CITY OF PHILADELPHIA
PENNSYLVANIA

OFFICE OF THE CONTROLLER

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WORKERS' COMPENSATION PROGRAM REVIEW

MARCH 2013

City Controller
ALAN BUTKOVITZ

CITY OF PHILADELPHIA

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April 2, 2013

Rob Dubow
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The Office of the Controller commissioned and oversaw an independent review and evaluation, conducted by the accounting firm of WithumSmith+Brown, PC of Philadelphia's Workers' Compensation Program. The purpose of this review was to evaluate the city's claims management procedures and methods for minimizing the financial impact of workers' compensation claims. This review was conducted pursuant to Section 6-400 (d) of the Home Rule Charter, and the results of the independent accountant's review are summarized in the executive summary attached to this report.

We discussed the findings and recommendations with you and your staff at an exit conference, and included your written response to the independent accountant's findings in Section II of the report. Our evaluation of your response is contained in Section III of the report. We believe the recommendations in the attached report, if implemented, will improve the effectiveness and efficiency of the city's Workers' Compensation Program.

We would like to express our thanks to you and your staff for the courtesy and cooperation displayed during the conduct of our work.

Very truly yours,

ALAN BUTKOVITZ
City Controller

cc: Honorable Michael A. Nutter, Mayor
Honorable Darrell L. Clarke, President
and Honorable Members of City Council
Members of the Mayor's Cabinet

WORKERS' COMPENSATION PROGRAM REVIEW

EXECUTIVE SUMMARY

Why The Controller's Office Conducted the Examination

For the fiscal year ended June 30, 2011, the City of Philadelphia reported payments totaling $53.7 million for workers' compensation claims, and a $230.8 million liability for future claims. From fiscal years 2000 to 2011, the total cost of the city's Workers' Compensation Program increased from approximately $29 million to $54 million. To evaluate the city's claims management procedures and methods for minimizing the financial impact of workers' compensation claims, the Controller's Office commissioned and oversaw an independent review and evaluation, conducted by WithumSmith+Brown (WS+B), of the Workers' Compensation Program overseen by the Risk Management Division of the city's Finance Office.

What The Controller's Office Found

Some of the more significant conditions are listed below. We believe these conditions, and others described in the report, warrant the immediate attention of management.

- Some city employees had a history of filing multiple workers' compensation claims. WS+B observed that 386 employees had filed 11 or more claims, and 2,203 employees had filed between five to ten claims during their respective periods of employment. Four employees had two claims open simultaneously.

- In 49 of 165 open claims tested, claimants made 30 or more visits for therapy, spanning a 15 month period. Typically, a physical therapist will release a patient after three months of therapy. This excessive number of visits contributed to a 35% increase in physical therapy costs between fiscal years 2007 and 2011.

- Delays were noted in the Independent Medical Examination (IME) process which kept claims open for unnecessary lengths of time. The elapsed time between the IME request and the evaluation of the IME report appeared excessive and compromised the city's ability to return claimants to active duty.

- The city did not pursue all possible subrogation recoveries in some cases where a negligent third party was involved in an employee injury which resulted in payments of workers' compensation claims.

- Defense legal costs of $2.8 million incurred by the city during fiscal year 2011 were not properly reviewed for accuracy and appropriateness by a subcontractor charged with this responsibility.

What The Controller's Office Recommends

Risk Management should: (1) identify those employees filing multiple claims and consider enrolling them in a vocational rehabilitation program or assigning them to modified duty; (2) require case managers to communicate with treating physical therapists to determine claimants' progress so these employees can promptly return to active duty; (3) streamline its IME process to ensure the evaluations are completed within one month from the time of the request; (4) be more aggressive in its pursuit of subrogation recoveries to offset its claims costs; and (5) implement a formal approval process and detailed review of invoices and billings to determine if counsel services are reasonable, and benchmark legal costs to identify excessive fees. These and other proposed actions are more fully described in the body of the report.

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SECTION I

INDEPENDENT ACCOUNTANTS' REPORT ON APPLYING AGREED-UPON PROCEDURES

WithumSmith+Brown
A Professional Corporation
Certified Public Accountants and Consultants

City of Philadelphia's Workers' Compensation Program

Independent Accountants' Report On Applying Agreed-Upon Procedures

For the fiscal year ended June 30, 2011

City of Philadelphia's Workers' Compensation Program
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Executive Summary:

Introduction:

WithumSmith+Brown (WS+B) has been engaged by the City of Philadelphia, Office of the City Controller to perform specific agreed-upon procedures enumerated in this report, of the programmatic operations of the City of Philadelphia Workers' Compensation Program for the fiscal year ended June 30, 2011, in accordance with attestation standards established by the American Institute of Certified Public Accountants and in accordance with Generally Accepted Government Auditing Standards. WS+B was not engaged to, and did not, conduct an examination, the objective of which would be the expression of an opinion on the financial and program operations of the city's Workers' Compensation Program (including Standard Workers' Compensation, Regulation 32 and Heart & Lung Act), and accordingly did not express such an opinion.

Description of City's Workers' Compensation Program:

The Workers' Compensation Program is as follows:

- Provide city employees with the provisions for medical care, indemnity costs, and other benefits in the event of being injured while performing their duties as city employees.
- Employees are covered by one of three types of classifications: Standard Workers' Compensation, Regulation 32, or the Heart & Lung Act.
- The Program is administered by a third party administrator (TPA), CompServices, Inc., whose responsibility is to manage, track, and process payments for all claims reported.
- Costs paid out for the Program during fiscal year 2011 were $53.7 million; reserve liabilities established for future estimated costs were $230.8 million as of the fiscal year ending June 30, 2011.
- The total costs of employee disability benefits paid has been consistently increasing year over year. The total cost for the Program was approximately $29 million in fiscal year 2000; this has almost doubled to approximately $54 million in fiscal year 2011.

Overview of Conditions Found:

The City of Philadelphia Workers' Compensation Program has many programmatic issues that hinder Risk Management's ability to better manage its reserve liabilities, costs of the Program, and overall exposure. In addition, certain parties involved in the Program tend to favor over treatment of the claimant which leads to excessive costs and the increase in lost time of duty. As more fully reported upon in the body of this report, the following conditions exist as summarized:

- There is a high occurrence of claimants being over treated for their respective injuries.
- There are medical cost saving measures and subrogation opportunities which are not being pursued.
- There are several claims under the Program whereby the employee and/or the treating physicians are not being cooperative in the process of bringing the employee back to duty.
- A number of employees have an active history of receiving claims under the Program. As of the fiscal year ending June 30, 2011, there were approximately 2,500 city employees that filed five or more claims over the course of their employment with the city.
- Delays were noted in the Independent Medical Examination (IME) process which kept claims open for unnecessary lengths of time. IMEs can provide evidence for litigating a Petition for Termination of Benefits in court, however, the elapsed time between the IME request and the

evaluation of the IME report appeared excessive, and compromised the city's ability to return claimants to active duty.

- Review of the city's legal defense costs are not being performed at an acceptable standard by a subcontractor hired by CSI, Inc., the city's third-party administrator for its Workers' Compensation Program. A detailed review of invoices should be performed and the legal costs should be benchmarked to identify fees which may be excessive.

All of the conditions above cause claims to be open longer and excessive reserve liabilities recognized by the City of Philadelphia. The costs of the Program continue to rise each year.

Summary of Recommendations:

The Workers' Compensation Program management, Risk Management, and the third party administrator should take a more proactive approach to investigating, overseeing, and closing workers' compensation claims in order to reduce the costs and exposure to the Program. Management should consider all possible avenues of cost savings. Management should also explore areas of the law that could lessen outside influence and develop a more streamlined process to litigating and disposing of outstanding claims.

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Independent Accountants' Report on Applying Agreed-Upon Procedures

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We have performed the procedures enumerated in this report, which were agreed to by the City of Philadelphia, Office of the City Controller, solely to assist you in evaluating the following aspects of the City of Philadelphia Workers' Compensation Program for the fiscal year ended June 30, 2011:

- Review the program operations of the Workers' Compensation Program which includes the management of claims, oversight of the third party administrator, claims litigation, treatment practices carried out by physicians, establishment of reserves, and settlement of claims.

This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and in accordance with *Generally Accepted Government Auditing Standards* issued by the Comptroller General of the United States. The sufficiency of these procedures is solely the responsibility of the parties specified in this report. Consequently we make no representation regarding the sufficiency of the procedures described in the report, either for which this report has been requested or for any other purpose.

We were not engaged to, and did not, conduct an examination, the objective of which would be the expression of an opinion on program operations of the Workers' Compensation Program. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the City of Philadelphia, Office of the City Controller and Risk Management and is not intended to be and should not be used by anyone other than the specified parties.

WithumSmith+Brown, PC

March 20, 2013

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Program Operations Findings and Recommendations

A. Introduction:

In 1993, the City of Philadelphia created the Division of Risk Management, a division of the Office of the Director of Finance, to oversee the Workers' Compensation Program. This responsibility includes the provision of medical care, medical case management and claims management for injured city employees. These services have been contracted to a Third Party Administrator (TPA); CompServices, Inc (CSI) was the contractor from 1993 to 2002. From 2003 to mid-2007, Ward was awarded the contract, and then CSI returned from mid-2007 until now. Risk Management manages an annual budget of approximately $55 million that includes indemnity costs, medical costs, and administrative services.

We were contracted by the City Controller's Office to review the City's Workers' Compensation Program. The Workers' Compensation Program has paid out $53.7 million and $49.6 million for the fiscal years ended June 30, 2011 and 2010, respectively. In addition, reserve liabilities, totaling $230.8 million at June 30, 2011, were established for future estimated costs. Appendix A displays the overall costs of the Program broken down by benefit type and fiscal year. Since fiscal year 2003, medical costs per year have more than doubled from $9.3 million to $20.6 million in fiscal year 2011. Indemnity costs have steadily increased over the same period from $19.0 million to $28.0 million. These increases have coincided with the implementation of the Heart & Lung Act which became effective, according to Risk Management, for police in October of 2003, fire in June of 2006, and sheriff's officers in July of 2008. The Heart & Lung Act was created under P.S. 53 §637, to provide benefits to police officers, fire fighters, sheriff's officers, and other public safety officers. Those covered under Heart & Lung are awarded with 100% of their gross salary; while on disability all medical costs are covered under the Program. The purpose of the Act is to provide benefits to those uniformed officers who have suffered an injury while engaging in their duties of enforcing public safety. There is other regulatory language that covers the civil service employees within the city; this is referred to as Regulation 32. Regulation 32 deals with temporarily disabled and permanently disabled employees in the civil service. Eligible employees receive 75% of their salary while on disability and are covered for medical costs. As Appendix A depicts, the Program is becoming costly, however, the number of new claims filed during these years have not substantially increased. Appendix B shows the number of claims for each fiscal year. Appendix C shows the paid cost per accident year excluding reserves for undeveloped claims costs of $153 million.

Two of the biggest factors that have caused the significant increase in Program costs over the years are overtreatment of physical therapy and the Heart & Lung Act benefits. Physical therapy treatment has increased by approximately $1 million since fiscal year 2007, however the number of open claims over the same period have decreased. During fiscal year 2011, approximately half of the Program costs were for Heart & Lung eligible employees. The Heart & Lung Act governs the provision of work-related injury benefits to police officers, fire fighters, sheriff's officers, and other public safety officers. These uniformed employees are eligible for this privilege due to the nature of their duties of their job. The primary focus of the act was to provide better benefits to those that are more at risk than the typical desk job. The police force consists of approximately 6,600 uniformed officers and there are approximately 2,100 uniformed firefighters in the city. Our review of fiscal year 2011 records indicated there were approximately 4,000 claims on file. Of the 1,074 open claims which we sampled from, 639 derived from police and fire.

Several schedules have been prepared utilizing the third party administrator's data, CSI, Inc., and are presented in an appendix to this report. These schedules of Program statistical data, sorted in a variety of ways, will assist the reader in analyzing Program areas and cost comparatives.

B. Agreed-Upon Procedure:

In order to determine whether claims under the city's Workers' Compensation Program are being handled aggressively and costs are being minimized under the constraints of the regulations of the Program, we performed in-depth reviews of the claims on a sample basis, inquired with management level personnel, and performed analytical procedures.

We were granted read-only access to the claims management database maintained by the third-party administrator, CSI, Inc. The claims review included but was not limited to gathering initial background on the incident and any relevant facts, subrogation opportunities if a third party was involved, and evidencing support for the determination and classification of the workers' compensation claim. Our focus also covered the monitoring of medical treatment plans and costs for claims cases.

C. Program Conditions:

1. Condition:

The greatest individual concern noted during testing was the excessive utilization of physical therapy in cases. The number of visits, and inherently the costs were staggering. Appendix D displays the rising costs per fiscal year of physical therapy treatment; from fiscal year 2007 to 2011, physical therapy costs have risen 35% to $4.4 million. In 49 of the 165 open claims tested, we noted claimants making 30 or more visits to physical therapy which spanned up to 15 months beyond the date of the injury. Typically in practice, a physical therapist will release a patient after three months of therapy, however, physicians treating city claimants prescribe therapy well beyond the average three month regimen which leads to much greater costs. It also appears that continuation of physical therapy has been used as a justification by the treating physician to prolong the claimant's ability to collect benefits under the city's Workers' Compensation Program.

Recommendation:

Risk Management should insist that CSI instruct its case managers to communicate with the treating physical therapists and ordering physicians to get a better understanding of the progress the claimant is making. Also, case managers should pay closer attention to the benchmarks used in order to determine the point when therapy is potentially excessive. By obtaining feedback from the treating therapists and primary care physicians, and by benchmarking treatments, case managers can better determine instances of over-utilization.

2. Condition:

For instances whereby a negligent third party is involved with an injury, the city is subject to subrogation recoveries. Under the terms of the contract between the City of Philadelphia and CSI, CSI is "responsible for the identification and collection of subrogation…" Typically, subrogation is potentially available due to auto accidents, falls on uneven pavement of private property, or malfunctioning equipment. During testing, we noted six occurrences whereby there was a negligent third party involved, however, no action was noted for pursuing subrogation recoveries. Currently, CSI has only one individual who handles all subrogation.

Recommendation:

Risk Management should be more aggressive in pursuing subrogation for claims involving a negligent third party. Risk Management should also consider adding another individual to handle the subrogation activities.

3. Condition:

It is part of claims management protocol to input the available facts of the claim and the claimant's demographics into a calculation that provides an Estimated Length of the Disability (ELOD). Case managers use this as a benchmark for the length of time treatment is provided and the claimant is out of work. The case managers at CSI should be adhering to specific guidelines for treatment, diagnosis, and ELODs. Through discussions with Risk Management, case management documentation, at times, for these guidelines are not accurate which yield an incorrect ELOD and treatment method. In addition, physicians also give their own estimates for the treatment terms and return to duty. For a majority of these cases, it was noted that these ELODs and physicians' estimates are consistently exceeded. In extreme cases, CSI and Risk Management will review the case and make telephone contact with the physician(s) to question the treatments provided and the length of treatment. However, through discussion with CSI and Risk Management, many of these phone discussions are unproductive because the physicians do not comply with any recommendations made.

Recommendation:

Risk Management should be using current data as used by the medical field to best determine the treatment of patients. As a rule, Risk Management should work with physicians that are motivated to return workers to their jobs as soon as medically reasonable. This may require changes in panel physicians allowed to treat workers' compensation patients.

4. Condition:

It is the claimant's privilege to request and be granted a second opinion or transfer to a different physician for treatment during the course of being under the city's Workers' Compensation Program. This privilege however does provide a loophole in the Program that tends to leave cases open longer upon a discharge from the initial physician. During testing and through discussions with both CSI and Risk Management, it is not uncommon for the initial physician to discharge or release the claimant for work then the claimant requests a transfer of care or a second opinion only to find the second physician disagrees with the initial discharge and continues with treatment. There were 135 occurrences during fiscal year 2011 whereby the claimant returned to limited duty or full duty briefly, requested a transfer of care, and was subsequently downgraded to no duty or limited duty; Heart & Lung claimants constituted 132 of this population. Appendix E depicts the summarized statistics of these figures. In our opinion, this suggests that physicians tend to over-treat.

Recommendation:

We recommend that Risk Management, through CSI, be more aggressive with physicians in determining if there is an over-utilization of services.

5. Condition:

There is a major concern with the length of time cases are left open after the claimant has been discharged. By leaving claim cases open, this leaves the city susceptible to additional medical and indemnity costs and keeps the associated liabilities captured in the financial records. These are cases that do not involve litigation or any subrogation, which typically extend the case. During testing, we noted that this delay was attributable to the Supplemental Agreement. The Supplemental Agreement essentially acts as a confirmation to terminate claimant benefits and that the employee has returned to duty; the document is endorsed by the employee. There were two particular areas of concern noted:

a. CSI is not timely in sending the Supplemental Agreement to the claimant upon discharge.
b. Risk Management asserted that represented employees are hesitant to sign the Supplemental Agreement.

The presence of the above two factors causes cases to remain open for an extended two to ten month time period. Once action is deemed necessary to close the case through litigation, a Petition to Terminate Benefits or a Suspension Termination Petition is generally filed which in turn causes the city to incur legal fees. The city may incur additional legal costs if the claimant decides to litigate with an attorney, in which case the city is responsible for legal costs when representing the city.

Recommendation:

Risk Management should develop a closeout best practice that requires employees to sign an agreement terminating claimant benefits upon complete discharge from a physician. Currently there is no such requirement. Risk Management should establish a procedure to document the date of discharge and the date of the agreement and implement a guideline for transmitting the agreement timely.

6. Condition:

During testing, it was discovered that some city employees have a history of filing several claims under the Workers' Compensation Program. Subsequently, a report was generated by CSI which showed that 386 city employees have filed 11 or more workers' compensation claims and 2,203 employees have filed five to ten claims during their respective employment. There were also four claimants noted during testing that had two claims open simultaneously. Accumulating such a high number of claims raises two points:

a. Individuals who routinely get injured while on duty may not be suitable for the job and the costs incurred to cover the individual under the Program may outweigh the benefit the individual provides to the city.
b. Such claims need to be closely monitored in order to best protect the city's interest.

Recommendation:

Risk Management should identify these particular employees and consider a vocational rehabilitation program and/or modified duty. For city employees with a high rate of claims, Risk Management should remind department supervisors and department safety directors to monitor these employees for adherence to safety guidelines.

7. Condition:

CSI, with Risk Management's approval, has contracted with SCRIPNET to provide the Workers' Compensation Program with a pharmacy benefit management network access system. Benefits pertaining to prescription drugs cost the Program $2.1 million and $2.0 million in fiscal years 2011 and 2010, respectively. Management at CSI, Inc has conducted its own research whether SCRIPNET is the best and most cost effective pharmacy network venue available. Through their research, it was discovered and recommended to Risk Management that there are other vendors in the market that can provide the same services at approximately a $300,000 annual savings on prescription drugs and services as compared to SCRIPNET. CSI has also addressed a concern regarding the fee schedule SCRIPNET utilizes; their main concern is that the fee schedules are not transparent.

Recommendation:

Risk Management should explore other venues for providing the prescription drug network management service. This could potentially save the Program future costs on prescription medicine and allow for more transparency of billings.

8. Condition:

Independent Medical Examinations (IME) can be requested by the City of Philadelphia if it is believed that the claimant can in fact return to work but continues to receive workers' compensation benefits. IMEs are conducted by independent physicians who ultimately determine if the claimant is or is not capable of returning to duty. If the IME report states that the claimant is capable of returning to work, this evidence can be used as leverage for litigating a Petition for Termination of Benefits in court. Such a tool can be very useful to limit the costs for a particular claim and reduce the reserves established for the claim. During testing, we noted there was a delay between the time an IME was requested by the case manager (CSI, Inc.) and the IME actually being performed and the results evaluated. The delay prolonged the potential for filing a Petition for Termination of Benefits which in turn directly kept claims open for unnecessary lengths of time. We selected 35 IMEs requested during fiscal year 2011, and noted there was an average of 90 days from the date a case manager sent the request for an IME approval to the date CSI received the results of the IME for evaluating the IME report. Also, one particular IME process took 212 days. In four of the 35 samples, the claimant did not show up for the IME appointment.

For a civil service employee earning a salary of $50,000 who goes on disability with bi-weekly doctor's visits and two visits to physical therapy per week at $90 per visit, the total benefits provided are approximately $1,900 over a two week period. Alternatively, the cost of performing an IME is usually $1,000 or less. When claims are left open for extended periods of time, it is easy to see how costs can accumulate quickly.

Recommendation:

Risk Management should establish a timeframe or other procedure to streamline the IME process to within one month from the time of request to the receipt of the IME report. This will allow for a quicker adjudication for cases where by the claimant has recovered from such injuries.

9. Condition:

The Pennsylvania Workers' Compensation Act, Section No. 306(a.2) states that any claimant who has received 104 weeks of total disability compensation should have an Impairment Rating Evaluation (IRE) in order to determine if that particular claimant is considered permanently disabled or temporarily disabled, and to potentially limit the reserves set for the claim. An IRE is similar to an IME in that an independent doctor performs an examination on the claimant to determine the status of one's injury, a rating system is applied to determine whether the injury(s) are considered long term or not. If the results of an IRE indicate a less than 50% rating, the city may be able to change the disability from total to partial which would cap the benefits at 500 weeks. Risk Management budgets for 200 IREs to be performed annually however, our review indicates there are far beyond that number which are eligible for an IRE.

Recommendation:

Risk Management should approve a greater number of IREs in order to close outstanding claims which could ultimately decrease those reserve liabilities and costs recognized in the general fund.

10. Condition:

Per the claims manual, which acts as a guideline for case managers overseeing claims, claims adjusters are required, at a minimum, to review and re-evaluate the reserves set for the claims every 90 days. During our testing, we noted this is not occurring regularly. We read through detailed notes documented in the claims database which showed no evidence of such re-evaluations of reserves.

Recommendation:

Risk Management should comply with its claims manual by re-evaluating the claims' reserves established for each claim and noting such re-evaluations in the system for purposes of an audit trail. It may also be beneficial to utilize a standard template for the re-evaluation to be streamlined and documented more consistently.

11. Condition:

The city has developed city-wide safety standards to prevent unnecessary harm or injuries for all employee classifications. Each department also has a set of safety standards that employees are required to abide by; these safety precautions not only are in the interests of protecting the employee but also in mitigating injuries occurring at the work place. A discussion with the Director of Safety and Loss Prevention confirmed that instances do occur whereby employees are negligent in not abiding by safety standards; however, no corrective actions such as employee counseling are taken. During testing, we observed certain instances where the claimant incurred an injury that could have been prevented had the claimant been in compliance with the safety guidelines. Such occurrences include toe fractures when steel toe boots should be worn, motor vehicle accidents where a seatbelt should be worn, and back injuries from lifting when a back support brace should be worn.

Recommendation:

We strongly urge Risk Management to remind department managers to enforce progressive disciplinary actions for not following safety policy.

12. Condition:

In cases where the claimant petitions the courts because he/she believes they are not being provided with their right to benefits, the claimant will hire counsel. Under regulations governing the Workers' Compensation Program, the City of Philadelphia is responsible for the legal costs incurred to defend the claimant challenge(s). During fiscal year 2011, legal costs amounted to approximately $2.8 million within the Program. Through inquiry with management at both Risk Management and CSI, Inc, it was noted that defense legal costs are not being monitored sufficiently. As part of their operations, CSI, Inc. subcontracts the litigation review and litigation administrative services. Through discussions with personnel within Risk Management, this service in particular gave rise to concern. The responsibility of reviewing the accuracy and appropriateness of legal billings from outside counsel are an important role that has a high level of subjectivity and inherently is a large cost. Risk Management believes that the legal reviews are not being performed at an acceptable standard; Risk Management also believes that case adjusters working on behalf of CSI do not have the skill set necessary to properly perform such tasks.

Recommendation:

Risk Management should implement a process for monitoring city defense counsel fees. There should be an approval process and a detailed review of invoices and billings to determine if the counsel services are reasonable. There should also be a method to benchmark the costs to determine excessive fees. Risk Management should request to renegotiate its contracting services for litigation reviews.

13. Condition:

CSI manages and administers a master database that allows storage of documents, adjuster notes, case information, doctor visits, benefit payments and claimant history. The adjuster accumulates information for each case which is referenced when making decisions and tracking the overall status of the case. During our testing of claims, it was noted that documentation is not well organized and does not provide a proper summary of any given case at any given time. This lack of organization makes it difficult to present the best evidence when petitioning to the courts for termination of benefits. In addition to the documentation issues, there was also a concern with completeness of the files. Through conversation with personnel from Risk Management, claims notes should include an ELOD which provides an estimate of the recovery time for the particular injury given specific circumstances. However Risk Management has stated that not all claims documentation include an ELOD. Typically these ELODs are to be performed by the first or second physician visit in order to establish an initial reserve, strategy for treatment, etc.

Recommendation:

Risk Management should stress to its staff the importance of thorough and organized documentation. Risk Management should consider conducting documentation audits to ensure such standards are being followed.

14. Condition:

Through claims testing, it was observed that there was a disparity among a few of the claims as to what specialists diagnosed compared to what the panel providers diagnosed. It was common, especially among Heart & Lung providers, to find that a specialist would release a claimant for duty however the panel providers denied the release and continued to treat the patient. In our opinion, a specialist would have better knowledge about a certain incident versus a panel provider. Risk Management agreed with this rationale however stated that it is the general belief of the courts that the panel providers know the patient, the city's Workers' Compensation Program, and the general job requirements of the claimant's employment and therefore have a stronger influence as to whether claimants are suitable to return to work.

Recommendation:

Risk Management should continue to look into this disparity and discuss such cases. Risk Management should focus on these cases and make recommendations for surveillance when necessary.

15. Condition:

Under the city's Workers' Compensation Program, claimants are not treated for past injuries or injuries that do not occur while performing their duties. During the initial documentation process of a claim, it is the adjuster's responsibility to research any available medical history that may provide a correlation to the claimed injury. The adjuster can use past medical history to make a determination as to whether the claimant should be treated under the Program or not. In many cases, CSI adjusters are at a disadvantage because of HIPPA standards when a claimant is typically treated by physicians out of network; in these instances, adjusters do not have access to any previous records. Through discussion with Risk Management, it was noted that HIPPA is proactively used to hide medical history among Heart and Lung claimants. Further, it was noted that Risk Management must subpoena past medical records. Obtaining subpoenas for past medical records is a time consuming process and leads to incurring legal costs. If medical records could be obtained voluntarily, this would save time and legal costs.

Recommendation:

As part of the initial documentation process, adjusters should request claimants to sign-off on authority to obtain medical history from outside providers. This approval should also be considered by the City of Philadelphia upon the filing of a claim by an employee.

16. Condition:

There is a 21 day window for CSI, Inc. to determine whether or not a claim will be accepted or denied once received. In many cases, there is not enough information provided to CSI in order to best determine if the claim should be accepted or not. There is a Temporary Notice of Compensation Payable provision available to CSI for these situations, however, through discussion with Risk Management the extension provision is not utilized enough. Instead, CSI is accepting to manage the case.

Recommendation:

Risk Management should stress the importance of properly and accurately documenting the initial stages of a claim and remind adjusters that a 21 day provision exists under the Temporary Notice of Compensation Payable. This provision still requires the city to respond in 21 days, but by allowing more time to make a determination, Risk Management can gather more information on a case to potentially avoid instances that should not be accepted under the Program.

17. Condition:

Monitoring of radiological studies needs to occur to prevent excessive long term costs. We noted that there were many occasions where initial radiological studies that demonstrated no clear indication of injury were followed up by MRIs. What is problematic is that MRIs tend to be used to document injuries that clearly cannot be defined by a clear treatment path (such as joint injuries and back pain) which leaves a wide berth or treatment options and opportunities for abuse. In some instances, we saw repeated MRIs being ordered for claimants less than 4-6 weeks after the initial MRI. Medical literature demonstrates that repeated MRIs within this period, with the exception of sudden onset of neuropathy or excessive pain, are unwarranted and are of no or limited value.

Recommendation:

Risk Management's medical director, in concert with CSI, should carefully monitor all requests for high end diagnostic radiology tests in the future to prevent both unnecessary treatments and excessive costs.

D. Other Matters:

During inquiries with management from Risk Management and CSI, Inc. there was a repeated need to settle a number of cases. However, due to the city's troubled financial condition in recent years, there were not adequate funds to settle these cases. Settling cases has a future benefit because the present value costs of the settlement are less than the potential future costs to the Program for continuing to compensate and treat a particular claimant. By settling cases, this removes the reserves, closes the claim, and has a determinable cost associated. It was also noted through discussions that there needs to be better efforts to find alternative employment for those claimants that are suitable for employment but may not meet the requirements for their previous employment position.

Recommendation:

The City of Philadelphia's Finance Office should consider the issuance of floating bonds in order to fund the settlement of cases.

We also researched the relationship between the fitness levels of uniformed employees (fire fighters, police officers, etc.) and the associated health costs, including claims under the city's Workers' Compensation Program. Risk Management discussed the levels of physical fitness among the uniformed employees such as police and fire. Risk Management has been attempting to incorporate a fitness program in each of the contract negotiations with the public safety departments but continues to get declined due to a lack of funding to institute the programs and because the unions refuse to include such programs in the negotiation process. Two leading academic institutions performed studies to measure the effectiveness of incorporating health programs into their fire fighter and police departments and included studies to support their positions. The studies recognized the critical importance that fire fighters and police officers provide to the communities they serve and that their wellness and fitness level had a direct correlation to their performance of duties while on the job. In addition, fire fighters and police officers place not only themselves at a great risk, but also their fellow emergency responders because of poor physical conditioning. One obesity study suggested that controlling one's weight would eliminate between 28 and 48 percent of hypertension. Another two-year study conducted by the University of the Pacific found that lost time from work-related injuries to firefighters dropped 477 percent following the full implementation of a wellness program for an undisclosed fire department. A study conducted by the Oregon Health & Science University performed roughly ten years ago included developing a health promotion program which yielded approximately a $1,500 annual savings per fire fighter in health benefit costs. The most important step in improving uniformed employees' health is the implementation of wellness and fitness initiatives. Both articles focused on the fire fighter occupation however the physical nature of both police officers and fire fighters are similar so the idea of health initiatives among police departments is just as imperative.

Recommendation:

Based on the results of such studies, the City of Philadelphia should consider implementing a trial health program among police officers and fire fighters. We foresee the results will be beneficial.

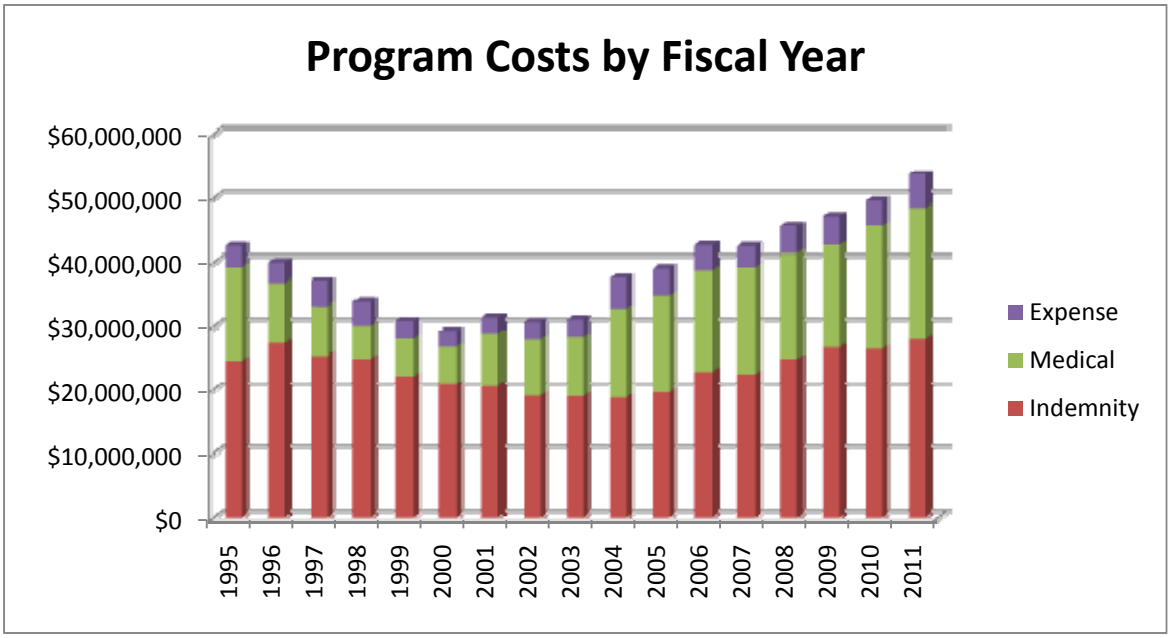
Another matter that has direct effect on the ability to assess whether an injured worker can return to work is an evaluation of body mass data. While similar to the foregoing discussion of fitness and the overall improvement of employee disability claims, this problem focuses on establishment of reserves and treatment protocols. It is well documented that early recognition of claimants obesity can help to mitigate related health conditions which, in turn, helps to achieve early return to work for the employee. Nationally one in three US adults is unfit, yet claims adjusters seldom ask claimants about height and weight during claims intake. To ascertain whether this was the case in the city, we randomly chose 15 claimants' records for review; of those 15 claimants, only four (26%) had height and weight included in their records. Of the four claimants that had data, one was of regular weight, one was overweight and two were unfit. There are also long term implications of overweight/unfit workers that are beyond return to work consideration including:

- Four fold increase in developing diabetes
- Two fold increase in developing coronary artery disease (CAD)
- Two fold increase in developing high blood pressure and/or having a stroke

Recommendation:

Based on the preceding information, we suggest that Risk Management insist that all providers fill out first report of injury documents to include claimant height and weight. By filling out the forms correctly, case managers and nurses at CSI will be in a better position to evaluate treatments suggested for the patient and establish more accurate reserves as set by CSI. It may also have the benefit of designing treatments for patients that have a higher likelihood for success based upon their health status.

Appendix A

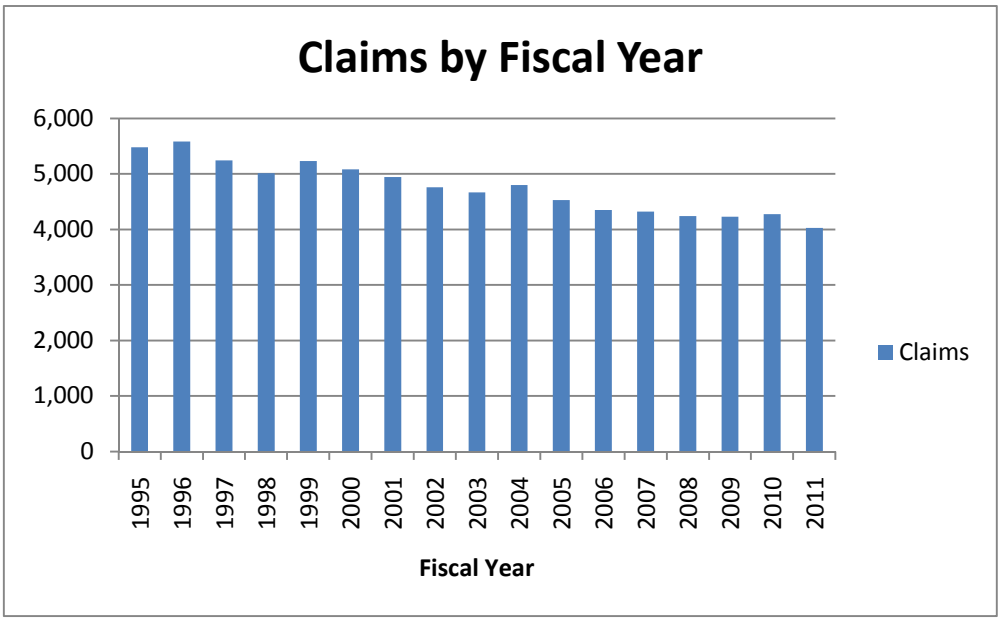


Fiscal Year	Benefit Type			
	Indemnity	Medical	Expense[1]	Total Benefits Paid
1995	$24,604,718	$14,755,488	$3,214,576	**$42,574,782**
1996	$27,353,289	$9,314,067	$3,454,816	**$40,122,172**
1997	$25,433,189	$7,756,816	$3,920,342	**$37,110,347**
1998	$24,927,375	$5,193,717	$3,652,221	**$33,773,313**
1999	$22,098,605	$5,941,632	$2,809,333	**$30,849,570**
2000	$20,942,465	$5,794,623	$2,531,248	**$29,268,336**
2001	$20,656,690	$8,220,734	$2,558,869	**$31,436,293**
2002	$19,052,876	$8,870,881	$2,797,270	**$30,721,027**
2003	$18,992,633	$9,278,776	$2,846,282	**$31,117,691**
2004	$18,776,768	$14,083,974	$4,808,661	**$37,669,403**
2005	$19,630,943	$15,085,746	$4,435,323	**$39,152,012**
2006	$22,844,638	$16,006,243	$3,813,103	**$42,663,984**
2007	$22,451,805	$16,874,057	$3,219,411	**$42,545,273**
2008	$24,951,230	$16,515,595	$4,250,028	**$45,716,853**
2009	$26,627,292	$16,115,616	$4,586,143	**$47,329,051**
2010	$26,404,879	$19,349,380	$3,873,449	**$49,627,708**
2011	$27,969,286	$20,642,271	$5,105,130	**$53,716,687**

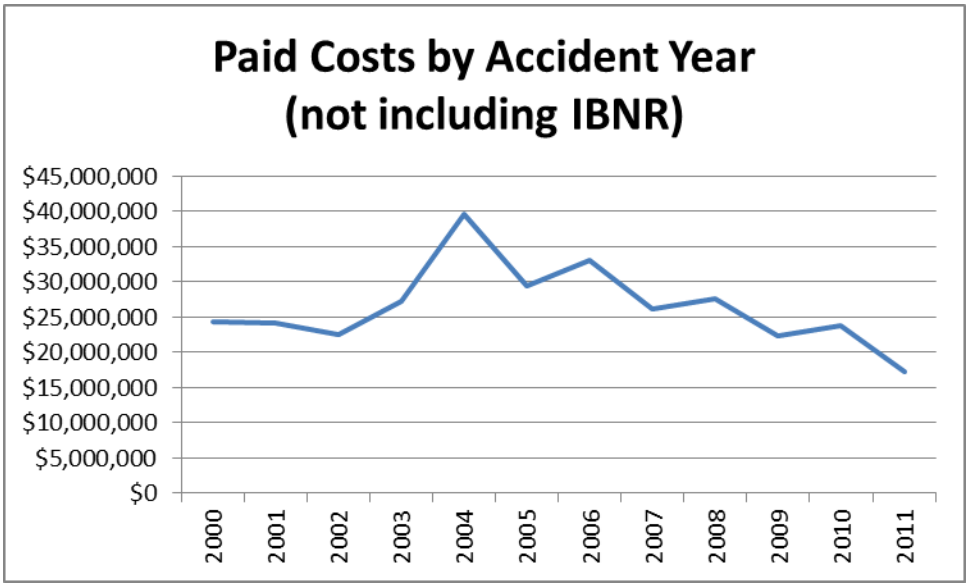
[1]Expenses includes legal fees, court fees, surveillance, and independent health evaluations.

These schedules were prepared from data provided by CompServices, Inc.
The periods of data reported in each appendix vary due to unavailable data.

Appendix B

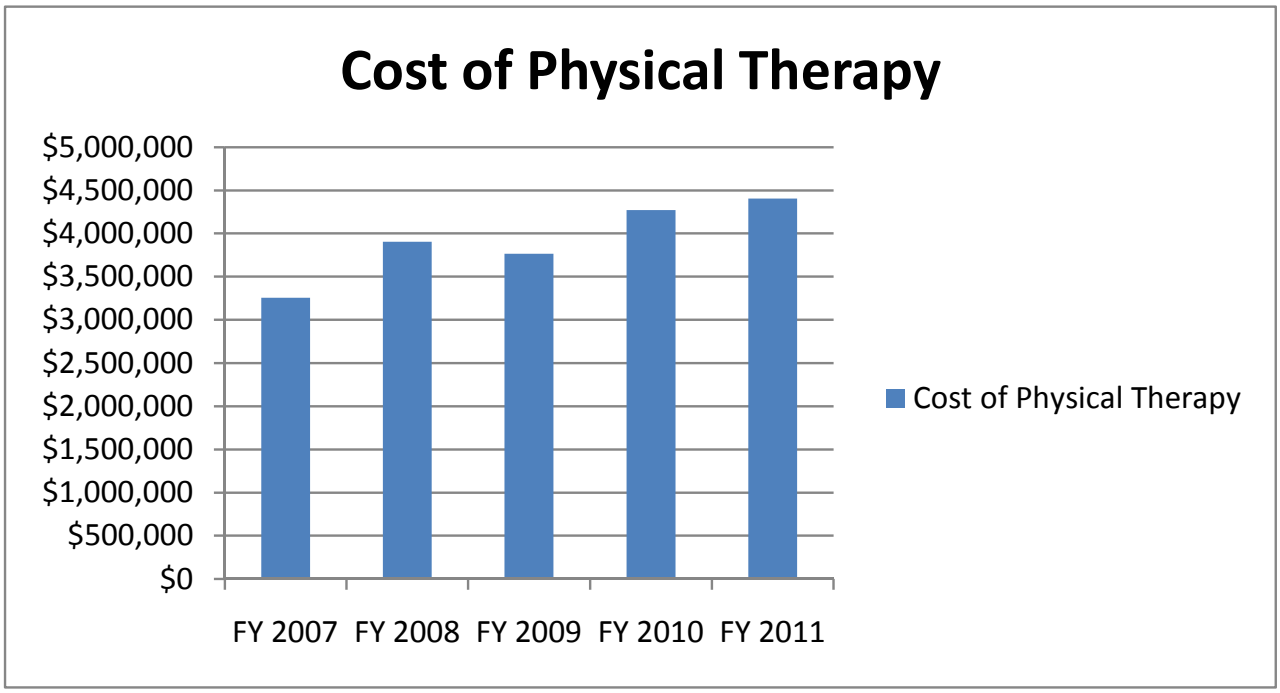


Appendix C



These schedules were prepared from data provided by CompServices, Inc.

Appendix D



These schedules were prepared from data provided by CompServices, Inc.

Appendix E

Workers' Compensation Type	Case Transferred to Doctor	Downgrade of Duty	Upgrade of Duty	No change in duty status	Total Transfer of Care Cases
Heart & Lung					
	A	1	0	2	3
	B	21	6	68	95
	C	8	1	25	34
	D	54	17	163	234
	E	0	1	1	2
	F	2	1	2	5
	G	2	2	10	14
	H	38	9	110	157
	I	6	6	24	36
	Heart & Lung Subtotal	132	43	405	580
Regulation 32					
	J	2	4	5	11
	K	0	0	5	5
	L	1	5	3	9
	M	0	0	0	0
	N	0	2	4	6
	O	0	0	0	0
	P	0	0	1	1
	Q	0	0	1	1
	Regulation 32 Subtotal	3	11	19	33
	Total	135	54	424	613

These schedules were prepared from data provided by CompServices, Inc.

SECTION II

MANAGEMENT'S RESPONSE

CITY OF PHILADELPHIA

OFFICE OF THE DIRECTOR OF FINANCE
1401 John F. Kennedy Blvd.
Room 1330, Municipal Services Bldg.
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(215) 686-6140
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ROB DUBOW
Director of Finance

April 2, 2013

The Honorable Alan Butkovitz
City Controller
1230 Municipal Services Building
Philadelphia, PA 19102

Re: City of Philadelphia Workers' Compensation Program – Independent Review
And Evaluation Conducted by the Accounting Firm WithumSmith & Brown, PC

Dear Mr. Butkovitz:

Thank you for the opportunity to review and discuss the contents of your draft report related to the City's Employee Disability Programs managed by the Finance Department's Office of Risk Management. We appreciate the efforts of your consultant, WithumSmith + Brown, and the opportunity to work cooperatively with your staff as we progressed through this review.

Prior to responding specifically to the individual conditions and recommendations noted in your report, I would like to offer some information regarding the various components of the City's employee disability programs, in particular the Pennsylvania Heart and Lung program; the rising costs associated with the program; and then respond to the overall themes that your consultant identified as concerns.

The City's Employee Disability Program includes three benefit types: Pennsylvania Workers Compensation ("WC"), the City's Civil Service Regulation 32 program ("Reg 32" – a benefit in-lieu-of workers compensation), and the Pennsylvania Heart and Lung Act ("H&L"). Each of these benefit types is governed by different regulations/laws and they have very different standards and parameters. Throughout the report, the term workers compensation is often used, and the findings do not always distinguish between the different employee benefit types noted above. In many cases, we believe that the conclusions drawn do not necessarily relate to the City's overall employee disability programs, but rather to the H & L claims experience, and we have noted that in the attached detailed response and in the information below.

The Pennsylvania Heart and Lung Program

The H & L program is based on legislation adopted in 1935, and was established (and subsequently revised) to provide benefits to injured police officers, firefighters, and other public safety officers. This benefit provides for an employer to pay medical costs and 100% of an injured employee's salary during their disability. It is a separate benefit from WC and operates under a different set of rules. The Pennsylvania Bureau of Workers Compensation manages the administration of workers compensation benefits (wage replacement and medical care for injured workers). There is no similar agency to manage the administration of H&L benefits. There are WC regulations that provide for adjudication of disputes and provide protections for employers from the impact of those who try to manipulate the system to fraudulently obtain benefits, but the H&L act provides none of these protections.

Without an oversight agency that regulates the benefit, towns, counties and municipal governments must try to interpret the 1935 H & L act as best they can. Different processes are used for adjudication of claims across the state and case law has produced a fragmented set of rules for the benefit. Over the years, this case law has also widened the applicability of the H&L benefit to cover additional workers, conditions and exposures. Because of the lack of controls and supports for the public entities covered by this law, this program easily disrupts many of the structures that the City has put in place to provide quality medical care while managing costs.

Many of the conditions and recommendations in your report relate almost exclusively to the impact of H&L.

We appreciate that your report acknowledges the many challenges that H&L presents to the City, as we have continually struggled with these challenges. Risk Management is happy to engage with the Controller's Office and others to address inequities and inefficiencies in the current structure.

Costs of the City's Employee Disability Programs

The report indicates that the cost of the City's employee disability program has increased from $49.6M in 2010 to $53.7M in 2011. Additionally, medical costs more than doubled from $9.3M in 2003 to $20.6M in fiscal year 2011, with indemnity costs rising from $19M in 2003 to $28M in 2011.

A large part of this increase is due to the rising costs of wages mandated by the state and the increase in allowable medical charges by providers. The Pennsylvania Statewide Average Weekly Wage that the City is required to pay to injured workers for 2003 was $675.04 and in 2011 it was $858.32, a 27.2% increase. Additionally, the Pa Bureau of Workers Compensation has also increased providers' allowable medical fee charges by more than 3.2% annually since 2003. Therefore, much of this overall increase is imposed by regulation and inflation.

However, we agree with the conclusion stated throughout your report that "these increases have coincided with the implementation of the Heart & Lung Act which became effective, according to Risk Management, for police in October of 2003, fire in June of 2006, and sheriff's officers in July of 2008" (Introduction). Also as noted in your report, during fiscal year 2011, over half of the program costs were for H & L eligible employees. Again, this further supports the conclusion that much of the rising costs are due to the high cost of the H&L program. In fact, while comprising only 45 percent of the claims receiving physical therapy, police claims account for more than half of the costs, further evidencing the high cost of this program that the City has limited ability to control.

Overtreatment and Uncooperative Physicians

Your report indicated that "there is a high occurrence of claimants being over treated for their respective injuries" and that there is "excessive utilization of physical therapy." The report also states that physicians are not cooperative with Risk Management in promptly returning employees to work.

Reg 32 has controls that specifically limit over treatment. Regarding WC, the only way for the City to stop treatment prescribed by the injury doctor, if we feel the doctor is over treating, is to file a Utilization Review (UR). In the event of a successful UR, only continued on-going treatment is curtailed. However, the excessive treatment must first be provided before the employer is permitted to stop payment for future treatment, somewhat limiting the cost savings associated with this action. Even though the H&L Act includes no such "appeal" provision and it is very unusual for an employer to file URs related to treatment by their own panel doctors, we have filed UR appeals to the Pennsylvania Bureau of Workers Compensation for treatment in H&L cases.

Most physicians and employees in the program are cooperative and seek a timely return to work. However, we agree there is a potential for overtreatment with regard to the H&L program. We continue to work aggressively with therapists and the prescribing physician to limit treatment to that which is medically necessary, but they do not always comply. Your recommendation that we change to physicians motivated to return employees to work would not produce the desired result. The physicians in this program are selected by the union and are frequently contacted, and possibly influenced, by the union about the care provided. Any replacement physicians would be selected by the unions as well.

In all cases, representatives of the City's Third Party Administrator work diligently with physicians to ensure that employees are afforded the proper care and to ensure timely return to duty as appropriate based on the employee's medical condition.

Multiple injuries

Your report indicates that city employees have a history of filing multiple claims and that Risk Management should consider enrolling employees in vocational rehab or assigning them to modified duty. You further state in your report that "costs incurred to cover the individual . . . may outweigh the benefit the individual provides to the city," and that "such claims should be closely monitored in order to best protect the city's interest."

We do not agree that multiple claims by an individual employee necessarily suggest the need for vocational rehab or limited duty assignments. Workers who experience a high number of injuries are generally in hazardous jobs (refuse collectors, police, correctional officers, etc.) where multiple opportunities for injury present themselves daily. Most of the injuries these workers experience can include minor injuries, such as cuts, scrapes, bruises, and involve only one-time or short-term medical treatment and little or no lost time. Additionally, limited or modified duty jobs are already provided by departments to transition our injured workers from no duty status to greater physical activity and ability when they cannot perform the full active duties of their job. Our current program allows workers to productively return to their jobs, therefore not needing vocational rehab. The provision of permanent modified duty in many of these cases would be inappropriate and would greatly diminish the City's ability to provide cost-effective services to taxpayers. We agree that claims should be closely

monitored, and Risk Management will continue its current practice of closely monitoring all workers compensation claims, including those related to employees with multiple injuries.

Independent Medical Examinations (IME)

Independent Medical Examinations (IME) can be requested by the City if it is believed that a claimant can return to work but continues to receive workers' compensation benefits. IMEs are conducted by independent physicians who determine if the claimant is capable of returning to duty. Your report indicated that the elapsed time between the IME request and the evaluation of the report appeared excessive and compromised the City's ability to return claimants to duty. You recommended that we establish a timeline of one month from request to completion.

We believe that one month is a very aggressive time line for completion of all IMEs. The most significant variables in the process of obtaining an IME report are obtaining an appointment with the desired specialist and the time after the examination while the specialist is preparing and forwarding their report. These items are out of the City's control and dominate the IME timeline. Additionally, it should be noted that claimants recognize that the IME is a tool to assist in limiting their benefits, and they may delay the process. Missed appointments are common and the City must get an order from a judge to compel the IME. This delays the ultimate receipt of the report. The City will continue to review our process for IME assignment to ensure that every action to minimize the IME process timeframe is being employed.

Subrogation

Your report indicated that subrogation opportunities are not being pursued.

All adjusters at CSI are trained to identify subrogation opportunities in their caseloads. These opportunities are forwarded to one adjuster/subrogation specialist who takes responsibility for following through on the prosecution of these recoveries. In the last four years, the City has received an average of more than $1 million annually from subrogation recoveries under this program. Additionally, we have increased the value of this subrogation recovery by negotiating the elimination of the fees charged by the TPA for this service. Finally, it should be noted that of the six cases where the auditor indicated that subrogation action was not pursued, half of them actually had no opportunity for subrogation (either City was at fault or for other reasons). A more detailed explanation is included in the attached.

Legal Fee Review

Your report stated that defense legal costs of $2.8 million were not properly reviewed for accuracy and appropriateness by the City's TPA.

It is the responsibility of CSI and their subcontractor to review legal bills for accuracy and reasonableness. To assist in this process, Risk Management has instituted Outside Counsel Guidelines which provide billing guidelines and identify services for which the City will or won't pay. These guidelines were established to ensure the best quality service for the taxpayer dollar. In addition, Risk Management has instituted a two tiered process for legal bill review by both the claims adjuster and the litigation specialist. Risk Management counsel, the litigation specialist contracted to CSI, and others have provided training to claims adjusters to improve legal fee review skills. We believe that this

education and the two tiered process has improved the legal bill review process. The City will continue to monitor and improve, wherever possible, the management of the City's legal defense costs

Overall, we believe that Risk Management is, in many cases, already performing the recommended actions aimed at managing a cost effective and efficient employee disability program. We will continue to monitor the program and adjust, as necessary, to improve the outcome for injured City workers and the City's taxpayers.

As previously noted, a more detailed response to each of the specific conditions and recommendations in your report is attached.

Thank you for the observations provided in your report and for the opportunity to respond. We look forward to continued cooperation with your office.

Sincerely,

Rob Dubow
Finance Director

cc: Fiona Greig
Joan Markman
Gerald Micciulla
Catherine Paster
Rebecca Rhynhart
Alan Ricchezza
Barry Scott

City of Philadelphia Workers' Compensation Program - Independent Review And Evaluation
Conducted by the Accounting Firm WithumSmith & Brown, PC

Office of the Director of Finance - Risk Management Response
April 2, 2013

Section C. Program Conditions

1. *Condition and Recommendation 1 - The report indicated that "The greatest individual concern noted during testing was the excessive utilization of physical therapy. The number of visits, and inherently the costs were staggering." You noted that physical therapy costs increased 35 percent from 2010 to 2011. You recommended that Risk Management insist that CSI instruct its case managers to communicate with the treating physical therapists and ordering physicians to get a better understanding of the progress the claimant is making. Also, case managers should pay closer attention to the benchmarks used in order to determine the point when therapy is potentially excessive.*

   Response: The City's contracted third-party administrator, Comp Services Inc. (CSI) provides claims adjusters to handle administrative tasks related to a claim as well as nurse case managers (NCM) who review medical treatment, coordinate and communicate with physicians and the treating therapists, arrange appointments and many other tasks for the duration of treatment. Since the beginning of the program, these NCMs have taken responsibility for communicating and coordinating with practitioners who treat our workers. The NCMs work as advocates for these workers in the medical care related to their injury. Also, they work daily with physical therapists and doctors to assure that appropriate treatment is timely and appropriately provided. They benchmark treatment and disability duration through the use of nationally relied upon occupational medicine and disability guidelines. Supported by CSI's and the City's medical directors, they discuss the care provided and, to the extent allowable under law, provide direction and information, as well as concerns and constraints. We will continue to have the NCMs provide this valuable service. We will also utilize their feedback to direct our legal interventions to challenge what we see as inappropriate treatment.

   Under Pennsylvania workers compensation rules, if a physician prescribes treatment, the employer must pay for that treatment, even if the employer considers the treatment to be excessive. In such cases, the recourse is to "appeal" to the Bureau of Workers Compensation for a determination of whether the prescribed treatment was reasonable and necessary. However, Pennsylvania law does not give us any option to stop what we believe is overutilization (or to stop paying for same) without review and written approval from the Bureau of Workers Compensation. Such approval is given only after the treatment is provided.

   The H&L program provides for no controls on the doctor's prescription of treatment. In fact, Police claims receiving physical therapy are only 45% of claims receiving physical therapy on average. However they account for 54% of the total physical therapy spend for the Employee Disability program primarily because of over treatment prescribed under the H&L program. We believe the 35 percent increase in costs that you reference is attributable to over-treatment in the H&L program.

   Additionally, we believe that two different issues are conflated in this finding which lead to your conclusion of "excessive utilization" of physical therapy. Those issues are uncontrollable treatment

under H&L and the City's preference for treatments with good long term outcomes. First, the providers under the H&L program have refused to follow established national standards and norms despite repeated interventions by the City. This continued overtreatment reflects, in part, a lack of experience with occupational injuries and a resistance to the established guidelines and practices of the industry. We see this being the significant driver as the physical therapy payments for Police (the predominant user of the H&L benefit) dwarf the payments for the rest of the City combined.

Second, we generally rely on physical therapy and other non-surgical treatments to heal our employees as they generally provide a better outcome for the worker and the City. When we are unsuccessful in getting a resolution with physical therapy, the next course in many instances is surgical intervention. The injured worker then needs a period of physical therapy post-operatively to recuperate and prepare to return to the workplace. This pattern of physical therapy, then surgery, then more physical therapy frequently produces a long period of physical therapy that may be considered excessive, but is consistent with the Medical Guidelines of the American College of Occupational and Environmental Medicine.

Finally, in the Executive Summary of your report, you reference a typical three month period for therapy after which point a therapist will release the patient. We disagree that there is a "typical" plan for physical therapy. The treatment pattern varies with the type of injury, body part, other injuries or medical conditions of the patient, as well as other factors. In addition, despite a therapist's recommendation, the physician can continue to prescribe further physical therapy.

2. <u>Condition and Recommendation 2</u> *As your report describes, in instances where a negligent third party is involved with an injury, the City is subject to subrogation recoveries. CSI is "responsible for the identification and collection of subrogation..." and has one individual responsible for subrogation activities. You report that during testing, you noted six occurrences where there was a negligent third party involved, but no action noted for pursuing subrogation recoveries. You recommended that Risk Management be more aggressive in pursuing subrogation for claims involving a negligent third party and that they consider adding another individual to handle the subrogation activities.*

   Response: All adjusters at CSI are trained to identify subrogation possibilities and pursue them. One adjuster takes responsibility for following through on these recoveries. Subrogation recoveries have doubled from FY2000 to FY2011, and in the last four years, the City has averaged more than $1 million annually from subrogation recoveries. Our review of the six files you identified as not addressing subrogation opportunities revealed that one claim involved a motor vehicle accident (MVA) with another City vehicle, therefore leading to no subrogation opportunity; another involved an MVA with a stolen auto leading to no subrogation opportunity; and a third involved a MVA where the City vehicle caused the crash, also leading to no subrogation opportunity.

3. <u>Condition and Recommendation 3.</u> *As your report explained, the claims management protocol involves inputting available facts of the claim and the claimant's demographics into a calculation that provides an Estimated Length of Disability (ELOD). You indicated that at times, case management documentation for these guidelines is not accurate, yielding an incorrect ELOD and treatment method. Additionally, physicians give their own estimates for the treatment plan and return to duty. In these cases, the ELOD (and physician's estimate) is often exceeded. You recommend that Risk Management use current data used by the medical field to best determine the treatment of patients and that they work with physicians that are motivated to return workers to their jobs as soon as medically reasonable. Your further state that this may require changes in panel physicians allowed to treat workers' compensation patients.*

Response: CSI does use current data to estimated ELODs. They use the most current versions of the Return to Work Guidelines (2013 Official Disability Guidelines, 18th edition) and information received from doctors in determining the ELOD. In most cases, the determination of the ELOD is reliably carried out. Non-compliance and unreasonably extended disability is only found in any significant amount for treatment provided under the H&L program/physicians. On average, similar injuries treated under H&L incur an additional $4,330 in medical costs and result in more than 192 additional days of disability than injuries treated under the Reg 32 system. We agree with your concern about the physicians treating under the H&L panel, who are selected by the union. These physicians are not as attentive to established guidelines and recommendations of the occupational medical field or direction from CSI's NCMs or medical directors. The City's Reg 32 panel of providers is reviewed at least twice annually and those not performing well are changed. Changing H&L panel physicians would not be expected to change the influence from union pressure to keep employees on disability.

4. Condition and Recommendation 4. *During testing and through discussions with both CSI and Risk Management, you advised that you determined it is not uncommon for an initial physician to discharge or release a claimant for work and then for the claimant to request a transfer of care or a second opinion, only to find the second physician disagrees with the initial discharge and continues treatment. You cited 135 occurrences during fiscal year 2011 where the claimant returned to limited duty or full duty briefly, requested a transfer of care, and was subsequently downgraded to no duty or limited duty; Heart & Lung claimants constituted 132 of this population. Your report states that this suggests that physicians tend to over-treat. You recommended that Risk Management, through CSI, be more aggressive with physicians in determining if there is an over-utilization of services.*

   Response: We believe that providing employees a second opinion helps to give them confidence that the program has their best interest at heart in their care and treatment. Additionally, transfers of care and second opinions are a right guaranteed by regulation or by labor contract. Some claimants seek downgraded duty status by using the transfer of care practice. It is mostly claimants treating under the H&L who use this benefit to shop for a downgraded duty status by pursuing transfers of care to select H&L practitioners. The testing of your consultant confirms that this is almost exclusively an H&L panel issue (132 of 135 cases were H&L).

   The work done by CSI's claims adjuster and NCMs to determine if there is over-treatment and to address same was described in the response to condition No. 1. Additionally, over-utilization has been a monthly topic of discussion, including the presentation of individual physician data, at the Panel Physician's meetings with the City's Medical Director. However, and also as explained in response to condition No 1, it is important to note that in cases where we identify over-utilization, we are not able to stop it with the tools available under current law.

5. Condition and Recommendation 5. *Your report cited a concern with the length of time cases are left open after the claimant has been discharged, leaving the city susceptible to additional medical and indemnity costs and keeping associated liabilities captured in the city's financial records. You indicated that this delay was attributable to Supplemental Agreements not being executed when claimants are discharged from treatment. You further explain that the Supplemental Agreement acts as a confirmation to terminate claimant benefits and confirms that the employee has returned to duty, and that the document is endorsed by the employee. You mentioned your two areas of concern being that CSI is not timely in sending the Supplemental Agreement to the claimant upon discharge, and that represented employees are hesitant to sign the Supplemental Agreement because of union influences. Because of this, cases are remaining open for an extended two to*

ten month time period. When it is necessary to close the case through litigation, the city incurs legal fees. You recommend that Risk Management develop a closeout best practice that requires employees to sign an agreement terminating claimant benefits upon complete discharge from a physician, establish a procedure to document the date of discharge and the date of the agreement, and implement a guideline for transmitting the agreement timely.

Response: The report refers to the Supplemental Agreement utility and rules relating to its usage in a manner inconsistent with current Pennsylvania law. Perhaps there is some confusion about the Supplemental Agreement and another Bureau of Workers Compensation (BWC) tool under section 413(c), the form LIBC-751. When timely submitted to the Bureau of Workers Comp, the LIBC-751, unilaterally serves to close the claim. We currently seek to get an agreement signed but we cannot compel a claimant to sign away their rights under workers' compensation law. However, Risk Management agrees that claims should be closed as expeditiously as possible after treatment is complete, and will review claims file closing practices to institute a process which consistently manages the claim to the best advantage of the City.

6. <u>Condition and Recommendation 6.</u> *Based on a report provided by CSI, you found 386 city employees who have filed 11 or more workers' compensation claims, 2,203 employees who have filed five to ten claims during their respective employment and four claimants that had two claims open simultaneously. You state that accumulating such a high number of claims indicates that "a. individuals who routinely get injured while on duty may not be suitable for the job and the costs incurred to cover the individual under the Program may outweigh the benefit the individual provides to the city and b. such claims need to be closely monitored in order to best protect the city's interest." You recommend that Risk Management identify these particular employees and consider a vocational rehabilitation program and/or modified duty. Further, you recommend that for city employees with a high rate of claims, Risk Management should remind department supervisors and department safety directors to monitor these employees for adherence to safety guidelines.*

Response: We do not agree that multiple claims by an individual employee necessarily suggest the need for vocational rehab or limited duty assignments. Workers who experience a high number of injuries are generally in hazardous jobs (refuse collectors, police, correctional officers, etc.) where multiple opportunities for injury present themselves daily. Jobs in local government are among the most disability producing vocations in the country. As the Bureau of Labor Statistics noted in a Nov 8, 2012 report "Police officers had an incidence rate of 659.4 lost day injuries per 10,000 full-time workers that was five times greater than for all occupations." While frequency of injury is thought to be associated with increased severity, scientific evidence to document the relationship has produced mixed results. Many of the second or third injuries only involve medical treatment and there are no lost wages or days away from work. Additionally, many of the injuries workers experience that are counted in these totals can include minor injuries, such as cuts, scrapes, bruises, and involve only one-time or short-term medical treatment and little or no lost time. Risk Management will continue its current practice of closely monitoring all workers compensation claims, including those related to employees with multiple injuries.

The proposed solution of the use of vocational rehabilitation is confusing. Vocational rehabilitation can be defined as the physical restoration of the worker's health and the vocational restoration to minimize wage loss. Limited or modified duty jobs are already provided by departments to transition our injured workers from no duty status to greater physical activity and ability when they cannot perform the full active duties of their job. Our current program allows workers to productively return to their jobs, therefore not needing vocational rehab. The provision of

permanent modified duty in many of these cases would be inappropriate and would greatly diminish the City's ability to provide cost-effective services to taxpayers.

Departmental safety officers are continually reminded to reinforce safety precautions for workers to limit the number of first-time and repeat injuries.

7. Condition and Recommendation 7. *Your report indicates that there may be other vendors who can provide prescription drug benefits for a lesser cost than those of the current provider, SCRIPNET. You recommend that Risk Management explore other venues for providing the prescription drug network management service, potentially saving the Program future costs.*

   Response: Risk has explored prescription benefit programs including the one providing services to CSI, and has decided for reasons of market availability, market appropriateness and customer service to maintain the current relationship with ScripNet. As part of that activity, we were able to negotiate a significant discount on the fees charged by ScripNet.

8. Condition and Recommendation 8. *Independent Medical Examinations (IME) can be requested by the City if it is believed that a claimant can return to work but continues to receive workers' compensation benefits. IMEs are conducted by independent physicians who determine if the claimant is capable of returning to duty. Your report indicated that the elapsed time between the IME request by CSI, the IME being performed, and the evaluation of the report by CSI appeared excessive and compromised the City's ability to return claimants to duty. The delay prolonged the potential for filing a Petition for Termination of Benefits which in turn directly kept claims open for unnecessary lengths of time. For 35 IMEs requested during fiscal year 2011, you noted that there was an average of 90 days from the date a case manager sent the request for an IME approval to the date CSI received the results of the IME for evaluating the report. You also noted that in 4 of the 35 cases, the claimant did not show up for the IME appointment. You recommended that we establish a timeline of one month from request of IME to receipt of an IME report.*

   Response: We believe that one month is a very aggressive time line for completion of all IMEs. The most significant variables in the process of obtaining an IME report are obtaining an appointment with the desired specialist and the time after the examination while the specialist is preparing and forwarding their report. These items, which dominate the IME timeline, are not within the City's control. Additionally, it should be noted that claimants recognize that the IME is a tool to assist in limiting their benefits, and they may delay the process. Missed appointments are common and the City must get an order from a judge to compel an IME. This delays the ultimate receipt of the report. The City will continue to review our process for IME assignment to ensure that every possible action is being taken to minimize the IME process time frame.

9. Condition and Recommendation 9. *Your report indicated that Risk Management budgets for 200 Impairment Rating Evaluations (IRE) to be performed annually, but your review found that there are many more that are eligible for an IRE. You recommended that Risk Management approve a greater number of IREs in order to close outstanding claims that could ultimately decrease reserve liabilities and costs recognized in the general fund.*

   Response: Since 2008, Risk Management has been more aggressive in obtaining IREs for qualifying injured workers. To resolve the backlog while controlling costs, Risk budgeted to do about 200 IREs per year. By the end of fiscal year 2011, Risk Management had successfully worked through the backlog of cases that had become eligible for IREs between 1996 and 2008. Currently, there is no specific limit on the number of IREs that will be approved for any year. However, it should be noted

that since catching up in 2011, in any given year, there have not been more than approximately 200 files that have matured to the 104 week mark that makes them eligible for an IRE. If there were more than that, IREs would be performed for all of them. Risk Management will continue to pursue IREs to limit the duration of liability for long term workers compensation claims.

10. Condition and Recommendation 10. *Risk Management should comply with their claims manual by re-evaluating every 90 days the claims' reserves established for each claim and noting such re-evaluations in the system for purposes of an audit trail.*

    Response: CSI has a claims manual that directs their claims adjusters and nurse case managers on how to handle the legal/administrative and medical components of all claims, including how to calculate the appropriate reserves. Although it may have been difficult for the auditor to locate the reserves worksheets electronically, there is documentation of any reserve change in the physical (paper) claim file. We will continue to work with our TPA to ensure that the electronic case file is documented completely as well.

11. Condition and Recommendation 11. *You referenced a discussion with the Director of Safety and Loss Prevention confirming that instances do occur in cases where employees have not abided by safety standards and no corrective actions, such as employee counseling, are taken. You reported that you observed certain instances where the claimant incurred an injury that could have been prevented had the claimant been in compliance with the safety guidelines. You recommend that Risk Management remind department managers to enforce progressive disciplinary actions for not following safety policy.*

    Response: There are various ways to mitigate potential for injuries/illnesses in the workplace and enforcement of safety standards & policies is only one. There are more protective controls such as eliminating the hazard, substituting for a less hazardous material or process, instituting engineering solutions to control the hazard, setting administrative controls or changing work practices to lower the risk of exposure, and providing personal protective apparel against the hazard. Those controls paired with effective enforcement help to mitigate injuries/illnesses. Good enforcement of safety & health standards includes continual education, refresher or remedial training, proper supervision & timely feedback, and follow-up discussions about correction of deficient actions or risky behaviors. Disciplinary actions lastly may be needed as part of enforcement to further prevent recurrence of willful negligence/disregard of safety standards/policies, if the other means are not successful. Risk Management works with all departments to develop, implement and maintain safety & health programs to better protect employees, thereby reducing hazards that may pose risk of injury or illness. Risk Management will continue to remind departments to develop, implement and maintain safety rules and enforcement programs and to educate their employees in these areas.

12. Condition and Recommendation 12. *You recommended that Risk Management implement a process for monitoring city defense counsel fees. There should be an approval process and a detailed review of invoices and billings to determine if the counsel services are reasonable. There should also be a method to benchmark the costs to determine excessive fees. Risk Management should request to renegotiate its contracting services for litigation reviews.*

    Response: It is the responsibility of CSI and their subcontractor to review legal bills for accuracy and reasonableness. To assist in this process, Risk Management has Outside Counsel Guidelines which provide billing guidelines and identify services for which the City will or won't pay. These guidelines were established to ensure the best quality service for the taxpayer dollar. In addition, Risk Management has instituted a two tiered process for legal bill review by both the claims adjuster and

the litigation specialist. Risk Management's counsel, the litigation specialist contracted to CSI, and others have provided training to claims adjusters to improve legal fee review skill. We believe that this education and the two tiered process has improved the legal bill review process. The City will continue to monitor and improve, wherever possible, the management of the City's legal defense costs.

13. Condition and Recommendation 13. *Your report indicated that CSI's documentation was not well organized and did not provide proper summaries of all cases at any given time, including lacking a calculated Estimated Length of Disability (ELOD) for each case. You recommended that Risk Management stress the importance of thorough and organized documentation and consider conducting documentation audits to ensure such standards are being followed.*

    Response: We agree that cases should be well documented, and Risk Management will continue to stress the importance of thorough and organized documentation to our third party administrator.

14. Condition and Recommendation 14. *Your report stated that there was a disparity among a few of the claims as to what specialists diagnosed compared to what the panel providers diagnosed. And, among H & L providers, it was common to find that a specialist would release a claimant for duty, but the panel providers would deny the release and continue to treat. You recommended that Risk Management continue to look into this disparity and discuss such cases, and that Risk Management make recommendations for surveillance when necessary.*

    Response: Again, this is a situation that only occurs in treatment provided by our H&L panel providers. Risk Management will continue to review these unusual cases, and will continue to recommend surveillance as necessary. Currently, Risk Management is averaging more than 200 surveillances annually.

15. Condition and Recommendation 15. *Your report accurately explains that claimants are not treated for past injuries or injuries that do not occur while performing their duties and that adjusters are responsible to research any available medical history that may provide a correlation to the claimed injury. You further state that, due to HIPPA standards, CSI adjusters are at a disadvantage when a claimant is treated by physicians out of network because in these instances, adjusters do not have access to any previous records. Further, you report that "through discussion with Risk Management, it was noted that HIPPA is proactively used to hide medical history among Heart and Lung claimants" and that past medical records must be subpoenaed by Risk Management. You recommended that adjusters should request claimants to sign off on authority to obtain medical history from outside providers.*

    Response: Actually, HIPAA standards are greatly relaxed in the workers compensation arena because of the medico-legal nature of the matters. CSI currently requires workers to complete medical releases at the time of the establishment of the claim. Workers do try to hide the names of their doctors but the City does have the medical releases to obtain records.

16. Condition and Recommendation 16. *The report states that CSI is not utilizing often enough the Temporary Notice of Compensation Payable provision, which would allow them additional time to determine if a claim should be accepted when they do not have enough information to make a determination. Instead, CSI is accepting the cases. You recommend that Risk Management stress the importance of properly and accurately documenting the initial stages of a claim and remind adjusters that a 90 day provision exists under the Temporary Notice of Compensation Payable that allows more time to make a determination of whether to accept a case.*

Response: Risk Management/CSI does use the Temporary Notice of Compensation Payable Provision to allow additional time for investigation of suspicious or complex claims. We will continue to stress to CSI the importance of using this tool to provide for more involved investigations on complex claims.

17. *Condition and Recommendation 17. You indicate that your review found many occasions where initial radiological studies that demonstrated no clear indication of injury were followed up by MRIs. Your report states that MRIs tend to be used to document injuries that clearly cannot be defined by a clear treatment path (such as joint injuries and back pain) which leaves a wide berth or treatment options and opportunities for abuse. In some instances, you found repeated MRIs being ordered for claimants less than 4-6 weeks after the initial MRI. Medical literature demonstrates that repeated MRIs within this period, with the exception of sudden onset of neuropathy or excessive pain, are unwarranted and are of no or limited value. You recommend that Risk Management's medical director, in concert with CSI, carefully monitor all requests for high end diagnostic radiology tests in the future to prevent both unnecessary treatments and excessive costs.*

Response: Again, we believe this situation relates solely to treatment provided by H&L providers. It is very common for these providers to prescribe frequent, expensive, and in some instances, unhelpful procedures. This has not been a problem with our Reg 32 panel. Under Pennsylvania WC regulations and H&L, there is nothing that the employer can do to stop workers from receiving treatment directed by a medical provider. Risk Management will continue to monitor requests for high end diagnostic imaging. Risk's medical director and CSI will continue to make every effort to limit this costly practice by H&L providers.

Section D. Other Matters

1. *You recommend that Finance Office should consider the issuance of floating bonds in order to fund the settlement of cases.*

   Response: The recommended course of action has significant implications for the City's debt load and the City is not in a position to issue additional debt for this purpose. As an alternative, Risk Management has been judiciously using current funds to settle appropriate cases. We have reduced our case load by more than 100 cases by pursuing this course over the last two fiscal years.

2. *You reported on studies showing the relationship between increased fitness levels of uniformed employees and an associated decrease in health benefit costs, including claims under the City's employee disability programs. You recommend that the City consider implementing a trial health program among police officers and fire fighters.*

   Response: We appreciate the information you have provided and are in agreement with this recommendation. In fact, while the City cannot unilaterally implement any such program, we have been engaged in a lengthy discussion of this type of program with the firefighters union. It will continue to be a topic in this year's labor arbitration.

3. *Your review found several cases where height and weight were not recorded and recommends that Risk Management insist that all providers fill out first report of injury documents to include claimant height and weight. You indicate that this information will better position case*

managers and nurses at CSI to evaluate treatments suggested for the patient and establish more accurate reserves. It may also have the benefit of designing treatments for patients that have a higher likelihood for success based upon their health status.

Response: While you may have found some cases where this information was missing, it is CSI's policy to obtain this information on the first patient visit at the treatment sites. CSI adjusters and NCMs use this information to tailor treatments for the best outcomes. CSI will continue to do this.

SECTION III

CONTROLLER'S OFFICE EVALUATION OF MANAGEMENT'S RESPONSE

We have evaluated management's response to the Agreed-Upon Procedures Report prepared by the independent accounting firm of WithumSmith+Brown, PC (WS+B). We disagree with some of management's comments because they are in conflict with the findings and recommendations made in the report. Our evaluations of management's comments are presented in the order of their response. Management's responses have been correlated to the condition numbers in the WS+B report. Where we disagree with management, we have provided reasons for our disagreements.

Management's Response (Condition 1)

In response to WS+B's comment suggesting excessive utilization of physical therapy, city management stated that under Pennsylvania workers' compensation rules, the employer must pay for that treatment, even if the employer considers the treatment excessive. Furthermore, Pennsylvania law does not provide an option to stop what the city believes is over-utilization of physical therapy without written approval from the Bureau of Workers' Compensation (BWC). Finally, management noted that under the Heart and Lung Act (H&L), there are no controls on the doctor's prescription of treatment, and H&L providers have refused to follow established national standards and norms.

City Controller's Office Evaluation

We stand by WS+B's finding that physical therapy is being over-utilized. WS+B's discussions with Risk Management and CSI personnel during its review did not disclose that BWC approval was necessary to halt an employee's physical therapy. City management should obtain BWC approval to stop physical therapy in all cases where it appears that it has been over-prescribed. In addition, we recommend that management instruct its lobbyists to seek changes to existing state legislation, including the H&L Act, to modify the rules and deter the over-utilization of physical therapy.

Management's Response (Condition 2)

City management disagrees with WS+B's finding that for six claims involving a third party, no action was noted for pursuing subrogation recoveries. Management states, "Our review of the six files you identified as not addressing subrogation opportunities revealed that one claim involved a motor vehicle accident (MVA) with another City vehicle, therefore leading to no subrogation opportunity; another involved an MVA with a stolen auto leading to no subrogation opportunity; and a third involved a MVA where the City vehicle caused the crash, also leading to no subrogation opportunity."

City Controller's Office Evaluation

We stand by WS+B's finding as stated in the report. Management's claim that subrogation recoveries were not possible in three of the six cases may be correct. However, at the time WS+B audit staff conducted their testing, they did not find any

information in those six files indicating that Risk Management or CSI had reviewed the claims and determined that subrogation recoveries were not possible in these cases due to the circumstances described in management's response.

When CSI evaluates claims for subrogation opportunities, it should notate the results of the evaluation in the applicable case files. Doing so would effectively document that such an evaluation was performed, the conclusions reached, and the amount of the recovery, if any. Without this documentation, it is possible that subrogation opportunities may go overlooked.

Management's Response (Condition 4)

Management took issue with WS+B's comment that physicians tend to over-treat employees based upon its finding that 135 employees who returned to duty requested a transfer of care and were subsequently downgraded to no duty or limited duty. In its response management stated, "It is mostly claimants treating under the H&L who use this benefit to shop for a downgraded duty status by pursuing transfers of care to select H&L practitioners."

City Controller's Office Evaluation

As indicated in our evaluation of management's response to Condition 1, management should seek to have sections of the existing law changed to make it more favorable and cost-effective for the city. We again suggest that city management instruct its lobbyists to seek changes in the existing state legislation that would no longer permit employees "to shop for a downgraded duty status" under the H&L.

Management's Response (Condition 5)

Management's response stated that there may have been "some confusion" about the Supplemental Agreement and another Bureau of Workers' Compensation tool under section 413(c), the LIBC-751.

City Controller's Office Evaluation

Discussions WS+B held with CSI, the city's third party administrator, confirmed that the form CSI uses to close claims is, in fact, the Supplemental Agreement and not the LIBC-751.

Management's Response (Condition 8)

Management contends that WS+B's recommendation to establish a timeline of one month from the request of an IME to the receipt of an IME report is "very aggressive" and does not reflect the fact that claimants may intentionally delay the IME process.

City Controller's Office Evaluation

The small number of IMEs performed annually as cited by WS+B is not a condition unique to this report. We have previously commented on the low number of IMEs completed in our Reports on Internal Control for the fiscal year 2010 and 2011 audits of the city's Comprehensive Annual Financial Report.

It appears the timeline currently employed is not resulting in an increased number of IMEs. If Risk Management is serious about appreciably increasing the number of IMEs performed annually, it must decrease the allotted time. We stand by WS+B's recommendation that the timeline be shortened to one month.