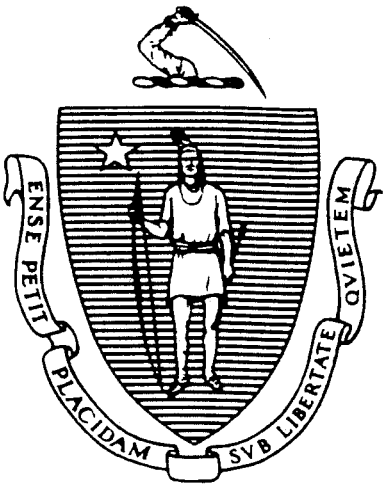

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

STATE OF THE WORKERS' COMPENSATION SYSTEM

FISCAL YEAR 1993

STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

FISCAL YEAR 1993 ANNUAL REPORT

March 30, 1994

ANNUAL REPORT
FISCAL YEAR 1993

Massachusetts Workers' Compensation Advisory Council

Current Advisory Council Members and Staff:

Chairperson **Jeanne-Marie Boylan** (Boston Sand & Gravel Company); Vice-chairperson **Edward T. Sullivan, Jr.** (SEIU, Local 254); **William Carnes** (International Brotherhood of Teamsters, Local 25); **Edmund Corcoran** (Raytheon); **James Farmer** (Glaziers & Glass Workers' Union, AFL-CIO, Local 1044); **Antonio Frias, Jr.** (S&F Concrete); **John Goglia** (International Association of Machinists & Aerospace Workers, AFL-CIO); **John Gould** (Associated Industries of Massachusetts); **Robert L. Jones** (Surety Insurance Agency, Inc.); **Christine Morris** (Secretary of Labor); **John Perry** (International Brotherhood of Teamsters, Local 82); **J. Bruce Cochrane** (Cochrane and Porter); **Gloria Larson** (Secretary of Economic Affairs); **Amy Vercillo** (Rehab Re-employment, Inc.); **Edwin Wyman, Jr., M.D.** (Massachusetts General Hospital).

Staff: Executive Director, **Matthew A. Chafe**, J.D.; Research Analysts **Jeremy Teres**, B.A., and **Ann Helgran.**

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Approved by: Philmore Anderson III, State Purchasing Agent

Recycled Paper

Advisory Council

The Massachusetts Workers' Compensation Advisory Council was created by the Massachusetts General Court on December 10, 1985 with passage of the Workers' Compensation Reform Act of 1985, chapter 572 of the Acts of 1985. Its function is to monitor, recommend, give testimony, and report on all aspects of the workers' compensation system, except the adjudication of particular claims or complaints. The council also conducts studies from time to time on various aspects of the workers' compensation system.

The Advisory Council is required to issue an annual report evaluating the operations of the Department of Industrial Accidents and the Massachusetts workers' compensation system. In addition, members are required to review the annual operating budget of the Department of Industrial Accidents, and, when necessary, submit its own recommendation.

The Advisory Council is comprised of leaders from labor, business, the medical profession, the legal profession, the insurance industry and government. Its sixteen members are appointed by the governor for five year terms and include: five employee representatives (each of whom is a member of a duly recognized and independent employee organization); five employer representatives (representing manufacturing classifications, small businesses, contracting classifications, and self-insured businesses); one representative of the workers' compensation claimant's bar; one representative of the insurance industry; one representative of the commonwealth's medical providers; and one representative of vocational rehabilitation providers.

The employee and employer representatives comprise the voting members of the council, and the council cannot take action without the affirmative vote of at least seven voting members. The council's chairperson and vice-chairperson rotate between an employee representative and an employer representative.

The Advisory Council is required by law to meet when the chairperson calls for a meeting or upon the petition of a majority of members. It usually meets on the second Wednesday of each month at 9:00 a.m. at 600 Washington Street, 7th Floor Conference Room, Boston, Massachusetts.

Meetings are open to the general public pursuant to the Open Meeting Laws (M.G.L., ch. 30A, sec. 11A½).

Studies

The Advisory Council over the years has conducted a number of studies on workers' compensation in Massachusetts. Some of these

studies were performed at the request of the legislature, and others council members chose to conduct.

The following are studies conducted by the council:

The Analysis of Friction Costs Associated with the Massachusetts Compensation System, Milliman & Robertson, John Lewis, (1989).

Analysis of the Massachusetts Department of Industrial Accidents Dispute Resolution System, Endispute, Inc., B.D.O. Seidman, (1991).

Assessment of the Department of Industrial Accidents & Workers Compensation System, Peat Marwick Main, (1989).

Medical Access Study, Lynch-Ryan, The Boylston Group (1990).

Report on Competitive Rating, Tillinghast, (1989).

Report to the Legislature on Competitive Rating, Massachusetts Workers' Compensation Advisory Council, (1989).

Report to the Legislature on the Mark-up System for Case Scheduling, Massachusetts Workers' Compensation Advisory Council, (1990).

Report to the Legislature on Occupational Disease, Massachusetts Workers' Compensation Advisory Council, (1990).

Report to the Legislature on Public Employees, Massachusetts Workers' Compensation Advisory Council, (1989).

The Advisory Council's studies are available for review Monday through Friday, 9:00 a.m. - 5:00 p.m. at the Massachusetts State Library, State House, Room 341, Boston, Massachusetts, 02133 or by appointment at the offices of the Advisory Council, 600 Washington Street, 2nd Floor, Boston, Massachusetts (617) 727-4900 ext. 378.

The Advisory Council is also in the process of conducting two studies mandated by the legislature as part of the chapter 398 reform act in 1991.

Study of Workers' Compensation Wage Replacement Rates, Tillinghast; Professor Peter Kozel.

This study will examine the impact of the 1991 legislative changes in wage replacement rates for partial and temporary total benefits under the workers' compensation law.

Under chapter 398 of the Acts of 1991, temporary total workers' compensation benefits were reduced from 66 2/3 of a

claimant's average weekly wage to 60%, while the maximum duration for collecting benefits was reduced from 260 weeks to 156 weeks. Partial incapacity benefits were reduced from 66 2/3 of the difference between the pre-injury average weekly wage and the average weekly wage the claimant is capable of earning after the injury, to 60% of that difference. The eligibility period was reduced from a maximum of 600 weeks to, under certain conditions, a maximum of 520 weeks.

The determination of optimal wage replacement rates is central to workers' compensation systems. Until the recent legislative initiative, Massachusetts utilized the standard recommended by the National Commission on Workers' Compensation Laws in 1972, which suggested that benefit levels be set at two-thirds of the injured employee's average weekly wage. However, concern with the increasing cost of workers' compensation insurance and the number of workers' compensation claims filed led to the reduction of certain benefits under the new law.

While research has shown that utilization rates increase as benefit levels rise, there are few equivalent studies that explore the impact of decreases in benefit levels. Since the change in wage replacement benefits under chapter 398 is intended to reduce costs and induce cost-saving behaviors, and because the maintenance of adequate benefit levels is of paramount importance to the commonwealth's workers' compensation system, this study will provide policy-makers with data on the new law in order to assess its impact.

Study of Workers' Compensation Insurance Rate Methodology, The Wyatt Company.

This study will evaluate the advantages and disadvantages of adopting hours worked as a methodology for establishing workers' compensation insurance premiums.

Massachusetts and most other states utilize employer payroll in establishing manual rates for employers in various industry categories. Some have argued that the payroll method of rate determination itself provides low wage employers with a competitive advantage in the marketplace. It is suggested that substituting the number of hours worked by an employer's work force will provide a more equitable policy and will result in a more competitive marketplace. This is seen to be particularly pertinent to the construction industry, where payroll disparities vary widely.

This study will provide the quantitative data needed to assess the potential implications of adopting the hours worked methodology in determining premiums for Massachusetts construction employers, as well as other key employer classes.

Claims Administration

When an employee is disabled or incapable of earning full wages for five or more calender days due to an injury, occupational disease, or death, the employer must file a First Report of Injury with the office of claims administration at the DIA, the insurer and the employee within seven days of notice of injury. If the employer does not file the required First Report of Injury with the DIA, they may be subject to a fine.

The insurer then has 14 days upon receipt of an employer's first injury report to either pay the claim or to notify the DIA, the employer, and the employee of refusal to pay.[1]

When the insurer pays a claim, they may do so without accepting liability for a period of 180 days.[2] This is the "pay without prejudice period" that establishes a window where the insurer may refuse a claim and stop payments at their will. Up to 180 days, the insurer can unilaterally terminate or modify any claim as long as they specify the grounds and factual basis for so doing. The purpose of the pay without prejudice period is to encourage the insurer to begin payments to the employee instead of outright denying the claim.[3]

After a conference order or the expiration of this 180 day period, the insurer may no longer unilaterally stop payments. The insurer must request a modification or termination of benefits based on an impartial medical exam and other statutory

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[1] If there is no notification or payment has not begun, the insurer is subject to a fine of $200 after 14 days, $2,000 after 60 days, and $10,000 after 90 days.

[2] The pay without prejudice period may be extended up to one year under special circumstances. The DIA must be notified seven days in advance.

[3] According to MGL 152 §8,"An insurer may terminate or modify payments at any time within such one hundred eighty day period without penalty if such change is based on the actual income of the employee or if it gives the employee and the division of administration at least seven days written notice of its intent to stop or modify payments and contest any claim filed. The notice shall specify the grounds and factual basis for stopping or modifying payment of benefits and the insurer's intention to contest any issue and shall state that in order to secure additional benefits the employee shall file a claim with the department and insurer within any time limits provided by this chapter."

requirements. A discontinuance or modification of benefits may take place no sooner than 60 days following referral to the division of dispute resolution.

Dispute Resolution Process

Requests for adjudication may be filed by either an employee seeking benefits, or an insurer seeking a modification or discontinuance of benefits following the payment without prejudice period. The claim can be resolved at any point during the DIA's three step dispute resolution period either by voluntary means (which may include a lump sum settlement) or by the decision of an administrative judge or administrative law judge.

At any point in the process, conciliators and administrative judges may review and approve any lump sum settlements negotiated. More commonly, however, settlements are approved at a lump sum conference conducted by an administrative law judge[4] after a determination the lump sum is in the employee's best interest.

Dispute resolution begins at **conciliation**, where a conciliator will attempt to resolve the dispute by informal means. Disputes should go to conciliation within 15 days of receipt of the case from the division of administration.

Disputes not resolved at conciliation are then referred to a **conference** where it is assigned to an administrative judge who must retain the case throughout the process if possible. The insurer will pay an appeal fee of 65% of the state average weekly wage (SAWW), or 130% of the SAWW if the insurer fails to appear at conciliation. The statute requires the conference to take place within 28 days of the receipt of the case by the division of dispute resolution. The purpose of the conference is to compile the evidence and to identify the issues in dispute. The administrative judge may require injury and hospital records as well as signed statements from the employee and any witnesses. The administrative judge is required to make a decision within seven days of the conclusion of the conference. This order may be appealed to a hearing within 14 days (which, by statute, is to take place 28 days after the appeal is received).

At the **hearing**, the administrative judge reviews the dispute according to oral and written documentation. The procedure at a hearing is formal and a verbatim transcript of the proceedings is recorded. Witnesses are examined and cross-examined according to modified rules of evidence. A decision is required within 28 days

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[4] An administrative judge (AJ) presides over conferences and hearings. The administrative law judges (ALJ) preside over the lump sum conferences and appeals of hearings decisions at the reviewing board. The ALJs are required to have a law background whereas it is only recommended for an AJ.

of the conclusion of the hearing. The administrative judge may grant a continuance for reasons beyond the control of any party.

Either party may appeal the hearing decision within 30 days. This time limit may be extended up to one year for reasonable cause. A fee of 30% of the state average weekly wage must accompany the appeal. The claim will then proceed to the reviewing board where a panel of administrative law judges will hear the case.

At the **reviewing board,** a panel of three administrative law judges will review the evidence presented at the hearing and may ask for oral arguments from both sides. They can reverse the administrative judge's decision only if they determine that the decision was beyond the scope of authority, arbitrary or capricious, or contrary to law. The panel is not a fact finding body, although it may recommit a case back to an administrative judge for further findings of fact.

All cases from the dispute resolution process may be enforced by the Superior Court of the Commonwealth. Cases may also be appealed to the Appeals Court or the Supreme Judicial Court. The cost of appeals are reimbursed to the claimant (in addition to the award of the judgement) if the claimant prevails.

Alternative Dispute Resolution Measures:

Arbitration

At any time prior to five days before a conference, the case may be referred to an independent arbitrator. The arbitrator must make a decision whether to vacate or modify the compensation pursuant to §12 and §13 of chapter 251. The parties involved may agree to bring the matter before an independent mediator at any stage of the proceeding. Mediation shall in no way disrupt the dispute resolution process and any party may proceed with the process at the DIA if they decide to do so.

Collective bargaining

An employer and a recognized representative of its employees may engage in collective bargaining to establish certain binding obligations and procedures related to workers' compensation. Agreements are limited to the following topics: supplemental benefits under §34, 34A, 35, 36; alternative dispute resolution (arbitration, mediation, conciliation); limited list of medical providers; limited list of impartial physicians; modified light duty return to work program; adoption of 24 hour coverage plan; establishing safety committees and safety procedures; establishing vocational rehabilitation or retraining programs.

Summary of Benefits under Chapter 152

An employee who is injured during the course of employment, or suffers from work related mental or emotional disabilities, as well as occupational diseases, is eligible for workers' compensation benefits. The largest expense for benefits is the weekly indemnity payments which provide compensation for lost income during the period the employee cannot work. Indemnity payments vary, depending on the average weekly wage of the employee (AWW) and the degree of incapacitation.

In addition to direct indemnity payments, the insurer is required to furnish the worker with adequate and reasonable medical and hospital services, and medicines if needed. The insurer must also pay for vocational rehabilitation services if the employee is determined to be suitable by the DIA.

The following are the various forms of indemnity and supplemental benefits employees may receive, depending on their average weekly wage and their degree of disability:

Temporary Total Disability (§34): Compensation will be **60% of the employee's average weekly wage (AWW)** before injury while remaining above the minimum and below the maximum payments that are set for each form of compensation. The maximum weekly compensation rate is 100% of the state average weekly wage (SAWW), while the minimum is 20% of the SAWW. The limit for temporary benefits is **156 weeks.**

Partial Disability (§35): Compensation is **60% of the difference** between the employee's AWW before the injury and the weekly wage earning capacity after the injury. This amount cannot exceed 75% of temporary benefits under §34 if they were to receive those benefits. The maximum benefits period is **260 weeks** for partial disability, but may be extended to 520 weeks.

Permanent and Total Incapacity (§34A): Payments will equal **2/3 of AWW** before the injury following temporary (§34) and partial (§35) payments. The payments must be adjusted each year for cost of living allowances (COLA benefits).

Death Benefits for Dependents (§31): The widow or widower that remains unmarried shall receive 2/3 of the worker's AWW, but not more than the state's AWW or less than $110 per week. They shall also receive $6 per week for each child, as is the case for the other forms of compensation (this is not to exceed $150 in addition to normal compensation). There are also benefits for other dependents. The limit on benefits paid to all dependents cannot exceed 250 times the state AWW plus any cost of living increases (COLA). Children under 18 may, however, continue to receive payments even if the maximum has been reached.

Burial expenses may not exceed $4000.

Supplemental (§36): There are also additional benefits to compensate for injuries such as loss of an eye, hearing, amputation, and scars on the face, neck and hands. Each payment is calculated according to the loss. For example, the loss of use of a foot would be compensated at the rate of 29 times the state AWW.

Subsequent Injury (§35B): An employee who has been receiving compensation, has returned to work for two months or more, and is subsequently re- injured, will receive compensation at the rate in effect at the time of the new injury (unless the old injury was paid in lump sum). If the old injury was settled with a lump sum, then the employee will be compensated only if the new claim can be determined to be a new injury.

Section 1: Department of Industrial Accidents

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Office of Claims Administration

The office of claims administration consists of the processing unit and the data entry unit (OCA) (where all DIA forms are reviewed and entered into the database), the record room (where all case records are filed and stored), and the first report compliance office (where fines are levied and collected). It is the responsibility of the Deputy Director of Claims Administration to answer all subpoena requests, certified mail and file copy requests. During FY'93, the office was also responsible for running the mail room.

Claims administration is responsible for reviewing, maintaining, and recording the massive number of forms DIA receives on a daily basis, and ensuring that claims forms are processed in a timely and accurate fashion. Quality control is the office's highest priority and is essential to ensure that each case is recorded in a systematic and uniform way.

At the close of FY'93, a backlog existed in the entry of some forms not pertaining to a scheduled appearance before the division of dispute resolution. Moreover, the record room was filled beyond capacity with a volume of material and case files breaching the walls of the room. Older case files have been reported missing as a result of this overcrowding.

Claims Processing Unit

The processing unit must open, sort, and date stamp all mail that comes into OCA. It then must review each form for accuracy, and return incomplete forms to the sender. Forms are then forwarded to data entry operators who enter each form into the Diameter database.

Data Entry Unit

The data entry unit enters all of the forms and transactions into DIA's Diameter database. As data entry personnel update the computerized records with new forms, they review the entire record of each claim being updated, both to ensure that duplicate forms are not contained in the database and that all necessary forms have been entered properly. While quality control measures slow down the entry of cases into the system, they are necessary for accurate and complete record keeping. Forms are entered in order of priority, with the need for scheduling at dispute resolution as the main criteria. All conciliations are scheduled upon entry of a claim through the Diameter case tracking system.

There is a backlog in the processing of some forms in the data entry unit. Because the volume of forms received on a daily basis is so high, forms are grouped and prioritized. Any form

that involves a meeting before the division of dispute resolution, such as a claim requiring a conciliation, must be entered within 24 hours.

Other forms, however, are entered as time allows. Many insurer forms and First Reports of Injury are relegated a lower priority and their entry has been delayed by as much as five months. At the close of fiscal year 1993, the OCA Weekly Report for week ending July 2, 1993 indicated the following delays: last date entered for First Report, April 6; Insurance Pay forms, February 17; Insurance Deny forms, February 8; and five other insurance forms with last date of entry in March.

According to the office, delays are unavoidable because of the volume of forms and the detail of information collected for each case. To help alleviate this problem, one temporary worker from the Department of Revenue (DOR) has been loaned to OCA for the exclusive purpose of processing first reports of injury. Because DOR relies on data on first reports filed to enable them to pursue "deadbeat dads" in delinquency payments for child support, this relationship constitutes a free exchange.

Delays are not new to the data entry unit, and the administration is now seeking ways to confront this problem. Much of the process could be automated with scanners and other time saving devices that will modernize the department and allow the capacity to increase. Plans to automate the processing unit and modernize the record room may be realized in the near future.

First Report Compliance Office

All employers are required to file a First Report of Injury (Form 101) within seven days of receiving notice that an employee has been disabled for at least five days. The first report compliance office issues fines to employers who do not file the First Report form in the allotted time.

Fines accrue at $100 per day, and rise to $200 per day when collection goes into demand status. Employers may appeal fines to the first report compliance officer for preliminary review. If the fine is sustained, then an appeal may be heard by the director of administration.

In fiscal year 1993, $85,707 was collected in fines out of 1,496 bills sent.

In FY'93, as in previous years, the majority of fines were contested. Out of 439 first report appeals, 151 fines were waived. Employers pursued the appeal process to the hearing stage in 69 cases, which resulted in 22 fines waived.

According to the office, many employers are unaware of their responsibility to file the First Report with DIA because their insurance company handles most aspects of an employee's injury

claim. Other employers simply ignore the filing of first reports of injury even though they know it is their responsibility.

The office also records on a separate database cases that are suspected of being fraudulent. Information is obtained from many sources (including the public, a DIA judge or employee), and the database is shared with the Insurance Fraud Bureau and the Attorney General's Office.

In addition, the first report compliance officer is responsible for recording in the database third party liens from the Department of Public Welfare, as well as notices of bankruptcy.

Record Room

The record room, located in DIA's Boston office, is responsible for filing, maintaining, storing, retrieving and keeping track of all files pertaining to a case in the dispute resolution process. Included in case files are copies of all briefs, settlement offers, medical records, and supporting documents that accumulate during the dispute resolution process. Couriers transfer files to and from the regional offices and Boston twice a week.

Records are kept in DIA's Boston office for about five years, depending on space. After this time they are brought to the State Record Center in Dorchester where they are kept for 80 years. Employees continuously box the files in preparation for storage at the State Center in an effort to create space in the record room itself.

An overall lack of space and storage facilities impedes the organization of the record room. Many of the files become very large as a hard copy of every document must be saved in them. Larger case files called "red ropes" (because of the accordion folders they are stored in) are retained in a different section of the room because they do not fit in their original place. File folders become tattered and worn down as they are stored in cabinets not suited to handle so many folders. This makes it more difficult and time consuming for their filing and retrieval.

Because conciliators, judges, and vocational rehabilitation officers frequently request case files, they must be easy to retrieve. It is essential that every document be accounted for, and with the current facilities, this is a slow process.

OCA is currently attempting to modernize the record room, along with the automation of data processing. They have put out proposals to modernize its storage and filing facilities similar to that of many hospitals. This would create greater capacity and efficiency for the storage of case files.

DIA Diameter Reports

The Diameter system at the DIA is the central database for all information regarding workers' compensations claims. The database tracks each case from the initial First Report of Injury to the conclusion of the case (conference order, hearing decision, withdrawal, or settlement). The database contains information regarding the claimant, insurer, as well as scheduled dates for dispute resolution and any dispositions issued.

Many of the statistics used in the annual report are from reports that originate from this database. The data processing unit handles all requests for information and runs the reports from the computer.

Reports for dispute resolution (conciliation, conference, and hearing) can be run by either *scheduled date* or *disposition date*. The difference between the two is that data pertaining to cases may be entered either according to the date a case was scheduled for a particular meeting, or according to the date of disposition. A disposition refers to the end result of the meeting whether the claim is withdrawn, resolved, rescheduled or referred for that stage of dispute resolution.

All the reports collected for the annual report are by *scheduled date* to remain consistent with previous annual reports and to make the data collection as consistent as possible for each department. The dispute resolution department now uses *disposition dates* for their internal analysis, while the conciliation department uses *scheduled date*.

Conciliation reports note whether cases originate from the employee or the insurer. According to these reports, an employee request for compensation is referred to as a *claim*, whereas an insurer's request for a discontinuance or modification is referred to as *complaint*.

For the purpose of the annual report, use of the term "claim" refers to a request for adjudication originating from either the employee or the insurer. We do not distinguish between the employee (claim) and the insurer (complaint).

Conciliation statistics are also available in two reports that differentiate between "finished" and "unfinished" cases. DIA report 17 only includes data for finished cases while Report 16 has two categories of "unfinished" cases, one for "no disposition entered" which may capture the lag in data entry or other minor discrepancies. The other "unfinished" category is to allow for reschedules.

The term "finished cases" is not used on conference and hearing reports because a judge may reschedule a case off the

computer system without creating a disposition for that action. Furthermore, conference and hearing dispositions do not necessarily indicate the case is completed, it just means it has finished one process.

Conciliation

The main objective of the conciliation process is to remove from the dispute resolution system those cases that can be resolved on an amicable basis. Conciliation requires that cases have the necessary documentation to substantiate the dispute and a conciliator is empowered to withdraw or reschedule a case until adequate documentation is presented. About half of the cases that proceed through conciliation are "resolved" as a result of this process. Such resolved cases take on a broad range of dispositions[5] including withdrawals, lump sums, and conciliated. The other half of the cases at conciliation are referred to a conference.

The Conciliation Process

Conciliations are scheduled automatically by computer at the office of claims administration. They usually take place less than 15 days after the OCA receives a request for modification/ discontinuance by the insurer or a claim for benefits by an employee. The insurer and employee are required to attend the conciliation, although the employer and other third parties involved (such as a doctor) may choose to attend as well.

In the Boston office, conciliations are scheduled for a certain day and time, but the case is directed to the first available conciliator. This is more efficient than the previous system of scheduling each conciliator with a set number of cases per day because it is difficult to determine how long a particular conciliation will last. Each conciliation may range from five minutes to almost an hour, making it difficult to accurately schedule a given number of cases per conciliator. In the regional offices, individual conciliators are scheduled for particular meetings every day.

Due to this scheduling format in Boston, conciliators do not have an opportunity to review the dispute beforehand. They must quickly review the information before the discussion begins, making it more difficult to review all the background information. This may impede the understanding of the case, but in most circumstances it is not necessary that the conciliator know the details of each case. Each case is distinct in its content, but it must be reviewed in a consistent manner. The conciliators ask for documentation to substantiate the dispute and they initiate

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[5] A *disposition* refers to the conclusion or end result of a particular process or meeting. The disposition of a case does not necessarily mean it is completed entirely, but reflects the conclusion of a particular meeting whether the case is "referred" or "conciliated."