

**Review of Workers' Compensation Program within the DOES
Summary of Findings and Evaluation of Management Response**

Exhibit A

<i>Finding</i>	<i>Effect (So What?)</i>	<i>Recommendation</i>	<i>DOES Response</i>	<i>Evaluation of DOES Response</i>	<i>Finding Status</i>
3. Inadequate controls in the case management process such as DOES-OWC's failure to perform adequate periodic and follow-up reviews. For example, an approved disbursement was not paid for more than ten years.	Increases the risk for fraud in the program and erodes its integrity.	A review of all cases to determine cases that should be re-evaluated and/or terminated.	Management did not concur with the finding. It is not contingent upon OWC to re-evaluate and/or terminate all Special Fund cases. There are two major categories of Special Fund cases and it appears that the auditors failed to make a distinction between the two: (1) Default and (2) Second Injury Fund cases. Actual claims processing activities are conducted by OWC involving Default cases, for the most part, insurance carriers conduct claims processing involving Second Injury Fund cases.	DOES management response is inadequate. There were no indications that follow-up reviews are performed on the Default and on Second Injury cases with the insurance carriers.	Unresolved. DOES needs to provide verifiable evidence that such a system as described in management response is available.

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4. Inadequate safeguarding of surety bonds in the record management function. We found several surety bonds posted by self-insured employers unsecured in the DOES-OWC office area.	Increases program inefficiency and delay in delivery of services.	That the surety bonds are sent to the Treasury and within a specified time period of receiving the surety bonds, the Treasury should inform DOES-OWC of all surety bonds it receives. Control procedures should be established to ensure that this communication occurs in a timely manner. DOES-OWC should not certify the applicants as self-insured employers until they confirm with the Treasury that the surety bonds in the required amounts are received.	Management concurs with finding. Audit recommendation will be implemented.	DOES management response is adequate.	Resolved. Follow-up review is recommended to ensure full implementation of the recommendations.

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5. Inadequate reporting of program costs. Salaries of employees not working on the program are included as part of the program cost.	Increases program cost and affects delivery of service.	Ensure that salaries of only the employees working on the program are included as program costs.	Management did not concur with finding. The DOES employee's official personnel form and budget funding documents (Form 1 and Schedule A), respectively, indicate that 100% of the individual's salary as being charged to a grant or program. However, this form is not used to determine the costs charged to the Workers' Compensation Program at year-end. The Form 52 currently used by the District Government will not accept more than one Agency Reporting Category (ARC). A majority of DOES employees provide service to more than one grant. Actual allocation of time and costs are processed through Federal Accounting and Reporting System (FARS) and recorded to the appropriate grant. The FARS system does not have multi-task ARC. In August 2000, DOES contracted with KPMG to develop an interface between FARS and SOAR due December 2000.	DOES management response is adequate.	Resolved. Follow-up review is recommended to ensure that regular and adequate reconciliation is performed to reflect actual program and/or grant costs.

Appendix B
***Full text on Management response
to findings and recommendations***

***RESPONSE TO THE
OFFICE OF THE
INSPECTOR GENERAL***

Report on the Review

of the

Workers' Compensation Program

within the

Department of Employment Services

Prepared by:
Gregory P. Irish, Director
Department of Employment Services



Gregory P. Irish
Office of the Director

MEMORANDUM

TO: Charles C. Maddox, Esquire
Inspector General

FROM: Gregory P. Irish
Director

DATE: OCT 11 2000

SUBJECT: Report on the Review of the Workers' Compensation Program
Within the Department of Employment Services - Draft Report

This is in response to your September 21, 2000 correspondence pertaining to the Draft Report on the "Review of the Workers' Compensation Program."

While the Department appreciates efforts expended by the auditors in conducting their investigations, disclosures outlined in the Draft Report clearly symbolize a misunderstanding of many of the operational components and processes associated with the Office of Workers' Compensation (OWC). Remaining cognizant that much of the findings directly impact and/or involve insurance carriers, self insurers and the claimant and attorney bars, it is important that the mistakes recorded in the Report are appropriately addressed. Without doubt, any release of the erroneous information would posture the District Government to encounter serious negative repercussions from the entire workers' compensation community, especially since carriers, major market employers, attorneys and other involved parties have remained extremely cooperative and responsive over many years.

The attached report "Response to Draft Report - Workers' Compensation Program" is designed in a manner which correlates with "Results in Brief" and "Summary of Recommendations." In the meantime, it is important for me to advise, in brief that:

"Up-front" Assessment

At the time that the audit was conducted, the Department was in its embryonic stages of designing a customer friendly approach to effecting extensive changes associated with conducting "up-front" assessment.

In addition to impacting numerous procedural processes within OWC, the requirement for up-front assessment drastically affected the business functions of insurance carriers and self insurers. Subsequent to the April 1999 passage of D.C. Law 12-571, the Department expended numerous staff hours in coordinating activities with carriers/self insurers, responding to questions, redesigning in-house processes and assembling and verifying all necessary assessment statistical data. Accomplishing these types of activities during a transition period was of grave necessity since the "first up-front process" required the Department to collect an enormous amount of funds affiliated with two fiscal years. Moreover, with the simultaneous advent of a bifurcated assessment system, carriers also began to use the transition period as an opportunity to become acquainted with the surcharge requirement; self insurers were introduced to the need to respond to an assessment exclusively for Special Fund expenditures.

The transition period proved to have been extremely beneficial for all parties. To date, there has been no dissatisfaction voiced by nor have official complaints been received from the insurance/self insured community. Assessment funds have been collected, as appropriate. For the auditors to have determined that an untimely process occurred during the infancy stages of major change certainly serves to defeat the positive efforts expended by the Department as well as the insurance carrier/self insurer community in achieving remarkable results.

Even more compelling is that the legislative body recognized the overwhelming monetary impact of the newly enacted law on the workers' compensation community. For this reason, the election of making quarterly payments was legalized in D.C. Law 12-571. This consideration, in itself, gives clear indication of the mere fact that *for the auditors to disclose late payments would be inappropriate.*

Special attention is made to the fact that with the exception of one self insurer, carriers/self insurers forwarded lump sum as opposed to taking advantage of sending intermittent payments. It is doubtful that this smooth process would have occurred without the careful and positive planning and coordinating efforts of all involved parties.

In addition to the above, there was no unavoidable delinquency by the Department associated with advising carriers and self insurers of their assessment levels. By necessity, all financial activities involving fiscal year program expenditures must correlate with those of the District's financial process. Needless to say, budgetary figures are not available at the same time that end of the year program activities conclude. Until official year end close-out is finalized and exact program expenditures are officially released by the Office of the Chief Financial Officer, it is *impossible* to establish the pro-rata share of costs for each carrier/self insurer. Historically, final expenditure data are not made available to OWC until late November or early December.

For years carriers and self insurers remained well versed concerning the District's process and they began to expect to receive the assessment notices at least 90 days following the end of the District's fiscal year. In fact, many welcomed the District's system since the arrival of our assessment letters generally occurred simultaneous to their end of calendar year/beginning of their new year processes. They were able to readily "roll-up" their financial matters involving costs associated with our program, as opposed to having to record a projected pro rata expense. Of course, changes are now effected as a result of up-front assessment as well as the requirement of a bifurcated system.

Bifurcated Assessment System

Again, major changes occurred in the Department's entire assessment process. Briefly, effective October 1, 1999, under a bifurcated assessment system, costs for administering the program and costs associated with the Special Fund are separate. Also, rather than reimbursing the program for accrued expenditures, legislative amendments require collection up-front.

There is indication in the Draft Report from the auditors that the amendments require employers and carriers to directly fund the expenditures incurred by the *Special and Administration Funds through the payment of assessments*. This information is not accurate. For clarification, the chart shown below may be useful. You will find information pertaining to "assessments vs. premium surcharges."

<i>Administrative Fund</i>	<i>Special Fund</i>
<p>The program is funded through an annual pro-rata assessment process where <i>private insurance carriers and self insured employers assume responsibility for all administrative costs.</i></p>	<p>A "Special Fund" is established for the disbursement of funds for (a) supplemental compensation for employees when an injury is a second injury; (b) the provision of vocational rehabilitation and utilization review at the direction of OWC; and (c) the satisfaction of an award, including reasonable medical expenses should an employer's solvency or other circumstances preclude the payment of benefits. Note: the second injury fund is abolished for new claims occurring after October 1, 1999. <i>Insured employers (through a surcharge based on insurance premiums) and self insured employers (via assessment based on paid losses) are responsible for all costs associated with the "Special Fund."</i></p>

Premium Surcharges/Delinquency of Premium Surcharges

The entire section in the Draft Report pertaining to "Premium Surcharges" is in error. For background, on November 30, 1999 I officially announced the new premium surcharge requirement to the insurance community nationwide. At the time of the announcement, information was forwarded concerning reporting requirements, the formula that was applied in calculating the first premium surcharge rate and schedules and formats to be used for remitting payments to OWC.

Briefly, a premium surcharge is collected from insured employers by insurance carriers as a method for assisting in satisfying obligations associated with the Special Fund. The total amount of surcharge collected by OWC from individual carriers is based on formula, the numbers of new and renewed policies and the cost of the policies. Information in the attached report provides details concerning the premium surcharge process and the associated collections by OWC. In reviewing the information, you will find the importance of being aware that (1) *legislation stipulates that surcharges can only be applied to policies written or renewed on or after October 1, 1999* and (2) *the surcharge is based on the amount of money collections made by insurance carriers—keeping in mind that insured employers may elect to pay their premiums monthly, quarterly, twice yearly, annually, etc.*

The reported delinquency of collecting "\$3.6 million in premium surcharges" is not factual and does not conform with legal mandates. A *fixed* amount of funds (as opposed to a projected amount, which is determined by formula) from insurance carriers to cover costs associated with the Special Fund is **nonexistent**.

The disclosure that "*OWC was able to collect only \$334,305 or 8.36 percent of \$3,995,002 due the Special Fund in premium surcharge assessments as of April 2000*" is erroneous. Again, a **"due and/or fixed" amount was not due**.

Significant Weaknesses in the Payment Process and Inadequate Controls in the Case Management Process

Payment Process - Particulars involving the payment process are outlined in the attached report. However, it is significant to advise that weaknesses do not exist. Since the early 1980s there have been in the range of 410 Special Fund cases. Only 48 have been under the direct purview of OWC where claims processing and decision-making (similar to actions taken by insurance carriers) can be independently effected. Currently, there are **three** claimants being paid through use of OWC's biweekly payroll system and the remaining cases 45 cases have been closed. It is necessary that this information is properly outlined in the Draft Report since the manner in which disclosures are documented by the auditor gives indication that a significant number of claimants are being paid bi-weekly.

Case Management Process - Information provided in the attached report provides details and appropriately outlines accurate facts concerning claims identified in the audit report. In the meantime, it is important to highlight that under the District's voluntary workers' compensation system, claimants [usually represented by counsel] and defense bars collaborate to resolve disputed issues involving the entitlement to benefits. When resolution is not achieved, either of the parties may elect to participate in an informal conference conducted by OWC staff. Also, hearing and appeal processes are in place for further resolution, as appropriate. OWC staff must remain an objective, unbiased entity within the entire process.

With reference to claims under the purview of the Special Fund, OWC may be restricted from conducting even some "routine" claims processing activities, especially when there is legal representation from either party and/or when claims have been adjudicated at the formal hearing/appeal levels. One example is that the auditor disclosed information pertaining to a claimant who had received medical treatment [at what appeared to have been at an excessive cost] in Switzerland. This matter was adjudicated at the formal hearing level with legal counsel representing both the claimant and the Department. In a June 30, 1992 Order, the hearing officer found that the *costs incurred for medical treatments by claimant at the Swiss Clinic were not unreasonable or excessive. Payment of claimant's medical expense was further Ordered.* Since the reasonableness and cost of the claimant's medical care had been fully adjudicated at the formal hearing level, the proper recourse of OWC was to make payment. As a result, the disclosure of the auditor that the claim had been mismanaged because OWC had honored payment of medical bills from Switzerland is not accurate.

Again, further information pertaining to claims activities is reflected in the attached report.

Inadequate Safeguarding of Surety Bonds

It is not in dispute that *non-negotiable* surety bonds have been secured in the OWC area. Although the attached report has been completed to show a corrective action measure, it is important to note that the Department remains active in coordinating with the Office of the D.C. Treasurer (the Office) for the storage of bonds. Historically, there have been serious problems involving the bonds. At one point the Office asked that OWC maintain the bonds. As recent as 3 years ago, the Office even requested that OWC delay the transfer of bonds and notify self insurers to forward bonds directly to OWC. This request was made by the Office while they extended efforts in attempts to locate misplaced or lost documents.

As indicated above, we are active in resolving all issues pertaining to the Bonds. There is optimism that the current agreed upon process with the Office will prove to be highly workable, to an extent where the original copies of non-negotiable bonds will be immediately transferred by OWC to the Office for safekeeping.

In conclusion, profound changes in the assessment process at the magnitude described above and in our attachment do not routinely occur. In having conducted an audit at such an early stage may not have properly produced expected results. Also, based on the high degree of complexity associated with operations of the program, the Department certainly can relate to the difficulty of the auditors in fully absorbing program particulars pertaining to claims processing matters in a short period of time.

Once again, we appreciate the efforts of the auditors. Yet, it is of the utmost importance for the insurance industry and other parties involved in our workers' compensation matters to view the Department's operation with a highest level of approval, lacking the benefit of any type of inaccurate information which could not only impact their business processes but also negatively affect their revenue.

In actuality, the Department remains proud of its accomplishments, to date. It is anticipated that at least a 3 year period would be required in order to adjust and/or fix processes so that any type of deficiencies beyond the control of OWC, especially as related to the complex assessment process, would not be commonplace.

I have forwarded a copy of the Draft Report to the Department's Chief Financial Officer for response to matters that are under the direct purview of that office. Meanwhile, for your reference, there are two points that may be of interest:

1. Legally there are no provisions whereby penalties can be imposed on carriers/self insurers when payments are not collected in time frames as indicated. Neither the Workers' Compensation Act nor governing rules and regulations provide such power. Provisions cite that the penalty for nonpayment of assessments is suspension or revocation of authorization to insure for workers' compensation in the District of Columbia.
2. Legislation stipulates that assessments cannot be made a part of the District's General Fund. Should the imposition of any type of late charge or penalty be considered or recommended, such would result in a useless, time consuming effort where money would be "recycled." The District would be calculating and collecting money from the entity that funds the program. So then, if interest collections are made from carriers/self insurers, the collections would be returned to the funding source (carriers/self insurers) or monies could be recorded as credits for carriers/self insurers against future program expenditures. In essence, any collected interest would not result in a benefit for the District. Ultimately, collections would be returned to the same entity that makes the late payment.

Certainly the Department cannot respond directly to matters involving "*the U.S. Treasury Current Value of Funds Rate (CVFP), which stipulates at 5 percent in the Federal Register.*" However, consideration must be given to the fact that there is no legal mechanism to ensure that collections flow and are deposited, as planned, from the insurance carriers and self insured employers for operations of the workers' compensation program that is funded by them.

I hope that the above information is beneficial. Please contact me if I may be of further assistance.

Attachment

RESPONSE TO DRAFT REPORT - WORKERS' COMPENSATION PROGRAM

Results in Brief	Summary of Recommendation
<p>Funds due from insurance carriers and self insured employers are not assessed and collected in a timely manner. Also, compliance with D.C. Law 12-571, which requires that funds must be collected by the beginning of the fiscal year, was not achieved. For example, assessment notices for payments due October 1, 1999 were not mailed to employers until December 27, 1999. As of April 10, 2000 assessments totaling more than \$3.3 million were more than 57 days past due resulting in approximately \$30,000 in lost interest revenue. An additional \$93,000 was lost in interest income because about \$3.6 million in premium surcharges were not collected timely.</p>	<p>Procedures to ensure that the assessment notices are sent out in a timely manner to ensure collection of assessments no later than October 1. This will ensure compliance with D.C. Law 12-571 and prevent taxpayer monies being used to pay for program expenses.</p>

Action Taken or Planned - See Information Provided Below. In addition, future processes associated with the yearly "up-front" assessment will be completed in a manner to ensure that letters are forwarded to carriers/self insured employers no later than September 1.

Target Date for Completion of Planned Actions - September 1, 2001.

Disagreement with the Issues/Comments

Funds due from insurance carriers and self insured employers are not assessed and collected in a timely manner.

For 18 years prior to the new legislation the assessment process was structured, as indicated below. Of significance is that the insurance/self insured community fully approved of the process:

- September 30 - Year-end activities conclude.
- October 31 - Fourth Quarter reports of the amount of paid benefits to claimants are due/received from carriers/self insurers.
- November - Appropriate information concerning fourth quarter activities is recorded by OWC and entered into the computer database. Review processes are conducted, as required, pertaining to costs associated with individual claims, amounts of expenditures, etc.
- November/Early December - Reviews of calculations, reconciliation activities, etc., are conducted; adjustments are made, as appropriate. As required, follow-up is conducted with insurers/self insurers to resolve discrepancies.

- End of November/Early December - Expenditure data are received from the Office of the Chief Financial Officer. The process of determining and assigning pro rata shares of costs for carriers/self insurers is initiated and accomplished.
- December/January - Final reconciliation activities are conducted and letters are prepared and forwarded to carriers.

It would have been *impossible* to mail assessment letters requesting reimbursement for prior year program expenditures at the time that end of the year program activities concluded without the benefit of (1) final reports from insurance carriers showing the total amount of compensation paid to individual claimants; (2) a period of review including reconciling data, coordinating with insurance carriers/self insurers; and (3) expenditure data from the Office of the Chief Financial Officer.

Another factor is that the auditor was correct in indicating that automation is not being fully utilized. Over the years, by necessity, OWC has been required to complete much of its "assessment" work manually. The antiquated IBM System 3600 was a major element in the prior processing of data. This system had been the one relied upon for years, even past the time of its usefulness as far as processing power and features. Needless to say, during recent fiscal year operations, the system was of absolute minimal use to the assessment process.

Because of the unreliable performance of the IBM System 3600, a state of the art IBM AS400 was procured. It is expected that this will allow the implementation of computer programs that will give OWC the means to avoid having to perform manual duties. As with all transitions, there are glitches to be addressed, but once the system has been fully configured and performance optimized, the slight performance problems that are currently being experienced will be eliminated.

The wealth of non-routine, meticulous "assessment-related work" accomplished during the early months of Fiscal Year 2000 represented the first effort associated with implementing the new amendments while concurrently conducting close-out of former processes. During this period it was a requirement to forward three assessment letters to self insurers and two assessment letters to insurance carriers, as follows:

Self Insurers

- (1) Letter advising of Fiscal Year 1999 actual expenditures from the Special Fund and expenditures for Administrative Costs. Reimbursement was requested based on the pro rata share of costs.
- (2) Letter requesting monies for projected Fiscal Year 2000 costs associated with the Special Fund.
- (3) Letter requesting monies for projected Fiscal Year 2000 costs associated with administering the program.

Insurance Carriers

- (1) Letter advising of Fiscal Year 1999 actual expenditures from the Special Fund and expenditures for Administrative Costs. Reimbursement was requested based on the pro rata share of costs.
- (2) Letter requesting monies for projected Fiscal Year 2000 costs associated with administering the program.

In addition to the two assessment letters forwarded to carriers, the OWC forwarded detailed information to them concerning the “new” surcharge process. (See further discussion below pertaining to the surcharge process.)

Based on information outlined above, the disclosure that *“funds due from insurance carriers and self insured employers are not assessed and collected in a timely manner”* is not all inclusive and some of the findings were not accurate. However, processes are now in place where letters (requesting up-front monies to fund costs for administering the program) will be forwarded to carriers/self insurers not later than September 1. Also, self insurers will be advised of their pro rata shares of costs for the Special Fund not later than September 1 of each year.

As of April 10, 2000 assessments totaling more than \$3.3 million were more than 57 days past due resulting in approximately \$30,000 in lost interest revenue.

The OWC notifies carriers and self insurers of their pro rata shares of payments in order to properly fund the program. Should carriers/self insurers fail to forward payments within designated time frames, the OWC’s only recourse is to contact them with a request for funds. Neither the Workers’ Compensation Act nor governing rules and regulations provide the power to penalize carriers/self insurers for “late” payments. In fact, legislation cites that the penalty for nonpayment of assessment is suspension or revocation of authorization to insure for workers’ compensation in the District of Columbia.

A “follow-up” system to collect outstanding assessments is in place. At the time that the comprehensive and frequent Collection Reports are received from the office of the Department’s Office of the Chief Financial Officer, the OWC reviews them to determine carriers/self insurers that have not forwarded checks. Telephone contact is made and, as appropriate, written documentation is prepared and forwarded by OWC to the carriers/self insurer. Generally written documentation is provided at the time that carriers or self insurers request copies of invoices.

To summarize, (a) *any lost revenue (as disclosed by the auditor)* that may have occurred as a result of not having received and deposited collections within designated time frames is beyond the control of OWC; (b) the control rests with the carriers/self insurers—the program is funded by them; (c) there is no penalty associated with payments not received in designated time frames and (d) assessment monies cannot become a part of the District’s General Fund.

An additional \$93,000 was lost in interest income because about \$3.6 million in premium surcharges were not collected timely.

The disclosure that premium surcharges were not collected timely is incorrect. There is no "fixed" amount involving the collection of premium surcharges. Detailed discussions concerning "premium surcharge" follows:

A premium surcharge is levied on insured employers by insurance carriers as a method for assisting in satisfying obligations associated with the Special Fund. So then, insurance carriers are no longer required to pay an assessment based on pro rata shares of costs to fund the Special Fund. Overall, the Special Fund is funded (1) through the collection of surcharges imposed on insured employers and (2) through the assessment of self insurers based on pro rata shares of costs.

The rate of surcharge to be imposed on employers is determined by formula. The determination is made yearly and carriers are notified of rate changes by OWC prior to the beginning of each fiscal year. The formula and computation factors follow:

Total Fiscal Year (prior completed fiscal year) reported losses of self insurers
and insurance carriers

Fiscal Year Reported Losses of Carriers ONLY

Fiscal Year Special Fund Assessment

Paid Workers' Compensation Insurance Premiums

Computations:

- (1) Determine Insurance Carriers' proportion of the total paid losses for the preceding completed fiscal year.
(Insurance carriers' paid losses divided by total paid losses = Insurance carriers proportion)
- (2) Determine the dollar amount of the Special Fund to be collected through the employer insurance premium surcharge.
(Special Fund assessment x insurance carrier proportion of total paid losses = projected amount to be collected through insurance premium surcharges)
- (3) Determine premium surcharge rate.
(Amount to be collected divided by the preceding year's paid workers' compensation insurance premiums = premium surcharge rate)

Legislation stipulates that the premium surcharge requirement is applicable for new or renewed policies written after October 1, 1999. Based on formula, up to \$3.6 million could have been generated during Fiscal Year 2000. However, in considering (a) a start-up period when all policyholders are not in position to renew policies and (b) a drastic upsurge in the number of new policyholders would not occur, in actuality \$3.6 million would not be generated over the first year. Even more important is that in coordination with the insurance community a schedule for remitting surcharge payments has been established by the OWC, where reports of surcharge payments and checks are sent from carriers on a quarterly basis.

In summarizing the above, \$3.6 million in surcharge premiums were not expected to have been remitted to OWC by insurance carriers during the period as indicated by the auditor. Monies to satisfy the \$3.6 million projection were to have been sent to OWC quarterly, based on the amount of collections from "new or renewed" policyholders.

Another point of interest is that "surcharges" are not applicable to self insurers. The self insured community satisfies requirements associated with the Special Fund by participating in an assessment process, where payments are determined based on each self insurer's pro rata share of costs.

The auditor noted in the Draft Report that *insurance carriers are required to pay surcharges on premiums collected from employers. These premiums are reported to the District's Insurance Administration Office that will then notify DOES-OWC.* This statement is not accurate. It gives indication that surcharges are based on premiums as reported to the Insurance Administration by carriers and that the Insurance Administration provides OWC with the information so that collections can be made, as appropriate. The fact is that the Insurance Administration compiles its data and shares a copy of a report with OWC concerning paid insurance premiums. Usually the report is available for distribution during the second quarter following the end of the previous fiscal year. While the report would serve as a useful tool to OWC in determining whether various insurance companies collected premium surcharges, neither the Insurance Administration, the insurance carrier nor OWC can determine the actual amount of premium surcharges that will be generated, up-front, as a result of imposing the surcharges.

Results in Brief	Summary of Recommendation
<p>Inadequate controls in the case management process such as DOES-OWC's failure to perform adequate periodic and follow-up reviews. For example, an approved disbursement was not paid for more than ten years.</p>	<p>A review of all cases to determine cases that should be re-evaluated and/or terminated.</p>

Action Taken or Planned - See Information Provided Below.

Target Date for Completion Planned Actions - See Information Provided Below.

Disagreements with the Issues/Comments

On page 7 "Benefit Payments," the auditor indicated that *DOES Assistant Corporation Counsel informed DOES-OWC on July 16, 1991 of the settlement reached with one employer and requested that payment be processed at DOES-OWC's earliest convenience. On January 8, 1993, the carrier submitted a request for reimbursement—it is unknown if an earlier request was made. This request was followed by subsequent requests for reimbursement on October 5, 1994, September 21, 1995 and February 11, 2000. Each of these requests for reimbursement referred to the prior requests and the need to be reimbursed. DOES-OWC failed to respond to the carrier's request for seven years and finally processed the reimbursement on February 22, 2000.*"

The facts of the case are, as follows:

- OWC denied petitioner's request for Special Fund Relief on February 4, 1991 and the Assistant Corporation Counsel entered appearance on behalf of the Trustee of the Special Fund in the appeal on March 7, 1991.
- On April 30, 1991, the Claims Examiner advised that the parties involved wanted to settle the claim. If unsuccessful at the formal hearing level, the Special Fund liability would have been \$100,000; a settlement offer of \$50,000 was recommended.
- At a formal hearing on June 25, 1991, the parties represented that the disputes in the case had been resolved and requested that the matter be remanded to OWC. The hearing officer dismissed and remanded the case.
- Via telephone with the carriers' attorney, the Assistant Corporation Counsel agreed to a settlement and on July 16, 1991 a memorandum from the counsel to OWC stated that the claim had been settled for \$50,000.

- On numerous occasions over the years following the agreement to settle the claim for Special Fund relief, the OWC requested a duly signed and executed settlement petition which, by necessity, would stipulate the terms of the agreement. Of particular note is that the carrier was well aware of both (a) the requirement to execute the settlement agreement and (b) the monetary benefits gained for the insurance company. Likewise, the Office of the Corporation was cognizant of the requirement to produce a settlement agreement in writing. While there did not appear to be a deliberate effort to circumvent the requirement to submit proper paper work, at one juncture the carrier elected to write letters to OWC requesting disbursement of the funds. At all times, OWC strongly encouraged the parties to work together in executing the appropriate agreement.

It was not until January 2000 that the agreement was received at OWC. Although there may have been several extenuating circumstances that contributed to the lateness of preparing and executing the agreement, the fact remains that OWC cannot participate in accomplishing tasks that are not within the realm of its responsibilities. To have initiated any action in preparation of a settlement agreement for the insurance carrier would have ultimately reflected unfavorably upon OWC, even to a degree where the action would be viewed as “a bias act upon OWC.”

Without doubt, OWC acted properly in this matter. OWC cannot arbitrarily approve the disbursement of funds until all documentation is available in order to determine the proper course of action. The disclosure of the auditor is inaccurate.

- The auditor further recommended “*review all cases to determine those that should be re-evaluated and/or terminated.*” In response:

As opposed to continuing use of a “manual and partial-automated system of control,” in March 1999 OWC created a database to record, process and track Special Fund reimbursement activities. Also, meetings have been held with external customers to discuss filing requirements in an effort to maximize the quality of services, minimize errors and ensure compliance with governing legislation. Within two weeks of receipt, reimbursement requests are processed by OWC and forwarded to the on-site Office of the Chief Financial Officer for payment.

It is not contingent upon OWC to re-evaluate and/or terminate all Special Fund cases. There are two major categories of Special Fund cases and it appears that the auditors failed to make a distinction between the two: (1) Default and (2) Second Injury Fund cases. Actual claims processing activities are conducted by OWC involving Default cases; for the most part, insurance carriers conduct claims processing involving Second Injury Fund cases.

There are systems in place to execute a full range of claims processing activities involving Default cases where reviews and follow-up are conducted especially within time frames as outlined in medical documentation of record. The disclosure by the auditors that claims processing activities are not being conducted is in error.

Of significance is that the Second Injury Fund has been abolished.

Results in Brief	Summary of Recommendation
<p>Significant weaknesses in the payment process such as a failure to (1) assess the reasonableness of claimant's medical and indemnity expenses and (2) verify the claimant's continued eligibility for program benefits. For example, we found cases where the agency paid about \$663,500 for a claimant, which included \$436,154 for a treatment received in Switzerland, and another \$196,500 in indemnity payments to two other beneficiaries on temporary injury status since 1985.</p>	<p>Procedures to ensure that the medical and indemnity expenses are reasonable, paying particular attention to claims outside of normal parameters. Justification supporting payment of large and unusual claims must be documented in the claim file.</p>

Action Taken or Planned - See Information Provided Below

Target Date for Completion Planned Actions - See Information Provided Below

Disagreements with the Issues/Comments

For clarification, it is necessary to outline some of the many adjudicatory actions that were taken with reference to the payment of benefits involving the claimant who received medical treatment in Switzerland. The disclosures of the auditor were inaccurate. In fact, continued eligibility for compensation was established, case monitoring processes were appropriately applied and payments were properly disbursed. For information, factual occurrences involving the claim for compensation are, as follows:

- On February 27, 1989, the Office of Hearings and Adjudication found that the claimant was totally disabled and entitled to continuing temporary total disability benefits from June 15, 1987 to present and continuing. Also, it was determined that the claimant was entitled to all related medical expenses, plus interest.
- The carrier was granted Special Fund Relief in the case by Order dated March 3, 1990.
- Medical care was provided to the claimant at Sibley Hospital and at a private clinic "the Clinique Bon Port" in Switzerland. As of January 24, 1991, medical bills associated with the clinic totaled \$436,154.30.
- On April 8, 1992, a full evidentiary hearing was held before a hearing officer, Office of Hearings and Adjudication. The employer and trustee of the Special Fund argued that the cost for treatment rendered outside of the United States to the claimant was unreasonable and excessive.

An independent medical examiner participated in the hearing and testified that the claimant had been referred to the clinic by treating physician in the United States. The medical examiner further opined that the cost of treatment in Switzerland is more expensive than in this country.

The claimant's treating physician also participated in the hearing and opined that due to claimant's diagnosed illness, it was necessary for to have received treatment outside of the United States so that there would be opportunity for improvement and recovery from condition.

- By Order dated June 30, 1992, the hearing officer, Office of Hearings and Adjudication issued a Supplemental Compensation Order declaring a Default. The issues were (1) whether the employer is in default of the February 27, 1989 Order for failure to pay claimant's medical expenses, as awarded; and (2) whether costs for medical treatment rendered to the claimant at the Switzerland clinic are unreasonable or excessive. Conclusion of Law - Employer and trustee are in default of the February 27, 1989 Order; costs incurred for medical treatment by claimant at the Switzerland clinic were not unreasonable or excessive. The payment of claimant's medical expenses was Ordered.

The above synopsis of the claim gives clear indication that indemnity and medical payments were issued, as appropriate. The OWC continues monitoring activities involving this claim for compensation.

The auditor disclosed inappropriate findings involving several other cases.

With reference to continuing eligibility for program benefits, two claimants have been receiving compensation payable through the bi-weekly payroll system since 1985. Eligibility for continuing benefits involving the two claims are supported by a Compensation Order and an Order from the Superior Court. (It is important to note that ONLY 3 claimants are paid through the bi-weekly system; one of the 3 is an eligible survivor—receiving death benefits.)

In recapping information involving the two claims:

- On October 30, 1985, the claimant (while carrying brick slades) sustained injury to back when fell down a flight of stairs. The claimant was a Cleaner, responsible for cutting grass and hedges, discarding trash and replacing window panes.
- In a September 30, 1987 Order issued by the hearing officer, Office of Hearings and Adjudication, the claimant was entitled to compensation in the amount of \$160.00 weekly beginning October 31, 1985 to present and continuing until there is a change in condition.

- Pertinent Medical - On February 13, 1996, the claimant was referred for an independent medical evaluation. medical problems included hypertension along with peripheral vascular disease. The past medical history included surgery for a gunshot wound to the head. A recommendation provided by the examiner was that the claimant required a comprehensive work hardening program beginning with flexibility conditioning and strengthening exercises and progress to work simulation. The examiner also opined "claimant able to return to work with limitations after completes the work hardening program. Claimant should be released to work with some limitations."
- In compliance with findings of the medical examiner, the claimant was referred for a functional capacity evaluation under a work hardening effort. Findings revealed that the claimant "is not appropriate for work hardening at this time. is a questionable candidate for return to work secondary to flat affect/cognitive status and current medical status. Would recommend a psychological consultation. Prognosis for Work Status - Poor."
- To effect change in the claimant's "continuing eligibility for benefits" status, it must be shown that the claimant is capable of work. The filing of a Motion for Modification of the Compensation Order would be required. The claimant is a 64 years old born on and has a 10th grade education. Needless to say, based on medical condition, age, educational level, and work experience as a laborer, the claimant is not a good candidate for vocational rehabilitation leading to unsubsidized employment. In the future there may be a settlement of the claim. However, the claimant will rightfully continue the receipt of compensation benefits, as appropriate.

Circumstances involving the second claim used in the auditor's sampling are almost identical to the one outlined above:

- On May 6, 1983, the claimant sustained an injury to back during the course of employment at a local restaurant. On October 28, 1983 maximum medical improvement was reached. was rated as having a 25 percent permanent partial disability of the lumbar spine due to herniated lumbar disc and as a result of surgery. The surgery included a L5-S1 laminectomy and discectomy with removal of free fragments and L4-5 laminectomy and discectomy with partial L4-5 facetectomy.
- On January 3, 1985, the claimant, receiving temporary partial disability, was awarded compensation under the Act for temporary total disability from May 12, 1983 through October 15, 1983 and temporary partial disability at the rate of \$93.00 per week from October 16, 1983 to present and continuing.
- On April 1, 1986, the claimant was granted Special Fund Relief in this matter.

- The claimant was released by physician to return to work in a light duty status. is employed on a part time basis as a cashier, averaging 25 hours per week.
- A Vocational Rehabilitation Report dated October 10, 1996 stated that the claimant dropped out of school in the 10th grade. tested in grade levels, as follows:
Arithmetic - 6; Spelling - 9; Reading - 11.

The auditor reported that the claimant's injuries were classified as temporary partial disability. In contrast, the claimant has a 25 percent permanent partial impairment of the body as a whole, which entitles to compensation based on any wage losses that are incurred while continuing part time employment.

The claimant is performing duties within her medical limitations. At the age of 56, enjoys part time job as a cashier and has no desire to seek other employment. weekly compensation is \$93.62. Being mindful that the claimant is represented by counsel, there is possibility of a future claim from the claimant and counsel for permanent partial disability benefits based on permanent wage loss. However, the Department would not concede to permanent partial disability in this matter since this would increase the fund's liability in supplemental payments for back wages and future allowances. Currently, a settlement is being negotiated and the fact that the claimant has not received permanent partial disability in this matter can be used as a leverage by the Department to negotiate a final closure of this case.

With certainty, there has not been a lack of periodic reviews nor a failure to assess the reasonableness of awards of compensation.

Results in Brief	Summary of Recommendation
<p>Inadequate safeguarding of surety bonds in the record management function. We found several surety bonds posted by self insured employers unsecured in the DOES-OWC office area.</p>	<p>That the surety bonds are sent to the Treasury and within a specified time period of receiving the surety bonds, the Treasury should inform DOES-OWC of all surety bonds it receives. Control procedures should be established to ensure that this communication occurs in a timely manner. DOES-OWC should not certify the applicants as self insured employers until they confirm with the Treasury that the surety bonds in the required amounts are received.</p>

Action Taken or Planned - OWC is actively coordinating with the Office of the D.C. Treasury to finalize a procedural structure for the maintenance and security of the non-negotiable surety bonds.

Target Date for Completion Planned Actions - December 31, 2000.

Disagreements with the Issues/Comments

N/A

Reporting Requirements

On page 7, the auditors indicated that there were problems associated with OWC's new reporting requirements. In response to this disclosure, the following is provided:

The "work-around reports" are statistical comparative reports derived from both the computer generated reports on the user side and carrier/self insured reports submitted annually. This process may appear to be laborious, but it is a type of check and balance to determine whether the statistical data reported annually by carriers and self insurers reconcile with the required forms filed during the fiscal year. Some of the data required to be reported were not automated at the time the first annual report was issued. The statistical data are now automated and a computer generated report is available.

The aging data that was referred to in the Draft Report relates to one statistical database concerning compensation cases that are paid over 500 weeks. To gather this type automated information would require programming expertise—which is not available in this Department.

OWC plans to solicit the services of a contractor who will be responsible for providing enhancements to the AS400, including programming ad hoc reports.



November 1, 2000

Charles C. Maddox, Esquire
Inspector General
Office of the Inspector General
717 14th Street, N.W.
Washington, DC 20005

Dear Mr. Maddox:

This is in response to your draft report entitled Review of the Workers' Compensation Program within the Department of Employment Services regarding the findings and recommendations on "Allocation of Personnel Cost". The Office of the Inspector General (OIG) report indicated that there was shifting of personnel cost from other programs at the Department of Employment Services (DOES) to the Workers Compensation Program and that labor distribution is erroneous.

The DOES employee's official personnel form and budget funding documents (Form 1 and Schedule A), respectively, indicate that 100% of the individual's salary as being charged to a grant or program. However, this form is not used to determine the costs charged to the Workers' Compensation Program at year-end.

The District's current payroll system, Unified Personnel and Payroll System (UPPS), does not have the flexibility to record more than one funding source or labor distribution rule per employee. The official personnel form (Form 1) that is generated from UPPS identifies the one funding source entered into the system upon the appointment of an employee. That funding source is attached to an authorized budgeted position listed on the congressionally approved Schedule A. However, all time and attendance records for the employees of DOES are dually captured on UPPS pre-printed timesheets and specialized Federal Accounting and Reporting System (FARS) Time Distribution (TD) forms. The UPPS timesheets are forwarded to the District's Office of Pay and Retirement Services (OPRS) for processing employees' payroll. This payroll information is then entered into the System of Accounting and Reporting (SOAR). The data from the specialized TD forms is keyed into the Time and Distribution Module of the FARS system by grant. FARS allocates costs based on the actual amount of time an employee works on a particular grant or program. Thus, an employee's time could be distributed to multiple grants in any given month based on the workload of that employee. Only costs



for employees working on the Workers' Compensation Program are recorded to the grant. The DOES Chief Financial Officer certifies to the Department of Labor (DOL) that the costs charged to the grant as recorded in FARS is accurate.

A reconciliation of FARS and SOAR is performed monthly. Detailed reports are generated through FARS to identify who is actually being charged to each grant. This data is then reconciled to the UPPS payroll data (previously recorded in SOAR), and corrected by journal entries to SOAR to ensure that personnel costs are recorded properly.

The OIG recommended that labor distribution on the *Personnel Action Form, Form 52*, should be correctly completed; i.e., the Agency Reporting Category (ARC) assigned to the employee should be that for the employee's actual functional responsibility at DOES.

The Form 52 currently used by the District Government will not accept more than one ARC. A majority of DOES employees provide service to more than one grant. Actual allocation of time and costs are processed through FARS and recorded to the appropriate grant.

The OIG recommended that employees who perform tasks that constitute indirect costs or tasks across program lines should not be assigned a direct cost ARC on their Form 52. Such employees should be assigned the multi-task ARC.

The FARS system does not have multi-task ARC. The FARS assigns an ARC for employees that constitute indirect costs.

The OIG recommended that once the above three steps are implemented, the discrepancy between SOARS' Administration Fund Expenditures Report for personnel expenditures (which ties to DOES Payroll Report) and FARS would be restricted to the allocation of indirect cost and multi-program cost. DOES should then reconcile these systems on a monthly basis.

This activity is currently being performed on a monthly basis. On a monthly basis, the agency reconciles the FARS Personal Services (PS) cost allocation with SOAR.

The OIG recommended that DOES should ensure that the payment of personnel expenditures by the Administration Fund is restricted to those employees who are actually involved in the administration of said program.

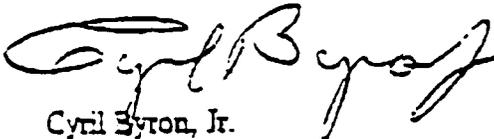
This activity is currently being performed. FARS allocates costs to a grant based on the information represented on an employee's TD. The TD reflects the number of hours an employee performed services for that particular grant. The Program Manager, verifying that the employee provided services for that particular grant, signs the TD.

The OIG recommended that DOES should work on having an integrated financial reporting system.

In August 2000, DOES contracted with KPMG to develop an interface between FARS and SOAR. The target date for completing the interface is December 2000.

If you have any further questions or concerns please contact me at (202) 724-7150.

Sincerely,



Cyril Byron, Jr.
Chief Financial Officer, DOES

cc: Narwar M. Gandhi
Chief Financial Officer

Greg Irish, Director
Department of Employment Services

Wilma G. Mathias
Director, LAIS