Milliman

Disability Management Claims Operational Review and Program Evaluation:

The City of Portland Bureau of Fire and Police Disability and Retirement Fund

FINAL REPORT

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I. BACKGROUND

A. Bureau of Fire and Police Disability and Retirement

The City of Portland, Oregon's Bureau of Fire and Police Disability and Retirement (FPDR) provides disability, death, and retirement benefits to the sworn employees of the Portland Fire and Rescue and the Portland Police Bureau and their survivors as determined under Chapter 5 of the Charter of the City of Portland.

The FPDR underwent significant changes in the administration and claims handling process for disability claims as a result of the 2006 Charter reforms. The reforms established the FPDR as a separate entity, administered by a qualified disability expert. The FPDR administrators determine claim compensability and independent hearing officers or panels determine claim appeals.

FPDR retained Milliman to perform an independent evaluation of its current disability management practices including: recommending improvements to its management practices; recommending potential cost saving process improvements; designing an internal benchmarking program to measure future performance; evaluating the disability benefits; comparing the disability benefits to similar public safety officers programs; and comparing our results to prior audits. Milliman performed the review in summer and fall of 2014. The work included an on-site component consisting of reviewing documents, extensive interviewing, and reviewing a sample of claim files.

B. Milliman's Expertise

The Milliman's claims professionals who preformed this evaluation have more than 150 years of experience reviewing and analyzing disability claims under a wide range of statutory or voluntary programs in all U.S. jurisdictions. Police and fire program claims have frequently been part of Milliman's claims work either as part of an engagement with municipal entities or their insurer, or as part of larger groups of claims from large insurers or reinsurers. Milliman consultants have participated in working groups revising workers' compensation (WC) statutes in which considerations of the effects of the revisions on police and fire claims were a significant part of the revision process. Milliman has wide-ranging experience with the specific issues of police and fire disability compensation and how those issues have been addressed in a wide variety of programs nationwide.

II. EXECUTIVE SUMMARY

Below are Milliman's high-level summaries of key findings.

- 93% of the claims we reviewed met or exceeded industry standards

- FPDR claim handling is significantly above industry standards and approaches or exceeds best practices in all key claim-handling activities. Areas of claims handling strength include:
    - Initial handling – FPDR is achieving three-point contact very quickly post injury, in many cases within the same day of injury report. The claim staff poses and obtains detailed responses to questions on the cause of injury, treatment course, prior injury history, etc.
    - Investigation – FPDR is actively gathering necessary and detailed information to make compensability determinations.
    - Medical management – FPDR is very thorough in evaluating treatment plans, prior injuries, injury mechanics, and work restrictions. The claim staff is thorough in the evaluation of injury history, injury mechanics, and treatment needs. Communication is maintained with the treating doctor and member with appropriate treatment questions, with any unresolved questions referred to an independent medical examiner (IME).
    - Return to work efforts – FPDR is communicating well with the member, treating doctor, and appropriate Bureau liaison regarding return to work efforts, in almost all cases sooner than industry standards.

- The FPDR is operating at or exceeding best practices levels, handling claims significantly better than normal industry levels for police and fire claims while providing appropriate level of service and benefits to the members. There are however, as would be expected in any disability program some improvements that can be made to the FPDR, including:
    - A detailed training program for the claim handlers, to ensure continued future claim handling consistency
    - Automated management reports to evaluate the program, measure performance, track the success of initiatives, and support the Bureau's risk management needs. We have identify three key, system created management reports for FPDR to implement that are in line with WC industry best practice claim reports:
        - Loss Run Report
        - Pending Claims Report
        - Total Benefits Paid Report

- There continues to be improvement to the FPDR claims management processes and handling since the 2006 reforms to the FPDR and Marsh's initial evaluation of the impact of the reforms on the FPDR's claims management. We didn't note any areas of

decline since Marsh's last review in 2009 and the two areas (three point contact and litigation management) that Marsh indicated were still in need of improvement appear to have significantly improved and are now in line with best practices.

- FPDR does not set case reserves for claims, which is atypical for police and fire programs in the industry. However, there is no financial reporting reason for FPDR to begin setting case reserves for claims. Moreover, we do not recommend that case reserving be introduced at this time, because it could create unintended consequences by creating situations in which the perceived financial value of certain claims could lead to claim handling decisions that are different from the currently successful practices. Should a future financial reporting or other requirement to produce case reserves arise care should be taken to ensure that it does not cause any unintended changes to the currently successful claims handling process.

III. DETAILED FINDINGS AND RECOMMENDATIONS

This section of the report will provide details of our observations, findings, and recommendations.

A. Program Overview

1. FPDR Key Reform Changes

The FPDR underwent significant changes when the 2006 reforms to Chapter 5 of the Charter of the City of Portland, Oregon became effective January 1, 2007. These reform changes have impacted how the FPDR handles disability claims. The major changes from these reforms that impacted FPDR's disability claims management included:

- FPDR was established as a separate entity in 2007
- The FPDR Board size was reduced from 11 to five people
- The FPDR Board no longer decides applications for benefits, however the Board was granted the power to prescribe rules and regulations for administration of Chapter 5
- FPDR is now administrated by a qualified disability expert
- Disability claim approvals are now determined by the FPDR administrator
- Claim appeals are now determined by independent hearing officers and panels
- FPDR is now authorized to recover medical costs in addition to time loss costs from third parties
- Post-retirement medical expenses are now covered for treatment related to accepted service-connected injuries for members who retire on or after January 1, 2007

More recently, in 2012, an Amendment to Chapter 5 of the Charter granted the FPDR the ability to settle claims. Also, in 2013 interim benefits were introduced, allowing for payment of benefits while the claim is being evaluated. However, if the claim is later denied and becomes final the member would be required to repay the benefits received. The ability to later recoup interim benefits on denied claims is unique to this program when compared to programs that fall under WC regulations.

2. Organizational Structure

The FPDR disability management claim department that administers the service and non-service disability benefits includes: a claims manager, two senior analysts, two claims analysts, one claim tech, one assistant claim tech, and two bureau liaisons. A senior analyst is designated to a specific Bureau to handle the complex service, occupational, and non-service disability claims. The claim analyst is responsible for handling the less complex medical only claims and is also responsible for some administrative functions for lost time claims. The claim tech and assistant claim tech provide the remaining administrative support functions for the claim department. The liaisons help facilitate communication between the FPDR, bureau, and member. Generally, the current claim staffing model is adequate and the claims are being handled in a consistent manner.

We have outlined the workflow, workloads, supervision, and recommendations for the organizational structure below:

a. Workflow

When a Disability in the Line of Duty Report (DILD) is received by the FPDR, the assistant claim tech reviews and sets up an electronic and paper claim file. The assistant claim tech upon receipt of the DILD initiates three-point contacts; requests the WC index and Insurance Services Office, Inc. report; sends the appropriate pending claim letter to the member and doctor if information is available; and gives the new claim to the claims manager, typically on the same date the DILD is received.

Once the claims manager receives the claim file and reviews the information, the claim is assigned to the appropriate claim handler (senior analyst or analyst) based on the complexity and bureau involved in the claim.

The claim handler is responsible for claims administration including: investigations, taking statements, compensability determinations, medical management, disability management, return to work efforts, vocational rehabilitation coordination, and disability payment authorizations.

When a claim is approved, the claim tech initiates medical bill reviews, applies fee standard reductions, prints and mails checks, and provides customer service functions for medical bill payments.

Based on our review the workflow process is operating efficiently with the appropriate claim handler receiving the claim in a timely fashion, often on the same day of report.

b. Workloads

The current FPDR claim staff is adequate to handle the disability claims in an effective and efficient manner. Claim handler workloads average approximately 85 open claims (this includes pended, approved, denied, monthly, and post-retirement medical claims). Appropriate workload levels depend not only upon the number of open claims, but also on the allocation by claim type. Claim handlers with many active, complex claims should have a lower workload than claim handlers with a larger proportion of relatively simple claims. The workloads for the senior analysts range from 70-110 open claims and the analysts range from 76-88 open claims. We noted in the workload reports from January 2014 through July 2014 that the senior analyst for the Fire Bureau is consistently handling over 100 open claims. This number is too high in our opinion and a reduction to approximately 80-85 complex claims should be considered. The movement of less complex claims to an analyst should be considered for this senior analyst. We noted claims in our claim file review that have effectively resolved except for certain mechanical processes or are less complex in nature that could be shifted to an analyst and used as a training opportunity to groom the employee for a senior analyst position in the future.

c. Supervision

The four claim handlers report to one claim manager who is their stated supervisor. These supervisory spans of control meet industry standards. We also noted that the claim manager is the designated handler for five claims. In the industry, the supervisor typically does not directly handle claims. The role of the supervisor should include mentor, data expert, trainer, claim file auditor, procedure compliance monitor, and performance evaluator.

d. Recommendations

- The Claim Manager should not be the designated handler of a claim file. We recommend active claim handling functions for open claims be assigned to a senior analyst or analyst if appropriate.

- The open claim count for one senior analyst is consistently too high. We recommend that claims that are non-complex in nature be assigned to an analyst when possible. The claim reassignment can be used as a training tool for the analysts, increasing their knowledge while preparing them to handle more complex claims. Claims for possible reassignment include:
    - Claims where the lost time component has resolved and the medical treatment has reached a maintenance status
    - Standard non-service injury claims

3. Transitional Duty Return to Work Program

The FPDR Transitional Duty Return to Work Program was designed to assist Members by providing incentives for the Police and Fire Bureaus to provide transitional duty work for Members who are temporarily disabled due to an injury or illness.

The FPDR, bureaus and liaisons work collaboratively to provide a safe manner for the member to return to work within their medical restrictions. Highlights of this program include:

- A member performing limited transitional duty will receive their regular rate of pay for any hours worked. If they are able to work a full shift, there will be no wage loss. If they work less than their full shift, a disability benefit will be payable in accordance with Chapter 5 of the City Charter and the FPDR Administrative Rules.

- The transitional duty assignment is for a maximum 180 days and is monitored by FPDR staff and the bureau liaison to help maintain the member's continued recovery.

- The Director may provide a wage subsidy not to exceed 75% of the member's wage for a specified number of days, not to exceed 180 days, approved for the transitional duty assignment.

Currently there are no automated metrics in place to determine if this program is successful. However, we feel that the Transitional Duty Return to Work Program has been successful and that it is exceeding best practices when the FPDR is compared to other such programs nationwide, achieving almost 100% success in returning the member to full duty work with their respective bureau in the files we reviewed. Ongoing measurements should be made periodically to evaluate the success of the program going forward. The comparisons should also be broken out by injury type and work capacity to determine if the program is more successful or needs modifications in a particular area.

B. Disability Benefit Comparison

1. Current Benefit Structure

For FPDR Two and Three members who are eligible for service connected or occupational disability benefits, the benefits are as follows:

- In the first year from the date of disability the member shall be paid 75% of the member's rate of base pay in effect at disability, reduced by 50% of any wages earned in other employment during the period the benefit is payable.

- After the first year and prior to the fourth anniversary of the date of disability the member shall continue to be paid the benefit as in the first year until the earliest date on which the member is both medically stationary and capable of substantial gainful activity (SGA).

- On the fourth anniversary of date of disability, if not medically stationary sooner, the member shall be deemed medically stationary for purposes of benefits, regardless of the status of the member's medical condition and benefits are as follows:
  - If the member is incapable of SGA, the benefit will remain at 75% of the member's rate of base pay in effect at disability.
  - If the member is capable of SGA, the benefit shall be 50% of the member's rate of base pay in effect at disability, reduced by 25% of any wages earned in other employment during the same period.

- The minimum benefit shall be 25% of the member's rate of base pay in effect at disability, regardless of the amount of wages earned in other employment.

- The member shall not receive benefits for time periods incarcerated subsequent to and for the conviction of a crime. However, the member's benefit shall be payable to their spouse, if not incarcerated, or the member's minor children, in the amount of one-half of such benefit, during such periods of incarceration.

For FPDR Two and Three members who are eligible for non-service connected disability benefits, the benefits are as follows:

- The benefit shall be 50% of the member's base pay in effect at disability, reduced by 50% of any wages the member earns in other employment during the period the benefit is payable. The FPDR Director may reduce, suspend or terminate the benefit if the member does not cooperate in treatment of the disability or in vocational rehabilitation or does not pursue other employment.

- The member shall not receive benefits for time periods incarcerated subsequent to and for the conviction of a crime.

2. Benefit Comparison to Similar Programs

The FPDR disability program is unique in the sense that it offers traditional disability benefits for non-work related injuries and benefits for work related injuries under the same program. The FPDR does not fall under WC statutory, regulatory or case law provisions like other public safety officer programs and therefore work related and non work related claims can be handled under the same program. Other public safety worker programs fall under statutory WC provisions so benefits for work related injuries are typically paid under the state mandated WC requirements. To our knowledge, few if any other public safety worker programs that rely on

WC statutes for work related injuries cover non-occupational accidents under the same program as their occupational benefit program. In this way the coordinated occupational / non-occupational benefits that are offered by the FPDR to FPDR members are largely unique except for a small number of very large public safety programs for cities much larger than Portland. Public safety worker programs typically cover non-occupational benefits under a separate disability benefit program, if any such coverage is provided. When such disability programs are operated separately issues of the relationship of work related vs non-work related injuries have been historically troublesome.

The benefits FPDR members receive for work related disabilities differ from other public safety officer programs that fall under the statutory WC regulations, but the benefit structure appears equitable and comparable to what other public safety workers receive under a traditional WC system. A comparison of the current work related disability benefit structure to the WC structure is outlined in the table below:

Benefit Type	*Workers' Compensation*	*FPDR*	*Key Differences*
Temporary Total	Typically 66 2/3% of AWW	75% of Base Pay	Specific WC benefits may be subject to COLA increases, while FPDR Benefits are subject to COLA and "Base Pay" increases
Temporary Partial	Typically 66 2/3% of AWW offset by earnings	75% of Base Pay offset up to 50% of earnings	FPDR has 25% min rate
Permanent Total	Varies but often no less than temporary rate	75% of Base Pay	WC often pays a set amount or lifetime award as long as unable to RTW; benefits can stop if able to RTW; award is often paid unless actually able to RTW
Permanent Partial	Varies but often less than temporary rate	75% or 50% of Base Pay subject to other wage offsets	Regardless of RTW an award or benefits often paid out in WC
Non-Occupational Injury	NA	50% of Base Pay subject to other earning offsets	WC programs don't cover non-occupational injuries

Further details about the nature of the different benefit types are outlined below:

a. Temporary Disabilities

- Under the typical WC system if a person has a work related injury or illness the person is paid a rate of 66 2/3% of their average weekly wage for benefits subject to a statutory minimum or maximum rate for a given accident year until they are able to return to work or reach maximum medical improvement (MMI). In the WC industry these benefits are referred to as temporary total disability (TTD) benefits, unless the injured worker is able to work partial hours or another job, then temporary partial benefits (TPD) are paid by offsetting post injury earnings with pre-injury earnings. Note that if the injured member is able to earn at pre-injury levels or greater then no wage replacement is paid. The weekly compensation rate paid is typically a static weekly rate based on the individuals' AWW at the time of injury, with the exception of some states that require cost of living adjustments to the benefit rate as required under state regulations.

- An FPDR member receives 75% of their base pay until they are able to return to work or MMI. This benefit is similar to the TTD benefits in WC. If the member is able to work other employment outside the bureau, the disability benefit is offset by up to 50% of wages earned. This benefit is similar to TPD benefits in WC. The members receive a minimum benefit of 25% of the member's rate of base pay in effect at disability, regardless of the amount of wages earned in other employment if they are unable to return to work at the bureau. However, if the member is able to work a full shift in a transitional duty position at the bureau, the member receives full pay from their respective bureau.

b. Permanent Disabilities

- Under the WC system if the injured person is able to work other employment or has reached MMI and is unable to return to work at his/her pre-injury job then temporary benefits cease and permanent impairment benefits may begin. Permanent benefits typically pay an injured worker a set amount in a lump sum or for a specified benefit amount over time based on the impairment rating, age of injured party, earning capacity, and other statutory WC requirements. These benefits can be for a limited number of weeks, until retirement age, or for the injured person's remaining life expectancy.

- If an FPDR member is unable to return to employment at the respective Bureau then permanent disability benefits are paid until the person reaches retirement age. The amount of the benefit paid is a maximum of 75% or 50% if member is capable of substantial gainful activity (SGA) and subject to a minimum of 25% of the base pay of the member at the time of injury. The minimum FPDR benefit is unique – disability benefits available to police and fire personnel through WC statutes generally pay benefits for the duration of the disability providing ongoing incentives for the member to

remain on compensation for long periods of time. The stepped reduction in FPDR benefits provides substantial incentives for the member to return to work or seek other employment beyond the police or fire job.

c. Other Similar Programs

- Based on our experience and research there are very few, if any, police and fire disability programs with all of the post-2006 FPDR law change provisions. Generally programs, which use the WC statutes, do not have the job search requirements of the FPDR program or if job searches are present in the statute (NY and PA are states with job searches included in the WC statutes) they are very difficult to administer and frequently fail to resolve claims. In NY, a jurisdiction in which Milliman has extensive experience with police and fire claims, special provisions in the WC law make enforcing job searches for police and fire claims very difficult. Almost all police and fire programs nationwide treat work related disabilities either as formal WC claims or use the local WC process if legally separate. In all such cases return to work programs are enmeshed in complex processes often involving formal litigation. Based on our experience and research we do not believe any such programs have demonstrated the consistent success FPDR has demonstrated since 2011 in achieving a virtual 100% return to work record.

C. Procedures, Policies and Practices

1. Procedures Manual

The procedure manuals are more of administrative processing outlines rather than a technical procedure manual. These documents do not address vital specifics such as timeframes within which a task must be completed. The manual does not provide the claim handler with objective criteria to effectively and efficiently resolve claims in a structured manner.

We recommend that a new technical claims manual be created to include specific details of important claims handling procedures including timeframes within which to complete tasks and a structured approach for resolving claims consistently. This will provide the claim staff with a readily-accessible information source, will provide management and the staff with the opportunity to thoroughly review and if necessary reevaluate and revise current claims practices, and will provide the manager with objective documented measures with which to evaluate claim-handling performance. A detailed manual also is an excellent primary source material for training and will allow for easier transitions when staff turnover occurs. The level of claim handling adequacy and efficiency is a result of the current staff and turnover could disrupt the FPDR performance without a detailed claim handling procedures manual. It should be noted that the creation of such a manual is not a one-time exercise. If the manual is not updated periodically it can become a source of inconsistent claims practices.

2. Training

Currently there is no formal training requirement in place for FPDR personnel outside of continuing education requirements for the state adjusters' license. The training program for FPDR needs to be more rigorous and tailored to the program and claims being handled by the FPDR. We recommend that the FPDR develop a formal training program for its claim handling staff. A tailored training program will develop consistency among claim handlers, develop staff knowledge, and help ease transitions from staff turnover. We understand that FPDR claims staff has prior work experience with regular WC claim handling, but that new claims handlers are now being utilized with no such prior experience. The level of formal training for the new personnel with no prior WC experience will be higher than the historic claims handlers, although in both cases training to achieve uniformity in the application of the FPDR policies and procedures will be useful. We recommend training for new non WC hires include an overview of basic back, neck and knee medicine including common surgeries and treatment protocols, an overview of opioid pain medications, specifics as to the physical requirements of police and fire jobs, specifics as to how light duty / limited duty programs address those physical requirements, guidance as to how to recognize serious medical conditions both as a source of disability claims and as comorbidities which may impair the ability of a member to return to work. All claims handlers should be instructed as to the specifics of the FPDR benefit calculations and payments procedures to insure uniformity. All claims handlers should have uniform instructions as to under what circumstances claim situations call for referrals to supervisors.

3. Management Reports

When addressing "Management Reports" it is imperative all such reports are system-generated in a consistent manner on a periodic basis, i.e. monthly, quarterly, annually, etc. The most effective approach to assure the consistency and accuracy of the data captured is to utilize predefined data, which is selected from a drop down menu or data that is selected from a predefined list of fields. By using drop down menus and/or predefined data you are assured of consistent terminology and eliminate or at least limit data entry errors such as misspellings, inconsistent abbreviations, typos, etc.

While a standardized list of management reports, generated at specific times, i.e. weekly, monthly, semi-annually, etc. is critical, it is also beneficial for management to have the capability of developing special "Ad Hoc" reports to address specific data requests. Unfortunately, the current claims program utilized by FPDR has data collection limitations, which restricts overall reporting capabilities and limits the management staff's abilities to easily generate any type of "Ad Hoc" reports. Data collection is basically "keyed" data, which is manually entered by various members of the claims staff and therefore allows for data entry errors such as misspellings, inconsistent abbreviations, etc. The generation of accurate reports is exceedingly important, but with the current claims system there are many ways inaccurate or corrupted data can make its way into the reporting features. Management's

ability to monitor workloads and productivity of individual staff members is critical, but with the current claims system a reliable open/closed claim count is almost impossible to generate.

The FPDR does not currently utilize a standard set of formalized management reports to track staff performance, claim trends, and success of newly implemented programs and processes. FPDR management has recognized that a lack of reports makes program and staff evaluations somewhat subjective. We feel that FPDR would benefit from the immediate implementation of three key management reports to better run the claim operation: a Loss Run Report; a Pending Claims Report; and a Total Benefits Paid Report. These key management reports are used by other WC programs that have a comparable benefit structure to FPDR and are in keeping with WC best practices. Further details about these three reports are provided below:

a. Loss Run Report

The first system report is a very basic "Loss Run" which captures data necessary to evaluate individual employees' workloads and allows management to sort the detail to provide an aging report as well as paid-to-date values by benefit type. Best practices dictate that the "Loss Run" be generated by the claims system on a monthly basis.

The "Loss Run" should contain the following basic data elements:

1) Analyst[1] (The individual responsible for the resolution of the various features or suffixes associated with the individual claim.)
2) FPDR claim number
3) Member's Last Name
4) Member's First Name
5) Injury Date
6) Bureau (Fire or Police)
7) Time Loss Paid-to-Date
8) Medical Paid-to-Date
9) Expenses Paid-to-Date
10) Feature / Suffix associated with claim number (Indemnity, Medical and Expense)
11) Feature / Suffix Status, i.e. Open, Closed, Reopened, Withdrawn or Denied

The "Loss Run" is not available to the management staff as there is currently no mechanism for capturing the individual "Features or Suffixes" associated with the individual claim number and the individual "Feature/Suffix" statuses are not captured by the claims system. This is a departure from "best practices" in that it does not allow for a physical count of features or suffixes that each member of the claims staff has in an Open or Reopen status. It is imperative the claims system capture the individual features/suffixes so that individual workloads may be determined. Capturing the features/suffixes will allow

[1] Generally speaking the Analyst originally assigned to the claim would be responsible for all features opened for the date of injury, but in situations where the indemnity feature / suffix is closed it may be that the medical and/or expense features / suffixes may be reassigned to a less another claims handler.

for identification of losses that can be reassigned to less/more experienced staff members to assure that the claims handlers are being utilized to their fullest potential. Reassignments of individual features/suffixes can also be used as a developmental tool for the less experienced staff.

b. Pending Claims Report

The second system report we recommend would be the "Pending Claims Report" and would contain only the "Open and Reopened" Features/Suffixes along with their individual Paid-to-Date values. The data captured in this report would be identical to the "Loss Run" report, but in addition to the "Loss Run" detail this report would group the features/suffixes in aging categories such as:

1) Feature/Suffix open less than 30 Days
2) Feature/Suffix open >30 Days, but <60 Days
3) Feature/Suffix open >60 Days, but <90 Days
4) Feature/Suffix open >90 Days

The aging categories can be adjusted or set to any timeframe selected by FPDR claims management, but we would recommend that the aging categories be limited to no more than 5 or 6 groupings. This report will help identify the larger long-term exposure claims and will also allow management to evaluate the timeliness of individual staff members. Individual claims will vary on the time required to resolve the issues, but a report such as the "Pending Claims Report" can help identify staff members who may be having problems with timely addressing claim issues. We would recommend that the "Pending Claims Report" be generated on a monthly basis.

c. Total Benefits Paid Report

The third system report we would recommend immediately be implemented would be the "Total Benefits Paid" report, and we would recommend it be generated quarterly. The "Total Benefits Paid" report will assist in identifying the larger exposure claims and any unusual trends that may be impacting benefit payments. We would recommend that this report include the following data elements:

1) Claim Number
2) Last Name
3) First Name
4) Injury Date
5) Payment date
6) Analyst
7) Bureau (Identifier for specific Station or Division)
8) Body Part
9) Payee
10) Payment Type
11) Medical Paid (CPT Codes used for breakdown, i.e. hospital, drugs, etc.)

12) Indemnity Paid (Also broken down by type of benefit, i.e. wage subsidy, pension, etc.)
13) AP Payments

The "Total Benefits Paid" report can be ordered for any date range, i.e. monthly, quarterly, paid to date totals, etc. The report can also be used to select individual "benefit payment types" to compare Bureaus or individual station locations. We would recommend that the payment detail be limited to total payments, i.e. quarterly, monthly, annually, etc. This report will also capture individual claims, groups of claims by location, body part, individual member, etc. When the data is extracted from the claims system, we would suggest that it be configured in an Excel format, which will allow the user the freedom to configure the payment detail in any manner needed. Once you have identified specific reports that you would like to see on a regular basis the IT department should be able to lock in the data format and those reports can be generated on a regular basis and maintained for historical purposes. From a management standpoint we would recommend using "Paid to Date" values, because individual payments will generate an extremely large report that normally would not be used by management. This same report could be run for an individual claim or a group of claims should the need arise.

In addition to these three identified reports, FPDR senior management provided an outline of data they felt was important to monitor, asked us several questions with regard to this list, and requested our assistance in developing management reports based on best practices. We have provided our comments and recommendations from that full management report list in Appendix A to this report. We do however recommend that caution be used in the development of management reports since it is possible that the generation of a large number of reports can have an adverse impact on the FPDR managers.

D. Cost Saving Recommendations

We noted a small area for improvement that may result in cost savings to the FPDR. The potential savings area involves the monthly benefit recipients that are unable to return to work for their respective bureaus. Our claim file review indicated there are some claims where the FPDR is requesting SGA information or wage information from the member without timely member response. We recommend that, under certain circumstances, the FPDR hold the member more accountable. For instance:

- When a member is non-compliant the FPDR can suspend benefits until the member becomes compliant.

- When a member is non-compliant with wage information the FPDR can reduce the benefit to the minimum level of 25% of the base pay.

The FPDR should also consider settlement in some cases. The use of settlement in the right situations could benefit the member and save the FPDR money in the long term.

When members are non-compliant or inconsistently compliant with job searches efforts to engage vocational job search agencies may be helpful. When job searches are unsuccessful based on a member's physician assigned limitations referrals to vocational evaluation resources may be helpful in resolving such issues.

E. Claim File Review

1. Claim Selection

We were provided with two lists from which we selected claims for review: the first list included all non-monthly claims with activity in fiscal year 2014 (331 open and 211 closed claims); and the second list included 31 open monthly benefit claims. The two lists contained 386 service or occupational related claims and 8 non-service or non-occupational related injury claims. We selected a sample of 48 open claims (42 non-monthly and 6 monthly) and 25 closed claims (all non-monthly) ensuring a representative mix by claim type and bureau.

2. Qualitative results

In 93% of the claims we reviewed, technical claims handling met or exceeded industry standards. Particular areas of strength noted in the claim files we reviewed included claim handler proactivity, claim file documentation, investigation, medical management, and return to work efforts.

Milliman assessed the following key areas of claims handling:

- Initial Handling – best practice is to setup a claim within 24 hours of notice and make three point contacts (Member, Bureau, and Physician)
- Investigation – best practice is to evaluate claim severity within 14 days; complete initial investigation and resolve coverage issues within 30 days
- Medical Management – best practice is to have medical payments processed/denied within statutory required deadlines if applicable or within 30 days post receipt; and if applicable medical case management or medical cost containment should be initiated within 7 days of any specific circumstance that arises
- Return-to-Work Efforts – best practice is to initiate return-to-work efforts as soon as medically safe for the individual
- Subro/Recovery – best practice is to identify and address any subrogation and recovery potential within 30 days of receipt of the claim

- Expense Control – best practice is to limit the use of outside resources for functions that can be handled internally (i.e. taking recorded statements, medical bill review, applying fee schedules, etc.)
- Claim File Documentation – best practice is to create a claim strategy/action plan to bring the claim to resolution within 30 days and provide updates/edits to that plan on a regular basis
- Litigation Management – best practice is to limit the use of outside counsel for claim handling functions and the claim handler to instruct and guide counsel of guidelines for assignment once notice is received, special notice that may be required, approved law firms, etc.
- Claim Handler Proactivity – best practice is for the claim handler to be in the claim on a regular basis, responding to changes in claim facts and key information in a timely fashion
- Supervisory Involvement – best practice is for supervisor involvement after initial instruction within 30 days and within 60 days thereafter until claim is closed/finalized

Best Practices Discussion: The FPDR program is implementing best practices in key areas including the initial processing and information-gathering of each claim, including the application of the specific FPDR statutory provisions and rules, managing the medical information flow and quality of medical reports, and enforcing the specific FPDR return to work / job search requirements. Members are returning to work at a much higher rate than generally seen in the industry for police and firemen. Moreover, if a position is unavailable, members are finding other employment to help minimize the benefits paid out of the FPDR program. While there is always the possibility of further efficiencies and cost savings the recent achievements of the FPDR program are significantly better than other police and fire programs nationwide.

We have the following high-level findings from the claim file review:

Initial Handling: In the claims reviewed, 100% met or exceeded industry standards for initial handling. The FPDR is consistently making timely three-point contact, often on the same day of claim reporting. The claim handlers are maintaining proper levels of communication, requesting pertinent injury information, and addressing any questions or concerns from the onset of the claim.

Investigation: In the claims reviewed, 99% met or exceeded industry standards for investigations. In fact, 12% of the claims we reviewed exceeded industry standards. The claim handlers are actively performing thorough detailed investigations, taking recorded statements, reviewing prior injury history, and evaluating injury mechanics to determine compensability.

Medical Management: In the claims reviewed, 99% met or exceeded industry standards for medical management. Our review indicated medical management as an area of strength, 14% of the claims we reviewed exceeded industry standards. The claim handlers are consistently

evaluating medical history, injury mechanics, and treatment necessity. Our claim review indicated the same level of detail with new and ongoing long-term medical claims.

Return to Work Efforts: In the claims reviewed, 97% met or exceeded industry standards for return to work efforts. The claim handler is communicating well with the member, treating doctor, and appropriate bureau liaison with return to work efforts. The use of transitional work positions are being coordinated appropriately, timely, and consistently helping members return to work with their respective bureau.

Subrogation/Recovery: In the claims reviewed, 99% met or exceeded industry standards for recoveries. The FPDR is appropriately and actively addressing any potential for recoveries.

Expense Control: In the claims reviewed, 100% met industry standards for expense control. The FPDR is consistently and appropriately handling the claims internally without reliance on outside sources. Frequently utilized outside sources in other police and fire programs include nurse case managers, vocational programs with little or no actual return to work success, IME medical evaluations which render opinions delaying or preventing return to work, third party medical providers who process medical bills at high cost, and use of defense counsel to engage in litigation which may or may not result in a near term resolution of a claim.

Claim File Documentation: In the claims reviewed, 95% met or exceeded industry standards for claim file documentation. The claim handlers are utilizing action plans and organizing claim files in a consistent manner. Although minor in nature, 5% of the claims reviewed were in need of improvement with the formal resolution of a claim file. There were prolonged periods of inactivity with no plan in place to address any outstanding claim questions prior to claim closure. The implementation of an automated diary system and utilization of aging reports will correct these periods of inactivity.

Litigation Management: In the claims reviewed, 100% met industry standards for litigation management. Although this category was not applicable to many of the claims we reviewed, in the litigated claim files we reviewed the FPDR staff maintained control of the claim and movement of the claim to resolution without abandonment to counsel.

Claim Handler Proactivity: In the claims reviewed, 93% met or exceeded industry standards for claim handler proactivity with regular activity and follow-up on the claim to ensure claim is moved toward closure/resolution. In over 20% of the claims reviewed the claim handler exceeded industry standards. The claim handlers were actively handling claims, providing detailed action plans, evaluating medical information, and moving claims to timely closures. Although minor in nature, 7% of the claims reviewed were in need of improvement with claim handler proactivity. The implementation of an automated diary system and utilization of aging reports will correct these inconsistencies.

Supervisory Involvement: In the claims reviewed, 99% met industry standards for supervisory involvement. Based on discussions with the claim handlers and the claim manager, the instruction and claim oversight is primarily verbal with limited documentation in the claim file

from the supervisor to the claim handler. Rather, the claim handler would indicate in the claim notes "discussed with manager" or "as discussed with manager," etc.

See Section V, Exhibit for a summary of our qualitative assessment findings by category.

3. Claim Examples

Examples of claims that exhibited excellent claims handling attributes included:

- 10260301, 12372801, 20140010, 20140026, 20140110, 20140206, 20140223, 20140287, and 20140332: The claim handler is proactively evaluating the medical history, medical treatment, injury mechanics, and appropriately addressing compensability questions.

- 20130096: This claim was a complex claim, with significant injuries suffered by the member. The claim handler exhibited great proactivity and communication to ensure the member's care needs were met in a timely fashion. The member suffered a severe spine injury that required home and vehicle modifications. The claim handler created detailed action plans and worked with the member to meet his care needs. The member was able to pass his driver test and move into a transitional work position within 10 months of the injury.

- 20140068: The subrogation investigation was active, and the claim handler asked detailed questions from the initial claim report to ensure potential recovery needs were evaluated.

- 20140119, 20140135, 20140213, 20140290, and 20140296: The claim handler worked well with the member, liaison, and treating physician to enable the member to return to work for the bureau in a transitional duty position.

Although most of the claim files we reviewed met or exceeded industry standards, there were some claims we felt had room for improvement.

- 20130151, 20140159, 20140178, and 20140279: These are examples of claim files that were in need of improvement due to inactivity from the claim handler at the end of the claim to formally close the claim file. As referenced above, a system generated auto-diary or inactivity-aging report will help eliminate this timing issue.

- 00389703: This is an example of a monthly claim where information regarding job search logs and work capacity evaluations appear to be in non-compliance. This might be a claim to consider holding the member more accountable with information requests.

F. Comparison to Prior Audit Report

Marsh was hired in 2007 to conduct the initial audit of the FPDR post 2006 reform changes. The initial review report was completed in March 2008. The initial Marsh review evaluated 45 claims with a focus on 2006 and 2007 claims management activity. The service connected disability claims were evaluated in ten categories: Initial three point contact; investigation, subrogation / recoveries; medical / cost containment; disability management / vocational rehabilitation; action plans; communication; litigation management; adherence to special instructions; and benefits. A comparison evaluation was done on the 45 claims to evaluate the claim handling differences between 2006 and 2007 claim handling practices on all claims. Marsh found that although some of the categories ranked differently the overall audit score results of 77% were the same for 2006 and 2007. Areas that scored low and were in need of improvement were three point contact, investigation, action plans, communication, and litigation management. In addition to the ten primary claim review categories, Marsh also noted inconsistencies in claim file documentation, the claim numbering system, no time limits on claim acceptance decisions, high staff turnover, inconsistent claim closures, and very little focus on claim costs.

Marsh also conducted a subsequent review in June 2009. When Marsh evaluated the program last in 2009, the overall review score had improved to 93% with the only remaining areas in need of improvement being three point contact and litigation management. Our evaluation categories and ratings were similar, although not identical, to those Marsh utilized. We found that 93% of the claims we reviewed met or exceeded industry standards. Since the 2009 audit, it appears as though the FPDR has improved their three-point contacts and litigation management. We did not find a decline in any of the claim handling categories that we analyzed.

G. Miscellaneous

The FPDR accountant is responsible for calculating the disability benefit. The accountant is manually entering data into various and numerous spreadsheets that need to be streamlined. The need for the enormous amount of manual data entry remains unclear, but it seems to be a less than optimal use of resources and also could lead to errors if this information is relied on for other tasks. A thorough analysis of accounting functions was outside the scope of this review but we recommend that FPDR follow-up with such an assessment to ensure that the accounting function is operating efficiently and effectively.

IV. LIMITATIONS

Milliman's work has been prepared solely for the internal use of FPDR. No portion of Milliman's work may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. Milliman's work may not be filed with the SEC or other securities regulatory bodies. Any reader of this report agrees that they shall not use Milliman's name, trademarks or service marks, or refer to Milliman directly or indirectly in any third party communication without Milliman's prior written consent for each such use or release, which consent shall be given in Milliman's sole discretion.

Milliman has prepared this report in conformity with its intended utilization by a person technically competent in the areas addressed and for the stated purposes only. Judgment as to the conclusions, recommendations, methods and data contained in this report should be made only after studying the report in its entirety. Furthermore, Milliman is available to explain and/or amplify any matter presented herein, and it is assumed that the user of this report will seek such explanation and/or amplification as to any matter in question.

For our analysis, we relied upon the accuracy of written and verbal data and information provided by FPDR in connection with this assignment. Milliman has made no independent analysis of the completeness of that data and information for the purposes of this report. Such a review was beyond the scope of our assignment. If the underlying data or information provided to us either verbally or in writing is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Our assessment of FPDR's claims operational structure and claims practices is based on our professional judgment after conducting interviews, reviewing a sample of claim files, and reviewing documents. Two experienced claim professionals, faced with the same set of facts, may arrive at different conclusions.

V. EXHIBIT

Milliman Review - FPDR - Qualitative Assessments

Total # of Claims Reviewed = 73

	Exceeds Expectations	Meets Expectations	Needs Improvement
Initial Handling	3	70	0
Investigation	9	63	1
Medical Management	10	62	1
Return-to-Work Effort	7	64	2
Subrogation/Recovery	2	70	1
Expense Control	0	73	0
Claim File Documentation	7	62	4
Litigation Management	0	73	0
Adjuster Proactivity	15	53	5
Supervisory Involvement	0	72	1
Total Assessments	**53**	**662**	**15**

APPENDIX A – REPORT RECOMMENDATIONS

1. Technical Claims Manual Creation

We recommend that a new technical claims manual be created to include specific details of important claims handling procedures including timeframes within which to complete tasks and a structured approach for resolving claims consistently. This will provide the claim staff with a readily-accessible information source; will provide management and staff the opportunity to thoroughly review and if necessary reevaluate and revise current claims practices; and will provide management with objective documented measures with which to evaluate claim-handling performance. A detailed manual also is an excellent primary source material for training and will allow for easier transitions when staff turnover occurs. The level of claim handling adequacy and efficiency is a result of the current staff and turnover could disrupt the FPDR performance without a detailed claim handling procedures manual.

2. Management Report Implementation

We feel that FPDR would benefit from the immediate implementation of three key management reports to better run the claim operation: a Loss Run Report; a Pending Claims Report; and a Total Benefits Paid Report. These key management reports are used by other WC programs that have a comparable benefit structure to FPDR and are in keeping with WC best practices.

3. Formal Training Program Implementation

Currently the FPDR has no formal, detailed training program in place for its claim handling staff. We recommend that the FPDR develop a formal training program for its claim handling staff for newly-hired staff as well as for when staff shifts positions and when changes are implemented. A tailored training program will develop consistency among claim handlers, develop staff knowledge, and help ease transitions from staff turnover.

4. Claim Reassignment

We recommend that senior claims analyst caseloads be rebalanced to 80-85 complex claims and that less complex claims be assigned to an analyst when possible. The claim reassignment can be used as a training tool for the analysts, increasing their knowledge while preparing them to handle more complex claims.

We also noted that the Claim Manager has a small active caseload. This is not in keeping with best practices. The role of the Claim Manager should include mentor, data expert, trainer, claim file auditor, procedure compliance monitor, and performance evaluator. We recommend active claim handling functions for open claims be assigned to a senior analyst or analyst if appropriate.

5. Automated Diary System

We recommend the implementation of a system generated, auto diary system. The implementation of an automated diary system will help increase claim handling efficiencies. System generated auto-reminders will help correct periods of claim file inactivity, while improving claim file documentation accuracy and claim handler proactivity.

6. New Initiatives/Program Evaluations

When a new initiative or increased emphasis is placed on a program, we recommend that objective measures be implemented that evaluate the success of the program and determine if the improvements or modifications are needed. For example, the transitional duty return to work program should be evaluated to determine if it is meeting its intended purpose and objectives. One measure of success for a program of this nature is average length of time off of work for claims before and after this program was implemented. The comparison should also be broken out by injury type and work capacity to determine if the program is more successful or needs modifications in a particular area.

7. Member Accountability

Our claim file review indicated there are some claims where the FPDR is requesting SGA information or wage information from the member without timely member response. We recommend that, under certain circumstances, the FPDR hold the member more accountable. For instance:

- When a member is non-compliant the FPDR can suspend benefits until the member becomes compliant.
- When a member is non-compliant with wage information the FPDR can reduce the benefit to the minimum level of 25% of the base pay.

8. Manual Accounting Function Analysis

Although the analysis of the accounting functions was outside the scope of this review, we recommend that FPDR conduct an assessment of that unit to ensure the accounting function is operating efficiently and effectively. The accountant is manually entering data into numerous spreadsheets that need to be streamlined. The need for the enormous amount of manual data entry remains unclear, but it seems to be a less than optimal use of resources and also could lead to errors if this information is relied on for other tasks.

APPENDIX B – SUMMARY OF INTERVIEWS

We interviewed the following individuals during the course of our review:

- Barb Aase, Analyst
- Heather Andrews, Assistant Claim Tech/Intake
- Darina Christensen, Analyst
- Diane Davis, Nurse Case Manager/RN
- Justin Delaney, Board Member
- Nancy Hartline, Finance Manager
- Sam Hutchison, Director
- Jason Lehman, Board Member
- Sheri Miller, IT
- Kimberly Mitchell, Claims Manager
- Yuliya Pathammavong, Claim Tech
- Patricia Rafferty, Accountant
- Gabe Sansone, Liaison - Fire
- Pam Schill, Senior Analyst - Fire
- Julia Towne, Senior Analyst - Police
- Crystal Viuhkola, Liaison - Police

All interviewees felt that the bureau liaisons were valuable; several interviewees felt that they might be underutilized and wondered whether there might be more that they could do to benefit both the bureaus and FPDR. For example, it was felt that when there is talk of a potential change, it would be better for the liaison to be involved in those discussions, provide insight into the likely reactions, and perhaps help with the planning and communicating of the change if it is implemented. Some interviewees felt that if the liaisons were provided with even limited access to claim information that might improve the process. It was acknowledged, however, that there is some history of distrust and FPDR should proceed with some caution and respect for the potential disparate interests of the parties.

A few interviewees mentioned that retired members may not have an “advocate” or Board representation, and want to ensure that going forward retired members’ rights and interests are protected.

It was widely held that Sam Hutchison is doing a very good job. He is good at accomplishing tasks and goals, he reports clearly to the Board on relevant topics, he is good at communicating, and he cares. Some interviewees said that they would like to see reporting to the Board about the success of the return to work programs. The Board is aware that Mr. Hutchinson and his staff are also interested in and have been working on ways to improve reporting and measuring the success of new initiatives and programs.

All interviewees agreed that the purpose of FPDR and the Board is not to look for ways to reduce benefits to members, but rather to administer benefits to which members are entitled in a fair and efficient manner.

A minority of the interviewees expressed a desire to have a heightened awareness of the specific roles and responsibilities of FPDR office employees. A few people felt that it would behoove them and the operation in general if there was more education or awareness about what each person is doing. None of the interviewees felt that a formal document was needed; just a review of the roles/responsibilities at a meeting occasionally, or in smaller groups (e.g., the roles of the handlers and support staff for a particular bureau) particularly if training/advancement is occurring and responsibilities are getting re-defined and re-allocated. (For example, some interviewees did not know whether Julia ~~Julie~~ was responsible for doing all vocational rehab, or just some of it.)

All interviewees felt comfortable and confident in their respective jobs. Nobody felt underutilized, nobody felt overworked or working beyond their experience or capabilities.

All interviewees felt that if they wanted to progress there were opportunities for development and promotion. Interviewees who were happy and settled in their positions with no ambition for advancement felt comfortable that their decisions were respected and they would not be pushed to advance.

Interviewees mentioned that there would be regular "roundtable" meetings beginning in the near future and all interviewees were excited about this. An occasional but regular meeting to discuss different topics, roles and responsibilities, changes, etc. including meetings led by outside speakers is welcome by all.

All interviewees who have worked for FPDR long enough mentioned that there were several changes implemented over the past few years, and all felt these changes were generally very good changes. There are some that are more comfortable with workers' compensation backgrounds and approaches, and others that are more comfortable distinguishing these disability claims from workers' compensation claims. Interviewees discussed what they felt were the pros and cons of having FPDR personnel with workers' compensation backgrounds.

A few interviewees mentioned that FPDR would benefit from clarifying certain processes, procedures, or philosophies. For example, it was unclear to some what the required procedure is when an injured member reaches substantial gainful activity status (SGA) but the job search requirements do not seem to be working well. That is, the SGA member complies with the technical requirements (e.g., complete and submit a form) but there is a strong sense or perhaps even knowledge that the person is not truly searching for work. In some cases, the person is not even compliant with the form submittal. Clarifying the steps that are to be undertaken in these situations would be beneficial. Other procedures or policies were also mentioned in interviews. For example, "I don't think we go after homeowners' insurance; but I'm not sure, and I'm not sure why. It would be nice to know."

Some interviewees felt that better use could be made of the diary system and that education and training about ways to use the diary system would be beneficial.

Almost all interviewees expressed that FPDR is characterized by great morale, great teamwork and great support. "We cover for each other, we consult with each other."

The claims system and technological capabilities have improved greatly in the last three years. Now, the database is into SQL format, and the Senior Business Systems Analyst can view the code behind it. They have more control over the information that they are storing, and greater understanding as to why they are storing certain data. There is a good testing system now, and much better security with respect to the data. They continue to grapple with data security with respect to emails, and transferring files seems to be a potential issue. The city does not have secure portals. However, there have been no problems (security breaches) as far as they are aware. Also, it was felt that improvement could be made with respect to creating and implementing a good, useable disaster recovery plan.

APPENDIX C – MANAGEMENT REPORTS

Milliman was asked to review the FPDR's existing management reports and provide feedback and assistance with the development of appropriate reports to better manage the FPDR claims operation. We do however recommend that caution be used in the development of management reports since it is possible that the generation of a large number of reports can have an adverse impact on the FPDR managers. There needs to be a balance of the number of reports FPDR management must review so that reviewing reports will not take away from the time necessary to properly perform their overall managerial responsibilities. Since the reporting issue is of paramount importance to the FPDR management team, they provided us with a list "FPDR Metrics – Disability" seeking our recommendations for management reports that would assist them with quantifying the success of recently implemented processes and procedures. With that in mind we have broken down this appendix into two main sections:

A. Milliman Recommended Reports
B. FPDR Specified Reports

A. Milliman Recommended Reports

1. Time Loss Closure Report by (quarter, fiscal year-to-date, and fiscal year)

a. Number
b. Reason
c. By type, cause, diagnosis
d. Duration and total paid

Topic: This would be considered by us to be the "Open/Closed" report. In our initial review of the reporting data available we discovered that one of the problems with the current system is identifying the claims that would be considered "open" from an industry standpoint. The inability to clearly identify claims that require periodic activity/attention by the staff makes it extremely difficult, if not impossible, to identify individual staff workloads. We would recommend that the claim staff jointly discuss and identify all claims of this nature and how all claims can be identified from initial assignment as "open" and at what point in the life of the claim where there is no additional work required and the claims can be placed in a closed status. Currently it appears that the system identifies claims as active or inactive, but an inactive claim can still require attention by the claims or supervisory staff. Although the activity on such claims may be limited, from an industry standpoint those claims would still be considered "open", since they continue to require some type of attention.

In order to build a report that would provide the monitoring of "closed" time loss benefits as proposed in Report #1, changes to the current data collection processes of the claim system would be required. Although Report #1 does not address the "open and closed" issue the report does include a request for the total "closed" claims by various timeframes, which provides us with the opportunity to address this very important aspect of any claims operating

system. As previously discussed, it is imperative that the open and closed statuses be addressed in the claims program.

With respect to Report #1, it requests data that we do not believe is specifically captured in the current claims program. Although "Reason and Diagnosis" are normally captured in the claim notes, in order to be addressed in a formal report the information must be consistently captured in a controlled field within the claims operating system. In order to compile the data indicated in Report #1 specific data fields for "Reason and Diagnosis" would need to be created as required data fields in the claims system.

❖ Data Elements recommended:
- Analyst
- Claim Number
- Last Name
- First Name
- Injury Date
- Bureau (Fire or Police)
- Station/Precinct
- Time Loss / Medical Only
- Claim Status, i.e. *Open, Closed, Withdrawn*[2], etc.

2. Pending Claims Report

Topics: Pending claims approaching 30, 60 or 90 days since receipt and pending claims older than 60 or 90 days are reports that would be very beneficial to the management and supervisory staff in that each would provide a method for tracking a critical aspect of the claim, that being the timely acceptance of the reported claims. In addition, these are reports that would help quantify the individual claim handler's productivity and also help avoid unnecessary litigation issues. This data is readily available by merely creating calculation dates that would allow for the counting of the number of days between "Date Claim Received" and "Decision Date", and identifying the group each pending claim falls.

❖ Data Elements recommended: (would include all claims where the "Decision Date" field is blank.)
- Claim Number
- Last Name
- First Name
- Injury Date
- Analyst
- Bureau (Fire / Police)
- Station / Precinct
- Date Claim Received
- *Calculation of days since receipt of claim* (claims placed in proper category)
- *Less than 30 Days*
- *Less than 60 Days (>30 days, <60 days)*

[2] The "Open and Closed" data elements would be redefined data elements and "Withdrawn" would be a newly created data collection item.

- *Less than 90 Days (>60 days, <90 days)*
- *Older than 60 Days (>60 days, <90 days)*
- *Older than 90 Days (>90 days)*

3. Total Benefits Paid

a. Medical benefits paid by quarter, year to date, and year
b. Total claims
c. Total dollars
d. By claim
e. By claimant
f. By payee

**Can we separate out pharmacy/prescription drug payments?

Topic: FPDR management asked, "Can we separate out pharmacy/prescription drug payments?" By either sorting by payment type or restricting the download to an individual payment type or specific payment types individual reports can be generated and once created, those reports can be scheduled to run on a regular basis.

The "Total Benefits Paid" report can be ordered for any date range, i.e. monthly, quarterly, paid to date totals, etc. The report can also be used to select individual benefit payment types to compare Bureaus or individual station/precinct. We would recommend that the payment detail be limited to total payments, i.e. quarterly, monthly, annually, etc. This report will also capture individual claims, groups of claims by location, body part, individual claimant, etc. When the data is extracted from the claims system, we would suggest that it be configured in an Excel format, which will allow the user the freedom to configure the payment detail in any manner needed. Once you have identified specific reports that you would like to see on a regular basis the IT department should be able to lock in the data format and those reports can be generated on a regular basis and maintained for historical purposes. From a management standpoint we would recommend using "Paid to Date" values, because individual payments will generate an extremely large report that normally would not be used by management. This same report could be run for individual claim or a group of claims should the need arise.

❖ Data Elements recommended:
- Claim Number
- Last Name
- First Name
- Injury Date
- Payment date
- Analyst
- Bureau (identifier for specific Division – Station/Precinct)
- Body Part
- Payee
- Payment Type
- Medical Paid (CPT Codes used for breakdown, i.e. hospital, drugs, etc.)

- Indemnity Paid (also broken down by type of benefit, i.e. wage subsidy, pension, etc.)
- AP Payments

B. FPDR Specified Reports

4. Disability Benefits (time loss) paid by quarter, year to date and year

a. Total claims
b. Total dollars
c. By claim
d. By claimant

Topic: The "Disability Benefits Paid" report referenced above can be utilized to accommodate the "Time Loss" report by merely limiting the data collection to indemnity benefits and utilizing the various indemnity benefit types captured by the beginning and ending dates of payments limited by the requested time frames. Again, we would recommend that the reports be captured by total payments by period rather than individual payments. This report will allow management to track indemnity payments by benefit type for comparison over varying timeframes. Report comparisons will require data collection over time, but it is possible that the historical data could be incorporated with new data to allow for historical comparisons.

❖ Data Elements recommended:
- Claim Number
- Last Name
- First Name
- Bureau (identifier for specific Division – Station/Precinct)
- Occurrence Status
- Injury Date
- Payment From and To dates (allows for calculating length of payments)[3]
- Indemnity Paid (broken down by type of benefit, i.e. wage subsidy, pension, etc.)

5. Timeliness of claims decided by quarter, year to date and year by time loss and medical only

Topic: Timeliness of claim decisions by quarter, fiscal year-to-date and fiscal year broken down by lost time and medical only will provide the management staff with details necessary for both staff evaluations and length of time "averages". This report can also be a very important tool in determining average decision times by Analyst, body part, Bureau (Fire / Police) and station/precinct. Based on our understanding the data captured by the claims system, sufficient data is captured to develop this report.

❖ Data Elements recommended:
- Claim Number

[3] Payment beginning and ending dates are critical to tracking such data and from the claims data reviewed it appears that "From and To" dates are not currently being captured and are critical to "payment period" reports.

- Last Name
- First Name
- Injury Date
- Analyst
- Date Assigned
- Occurrence Decision
- Number of days from assignment to decision (Date Assigned – Occurrence Decision = X days)
- Bureau (Fire or Police)
- Station/Precinct
- Body Part
- Time Loss / Medical Only

6. Disability claims received by quarter, year to date and year by time loss and medical only

a. Received
b. By type of disability; cause and diagnosis
c. By bureau (police or fire)
d. By quarter, year to date and year by time loss
e. Withdrawn
f. Other

Topic: Disability claims report by quarter and year-to-date broken down by Lost Time and Medical only. This report would allow for the tracking of claims activity over time and if historical data is available the report will help identify any unusual growth or decline of claims reported. The outline provided for this report included data related to claims that were withdrawn and other, but *based on our review of system data information regarding "diagnosis, withdrawn and other" statuses are not captured in a consistent format that is required for reliable reporting*, therefore to capture such detail, additional fields would need to be added to the claims operating system. From a claims management standpoint, collection of this additional data should be evaluated by the Information Technology ("IT") to determine the necessary system modifications required to capture this level of detail. We would also recommend that the claims staff be involved in this process in order to determine the impact on productivity. If system modifications and the impact on productivity were to be unacceptable, we would recommend using a limited version of Report #3, "Total Benefits Paid" rather than creating additional system fields. Using Report #3 less the payment detail would provide a reasonable alternative to Report #6 and would provide excellent detail on claims activity from a loss control standpoint.

❖ Data Elements recommended
- Claim Number
- Last Name
- First Name
- Injury Date
- Analyst

- Bureau (identifier by Bureau: Fire or Police and individual station/precinct)
- Body Part
- *Diagnosis*
- Claim Status, i.e. Open, Closed, *Withdrawn and Other*

7. Medical cost savings and savings as a percentage of total medical costs

Topic: Medical cost savings and savings as a percentage of total medical costs would be an excellent report for tracking the effectiveness of the medical bill audit team and would allow for tracking of both increases and decreases with respect to medical bill reductions. We consider this a very important tool for measuring the effectiveness of your medical audit team. This report could also be used in the evaluation of the individuals who make up the unit.

In order to calculate the actual savings the amount of the original medical invoice would have to be captured and then compared to the actual amount paid with the result appearing in both a monetary value and as a percent of savings. The calculated results would be captured by claim.

❖ Data Elements recommended:
- Claim Number
- Last Name
- First Name
- Injury Date
- Payment date
- Analyst
- Bureau (identifier for specific Division – Station/Precinct)
- Body Part
- Payee
- Medical Paid (CPT Codes used for breakdown, i.e. hospital, drugs, etc.)
- Savings Amount
- Savings Percentage

8. Total benefits paid by quarter, year to date and year (by claimant)

a. Total dollars by claimant
b. Total dollars by claimant (all disability and medical benefits ever paid to claimant)

Topic: Total benefits paid by claimant will capture total claim history of individual claimants by claim number and body part. Such data will allow for claim comparisons between the various Fire and Police Bureaus as well as by individual station/precinct. An historical run of this data will provide both claim information by body part, but will also allow for the identification of factors causing claim frequency for comparison purposes. Such a report will allow for identification of claim costs by location, body part, injury dates, etc. We would recommend that this report be considered for being captured annually as of the end of the fiscal year. We would also suggest that this report be distributed to the individual station/precinct in order to provide senior management of each station/precinct insight into their physical locations

compared to the other stations/precincts. We would recommend that distribution be limited to senior management by Bureau.

❖ Data Elements recommended:
- Claim Number(s)
- Last Name
- First Name
- Injury Date(s)
- Body Part
- Bureau (identifier for specific station/precinct)
- (Total) Medical Paid (CPT Codes used for breakdown, i.e. hospital, drugs, etc.)
- (Total) Indemnity Paid (also broken down by type of benefit, i.e. wage subsidy, pension, etc.)
- (Total) AP Payments

9. Active Disability – Snap shot as of report run

a. *Number*
b. By type, cause, *diagnosis*
c. *Duration* and total paid to date
d. Claimants on short term disability (biweekly payments)
e. New claimants (in last year) on short term disability
f. Claimants on long term disability (monthly payments)
g. New claimants (in last year) on long term disability

Topic: "Active Disability" a snap shot report that is run on a specific as of date, that would provide management staff with the number and distribution of "Time Loss" claims and at the same time provide both Bureaus and individual station/precinct with manpower replacement needs, as well as insight into potential availability of "light duty" vacancies that may be utilized in the transitional duty return to work programs.
Based on our understanding of the current claims system there would need to be an addition of calculation fields to provide the total number of claims for each benefit category and calculation fields to determine claims that fall into each bucket (i.e. biweekly, monthly, previously reported, newly reported, etc.).

❖ Data Elements recommended:
- Claim Number
- Last Name
- First Name
- Injury Date
- Analyst
- Bureau (identifier for specific Bureau – Station/Precinct)
- Body Part
- Medical Paid (CPT Codes used for breakdown, i.e. hospital, drugs, etc.)
- Indemnity Paid (including type of benefit, i.e. wage subsidy, pension, etc.)

- Body Part
- Medical Paid (CPT Codes used for breakdown, i.e. hospital, drugs, etc.)
- Indemnity Paid (also broken down by type of benefit, i.e. wage subsidy, pension, etc.)

10. Active time loss claims approaching 30/60/90/180 days and one year in duration

Topic: "Active time loss claims approaching that remain open after 30, 60, 90, 120 and approaching one year in duration" report would provide management staff with insight into the emergence or larger time loss claims. The reports could also assist with identification of the larger medical exposure claims so that additional resources may be assigned to the case in order to better control financial exposures. It would be our recommendation that this report be combined with Report #9, thereby reducing the number of reports generated for any given period of time. We would also recommend that these reports be distributed to the claims management and supervisory staff, management staff at the bureau and station/precinct levels. In producing reoccurring reports of this nature it is important to discourage claims handlers from copying and pasting narratives from previous reports and just adding a small number of new items. Instead each report should be concise and be aimed at providing new information as opposed to rehashing previous information making it more difficult to read and discern the new from the old.

❖ Data Elements recommended:
- Claim Number
- Last Name
- First Name
- Injury Date
- Analyst
- Bureau (Fire / Police)
- Station / Precinct
- Body Part
- Medical Paid (CPT Codes used for breakdown, i.e. hospital, drugs, etc.)
- Indemnity Paid (also broken down by type of benefit, i.e. wage subsidy, pension, etc.)

11. Active time loss claims older than one year with no *Medically Stationary or Substantial Gainful Activity (SGA) decision* yet made

Topic: "Active time loss claims older than one year" report would provide senior management with a list of claims with the potential of becoming large exposure claims so steps can be taken to move the claims toward finalization. This report will help identify stagnant claims that have fallen off diary or are allowed to linger by the claim handlers. The older the claim, the more likely it is to become a maintenance claim rather than a claim that is closely monitored. Given the potential for long-term exposure claims in this category, we would recommend this report be generated at least on a quarterly basis. This would be a senior management report that would help with the timely identification of claims with the potential of becoming large exposure claims.

In order to generate this report both *Medically Stationary and SGA* data fields will have to be created and they would have to be required data fields to complete. The Medically Stationary or SGA statuses are generally only addressed in the claim file notes, it would be a major undertaking to go back and capture this information on the existing claims. We would recommend that such information only be required to be completed on claims reported on a specific date going forward.

Since Report #9 will provide detailed information related to aging claims, we do not feel that this should be a mandatory report. If the data were collected on newly reported claims, it would require an extended period of time before a reliable report could be generated. Our recommendation would be to utilize Report #9 for the identification of aging claims rather than generating an additional report that would identify only a limited number of claims.

❖ Data Elements recommended:
- Claim Number
- Last Name
- First Name
- Injury Date
- Analyst
- Bureau (Fire / Police)
- Station / Precinct
- *Medically Stationary status*
- *SGA status*

12. *SGA* decisions made by quarter, year-to-date and year

Topic: SGA decisions made by quarter, year-to-date and yearly would also require that the SGA detail be extracted from the running claim notes or applicable to only future claims. In addition to identifying the SGA status, an additional field to capture the date of the decision would need to be added to the claim operating system and both the SGA and date fields would have to be required fields for all claims subject to status. We question the benefits that would be generated by such a report.

❖ Data Elements recommended:
- Claim Number
- Last Name
- First Name
- Injury Date
- Analyst
- Bureau (Fire / Police)
- Station / Precinct
- *SGA status*

13. Return to work, vocational rehabilitation and job support services offered by quarter, year to date and year

14. Claimants earning other income by quarter, year to date and year

Topics #13 and #14: Reports of this nature would not only require that a number of specific data fields be added to the current claims system, but some of the items such as services offered could require multiple date fields in order to capture the full "offer" history. The same would be true for claimants earning other income, since you would need to account for those claims were the claimants return to work, are taken back off due to medical reasons or job availability, etc., which could happen multiple times over the life of a claim.

Although we agree it would be nice to capture such data, we do not feel that the man hours required capturing the data, nor the benefits gained from such knowledge and the fact that such data can occur multiple times over the life of a claim would prove beneficial to the overall management of the department.

❖ Data Elements recommended:

- Claim Number
- Last Name
- First Name
- Injury Date
- Analyst
- Bureau (Fire / Police)
- Station / Precinct
- *Return to work (either a yes or no response or a date field would be added)*
- *Vocational Rehab*
- *Job Support Services*
- *Claimant's earning with multiple date options*