability as an impairment rating, which is then converted to a permanent disability rating ranging from 0% - 100%; this rate factors in the claimant's age, occupation, and future earning potential. It represents a diminished earnings capacity due to the industrial illness or injury and is typically paid out bi-weekly until the full amount is paid. Even if an employee has been classified as permanently disabled, an employee can still return to work.

Claims examiners make estimates on the permanent disability rating and initiate advance permanent disability payments. A Workers' Compensation judge determines the final settlement amount when the case is eventually heard and an award is granted.

Unless there is a "compromise and release settlement", future medical expenses continue on the claim, as determined by the physician's treatment plan. Even with the final settlement, it is possible for claims to be re-opened, or new claims may be opened and medical expenses continue.

Claims Management Processes

Claims management is a key component in providing workers' compensation services, which includes timely processing of:

- New claims set-up – this includes the investigation to determine the acceptance or denial of the claim, that is, whether or not it is compensable. This is done through the three-point contact wherein the claims examiner contacts the employee, employer (supervisor) and the physician[8] in order to determine the nature and cause of the injury, fraud potential, subrogation potential (i.e., if a third party is responsible for the injury), and apportionment potential (if it is related to a prior claim or is attributable to a non-City activity such as another job or a hobby);

- Ongoing claims management – monitoring and documenting all aspects of the claim, including medical procedures, rehabilitation and work restrictions, and communications with the claimant, medical providers, and the employer until the employee reaches MMI and the claim is closed;

- Medical bill payment oversight – ensuring medical services are authorized and payments are made according to State-mandated fee schedules or the City's negotiated pricing;

- Temporary disability (TD) – authorizing payments to claimants, ensuring that payments agree to applicable laws and regulations and that the timing of payments is monitored in accordance with the physician's determination; and

- Permanent disability (PD) – calculating advances and award payment schedules and authorizing payments to claimants.

Expediting medical authorizations and procedures may allow for an employee's quicker return to work, providing relief to the injured employee and relieving the burden on the employer. Since workers' compensation is highly regulated and the State imposes penalties for delays in various notifications or payments, the degree of effectiveness in

[8] Unless an employee has pre-designated a physician to provide treatment for a workplace injury, the City can designate its own physicians to initially evaluate and provide treatment for a workplace injury for the first 30 days after the injury was reported. An employee may choose their own physician after the first 30 days. Pre-designation must take place prior to the employee sustaining an injury.

claims management can be measured by the claims examiner's ability to meet deadlines, prevent penalties and stave off unnecessary costs.

Contracted Services

Tristar was responsible for effectively managing the City's workers' compensation claims for sworn employees. The City's contract established staffing and workload levels, set requirements to determine compensability, deliver benefits to injured employees and manage costs and losses in accordance with legal requirements, industry best practices and financial accountability procedures. The original contract established key performance standards that required Tristar to:

- Provide 111 professional and support staff to ensure the average caseload of a claims adjuster does not exceed 200 open indemnity[9] claims;
- Set-up new claims within one day of receipt and complete the initial work up of the claim within the first five business days of receipt;
- Complete the three-point contact within two business days of receipt of the claim and determine whether the claim is compensable. Claimants should be notified within 14 days of claim receipt if the compensability determination requires more investigation (delayed claim);
- Maintain accurate and timely claim files, including diaries to document activities to date;
- Establish reserves based on the estimated value of the claim. Initial reserves should be set up within five business days of receipt of the claim;
- Identify subrogation potential (third party liability) and potential workers' compensation fraud; and
- Review medical bills for appropriateness and potential as a duplicate payment.

Tristar was compensated a monthly service fee based on the claims workload. The monthly service fee, as established in the original contract and revised in a subsequent amendment, was determined based on an average caseload of 200 open indemnity claims per examiner, which was then reduced to 175 open indemnity claims per examiner. The contracted fee structure was designed to ensure an appropriate staffing

[9] The City's contract defines an indemnity claim as any claim involving the payment of temporary disability benefits, an expected ratable permanent disability, death benefit claims, adjudicated or litigated claims, subrogation claims or claims involving medical expenditures anticipated to exceed $3,500.

ratio. The monthly service fees could be reduced if Tristar exceeded the monthly workload per examiner, and for overpayments, fines, penalties, attorney's fees, interest, medical costs, rehabilitation costs, and disability benefit payments which the City paid or was required to pay as a result of the contractor's acts, errors, and/or omissions which violate law, administrative procedure or which fail to comply with industry best practice standards. Tristar must also reimburse the City for any additional costs that the City must pay as a result of the Contractor's improper handling or insufficient follow-up on claims.

TPA Performance Reports

The City's contract with Tristar described several computerized statistics, called WorkCompStats that were to be used to track and monitor claims examiners' performance. These included bill turnaround time, rejected bill counts, closing ratios, and three-point contact thresholds (i.e., timing). The data for the statistics was generated through LINX, the City's bill review contractor (Aon), and other sources. Tristar management was expected to discuss its claims management performance, as measured by the monthly WorkCompStats reporting package, with its supervisors and Personnel on a regular basis. Tristar also reported the following statistics in the reporting package:

- Caseload
- Court Appearance
- UR Graph
- Supervisor Audits
- Diary (Fire and Police, separately)
- IOD (Fire and Police, separately)
- Settlement Requests (Fire and Police, separately)

Other Controller Audits of Workers' Compensation Related Activities

This audit focused on the claims management and administration for workers' compensation claims submitted by the City's sworn personnel. A separate audit of payments to workers' compensation medical providers, as processed by Aon is being released simultaneously herewith. In addition, audits examining the Fire and Police Departments' efforts in preventing workers' compensation injuries and claims, including the promotion of safety and wellness are currently in progress. Other related audits include the following: a) Investigation of Workers' Compensation Overpayments to Medical Care Providers (issued June 25, 2012); b) Audit of Salary Continuation Payments Made to Non-Sworn Employees under the City's Workers' Compensation Program (issued April 17, 2013) and c) Performance Audit of the Los Angeles City Attorney's Workers' Compensation and Subrogation Program (issued October 13, 2010).

OBJECTIVES, SCOPE AND METHODOLOGY

The primary objective of this audit was to assess the effectiveness of the City's workers' compensation claims management for sworn personnel as performed by Tristar. The specific audit objectives included:

- Examine whether internal controls were in place and operated effectively at Tristar to safeguard City funds in order to prevent overpayments and ensure workers' compensation payouts were for valid claims and in accordance with approved payment rates;

- Determine whether Tristar was complying with the contract terms for claims management. Key contract requirements included: ensuring appropriate staffing and case workload volume; establishing medical costs containment practices; paying established medical rates; ensuring adequate documentation and reporting; following service standards and policies; and establishing fraud and quality assurance programs;

- Evaluate the Personnel Department's oversight and monitoring of the workers' compensation claims processing for sworn personnel;

- Examine whether internal controls were in place and operated effectively to prevent overpayments/duplicate payments when IOD payments should terminate and employees should be paid State Rate Workers' Compensation.

The scope of this audit did not include a review of "conflict claims" (claims from employees of the Personnel Department or City Attorney's Office), which were also managed by Tristar. In addition, we did not question whether the claims were compensable or the medical necessity of treatment provided to claimants.

Our audit was performed in accordance with Generally Accepted Government Auditing Standards and covered activities from July 2010 through June 2012. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Fieldwork was conducted from July 2012 through January 2013.

We interviewed Tristar management and staff, Personnel's Workers' Compensation management team and the City Monitor, medical liaisons at the Police and Fire departments and personnel from the City Attorney's Office (the Workers' Compensation Special Investigative Unit and Subrogation Division). We reviewed applicable State Labor Codes and regulations governing California workers' compensation laws, the

Tristar contract, policies and procedures, meeting minutes, and management reports. We also conducted walkthroughs of processes related to payment, claims set-up and monitoring, and the information systems used by Tristar.

We examined provider invoices, reimbursement requests, liens, utilization reviews, medical reports, permanent disability advances and awards, and electronic and physical claims files. We also examined Tristar's invoices to the City. We conducted testwork on new claims, claims management monitoring and payments to providers and claimants.

AUDIT FINDINGS

Section I: Claims Management

As the City's TPA, Tristar provided claims management and benefits administration for sworn employees. Claims management focused on monitoring the claim to ensure the injured employee received the necessary medical care and expeditiously returned to work, if possible. Tristar's claims management activities generally included the following:

- Conduct sufficient investigation as to the facts of the injury that prompted the claim, including completing the three-point contact to determine compensability,[10] or claim eligibility;
- Accept, deny or delay[11] claims;
- Determine subrogation potential;
- Identify potential workers' compensation fraud for referral to the City Attorney's Office, Workers' Compensation Division or the Police Department's Workers' Compensation Fraud Unit;
- Ensure medical treatment is appropriate based on medical report and/or injury;
- Establish and monitor the adequacy of reserves for the four expenditure components of a claim: medical, permanent disability, temporary disability and miscellaneous expenses;
- Determine the need for nurse case management; and
- Monitor the claimant's return to work, including offering modified duty.

Benefits administration focuses on payments to the injured employee (i.e., salary continuation and permanent disability awards). The City required Tristar to document its claims management and benefits administration activities in the City's claims management system; LINX was used during the audit period. Hard copy claims files were also created and maintained by Tristar.

[10] Compensability is defined as entitled to compensation or capable of being compensated in the form of disability payments and medical treatment benefits. For workers' compensation compensability, it is when an employee incurs an industrial injury or illness arising out of or in the course of employment (AOE/COE).

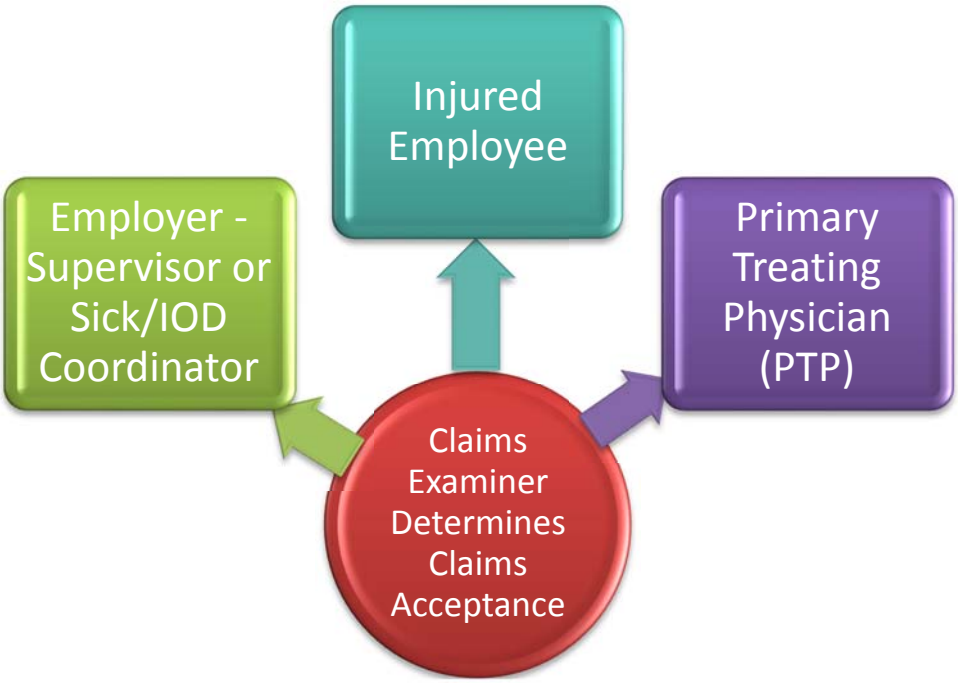
[11] Claims examiners have 14 days to make a determination to accept, deny or "delay" a claim. The determination may be delayed if the examiner is unable to complete the investigation within 14 days which extends the timeframe to 90 days to determine acceptance or denial of the claim.

Finding No. 1: Incomplete claims management practices and inadequate supervisory oversight put the City at risk for inappropriately accepting claims as compensable and incurring unnecessary costs.

Three Point Contact to Determine Compensability

With the City spending approximately $139 million in FY 2011-12 and more than $138 million in FY 2013-14 for workers' compensation expenses related to sworn employees, it is critical that there are adequate controls to ensure an employee's injury/illness arose out of or in the course of employment and whether there is an at-fault third party. According to Personnel, the majority of expenditures in a given year are related to claims filed in the prior six to seven years. Therefore, it is essential that compensability and whether the City is fully liable be accurately determined at the time the claim is filed by an employee. The determination of compensability establishes whether the City is liable for medical expenses, salary continuation or State Rate compensation and permanent disability. Without a timely and thorough investigation of workers' compensation claims, the City may be incurring unnecessary costs, potentially for many years.

Tristar's claims examiners were required to contact 1) the employee (claimant), 2) the employee's supervisor and/or departmental IOD Coordinator, and 3) the treating physician, in order to determine the facts and circumstances of the claim, including whether the injury was work-related. This three-point contact enabled claims examiners to conduct a thorough review of the facts to determine compensability and potential for apportionment and subrogation. The three-point contact should be completed within two business days of Tristar receiving the claim and be documented in the claims management system.



However, the City cannot be assured that Tristar had consistently performed the three-point contact timely due to insufficient claims documentation and flawed WorkCompStat performance reports. As a result, the City was potentially at risk for inappropriately accepting claims as compensable. For example, based on reviewing a sample of 15 new claims that had been opened by different claims examiners, 6 claims (40%) did not have sufficient documentation confirming that the three-point contact had been performed timely. In all six cases, there was no documented contact with the supervisor; although for one claim, the examiner made three attempts at contact. The supervisor or departmental IOD Coordinator contact is important to ensure the claims examiner has sufficient information to determine whether the injury or illness is compensable.

Further, during our audit, we discovered that the three-point contact was documented on a LINX screen that did not differentiate between attempted contacts (i.e., left a message) and the actual contact with the employee, supervisor, etc. The LINX comments field could be used by examiners to describe the "contact". Since the LINX management report for three-point contact performance could have been based on less meaningful information (an attempted contact was considered the same as an actual contact), Tristar and Personnel could not be assured that three-point contacts were being performed timely. Since our fieldwork completion, Personnel has implemented a new claims management system; with the new system, management should ensure that three-point contact is accurately captured, included in performance reports and closely monitored for compliance with contracted service standards.

In addition, the claims examiner has 14 days to notify the claimant of acceptance or delay of the claim. Claims that are not denied within 90 days of filing are deemed to be compensable per State law, unless there are special circumstances, such as fraud, in which case the timeframe for denial does not apply.

We noted that for two of the claims in our sample, it appears they were accepted because the time limit to determine compensability had passed. In one case, the documentation indicates acceptance because there is no mention of the three-point investigation until one month had passed, indicating the examiner did not issue a delay notice within the mandated 14-day period. For the second claim, which was delayed, the claims examiner's comments stated that the "claim is accepted due to timing", with no evidence of further investigation within 90 days of opening the claim.

We are not concluding that the claims should have been accepted or denied, our test work identified a potential risk of inappropriately accepting claims as compensable if adequate procedures are not followed for timely processing.

Subrogation Referrals

Tristar reviewed new claims for potential subrogation and submitted those identified with potential third party liability to the City Attorney's Office for further investigation and recovery efforts. At our request, Personnel generated a report showing that subrogation recoveries totaled approximately $1.15 million for 92 police claims and $50,000 for 5 fire claims during our two-year audit period. However, Tristar did not track or follow up on referred subrogation claims. As a result, the Personnel Department lacked a process to determine Tristar's effectiveness with subrogation identification and whether the amount the City is entitled to has been recovered from at-fault third parties.

We also noted that Tristar claims examiners did not consistently identify claims as having a potential for subrogation by assigning the "SB" prefix in the LINX claims file, that would have facilitated referrals and monitoring, nor did they always identify and refer potential subrogation claims to the City Attorney. For example, 2 of 15 new claims in our sample appeared to have subrogation potential because the injury was from accidents caused by non-City motor vehicles, but there was no indication of a referral in LINX and the City Attorney's records did not list the claims. In other testwork, we noted that a claim took 7 months to refer even though the City's contract required Tristar to refer the claims to the City Attorney within 10 calendar days of the notice of claim.

Under workers' compensation law, employers are responsible for payments of benefits to the injured employee, even if there is a third party at fault. However, the employer is entitled to recover those expenditures by way of subrogation against the responsible party. Therefore, timely identification of subrogation potential is critical to seeking recovery of workers' compensation costs when a third party is liable for the injury.

In addition, because Tristar did not track or monitor subrogation referrals, it did not provide the Personnel Department with required quarterly reports on the status of each subrogation referral (see Finding #4).

Fraud Referrals

The City's contract required Tristar to implement a program to identify and intervene in potential fraudulent claim issues. In addition, Tristar was required to provide training to its claims examiners to identify potential fraud and abuse (i.e., over utilization, questionable billing and "self referral" by vendors) of the workers' compensation process and aggressively investigate and resolve such issues.

We confirmed that training was provided to claims examiners and potential fraud issues were referred to the City Attorney's Workers' Compensation investigators or the Police Department's Workers' Compensation Fraud Unit, during our audit period. However, neither Tristar management nor Personnel monitored fraud referrals. Tristar maintained a log to track the location of claims files forwarded to fraud investigators; however, this log did not provide an adequate record of fraud referrals and outcomes. Also, while individual claims files may indicate potential fraud and note a referral was made to the appropriate investigation unit, there was no process to summarily track and monitor fraud referrals. Without a process to track and monitor fraud referrals, the City could not determine Tristar's effectiveness in identifying potential workers' compensation fraud (see Finding #4) and whether the potential fraud had been investigated.

Tristar Quality Assurance Processes

Tristar supervisors were required to audit 10 new claims each month to confirm claims files (both LINX and physical files) were adequately documented with regard to meeting required deadlines, and that the three-point contact was thorough and timely. These practices were established to ensure that compensability was determined, subrogation potential was identified, and fraud potential was considered. The supervisors completed a checklist to document the results of each claim audit.

However, supervisor claim audits were not always adequately or accurately documented or resolved timely to ensure claims were investigated and managed appropriately. For example, we reviewed 24 supervisory audits and noted:

- 10 audits were not noted in the LINX claim records. Supervisors were required to diary and document claim reviews to demonstrate that claims

examiner's work was being monitored and if there was any action plan that needed to be addressed.

- 4 of 14 audits with findings did not demonstrate follow-up by the supervisors to ensure the issues had been addressed by the examiners. In one case, there was a two-month delay in the necessary action by the examiner, which could have resulted in a penalty.

- 4 audits had supervisory comments that did not correspond with examiners' notes in LINX. For example, one audit checklist noted subrogation potential, which was not likely since the claim was for a cumulative trauma injury that had occurred over time. This raised questions as to the quality of the supervisory review.

In addition, we noted that the audits were not summarized or reviewed with Tristar management or the City to help ensure that common or significant problems were resolved. In the absence of adequate supervisory review and City oversight, the City lacked assurance that workers' compensation payments and claims management were being monitored and paid accurately.

The claims audits and the audit forms were focused on documenting whether required notification by the examiners had occurred. Follow-up items were typically noted in the comments section of the audit form, but not necessarily in the LINX system, which may not facilitate resolution by the examiner. According to Tristar's policies and procedures, supervisory reviews should be diaried, which enables monitoring. Tristar should have utilized LINX comments and diaries to facilitate follow-up actions.

Further, while it is important to ensure required notices and compensability concerns are appropriately addressed for new claims, ongoing claims should also be subject to supervisory audits. This would help assure that ongoing claims are also handled appropriately. Tristar and Personnel monitored new claims and high profile claims (e.g., high dollar claims); however, ongoing claims did not receive the same level of attention through supervisory audits.

Physical and Electronic Claims Files

Tristar did not consistently maintain standardized physical or electronic claims files, which could lead to costly errors because a complete claim file was not readily available.

Physical Files

Tristar had difficulty locating some of the files and documents that should have been included related to invoices that had been manually processed for payment. While Tristar eventually found the requested files, some invoices were not available because of inadequate file maintenance. Personnel uses electronic imaging for the civilian workers' compensation claims; however, the imaging system was not implemented for sworn employees' workers' compensation claims handled by Tristar.

LINX

We noted a number of errors or incomplete use of LINX data fields, including the claims comments. Specifically,

- In 7 of 20 claims files examined, there was no indication that the claims examiner had monitored the claim for 5 months or longer. Generally, the diary should be set for notations every 30-45 days.

- 10 of 18 Police claims reviewed that had subrogation recoveries did not have the SB prefix, which would facilitate tracking and reporting subrogation claim data. These claims were identified based on an audit request for data extracted from LINX comments denoting "subrogation".

- 4 of 50 payments examined were miscoded with an incorrect payment description based on discussions with the TPA and the City's contract Monitor. For example, a payment for utilization review was coded to "medical payment", pay code 20 and not to the utilization review code.

- In addition, the TPA and City Monitor may not have a clear understanding of how medical liens should be coded. We noted 9 lien payments were coded "medical payment", pay code 20. While the TPA and City Monitor indicated these should have been coded to "medical-legal (incl. lien)", code 24; Personnel management later clarified that the lien payments in our sample had been correctly coded. Additional training should help clarify the correct usage and understanding of payment codes.

Tristar's policy and procedure manual included criteria for documentation and diaries, as well as file organization and maintenance. It outlined requirements for making regular comments in the claims file and the specifics on filing physical documents such as paid invoices. The policy required regular documentation on the current claim status and plan of action. Additionally, the City's contract required Tristar to create clear, complete, and timely documentation of critical claims information in the claims management system. Tristar management indicated that informal training on the LINX

system may have occurred for new or promoted Tristar staff; however, there was inadequate formalized training or reference documentation to inform staff about the various screens, fields, and what was expected for documentation in the claims management system. Supervisors should review electronic claim files to ensure claims examiners are adequately and accurately documenting their claims management activities.

This lack of adequate training coupled with faulty physical file maintenance created an environment that will not ensure claims management is being adequately performed. Since each claims management system data field is used or can be used in management reporting, incomplete or incorrect data will result in unreliable reports used by Tristar and Personnel to monitor claims management performance.

Recommendations:

Personnel Management should:

1.1 Consider the recommendations noted in this audit for applicability to the TPAs with current contracts for workers' compensation claims administration.

1.2 Ensure there are effective procedures to monitor the TPA's adherence to three-point contact requirements, subrogation identification and tracking and quality assurance processes.

1.3 Ensure the new claims management system accurately tracks three-point contact timeliness.

1.4 Ensure that TPAs monitor new claims to ensure the three-point contact and initial investigation is completed timely and the compensability determination is appropriate, and completed within time limits.

1.5 Ensure TPAs track, report, and monitor subrogation referrals to the City Attorney and that referrals are made timely as required by the City's contract.

1.6 Ensure TPAs audits and findings are documented for tracking purposes and are monitored for timely resolution. Supervisor audits should include on-going claims.

1.7 Direct TPAs to enforce their policy and procedures for claims filing and documentation.

1.8 Develop and provide training on the claims management system to ensure that all claims examiners and assistants are familiar with the proper use of all data fields, coding, and documentation requirements.

1.9 Direct TPAs to monitor, through supervisory reviews that claims examiners are documenting claims management activities accurately and completely in the claims management system.

Section II: Workers' Compensation Payments

Tristar was responsible for approving and monitoring workers' compensation claims expenditures for the injured employee's medical treatment and salary. Medical treatment, permanent disability, and State Rate (temporary disability) payments were processed in LINX, while salary continuation payments or IOD pay was processed through the City's payroll system (PaySR).

Finding No. 2: Inadequate bill review processes may have resulted in the City incurring unnecessary costs by paying for unauthorized medical care or paying more than mandated/discounted fees.

Medical Treatment Authorizations

Claims examiners were required to ensure that expenditures comply with the authorized treatment plan. Medical necessity and treatment authorization will have already been determined because it is either an in-house preauthorized treatment or has been certified through the UR process. The claims examiners were required to note the UR certification number on the invoice and approve it with their stamp or initials.

However, claims examiners did not always approve medical invoices or document treatment authorizations on bills, which can result in the City incurring unnecessary costs due to paying for unauthorized treatment. For example, we identified 4 of 30 bills in our sample that did not have evidence of UR certification; and 1 of these did not have the examiner's approval. Without evidence of the examiner's verification of medical necessity, it cannot be readily determined if the provider's bill should be paid.

Bill Review and Payment Processing

The City contracted with Aon to review bills submitted by health care providers to ensure that medical charges were appropriate and complied with established State-mandated fee schedules, negotiated rates or usual, customary and reasonable rates. Medical bill review helps to manage workers' compensation medical expenses by eliminating excessive charges. Medical costs can be further reduced when claimants utilize the City's contracted network providers for common types of medical treatment. The network charges the City rates that are discounted from the State's fee schedule.

The City also has a Pharmacy Benefits Management and Durable Medical Equipment (DME) Program whereby claimants can receive prescribed medications and equipment for treatment of their injuries, eliminating the need for claimants to pay out-of-pocket costs, such as co-pays, and request reimbursement. The City incurs costs at or below the State's fee schedule, which may be less than retail pharmacy/DME supplier

charges. As part of this Program, all pharmacy and DME bills were subject to bill review by Aon before payment was made.

However, keyed-in payments processed by Tristar staff were not always submitted to Aon for bill review to ensure discounted rates were applied. As a result, the City may have potentially paid higher costs for claimants' health care because they were handled as keyed-in payments by Tristar and not submitted for bill review and contract discounts (if applicable). We selected a sample of keyed-in payments[12] from a population of more than 6,100 keyed-in payments to evaluate whether claims examiners reviewed the expenditure for appropriateness as a keyed-in payment and assured the correct amount was paid. We requested Aon to review the pricing of 25 of these payments to confirm the correct amount was paid. The following issues were noted:

- Provider invoices were not always submitted to Aon for bill review and instead were processed as keyed-in payments. For example, we noted four invoices were from providers for services such as a rehabilitation hospital stay, medical case management, hearing aid and hearing aid batteries. Personnel management stated that since these services were not subject to State Fee schedule or contract discounts, they were not reviewed by Aon. However, their policy states that all medical payments should be submitted to Aon, and Personnel management indicated these types of invoices are now submitted for bill review. During our analysis of medical payments made during the audit period, we noted two duplicate payments to providers occurred because Tristar processed a keyed-in payment and the invoice also went through Aon's bill review and payment process.

- Keyed-in payments included claimant reimbursements for health-care services, which did not consider discounted/negotiated rates. For example, we noted four reimbursement keyed-in payments for dental x-rays, a chiropractor visit, blood test and medical supplies. Aon reviewed these payments and determined the keyed-in payments exceeded discounted/negotiated rates. These providers did not submit bills for services and instead collected payments from the claimants, which is prohibited by the State's Labor Code. Because the claimant requested reimbursement for their out-of-pocket expense, Tristar processed the payment as a key-in and there was no discounted/negotiated rate applied to reduce the payments.

- There is an opportunity for the City to pay less for claimants' prescribed medications as employee reimbursements. For example, Aon determined one

[12] Tristar can key-in payments for non-health care expenses, such as photocopy services, lien payments or claimant reimbursements, such as for mileage, medications.

reimbursement to a claimant for medications was more than the City's negotiated rates and in one case, a claimant's co-pays could have been avoided had the claimants used the City's Pharmacy Program.

- Lien settlement payments may exceed recommended pricing. Three of the nine lien settlements were paid more than recommended pricing. Many factors are considered during lien settlements with the bill review lien representative providing a recommended settlement amount.

In addition, Aon was unable to price five of the expenses because there was incomplete coding on the bill. While the provider is expected to document the correct service code, claims examiners should ensure that bills are complete through their approval process (medical treatment authorization). Without sufficient information, it cannot be determined whether the amount paid was reasonable. It is not clear what Tristar used as a basis for determining the amount billed and paid was appropriate.

Medical-Provider Network

The City does not have a State approved medical provider network (MPN), therefore, according to Personnel, employees cannot be *required* to utilize the City's Pharmacy/DME Program and can utilize retail pharmacies and DME providers. As a result, the City reimburses employees for the actual costs incurred, regardless of whether the costs would be less through the Pharmacy/DME Program.

In accordance with Labor Code Section 4600I, unless an employer has established or contracted with a MPN, an employee may be treated by a physician of his or her own choice or a facility of his or her own choice after 30 days from the date the injury is reported. Employees may also pre-designate a physician to provide treatment prior to the date of injury by notifying his or her employer. Without a contracted MPN, the City can designate physicians to initially evaluate and provide treatment for a workplace injury for only the first 30 days after the injury was reported.

We learned that the Cities of Long Beach, San Jose, San Francisco and San Diego and the County of Los Angeles each utilize a MPN. A MPN can help provide better medical control through improved communications with medical providers and facilitating employees' return to work with or without work-related restrictions. In addition, a MPN would enable the City to require employees to use the City's Pharmacy/DME Program. The Personnel Department has not performed an analysis to determine whether the City would benefit from establishing or contracting with a MPN. An analysis should be performed to determine whether the City would benefit from increased medical control and/or potentially reduce workers' compensation costs by establishing or contracting with a MPN.

Keyed-in payments are generally for non-health care expenses, such as ergonomic evaluations, medical liens, copy expenses and employee reimbursements for approved out of pocket expenses such as mileage for traveling to medical appointments. Payments to health care providers are not included in the list of approved keyed-in payments, and expenses coded as medical are to be submitted to Aon for bill review. However, the types of expenses that can be keyed-in by Tristar staff have not been clearly defined. For example, Tristar's description of Key-in Payment Procedures states that "any payment that falls under a medical code payment must be processed through Aon." However, despite indicating that medical expenses are to be submitted for bill review, reimbursements to employees for medical costs are processed as keyed-in payments.

Based on our testwork, there were keyed-in payments that should have gone through bill review to ensure the City's costs were minimized. Also, because claimants are reimbursed for all out of pocket expenses without consideration of discounted/negotiated pricing, the City's costs are not being minimized.

Recommendations:

Personnel Management should:

2.1 Ensure TPAs follow procedures for reviewing and approving invoices based on proper medical authorizations.

2.2 Direct TPAs to process bills through the bill review company unless specifically identified as acceptable keyed-in bills.

2.3 Direct TPAs to promptly and consistently communicate with new and existing claimants to have medical providers submit bills to the City and determine whether reimbursement requests for health care expenses can be rejected.

2.4 Encourage the use of the City's pharmacy/DME benefits program to help minimize costs.

2.5 Perform an analysis to determine whether the City would benefit from increased medical control and/or potentially reduce workers' compensation costs by establishing or contracting with a MPN.

Section III: Personnel's Oversight of TPA's Performance

Tristar's contract described the periodic review and performance monitoring that Personnel was to perform in order to monitor the TPA's compliance with service standards. The management tools utilized by Personnel to oversee the contracted activities included periodic working meetings, an assigned City Monitor and WorkCompStats, statistics primarily generated from LINX and iVOS that were to be used to monitor adjusters' performance related to bill turnaround time, rejected bill counts, closing ratios and three-point contact timeliness.

We noted Personnel adequately validated Tristar's staffing and workload to ensure compliance with the contract. Although Personnel established some processes to facilitate formal oversight of Tristar's performance as a workers' compensation claims management function, we noted some service expectations and responsibilities were not clearly communicated or formally documented. In addition, contract monitoring reports did not adequately measure the TPA's performance.

Finding No. 3: Personnel had not developed formal guidelines or policies regarding keyed-in transactions, which do not benefit from bill review processes, high profile claims, which may have special handling for medical expenses and its own contract monitoring function.

Keyed-in Payment Process

As discussed in Finding #2, the types of expenses that may be keyed-in by Tristar staff was not clearly defined. As a result, some invoices were paid twice, or payments to providers were for more than discounted rates. The types of expenses that could be keyed-in by Tristar staff were not clearly established and understood by Tristar or Personnel. For example, Tristar's keyed-in payment procedures stated that "any payments that fall under a medical payment code must be processed through Aon"; yet, our audit disclosed medical provider payments were not submitted to Aon but processed as keyed-in payments. As another example, Priority Care Solution (PCS) invoices (contracted provider for durable medical equipment, transportation services, etc.) were processed as keyed-in payments at least since February 2012. However, Tristar's key-in payment procedures stated that "only hearing aid bills from PCS should be forwarded to Tristar for submission to Aon for review". Yet, Personnel management indicated that all these invoices go directly to Aon for bill review. As a result of our audit inquiry, Personnel instructed Tristar that all PCS invoices should be submitted to Aon for bill review.

Tristar's client service instructions (which augment the contract service standards) were not updated for current practices, resulting in some confusion and discrepancies over which payments can be keyed in and how exceptions should be addressed. As previously described, we noted there was a lack of clarity in how managed care provider invoices and employee reimbursements should be processed. Without clear, documented instructions, Tristar may not have fully met the City's expectations related to claims management and managing workers' compensation costs.

High Profile Claims

Neither Personnel nor Tristar provided specific criteria for designating a workers' compensation claim as "high profile". According to Personnel and Tristar, generally, high profile claims were more medically complex where the injured employee may have special needs or require extensive medical care, such as inpatient hospitalization or rehabilitation. There was closer monitoring of these claims by Tristar and Personnel to ensure appropriate medical care; high profile claims were generally handled by examiners with lighter case loads with additional management oversight. These claims may incur significant medical costs, so any potential penalties would be costly.

However, we were also informed that others may be considered high profile claims, without regard to whether the medical costs were significant. Although our audit testwork sample identified only two high profile claims, we noted different procedures were followed for those claimants including how authorizations were obtained and documented and the types of employee reimbursements that were keyed-in payments. For example, one of the claims had many UR certifications to determine medical necessity performed by Tristar UR staff rather than through the contracted UR company. This is in contrast to the typical UR certification process whereby Tristar UR staff authorized treatments identified on the Trigger List. Additionally, we noted that high dollar medical expenses were keyed-in payments that did not benefit from Aon's bill review to ensure costs meet fee schedules or negotiated rates.

Personnel management indicated that due to the complexity of high profile claims, it is critical to process claims transactions quickly in order to provide timely care to the injured employee.

Personnel management has discretion regarding how to address the more medically acute claims and the corresponding special needs. However, without a clear definition and formalized policies and procedures for handling high profile claims, it is difficult to ensure each claimant receives the appropriate level of attention, and to ensure the reasonableness of medical expenditures.

Personnel Management Reviews

We also noted Personnel did not always document in LINX its review or approval of medical bills or other expenses, typically involving highly complex/high profile claims when the bill would not be reviewed by Aon. Instead, Tristar claims examiners added comments that the City had authorized the expense, rather than Personnel documenting that approval. With the exception of some comments by the current City Monitor, we did not find evidence of Personnel's audits, reviews or approval in the LINX claims files. To clearly define the Department's acceptance of claims processing exceptions, it is critical that Personnel document its review and approval in the claims management system, including the reason for the exception.

City Monitor

Personnel did not formalize its procedures to provide oversight of Tristar's TPA activities. Personnel's City Monitor was on-site at Tristar's offices and focused on specific aspects of contract compliance. The City Monitor described the related oversight duties to include the following:

- Review and provide settlement authorization on non-litigated claims submitted for Workers' Compensation Board approval;
- Review and provide authorization for Indemnity Award payments and Medical/Expense key-in payments;
- Review medical bills of $10,000 or more for appropriateness and approved in iVOS bill payment claims system;
- Review and make recommendations for the delivery of benefits to injured employees in accordance with State guidelines; and
- Review and make recommendations to Department management regarding claims to ensure industry best practice standards for claims management.

Personnel management rotated staff assigned to function as the City Monitor. During our audit period, there were two different City Monitors. We identified some inconsistencies between the two City Monitors performing that function, both in how they tracked penalties (which may be deducted from Tristar's invoices) and whether comments (demonstrating Personnel's review and approval) are documented in the claims management system's claims files. Without clearly defined procedures, the individual assigned as City Monitor can use their own discretion to determine the level of oversight that should be performed.

A procedure manual has not been developed for the Monitor, which would provide guidance on what the oversight role entails. Without management formally defining expectations and procedures, there is a risk that the assigned Monitor may not be focused on areas of importance to Workers' Compensation management or areas critical to contract oversight, such as ensuring medical expenses that should go through bill review are not processed as keyed-in payments (Finding #2) and Tristar's quality assurance procedures (e.g., supervisory audits) were sufficient and effective (Finding #1).

Recommendations:

Personnel Management should:

3.1 Establish formal guidance for keyed-in payments that may be processed by the TPA.

3.2 Establish formal guidance and criteria for processing high profile claims.

3.3 Ensure management's approval of medical treatments, medical/expense payments and explanations for procedural exceptions is clearly documented in the claims management system.

3.4 Establish formal guidance for the role of the City Monitor, including prioritizing functions and develop a procedure manual for the function.

Finding No. 4: Personnel management had not ensured that all management reports to monitor Tristar's performance could be generated, were periodically provided, and included meaningful, accurate statistics.

The City's contract with Tristar described several computerized statistics, called WorkCompStats that were to be used to track and monitor claims examiners' performance. These included bill turnaround time, rejected bill counts, closing ratios, and three-point contact thresholds (i.e., timing). The data for the statistics was generated through LINX, the City's bill review contractor (Aon), and other sources. Tristar management was expected to discuss its claims management performance, as measured by the monthly WorkCompStats reporting package, with its supervisors and Personnel on a regular basis. Tristar also reported the following statistics in the reporting package:

- Caseload
- Court Appearance
- UR Graph
- Supervisor Audits
- Diary (Fire and Police, separately)
- IOD (Fire and Police, separately)
- Settlement Requests (Fire and Police, separately)

We noted some contract-required statistics were not reported. Because Personnel is unable to generate the required data, statistics related to bill turnaround time and rejected bill counts were not available. In addition, because Tristar did not monitor subrogation referrals, the required quarterly reports on the status of subrogation referrals were not provided (See Finding #1). Also, although the contract required Tristar to implement a Fraud Program, there was no mention of providing periodic reports on fraud referrals and outcomes to Personnel.

While these statistical reports were intended for Tristar and Personnel to monitor key performance indicators; there were weaknesses in data collection. For example,

- Three-point contact report listed a count of claims where the contacts were performed timely and those that were late. The source of this report was a specially designed screen that identified a contact was made. However, by entering *any* data into the field, it was considered a contact (even if only a message was left and no actual contact was completed). The three-point contact is critical to the acceptance and compensability of a claim, as it includes the identification of potential fraud, subrogation, and apportionment considerations.

- Supervisor audits report only lists the count of audits performed by supervisor, it did not include which claims were reviewed, any summarization of findings, or whether follow-up was required.

- Diary report listed a count of diaries that were satisfied and how many were late. However, claims examiners had the ability to indicate either that the diary was satisfied, or they could extend the date, even if the item needing to be addressed was delinquent. By entering either an "S" for satisfied or entering a new date to extend the time, a diary was considered satisfied.

We confirmed that Personnel and Tristar met monthly and discussed some key performance activities, such as utilization reviews, IOD and settlements. However, the monthly meetings did not have formalized agenda items to ensure that some key ongoing claims management areas were discussed, such as subrogation referrals and findings on supervisor audits.

There were several system limitations to LINX, and since the conclusion of our audit fieldwork, Personnel has implemented a new automated claims management system to replace LINX. Our audit observations are intended for Personnel to ensure it receives sufficient and accurate data to measure the TPA's performance and to ensure that there are appropriate performance measures reported by the new system.

Recommendations:

Personnel Management should:

4.1 Work with TPAs to review and revise, if necessary, the required statistical reports that should be provided and the frequency for providing the reports.

4.2 Include a requirement for TPAs to formally report on fraud referrals and outcomes of investigations by the City Attorney and/or Police Department.

4.3 Incorporate standard agenda items for monthly meetings to discuss the statistical reports and the TPA's performance.

Finding No. 5: Personnel's process to review and approve Tristar's invoices did not ensure all potential deductions had been considered, resulting in the City paying Tristar more than necessary. The overpayments to Tristar could not be systematically determined due to unreliable penalty coding issues and manual processes.

Under the terms of the contract, Tristar was paid monthly service fees dependent on the level of staffing, but must reimburse the City for overpayments, fines, penalties, and other errors. Tristar self reported overpayments, fines, etc. as deductions to its fees on the monthly invoice. Personnel reviewed Tristar's invoices and supporting data. However, Tristar's penalty deductions were not compared to LINX-designated penalties to ensure completeness. Penalties may have been missed due to coding issues and therefore system-designated penalties may not have been accurate.

We compared LINX penalties for FYs 2010-12 to penalty tracking sheets for the same period. LINX reported penalties totaling $442,000, while the tracking sheets showed penalties totaling $402,000. Without reconciling Tristar's reported penalty deductions to the system's reports, Personnel cannot determine the reason for any differences or be assured that Tristar's invoices were accurately adjusted.

We also noted that penalties related to timely processing of permanent disability payments do not consider the lost opportunity to pay a decreased amount. Section 4658 of the State's Labor Code requires an adjustment to the employee's permanent disability payments based on the employer offering the injured employee regular, modified or alternative work within 60 days of their reaching MMI. For 2012, standard permanent disability payments were $230 per week (paid out bi-weekly) until the full amount of the permanent disability award is received by the employee. If the return to work offer is made timely, then the employee is back to work earning wages and the employer reduces the weekly amount on any future permanent disability payments by 15%; if the return to work is not offered timely, the weekly amount is increased by 15%.

Personnel made a deduction to Tristar's invoices for the 15% increase in permanent disability payments. However, Section 4658 of the Labor Code also allows for an employer to actually pay 15% less than the scheduled monthly permanent disability payment if the return to work offer is done timely, which is not included in the adjustments to the TPA's invoice. Neither Personnel nor Tristar considered the lost opportunity to pay less if notifications were done timely as an "increased cost" to the City that should have been deducted from Tristar's invoiced amounts.

Recommendations:

Personnel Management should:

5.1 Define and determine which pay codes should be used as the basis for the analysis of penalty and overpayment deductions to the TPA's invoices.

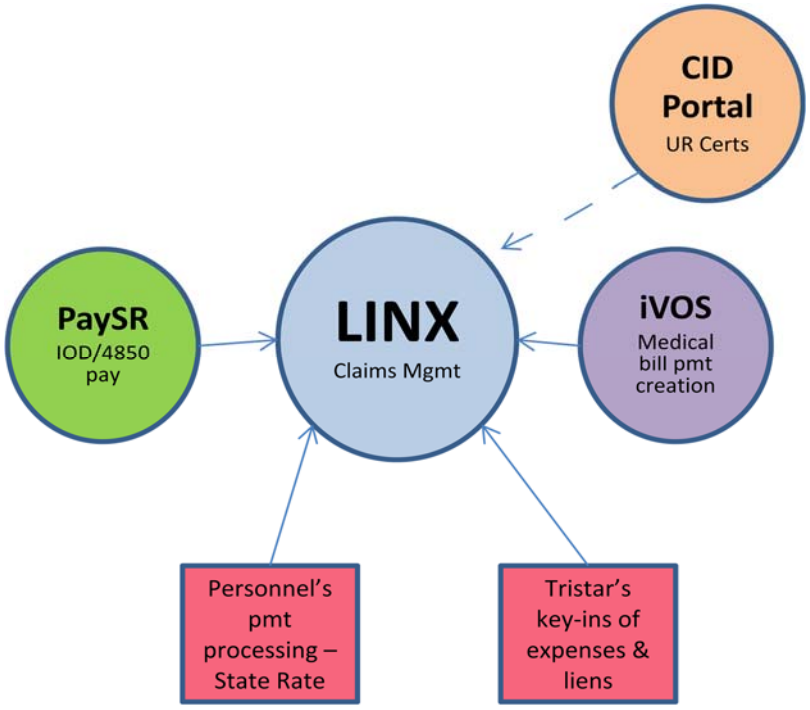
5.2 Implement procedures to reconcile penalty tracking records to a system-generated penalty report to ensure all invoice deductions have been identified.

5.3 Ensure that adjustments to the TPA invoices are calculated correctly to recover the actual cost to the City due to untimely return to work notifications for permanent disability payments and recover prior incomplete deductions.

Section IV: Information Systems

There were four key disparate information systems and databases used by Tristar and the City to manage workers' compensation claims and related expenditures: LINX, iVOS, CID's portal, and PaySR. There was not a fully integrated system; therefore, Tristar had to refer to a number of systems in order to validate payments or authorizations. Additionally, there were a significant number of manual processes used by Tristar in their claims management.

Other departments had systems that were used to help manage the workers' compensation program, such as the City Attorney's Office use of A1 Law for calendaring, claims tracking databases used by the medical liaisons within the Police and Fire departments, and ChequeScribe used by the Controller's Office for check processing. Claims examiners also utilized the portal provided by Cypress Care (managed care pharmacy provider) to view the status of claimants' prescriptions. A-1 Law, ChequeScribe and the Cypress Care systems were not examined in this audit.



I. LINX

LINX was the primary claims management system used by the City for all workers' compensation claims for logging activity and certain payments. The system was outdated and a number of modifications had to be implemented to provide for some integration and visibility of the entire claim history. It contained a basic screen or face sheet, which summarized key claim information, payment information, and comments. Add-on features were built that did not fully integrate within the program or with other systems. For example, the three-point contact screen, while used as a monitoring tool, did not integrate within the claim file so the comments component of the claim was not updated. The City abandoned some of these added features and as Personnel recognized the limitations of the LINX system has now replaced it as of May 27, 2014.

Payments were entered either directly into LINX by key-in processes executed either by Tristar or Personnel's accounting staff, or payment files were created by other systems and uploaded into LINX. Tristar could directly enter into LINX the "keyed-in" payment requests to pay for medical liens, copy expenses, claimant's reimbursements for mileage and other City-approved payments. Personnel's accounting staff could process payments directly into LINX to pay State Rate temporary disability payments, permanent disability award or advance payments, life pension payments, and death benefit payments. Payment information for medical bills processed by iVOS or IOD payments processed by PaySR were entered into LINX via automated processes.

II. iVOS System

Aon used a module of iVOS in their processing of the City's bill reviews; therefore, Tristar accessed a portion of the iVOS system to look up and verify bill review documents (Explanation of Reviews) and review the creation of bill payment files. Features in iVOS included a review for duplicate billings; however, it was not integrated with LINX and payments were only posted into LINX after the payment file was created. Tristar performed a quality review on payment files generated by iVOS to verify transfer of payment files.

III. CID portal

The utilization review company provides access to their certifications online; there was no integration into LINX or the bill review module of iVOS. Tristar had to reference those reviews by denoting them in the LINX claim file. The information was accessible online to Tristar personnel and certification or non-certification reports were issued to the requesting physician, provider (if known) and the claims examiner with an assigned certification number. Aon performed the bill review and generated a payment file when they received the certification number or approval from Tristar's in-house UR team, who verified authorization of the treatment.

IV. PaySR

This is the City's payroll system, which is used to process/generate the first year of salary continuation, or IOD pay; claimants may also receive any available supplemental pay (vacation, sick) through PaySR if they are on State Rate. A separate routine was created to allow for posting of the PaySR payments into the LINX claims files.

Finding No. 6: The City did not have a fully integrated claims management system to help manage workers' compensation claims and disability payments.

The City's multiple computer systems did not ensure that the maximum hours of IOD pay are not exceeded or prevent employees from receiving both IOD and State Rate payments at the same time. We also noted that Tristar had limited electronic imaging available.

PaySR System

The City's payroll system, PaySR, has not had a system control to ensure IOD hours do not exceed the maximum. Aggregate IOD hours were manually monitored to ensure salary continuation did not exceed the equivalent of one year. Claims may be handled differently based on the Labor Code requirements in effect at the time of injury (there are maximum time thresholds for aggregate disability payments depending on the date of injury). Setting a cap for the maximum number of hours that generally applies should trigger a review to determine whether it is appropriate for IOD hours to exceed the maximum. This issue was previously noted in a separate audit report issued by the Controller's Office on April 17, 2013.

Electronic Imaging

While the City's contract discussed the use of electronic imaging, Personnel management did not provide an electronic imaging system to Tristar. While Aon processes invoices were electronically scanned, Tristar relied on physical copies for keyed-in invoices and important documents (e.g. permanent disability awards, medical reports, etc.). Missing documents may have been prevented (See Findings #1 and 2) if electronic imaging was available for Tristar's claims documentation.

Interfaces and Data Collection – LINX and PaySR

There was no systems check to ensure that IOD salary continuation and State Rate payments were not made for the same time frame. Using our data analytic software, we analyzed IOD payments from PaySR and State Rate payments from LINX made during FYs 2010-12. We identified seven instances wherein the claimant received both IOD salary continuation payments through PaySR and State Rate payments through LINX for the same time period.

Claims examiners were expected to monitor the IOD salary continuation process. This was done through coordinating between the primary treating physician, medical liaisons and IOD coordinators, in addition to reviewing the LINX downloads from PaySR. The design of the interface between PaySR and LINX relied on certain designated coding being pulled into LINX. We noted that a new IOD payroll code was added to PaySR which was not incorporated into LINX reporting. The Police Department had requested adding another IOD payroll code which was unknown to Personnel. As a result, Personnel had incomplete data collection for approximately six months. In spite of the incomplete reporting of temporary disability for Police claimants, we did not identify any PaySR overpayments that had not been already corrected by the City and Tristar.

The Personnel Department worked on replacing the LINX claims management system as early as 2008. On June 29, 2012, a contract was signed for the replacement of LINX with the iVOS claims management system and the new system went live on May 27, 2014. We understand that iVOS allows for more automation of notices, electronic imaging, provide integration with bill payment file creation and incorporates the City Attorney's calendaring. The new system also allows Personnel to consider better data collection, security and reporting. While there will still be a distinct system for processing the first year of temporary disability payments with the City's payroll system, PaySR, most redundancy should be eliminated through the new, more integrated system. The initial phase of implementation for iVOS was May 27, 2014; our audit did not evaluate this new system.

Recommendations:

Personnel Management should:

6.1 Work with the Controller's Office to identify potential changes to PaySR to establish thresholds for IOD hours and ensure modifications to workers' compensation PaySR payroll codes are approved.

6.2 Ensure TPAs are using electronic imaging for claims file documentation.

Finding No. 7: System access controls did not prevent modifications to key claimant identification fields, which could have allowed unauthorized payments.

System access controls were not appropriately established or monitored. For new claims, LINX had a control to validate claimants were City employees; a LINX claims file could not be set up if the claimant was not on the City's payroll. However, after the initial set up, a claimant's name, address, and social security number could be changed by claims examiners and claims assistants. While it may be appropriate to revise a claimant's information, access controls over any payment initiation are essential. Access to change a claimant's name and address should be restricted to a limited number of City personnel, and changes to social security numbers should never be allowed.

Recommendations:

Personnel Management should:

7.1 Ensure that system controls are operational in restricting access to change data fields, especially those affecting payments.

7.2 Evaluate and monitor system controls on a regular basis.

Respectfully submitted,

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APPENDIX I: SUMMARY OF FINDINGS AND AUDIT ACTION PLAN

DESCRIPTION OF FINDING		RECOMMENDATIONS	ENTITY RESPONSIBLE FOR IMPLEMENTATION	RANKING
Section I: Claims Management				
1	Incomplete claims management practices and inadequate supervisory oversight put the City at risk for inappropriately accepting claims as compensable and incurring unnecessary costs.	Personnel Management should:		
		1.1 Consider the recommendations noted in this audit for applicability to the TPAs with current contracts for workers' compensation claims administration.	**Personnel**	2
		1.2 Ensure that there are effective procedures to control workers' compensation costs through monitoring TPA's adherence to three-point contact requirements, subrogation identification and tracking and quality assurance processes.	**Personnel**	2
		1.3 Ensure the new claims management system accurately tracks three-point contact timeliness.	**Personnel**	2
		1.4 Ensure that TPAs monitor new claims to ensure the three-point contact and initial investigation is completed timely and the compensability determination is appropriate, and completed within time limits.	**Personnel**	1
		1.5 Ensure TPAs track, report, and monitor subrogation referrals to the City Attorney and ensure referrals are made timely as required by the City contract.	**Personnel**	2
		1.6 Ensure TPAs' audits and findings are documented for tracking purposes and are monitored for timely resolution. Supervisor audits should include on-going claims.	**Personnel**	2
		1.7 Direct TPAs to enforce their policy and procedures for claims filing and documentation.	**Personnel**	2
		1.8 Develop and provide training on the claims management system to ensure that all claims examiners and assistants are familiar with the proper use of all	**Personnel**	2

Description of Finding		Recommendations		Entity Responsible for Implementation	Ranking
			data fields, coding, and documentation requirements.		
		1.9	Direct TPAs to monitor, through supervisory reviews that claims examiners are documenting claims management activities accurately and completely in the claims management system.	**Personnel**	2
Section II: Workers' Compensation Payments					
2	Inadequate bill review processes may have resulted in the City incurring unnecessary costs by paying for unauthorized medical care or paying more than mandated/discounted fees.		Personnel Management should:		
		2.1	Ensure TPAs follow procedures for reviewing and approving invoices based on proper medical authorizations.	**Personnel**	1
		2.2	Direct TPAs to process bills through the bill review company unless specifically identified as acceptable keyed-in bills.	**Personnel**	1
		2.3	Direct TPAs to promptly and consistently communicate with new and existing claimants to have medical providers submit bills to the City and determine whether reimbursement requests for health care expenses can be rejected.	**Personnel**	2
		2.4	Encourage the use of the City's pharmacy/DME benefits program to help minimize costs.	**Personnel**	2
		2.5	Perform an analysis to determine whether the City would benefit from increased medical control and/or potentially reduce workers' compensation costs by establishing or contracting with a MPN.	**Personnel**	2

Description of Finding		Recommendations		Entity Responsible for Implementation	Ranking
Section III: Personnel's Oversight of TPA's Performance					
3	Personnel had not developed formal guidelines or policies regarding keyed-in transactions, which do not benefit from bill review processes, high profile claims, which may have special handling for medical expenses and its own contract monitoring function.		Personnel Management should:		
		3.1	Establish formal guidance for keyed-in payments that may be processed by the TPA.	**Personnel**	1
		3.2	Establish formal guidance and criteria for processing high profile claims.	**Personnel**	1
		3.3	Ensure management's approval of medical treatments, medical/expense payments and explanations for procedural exceptions is clearly documented in the claims management system.	**Personnel**	1
		3.4	Establish formal guidance for the role of the City Monitor, including prioritizing functions and develop a procedure manual for the function.	**Personnel**	2
4	Personnel management had not ensured that all management reports to monitor Tristar's performance could be generated, were periodically provided, and included meaningful, accurate statistics.		Personnel Management should:		
		4.1	Work with TPAs to review and revise, if necessary, the required statistical reports that should be provided and the frequency for providing the reports.	**Personnel**	2
		4.2	Include a requirement for TPAs to formally report on fraud referrals and outcomes of investigations by the City Attorney and/or Police Department.	**Personnel**	2
		4.3	Incorporate standard agenda items for monthly meetings to discuss the statistical reports and the TPA's performance.	**Personnel**	2
5	Personnel's process to review and approve Tristar's invoices did not ensure all potential deductions have been considered, resulting in the City paying more than necessary. The overpayments to Tristar could not be systematically determined due to unreliable		Personnel Management should:		
		5.1	Define and determine which pay codes should be used as the basis for the analysis of penalty and overpayment deductions to the TPA's invoices.	**Personnel**	2
		5.2	Implement procedures to reconcile	**Personnel**	2

	Description of Finding		Recommendations	Entity Responsible for Implementation	Ranking
	penalty coding issues and manual processes.		penalty tracking records to a system-generated penalty report to ensure all invoice deductions have been identified.		
		5.3	Ensure that adjustments to the TPA invoices are calculated correctly to recover the actual cost to the City due to untimely return to work notifications for permanent disability payments and recover prior incomplete deductions.	**Personnel**	2
Section IV: Information Systems					
6	The City did not have a fully integrated claims management system to help manage workers' compensation claims and disability payments.		Personnel Management should:		
		6.1	Work with the Controller's Office to identify potential changes to PaySR to establish thresholds for IOD hours and ensure modifications to workers' compensation PaySR payroll codes are approved.	**Personnel Controller's Office**	2
		6.2	Ensure TPAs are using electronic imaging for claims file documentation.	**Personnel**	2
7	System access controls did not prevent modifications to key claimant identification fields, which could allow unauthorized payments.		Personnel Management should:		
		7.1	Ensure that system controls are operational in restricting access to change data fields, especially those affecting payments.	**Personnel**	1
		7.2	Evaluate and monitor system controls on a regular basis.	**Personnel**	2

Description of Recommendation Ranking Codes

1 – **High Priority**: The recommendation pertains to a serious or materially significant audit finding or control weakness. Due to the seriousness or significance of the matter, immediate management attention and appropriate corrective action is warranted.

2 – Medium Priority: The recommendation pertains to a moderately significant or potentially serious audit finding or control weakness. Reasonably prompt corrective action should be taken by management to address the matter. The recommendation should be implemented within six months.

3 – Low Priority: The recommendation pertains to an audit finding or control weakness of relatively minor significance or concern. The timing of any corrective action is left to management's discretion.

N/A- Not Applicable