John Keel, CPA
State Auditor

An Audit Report on

Workers' Compensation at the State Office of Risk Management

December 2010

Report No. 11-013

State Auditor's Office

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Overall Conclusion

The State Office of Risk Management (Office) consistently paid valid workers' compensation indemnity and medical benefits within the required time lines and in accordance with state statute and rules from September 2008 through February 2010. However, it did not consistently pay the correct amount or fully recover overpayments of indemnity benefits.

The Office pays two types of workers' compensation benefits:

- **Indemnity Benefits** – These are primarily payments to compensate state employees, or their beneficiaries, for lost earning capacity resulting from a work-related injury.
- **Medical Benefits** – These are payments for reasonable and necessary medical services related to a work-related injury.

Background Information

Texas has designated the State Office of Risk Management (Office) to administer the workers' compensation program for state employees. The Office acts as the State's insurance carrier and must follow workers' compensation laws as an insurance carrier.

The Office makes medical and indemnity payments for workers' compensation claims filed by or on behalf of state employees. It also charges covered state agencies and institutions of higher education assessment fees based on a formula that includes:

- The claims history of each covered agency and institution of higher education and the related costs incurred in administrating the claims.
- The current and projected size of each covered agency's and institution of higher education's workforce and payroll.

The Office received $46,918,021 from the covered state agencies and institutions of higher education for fiscal year 2009 workers' compensation coverage.

Sources: Texas Labor Code, Chapter 412, and the Office.

Indemnity Benefits

All 37 indemnity benefit claims (claims) that auditors tested were valid. In addition, 36 (90 percent) of the 40 individual payments tested were made in a timely manner and in compliance with Texas Administrative Code requirements.

From September 1, 2008, through February 28, 2010, the Office made incorrect indemnity payments on 26 of the 37 claims auditors tested. These errors resulted in overpayments of $33,191 (2.8 percent) and underpayments of $10,520 (0.9 percent) of the $1,166,165 total payments made on these claims during this time period.

The Office has processes in place to review indemnity payments for accuracy, and it generally ensured that it paid injured employees for all identified underpayments, including interest. However, these reviews did not sufficiently identify errors in a timely manner to facilitate the full recovery of overpayments.

This audit was conducted in accordance with Texas Government Code, Section 321.0132.

For more information regarding this report, please contact Ralph McClendon, Audit Manager, or John Keel, State Auditor, at (512) 936-9500.

Identifying errors early in the life cycle of a claim is important because the Texas Administrative Code places limitations on the recovery of workers' compensation overpayments. Specifically, the Texas Administrative Code limits recoveries of certain types of indemnity benefit overpayments to only 25 percent of future benefit payments.

The Office's current processes limit its efforts to recover overpayments. The Office identified $731,643 in overpayments made on 835 claims it reviewed from September 1, 2008, through February 28, 2010. Of this amount, the Office determined that $318,519 (43 percent) was unrecoverable.

Medical Benefits

The Office made 98 percent of the 128,886 medical payments from September 1, 2008, through February 28, 2010, within the time lines required by the Texas Labor Code and the Texas Administrative Code. Additionally, all 30 medical bills tested by auditors were for valid claims, and the Office generally paid the correct amounts.

Tracking Overpayments

The Office did not efficiently track overpayments. While the Office maintained information related to indemnity and medical overpayments in spreadsheets, it did not use its Claims Management System (CMS) to capture this information in an efficient manner. More efficient tracking could help the Office better manage the amounts due to it.

Summary of Management's Response

The Office concurs with many of the report recommendations; however, it disagrees with the conclusion that it did not efficiently track overpayments.

Auditor Follow-up Comment

The Office did not specify how it will address the recommendations nor did it offer alternatives on how it will take corrective action to resolve the issues identified in this report. The State Auditor's Office stands by its conclusions based on the evidence presented and gathered during this audit.

Summary of Information Technology Review

Auditors reviewed access and change management controls over CMS and the FileNet imaging system. The Office uses CMS to track and manage workers' compensation claims, including payments to all injured workers and health care providers. It uses the FileNet imaging system to store electronic files containing confidential information related to workers' compensation claims. The Office should ensure that the controls over password configuration and access rights are

strengthened. Additionally, the Office should develop documented policies and procedures for certain business functions and improve its testing of backup restorations. All of the underlying data for the indemnity and medical payments tested was accurate, based on auditors' comparison to the supporting documentation reviewed.

Summary of Objective, Scope, and Methodology

The audit objective was to determine whether the Office has processes and related controls for workers' compensation claims that provide assurance that only valid medical and indemnity claims are paid in the correct amounts and in a timely manner in compliance with applicable laws, regulations, and Office policies and procedures.

The scope of this audit covered the Office's processes for managing state employee workers' compensation claims from September 1, 2008, to February 28, 2010.

The audit methodology included conducting interviews; collecting and reviewing information; recalculating indemnity and medical payments; and performing tests, procedures, and analysis against predetermined criteria.

Auditors also communicated other, less significant issues to Office management separately in writing.

The State Auditor's Office uses the Office for reporting and paying workers' compensation claims. However, the information in this report was subject to certain quality control procedures to ensure independence, objectivity, and accuracy.

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Detailed Results

Chapter 1

While the Office Made Workers' Compensation Indemnity Payments in Accordance with Statute and Rules, It Did Not Consistently Pay the Correct Amount or Fully Recover Overpayments

Chapter 1-A

The Office Made Indemnity Payments in a Timely Manner and in Accordance with Statute and Rules

All 37 of the State Office of Risk Management's (Office) workers' compensation indemnity claims tested by auditors were valid. In addition, the Office completed its initial reviews of all 37 claims according to its policies and procedures (see text box for information about the types of workers' compensation benefits).

The Office correctly calculated and paid 36 of the 40 individual indemnity-related payments tested, resulting in an accuracy rate of 90 percent. The 4 errors resulted in overpayments of $795 (0.2 percent of the $448,319 tested).

Of the 40 indemnity payments tested, 3 were canceled and 1 did not have timeliness requirements. Of the remaining 36 payments tested, the Office made 32 (89 percent) in a timely manner and in compliance with Texas Administrative Code requirements. Of the four payments that the Office did not make in a timely manner:

- Two were death benefit lump sum payments that were late due to processing errors. The Office made one payment of $245,336 three months late and one payment of $55,119 two days late. Both of these payments were made to the Division of Workers' Compensation at the Department of Insurance's (Division) Subsequent Injury Fund.
- One payment of $2,801 was to correct prior underpayments errors made by an Office adjuster.
- One was a $4,892 payment to an injured worker's attorney that was made 3 days late.

Auditors determined that the indemnity claims were valid if the supporting documentation agreed with the data in the Office's Claims Management System (CMS). Auditors did not assess the medical validity of the claims.

Workers' Compensation Income (Indemnity) Benefits

Workers' compensation income benefits—frequently referred to as **indemnity benefits**—compensate an injured worker for the loss of income or earning capacity resulting from a work-related injury. Indemnity benefits are usually paid on a weekly basis.

The Office reported that it received 7,926 workers' compensation claims and expended $17,177,954 for workers' compensation indemnity benefit payments for fiscal year 2009.

There are five types of indemnity benefits for which an injured worker or surviving dependent may qualify as the result of a work-related injury. These are:

- **Temporary Income Benefits** –Benefits paid if a work-related injury results in the worker missing all or a portion of his or her normal work schedule for a limited amount of time.
- **Impairment Income Benefits** – Benefits paid if a work-related injury results in a permanent impairment of the worker's body.
- **Supplemental Income Benefits** – Benefits paid if a work-related injury results in a reduced earning capacity for the injured worker.
- **Lifetime Income Benefits** – Benefits paid if a work-related injury results in certain statutorily defined losses of physical abilities.
- **Death Benefits** –Benefits paid to surviving beneficiaries if a work-related injury results in the worker's death.

Sources: Texas Labor Code, Chapter 408, and the Office's workers' compensation claim payment records.

Management's Response

The Office agrees. The Office focuses considerable resources on timely compliance with the Workers' Compensation Act and Rules promulgated by Texas Department of Insurance, Division of Workers' Compensation (DWC), as reflected in the high rate of timely payments found both in this audit sample and the 2009 and 2010 Performance Based Oversight audits completed by the DWC. The Office's timeliness of initial indemnity payments in the much larger DWC sample was validated at 95.76%. The Office strives for both accuracy and timeliness but stresses that a failure to timely pay a benefit places the Office at risk for fines of up to $25,000 per day, per violation.

Respecting the examples of untimeliness, the auditors' judgmental sample of death income benefits identified a late payment triggered by a surviving spouse's remarriage. This resulted in a change of benefits from a weekly payment to a single lump sum "dowry" payment and a final payment to the Subsequent Injury Fund. The timely-ordered weekly payment was canceled and new lump sum payments issued. The need for a $2,801 adjustment to a separate claim was identified by the Office's own audit process prior to the SAO audit, and was addressed timely when made. Respecting the attorney fee payment, the Office is unsure of the basis for the SAO's conclusion. Both the OAG and the Office were closed when an attorney fee order was sent via facsimile on January 2, 2009; it was received by the adjuster the following Monday, the 5th; payment was ordered from the Comptroller on Wednesday the 7th; and a warrant returned and mailed to the attorney on Friday the 9th, within the deadline for making such a payment.

Chapter 1-B

The Office Did Not Consistently Pay Claimants the Correct Amount of Indemnity Benefits throughout the Life of a Claim

Most workers' compensation claims (claims) consist of multiple indemnity payments, usually paid weekly throughout the life of the claim. As discussed in Chapter 1-A, the Office correctly paid the majority of the individual indemnity payments that auditors tested. However, the Office had a significantly higher error rate for payments tested on a claim basis.

Specifically, auditors tested all of the indemnity payments made from September 1, 2008, through February 28, 2010, for 37 claims[1]. Of these 37 claims tested, the Office made at least one incorrect indemnity payment on 26 of the claims. These errors resulted in overpayments of $33,191 (2.8 percent)

[1] In order to test each type of indemnity benefit, auditors randomly selected 27 indemnity benefit claims and judgmentally selected 10 claims representing the less frequent supplemental, lifetime, and death benefit claims.

and underpayments of $10,520 (0.9 percent) in the $1,166,165 total payments tested from September 1, 2008, through February 28, 2010.

Overpayments increase costs for workers' compensation coverage to affected state agencies and institutions of higher education. Underpayments may create a hardship for an injured worker because the indemnity benefits are intended to replace lost wages due to a work-related injury.

Auditors identified several basic causes for the incorrect indemnity payments. Specifically:

- 53 percent of the errors were due to Office staff making incorrect calculations.
- 25 percent of the errors were due to the employing agencies not submitting accurate wage information on a timely basis to the Office.
- 18 percent of the errors were due to physicians not submitting medical evaluations on a timely basis to the Office.
- 2 percent of the errors were due to the injured worker not submitting correct wage or other relevant information on a timely basis to the Office.
- Additionally, some incorrect payments were the result of an injured worker disputing the Office's calculation of indemnity benefits. When an injured worker and the Office disagree about the indemnity benefit amount, the worker can file an appeal with the Division. In some cases, the Division may order the Office to pay benefit amounts that differ from the amounts that the Office initially calculated. However, auditors identified some claims for which the Office did not accurately apply the Division's orders or other agreements with the injured worker.

Indemnity benefit calculations can be complex and auditors identified instances in which the Office did not receive necessary information in a timely manner related to a claim from medical providers, injured workers, and/or the injured worker's employer. Because of this, it is important that Office conduct timely and thorough reviews of indemnity benefit payments.

The Office complied with its policies and procedures for reviewing indemnity payments made on workers' compensation claims. These reviews include:

- The initial setup of the claim to verify that all of the parties involved with the claim have been contacted for information.
- Changes that occur to the claim, such as changes in indemnity type, wage information, or the injured worker's employment status.
- Verification of the correctness of payments when an Office adjuster, supervisor, or claimant requests such a review.

- Payment amounts that exceed established thresholds and require various levels of approval.

However, Office procedures do not require the initial indemnity payment calculations to be reviewed for accuracy. While the Office cannot guarantee that external parties will provide accurate and timely information to facilitate accurate indemnity payments, it may potentially reduce the number of errors by up to 50 percent if it ensures that all of the initial calculations of benefits are reviewed for mathematical accuracy.

In addition, the Office's reviews of supplemental, lifetime, and death benefit payments do not occur on a regular basis to identify payment errors. The Office's reviews of these types of indemnity benefits payments are less frequent than its reviews of temporary and impairment benefit payments. However, 6 (60 percent) of the 10 claims that auditors tested that contained supplemental, lifetime, or death benefit payments contained errors.

The errors auditors identified in the supplemental, lifetime, and death benefit payments signify a risk that these types of indemnity payments are susceptible to errors. One of the claims contained a recurring error that resulted in a total overpayment of $30,284 over the life of the claim, dating back to 2004. Another claim contained a $38,885 underpayment error dating back to 1996. The Office identified the $38,885 underpayment while reviewing the payments in response to auditors' questions. The Office paid the amount owed, including interest, to the claimant on September 28, 2010.

A third claim contained overpayments totaling $78,217 dating back to 2004. Because the overpayments were the result of an incorrect order for payment the Office received from the Division, the Office was able to request reimbursement for the overpayments from the Division's Subsequent Injury Fund after auditors brought this error to the Office's attention.

The Office does not report workers' compensation indemnity payments and related overpayment and underpayment information to the Legislative Budget Board or the covered agencies and higher education institutions. This information could assist the Legislative Budget Board with its budget preparation and forecasting responsibilities. The source of the funds used for indemnity benefit payments is the assessments paid by the agencies and higher education institutions based partly on the agencies' and higher education institutions' claim histories. The payment and error information could also assist the agencies and higher education institutions to identify and address the dollar impact of the payment errors resulting from their submission of late or incorrect information.

Recommendations

The Office should:

- Develop processes and procedures to review initial indemnity benefit calculations for accuracy, including supplemental, lifetime, and death benefit types of indemnity payments.

- Work with the external parties, including state agencies and institutions of higher education, to develop and implement processes and procedures to improve the timeliness and accuracy of critical information necessary to determine accurate indemnity benefit payments.

- Report indemnity payments—including overpayments and underpayments, the causes of errors, and underpayment recovery amounts—to the Legislative Budget Board and related injured workers' employing state agencies or institutions of higher education on a quarterly basis.

Management's Response

The Office agrees with the Chapter 1-B recommendations, bullets One and Two, as stated, but believes further context is required. Workers' compensation law places paramount importance on timely compliance and contemplates fluctuations which result in periodic payment adjustments. Carriers are required to make a timely payment even with incomplete information. See e.g. Rules 128.2, 128.3(g), 129.3(b)(2) and (3), 129.4(a). The report does not convey the variables or complexity of calculating indemnity benefits. While simple calculation errors do occur, numerous iterations and recalculations are frequently necessary. Further, timelines frequently work at cross purposes and leave a carrier with little or no chance of making an accurate payment while being required to make a timely one. See e.g. Rules 129.4 and 120.3(b), requiring timely weekly payments by a carrier while providing employers 10 days after a the pay period to report earnings changes to the carrier. State employee pay periods are generally monthly.

The Office agrees incorrect payments may occur as the result of the misapplication of available information and that errors by staff are included in the sample. However, the report uses the terms "overpayment" and "underpayment" synonymously with the terms "incorrect" and "error." A payment which is made in accordance with law, based on the available information may, in hindsight, be determined to be an overpayment or underpayment, but the payment itself cannot be categorically characterized as incorrect or in error. The report correctly notes that the Office makes payments in accordance with statutes and rules, but it nonetheless impliedly

characterizes all payments later determined to require adjustment as erroneous or inaccurate.

Identifying underlying causes is important to rectifying process deficiencies where they exist; however, the Office has not been given sufficient information on the audit findings to confirm or deny the frequency or apportionment of true errors. The Office is only able to validate 24 of the 37 claims subject to adjustment in the sample set. The Office does not significantly disagree with the overall findings of the audit as to the accuracy of payments, but the Office disagrees with the auditors' generalizations of cause for, and categorization of incorrect indemnity payments. Overpayment recovery is discussed in the Office's response to Chapter 1-C.

Respecting recommendation Three, the Office does not object, but notes the following: Any snapshot of payment categorizations are subject to substantial fluctuation due to new information received and internal and external review and actions conducted. The program administered by the Office is on a fiscal year cash basis method. Identification of adjustments is retrospective, often going back over a period of months or years as in the cases cited in the report dating back to 1996 and 2004. Any collection of an identified overpayment or correction of an underpayment is reflected in the current fiscal year's total indemnity payments. With the appropriate CMS system enhancements net adjustments could be tracked for the cumulative life of all individual claims but would have limited correlation with current period payments.

The current Claims Management System (CMS) is the Office's mainframe application written in the "Natural" programming language. This mission critical system has been in production for approximately 14 years and, while still functional, has become increasingly difficult to enhance. The Office has previously identified in its Strategic Plan the need to redesign the system to provide stable and supportable platforms which will greatly enhance the Office's ability to create and provide the recommended reports. The Office will include this reporting recommendation into the redesign of the system once authorized.

Chapter 1-C

The Office Conducted Reviews to Identify Indemnity Payment Errors Too Late in the Claim Process to Adequately Recover Overpayments

The Office has processes in place to review and identify incorrect indemnity payments. The Office generally ensures that it pays injured employees for all identified underpayments, including interest, in a timely manner. However, these reviews frequently occur too late in the claims process to facilitate the Office's full recovery of overpayments. The Texas Administrative Code specifically allows the Office to recover indemnity benefit overpayments from

future payments when the cause of the error is incorrect average weekly wage calculations. These deductions may not exceed 25 percent of any single indemnity payment unless the Office is able to enter into an agreement with the injured worker or contacts the Division for approval.

Often, however, by the time the Office identified overpayments caused by incorrect wage calculations, there were few, if any, remaining indemnity benefit payments from which the Office could recover the funds. The Texas Administrative Code does not address how the Office should recover overpayments resulting from other causes, such as an incorrect return-to-work date or the incorrect application of available leave balances used by the injured worker. See Appendix 3 for excerpts from the Texas Administrative Code related to the recovery of workers' compensation overpayments.

During the period from September 1, 2008, through February 28, 2010, the Office reviewed $15,718,430 of indemnity benefits paid on 1,294 claims and identified $731,643 (4.7 percent) in overpayments on 835 claims. These reviews included all of the indemnity payments made since the beginning of the claims. Of the $731,643 in identified overpayments, the Office recovered $290,405 (40 percent) and determined that:

- $122,719 (17 percent) was pending recovery.
- $318,519 (43 percent) was unrecoverable.

The Office's ability to recover indemnity benefit overpayments also is hindered by its interpretation of its statutory authority to recover overpayments. While the statute is silent on the ability to use other recovery methods, the Office interprets the Texas Labor Code, the Texas Administrative Code, and Department of Insurance appeals panel decisions as limiting its recoveries of overpayments to only allowable deductions from future benefits. The Office did not have an established procedure for documenting its attempts to contact the claimants and request repayment of any amounts overpaid. As a result, for claims on which all indemnity payments have been made, the Office could not provide evidence that it adequately attempted to notify the claimant and request repayment of any amounts overpaid.

While the Texas Labor Code authorizes the Office to make indemnity payments, it is understood that the payments must be correct. In addition, statute does not expressly prohibit the Office from pursuing recovery efforts beyond reducing future indemnity payments.

Recommendations

The Office should:

- Conduct reviews earlier in the life of a claim to better facilitate recoveries of identified overpayments.
- Develop and implement effective alternative methods to recover indemnity benefit overpayments.
- Seek advice from its legislative oversight committees regarding interpretation of the lack of direct statutory authority addressing recovery of indemnity benefit overpayments.

Management's Response

The Office does not disagree with the 1-C recommendations as stated, but offers clarification respecting the text of the report. The Office agrees with the audit report to the extent that it is important to recover as many overpayments as possible within the limits of applicable law. However, the report may be misconstrued to imply the amounts noted are related to the limited audit period, whereas the recoupment figures identified by the Office represent the totality of the known universe of such payments over time. The report's characterization of a lack of a recovery as a per se error in each and every case is inaccurate. As evidenced by the statutory and administrative excerpts included by the SAO in the appendices, such recoveries are permissive, not mandatory. The Office agrees that seeking recovery to the fullest of extent of law is necessary, but disagrees that the silence of the law on a remedy is either a requirement or a consent to exercise unstated authority. The payments identified by the Office as "unrecoupable" included claims in which no further benefits are due or being paid from which to recover.

The Office respectfully disagrees with the suggestion that it is the Office's own interpretation of statute, rule and case law that hinders recovery. See Appeals Panel decision No. 060318, citing Smith v. Baldwin*, 611 S.W.2d 611 (Tex. 1980). The Appeals Panel determined that nothing in the statute specifically allowed for a recoupment, citing to the Texas Supreme Court for the premise that a term used in one section of a statute and excluded in another cannot be implied where excluded.*

Chapter 2

The Office Made Workers' Compensation Medical Payments in Accordance with Statute and Rules

Workers' Compensation Medical Benefits

Under Texas Labor Code, Section 408.021, an employee who sustains a compensable injury while performing his or her duties as a state employee is entitled to all necessary and reasonable health care related to the injury.

For fiscal year 2009, the Office reported that it expended $28,840,939 for workers' compensation medical bills.

The Office makes payments to health care providers for medical bills on behalf of an injured state worker (see text box for more information). The Office made 98 percent of the 128,886 medical payments from September 1, 2008, through February 28, 2010, within the time lines required by the Texas Labor Code and the Texas Administrative Code. The majority of the medical payments not made within the required time lines were attributable to health care providers' requests for reconsiderations and reprocessing of the original billings.

Auditors tested 30 medical bills totaling $6,407 and identified 4 errors totaling $201 (3 percent). All 30 medical bills were for valid claims.

The Office has processes in place to review and identify incorrect medical bill payments. These processes include:

- An initial review of medical bills for adequate documentation and possible duplicates.
- System edit checks to identify potential errors, such as old bills, duplicates, excessive bill amounts, service date mismatches, and potential vendor problems.
- Post-payment reviews of medical bill payments, which the Office implemented in fiscal year 2010.

Additionally, the Office contracts with cost-containment vendors (vendors) to review medical and pharmaceutical bills for:

- Reasonableness and necessity of billed treatment related to the work-related injury.
- Correct billing amounts, based on the Division of Workers' Compensation's medical fee guidelines.

While the Office implemented post-payment reviews during fiscal year 2010, it stopped conducting the reviews in January 2010. Post-payment reviews are designed to provide the Office with additional assurance that payments were made correctly and to identify errors in the medical bill payments.

Recommendation

The Office should ensure that it conducts post-payment reviews of medical bill payments on a regular basis.

Management's Response

The Office agrees with the Chapter 2 recommendation, but clarifies that the post-payment review process was not terminated, but temporarily suspended in mid-January 2010 to move resources to the Medical Cost Containment Unit, which was experiencing a surge of medical billing requiring concurrent review. The post-payment audit was reinstituted on March 8, 2010 and continues.

The Office Did Not Efficiently Track Overpayments

While the Office maintained information related to workers' compensation overpayments, it did not use its Claims Management System (CMS) to capture this information in an efficient manner to manage the amounts due the Office. The Office has taken steps to address weaknesses in its tracking of overpayments, as identified in a 2006 State Auditor's Office report.[2] However, the Office should continue to strengthen its tracking of overpayments. For example, it should consider using CMS to more efficiently track the amounts of overpayments for indemnity benefits and medical bills.

Currently, the Office uses spreadsheets to track overpayments because CMS lacks dedicated data fields that would allow the Office to enter overpayments. The Office maintains comments within CMS that identify indemnity benefit overpayments; however, these comments cannot be readily queried to generate reports of overpayments for management purposes.

Using spreadsheets limits the Office's ability to ensure that the data is complete and accurate and to manage the claims payment process. In addition, the Office cannot reconcile the amounts on the spreadsheets to CMS to ensure the spreadsheets' accuracy due to the limitations of the Office's tracking processes.

Recommendation

The Office should consider modifying CMS to capture overpayment information in dedicated fields, or it should develop and implement defined procedures and controls for tracking and monitoring overpayment information and generating reports for management purposes.

Management's Response

The Office respectfully disagrees that it does not efficiently track overpayments, but agrees in principle that tracking overpayments in CMS may be more efficient. In its Strategic Plan, the Office has identified a redesign of the claims management system as a priority. Currently, the limitations of CMS do not allow for the enhancements necessary to fully implement this recommendation. The Office will include this tracking and monitoring recommendation into the redesign of the system once authorized.

[2] *An Audit Report on Expenditures at the State Office of Risk Management*, State Auditor's Office Report No. 06-043, June 2006.

The Office Should Improve Its General Controls and Documented Policies and Procedures for Its Information Technology Systems

The Office should ensure that the controls over password configuration and access rights for information technology systems are strengthened. It should also develop documented policies and procedures for certain business functions and improve its testing of backup restorations.

The Office is administratively attached to and relies on the Office of the Attorney General for information system support and administration functions. As a result, the Office must coordinate its efforts with the Office of the Attorney General to address the weaknesses discussed below.

All of the underlying data for the indemnity and medical payments tested was accurate, based on auditors' comparison to the supporting documentation reviewed. Some of the payment errors discussed in Chapter 1 were the result of the Office's staff applying information incorrectly to determine the payment amounts.

The FileNet imaging system lacks strong password controls. The Office uses the FileNet imaging system to store electronic files containing confidential information related to workers' compensation claims. FileNet does not allow system administrators to set password rules, such as requiring complexity or setting the frequency with which users must change their passwords. Auditors identified users who did not change their passwords. Allowing system administrators to set password rules would help reduce the risk that unauthorized users could gain access to the system and the workers' compensation-related information.

The Office does not properly review and limit access levels to its CMS and FileNet application or ensure that user access is appropriately modified or deleted as needed. Auditors identified users who had an inappropriate level of access to CMS and the FileNet imaging system. Specifically, auditors determined that:

- Seventeen of 138 active users had inappropriate levels of access to CMS, which the Office uses to record, process, and manage workers' compensation claims, as well as record its financial transactions.
- A total of 161 of 311 active user IDs had inappropriate levels of access to FileNet, which contains confidential information related to workers' compensation claims.

Inappropriate access can be a result of:

- Not removing access for terminated employees.
- Not changing access for users that change job responsibilities.

- The use of generic user ids.

Ensuring that users' access levels align with their assigned duties is an important control to reduce the risk that the data within the systems could be compromised. To minimize the security risks associated with this issue, auditors communicated specific details separately to Office management in writing.

The Office lacked formal, documented policies and procedures for certain essential business functions, such as user access and change management. While the Office had a draft change management policy dated July 2010, this draft policy did not address:

- Obtaining quality assurance of programming code prior to placing it into production.

- Segregating duties of the programmer from the production environment.

The Office also did not have documented policies and procedures addressing the granting, reviewing, and removing of user access to its information systems. In addition, the Office's disaster recovery plan lacked certain essential elements, including:

- The prioritization of business processes to restore and recover.

- Procedures for responding to temporary interruptions of power.

- Provisions for annual testing.

Not formalizing and documenting these essential policies and procedures increases the Office's risk that business functions may not be adequately or consistently performed by all personnel.

The Office had not ensured that user testing of FileNet backup restorations was conducted. As discussed above, the Office relies on the Office of the Attorney General for information system support. The Office of the Attorney General contracts with a third-party vendor for data center services for its FileNet imaging system, including data backup and restoration testing. The Office received assurances from the Office of the Attorney General that the FileNet imaging system's data files were successfully restored as part of disaster recovery testing; however, the Office did not ensure that the Office of the Attorney General's disaster recovery testing restored the FileNet application or verify that the application and restored data was operational. Even though it relies on the Office of the Attorney General for information system support, the Office is responsible for ensuring data integrity and that reliability risks are adequately addressed for its information technology system applications.

The FileNet imaging system contains electronic images of the supporting documentation for all of the workers' compensation claims the Office

processes. If staff could not use the restored backups, it would be extremely difficult to re-create the files. The Office would have to rely on numerous entities (injured workers, state agencies, institutions of higher education, health care providers, cost-containment vendors, and others) to re-create the supporting documentation.

Recommendations

The Office should:

- Coordinate with the Office of the Attorney General to ensure that the password controls over the FileNet imaging system include passwords that are appropriately complex; required to be changed on a regular basis by users; and comply with the security standards requirements in Title 1, Texas Administrative Code, Chapter 202.

- Document and implement a process to monitor and regularly update user access to the information technology applications that the Office uses to process workers' compensation claims to ensure that access is appropriate and is based on each user's job roles and responsibilities.

- Develop, approve, and implement documented policies and procedures for all essential business functions, including user access and change management.

- Coordinate with the Office of the Attorney General to ensure that periodical user testing of FileNet backup restorations is performed to ensure that the Office could recover from a catastrophic data or system failure.

Management's Response

The Office agrees with the Chapter 4 recommendations. Respecting recommendation Four, the Office strongly agrees with the recommendation to ensure that FileNet backup restorations are fully functional in the event of a catastrophic data or system failure, and with its interest in and responsibilities regarding data integrity and reliability. The Office offers clarification that it has repeatedly requested testing and confirmation of the successful restoration of the FileNet data; however, the third party vendor has so far provided no more than an assurance of the restoration. The Office notes that it is not a recognized party to the OAG contract, and does not have independent access or control over the services provided thereunder or in fact the data itself, to allow it to confirm a successful restoration or to perform user testing on restored data. The Office will continue to request adequate service recognition and to seek appropriate access to its data to ensure restored data is usable should a system failure occur.

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

The objective of this audit was to determine whether the State Office of Risk Management (Office) has processes and related controls for workers' compensation claims that provide assurance that only valid medical and indemnity claims are paid in the correct amounts and in a timely manner in compliance with applicable laws, regulations, and Office policies and procedures.

Scope

The scope of this audit covered the Office's processes for managing state employee workers' compensation claims from September 1, 2008, to February 28, 2010.

The State Auditor's Office uses the Office for reporting and paying workers' compensation claims. However, the information in this report was subject to certain quality control procedures to ensure independence, objectivity, and accuracy.

Methodology

The audit methodology included conducting interviews; collecting and reviewing information; recalculating indemnity and medical payments; and performing tests, procedures, and analysis against predetermined criteria.

Information collected and reviewed included the following:

- Office internal policies and procedures for receiving, processing, and paying workers' compensation claims.
- Office internal policies and procedures for information system access.
- Interviews with Office staff and management.
- Workers' compensation claim records, including medical and indemnity benefits' expenditure data.
- The Office's workers' compensation overpayment and underpayment tracking spreadsheets.
- The Office's Claims Management System (CMS) and FileNet access logs.

- Employee job descriptions.
- Employee hire and termination listings.
- CMS edit checks.
- The Office's contracts and operating agreements with cost-containment vendors.
- *Comptroller Manual of Accounts*, Volumes I and II, Office of the Comptroller of Public Accounts, September 1, 2009.

Procedures and tests conducted included the following:

- Interviewed key personnel at the Office.
- Tested workers' compensation payments for compliance with statute, rules, and Office policies and procedures, including accuracy and timeliness requirements.
- Compared claim information in CMS to source documents contained in FileNet for data accuracy.
- Reviewed Office overpayment and underpayment records.
- Tested access and security controls over CMS and FileNet.
- Reviewed CMS edit checks.
- Reviewed Office procedures for change management of information systems.
- Reviewed results of Office testing of system and data backup restorations.

Criteria used included the following:

- Texas Labor Code, Chapters 408, 409, 412, 413, and 501.
- Texas Government Code, Section 2101.012.
- Title 1, Texas Administrative Code, Chapter 202.
- Title 28, Texas Administrative Code.
- *Comptroller Manual of Accounts*, Volumes I and II, Office of the Comptroller of Public Accounts, September 1, 2009.
- Office policies and procedures.

Project Information

Audit fieldwork was conducted from April 2010 through October 2010. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The following members of the State Auditor's staff performed the audit:

- Robert G. Kiker, CGAP (Project Manager)
- Namita Pai, CPA (Assistant Project Manager)
- Michael F. Boehme, CIA, PHR
- Robert Burg, CPA
- Matthew Byrnes, CIDA
- Tracy L. Jarratt, CPA
- Ellie Thedford
- Charles P. Dunlap, Jr., CPA (Quality Control Reviewer)
- Ralph McClendon, Jr., CISSP, CCP, CISA (Audit Manager)

Appendix 2

Excerpts from Texas Labor Code, Chapter 408, Related to the Recovery of Workers' Compensation Overpayments

The Texas Labor Code does not contain provisions specifically addressing methods of recovering workers' compensation indemnity benefit overpayments. Additionally, it does not contain any provisions prohibiting deductions of medical bill payments to recover overpayments.

Texas Labor Code, Section 408.0271, requires health care providers to reimburse an insurance carrier for inappropriate charges. Texas Labor Code, Chapters 412 and 501, and Title 28, Texas Administrative Code, Chapter 109, collectively define the State Office of Risk Management as an insurance carrier for covered state agencies and universities.

Below is Texas Labor Code, Section 408.0271, related to reimbursements (auditors bolded some text for emphasis).

> Section 408.0271 REIMBURSEMENT BY HEALTH CARE PROVIDER.
>
> (a) If the health care services provided to an injured employee are determined by the insurance carrier to be inappropriate, the insurance carrier shall:
>
> > (1) notify the health care provider in writing of the carrier's decision; and
> >
> > (2) **demand a refund by the health care provider of the portion of payment on the claim that was received by the health care provider for the inappropriate services**.
>
> (b) The health care provider may appeal the insurance carrier's determination under Subsection (a). The health care provider must file an appeal under this subsection with the insurance carrier not later than the 45th day after the date of the insurance carrier's request for the refund. The insurance carrier must act on the appeal not later than the 45th day after the date on which the provider files the appeal.
>
> (c) **A health care provider shall reimburse the insurance carrier for payments received by the provider for inappropriate charges not later than the 45th day after the date of the carrier's notice. The failure by the health care provider to timely remit payment to the carrier constitutes an administrative violation.**

In addition, as shown in the excerpt below, the Texas Labor Code authorizes interest to be collected on medical services overpayments (auditors bolded some text for emphasis).

Section 413.019 INTEREST EARNED FOR DELAYED PAYMENT, REFUND, OR OVERPAYMENT.

(a) Interest on an unpaid fee or charge that is consistent with the fee guidelines accrues at the rate provided by Section 401.023 beginning on the 60th day after the date the health care provider submits the bill to an insurance carrier until the date the bill is paid.

(b) **Interest on a refund from a health care provider accrues at the rate provided by Section 401.023 beginning on the 60th day after the date the provider receives notice of alleged overpayment from the insurance carrier until the date the refund is paid.**

As shown in the excerpt below, Texas Labor Code, Section 408.027, contains provisions addressing medical bill payments to health care providers (auditors bolded some text for emphasis).

Section 408.027 PAYMENT OF HEALTH CARE PROVIDER.

(b) **The insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim.** The carrier may request additional documentation necessary to clarify the provider's charges at any time during the 45-day period. If the insurance carrier requests additional documentation under this subsection, the health care provider must provide the requested documentation not later than the 15th day after the date of receipt of the carrier's request. If the insurance carrier elects to audit the claim, the carrier must complete the audit not later than the 160th day after the date of receipt by the carrier of the health care provider's claim, and, not later than the 160th day after the receipt of the claim, must make a determination regarding the relationship of the health care services provided to the compensable injury, the extent of the injury, and the medical necessity of the services provided. If the insurance carrier chooses to audit the claim, the insurance carrier must pay to the health care provider not later than the 45th day after the date of receipt by the carrier of the provider's claim 85 percent of:

(1) the amount for the health care service established under the fee guidelines authorized under this subtitle if the health care service is not provided through a workers' compensation health care network under Chapter 1305, Insurance Code; or

(2) the amount of the contracted rate for that health care service if the health care service is provided through a workers' compensation health care network under Chapter 1305, Insurance Code.

(d) If an insurance carrier contests the compensability of an injury and the injury is determined not to be compensable, **the carrier may recover the amounts paid for health care services from the employee's accident or health benefit plan, or any other person who may be obligated for the cost of the health care services.** If an accident or health insurance carrier or other person obligated for the cost of health care services has paid for health care services for an employee for an injury for which a workers' compensation insurance carrier denies compensability, and the injury is later determined to be compensable, the accident or health insurance carrier or other person may recover the amounts paid for such services from the workers' compensation insurance carrier. If an accident or health insurance carrier or other person obligated for the cost of health care services has paid for health care services for an employee for an injury for which the workers' compensation insurance carrier or the employer has not disputed compensability, the accident or health insurance carrier or other person may recover reimbursement from the insurance carrier in the manner described by Section 409.009 or 409.0091, as applicable.

Appendix 3

Excerpts from Title 28, Texas Administrative Code, Chapters 128 and 133, Related to the Recovery of Workers' Compensation Overpayments

Title 28, Texas Administrative Code, Chapter 128, authorizes deductions of workers' compensation indemnity benefits to recover overpayments when the cause is erroneous calculations of the employee's average weekly wage. The Texas Administrative Code does not address recoveries of overpayments due to other causes, such as an incorrect date of the employee's return to work or incorrect calculations of available leave balances used by the injured employee.

Although Title 28, Texas Administrative Code, Section 128.1, limits deductions to 25 percent of future workers' compensation payments, it does allow for larger deductions if an agreement can be reached with the injured employee or with the Division of Workers' Compensation at the Department of Insurance. It also states that the deduction amount should be set so that the entire overpayment can be recovered. Below is an excerpt from this section of the Texas Administrative Code (auditors bolded some text for emphasis).

> Rule 128.1 Average Weekly Wage: General Provisions
>
> (e) If a carrier determines or is notified that the employee's AWW [average weekly wage] is different than what the carrier had previously determined (either as a result of subsection (c)(2) of this section, receipt of an updated wage statement, or by operation of other adjustments permitted/required under this title), the carrier shall adjust the AWW and begin payment of benefits based upon the adjusted AWW no later than the first payment due at least seven days following the date the carrier receives the new information regarding the AWW.
>
> (1) If, as a result of the change, the carrier owes additional benefits to a claimant for benefits previously paid at a lower AWW but the carrier is not currently paying indemnity benefits, the carrier shall make payment in this amount within seven days of the date the carrier received the new information.
>
> (2) If, as a result of the change, the carrier finds that it has **overpaid** benefits to a claimant, **the carrier may recoup the overpayment as follows**:
>
> (A) If the claimant's benefits ARE NOT concurrently being reduced to pay approved attorney's fees or to recoup a commission approved advance, **the carrier may recoup the overpayment under this subsection in an amount not to**

exceed 25% of the benefits the claimant is entitled to based upon the new AWW.

(B) If the claimant's benefits ARE concurrently being reduced to pay approved attorney's fees or to recoup a commission approved advance, **the carrier may recoup the overpayment under this subsection in an amount not to exceed 10% of the benefits the claimant is entitled to based upon the new AWW**.

(C) **If the carrier wishes to recoup the overpayment in an amount greater than that permitted by this subsection, the carrier may attempt to enter into a written agreement with the claimant or, if unable to do so, contact the commission.** In determining whether to approve an increase in the recoupment rate, the primary factor the commission will consider is the likelihood that the entire overpayment will be recouped. **The rate should be set such that it is likely that the entire overpayment can be recouped.** The commission may also consider the cause of the overpayment and the financial hardship that may reasonably be created for the claimant.

(f) The carrier shall provide notice to the employee and the commission of any adjustments to the AWW and its affect on benefits in accordance with the requirements of §124.2 of this title (relating to Carrier Reporting and Notification Requirements). In addition, if the carrier elects to recoup an overpayment under subsection (e) of this section, the carrier's notice to the employee shall identify the amount that was overpaid.

Title 28, Texas Administrative Code, Chapter 133, prohibits an insurance carrier from changing a medical billing code and from paying a billing code using a different billing code's rate. However, the Texas Administrative Code does not specifically prohibit deductions from medical bill payments to recover overpayments. Below is an excerpt of Title 28, Texas Administrative Code, Section 133.240 (auditors bolded some text for emphasis).

Rule 133.240 Medical Payments and Denials

(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

(b) For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement

based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments)

(c) **The insurance carrier shall not change a billing code on a medical bill or reimburse health care at another billing code's value.**

As shown in the excerpt below, Title 28, Texas Administrative Code, Section 133.260, limits the period during which insurance carriers can request refunds of overpayments (auditors bolded some text for emphasis).

Rule 133.260 Refunds

(a) **An insurance carrier shall request a refund within 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230** (relating to Insurance Carrier Audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or **when an overpayment was made for health care provided.**

Appendix 4

Related State Auditor's Office Work

Related SAO Work		
Number	**Product Name**	**Release Date**
08-013	An Audit Report on Performance Measures at the State Office of Risk Management	November 2007
06-043	An Audit Report on Expenditures at the State Office of Risk Management	June 2006

Copies of this report have been distributed to the following:

Legislative Audit Committee

The Honorable David Dewhurst, Lieutenant Governor, Joint Chair
The Honorable Joe Straus III, Speaker of the House, Joint Chair
The Honorable Steve Ogden, Senate Finance Committee
The Honorable Thomas "Tommy" Williams, Member, Texas Senate
The Honorable Jim Pitts, House Appropriations Committee
The Honorable Rene Oliveira, House Ways and Means Committee

Office of the Governor

The Honorable Rick Perry, Governor

State Office of Risk Management

Members of the State Office of Risk Management Board
- Mr. Ernest C. Garcia, Chairman
- Mr. Ronald J. Walenta, Vice Chairman
- Mr. Lloyd M. Garland, M. D.
- Mr. Ruben W. Hope, Jr., J.D.
- Mr. Kenneth N. Mitchell

Mr. Jonathan D. Bow, Executive Director