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OFFICE OF WORKERS' COMPENSATION PROGRAMS

Further Actions Are Needed to Improve Claims Review

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Strategic Issues

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Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to testify today on issues regarding the Department of Labor's Office of Workers' Compensation Programs (OWCP). During fiscal year 2000, OWCP paid compensation totaling about $2.1 billion in medical and death benefits and received approximately 174,000 new injury claims. Issues related to OWCP have been, for a number of years, a particular focus of this subcommittee. I am here today in response to your request that the we examine selected issues associated with OWCP's claims' adjudication process, which has been the subject of previous hearings before your subcommittee. We believe the report we are issuing to you today and our testimony will provide a further understanding of the federal government's employee compensation program.

As you requested, we looked at selected aspects of OWCP's process for adjudicating claims appeals. In summary, we found the following:

- Approximately one in four appealed claims' decisions are reversed or remanded to OWCP district offices for additional consideration and a new decision because of questions about or problems with the initial claims decision.

- In response to the Federal Employees Compensation Act's (FECA) requirement on the timing for informing claimants of hearing decisions, OWCP has established a goal of informing 96 percent of claimants within 110 days of the date of the hearing. Our sample showed that it provides notification to 92 percent of claimants within this period.

- Nearly all physicians used by OWCP to provide opinions on injuries claimed were board certified and state licensed, and were specialists in areas that appeared to be consistent with the injuries they evaluate.

- OWCP has used mailed surveys and more recently telephone surveys and focus groups, to measure customer satisfaction. Those efforts have shown mixed results. Finally, the Labor inspector general is primarily responsible for monitoring potential fraud within OWCP's workers compensation program and uses the claims examiners as one source in identifying potentially fraudulent claims.

In addressing the objectives, we reviewed a statistical sample of more than 1,200 of the estimated 8,100 appealed claims for which a decision was rendered by the Branch of Hearings and Review (BHR) or the Employees

Compensation Appeals Board (ECAB) during the period from May 1, 2000, through April 30, 2001.

How the Claims Process Works

As you know, FECA[1] authorizes federal civilian employees compensation for lost wages and medical expenses for treatment of injuries sustained or for diseases contracted during the performance of duty. A worker's compensation claim is initially submitted through the employee's agency to an OWCP district office and is evaluated by a claims examiner. The examiner must first determine whether the claimant has met each of the following five criteria for obtaining benefits:

- The claim must have been submitted in a timely manner. An original claim for compensation for disability or death must be filed within 3 years of the occurrence of the injury or death.
- The claimant must have been an active federal employee at the time of injury.
- The injury, illness, or death had to have occurred in a claimed accident.
- The injury, illness, or death must have occurred in the performance of duty.
- The claimant must be able to prove that the medical condition for which compensation or medical benefits is claimed is causally related to the claimed injury, illness, or death.

Because medical evidence is an important component in determining whether an accident described in a claim caused the claimed injury and if the claimed injury caused the claimed disability, workers' compensation claims are typically accompanied by medical evidence from the claimant's treating physician. Considerable weight is typically given to the treating physician's assessment and diagnosis. However, should the OWCP claims examiner conclude that a better understanding of the medical condition is needed to clarify the nature of the condition or extent of disability, the examiner may obtain a second medical assessment of the claimant's condition. In such instances, a second-opinion physician, who is selected

[1] 5 USC 8101, et seq.

by a medical consulting firm contracted by an OWCP district office, reviews the case, examines the claimant, and provides a report to OWCP.

If the second-opinion physician's reported determination conflicts with the claimant physician's opinion regarding the injury, the claims examiner determines if the conflicting opinions are of "equal value."[2] If the claims examiner considers the two conflicting opinions to be of equal value, OWCP appoints a third or "referee physician" to evaluate the claim and render an independent medical opinion.

Claims may be approved in full or part, or denied. When all or part of a claim is denied the claimant has three avenues of recourse for appeal: (1) an oral hearing or a review of the written record by the Branch of Hearings and Review (BHR), (2) reconsideration of the claim decision by a different claims examiner within the district office, or (3) a review of the claim by the Employees Compensation Appeals Board (ECAB). While OWCP regulations do not require claimants to exercise these three methods of appeal in any particular order, certain restrictions apply that, in effect, encourage claimants to file appeals in a specific sequence—first going to the BHR, then requesting another review at the OWCP district office, and finally involving the ECAB.

[2] OWCP's procedures manual state that to determine if the medical evidence is of equal value, each physician's opinion is to be considered against the following factors: (1) whether the physician involved in the case is a specialist in the appropriate field relevant to the claimant's injury or illness, (2) whether the physicians' opinions are based upon a complete and accurate medical and factual history, (3) the nature and extent of findings on examination of the claimant, (4) whether the physicians' opinions are rationalized, and (5) whether the physicians' opinions are stated unequivocally and without speculation.

Evaluation Problems, Case File Mismanagement, and New Evidence Are Reasons Appealed Claims Decisions Are Reversed or Remanded

From May 1, 2000, to April 30, 2001, decisions were rendered by BHR or ECAB on approximately 8,100 appealed claims. We found that BHR and ECAB affirmed an estimated 67 percent of these initial decisions as being correct and properly handled by the district office, but reversed or remanded an estimated 31 percent of the decisions[3]--25 percent because of questions or problems with OWCP's review of medical and nonmedical information or management of claims files, and the remaining 6 percent because of additional evidence being submitted by the claimant after the initial decision.

About one-fourth of the appealed claims decisions were reversed or remanded due to OWCP evaluation problems or claims file mismanagement

We found that about one in four appealed claims decisions during our period of review were reversed or remanded because of questions about or problems associated with the initial decision by the OWCP district office. These included problems with (1) the initial evaluation of medical evidence (e.g., physicians' examinations, diagnoses, or x-rays) or nonmedical evidence (e.g., coworker testimonies) or (2) management of the claim file (e.g., failure to forward a claim file to ECAB in a timely manner). Problems in evaluating medical evidence frequently involved, for example, an OWCP district office failing to properly identify medical conflicts between the conclusions of the claimant's physician and OWCP's second-opinion physician, and therefore not appointing a referee physician as required by FECA. OWCP has interpreted the FECA requirement for referee physicians to apply only when the opinions of the claimant's and second-opinion physicians are of equal value, that is, when both physicians have rendered comparably supported findings and opinions.

Some remands and reversals resulted from OWCP failing to administer claims files in accordance with FECA or OWCP guidance for claims management. The guidance includes (1) a description of the information that is to be maintained in the claim file and transmitted by OWCP to the requestor (i.e., BHR or ECAB) and (2) requires claims files to be transmitted within 60 days after a request is received. Failure to meet this 60-day requirement was one of the more common deficiencies in claims file management. For example, ECAB initially requested a claim file for one

[3] The remaining 2 percent of the decision summaries we examined did not include information regarding what decision was reached on the claimant's appeal or the rationale for the decision.

injured worker from OWCP on April 29, 2000. On December 19, 2000 (almost 8 months later), ECAB notified OWCP that the claim file had not been transferred and that if the file was not received within 30 days, ECAB would issue orders remanding the claim decision to the relevant district office for "reconstruction and proper assemblage of the record." As of March 12, 2001—more than 10 months after the initial ECAB request —the claim file had still not been transferred and the decision was remanded back to the district office. We estimate that 4 percent of appealed decision were reversed or remanded by BHR or ECAB because of claim file management problems.

For claims that were initially denied at a district office and then decisions were reversed by BHR or ECAB due to problems identified with the initial evaluation of evidence or mismanagement of claims files, there are delays in claimants receiving benefits to which they were entitled. According to OWCP, the average amount of time that elapsed from the date an appeal was filed with BHR or ECAB until a decision was rendered was 7 months and 18 months, respectively, in fiscal year 2000. Thus, when an initial claims decision is reversed upon appeal, while claimants are provided benefits retroactively to the date of the initial decision, claimants may be forced to go without benefits for what can be extended periods and may have to incur additional expenses during the appeals process, such as representatives' fees, that are not reimbursable.

New Evidence Submitted After OWCP Rendered Decision Also Result in Reversals and Remands

We also found that 6 percent of appealed claims decisions were reversed or remanded because of new evidence being submitted by the claimant after the initial decisions were made. OWCP regulations allow claimants to submit new evidence to support their claims at any time up until 30 days—or more with an extension—after the BHR hearing or review of the record occurs.[4] Additional evidence could include medical reports from different physicians or new testimonial evidence from coworkers that in some significant way were expected to modify the circumstances concerning the injury or its treatment and make the previous decision by OWCP now inappropriate. Upon appeal of the earlier district office decision, the BHR representative determines whether any new evidence is sufficient to remand the decision back to the district office for further review, or to reverse the initial decision.

[4] Most reversals and remands resulting from claimants submitting new evidence were made by BHR.

OWCP Has Taken Some Actions to Identify and Address the Causes of Reversals and Remands

OWCP officials told us that several actions are taken to monitor remands and reversals. For example, ECAB decisions are reviewed and advisories are prepared to call claims examiners' attention to select ECAB decisions which represent a pattern of district office error or are otherwise instructive. Where more notable problems are identified through ECAB reviews, OWCP informed us that a bulletin describing correct procedures may be issued or training might be provided. While OWCP similarly monitors reasons for BHR reversing and remanding claims decisions, this information is not as routinely disseminated to claims examiners as is done for information on ECAB decisions.

Clearly, these actions are providing some information on reasons for remands and reversals. However, this information is not providing a full picture of the underlying reasons for remands and reversals occurring at their current rates and what actions might be taken to address those factors. For example, OWCP might detect that district offices are failing to appoint referee physicians when required. OWCP might then notify district offices that such a problem was occurring. However, with the information currently available, it would not be able to identify the nature or frequency of specific underlying reasons, such as (1) how often are inexperienced claims examiners not sufficiently aware of the requirement for a referee physician when a conflict of equal value occurs or (2) how often are examiners experiencing difficulty in determining whether two physicians' opinions are of equal value? Not knowing the frequency with which reasons for remands and reversals are occurring, or the specific underlying causes, it would be difficult for OWCP to identify actions that might be taken to address the problem.

We believe that OWCP should examine the steps it currently takes to determine whether more can be done to identify and track remands and reversals—including improper evaluation of evidence and mismanagement of claim files—and address their underlying causes.

OWCP officials told us that they have not conducted such an overall examination of its current process, adding that they instead rely on adjustments to their current monitoring and communication process (circulars and bulletins) based on available information.

OWCP Has Established a Hearing Standard That Allows 110 Days For Claimant Notification

FECA requires that OWCP notify claimants in writing of hearing decisions "within 30 days after the hearing ends." In interpreting this provision of the act, OWCP has allowed time for certain actions to take place, such as claimant and employing agency reviews of and comment on hearing transcripts. Accordingly, in setting guidelines, the BHR director told us that the hearing record is not closed until two separate but concurrent processes are completed: (1) printing of the hearing transcript and review of the transcript by both the employee and the employee's agency, which can take from as few as 25 days to as many as 47 calendar days or more from the hearing date and (2) opportunity for the claimant to submit new evidence for 30 days following the date of the hearing, and longer if the claimant needs additional time (regulations allow the OWCP hearing representatives to use their discretion to grant a claimant a one-time extension period, which may be for up to several months).

Considering these factors, OWCP has established two goals for the timing of notifying claimants of final hearing decisions: (1) notifying 70 to 85 percent of the claimants within 85 calendar days and (2) informing 96 percent of claimants within 110 calendar days following the date of the hearing. Based upon our review of the applicable legislation, we determined that OWCP has the authority to interpret the FECA requirement for claimant notification in this manner.

Of an estimated 2,945 appealed claims for which BHR rendered a decision on a hearing during our review period, notification letters for an estimated 2,256 (77 percent) were signed by OWCP officials within 85 days of the date of the hearing and an estimated 2,716 (92 percent) of the claims were signed within 110 days of the hearing date.[5] OWCP officials signed an estimated 158 (5 percent) of the claimants' notification letters from 111 to 180 days after the hearing date and 70 claims (2 percent) from 181 days to more than 1 year after the hearing date.[6]

[5] Our analysis reflects only appeals for which necessary dates were available in the claim decision files. We estimate that the dates we used to determine the length of time required to provide decision information to a claimant were available in the decision files for 95 percent of the BHR appeals with hearings.

[6] The percentages of claim decision notifications signed within 110, 111 to 180, and 181 days or more of the hearing date do not total 100 percent due to rounding.

OWCP's Physicians Were Board Certified, Licensed, and had Specialties Consistent with the Injuries Examined

OWCP referee physicians in our sample were nearly all board certified and state licensed. We also found that OWCP's second opinion and referee physicians had specialties that were appropriate for claimant injuries examined.

Most of OWCP's Physicians were Board Certified and Have State Medical Licenses

Although neither FECA nor OWCP's procedures manuals require second-opinion physicians to be board certified, the procedures manual provides that OWCP should select physicians from a roster of "qualified" physicians and "specialists in the appropriate branch of medicine." The manual further requires that for referee physicians "the services of all available and qualified board-certified specialists will be used as far as possible." The manual allows for using a noncertified physician in special situations.

Based on our statistical sample, we estimate that at least 94 percent of OWCP's contracted second-opinion physicians and at least 99 percent of the contracted referee physicians were board certified.[7] In making these determinations, we relied primarily on information from the American Board of Medical Specialties (ABMS), the umbrella organization for the approved medical specialty boards in the United States. For the remaining 6 and 1 percent of the second-opinion and referee physicians in our sample, respectively, information we reviewed was not sufficient to determine whether they were or were not certified.

Although neither FECA nor OWCP regulations specifically require either second-opinion or referee physicians to be licensed by the state in which they practice, OWCP officials stated that OWCP has the expectation that all physicians will have valid state medical licenses. Based on our sample of physicians, we estimated that at least 96 percent of the second-opinion physicians and at least 99 percent of the referee physicians had current

[7] We were only able to search for board certification and licensing for—and consequently only included in our sample—those physicians for whom we could identify a first and last name and an area of medical specialty from the appealed claims decisions summaries. Our estimates regarding board certification and licensing cover about 63 percent of second-opinion and 85 percent of referee physicians.

state medical licenses. For the 4 and 1 percent of the remaining physicians respectively, we did not have sufficient information to determine their licensing status.

Second-Opinion and Referee Physicians had Specialties that were Relevant to Injuries Evaluated

We also estimated that 98 percent of OWCP's second-opinion and referee physicians had specialties that appeared to be relevant to the types of claimant injuries they evaluated. While there is no specific requirement related to physician specialties, OWCP officials told us that a directory is used to select referee physicians—with appropriate specialties—to examine the type of injury the claimant incurred.

For assistance in reviewing relevancy of physician specialties, we contracted with a Public Health Service (PHS) physician. With that assistance, we were able to review our sample of claimants' injuries and the board specialties of the physician(s) who evaluated them to determine if the knowledge possessed by physicians with a specific specialty would allow them to fully understand the nature and extent of the type of injury evaluated.[8]

Several Methods Are Used to Identify Customer Concerns and Potential Claimant Fraud

OWCP uses surveys of randomly selected claimants and focus groups to monitor the extent of customer satisfaction with several dimensions of the claims program, including responsiveness to telephone inquiries. Claims examiners and employing agencies are among the inspector general's (IG) primary information sources for identifying potentially fraudulent claims. When such potential fraud is detected, the IG will investigate the circumstances and, if appropriate, prosecute the claimants and others involved.

[8] We were not able to attempt to evaluate the appropriateness of the physician's specialty in comparison to the injury for some claims because the claims decisions summaries did not contain the type of injury or the physician's specialty. We estimate that the information needed to evaluate the appropriateness of the specialty was available in the appealed claims decision summaries we used for an estimated 61 percent of second-opinion physicians and 83 percent of referee physicians.

Customer Satisfaction with the Claims Process

OWCP obtains information concerning customer satisfaction with the handling of claims through surveys of claimants and conducting focus groups with employing agencies. Since 1996, OWCP has used a contractor to conduct customer satisfaction surveys via mail about once each year to determine claimants' perceptions on several aspects of the implementation of the workers' compensation program. For example, the surveys ask claimant's about their satisfaction with overall service, as well as questions about selected aspects of the program, such as whether claimants knew their rights when notified of claims decisions, and whether or not they receive written responses to claimants' inquiries in a timely manner.[9] Because the questionnaires we reviewed did not include questions specific to the appealed claims process, it was not clear whether any respondents based their responses on experiences encountered when appealing claims.

In the 2000 survey, customers indicated a 52 percent satisfaction rate with the overall workers compensation program, and a 47 percent dissatisfaction rate.[10] The level of claimant satisfaction indicated in their responses for selected aspects of the program have been largely mixed (i.e., more positive responses for some questions and more negative responses for other questions). For example, survey responses in fiscal year 1998 showed that 34 percent of the respondents were satisfied with the timeliness of responses to their written questions to OWCP concerning claims, while 63 percent were not, and 35 percent were satisfied with the promptness of benefit payments, while 26 percent were not. Based on these and previous survey results, OWCP created a committee to address several customer satisfaction issues, including determining if the timeliness of written responses could be improved.[11]

In fiscal year 2001, OWCP took two additional steps to measure customer satisfaction. First, OWCP used another contractor to conduct a telephone survey of 1,400 claimants focused on the quality of customer service

[9] The claimants were selected on a random sample basis and the surveys were conducted in 1996, 1997, 1998, and 2000.

[10]The remaining 1 percent did not provide information on overall satisfaction level.

[11]Prior GAO testimony, U.S. General Accounting Office, *Office of Workers' Compensation Programs: Goals and Monitoring Are Needed to Further Improve Customer Communications*, GAO-01-72T, (Washington D.C.: Oct. 3, 2000) addresses deficiencies in the goals OWCP set for customer satisfaction and the evaluative data collected for measuring progress in improving customer satisfaction.

provided by the district offices. As of March 25, 2002, a contractor was still evaluating the results of this survey. Second, OWCP held focus group meetings with employing agency officials in the Washington, D.C., and Cleveland, Ohio, district offices jurisdictions. An OWCP official stated that this effort provided an open forum for federal agencies to express concerns with all aspects of OWCP service. In the Washington D.C., focus group, employing agency officials expressed their belief that some of the claims approved by OWCP did not have merit, while in the Cleveland, Ohio focus group, employing agencies expressed frustration about not being informed of OWCP claims decisions.

The DOL IG Monitors Potential Claimant Fraud

The Department of Labor's IG—using information from claims examiners and other sources—monitors, investigates, and prosecutes fraudulent claims made by federal workers. The IG's office provides guidance to claims examiners for identifying and reporting claimant fraud, including descriptions of situations or "red flags" that could indicate potentially fraudulent claims. Red flags include such items as excessive prescription drug requests and indications of unreported income. DOL's *Audits and Investigations Manual* requires claims examiners and other employees to report all allegations of wrongdoing or criminal violations—including the submission of false claims by employees—to the IG's office.

Once a potentially fraudulent claim is identified, the IG will review information submitted by the claimant, coworkers, physicians, and others. If appropriate, based on this review, the IG will also conduct additional investigations. According to the Office of the Inspector General, approximately 600,000 workers' compensation claims were filed with district offices from fiscal years 1998 through 2001. During this time, the IG opened 513 investigations of claims that involved potential fraud. Of these, 212 led to indictments and 183 resulted in convictions against claimants and/or physicians.[12]

In summary, based on our sample, one out of four initial claims decisions were either reversed or remanded upon appeal because of questions about or problems with either OWCP's evaluation of medical and nonmedical evidence or improper management of claims files.

[12]A number of the cases involved more than one claimant or physician.

While OWCP monitors and disseminates some information on BHR and ECAB remands and reversals, we believe that OWCP should examine the steps it is now taking to determine whether more can be done to identify and track specific reasons for remands and reversal and in so doing better address underlying causes. OWCP comments and our related responses are detailed in our report.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to answer any questions you or other subcommittee members may have.